

Knowledgeshare

Reviews

Transcultural Health and Social Care: development of culturally competent practitioners

Irena Papadopoulou (ed)

Churchill Livingstone Elsevier: London,
ISBN: 978-0-443-10131-1, 2006, 351 pp

Transcultural or cultural competence is considered by experts in the field to be a health and social care imperative in the 21st century. Practitioners involved in delivering healthcare services to an increasingly diverse population, in many healthcare contexts and often with limited resources, are expected to deliver care that is culturally sensitive and culturally competent. This timely book, which considers the development of transcultural nursing and achievement of cultural competency, is a welcome contribution to the body of transcultural nursing literature. It combines intellectual rigour with a caring approach in considering the sensitive issues facing health and social care workers today, many of whom face challenges in providing services to clients and communities across cultures.

The book takes a structured approach to the concept of cultural competency by first considering culture-generic competency before moving to examine the development of culture-specific competency. Cultural development is examined through a professional discourse that includes European and global perspectives. The book draws on the work of key writers in the field along with other professions aligned to health and social care. In doing so, the book is neither parochial nor uniprofessional, providing as it does a multinational perspective on transcultural care.

The book explores culture-generic competence under four headings: 'Part one: Transcultural health care and the development of culture-generic competencies' provides the context for the debates throughout the book by discussing the Papadopoulou, Tilki and Taylor model of cultural competence. The authors argue that while progress has been made in the last 10 years in relation to the development of cultural competence, much still needs to be done, especially with regard to the development of client assessment tools to include 'culture assessment'. The model of cultural competence proposed provides the means to

engage practitioners in a meaningful way with the concept of cultural competence and its application to practice, and provides the structure through which transcultural nursing care can be improved. Human rights and health inequalities, migrants and refugees, and the ethics of culturally competent health and social care are discussed, focusing in particular on the effects and impact of policies and legislation on the experience of clients from multicultural backgrounds. Part one concludes with a discussion of cultural competence within the context of research. Papadopoulou argues that the model for developing cultural competence is equally applicable and transferable to the domain of research.

Part two of the book draws on a number of studies focused on the development of culture-specific competencies in a range of care settings. 'Cancer and culture: meaning and experiences' uses a broad explanatory framework for considering variations in cancer incidence, including artefact, material, social selection, migration, racism, genetic, and cultural explanations. The health and social care needs of Ethiopian asylum seekers and refugees living in the UK are considered by looking at British immigration legislation and its impact on the ethno history of Ethiopia. Notions of motherhood and the maternity needs of Arab Muslim women are considered by exploring patterns of communication between maternity practitioners and Arab Muslim users of the UK NHS. An insight is then given into illegal drug use: knowledge, attitudes and drug habits of the Greek and Greek Cypriot youth living in London. Finally, culturally competent health promotion for minority ethnic groups, refugees, gypsy travellers and New Age travellers in the UK is discussed. In Part three the book turns to European perspectives on cultural competence and develops the reader's understanding of the wider issues facing practitioners working with multi-ethnic groups. Health and healthcare issues affecting individuals in Finland, Germany, Greece, and Spain are considered. The final section of the book ('Global perspectives and cultural competence') expands the discussion into a global setting. Healthcare decision making and service provision in the Muslim Arab world, transcultural healthcare in Israel, transcultural nursing in Australia, and culture and health in Canada provide a useful international perspective. 'Reflections and conclusions' draws together the issues, clarifies the debate and points the way forward for transcultural nursing and the development of cultural competence in the 21st century.

This is an insightful and challenging book, which contextualises the debates around cultural competency. Its unique approach to the topic, which draws on expert knowledge from a multiprofessional perspective and a multinational context, succeeds in delivering a comprehensive resource for all practitioners, lecturers and students concerned with the challenge of delivering culturally competent healthcare.

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Doing Research with Refugees: issues and guidelines

Bogusia Temple and Rhetta Moran (eds)

The Policy Press: Bristol, ISBN: 10-86134-598-4, 2006,
215 pp

The title of this book led me to expect something rather dry which would only be of interest to academics actively engaged in very specific research. I was surprised, therefore, to find it a lively, accessible book with a humane and open approach to the subject.

Arranged as a series of 11 essays arising from seminars hosted by the Economic and Social Research Council (ESRC), each chapter looks at a different aspect or issue that can arise, using the author's research experiences. Perhaps inevitably, communication and language are strong central themes throughout the book, and some of the solutions, which look beyond the use of interpreters and at a greater collaboration with refugees, are very interesting not only for researchers, but for a wider audience as well.

The pitfalls that a researcher might encounter with this group are discussed with refreshing honesty in several chapters. These unique insights, based on experience and the ways in which the authors seek to resolve them, provide some of the highlights of the book. There is a particularly useful discourse on hierarchies and how researchers can manage to access a truly representative sample in social groups, which are sometimes hard to infiltrate. For any potential qualitative researchers, the illuminating chapter by Harris and Robert on facilitating research with disabled refugees is a must.

The book is well researched and has good references for readers using it as an academic resource. It also has clear methodological directions and includes the 'Eliciting the views of refugee people seeking asylum' guidelines at the back. More significantly, in my view, is the fact that it also provides a thorough introduction to the world of refugees, with plenty of context and background data included in each chapter. By the end,

it has given the reader a rounded view of the problems they face and the reasons why these are so relevant in a research setting.

The book's authors offer a moral and sensitive approach to the subject of researching a group of people facing poverty, homelessness and social deprivation, which includes looking at issues of remuneration and assistance during the research. The chapter on 'Action learning' challenges the role of researcher in a community which is in desperate need of support, and raises questions about the nature and purpose of research in this setting.

In conclusion, this is a useful and thorough guide for anyone planning to undertake research in this area. It allows the reader to benefit from the authors' considerable experience in their chosen fields and to share their solutions. On another level, it is a fascinating read for anyone interested in refugees, as these problems can arise in any area (particularly in health and social settings) and the creative ways of solving them would be helpful beyond the arena of research. Finally, it is a thought-provoking and sometimes moving account of a diverse group of people who have used research in an attempt to give refugees a greater voice in society.

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Seminar and conference reports

Anti-terrorism laws: the experiences of the Irish and Muslim communities in the UK – report of a seminar held at Birmingham University 21 April 2006

This seminar was organised jointly by the Commission for Racial Equality (CRE) and the Centre for the Study of Ethnicity and Culture at Birmingham University as part of the CRE's Safe Communities Initiative. Both Irish and Muslim speakers addressed the experiences of their communities and how both had been labelled as enemies of the state. Participants received copies of the CRE's *Defeating Organised Racial Hatred* information pack.

Overall this day was rather disappointing. Many presentations were rushed and it was difficult to see clearly what points were being made. What emerged was a feeling that, yes, there were similarities between the experiences of the two communities in the wake of violence and the reactions of the state, both of which worked to suppress political dialogue. The reactions of the state to the civil rights movement in Northern Ireland and the subsequent development of anti-terrorist

legislation laid the basis for the current vilification of Muslims and Islam. On one level, the Irish and Catholicism have been supplanted by Muslims and Islam as the enemies of the state. Muslims feel beleaguered, look inwards into their communities and religion and some are clearly, and justifiably, both very angry and afraid. However, these analyses, interesting though they were, produced no specific ideas for a way forward, which was a pity given that there was at least one veteran peace campaigner from Northern Ireland among the audience.

On another level, it could be argued that each community must find its own way to peace, but this seminar missed an important opportunity to establish a meaningful dialogue which might have benefited both. The position of the Irish in Britain has changed, mainly through the use of political dialogue, but also through other channels. The increased prosperity of Ireland and changes in social attitudes among the British mean that while discrimination remains, it is far less overt. Certain aspects of Irish culture are now considered trendy and though these may not reflect the reality of Irish lives, being Irish is no longer a cause to keep silent about one's ethnicity. English Catholicism has also been re-evaluated. Discrimination remains and Catholics are still barred by law from certain positions but, with many high-profile converts, being Catholic has become what some might regard as almost a fashion statement. How and why have these changes occurred? What social and political processes facilitated their passage? Addressing these questions might have yielded some valuable insights but instead I was left simply wondering who will be next in the frame when it is no longer the Muslims' turn.

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The Inaugural Lesbian, Gay, Bisexual and Transgender Health Summit

The Inaugural Lesbian, Gay, Bisexual and Transgender (LGBT) Health Summit, which took place in June 2006 at Guy's Hospital London, highlighted significant health issues and inequalities for these communities. The summit was groundbreaking for two reasons: it was attended by key stakeholders from the Department of Health and it included transgender issues.

In his plenary address, Surinder Sharma, Director of Equality and Human Rights for the Department of Health, said: 'I am delighted to be chairing one of the sessions so I can hear first-hand both the successes and the challenges for the NHS in meeting the needs of the LGBT community'.

The summit premiered a commissioned film on transgender people's experiences of health services, which will form the basis of a training resource on transgender health to be developed in partnership with Health First, the NHS health promotion agency in South East London. A substantial number of transgender people were encouraged to attend because the summit's commitment to transgender health was explicit. The summit also showed the Department of Health's new web-based films for raising awareness of LGBT health issues – *Real Stories, Real Lives*.

One hundred and fifty delegates from across the UK attended the summit, including health professionals from the statutory and voluntary sectors, LGBT researchers, health activists and members of the LGBT strand of the Metropolitan Police Diversity Directorate. Health was thus broadly conceptualised to include community safety – particularly relevant as the summit took place in the same week as the sentencing of the two killers of Jody Dubrowski (Jody Dubrowski was a 24-year-old gay man who was beaten to death in a homophobic attack in London in October 2005). Workshops included presentations on disability, crime, mental health, the impact of stereotypes and identity, ageing, young people, smoking, drugs, alcohol, lesbian and transgender health issues.

A panel of the devolved nations presented some of the innovative work in LGBT health taking place across the UK. The Scottish Health Inclusion Project, working jointly with NHS Scotland, has led the way by commissioning research and reports, producing good practice guides, LGBT research guidelines and a research database. The Welsh Assembly and the Equality Commission in Northern Ireland are also seeking to provide appropriate healthcare to meet the needs of LGBT people. In England, the Department of Health has established a Sexual Orientation and Gender Identity Advisory Group to assist in the development of a national agenda on LGBT health through four work-streams: Better employment, Inclusive services, Transgender health and Reducing health inequalities. The Department of Health has outlined its commitment to promoting equality for LGBT people in both health and social care. A strategy for social care has yet to be initiated; it might include issues such as domestic violence, fostering and adoption, services for older LGBT people and LGBT people with learning disabilities. In social care, it is in voluntary sector agencies, such as Age Concern and Broken Rainbow, where innovations have taken place.

The summit was timely because it took place at the end of the government's consultation process on its proposed amendments to the Equality Act 2006 which will prohibit discrimination on the grounds of sexual orientation in the provision of goods, facilities and services. The work reported here will contribute to

improved access to and delivery of appropriate services in health, education and other public functions.

RELEVANT WEBSITES

- www.ageconcern.org.uk
- www.broken-rainbow.org.uk
- www.dh.gov.uk/equalityandhumanrights
- www.lgbthealthscotland.org.uk

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Practice report

Enhancing care for Muslim patients in Bradford

Bradford is a city boasting a rich multicultural population of 500 000, including 75 000 Muslims, the largest proportion of the South Asian community. The referral of Muslim musculoskeletal patients to the physiotherapy department is approximately 1830 per year. This initiative was specifically looking at improving the service for this group of patients. The resulting leaflet, *Taking Care of your Health, Islam & Chronic Pain Information Leaflet for Muslim Patients*, which uses Islamic teachings, provides religious backing for physiotherapy and physical rehabilitation and explains to patients that they are not compromising their religious beliefs by accepting treatment.

For chronic pain patients, decreased physical activity, loss of work and reduced sports and hobbies result in physical deconditioning. This can result in other health problems, e.g. heart disease, diabetes and asthma, and so both physical and mental health can be affected. Thus it is vital for patients to be able to undertake stretching and strengthening exercises, to restore fitness and health.

The Chronic Pain Rehabilitation Team, Bradford Teaching Hospitals Trust, highlighted a lack of understanding by professionals and some of the Muslim patients attending for treatment in the physiotherapy department. Resources were not being used to best effect, and although a first class service was being provided to the majority of patients, for a minority it was not being effective. While language problems could be addressed, these were not the main barrier. Rather, it was the need for professionals and patients to have a shared understanding of the outcome of care and treatment. The lack of understanding that physiotherapy and the rehabilitation process will involve undertaking active exercises

and self-management was also a difficulty. In addition, in the Islamic faith, it is a virtuous act to take over the care of a relative who is sick or in pain, thus encouraging the patient's physical inactivity

We have learnt that while it is vital to ensure all patients receive the best possible care, they also need to know the part they can play in helping themselves. Therefore, this project was about increasing knowledge and patient involvement in terms of information provision. This was a challenge to the healthcare professionals: to think about their treatment and to make it relevant to the Muslim faith and culture, rather than take a 'one size fits all' approach.

Objectives of this initiative were to:

- 1 develop a leaflet about rehabilitation for chronic pain for Muslim patients
- 2 improve the care that these patients experience and how they manage themselves, thereby improving patient satisfaction with the physiotherapy treatment and improve patient outcome including patients' physical and mental health
- 3 improve the patient's understanding of the self-management approach to rehabilitation treatment, by providing supporting evidence from Islamic teachings
- 4 improve healthcare professionals' understanding/communication, by increasing cultural awareness and knowledge of Islamic beliefs, to help them to work more effectively with Muslim patients
- 5 enhance patient-physiotherapist relationships within the treatment processes, to encourage partnership working and optimise the outcome.

This is a pioneering and powerful project which has been developed using a broad spectrum of professional knowledge. It crosses the boundaries between departments, cultures and faiths, with the chronic pain rehabilitation team and physiotherapy department working with the chaplaincy department, in particular the Muslim chaplain. This has been patient centred at every stage of the process, from the initial listening to the patients' and healthcare professionals' concerns, to using feedback from patient focus groups to draw up the final copy of the leaflet.

The leaflet has helped patients to regain their health, independence and quality of life and their willingness to undertake and continue treatment and their own care. It has helped not only the healthcare professionals but also the patients to distinguish between the religious and cultural issues.

This work has led to a change in the questioning in the physiotherapist's assessment process. We now ask about relevant daily activities for a Muslim patient, such as prayer positions and washing rituals, so that the exercises and stretches can be tailored to enable the patient to achieve these. Many patients are keen to be able to pray prostrate on the floor rather than sitting,

as is allowed if you are in pain or disabled, as this is seen to carry greater reward in the Islamic faith. The goal setting can involve areas for Muslim patients, which bring high reward in the Islamic faith, e.g. walking to the mosque to pray rather than praying at home, and male Muslim patients being involved with the children. These areas can all be used to help increase the patient's physical fitness and stamina.

We were previously unaware of this knowledge and it has made such a difference when working with Muslim patients. We have found that unlike Western culture, where asking about religion and prayer may be thought of as intrusive or impolite, the Muslim patient is happy and pleased to talk about these issues, as they are an integral part of their everyday life.

In an audit of verbal and written feedback, 66% of patients found that the leaflet had been moderately to very helpful, by helping them to become clearer about treatment. The staff feedback collected showed that the increased understanding had enabled much more engagement with the patients, increasing collaboration, empathy and understanding of the Islamic community and improving patient outcome.

Our assessment and treatment have changed, so that we collect more relevant information, and we are able to tailor exercises to be more sensitive to religious and cultural needs.

This initiative has used existing resources within the trust. It is making better use of consultation and treatment time, therefore saving time and resources. Also the project is low in cost and time and should be easy to sustain. Another benefit of this work and the principle is their transferability across many areas; it has been rolled out to all areas of the physiotherapy department throughout the trust, and we are now working on a generic leaflet to be used in other departments and wards. We have presented this work at several local and national conferences for different professions, including one organised by the Bradford Council of Mosques.

We were very proud to also have won a West Yorkshire NHS Modernisation Award for improving the patient experience in 2005, and an article about the work featured on the Department of Health website. As a result of the publicity following these, we have been contacted by other areas with similar populations, e.g. Birmingham, Oldham, Bristol and Newham.

At present, on the advice of our Muslim chaplain, the leaflet is only available in English; however, we are recording the information onto CD in both Urdu and English, as some of the patients speak Urdu but do not read it.

Another interesting learning point for us concerned the collection of feedback. In our trust we usually use written feedback. When we used this with some of the Muslim patients we were very surprised that all the feedback was good. Our Muslim chaplain again

advised that, especially with the older patients who have not been educated in this country, rather than seeing any suggestion for improvement as useful feedback, they would see this as insulting criticism of the service and your time and effort. These patients are grateful for any service provided, as this is probably more than that provided in South Asia. Therefore we used verbal reports and focus groups to collect our feedback, which proved much more helpful and realistic.

Working closely with the Muslim chaplain and linking with Islamic religious teachings carries a lot of weight with the Muslim patients and has been an extremely helpful approach. This approach may also be transferable to work with other religions and client groups.

The main achievement has been the active involvement of patients in creating cultural understanding of care processes by healthcare professionals, thereby influencing and improving the quality of care patients experience, and improving health.

This has been achieved by:

- partnership working across boundaries to promote improved patient experience for Muslim chronic pain patients
- incorporating a patient-centred approach, especially looking at cultural and religious issues
- working differently and innovatively
- recognising that good practice change doesn't always mean high cost: simplicity has been the key.

Understanding differences will make a difference

For further information, please contact Gill Fletcher, Senior Physiotherapist, Chronic Pain Rehabilitation Team, St Luke's Hospital, Bradford BD5 0NA, UK. Tel: +44 (0)1274 365627, or Maulana Mohammed Arshad, Muslim Chaplain (Imam), Chaplaincy Department, St Luke's Hospital, Bradford BD5 0NA, UK. Tel: +44 (0)1274 365096.

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Resources

Obtaining consent in research studies

Problems related to obtaining informed consent can be a reason (or indeed an excuse) for excluding patients without literacy skills in English from recruitment to research projects. In some ethnic groups, limited literacy skills in any language may be an

additional problem which restricts the usefulness of translated written materials. For our research involving the South Asian community in Leicester, we have developed procedures which can be used for recruiting samples with mixed language and literacy skills. We have used audiotape-recorded versions of information sheets, which can include an explanation of what is implied by giving consent. This ensures standardisation of the information given. Recordings can be made in any number of languages and were available in Gujarati, Hindi and Punjabi for one of our projects (Stone *et al*, 2005a). We have also developed a consent form suitable for use with patients with varied language and literacy needs. The following wording is included in the statement signed by the person taking consent: 'If the person being recruited is unable to understand written English, I confirm that the nature of the research study and the consent procedure have been explained to them in an appropriate language and that I am confident that they understand the implications of signing ...'. Patients in this category then sign (or mark if unable to sign) a special section of the consent form, while those able to read English sign in the usual way. This consent form has been approved by the ethics committee for use locally in past work (Stone *et al*, 2005b), and continues to be part of our methodology for working in diverse populations. For further information contact the author at mas20@le.ac.uk.

REFERENCES

- Stone MA, Pound E, Pancholi A, Farooqi A and Khunti K (2005a) Empowering patients with diabetes: a qualitative primary care study focusing on South Asians in Leicester, UK. *Family Practice* 22:647–52.
- Stone MA, Pancholi A, Khunti K, Davies MJ and Farooqi A (2005b) A qualitative investigation of group education provision for patients with type 2 diabetes from ethnic minority backgrounds. *Diabetic Medicine* 22(suppl 2): 324.

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Cultural Awareness Resource Pack

Geeta Pankhania

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This guide is described by the author as 'an aid to service providers in order to assist them in asking the right questions' in providing care for clients 'from diverse cultures'. In Section one it has chapters on religious groups (Muslims, Sikhs, Hindus); religions – Christianity, Buddhism, Judaism, and 'African/Caribbean culture, and 'Gypsy traveller culture'. Section two provides contextual information about Portugal, Iraq and Afghanistan.

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Diversity webwatch

Autistic spectrum disorders

A new leaflet *What is Autism and the Ways you can Help* aimed at parents/carers has been translated into Chinese, Somali, Portuguese, Polish, and Tamil by the National Autistic Society. Most of these have been uploaded onto their website at the following link: www.autism.org.uk/nas/jsp/polopoly.jsp?d=650

For further information please contact Prithvi Perep, National Autistic Society, tel: +44 (0)20 7704 3806.

HIV/AIDS

AIDS & Mobility Europe (A&M, www.aidsmobility.org/index.cfm) is a network for the support of European organisations that provide HIV/AIDS prevention and care to mobile and migrant populations. A&M pays special attention to young migrant people. It is co-ordinated by the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ), and is supported by the European Commission.

Knowledgeshare welcomes the following contributions:

- short accounts/evaluations of specific initiatives to improve practice or education in health and social care
- reviews of books, websites, games or other resources that can inform practice or education
- information about assessment tools and their applications
- conference reports
- other information that may inform the development of health and social care practice.

All contributions for this section should be sent to Lorraine Culley, email: lac@dmu.ac.uk