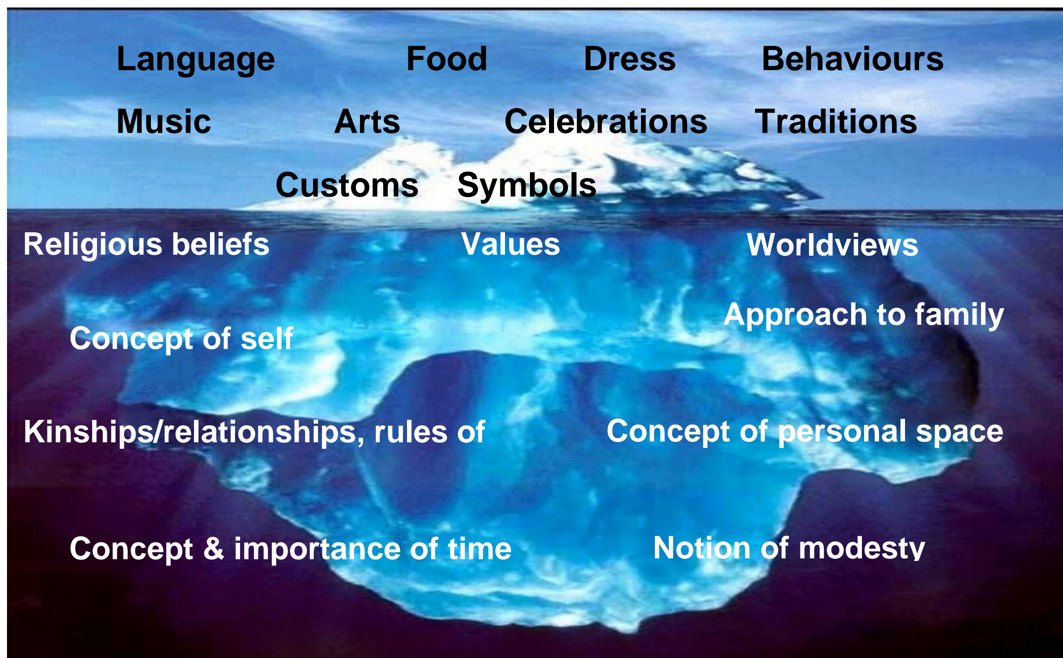
Black and Ethnic Minority Working Group

Working with minority communities within
the Health and Social Care Sector in Hackney

Cultural Competency Toolkit: Health and Social Care



A resource for promoting cultural competency in health and social care services

Cultural Competency Toolkit: Health and Social Care

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Acknowledgement

BEMWG strives on embracing diversity which dictates our work. As part of that, we have produced this resourceful cultural toolkit. BEMWG is very grateful to a number of people for their collective efforts, dedication and commitment that made it happen. Their contribution will be cherished as long as this toolkit keeps making a difference.

We have been extremely fortunate to have Marika Mason as the consultant who developed this toolkit. Our deepest appreciation and thanks go for her work and contribution, in researching, correcting and validating the data.

We are also grateful to the community members who gave their time and expertise in carefully reading, amending and providing insightful and constructive comments on the cultural profiles of the communities. To them all a big thank you. We hope that, you will find it a useful resource.

Aliya El Agib
Dierctor - BEMWG

Foreword

BEMWG has developed this Cultural Competency Toolkit in response to demand from health and social care institutions for guidance on meeting statutory obligations under the Race Relations (Amendment) Act 2000. As the representative body for black, Asian, minority ethnic and refugee (BAMER) health and social care organisations in City and Hackney BEMWG is committed to race equality and enhancing the quality of health and social care services experienced by what is an increasingly diverse, multi-faith and multicultural population.

Our mission is to improve the accessibility and quality of health and social care services for BAMER people. By embedding race equality in health and social care individual practitioners and institutions can ensure that they acknowledge the experiences and values of all service users, including black, Asian and minority ethnic people, asylum seekers and refugees.

This Toolkit is not prescriptive. What it does is offer a scheme for how cultural competency can be addressed in health and social care services through encouraging providers to evaluate and review their policies, systems and practices to create as inclusive and culturally appropriate services as possible.

Leadership and support at institutional level are pre-requisites for the successful mainstreaming of equality and diversity issues in health and social care services. The Toolkit, therefore, encourages organisations to develop the corporate strategies necessary to support individual practitioners and agencies in mainstreaming race equality issues. Top-level commitment is vital if we are to deliver effectively on race equality, an issue that is important for all of us.

Dr. Nazima Osman
Chair of BEMWG

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Section 1:
About this toolkit

1.1 Who we are?

Black and Ethnic Minority Working Group (BEMWG), an equality specialist network organisation, aims to improve the quality of life and well being for the black, Asian and minority ethnic and refugee (BAMER) communities, particularly in relation to health and social care services in City and Hackney.

As a registered charity BEMWG was established in 1991 to provide a platform for BAMER organisations to voice their concerns about health and social care issues affecting the people they serve. We currently have 225 members, most of whom are community-based organisations providing services in areas of greatest need to those who need them most. The overarching objective for our members is to improve the quality of life for BAMER people through the provision of local health and social care services.

Our mission is to:

> "*Advocate for and support the improvement of quality of life and well being for black and minority ethnic communities locally in City and Hackney and London wide; reduce inequalities in health and social care services for BAMER communities; ensure services are accessible and culturally appropriate*".

1.2 Purpose of the toolkit

BEMWG have produced this Toolkit aimed at frontline practitioners that work with BAMER communities affected by health and social care issues. The Toolkit includes tools and resources to assist health and social care practitioners and service providers in providing culturally competent health and social care services.

The Toolkit provides the following:

- Principles of cultural competency and its importance in relation to the planning, development and delivery of health and social care services.

- Demographics of BAMER people living in City and Hackney.

- ☐ Specific information about BAMER communities, that is, the cultural profiles.
- ☐ Self assessment tools that support planning and assessment of processes and practices at both individual and organisational levels.

The objectives of this Toolkit are to:

- ☐ Assist health and social care professionals in providing culturally competent health and social care.
- ☐ Offer practical resources and tools that will enable health and social care service providers to implement changes in policy and practice.
- ☐ Provide health and social care providers with the motivation to implement an organisational cultural competency assessment and strengthen their commitment to operating in a culturally competent manner.
- ☐ Offer practical assistance to promoting equality for all. BAMER communities require fair access, treatment and care and this toolkit is a contribution to this.

This Toolkit does not provide a step-by-step guide to becoming culturally competent. The road to cultural competency is unique for each individual or organisation; there is no "one size fits all" solution. It is our hope that this Toolkit can help practitioners and organisations tailor their interventions to meet the unique needs of their culturally diverse patients and clients.

1.3 Who is this Toolkit for?

This Toolkit is for professionals working within the health and social care sector, including:

- Front-line staff
- Management and administrative staff
- Primary health care providers
- Social care providers
- NHS organisations
- Strategic health authorities.

1.4 Public Sector Equality Duty

A new streamlined public sector equality duty is due to come into force in 2011, which will replace the race, disability and gender equality duties. This equality duty will also be extended to cover age, sexual orientation, religion or belief discrimination and gender reassignment. The new duty will be on public authorities to pay due regard to the following when carrying out their functions:

- Eliminating discrimination, harassment, victimisation and any other conduct prohibited by the Bill;
- Advancing equality of opportunity between people who are share a protected characteristics[1] and people who do not share it;
- Fostering good relations between people who are share a protected characteristics and people who do not share it.

The government's view is that the legislation across the equality strands has suffered from patchy implementation and inconsistent obligations. The challenge is to turn the Equality Duty into improvements in service provision for the whole community.

As the largest provider of public services and the largest UK employer the NHS has huge potential to bring about race equality, harmonious relations and greater social justice. To achieve this, the NHS needs to concentrate on better outcomes for patients and staff. There is synergy between the laws on equality, the NHS policy to increase the responsiveness of services to patients, reducing health inequalities and improving the working lives of employees. Delivery of race equality can help to improve services and health and social care for all.

1.5 Using the Toolkit at an individual level

The Toolkit provides professionals with the tools and resources to improve their cultural awareness and relate to clinical or social work practice or service delivery. These tools will enable practitioners to cultivate awareness, increase their knowledge and skills thus improving their cultural proficiency to work effectively with BAMER clients or patients.

1.6 Using the Toolkit at an organisational level

The Toolkit provides ideas for corporate-level action. A selection of tools has been identified as ones that could assist organisations with taking forward culturally competency ideas. These actions would also help organisations meet race equality legislation, particularly in health and social care provision.

1.7 Structure of this Toolkit

This toolkit is divided into the following sections:

Section 1
Explains the purpose of the Toolkit and gives an overview of its content.

Section 2
Offers an introduction to the concept of cultural competence and how it can benefit your organisation.

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[1] The following are protected characteristics in equality legislation: sex, race, disability, age, religion or belief, gender reassignment, sexual orientation, pregnancy and maternity, marriage and civil partnership.

Section 3
Explains how the quality for all approach can help tackle health inequalities through incorporating equality initiatives into quality improvement processes.

Section 4
Presents the evidence base of why culture matters.

Section 5
Describes BEMWG's model for increasing cultural competence at the individual and organisational levels.

Section 6
Includes resources and tools for individual practitioners to improve their cultural competence.

Section 7
Provides resources and tools for organisations to improve their cultural competency in the design, planning and delivery of health and social care services.
12 © GLDVP 2008 - Section 2

Section 8
Firstly, introduces aspects of cultural diversity together with good practice guidelines. Secondly, presents cultural profiles for certain BAMER communities in Hackney.

Appendix 1
Covers a health and social care checklist for providing culturally sensitive services.

Appendix 2
Explains the food preferences for different religious groups.

Appendix 3
Gives a correction form for submitting amendments or additions to this Toolkit.

Section 2: Introduction to cultural competence

2.1 What is cultural competency?

Many definitions of cultural competency exist. In this Toolkit we define cultural competency as:

> *The ability to interact effectively with people from different cultural backgrounds, that is, practitioners and organisations implementing the policies, knowledge and skills to meet the needs of the diverse people they serve.*

Cultural competence also means:

- □ The idea of operating effectively in different cultural contexts. For instance, this can involve designing services to meet the cultural and linguistic needs of BAMER communities.
- □ Integrating and transforming knowledge about diverse groups of people into specific standards, policies and practices to deliver culturally appropriate services in health and social care settings.
- □ How well an organisation provides care to people with diverse values, beliefs and behaviours.

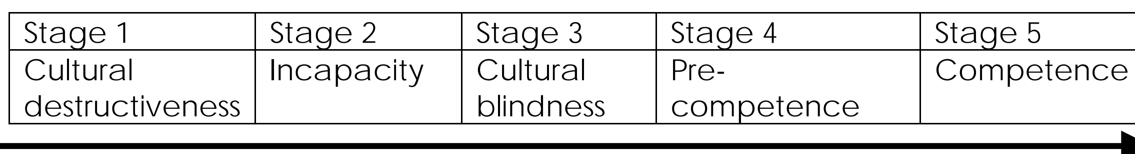
These approaches all help to improve the quality of health and social care services and produce better outcomes for everybody.

Historically the approach to cultural competence has been identified as if it were the sole responsibility of individual practitioners. Both development and delivery of culturally competent services were expected to rely upon the "sensitivity" of the individual practitioner. However cultural competency is practically impossible for individuals to adopt successfully in isolation. Cultural competence is the responsibility of the whole organisation. This means that discussions about cultural competence must include the rules, regulations, infrastructure and policies of health and social care organisations as well as the knowledge, skills, values, beliefs and attitudes of individuals.

2.2 Stages of cultural competence

Several models explain how to foster cultural competency within individuals and organisations. In some of these models cultural competence is often represented as a continuum for individual and organisational assessment. For example, in Figure 1 James Mason[2] presents five stages in his cultural competence model: cultural destructiveness, incapacity, blindness, pre-competence and competence. His self-assessment questionnaire enables individuals and organisations to determine their present state and measure their journey towards cultural competence over time.

Figure 1. James Mason's Stages of Cultural Competence

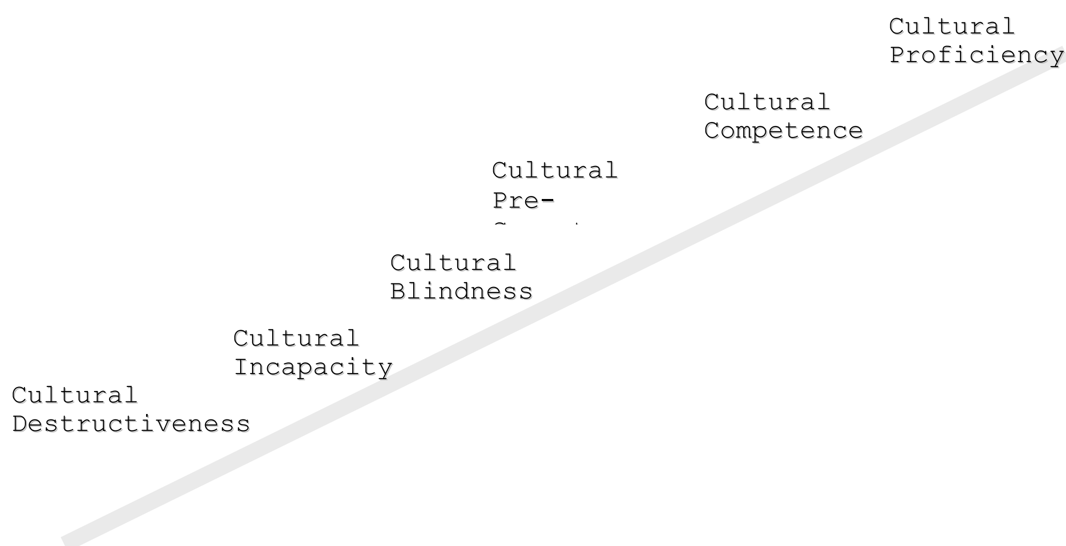


Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Cultural destructiveness	Incapacity	Cultural blindness	Pre-competence	Competence

Whilst Cross et al[3] present a 6-stage cultural competence continuum as highlighted in Figure 2. They define cultural competency as:

> *...'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations'.*

Figure 2. Cross et al cultural competence continuum



[2] Mason, J. L. (1993). Cultural competence self-assessment questionnaire. Portland, OR: Portland State University, Multicultural Initiative Project.
[3] Cross T, Bazron BJ, Dennis KW, et al. "Towards a Culturally Competent System of Care." Washington: National Institute of Mental Health, Child and Adolescent Service System Program; 1989:13.

Stage 1 Cultural destructiveness This represents attitudes, policies, structures and practices within a system or organisation that are destructive to a cultural group. Examples include: forced assimilation, subjugation, segregation, apartheid.

Stage 2 Cultural incapacity This is the lack of capacity of organisations to respond effectively to the needs, interests and preferences of culturally and linguistically diverse groups. Characteristics include: institutional or systemic bias; discrimination in hiring or promotion; disproportionate allocation of resources that may benefit one cultural group over another; messages that some cultural groups are neither valued nor welcomed.

Stage 3 Cultural blindness This expresses the philosophy of viewing and treating all people as the same. The traditional helping approach is viewed as universally applicable to everyone: 'one size fits all'. Characteristics include: services ignore cultural strengths, little value placed on training that assist cultural and linguistic competence, workforce lack diversity, few structures and resources dedicated to acquiring cultural knowledge.

Stage 4 Cultural pre-competence This shows a level of awareness within organisations of their strengths and areas for improvement to respond successfully to culturally and linguistically diverse service users. Characteristics include: hiring practices that support a diverse workforce; having the capacity to conduct needs assessments in diverse communities; effort made to improve service delivery for specific cultural groups; tendency for token representation on committee or advisory group; no clear plan for achieving organisational cultural competence.

Stage 5 Cultural competence This demonstrates organisations commitment to and respect for cultural differences. Characteristics include: creating a mission statement with principles for cultural competence in all aspects of the organisation; implementing policies and procedures that integrate cultural competence in each core function of the organisation; developing structures and strategies to ensure community participation in planning, delivery and evaluation of the organisation; implementing policies and procedures to recruit diverse workforce; providing support for professional development and incentives for improvements of cultural competence at board, programme and staff levels; dedicating resources for both individual and organisational self-assessment of cultural and linguistic competence; developing the capacity to collect and analyse data using variables that have meaningful impact on culturally diverse groups, applying the principles of community engagement that result in transfer of knowledge and skills between partners and stakeholders.

Stage 6 Cultural proficiency This demonstrates organisations hold culture in high esteem and use this as the basis for their work. Characteristics include: employ staff with expertise in cultural and linguistic competence in health and social care services; publish and disseminate evidence-based practices

and interventions; disseminate promotional materials adapted to the cultural and linguistic contexts of people served; seek resources to expand the organisation's capacities in cultural competence; advocate for people who are traditionally unserved or underserved; establish partnerships with diverse constituency groups to eliminate racial disparities in health and social care.

This 6-stage continuum provides a useful set of guidelines for providers to assess their professional and organisational level of cultural competence as well as to develop culturally competent policies and practices.

The cultural competence concept is not limited at the level of the individual professional. Health and social care providers can create the infrastructure (systems, policies and procedures) to support cultural competence within their organisations. Systems of care can be organised in ways that foster culturally sensitive service to a wide range of cultural groups. In other words, organisations and professionals can come together to provide culturally competent services.

2.3 Rationale for cultural competent care

Cultural competence is important because:

- Everyone has a right to health and social care that meets their needs.
- It responds to demographic changes - the diversity of the UK's population is increasing. There is a need to respond strategically to these demographic changes.
- It can help eliminate disparities in the health and social care status of people of diverse racial, ethnic and cultural backgrounds.
- It can improve the quality of services and outcomes.
- It enables organisations to meet legal requirements and deliver equal opportunities.
- Health and social care service managers and practitioners are accountable for meeting the needs of all service users.
- It improves health and well being by integrating culture into the delivery of health and social care services.
- It is everyone's responsibility, not just special interest groups. In short, it is a mainstream issue.
- It is not new. Good health and social care policies and services meet service users' needs.
- It can decrease the likelihood of liability and malpractice claims.

2.4 Benefits of cultural competency

The benefits that can accrue for service users, practitioners and institutions are as follows:

- ☐ Addresses inequitable access to primary health care.
- ☐ Improves equity and access for all groups.
- ☐ More effective health and social care services for BAMER service users and carers.
- ☐ Cost effective and better use of health and social care resources.
- ☐ Reduces disparities in health services and increases detection of culture specific diseases, e.g. sickle cell and thalassemia.
- ☐ Responds to City and Hackney's changing demographics – an increasingly diverse population.

2.5 Culturally competent health or social care system

Culture and language may influence:

- ☐ Health, healing and wellness belief systems.
- ☐ How illness, disease and their causes are perceived by the patient or service user.
- ☐ The behaviours of patients or service users who are seeking health or social care and their attitudes toward health and social care providers.
- ☐ The delivery of services by the provider who looks at the world through his or her own set of values, which can compromise access for patients or service users from other cultures.
- ☐ Client/patient interaction with the health or social care provider.

Like health and social care generally, culture sensitive care is based on the principles of knowledge, mutual respect and negotiation.

Cultural competence also focuses its attention on population-specific issues including:

- □ Health-related beliefs and cultural values (socio-economic perspective)
- □ Disease prevalence (the epidemiological perspective)
- □ Treatment efficacy (the outcome perspective).

Cultural competence requires that organisations:

- □ Have a defined set of values and principles and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.

- □ Demonstrate the capacity to (a) value diversity, (b) conduct self-assessment, (c) manage the dynamics of difference, (d) acquire and institutionalise cultural knowledge and (e) adapt to diversity and the cultural contexts of the communities they serve.

- □ Incorporate the above in all aspects of policy making, administration, service standards, service delivery and systematically involve consumers, key stakeholders and communities.

Service providers require an understanding of the communities being served. By devising strategies to identify and address cultural barriers to health and social care services these providers gain better insight into ensuring better access to services.

Section 3: Quality health and social care for all

3.1 Quality care for all

In the NHS and social care settings the most deprived and vulnerable service users come from a variety of social, cultural and ethnic backgrounds. This diversity must be taken into account to deliver the best services to all. The goals for health care and social care are:

- Improved health and social care outcomes for BAMER individuals and communities – *effectiveness*
- Improved safety for service users – *safety*
- Fewer unnecessary costs – *efficiency*
- Reduced racial and ethnic disparities in service user care and increased satisfaction – *equity.*

Improving the quality of care for NHS patients is the guiding principle of Lord Darzi's review[4] and confirms a shift in the government's approach to health policy, from speed of care (e.g. reducing waiting lists) to quality that takes account of service users' experiences and outcomes. It is widely known that there are variations in the quality of care that is provided, i.e. postcode lottery. Yet the NHS wants to respond flexibly to the needs of local communities. People want a greater degree of control and influence over their health and social care services. So personalising services, for example, means making services fit for everyone's needs.

The government defines quality in terms of three criteria:

(1) Patient safety (doing no harm to patients);
(2) Patient experience (care characterised by compassion, dignity and respect);
(3) Effectiveness of care (to be measured using survival rates, complication rates, measures of clinical improvement, and patient-reported outcome measures).

[4] Lord Darzi, *High Quality for All*, Department of Health, June 2008

High quality care should be as safe and effective as possible with patients treated with compassion, dignity and respect. New developments forthcoming are:

- For the first time all the NHS healthcare providers will be required by law to publish 'Quality Accounts', which will include patients' views on the success of treatment and the quality of their experiences.
- Patients' assessments will have a direct impact on the way hospitals are funded.
- The new NHS constitution will set out for the first time the legal rights patients have in relation to the NHS.

3.2 The journey towards race equality

Studies have repeatedly shown that there are major differences in the way BAMER people experience health care and social services compared to the rest of the population. The government recognises the need to address disparities in access, experience and outcomes. However, race equality is often viewed as a negative issue consisting of multiple "problems" and requiring extra work that is separate to mainstream business – the provision of health and social care services. Yet the Race Relations (Amendment) Act 2000 has created an environment where public sector organisations are expected to promote race equality. For agencies the two significant challenges in responding to this agenda are:

1. Mobilising staff, members and non-executive directors to develop locally specific, aspirational vision of the outcomes that need to change; and

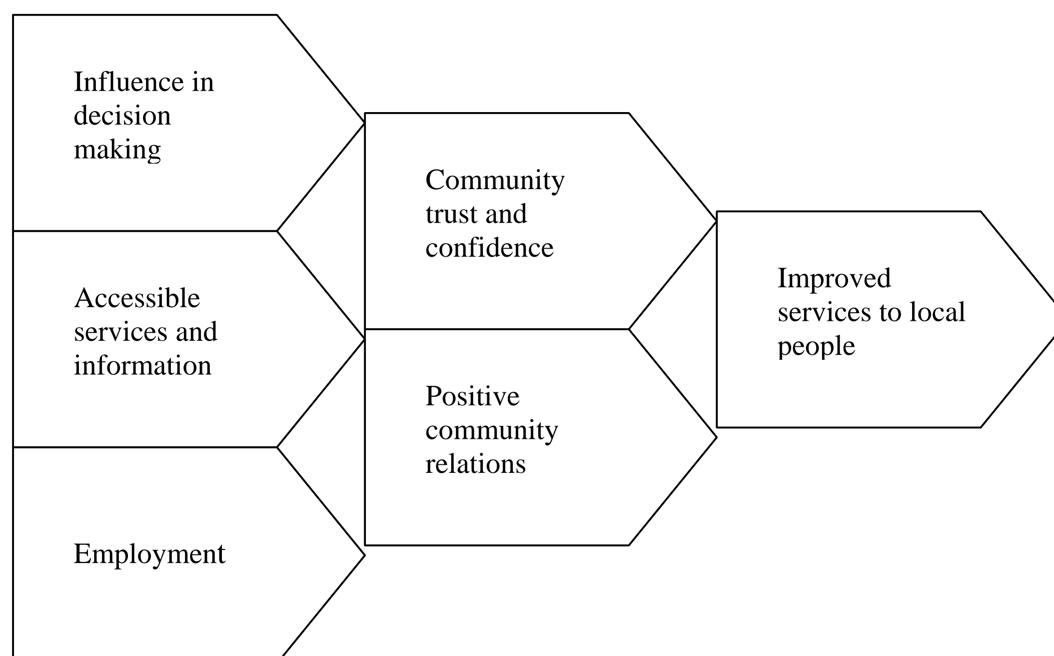
2. Understanding and tackling the institutional practices that get in the way of making progress.

Addressing these challenges is fundamental to promoting race equality as a positive benefit for the whole community and making a real difference to the outcomes and experiences for BAMER communities.

Public agencies need to develop a realistic and achievable vision for race equality based on good understanding of local needs. There are common perceptions about where inequality exists, reflected by national data. Despite this, many public agencies still struggle to be specific about what race equality means. For instance, the Audit Commission[5] identified key race equality outcomes where clear and focused action will improve the quality of life for diverse black and minority ethnic communities. See Figure 3. It is for public agencies to think through the action they will need to take to deliver those outcomes in a way that reflects local circumstances.

[5] Audit Commission, The Journey to Race Equality: Delivering Improved Services to Local Communities, Public Sector Briefing

Figure 3 Local outcomes for race equality



Agencies can facilitate access to appropriate services through:

- Promoting access – this will entail reviewing barriers to care and provision of information on services available.
- Providing bilingual services for effective communication.
- Education and training for health and social care professionals and other staff.
- Having appropriate and acceptable service provision.
- Provision of religious and dietary choice with meals offered in hospitals.
- Diversity workforce issues, including addressing racial discrimination and harassment within the workplace and promoting race equality and valuing diversity in the workforce.
- Community engagement and participation.

Most public agencies recognise that race equality is an important aspect of good performance. However, many are unclear about what they are trying to achieve to comply with the requirements of the Act. Local agencies display different levels of optimism about progress. Many are at different stages of the journey to race equality.

3.3 Health inequalities in City & Hackney

City and Hackney are two London boroughs which depict a tale of two cities: the City is one of the richest areas in the UK; and Hackney is one of the poorest areas in the UK. Lack of access to health care and social services has long been implicated as a contributory factor to the health disparities experienced by BAMER people. Table 1 lists the key areas of health inequalities in Hackney. BAMER are identified in the plan as one of the

vulnerable, marginalised groups. All nine key outcome areas disproportionately affect BAMER people:

1. Cancer
2. Circulatory disease
3. HIV and sexually transmitted infections
4. Teenage pregnancy
5. Tuberculosis
6. Mental health
7. Diabetes
8. Infant mortality
9. Life expectancy.

Table 1. Health Inequalities

OUTCOMES	INEQUALITIES
Cancer	• Hackney is in the bottom 20% of all local authorities for cancer mortality under 75. • Smoking biggest single preventable risk factor and smoking affects those already disadvantaged by poverty. • Poor diet, 2nd largest risk factor. The affluent tend to eat more fruit and vegetables. • Communities most at risk have poorer access to preventive services (e.g. cancer screening rates).
Circulatory diseases	• Hackney is in the bottom 20% of all local authorities for circulatory disease mortality under 75 • Exemplifies inequalities in health – manual vs. professional. • **South Asians – higher rates of premature mortality from coronary heart disease.** • Smoking related – social class gradient • Diet and exercise – social class gradient • Chronic stress and heavy drinking
HIV & sexually transmitted infections	• Young people 16-19 experienced highest rise. • Some risky sexual behaviours more common in London than elsewhere and increasing • Prevalence of HIV in City & Hackney much higher than in London as a whole. • **70% women diagnosed with HIV in City & Hackney are Black African.** • Terminations in City & Hackney twice national average and higher than in London. • Huge increase in sexually transmitted infections in recent years, e.g. Chlamydia up 185% 1995 to 2003 in London
Teenage pregnancy	• City & Hackney have one of the highest rates of teenage pregnancy in the country. However, rates have been falling over the past 4 years. • Young women from disadvantaged backgrounds far more likely to become pregnant as a teenager. Many do not want to become a parent – half opt for a termination. • Certain groups more likely to become a teenage parent: those in or leaving care, homeless, school excludees, children of teenage mothers. • Teenage pregnancy can lead to negative health and mental health

	outcomes for young mothers. • Babies of teenage parents tend to have lower birth weight, less likely to be breastfed, increased risk of poverty, poor housing and poor nutrition.
Tuberculosis (TB)	• Rates of TB in Hackney are as high as in some developing countries and the highest in the UK. • They are above the level at which WHO believes urgent action is required. • Drug resistance is becoming a problem due to non-completion of treatment. • **Increased particularly amongst Black African, Black Caribbean and White people.** • Cannot be explained by immigration alone and is suggestive of ongoing transmission in the community. • Linked to homeless, overcrowding, poor housing, injecting drug users, excessive alcohol consumption
Mental health	• Smoking biggest single preventable risk factor and smoking affects those already disadvantaged by poverty. • City & Hackney have unusually high rates of mental illness. • Admissions to hospital for schizophrenia - x 3 in Hackney vs. England for both men & women. - x 2 men vs. women. - Very high amongst black men. • 1 in 10 children and 1 in 6 adults has a mental health problem. • 1 in 4 consultations with a GP concern a mental health issue. • Suicide leading cause of death among young men. • **BME worse access to and least satisfied with mental health services.**
Diabetes	• Significant inequalities exist in - the risk of developing diabetes - access to health services for diabetes - quality of services for diabetes - health outcomes for those with diabetes • Obesity and overweight increase risk of developing diabetes. • **Obesity more prevalent amongst particular BAMER groups** • Rise in childhood obesity. • **Higher prevalence of Type 2 diabetes in South Asian and Caribbean people** • Only half of those with diabetes in City & Hackney receive annual retinal screening. • City & Hackney have a higher rate of diabetes mortality than national average.
Infant mortality	• 5 infant deaths (including still births) a month in City & Hackney higher than in London & England. • **Varies by ethnic group – Pakistani, Caribbean and West African women suffer high rates.** • Low birth weight major cause & varies by socio-economic group. • 10% births in Hackney are low birth weight. • Smoking is a major modifiable risk factor contributing to low birth weight. • Smoking cessation in pregnancy affected by socio-economic status. • Benefits of breastfeeding – social class variant.

	• Inequalities in antenatal service use.
Life expectancy	• Men in Hackney have a life expectancy 2 years less than the England average. • Life expectancy for women is similar to that for London & England overall. However, local women are less likely to take up preventive health services, e.g. screening. • Life expectancy is related to deprivation. Hackney most deprived local authority in England. • Vulnerable groups such as homeless, drug users, people with disabilities and those with serious mental health problems have a much lower life expectancy. • Linked to income, education and employment. • Poor diet is the second largest risk factor. The affluent tend to eat more fruit and vegetables.

Source: City & Hackney Health Inequalities Programme 2005-2008.

To eliminate health disparities organisations need a plan outlining specific steps to:

- □ Improve access to services for people who are not able to speak English;
- □ Increase the cultural and linguistic competence of staff;
- □ Have a workforce capable of working effectively with diverse patients, clients and communities;
- □ Evaluate progress; and
- □ Communicate the organisation's plans and progress.

Health Trusts have the challenging task of ensuring that their services cater not only for the common causes of death and disability but also take account of any unusual patterns of diseases in their population as highlighted in Table 1.

3.4 Cultural competence as quality improvement

Heath and social care agencies that want to provide the best service possible will need to develop their cultural competence. These agencies are accountable to regulators, funders, commissioners, service users and the public. Assuring quality is learning about what health or social care organisations are doing well and what needs improvement and then using that information to do better. To measure quality or cultural competence effectively health and social care organisations need to gather and analyse evidence about:

- What the organisation is doing
- How it is doing it
- Its results.

Equality = E+quality for all

Once areas for improvement, e.g. cultural competence has been agreed they can be prioritised and a plan drawn up. The plan will include what needs to be done, who will do it, how it will be done and when.

Self assessment is an important learning and development tool. It can help practitioners develop confidence in what they are doing well, stimulate new ideas and develop a shared purpose. Of course there is an issue of what is more valid – external verification or internal self assessment processes. A formal process for assessing and reviewing performance on cultural competence is required. Section 2 describes the benefits for organisations when they assess and improve cultural competence. Cultural competence has to be an integral part of planning and management.

3.5 Improving equality through public procurement

Public bodies like the local authorities and health authorities provide a wide range of services to the community. In some cases these are provided directly by the authority or in other cases these are provided by contractors and partners. Public authorities spend on behalf of the community £160 billion each year purchasing goods and services from the private and voluntary sectors. Therefore, the services provided to the community should be geared towards their diverse needs and requirements.

Spending by public authorities sustains and maintains a significant number of jobs within a local area. Local authorities, for example, have a statutory duty to ensure that public money is spent in a way that ensures Best Value and does not lead to unfair discrimination and social exclusion. Thus procurement can play a major role in promoting the race equality agenda and moreover has been identified as a key area in guidance published by the Department of Health.[6] Most procurement or tendering processes include an obligation on suppliers to demonstrate their commitment to equality and diversity.

New legislation is planned to reinforce the need for supplier diversity within procurement.[7] For instance, the promotion of equality in procurement will help public authorities to:

- Improve the overall value for money for local authorities in terms of good and services they purchase.
- Improve the quality, responsiveness and appropriateness of their services.
- Ensure that public money is not spent on practices which lead to unfair discrimination to sections of the community.
- Create a diverse and integrated workforce.
- Deliver more responsive and flexible services in combating social exclusion and building stronger and cohesive communities.

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[6] http://www.mosaic.nhs.uk/

[7] The Single Equalities Bill seeks to use public procurement to improve equality.

Public bodies need to ensure that procurement and equality are appropriately integrated to ensure compliance with their statutory obligations and to promote their vision of valuing diversity throughout their partnerships and contractual working.

3.6 Promoting equality through commissioning

As the NHS moves from being a provider driven service to a commissioning driven service, there is a greater emphasis on securing a more diverse range of high quality services that reflect patient choice. The White paper 'Our Health, Our Care, Our Say' on community services includes a commitment to promoting equality. The Department of Health's commissioning framework for health and well being builds upon this commitment and recognises the importance of promoting equality through commissioning.

Commissioning is the process whereby a patient's or service user's is need is assessed and services are planned to meet those needs. This process involves setting priorities and allocating resources and, in particular, developing specifications on what services are required by the public and then securing these services. Commissioning takes place through different means. Most local primary care trusts (PCTs) and some strategic health authorities undertake commissioning.

Importantly, some commissioning is undertaken in partnership with local authorities, such as addressing needs of people with a disability. The future of commissioning is changing not least because different stakeholders are increasingly involved in the decision making process. In addition, there are key policy drivers, such as a patient-led NHS, patient choice, and payment by results, which all impact and influence the way commissioning will be carried out in the future.

A historical division exists between procurement (the acquisition of goods and services from public sector agencies and commercial providers to support health care provision and, therefore, to those that provide direct patient care) and commissioning, which is focused on the provision of direct patient care and associated services in support and promotion of patient choice. But the distinction between procurement and commissioning tends to be more organisational rather than methodological; that is, although there have been some attempts to distinguish between the two there are many similarities in terms of process and procedure. Mindful of this, some organisations are now looking at ways in which the skills of staff and the particular functions can be pooled to provide more effective links between procurement and commissioning.

3.7 Contract standards

Some public sector agencies publish contract standards for the provision of services. For example, contract standards for homecare providers in

Hertfordshire[8] include the following for the provision of culturally appropriate services:

> *The agency has procedures in place for dealing with discriminatory attitudes or remarks made by care workers, service users and their carers.*
>
> *Services are provided in accordance with the needs of the service users and carers, including those relating to race and gender.*
>
> *Where the experience and resources of the agency are not adequate to meet these needs, specialist input and advice is sought from appropriate sources including, where necessary, BAMER community resources.*
>
> *Services are provided to take account of the physical, social and emotional needs of service users.*
>
> *Services are provided in ways that encourage service user participation and respect choice.*
>
> *Information about service users is dealt with sensitively and confidentiality is maintained.*
>
> *Individual records are kept which include: Name, address, date of birth, next of kin, GP, ethnic origin or religion, copy of the care plan, risk assessment, moving and handling assessment, local authority care manager (where appropriate), details of other services involved and contracts if appropriate*
>
> .

[8] Hertfordshire County Council, *Back to Basics: Providing Culturally Appropriate Healthcare,* 2007

Section 4:
Why Culture Matters

4.1 Key concepts

Culture

Culture is the sum total of a way of living, which includes values, beliefs, standards, language, thinking patterns, behaviours and communication styles. Seen as a set of guidelines culture is passed on to the next generation to provide cohesion and continuity in society. Hence culture is a social construct that is constantly changing and difficult to measure. The concept of 'culture' is further complicated by societies consisting of subcultures in which individuals undergo acculturation, adopting some of the attributes of the majority society. Although an individual's cultural background has profound influence on their health and social care, it is only one of number of influences on health – social, political, historical and economic to name but a few.

All people are cultural beings. Culture ….

- □ Is shared when individuals agree on the way they name and understand reality.
- □ Is symbolic, often identified through symbols such as language, dress, music and behaviours.
- □ Influences people's norms, values and behaviours.
- □ Influences how people understand, interpret and respond to themselves, other people and the world around them.
- □ Is learned and passed on through generations, changing in response to a generation or individual's experiences and environment.
- □ Is integrated to span all aspects of an individual's life.
- □ Is dynamic, ever evolving and changing, created through individuals' interactions with the world.

The first step in developing cultural competence is 'cultural self-awareness', which involves knowing and understanding your own culture. Cultural awareness is appreciating and accepting differences between individuals

and cultures. The opposite of this is cultural blindness where differences are ignored and people behave as though differences do not exist.

Ethnicity

Everyone belongs to an ethnic group, including the majority white British population. In this Toolkit we include the needs of refugees and asylum seekers. Refugees are a diverse group who have wide-ranging health, social and educational needs. Data on minority groups used to be presented to highlight differences rather than similarities. This ethnocentric approach, where the 'white' group was taken as the norm and partial analyses were made of a limited number of disorders, has led to misinterpretation of priorities.

Ethnicity is multi-dimensional and usually encompasses one or more of the following:

> *'shared origins or social background; shared culture and traditions that are distinctive, and maintained between generations, and lead to a sense of identity in groups; and a common language or religious tradition.'*[9]

Ethnicity is also usually a shorthand term for people sharing a distinctive physical appearance (skin colour) with ancestral origins in Asia, Africa, Latin America or the Caribbean. It is also used as a synonym for 'race' to distinguish people with common ancestral origins. Indeed, 'race' has no scientific value and is a discredited biological term, but it remains an important political and psychological concept.

Ethnic group has been measured by skin colour, country of birth, name analysis, family origin and as self-identified on the UK census question on ethnic group. All these methods are problematic, but it is accepted that the self-determined census question on ethnic group overcomes a number of conceptual limitations. For local ethnic monitoring, it is good practice to collect a range of information such as religion and languages spoken. There is a marked variation in quality of ethnic monitoring data collected and caution is advised in interpreting such data. In recognising that individuals in all groups belong to an ethnic group – it is simply that these groups vary in size and the focus in this Toolkit is BAMER group. The term 'black' has also been used as an inclusive political term to counter the divisive aspects of racism. Debate and controversy continues amongst other minority ethnic groups, as 'black' does not allow them to assert their own individuality in historical, cultural, ethical and linguistic terms.

Several methods used to allocate individuals to ethnic groups are discussed briefly below:

(a) **Skin colour** — is subjective, imprecise and unreliable. For example, colour cannot distinguish between the majority 'white' group (i.e.

[9] Paramjit S Gill, Joe Kai, Raj S Bhopal and Sarah Wild, *Health Care Needs Assessment: Black and Minority ethnic Groups. The Epidemiogically Based needs Assessment reviews.*

between the English and Irish) and minority ethnic groups (e.g. Polish, Kurdish, Turkish).

(b) **Country of birth** — commonly used as a proxy for ethnicity. A question on country of birth has been included in each census since 1841. However it does not take account of the children of migrants (i.e. second generation who do not view themselves as immigrants).

(c) **Name analysis** — South Asian[10] names are distinctive and relate largely to religion, where endogamy (marrying within one's own group) is the norm. The validity of this method has been shown to be good, though this will diminish with increasing exogamy (marrying a person belonging to another group).

(d) **Family origin** — based on country of origin so should be straightforward. But the difficulty with this approach occurs when individuals state they have mixed family origins.

(e) **2001 census question on ethnic group** — The question does not deal adequately with people of mixed parentage – most of whom have one ethnic minority parent and one white. Another issue is that the 'white other' group conflates a number of groups which have distinct cultural, geographical and religious heritages, e.g. those of Greek/Greek Cypriot or Turkish origin, Eastern European.

Assumptions

As individuals we often consciously or unconsciously make two key assumptions:

1. Everyone who looks or sounds the same IS the same.

2. Everyone who looks or sounds like us IS like us.

We need to pay attention to how we think or feel about other people and how these beliefs will influence our behaviours towards them. It is important to be aware of our biases, which are part of our own cultural backgrounds so that we can reduce the barriers that keep us from understanding each other.

Our understanding of our own culture and cultures other than our own will influence how we interact with people not of our culture. Limited understanding can lead us to making mistaken assumptions or judgments and placing expectations that might not be clear to the other person and so on.

Ethnic monitoring

Ethnic monitoring requires the self-identification of individuals as belonging to one or more groups, defined in terms of their culture and origin. As BAMER communities are not a homogeneous group, it is not easy to categorise them using the 2001 Census categories. Instead the London Borough of Hackney

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[10] Nam Pehchan, a software package, developed by Bradford Health Authority and the City of Bradford Metropolitan Council, is available which can identify South Asian names.

expanded in 2006 its ethnic monitoring form (Figure 4) to reflect more fully the cultural and ethnic diversity of its residents.

Figure 4 Ethnic Monitoring Form devised by LB Hackney

WHAT IS YOUR ETHNIC GROUP?

Our ethnic background describes how we think of ourselves. This may be based on many things, for example, our language, culture, ancestry or family history. Ethnic background is not necessarily the same as nationality or country of birth. It is not possible to list all of the ethnic groups but those listed below reflect the largest ethnic groups in Hackney. Please study the list and tick which is closest to how you see yourself, or write in a more specific group if you wish.

Asian or Asian British Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background ☐ (please specify if you wish)	**Mixed** White and Asian ☐ White and Black African ☐ White and Black Caribbean ☐ Any other Mixed background ☐ (please specify if you wish)
Black or Black British African – Congolese ☐ African – Ghanaian ☐ African – Nigerian ☐ African – Somali ☐ Caribbean ☐ Other West African ☐ Any other African or Black Background ☐ (please specify if you wish)	**White** British ☐ Charedi (Orthodox Jewish) ☐ Greek/Greek Cypriot ☐ Gypsy Roma ☐ Irish ☐ Jewish ☐ Traveller of Irish heritage ☐ Turkish Cypriot/Turkish-speaking (including Kurdish) ☐ Other Kurdish ☐ White Eastern European ☐ White Other European ☐ Any other White background ☐ (please specify if you wish)
Chinese or South East Asian/South East Asian British Chinese ☐ Vietnamese ☐ Any other South East Asian ☐ (please specify if you wish)	**Any other ethnic group** Any other group ☐ (please specify if you wish)

RELIGION/BELIEF MONITORING INFORMATION

Please tick the box from the list below which best describes your belief or faith

Atheist/No beliefs ☐
Buddhist ☐
Christian ☐
Hindu ☐
Muslim ☐
Orthodox Jewish/Charedi ☐
Other Jewish ☐
Sikh ☐
Secular beliefs ☐
Other faiths/beliefs (please specify) ☐

Source: London Borough of Hackney

Equitable access to health and social care

It is an issue for BAMER people living in deprived areas like Hackney to get the health and social care they need. Those people who are most in need of health or social care are often the least likely to know how to access these services. Equitable access recognises that factors like geographic location, communication styles, language of service, signs, physical design and service delivery style influence a person's access to health and social care services and strives to address these issues. This leads onto tackling health inequalities as detailed in Section 3. There are measures organisations can take to improve access to health and social care services. Otherwise, language barriers, for example, to access in health promotion, prevention and screening can result in inequitable access leading to the use of more expensive services as a person's health deteriorates.

When we treat people EQUALLY we ignore differences.
When we treat people EQUITABLY we recognise and respect differences.

When individuals from one culture find themselves living in a different cultural context, one of four processes may occur, namely assimilation, integration, separation or marginalisation. These are defined as follows:

1. ***Assimilation**:* minority group does not maintain identity and seeks daily interaction with majority, dominant culture.
2. ***Integration**:* maintaining own group values and beliefs together with those of the majority group to an extent.
3. ***Separation**:* maintaining own culture and avoiding interaction with other cultures.
4. ***Marginalisation**:* contact with own and other cultures is avoided.

People will experience different degrees of each process at different points in time.

4.2 Why culture matters

Culture affects the way people label illness, identify symptoms, seek help, decide whether someone is normal or abnormal, set expectations for clients, give themselves personal meaning and understand morality. Culture is often referred to as the totality of ways being passed on from one generation to another. Competence implies having the capacity to function effectively within the context of diverse cultures.

How we communicate about our health or social care problems, the way we present our symptoms, when and to whom we go for care, how long we remain in care and how we evaluate that care are all affected by cultural beliefs.

4.3 Culture is like an iceberg

Culture is often represented as an iceberg to illustrate the visible cultural differences and invisible cultural roots, as shown in Figure 5. Part of culture is "above the water" in that it is visible and easy to identify and know. Just as nine-tenths of an iceberg is below the surface of the water so is nine tenths of culture out of your conscious awareness, i.e. your invisible cultural roots. The visible cultural differences are what you can see in the physical sense. These are the elements that we come into contact with when travelling to a new country for instance. Such visible elements include things such as language, music, dress, food. It can also relate to behaviours such as ignoring red traffic lights or queuing for a bus.

None of the visible elements or cultural differences will make sense without understanding the drivers behind them, i.e., the invisible cultural roots, which are hidden on the bottom side of the iceberg. Nine tenths of an iceberg is out of sight below the water so nine tenths of a culture is also hidden or invisible from view. So when thinking underneath the iceberg about the invisible cultural roots this will include such things as beliefs, values, religious or spiritual beliefs, worldviews, rules of relationships, approach to family, communication styles, etc.

Figure 5 Culture as an iceberg

4.4 Cultural and religious diversity in City & Hackney

Table 2 shows the cultural diversity of City and Hackney. In Hackney less than half of the borough's residents identify themselves as white British. Black and Black British residents are the second largest ethnic group. South Asians make up 1 in 10 (10%) of the population. The Charedi population is estimated to be 8% and the Turkish population is estimated to be 5%. Hackney has a population of 212,200 according to the Office for National Statistics Mid Year Estimates, 2007. The Greater London Authority (GLA) states Hackney's population is 218,000 compared with the 256,000 people on its GP registers according to the City and Hackney Primary Care Trust.

Hackney has one of the largest refugee and asylum seeker populations in London. Their health and social welfare needs are often complex and are likely to require considerable support. Refugees and asylum seekers may suffer from physical and mental health problems as a result of experiences in their country of origin. This is sometimes made worse by poor access to health and social services.

Table 2 Ethnicity of residents of the City and Hackney

	City of London	Hackney
All Groups	8,000	212,200
White: British	5,500 (69%)	102,917 (48.5%)
White: Irish	200 (3%)	5,050 (2.38%)
White: Other White	800 (10%)	23,342 (11%)
WHITE	6,500 (81%)	131,305 (62%)
Mixed: White and Black Caribbean	0 (0%)	3,332 (1.57%)
Mixed: White and Black African	0 (0%)	1,719 (0.81%)
Mixed: White and Asian	100 (1%)	1,825 (0.86%)
Mixed: Other Mixed	100 (1%)	2,737 (1.29%)
MIXED	200 (3%)	9,613 (4.53%)
Asian or Asian British: Indian	200 (3%)	8,806 (4.15%)
Asian or Asian British: Pakistani	100 (1%)	3,438 (1.62%)
Asian or Asian British: Bangladeshi	300 (4%)	5,963 (2.81%)
Asian or Asian British: Other Asian	100 (1%)	2,122 (1%)
ASIAN	700 (9%)	20,329 (9.58%)
Black or Black British: Black Caribbean	100 (1%)	18,419 (8.68%)
Black or Black British: Black African	200 (3%)	21,453 (10.11%)
Black or Black British: Other Black	0 (0%)	4,562 (2.15%)
BLACK	300 (4%)	44,434 (20.94%)
Chinese or Other Ethnic Group: Chinese	100 (1%)	2,928 (1.38%)
Chinese or Other Ethnic Group: Other	100 (1%)	3,841 (1.81%)
CHINESE	200 (3%)	6,769 (3.19%)

Source: ONS 2005 (the City) & ONS Mid Year Estimates 2007 (Hackney)

Hackney has a young population with more than one in four (27%) residents under 20 years old and only 15% over 55 years old. This growth is expected to continue over the coming decades with the GLA predicting that Hackney's population will reach 244,376 by 2021 (see Table 3).

Table 3 Latest population estimates for Hackney and the City

	City of London	Hackney	City & Hackney
Office for National Statistics	8000 (3.7%)	212,200 (96.3%)	220,200
Greater London Authority Population projections	9137 (4.1%)	235,239 (95.9%)	244,376

Source: ONS 2005, ONS Mid Year Estimates 2007, GLA 2008

According to the 2001 census more than half of the residents of the City (55%) and just under half (47%) of the population of Hackney identify as Christian. See Table 4. 12% of Hackney residents did not answer the question about religion. 1 in 4 residents of the City and 1 in 5 Hackney residents stated that they did not belong to any religion. Hackney also has large Muslim (14%) and Jewish (5%)[11] communities.

Table 4 Religions in City and Hackney

Religious Denomination	City of London	Hackney
Christian	55%	47%
No religion	25%	19%
Muslim	6%	14%
Jewish	3%	5%
Buddhist	1%	1%
Hindu	2%	1%
Sikh	0%	1%
Any other religion	1%	1%
Religion not stated	9%	12%

Source: ONS 2001 Census

Hackney's 2004 Household survey estimated that more than 100 languages are spoken in the borough. Two thirds (66%) of households stated that English was the only language they spoke at home; 1 in 5 (22%) said that English was the main language spoken at home and a further 12% said that they did not speak English at home. The results from those households who had another or main language besides English spoken in the home are listed in Table 5. This shows that the most widely spoken languages are Turkish, Yiddish and French.

[11] This figure does not accord with the Jewish population figure of 8% which is based on a population survey carried out by London Borough of Hackney in 2006.

Table 5 Languages spoken with English not as main language

Rank	Language	Percentage of households	Rank	Language	Percentage of households
1	Turkish	5.5%	**11**	Twi[12]	0.8%
2	Yiddish	5.2%	**12**	Arabic	0.7%
3	French	2.2%	**13**	Italian	0.6%
4	Gujerati	1.8%	**14**	Kurdish	0.6%
5	Bengali	1.6%	**15**	Vietnamese	0.6%
6	Yoruba	1.3%	**16**	German	0.6%
7	Spanish	1.0%	**17**	Polish	0.6%
8	Punjabi	1.0%	**18**	Chinese	0.5%
9	Portuguese	0.9%	**19**	Hebrew	0.5%
10	Urdu	0.9%	**20**	Greek	0.4%

Source: Household Survey, 2004

[12] Twi is one of the dialects of the Akan language that is spoken by Ghanaians

Section 5:
BEMWG's cultural competence model

5.1 Cultural competence at the organisational and individual levels

As an equality specialist organisation BEMWG wants to increase the ability of health and social care agencies to provide services to BAMER service users that meet their cultural and linguistic needs. BEMWG presents a model for achieving cultural competence based on previous work undertaken by Cross and others.[13] Cultural competence requires that organisations and their staff have the capacity to:

1) Value diversity
2) Conduct self assessment
3) Manage the dimensions of cultural difference
4) Obtain and institutionalise cultural knowledge, and
5) Adapt to the cultural diversity of the community served.

These aspects need to be incorporated in policy making, administration, practice, service delivery and systematically involve service users.

BEMWG recognises that cultural and linguistic competences are developmental processes and evolve over time. Both individuals and organisations are at various levels of awareness, knowledge, skills and practice along the spectrum of cultural competence. Cultural competence involves developing at individual and organisational levels:

- An understanding that other people see the world differently; they have the right to see the world differently and they deserve your respect regardless of their world view.

- The necessary self awareness and knowledge of others, skills and practices for engaging effectively with people who are not from your own culture, ethnicity or racial background.

[13] Cross et al, "Towards a Cultural Competent System of Care", NIMH, 1989

5.2 Principles of Self Assessment

BEMWG uses a set of principles to guide all self assessment activities:

- Builds on existing strengths — it promotes growth among individuals and organisations that will enhance their ability to deliver cultural competent services.
- Non-judgemental environment — Practitioners need to be able to give honest feedback of their level of awareness, skills and practice. It is assumed the information will be used to effect meaningful change.
- Value the experiences and involvement of the community which uses services — community is seen as a key stakeholder where agencies can forge meaningful partnerships.
- Enhance and build capacity – self assessment gives a snapshot of where an individual or organisation is at a particular point in time. Results are used to plan and enhance the capacity of the organisation to deliver culturally competent services at all levels of the organisation.
- Variety of dissemination strategies used – self assessment results should be shared with key stakeholders in a way that meets their needs, for example, reports, executive summaries, Power Point presentations or strategic planning sessions.

5.3 The Benefits of Self Assessment

The ability to engage in self assessment helps organisations to:

- Measure the degree to which they are addressing the needs of culturally diverse groups
- Improve BAMER people's access to and take up of services
- Strategically plan for the incorporation of culturally and linguistically competent policies, structures and practices.
- Allocate resources to enhance service delivery.
- Identify individual and organisational strengths and areas for improvement.

BEMWG views self assessment as an ongoing process, not a one-off activity. It offers organisations and their staff the opportunity to assess individual and organisational progress over time.

5.4 BEMWG's 4-dimension model for assessing cultural competence

Cultural competence embodies the awareness, knowledge, skills and practices that allow an organisation or individual to deliver cultural competent services. We propose a model consisting of these four elements – awareness, knowledge, skills and practices – that contribute to enhancing organisation's or an individual's ability to become culturally competent, i.e. able to interact effectively with people of different cultures.

BEMWG's model can be used at two levels:

(1) Individual practitioner and
(2) Organisational.

The model consists of these four elements:

1. **Awareness** – examining and describing your own personal values[14] and beliefs.[15] This self awareness contributes towards understanding of cultural identity. Become aware that your cultural background is a major factor in shaping your values and beliefs which influences your health and beliefs and practices. Greater awareness reduces the risk of cultural bias towards clients.[16]

2. **Cross-Cultural Knowledge** – gaining cultural knowledge through meaningful contact with BAMER people and increasing your understanding of the problems they face. This knowledge is required to understand the similarities and differences of cultural groups as well as health inequalities within and between groups.

3. **Cross-Cultural Skills** – applying skills that reflect the practitioner's understanding of the role of culture in the helping process, e.g. becoming more comfortable in cross-cultural situations; learning verbal and non-verbal cues of other cultures; assessing what works and what does not; assessing how the beliefs and behaviours of the cultural group affect the client; learning to negotiate between the client's beliefs and practices and the culture of your profession; learning to develop culturally appropriate interventions.

4. **Practices** – applying and integrating knowledge about culturally diverse individuals and groups of people into specific standards, policies and practices to be used in health and social care settings to increase the quality of services thus producing better outcomes.

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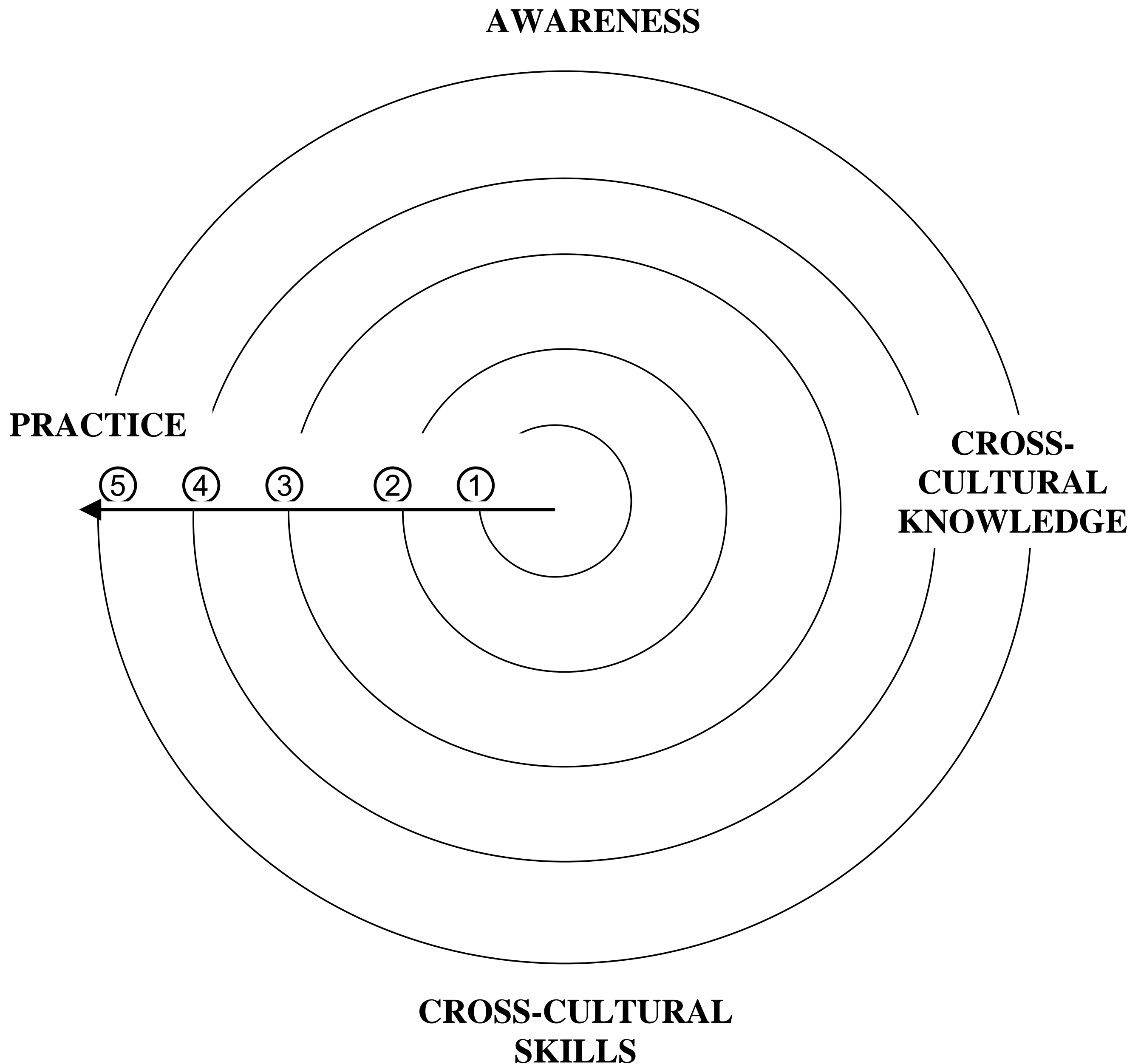
[14] Values are about how we have learnt to think things should be or people should behave, e.g. honesty, integrity, openness.
[15] Beliefs are the assumptions we make about ourselves, about others in the world and how we expect things to be.
[16] Clients' is used inclusively to refer to individuals, families, groups, organisations and communities

Figure 6 Using a spider gram to measure culture competence



5.5 Using a Spider gram to measure cultural competence

The spider gram in Figure 6 provides a visual map for broadly assessing cultural competency. This method can be used to measure how well an organisation or professional is working towards achieving its cultural competency objectives. The spider gram provides a visual means for measuring changes or indicators of cultural competence. A scale of 1 to 5 is given so it will be easier for people to reach a consensus but the answer will serve only as a general indication.

The spider gram has lines in which cultural competency can be measured across the four dimensions – awareness, knowledge, skills and practices.

DIMENSIONS	MEANING
Awareness	Self awareness of personal values, beliefs and biases that inform practice and influences relationships with clients/patients
Cross-cultural knowledge	Knowledge regarding various cultural groups where health care or social care professionals acknowledge individual differences within cultural groups and avoid stereotypes
Cross-cultural skills	Health and social care practitioners and service providers apply practical skills that reflect the role of culture in the helping process
Practices	Cultural competence is incorporated and reflected in the organisation's policies, procedures and service planning and delivery

Instructions for using the spider gram

a) For each dimension mark a X on the line where you think your organisation has achieved using the scoring criteria given in Table 6.

b) After marking the four Xs along the dimension lines then draw a line to join up the Xs to see what shape your spider gram takes. The more your lines reach towards the outer edge of the spider gram the closer your organisation is towards achieving cultural competence, i.e. marks of 4 and 5.

c) If you have lower marks, (1, 2 or 3) then complete an Action Plan to address the gaps. See sample action plan below.

Action Plan			
Action Agreed	By when	By whom	Review date

d) You can use the spider gram to help you decide whether cultural competence in each of these areas is broad (mark 4 or 5) or narrow (mark 1 or 2). When the level of cultural competence has been marked on each line of the spider gram the marks can be joined up to show a spider web as shown in the example below (Figure 6).
e) At a later stage you can repeat this activity to decide whether the level of cultural competence has changed over time.

Table 6 SELF ASSESSMENT – SCORING CRITERIA

AWARENESS	
1	Lack of awareness of the demographic information on culturally diverse groups
2	No recognition of cultural differences. Everybody is to be treated the same.
3	Practitioners identify and examine their own values and beliefs. They are able to evaluate themselves and have a sense of their own culture.
4	Awareness and acceptance of cultural differences; the organisation values diversity.
5	Diversity is valued. Care is given with an understanding of and respect for the client's or patient's health-related beliefs and cultural values.
KNOWLEDGE	
1	Staff have a lack of knowledge and understanding about the world views of culturally diverse groups
2	Lack of understanding and knowledge of best practice treatments and diagnostic tools for culturally diverse groups
3	Learn about patients/clients' culture. Obtain knowledge of other cultures different from your own.
4	Understanding the barriers that prevent equality and access to health and social services for BAMER communities.
5	Understanding the values, beliefs and practices related to illness, health and well being of different cultural groups.
SKILLS	
1	Lack of communicating with culturally diverse clients/patients
2	Lack of cultural sensitivity in how professionals view people in their care; cross-cultural interpersonal communication is not seen as important.
3	Ability to establish a rapport with clients/patients of culturally diverse backgrounds
4	Ability to collect culturally relevant information about the patient/service user's health and/or social care and interpret these for the purpose of culturally appropriate interventions.
5	Engage effectively in cross-cultural interactions with BAMER clients/patients.
PRACTICES	
1	Lack of gathering and use of data as it relates to culturally diverse groups for policymaking and planning and service delivery
2	Lack of culturally diverse professional staff across all providers;
3	Cultural competency training offered by the organisation for practitioners to access cultural competency as part of their continuous professional development
4	Practitioners/agencies evaluate their level of cultural competence and develop a plan for improvement; providers analyse their structures, policies, practices, systems and procedures and implement action plan for improvements.
5	Practitioners/agencies deliver culturally appropriate services in ways that reflects the culture and traditions of the people served, Involve BAMER community in defining and addressing service needs. Cultural competence is integrated in all aspects of the organisation.

Figure 7 Sample spider gram

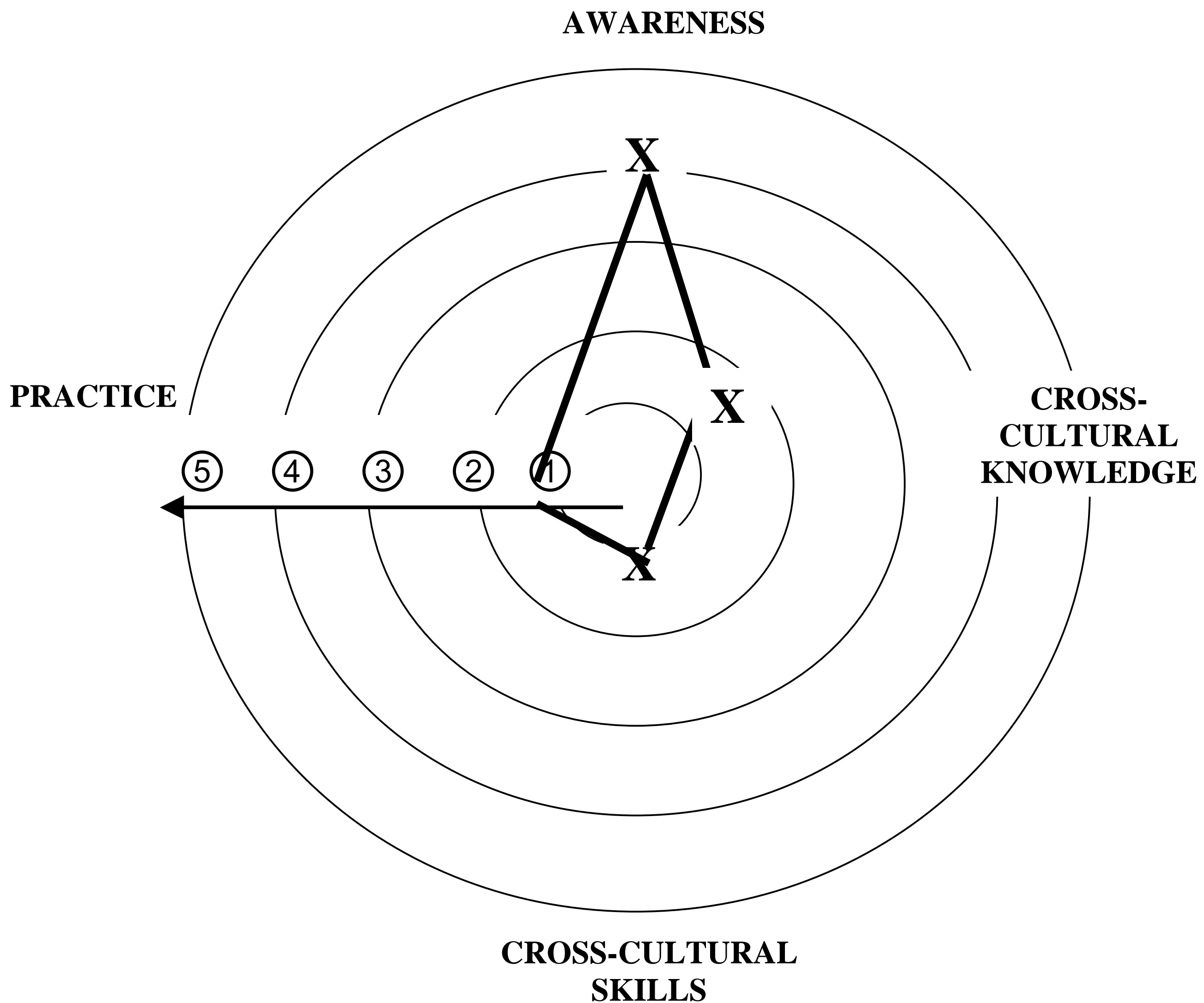


Figure 7 shows a sample spider gram. The results on the spider gram show that awareness is very good. However, in the other areas cultural competency was quite low. When the team discussed their experience of using the spider gram as a tool for measuring cultural competence they concluded that:

- It gave them new insight about how cultural competency took place in their organisation.
- It gave information about each of the four dimensions on which decisions could be based.
- It helped the team clarify their views about cultural competency and promoted exchange of views within the team.

5.6 Addressing cultural competence at individual and organisational levels

Individual level

Cultural assessment is the ability of health and social care professionals to collect relevant data regarding the service user's health history and presenting problem in the context of their culture. The basic premise of a cultural assessment is that service users have a right to their cultural beliefs, values, and practices, and these factors should be respected, understood, and considered when rendering culturally competent care. Understanding and negotiating with patients about the many social and cultural factors that influence their care can improve treatment outcomes and foster greater patient satisfaction.

An individual practitioner must gain an awareness and acceptance of cultural differences. If you do not recognise difference, then you cannot advance to learn to appreciate what difference can offer. An individual must have an awareness of his or her own cultural roots and customs. These are two important components of what makes each person different from everyone else in the world.

Learning about the dynamics of difference and how they can both positively and negatively affect a situation is key to advancing in cultural competency. An individual should never stop learning about new and different cultures and societies. It helps to expand one's view of the world and helps to create a better understanding among community members.

Taking the above steps will help the individual in adapting his or her service provision to the cultural context of the client being served, thereby making a more effective impact upon the client through culturally competent services.

Organisational Level

A service provider must first recognise the value that diversity brings to its provision. Such a valuation must come from the top of the organisation. Without placing a significant value on diversity, cultural competence is not achievable. Organisations may pay lip service to holding such values, but unless they are practiced and revered, from the top on down, the organisation will not advance.

An organisation must make the commitment to assess itself to determine just how culturally competent it is as an institution. Only then will management know how to progress to attain a greater degree of competency. It then becomes incumbent upon management to effectively deal with the dynamics of difference, utilising the organisations strengths and identifying its weaknesses, so as to be better prepared to move forward in a continuum of self-improvement.

The organisation must take an inventory of its cultural knowledge, which should be available for sharing with all employees. The inventory should be updated on a regular basis.

Finally, the organisation must adapt its policies, structure, values and services to reflect a culturally competent entity. It should then more closely reflect the community that it serves.

Because culture competence is not limited at the level of the individual practitioner organisations need to establish policies that support cultural competence. Thus, the practitioner and the organisation come together to provide cultural competent services.

5.7 Taking the next steps

The self-assessment process will produce information about the organisation's strengths and areas for development. Consideration should be given to:

- ☐ Setting organisational priorities.
- ☐ Devising strategic plans to sustain the strengths and address the development areas.
- ☐ Allocating resources to achieve the goals and objectives set out in the strategic plan.
- ☐ Establishing and maintaining partnerships with community stakeholders.
- ☐ Incorporating self-assessment results into the improvement planning and development process of the organisation.

The self assessment process may lead to changes in: organisation mission, values, policies, structures and procedures, staffing, service delivery, outreach approaches, composition of advisory committees or boards, professional training and development activities, management information systems. Achieving cultural competence is a long-term commitment. Progress is made incrementally one step at a time.

Section 6:
Cultural Competence Tools – Individual

6.1 Definition for individuals

For the individual cultural competency is defined as:

Being capable of working effectively in cross-cultural situations.

Cultural competency involves developing the necessary skills, self awareness and knowledge of others and engaging in cross-cultural situations to interact with people effectively who are not from your own cultural, ethnic or racial background. Cultural competence begins with a desire not to allow biases to keep you from treating every individual with respect. It requires an honest assessment of your positive and negative assumptions about other people. An organisation can help its health and social care practitioners to gain cultural competence through formal training although like most people cultural competence takes consistent practice over time.

6.2 Tools for individuals

We include tools or strategies for promoting self awareness about attitudes and beliefs that may affect or influence care. These tools will help you recognise your own biases as well as encourage self reflection. Furthermore, self assessment tools can help you engage in discussions about the needs, resources and goals for providing the highest quality of health and social care to every person served.

The tools can be used individually or in teams.

Here are several tools that individual practitioners can use to improve their understanding, awareness, skills and practice of cultural competency.

Table 7 Cultural Competency Tools for Individual Practitioners

DIMENSION	TOOL TITLE
Awareness	• Tool 1 – Practitioner Quiz • Tool 2 – Cultural Diversity Barriers
Knowledge	• Tool 3 – Quality and Culture Quiz • Tool 4 – Improving communication, improving care
Skills	• Tool 5 – Cross-cultural communication skills • Tool 6 – Working with interpreters
Practice	• Tool 7 – Self assessment checklist for practitioners • Tool 8 – Checklist for facilitating the development of cultural competency policies and practices

AWARENESS TOOL 1
Practitioner Quiz:
Are you providing culturally competent care?

Purpose:

To determine the level of awareness about the health issues affecting BAMER patients/clients.

INSTRUCTIONS

1. Name two diseases/conditions that are influenced by racial/ethnic factors. Explain
2. Describe two cultural values or beliefs that influence how a cultural group, different from your own, responds to being sick.
3. Do you respect differences in health behaviours practiced by your client?
4. Name two ways in which your practice is responsive to the needs of diverse groups?
5. Do you take culture, gender, and race into consideration when examining risk factors faced by your clients?
6. Do you involve your clients in the decision making when considering a course of treatment?
7. What is a question you commonly ask to learn about your clients' ethnic or cultural background? How is this information relevant to your practice?

Add up your score.

Give yourself 1 point for each item named on questions 1, 2, 4, and 7.

Give yourself 1 point for a Yes on questions 3, 5, and 6.

Score 9-10: Good work, keep it up! Cultural competence is a continuous quality improvement process.

Score 2-8: Keep working, you have a way to go.

Score 0-1: Better start developing your competency skills.

AWARENESS TOOL 2
Cultural diversity barriers

Purpose:
To examine the five assumptions in the mainstream culture of the UK.

There are many barriers to building cultural awareness in organisations. Awareness of the following themes is one way of overcoming cultural barriers.

1. ***The United Kingdom is a "level playing field" for someone, no matter what his or her culture.***

The socialisation process in schools and the media regularly project institutions as being "colour-blind" and present mainstream culture as being fair to everyone (a so-called "level playing field"). A "level playing field" is a situation in which people are required to follow the same rules and are given an equal ability to compete. The assumption is that if someone does not succeed it is because they are lazy or have personal faults – and that it is the fault of the individual and not the mainstream culture.

BAMER people disproportionately suffer from certain illnesses. Many do not have access to health care and do not receive the same quality of care. For instance, they are diagnosed for cancer at later stages and as a result of lack of access are more likely to die from preventable, treatable cancers. Another example is the diabetes rates for BAMER people which are excessively higher. Consequently, end stage renal disease disproportionately impacts BAMER people.

Do we blame BAMER people for this or take the necessary steps to reduce the burden of chronic conditions and diseases? Health care is not a level playing field. There is a need to promote awareness of health disparities to stimulate discussions on the importance of addressing health disparities as we move towards reform of the NHS and social care systems.

2. ***British people don't have a culture.***

This is an unconscious norm for mainstream British culture, based on the idea that white British people do not have a culture. All other groups have a culture but the white British group do not. They are the norm by which other groups are judged.

3. ***If it's different, it's wrong.***

This assumption has been referred to as racism, but relates to many "isms", such as anti-Semitism, classism and to anti-migrant, anti-refugee biases. The

popular belief in the race concept dates back to at least beginning of the 16th century when Europeans built overseas empires in the Americas, Asia, and Africa. The race concept supported the destruction and impoverishment of the indigenous people on these continents.

4. You shouldn't talk about cultural diversity.

This assumption is based on the policy of "we're all the same". Many think that if you talk about cultural differences it perpetuates problems and is "divisive" – and just brings up problems that are already solved. It also involves the concept of invisibility – if you do not talk about different groups, they are not there. This approach, for instance, involved the forced assimilation of English Romany Gypsies. This assimilation has brought about a loss of cultural heritage among Romany people in Europe.

5. You shouldn't admit to being prejudiced.

This is another age-old approach. If you do not admit to even a perception of prejudice or institutional and system inequities, it supports the idea that life is on a level playing field – and then you do not have to do anything about it.

KNOWLEDGE TOOL 3
Quality and culture quiz

Purpose:

To test your current knowledge of cultural competence with this true/false quiz. It helps you to reflect on your own knowledge and experience about working with culturally diverse people.

INSTRUCTIONS

This quiz takes about fifteen minutes - there are 12 multiple choice and true/false questions.

1. Cross-cultural misunderstandings between service providers and clients can lead to mistrust and frustration, but are unlikely to have an impact on objectively measured clinical outcomes.

   True ☐
   False ☐

2. When the client and provider come from different cultural backgrounds, the medical history obtained may not be accurate.

   True ☐
   False ☐

3. A conscientious health or social care provider can eliminate his or her prejudices or negative assumptions about certain types of service users.

   True ☐
   False ☐

4. When taking a case history from a patient or client with a limited ability to speak English, which of the following is LEAST useful?

   a. Asking questions that require the patient to give a simple "yes" or "no" answer, such as "Do you have trouble breathing?" or "Does your knee hurt?"
   b. Encouraging the patient to give a description of her/his situation, and beliefs about health and illness.
   c. Asking the patient whether he or she would like to have a qualified interpreter for the medical visit.

d. Asking the patient questions such as "How has your condition changed over the past two days?" or "What makes your condition get better or worse?"

5. During a medical interview with a patient from a different cultural background, which is the LEAST useful technique?

   a. Asking questions about what the patient believes about her or his illness - what caused the illness, how severe it is, and what type of treatment is needed.
   b. Gently explaining which beliefs about the illness are not correct.
   c. Explain the "Western" beliefs about the patient's illness.
   d. Discussing differences in beliefs without being judgmental.

6. When a patient is not adhering to a prescribed treatment after several visits, which of the following approaches is NOT likely to lead to adherence?

   a. Involving family members.
   b. Repeating the instructions very loudly and several times to emphasise the importance of the treatment.
   c. Agreeing to a compromise in the timing or amount of treatment.
   d. Spending time listening to discussions of folk or alternative remedies.

7. Which of the following are the correct ways to communicate with a patient through an interpreter?

   a. Making eye contact with the interpreter when you are speaking, then looking at the patient while the interpreter is telling the patient what you said.
   b. Speaking slowly, pausing between words.
   c. Asking the interpreter to further explain the patient's statement in order to get a more complete picture of the patient's condition.
   d. None of the above.

8. If a family member speaks English as well as the patient's language, and is willing to act as interpreter, this is the best possible solution to the problem of interpreting.

   True ☐
   False ☐

9. Which of the following statements is TRUE?

   a. People who speak the same language have the same culture.
   b. The people living on the African continent share the main features of African culture.
   c. Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country.
   d. An alert provider can usually predict a patient's health behaviours by knowing what country s/he comes from.

10. Some symbols—a positive nod of the head, a pointing finger, a "thumbs-up" sign—are universal and can help bridge the language gap.

True ☐
False ☐

11. Out of respect for a client's privacy, the provider should always begin a relationship by seeing an adult client alone and drawing the family in as needed.

True ☐
False ☐

12. Which of the following is NOT TRUE of an organisation that values cultural competence?

a. The organisation employs or has access to professional interpreters that speak all or at least most of the languages of its clients.
b. The organisation posts signs in different languages and has patient education materials in different languages.
c. The organisation tries to hire staff that mirror the cultural diversity of its clients.
d. The organisation assumes that health or social care staff do not need to be reminded to treat all patients or clients with respect.

QUIZ ANSWERS

1. **Cross-cultural misunderstandings between providers and clients can lead to mistrust and frustration, but are unlikely to have an impact on objectively measured clinical outcomes.**

   False: Low levels of cultural competence can impede the process of making an accurate diagnosis, cause the provider to order contraindicated medication, and reduce patient adherence to recommended treatment.

2. **When the client and provider come from different cultural backgrounds, the medical history obtained may not be accurate.**

   True: Because of language and cultural barriers, the patient may not understand the questions or may be reluctant to report symptoms; in turn, the provider may misunderstand the patient's description of symptoms.

3. **A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of patients.**

   False: Most of us harbour some assumptions about patients, based on race, ethnicity, culture, age, social and language skills, educational and economic status, gender, sexual orientation, disability/ability, and a host of other characteristics. These assumptions are often unconscious and so deeply rooted that even when an individual patient behaves contrary to the assumptions, the provider views this as the exception to the rule. A conscientious provider will not allow prejudices to interfere with making an accurate diagnosis and designing an appropriate treatment plan.

4. **When taking a medical history from a patient with a limited ability to speak English, which of the following is LEAST useful?**

   Answer: a. While it may seem easier to ask questions that require a simple "yes" or "no" answer, this technique seriously limits the ability of the patient to communicate information that may be essential for an accurate history and diagnosis. The most effective way to put the patient at ease and to ensure that the patient provides essential information about his or her symptoms is to combine two types of questions: 1) open-ended questions such as "Tell me about the pain in your knee" and 2) more directed questions, such as "What makes the pain get better or worse?" Always get a qualified interpreter when possible.

5. **During a medical interview with a patient from a different cultural background, which is the LEAST useful technique?**

   Answer: b. Although the provider may be tempted to correct the patient's different beliefs about illness, this may lead the patient to simply withhold his/her thoughts in the future and interfere with building a trusting relationship. It is more effective to be nonjudgmental about differences in beliefs. The provider should keep in mind two goals: 1) the patient should reveal her/his medical history and symptoms to help the provider make an accurate diagnosis, and 2) the patient should develop trust in the provider's medical advice and be willing and able to adhere to that advice. To accomplish these goals, it is essential to treat the patient with respect, openly discussing differences in health beliefs without specifying "correctness" or "incorrectness."

6. **When a patient is not adhering to a prescribed treatment after several visits, which of the following approaches is NOT likely to lead to adherence?**

   Answer: b. Non-adherence can be the result of many different factors that may require a variety of interventions. Simply repeating the instructions may not address the real issues that are keeping the patient from adhering to the regimen. Family members can provide valuable support. It may also be necessary to set small, realistic goals in order to achieve long-term behavioural change. Finally, an understanding of the patient's beliefs about other remedies may offer valuable clues to her/his reluctance to adhere to treatment.

7. **Which of the following are the correct ways to communicate with a patient through an interpreter?**

   Answer: d. Although it may seem natural to look at the interpreter when you are speaking, you want the patient to feel that you are speaking to her/him, so you should look directly at her/him, just as you would if you were able to speak her/his language.

8. **If a family member speaks English as well as the patient's main language, and is willing to act as interpreter, this is the best possible solution to the problem of interpreting.**

   False: This is an inappropriate responsibility for families to take .The rationale for using professional interpreters is clear. Professional interpreters have been trained to provide accurate, sensitive two-way communication and uncover areas of uncertainty or discomfort. Family members are often too emotionally involved to tell the patient's story fully and objectively or lack the technical knowledge to convey the provider's message accurately.

9. **Which of the following statements is TRUE?**

   Answer: c. The only assured similarity among people from around the world who come to you for care is the fact that they are your patients and they hope to be treated with respect and with concern for their individual health needs. As a health care practitioner, it is important to have a basic understanding of your patients' cultures—and to recognise the similarities and differences among people from the same region of the world and the same country. Differences in cultures within a region can be pronounced. Each patient is the product of many cultural forces. People from the same continent, the same country, the same part of the country, and even the same city, may have major differences in cultural heritage, traditions, and language, as well as differences in socioeconomic status, education, religion, and sexual orientation. It is the combination of all of these factors that make up a person's "culture.")

10. **Some symbols—a positive nod of the head, a pointing finger, a "thumbs-up" sign—are universal and can help bridge the language gap.**

    False: Each of these symbols has a very different meaning in different cultures and may be offensive.

11. **Out of respect for a patient's privacy, the provider should always begin a relationship by seeing an adult patient alone and drawing the family in as needed.**

False: In many of the world's cultures, an individual's health problems are also considered the family's problems, and it is considered threatening to exclude family members from any medical interaction. The provider should ask the patient whether she/he would prefer to be seen alone or with the family. It should be the provider's purpose to help the patient to express her/his true preference about this - without offending any family members. The provider might ease any tension around this issue by assuring family members that they will be asked to return to the examining room in a short time.)

12. Which of the following is NOT TRUE of an organisation that values cultural competence:

Answer: d. Even the most conscientious, committed staff that have been trained in cultural competence may need periodic reminders. In a busy practice, it is easy for providers to seek shortcuts, slipping into assumptions about the culturally diverse they serve and failing to take the time needed to fully understand the health beliefs and values of each client.

KNOWLEDGE TOOL 4
Improving communication, improving care

Purpose:

To explore verbal and non-verbal communication which impact on the client/provider relationship.

Communication is much more than verbal exchanges. Non-verbal communication, in the form of body language, silences and signals, plays a large part in successful communication. However, these forms of communication are also subject to cultural and individual differences.

The quality of the client-provider interaction has a profound impact on the ability of patients to communicate symptoms to their provider and to adhere to recommended treatment. It also has an impact on the patient's feelings about being respected (or disrespected) as an individual, a member of a family and a member of a cultural group.

As forms of non-verbal communication are influenced by cultural and individual considerations, it is not possible to provide a list of dos and don'ts beyond highlighting the need for sensitivity in any exchange.

Be aware of the following:

Styles of speech: People vary greatly in length of time between comment and response, the speed of their speech and their willingness to interrupt.

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges and even interruptions are part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruption, especially if the patient is older than you are.

Eye contact: The way people interpret various types of eye contact is tied to cultural and life experience. The amount of eye contact that individuals are comfortable with may differ between cultures. In some cultures, direct eye contact may be seen as impolite and disrespectful whilst for others, avoidance of eye contact may be interpreted as disinterest or untrustworthiness.

- Most British people expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a client to make eye contact with you.
- If a client seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body language: Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, gender and age.

- Follow the client's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gesture and body language. Ask clients about unknown gestures or reactions.
- Do not interpret a client's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Guide client conversation: The English language predisposes us to a direct communication style; however, other languages and cultures differ.

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally; no matter how long they have known the health care worker or social worker. If the client's preference is not clear, ask how they would like to be addressed.
- People from other cultural backgrounds may be less likely to ask questions and are more likely to answer questions through narrative than direct responses. Facilitate client-centred communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered "yes" or "no". Research indicates that when clients, regardless of cultural background, are asked, "do you understand?" many will answer "yes" even when they really do not understand.
- Steer the client back to the topic by asking a question that clearly demonstrates that you are listening. Some clients can tell you more about their health through storytelling than by answering direct questions.

The following case studies provide examples of non-verbal miscommunication that can sabotage a client-provider encounter. Broad cultural generalisations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalisation** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Eye Contact

Most professionals are taught that making eye contact with service users is essential. However, service users may come from cultures where looking someone directly in the eye is disrespectful. Whereas health and social care providers may view lack of eye contact as discomfort, service users may see it as a gesture of respect.

> *Case Study 1*
> *Maureen was trying to teach her Asian client, Subash Patel, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She concluded from this that he was uninterested and therefore not listening to her.*

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health and social care professionals in most Asian and African countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

> *Case Study 2*
> *A doctor asked for help encouraging young female clients to make and keep their first well woman appointment. The doctor stated that this group had a high no-show rate and appointments did not go as smoothly as he would like.*

Talk the client through each exam so that the need for the physical contact is understood before undertaking the examination. Ease into the clients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the client's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

> *Case Study 3*
> *An English patient named Steve Dent called out to Elena, a Filipino nurse: "Nurse, nurse". Elena came to Mr. Dent's door and politely asked, "May I help you?" Mr. Dent indicated for her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Dent was confused. Why had Elena's manner suddenly changed?*

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Dent's innocent hand gesture. In the Philippines the "come here" hand gesture is used to call animals.

Body Posture and Presentation

> *Case Study 4*
> *Karen, the social worker, was surprised to see that Mr.Perez was dressed smartly for his assessment visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the office either made a mistake documenting his ability to pay for the service or that he falsely declared his income.*

Many cultures prioritise respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the socio-economic background or the physical condition of the individual, going out in public or meeting with a government employee involves creating an image that reflects positively on the family – the clothes are ironed, the hair is combed and shoes are polished. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

> *Case Study 5*
> *Dr. Wilson had three clients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Thu. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tuu to take an active part in the visit.*

The use of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.

SKILLS TOOL 5
Enhancing cross-cultural communication skills

Purpose:

To elicit information about client's or patient's beliefs and understand their social context. Communication is an essential skill for any practitioner working in a health or social care setting. It is important to identify belief systems of cultural groups to identify blocks to communication.

Cross-cultural communication skills involve demonstrating respect for patients and their beliefs through: active listening, eliciting patient beliefs and information, understanding the client's social context and negotiation skills.

So that I might be aware of and respect your cultural beliefs ...

1. Can you tell me what languages are spoken in your home and the languages that you understand and speak?
2. Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
3. Can you tell me about beliefs and practices including special events such as birth, marriage and death that you feel I should know?
4. Is there anything else you would like to know? Do you have any questions for me?
5. Do you use any traditional health remedies to improve your health?
6. Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
7. Are there certain health care procedures and tests which your culture prohibits?
8. Are there any other cultural considerations I should know about to serve your health needs?

One model for bridging cultural differences is ETHNIC.[17]
E Everyone has a culture.
T Take time to collect relevant cultural information.
H Hold all judgments. Be careful about interpreting culturally different behaviour.
N Notice and negotiate differences in understanding.
I involve cultural resources as appropriate.
C Collaborate to develop objectives and strategies.

[17] http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/culture1.htm

SKILLS TOOL 6
Working effectively with professional interpreters

Purpose:

To make more effective use of professional interpreters.

Health and social care workers may find themselves using an interpreter when working with clients who are unable to speak English. When they do so, sometimes question arise:

How can I feel more comfortable using interpreting services?

How do I know if my service users really understand what I was saying?
Should I be saying or doing something different to ensure accuracy?

Where language support is required, it is always preferable to use trained interpreters. The following actions should help ensure that the interpreter is able to act as effectively as possible:

- Acknowledge and respect the role of the interpreter as a professional communicator.
- Meet with the interpreter beforehand to discuss how you will work together.
- Explain the purpose of the interview or visit and what information is required from it.
- Clarify any terms that you will use and which the interpreter is unfamiliar with.
- Ask the interpreter to alert you to any cultural or other issues which might lead to a misunderstanding or unknowingly give offence.
- Respect the interpreter's judgement that a particular question may be culturally inappropriate and seek their advice in rephrasing it or finding an alternative means to elicit the relevant information.
- Check that the interpreter will keep the individual informed of what is happening.
- Allow more time for the appointment to take place as all discussion will have to go through the interpreter twice.
- Allow time before the formal appointment for the interpreter and individual to get to know each other and feel comfortable in each other's company.

During the interview the following steps should be taken:

- Any seating arrangement should be informal and based on the points of a triangle.

- Check that the client is happy to talk openly through the interpreter.
- Stress that all information will remain confidential.
- During the session, speak directly to the individual and not the interpreter.
- Speak at an even pace in relatively short segments and take regular breaks to allow the interpreter to interpret.
- Be aware that many of the concepts and terms used will have no direct linguistic or conceptual equivalent in other languages and that the explanation given by the interpreter will take longer than your original speech.
- Avoid idiomatic speech, complicated sentence construction, fragmented sentences, asking multiple questions at one time and changing thoughts in the middle of a sentence.

When the interview is coming to an end:

- Check that the individual is happy with how the discussion has progressed and any outcomes that have been agreed.
- Ensure that the client is clear about what will happen next.
- Discuss the client's preferences for information, i.e., a record of the assessment, to be made available to them in an accessible format

And finally:

- Arrange for a brief post interview meeting with the interpreter to assess how things went and to find out if there are any outstanding questions or concerns which may need to be followed up at a later date.

Taken together these tips can do much to ensure that effective communication between all parties concerned becomes a reality.

PRACTICE TOOL 7
Self-assessment checklist for care practitioners[18]

Purpose:

To increase the awareness of practitioners to the importance of cultural and linguistic competence in health and social care settings. It provides examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level.

INSTRUCTIONS

Please select **A, B** or **C** for each item listed below.

A = things I do frequently
B = things I do occasionally
C = things I never do

	Environment	
1.	I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of individuals or families to whom I provide service.	
2.	I ensure that brochures, magazines and other printed materials in reception areas are of interest to and reflect the cultural diversity of the community in which I serve.	
3.	When using DVDs, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families to whom I provide a service.	
4.	I ensure the printed information I provide takes account of the literacy levels of individuals or families to whom I provide a service .	
	Communication styles	
5.	When interacting with individuals and families who have limited English proficiency, I always keep in mind that: limitations in spoken English do not reflect in any way on their intellectual capability. their limited ability to speak English has no bearing on their ability to communicate in their own mother tongue.	

[18] This tool has been adapted from *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia,* Nova Scotia Department of Health, 2005

6.	I use bilingual staff trained in medical interpretation when required or requested.	
7.	For speakers of other languages I try to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.	
8,	I understand the cultural context for naming diseases and try to be respectful of this in my interactions. In some cultures there is stigma attached to terminal disease and sexually transmitted diseases.	
9.	I can provide alternatives to written information if required.	
	Social interaction	
10.	I understand and accept that family is defined in a variety of different ways by different cultures (e.g., extended family members, kin, godparents).	
11.	Even though my professional or moral point of view may differ, I accept individuals and families as the ultimate decision makers for services impacting their lives.	
12.	I understand that age, sex and life cycle factors need to be considered in interactions with individuals and families. For instance, a high value may be placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family.	
13.	I accept and respect that male-female gender roles may vary among different cultures and ethnic groups (e.g., which family member makes major decisions for the family).	
	Health, Illness and End of Life Issues	
14.	I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.	
15.	I recognise that the meaning or value of medical treatment and health education may vary greatly among cultures.	
16.	I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.	
17.	I understand that grief and bereavement differ by culture.	
18.	I seek information from individuals, families or other key informants that will to respond to the needs and preferences of culturally and ethnically diverse communities served by my organisation.	
19.	I keep abreast of the major health or social care issues for culturally diverse groups living in the local area served by my	

	organisation.	
20.	I am well versed in the most current and proven practices, treatments and interventions for major health problems among culturally diverse groups in the local area served by my organisation.	
	Values and attitudes	
21.	I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.	
22.	I screen books and other resources for cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my agency.	
23.	I intervene in an appropriate manner when I observe other staff or service users within my agency engaging in behaviours that show cultural insensitivity, racial biases and prejudice.	
24.	I understand and accept the family is defined differently by different cultures (e.g. extended family members, godparents).	
25.	I am aware of the socioeconomic and environmental risk factors that contribute to health problems of culturally diverse groups served by my agency.	
26.	I recognise that the meaning and value of medical treatment and health promotion may vary greatly among cultures.	
27.	I understand that the perception of health, wellness and preventative health services have different meanings to different cultural groups.	
28.	I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.	
26.	I avail myself of professional development and training to enhance my knowledge and skills in the provision of services to cultural diverse groups.	
27.	I advocate for the review of my organisation's mission statement, goals, policies and procedures to ensure that they incorporate practices that promote cultural and linguistic competence.	

PLEASE NOTE:

There is no answer key with correct responses. However, if you frequently responded with "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural competence in working with BAMER clients or patients.

PRACTICE TOOL 8
Checklist to facilitate the development of culturally competent care policies and structures

Purpose:

To facilitate policy making that supports culturally and linguistically competent primary heath care services. The following checklist is aimed at individuals who have a role in shaping policy at the local or regional levels. Policy makers may be board members, advisory committee members, agency directors, staff of community organisations, commissioners, legislators.

Does the organisation or programme have:

- ☐ A mission statement that articulates its principles, rationale and values for culturally and linguistically competent health and social care services?
- ☐ Policies and procedures that support a practice model which incorporates culture in the delivery of services to culturally and linguistically diverse groups?
- ☐ Structures to ensure the meaningful participation of clients/service users and communities in planning, delivery and evaluation of services?
- ☐ Processes to review policy and procedures systematically to assess their relevance for the delivery of culturally competent services?
- ☐ Policies and procedures for staff recruitment, hiring and retention that will achieve the goal of a diverse and culturally competent workforce?
- ☐ Policies and resources to support ongoing professional development and in-service training (at all levels) for awareness, knowledge and skills in the area of cultural and linguistic competence?
- ☐ Policies to assure that new staff are provided with training, technical assistance and other supports necessary to work within culturally and linguistically diverse communities?
- ☐ Position descriptions and personnel/performance measures that include skill sets related to cultural and linguistic competence?
- ☐ Financial support and incentives for the improvement of cultural competence at the board, agency, program and staff levels?

- ☐ Policies for and procedures to review periodically the current and emergent demographic trends for the geographic area it serves?

- ☐ Methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas?

- ☐ Policies and allocated resources for the provision of translation and interpretation services, and communication in alternative formats?

- ☐ Policies and resources that support community outreach initiatives for those are speakers of other languages and/or are not literate or have low literacy skills in their mother tongue?

- ☐ Requirements that contracting procedures and proposals and/or request for services include culturally and linguistically competent practices?

Section 7:
Cultural Competence Tools – Organisational

7.1 Developing cultural competency in organisations

Cultural competence requires that organisations:

- Have a defined set of values and principles and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally with people from different ethnic and cultural backgrounds.

- Incorporate the above in all aspects of policy making, administration, practice/service delivery and systematically involve families and communities.

In working towards the goals of quality care and professional standards, organisations must foster operating environments that support cultural competence in care delivery. They must value diversity to establish the policies and procedures needed for the people in the organisation to develop and "live" cultural competence. At the most basic level they must choose to positively engage in the diversity agenda if real change is to happen. This engagement involves creating an inclusive environment in which diverse skills, cultural perspectives and backgrounds are recognised and valued.

Health and social care providers vary in their awareness of how racial, cultural, ethnic, sexual orientation and gender issues impact their service users or staff. Institutions that recognise and value diversity will be in a better position to offer culturally relevant services to their multicultural populations. Determining what the organisational culture is like, what policies or practices either facilitate or impede cultural diversity and how to implement change is fundamental. The process for achieving organisational cross-cultural competence is neither a short-term commitment nor a one-off exercise that begins and ends with several training sessions per year.

To become culturally proficient both personally and organisationally requires a well-planned and consistent approach that includes the following components:

- Having a genuine commitment to diversity from organisational leaders, including boards of trustees and senior leadership staff.
- Promoting inclusive policies and practices that support cultural competence at all levels of the organisation.
- Defining the mission, goals, human resources policies and procedures and reward structure that communicate a commitment to diversity.
- Hiring and promoting employees from culturally diverse communities at all levels of the organisation.
- Involving BAMER community representatives in aspects of the healthcare and social care organisation's planning and delivery processes.
- Systematically conducting community needs assessments, collecting demographic data and language preference information to make decisions regarding appropriate interventions and services.
- Learning more about the influence that socio-cultural factors may have on health beliefs and behaviours of the individuals or communities being served.
- Investing financial resources into developing culturally relevant interventions and services to meet the identified needs of culturally diverse communities.
- Asking service users and leaders from diverse communities to evaluate the effectiveness and appropriateness of the efforts undertaken by organisations.

7.2 Organisational Tools

Here are several tools that organisations can use to increase their cultural competence in working with culturally diverse service users.

Table 8 Cultural Competency Tools for Organisations

DIMENSION	TOOL TITLE
Awareness	• Tool 1 – Developing a cultural competency policy • Tool 2 – Workforce diversity audit
Knowledge	• Tool 3 – Knowledge of diverse communities • Tool 4 – Developing a supportive infrastructure
Skills	• Tool 5 – Clinical practice • Tool 6 – Organisational self-assessment tool
Practice	• Tool 7 – Collecting and using data to improve services • Tool 8 – Checklist for facilitating community engagement

AWARENESS TOOL 1
Developing a cultural competency policy

Purpose:

To explore organisational commitment to provision of cultural competent services and the extent to which it is legitimised in policy.

1. Does your organisation have a mission statement that incorporates cultural and linguistic competence in service delivery?
   ☐ Yes ☐ No

2. Does your organisation consider cultural and linguistic differences in developing quality improvement processes?
   ☐ Never ☐ Sometimes ☐ Fairly often ☐ Very often

3. Does your organisation advocate for culturally diverse service users regarding quality of life issues (e.g. employment, housing, education) in your area?
   ☐ Never ☐ Sometimes ☐ Fairly often ☐ Very often

4. Does your organisation systematically review procedures to ensure that they are relevant to delivery of culturally competent services?
   ☐ Never ☐ Sometimes ☐ Fairly often ☐ Very often

5. Does your organisation systematically review procedures to ensure that they are relevant to delivery of linguistically competent services?
   ☐ Never ☐ Sometimes ☐ Fairly often ☐ Very often

6. Does your organisation help service users get the support they need to access health or social care?
   ☐ Never ☐ Sometimes ☐ Fairly often ☐ Very often

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7. Are there structures in your organisation that enable service users to participate in:

	Not at all	Sometimes	Fairly often	Very often
a. Service planning	☐	☐	☐	☐
b. Service delivery	☐	☐	☐	☐
c. Evaluation of services	☐	☐	☐	☐
d. Quality improvement	☐	☐	☐	☐
e. Recruitment practices	☐	☐	☐	☐
f. Performance appraisal	☐	☐	☐	☐
g. Customer satisfaction	☐	☐	☐	☐

8. Does your work environment contain décor reflecting the cultural diversity of your local area?

☐ None ☐ Some ☐ Quite a few ☐ Many

9. Does your organisation post signs and materials in languages other than English?

☐ None ☐ Some ☐ Quite a few ☐ Many

AWARENESS TOOL 2
Workforce diversity audit

Purpose:

To measure an organisation's ability to sustain a workforce that is culturally and linguistically competent.

INSTRUCTIONS

1. Are there policies that support workforce demographics of the local area?

☐ Yes ☐ No

2. Are members of the following culturally diverse groups represented on the staff of your organisation?

Designated cultural groups	None	Some	Quite a few	Many

3. Does your organisation have culturally and linguistically diverse individuals as:

	None	Some	Quite a few	Many
a. Board members	☐	☐	☐	☐
b. Directors	☐	☐	☐	☐
c. Senior managers	☐	☐	☐	☐
d. Doctors	☐	☐	☐	☐
e. Consultants	☐	☐	☐	☐
f. Clinical staff	☐	☐	☐	☐
g. Administrative staff	☐	☐	☐	☐
h. Support staff	☐	☐	☐	☐
i. Volunteers	☐	☐	☐	☐

4. Is there a policy that supports recruitment of staff, board members, consultants and volunteers?

☐ No policy ☐ Developing policy ☐ Don't know
☐ Informal policy ☐ Formal policy

5. Does your organisation have incentives for the improvement of cultural competence throughout the organisation?

☐ None ☐ Some ☐ Quite a few ☐ Many

6. Does your organisation have procedures to achieve the goal of a culturally and linguistically competent workforce includes:

	Yes	No
a. Staff recruitment	☐	☐
b. Hiring	☐	☐
c. Retention	☐	☐
d. Promotion	☐	☐

7. Are there resources to support professional development and in-service training for staff at all levels of the organisation?

☐ None ☐ Some ☐ Quite a few ☐ Many

8. Are in-service training activities on culturally competent health and social care conducted for staff at all levels of the organisation?

☐ None ☐ Some ☐ Quite a few ☐ Many

9. Are in-service training activities on linguistically competent health and social care conducted for staff at all levels of the organisation?

☐ None ☐ Some ☐ Quite a few ☐ Many

KNOWLEDGE TOOL 1
Knowledge of diverse communities

Purpose:

To identify the cultural groups and how they differ from the majority culture taking account of cultural beliefs, community demographics and local context.

1. Is your organisation able to identify the culturally diverse communities in your area?

Cultural groups	Very well	Fairly well	Barely	Not at all

2. Is your organisation familiar with current and projected demographics for your area?

Cultural groups	Very well	Fairly well	Barely	Not at all

3. Is your organisation able to describe the social problems of diverse cultural groups in your area?

Cultural groups	Very well	Fairly well	Barely	Not at all

4. Is your organisation aware of health or social care disparities among diverse groups in your area?

Cultural groups	Very well	Fairly well	Barely	Not at all

5. Is your organisation able to describe the languages used by the culturally diverse groups in your area?

Cultural groups	Very well	Fairly well	Barely	Not at all

6. For the culturally diverse groups in your area does your organisation know

	Very well	Fairly well	Barely	Not at all
a. The way illness and health are viewed, i.e. health beliefs				
b. The religious or spiritual beliefs held				
c. Dietary requirements				
d. Family/support structures				
e. Birthing				
f. Dying and death/end of life issues				

KNOWLEDGE TOOL 2
Developing a supportive infrastructure for cultural competence

Purpose:

To consider the factors that help build a foundation for meeting the needs of culturally diverse service users.

A commitment to culturally competent care can be reflected at the highest level by incorporating these ideals into an organisation's mission, planning and corporate-wide policies. These types of high-level activities can help organisations develop a cohesive message about meeting the needs of diverse people and better communicate this vision to staff, patients, service users and the public.

Starting with the Mission

As an agency's policies and practices are driven by its mission, vision and values organisations may want to incorporate a commitment to cultural competence in its guiding principles – particularly in the mission statement. Health and social care organisations use a variety of terms to refer to their commitment to meeting the needs of diverse population. While it cannot be claimed that a verbal commitment to meeting the needs of service users of diverse cultural backgrounds is not equivalent to providing culturally competent care it is important to recognise that organisations are making strides by including cultural competence issues at a strategic level and mentioning them in their organisation's mission, vision or values statement.

Making cultural competence a part of organisational planning

Health and social care providers can integrate cultural competence into their organisational planning. One way to do this is to use the former Commission for Racial Equality guidance or Department of Health guidance as a blueprint to guide equitable care. While standards do not prescribe how organisations should provide culturally and linguistically appropriate care, they present a starting point of a framework, identifying areas in which organisations should have systems or processes in place to address service users' needs.

Developing policies for cultural competence

Policies offer another vehicle for communicating the organisation's commitment to cultural competence. Organisational policies articulate to the staff the "dos" and "don'ts" but are limited in their ability to provide guidance beyond that. Despite these limitations, policies can help ensure

staff recognise the importance of culturally appropriate care to the organisation and to client care as well as their role in upholding these ideals.

Any organisational policy should be accompanied by staff training. Diversity and equal opportunities policies and cultural competency policies, by themselves, will not bring about racial equality. Organisations must have a system for checking whether their policies are being carried out and whether they are working.

Recruiting and retaining a diverse workforce

Health and social care providers can prioritise diversity within recruitment and hiring processes in order to incorporate cultural competency considerations at the workforce level. Some organisations undertake efforts to increase their BAMER staff to reflect the local population. New equality legislation will broaden the scope for employers to take positive action in recruiting under-represented groups.

Recruiting a diversified workforce does not come without its challenges. The competitive environment of recruitment in the health and social care sector, for instance. Once institutions have a diversified workforce they must also consider how they will maintain that workforce.

Having a high-level task force

It is important to establish a high-level task force – a strategic committee – to drive the cultural competency initiative and to take responsibility for diversity issues within the organisation. Recognition by the board leadership is necessary to its influence in effecting change within the organisation. This task force has to have the power to influence planning and organisational-level change. This is a substantial undertaking that requires the active participation of senior managers throughout the organisation, including board leadership.

Setting a budget

Another element required to support cultural competence within the organisation is setting internal budgets that support culturally and linguistically appropriate care. How do organisations overcome the financial challenges?

Conclusions

Building an infrastructure by developing corporate policies and procedures that support cultural competence is a crucial part of meeting the needs of diverse service users. Integrating cultural and linguistic considerations into organisational policy requires a demonstration of commitment. Without an organisational commitment to cultural competence and subsequent action at the policy and procedural level, these initiatives can be overshadowed b other organisational priorities. This can lead, for instance, to lack of financial and other resources for culturally competence services. Another challenge is

lack of clarity about who is responsible for providing culturally competent care.

To resolve these challenges, it is important for providers to clarify their commitment to providing culturally competent care by creating a supportive infrastructure of policies and procedures that enable staff to put those aspirations into action.

The self-assessment questions in Organisational Tool 6 can help organisations further explore the type of policies and procedures that will support their organisations in meeting the needs of diverse service users.

SKILLS TOOL 1
Clinical practice

Purpose:

To adopt approaches to health and social care delivery taking account of cultural and linguistic differences.

1. Do you use health assessment or diagnostic protocols that are adopted for culturally diverse groups?

Designated cultural groups	Never	Seldom	Sometimes	Regularly

2. Do you use health promotion, disease, prevention and treatment protocols that are adopted for culturally diverse groups?

Designated cultural groups	Never	Seldom	Sometimes	Regularly

3. Do you differentiate between racial and cultural identity when serving diverse service users?

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

4. Does your organisation use either of the following staff to provide interpretation services?

☐ Health advocates/interpreters

5. Does your organisation:

`

a. Train staff and use patient consent forms, materials and other information in other languages

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

b. Ensure materials address the literacy needs of the service users.

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

c. Assess the health literacy of service users.

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

6. Does your organisation evaluate the quality and effectiveness of interpreting and translation services it either provides or contracts?

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

ORGANISATIONAL TOOL 6

SKILLS TOOL 2
Organisational self-assessment tool

Purpose:

To enable you to have a better understanding of how you can help your organisation advance in the process of achieving cultural competence.

INSTRUCTIONS

Complete the assessment statements by ticking the box that applies to you below for each phase. This will help provide you with a clearer picture of where you are – where you may want to go, and what you may need to do to get there.

The intended outcomes of the self-assessment are the following:

- An understanding of the strengths, gaps, and areas where development is needed among agencies
- A set of results that will assist the agency to identify training and other needs to address gaps and developmental issues.
- A foundation for recommendations and action planning that will guide the work of the agency.

Your assessment results will assist you to have a better understanding of how you can contribute to help your organisation advance in the process of achieving cultural competence.

Organisational Policies and Practices	Yes	No	Don't know
1. Anti-discrimination and workplace harassment policies are in place			
2. Existing policies have been examined in order to identify barriers to inclusion			
3. Issues of diversity and social inclusion have been addressed in a strategic action plan			

Leadership in policy implementation	Yes	No	Don't know
4. A strategic action plan to reduce barriers to social inclusion has been established.			
5. This plan addresses issues of diversity, inclusion and equity as well as workplace discrimination and harassment.			
6. Steps to monitor, review and evaluate the plan are in place.			
7. Resources have been explicitly allocated for effective implementation of the plan.			

Communications and decision making	Yes	No	Don't know
8. The organisation has compiled an updated regional/local profile of the community including demographics, socio-economic issues and environmental issues relevant to health status.			
9. A list of community, regional and provincial organisations that work directly with BAMER has been developed.			
10. A list of other points of access to diverse communities (places of worship or social clubs etc.) has been developed.			
11. A comprehensive list of black, Asian, minority ethnic and refugee media has been developed.			
12. Communication strategies have been developed to provide necessary information to the various communities within a service area.			

Measuring progress in removing barriers	Yes	No	Don't know
13. A policy for monitoring and evaluating progress in elimination of barriers to inclusion is in place.			
14. All staff have opportunities for involvement in evaluation and providing input in areas related to diversity and social inclusion.			

Service planning	Yes	No	Don't know
15. Engagement with representatives from the diverse communities has been undertaken to inform organisational planning.			
16. Information about the health and/or social care needs and information needs of BAMER communities has been obtained.			
17. Outreach strategies have been developed and resources have been allocated equitably.			
18. Programs and services are adapted to respond to expressed [or identified] needs and issues of diverse communities within the service area.			
19. Resources have been allocated to provide appropriate linguistic services.			

Staff recruitment and retention	Yes	No	Don't know
20. Possible barriers to recruitment, hiring, promotion and retention of members of diverse cultural groups as staff, volunteers and partners have been explored.			
21. Employment opportunities (paid and volunteer) have been advertised in BAMER media outlets e.g. at social clubs or places of worship.			
22. Employment opportunities (paid and volunteer) have been advertised using appropriate languages based on the demographics of the service area.			
23. Programs and services are adapted to respond to expressed [or identified] needs and issues of diverse communities within the service area.			
24. Resources have been allocated to provide appropriate linguistic services.			

PRACTICE TOOL 1
Collecting and using data to improve services

Purpose:

To follow good practice guidelines in collecting and using data to improve services.

The collection and use of data is essential to improving health and social care services, including those services developed for service users of culturally diverse backgrounds. Instituting practices to systematically collect data allows the effectiveness of services to be monitored and evaluated. These practices can be useful for planning and designing services to provide safe, quality care and decrease health disparities.

There is wide support for the systematic collection and analysis of data and its use in quality improvement.

Assessing the need for culturally competent services

As there is no "one size fits all" plan for providing culturally competent care each organisation must assess its own needs and resources and plan accordingly. Before determining which services are appropriate to introduce it is important to collect and review data to assess community and service user needs.

Collecting community-level data

Demographic information about the service area population is essential to an organisation's ability to fully appreciate and accommodate the needs of its community. Data collected at the community level provide insight into populations that use local services as well as groups that may need targeted outreach to increase access and engagement with the organisation.

Demographic data may include a variety of characteristics such as race/ethnicity, gender, age, primary spoken and/or written language, religion and socio-economic status. Identifying different populations within the community allows an organisation to respond to changing demographics, changing health needs and the changing market.
Collection of data is critical. Data shows you who your populations are and what languages these people speak. Further scrutiny of the data allows the organisation to find out what is missing from the services, i.e. what needs are not being addressed.

Collecting service user-level data

Collecting data on race/ethnicity, gender, age, primary spoken and/or written language, religion during patient or service user encounters can help organisations monitor which populations currently seek cultural and linguistic services and what services should be provided in the future. To make sure that appropriate data is collected organisations may ask service users open-ended questions, such as *Is there anything else about you, your cultural background or your family that we should know that might help us provide the best possible care for you?* Questions such as these allow unique service user-level information to be captured and addressed.
It is important to ensure that the data is accurate and systematically collected. Ethnicity data is usually more difficult to collect. The current classification of the Census does not identify categorisation of ethnicity beyond Black African, Black Caribbean, Asian, and Chinese. This is insufficient when organisations serve large populations that do not identify themselves among the existing Census classifications. In addition, collecting this information can prove to be sensitive to the service users.

Ethnic monitoring and the duty

The race equality duty requires public authorities to monitor their functions and policies for any adverse impact on race equality. They are also required to assess the likely impact of any proposed policies on the promotion of race equality. This means that they will have to develop and adopt ethnic monitoring systems for the work they carry out to meet their legal responsibilities.

Many public authorities are already carrying out ethnic monitoring of their policies, and we recommend that you can adapt your existing systems to record ethnicity to achieve race equality outcomes.

Monitoring policy and service delivery

Public authorities bound by the specific duties are required to monitor all their functions and policies that are relevant to the general duty.

The CRE's statutory code of practice defines functions as the full range of a public authority's duties and powers. It defines policies as the formal and informal decisions a public authority makes to carry out its duties and use its powers.

Most public authorities should have now identified and put in place the monitoring systems for the main areas of their service delivery. Public authorities are also required to publish the results of the monitoring annually. By now, most public authorities should have made significant progress in monitoring, and taking action to address the results of the monitoring.

Monitoring is not just an end in itself or just a paper exercise. Public authorities should be developing and refining the outcomes they wish to achieve in their

service delivery areas and using their monitoring to measure the progress they are making in meeting these goals and targets.

Monitoring employment information

Most public authorities bound by the general duty also have a specific duty to promote race equality as employers.

If you are one of these authorities, the duty says that you have to monitor, by their ethnic groups, all your employees, and all applicants for jobs, promotion and training.

If you employ more than 150 people, you also have to monitor the number of employees from each ethnic group who:

- receive training;
- benefit (or suffer disadvantage) as a result of performance assessments;
- are involved in grievances;
- have disciplinary action taken against them; and
- end employment with the authority.

It is important to monitor other aspects of the employment process as well. This will help you to meet the employment duty more effectively and to meet the general duty and other specific duties. For example, if you want to assess the impact of your selection policy and procedures, information about the number of job applicants will not be enough. You will also need to know how many applicants from each ethnic group succeed and how many do not, at each stage of the selection process.

PRACTICE TOOL 2
Checklist for facilitating community engagement

Purpose:

To illustrate the importance of working with partnership with patients, service users and community.

Does your health or social care organisation have:

- ☐ A mission that values communities as essential allies in achieving its overall goals?
- ☐ A policy and structures that explain community and consumer participation in planning, implementing and evaluating the delivery of services?
- ☐ A policy that facilitates employment and the exchange of goods and services from local communities?
- ☐ A policy and structures that provide a mechanism for the provision of funding, contracting and providing in-kind contributions to community partners, agencies or organisations?
- ☐ Have HR performance measures that include areas of knowledge and skill sets related to community engagement?
- ☐ A policy, structures and resources for in-service training, continuing education and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- ☐ A policy that supports the use of diverse communication methods and technologies for sharing information with communities?
- ☐ A policy and structures to periodically review current and emergent demographic trends to:

  – determine whether community partners are representative of the diverse population in the geographic or service area?
  – identify new collaborators and potential opportunities for community engagement?
- ☐ A policy, structures and resources to support community engagement in languages other than English?

Section 8: Introduction to the cultural profiles

8.1 Introduction

An individual's cultural background has a profound influence on their health and social care, but it is only one of a number of influences on health – social, political, historical and economic, to name but a few.

This section provides basic information about some of the cultural groups in Hackney. At the same time it is vital to recognise that every patient or service user is an individual with a unique personal history, beliefs, communication style and health or social care status. Stereotyping service users can lead to misconceptions about the individual seeking your care. These cultural profiles provide an overview of cultural information about some of the BAMER groups living in Hackney. These descriptions may not apply to all BAMER people as individual experiences may vary. The profiles can however be used as a pointer to some of the issues that may concern your service users.

We have organised the material so that amendments can be made. There is a correction sheet attached as Appendix 3 for you to complete and submit to us. We will consider your corrections and additions as we improve and periodically update this Toolkit.

8.2 Cultural dimensions

Aspects of cultural diversity are detailed under these headings:

- Language and communication
- Health beliefs
- Family and kinship
- Gender issues
- Religion
- Dietary requirements
- Birth
- Dying and death
- Medical procedures.

language and communication

Service users whose first language is not English can be at a major disadvantage in accessing to health and social care. At the same time language is only one of the potential barriers to effective communication. Professionals and service users each bring their own expectations to any interaction.

Some examples for tackling communication barriers:

- Trained interpreters for those community languages where there is sufficient demand and in particular for important discussions such as taking a medical history, discussing treatment options and obtaining informed consent.
- Register of hospital staff who speak less frequently needed languages for use in emergency situations within the hospital in question.
- Training for health and social care workers in the most effective use of interpreters.
- Recruitment of lay health workers and community workers who speak one or more of the community languages.
- Hospital and clinic signs in English and in the most commonly used community languages.
- Well-translated leaflets on important health topics and on topics of special relevance to people who are unfamiliar with NHS provision e.g. how it works, what to bring into hospital for an inpatient stay, how to get the help needed, how to choose and change your GP and patients' rights. Decisions on which leaflets to translate should be taken in consultation with the BAMER communities.
- Leaflets and other materials written in plain English or produced in audio-visual form so that they can be understood by everyone.
- Training for staff particularly those on reception, as the first point of contact, to improve their own communication skills, including an opportunity to examine their own expectations of BAMER service users.
- Posters and leaflets, etc reflecting the diversity of the population so that members of all groups realise that the service is there for them.
- Communication strategy to publicise the interpreting service and its availability to staff, patients, carers and BAMER community organisations.
- Recording and monitoring of the language of patients or service users who do not speak English.[19]

Please also refer to Individual Tool No. 6 on working with interpreters in Section 6.

naming system

Naming systems in BAMER groups may vary greatly from British conventions. Some BAMER groups have naming systems which differ from the British naming system on which NHS records are based.

[19] http://www.dhsspsni.gov.uk/raceeqhealth_part2.pdf

Examples of good practice include:

- □ Take your lead from a patient/service user or staff member and use their preferred name. Make a note of this in the patients'/service users' case notes for future reference.
- □ If you are not sure how to spell a patient's/service user's name, then ask them to spell it out or write it out for you on a piece of paper to ensure that it is spelt correctly in their records.
- □ A name is a very important part of a person's identity. Never use a familiar name, nickname or shortened version unless specifically asked to do so – always use a title and family name at least. This is especially important when addressing members of the opposite gender or older members of a group.
- □ Training receptionists and medical records staff in how to record names and how to avoid entering mistakes.
- □ Training for nursing staff and GPs in the different naming systems and how to address people correctly and politely.
- □ To improve continuity of care of nomadic Traveller families, health providers should be encouraged to issue patient-held family health records.
- □ Create mechanisms to allow Travellers, Gypsy and Roma access to local GPs on a temporary basis, without them having to make new applications. Otherwise, Roma, Gypsy and Travellers will find it difficult and time consuming to access health services and will be reliant on Accident and Emergency units of hospitals.
- □ Consideration given to introducing clear, pictorial or colour-coded instructions on medication.[20]

health beliefs

Every culture has a particular approach to the understanding and treatment of health and illness. All cultures have their own approaches to diagnosis and treatment and many, if not all, cultures have herbal remedies and medicines. Whilst some rely on 'modern' Western medicine, others believe that traditional medicines are more effective.

How do members of a cultural group define health and illness? How do they view disease causation? Do they believe in traditional folk practitioners? What preventative measures are seen in the culture? How do they view health and social care practitioners? These questions indicate the health beliefs of cultural groups. Health beliefs influence our behaviour as the ways in which we understand health, illness and treatment will affect the ways in which we act on health education messages and interact with health services, for example, compliance with medical treatment. In addition, the ways in which ill health is defined will not only influence our help-seeking behaviour but also from whom that help is sought. Health behaviour is any activity undertaken, or not undertaken, by a person for the purposes of preventing disease or detecting it at a symptomatic stage.

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[20] Ibid, p.48

All cultural groups hold concepts related to health and illness for maintaining well being or providing treatment when it is indicated. For a BAMER individual socioeconomic, educational, geographic, religious and other factors will mediate and shape cultural beliefs. For this reason a health or social care practitioner should never assume that an individual from one ethnic group holds the same beliefs as another individual from the same ethnic group. Caution is needed to avoid stereotyping.

However, there are common elements of belief that may be shared among members of cultural and ethnic groups and a general familiarity with these can be very helpful in further understanding a service user's particular perspective. Members of a cultural or ethnic group who are younger, more educated and more acculturated into mainstream society may not adhere to popular and folk medical beliefs. However, it is likely that others in their social network will rely upon these concepts when such an individual becomes ill in order to identify the illness, suggest treatment and evaluate prescribed treatment.

family and kinship

Concept of family structure and identity for BAMER families often extends beyond the sphere of the nuclear family. Service user decision making may include extended family members and the community. In some cultures involvement of family members in health or social care is a normal occurrence. Although providers may feel that the service user is the sole focus of care, a service user may view family members as an essential source of support. Thus, providers may be required to move out of their comfort zone and engage family members in the treatment process. Providers should consider family influence on treatment decisions.

gender issues

Gender roles are very much influenced by culture. Gender roles are defined differently and may vary. In many cultures, men and women are strictly segregated. This may have implications for healthcare in relation to admission onto a mixed ward and physical examinations or tests being carried out by staff of the opposite gender. There may even be implications for staff, who may not feel comfortable treating members of the opposite sex. Where possible, arrange for women to be treated by women and admitted to all-female wards; similar consideration should be shown to men. Children and women may feel more comfortable being treated if they are allowed to have a chaperone with them at all times. For married women, this may be their husband or a female relative. For children, this might be the mother.[21]

In many cultures, men and women are strictly segregated. This may have implications for healthcare in relation to admission onto a mixed ward and physical examinations or tests being carried out by staff of the opposite gender. There may even be implications for staff, who may not feel comfortable treating members of the opposite sex. Where possible, arrange for women to be treated by women and admitted to all-female wards; similar

[21] http://www.ethnicityonline.net/gender_good_prac.htm

consideration should be shown to men. Children and women may feel more comfortable being treated if they are allowed to have a chaperone with them at all times. For married women, this may be their husband or a female relative. For children, this might be the mother.[22]

This may have implications for the gender match between the service provider and the individual and its impact on an individual's comfort level. This may go as far as the need for a gender match between service provider and service user when in situations perceived by the service user as compromising or sensitive, (e.g. physical examination).

religion

Religion still plays a major role in many people's lives. Religious beliefs have a major impact on attitudes toward many procedures in the hospital, e.g. organ transplantation, birthing practices, death and dying, diet, gender issues, abortion and modesty, to name a few. Religious beliefs impact what medicines or procedures a person can accept and when s/he accept them, what a patient or client will eat, and who should be consulted in the decision making process.[23]

Some hospitals set aside a room for use by religious worship by different faith groups. Good practice includes:

- The provision of a non-denominational quiet room for prayer or contemplation.
- Accessible list of religious leaders to be contacted on request or as part of the care of terminally ill or dying patients.
- Written information about access to religious and spiritual support translated into community languages.
- Provision in maternity services for staff to cater for religious requirements and ceremonies relating to childbirth.
- In the event of a death, consultation with the patient's carers regarding their preferences in relation to the preparation of the body and other religious requirements. Privacy and space for families to spend time together or to perform religious ceremonies should be allowed.
- Religious items, including religious and wedding jewellery to be treated with respect and not removed without the consent of the patient or their next of kin.
- Staff awareness of festivals, celebrations and holy days as these may affect procedures such as discharge.[24]

dietary requirements

Food has cultural significance in terms of gaining and maintaining health. In some cultures, including some Asian and Latin American cultures, people believe in the hot and cold theory of food and disease. According to such beliefs, certain foods may be classified as "hot" or "cold". This refers not

[22] http://www.ethnicityonline.net/gender_good_prac.htm
[23] Multicultural Handbook for Staff, Southern Areas Health Authorities
[24] http://www.dhsspsni.gov.uk/raceeqhealth_part2.pdf

necessarily to the temperature at which food is served, neither the spiciness nor its energy value but to its effect on the body.

Patients/clients should be asked about their preferred diet. Many BAMER patients are unable to eat food from the standard hospital or day centre menu, either for religious reasons or because they are simply unused to a western diet. Health and social care providers have an obligation to provide appropriate choices for meals for service users. The best way to check on patients' dietary and eating requirements is to ask them directly.

Dietary restrictions may make it impossible for some patients to eat hospital food unless arrangements have been made. For example, Halal or Kosher food may be obtained from a supplier. It can then be stored in a separate fridge. Alternatively, if the patient/client is on a special diet, storage facilities should be available in every ward so that the hospital diet can be complemented where necessary by bringing food in from outside.

Fasting is required by some religions during particular times (e.g. during Ramadan among Muslims).

Good practice includes:

- Procedures to record information relating to diet and cultural and religious requirements on service user records.
- Menus available in community languages with details of ingredients if requested.
- Relatives should be free to bring in food from home and adequate storage and heating facilities (within appropriate health and safety guidelines and in consultation with hospital staff) for such food should be provided.
- Training for dieticians and catering staff in assessing and delivering appropriate diets.

In BAMER communities' diet is linked to religion and culture. Food is part and parcel of people's existence. Therefore, acknowledging this in the provision of services goes a long way in providing a package of support to BAMER service users.

birth

The time surrounding pregnancy and childbirth is one when women are particularly vulnerable. This may also be the first time that some women come into close contact with health and social care providers. In addition, many parents may have approaches, practices and priorities in childrearing which are different from those of the service provider but which are equally valid.

Specific examples of good practice include:

- Cultural sensitivity in teaching hospitals, for example, in making it possible for patients to request that only female medical students be allowed to observe an examination.

- Ante-natal classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is not English.
- Basic information and instruction sheets should be translated and circulated.
- Health education programmes should highlight the importance of both ante-natal and post-natal care.
- Support to meet the particular needs of mothers and children from BAMER group, e.g. bilingual mother and toddler groups, appropriate childminding provision, play groups and day nurseries and support groups for women of different communities where they can relax and speak their own language.
- Active recruitment of BAMER health workers who share the cultures, values and backgrounds of local BAMER groups.
- Training in relevant cultural and religious needs for those named ante-natal midwives who are assigned to BAMER mothers.[25]

dying and death

Issues around dying and dying in certain cultures are often surrounded by mystery. It is difficult to ask patients/service users and carers questions about these sensitive issues when the patient is very ill or in the case of sudden death. Yet it is important that these issues are not ignored and help should be sought from more experienced staff. The effects of inappropriate intervention can result in long term distress for the family in their bereavement.

Every culture recognises phases in the human life cycle. Death is a cultural as well as a biological event. Grieving and death rituals vary across cultures and are often heavily influenced by religion. This includes arrangements for spiritual support. Even people who do not practice any religion may return to the religion of their upbringing when dying. Health and social care professionals need to be aware of the cultural and religious beliefs of their dying patients and their families.

Good practice guidelines for dying are recommended as follows:

- If possible, discuss with a patient's family any requirements they may have for the process of death – for example, facing the bed towards Mecca, being visited by their extended family or having prayers said.
- Many complications arise regarding the use of life support. It is a good idea to talk to the patient and their family about any concerns they may have with life support in advance.
- Many people, including those from some cultural groups, may not want to know if they are dying, or may not want their families to know. If possible, discuss this with the patient, or ask to talk to their religious leader, etc.
- The accepted definition of death and when exactly it occurs may vary between groups and even within a group. The use of life-support systems may further complicate this issue.
- Many groups do not agree with organ donation or post-mortems. For this reason, it is not appropriate to talk to the patient or family about

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[25] Ibid, p. 49

these issues unless they feel that they can say 'No' without penalty. It is a good idea to consult a local group about their beliefs in these areas before talking to the patient or their family, or talk to an expert within your organisation about how to handle the situation.[26]

As service providers it is useful to know this information when planning events or when asking service users to follow certain instructions. Numerous culture-based rituals involve the phenomenon of death. Some of these rituals may preclude the conduct of an autopsy. Providers may value the scientific contribution of this procedure, but families may see it as a violation.

Here are some good practice guidelines:

- If possible, leave a light on in the room where a body is lying. Members of many ethnic groups will find this comforting.
- Do not remove jewellery, ritual clothing or items associated with the faith or culture of the deceased after their death. The family may wish to do these themselves.
- Keep a body covered at all times to preserve dignity and modesty. If possible, wrap the body in clean, white cloth until the family can arrange to wash and dress the body themselves.
- Whenever possible, do not touch the body directly, but use gloved hands instead. Some groups do not like to have their dead handled by people from outside their community.
- Unless absolutely necessary, do not wash the body. Friends and family may wish to do these themselves as a last mark of respect for their dead.
- Some groups may wish to recover the remains of their dead as quickly as possible for the speedy burial or cremation that is required by their cultures.
- If the deceased was not born in the UK, the body may need to be quickly released for transportation to their home country before burial.
- If a post-mortem is required by law, then take the time to explain this tactfully to relatives, whom might be distressed by what they consider to be desecration.
- If a post-mortem is not required by law, but would be beneficial, then approach this subject carefully; many groups will not permit their dead to be disturbed in this way, whereas others may give permission if they understand the reasons behind the request.[27]

In summary, health and social care practitioners and service providers may be faced with bridging gaps between their cultural worldview and those of their patients. Effective service provision requires negotiation of provider and service user perspectives on the nature of the problem as well as how to resolve it.

[26] http://www.ethnicityonline.net/death_good_prac.htm
[27] http://www.ethnicityonline.net/death_good_prac.htm

The remainder of this section presents specific cultural information for some of the main groups in Hackney.

Cultural profile Fact Sheet Number	Fact Sheet Title
1	Bangladeshi Cultural Profile
2	Charedi Cultural Profile
3	English Romany Gypsies, Irish Travellers and Roma Cultural Profiles
4	Ghanaian and Nigerian Cultural Profiles
5	Indian Cultural Profile
6	Kurdish Cultural Profile
7	Pakistani Cultural Profile
8	Polish Cultural Profile
9	Somali Cultural Profile
10	Turkish Speaking Community Cultural Profile
11	Vietnamese Cultural Profile

N.B. These cultural profiles were correct at time of production; consequently, these profiles will require updating.

DISCLAIMER

This section is a synthesis of information from a range of sources believed to be reliable. BEMWG gives no warranty that these sources are correct, and accepts no responsibility for any errors resulting from any decision or actions taken as a result of any damage.

BANGLADESHI CULTURAL PROFILE

This profile is a general guide offering cultural information about Bangladeshis living in Hackney. Please check with each individual about their personal needs.

demography

There are 5,963 Bangladeshi people living in Hackney representing 3% of the borough's population.[28]

language and communication

Bengali is the spoken language. Sylheti is also widely spoken because many Bangladeshis came from the Sylhet region of Bangladesh.

naming system

It usual to have two or three names: that is, personal name, religious name, and sometimes family names.[29] Men traditionally have two or three names: a personal name, a religious name and a last name, which may be a male title or a family name such as Khan or Chaudri. Use of the last name is optional. In some cases the father's personal name may have been adopted as a British style surname for official reasons, as common family surnames are not used in Bangladesh, for example: Yunus (personal name) Muhammed (religious name) Khan (clan name).

Women usually have two names: a personal name followed by a female title such as Amina Begum, which is similar to Mrs or Miss. Therefore, it is not appropriate to address a woman as Mrs Begum. Some women also use their husband's or father's name as a surname.

health beliefs

Youth and health are usually viewed as virtually synonymous and physical degeneration and weakness as an inevitable consequence of aging. Larger body size is generally viewed as an indicator of "more health" and thinness with "less health," but many also perceive that "too much health" (that is, too large a body size) is undesirable.

Illness is generally attributed to events or agents outside the body rather than to primary failure of an organ within it. Another factor influencing health beliefs includes heredity (the notion of an agent transmitted through "shared blood" rather than an inherited predisposition) and germs.

Foods are grouped according to their perceived strength (nourishing power) and digestibility. "Strong" foods perceived as energy giving and include white sugar, lamb, beef, ghee (derived from butter), solid fat and spices. Such foods are considered health giving and powerful for the healthy body and suitable for festive occasions, but liable to produce worsening of illness in the old or debilitated. "Weak" foods preferred in the everyday menu and for the old or

[28]ONS Mid Year Estimates, 2007

[29] Sheffield City Council, *Cultural Awareness Handbook,* September 2003

infirm and include boiled (pre-fluffed) rice and cereals. Raw foods considered indigestible as are vegetables that grow under the ground. Foods of low digestibility considered unsuitable for elderly, debilitated or young people.

Many cultures equate balance with health and imbalance with illness. There is a strong and almost universal belief among the Bangladeshis that both the onset and the control of disease depend on the balance of food entering the body and on balanced emission of body fluids such as sweat, semen, urine, menstrual blood, etc. Excess emission is perceived as depleting the internal stock. Low quantity of emissions indicates inner build up and putrefaction and thin quality a weakening of the internal stock. Weakness (as in diabetes) is perceived as a result of such depletion or weakening.

Exercise in the context of health and fitness have little cultural meaning. Exercise is viewed as potentially exacerbating illness or physical weakness. But ritual Muslim prayers (namaz) are thought as a worthy and health giving form of exercise. The Sylheti language has no expression for physical activity that has the same connotations of vitality, improvement in body condition, social desirability and inherent "moral" value as the word 'exercise'. The closest translation for the word "exercise" is "beyam," a word of vague etymology. The prefix "bey" in Sylheti often has negative connotations—for example, "beyaram" (meaning illness, literally "no comfort") or "beytamiz" (poor etiquette, literally "no manners"); there is a lack of positive connotations accorded to the concept.[30]

family and kinship

Traditionally Bangladeshi families are family focussed and live in large extended families. Marriages may be arranged. The extended family is very important in the Bangladeshi community. Family members will assist one another and share responsibilities. However, Bangladeshis live in a society in which respect for authority seems to be breaking down and younger Bangladeshis are inevitably influenced by these attitudes despite their parents' attempts to uphold traditional values.

The elderly in the community are regarded with deep respect. Whether they live together with their children or separately, parents are usually consulted in decision making processes.

gender issues

In Islam men and women are equal but their respective roles can be distinct. Muslim men should not shake hands with women or vice versa. Men are head of the household. Men and women may not gather socially in the same room where there are people from outside of the family present. The mixing of the sexes is not allowed in Islam, unless closely related. For instance, in hospital a practicing Muslim will feel uncomfortable if their bed is next to or

[30] 1998;316:978-983 (28 March) T, Helman, C & Chowdhury, AM, "Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study", British Medical Journal, 1998;316:978-983, 28 March

near a patient who is not of the same gender. Where facilities exist Islam requires male patients to be seen by male staff and female patients to be seen by female staff. Where this facility does not exist it is preferable that a female member of staff is present when a female patient is examined.[31]

Some Muslim women and girls wear a head covering. All are expected to dress modestly. Both males and females may choose to wear clothes that reflect their cultural background.

religion

Most Bangladeshis are Sunni Muslims. A minority may be Hindu, Buddhist or Christian. There are two branches of Islam: over 90% of the world's Muslims are Sunni Muslims; the remaining 10% are Shiite Muslims. Both Sunni and Shiite Muslims believe in the Five Pillars of Islam (see below). The differences between the two branches relate to the early history of the religion. The core belief of Islam is to submit to the will of Allah as set out in the Qur'an. The Five Pillars of Islam set out the essential aspects of the faith which are:

1. Shahadah – reciting a declaration of faith
2. Salat – praying five times a day
3. Zakat – giving alms to the poor and needy
4. Sawm – fasting during the month of Ramadan between dawn to dusk.
5. Hajj – going on a pilgrimage to Mecca at least once in a lifetime.

The mosque is the communal building for prayers. Women may not be allowed to enter the mosque. The leader of the mosque is called the Imam and may be a useful contact in communicating important information to the community. Male Muslims attend the midday congregational prayer on Fridays.

dietary requirements

Muslims eat Halal food which is meat that has been ritually slaughtered and cooked using separate utensils. Halal food should not be stored with non-Halal food. Pork and its products such as bacon, ham, and sausages are forbidden. Drugs and alcohol are forbidden.

birth

When a Muslim child is born it is required that as soon as possible a family member it is customary for the father or a respected member of the local community to recite or whisper in the baby's right ear a short prayer (the Adhan). The entire ceremony takes only a few minutes, and it is generally appreciated if parents are allowed the opportunity to perform this rite in privacy.[32]

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[31] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/muslims

[32] Rgatrad, A & Sheikh, A, "Muslim Birth Customs", *Arch Dis Child Fetal Neonatal Ed* 2001;84:F6–F8

For Muslims religious law authorises male circumcision. Circumcision is usually performed within a few weeks of birth. The birth hair is always shaved off, traditionally on the seventh day of life.

dying and death

Dying

When a Muslim is dying, the face should be turned towards Mecca (south east in UK). A dying Muslim will need to say or hear "There is no God but the God and Muhammad is His prophet". Muslims believe in an after life and believe illness and death should be faced in a spirit of acceptance of Allah's will.[33]

Death

For a patient who has just died the face of the deceased should preferably be turned towards Mecca. The whole body of the deceased must be covered by a sheet. The body must be handled as little as possible. Muslims believe that the body 'feels' pressure and pain numerous times more than that applied. Muslims also believe that the soul remains close to the body until burial. The body must be handled with utmost respect only by a person of the same sex. Relatives may wish to pray close to the body or in a room close by.

Muslims believe in the resurrection of the body after death, therefore Muslims are always buried, never cremated. The body will be ritually washed by the family or Muslim funeral directors before burial. Muslim funerals take place as soon as practicable, preferably within 24 hours. If the death has to be reported to the Coroner, s/he should be informed that the patient was a Muslim and be asked if the procedures can take place as soon as possible.[34]

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

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[33] http://66.102.9.132/search?q=cache:hmNRPklBVksJ:www.braintree.gov.uk/NR/rdonlyres/DF4745D7-5B27-438FBB755206D27932C1/0/FaithCard.doc+death%2Britual + bengali&cd= 18&hl= en&ct= clnk&gl=uk

[34] South Devon Healthcare NHS Trust, *Handbook on Cultural, Religious and Spiritual Beliefs*, 2005

CHAREDI CULTURAL PROFILE

This profile is a general guide offering cultural information about Charedi community living in Hackney. Please check with each individual about their personal needs.

demography

There are 16,776 Charedi people living in Hackney representing 8% of the borough's population. This community is growing with more than 52% of Charedi residents under the 20 years old.[35] The Jewish community is one of the oldest established in the London Borough of Hackney and dates back to 1674.[36]

The Jewish community considers itself both as a religious community and an ethnic group.

language and communication

The main languages are English and Yiddish. Hebrew is the language of prayer and Israelis.

naming system

Jewish names usually consist of one or more given names followed by a family name.

health beliefs

According to people who interpret Jewish law, each person has a duty to keep themselves in good health. This includes physical and mental well-being as well as early treatment for illness and prevention. In orthodox denominations of Judaism, the taking of medication on the Sabbath, that is not necessary to preserve life, may be viewed as "work" and would therefore be unacceptable. All Jewish denominations recognise that religious requirements may be laid aside if a life is at stake or if an individual has a life-threatening illness.[37]

family and kinship

Marriage and family life are integral to the personal and communal life of the Charedi community. Judaism places a strong emphasis on the home and family. Family is a vital part of the community as is the importance of scholarship, particularly religious learning. The significant majority of children attend independent boys and girls schools. With an emphasis on faith there is a desire for many to be taught in both English and Yiddish. It is essential to recognise the specific cultural and faith dynamics that lead most Orthodox Jews to prefer service provision within and by their community.

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[35] http://www.cityandhackney.nhs.uk/pdf/Chapter%201%20The%20people%20of%20Hackney%20and%20the%20City%20DSW.pdf
[36] http://www.untoldlondon.org.uk/collections/AM29553.html
[37] Purnell, L. D., & Paulanka, B. J. (1998). *Transcultural Health Care: A Culturally Competent Approach.* Philadelphia, PA: F. A. Davis Company

There is great value placed on helping others in need hence many community organisations exist to serve and work with the Charedi community around all aspects of life, including education and training, residential care, early years and youth services, and support for the elderly, which reflects the historical significance of mutual support.

gender issues

Traditionally women play an important role in raising children, giving them a religious education and creating a kosher domestic environment, but they often also have responsibility outside the home in both community activities and paid employment. Orthodox girls and women generally dress modestly, with sleeves covering the elbows and skirts reaching well below the knees.[38]

Modesty is an important religious issue for Charedi people. Charedi women will express a preference for women medical staff examining them, for reasons of modesty and care needs to be given to what contact is necessary between the service provider and client.

Young people are educated in single sex schools and have limited contact with members of the opposite sex outside their immediate family. As they reach adulthood their parents will help them to make a marriage match. Before marriage both sets of parents will set about to find and obtain suitable accommodation for the young couple. After marriage the husband is expected to devote time to his religious studies. The man is expected to obtain employment that accommodates his religious observances. The Charedi community usually has large families.

Charedi men keep their heads covered at all times with a hat or skull cap (kippah). Jewish men wear a head covering during prayer. During morning prayers a prayer shawl is worn and tephilin (phylacteries) are worn on the arm and forehead. As there are restrictions about shaving so many Jewish men will be bearded and some groups wear side curls and the strictly observant will wear a prayer shawl permanently. Many women cover their hair in public with a scarf or a wig. Men will not shake hands with women and prefer not to speak or look at them.[39]

religion

There are three major categories of Judaism: Charedi, Orthodox, and Reform. The difference depends on the degree of interpretations and adherence to ancient law and practice as opposed to acceptance of modern ways. Jews believe that God has made an eternal covenant with them that requires them to live according to the Torah (law). The aim of life is to live according to God's law as revealed by Moses. Because life is governed by the Torah there are strict rules about behaviour, dress and conduct. For the Charedi community their religion is an integral part of their way of life. The differences between them relate to how they view the Torah (the five "books of Moses" that form the central Jewish scriptures), the halachic laws (derived from Torah

[38] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf
[39] Ealing Hospital NHS Trust, *Guide to Ethnicity Information When Caring for Patients,* 2006

and later interpretations) and traditions (often codified later by important rabbis and writers).

Rabbis are chosen by their communities as teachers and leaders and have usually been trained. The Sabbath (Shabbat) is the Jewish day of rest. The Sabbath begins at sunset on Friday and ends on Saturday evening. On the Sabbath, Charedi may not do any kind of work; this includes travelling (except on foot), writing, carrying, switching on and off electricity, using a telephone unless these acts are necessary to save a life.

Charedi are more theologically conservative than Orthodox Jews. The term "Haredi" means "one who trembles" in reference to their reverence for God. They may also describe themselves as Torah Jews and many are Hasidic Jews, who practice a form of celebratory Judaism developed in the seventeenth century in central Europe. Some wear the clothes of that time, including a kaftan on Sabbath and various types of headgear from the period. Many live in Stamford Hill in London and belong to communities that lead a relatively closed existence there. Many communities function around a rebbe, a spiritual leader, often from a dynasty of rebbes.

Charadi pray three times a day and prayers should not be disturbed unless it is medically essential. The Jewish place of worship is called a synagogue. The religious leader is called the Rabbi.[40]

dietary requirements

Jewish dietary laws – kashrut – dictate what constitutes kosher food. Orthodox Jews observe the laws of Kashrut, which set out what can and cannot be eaten and how those foods must be prepared and eaten. Kosher describes food that meets these standards. This means that they may not eat meat and dairy foods together, nor do they eat products that contain non-kosher ingredients. Milk and meat foods are stored and cooked separately and this requires two sets of cooking utensils, crockery and cutlery used exclusively for the preparation and eating of kosher food.[41]

Charedi will only eat food certified as Kosher. Only kosher meat (killed and prepared according to the laws of Kashrut is eaten. Pork and pork products are strictly forbidden. The consumption of shellfish and fish without scales or fins is also forbidden. Refer to Appendix 2 for list of food preferences.

Fasting is required on certain days. One fast every Jew observes is, Yom Kippur, the Day of Atonement. Observance means a twenty-five hour fast, usually falling in late September/October according to the lunar calendar. During the eight days of Passover, Jews refrain from eating bread and wheat products.

[40] Sheffield City Council, *Cultural Awareness Handbook,* September 2003
[41] Ibid, p. 23

birth

Jewish boys are circumcised, usually eight days after birth. This is performed by a qualified Mohel, a trained and medically certificated Jewish man in the practice of Brit milah (circumcision). Circumcision is delayed if the baby is jaundiced, small or is unwell for any reason. The ceremony itself is usually performed at home, although it can take place in hospital.

The naming ceremony for Jewish boys is held on the eighth day after birth, usually together with the circumcision ritual. The baby is then welcomed into the community and his name is announced both in Hebrew and English. Jewish baby girls can be named at any reading of the Torah, but increasingly families are choosing to have a blessing at a synagogue, followed by a celebration similar to that for boys. Each parent, relatives and friends, all say prayers for the baby's health and a happy life. There are gifts for the baby, speeches about childhood and a meal for everyone.[42]

dying and death

Judaism does not have a special ceremony of "last rites", but a patient may wish to recite the "Shema", or special psalms as well as a death-bed confession known as "vidui". Most patients will want to see a Rabbi, and arrangements for this can be made through their local synagogue.

Death

Funeral arrangements are carried out by the Chevra Kaddisha (holy society) which is a group of members drawn from each synagogue.

Jews must be buried as soon as possible. Jewish law requires burial to take place immediately, either on the same or following day. Cremation is not permitted. The body is covered with a white sheet. Wherever possible, the body must not be left unattended. The family or community will operate a system of watchers who stay with the body day and night.

The week of mourning only begins with the burial and lasts for seven days. During this time, known as the shivah, the family will not be expected to return to work and relatives and friends will visit. Evening prayers are held in the home for friends, relatives and members of the community.[43]

Jewish funeral ceremonies are simple, consisting of Kaddish prayer, psalms and a memorial speech. Kaddish is a praising of God representing ideas of continuity. Flowers are not common at a Jewish burial but donations are often given to charity in memory of the deceased. At the grave, the male mourners cast three shovels of earth on the casket. When the mourners leave the

[42] http://www.confetti.co.uk/article/view/8089-8311-0-Naming_traditions_and_ ceremonies_ rom_around_the_world_Baby_Shower.do
[43] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf

gravesite, they wash their hands to symbolically dispel the spirits of uncleanness that accompany death.[44]

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

[44] http://www.harpweb.org.uk/external.php?url=http://www.ukm.uio.no/utstillinger/farvel/jew.html&harpid=577

ENGLISH ROMANY GYPSIES, IRISH TRAVELLERS AND ROMA CULTURAL PROFILES

This profile is a general guide offering cultural information about the English Romany Gypsies, Irish Travellers and Roma who pass through or live in Hackney. This profile only refers to English Romany Gypsies, not Scottish or Welsh Romany Gypsies. Please check with each individual about their personal needs.

demography

English Romany Gypsies and Irish Travellers are recognised as ethnic groups under the Race Relations Act as they have shared cultures, languages and beliefs. It is difficult to estimate the size of the English Romany Gypsies, Irish Travellers and Roma population in Hackney. In the 2001 census, English Romany Gypsies or Irish Travellers were not included as a separate ethnic category and they were expected to identify as 'White Other'. It seems likely that the 2011 ONS census will begin to record the ethnicity of English Romany Gypsies and Irish Travellers.

There is an estimated population of 300,000 English Romany Gypsies and Irish Travellers in the UK today. They follow a nomadic lifestyle, which means travelling seasonally usually with small family groups using certain routes in search of trade and work. Official figures which are drawn up bi-annually by the Department of Communities and Local Government tend to be much lower than this as they only count caravans not people and they do not take settled or housed Irish Travellers into account. The process of shifting to a more sedentary way of life has not been a choice but the result of successive assimilationist laws that has had the effect of criminalising nomadism. While nomadism has been an integral part of cultures of English Romany Gypsies and Irish Travellers most settled or housed Romany Gypsies and Irish Travellers have not relinquished their distinctive cultural identity and still aspire to a travelling way of life.[45]

Definitions of English Romany Gypsies, Irish Travellers and Roma

a) English Romany Gypsies – originated from India and migrated to Europe around 1000 A.D. Today most English Romany Gypsies are directly descended from the Roma. The Roma people who have arrived in the UK from central and eastern Europe in recent years have a distinct culture and life style and are described in point c below.
b) Irish Travellers – are a nomadic Irish ethnic group with a separate identity, culture, language and history. They refer to themselves as 'Pavee' or 'Minceir', are native to Ireland and have been part of Irish and British society for centuries. Some families have made their

[45] Dr Colin Power, Room to Roam: England's Irish Travellers', 2004 http://www.irish.org.uk/pdfs/room-to-roam.pdf

home in the UK although there are many Irish Travellers resident in Britain for only part of the year.[46]

c) Roma – The Roma who have moved from EU accession countries have established significant communities around the country, in partucluar North and East London. They are predominantly Slovak, Czech and Romanian Rom communities. The Roma have moved here to find work and to escape racism and persecution. There are substantial restrictions placed by the UK Government on most of these nationals from EU Member states in respect of employment, residence and benefits. However they do have the right to medical treatment within the NHS and to education. They are still a largely hidden community, with Romanian Roma appearing to be the most disadvantaged and poorest (due in part to employment and benefit restrictions).[47]

language and communication

English Romany Gypsies speak English. Most of them speak in *Romani*, which has its roots in many of the Indian languages. All Irish Travellers speak English Irish Travellers often communicate using languages known as *Shelta* or *Gammon*. Most Roma speak the language of their home states.[48]

naming system

In English Romany Gypsy and Irish Traveller groups traditional names are in frequent use, often being associated with a grandparent or other important family member. A feature of Irish Traveller groups is their use of maternal and paternal surnames interchangeably. This can be confusing to those outside the community, especially as children may also have a baptismal first name and a 'family' name. It is traditional to name first sons and daughters after their grandparents. In a large family group there may be, for example, three or four cousins with the same names. Thus the need for family names can be appreciated. Be guided b[49]y the individual's self-description as to how they would like to be known.

health beliefs

Cleanliness to English Romany Gypsies and Irish Travellers is not just a question of comfort but of moral standards. There is a clear distinction between the inside and outside of a caravan as there is between the inside and outside of the body. The preoccupation with cleanliness has beneficial effects for the community: the incidence of stomach and other infections in young children is extremely low despite the lack of often basic sanitation such as toilets and showers on unauthorised sites.[50]

[46] Ibid
[47] *New Roma Communities in Britain,* European Dialogue
[48] Academically known as 'Shelta'.
[49] Southend-on-Sea Borough Council, *United in Harmony: A Guide to Religious, Cultural and Ethnic Diversity in Southend*
[50] http://www3.hants.gov.uk/gypsy_travellver_information_pack_2.doc

Many women from the English Romany Gypsies and Irish Traveller communities will only want to be seen by a female doctor, nurse or paramedic and will not discuss any form of gynaecological issues in front of men.

In a research study about the cultural influences on health among Romany Gypsies and Irish Travellers fatalism was identified as an underlying belief, a belief that all events in life are predetermined and inevitable. There was a widely held belief that health and illness are things that are 'given' to you, or that you are born with, or that simply happened and over which a person had little or no control. Another belief was the sense of well-being that Romany Gypsies and Travellers feel when they are actively travelling, which includes the sense of freedom, being in the fresh air and being near to extended family. This concept of 'the travelling way' is well recognised by those who have worked with the community and should be of particular interest to healthcare professionals.[51]

Many Irish Travellers have strong beliefs in the power of prayer, religious icons and holy water. In addition to their respect for Western medicine many tend to use traditional folk healing practices including oils, ointments and cures. These beliefs, including any folk healing remedies that the person carries and religious symbols, need to be treated with respect.[52]

Roma who enjoy good health are believed to be blessed with good fortune, and those who are ill are said to have lost their good luck. Roma believe that actions (e.g. clean or polluting) can promote health or result in illness. To return to a state of purity, cure and good health one must conform or correct the marimé (polluting) social behaviour. The Romani people tend to use the mainstream health care system only in crisis situations when there is an acute and/or unresolved condition for which folk medicine has failed.[53]

family and kinship

Family and kinship ties are very strong amongst the English Romany Gypsies and Irish Traveller communities. Although there is no universal Romany or Roma culture there are attributes that English Romany Gypsies, Irish Travellers and Roma share in common: a strong sense of interdependence, loyalty to family (extended and clan) and tradition of maintaining close family ties.[54] The centrality of the family is a core factor in life, with strong cohesion among extended family groups. Family size is often large.

Education for children is a contested issue for English Romany Gypsies, Irish Travellers and Roma people. There is an ongoing issue of discrimination by school authorities in the UK. The historic practice has been for young Irish Travellers, for example, to gain a primary school education but only access

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[51] Zena Dion, "Gypsies and Travellers Cultural Influences on Their Health", *Community Practitioner,* June 2008

[52] http://www.hse.ie/eng/services/Publications/services/SocialInclusion/InterculturalGuide/Traveller/Traveller.pdf

[53] www.duke.edu/web/equity/ethnic_community_profiles.pdf

[54] https://gateway01.lpplus.net/sites/wmc/historyculture/Pages/Gypsies.aspx

the secondary level intermittently. Many Roma children have been barred from education in their home states. There remains, however, a strong desire on the part of both parents and children to gain a good education, particularly one which provides vocational skills and qualifications.

gender issues

From a young age, English Romany Gypsies, Irish Travellers and Roma children are taught to be independent, to value their culture and understand their specific roles within it as men and women. The beginning of adolescence is a time when a boy or girl takes on the adult responsibilities of generating an income or working in the home.
The culture and lifestyle of nomadic groups such as the English Romany Gypsies, Irish Travellers and Roma are not understood or respected by settled society and these people experience great pressure to conform to wider social norms. Equally, there is pressure within the community to retain customs and traditions, and a particular fear that young people will follow the ways of the settled population. These groups are among the most disadvantaged in British society; they are socially excluded and discriminated against, and have low life expectancy and high rates of physical and mental illness. .

religion

The range of religious belief amongst the English Romany Gypsies and Irish Traveller population usually reflects the country in which they are living. In the UK a significant number of Romany Gypsies are evangelical Christians, whereas Travellers of Irish heritage are most often Roman Catholics.

The Roma do not have their own religion. Historically, their beliefs revolve around a good and evil force, along with an indefinite number of entities or presences that are there at night. Generally however, most Roma adopt the dominant religion of their host country. They prefer to carry out religious rituals in their own homes or as part of folk observances.[55] Evangelical activities among the Roma have increased in recent years. Although the Roma adopt the religious practices of those around them, they also maintain several strong faith practices and beliefs in the supernatural, omens and curses. They also have female healers who prescribe traditional healing rituals and cures.[56]

dietary requirements

English Romany Gypsies and Irish Travellers mostly adopt the food of the country they live in and what is locally available.

birth

Amongst the English Romany Gypsies and Irish Traveller communities births are celebrated as a new addition to the community. Most women prefer to go into hospital to give birth as a birth in the caravan is seen as polluting it. After the birth, the new mother is only permitted to touch essential items during what amounts to a quarantine, until she is 'purified' after two or three weeks.[57]

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[55] Ibid
[56] http://www.rcn.org.uk/__data/assets/word_doc/0004/108796/Diversity_Champions_update_3.doc
[57] http://www3.hants.gov.uk/gypsy_traveller_information_pack_2.doc

dying and death

Dying

If a person is dying many relatives will travel in order to visit their bedside.

For Irish Travellers who are Roman Catholics then a priest should be called to administer religious services.

Death

For English Romany Gypsies and Irish Travellers when a death occurs a fire is lit outside the caravan, which will continue burning until the deceased has been buried. Many relatives will travel to the funeral. Following the funeral all possessions not transferred to another in the deceased's lifetime will be burned or ceremonially broken.[58]

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

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[58] Ibid.

GHANAIAN AND NIGERIAN CULTURAL PROFILES

This profile is a general guide offering cultural information about Ghanaians and Nigerians living in Hackney. Please check with each individual about their personal needs.

demography

There are 21,453 Africans living in Hackney, representing over 10% of the population.[59] This figure does not give a breakdown of the different African nationalities that make up the local population.

Information based on ethnic monitoring of specific African communities can be difficult to come by. Sources such as the 2001 Census provide information on selected ethnic groups and country of birth. Ghanaians and Nigerians are subsumed into 'Black African' category on ethnic monitoring forms, which in the London context, includes a significant Somali population as well as North African, East African and Central African communities. Country of birth information can also be misleading because it includes people who do not share a West African heritage but excludes the second generation born in the UK. The ethnic monitoring form devised by London Borough of Hackney (refer to Section 4) proposes to give detailed breakdown of the African population in the borough.

language and communication

Ghanaians speak English and many also speak one of the African languages, such Twi, Fante, Hausa, Dagbani, Ga, Ewe and Nzema.

Nigerians speak English and some may also speak one of the African languages, such as Yoruba, Ibo and Hausa.

Because both Nigeria and Ghana has English as their official language children are taught and encouraged to speak English most of the time. Children, who came to the UK very young or were born in the UK, may forget how to speak their mother tongue very quickly. This depends on the parents and how important the African language is to them. The character of the child and whether he or she is subject to teasing may also affect a child's confidence to speak an African language. The older ones may do their best to remember but sometimes it is hard when they do not hear the languages regularly.

naming system

Ghanaians

A first name is followed by the group or religious name and then family name. In addition, a person is often given a day name, i.e. the day of the week they were born and the order in which they were born, e.g. third child, For

[59]ONS Mid Year Estimates, 2007

4. GHANAIAN & NIGERIAN

example, Kofi Annan was born on a Friday. Below are some of the names that people are called by and the corresponding days on which they were born:

Day of the Week	Male	Female
Monday	Kojo	Adjoa
Tuesday	Kwabena	Abena
Wednesday	Kwaku	Akua
Thursday	Yaw	Yaa
Friday	Kofi	Afua
Saturday	Kwame	Ama
Sunday	Kwesi	Akosua

If the woman is married in church or by a civil ceremony she will take her husband's name. If married under local custom law they do not always take their husband's name. Children take their father's last name and occasionally their mother's last name.[60]

Nigerians

The naming customs of Nigerians vary according to the ethnic group a person belongs to, e.g. Yoruba, Igbo, Hausa-Fulani. Besides first names, people may have names indicating a day and area in which they were born or they may be given a name of a close relative or family friend. Some names commemorate an important event.

family and kinship

Ghanaians

Family is the primary source of identity, loyalty and responsibility. Family obligations take precedence over everything else together with extended family duties and responsibilities. Individuals achieve recognition and social status through their extended family. A cultural variation among the Akan, Ashanti and Fanti people is that affiliation within the clan is through women. Mothers have a higher status because from their point of view people get their blood from mothers.

It is important for Ghanaians to maintain dignity, honour and a good reputation. The entire family shares any loss of honour, which makes the culture a collective one. In order to protect this sense of face there is a need to maintain a sense of harmony; people will act with decorum to ensure they do not cause the family embarrassment.[61]

Nigerians

Extended families still play an important role in the Nigerian culture. Family relationships are guided by hierarchy and seniority. Status and recognition are achieved through extended families. Similarly a family's honour is influenced by the actions of its members. Individuals turn to members of the extended family for financial aid and guidance, and the family is expected to provide for the welfare of every member. Although the role of the extended

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[60] United Bristol Healthcare NHS Trust, *A Guide to International Naming Systems,* version, 2 May 2007

[61] http://www.kwintessential.co.uk/resources/global-etiquette/ghana.html

family is diminishing, there remains a strong tradition of mutual caring and responsibility among the members.[62]

health beliefs

Ghanaians

There are some interconnections between the modern and traditional medicines. Traditional medicine and medical practitioners remain important. Customary treatments for disease concentrate equally on supernatural causes, the psycho-sociological environment and medicinal plants. Priests and priestesses deal with illness through prayer, sacrifice, divination and herbal remedies. Keepers of fetish shrines focus more heavily on magical charms and herbs.[63] There is a strong belief in witchcraft.[64] Also Ghanaians in common with Africans generally believe that people are made up of body, soul and spirit and afflictions to any part or combination of part is correspondently met and treated as such, e.g. mental illness is deemed by some as a spiritual illness requiring spiritual intervention in accordance with the person's spiritual beliefs.

Nigerians

In many was as in Ghana traditional healing practices aim to achieve a balance between the invisible world of the deities, ancestral spirits of good or evil and other beings inhabiting the "other" world. Spirit causation remains a significant part of the traditional medicine and the presence of disease or illness may be seen as a warning sign that there is an imbalance with either the natural or the spirit world. There also is widespread use of medicinal plants or herbal remedies to treat illness.

gender issues

Ghanaians

Although women have equal status with men, they do not enjoy equal rights with men. Moreover, traditional practices such as female genital mutilation, bride price and forced marriage are issues that further undermine the status of Ghanaian women.[65]

Nigerians

Nigerian women are appreciated for traditional roles as daughter, wife and mother. However, the notion that man is on top of and superior to woman pervades and defines social relationship, which is persevered and transmitted by culture. The numerous women's organisations testify to the reality of women's oppression and the recognition of collective action for women to get their voice heard.

[62] http://www.kwintessential.co.uk/resources/global-etiquette/nigeria.html
[63] http://www.everyculture.com/Ge-It/Ghana.html
[64] UK Boarder Agency, "Operational Guidance Note Ghana", 28 January 2009, Home Office
[65] http://www.womankind.org.uk/why-ghana.html

religion

A mix of religions is practised within the West African communities depending on country of origin. According to the last census over 69% of Africans are Christians, while 20% are Muslims. African Muslims in London are mainly from northern *Nigeria* and groups such as the Somalis.

About 50% of Nigerians are Muslim and 40% are Christian.[66] Although most people practice Islam or Christianity, many also engage in practices derived from indigenous (traditional) religions. Islam is a monotheistic faith, that is, a belief in one God, Allah. Muslims base their laws on their holy book the Qur'an. All Muslims are expected to believe and practice the Five Articles of Faith, and the Five Pillars of Faith. The Articles of Faith are: belief in Allah[67] as the one and only God, in angels, in the Prophets (Mohammed is the final prophet), in the Day of Judgement and in predestination. The Pillars of Faith are: declaration of faith, praying five times a day, giving money to charity, fasting and a pilgrimage to Mecca (at least once in a lifetime).[68] Mosques are the places of worship; their spiritual leaders are called imams.

Christians believe in one God and in Jesus Christ as the son of God whom they have accepted as their saviour. God is worshiped in three persons: the Father (the creator), the Son (Jesus Christ) and the Holy Spirit (the power of God). This is known as the Holy Trinity.[69] Jesus is recognised as the Son of God sent to save humanity from the consequences of its sins. Important concepts in Christianity is that of Jesus giving his life on the Cross (the Crucifixion) and rising from the dead on the third day (the Resurrection), which marks his triumph over sin and death.

Christians believe that through their belief in Jesus as the Son of God, and in his death and resurrection, they can have a relationship with God whose forgiveness was made once and for all through the death of Jesus Christ. Christians believe there is life after death. The Christian holy book is the Bible; churches are the places of worship. Their spiritual leaders are called priests or ministers or pastors.[70]

One significant worldview shared among *Ghanaians* and *Nigerians* generally, is a spiritual vision of life and the world, according to which all beings of a visible nature are connected with the invisible spiritual world. People believe

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[66] http://www.everyculture.com/Ma-Ni/Nigeria.html
[67] The Arabic word for God is Allah.
[68] http://www.bbc.co.uk/religion/religions/islam/beliefs/beliefs.shtml
[69] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf
[70] http://www.bbc.co.uk/religion/religions/christianity/beliefs/basics_1.shtml

in a Supreme Being who rules the universe, and in supporting deities, spirits and ancestors who act as intermediaries between the Supreme Being and humans. Religions may include the worship of gods that manifest themselves through animist forms, which believe that trees, stones, stars, rivers and people have living souls. Traditional religious practices are closely connected with traditional medicine and magical practices.[71]

dietary requirements

Muslims will eat only permitted food (halal) and will not eat or drink anything that is considered forbidden, such as pork, alcohol. There are no dietary requirements for Christians, except Roman Catholics who may not eat pork and meat on Fridays. Refer to Appendix 2 to check food preferences.

birth

When a Muslim child is born, as soon as possible a member of the family must recite in the baby's ear a prayer that normally lasts a minute or two (Azaan). A Muslim boy must be circumcised as soon as possible. It is not a religious requirement for girls to be circumcised.

In a Christian family the baby is usually publically named and blessed after a few weeks or months following the birth. Some have a christening or a baptism, while others have a service of blessing and thanksgiving. This is practiced by many denominations of Christianity (Methodists, Catholic Church, Evangelical, Pentecostal, etc).

For a Christening, family and friends gather in a church and the baby is dressed in a white Christening gown. The parents have to choose godparents who will help the child to live as a Christian and will act as guardians in the absence of the parents. The priest asks the parents to give the 'Christian' name they have chosen for the child. The priest then says a prayer of blessing over the water in the font and then pours it on the baby's head. This symbolises purification and the fresh start of a life. Then the priest calls the baby by name and welcomes him or her into the Christian Church and community. A record of the christening or baptism is recorded in the church's register. There is usually a celebration afterwards, where gifts are given for the baby.[72] In Ghanaian and Nigerian cultures there is the traditional custom of 'outdooring' of a baby a week after birth where the child is brought out of doors to family and the community.

dying and death

Dying

The family and extended network is usually involved in the care of the dying. It is an important religious duty to visit the sick and dying so many visitors may arrive at all hours. A dying person, depending on their religious beliefs, may want to be comforted with prayers from the Bible or verses from the Qur'an.
At the time of death the pastor or Imam may need to be present.

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[71] http://en.wikipedia.org/wiki/African_traditional_religion
[72] http://www.confetti.co.uk/article/view/8089-8311-0-Naming_traditions_and_ceremonies_from _around_the_world_Baby_Shower.do

Death

For a Muslim person, the next of kin will want to arrange to wash the body before burial. Muslims are always buried as they believe in the resurrection of the body after death. In Islam the body must be buried as quickly as possible, preferably within 24 hours. Cremation is forbidden.

Christians believe that Jesus will return to earth to rule forever and that the dead will be resurrected to join in his glory. Because of this conviction, in the past most Christians believed that they should be buried and not cremated. Nowadays, however, cremation is acceptable to some Christian denominations.[73]

The funeral arrangements reflect the West African attitude to death. If there is to be a burial then the body may be laid out and viewed at the funeral home or in the church. The funeral is seen as a farewell because a loved one is going "home". Relatives and friends pay tributes in memory of the dead in church before the burial. At the graveside relatives and friends will fill the earth in the grave together. After the funeral there is usually a reception for the guests and well wishers.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

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[73] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf

INDIAN CULTURAL PROFILE

This profile is a general guide offering cultural information about Indians who identify themselves as British born Indians or Indian living in Hackney. Please check with each individual about their personal needs.

demography

There are 8,606 Indians living in Hackney representing 4% of the borough's population.[74] Many Gujaratis in Britain came from Gujarat via East Africa and the Gujarat region of India.

language and communication

Common languages spoken amongst the Indian communities, other than English, include Punjabi, Hindi, Urdu and Gujarati.

naming system

Hindus

Hindus usually have three names: a personal (first) name followed by a middle name (commonly either the father's or husband's name) and the last name is the family name. Traditionally, Hindu women take their husband's first name as the middle name and last name upon marriage and use the family name for record purposes as a last name.[75]

Sikhs

Most Sikhs have three names: a first name irrespective of gender, a religious middle name and a family name. The religious middle name is always SINGH (lion) for men and KAUR (princess) for women. Some Sikhs just use this religious title, e.g. Mr Singh. The wife of "Mr Singh" is never "Mrs Singh" but "Mrs Kaur" and vice versa 'Kaur' and 'Singh' may often be used as last names. Upon marriage, a woman may take her husband's family name or may call herself 'Mrs Kaur'. Other Sikh women may take the husband's name and call themselves 'Singh'. Sikhs may be prepared to use the family name, where authorities prefer not to have extensive lists of people with the same last name.

Muslims

For Muslims names can include personal names, religious names and sometimes family names. Muslims usually adopt their father's but not their husband's name. It can be seen as disrespectful to address a Muslim by their religious name, for example, "Mohammed", therefore it is important to ask people what they want to be called. A woman may have two names – a personal name followed by a title (such as Begum or Bibi), which is reminiscent of Mrs or Miss. Therefore, it is not appropriate to address a woman as Mrs Begum or Mrs Bibi.

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[74] ONS Mid Year Estimates, 2007
[75] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf

health beliefs

Hindus have strong beliefs in astrology. The movement of the planets has a major influence on human life. Illness may be attributed to supernatural causes. Pain and suffering may be seen as the result of sinful acts or deeds in this or previous lives. This belief may impact the individual's reporting of pain. Protective jewellery or sacred strings may be worn.

Many Hindus are strict vegetarians and connect this dietary choice to spirituality. Patients may refuse medication by capsule because of its gelatine. Cows and pigs are a source for the manufacture of some capsules.[76]

family and kinship

The joint family system, in which members of one family lived together under a common roof, including married brothers, their children and grandchildren, is in practice amongst many Indian families. Under this system, the members of a family share houses, assets, food and their value systems.

Family is of utmost importance; family members have different roles. The elders advise and guide; the elders have a strong influence on decisions. The younger family members are expected to listen, respect and take advice. The sense of family responsibility remains strong even when extended family members may not necessarily live together.

gender issues

Hindus

As with all Asian patients, Hindu women prefer to be seen by female healthcare staff. Consideration should be given to their modesty when being dressed for x-ray or surgery (especially older patients). Hindu women will feel more comfortable in a ward which has women patients only and the same applies to Hindu men who feel less embarrassed in all male wards

Sikhs

As with all Asian patients, Sikh women are likely to prefer to be seen by the female health care staff. Consideration should be given to their modesty when being dressed for x-ray or surgery. Sikh women patients will feel more comfortable in a ward which has women patients only, and the same applies for the men.[77]

Muslims

See other cultural profiles – Bangladeshi, Pakistani.

religion

Most Indians are Hindus or Sikhs. There are also Muslims, Ismalils and other minority religions such as Buddhists, Jains and Zoroastrianists.

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[76] http://www.jamardaresources.com/sample/subpages/hinduism/hinduism_health_beliefs.htm

[77] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/sikhs

Hinduism
The three most important gods are Brahma - the Creator, Vishnu - the Protector and Mahesh - the Destroyer.[78] It is difficult to establish a list of beliefs that all Hindus adhere to because of the diversity of this belief system. But an understanding of the following concepts is important:

- Karma: the consequences of one's actions ("what you sow, so shall you reap")
- Samsara: reincarnation, the cycle of birth, death and rebirth
- Dharma: one's duty according to his or her caste and life stage (varnasrama-dharma)
- Maya: the illusory nature of the world
- Moksa: the release from the cycle of samsara.

It is important to develop an understanding of how this belief system impacts on the everyday life of a Hindu, e.g. the role of ritual in such places as the banks of the Ganges (Varanasi), samskaras (the transformative rituals in Hinduism, e.g. birth, marriage, death) and puja.[79] Many Hindus perform an act of devotion every day at home where most families will have a personal shrine.

There are two kinds of scripture in Hinduism, the holiest texts, called the Vedas together with the Upanishads, and the great epics of the Mahabharata and Ramayana. The Bhagavad-Gita is part of the Mahabharata and can be called a 'handbook' for people's spiritual development. There is a strong belief in Karma, a moral law of cause and effect, which relates to the form in which a person may be reborn. The Mandir is the Hindu place of worship. Hindus will wish to pray twice daily. At home, daily Pujah (worship) takes place before a shrine, sometimes in a room set aside for prayer. Horoscopes are an important part of Hindu religious belief. The Hindu priest is called the 'Pandit' or Pujari'.

jainism
Jains practise reverence for all life; they are vegetarians and try to avoid taking any life, large or small. Jainism teaches the way to liberation and bliss is to lead lives of harmlessness and renunciation. The essence of Jainism is concern for the welfare of every being in the universe and for the health of the universe itself.

Sikhism
Sikhism is a monotheistic religion stressing the importance of doing good actions. Sikhs aim to enable the soul to re-unite with God by remembering God in daily life, living truthfully and serving others. The religion was founded by Guru Namak Dev Ji and Sikhs' holy book is the "Guru Granth Sahib". The Sikh place of workshop is called a temple or Gurdwara is the place of worship.

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[78] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf

[79] http://www.hsc.csu.edu.au/society_culture/belief_systems/focus_studies/2499/BSFocus_Hinduism.html#tr

Religious Sikhs follow the 5 Ks as an outward sign of their religious devotion:

1) Kesh – long hair which is never cut;
2) Kanga – a comb;
3) Kancha – shorts
4) Kara – metal bracelet
5) Kirpan – a ceremonial dagger.

These five items are sacred and should not be disturbed. Sikh men are required to wear turbans to cover their uncut hair. Sikh women may also wear turbans if they choose. The five Ks will be worn about the person. Some married women wear a bindi – a red powder mark on the forehead. Sikhs do not have a specific holy day: British Sikhs have adopted Sunday as the holy day. Prayers are read up to five times daily.

Islam

Islam is based on the Qur'an, the book of teachings by the prophet Mohammed, who was the last in a line of prophets that includes Abraham, Moses and Jesus. Muslims recognise one God (*Allah*) and follow the five pillars of Islam: declaration of the faith, daily prayers five times a day, alms for the poor and needy, fasting during the month of Ramadan, and if possible, the *hajj* (pilgrimage) to Mecca once in a lifetime. Muslims are obliged to observe a dawn to dusk fast for one lunar month every year which is known as Ramadan. Fridays are special days of prayers for Muslims.

Buddhism

Buddhists do not worship gods but strive to free themselves from desire, which is the root of all suffering. By following the teachings of the Buddha a person can free oneself from the cycle of death and rebirth. Buddhism involves seeking life as a process of birth, ageing, illness and death in which people seek enlightenment.

dietary requirements

Hindus

Hindus are generally vegetarians. Many strict Hindus will not eat fish or eggs. Those that are not vegetarians will not eat beef. They usually restrict their diet to chicken, mutton or fish. Pork is rarely eaten.[80] Hindus will not to use plates and utensils that have been used for non-vegetarian food.

The cow is the most sacred animal to Hindus and to kill a cow is one of the greatest religious crimes. Hinduism forbids the consumption of alcohol. Garlic and onions are thought to be foods discarded by the gods, mainly practiced by Jains.

Some Hindus fast. Fasting is related to penance. You do certain prayers to achieve goals.

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[80] http://www.copfs.gov.uk/Resource/Doc/13928/0000571.pdf

Muslims

Muslims are forbidden to eat pork or any animal not killed according to with Islamic law, i.e. halal meat. They are also forbidden to take drugs or drink alcohol.

Sikhs

Sikhs are forbidden to eat Halal, Kosher and beef. It is important that even when cooking, the same utensils should not be used to cook for Sikhs which have been used to cook or store Halal, Kosher or beef. Some Sikhs are vegetarians, which are individual preferences. Sikhism forbids smoking and alcohol and a devout Sikh will not eat animal by-products, eggs or pork. Sikhs do not observe fasting for any religious reasons.

Jains

All Jains are strict vegetarians. They do not eat root vegetables because they will have millions of bacteria. Dairy products such as milk, curd and ghee (clarified butter) are permitted but not eggs or honey.[81]

birth

Hindus

Hindus believe in rebirth, that the soul is reborn many times in different bodies. During pregnancy the mother is encouraged to read and recite Hindu scriptures so they have a positive influence on the unborn baby. The exact time of birth is noted and the priest calculates the lucky initials for the baby according to the corresponding astrological constellation and this information is also used to make a horoscope for the child. The family then has to decide on a name beginning with one of those initials.

After 40 days the baby is taken to a Hindu temple for the naming ceremony. The priest announces the name and says prayers for the long life, health and well being of the baby. Blessed water is sprinkled on the baby and a few drops of 'amrit' (sweetened water) are put on the tongue. At the first birthday, the baby's head is completely shaved for the first time, as a symbol of leaving any bad deeds from a past life behind and making a fresh start in the new life.[82]

Sikhs

During pregnancy the mother is encouraged to go to the Sikh temple to read or recite the holy hymns from the Sikh scriptures. Soon after birth, a respected elder gives the baby a few drops of honey and water, while reciting the first verses of the Japji Sahib, a hymn by Guru Nanak.

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[81] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/jains

[82] ceremonies_ from _around_the_world_Bhttp://www.confetti.co.uk/article/view/8089-8311-0-Naming_traditions_and_aby_Shower.do

After birth the child is brought home and when the mother is able and well, they will take it to a gurdwara for the naming ceremony. This ceremony is mostly done on Sunday during the service. There is a reading from the Sikh holy book, Siri Guru Granth Sahib, where the passage is selected by opening the book at random and reading the first words of a passage on the left hand page. The first letter of the word at the beginning of this passage is taken as the first letter of the baby's name, which is then chosen by the parents. All boys are given the same second name, 'Singh', meaning lion, and for all girls, the second name is 'Kaur', meaning princess. Sweetened blessed water called Amrit is put on the baby's tongue. The baby also has a tiny steel bracelet, called Kara, put on its right wrist. The circular shape symbolises God, who like the circle, has no beginning and no end. Family and friends are given 'kara prashad' a sweet blessed food, made with flour, sugar and clarified butter, followed by a communal meal.[83]

Muslims

Birth ceremonies include the rites of Adhan and Iqamat, shaving of the head, naming and circumcision. When a Muslim baby is born, it is bathed and the Adhan is whispered softly into his or her right ear. The Iqamat is said into the left ear. Soon after birth, something sweet is placed in the baby's mouth. The baby is named on the 7th day after birth. On the 7th day after the birth the head of the baby is shaved and all boys are circumcised. However, Islam does not sanction female circumcision.[84]

jains

The rites through which a Jain passes are the same as Hindus and it is often Hindu priests who perform these ceremonies.

dying and death

Hindus

A Hindu patient may request the services of a Hindu Priest during the last stages of life. If a Hindu patient requests to lie on the floor during his/her dying moments then every possible step should be taken to grant their wish. There are several reasons for the custom. The main reason is to ease the breathing so that the soul can depart easily. Hindus believe that the human body is made of five elements i.e. earth, water, fire, air and ether. A wish to lie on the floor symbolises the closeness to mother earth. Hindu patients may wish to die at home which has religious significance. A dying Hindu may receive some comfort from hymns and readings from holy books. Some may wish to have images or pictures, praying beads and blessings (e.g. flowers) on or near the bed.

A Hindu priest may be called to perform holy rites - the priest may tie a thread around the neck or wrist of the dying person to bless him/her. Religious rites will be performed. The oldest son has a sacred duty to perform death rites for the father. A close male family member will be selected to perform these duties if it is impossible for the eldest son to do so. The family will want to wash

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[83] Ibid

[84] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/muslims

the family member's body following death (symbolises cleansing of the soul). Threads tied to the body by a priest or any jewellery should be left in place. The priest may pour a small amount of sacred water in the mouth of the dead person as part of religious rites of death.

After death the eyes should be closed and limbs straightened, leaving jewellery, sacred threads and other religious objects in place and the body should always remain covered with a plain white sheet. A piece of gold is placed in the mouth of the deceased before they are cremated.

Hindus believe that a body without a soul is a carcass that should be returned to nature and so is cremated. The hospital should try to release the body as soon as possible so that the family can make arrangements for the cremation. Cremation is seen as a method of purifying the dead and expediting the travel of the soul from this world to the next. Children are generally buried because their personalities are not fully formed and therefore, do not need the purification provided through cremation.[85]

Sikhs

A dying Sikh may receive comfort from reciting hymns from the holy book and patients may request the service of a Sikh priest who can recite Gurbani (writings of the Gurus) and perform Sikh prayers. At the departure of their loved ones, Sikhs console themselves with the recitation of their sacred hymns.

If no relative or family is present at the time of death, then they should be contacted as soon as possible. The body of the deceased should be covered, and must not be sent to the hospital mortuary before the immediate family or relations arrive. The body of the deceased can be handled by the hospital staff, preferably women by females and males by males.

Sikh faith requires the carrying out of the funeral as soon as possible after death. All the funeral arrangements are made by the family, who will appoint a funeral director to do all the necessary work. During the preparation of the body for funeral, the body is washed by the relatives and family members. Women wash females and men wash the males. All this is carried out at the funeral directors. The body is then brought to the Sikh temple for the last prayers and rites and then taken to the cemetery for cremation. It is noted that all Sikhs, whether male or female, over the age of five years are cremated. After the funeral the ashes are collected and scattered in a river or sea.[86]

Muslims

Muslims are always buried as they believe in the resurrection of the body after death. For further information see the cultural profiles for Bangladeshi or Pakistani.

[85] http://www.jamardaresources.com/sample/subpages/hinduism/hinduism_death.htm
[86] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/sikhs

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

KURDISH CULTURAL PROFILE

This profile offers general cultural information about Kurdish people living in Hackney. Please check with each individual about their personal needs.

demography

Most commentators agree that there is little comprehensive data on the Kurdish population in the UK and that which exists is conflated. Using anecdotal data, London Borough of Hackney estimates the Kurdish population in Hackney to be 25,000 but it is acknowledged that this is just an estimate rather than accurate figure.[87]

Despite a long period of settlement in the UK local and national authorities are still unable to assess the number of Kurds and are unable to plan service provision accordingly. Official data like the Census and the Labour Force Survey renders Kurds invisible as they are classified as 'White' and while this is sub-divided into various ethnic or national groups most Kurds are classified as 'White Other' as there is no specific category for them.[88]

language and communication

Although Kurds have been scattered mainly into four countries (Turkey, Iraq, Iran and Syria, there are some Kurdish communities also live in Armenia and Azerbaijan. The Kurdish people are a distinct ethnic group, who have a unique, recognised historical identity and culture stretching back centuries as well as their own language (which is made up of several distinctive dialects). Kurdish is the language used by Kurds regardless of country of origin, although different dialects are used. Linguistically, there are distinct dialects of Kurdish language, such as Sorani, Gorani and Kurmanji plus other sub dialects. Awareness of these significant differences is important for organisations using interpreters and translation services, as speakers of one dialect are not necessarily able to understand one of the others.

Kurds coming from Turkey also speak Turkish since the Kurdish language was until recently outlawed in Turkey.

naming system

There is no specific naming system. Children traditionally receive as a last name the paternal grandfather's given name. In some cases the personal name is followed by the father's then by the grandfather's name or by the name of a close relative. Married women tend to adopt their husband's family name. Some parents name their children after well known Kurdish national figures.

Many Kurds from Iraq use the Islamic naming system where three names are given – a personal name followed by their father's name then the

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[87] Holgate, J, Poliert, A and Keles, J. "To whom do I turn when I am invisible? The experiences of Kurdish workers who have problems at work", Paper presented at the British Sociological Association Annual Conference, Cardiff, 15-17 April 2009

[88] Ibid, pp. 3

grandfather's name. For instance, several boys in the family would have the same second and third names. Girls may be given their grandmother's name. Women keep their own names on marriage.[89]

family and kinship

Kinship and community networks are important to the lives of Kurds. Rights and obligations centre on the extended family and the family remains the primary focus of loyalty.

As for the most communities, respect and honour are very important in the Kurdish culture and are especially given to the older members. Family 'honour' revolves around the public perception of the individuals more than their actual behaviour. Causing a scandal or gossip within the community is often the most significant aspect of an offense against 'honour'.

gender issues

Gender roles may be patriarchal with wives and daughters expected to be subordinate to their husbands and fathers and even their own sons. Women's role is ancillary as an obedient wife or a dutiful daughter and self sacrificing mother. Women are not expected to show autonomy but to work for their families. A woman's 'honour' is directly linked to her conformity to traditional roles. Any perceived rebellion against these restrictions may be seen as a loss of 'honour.'

Female genital mutilation, honour killings and forced marriage are harmful practices affecting girls and women.

health beliefs

There is no specific information available at this time.

religion

Most Kurds mainly follow the Sunni tradition of Islam and the Alevi belief (especially the Kurds in Turkey) although there are smaller numbers of Shia Muslims, Christians, Jews and a number of locally specific religions, Kakaii, Yazidi, Zardashti and Zoroastrianism being the main examples. Religion is not a dominating factor in Kurdish cultural and social life.

In the UK most Kurdish people coming from Turkey are Alevis, that is considered as a culture, a doctrine, a way of life and a philosophy by some rather than a religion. The Kurds from other parts such as Iraq, Iran and Syria are mainly Sunni Muslim.

The Five Pillars of Islam describe the religious duties of Muslims: faith in God and Muhammad as his prophet, prayer (pray at least five times a day at set times); fasting during Ramadan; giving alms, making a pilgrimage to Mecca at least once in their life (Hajji). The most important holiday is Kurdish New Year (Newroz), on March 21, celebrating an ancient Kurdish legend marking the independence of Kurds. Kurds also observe the religious period of

[89] http://bearspace.baylor.edu/Charles_Kemp/www/kurdish_refugees.htm

Ramadan, although the strictness of adherence to the rules on fasting vary considerably according to their orthodoxy.[90]

dietary requirements

The diet of Muslims has religious importance and pork and pork products are forbidden. Other meat may be eaten, provided that it is halal that is killed in the manner prescribed by Islamic law. All alcoholic drinks and any dishes containing alcohol are prohibited.

Refer to Appendix 2 for the list of food preferences.

birth

The birth of a child is celebrated by a feast given by the parents and their family. Newborn boys are typically circumcised within the first month or two. Girls are subjected to female genital mutilation from the age of 4.

dying and death

Dying

An imam, a religious leader, is not necessary when a Muslim is dying. Family members will give comfort and pray. It is normal for them to perform all the rites and ceremonies. It is recommended, if at all possible, for a Muslim's last words to be the declaration of faith: "I bear witness that there is no god but Allah."[91] If possible the dying Muslim should sit or lie with his face turned towards Mecca.

Death

Once a Muslim is dead, ideally the body should not be touched by non-Muslims but if essential, non-Muslims should wear disposable gloves to prevent actual contact. If the family is willing, the eyes should be closed, the limbs straightened and the head tuned toward the right shoulder (in order to bury the body with the face turned towards Mecca. The body should be wrapped in a plain sheet.

At death, the body is ritually washed by an Imam (for a male) or a devout older woman for females and covered with a white sheet, fitted to the body. This is typically done at a mosque but can be performed at a funeral home.

Muslims are buried and never cremated. This usually takes place within 24 hours. The body is placed in the grave so that the head faces Mecca. At the burial, family and friends gather, and the Imam recites from the Qur'an. Others read from the Qur'an as well in the name of the deceased.

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[90] http://bearspace.baylor.edu/Charles_Kemp/www/kurdish_refugees.htm
[91] http://islam.about.com/cs/elderly/a/funerals.htm

The funeral party then returns to the house of the deceased for prayers and a feast. Mourning usually lasts about a month and relatives and friends visit and bring comfort. They talk about the person who has died, extolling his/her virtues and sharing the loss. The family stays at home for about three days. They do not cook but are brought in food by friends and relatives.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

PAKISTANI CULTURAL PROFILE

This profile is a general guide offering cultural information about Pakistanis living in Hackney. Please check with each individual about their personal needs.

demography

There are 3,438 Pakistani people living in Hackney.[92]

language and communication

Urdu is the official language of Pakistan and is the main written language. Almost all Pakistanis speak Urdu. Most Pakistanis in Hackney speak Punjabi, although those from Mirpur speak the Mirpuri dialect. Gujarati and Pushto are also spoken by some Pakistani.

7. PAKISTANI

naming system

The convention is a personal name followed by a middle name which may or may not be a Muslim religious name, e.g. Anwar (personal name), Muhammad (religious name) and Khan (family name). It can be seen as disrespectful to address a Muslim by their religious name, for example, "Mohammed", therefore it is important to ask people what they want to be called.[93] But some men do not have a religious name and use two personal names, e.g. Anwar Salim or Salim Malik. In this case the second name is used as the family name.

Most Muslim women traditionally have two names – personal name followed by a female title, e.g. Begum or Bibi, which is similar to Mrs or Miss, e.g. Amina Begum. A woman will be addressed informally by her personal name or formally by her full name. When Pakistani women marry, they do not usually change their name, i.e. adopt the name of their husband.

It is however, more common amongst some second and third generation Pakistanis settled in Britain to have a shared family name following a personal name as in the British system and for women to take the family name on marriage.

health beliefs

Islam does not believe in mind- body dualism. Maintaining spiritual peace is thought to be an essential part of health. Older people who are often bound to traditions may believe that disease can be a direct punishment of God for sins committed. Following religious teachings and not doing evil, therefore, is viewed as an integral part staying healthy. Elders, especially women, may try traditional folk medicine initially when illness strikes and seek allopathic medical help only when the suffering due to the disease becomes intolerable.[94]

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[92] ONS Mid Year Estimates, 2007
[93] Sheffield City Council, *Cultural Awareness Handbook,* September 2003
[94] http://www.stanford.edu/group/ethnoger/pakistani.html

Unani is traditional medicine used in Pakistan.[95] According to Unani, there are three states of the body: health, disease, and the neutral state between the two when one is not truly healthy but the signs of disease are not fully manifest. Unani also propounds the six primary factors in relation to health and disease: (1) the air of one's environment, (2) food and beverages, (3) movement and rest, (4) sleep and wakefulness, (5) eating and evacuation, and (6) emotions. These six factors must be properly apportioned in quantity, quality, time, and sequence in order for a person to be healthy. Diseases are caused when the functions associated with the vital, natural, and psychic forces of the body become "obstructed," or unbalanced, owing to a deviation in the humour away from its characteristic temperament. The Hakim (Unani practitioner) after identifying the imbalance will then often recommend among other things, appropriate foods that are specifically chosen to correct the imbalance and restore equilibrium.

Muslims may wear the taawiz, an amulet containing verses from the Qur'an when ill. The taawizes are symbols of Islamic faith, given by the priests) and worn by adults to cure and prevent illness caused by the evil eye, ghosts, or spirits.

family and kinship

Religious practices are an integral part of everyday life for many most people of Pakistani origin are Muslims. Education is also highly regarded and traditional family values are highly respected and considered sacred. In extended families, the network of relatives acts as a close-knit community and can include cousins, aunts, uncles and grandparents.

The extended family can pose a challenge for young people from Pakistani families who may find themselves torn between two cultures – one based on family values and loyalty and the other based on the majority's culture of individuality.

Old age is respected in Pakistan. Elders should be treated with utmost courtesy and respect. Older Pakistanis may wear religious paraphernalia e.g. taawiz (amulet) or topi (religious cap). These should not be removed without the permission of the owner.

gender issues

Under Islam, men and women are considered equal. However, it is accepted that the man is the provider and decision maker whilst the woman is for taking care of the family and household. The importance of family loyalty is instilled in children from an early age and it is a matter of family honour that older and vulnerable family members are supported.

Women are the centre of the family and the more traditional Muslim fathers and husbands may be reluctant for their daughters and wives to go out to work. However, under most Islamic teaching and practice, Muslim women

[95] http://library.wellcome.ac.uk/assets/native_wt015174.pdf

are allowed the right to an education and career and may work outside the home.

Both men and women are required to dress and behave modestly. Women must cover their hair and conceal the shape of their bodies. In some traditions women also cover their faces. Men may cover their heads with a hat.[96]

religion

Most Pakistanis are Sunni Muslims. Muslims believe that there is only one God, Allah, and that the Prophet Muhammad his final messenger. The word `Islam' means peace and submission, implying a peaceful way of life based on submission to the will of Allah. There are five fundamental principles – called the five pillars – that are to be practised by every Muslim:

1) Believing in the oneness of God (Tawhid)
2) Reciting five daily prayers at set times (Salat)
3) Giving alms to the needy (zakat)
4) Fasting during the month of Ramadan
5) Taking on a pilgrimage to Mecca (Haji).

The Qur'an is the most important holy book for Muslims. The Qur'an must be handled only after ablution and must be treated with care and respect. No other book must be placed upon it and nobody should talk, eat or smoke whilst it is being read and must not be touched by non-Muslims. The mosque is the place of worship for Muslims.

dietary requirements

Muslims must not eat pork or anything containing pork. All other meat is acceptable providing that it had been killed in a certain way (halal). Most Pakistanis follow this diet restriction strictly and will even avoid foods cooked with lard. Alcohol is also prohibited in Islam. During the cooking process, any meat or meat products such as gelatine are avoided. The use of separate utensils when cooking or serving the Halal and non -Halal food is essential

It is important to bear in mind that some second generation Muslims will have an English meal; i.e. vegetables, fish, rice etc. but they will need to avoid pork and other impermissible foods.

Fasting: During the month of Ramadan (the dates change each year) no food or drink is taken 1.5 hours before sunrise until sunset.

birth

Birth ceremonies include a number of elements:

- The Adhan is the Muslim call to prayer. After birth the baby is washed and the Adhan, a short prayer, is whispered into its right ear. The Iqamat is said into the baby's left ear.

[96] http://www.bradfordhospitals.nhs.uk/patients-and-carers/chaplaincy-new/faith-requirements-information/muslims

- Something sweet (a small piece of date or some honey0 is placed in the baby's mouth soon after birth.
- The baby is named on the seventh day after birth.
- The baby's head is shaved on the seventh day after birth.
- All boys are circumcised.
- Islam does not sanction female circumcision.[97]

death and dying

Dying

Muslims understand death to be the transition from one state of being to another. Rather than fearing or fighting death, Muslims are encouraged to accept death as part of the will of Allah.[98]

When a Muslim patient is near death, the relatives and/or a member of the local Mosque committee should be informed. It is usual for many people to visit the dying person. Visitors will sit by the patient's bed and recite verses from the Qur'an, and pray for the peaceful departure of the soul.

The patient on the point of death should, if possible, be turned to face in the direction of the ka'bah in Makkah. (A south easterly direction in the U.K.) The patient should be turned onto their right side facing south east. When a patient is unable to be turned, they may be placed on their back with the feet in the south easterly direction and their head slightly raised.

If the patient is in a state of consciousness, those present at his bedside will encourage him to recite the Shahadah - the declaration of faith. This is done to invoke the blessings of Allah and in the hope that Allah will accept his life as a Muslim and forgive his sins in the hereafter.

Death

When a patient has died, recitation of the Qur'an ceases in their presence. Immediately after death, relatives will want to get the body ready for enabling washing and shrouding.

The corpse should be handed over to the relatives or the Muslim community of the locality who will make arrangements for the washing, shrouding and burial according to Islamic regulations. Any tubes etc. or artificial limbs should be removed and incisions plugged so as to prevent or stem a flow of blood. Muslims do not usually bury the corpse in a coffin, but if special circumstances apply or if the law requires this, then Muslims will not object to this.

Muslims are always buried as they believe in the resurrection of the body after death. They also believe that unless the body is buried within 24 hours of death (i.e. the soul leaving) the soul will be unable to progress to heaven.

[97] http://www.radcliffe-oxford.com/Books/samplechapter/2609/ch04-5-3c6a85c0rdz.pdf
[98] Ibid, p.17

Islamic law also decrees that a body must not be interfered with once the soul has departed.

Due to these laws and beliefs, a delay in burial or a post-mortem examination can be deeply distressing for a bereaved family. Where either is unavoidable the reasons must be carefully and tactfully explained.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

POLISH CULTURAL PROFILE

This profile is a general guide offering cultural information about Polish people living in Hackney. Please check with each individual about their personal needs.

demography

There are no estimates of the size of the Polish population in Hackney. Polish residents are ethnically 'classed' as 'White Other', of which Hackney had over 23,0000 at the time of the 2001 Census, making it one of the borough's largest ethnic groups.

language and communication

Many Polish speak both Polish and English particularly the younger generation.

naming system

A Polish personal name consists of two parts: the first or given name and the surname or family name. The first name indicates the person's sex. Almost all Polish female names end in the vowel *a*, whereas most male names end in a consonant or a vowel other than *a.* e.g. husband *Piotr* Malinowski, Wife *Krystyna* Malinowska.[99]

Among Catholics it is customary to adopt the name of a saint as an informal third name given at the time of confirmation but does not have any legal effect. People celebrate *name days* (imieniny) on the day of their patron saint. Name Day is a Polish tradition that was originally a day for honouring Patron Saint.[100] Birthday celebrations are more fashionably among the younger generation. Many families today still observe Name Day but it is more focused on partying and gift giving rather than remembering and celebrating Saints.[101]

health beliefs

Complementary medicine is seen to have an integral role in people's health alongside western medicine. Some people will use homeopathic remedies in combination with changes in lifestyle and eating habits. Some herbal medicine and pharmaceuticals are often privately imported from Poland. Word-of-mouth medication recommendations also carry a lot of weight with older Polish people.[102]

Poles also typically follow medical orders carefully and submit to various kinds of medical treatment, including tests, operations and medication. Going to health professionals is usual and Poles are used to the medical hierarchy (i.e. GPs for overall health with referral to specialists as needed for more in-depth treatment. Traditionally, doctors and other health professionals are given

[99] http://en.wikipedia.org/wiki/Polish_name
[100] http://centraleuropeans.co.uk/?page=56&article=76
[101] http://www.easterneuropeans.co.uk/?page=56&article=43
[102] http://www.diversicare.com.au/upl_files/file_35.pdf

great authority in various aspects of life and are well respected within the Polish community. Because Poles are polite to authority figures they may not ask a doctor for clarification fearing doing so may offend the doctor.[103]

family and kinship

The family is the centre of the social structure. One's obligation is to the family first and foremost. Extended families are still the norm and really form an individual's social network. Poles draw a line between their inner circle and outsiders. Family members are naturally part of the inner circle along with close friends, usually "family friends". Poles will interact differently with their inner circle and outsiders. The inner circle forms the basis of a person's social and business network. The people from the inner circle can be relied upon to: offer advice, help find a job, cut through bureaucracy, or even rent an apartment. There is an elaborate etiquette of extending favours and using contacts to get things done.[104]

The father is generally the head of the family where often both parents work. The most popular family model is the 2 + 2 formula (mother, father and two children). Traditional family values and loyalty are strong in most Polish households. Older people play an active role in helping adult children in their daily routine with families. The extended family is also very important, however many older Poles do not have extended family.

Poles recognise kinship through both genders and use the same kin terms for both father's and mother's relatives but differentiate between genders and generations. When individuals try to manipulate the formal economic and political systems, they try to utilise kin ties to do so. Groups of relatives assemble for formal occasions, especially for funerals and weddings.[105]

gender issues

Traditionally, the women's place was in the home and men were head of the family. In modern times, the situation for Polish women is still defined by the double role that woman are expected to fill according to the stereotypical dominant model of family life. This model requires that a woman's job or career must be reconciled with her role in the family life, particularly, with meeting the social expectations related to motherhood and to caring for the elderly.

religion

Most Polish people are linked to the Catholic Church. Religion plays an important role in the Polish society and is deeply intertwined with Polish society. Christianity is the main religion practiced in Poland, with Roman Catholicism being the largest denomination.

Roman Catholics believe that Jesus Christ was the Son of God and that he instituted a living church on earth during his ministry. It is believed that the

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[103] Ibid.
[104] Ibíd.
[105] http://www.everyculture.com/No-Sa/Poland.html

Jesus left the church in the care of Peter, his chief apostle, and that Peter then delegated leadership of Jesus' church to his successors down to the current Pope. Besides the Ten Commandments the core beliefs of Catholics are:

1) To hear Mass on Sundays and other special days called "holy days of obligation".
2) To fast on specified days.
3) To observe the sacrament of reconciliation when conscious of having sinned gravely or at least once a year.
4) To receive the Eucharist at least once a year. If only received once a year this should be at Easter time.
5) To support pastors.
6) To observe the Church's laws on marriage

The sacrament of reconciliation includes declaring sins to a priest who can give absolution (forgiveness).

Christmas is an important holiday for families. Easter is the most important holiday for Christians. There are many Polish celebrations associated with Easter.

dietary requirements

There are no dietary requirements determined by religion. However, most people do not eat meat on Fridays and fast at least once a year on Good Friday.

birth

There is no specific information available at this time.

dying and death

Dying

The patient will probably wish to be visited by a Catholic Priest and to receive Holy Communion and the "Sacrament of the Sick". This is not only for the dying, but also for the sick, especially before a major operation. The Sacraments are very important. This involves a priest using holy water or oil to make the sign of a cross on the patient's forehead. Some Catholics may refer to this sacrament as "the last rites" for terminally ill patients. The Catholic Priest must be called to the dying patient and if the death is sudden, immediately afterwards.

Death

Catholics may be buried or cremated.[106] After the funeral mourners are invited for a wake or '*stypa*' where drinks and food are served in memory of

[106] http://www.diversicare.com.au/upl_files/file_35.pdf

the person. Family wear black clothing on the day of the burial. The spouse may choose to wear black clothes for up to 1 year (the year of mourning). Graves of loved ones are visited for years to come, particularly on All Saint Day, which is 1st November, when flowers and candles are placed on the graves.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

SOMALI CULTURAL PROFILE

This profile is a general guide offering cultural information about Somalis living in Hackney. Please check with each individual about their personal needs.

demography

For official monitoring purposes 'Somali' as an ethnic group is subsumed within the broader Census category of 'Black African'. The resulting absence of specific demographic information is indicative of the lack of strategic planning in addressing the needs of this community. There are only rough estimates available about the size of the Somali community. The 2001 census estimated that there were 34,000 Somalis in London while a 2003 report estimated that there were 70, 000 in the capital.[107]

Minority groups from Somali include the Banaadiris, the Brawans or Bravanese, and the Bajuni. Both communities have significant numbers in the UK.

language and communication

Somali is the language spoken.[108] The Bravanese speak Chimini or Bravanese which is closely linked to Swahili. The Brajuni speak Kibajuni, a dialect of Swahili. Some Bravanese and Bajuni children and older people may not speak or understand Somali.[109]

Naming system

Somali names have three parts but only use the first and second names. The first name is the given name after the grandparents. The second name is of the child's father, and the third name is of the child's paternal grandfather, for example, Musa Ali Abdi: Musa, son of Ali and grandson of Abdi. Thus siblings, both male and female, will share the same second and third names.

Women, when they marry, do not change their names. By keeping the name of their father and grandfather, they are maintaining their affiliation with their family.[110]

family and kinship

Family is very important in the Somali community. A woman's status is enhanced by the number of children she has.[111] Somalis will live with their parents until they get married. In times of sickness or marriage, all resources are pooled and it is understood that whatever you have is not only yours.

Elders are respected, and continue to have an active role in the family for as long as they are able. Elders are addressed as "aunt" or "uncle", even if they

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[107] http://www.portcities.org.uk/london/server/show/ConNarrative.109/chapterId/2320/The-Somali-Community-in-

[108] Ealing Hospital NHS Trust, "Guide to Ethnicity Information When Caring for Patients", 2006

[109] http://www.wandsworth.gov.uk/education/infoforschools/NIC/ethnic/refugeesnewarri_/somalipupils_/workingwithsoma/WorkingwithSomalichildren.pdf

[110] http://www.qcda.gov.uk/libraryAssets/media/qca-05-1753-11324_somalia.pdf

[111] http://www.healthconcerns.org.uk/documents/Information_for_caregivers.pdf

9. SOMALI

are strangers. Living with extended families is the norm. Similarly, people who do not marry tend to live with their extended families. Divorce does occur, though proceedings must be initiated by the husband.

health beliefs and practices

Somalis generally view health as a gift from Allah (God) hence people are responsible for maintaining their health. A common view among Somalis is that an individual cannot prevent future illness, as the ultimate decision is in God's hands. Illness prevention, in the traditional Somali view, is primarily through the use of prayer and living a life according to Islam. Health care services, both traditional and western, are used for acute illness, while minor illnesses are cared for in the home.

Herbal medicines are still widely used. In the traditional Somali worldview, illness may be caused by infection, by God or by spirit possession. The "evil eye" is a concept believed in by some Somalis. The evil eye is misfortune or illness caused by a person wishing harm on another. Spiritual healers have rituals for healing if the illness has spiritual causes. Traditional healers are skilled in the use of herbal medications. They are the wise men or women in the community who learned their skills from older family members.

gender issues

The father is the decision-maker and wage earner for the family. He interacts with society outside of the home. If the father is absent, the decision-making role for the family is passed on to an older male relative or to an adult son. Traditionally, the roles of men and women have been separated in most areas of life. Today, Somali women carry out many of the duties previously performed by men. This change is in part due to the civil wars when women had to take over many of men's tasks while the men were involved in the war.

This shift in gender roles continues to be a source of conflict, confusion and upheaval within the Somali community. For men the effects of status loss have been acute. For some, their lives have been transformed from that of breadwinners and decision makers to being supported by their wives. The change in the male role has created a space for women to develop work and educational opportunities for themselves which would previously would have been much less possible.

religion

Most Somalis are Sunni Muslims and religion plays an important role in daily life. This is not to suggest there is religious uniformity within the community. Nevertheless, these variations in interpreting the faith across the Somali community need to be acknowledged. These include:

a) ***Appearance*** – As with all Muslims, the way Somalis dress varies considerably. It is common for Somali women to wear the headscarf, although some younger women may choose not to. In keeping with Islamic dress codes, Somali women for the most part do not wear tight clothing or short skirts. The wearing of a long skirt is usual. Some

women wear clothing that covers the whole body except the face and hands. For Somali men it is important that they cover the part of the body from the navel to the knees.

b) ***Prayer*** – Practising Somali Muslims (both men and women) are required to recite five daily prayers (salah). Muslims can pray in any place as long as it is clean and quiet and they are orientated in the right direction. Friday is the important prayer day when the main congregational prayer, *Jumu'ah* is performed in a mosque between 1 pm and 2 pm Attendance is mandatory for men.

c) ***Fasting*** – As Muslims, Somalis are obliged to observe a dawn to dusk fast for one month every year which is known as Ramadan. Because Muslims follow a lunar calendar, the starting date for Ramadan will differ from year to year although it generally takes place in autumn or winter. All able bodied Muslims who have reached the age of puberty are required to abstain from food, drink and smoking during the hours of abstinence. Pregnant women, sick people and those who are travelling are exempt. The fast is broken at sunset to begin again at sunrise the following day.

Before adopting Islam, Somalis followed a belief system that included folklore and reverence for ancestors. Elements of this spirituality still survive in Somali culture.[112]

dietary requirements

Like all Muslims, Somalis are not allowed to eat any part of the pig; the blood of any animal; animals not slaughtered in accordance with the Halal[113] way, nor any alcoholic drinks or foods containing alcohol. [114]

birth

Traditionally when a Somali woman gave birth she remained at home for 40 days and was helped by female relatives and friends. During this period there would be a naming ceremony but hospital procedures requiring birth certificates have changed this practice.

Both boys and girls must be circumcised to be considered clean and eligible for marriage. Boys are circumcised within a month of their birth. Female circumcision also known as Female Genital Mutilation is not allowed in the UK. However some girls are taken abroad to have this procedure done, which is illegal in the UK. This procedure is usually performed by female family members.

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[112] Ibid
[113] http; .everyculture.com/ -th/omli.html
[114] Ibid

death and dying

Dying

When a patient is terminally ill, the person receives support from family and friends. The Imam will read certain sections of the Qur'an when death near.

Death

Following a death, a religious leader is called to prepare the body. The deceased person must buried within 24 hours. For religious reasons cremation is not allowed. A religious woman cares for women, and a religious man cares for men. The religious person cleans and perfumes the body, places it in white clothing, and says the appropriate prayers. In the UK, the Islamic funeral director or the mosques handles all arrangements, if a family requests them to do so.

After death occurs, loved ones may be comforted by passages from the Qur'an. Although there is no traditional mourning period, widows may show that they are in mourning by wearing white clothes or a white head covering for four months and ten days.

In Somali culture, community support is an integral part of the bereavement process. Community members cook, baby-sit, and pitch-in financially to cover funeral costs and help family members of the deceased. Though Western expressions of sympathy such as sending cards and flowers are appreciated, giving money is the Somali tradition. Community members visit with family members and provide comfort. Even if the deceased is not personally known, every effort is made to express condolences to the family.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

TURKISH-SPEAKING COMMUNITY CULTURAL PROFILE

This profile is a general guide offering cultural information about Turkish and Turkish-Cypriot people living in Hackney. Please check with each individual about their personal needs.

demography

According to the London Borough of Hackney the size of the Turkish speaking community in Hackney is 10,395 which represent 5% of the local population.[115]

The Turkish speaking community in the UK is very diverse and comprises several communities including Turkish Cypriots, Turks from mainland Turkey and Kurdish people from Turkey. A separate Cultural Profile has been written for the Kurdish community but some information can also be found here.

Three distinct groups need to be recognised in looking at demographic data: Turks (Turkish nationals), Turkish Cypriots coming from Cyprus and Kurds from Turkey (Turkish passport holders but ethnically Kurdish). While the term 'Turkish speaking community' has been applied to encompass Turks in the UK for some Kurds this might be deemed offensive since they have their own language. Changing the term to 'Turkish and Kurdish speaking community' would include Kurds from Iran and Iraq who are present in significant numbers in the UK. Also aspiring to become their own nation, some Kurds object to being referred to as Turkish Kurds (or Iraqi Kurds or Syrian Kurds). The authors propose compromise term 'Cypriot-Turkish-Kurdish' communities (CTK).[116] In this Toolkit the term 'Turkish speaking' community is used.

language and communication

Turkish is the language spoken by Turkish mainlanders, Turkish Cypriot and Kurdish people. Kurdish, Arabic and several other languages are also spoken in Turkey. Kurds, who make up nearly 20% of the population, live mainly in the east and southeast part of the Turkey. There are also isolated Kurdish villages in other parts of Turkey. Due to the ethnic clashes in the last two decades in the fore mentioned regions, many Kurdish people moved to big cities in the west and south of the country such as Istanbul, Izmir, Adana, Mersin ant etc or migrated to other countries, including UK.

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[115] http://www.cityandhackney.nhs.uk/pdf/Chapter%201%20The%20people%20of%20Hackney%20and%20the%20City%20DSW.pdf

[116] King, R & Thomson, M, 'Turks' in London: Shades of Invisibility and the Shifting Relevance of Policy in The Migration Process', Working Paper No. 51, Sussex Centre for Migration Research, University of Sussex, September 2008

There remains a sense amongst the Kurdish population in the UK that their culture and language are very much undervalued. The fact is Kurds are routinely registered as Turks with local authorities in the UK lends weight to the argument that they themselves represent a particularly neglected ethnic group. This is why some insist that using the term 'Turkish-speaking community' is not neutral.

naming system

For Turkish people from the mainland and the Kurdish people from Turkey the naming system is the same as in the UK that is personal name followed by last name, e.g. Mr. Tunay Ince or Mrs Hilal Talay. For Turkish Cypriot men their personal name is followed by their last name. Married women and children adopt their husband's personal name, e.g.

(Male) *Ahmet* Ersoy
(Wife) *Munevver* Ahmet
(Son) *Halil* Ahmet

Thus, most Turkish Cypriot men will not have the same last name as their wife or children.

health beliefs

There is no specific information available at this present time.

Family and Kinship

Today's Turkish family may be considered in two groups:

Extended family - examples of which are becoming less and less. That is, there are three generations living together in one house: usually sons, their wives and children under the authority of grandparents. Another form of the family there is the following hierarchy: the head of the family, his wife and his elderly parents, unmarried brother or sister.

Nuclear family - consisting of mother, father, their children (unmarried). This is the most widespread family structure that exists today.[117]

gender issues

The male head-of-household figure has traditionally been very important in Turkish speaking communities. Because these communities are largely patriarchal and male-dominated, this has meant that the expectations of men and women in the family differ markedly. Often, men have a lot more freedom to go out and about and not to be questioned about their activities. Women are expected to carry out their traditional roles of wife and mother as well as having a job. Although this is now changing and women are becoming less tolerant of traditionally ways men conduct themselves. Turkish women are the main carers as well as second wage earners within the family.

The role of the male head-of-household figure is changing however. Women, particularly those, who are working, no longer find it as acceptable and want

[117] http://en.turkeyforfriends.com/forum/3-126-1

to be treated as equals and have more independence. This sometimes leads to marital problems as the husband and wife's expectations no longer match. More recently, with the greater numbers of community organisations being set up, more women have been able to access help with domestic violence and breaking out of unsatisfactory relationships.

Treatment by medical staff of any religion is permissible but both men and women usually prefer to be treated by members of the same sex.[118]

religion

Most members of the Turkish speaking community are Muslims. The majority follow the Sunni tradition but there is a Shi'ite minority. There is also Alevi population representing the biggest minority group (about 15 million) both from Turkish and Kurdish ethnicities and which is considered as a culture, a doctrine, a way of life and a philosophy by some rather than a religion. The Alevi population in Turkey do not pray in mosques, they have places which is called "Cemevi" where people come together to exercise their belief. Most Alevi people, including the ones in the UK, claim they still suffer persecution and discrimination in Turkey because of their belief.

In the 1920s, the traditional day of rest and devotion was changed from Friday to Sunday. Even though Friday is now a day of work, many people still go to the mosque for special *cuma* prayers (Friday prayers). And for some, in today's Turkey religion is kept separate from secular life.

dietary requirements

There are no dietary requirements except for Muslims who must not eat pork or products. Alcohol is also forbidden. See Appendix 2 for list of food preferences.

Birth

Circumcisions are important. Boys are usually circumcised before the age of seven. This is a very important day for boys as for some this is when they are considered to be true Muslims or true men. Many Turkish speaking communities also believe that circumcision is good for health. Most families celebrate it by throwing a party and everyone brings presents for the boy or gives money.

dying and death

Dying

When a Muslim is dying, the face should be turned towards Mecca (south east in UK). A dying Muslim will need to say or hear "There is no God but the God and Muhammad is His prophet". Muslims believe in an after life and believe illness and death should be faced in a spirit of acceptance of Allah's (Gods) will.[119]

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[118] http://www.suffolk.nhs.uk/LinkClick.aspx?fileticket=4zu3L5Aa5Cg%3D&tabid=1439&mid=2879
[119] www.braintree.gov.uk/NR/rdonlyres/DF4745D7-5B27.../FaithCard.doc

Death

Usually Muslim men handle a male body and women a female body. The body should be laid on a clean surface and covered in a plain cloth. Next of kin usually make arrangements for burial, which should take place as soon as possible.[120]

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

[120] http://www.suffolk.nhs.uk/LinkClick.aspx?fileticket=4zu3L5Aa5Cg%3D&tabid=1439&mid=2879

VIETNAMESE CULTURAL PROFILE

This profile is a general guide offering cultural information about Vietnamese people living in Hackney. Please check with each individual about their personal needs.

demography

There are about 5,000 Vietnamese people living in Hackney according to the local Vietnamese community centre.

Language and communication

The Vietnamese people speak one or both of two languages: Vietnamese and Cantonese. All Vietnamese of Chinese origin will speak Cantonese. Vietnamese has three basic dialects; all are generally understood by most Vietnamese speakers.

naming system

Traditionally, Vietnamese people list their family name (surname) first, then their middle name, with their first (given) name listed as last. Family members use different given names (first names are not passed down) and the name reflects some meaning. Most names can be used for either gender. For example, if the name is Nguyen Van Hoa, Nguyen is the family name and Hoa is the person's given name.[121] The middle name indicates the person's sex, such as Van for a boy and Thi for a girl.

Women do not change their name on marriage but are commonly addressed by their husband's family name. Some married Vietnamese women adapt to British culture by having the husband's surname as their family name. Children take their father's name. Some Vietnamese residents put their *personal name* first and their family name (surname) last.[122]

health beliefs

Traditional and Chinese medicine play an important role in health care and people may express a preference for herbal remedies rather than Western medicines. However, most Vietnamese prefer Western medicines. Although some Vietnamese have converted to Christianity most follow Buddhist concepts which has an impact on their health beliefs and practices. Buddhism teaches that life is a cycle of suffering and rebirth. If one follows the Buddhist path in a correct way then one will experience less suffering in future lives. Buddhism promotes inner peace and peacefulness of surroundings.

Illness can be understood from three different, overlapping models. The first is attachment to sprits, where mental illness, for instance, can be brought on by a curse or sorcery or not observing a religious ethic. Traditional medical

[121] Multicultural Handbook
[122] United Bristol Healthcare NHS Trust, *A Guide to International Naming Systems,* version, 2 May 2007

practitioners are common in Vietnam culture. They may be called upon to exorcise a bad spirit through chanting, a magical potion or a consultation from and recitation from ancient Chinese texts or using amulets and other forms of spiritual protection. For example, babies and children wear *bua*, an amulet of cloth containing a Buddhist verse or blessing from a monk.

The second model relates to balance; there is a widespread belief that the universe is made up of opposing elements held in balance; consequently, health is a state of balance between these forces, known as 'Am' (hot) and 'Duong' (cold) in Vietnamese based on the familiar concept of *yin* and *yang* in China. Illness results when there is an imbalance of these forces. Balance can be restored by several means: diet changes to compensate for the excess of "hot" and "cold", western medicines and injections, traditional medicines, herbs and medical practices.

The third model is western medicine. Most Vietnamese recognise the western concepts of causes of disease, like germ theory. When they enter the western medical health system they do so to relieve the symptoms. They discontinue medication after symptoms disappear. Hence there are serious implications for long-term conditions like hypertension medication. Similarly if there symptoms are not perceived then there is no illness.

Many Vietnamese employ a medicinal system based on Chinese medicine. This system is based on the premise that living things are composed of four basic elements, air, fire, water and earth with the associated characteristics of cold, hot, wet and dry. This hot/cold belief system is common to many Vietnamese, regardless of their educational status or occupation (rural vs. urban). Many see traditional herbal remedies, tonics, massage, and avoidance of excess as the pathway to good health.

Mental illness is a shameful thing among most Vietnamese cultures. Because of this shame, mental illness is often feared or denied, and those who are ill are hidden away by their families until the family can no longer care for them. Some people think of mental illness as bad karma that has accumulated because of misdeeds done in past lives. Due to the stigma of mental illness, many refugees tend to somatises and will avoid referrals to mental health clinics.

family and kinship

The traditional Vietnamese family is patriarchal, often with two to four generations under one roof. There is the immediate family (nha) and the extended family (ho). In Vietnam, the immediate family is the nuclear family plus the husband's parents and the grown sons' spouses and children. The extended family is the immediate family plus family members of the same name and relatives residing in close proximity.

Family members are expected to work and behave for the good of the group. Families may publicly denounce a member who is ill behaved; they may also pronounce family achievements. Each member has a designated kinship term, and these are used when addressing one another. The father has ultimate responsibility and acts as an authority figure while delegating

tasks and involving others in decision making. The father also leads the family in ancestor worship. In Vietnam, the father often worked outside the home, while the mother cared for the children and managed the household. Grandparents helped with childcare, and children helped with various chores. Younger siblings are to respect and obey older siblings, and aunts and uncles are treated as parents.

Vietnamese people hold their elders in high regard and great significance is placed on family obligations. When speaking to a more senior person it is recognised as a sign of respect to lower the eyes. Worship of ancestors is of extreme importance.

Influenced by Buddhist theology and Confucian philosophy, Vietnamese believed that fate in marriage, as well as wealth and position, were preordained, though choice could play some role in activating a positive or negative fate. Traditionally, children lived with their parents until marriage, then the couple moved to the husband's father's household. The extended family arranged marriage, but individuals were usually consulted on the choice of their mate. Although arranged marriages have declined due to the influence of western culture the extended family still has a heavy influence over the decision to marry.

gender issues

According to Confucian tenets, men have higher status than women, and sons are valued more highly than daughters. Traditionally, an ideal man should develop through four steps. First, he must learn how to cultivate himself and next, to govern his family. If he does this successfully, he can rule the country and pacify the world. To do this he must be merciful and kind, adhere to the rites and ceremonies of family and social hierarchy, help the needy, be strong and determined, and be trustworthy and loyal.

A traditional Vietnamese woman is governed by three basic tenets from Confucianism. First she must submit to her father, next obey her husband, and then if widowed, obey her eldest son. She is considered "virtuous" if she is an effective homemaker, a good cook, and has the appearance of modesty coupled with feminine grace. Ideally, she is soft spoken, and above reproach for her moral conduct. In reality Vietnamese women are not docile. The mother is considered the home minister (noi tuong) and is responsible for family harmony, the family budget, and family schedules. She also makes decisions with the father.

With migration to the UK Vietnamese men have been forced to take work with less status than they could have done in Vietnam. This has created a situation where many families are more dependent on the income of the mother, causing readjustment of family roles and expectations. Because of the effects of migration and western influence, traditional gender roles are changing, and Vietnamese families show varying degrees of traditionalism.

Vietnamese women hold a responsible role in keeping the family in good health, wealth and happiness. If unexpected 'incidents' happen to the family, for example, marriage break down, people usually think that is the

woman's fault. In addition, it is more acceptable for a husband to have an affair or to leave his wife than a woman. It is a very bad and wrong conduct for a woman to leave the husband for another man. She will automatically lose her good reputations within the family and community'.

religion

Vietnamese are essentially polytheistic in their religious beliefs. Ancestor worship is important to the Vietnamese. Most Vietnamese are Buddhists but they are also influenced by the Chinese philosophies of Confucianism and Taoism. Some are Vietnamese are Roman Catholics; and others have grown up as atheists under the North Vietnamese communist government. It is common to combine these belief systems, for example, in Buddhist and Catholic families, there may be a family shrine dedicated to ancestors, often featuring photographs of recently deceased relatives. Set forms of prayer are only used in Catholic families.

Co-existing with the Buddhist religion are the deeply held practices of ancestor worship and animism (worship of spirits and natural forces) and principles of Confucianism, all of which determine everyday person conduct. Confucianism underlies many Vietnamese traditions shared by people of various religions.

Buddhism

The majority of Vietnamese are Buddhists. The religion is based on the teachings of Buddha and aims to achieve enlightenment. There are different traditions within Buddhism: the Hinayana believe only monks and nuns can achieve enlightenment; while the Mahayana believe lay people can attain enlightenment as well.

Buddhism sees life as a process of birth, ageing, illness and death in which people achieve enlightenment by suffering and overcoming grief. Buddhists may meditate daily and use the home shrine or visit a Buddhist centre as a focus for devotion. In some Buddhist homes you may find a shrine with a statute of Buddha. You must not touch this. The Buddhist place of worship is called a "vihara".

Confucianism

Confucianism is more a code of behavior than a religion, which emphasizes law and respect for authority as central to making life possible. Social rites are very important.

Taoism

Taoism sees life as a balance of metal, wood, water, fire and earth. Founded by a Chinese philosopher, Lao-tzu, this religion teaches that the goal of becoming an Ultimate and Unconditioned being can be achieved through thrift, humility and compassion. Taoists may worship many gods, and value simplicity, patience and contentment. They avoid confrontation and strive for harmony both between men and between man and nature. Some Taoist groups also worship deities or other religions. They have an organised clergy and temples. Though many Vietnamese do not practice this religion, Taoism has strongly influenced Vietnamese culture.

Catholicism
Introduced in late sixteenth century by Portuguese, Spanish and French, Catholics in Vietnam have intermittently suffered persecution. Before the collapse of South Vietnam, an estimated 2 million people (of a population of 17 million) practiced Catholicism. This is the religion of many first wave Vietnamese refugees.

dietary requirements

Dietary restrictions result from an individual's own choice. Some Vietnamese are vegetarians and others do not eat meat for a number of days each month. Milk and dairy produce is not to be found within the traditional diet. There are no particular periods of fasting.

birth

A special meal is prepared one month after the birth to celebrate the arrival of the baby into the community.

dying and death

Dying

Buddhists believe in rebirth after death so the state of mind of a person at the moment of death is important in determining the state of rebirth. They like to have full information about their imminent death to enable them to make preparation. Peace and quiet for meditation and visits from other Buddhists will be appreciated. Some form of chanting may be used to influence the state of mind at death so that it may be peaceful.[123]

Death

Traditions vary according to culture. Most Buddhists are cremated and the body should be disposed of (buried/cremated) within 3-7 days. Although there is no prescribed order of funeral services which can be applied to all Buddhist traditions. But there are three components most common to Buddhist services: chanting, the burning of incense and post funeral memorial services.

Buddhists believe that the dead are reborn at higher or lower planes of existence, depending on merits they have built up in this life and former lives. To enter death in a positive state of mind in the company of monks and family members can contribute to rebirth on a higher level.

medical procedures

Blood transfusions

According to most of the communities in this profile, there is unlikely to be any objection for blood transfusions.

[123] South Devon Healthcare NHS Trust, *Handbook on Cultural, Religious and Spiritual Beliefs,* 2005

Organ transplantation

In consulting with communities on the profile there are different opinions regarding organ transplantation. It is advisable to seek individual consultation on this matter.

Post mortem

Post mortems differ within different communities. For some it is not permitted unless legally required. When there are clear indications for a post-mortem, these should be discussed with the family/next of kin. In general these should only be done where legally mandatory or where compelling medical reasons exist, because of the imperative to bury the body intact. It is advisable also to seek permission from the concerned families.

APPENDIX 1
CULTURALLY SENSITIVE HEALTH AND SOCIAL CARE CHECKLIST

The following issues should be recorded when addressing the health and social care needs of patients/clients:

NAMING:

Preferred name/form of address

This may also be used to record name of significant relative(s) if, for example, the partner's name is different. Ask both the individual and partner for their official name and 'what you would like us to call you'.

LANGUAGE:

(spoken and written)

A selection of the most likely options should be offered.

INTERPRETER NEED:

This should be recorded along with the preferred gender of the interpreter.

DIET OPTIONS:

Key preferences will be suggested: some patients/clients will want the option to choose from the English menu as well as special diets.

PRAYER OBSERVATION:

Times and requirements (e.g. washing, privacy, prayer mat).

SIGNIFICANT DATES
Key dates of major festivals, fasts, etc. should be noted.

ACTIVITIES FOR DAILY LIVING:
Includes questions of modesty clothing and skin and hair care.

BIRTH ISSUES:
Major traditional practices (if known) – this may be very personal.

RELIGIOUS BELIEF:
Record which particular place of worship or religious worker (Priest, Imam, etc.) should be notified, if necessary

DYING AND DEATH:
Guidance on some traditional responses and needs at such times: Do not remove jewellery, sacred threads or significant religious items of clothing

APPENDIX 2
FOOD PREFERENCES

Food	Buddhists	Christians	Hindus	Jains	Jehovah's Witnesses	Jews	Muslims	Seventh Day Adventists	Sikhs	Rastafarians
Beef	Yes	Yes	Some	No	No	Kosher+	Halal#	No^	Yes	No
Butter/ghee	Yes	Yes	Yes		Yes	Yes	Yes	No	Yes	Some*
Chicken	Some*	Yes	Some*	No	No	Kosher+	Halal#	No	Some	No
Cheese	Yes	Yes	Yes		Yes	Yes	Yes	No	Yes	Some*
Eggs	Some*	Yes	Some	No	Yes	Yes	Yes	Some*	Some	Some*
Fish	Some*	Yes	No	No	Yes	Yes	Yes	Some*	Some	Yes
Shellfish/seafood		Yes	No	No	No	No		No		No
Margarine/ vegetable oils	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes – only olive oil	Yes	Yes
Milk/yogurt	Yes	Yes	Yes		Yes	Yes	Yes	No – milk made from cereal	Yes	Some*
Mutton	Some*	Yes	Some*	No	No	Kosher+	Halal#	No	Some	No
Pork	Some*	Yes	No	No	No	No	No	No	Rarely	No

* Very strict followers avoid this.
# Halal meat must be killed, dedicated and prepared in a special way.
+ Kosher meat for Jews requires special rituals and butchering procedures in preparation.
^ Encourage vegetarian diet; do not drink or smoke.

APPENDIX 3
CORRECTION/ADDITION FORM

Please complete the following page if you are aware of either incorrect details or you know of additional resources that should be included.

Item	Correction
Section: **Page:**	

Send this form to the following email address:

post@bemwg.org.uk

or post this form to the following address:

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Unit C4,
3 Bradbury Street,
London N16 8JN

Thank you for your assistance in keeping this document current.

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