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TRANSCULTURAL NURSING:

BENEFITS

Better & Effective Nursing Education For Improving Transcultural nursing Skills

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TRANSCULTURAL NURSING: BETTER & EFFECTIVE NURSING EDUCATION FOR IMPROVING TRANSCULTURAL NURSING SKILLS (BENEFITS)

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Editors

Ayla YAVA, Betül TOSUN

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FOREWORD

Natural disasters, wars, unemployment, the desire for a better life, travel, health tourism, education opportunities, and political asylum have all contributed to rapid geographic mobility in the globalized globe. As a consequence of this movement, individuals bring aspects of their own culture to the locations they visit, forming multicultural societies as a result of their interactions with the locals. Increased population movement has necessitated the health care requirements of individuals of varied cultural and ethnic origins, and the notions of cultural care, cultural competency, and now cultural safety have gained importance within the health-care system and nursing education. In this context, in 2019, we began working on the BENEFITS - Better and Effective Nursing Education for Improving Transcultural Nursing Skills project with nurse researchers from Belgium, the Czech Republic, Slovenia, Spain, Hungary, and Turkey. We developed a curriculum as part of the project to help nursing students receive a better intercultural nursing education. We have also developed an assessment tool to evaluate the effectiveness of this curriculum. We implemented this curriculum as an intensive training program with 25 nursing students from 6 countries and evaluated the results. We also started to implement this curriculum as a one-semester course in two universities in Turkey. In this process, we worked intensively, got very tired, sometimes we came to a consensus, sometimes we discussed for long hours. This books tries to summarize key information for students with an interest in Transcultural Nursing and how to improve their skills on a much needed field of our discipline. Of course, new information will continue to be added to the literature. There is much more to learn or talk about in transcultural nursing. We hope that this book will contribute to the nursing literature and support nursing students in their learning. We would like to thank all our project partners who contributed to the writing of this book, as well as our authors. We would like to thank our dear students for the beautiful experiences they had in this project and for immortalizing this experience with the narrative photographs they took in the last part of the book. We would like to thank our colleagues Angela Kyyd, Canan Öztürk, Sara Nissim and Alfonso Pezzella for lending their time to provide critical feedback on this book. You can see the comments of our valued reviewers in the last part of the book. Finally, this book, which is one of the primary outputs of the project, can be downloaded and used free of charge by all nursing students, teachers, graduate students and of course nurses and other healthcare professionals.

AYLA YAVA & BETUL TOSUN

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CHAPTER I

INTRODUCTION to TRANSCULTURAL NURSING

A) MIGRATION, GLOBALISATION and NURSING

Mirko Prosen, Igor Karnjuš, Sabina Ličen

Key Points

1. Globalisation processes have contributed to an increased awareness of global health problems and the resulting health inequalities.
2. Globalisation describes the increasing socioeconomic interdependence among countries worldwide.
3. Global health encompasses actions and opportunities to improve global health through the combined efforts of countries worldwide.
4. Global health issues have led to changes in nursing practice.
5. Migration is one of the main features of globalisation.
6. Although health is recognised as a basic human right, there is still considerable debate about the extent to which migrants enjoy the same rights as non-migrants in terms of access to healthcare.
7. In addition to cultural competencies, nurses need to develop global nursing competencies when providing care in a multicultural setting.

INTRODUCTION

Nowadays, our lives are shaped by numerous global societal, socio-economic, epidemiological, and environmental challenges. This also has profound implications for population health and delivery of care. At a time when the world has become a "much smaller place", interdependence and collaboration between countries have become even more important in managing the consequences of the ever-changing social context. As the largest group of health professionals within the health system, nurses play a significant role in addressing global health challenges and related health disparities, particularly in the context of migration. Over the last decade, global migration patterns have changed dramatically, leaving millions of people without satisfactory living conditions and therefore without adequate access to healthcare. This challenges nursing as a profession and nurses as professionals to develop the appropriate cultural and global health competencies and respond effectively to the challenges posed by the processes of globalisation and migration.

This chapter provides an introduction to the field of globalisation as one of the most controversial concepts in society today and continues with global health as a direct result of globalisation and global nursing as one of the ways to address the related issues of migration, its impact on the health status of migrants, and the role of culturally competent practicing nurses.

GLOBALISATION

The term 'globalisation' seems to be highly controversial, as there are different definitions of the term depending on the perspective from which this process is viewed. The term 'globalisation' is commonly used to describe the increasing socio-economic interdependence between countries (Bradbury-Jones & Clark, 2017) or as explained by Hanafeld and Lee (2014, p. 1):

> "It is a set of global processes that are intensifying the interconnected nature of human interaction across economic, political, cultural, and environmental spheres."

The process of globalisation has accelerated due to the fact that we are becoming more interdependent than ever before in human history, as well as due to the major advances in global telecommunications, technology, and transportation that have become more affordable. This has led to people being more closely connected and sharing information at a much faster pace and on a much larger scale. In this respect, globalisation has made the world a 'much smaller place' for the first time in human history, and has brought many positive social impacts, but also many dangers, and this is also true for healthcare (Helman, 2007). The impact of globalisation on health can be clearly seen in three aspects of health that have changed over time: communicable diseases, non-communicable diseases, and the health impact of human migration (Bradbury-Jones & Clark, 2017). We are now seeing these examples being affected by globalisation, both in the way of life in developing countries compared to developed countries, and in ways in which access to the internet, i.e. information, and the ability to travel influence the understanding and occurrence of disease.

Hanefeld and Kelley (2014) suggest that globalisation can be understood through three dimensions of global change: *spatial, temporal*, and *cognitive*. The first dimension – *spatial change* − refers to the changes globalisation brings along spatial dimensions, including how we experience and understand these changes in physical or territorial space. This space, of course, has remained the same, but the difference lies in the ways we interact with it: how we move through space, how we define it, and how it changes us. The second dimension – *temporal change* – refers to our understanding and experience of time, especially in relation to space, as our mobility has increased due to technological advances. On the other hand, communication technology has also evolved, which means that we no longer have to bridge physical distances in order to interact with other people. The third dimension – *cognitive change* − refers to how globalisation influences our perception of who we are and of the world that surrounds us. The factors that affect our cognitive perspectives include mass media, social networks, educational institutions, religious and political ideology, etc. This influences our attitudes, values, norms, beliefs, knowledge and skills, ideologies, and worldview.

Globalisation is undoubtedly impacting our way of life and has shifted the patterns of how health and illness exist and how we experience them. One way to counter the negative effects of globalisation is through *glocalisation,* "which means integrating local and global concerns by 'localising' global forces and influences, and thereby 'taming' them in the process." (Helman,

2007, p. 305). In other words, empowering local populations would ultimately contribute to better global health (Wilson et al., 2016).

GLOBAL HEALTH

Global health can be defined as a health challenge that cannot be geographically contained and can only be addressed interdependently by many countries, states, governments and health systems (Bradbury-Jones & Clark, 2017). It can be understood as a constellation of actions and opportunities for the health and well-being of all people worldwide with far-reaching socio-economic, political and social implications, which can only be addressed through a coordinated and multinational approach (Reinsel & Andrews, 2016). The definition of global health proposed by the Global Advisory Panel on the Future of Nursing is as follows (Wilson et al., 2016, p. 1536):

> "Global health refers to an area for practice, study and research that places a priority on improving health, achieving equity in health for all people (Koplan et al., 2009) and ensuring health-promoting and sustainable sociocultural, political and economic systems (Janes & Corbett, 2009). Global health implies planetary health which equals human, animal, environmental and ecosystem health (Kahn et al., 2014) and it emphasizes transnational health issues, determinants and solutions; involves many disciplines within and beyond the health sciences and promotes interdependence and interdisciplinary collaboration; and is a synthesis of population-based prevention with individual holistic care (Koplan et al., 2009)."

Havemann and Bösner (2018) note that most definitions of global health refer to global health or worldwide health and refer to the social determinants of health, thus defining 'global' as an interdependence between countries/nations, as distinct from international as transcending national boundaries. However, in the era of globalisation, the concept of *planetary health* has gained greater prominence. Planetary health is a concept that brings together concerns, actions, and efforts (e.g., sustainable development goals) related to global health, public health and environmental health, while incorporating the connection to Earth systems as the basis for health. The term 'planetary' in planetary health essentially refers to identifying systems and boundaries that are at a critical juncture and proposing policies that address planetary issues such as overconsumption, health and social inequalities, interconnectedness, and the need for global comprehensive social action (Gabrys, 2020).

GLOBAL NURSING

Global health issues have led to changes in the field of nursing practice, as nurses form the largest group of health professionals positioned at the entry point to the health system. Nurses are therefore uniquely positioned to promote, exercise, and translate global health policies and evidence-based programmes into clinical practice in the globalised world (Bradbury-Jones & Clark, 2017). To this end, nurses must be adequately prepared to identify global health issues and related patient needs that arise from their cultural backgrounds and are affected by global events (e.g., natural disasters), and develop the necessary skills that facilitate the process of

developing cultural competencies (Prosen, 2015; Prosen et al., 2017). On the other hand, academia, policy makers and health institutions must also address the impact of globalisation on the nursing workforce (Bradbury-Jones & Clark, 2017) (e.g., nursing shortages, nursing workforce migration, etc.) which affects global health and, consequently, the quality and safety of care.

Global nursing is defined as (Wilson et al., 2016, p. 1537):

> "… the use of evidence-based nursing process to promote sustainable planetary health and equity for all people (Grootjans & Newman, 2013). Global nursing considers social determinants of health, includes individual and population-level care, research, education, leadership, advocacy and policy initiatives (Upvall et al., 2014). Global nurses engage in ethical practice and demonstrate respect for human dignity, human rights and cultural diversity (Baumann, 2013). Global nurses engage in a spirit of deliberation and reflection in interdependent partnership with communities and other healthcare providers (Upvall et al., 2014)."

Despite being the largest health workforce in the world, nurses are rarely included in the decision-making process and policy design in the context of global health. The International Council of Nurses recommends three key strategies to increase nurses' participation in policy making: coordinating nursing actions, maintaining professional solidarity, and developing strong leadership (Gimbel et al., 2017). In this context, global health nursing education can adequately prepare nurses to provide competent, holistic, safe and culturally appropriate care in a range of multicultural settings (Gimbel et al., 2017) and support healthcare organisations in promoting inclusive work environments through the collective development of interpersonal and intrapersonal humility (Markey et al., 2021).

MIGRATION

Migration is one of the key characteristics of globalisation. Over the past decade, its impact has been significant throughout the world. During this period, the push and pull factors have changed dramatically, which in turn has led to new and rapidly changing migration trends that are now more unpredictable than ever before in human history (Prosen et al., 2019). According to the International Organization for Migration (2020), there were 272 million international migrants worldwide in 2019; 52% of them were male and 48% female; 74% of all international migrants were of working age (20-64 years). In 2019, Europe and Asia hosted around 82 million and 84 million international migrants respectively (61% of total international migrants globally). India remains the largest source country of international migrants, while the United States of America remains the top destination country with 50.7 million international migrants. Between 2013 and 2017, high-income countries experienced a slight decrease in migrant workers, while middle-income countries saw the largest increase. In 2018, there were a total of 25.9 million refugees worldwide. The number of people displaced internationally due to violence and conflict increased, reaching 41.3 million. The Syrian Arab Republic and Turkey were the countries of origin and host countries of the largest number of refugees worldwide, with 6.7 million and 3.7 million respectively, while Canada became the largest resettlement country for refugees. Overall, migration has been a key driver of population trends in several countries around the world (International Organization for Migration, 2020).

Migration is the process of moving from one location to another. Migration means moving from one region of a particular country to another region in the same country or from one country to a new country (International Organization for Migration, 2020). Migration can be either *external* – across national borders — or *internal* – within national borders. Migration can be *voluntary*, when people choose to leave their homes, or *involuntary*, when people are forced to leave their homes due to social unrest or natural disasters. Migration can be *temporary* or *permanent* (Helman, 2007). However, when it comes to defining who migrants are, the definition must be placed in the context of the reasons for migration. According to the International Organization for Migration (2021), a migrant is:

> "an umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons."

This term includes many categories of migrants, from refugees, asylum seekers, internally displaced persons, migrant workers, undocumented migrants, international students, etc.

The impact of migration on health

The term migration health describes a public health topic which refers to the theory and practice of assessing and addressing migration-related risk factors that may affect the physical, social, and mental well-being of migrants and the public health of host countries (International Organization for Migration, 2021). While migration can lead to the exposure to greater health risks, it may also be associated with improved health – for example, moving from an environment of persecution and fear of violence to a safer environment (International Organization for Migration, 2020). Although health is recognised as a fundamental human right, there remains considerable debate about the extent to which migrants share the same rights as non-migrants in terms of access to health care (Prosen et al., 2019). When accessing the health system, newly arrived migrants in particular face barriers stemming from personal factors such as age, gender, socioeconomic status, ethnicity and language skills, proximity to health services, social exclusion, health-seeking behaviour, and health-related beliefs. In addition to barriers at the level of the health system, such as health policy and the legal status of migrants in the host health system, the characteristics of individual health systems can also have an impact (Hargreaves & Friedland, 2013). Figure 1 shows the application of the World Health Organization (WHO) determinants of health across the migration cycle.

In 2019, the World Health Organization stated in its "Global Action Plan, 2019–2023" that each national health system should build the capacity of its health workforce, including nurses, doctors and other health professionals, to provide basic health services to refugees and migrants. Moreover, several key principles and priorities were identified that should guide health professionals and other stakeholders to deliver holistic, culturally appropriate, non-discriminatory, and patient-centred care (Gunn et al., 2021; World Health Organization, 2019). The priorities of the Global Action Plan (WHO, 2019, pp. 7-12) include the following:

1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions.
2. Promote continuity and quality of essential healthcare, while developing, reinforcing and implementing occupational health and safety measures.

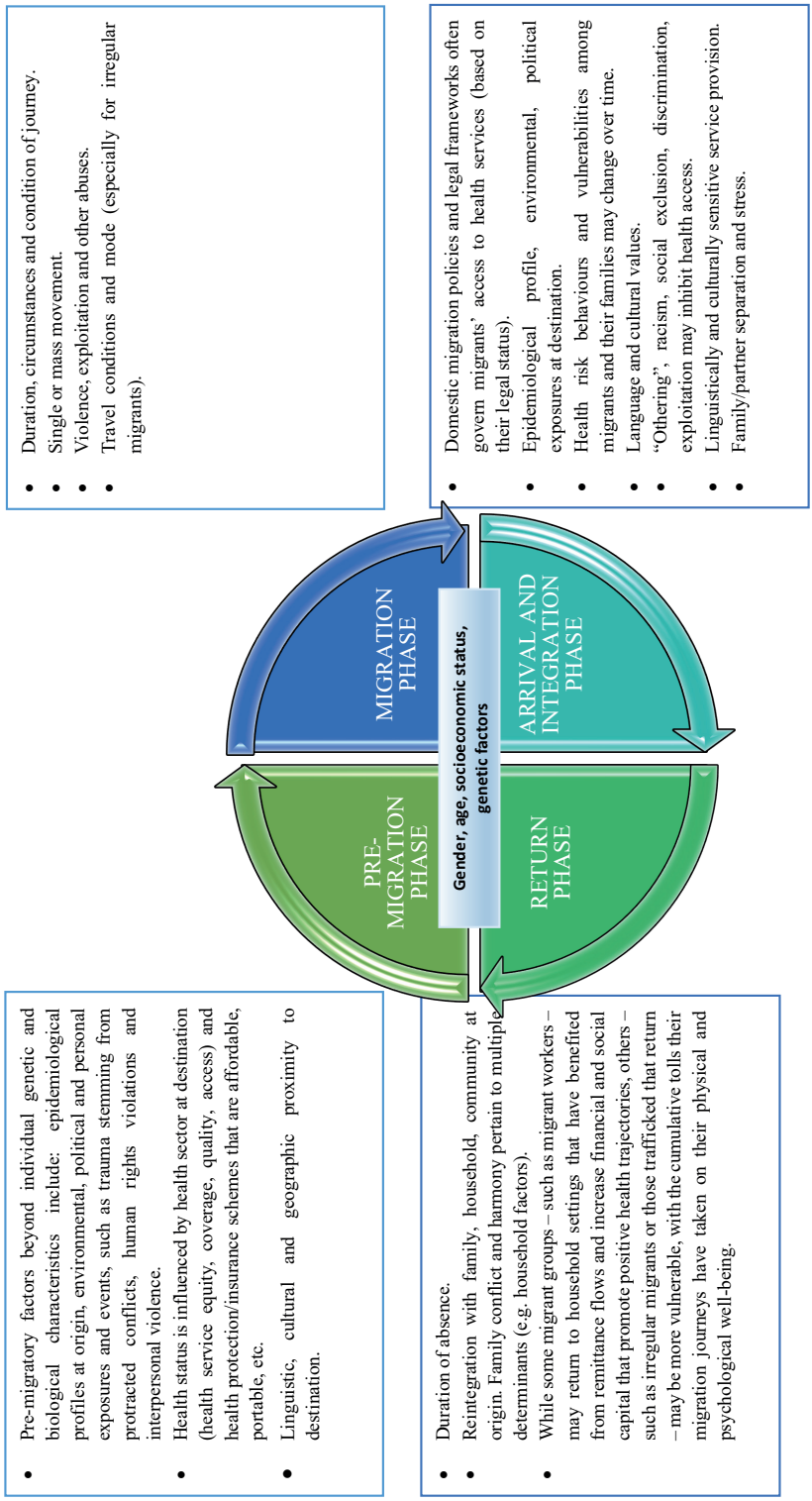

Figure 1. The determinants of migrant health through different stages of migration cycle (Adapted from International Organization for Migration, 2020, p. 212)

3. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee- and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms;
4. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage;
5. Strengthen health monitoring and health information systems;
6. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health.

NURSING CONTEXT

Due to globalisation and its impact on our daily lives, as well as the current health situation worldwide, nurses must have sufficient understanding, knowledge, and skills to address global health challenges. To provide culturally competent care and successfully alleviate health disparities, nurses need knowledge of a broad range of topics that transcend geographic boundaries (Torres-Alzate et al., 2020). Nurses, whether they work internationally or not, should be aware of certain concepts which form the basis of global public health, particularly the concepts of *partnership* and *sustainability*. *Partnership* follows the idea that development is driven by collaboration between peers who possess complementary and equally important expertise, while *sustainability* supports the idea that interventions should be easily sustained by the target community after outside support has ended. In addition to these two concepts, another three characteristics are critical to the success of global health interventions: *availability*, *accessibility*, and *acceptability* (Leffers & Mitchell, 2011; Reinsel & Andrews, 2016). This conceptual model outlined by Leffers and Mitchell (2011) can be used to guide nurses in establishing successful partnerships for global health and global health nursing built on community-based participatory research. Figure 1 illustrates the key elements of the process of partnership formation.

The concept of sustainability means that once a global health project is completed, the outcomes can be sustained by the community or government without further outside support. This therefore ensures a sustained improvement in outcomes as a successful combination of program factors inputs and project processes (Figure 3).

CONCLUSION

As globalisation continues, health challenges around the world are increasing. The COVID -19 pandemic has clearly demonstrated the importance of addressing global health issues, or better yet, the reasons why we should not neglect these issues in the future. In the discipline of global health nursing, nurses assume various roles and responsibilities. However, regardless of the role of the nurse, cultural competency must be an essential component of nursing in a multicultural setting, as it is forms the foundation for addressing health disparities. In addition to cultural competencies, nurses must develop global nursing competencies that include exercising leadership and social advocacy, promoting social justice and patient-centred care, monitoring

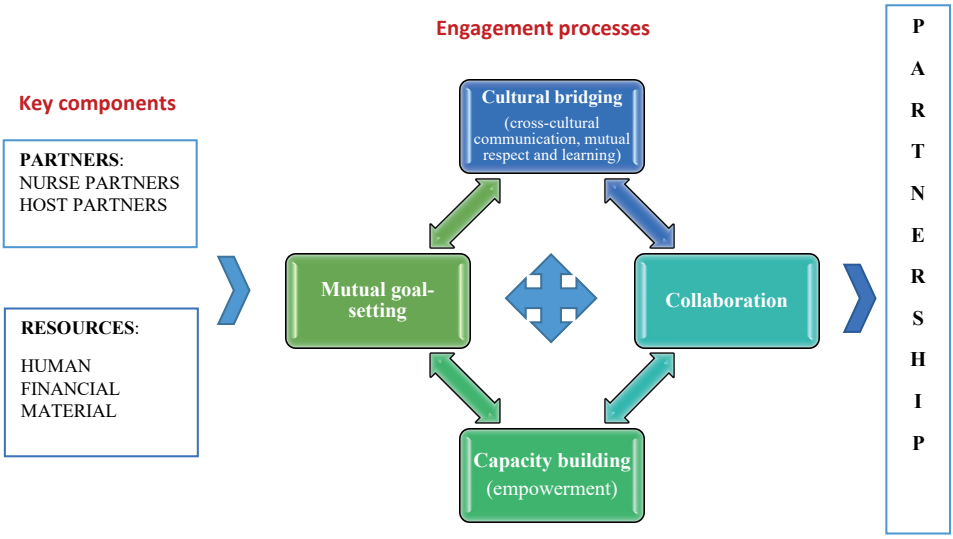

Figure 2. The process for partnership (Adapted from Leffers & Mitchell, 2011, p. 95)

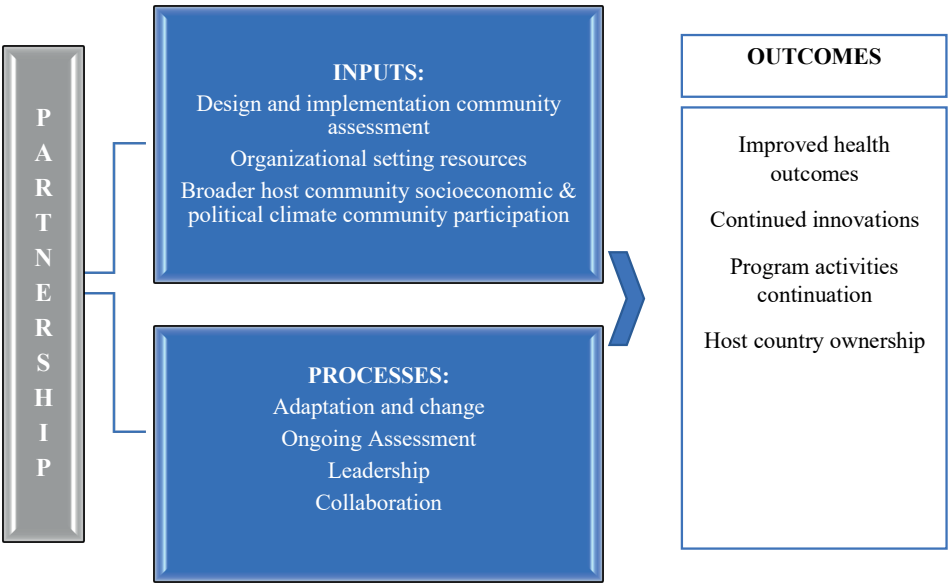

Figure 3. Sustainability of global health nursing interventions (Adapted from Leffers & Mitchell, 2011, p. 95)

the impact of social determinants of health, and participating in global public health decision-making.

Review Questions

1. What are some examples of the impact of globalisation on health and healthcare?
2. Can you explain the effects of changes in globalisation on health and healthcare over time?
3. Can you list at least five sustainable development goals set by the UN?
4. How do you see the role of a global health nurse?
5. How familiar are you with migration flows within or outside your country?
6. Can you explain how socioeconomic inequalities affect migrant health or access to healthcare?
7. Can you explain the meaning and approach of community-based participatory research?
8. Brainstorm some ideas for implementing projects in your community or more broadly in your country that involve the process of partnership and sustainability.

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B) BASIC CONCEPTS of TRANSCULTURAL NURSING

Vera Hellerova

Key Points

1. The family is the basic structure of any society. Its definition and dimensions are strongly linked to culture.
2. Although the concept of the family is one of the oldest and strongest, it is not immutable.
3. Diversity, prejudice, stereotypes, ethnocentrism, stigmatization, etc., refer to concepts and phenomena that every healthcare professional encounters and needs to be understood when developing cultural competencies.
4. Awareness of one's own culture, ethnocentrism, and prejudice are some of the basic steps needed for developing and acquiring one's cultural competences.

FAMILY and COMMUNITY

The family is considered the basic structure of each society (Arias & Punyanunt-Carter, 2017). It is one of the oldest and strongest social institutions involving genetic characteristics, the environment, attitudes, and lifestyle (WHO, 1974). Sociologists and others have studied its definition for many years. One of the older definitions (according to Murdock, 1949, quoted by Settles, Steinmetz, 2013, p. 56; quoted by Pathak, 2017, p. 83) states that it is a social group characterized by co-living, economic cooperation, and reproductive functions. The family group includes two adult individuals who cohabitate in ways acceptable to the given society. There may also be one or more natural children, adopted children, or blood relatives in this cohabitation. In accordance with the definition of family, it can be considered a universal phenomenon and unit necessary for survival (Pathak, 2017). The term *"family functioning"* is used to express the functionality of the processes that govern the family. This connection includes incorporating the individual into the family structure and gaining a sense of belonging, economic support, care, upbringing, associated socialization, and protection of vulnerable members. The basic and supporting principles of family functioning include cohesion, adaptability, and communication (Sobotka, 2012).

Coser (1964, quoted by Settles & Steinmetz, 2013, p. 56) defines the family as a social unit formed by marriage and involves formal and functional characteristics. Therefore, in its structure, we find a husband, wife, and children born from this union. However, the family exists not only as a structural unit but also represents an economic, legal, moral, religious, and socialization system within a given culture.

Giddens (2009) defined the family in a similar way. He characterized it as a group that is directly related. The responsibility for children rests with each of the family members. Within the family, we encounter kinship. That is unions between individuals that arise from marriage or bloodlines. In this context, marriage can be defined as a socially recognized and accepted sexual union between two adult individuals. However, marriage not only brings with it the union of two adult individuals but also means a union with a broader range of new relatives (i.e., connecting families and obtaining relatives via a partner) (Giddens, 2009). Like Giddens, Stephens (1963,

quoted by Settles & Steinmetz, 2013, p. 56) points to the role of parenting and parenthood as a family function.

A feature of different cultures is that all have a version of the nuclear family. It is represented by two adults who live in a common household together with their own or adopted children. If the family lives in a common household with other relatives (e.g., grandparents), then we are talking about an extended family unit. For Western societies, marriage family are associated with monogamy. However, polygamy and polyandry (Giddens, 2009) can also be found. In such different family systems (e.g., polygamous), and despite the non-fulfillment of the characteristics of the "nuclear family," we see the fulfillment of the individual functions of the family (i.e., socialization, economic support, etc.) (Reiss, 1965).

From the above, it is clear that the family is a phenomenon that is very closely associated with culture (Bales & Parsons, 2014); this brings different interpretations of the family based on cultural differences. Regardless of cultural differences, we also find common features, communication processes, and typical roles within functioning families (Arias & Punyanunt-Carter, 2017).

Changes in family dynamics should be expected in Western countries, due to globalization and increasing migration. These changes are particularly noticeable with the arrival of families from collectivist cultures. According to Wali & Renza (2018), who has been researching families coming to Australia, these changes mainly concern:

- changes in the position of women and the difficulty of the transition to an egalitarian society, and increasing conflicts within the family stemming from the disruption of traditional gender roles,
- managing family income (sending part of the earnings to family and friends in the country of origin),
- the presence of intercultural conflicts and language barriers
- lifestyle changes linked to social isolation,
- the presence of culture shock.

A community can be defined as an autonomous unit consisting of people living in a precisely defined area in which they perform daily activities. The concept of community is based on the Latin word *communitas*. Initially, this word had several meanings. It was used to designate society and coexistence; to express a certain degree of community; it was also used as a designation for kindness (Slaměník et al., 2019).

According to the WHO (1984), the community is a social group determined by geographical boundaries, shared interests, and values. People within the community usually know and influence each other. The community is outwardly manifested by the norms, values, and social institutions it creates (WHO, 1974; Weber & Kelley, 2013). Each community (despite its diversity) exhibits three common elements: community members, place and time limits applicable to that community, and community features. What is significant is the sense of belonging. According to Blum (1974, quoted by Jarošová, p. 24), we distinguish the following community typology:

- Face-to-face communities
- Neighborhood communities

- A community with the ability to identify needs
- Community with environmental problems
- Community by interest
- A community with unique characteristics
- A community with the ability to change
- Community with the ability to act
- A community based on a court order.

The health of community members is then determined by biological differences, the environment, health systems, and lifestyles within the community (see Figure 1).

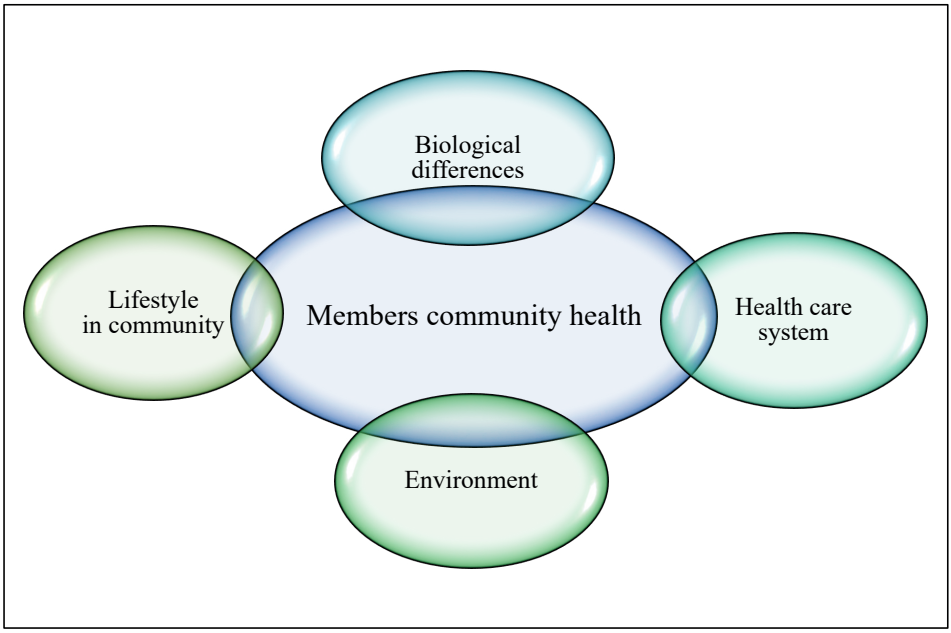

Figure 1. Factors affecting the health of community members (WHO, 1974, p. 8)

DIVERSITY, PREJUDICE, STEREOTYPES, DISCRIMINATION, STIGMATIZATION, and OTHER KEY CONCEPTS RELATED to TRANSCULTURAL NURSING

Diversity is a term that refers to the state of being diverse or have variety. In transcultural nursing, the concept of cultural diversity is frequently *encountered* and refers to the diversity of cultural groups and the differences between them. Therefore, there are a plethora of cultural variations. An example is the internal differences within the Roma community. Although the Roma culture has its own characteristics, we see differences between these characteristics depending on where

the Roma are living. Understanding diversity (even within one culture) helps nurses develop and deepen their cultural competences (Kutnohorská et al., 2012; Baer, 2004).

Prejudice comes from the Latin word *praejudicium*. Its original meaning referred to a precedent, a particular judgment based on past decisions and experience. In English, this term was later used to describe premature or hasty judgment (Škoda, 2016). At present, however, prejudices represent the views and attitudes of one group as they relate to members of another group. These views are often biased and stem from hearsay rather than experience. They are, therefore, a particular negative judgment about a group or its members. Because prejudices are nurtured by societies, they are very difficult to change (Giddens, 2009; Škoda, 2016). In addition to adverse impacts, prejudices can also have positive effects. However, awareness of prejudices is an essential prerequisite for obtaining and developing cultural competences because when coming into contact with patients and their families, colleagues, etc., prejudices can influence the behavior of the healthcare professional. This influence can be both positive and negative (Giddens, 2009; Škoda, 2016). It should be borne in mind that an individual (and a health professional) with strong prejudices against foreign cultures can deliberately seek out situations that support, reinforce and, as a result, strengthen negative attitudes (Gillern et al., 2011).

Škoda (2016) mentions the presence of prejudicial attitudes towards the mentally ill among Czechs. In G.W. Allport›s publication «On the Nature of Prejudice,» the author divides the manifestations of prejudicial behavior towards another person into 5 degrees according to its severity:

1. Resentment or denounce is more associated with the sharing of prejudices through verbal interpretation among like-minded persons. Most of the time, it remains verbal and takes the form of slurs or insults.
2. Avoidance is the second stage of prejudicial behavior. As the term suggests, a person with prejudices purposefully avoids unpopular social groups, despite the inconveniences such behaviors may cause.
3. Discrimination is the third stage of prejudicial behavior. Here, the person involved actively discriminates against another group. An example is the effort to actively exclude all members of an unpopular (or specific) group from certain jobs, neighborhoods, etc.
4. Physical assault, as the term suggests, is associated with an escalation of emotions associated with prejudice to the level of physical violence.
5. Extermination is the highest degree of prejudicial manifestations. It can be represented by lynching, pogroms, massacres, etc.

Stereotypes represent fixed, immutable characteristics associated with specific groups of people. These characteristics are not associated only with the attributed properties. In some cases, it is associated with an explanation that gives the person an opportunity to understand the stereotype (Neculaesei, 2017; Weiner, 2015). Neculaesei (2017), in a review, points to the work of several authors who see stereotypes as a person's tendency to rearrange events based on similarity. However, they do not identify the category; instead, they characterize it. It also points to the importance of stereotypes in processing information and that they can change over time.

Stereotypes are often the basis of prejudice and can be based partly on previous truths; others may be completely unfounded (Giddens, 2009; Weiner, 2015). Stereotypes are often associated

with national minorities or subcultures (in the Czech Republic, national minorities like the Roma or subcultures like the homeless are good examples).

Brauer (2009) characterizes the origin of stereotypes using three basic theoretical approaches:

- A psychoanalytic approach where stereotyping is perceived as a defensive mechanism by which a person assigns negative feelings towards another group or its members,
- A sociocultural approach where stereotypes are considered to be the result of conflicts between groups (especially after a struggle for resources),
- A socio-cognitive approach where stereotypes are processed with some initial knowledge and a certain degree of adaptive function to simplify the social environment according to some classification.

Discrimination refers to factual behaviors that are directed at a particular group of people or individuals. Although often related to prejudice, they can also exist independently of each other (Giddens, 2009). The American Psychological Association (APA) (2019) defines discrimination as unfair or biased dealings with people or groups based on their characteristics (e.g., based on race, gender, sexual orientation). Within the definition of discrimination, the APA adds that classifying things based on specific features is part of natural human thinking. However, placing value on these categories is based on socialization (APA, 2019).

In the characterization of discrimination, we must not forget the basic thesis involved in this area; Fellows (2013) states that in everyday language, the concept of discrimination tends to be associated with the ability to distinguish different traits between objects in our environment. However, the differentiation and the response to the differences are two entirely different concepts.

The CDC (2021) distinguishes between different forms of discrimination in relation to equal access to employment, which can be perceived as valid under certain circumstances:

1. Age-based discrimination, which is often linked to disadvantages for persons over a certain age
2. Discrimination based on a disability
3. Discrimination based on sexual orientation or gender identity
4. Discrimination based on parenthood, whether in the sense of the presence of a social role as a parent or its absence
5. Discrimination based on religion
6. Discrimination based on national affiliation, national origin, culture, language characteristics
7. Discrimination based on pregnancy or lack thereof
8. Discrimination related to sexual harassment
9. Discrimination related to race, color, or gender
10. Discrimination based on retaliation, on an attempt to retaliate against a person.

Equality, which can be considered the opposite of discrimination, must be seen in a broader context. The fundamental idea of equality in terms of access is the belief that all people should have the right to be treated equally and fairly, regardless of the situation in which they find

themselves or the characteristics they are in. As a result, equality of access should guarantee people equal chances of having a full, quality, and happy life. However, we must not forget that people are not born the same, and their potential is determined by factors that can be influenced but also by factors that cannot be influenced (Tomšej, 2020).

Knauss et al. (2015), based on research carried out in Berlin, pointed out that subjectively perceived levels of discrimination can negatively affect immigrant welfare. In the research group for this study, 29 participants with a migration background confirmed experiencing either strong or very strong discrimination in at least one area of public life. In the research, the authors worked with perceived group discrimination, i.e., discrimination, which includes the group as a whole, and personal discrimination, which is linked to one's personal experience with discrimination.

Race

The concept of race is very complex, from a sociological point of view. The definition is also very complex due to historical events. Havlík (2015) describes races as large groups of anthropologically different people (e.g., biological signs – skin color). From this point of view, it is possible to distinguish the following races yellow, black, white, and multi-racial people. Schlesinger et al. (2007), on the concept of race, states that it is a means of thinking that expresses a general idea, experience, or description of reality. As a result, this allows a person to sort and classify social realities, which might otherwise be perceived as confusing. They add that the existence of a particular race or population cannot be inferred from a sociological point of view based on this generalization. With this idea agree also Hall & Fields (2013). These authors in literature review state that it is impossible to infer the existence of a particular race. This is mainly because people across different races share 99.9% of their DNA. That means only 0.1% remains to account for observed human diversity, which is why we need to talk about races. Their analysis of the sources shows that race is not a biologically-based term; it is a social construction and is significant only within this context. In nursing, we often encounter racial health differences and health care inequalities, i.e., differences in access to care and diagnoses based on race, etc. (Hall & Fields, 2013).

The importance of obtaining race information, understanding the meaning of this word, and being aware of one's attitude towards race is critical since the concept is deeply rooted in society. Even ancient civilizations made efforts to divide populations into social groups according to visible differences (e.g., skin color) or based on tribal or kinship affiliations. That is, based on cultural similarity and/or being part of a particular group. However, these classifications were not related to our current understanding of biology and genetics (Giddens, 2009; Hall & Fields, 2013; Havlík, 2015).

Racism is the most widespread form of prejudice. It is based on socially significant physical differences between people. It is associated with the belief that some individuals are superior to others based on specific racially conditioned characteristics (Giddens, 2009). Racial-anthropological theories go back to the 19th century when they appeared mainly in the works of Arthur de Gobineau and later in the works of H. S. Chamberlain. The basis of these theories was the belief in racial inequality based on the predominance of one and the subordination of others (Havlík, 2015).

In the context of studying racism and trying to understand its foundations, we can see the situations that may explain the racism seen in today's globalized world. Havlík (2015) noted that these situations, in the context of transcultural societies, include:

- Peaceful coexistence, mutual respect, enrichment,
- Political autonomy and emancipation (e.g., the emancipation of newly created states after disintegration of the preexisting state, where there may be conflicts between subpopulations),
- Integration (especially when trying to integrate into society without losing the characteristics of the original culture),
- Long-term, spontaneous but also violent assimilation, which is associated with a loss of the original culture's characteristics,
- Discrimination, blocking access to resources, various forms of oppression,
- Various forms of separation, spatial segregation (e.g., forcing people into ghettos),
- Mass relocation, removal, escape from the country, etc. (e.g., an expulsion of inhabitants from border regions of countries),
- Genocide.extermination.

Stigmatization is a term based on the definition of stigma or "mark of disgrace." Originally, this Greek term was used to indicate different or unusual body features, tattoos, or branding. The purpose was to signify the person as amoral, unusual, inappropriate, or unclean. Currently, the term stigma is used for any difference that distinguishes its carrier from the majority of the "normal" population (Ocisková & Praško, 2015; Novosad, 2011). Novosad (2011) describes the common traits of individual stigmatized groups in relation to stigmatization. As an example, he cites the disabled, criminals, and members of various minorities. Although each group has its characteristics, it can be stigmatized by society since the members of each group are perceived as outsiders by the "normal population," i.e., people whose appearance, behaviors, values, etc., differ from the generally accepted social norms. Stigmatization occurs when negative characteristics are attributed to a person or group based on perceived differences.

PROFESSIONAL ROLES and ATTRIBUTES in TRANSCULTURAL NURSING

The purpose of transcultural nursing is to develop knowledge in providing culturally specific and universal nursing care to individuals, families, groups and communities, and institutions within a multicultural framework. To achieve this objective, healthcare providers need to support the values, behaviors, knowledge, and skills necessary for working in a culturally diversified environment. To do this, healthcare professionals must have adequate knowledge and skills related to the provision of culturally differentiated care. This care should then be professional, culturally sensitive, appropriate, and competent (Andrews & Boyle, 2016; Holland, 2017).

Culturally specific care reflects specific values, beliefs, experiences, behavioral patterns that are group-specific and that are not shared with other members of other cultures. This places considerable demands on the education of those who provide culturally differentiated care. Healthcare professionals providing culturally differentiated care must have an in-depth understanding of the minorities in their catchment area. Without this understanding, healthcare professionals are at risk of misunderstanding or misevaluating the health and culturally based needs of patients.

Culturally universal care is a system of shared values, beliefs, experiences, norms, and patterns of behavior and lifestyle attributes.

Culturally sensitive care is based on basic knowledge and constructive attitudes regarding the health traditions of the different cultural groups that live in the environment in which care is provided.

Culturally appropriate care is provided in accordance with the basic knowledge that a healthcare professional must have to provide patients with the best healthcare possible.

Culturally competent care is provided by healthcare professionals who understand and consider the full context of the patient's situation. Therefore, it is a combination of knowledge, attitudes, and practical skills.

Quality education in transcultural nursing and transcultural models and theories provides health professionals with the opportunity to achieve cultural openness, attitudes promoting cultural self-awareness, and the development of transcultural skills (Saha et al., 2008; Tothová et al., 2012; Andrews & Boyle, 2016; Holland, 2017). Therefore, it is crucial not only for nursing students but also for nurses, as part of lifelong learning, to acquire the knowledge and experience necessary to appreciate cultural differences as they relate to differences in values, beliefs, and habits affecting health and home care. From the point of view of further development, the role of EBN (Evidence Based Nursing) and EBP (Evidence Based Practice) in promoting the importance and development of quality nursing care from different cultural perspectives is very important. There is still a need to address the issue of effective nursing interventions that help to specify culturally competent care so that it is meaningful and acceptable to patients from different cultural backgrounds (Maier-Lorentz, 2008).

AWARENESS of THE IMPACT of CULTURALLY SENSITIVE CARE for DIVERSE POPULATIONS

Migration trends and globalization have had dramatic impacts. One of them is the challenges presented to healthcare professionals and other healthcare providers. These challenges are linked, among other things, to culturally competent services. A culturally competent health care system aims to improve health, quality of care and eliminate differences in healthcare provided to racial and ethnic groups. A practical example of the changes being implemented in this area is enriching nursing education programs with transcultural nursing courses and activities related to cultural competences. The development and deepening of this knowledge base are not only related to transcultural care but also the acquisition and deepening of knowledge related to the health issues of individual minorities and communities living in a country. For example, the Health Policy Institute (2002) states that racial and ethnic minorities, in some cases, have higher morbidity and mortality rates for chronic diseases. As a result, this increases the financial burden on the health system.

Cultural competences are seen as one of the pillars to help reduce health inequalities among national, ethnic minorities, and marginalized groups (i.e., groups at risk of stigmatization or discrimination for non-ethnic reasons) (AHRQ, 2014). The positive effects of culturally appropriate and sensitive care were confirmed, for example, by Tucker et al. (2011). The Expression of cultural sensitivity by care providers has been shown to positively affect patient comfort, trust, and satisfaction. The impact was also seen in relation to adherence to dietary programs and treatment regimens.

BARRIERS to and FACILITATORS of ENHANCED CULTURALLY COMPETENCIES

Transcultural nursing is used to describe the connection between nursing and anthropology within the nursing profession. The essence of transcultural nursing is to respond to the need to develop a global perspective for nursing practice that is in line with current globalization trends and the interdependence of nations and peoples worldwide. Leininger noted that changing demographic trends would affect demand for culturally specific and universal care (Andrews & Boyle, 2016). The following are among the fundamental factors leading to the development of transcultural nursing:

- Increasing global migration between countries,
- Patient expectations associated with the provision of care that respects cultural values, experiences, and standards,
- Development of scientific and technical knowledge applicable to the provision of care in culturally and ethically demanding situations,
- Highlighting cultural conflicts in the provision of care,
- Tourism promotion,
- Differentiation of patients, based on age, gender, etc.,
- Development of community care that emphasizes culturally sensitive care and context (Andrews & Boyle, 2016).

Quality education in transcultural nursing provides health professionals with the opportunity to achieve cultural openness, develop attitudes promoting cultural self-awareness, and develop transcultural skills. An essential point in developing cultural competences is undoubtedly the ability to characterize one's own culture. For this characteristic, a schematic can be used (Diagram 2) as well as awareness of values and traditions associated with one's own culture (Diagram 3).

Cultural context	Environmental factors and environment	
	Social factors and structures	
	Economic factors	
	Religious factors	
	Philosophical factors	
	Morals, values	
	Legal, legislative factors	
	Political factors	
	Educational factors	
	Biological, genetic factors	
	Technological factors	

Figure 2. Characteristics of culture — cultural context. (Free according to Andrews & Boyle, 2016, p. 13)

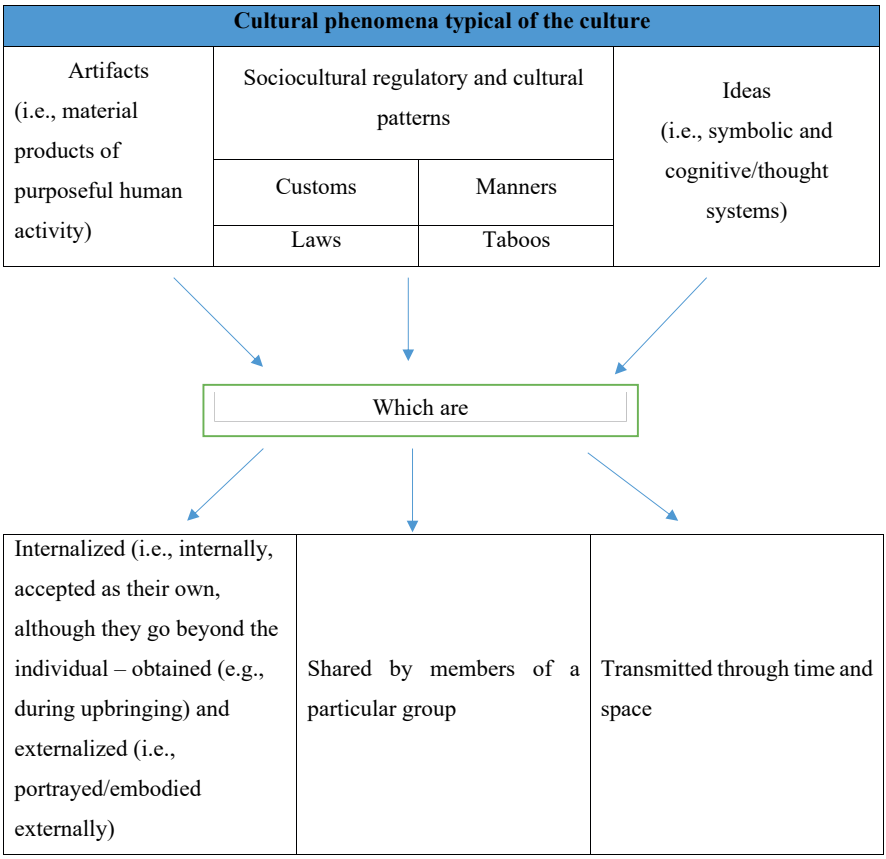

Figure 3. Overview of cultural events characterizing a culture. (Free according to Soukup, 2011, p.38)

GLOSSARY of RELATED TERMS:

- *Ethnicity* (also an ethnic group) is a culturally differentiated and defined group of people whose participation is assigned at birth (shared sense of belonging). Common features of ethnic groups include linguistic, cultural, religious, and biological differences and the origin of ancestors.
- Ethnicity is an interconnected system of factors, historical facts, and ideas of common origin acting together. It is a social phenomenon, a concept that one learns through socialization as one adopts the lifestyle, norms, and beliefs of their ethnic community.
- Ethnocentrism is based on suspicion of foreigners and a tendency to evaluate foreign cultures according to the standards of one's own.
- *Ethnicity* refers to an individual's belonging to an ethnic community based on its ethnicity.
- *A nation* is a designation for a specific, conscious cultural and political community affected by a shared history and territory. It is identified by the criterion of culture, political existence, and psychological criterion.
- *Nationality* is a designation for belonging to a particular nation or ethnicity.
- *A national minority* is defined by special cultural or physical features, internal cohesion, and self-awareness, with hereditary membership. National minorities are a subordinate part of state communities.
- *Marginalized* to be treated as insignificant or made to feel excluded from society.
- *Subcultures are predominantly young people who differ in their lifestyle* and values from others; they fight against everyone and everything.
- *Race is* an anthropological term indicating individuals sharing a genetic heritage (e.g., distinct physical features). We distinguish three main races: the Eurasian (Europoid), the Asian-American (mongoloid), and the equatorial (negroid).
- *Culture* is a designation that includes religious, ethnic values and systems, government, and customs typical of a given society. It is a shared system of verbal expression, mimics, gestures, attitudes, how food is cooked, prepared, and consumed, perception of reality, thinking, and behavior.
- *Enculture* characterizes the process of being incorporated into a given culture, e.g., the transfer of ideas.
- *Acculturation* is a process of cultural change in relation to interactions with other cultures.
- *Assimilation* refers to full integration into a different culture with the loss of original characteristics.
- *Culture shock* is a psychological response to unusual situations where previous behaviors lose their effectiveness. It is a feeling of disorientation and stress in those entering an unfamiliar cultural environment.
- *Race is* a designation for a group of people sharing the same genetic traits, such as skin color, hair type/texture, eye color, and eye shape.

- *Religion* represents a belief in a divine or superhuman power and is often associated with some form of worship. It is represented by a system of beliefs, practices, and ethical values. Religion is considered one of the most important attributes of ethnicity.

Review Questions

1. Think about which prejudices exist against other cultures, religious groups, and subcultures in your country. What does this prejudice stem from?
2. In which areas can prejudice negatively affect the provision of health care?
3. Think about the stereotypes that appear in your country towards other cultures, religious groups, and subcultures. What does this prejudice stem from?
4. What is the importance of transcultural care in contemporary nursing?
5. Think about your chosen ethnic group, subculture, or religion and consider which is more widely represented in your country and which, if any, are at risk of stigmatization or discrimination. Try to characterize this selected group using Scheme 2 (Characteristics of culture and cultural context).

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CHAPTER II

THE THEORETICAL BACKGROUND and HISTORY of TRANSCULTURAL NURSING

Juan M. Leyva-Moral, M. Dolors Bernabeu-Tamayo

Key Points

1. Relationship between Watson human care and Cultural Competence
2. Overview of Transcultural Nursing theory
3. Description of the main Cultural Competence models
4. Cultural Competence assessment tools
5. Case study for discussion in the classroom

RELATIONSHIP BETWEEN WATSON HUMAN CARE and CULTURAL COMPETENCE

Training in cultural competence (CC) involves a self-analysis exercise that allows nurses to understand why this training is needed and to reflect on the consequences, in terms of nursing care, of not providing such culturally competent care. For this reason, prior to discussing a specific topic, such as CC, it is important to discuss the ontological (to know) and epistemological (to know how it is known) background of caring and nursing care. Ontology refers to the study of the nature of being based on a substantive approach of a discipline (Reed, 1997; 2018). Conversely, epistemology is the study of the nature of real knowledge, centered on what is considered justified knowledge (Stanford Encyclopedia of Philosophy, 2020). Thus, according to Chinn y Kramer (2015), epistemology is the "*how to*" of knowledge development.

Nurses must recognize that caring is a complex task, understanding complexity as a network of events, acts, interactions, feedback, and opportunities that comprise the phenomenon on which we focus (Morin, 2007). Positioning oneself among complexity means assuming that knowledge emerges from the conjunction of subjective and objective realities. Approaching the ontological understanding of the study of being (and of living) entails conceiving cognitive consciousness beyond the sum of knowledge about care, but also requires the incorporation of conscious reflection and critical reorganization of what has been learned (which can lead to new approaches and positions). This exercise also requires caring for oneself in addition to others, since caring always involves "*being in the world*," as Heidegger (2010) stated.

To understand and deeply explore the theoretical contents that will be presented in this study, nursing must be understood from a transformative perspective. It should be recalled that Fawcett (2005) and Newman (1997) identified three visions of the nursing discipline: a) reactionary or deterministic, b) reciprocity or interactive integrative, and c) simultaneous or unitary transformative. Deterministic vision was born from positivism, a philosophical paradigm that

understands science as objective, measurable, and quantifiable, and seeks the proven truth (Polit and Beck, 2020). Interactive integrative vision originated from post-positivism and focused on the person, context, values, beliefs, interests, and experiences. This vision conceives people as changing, persistent, and constantly interacting entities; therefore, people are an integrated whole, organized, and not reducible to the sum of isolated parts. Consequently, care extends beyond the physical and contemplates emotional, social, and spiritual aspects. Finally, transformative unitary vision emerged by combining elements of organicism, simultaneity, change, and the transformative unitary (Merriner, 2005), constituting a characteristic way of interpreting the world and people as a dynamic organization that evolves through time and context. This last vision is based on post-positivist paradigms such as phenomenology, hermeneutics, humanism, idealism, and existentialism (Polit and Beck, 2020).

Prior to explaining the three best-known theoretical models of CC, it is appropriate to remember that the final aim of nursing care is based on providing humanized care centered on the person, health, environment, and nursing (Watson, 2005). This humanized care is based on the application of the10 Caritas Processes:

1. *Consciously practicing kindness and honesty in the act of caring* Would it make sense to discuss CC without conceiving that caring contemplates conscience, goodness, and honesty? Why should nurses train in CC if these three elements are not systematically practiced in the action of caring?

2. *Be present in an authentic and facilitating manner*. Similarly, the same question arises: what is the point of considering incorporating CC in healthcare practice if it is not going to be carried out in a responsive and genuine way? It would all be so disingenuous that cultural care would be condemned to failure.

3. *Cultivate spirituality by extending beyond one's self.* The act of caring in a culturally competent way must transcend the self because, although the protagonists of the action are the nurse and the patient, the latter requires special attention, knowledge, and respect for their particularities, whether they coincide with those of the nurse or not. It is important to identify the spiritual aspects of both individuals and to understand how to promote, respect, and consolidate them.

4. *Develop and maintain trusting relationships.* How is this possible if we start with the idea that the professional plays a superior role? How is this possible if we do not understand and respect the cultural differences between individuals and families?

5. *Be present and support the expression of positive and negative feelings.* Again, a genuine, authentic, and non-hierarchical presence is essential for incorporating CC into daily practice. Otherwise, it will be difficult for patients to open their hearts and confide in professionals with their emotions.

6. *Contemplating and using creativity to obtain information during the care process.* Are only the physical and objective aspects crucial for planning care? If so, the time has come to stop and reflect on the importance of beliefs, values, imagination, and interactions, and on how these elements can provide valuable information to facilitate realistic, adapted, and effective care. Be creative, go beyond the obvious.

7. *Get involved in genuine teachings and learning that contemplate phenomena in a global way, always taking into account the perspective of the other.* To do this, a few moments must

be spent reflecting on and understanding the importance of the previous steps. Would it make sense to train in CC believing that only the nurses' reality is valid?

8. *Create healing environments that enhance integrity, comfort, dignity, and peace.* For this, it is essential to understand and incorporate the perspective of the other of whom we take care, and that it may be different from our way of understanding the world. However, this does not prevent us from adapting spaces and practices to the specific needs of the people we care for.

9. *Assist with basic needs in a conscious and intentional way, empowering the mind, body, and spirit.* How can this step be implemented if, again, we prioritize the physical, objective, and measurable? Where do our beliefs and those of the patients factor in? How can we incorporate CC with reductionist approaches?

10. *Be open to aspects of life and death, including care for the soul of both the professional and the patient.* In summary, we should reflect on and self-evaluate our position regarding accompaniment to life and death. What do we know about this? How do we feel about it? Are we willing to help others, even if their beliefs do not coincide with ours?

Considering the above, nursing practice is clearly not the mere application of techniques and procedures; it is a much more complex act that requires an exercise of commitment, belief, and respect regarding the diversity of perspectives. Remember: "*Being is caring*" and it is through care that the transcendence of the human condition is achieved, the existence of the "*other*" is perceived, and it is also understood that it is the "*other*" who gives the meaning of "*I* "(Heidegger, 2010).

TRANSCULTURAL CARE THEORY by M. LEININGER

Madelaine Leininger is considered to be one of the most relevant nursing theorists in modern times. In 1955, practicing as a nurse in child psychiatry, she observed that health professionals did not have enough knowledge about cultural aspects to apply to their care, a deficit that has long existed in nursing training. Thus, it became clear that the profession needed to be effectively practiced in a world that was becoming increasingly multicultural. These observations were the basis for developing a model with a cross-cultural vision of caring for a person.

Based on social anthropology and nursing science from a transcultural perspective of human care, Leininger developed a theory called Transcultural Nursing. Aspects that supported the theory—culture, care, worldviews, and health systems or traditional well-being helped to emphasize the conviction that people from different cultures can offer information and guide professionals to receive the kind of care they want or need (González, 2006). Leininger developed his model, called the "*Sunrising Model*," which considers the nurse as the bridge between popular knowledge and professional knowledge. Further, it facilitates the practice of nursing while considering human beings as separate from its cultural references, social structure, world view, history, and environmental context (Munhall, 2007).

Care is the essence of nursing and a central, dominant, and distinctive element of the discipline. If care is essential for well-being, health, healing, development, and survival, as well as for coping with disability or death, cultural care is the broadest holistic means that allows interpretation and prediction of nursing care phenomena to guide the practice of the discipline (Raile & Marriner, 2011). Leininger's theory of transcultural care proposes that knowledge of the cultural and social structure of a community, group, or person can determine the achievement of objectives

in nursing care practices. He was responsible for defining the main concepts, theoretical notions, and practical procedures of cross-cultural nursing (Leininger, 1999), as shown below:

- *Transcultural Nursing:* A formal area of study and practice of nursing focused on providing holistic care to individuals and groups, respecting differences and similarities regarding cultural values, beliefs, and practices, and providing culturally competent, congruent, and sensitive care to people of diverse cultures.
- *Ethno-nursing:* The study of nursing care beliefs, values, and practices as perceived and understood by a specific culture through direct experience, beliefs, and value systems.
- *Culture:* The learned, shared, and transmitted values, beliefs, norms, and way of life of a specific group that guides its thoughts, decisions, and actions in a systematic way.
- *Cultural care:* The values, beliefs, and lifestyles systematized, learned, and transmitted subjectively and objectively to help support, facilitate, or allow other people or groups to maintain their well-being and health, improve their way of life, or deal with illness, disability, or death.
- *Diversity of cultural care*: The variation or difference that exists in the meanings, models, values, ways of life, or symbols related to care within a community or between different human groups, to help support or facilitate assistance measures aimed at people.
- *Cultural universality of care:* The dominant similarity or uniformity in the meanings, models, values, ways of life, and symbols of care that are manifested among many cultures and reflect the modes of support, assistance, and training to help people.
- *Nursing:* A humanistic and scientific profession and discipline that focuses on human care and activities to assist, support, facilitate, or allow people or groups to maintain or recover their well-being or health in a culturally meaningful and beneficial way, or to help people cope with their disability or death.
- *Worldview:* The way in which people view the world or the universe and how they form "*an image*," or "*a point of view,*" about the world and their lives.
- *The generic care system (traditional or popular):* The traditional and popular knowledge and skills learned and transmitted that are used to facilitate assistance, support, training, and helpful actions for another person, group, or institution.
- *Professional nursing care:* The knowledge and practice of professional care learned in a formal and cognitive way and practical skills obtained through educational institutions that are used to provide assistance, support, and facilitate other people or groups to improve the human health condition (or well-being), disability, lifestyle, or to work with dying patients.
- *Health:* A culturally defined, valued, and practiced state of well-being that reflects the ability of individuals or groups to conduct activities of daily living according to a culturally specific, beneficial, and structured lifestyle.
- *Cultural dimensions and social structure:* The participation and characteristics of the interrelated structural and organizational factors of a specific culture (subculture or society) that includes religion, kinship, politics, economy, education, technology, and cultural values.

- *Environmental context:* The totality of a particular event, situation, or experience that gives meaning to human expressions, interpretations, and social interactions in physical, ecological, socio-political, and cultural environments.

SUNRISE MODEL

In 1970, Leininger developed a model that represents the essential components of the theory. Symbolizing the "*sunrise* (beware)," the model is described by Rohbach Viadas (1998) as follows:

"The model symbolically signifies the knowledge of the nursing discipline that is raised and recognized more and more clearly. The upper part of the model can be a guide in daily practice and is of great help during field research. The lower part of the model shows nursing practice more specifically, and following this scheme, once the cultural care and worldview of the cultural group studied are known (consult the dimensions in the scheme), nursing care is transformed into the union of generic systems and professional systems. Nursing care is a mixture of these two systems."

The upper half of the circle represents the social structure and worldview factors that influence care and health through language and environment. These factors influence the traditional, professional, and nursing system(s) in the lower half of the model. Together, the two halves form a full sun, which represents the universe in which nurses must consider making decisions and actions for human health and care (Figure 1).

The model describes the human being as an integral entity that belongs to a social structure and has a cultural origin from which it cannot be separated, nor can it be separated from its conception of the world. This is what constitutes one of the fundamental principles of Leininger's theory (Leno, 2006), which consists of four levels.

1. Level one represents social systems and one's vision of the world. It conveys the study of the nature, meaning, and attributes of care from three perspectives: micro-perspective (which refers to individuals of a culture), medium perspective (more complex factors of a specific culture), and macro perspective (transversal phenomena that appear in different cultures). These characteristics represent the environment in which individuals develop through social structures (Aguilar et al, 2006).
2. Level two provides information about individuals, families, groups, and institutions in different health systems, as well as the meanings and specific expressions related to health care (Aguilar et al, 2006).
3. Level three provides information about generic, traditional, and professional systems, including nursing, that act within a culture and identify the diversity and universality of cultural care. This level comprises the philosophical approaches of the human being; therefore, it is necessary to support and promote multidisciplinary work that allows professionals to provide comprehensive care for the individual, using traditional knowledge and skills as a reference (Aguilar et al, 2006)
4. Level four defines the different levels of action and decisions of nursing care and are as follows:

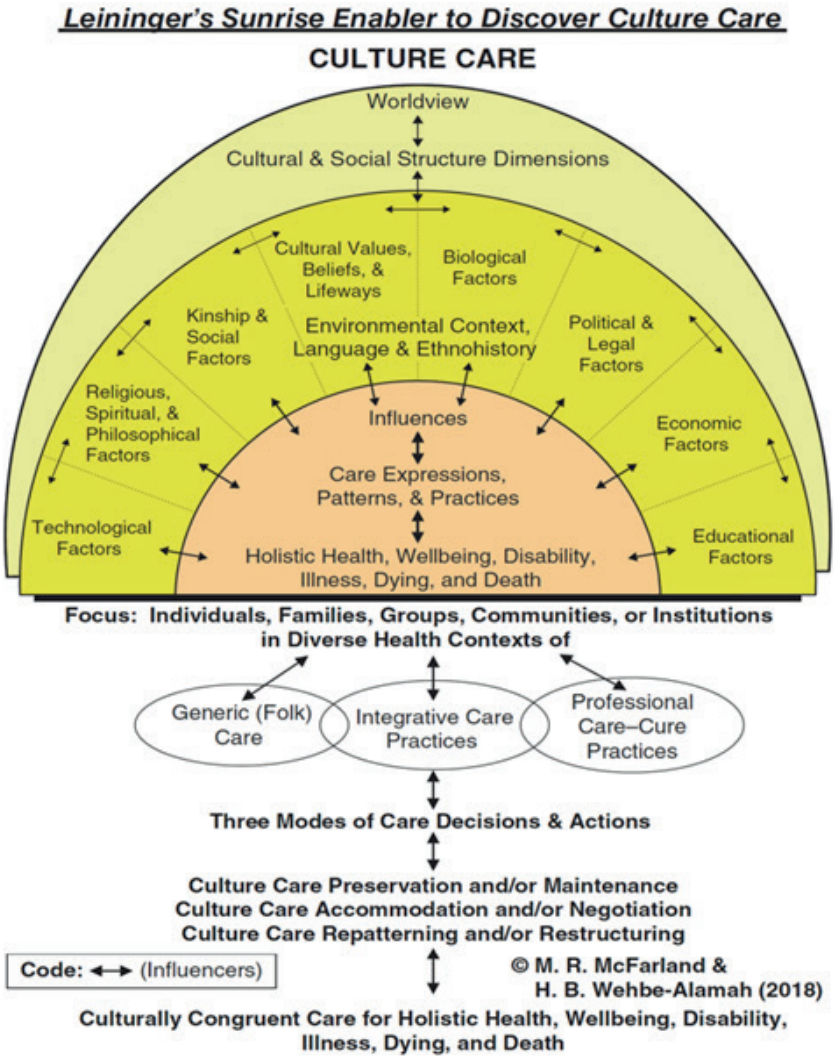

Figure 1. Leininger's Sunrise Enabler to Discover Culture Care (McFarland and Wehbe-Alamah, 2018). Used with permission.

- The preservation or maintenance of cultural care refers to the actions and professional decisions of care that help the individual, of a specific culture, to maintain or preserve their health, and recover or preserve their well-being.
- The location or negotiation of cultural care refers to professional activities that help people of a specific culture to adapt through assistance, support, facilitation, and training.
- The redesign or restructuring of cultural care refers to actions and decisions that help clients to readjust or change their lifestyles for new patterns or models of health care (Leno, 2006).

Leininger (1995) proposes that a person is visualized in a holistic way, with the cultural factor as the central axis of the model. From this nursing perspective, the challenge is to discover the meaning of behavior, flexibility, creativity, and knowledge of different cultures to adapt to nursing interventions.

CULTURAL COMPETENCE

Cultural competence (CC) is a process by which health professionals continually strive to achieve the ability and availability to work effectively within the cultural context of the family, the individual, or the community (Campinha-Bacote, 1999). This process involves the integration of various elements based on the theoretical reference on which our actions are based.

CC requires professionals to take responsibility for defending the under-served due to their ethnicity and empowering people to participate in health decisions. In addition, it requires advocating for the right of individuals to be treated appropriately and without prejudice due to their ancestry, and promoting equality and the self-worth of individuals (Papadopoulos, 2006). The commitment to help the under-served extends beyond ethnicity and involves acting to defend such individuals, whether due to religion, sexual orientation, literacy, identity, expression, gender, economic level, political beliefs, or other aspects of diversity. It must diverge from the widespread erroneous belief that cultural competence is exclusive to ethnic and/or religious diversity, and must adopt a much broader approach. According to the American Nursing Association's Panel of Experts on Cultural Competency (2007), cultural competence is as follows:

a. Cultural competence allows one to have knowledge, understanding, and skills about a diverse cultural group, a fact that allows health professionals to provide appropriate cultural care.

b. Cultural competence is a continuous process that involves accepting and respecting differences and does not allow one's personal beliefs to have an excessive influence on those who have a different vision of the world from their own.

c. Cultural competence includes familiarity with general culture, as well as culturally specific information in such a way that the professional knows what questions to ask.

In short, cultural competence is a good mechanism for minimizing unconscious bias, which is highly prevalent in most people. This bias refers to trends, attitudes, or stereotypes that affect our understanding and is manifested through actions and decisions that are formed outside of our own conscious awareness (Boscardin, 2015).

LARRY PURNELL'S MODEL of CULTURAL COMPETENCE

This mid-range theory was created by Larry Purnell in 1991. In 1989, Purnell described a holistic model for clinical assessment that originated from his practice during his hospital rotation with nursing students. He identified the need for a theoretical framework, both for students and professionals, that would allow them to learn about their own cultures and those of the people served (Purnell, 2005). Purnell evidenced the increased need for cultural competence among North American health professionals, justifying his view with the notion that people deserve respect based on their cultural background (also as individuals). It was clear that many cultural groups were vulnerable to significant disparities in health. Therefore, professionals and institutions should recognize and acknowledge the cultural values, beliefs, and practices of

the people they serve; otherwise, care is compromised, health outcomes are worse, and health spending increases.

Purnell's model is based on five general concepts:

1. The individual is a biopsychosocial being who is continually adapting to the environment, with their own sense of self, values, beliefs, and ideas that can affect how they would like to be treated.
2. Family is understood to be two or more people who are emotionally connected and do not necessarily live close or share blood ties.
3. A community is a group of people with a common interest who live in a specific place; it includes the physical, social, and symbolic characteristics that produce a connection between them.
4. Because today's world is highly interconnected, we are immersed in a global society comprised of a wide range of people with diverse ethnic and cultural origins.
5. Health is a state of being healthy, defined by a person or an ethnic group, and generally has biopsychosocial and spiritual implications that interact with the family, community, and global society.

Likewise, it should be remembered that Purnell's model (2005, 2014) is based on various assumptions that give meaning to the model:

- All health professionals require information on cultural diversity and concepts related to the meta-paradigm of global society, community, family, the individual, and health.
- One culture is not better than another; they are simply different.
- All cultures share central similarities.
- There are differences within each culture, and between them.
- Cultures change over time.
- The primary and secondary characteristics of a culture determine the degree to which it differs from the dominant culture.
- If patients are co-participants in their care and have a choice regarding health goals, plans, and interventions, health outcomes will be improved.
- Culture has a powerful influence on self-interpretation and responses to healthcare.
- Individuals and family members belong to various cultural groups.
- Each individual has the right to be respected for their uniqueness and cultural heritage.
- Nurses require general and specific training in culture to provide sensitive and competent care.
- Nurses can evaluate, plan, and intervene to competently improve the care of patients from a given culture.
- Learning culture is an ongoing process developed in a variety of ways, but primarily through encounters with various cultures.

- Biases can be minimized with cultural understanding.
- To be effective, health care must reflect a unique understanding of the values, beliefs, attitudes, and worldviews of diverse populations and individual acculturation models.
- Differences in race/ethnicity and culture require different interventions.
- Nurses are better at learning about their own cultures.
- Professionals, organizations, and associations have their own cultures.

Finally, the model proposed by Purnell (2014) proposes a complete understanding of 12 domains to apply culturally competent care:

1. *General description and assets*: assets and current residence, reasons for migration, political educational status, and occupation.
2. *Communications related to the dominant language*: dialects, parallel language variations (volume, tone of voice), non-verbal communication, temporality in terms of past, present, and future orientation.
3. *Roles and organization of the family:* who is the head of the family, what are the gender roles, who forms the extended family and the acceptance of different lifestyles, non-traditional sexual orientations, childless marriages, and divorce.
4. *Work*: what autonomy and culture occur in the workplace.
5. *Biocultural ecology*: color of the skin, biological variations, health conditions and variations in drug metabolism.
6. *High-risk health behaviors:* use of tobacco, alcohol, and recreational drugs, lack of physical activity, failure to use safety measures such as seat belts and helmets, and unsafe sexual practices.
7. *Nutrition*: includes the meaning of food, common foods and rituals, nutritional deficiencies, and dietary practices related to health promotion.
8. *Pregnancy and maternity practices*: culturally sanctioned and non-sanctioned fertility practices, opinions about pregnancy, and prescriptive, restrictive, and taboo practices related to pregnancy, childbirth, and the puerperium.
9. *Death rituals*: contemplating death and euthanasia, rituals to prepare for death, burial practices, and grieving behaviors.
10. *Spirituality*: formal religious beliefs related to faith and affiliation and the use of prayer, practices that give meaning to life, and individual sources of strength.
11. *Health care practices:* approaches to health-related beliefs and behaviors, cultural response to health and disease, people's practices, responsibility for health, barriers to health care, rehabilitation, blood products, and organ donation.
12. *Health professionals:* biomedical and traditional health care status and the gender of the provider.

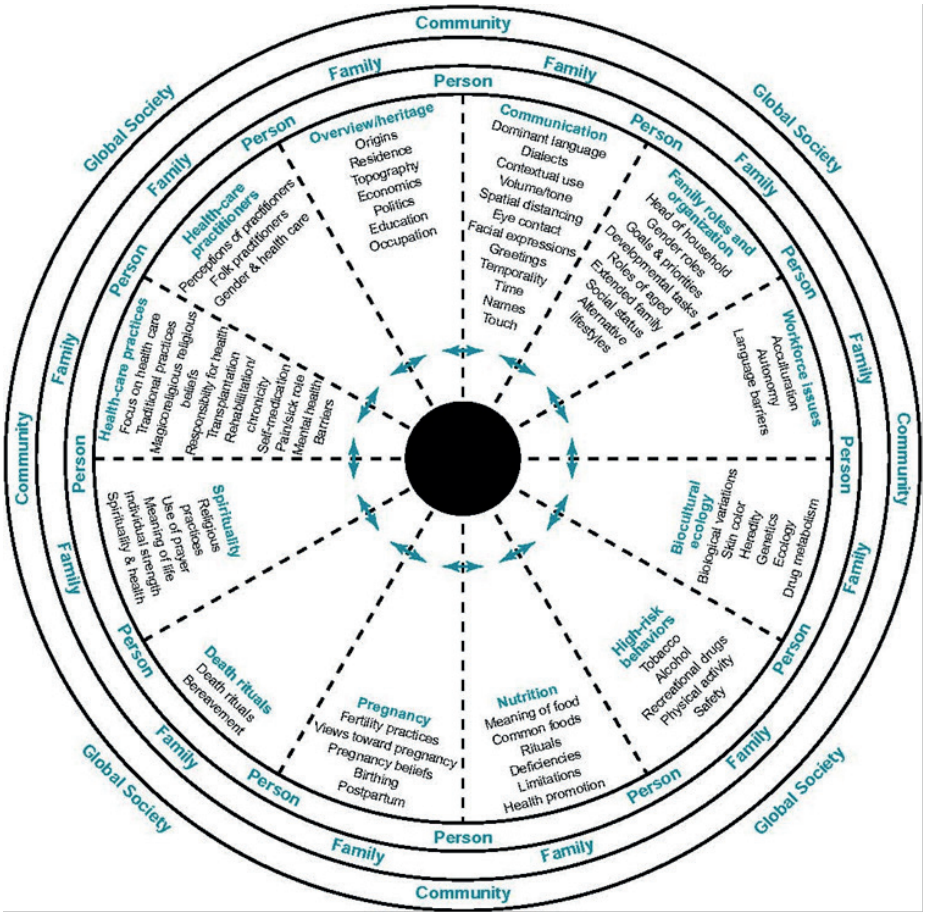

Figure 2. Purnell Model of Cultural Competence (Purnell, 2014). Used with permission.

The center of the diagram is blank because we are not fully aware of the culture. The irregular line at the bottom of the model represents the non-linear concept of cultural awareness, which, based on our knowledge, skills, and attitudes of the aforementioned domains can entail (Purnell, 2014):

A. *Unconsciously incompetent:* not being aware that one lacks knowledge about another culture.

B. *Consciously incompetent*: awareness that one lacks knowledge about another culture.

C. *Consciously competent*: learn and verify generalizations about the client's culture, and provide culturally specific interventions.

D. *Unconsciously Competent:* automatically provide culturally consistent care to clients of diverse cultures (Figure 2).

CAMPINHA-BACOTE CULTURAL COMPETENCE MODEL

This model originates from the idea that cultural competence is a process in which healthcare professionals continually strive to achieve the ability and availability to work effectively within the cultural context of the family, individual, or community. This process involves the integration of cultural awareness, knowledge, skills, encounters, and desires. The model is based on the interaction of six constructs (Campinha-Bacote, 2002):

1. *Cultural desire:* refers to the professionals themselves in terms of their desire to learn and understand the other, as well as to be open to new ideas.
2. *Cultural knowledge*: understood as the training and search for information on how to approach health and disease. In short, obtaining a global vision for understanding the foreign group to be served.
3. *Cultural awareness:* understood as respect and the elimination of prejudices to better understand different cultures and be more sensitive to their needs.
4. *Cultural skills:* refers to the development of methods to capture an individual's views, concerns, etc. to be able to propose an appropriate treatment.
5. *Cultural encounters:* invite interactions with people of diverse cultural origins in order to understand their culture. It also includes knowing the idiosyncrasies of each culture at an educational, cultural, and economic level.
6. *Cultural sensitivity:* essential to generate trust, acceptance, and respect, as well as facilitation and negotiation. The development of transcultural communicative competence has also been proposed.

Thus, it is a model that considers cultural competence as a process and not as an isolated event. Likewise, the model affirms that there is a direct relationship between the level of cultural competence of health professionals and their ability to provide cultural care that responds to the care needs of patients, always taking diversity into account.

MODEL of CULTURAL COMPETENCE of PAPADOPOULOS, TILKI, and TAYLOR

One of the most recent of the several models of cultural competence is that of Papadopoulos, Tilki, and Taylor (1998)—a model for the development of culturally competent health professionals. It refers to the knowledge and skills that nurses must possess to provide care, considering the needs and cultural beliefs of individuals, thus, emphasizing an ethno-culturally sensitive practice (Grou & Leite, 2016).

Papadopoulos (2006) defines the concept of culture as the shared ways of life of a group of people, including beliefs, values, ideas, language, communication, norms, and practices that are expressed through customs, art, music, clothing, and etiquette. Culture influences people's lifestyles, personal identity, and their relationship with others, both inside and outside their culture. Cultural competence is defined as: the responsibility of professionals to advocate for those under-served due to their ethnicity and for their right to be treated properly without prejudice to their ancestry, as well as to empower people to participate in health decisions. Further, Papadopoulos promotes equality and individuals' self-worth. This concept of

culture allows the model to emphasize that nurses possess both generic and specific cultural competence. Specific cultural competence refers to both the knowledge and skills related to a specific ethnic group that facilitate an understanding based upon the cultural rules and values held by a specific culture. In terms of generic cultural competence, it refers to knowledge and skills, but applies to all ethnic groups. The model also stresses that nurses should promote practices against oppression and discrimination (Gerrish & Papadopoulos, 1999). The model consists of four constructs (Figure 1):

1. Cultural awareness
2. Cultural knowledge
3. Cultural sensitivity
4. Cultural competence

The first three constructs led to the achievement of the fourth, that of cultural competence. The first stage of the Cultural Awareness Model is based on awareness of our cultural identity to understand our cultural heritage and that of others, based on our values and beliefs, and how these influence the health and health practices of individuals. These values and beliefs guide decisions and judgments and are influenced by an early age, both by family and social environment, and allow us to consider the risks of ethnocentrism and stereotypes and their relationship with discrimination.

The second stage of cultural knowledge can be acquired in various ways, such as through disciplines, including anthropology, psychology, sociology, medicine, and nursing. Another way is through specific contact with people of different ethnic groups, which allows us to gain awareness of how people interpret health/disease through their beliefs and practices, and their strategies to address it. In addition, links between personal points of view and structural inequalities are established.

Achieving the third stage of cultural sensitivity requires understanding how health professionals view the people they provide care for; therefore, adequate interpersonal relationships must be established with them. Treatment must be between equals, through trust, acceptance, and respect, as well as facilitation and negotiation, to demonstrate that culturally sensitive care is being achieved.

To reach the fourth stage, cultural competence a synthesis of cultural awareness, cultural knowledge, and cultural sensitivity is required; therefore, this stage can be considered both a process and a product of the knowledge and skills acquired during our personal and professional lives, enabling us to assess needs and make a diagnosis to provide care for the people we serve.

THEORY-BASED ASSESSMENT TOOLS

Multiple instruments to assess cultural competence in the health environment are available, primarily in the Anglo-Saxon context. The following table lists some of the most commonly used tools available, as well as various links to institutions where they can be found.

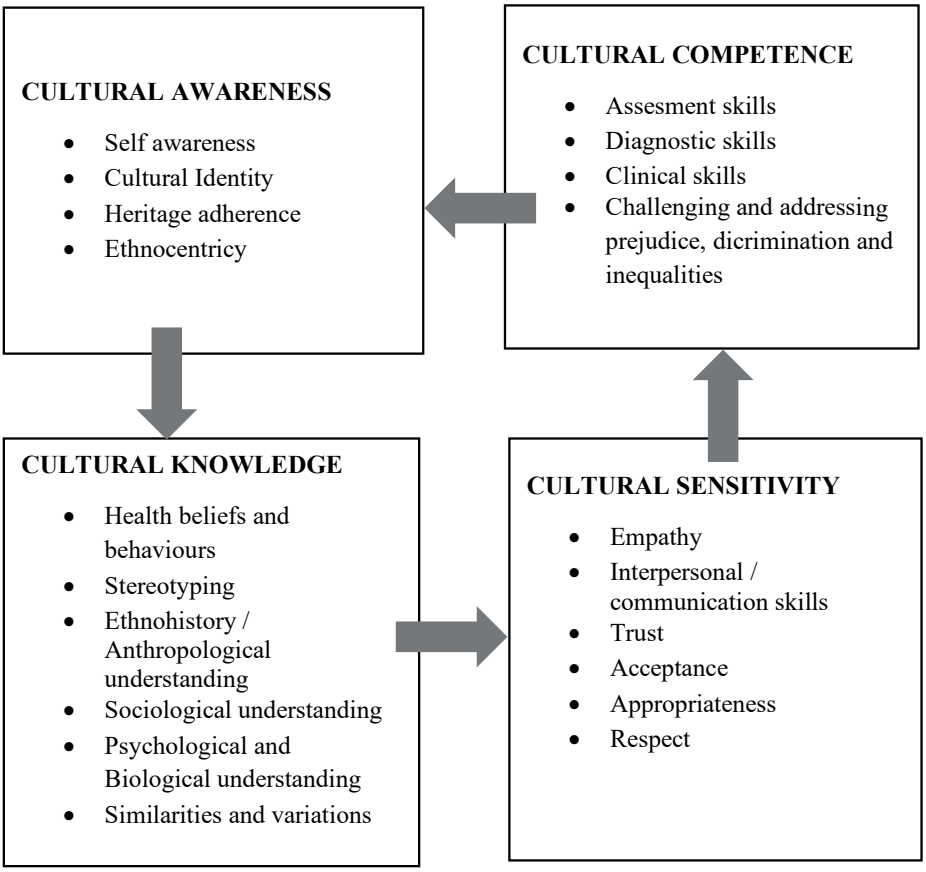

Figure 3. The Papadopoulos, Tilki, and Taylor Model for Developing Cultural Competence (Papadopoulos, 2006). Used with permission.

The Georgetown University National Center for Cultural Competence (USA)

Online self-assessments:

- Cultural and Linguistic Competence Health Practitioner Assessment (CLCHPA). Available at http://www.clchpa.org/
- Leadership Competencies Self-Assessment. Available at https://www.mchnavigator.org/assessment/
- Several assessment tools applied to cultural and linguistic competence available at https://nccc.georgetown.edu/assessments/

National Center for Biotechnology Information (NCBI) Bookshelf: A service of the National Library of Medicine, National Institutes of Health

- Counsellor Self-Assessment Tools

- Self-Assessment Checklist for Personnel Providing Services and Support to Children and Youth with Special Health Needs and Their Families. Available at: http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf

- Centre for research & education on Violence against Women & Children
  - Cultural Competence Self-Assessment Checklist. Available at : http://rapworkers.com/wp-content/uploads/2017/08/cultural-competence-selfassessment-checklist-1.pdf

Table 1. Cultural Competence Assessment Tools

Instrument	Content	Reference	Target population
Cultural competence self-assessment questionnaire (CCSAQ)	Knowledge of communities. Personal involvement. Resources and linkages. Staffing. Organizational Policy and Procedures. Reaching out to Communities.	Mason, J. L. (1995). Cultural competence self-assessment questionnaire: A manual for users. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.	Service providers
Gender Inclusivity Self-reflection	N/A	American Speech-Language-Hearing Association. (2021). Self-Reflection: Gender inclusivity. https://www.asha.org/siteassets/uploadedfiles/multicultural/gender-inclusivity-selfreflection.pdf	Health practitioners
Cultural competence check-in: self-reflection	Awareness about linguistic and cultural factors	American Speech-Language-Hearing Association. (2021). Cultural competence check-in: Self-reflection. https://www.asha.org/siteassets/uploadedfiles/multicultural/self-reflection-checklist.pdf	N/A
Tool for Assessing Cultural Competence Training (TACCT)	Rationale, Context, and Definition. Key Aspects of Cultural Competence. Understanding the Impact of Stereotyping on Medical Decision-Making. Health Disparities and Factors Influencing Health. Cross-Cultural Clinical Skills	Lie, D. A., Boker, J., Crandall, S., DeGannes, C. N., Elliott, D., Henderson, P., … Seng, L. (2008). Revising the Tool for Assessing Cultural Competence Training (TACCT) for curriculum evaluation: Findings derived from seven US schools and expert consensus. Medical Education Online, 13, 11.	Medical Schools

Instrument	Content	Reference	Target population
Examination of Cultural Competence in Social Service Agencies	Culturally competent practices as evidenced in staff selection, agency policy, and attitudes. Available services. Relationship to the ethnic community. Training. Evaluation.	Dana R. H., Behn, J. D., & Gonwa, T. (1992). A Checklist for the Examination of Cultural Competence in Social Service Agencies. Research on Social Work Practice, 2(2), 220-233	Policy Makers, Administrators, Staff
Cultural competence self-assessment questionnaire (CCSAQ)	Knowledge of community. Personal involvement. Resources and linkages. Staffing. Organizational policies and procedures. Community outreach.	Mason, J. L. (1995). Cultural Competence Self-Assessment Questionnaire: A Manual for Users. Portland State University, Research and Training Center on Family Support and Children's Mental Health.	Direct service providers and administrative staff working with children with disabilities and their families
Cultural Self-Efficacy Scale (CSES)	Knowledge of cultural concepts. Knowledge of cultural patterns. Skills in performing key trans-cultural nursing functions.	Bernal, H. & Froman, R. (1987). Influences on the Cultural Self-Efficacy of Community Health Nurses. Journal of Trans-cultural Nursing, 4(2), 24-31.	Nursing faculty
Measuring Cultural Awareness in Nursing Students	General educational experiences. Awareness of attitudes. Classroom and clinical instruction. Research issues. Clinical practice.	Krainovich-Miller, B., Yost, J., Norman, R., Auerhahn, C., Dobal, M., Rosedale, M., Lowry, M., Moffa, C. (2008). Measuring Cultural Awareness of Nursing Students: A First Step Toward Cultural Competency. Journal of Transcultural Nursing 19, 250-258.	Nursing students
Multicultural Counseling Self-Efficacy Scale - Racial Diversity Form (MCSE-RD)	Basic skills. Therapeutic relationship. Session management skills. Termination and referral. Multicultural assessment. Est interpretation/case, conceptualization/goal setting. Multicultural interventions.	Sheu, H., & Lent, R. (2007). Development and Initial Validation of the Multi-Counseling Self-Efficacy Scale-Racial Diversity Form. Psychotherapy Theory, Research, Practice, Training, 44(1), 30-45.	Mental health clinicians.

CASE STUDIES for NURSING STUDENTS

The following cases were created by Juan M. Leyva and M. Dolors Bernabeu and employed in their classes at the Universitat Autònoma de Barcelona in the Nursing Degree Program. The objective of these teaching activities is mainly focused on the acquisition of knowledge, attitudes, and skills related to cultural competence. The cases were followed with various questions to promote reflective and critical thinking during the discussion sessions with the students. A brief assessment rubric is presented as an example.

CASE 1

Agnès has been a nurse in a prison in the province of Girona for over a year. During the months that she has been working there, she noticed that apart from the nationalities of the inmates, various cultural groups were observed inside the prison. She had worked for five years as a rural nurse in the Alt Urgell region, and she was not used to this diversity. She is not bothered by the situation, but realizes that she needs to greatly improve her cultural competence. She remembers when she was a student; she took classes on transcultural nursing and decides to review her books and articles. She is very motivated and discusses it with her team, but they do not understand it; they tell her that they do not see the need to go into it because it is very theoretical and useless for practice. She disagrees and decides to prepare a lecture using real examples to explain the main features of the model and how it can be applied in practice.

CASE 2

Julia is a recent graduate nurse who works as a pediatric nurse at a community center in Tarragona. Among the schools to be visited as part of the Healthy Schools program, there are three high schools run by Catholic nuns. She identifies as agnostic, feminist, and socialist. Today, 16-year-old Ximena visited her with many doubts about sexual health and affectivity. She has told her that she has started dating a boy from the village and that she does not feel comfortable when it comes to her private parts and even less so when he asks her to have sex as she wants to remain a virgin until marriage. For Julia, this situation is a great challenge as it represents the opposite of her thoughts and activism, but she knows that as a nurse, she must be able to offer culturally competent care to Ximena. Since she does not know what to say at that moment and wants to respect Ximena's decisions, Julia tells her that she will look for information and they will talk again next week. Ximena accepts this and feels respected. When Julia gets home, she discusses the situation with her roommates, and they tell her that they do not understand how she can do this job; they accuse her of going against her principles.

CASE 3

Zafiro is a 23-year-old girl who decided to follow a vegan diet. She explained her beliefs and reasons to her parents and friends and they supported her, although they recommended her to visit the nurse practitioner to get some tips on nutritional facts. Zafiro only eats eco-friendly food and does not use any product that has been previously tested on animals. She strongly believes that no animal life should be endangered to improve human lives, and she also thinks that "we are what we eat." When she visits a nurse practitioner, she receives no good feedback. The nurse

introduces herself, sits next to her, and asks her "what brings you here?" The nurse changes her expression during the conversation and looks as if she does not care. She tells Zafiro "*If you have decided to follow this diet to lose some weight, you should know there are more balanced options*." Zafiro is shocked because she has not told her anything about losing weight. Zafiro tells the nurse that this is just a matter of personal beliefs. The nurse tells her *"Come! We are in the 21st century, and we have no need to go back to caves. You should eat meat and fish every day if you want to stay healthy; this thing of veganism is a stupid trend."*

CASE 4

Rafael is a 31 year old Roma boy who lives in Mallorca, Spain. He has been married to Soraya (30 years old, also Roma) for 15 years and has two sons (13 and 12) and one daughter (8 days old). Today, they have visited the community pediatric nurse for advice on breastfeeding for the daughter. Anna, the nurse, collects all the required biological, psychological, and social information to perform a holistic assessment. She discovers Soraya is alone at home the whole day with the help of her mother-in-law and her sister-in-law. Rafael works the entire day selling fruits in mobile markets. Soraya complains that she would like her husband to cooperate more at home, but she accepts it because "it is the right thing to do by men." She would have loved to study to become a nail aesthetic professional, but it has been impossible to take care of the house, children, and husband. In addition, Anna discovers that the oldest son (Nauel) sometimes skips classes to help his father. Both parents agree because they believe "boys must obey and help their parents always" even though their grades are falling dramatically. Anna gets upset, stands up in the middle of the visit, and says, "What is going on here? You are doing everything wrong! If you do not change immediately, I will call social services." Rafael gets upset too and yells at her, "You are no one to tell me how to raise my family. We do it this way. It has been like this for ages! You do not understand anything." By chance, Anna's supervisor listens to the screams and asks Anna to leave the room for a minute. The supervisor asks Anna: "What is going on here? You need to improve your behavior, especially in terms of culturally competent care." Anna does not understand; she believes that she is right and has done nothing wrong.

CASE 5

Miquel is a nurse in the intensive care unit of a large hospital in Tarragona. During his shift, Ashma, a 38-year-old Muslim woman with a very serious condition and in need of enteral nutrition, was admitted. The family is badly affected and suffer because they do not know if she will survive. They speak fluent Catalan and her husband asks what the food, being administered by tube, is made of. He is very restless. Miquel asks him what is wrong with him, and he tells him that he worries that there might be pork in the artificial food. Miquel tells him to give up religion right now, because the most important thing is to save Ashma's life. The husband becomes angry and asks Miquel to think about the importance of providing culturally competent care. A few days before, Miquel half-read a document that talked about Purnell's model and did not finish it because he did not consider it important. Now, he remembers it and thinks that it may help him. The next day, he resolves the problem with the husband, and they both feel much better. Because of this experience, he decided to hold a training session for the entire team, explaining Purnell's model with examples.

CASE 6

Bertha is a 39-year-old Peruvian woman who has been living with HIV for 3 years. She now lives in a village in Castellón, although she has always lived in Barcelona. Today, she visits her primary care center nurse to check her diet. It is the first time she has been there and when she tells the nurse, Rosa, about her serological situation, she replies with some contempt: "Well, you already know that Latinos are very sexual. It's normal that you have been infected." Bertha feels hurt. She does not understand the comment and also sees how Rosa cleans the desk and chair when she gets up to leave. In addition, Rosa tells her that the next time she comes, she should book the last hour of the day so as not to mix with the other patients. Rosa comments on the situation with a colleague, and he tells her that what she did was discriminatory and stigmatizing. A colleague invited Rosa to train. How should Rosa work to improve her cultural competence? How would you explain the content in a clear and exemplary way? What educational tasks come to mind, and why?

CASE 7

Ignatius is a transboy from Terrassa who has decided to start his transition process. He goes to his Primary Care Center and the nurse practitioner tells him "We can't treat this disease here." Ignatius cannot believe the nurse's answer; he does not think he has any illness. He feels rejected. Days later, he comments on his case in a community association in his neighborhood and is referred to a team where they will help him carry out the transition and follow up. During the first visit, a psychiatrist sees him and gives him a series of diagnostic tests to "confirm," according to the specialist, if he has gender dysphoria. A psychologist who conducts a few personality tests sees him. Ignatius does not like the visit at all; he feels like he has a serious illness that someone has to put a label on to treat him. He understands nothing of what is going on and feels distressed. When he comments on the visit with colleagues from the community association, they tell him something about the pathologization to which trans people are subjected. He does not quite understand it and decides to do some reading to train and take action to fight the pathology. What can Ignatius do? What would you do in a clear, exemplary, respectful, and formative way? What are the consequences for the trans people of this care model? How is cultural competence related to this case?

Review Questions

1. What problems can you identify? Why?
2. What interventions are needed? Why?
3. What do you think the nurse should improve? Why? How could he/she do it?
4. What could happen if he/she does nothing?
5. Is the nurse providing proper Culturally Competent care? Why?
6. What knowledge is needed to solve the problem?
7. What are the difficulties the nurse will have to deal with? Why?
8. What are the possible benefits of the nursing interventions?
9. Which theoretical concepts do you identify in this situation?

Rubric for evaluating the case study discussion

Always= 5 points; Very Frequently = 4 points; Occasionally = 3 points; Rarely = 2 points; Very Rarely = 1 points; Never = 0 points	
	Points (0-5)
Demonstrates a critical attitude, confronting various sources and issuing his own speech	
Demonstrates a reflective attitude, making it clear what you need to learn and why	
Uses the appropriate theoretical references	
Demonstrates a critical attitude, confronting various sources and voicing his/her opinion	
Demonstrates a reflective attitude, making it clear what you need to learn and why?	
Uses the appropriate theoretical references	
Explains the theoretical models related to the case	
Explains the theoretical concepts of the case	
Identifies the power relations present in the case	
Identifies the determinants of health and the axes of inequality observed in the cases	
Proposes realistic and clear interventions	
Promotes respect and tolerance for diversity	
Uses references from reliable sources	

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CHAPTER III

CULTURAL DIVERSITY

Radó Sándorné, Katalin Papp, Andrea Szelesné Árokszállási

Key Points

1. Cultural diversity
2. Diversity awareness
3. Aspect of cultural diversity in nursing
4. Most prevalent cultural groups characteristics
5. Religion / culture based practices

1. CULTURAL DIVERSITY

Changes in the patient care system these are new challenges today for nurses in all countries of the world. Maybe it has never been so topical to deal with this subject as now.

In the world, there are countless racial, ethnic and there are other minority groups and communities. The nurse has a wide variety of cultures will meet a group of patients, so you need to be prepared for quality, but in a variety of colours also for community groups provide adequate care. That's why he has it importance for clarification during care avoid clarification of cultural otherness where the nurse is working. In holistic patient care, the different cultures of individual people cannot be ignored. Nurses need to be able to meet individual needs and requirements. Culture, that is within a certain group, community values, behaviours, lifestyle it becomes a defining link, which at the same time a means of acceptance and survival with others is. To see clearly what the culture is, you need to know its characteristics (Balogh, 2012).

Our 21st century history is our membership of the European Union, the citizens of the EU free movement, establishment and employment are further enhanced by multiculturalism and if we look even further, we find that it is dominant monoculture is almost without exception being replaced by multiculturalism in European countries.

Despite the ethnic-cultural diversity presented, it stems from multiculturalism the problem is markedly limited to a few ethnic / religious groups.

The growing diversity of the population brings immense opportunity to enhance many aspects of society, and healthcare is no exception. Ensuring equity in healthcare is tremendously important in promoting positive health outcomes. Diversity in nursing is particularly critical because of the close relationships that nurses build with their patients and the sensitive nature of the healthcare that nurses provide. A nursing workforce that reflects the population it serves can only strengthen healthcare. As a current or aspiring nurse considering a Doctor of Nursing Practice degree, you may be particularly interested in knowing the importance and benefits of diversity and nursing, as well as related statistics and initiatives. While there have been improvements in nursing diversity

over the past few decades, there are still many more that can be made. As patient populations become increasingly diverse, there's a growing need for all healthcare professionals to treat and collaborate with patients from a culturally sensitive perspective (Wilbur, 2020).

The use of culturally competent communication contributes greatly to the reduction of racial and ethnic inequalities. Recently, some of the plans developed by health organizations have already focused on how they could deal with problems arising from cultural differences (Taylor, 2004).

Intermediate schools in the United States must meet the health and pharmaceutical needs of different racial and ethnic minorities in all areas. One solution to this problem is to develop or expand didactic courses to deal with this type of difficulty.

Curricula in institutions should comply with the principles of competent care that adequately address the evidence-based health care needs of racial and ethnic minority groups.

In the case of students, the most important thing is to educate and prepare for cultural awareness and cultural sensitivity (Shaya, 2006).

THE IMPORTANCE of CULTURAL DIVERSITY in EDUCATION

The emergence of cultural differences in education is also key.

Everywhere in the world, students have the right to access quality higher education, based on the need for educational institutions to be open to cultural diversity.

Students who learn the guidelines for dealing with differences from different cultures during their training will be able to play a much more effective role in transcultural patient care in their subsequent work. Acquiring this knowledge will make them more confident, experienced, and determined in patient care (Budhai, 2021). The most common cultural differences in the classroom:

Ways of Knowing

How do students from different cultures get the information they need?

In many cultures, the primary source of lexical knowledge is the textbook, or journal, which students have the best access to in libraries. In some cultures, however, the Internet is the primary information portal, while there are students who gain their knowledge from non-academic sources.

Ways of Solving Problems

There are also a number of cultural features in the solution of each problem. The solution solution used depends largely on the thinking, the preferences of the specific values.

Ways of Communicating Non-verbally

It is very important for educators to be aware of the characteristics of non-verbal communication from students from different cultural backgrounds.

For some students, making eye contact with the teacher is a sign of disrespect. The smile for Korean students e.g. it is often not a form of joy but a form of uncertainty, confusion, or shallow thoughts (Dreser, 1996).

Ways of Learning

Different cultural groups learn differently. In the United States, group learning is most prevalent, while in Europe the teacher plays a central role and education is often one-way.

Students are less active in this case, do not have the opportunity, or are ashamed to ask back during class.

Ways of Dealing with Conflict

Conflicts can occur in all social interactions. These conflicts can be destructive and constructive. Conflicts are generally undesirable in the United States, and face-to-face meetings are often used to resolve conflict. In some Asian countries, the so-called support silent conflict resolution. In most cases, written correspondence is used to solve this (Dupraw and Axner, 1997).

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2. DIVERSITY AWARENESS

Katalin Papp

The term *diversity* refers to the difference or distinction between people or things, diversity, infinity, or the multiplicity, similarity, inequality, or multiplicity of different things. *The awareness* varies from person to person. Human awareness can be developed through learning. Consciousness is nothing but an awareness of our power over our minds. Awareness is the way to exercise control over the mind. Interestingly, awareness is needed to increase awareness. The awareness means that a person recognizes, learns something. These are achieved through the use of cognitive ability and many many practices. So it is based on continuous learning.

Some interesting things

Simple steps and exercises to strengthen and raise the awareness:

1. Truth increases awareness, untruth decreases it.
2. Courage increases awareness, cowardice decreases it.
3. Mercy increases awareness, cruelty decreases it.
4. Desire increases awareness, indifference decreases it.
5. Attention increases awareness, lack of attention decreases it.
6. Knowledge increases awareness, ignorance decreases it.
7. The intellect increases awareness, irrationality decreases it.
8. The company of conscious people increases awareness that of non-conscious people decreases it.
9. Energy raises awareness, illness reduces it.
10. The intention to raise awareness really increases it. The intention to reduce awareness reduces its level.

The discovery and application of vaccines has radically changed the quality of life of the population. The in-depth interest of the researchers and the provision of adequate financial and human resources were important for the recognition. Through their work, they have radically changed the awareness of the people of the earth about illness and health.

WHAT is CULTURAL DIVERSITY?

Cultural diversity is a principle that recognizes and legitimizes cultural differences between different groups of people and the existence, coexistence and interactions of different cultures in the same geographical area. Through cultural diversity, we can appreciate different cultural expressions in a city, country, or region that have been modified or affected by cultural expressions in other areas due to other factors. We can say that cultural diversity is of such a quality that it accepts and shares the characteristics of one culture or another in a given geographical area (Carr-Ruffino, 2006). Therefore, the concept of cultural diversity is closely related to cultural identity, intercultural and multicultural meanings, which mean the connection between different

languages, ethnic groups, religions, artistic expressions, values, gastronomies and worldviews, among others. These exchanges of knowledge, knowledge and expressions enrich the cultural capital of a country or region (Balogh, 2004).

In this sense, cultural diversity is considered a high-value cultural heritage by UNESCO, which resulted in the 2001 UNESCO Universal Declaration on Cultural Diversity, which expanded the scope for policy-making national and international cultural events. Similarly, following that declaration, UNESCO became 21 May World Day for Cultural Diversity in Dialogue and Development (Balogh, 2012).

On the other hand, it is worth mentioning that cultural diversity is the result of various processes of a historical, political, social, economic and technological nature that have in some way contributed to the encounter and even different disappearance of different cultures.

Cultural diversity has fostered the recognition of the alien and the exchange of knowledge and values such as respect, tolerance, understanding and coexistence between different groups living in the same space (Földes, 2007).

Among the fears caused by cultural diversity is the possible configuration of a homogeneous culture in which the cultural identities of minority groups are lost.

CAUSES of CULTURAL DIVERSITY

Cultural diversity began as a slow process that progressed at an unstoppable pace with the passage of time and the development of human activities.

For example, cultural diversity stems from the process of invasions, battles, and conquests of new territories in which people of different backgrounds met. Today, cultural diversity is ubiquitous and has made it possible to develop new knowledge (Tiedt, 1995). For example, countries with great cultural diversity include Australia, China, the United States, but we can already find such in Europe, e.g. England, France, Germany. On the other hand, economic and political activities have also promoted cultural diversity through various means (Tiedt, 1995).

Similarly, industrial and technological development, which has led to the search for better jobs, has led to the migration of scientific exchanges and other opportunities for personal development of the individual. Finally, the process of globalization is an extremely important factor in cultural diversity. This phenomenon has changed communication, international relations, transportation, information exchange, economic and political systems, and culture (Patreese).

WHAT is CULTURAL GLOBALIZATION?

Cultural globalization refers to the dynamic process of interconnection and assimilation of cultures, from which a homogeneous and common culture is created in the world. Globalization is a process that, in principle, covers economic, political and social aspects, but also affects the positive and negative ways in which the diversity of existing cultures (Balogh, 2014).

Globalization, as the capitalist mode of production and development that generally seeks the well-being of society, has provoked various economic, industrial, technological, and political patterns around the world that have upset different cultural identities.

That is, cultural globalization is the result of a set of measures aimed at the continuous development of society, which has facilitated and significantly increased international relations and cultural exchanges among individuals seeking opportunities for development (Falkné, 2001).

In this way, millions of people around the world connected, met for a variety of reasons, allowing for cultural exchange. Now, given the economic and industrial development brought about by globalization, it is possible to further assess the scale of this cultural change in the consumption of both goods and services (Tiedt, 1995).

It should also be mentioned that important technological developments in the field of communication have made social, labor, scientific, family relations much easier and faster without losing their connections. From this acquisition of information and the exchange of goods and services, the various cultural expressions that exist are linked, and this amount creates a globalized culture in which every individual has a concept.

Nevertheless, everyone knows how to recognize their cultural differences, so they identify themselves as citizens who have their own cultural identity.

Examples of cultural globalization can be found in habits that have been adapted to the characteristics of others, i.e. redefined, and this can be observed in artistic terms, fashion, gastronomy, music, any country, among others (Balogh, 2014). For example, we can listen to the songs of a famous musical ensemble on every continent without the language difference being an obstacle as all fans sing the same.

CONSEQUENCES of CULTURAL GLOBALIZATION

The main consequences and changes caused by cultural globalization are presented below.

POSITIVE CONSEQUENCES

A homogeneous culture that embraces general customs and is recognized by individuals comes from a series of heterogeneous cultures. Cultural, social and political values have been redefined to protect human rights. Global connectivity has allowed us to learn about the great cultural diversity that there are more and more societies that, however special, are more common because of globalization: People are learning the most widely spoken languages to expand their knowledge and development skills and their opportunities. Media and audiovisual media the development of cultural globalization has been promoted in various ways by introducing brands, trends, language expressions that are recognized by more people. Cultural exchange and multicultural culture have increased. Cultural globalization was a phenomenon that joined millions of people.

NEGATIVE CONSEQUENCES

Cultural globalization is a phenomenon that regulates and standardizes cultural expressions: the cultures of the regions or cities with the fewest people have been influenced by the cultures of the largest and most influential regions or countries and have left their own identities. Certain cultural customs or traditions that have been abandoned by others influencing others are in danger of being lost or forgotten. Cultural diversity is declining with the creation of folk culture.

They apply the customs of the most developed and influential countries in the world. It is a dynamic phenomenon generated by trade, political and social exchanges, making it difficult for culture not to be touched and modified. Cultural globalization can lead to the loss of a nation's sovereignty. Brands take precedence over the consumption and promotion of production and represent the culture or region of the country (Polyák, 2015).

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3. ASPECTS of CULTURAL DIVERSITY IN NURSING

Andrea Szelesné Árokszállási

Transcultural care is playing an increasingly important role in healthcare today. One reason for this is that the growing cultural diversity in Europe poses a challenge to nurses, who, according to a holistic approach to nursing, need to provide care tailored to the whole person and individual. In order to follow this model of care, it is important to study the physiological, psychological, sociological, and religious implications of the use of culture. Knowledge of these factors underpins culturally authentic nursing. In this chapter, we outline the cultural differences in the values, beliefs, and habits that occur in health care. Culturally authentic care clearly promotes patient satisfaction and much more positive feedback. It is important for nurses to acquire the knowledge, skills, and abilities necessary for cultural competence (Maier-Lorentz, 2008).

Understanding how "culture" affects you what we consider "normal". Normality is particularly important in health care because pathology and deviance ideas determine with treatment professional decisions. Intercultural environment is not always easy to distinguish cultural norms from such from individual behaviours and ideas, which appear to be "out of the ordinary." health professionals therefore make mistakes can be committed if culturally in the course of their work they are insensitive. However, another common mistake is when the inexplicable behaviours we systematically “culturalize”. That's the attitude can lead to stereotyping and discrimination. Intercultural competence prepares the professionals on possible assumptions broadening the scope of ethnographic evidence using to form a general can be used for background knowledge while complete pays attention to individual identity complexity and context (Napier et.al 2014,Robak et.al.2013)

They are all different in terms of race, ethnicity, gender, sexual orientation, socio-economic status, groups defined by age, physical ability, religious and political beliefs, or other ideologies we belong, but none of these groups define us. They are all unique and special we are. Diversity as a concept focuses on the differences and similarities between people. Analytic level is used to describe human diversity, but it also includes a normative dimension, pluralism and a commitment to recognition of difference (Robak et al., 2013).That is not the difference and the similarity a peculiarity of people, but always the product of a relational observation.

Diversity management is a future-oriented, value-driven strategy, communication and leadership process of active and conscious development, which is the acceptance of certain differences and similarities and a given 139 means potential use in an organization, a process that adds value creates for the company” (Keil et al. 2007: 6).

Nursing recognized the importance of transcultural nursing and set out to develop into a culturally diverse, professionally grounded discipline. However, various studies show that this development is rather slow and stagnant. (Bjarnason, et.al.2019). In the 21st century, in multicultural societies, the nurse has prepared to take on an expanded role in her work. Institutions training health professions have become global, allowing them to train nurses who are willing to partner in the health care they need. As Europe’s rapidly changing diverse population grows, so has the need for the nurses that multicultural communities need at local, national and global levels. This is why diversity and cultural competence have become extremely important in nursing education. In addition, research, practice and health policy have become central to education. In nursing training, affirmative action, recruitment, and retention are no longer enough. It becomes important to create a corporate environment that integrates diversity and cultural competence

into the curricula of school teachers through subject descriptions, research, practice, and public policy to address health inequalities. It is important that educators, students, university citizens and the community in general are involved in this work (Siantz, 2008).

Since 2013, international migration has become an increasingly important and critical issue in Europe, a new phenomenon that poses a new challenge and challenge to the European Union's (EU) healthcare system. The need for "culturally competent" health care systems that takes into account religious. Cultural, linguistic and gender diversity and the ability to adapt to and respond to the needs of a diverse population is an increasingly challenging task across Europe. Based on research findings, it is increasingly accepted that differences in health status can be attributed to socio-economic factors. These differences are clear for some ethnic and cultural minority groups. Minorities often face difficulties in accessing health care. These are primarily cultural and linguistic difficulties. These are manifested primarily in communication and other interactions between the patient and the healthcare provider. Among nurses, these communication problems and misunderstandings can lead to anxiety and prejudice, reduced collaboration among patients, and this can lead to poorer health outcomes. It is an important task to solve the problems arising from linguistic, cultural and religious differences in order to provide the same standard of health care for migrants, ethnic or other minorities. In order to be able to achieve all this, it is important to develop intercultural competencies in health care (Marek -Németh, 2020).

The United Nations Educational, Scientific and It was adopted by the United Nations Cultural Organization (UNESCO) in 2001 Universal Declaration on Cultural Diversity, in which the concept of culture is defined as follows: 'A society or social group has a specific spiritual, social an ensemble of intellectual, emotional, and emotional traits that is within itself in addition to the arts and literature, lifestyle ways of living together, the value system, the traditional beliefs .Cultural background in many areas of life including language, religion, worldview, interpretation of space and time, family structure, a beliefs, rituals, diet, behaviour, attitudes towards pain and pain, etc. All this and may be directly or indirectly affected the health of individuals and communities and their relationship with the care system. The cultural circle, in which we were born and in which we live is not purely, self- health-related beliefs. Our health and health behaviours, but also many together with other factors. There may be such factors certain individual, personal factors (such as gender, age, deep experience, physical and emotional state), school (including those belonging to a particular religious subculture) 'Education') and some socio-economic factors, including the social support environment, or lack thereof and possible discrimination (Helman, 2007).

'Cultural competence' and 'intercultural competence' international concepts literature is almost equivalent, interchangeable. But theoretically uses 'intercultural', refers more explicitly to the differences between competencies intercultural nature. Widespread but relatively less commonly used cognate term is still 'multi-cultural' competence and 'transnational' competence, and even sporadically even in the US the term 'cross-cultural' taken from the foliage also appears (Koehn – Swick, 2006).

Cultural diversity', 'cultural diversity' and 'cultural 'cultural sensitivity' and 'diversity'. diversity sensitivity'. The latter terms social and cultural diversity (diversity). Approach to health inequalities from the point of view of needs and special needs and the main focus placed primarily on diversity, such as gender, culture and religious) and less migrants or ethnic groups intercultural context affecting minorities (Renschler - Cattacin, 2007).

Although not yet scientifically substantiated, a number of known author and research team makes it likely that the healthcare workers developing clinical intercultural competencies have an indirect positive effect on patient's health indicators. It is now well known that the causes of health inequalities are multifaceted, are historical and, to the greatest extent possible, factors contribute to the social determinants of health. social determinants of health (SDHs) related (Marmot-Allen-Goldblatt et al.2010). Such factors include low education and employment, lack of insurance and poorer access to health services. access also; studies show that Western socio-economic These inequalities are particularly evident in among certain ethnic and cultural minorities, be it a domestic minority or an immigrant population. This particularly vulnerable in the latter group. Wars and political, racial or religious persecution. Asylum seekers fleeing asylum and international protection beneficiaries. For the quality of care in addition to social determinants, there are a number of other factors between the care system and the patient, communication, including the decision-making process is (Marek-Németh, 2020).

Culture is the values, beliefs, customs, traditions, norms and morals of an individual or a population. Cultural factors determine our thinking, decisions, and perceptions of life. Learned behaviors and beliefs are inherited through generations. Culture also determines how we behave in our family environment as a brother, or husband, wife. What roles we take on and what behaviors we pair with in a family environment do so along defined definitions. There are additional cultural norms within a given ethnic group, despite the fact that each ethnic culture is unique. Even within the same family, specific elements of culture may differ due to generational attractions. Not all members of an ethnic group may accept customs or religious beliefs. Therefore, if a health care provider treats multiple members of a multi-generational family, there may be a problem in their care. The healthcare professional should be sensitive in assessing the exact medical history and communicate the care plan in a culturally sensitive manner (Young-Guo, 2020).

The nursing profession considers it important to be a culturally diverse profession. As a result of a culturally diverse workforce and culturally competent care, nursing behaviors and actions must yield positive results. Cultural competence includes the behaviors and actions of nurses that incorporate culture-specific knowledge in the care of culturally appropriate interventions (Lowe-Archibald, 2009). Culturally specific interventions should be acceptable and mutually adherent for both healthcare professionals and patients. Nursing science, as a culturally diverse profession and discipline, can also bring about constructive changes in health care, meaning that it can sensitize the cultural dimension within health needs. Health inequalities can also be affected by the culturally diverse nursing profession. Although change is a slow process in nursing, the obvious reasons for this are: weaker representation of ethnic and cultural minorities in the nursing profession, late responses to increased nursing needs, coalitions between national, state and local nursing professional associations / organizations, and ethnic minority and lack of connection between cultural communities. However, increasing the number of ethnic and cultural nurses in the profession could also help the pervasive and growing shortage of nurses. Nursing should represent a culturally diverse profession and discipline with its behavior and behavior (Young-Guo, 2020).

"Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that combine in a system, agency or between professionals and enable them to work effectively in intercultural situations. "Culture refers to unified patterns of human behavior that include the language, thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." Competence "means the ability to function effectively an

individual and an organization in the context of cultural beliefs, behaviors, and needs presented by consumers and their communities (Young-Guo, 2020).

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4. MOST PREVALENT CULTURAL GROUPS CHARACTERISTICS

Andrea Szelesné Árokszállási

There are some 160 culturally distinct groups in Europe. They are designed to describe the "ethnic types" of the different ethnic groups living in Europe, but these are primarily physical characteristics that provide statistical and descriptive data. Each of these groups exhibits two important properties. One important feature is that each member has a degree of self-recognition, although the basis for such a collective identity varies from group to group. The other is that all groups, with the exception of Jews and Roma, live within a typical territorial homeland and are numerically dominant. However, there are still territorial differences in linguistic and other cultural aspects, which have been of great social and political importance in Europe. These differences separate Europe from relatively recently colonized countries such as the United States, Canada and Australia (Encyclopaedia Britannica, https://www.britannica.com/place/Europe/People).

Ethnographers were able to link primary European cultural groups to 21 cultural areas. These groups are primarily defined by territorial proximity and linguistic similarities. Although individuals within a group are generally aware of their cultural attachments, different groups within a given cultural area do not necessarily recognize their kinship toward each other. The Balkans should be highlighted here, where this is particularly the case. Exceptions to this are peoples of Scandinavian and German (German-speaking) culture who are aware of their own (Encyclopaedia Britannica, https://www.britannica.com/place/Europe/People).

The way of thinking, habits, and values and consequently, everyday experiences of individuals are fundamentally influenced by the cultural characteristics of their family and the wider social group. In many cases, these characteristics do not enter the individual's mental supply, not consciously, but as part of the family paradigm, in response to stimuli from the world. Culture is a complex system, with elements of core values, norms based on them, beliefs, symbols, technology and language. Individuals who experience each element similarly in their capacity are organized into groups by consciously or unconsciously communicating with each other. These attitudes can be similar, but they can also be explicitly contradictory - they have a decisive force within the given group, community, their influence is not questioned, and as such a common ground, it also has emotional determination. For each group. The cultural basis of communities determines, among other things, the relationship of individuals to society as a whole, to other groups, to lifestyle and lifestyle, to work and to education (Oetting.et.al.1998, Blanchet, 2014, Rozsos, 2006, Červený-Kilíková, 2018).

Our society and the culture around us are diverse and varied we experience its appearances every day in our work. This is the case when we care for patients from different ethnic groups.

We all know the struggles of the patient coming from poverty, from difficult circumstances. The cultural diversity in which ethnic groups, a gender differences, older and younger people, age differences, geographical differences, religious differences, special educational needs, able at risk of poverty and at risk of poverty patients, we discuss the social, cultural and educational issues and contexts of linguistic diversity. More and more specifically against teachers the need to acknowledge differences in school practice, openness, empathy, the existence of tolerance, the coexistence of plural value systems acceptance. Recognizing the diverse social and cultural backgrounds of students to be aware and properly treated in a positive, accepting spirit have the appropriate knowledge and skills in addition to their attitude for teachers. The basic desire is

openness, tolerance, others away the requirement to receive it, to take into account the values, norms and habits brought from home and family, to base it on the process of teaching and educational work. We must not forget that a sick person can only be understood by looking at his environment, This, it is difficult to carry out successful healing work without knowing its cultural background, language, symbol system, customs, and values (Oetting et.al. 1998, Blanchet, 2014, Balogh, 2014 Červený-Kilíková, 2018).

Culture was defined as the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. The learning pathways, knowledge,

Figure 1: Distrubution of Europan ethnic culture areas

Source: Map showing the distribution of various culture areas, each inhabited by groups exhibiting linguistic and other cultural similarity, in Europe.
Image: Encyclopædia Britannica, Inc.

values, patterns, and normative practices learned by members of the nursing profession in a given society are called nursing culture. An important principle in transcultural care is that nurses recognize the importance of cultural differences by valuing, incorporating, and examining their own and their health organizations 'health values and beliefs, all of which are essential to meet the unique and diverse needs of patients in Europe and the United States (Červený- Kilíková, 2018, Bjarnason et.al. 2009).

In Europe, ethnic groups are primarily defined by their geographical origin, e.g. residents of Turkish, Moroccan or Surinamese origin. Ethnic diversity in Europe is influenced by several factors. The characteristics of the groups are determined by the genetic stock of the culture, but are influenced by their socio-economic background and discrimination. Different ethnic groups have different health problems and access to health care. Unfortunately, we do not yet fully understand which of these specific characteristics leads to health problems or a specific pattern of health care, so it is necessary to classify patients into ethnic groups. Ethnicity is a good starting point for dividing health care into patient groups, thus promoting better quality of care. The ethnic diversity of medical practices and nursing practices is evolving rapidly (Stronks, 2013).

Transcultural care is emerging as a new concept in Europe, which is it requires new knowledge and a new attitude from healthcare workers. The borders with its interoperability, more and more individuals with a culture and religion foreign to us are present in Country as tourists, workers, settlers; during their stay they may also need medical care: they may have an accident or suddenly may become ill. Nurses, when they encounter a patient with a different culture from them, most often they collide with otherness. The nurse should recognize the other special habits and behaviours arising from culture. Used in transcultural care approaches should reduce tension. The nurses recognized that all their efforts will be ineffective, turning into frustration and negative impact who do not know the cultural values of the client to be cared for. Transcultural care is a specific direction that is specific to different cultures focuses on its approach, values and lifestyle. Acquired knowledge individuals, families with different identities, care for groups (Leininger, 2002, Červený-Kilíková, 2018, Cuellar, 2017).

Throughout our 21st century history, EU citizens free movement, establishment and employment are further enhanced by multiculturalism and if we look even further, we find that it is dominant monoculture is almost invariably being replaced by multiculturalism in European countries. Despite the ethnic-cultural diversity presented, it stems from multiculturalism the problem is markedly limited to a few ethnic / religious groups (Balogh, 2014, Cserkész, 2006, Szirtes, 2002).

In the following, four ethnic / cultural groups are described without claiming to be exhaustive

characteristics: Judaism, Chinese from the Asian ethnic group, Mohammedan religion and the Roma who have lived with us for a long time.

A significant cultural circle is **the Roma**. In everyday practice we meet them a most often. The basic unit of Roma society is the extended family into which the brothers, families of cousins are also included. Male opinions are primary, women are given a subordinate role. After hospitalization, it is difficult to bear separation from the family. Of this due to the fact that even beyond the time of the visit, the relatives are larger they surround the patient's bed in groups. It is important for health how staff can handle the above habit without conflict situations. Whether the health care institution is able to persuade that community to comply with the rules? If emergency care is needed and a doctor needs to be called, 2-5 people can be called are sent

to the office. Typically, more people speak at the same time and overdo the patient's condition juice. Experience that in such a case to the loudest speaker or the elder you need to speak in a moderate tone so you can calm down and know the problem to say. The doctor who arrives at the scene finds that there are so many around the patient they crowd as many as they can. In this case, either the local voivodship or one of them an older person should be required to be deported outside of the nearest relatives everyone. If the patient can go to the doctor on their own, they can accompanied by several. They communicate much louder than other patients. The wait is hard to bear. Then you have to go out to the waiting room, reassure them, and their attention should be drawn to waiting in accordance with the policy. Rome when examining women, it should be borne in mind that most of them are very shy and reluctantly undressing. It is common for Roma to spasmodically cling to their ancient superstitions and to their world of beliefs. If we come across a habit that affects our health we consider them harmful, they must be persuaded to leave it. We have to accept that the emotional outbursts of the Roma are stronger than average, so if the in a family death, several people wail at once, loudly they sob, women tear their clothes many times, men can cut them with a knife forearms, bellies, chest. You must not be afraid or indignant at the sight of these, to be offended, or even to speak out, because it can have fatal consequences. In this case, you should behave calmly and calmly, and with quieter responders should be mixed (Balogh, 2014, Cserkész, 2006, Szirtes, 2002).

Judaism, a community of Israelites. They are the ones whose different habits as they are rarely encountered in everyday life because they form a closed community. They also seek to provide health care within their own spheres, with the exception of emergencies when it is strict, such as kosher meals. These customs stem from inviolable religious requirements and need to be treated properly in the absence of knowledge it is very difficult. In such cases, it is worth so professional-religious organizations that can help solve the problem. It is important to know that pork in all its forms is prohibited in their meals and those that have no scales or fins. Meat and dairy products separately must be served, prepared and stored in a container. The dairy product must be served first, then meat can follow in four to six hours. These hospitals cannot perform, so it is advisable to involve the family. Jewish families they do everything they can to care for the patients, it is also their religious duty. After birth, in Orthodox Jewish culture, ritual circumcision, circumcision is all boy is mandatory for newborn.

The Sabbath (Sabbath) is a weekly feast of Judaism that begins on Friday and Saturday lasts until dusk. No work is allowed on Saturday and nothing is done to perform an action that leads to work (Cserkész, 2006, Balogh, 2014).

Mohammedans. The "Arab world" includes 22 countries in the Middle East and in North Africa, with a population of 180 million. Arabs who speak the Arabic language different dialects and share the values and beliefs of Arab culture. The majority of Arabs are Mohammedans. They do not eat because of their conservative religious beliefs pork and do not consume alcohol. They respect Ramadan, which is everything Mandatory for healthy Mohammedans over 12 years of age. However, the patients, children and pregnant women to do this from sunrise, you must not eat, drink, smoke or make love until sunset. After sunset however, you can eat and drink from everything. It is the nurse's job to set aside the patient's food and drink during the day so that he or she can take it away at night to consume. In prayers, reading the Qur'an gives help and comfort to the sick and family members and helps the patient recover. Ritual prayer consists of certain formulas and Qur'anic quotations. It should always be performed in the direction of Mecca. It is preceded by ritual washing. It should be performed five times a day: at dawn, noon, afternoon, sunset and evening. If someone is ill, they can pray while sitting or lying down. It

is advisable to provide the patient with a separate room or screen free of charge to practice religion. When a patient is hospitalized, there is a social obligation on the part of friends and family to visit and bring gifts such as flowers, cakes or chocolate. Around the parent woman usually female relatives and girlfriends help out, fathers don't go in to the maternity ward. The family honor is determined by female purity, morality and extreme sexuality segregation must be maintained at all times. During pregnancy or gynaecology for studies, women prefer a female doctor. Male nurses cannot be ordered next to Muslim woman. It is the man's responsibility to protect a woman's virtue from health during care; many times a simple sign on the door - that says "Please knock entry before"- can help them with their care. Reluctant to provide details information about themselves, their families to strangers. Conservatives, embarrassed come when it comes to sexual intercourse and other personal issues. During Ramadan, many patients do not take medication or abstain from eating during the day (Cserkész, 2006).

The Chinese. Chinese medicine teaches that health is mental and physical harmony state with nature. A healthy body is in a state of equilibrium. When it is balance is upset, resulting in disease. YIN-YANG a clear contrast that is in many areas of life, including the development of diseases and it also plays an important role in medicine. Yin and Yang generally express each other opposing forces, which include cold-heat, fire, and water. Opposite pairs are one they form a whole, so if there is much or little of something at a given moment, then equalization should be sought. Strictly according to traditional Chinese traditions it is tailored to what to eat and what pairs to avoid. For women they need a different type of diet depending on their menstrual cycle. The bleeding during this period, for example, it is believed that the body loses Yin, that is, cold. It needs to be replaced with Yang, that is, warmth. Therefore, this period is only warm fluids can be consumed and cold foods should be avoided. It is believed that their bodies were given to them by their parents as a gift. Their own organization is not his personal their property must be cared for and well maintained. The Chinese patient for the first time is traditional uses Chinese medicine eg. acupuncture. According to Chinese medicine, the diseases develop from gases and it is very unhealthy to keep anything inside, therefore it is not indecent for them to belch and discharge their intestinal gases into the company. The Asian patient rarely complains that something is bothering him. Often the only one a sign that there may be a problem with an intact tray of food or the patient is quiet retreat. The nurse should not offer help e.g. offering painkillers, linen change but do it automatically.

Transcultural care is a specific direction that is specific to different cultures focuses on its approach, values and lifestyle. Acquired knowledge individuals, families with different identities, care for groups (Cserkész, 2006).

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5. RELIGION/CULTURE-BASED PRACTICES

Radó Sándorné

"**Religion** is a set of cultural systems, belief systems, and worldviews that bind human life to spirituality and, at times, to moral values. Many religions include legends, symbols, traditions, and sacred stories that try to explain the meaning and origin of life. Religion tends to derive morality, ethics, religious laws, or a way of life considered salvated from its teachings about the universe and human nature. Many religions are characterized by rituals, have a priesthood, define who is a follower or member of a religion, with a secular church, regular gatherings and ceremonies for the common worship and prayer of God, have holy places (whether natural or built) and / or sacred writings. In addition, the practice of religion may include sermons, commemorations of the deeds of god or gods, sacrifices, feasts, feasts, transitions, initiations, funerals and marriages, meditation, music, art, dance, community service, and other elements of human culture. However, there are religions that more or less lack the above structures, views or practices. " (Council of Europe: Manual for Human Rights Education with Young People, 2002)

About 85% of the world's people identify with a religion. The most popular religion is Christianity, followed by an estimated 2.38 billion people worldwide. Islam, which is practiced by more than 1.91 billion people, is second. However, population researchers predict that Islam will have nearly caught up to Christianity by 2050. The Islamic religion for the past 20 years it gathered more than half a billion followers. Hinduism is 15% while Buddhism is 7% you can book a share for yourself. (World Population Review, 2021).

THE FIVE MOST COMMON RELIGIONS in THE WORLD

Christianity

Christianity was founded in the first century on the teachings of Jesus Christ. While Christianity considers both the Old Testament and the New Testament to be their holy books, the Jews only honor the former, not believing that Jesus would be the Messiah sent by God for our salvation.

Christianity was persecuted for a long time in the Roman Empire, and finally in 312 the Roman emperor Constantine I allowed the free practice of religion. The first great separation of Christianity was the great East-West rift in 1054, followed a few centuries later by the break-up of English Catholics when VIII. Henry's will led to the birth of the Anglican Church, headed by the English ruler. The next major rift occurred in 1517: it was the Reformation (Bloom, 2007).

Islamic

The most important person in the monotheistic, religion is the Prophet Muhammad, who in the 7th century unified the creeds of religion, which Allah himself, the god, sent to him through the archangel Gabriel. There are five pillars of religion: unconditional faith in Allah, prayer five times a day, fasting on the month of Ramadan, every believer must make a pilgrimage to Mecca at least once in his life, and give alms to the poor (Edis, 2007).

Hinduism

The founding of Hinduism cannot be traced to any person: it developed over centuries, which is why it is called the eternal religion. According to faith, people are ruled by world laws, dharmas1. Just as animals and plants are organized into species and groups in nature, so it organizes people into separate groups and castes. There are four castes formed from the body parts of a primitive creature, Purusa: the priests were born from the mouth, the warriors from the arm, the workers from the legs, the servants from the feet. He believes in the migration of souls: in our next life we will receive a destiny that we deserve based on the actions of our present life (Brown, 2008).

Buddhism

Buddhism originated in India in the 6th century BC. According to Buddhists, life is suffering, the source of which is sensuality, longing for life, and ignorance. One's goal is to get out of this suffering and reach the state of nirvana, or "total non-existence." According to the teachings of Buddhism, a restrained, extremist life is important, and happiness should not be sought in material possessions. They live their lives according to five simple basic laws that prohibit, among other things, theft and intentional harm to others (McMahan, 2017).

Taoism

Taoism is the most widespread religion in China and has a major impact on culture, politics and the economy. Central to religion is a mysterious force that keeps the world in constant change, making it unpredictable. Believers try to live in harmony with this force. The goal is to become one with the Tao. His most famous philosopher is Lao-ce. According to him, the world is in a constant cycle, everything is born of being and non-being, of two opposing states (Moeller, 2012).

DISCRIMINATION and INTOLERANCE BASED on RELIGION or BELIEF

Religious intolerance is experienced at different levels: among adherents of the same religion (intra-religious intolerance); between two religions or religious approaches, manifested in different conflicts between individuals and groups (inter-religious intolerance); and in a situation which does not allow others to choose freely, to practice their religion or to commit themselves to a worldview; Religious intolerance is often confused with xenophobia and other forms of discrimination; it is also sometimes used to justify discrimination.

No social group, religion, or community has a special right to discriminate against others. Although the level of protection afforded to freedom of religion and belief may vary considerably from one Council of Europe member state to another, religious intolerance and discrimination affect everyone in Europe (Woodhead, 2009).

Culture is much more than a list of holidays or eating preferences, or the language someone speaks. Culture is the framework around which we build our identity. It affects how we relate to the world, what aspects we choose, and what expectations we have. We all have a culture, and most of our identities are made up of multiple cultures.

By cultural care, we mean the values, beliefs, and patterned lifestyles that are subjectively and objectively learned and passed on that help, support, facilitate, or enable another individual or group to maintain their well-being, health, or improve their life (Leininger, 1991) .

The systematization of dealing with patients from different cultures on a scientific basis began in America. In 1960, Madeleine Leininger formed the Transcultural Nursing Group. She first examined the origins and behaviours of different cultures, with particular reference to issues affecting the practice of care. She first recognized the role of cultural sensitivity in nursing, which she enshrined in a new nursing theory, the Sunrise Model. Through her observations as a nurse, Madeleine Leininger identified a lack of cultural and caring knowledge as the main missing component to help the caregiver understand the many options that require inpatient care to support compliance, recovery, and well-being. Prompted her to develop and create The Theory of Transcultural Care, also known as Culture Care Theory.

All health care workers need to rethink how their work can be effective in caring for different communities, ethnic and religious groups. Planning for modern care cannot deprive the nurse of adequate cultural knowledge. Knowledge of cultures, sensitivity to cultures leads to the realization of a high level of transcultural care (Balogh, 2014).

WHAT to AVOID?

- Stereotype: a negative assumption based on bias, exaggeration, and simplification against a group
- Prejudice: a negative emotional attitude towards members of a group based on the fact that these people are members of the group
- Discrimination: treating people unfavourably because they are part of a group
- Ethnocentrism: the belief that our own ethnic group or nation is superior to others
- Stamping for deviant

Review Questions

1. What are the reasons for developing culturally competent care?
2. Could you define the definition of the diversity and awareness! How can the person develop his/her awareness?
3. What makes health work effective when we encounter a cultural difference?
4. What are the most common cultural groups? Describe them briefly!
5. What are the causes of religious conflicts?

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CHAPTER IV

ETHICS and CULTURAL CARE

Katalin Papp

Key Points

1. Ethical principles should be embedded in cultural competence
2. There are many factors to consider in order to make the ethical decision with the least error and the most positive results.
3. Using a step-by-step decision-making process can help you make more deliberate, thoughtful decisions by organizing relevant information and defining alternatives.

1. ETHICAL PRINCIPLES EMBEDDED IN CULTURAL COMPETENCE

Ethics: a science of a philosophical nature, the subject of which is morality. It forrnulates the expected forrns ofbehavior, it is based on the ranked human value system that deterrnines the decisions of each person (The lCN Code of Ethics for Nurses. lCN, 2012).

Culture is the characteristics and knowledge of a particular group of people / nation, encompassing language, religion, cuisine, social habits, music and arts and many other things. But culture can be seen in a broader sense, which is determined by the patterns of behavior, interactions and cognitive abilities acquired / learned through socialization. In this interpretation, social patterns specific to a group of people or a nation help shape it.

"Culture encompasses religion, food, what we wear, how we wear it, our language, marriage, music, what we believe is right or wrong, how we sit at the table, how we greet visitors, how we behave with loved ones, and a milli on other things" Cristina De Rossi, an anthropologist at Bamet and Southgate College in London, told Live Science (Zimmermann, 2012).

Culture (derived from the Latin cultura, colo, colere, meaning "to cultivate") broadly encompasses everything that people themself creates - unlike the part of nature that they did not create or change. In the general sense of the term, the totality of the customs and traditions of a group of people, or in anarrower definition, the so-called "high culture". In the traditional sense, the intellectuallife of society (Cerveny, et al., 2020).

Competence is not synonymous with skill, but the ability to successfully solve complex tasks in a giv en context. The concept includes the mobilization of knowledge, cognitive and practical skills, social and behavioral components and attitudes, and emotions and values alike (Nagy, 1996).

Categories of key competencies:

1. Competencies related to autonomous action:
   - Development of own (life) plans, personal ideas, independent management;

- Enforcement and protection of rights, needs and interests

2. Competencies related to using interactive tools:
   - Interactive use of knowledge and information;
   - Interactive use of technology;
   - Interactive handling of language, symbols, texts
3. Competencies related to operating in a socially heterogeneous environment:
   - Building relationships with others;
   - Cooperation in group work;
   - Conflict management and resolution.

Members of the healing community raise the profile of health care by appearing in the workplace (Balogh, et all, (2011). Members of the healing community guarantee respect for the human dignity of the individual receiving care, and the exercise of their personal rights, which may not be restricted by national law. aspects related to affiliation, commercial interest, race, religion, skin color, age, gender, political or social status. AlI members of the healing community are committed to acting and behaving in accordance with their professional goals (Andrews, 2003).

WESTERN CULTURE

The roots ofWestem culture go back to the Greco-Roman historicai age and are closely linked to the strengthening of Christianity in the Middle Ages, around the 14th century.

Western human image

- Separated from others, free, identical with oneself.
- Success and performance focused.
- They have individual goals. They evaluate their life in terms of achieving these goa1s. They will succeed if they have achieved their individual goals. Fail if not.
- Makes independent, reasonable decisions to achieve their individual goals.
- They control their behavior and they are responsible for themself.
- Feel good when they think of themself.

EASTERN CULTURE

Eastern culture is the social norms of the countries of the Far East. Here, as in the West, the influential power of religion is strong. But the planning of the weather and farm work was also taken into account. In contrast to Western culture, they make less of a distinction between secular society and religious philosophy (Zimmermann, 2012).

EASTERN HUMAN IMAGE

- Connected, committed to others.
- Relationships, roles, groups, institutions determine action, not individual goals.
- They are interested in the groups - the family, the workplace, the small community - working weIl.
- They naturally seeks to meet their obligations arising from these relationships.
- That is why it tries to reach an agreement with others and take into account the requirements of the community.
- They c1assifies their life on the basis ofhis contribution to the well-being of the community.
- Adaptive and group-focused.
- Puts their personal needs and opinions under relationships and rules. .

MIDDLE EASTERN CULTURE

In the middle eastern culture the religion is a cultural area that is a common. Many middle eastern country has the same religion, that is the Judaizm. The Judaizm in middle eastern was the place of birth of the Christianity and the Islam religion.

CONSTANT CHANGE

This makes it that it is difficult to define any culture in only one way. They are essentially and constantly in motion. The world and culture are changing very fast, in the long run none will remain elean. The change is rapid and covers many areas. While change is inevitable, the past should also be respected and preserved. The United N ations has created a group called The United Nations Educational, Scientific and Cultural Organization (UNESCO) to identify cultural and natural heritage and to conserve and protect it. Monuments, building and sites are covered by the group's protection, aceording to the international treaty, the Convention Concerning the Protection of the World Cultural and Natural Heritage. This treaty was adopted by UNESCO in 1972 (Zimmermann, 2012). If a country wants to protect part of its culture, use UNESCO's right to protect it. These are usually great ideologicalor

material values of culture. We know many of the many values in the world that are a UNESCO World Heritage Site.

2. ETHICAL DECISION-MAKING PROCESS

Decision-making is the most important content element of management and managerial work, and its role is primarily in solving problems and developing longer-term strategies. It consists of:

- Preparation / collects the information, analysis /,
- Outlining and considering alternative solutions,
- Ex-post evaluation of the decision.

The most important criterion of a decision is the choice, which is always influenced by the given external and internal environmental as well as subjective and objective conditions and circumstances.

The decision is formally a choice between options.

The decision:

- Objective coercion
- A symptom of the problem
- The source is the contradiction between the goals and the endowments
- Future oriented is characterized by the personality and will of the decision maker.

The decision itself essentially consists oftwo moments:

- Comparison of options - consideration,
- Election - judgment.

Limitations of decision-making: Target limit,

- Resource constraint,
- The number of problem owners is limited,
- Hierarchical limit,
- Competence limit.

Methodologicallimitations:

- Detection limit,
- Limit of discrimination,
- Measuring barrier,
- Communication barrier.

Stages of the decision-making process:

- Recognition ofthe decision situation
- Situation assessment
- Development and evaluation of altematives
- Decision

- Implementation, monitoring, evaluation.

People, health professionals often have to make decisions. Decision making should be an extremely thoughtful process. There are many factors to consider in order to make the decision with the least error and the most positive results.

Observance of ethical rules and procedures is also a very important aspect for making the right decision (http1). Decision making is the process of making choices by identifying a decision, gathering information, and assessing alternative resolutions. Using a step-by-step decision-making process can help you make more deliberate, thoughtful decisions by organizing relevant information and defining alternatives. This approach increases the chances that you will choose the most satisfying alternative possible (Figure 1).

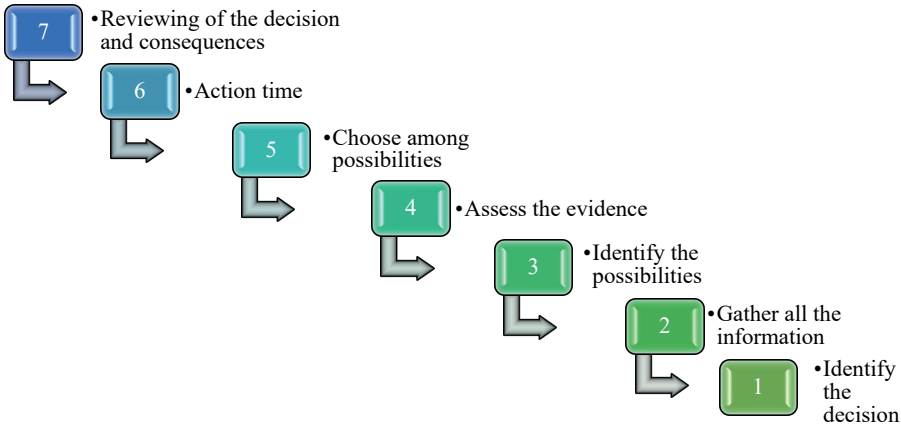

Figure 1. Seven steps to effective decision making (*Source: https://www. umassd. edu/fycm/. decision-making/process/)*

STEP 1: IDENTIFY THE DECISION

The first step is very important, the foundation for making a good decision. The origin of the decision must be determined, the known facts must be revealed.

STEP 2: GATHER ALL THE INFORMATION

Gather as much information as possible to make the best decision. A decision map can be created with alternatives. The information includes professional background, human resources, material and device conditions.

STEP 3: IDENTIFY THE POSSIBILITIES

In this case, you have to think freely about everything. Consider all possible aspects. Outline the optimal / ideal options, but think about the difficulties and obstacles.

STEP 4: ASSESS THE EVIDENCE

At this stage, the steps for solving each alternative need to be considered. The result will be finding the best solution based on the most optimal information. We can rank among the solutions and we have thought through. This will also prove the effectiveness of making the best decision.

STEP 5: CHOOSE AMONG POSSIBILITIES

In this step, all the evidence modeled in the previous point must be selected. It is still possible to switch between pieces of evidence and create a combined version. An important consideration is to consider a decision that is supported by the best evidence.

STEP 6: ACTION TIME

Knowing all the alternatives and evidence, it is time to implement the selected alternative.

STEP 7: REVIEWING of THE DECISION and CONSEQUENCES

It is now necessary to evaluate the result of the decision made, whether the implementation has achieved this goal. Whether the result is effective enough. If the effectiveness of the decision is not satisfactory, a more efficient process can be outlined with another survey, information gathering / expansion.

This process is very well known to nurses / health professionals. The steps are the same as for the nursing process:

- Assessment
- Definition of goals
- Planning
- Implementation of the planned interventions
- Evaluation / Reassessment (Figure 2).

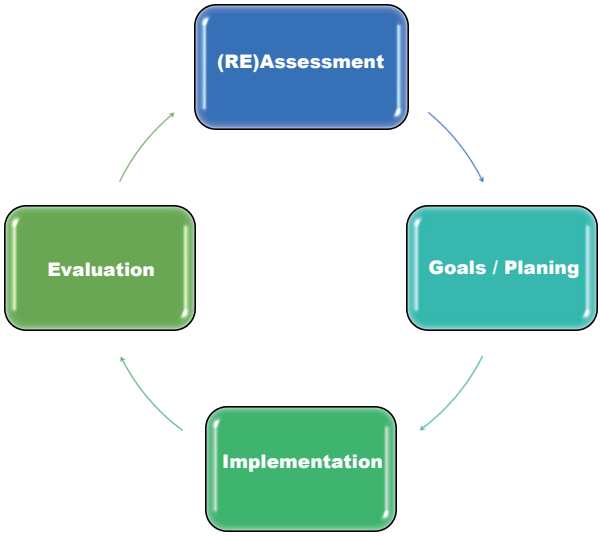

Figure 2. Nursing Process similarities steps of the decision making

The decision-making process for health professionals / nurses can start with the last point, which is the result. In the hope of the best result, the peculiarities ofthe given circumstance are taken into account: - material conditions - personal conditions - regulations, rules, protocols - of course, ethical standards, written and unwritten standards. The decisions made should meet the expectations: - patient and relatives - the health care system, the local organization - staff who are institutional management, line managers, and line colleagues. In order for a healthcare professional to feel comfortable making a deci sion, it is important that they are in harmony with both their personal and professional expectations. A nurse / professional who does not have to participate in the implementation of such a deci sion loses his / her motivation and internal motivation. Knowing the aspects listed, if the intervention is need later in the decision-making process, it is easy to decide the fact of the change. After alI, each aspect may have different influencing factors and limitations.

3. EXAMPLE CASES of CULTURAL CARE

As an example, the author of the chapter mentions three cultures in the chapter. One is the culture of one ethni c group, the others are the culture of a religious group. Mentioned by name, the Roma population, the culture of the Jehovah and Catholic religion.

THE CULTURE of THE ROMA POPULATION

The basic unit of Roma society is the extended extended family, which also includes the families of siblings. The male opinion is given the primary role, the women are given a subordinate role. This is the most common encounter in everyday practice in Hungary. When hospitalized, Roma find it difficult to bear separation from their families. This is due to the fact that even beyond the time of the visit, relatives surround the patient's bed in larger groups.

It is extremely important that health care personnel are able to handie the situations arising from the above habít wíthout conflict. Is it able to persuade a given community to follow the rules of a health care institution? If someone in the Roma community needs emergency care and a doctor needs to be call ed, 2-5 people will be sent to the c1inic. In such cases, kicking the rules often does not knock, but punches the door of the medical room in fright. For them, this is the way to ask for help. It is typical that more people speak at the same time and describe the patient's condition asexaggerated. In this case, the loudest speaker or the elder should speak in a moderate tone, so that they can calm down and summarize their problem. In this case, the oldest person should be called upon to expel everyone except the next of kin (Cserkész, 2006). If the patient can go to the doctor on their own, more people will accompany them. They are already noisier on the street, which is noticed by passers-by. They won't be quiet in the waiting room either. They communicate much louder than other patients. It happens that mothers with small children also take their child with them, who may be crying or making noise. The wait is hard to bear. In such cases, they should go out to the waiting room, reassure them, and draw their attention to waiting in accordance with the policy. When examining Roma women, it should be bome in mind that most of them are very shy and reluctant to undress. Healthcare workers, social workers, nurses, often encounter Roma in their work who cling to their ancient superstitions and beliefs (Prokesová, et al. 2016).

If we come across a habit that we consider harmful to our health, we need to convince them to leave it. We have to accept that the emotional outbursts of the Roma are stronger than average, so if there is a death in the family, many people will moan and sobb loudly at the same time, women will often tear their c1othes, men may cut their forearms, bellies and chests with a knife. We should not be frightened, outraged, upset, or even spoken out when we see them, because they can have fatal consequences. In such a case, you should behave calmly and calmly and mingle with those who react more quietly.

When a newbom is bom, the mother usually carries a pre-weighed strap of red thread, which she asks to be tied around the newbom's neck immediately after birth. However, this is very dangerous because the child makes coordinated movements with his hands, his fingers can get caught and strangle himself. We need to talk to mom that we might only be able to tie it to their wrist if they really stick to it. They consider this a good protection against eye beating. Roma women have been breastfeeding for a very long time. They fit them too, so they do everything they can to make it happen. It is believed that they will not become pregnant again during breastfeeding because contraceptive methods are not used.

JEHOVAH'S RELIGION

Jehovah's Witnesses started from a 19th-century movement started by Charles Taze Russell, although the influence of the founder can only be traced. They have been calling Jehovah's Witnesses since 1931, and there are now about 6 million people worldwide. Aceording to their doctrine, humanity has been alive in the last days, counting from 1914 onwards. Since then, they have been constantly trying to convince people to join them, aware of the shortness of time. Jehovah's Witnesses is a religious organization, an international organization of the American Jehovah's Witnesses, the Watchtower Bible and Tract Society, which has been registered in Hungary since 1989. Among them, infant baptism is forbidden, the reason for which is explained. Abortion cannot be used as a method ofbirth control, because aceording to the Bible, God considers life sacred from the moment of conception, so he is already a living being. It is wrong to hold or actively participate in public or religious holidays because it violates their politicai neutrality.

It is a sin for members to accept blood transfusions and certain blood products, but they may accept products containing different fractions of blood if their conscience allows. Any introduction of foreign blood into the body, either orally or intravenously (e.g., transfusion, blood exchange), clearly violates their view. Members accepting a blood transfusion are not excluded from their ranks, but the procedure is considered a crime.

Currently, thousands of doctors around the world use blood-saving techniques for complicated surgeries, so there is no need for transfusion. This is the case even in developing countries, and many patients in addition to J ehovah's Witnesses use these methods.

With an this, we want to get the best possible medical treatment. If they are sick, they will see doctors who have the expertise and experience in bloodless medicine and surgery. The achievements of medicine are highly valued. Bloodless methods developed for the benefit of Witness patients are now used for the benefit of an patients. In many countries, it is possible for any patient to choose to avoid the risks associated with transfusion, such as blood-bome diseases, the immune response, and the consequences of human error.

THE CHRISTIAN RELIGION

The cross is a symbol both of the Christian religion and of the history and tradition of Europe. Eating habits. They used to pray at the beginning and end of the meals, expressing that the food and the good on earth (also for the joy ofthe table community) are from God, to whom they give thanks. The blessing of the table is the responsibility of the head of the table, the host, the ordained person present, who, if he is a Catholic, is baptized, and another Christian is a simple prayer (for example, "Come, Jesus, bless us, and bless the foods.") This is where the meal begins, before that it is indecent to eat anything - (except for an aperitif, as it is not consumed at the table). At the end of the meal, the usual prayer is, "Whosoever hath given food and drink, let his name be blessed." There are no special regulations regarding food, but the discipline of the Catholic fast is worth watching over. Catholics do not eat meat on Ash Wednesday (40 days before Easter) and Lent Fridays (Friday before Easter). At receptions, this can be eas ily bridged by offering vegetables, fish and cheese products in addition to meat dishes, and non-meat snacks at cocktail parties.

"Because the Church has received a command from the Lord to heal the sick, she feels obligated to care for the sick and to pray for them. Above an, he has the sacrament for the benefit of the sick, founded by Christ himselfand witnessed by St. James. "(James 5: 14-15; ef. Mark 6: 13). The Catholic Church, therefore, in order to confinn those who had been afflicted by a serious illness, gave them a special sacramental rite of anointing the sick, which is one of the seven sacraments.

The ordinance, also known as the last anointing in the narrow sense, has been increasingly given only to the dying since the middle ages, but the new provisions point out that the period when a believer's life is beginning to be endangered by illness or old age is certainly suitable. The anointing of the sick shall be given only by priests, during which they shall anoint the patient's forehead and both hands with oil, possibly blessed by the bishop, accompanied by a sacramental prayer. The effect ofholiness is that through it the Holy Spirit increases sanctifying grace, gives spiritual healing, peace, and inner peace to endure suffering, and may even restore physical health if it is for the salvation of the soul. The anointing of the sick also removes the remnants of sin and temporary punishments. The ceremony may be preceded by confession and followed by Holy Communion. The Holy Communion or sacrifice is the partaking of the sacramental marks of the Christian Eucharist] and thus union with Christ (Latin communio). This is how the Catholic Church calls the reception of the body and blood of Christ in the Sacrament of the Altar. The sacrament of the altar is the bread (and sometimes wine) consecrated during the Christian (Douglas, 2012).

EUCHARIST

Confession (Latin confessio) is a confession, in the Christian sense, a confession of repentance and the intention of repentance. Sin is primarily the offense of God, the interruption of fellowship with him. In confession, fellowship with God is restored.

Baptism is basically a religious rite that has spread mainly in Europe. Catholics, Reformed, Lutherans and Baptists are also baptized. It is a so-called initiation sacrament, which means incorporating the recipient ofbaptism into the community ofbelievers.

By baptism, aceording to the teaching of religion, the person become a child of God, a member ofthe church, the temple of the Holy Spirit.

Review Questions

1. Try to describe, explain the definition of ethics and culture!
2. Coulkd you explain why is the first and important step is in the decision making proess to define the nature ofthe deci sion?
3. Could you mention some examples from the key competence categorize? Could you mention some similarity and difference among competence / skill / knowledge?
4. Why is important the lCN Code of Nursing Ethics for the nurses / health care professionals?
5. We as a health care professionals know well the Maslow's pyramid of needs. Where is the status / place is of the belive / fath in the pyramid? What do you think is this need important for the patients?

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CHAPTER V

CULTURE, HEALTH and ILLNESS

A) CULTURALLY BASED HEALTH and ILLNESS BELIEFS and PRACTICES ACROSS THE LIFESPAN

Valerie Tóthová

Key Points

1. Cultural background has a significant impact on many aspects of people's lives. Its impact on health and health care is very significant.
2. Cultures also differ in that they have their concepts of physical health and diseases, which gradually arose during the historical development of the culture.
3. Using the right tool to evaluate patients during illness leads to a better understanding of the cultural and religious concepts influencing patient behavior and response to disease.
4. Patients play active and essential roles in managing and treating their diseases; cultural customs and habits can strongly influence these roles.

IMPACT of CULTURE on HEALTH PERCEPTION and HEALTH CARE

All societies are characterized by typical social and cultural features that persist over time even as one generation leaves and another is born, with the traits surviving for several generations. A child who is born into a particular cultural environment adopts certain habits and patterns of behavior. This cultural learning and adaptation process is more intense in the early stages of development, but it lasts throughout our lives. At the beginning of the third millennium, the term culture dominates social science debates and has become one of the most frequently used words in human society. Culture has become a fashionable discourse of contemporary society (Horáková, 2012).

Thus, the cultural background has a significant influence on many aspects of people's lives, including their faith, behavior, perception, emotions, language, religion, rituals, family structure, diet, clothing, body image, conception of the universe, and conception of time, and attitudes toward disease, pain and other forms of misfortune. All of which can have significant consequences for health and health care. The American anthropologist Richard Handler aptly described the relationship between man and culture when he states that culture cannot exist without the people who create and use it, nor can people exist without culture (Handler, 2004). Culture significantly influences people's thinking and behavior, and therefore cannot be ignored even in the provision of health services and nursing care (Kutnohorská 2013). In order to provide culturally competent care, nurses must know the cultural customs and habits of individual minority groups they most often encounter when providing care. However, it must be remembered that certain practices and opinions cannot be understood separately from the whole culture. When studying culture, we

must orient ourselves relative to its values. It is necessary to recognize that cultural differences can affect lifestyle, eating, stress, a person's attitude toward treatment, proper self-care and preventive treatment, and the perception of symptoms and emotional states. Cultural differences can also influence an individual's views regarding appropriate behavior by healthcare providers and patients. Cultural differences can affect disease outcomes and the compliance of patients and their families (Shaw, 2008).

In traditional cultures, the family was the primary institution dealing with disease and hardship. There have always been people who specialized in healing, using physical and magical remedies. Many of these traditional treatment systems still survive in non-Western cultures around the world. Many of them fall into the category of alternative medicine (Giddens, 2013).

Health status in industrialized countries is closely linked to ethnicity. Anthony Giddens points out that we only partially understand the relationship between ethnicity and health even ongoing research has not provided conclusive evidence since other factors often overshadow tendencies stemming from an individual's ethnicity. Giddens (2013) states that there are also differences in the incidence of certain diseases, such as mortality from liver cancer, tuberculosis, and diabetes, which are higher in those of Afro-Caribbean or Asian descent than in whites. People with Afro-Caribbean roots suffer from above-average blood pressure and sickle cell anemia (a hereditary disorder affecting red blood cells). People from the Indian subcontinent more often die from heart disease. Some research teams are looking to explain ethnic health patterns within a cultural context or in relation to cultural behaviors. Their explanation emphasizes the role of individual and group life in the deterioration of health. Health is often associated with religious beliefs and culture, e.g., eating habits and food preparation or blood kinships (the practice of marriages between "second-degree" relatives) (Giddens, 2013).

Over time, countless explanatory models have been developed to define health and disease. Each of them is valid, each of them is time-tested, and each of them is relevant as we move forward into the new century and millennium.

CULTURALLY DEFINED CONCEPTS of HEALTH and DISEASE

Health represents a shared value for almost every person in the world. However, there are differences in his concept (Tóthová, 2010). Differences in health perception arise from various factors such as developmental status, social and cultural influences, past experiences, expectations of oneself, perception of one's own identity, and social status (Seedhouse, 2006; Křivohlavý, 2009). Cultures also have different concepts of physical health and disease and therefore differ in what they consider healthy and normal.

Frequently asked health questions include: How can we define health? How can we determine when someone is healthy?

Trying to define the concept of health is as old as medical science itself. We intuitively understand the concept of health, but it is very difficult to define it precisely. We often define health as the normal state of man (but the concept of normality is also ambiguous). Sometimes we define health as the absence of disease. However, even this is not right; health is more than just the absence of disease (Křivohlavý, 2009).

A functional definition of health should have the following starting points:

a) Health and disease are a manifestation of life, a process that has its own development

b) It takes place within an integrated system of man and environment; the environment is understood in all its complexity, with all relationships and connections (Líšková, 2013).

The World Declaration of Health, adopted by the World Health Organization (WHO) at the 51st World Assembly in May 1998, is a document with which we are all familiar. The WHO defines health as: a state of complete physical, mental and social well-being, and not just the absence of disease or dysfunction (Uskul, 2009). The WHO considers the right to health to be one of the most fundamental rights of man, regardless of race, religion, political beliefs, economic, or social status. According to the WHO Institute, state governments are responsible for the health of their populations, with health only being achieved by ensuring adequate health and social measures (Ivanová, Špirudová, Kutnohorská, 2005).

This document builds on the essential vision of health programs with the goal of achieving full health potential for all in the 21st century (Zdraví 21, 2001). Health promotion is a process that helps individuals and communities positively influence health factors and thus improve their health (Farkašová, 2006). It includes improvements in lifestyle and other social, economic, and personal factors that affect health. This includes increasing awareness of important health issues and providing necessary information for addressing some of these health issues, as well as promoting proper nutrition and life management.

In society, health promotion takes place at the level of society, community, and individual. An important method of promoting health is health education, which is a fundamental duty of every healthcare professional. The main goal of health education is to influence health habits, promote healthy lifestyles, and influence behaviors that will lead to health maintenance (Svěráková, 2012). According to the World Health Organization, health education is a medical field that aims to create knowledge and maintain activities that promote and preserve the health of individuals and populations. Health promotion is intricately linked to disease prevention. They are divided into primary, secondary, and tertiary.

Each culture has its concept of health and disease, i.e., risky behaviors, what constitutes a disease, when to seek health care, etc. There are currently several manuals that educate health professionals regarding health and disease as they relate to various ethnicities. Literature describing specific medical needs, common ways of responding to illness, and medical procedures help health professionals gain a deeper understanding of minority healthcare-related issues. However, it does not consider individual and family differences as they relate to patients/clients.

There are several programs for maintaining and strengthening the health of certain minorities. However, many leading experts are somewhat skeptical about the value or benefits of such activities since the programs only support part of the population, namely those who are interested in maintaining and strengthening their health. These programs do not benefit unskilled citizens, those with less education, refugees, and immigrants. For this reason, it is necessary not only to evaluate health needs for secondary and tertiary care purposes but, above all, to focus on health needs for primary care purposes (Mares et al., 2005).

Nurses play an indispensable role in the overall health care of ethnic groups, i.e., at the primary, secondary, and tertiary levels of prevention. The basis of the care provided is a complete patient history taken by the nurse. At this stage, the nurse can discern various cultural and religious factors that could affect the individual's healthcare. One way to unify patient history information

from individuals of different ethnicities is to use specific nursing history-taking models (Tóthová, 2010).

Research shows that culture cannot be ignored by science-oriented clinics, disease specialists, and policymakers, demonstrating the need to understand the effect of culture, however, defined in caring for each other in the 21st century. Understanding culture and its importance is essential for improving health, which is why disciplines that once focused only on the study of other societies are now at the heart of our future health and well-being. Today, the anthropological and medical humanities approach to health and well-being is necessary to reshape our understanding of how we embrace health and what makes us healthy (Napier, 2014).

Affecting factors of health. It has already been mentioned above how culture affects health-related beliefs and behaviors. However, it is necessary to remember that many other factors can also affect health. Helman (2013) lists the following in his publication:

- Individual factors (such as age, gender, size, appearance, personality, intelligence, experience, physical state, and emotional state)
- Educational factors (formal and non-formal education, religious education, ethnic or professional subcultures)
- Socioeconomic factors (such as poverty, social class, economic status, occupation or unemployment, discrimination or racism, as well as social support networks from other people)
- Environmental factors (such as weather, population density, or habitat pollution, including types of available infrastructure such as housing, roads, bridges, public transport, and health facilities).

It is essential to point out that economic factors and social inequality can also affect health. For example, poverty, poor nutrition, inadequate clothing, low levels of education, poor housing, inappropriate employment in areas with greater environmental hazards can all impact health. Individuals living in unsuitable conditions are more likely to be exposed to physical and psychological violence, psychological stress, and drug and alcohol abuse. Often individuals from different minority groups find themselves in these conditions. Results from several studies conducted in the US have shown that members of minority groups suffer disproportionately from diseases such as heart disease, diabetes, asthma, cancer, and other diseases (Helman 2013).

Disease: There are many questions that need to be answered relative to the term disease: What determines a disease? How does a person know they are sick? What factors lead to seeking help from the health care system? At what point are self-remedies judged to be a failure? Where can you find help? And from whom?

We tend to regard disease as a lack of health, yet previously we showed that health is at best a term that defines a specific definition (Spector, 2004).

A more recent definition of the disease is “a highly personal condition in which a person feels unhealthy or sick, which may or may not be related to a disease.” As with the word health, the word disease can be subjected to extensive analysis. What is a disease? A generalized reaction, such as the unusual functioning of a body system or systems, will develop into a more specific assessment of what we observe and consider dysfunctional. The disease is a sore throat, headache, or fever - which is not necessarily determined by measurement on a thermometer,

but by a flushed face, a warm feeling on the forehead, back, and abdomen, and general nausea (Spector, 2004).

THE ROLE of THE SICK

In our society, a person is expected to have symptoms of a disease that a member of the medical profession can confirm. In other words, the sick must first legitimately be granted this privilege to that person.

Spector (2004) cites the role of the patient from Talcott Parsons (1966).

1. A sick person shall be exempt from certain of their normal social obligations.
2. A sick person shall also be exempted from certain types of responsibility for their condition.
3. However, the legitimation of the sick role is only partial.
4. To be sick, except in the mildest cases, requires help.

The disease experience depends on what the disease means to the sick. The disease also refers to a specific condition and role in each society. The disease must be approved by a doctor before the sick person can take on the role of a sick person; additionally, it must also be sanctioned by the structure of the community or society of which the person is a member. Alksen (N.D.) divides this experience into four phases that are general enough to apply to any society or culture.

Beginning. Onset is the time when a person feels the first symptoms of the problem. This event can be slow and insidious or quick and acute.

Diagnosis. In the diagnostic phase of the disease, the disease is identified, or efforts are made to identify it. The role of the person is now approved, and the disease is socially recognized and identified

Patient status. During this period, the person adapts to the social aspects of the disease and accepts the limitations associated with the disease.

Recovery. The final stage is generally characterized by relinquishing the patient role and returning to normal roles and activities.

A tool designed to evaluate the patient during the four stages of a disease is provided in the table. If the provider can answer all the questions raised, it will be easier to understand cultural variations in the patient's behavior and perspective.

Table 1. A Tool for the Assessment of a Patient During the Four Stages of Illness

Onset	Diagnosis	Patient status	Recovery
A. The Meaning of the Illness			
1. What are the patient's chief complaints? 2. How do they judge the extent and kind of the disease? 3. How does this illness fit with their image of health? Himself, yourself? 4. How does the disease threaten them? 5. Why did they seek medical help?	1. Do they understand their diagnosis? 2. How do they interpret the illness? 3. How can they adapt to the illness? 4. How do they think others feel about their illness?	1. Has their perception of their illness changed? 2. What are the changes in his or her life as a consequence? 3. What is their goal in recovery, i.e., the same level of health as before the illness, attainment of a maximal level of wellness, or perfect health? 4. How do they relate to medical professionals? 5. What are the social pressures leading to recovery? 6. What is motivating them to recover?	1.What are the signs of recovery? 2. Can they resume their pre-patient role and functions?Has their self-image been changed? 3. How do they see their present state of health, i.e., more vulnerable or resistant?
B. Behavior in Response to Illness			
1. How do they control anxiety? 2. How are responses to concerns expressed? 3. Did they seek some form of health care before they sought medical care?	1. What treatment agents were used?	1. How do they handle the patient role? 2. How do they relate to medical personnel?	1. Are there any permanent aftereffects from this illness? 2. How do they resume old roles?

Source: Alksen, L., Wellin, E., Suchman, E., et al. A Conceptual Framework for the Analysis of Cultural Variations on the Behavior of the III. Unpublished report. New York City Department of Health. Reprinted with permission. (from the book: Spector,2004 p. 65)

The trajectory of a disease

Another way to describe a disease is to follow its trajectory as experienced by the individual. Attention is now beginning to shift to the active role that the patient plays in shaping and defining the course of a disease. For example, a person with a disease may have the following trajectory: acute illness, return or recovery, stable condition, unstable deterioration of the condition, and death. In this environment, acute stages of return and rehabilitation occur. The management of the chronic phase, except for acute episodes, is carried out at home or in an institution that is either a rehabilitation facility or a long-term care facility (Spector, 2004). Surbone et al. (2007) drew attention to the importance of understanding, perceiving, and experiencing the trajectory of diseases since they are essential for planning and providing effective care. These steps are important for both the sick person and their family since the disease can profoundly affect their lives financially, emotionally, and spiritually. Thus, disease treatments allow patients, family

members, healthcare providers, and health planners to prepare for the next steps and make better informed critical care decisions (Adil, Larriviere, 2017). Knowing how older people understand, perceive, and experience the trajectory of their illnesses is essential for planning and providing effective care, e.g., cancer care and decision making.

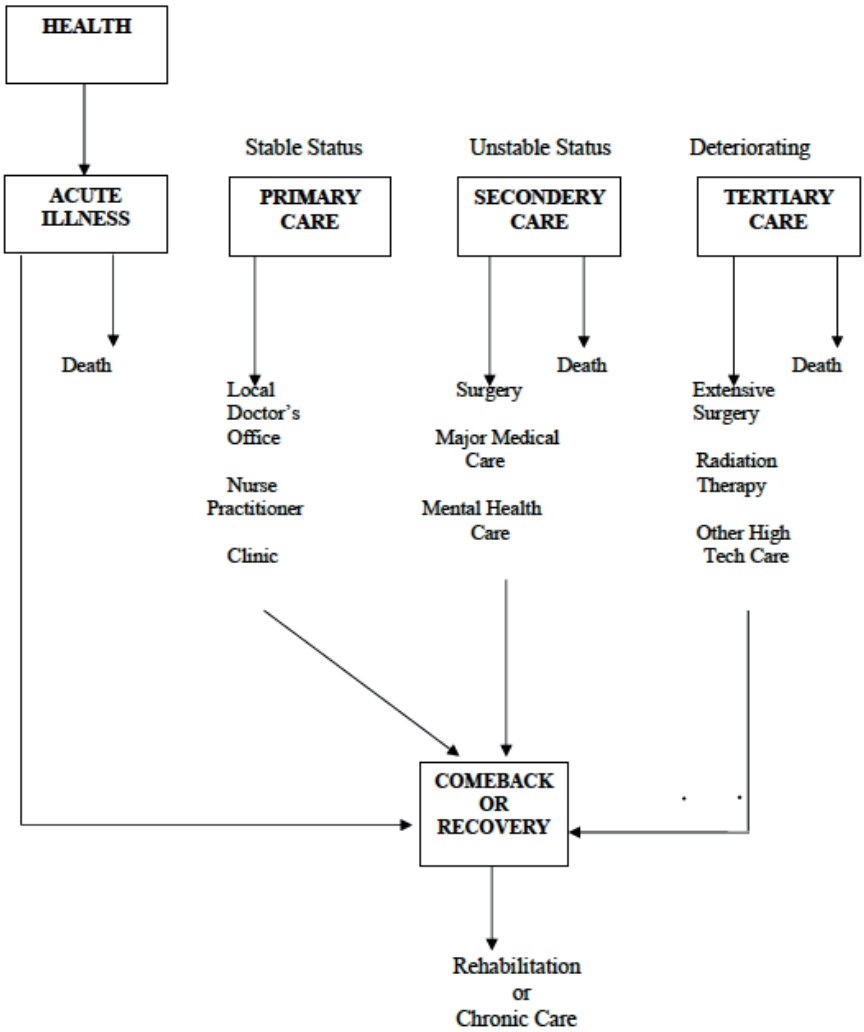

Figure 1. The trajectory of a disease (*Spector, (2004). Cultural Diversity in Health and Illness.* New Jersey: Pearson Education, Inc. p. 67)

CULTURAL INFLUENCES AFFECTING THE BEHAVIOR of CHILDREN

Andrews, Boyle (2003) elaborated on the impact of cultural customs and habits on children's upbringing and behavior. Children's health, as well as the health of adults, who come from different cultural backgrounds, is affected by many factors, including access to health services. These obstacles include poverty, geography, the lack of culturally competent healthcare providers,

racism, and others. Families from different cultures may have difficulty interacting with nurses and other healthcare providers, and these problems can negatively impact healthcare provision. Because ethnic minorities are underrepresented among healthcare professionals, parents and their children often have different cultural backgrounds than their healthcare providers. The parents and other caretakers with whom we work may have a different vision of what is important for their children's well-being and may rely on different methods to assist their child in reaching these goals (Maschinot, 2008).

The socialization of children from different cultural backgrounds is also influenced by parents' experiences of prejudice and discrimination, educational opportunities, and other events involving their racial and ethnic heritage. Socialization prepares children for life in a society where they find that the color of their skin, the origin of parents in a different cultural environment determines how others treat them (Andrews, Boyle, 2003).

Andrews, Boyle (2003) further states that in all cultures childbirth means that the human race will continue for generations to come. From the moment of birth, there is a differentiation between the sexes. Early differentiation of sex roles is manifested in terms of sexually specific tasks, play, and dressing. In childhood and adolescence, girls and boys go through a process of socialization, which aims to prepare them for their roles as adults in the society into which they were born or migrated. As children grow and develop, their interaction with other siblings, the wider family, teachers, peers, etc., increases. Children learn communication, language, and other skills needed to interact with people in a cultural context. The Cultural beliefs and practices related to learning have a strong impact on children's social interactions (Wade, Kidd, 2018). All parents want their children to be treated with respect and want them to show respect for other individuals in society and learn to express these verbally and nonverbally. When children behave in a culturally appropriate way, parents are proud, and it brings honor to their family and cultural heritage (Sagar, 2014, Tóthová et al., 2012).

When caring for children from different cultural backgrounds, it is essential to monitor clinically significant behavior in the families. We are primarily interested in clinically significant information, such as nutrition, sleep, elimination, parent-child relationships, discipline, and related concepts. In addition to knowing these cultural practices, it is necessary to monitor parent-child interactions and discuss child-rearing with parents.

Feeding

In many cultures, breastfeeding is traditionally practiced for different lengths of time after the birth of a child: 1 year, 2 years, until the birth of another child, etc. With the increasing availability and practicality of packaged nutrition, in addition to the manufacturers of these products having effective marketing campaigns in recent decades, there has been a reduction in the number of breastfeeding women.

In some cultures, mothers will chew a bite of food for infants and young children in the belief that it will facilitate digestion. From a nutritional point of view, this practice removes some of the vitamins and minerals from food before it reaches the baby and increases its acidity. Mothers should be warned to avoid this practice if they have an upper respiratory tract infection, sore throat, or other infection that could be transmitted to the baby. Health status is partially dependent on nutritional intake, which links the nutritional status and health of the mother and child. Early and frequent exposure to a variety of foods is likely to encourage healthy eating habits throughout life (Smith, M, et al., 2004).

The extent to which families retain their cultural eating habits varies greatly. Since the recovery of a hospitalized child can be strengthened by known foods, there is a need to assess the effect of culture on the child's eating habits. For hospitalized children, foods need to be familiar and similar to what is eaten in the home. Family members can be encouraged to visit during meals if appropriate (Sagar, 2014, Andrews, Boyle, 2003, Tóthová, etc., 2012).

Sleep

Although the amount of sleep needed in different age categories in different cultures is similar, there are differences in sleep regimes and bedtime rituals. The practice of sleeping in a family home reflects some of the most profound moral ideals of the cultural community. Nurses working with families of young children in both community and inpatient environments often encounter cultural differences in sleep behaviors.

Some parents sleep with their children for part of the night, some, when the child is upset, stay in bed with them longer, and some even sleep the entire night with their children. During hospitalization, suspension of this habit can disrupt the child's sleep. It is necessary to identify other bedtime routines during hospitalization, e.g., does the child have a favorite toy they sleep with or a favorite fairy tale, or are there religious rituals or prayers associated with bedtime. This information is important so that nurses can ensure that children sleep well even during hospitalization (Andrews, Boyle, 2003).

Health and health promotion

The concept of health varies greatly in different cultures. Regardless of culture, most parents want good health for their children and engage in activities they believe will promote good health. Because health-related beliefs and practices are an integral part of a culture, parents often retain culturally based beliefs and practices, even when scientific evidence refutes them or try to modify them to match the current knowledge of health and disease.

Illness

The family is the primary care provider for infants, children, and adolescents. It is the family that determines when the child is sick and decides when to seek help in managing the disease. Health, disease, and treatment (treatment/healing) are in part defined by a child's cultural heritage. Every society has an organized response to specific health problems, with certain people being responsible for deciding who is sick, what kind of disease this person has, and what kind of treatment is necessary to restore health.

Overview of cultural influences on adulthood

Until recently, little interest, attention, or research was focused on developmental processes and health problems in adulthood. However, the middle years are a time of physical and psychosocial change. On the one hand, psychological changes are evident in response to hormonal changes that occur in middle-aged men and women, while psychosocial changes can be much more subtle. Both physiological and psychosocial changes are influenced by cultural values and norms (Andrews, Boyle, 2003).

Cultural influences affecting adulthood

Each culture has very specific chronological standards for what is and is not appropriate behavior, and that these cultural standards prescribe the ideal age for leaving the protection of parents and

family, choosing a profession, getting married, having children, etc. It has been shown that these events in and of themselves do not necessarily cause crises or change. More important is the timing of these events, which is important and potentially unique for every culture. Depending on how each culture measures social time, individuals tend to mark their achievements and adapt their behaviors according to the social clock of their culture.

Awareness of this "social schedule" is often reinforced by the judgments and insistence of friends and family who say, "It's time for you to …" or "You're getting older …" or "… act your age." Problems often arise when social timetables change for unanticipated reasons. An example is the recent trend of adult children, often divorced or unemployed, or both, returning to live with their parents, often with children of their own (Andrews, Boyle, 2003). In East Asian cultures, there is a strong emphasis on adjustment to age-graded roles and tasks, which might protect Asian older adults against the difficulties faced by their European American counterparts (Kitayama, Berg, Chopik, 2020).

Culture has a significant impact on human development because it provides a means for recognizing the stages on the continuum of individual development during life. Culture defines social age and what is considered appropriate behavior for each stage of development during life. In almost all societies, expectations regarding the role of adults are often conveyed at a young age. Several cultures have defined "rights of passage" that mark the boundary between childhood and adulthood.

The developmental outcome is affected to a certain degree by the given context depending on its meaning for the person and the person`s active modification of the context during his or her own development. Thus, possible universalities of human development which are based on biological processes may function in different ways according to the given cultural context and the related proximate contexts (e.g., the family) according to its respective cultural and subjective meaning (Albert, Trommsdorff, 2014).

Social and civic responsibility is partly culturally defined. For example, in some groups, religious obligations may take precedence over civic obligations. Many religious groups have historically not supported women in leadership roles within religious institutions or in wider society. Some religious, ethnic, and cultural groups believe that women's place is at home, and women who want to have careers or engage in activities outside the home are condemned by other members of the group.

Moreover, the emphasis on an emotionally close interpersonal relationship between husband and wife can be a culturally defined value. Studies suggest that in some groups, women develop more intense relationships or affective relationships with their children or relatives than with their spouses (Sagar, 2014; Andrews, Boyle, 2003; Tothova, et al., 2012).

Cultural beliefs and values influence health promotion, disease prevention, and disease treatment. When a disease has a social and/or cultural connotation, problems become more complex. Medical care and nursing care must consider the values, beliefs, and practices of a culture when it affects the ability of the client and family to cope with disease and assess whether the interventions prescribed are culturally feasible.

Review Questions

1. Describe what health means to you and describe, based on your experience, how you perceive disease and what changes in your daily life disease has caused.
2. Consider which questions you would ask to identify the patient`s attitudes and opinions of health/illness, and the approach to the therapeutic process.
3. Try to identify concepts, elements of experiencing, attitudes, beliefs that can be decisive for the development of the nursing care plan and planning of interventions (including the education). Mind the question of the socio-economic status and health literacy. Pay also attention to individual participants in the process, not only to the patient. Pay attention to the role of communication, possible misunderstandings when getting information, the problems of not understanding any expressions or idioms.
4. Try to identify the elements of cultural health beliefs about health/illness, which can influence the patient`s self-management.
5. Describe which cultural/societal habits most affect our behavior in childhood and adulthood.

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B) CULTURALLY BASED HEALING and CARE MODALITIES

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Key Points

1. Cultural beliefs may affect health, self-care practices, type of health care sought, and degree of concordance.
2. Health consists of physical, mental, spiritual, and social components. Spiritual health is a high level of faith, hope, and commitment.
3. Traditional healing practices are holistic and necessary to offer adequate and effective mental and spiritual healing.
4. Complementary and alternative medicine is the term for medical products and practices that are not part of standard medical care.
5. Traditional healing refers to health practices, approaches, knowledge, and beliefs incorporating traditional healing and wellness while using ceremonies, plant, animal, or mineral-based medicines; energetic therapies; or physical/hands-on techniques.

INTRODUCTION

Traditional cultures recognize that divine power or presence has a healing effect. Therefore, it uses holistic practices to heal any body, mind, or spirit deterioration. In most traditional healing systems, the illnesses arise when a problem arises in the body, mind, or spirit. The illnesses can result from the physical, psychological, or spiritual areas, and illness symptoms may occur in one or all of these areas (Lichtenstein et al., 2017). What meaning is attributed to the disease in any culture or the words and phrases used while expressing the disease affect the disease behaviors or experiences of the people in that culture, and the social reactions of the sufferer. Culture affects the perspective of individuals or communities towards diseases and disorders and affects their thoughts and behaviors about mental health and treatment techniques (Adekson, 2017).

Traditional healing practice is a holistic approach, and its purpose is to improve individuals' and communities' health. It assumes that body, personality, and community interact in a balance. The holistic approach encompasses the values, wishes, desires, faiths, interpersonal relationships, and moral dimensions of individuals or communities (Haque et al., 2018). With the increasing effects of globalization and cultural diversity, health care providers are faced with different healing and cultural practices of care recipients and their other thought and behavior patterns (Lichtenstein et al., 2017). Today, migration, communication over a distance by cable, telegraph, telephone, or broadcasting, and mass media raise the concerns of health care providers because they want to provide culturally competent care in this environment where cultural diversity is increasing (Kirmayer, 2013). Cultural healing practices also reveal cultural connections. Cultural connections and communication cause a dynamic process between patients and healthcare providers. The process increases their self-awareness, helps them discover their thoughts and perceptions about life, and gains insight into their coping and problem-solving skills (Adekson, 2017).

CULTURAL BELIEFS

Culture and health are interconnected. The methods of individuals or communities to cope with stress and intervene in diseases, their approaches to conditions, and their practices of maintaining health are affected by their cultural backgrounds and identities (Sobralske, 2006). Beliefs are influenced by the content of the culture to which the individual belongs and are shaped according to his cultural background. Cultural beliefs are learned and transmitted through interaction within the family and society. Cultural beliefs are thoughts, attitudes, and activities shared in the family or social life and transmitted from generation to generation (Shahin et al., 2019).

Cultural beliefs affect their health and disease practices, daily life activities, professional help-seeking behaviors, and participant on health services. Also, beliefs about health, diseases, remedy, and therapy are primary indicators of adjustment to individuals with chronic illness medication (Al-Noumani et al., 2019). Therefore, nurses need to understand people's cultural care faiths, values, and lifestyles to provide culturally competent nursing care (Busher-Betancourt, 2015).

HEALTH BELIEFS

Health is culturally described and evaluated. People can apply daily life activities by the characteristics of their culture. Health beliefs affect health behaviors and behaviors of protecting health. For example, health beliefs of patients with hypertension are self-efficacy, internal locus of control, perceived good general health, perceived good relationship with health care providers, perceived good relationship with spouses, perceived reasonable control over disease, perceived strong family support, and low perceived stress (Al-Noumani et al., 2019). In another study, Saudi people believe in the efficiency of Meswak, flossing efficiency, the importance of regular dental checkups, that carbohydrates could cause caries, gum bleeding is normal, your teeth affect your appearance, and oral health affects general health (Hamasha et al., 2018).

ILLNESS BELIEFS

Illness is also culturally described and includes physical and mental signs, perceived physical, psychological, intellectual, and spiritual complaints. Perception of illness is personal beliefs and contains evaluating the meaning of the illness or physical symptoms, reacting to these symptoms or finding a solution, and assessing the positive or negative effect of the solution (Shahin et al., 2019). Illness beliefs consist of individuals' information about psychological disorders, their thoughts about a relative living with that illness, the forms of communication with these people, and common attitudes toward mental illnesses in the culture (Choudhry et al., 2016).

For example, according to Islamic belief in Muslim societies, mental illnesses result from acting contrary to religious practices or approaching God and spiritual teachings with suspicion (Farooqi, 2006). Choudhry et al. (2016) obtained some themes from the disease definitions of the participants in their systematic review study. To make these themes more understandable, we have drawn the concept map. Figure 1 illustrates beliefs about mental health problems.

HEALTH BELIEF MODEL

The Health Belief Model (HBM) is a theory developed by social psychologists to describe people's health behaviors and the factors that influence them. The model tries to identify what people do or why they do nothing to prevent illnesses (Ban & Kim, 2020). It identifies cultural practices that will positively change individuals' behaviors and identify their cultural beliefs, feelings, and values that influence health and illness practices (McElfish et al., 2016). The central concept of the model is the prediction of determinants of preventive health behaviors. The model explains screening behaviors and patient behavior, patient role behaviors, and factors that facilitate the realization of health behaviors.

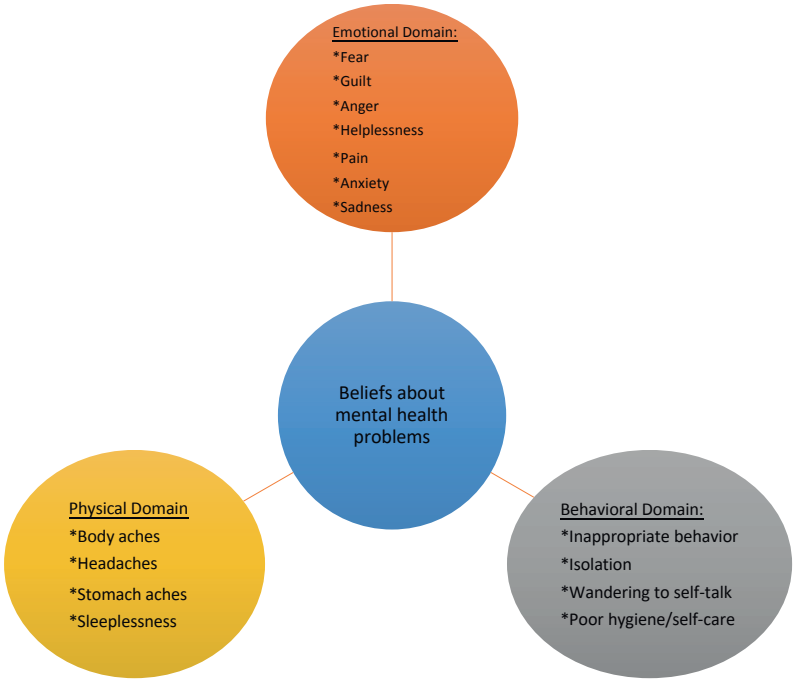

Figure 1. Beliefs about mental health problems

Key components of the Health Belief Model are perceived susceptibility, perceived severity, perceived threat, perceived benefits, perceived barriers, cues to action, and self-efficacy (Skinner et al., 2015). Also, it has three parts: 1) individual perception, 2) modifying factors, and 3) likelihood of action. Individual perceptions are associated with the modifying factor known as a perceived threat. The modifying variables are culture, education level, experience, skills, and motivation (Anuar et al., 2020).

1. *Perceived susceptibility is thoughts about how a person perceives the possibility of developing an illness (Skinner et al., 2015). It refers to the person's awareness of the possibility of facing an illness that will harmfully affect their health (Athbi & Hassan, 2019).*

2. *Perceived is the thought about the likelihood of having a disease or the consequences of not being treated, including the physical, mental, and social effects of the disease (Skinner et*

al., 2015). It shows how the person perceives the severity of a disease and its consequences (Salah-Mustafa et al., 2017).

3. *Perceived benefits of an action are beliefs about positive features and benefits of a suggested effort to decrease the risk (Skinner et al., 2015). It is also associated with eliminating the possibility of getting the disease or acquiring new behaviors that will improve health (Salah-Mustafa et al., 2017).*
4. *Perceived barriers are possible obstacles or adverse consequences to taking action (Skinner et al., 2015). It refers to a person's assessment of the challenges to behavior change (Salah-Mustafa et al., 2017).*
5. *Cues to action are any factor that can effectively teach a healthy behavior (Skinner et al., 2015). It is necessary for prompting engagement in health-promoting behaviors (Salah-Mustafa et al., 2017).*
6. *Self-efficacy is an individual's thought that they can do a health practice that needs to be practiced (Skinner et al., 2015). It is that a person can complete and practice behavior (Salah-Mustafa et al., 2017).*

The HBM improves health-related behavior as an independent risk factor (Anuar et al., 2020). The HBM is used to predict a person's attitude to health or illness. It covers the applications made to heal from the disease or get rid of the problem (Ban & Kim, 2020). The HBM underlines cognitive factors. According to cognitive factors, an individual's attitude is associated with reasonable assumptions. It highlights the internal psychological structure of decisions (Kim & Kim, 2020).

SPIRITUALITY and RELIGIOSITY

Spirituality and religiosity have different meanings, but they are closely related. Spirituality is a belief in divine power and is internal independence. Religiosity defines participation in activities and practices determined by divine power or religion and being in control of external factors (Shahin et al., 2019). Spirituality is described by expressions, including meaning, connectedness, and transcendence. However, religion is defined by social words, such as standard practices and faiths, participation in religious activities, and being together for a particular purpose (Rumun, 2014)

Health consists of physical, mental, spiritual, and social components. Spiritual health requires belief, expectation, and connection. It discloses individuals' capacities, facilitates finding and applying the meaning and purpose of life, and supplies inner peace and motivation (Vaineta, 2016). Spiritual health has three domains; 1) Self-evolution, 2) Self-actualization, and 3) Transcendence (Dhar et al., 2011). Fisher (2011) explained four domains of spiritual health and well-being; 1) Personal domain (meaning, purpose, and values), 2) Communal domain (morality, culture, and religion), 3) Environmental domain (care, nurture, and stewardship), and 4) Transcendental domain (relation with transcendent Other) (Figure 2).

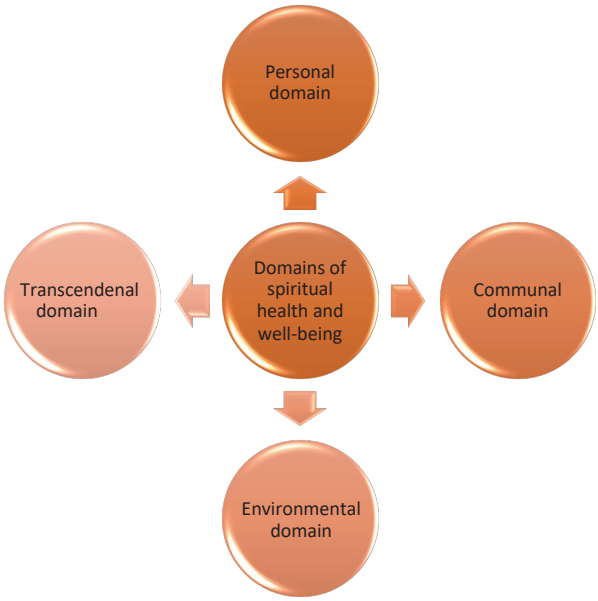

Figure 2. Domains of spiritual health and well-being (Fisher, 2011)

Spirituality refers to the meaning of life and one's goals. It is a concept that focuses on one's connection with oneself, other beings, and divine power (Shahin et al., 2019). Religiosity is based on experiences, ideas, beliefs, cultural backgrounds, and spirituality, relating to mental, social, and dogmatic rituals. Religiosity encompasses an individual's religious practices, beliefs, teachings, and frequency of participation in spiritual practices (Holdcroft, 2006).

Spiritual and religious faiths or routines can influence deciding on a topic or event, coping strategies, social relationships and connections, adjustment to a medication or other practices, use of complementary and alternative medicine, and being comfortable, healthy, or happy (Rumun, 2014). Spiritual rituals and beliefs help a person be self-confident, more assertive, and have fewer spiritual problems. These results cause the person to feel more competent and less physically and spiritually incapable, contributing to the preservation and maintenance of health (Dhar et al., 2011).

HEALING

The healing consists of all religious beliefs and practices. It aims to repair health, provide integrity, and reduce pain and hurt. It is associated with religion. It contains the physical, psychological, social, and spiritual aspects of human life (Dein, 2020). Traditional healing practices are holistic and necessary to offer adequate and effective mental and spiritual healing (Orcherton et al., 2021). Holistic medicine does not focus on a specific health problem or a specific aspect of health. It is a healing method that treats the person holistically. Holistic health care providers aim to prevent deterioration of health by focusing on the interaction between body, mind, and mental health.

Traditional healing and wellness are an essential part of communities' health that organizations often overlook. Applying to traditional healing practices is necessary to increase the well-being of communities by incorporating conventional healing practices, finding a cure for diseases, and supporting health and well-being. An essential aspect of traditional healing and wellness is to provide stability and way between the physical, mental, emotional, and spiritual health dimensions (First Nations Health Authority, 2021).

Cultural/traditional healing practices are based on speech, religious ceremony, and traditional symbols. Therefore, it consists of psychological, physical, social, cultural, and spiritual dimensions. It aims to help individuals get rid of their patient identity, go back to their daily routines, and increase their sense of well-being (Ariff & Beng, 2006). Cultural healing includes developing healthy relationships, obtaining help from others, supporting others, and participating in ceremonies and traditions. It also consists of understanding traditions, staying physically active, revitalizing good values, expressing emotions and feelings, being connected through religion, and being spiritually connected (Orcherton et al., 2021).

RELIGIOUS HEALING

There are different types of religious healing. It consists of supernatural attempts to influence, using metaphysical energies to improve interpersonal and social relationships. These initiatives include praying, practicing spiritual practices, and reading a religious text (Dein, 2020). Religious healing practices can help patients cope with chronic diseases, provide comfort, and increase knowledge about their disease. It also encourages treatment adherence, enhances self-care motivation, prevents serious illness, decreases anxiety, and improves physical and psychological health (Heidari et al., 2017). These practices can also increase self-value, improve anger management and coping strategies, heal physical and psychological illnesses, and create new meaning in life (Austad et al., 2020).

FAITH/SPIRITUAL HEALING

Faith is finding and seeking a reason for which something is done or created or a sense in life. Faith healing is trying to heal health problems with faith and faith-related practices instead of medical methods (Gopichandran, 2015). Faith healing practitioners seek to identify and heal illness through the connections between mind, body, and spirit (Peprah et al., 2018).

Faith healers apply to religious practices, ceremonies, charms, prophecy, and blessing to cure psychological diseases and other treatments, such as herbs, cupping, acupuncture, and homeopathy to complement physical and mental treatments (van der Watt et al., 2018). Different societies or cultures use similar faith practices as well as various practices. For example, Islamic Faith Healing helps individuals realize their beliefs and create alternatives to make their life and existence in the world meaningful. For example, surrender to divine power and adherence to the teachings of the religious book and the prophet. The spiritual connection between Muslim religious scholars and people increases mutual understanding, expressing and releasing from repressed emotions, and acceptance regarding the causes and solutions of the problems experienced by the person (Farooqi, 2006).

Spiritual healing techniques are similar to spiritual care in nursing care. Patient-centered spiritual care practices facilitate to find meaning and purpose from the experience of illness, find hope;

cope with physical and mental problems; and connect to "self, others, and a higher power of nature" (Zumstein-Shaha et al., 2020). Spiritual care for individuals with psychological disorders is related to psychological well-being findings, such as feelings of enjoying, satisfaction, and pleasure, healthy mood, high confidence and enthusiasm, and better physical and mental health (Salimena et al., 2016).

HEALING PRINCIPLES

According to Mamidi et al. (2021), principles of healing are following as:

- *Emphasize effective communication between the patient and healer*
- *Encourage spiritual and religious healing practices*
- *Improve the self-care activities and authority of the sufferer in the healing process*
- *Seeing the mind, body and spirit as a whole*
- *Evaluate any psychological and moral factors that may cause the disease*
- *Maintain the coherence between the psychosocial and physical environment of the patient*
- *Contributing to health by regulating diet, increasing physical activity, and reducing stress*
- *Focusing on the person, not the disease, and adopting an individual-centered approach*

COMPLEMENTARY and ALTERNATIVE MEDICINE

Complementary and alternative medicine (CAM) is any traditional practice and product that is not included in the standard treatment of illness (National Cancer Institute, 2021). The CAM is a healing practice that includes the methods, procedures, and underlying hypotheses and faiths of cultural communities or people to protect health and treat diseases, apart from the standard treatments used in the health system. It covers all interventions and ideas applied to cure disease, alleviate symptoms, or maintain and promote health (Pal, 2002).

Factors affecting a person's decision to use the CAM methods are an increase in the high rate of chronic illnesses, researching health-enhancing practices, getting tired of paternalism, desire for a better quality of life, low belief in treatment, concern about the adverse effect, and increased interest in spiritualism (Pal, 2002). Patients with cancer use CAM to deal with sickness, suffering, and tiredness, relieve and alleviate anxiety caused by the disease, its diagnosis, and treatment methods, contribute to recovery, and attempt to get ridden of the disease (National Cancer Institute, 2021).

Reasons for individuals with chronic diseases to use CAM methods: 1) Increase in treatment costs in parallel with new developments in care and treatment, 2) Controlling their health, 3) Desire to live a healthy life, 4) Doubts about current care and treatment methods, and 5) Fear of possible side effects (Çakmak & Nural, 2017). Patients with gynecological cancers use CAM methods for some reason, such as fighting against disease, increasing the body's resistance, fixing physical appearance, providing emotional healing, hope, and positive thinking, not feeling pain, and reducing the effects of the disease (Öztürk et al., 2016). Older people use CAM methods to be healthy, increase body resistance, prevent diseases, relieve constipation and sleep problems, calm down, and heal (Dedeli & Karadakovan, 2011).

COMPLEMENTARY MEDICINE

Complementary medicine is used to assist in the standard treatment and care of disease (National Cancer Institute, 2021). Complementary medicine is the treatment used to supplement traditional medicine and are combined with standard therapy.

ALTERNATIVE MEDICINE

Alternative medicine is used instead of standard medical treatment (National Cancer Institute, 2021). Alternative medicine practices are health and illness strategies that are not easily integrated into the standard health system (Pal, 2002).

INTEGRATIVE MEDICINE

Integrative medicine methods are CAM practices that have proven to be confident and efficient when applied with standard therapy. This approach cares about the patient's wishes and tries to cure all aspects of health (National Cancer Institute, 2021).

HEALING PRACTICES

Studies on Traditional Healing Practices

Traditional healing refers to health practices, approaches, knowledge, and beliefs that integrate traditional healing and standard treatment using medicines and energy-based techniques derived from animals, plants, or substances (First Nations Health Authority, 2021). Harmony and balance within the physical, environmental, emotional, and spiritual domains was the goal of healing practices. Traditional healing methods are natural medicinal substances and items like supernatural powers, talismans, magic words, religious verses, moral techniques, sacrifices, and religious practices (Haque et al., 2018).

The traditional healer does practices based on traditional information, behaviors, and faiths about the reasons for physical, mental, and social health problems as well as social, cultural, and spiritual characteristics (Shankar et al., 2012). They are accessible in the community and share the same culture, beliefs, and values as the applicants. In certain situations, they use specific techniques and make use of herbs. Their interpersonal relationships are developed, and their communication skills are good.

Karadağ & Yüksel (2021) found that techniques used by cancer patients were walking, listening to music, watching films, receiving massages, reading, doing sports, and dreaming. Spiritual practices were praying, engaging in salat, and reading religious texts. Kebede et al. (2021) found that patients from the Gulf region received massage therapy, hijama, spiritual healing, acupuncture or herbs, homeopathy, and manipulations. The dietary supplements were ginger, bee products, garlic, cinnamon, and vitamins. The most common self-help practices were praying for health, meditation, relaxation techniques, and yoga or visualization.

Types of Healing Practices

-Whole Medical Systems (WMS)

Aims to promote preventive and curative health and is holistic, nonatomistic ontological, epistemological, and practice orientation. The WMSs include individualized care, medicinal use of different herbal, mineral, and zoological substances, and nonmedication treatment modalities (Baars & Hamre, 2017). The WMS interventions consist of many different and connected parts. These interventions are healthy eating, physical activity, stress management, mind-body exercises, and dancing therapy (Ijaz et al., 2019). They are Ayurveda, Homeopathy, Naturopathy, and Traditional Chinese medicine.

Ayurvedic medicine is originated from the opinion that health and wellness are bound up with sensitive stability between the mind, body, and spirit. Its primary purpose is to improve health, not struggle with illness (Miller, 2021). Ayurveda defines three fundamental kinds of energy or valid principles existing in everyone and everything. These are Vata, Pitta, and Kapha and are related to the body's functioning. Energy is necessary to compose a physical activity, so fluids and nutrients begin to move, come to the cells, and start functioning. Vata is the power for movement; Pitta for chemical processes; Kapha for greasing and system (Lad, 2006).

Homeopathy is originated from the opinion that the body can heal itself using natural products, like herbs and minerals (Ratini, 2021a). Homeopathy is a medical system that utilizes especially created, highly liquid ingredients to extensively stimulate the body's self-healing. It is a drug treatment (Doerr, 2001).

Naturopathy is a medical system that combines a set of therapies. It is based on the opinion that the body can better struggle with health problems If its balance is repaired or kept (Kohli & Kohli, 2014). Naturopathy aims to cure a person's mind, body, and spiritual dimensions. It also seeks to eliminate the main reasons for disease and alleviate the symptoms (Ratini, 2021b).

Traditional Chinese Medicine comprises three primary modalities: CHM means the methods of heal with plants and other products. Acupuncture cures illnesses by adding items into particular locations along particular routes in the body. Physical therapy covers all parts of manipulative therapy where parts of the patient's body are acted passively or actively in a structured style to reveal healing effects (Leung, 2010).

Mind-body therapies (MBTs) aim to connect the brain, mind, body, and attitude to utilize the mind to influence physical health (Garland et al., 2020). MBTs are used for pain management, mental and cognitive health problems, physical illnesses such as cancer (Carlson et al., 2017, Garland et al. 2020, Laird et al., 2018). Some of the most popular MBTs are relaxation and imagery, hypnosis, yoga, meditation, tai chi and qigong, relaxation, cognitive behavioral therapy, and art therapies (Carlson et al., 2017, Garland et al., 2020). MBTs effectively cure widespread the side effects of chemotherapy, such as nausea and vomiting, pain, fatigue, psychological symptoms, and increase life satisfaction (Carlson et al., 2017).

Biofeedback is a method of self-regulation. People try to control things they have difficulty controlling. It is applied by an expert to transform physiological signals into expressive visible and audible cues. Individuals receive feedback on controlling their physical symptoms using a screen such as a computer monitor (Frank et al., 2010).

"Guided imagery" encompasses different modalities such as easy visualization and imagery, metaphor, telling or writing stories, imagination, and playing games. It also includes a conscious

rendering of events or objects, dream interpretation, illustration, and active imagination (Prabu & Subhash, 2015). In guided imagery, the person's thoughts and imagination are focused on and oriented to a specific goal by a guide. Images in the guided imagery include all the five senses. The understanding that the body and mind are connected is vital, and the mind may affect the body (Elgit et al., 2020).

Hypnosis is a state of mind to focus attention and grasp and follow suggestions. It is done in two ways: either by directions or naturally. Positive suggestions are given during hypnosis. Then, the person's transition to another mental condition is ensured with directions and transactions (Garba & Mamman, 2020). It includes changes in consciousness and mind, increased sensitivity to the proposal, and the production in the subject of reactions and opinions unknown to him in his usual state of mind (Mathew, 1993).

Meditation describes many contemplative techniques to move from everyday consciousness to another consciousness. These techniques are mindfulness meditation, compassion-based meditation, body scan meditation, vipassana, or insight meditation (Ajari, 2020). Meditation is also a practice for improving mindfulness. Mindfulness is self-awareness and interest in the current moment, supporting non-judgemental behavior to develop calmness and recession (van der Riet et al., 2018). Mindfulness meditation is the most popular type of meditation (Ajari, 2020).

Relaxation is a technique that helps individuals to withdraw psychologically from the environment. It facilitates slow thoughts, relaxes muscles, and continues a relaxed status for a while to reduce physical and psychological symptoms (DeMarco-Sinatra, 2000). Relaxation techniques have an effect by reducing the individual's feelings of discomfort and restlessness, strengthening their coping skills, and improving psychological problems. It helps to improve physical symptoms as well as psychological symptoms (Norelli et al., 2021).

Biologically-based therapies utilize natural products to improve health. The National Center for CAM defines Biological-based therapies cover the usage of products found in nature, such as herbs, foods, and vitamins (Chagan et al., 2005).

Botanical (Herbal) Medicine, plant products are used to treat and prevent illnesses. It utilizes herbs, plant components, plants' water or self, and essential oils. It is a product made from herbs used for therapeutic purposes to help the functioning of the systems (Raghavendra et al., 2009).

Natural products are plants, plant combinations, dietary supplements (Mikail, 2011). The most used natural product is herbs and dietary supplement. A dietary supplement is not a medicine, and it is a product to complete the diet with one or more of the following: vitamins, minerals, herbs, and amino acids (El-Khoury et al., 2016).

Chelation therapy works at the cellular level. It tries to diminish the excessive accumulated iron load (Di-Maggio & Maggio, 2017). In treatment, a drug called a chelator is administered. This drug can attach to a metal, become magnetically charged, and excrete the metal in the urine (Lamas, 2015).

Manipulative and body-based therapies cure different health problems through physical manipulation. These therapies can be applied to many organs and systems, such as bones and joints, soft tissues, and the circulatory and lymphatic systems (National Center for Complementary and Integrative Health (NCCIH), 2014).

Chiropractic cures musculoskeletal system diseases. Its focal point is healing the spine. Traditionally, chiropractic believes that the problems with the musculoskeletal system are associated with central nervous system diseasese (Burgess, 2018). Chiropractic manipulation aims to accurate alignment problems, reduce pain, develop performance, and assist the body's capacity to recover itself (NCCIH 2014).

Osteopathic manipulation consists of four basic principles: the human body is dynamic; the body has a capacity of regulating; functions are interconnected, and treatment is set up on these principles. It reduces somatic symptoms by healing physiologic function and balancing homeostasis (Licciardone et al., 2020).

The bruising caused by vacuuming in *cupping therapy* directs all the constructive and healing chemicals to that area. All muscle, joint, and nerve structures are refreshed and a healthy body is achieved. Cupping therapy affects the skin's blood flow, the skin's biomechanical properties, feeling of pain, regional anaerobic metabolism, inflammation, and the cellular immune system (Aboushanab & AlSanad, 2018).

Massage therapy is the manipulation of the muscles and other soft tissues of the body by a massage therapist for relieving pain, promoting healing, or improving physical functioning (Merriam-Webster Dictionary, 2021). *Reflexology* is also a massage, and it includes performing changing amounts of force to the feet, hands, and ears. Reflexology rests on the ancient Chinese belief in qi or vital energy. Reflexology facilitates the progression and movement of qi throughout the body, balancing it and preventing diseases (Cirino, 2018).

Energy Therapies, the concept of energy medicine is based on the fact that a disease's cause is disturbances in body energies (Farooqui et al., 2013). Mind-body energy healing techniques are based on mantras, meditations, breathing exercises, physical exercises, and relaxations, believing that human thoughts, feelings, and emotions can affect both physical and mental well-being (Rogers et al., 2021). Therapeutic touch, healing touch, Reiki, massage, acupressure, magnetic, and acupuncture are some energy healing therapy practices (Guthrie & Gamble, 2001). These methods reduce adverse mental effects of cancer such as anxiety, depression, and the impact of chemotherapy-related nausea, pain, and vomiting (Demir et al., 2015; Farooqui et al., 2013).

Acupuncture; Latin for needle (acus) and puncture (punctura) consists of words. Translation into Turkish as "to pin" can be done. In Traditional Chinese Medicine, it is assumed that diseases are caused by disturbances in the flow of life energy (Qi) circulating in channels called meridians in the body. With acupuncture, it is aimed to correct the disrupted energy flow by inserting needles into certain points on the meridians in the body (Brazier, 2017).

Magnetic therapy utilizes magnets of different sizes and strengths that are put on the body to reduce pain and cure disease. Magnets are attached to the body by various means such as necklaces, bracelets, and belts. The magnetic effect of magnets activates the metabolism, increases the amount of oxygen in the body, and reduces the amount of acid (Davis, 2021).

Qi gong and Tai chi are parts of traditional Chinese medicine using kind positions, mindful action, and the breath to equalize the individuals' energy better. These practices mix slow, intentional techniques, meditation, and breathing exercises. Both are martial arts that can help your motion, equilibrium, and alignment (Helmer, 2021).

Reiki is an energy healing therapy. The Reiki means the energy of life force. Reiki repaired and stabilized the power of the body (Demir et al., 2015). The Health beliefs of Reiki are relieving

pain, anxiety, and fatigue, treating depression, enhancing the quality of life, boosting mood, and improving some symptoms and conditions such as headache, tension, insomnia, and nausea (Cronkleton, 2018).

Therapeutic touch (TT) uses energy, which one feels or perceives, for medicinal purposes to restore balance within. TT is the power-changing process; practitioners try to influence patients' bodies towards healing (Bagci & Cinar-Yucel, 2020). The TT is beneficial in healing mood, health, and interpersonal connections, reducing pain, nausea, worry, and fatigue, improving life energy and pleasure with it (Tabatabaee et al., 2016).

Review Questions

1. "…… are beliefs about positive features and advantages of a recommended effort to reduce threat." fill in the blank.
2. "…….. refers to therapies that complement traditional western (or allopathic) medicine and are combined with conventional medicine." fill in the blank.
3. Traits such as faith, hope, and commitment are part of what health?
4. Explain the factors that affect cultural beliefs.
5. Give examples of whole medical systems.

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CHAPTER VI

CULTURALLY SENSITIVE COMMUNICATION in HEALTHCARE

A) ONE-TO-ONE CULTURALLY SENSITIVE COMMUNICATION WITH PATIENTS, FAMILY MEMBERS, and CAREGIVERS

Ann Claeys, Sandra Tricas-Sauras

Key Points

1. This chapter describes the essential elements of intercultural communication, as well as the main challenges of intercultural communication in health care.
2. Good communication in healthcare leads to better health outcomes, greater trust in healthcare, and greater patient satisfaction.
3. It reduces the number of medical errors and increases access to and the use of medical facilities, including preventive care.

DEFINING CULTURALLY SENSITIVE COMMUNICATION ELEMENTS

What is effective communication?

Communication is a broad concept. It is essential in both human and patient care relations. Communication includes all possibilities in which people can exchange information with each other. This may include the notification, connection, and transmission of information, knowledge, and messages (Anderson et al., 2003; Schouten & Meeuwesen, 2006). There are different definitions of communication, including a definition in which communication is seen as a two-way process is a very applicable definition for healthcare. In this two-way-process, interaction is key. This interaction may refer to both the feedback processes as well as to direct interaction between people. It can also refer to a more abstract concept of interaction concerned with how people relate to other meanings in developing their own meanings (Ruler, 2018). Efficient communication happens if the receiver of the message interprets it correctly, as the sender intended. Healthcare delivery fundamentally depends on effective and efficient communication (Roberts, 2008; Valero-Garcés, 2014).

Communication has several functions:

- Communication allows behavior to be controlled. By making rules and agreements, certain behavior can be directed.
- By explaining, for example to patients, what to do, how well one is doing, or what to change in order to achieve even better results, one can motivate people through communication.

- Through communication one can discuss feelings and thoughts, express social needs, and engage in social interaction.
- Decision-making is possible because people have the information they need to make decisions.

Effective communication in healthcare helps in achieving good quality treatment for the patient, or in making well-considered choices by allowing the patient to take charge of his/her own care trajectory. There are interventions specifically for the nursing discipline that require good communication, and in addition to establishing a good care relationship, the nurse and the patient are responsible for planning, coordinating, monitoring, executing, evaluating, and adjusting the care. The nurse takes into account the values and norms, as well as the cultural and philosophical views of the patient, and asks whether the patient has understood the information.

Communication has the following goals:

- Wanting to reach each other: you want to tell or ask the other something.
- Ensuring more contact, better interaction with each other.
- Getting to know and understand each other better.
- Better cooperation.
- Providing better care and services.
- A good conversation, a dialogue including listening and speaking.

With 'noise' in the communication, the communication process 'stalls' somewhere. The message arrives differently or does not arrive at the receiver, as intended by the sender. Neither party understands the other, there is no contact (Gibson & Zhong, 2005).

NON-VERBAL COMMUNICATION

In most conversations, non-verbal messages have a greater influence than the verbal message. Especially when emotions play a role, non-verbal signs gain importance in the communication process. About 80 percent of the communication is non-verbal, so it is very important to pay attention to your facial expressions and body language and to know their meaning (Gibson & Zhong, 2005).

People can also communicate without speaking to each other. Eye contact, posture, the use of voice, gestures, facial expressions, clothing, space, and movement all influence the communication process. However, body language is not always universal. These signs are often interpreted culturally and therefore differences will always occur in their interpretation (Valero-Garcés, 2014)

COMMUNICATION BETWEEN CAREGIVER and PATIENT

Communication between the caregiver and the patient can be disrupted by a barrier in communication. By confirming and validating the patient's communication verbally and non-verbally, effective communication is achieved (Roberts, 2008). Effective communication correlates with improved health outcomes, including physiological criteria such as blood

pressure and sugar levels. Conversely, professional, language, and cultural barriers can hamper communication and detoriate the care relationship (Cass et al., 2002; Ikhilor et al., 2019)

The caregiver must be aware of the level of language and must then adapt to the language level of the patient. Medical jargon is not accessible to many people. By means of non-verbal signals and feedback or control questions, the caregiver can check whether the patient has understood his message.

The caregiver must introduce himself and thus initiate communication. The caregiver should always address the patient appropriately and with due respect. For a foreign-speaking patient, a greeting in his native language can help to break the ice. The caregiver should be aware that there are several ways to greet the patient, for example shaking hands, nodding the head, bowing, hand on the heart. Thus the appropriate way must be chosen for the appropriate situation. The competences of multilingual caregivers must be recognized and used correctly.

Secondary communication is the interaction between a caregiver, an intermediary, and a patient. Communication therefore takes place indirectly through an intermediary who is asked to facilitate the communication. When asking a third party in the conversation, the caregiver should be aware of the sensitivities of the communication, both in the message to be conveyed and in the (cultural) sensitivities in local communities (Valero-Garcés, 2014; Antonini et al., 2017)

INTERCULTURAL COMMUNICATION

If the caregiver and patient have a difference in sociocultural background, this can hamper communication. Communication between people with different cultural backgrounds is called intercultural communication. Intercultural communication competence is commonly known as the knowledge, motivation, and skills to interact effectively and appropriately with members of different cultures (Gibson & Zhong, 2005). Different communication patterns can lead to miscommunication and can be a barrier in providing qualitative care.

Previous studies have suggested that caregivers communicate less effectively with racial and ethnic minorities, older patients, and those with lower educational attainment levels (Kaplan et al., 1995; Brown, 1999). The attitude of the caregiver plays an important role in intercultural communication. Intercultural communication includes respect for, and interest in, patient experience. Respect for the person, trust, and accessibility are important conditions for building a care relationship and improving communication (Roberts, 2008; Papadopoulos, et al., 2016).

Three key areas seem important within intercultural communication, which comprise identity, intercultural communication competence, and acculturation.

- Identity is a multidimensional notion that consists of psychological and social factors and is negotiated until communicators reach a mutual understanding and agreement on identity (Croucher et al., 2015). The ethnolinguistic identity theory (ELIT) is a social psychological theory about the variables and mechanisms involved in the maintenance of an ethnic language in different settings. The theory explains why a specific group of individuals in an interethnic context choose a specific language strategy, and why the in-group in a certain interethnic context chooses a different strategy then the out-group. This theory predicts that if an individual perceives high in-group identification, then more intergroup boundaries and intergroup differentiation will occur (Croucher et al., 2015).

- Intercultural competence can be affected by various factors, such as cultural sensitivity, communication skills, cultural knowledge, individual behavior, and gender. Competence is an important element in any communication interaction, not only in healthcare, but in all different fields (Croucher et al., 2015). The anxiety/uncertainty management (AUM) theory states that intercultural communication is essential in overcoming and managing uncertainty and anxiety in caregivers in providing intercultural care (Gibson & Zhong, 2005; Croucher et al., 2015).
- The model about acculturation strategies shows four strategies that a newcomer can use when encountering a new environment and a new culture. These four strategies are assimilation, separation, marginalization, and integration (Croucher et al., 2015).

CHALLENGES in CULTURALLY SENSITIVE COMMUNICATION

The ability to be empathetic and the experience of living in a different culture can help to overcome challenges in culturally sensitive communication. Cultural sensitivity is related to effective intercultural communication between the patient and caregiver (Ulrey & Amason, 2001). To engage in intercultural communication, the caregiver needs communication and social skills. The caregiver needs to communicate at the patient's level. Although the caregiver is highly educated, they must be able to adapt in communication to the level of education and language usage of the patient. In addition, it is also important that the caregiver does not speak too quickly, and that they pay attention to the interaction with the conversation partner. If the caregiver notices that the patient is no longer listening intently, the message will be lost. The caregiver can ask for feedback from the patient at certain times, to check whether the patient is still up to date with the message and the conversation. The caregiver must also have the skills to dose the message, according to the patient's ability. Sometimes, verbal communication and written information can be combined to support the patient in capturing the message. Finally, it is of great importance that the non-verbal communication of the caregiver is supportive of the verbal message that they give, and that the non-verbal signals are in line with the values and norms that the patient has.

Additionally, the ability to be speak a different languages can help the caregiver in overcoming the challenges in culturally sensitive communication (Gibson & Zhong, 2005). Language is an important factor in intercultural communication. However, it is not only the language that plays a role. Sometimes, words can also have a different meaning or connotation in other countries or cultures. The meaning of words can also change over time and across generations. Language is not only necessary to formulate and understand the patient's request for help, but language is also important when taking an anamnesis or for communicating a diagnosis. Interpreters are available in most European countries. More can be read about language support by means of an interpreter next in this chapter.

When caregivers lack the skills needed for communication in a different language, they search for adequate language support. Caregivers should become more aware of the different types of language support that exist. These types of support could be professional translators (trained and certified interpreter), informal interpreters (e.g., multilingual healthcare staff or family members), remote interpreting services through communication technologies (e.g., Skype, telephone, video link), translation technologies (e.g., Google Translate, Skype Translator), or multilingual healthcare apps (Krystallidou et al., 2021)as well as on the currently available

solutions to language discordance in healthcare. We discuss issues pertaining to i. Although the work of interpreters in healthcare has a beneficial effect on health care outcomes, interpreters are not often called upon in healthcare situation, according to international studies (Flores, 2005). When professional interpreters are not available or accessible, patients may have to rely on medically inexperienced, bilingual relatives or non-medical staff, which can increase the risk of miscommunication, communication errors, privacy questions and workload for the multilingual staff. Moreover, selective perception can disrupt the communication process, because the receiver of the message pays extra attention to certain aspects and at the same time does not capture other aspects in the communication message (Gasiorek & van de Poel, 2018). It is important to improve the skills of the caregiver to include the use of communication technologies. This can be facilitated through hands-on technology-assisted training or short interventions in the clinical practice (Krystallidou et al., 2021).

Finally, giving meaning is also important in intercultural communication. This is how to explain illness and health and therefore also how to communicate about it. Sometimes, the communication is also filtered, to make the message come across differently and more socially desirable, or because people feel that they have to meet certain social standards. In addition to culture, gender, class, generation, sexual preference, age, and personality also play a role in giving meaning, and these factors therefore also influence how people communicate. Intercultural mediation could be a solution for this challenge. Intercultural mediation is an intervention that takes into account cultural differences when translating (Gibson & Zhong, 2005). It is important that caregivers take sufficient time to communicate, specifically with the patient and their family, and ask them about their wishes and preferences. By investing sufficient time, one can overcome certain barriers, such as differences in meaning or language differences (Roberts, 2008). Little attention is paid to ways of nuance or bridging cultural differences in the workplace. There appears to be no tradition within nursing of reflection on one's own motives and on the question whether the care provider has sufficient communication skills themself. Nurses often talk with reference to us/them and have a stereotypical image of non-Dutch speaking patients (Barclay et al., 2007; Claeys et al., 2020).

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B) CULTURALLY SENSITIVE COMMUNICATION WITH PATIENTS, CAREGIVERS, and FAMILY MEMBERS VIA an INTERPRETER

Betül Tosun, Ayla Yava, Ezgi Dirgar

Key Points

1. The language barrier is the most important challenge when communicating with patients, the patient's family, and/or caregivers.
2. Culturally competent and safe healthcare relies on an open exchange of information between nurses and patients, parents, and/or caregivers.
3. It is correct to use primarily trained professionals as interpreters, and secondarily, bilingual health professionals. If these two options are not possible, then it is correct to apply as an interpreter to communicate with the patients' relatives.
4. The main role of a medical interpreter in a healthcare setting is to provide synchronization between the healthcare professionals and the patients, the patient's family, and/or caregivers.
5. Nurses should know the best practices in communication trough the interpreter. In addition, interpreters should work as a team, and cultural factors should not be allowed to create gaps in care.

INTRODUCTION

Given the many cultures and subcultures around the world, it is impossible for nurses to know everything about them all; however, it is possible for nurses to develop adequate cultural assessment and intercultural communication skills, and follow a systematic, orderly process to provide culturally competent care (Andrews & Boyle, 2016; Giger & Haddad, 2021). Culturally competent and safe healthcare relies on an open exchange of information between nurses and patients/families/caregivers. Nurses aim to work collaboratively by sharing complete, honest, and unbiased information. Language is a major barrier to providing quality health care, because language is the whole of symbols that feed the culture and provides the transfer of our culture. Language has a great role in the formation and transmission of material and spiritual cultural values. Language is the most important element that reflects society. Language barriers that impair communication affect patient care in healthcare (Salavati et al., 2019; Boylen et al., 2020). These can lead to increased risk of misdiagnosis, communication errors in information exchange among nurses, patients, relatives, caregivers, and non-native language speakers may receive a lower standard of care when compared to the rest of the population (Andrews & Boyle, 2016; Williams et al., 2018; Salavati et al., 2019). In order to eliminate this barrier, the use of an interpreter is generally preferred in health care settings during communication with patients, the patient's family, and/or caregivers (Williams et al., 2018; Jaeger et al., 2019; Angelelli, 2020).

WHO CAN BE an INTERPRETER in HEALTH CARE SETTINGS?

The laws of many countries require the government to provide free interpreting services for the asylum seekers, refugees, and immigrants (Eklöf et al., 2015; Lee et al., 2018; Jaeger et al., 2019). An interpreter is defined as a person who "translates speaking from one language

to another language" (Angelelli, 2020). However, the competence of the interpreter is also an essential element. The inadequate training of interpreters can negatively affect the quality of interaction between nurses, patients, and interpreters. Effective interpreter usage in a health care setting requires systems that support efficient interpreter access, and that healthcare providers recognize what language their patients speak and whether an interpreter is needed (Mithen et al., 2021).

To aid in communication, nurses often rely on other healthcare providers and/or family members who are fluent in the required language, or informal interpreters. The reasons for choosing informal interpreters instead of healthcare interpreters include immediate access to family members, the need to book a health interpreter, hospital availability of health care interpreters, and time constraints. Additional reasons may include privacy, confidence in one's own language skills and difficulty in assessing the need for an interpreter, lack of knowledge about the interpreter service or reservation system (Blay et al., 2018). Patient preference and satisfaction of a healthcare translator compared to an informal translator(s) is not clear in the literature. Some cancer patients prefer family members as interpreters (Simon et al., 2013). Results from a systematic review found that patients were satisfied with bilingual clinicians and healthcare interpreters who shared the same cultural values as the patients (Joseph et al., 2018), whereas Emergency service patients reported higher levels of satisfaction when communication was provided by healthcare interpreters when compared to informal interpreters (Bagchi et al., 2011).

According to the literature, it is correct to use primarily trained professionals as interpreters, and secondarily, bilingual health professionals. If these two options are not possible, it is correct to apply to be an interpreter to communicate with the patients' relatives (Joseph et al., 2018). The risks of using family members or other untrained interpreters include both linguistic and ethical problems. Linguistic problems include ambiguity about language ability, lack of knowledge of health care or medical terminology, and comprehension and language ability being affected by stress. Other linguistic issues may be additions to what has been said (offering advice or opinions), and selectivity with regard to what to translate. These problems are particularly related to the family member not being familiar with the difficult translation task. Such problems have the potential to lead to malpractice and liability. Ethical problems include issues with confidentiality and privacy difficulty with sensitive discussions (such as matters of sexuality or abuse), changes to the family dynamics in terms of power when members take on different roles, adverse effects if non-adult children are used, and family members imposing their own agenda and/or priorities (distorting communication and affecting patient autonomy) (Hsieh & Kramer, 2012; Jaeger et al., 2019; Boylen et al., 2020). The latter can include offering advice and may be characterized as a role conflict (Gray et al., 2011). In some cases, communication is about dying, end of life, or issues that family members placed in this role may feel uncomfortable should sensitive issues or questions arise (Ferrell, 2015).

ROLE and RESPONSIBILITIES of MEDICAL INTERPRETER

It can be difficult to define the role of interpreters. Interpreters are expected to be an unbiased channel of transferring information from one language to another, but they are also expected to sometimes serve as cultural mediators. Studies have shown that healthcare professionals, patients, and interpreters play an active role in healthcare settings when different cultures and languages come together (Hsieh & Kramer, 2012; Hadziabdic et al., 2014; Eklöf et al., 2015; Blay et al., 2018)Australia in 2014–2015. Descriptive analyses were used to explore demographic and

diagnostic data. Chi-square and analysis of variance were used to test for association between variables.\nResults: The site hospital provided for 19,627 overnight-stay episodes of care over the one year period. Emergency admissions made up 70.5% (n = 13,845. The main role of a medical interpreter in the healthcare setting is to provide synchronization between healthcare professionals and patients/families/caregivers. This can sometimes include informing the patient about the diagnosis, discussing the patient's needs with the patient's relatives, helping the patient explain his/her health status, or explaining the treatment programs to the patient. In some cases, it includes having communication and expression skills that can explain medical terminology simply and accurately to the patient (Biagin et al., 2017). Healthcare providers must agree to work with an interpreter as part of their job, and the patient must be an active, confident participant. Patients view the interpreter from a cultural point of view, and inadequate language bonds between patients and healthcare providers, differences in cultural backgrounds, fear, suspicion, and a lack of trust in the interpreter can cause problems. Interpreters should see themselves as part of the healthcare staff, and healthcare staff and patients should accept interpreters as a member of the team (Hsieh & Kramer, 2012; Jaeger et al., 2019; Salavati et al., 2019). Health problems are privacy aspects of the individual life. Therefore, confidentiality is the primary duty of a medical interpreter; hence, they must maintain patient confidentiality. Professional interpreters do not share any information about the patient with other people, including their medical history or rehabilitation records (Eklöf et al., 2015).

Best Practices in Communication Through an Interpreter

It is necessary to pay attention to some points when communicating with patients/families via an interpreter:

- It was determined that specially trained medical interpreters had positive effects on the patients and their families, and the satisfaction of the patients was high. For this reason, interpreters with special training in professional and medical subjects should be preferred (Joseph et al., 2018).
- Before arranging for an medical interpreter, the language that the patient speaks at home should be determined, as it may differ from the language spoken in public (for example, French or English is sometimes spoken by well-educated members of certain Asian or Middle Eastern cultures) (Andrews & Boyle, 2016).
- The health literacy level of the patient or their relatives is one of the most important factors that determines the level of communication with the nurse. For this reason, how the patients and their relatives use technological devices, tablets, computers, phones, and the Internet should be observed. It should be evaluated and recorded as it may be important during communication (Andrews & Boyle, 2016).
- An interpreter of similar age will make the patient feel more comfortable. A same-sex interpreter can make the patient feel better (Hadziabdic, 2011; Giger & Haddad, 2021)
- If there is no clue about sexual orientation, judgments and comments on this subject should be avoided.
- Before meeting at the bedside, the interpreter alone should definitely be talked to alone, at which time, information about the patient should be given and the expectations of the interpreter should be expressed.

- Some cultures value formal greetings at the beginning of the day or when the first encounter of the day occurs. When communicating with people from cultures that tend to be more formal, it is considered a sign of respect to address someone by title such as Mr., Ms., Ms., Dr., Madam, or Sir. A recommended best practice when first meeting a patient or a new member of the healthcare team is to say their name and then ask what name they prefer to be called by (Andrews & Boyle, 2016).
- When first entering the patient's room, the patient/family should be greeted. It is best to introduce oneself and wait for the interpreter to introduce himself/herself. Then, an explanation should be given about how long this meeting will take and what will happen. It should also be remembered that gestures and mimics can have different meanings in different languages.
- When communicating with the interpreter and the patient, a triangle-shaped position should be formed (Figure 1.). The patient/family should be able to see both the nurse and the interpreter. All communication should be directed toward the patient/family, not the interpreter. The urge to talk to or look at the interpreter should be avoided unless it is necessary to clarify something that was said.

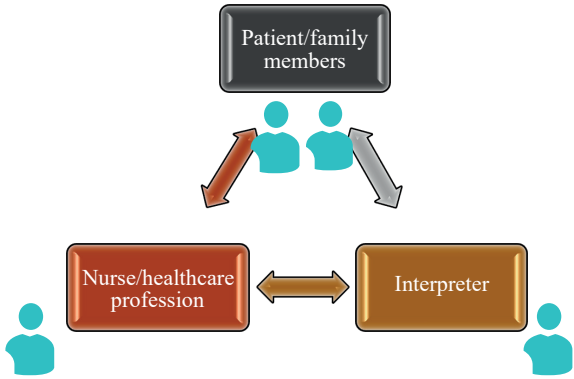

Figure 1. Triangle of the communication position

- Speaking in shorter sentences than usual is recommended. Doing so makes it easier for the translator to remember the sentence and ensures the accuracy of the translation. Sometimes, using technology, an interpreter is used via telephone or video conferencing. All topics discussed should be clear and concise (Squires, 2018; Giger & Haddad, 2021).
- If the interpreter seems confused about something that has been said, the interpreter should be asked if they need clarification or restatement.
- It is best to not interrupt the interpreter when translating the patient's response, as some cultures view interception as rude.
- Sometimes it is necessary to talk to patients and their families about bad news, end-of-life care, forensic cases, offenders, or victims. The response to bad news varies from culture to culture. Common emotions are anger, sadness, love, anxiety, and relief. Individuals may also experience feelings of denial, blame, guilt, disbelief, fear, or loss. They may also feel the need to intellectualize the causes of the situation ("This happened because…"). Some people may try to leave the room or withdraw into themselves.

- When the interview is over, the patient should be asked if he/she or she needs anything else while the interpreter is still in the room. Many patients have more needs and often, the encounter with an interpreter makes them feel comfortable.
- After the medical staff and interpreter leave the room, the interview should be reviewed to make sure that both the medical staff and the interpreter have in the same understanding. The interpreter may also have some cultural insights that can help with care planning. The interpreter's additions and cultural recommendations should be considered carefully (Andrews & Boyle, 2016; Squires, 2018; Giger & Haddad, 2021)

Advantages and Disadvantages Communication Through Interpreter

Advantages

- Increases the quality of communication between patient/patient relatives and healthcare professions
- It helps to avoid misunderstandings
- It makes the patient or patient relative feel safe.
- It provides an understanding of the hidden cultural characteristics that will affect treatment and care (Al Shamsi et al., 2020).
- It facilitates the management of pain and complications.
- It increases the patient's autonomy and satisfaction.
- It reduces the length of stay in the hospital (Hadziabdic, 2011; Ferrell, 2015; Andrews & Boyle, 2016).

Disadvantages

- Availability: In a study conducted with nurses, it was stated that it was difficult to plan and use an interpreter. In some cases, they can use technologic devices (telephone, internet, video call…) (Joseph et al., 2018).
- Communication duration: It increases the workload of the nurses, as it prolongs the duration of communication and prolongs the time that must be spared for the patient (Salavati et al., 2019).
- Trust: Some patients do not trust the interpreter and may not disclose things during communication. What should be paid attention to in this situation? Are the characteristics of the interpreter important in this case?(Hadziabdic et al., 2014).
- Ethical problems: A professional interpreter is expected to follow a practice and a national and international code of ethics, which includes information about the professional ethics, working conditions, and contract; however, it does not provide consistent guidelines for use in clinical practice (healthcare)(Mithen et al., 2021). In one study, the protection of patient privacy was considered challenging when using an interpreter. Due to the immigrants' relatively small and tight ethnic and cultural groups, the confidentiality of the interpreters was sometimes questioned. "I know I should trust them (the interpreters), they are professionals, but the ethnic groups are so small, and everybody knows everybody."; "There, he/she (the patient) is sitting as if on trial, telling strangers about his/her personal life". Mistrust toward

the interpreter was the most common reason for the patients' unwillingness to use interpreters or speak about their health problems (Eklöf et al., 2015).

- Costs: Interpreter services are expensive and this increases the cost of healthcare. In some countries or private hospitals, patients must pay these costs. Therefore, For this reason, it is not easy to assign interpreters to nurses at any time. (Jaeger et al., 2019).

Documentation of the Communication

The use of medical interpreting services should be documented. Documenting the use of interpreters is as important as documenting any other clinical interventions. Not only should an interpreter be used, but the type of translation should also be documented. For example, it should be stated whether it is at admission or discharge, or whether it is for informed consent or for patient education. It should then be documented whether the interpreting was performed by a medical interpreter face-to-face or over the phone or via video conference, and the interpreter's name. The interpreter will include information such as the patient's unique identifier, the time and duration of the interview, and any other information requested by the organization (Gray et al., 2011; Hadziabdic et al., 2014; Joseph et al., 2018; Squires, 2018)which is also used by New Zealand through Language Line (LL.

When a nurse has to rely on a staff member or family member to interpret due to a lack of interpreters or technological difficulties, documenting the decision behind it will also help to protect the nurse. A policy that every effort is made to adhere to the organization means that the nurse is doing what is legally required (Squires, 2018).

ROLE PLAY CASES

Case 1 (A small part of a nurse-patients-patient's relative communication scenario)

Ayşe, 65 years old, will have hip joint arthroplasty surgery in the orthopedics and traumatology clinic in 1 week. She emigrated from Turkey 6 months ago to live with her son (Muhammed). In the outpatient clinic, the nurse wanted to inform the patient about the perioperative period.

Ayşe, who entered the training room with her son, hid behind him. Muhammed sat in front of the nurse and Ayşe sat next to him.

Nurse: *Hello Ayşe, welcome.*

Muhammed: *Thank you nurse. My mother can't speak your language; I will translate what you say to her.*

Nurse: *Really? I see. In fact, if you had requested or informed us about an interpreter earlier, we could have planned for that.*

Muhammed: *No, No matter. My mom doesn't quite understand what she's talking about anyway.*

The nurse's face fell and she found the situation to be strange:

Nurse: *Well, if Ayşe wants it this way.*

Seeing the nurse's pout, Ayşe was frightened:

Ayşe: *"Ne oldu Muhammed? Neden hemşire adımı söyledi? Ne dedi?"*

(What happened, Muhammed? Why did the nurse say my name, what did she say?)

Muhammed translation: *"Endişelenme, bir şeyler anlatıyor işte. O bana anlatacak ben de sana anlatacağım. (Don't worry, mom, the nurse said something. She will tell me and I will tell you.)*

Ayşe: *"Hemşire hanım oğlum dilinizi çok iyi konuşur sağ olsun onun yanına taşındım artık. Kalçam çok ağrıyor. Yakı da yaptım, zencefil ve zerdeçal çayı da içtim aylardır ama geçmedi. Ağrılarım ameliyat sonrasında hemen azalırsa ona daha fazla faydam olur. Ağrılarımı dindireceğiniz için size çok teşekkür ederim."*

(Dear nurse, my son can speak your language very well. Thanks to him, I moved here 6 months ago. My hip hurts a lot. I also use yak (a traditional pain reliever, stuck to the injured body area) and drank ginger and turmeric tea for months as well (these teas have the same effect as an antiaggregant), but the pain doesn't go away. If the pain goes away right after the surgery, I will be more helpful to him. Thank you so much for relieving my pain.)

Nurse: *What does your mother say?*

Muhammed: *She thanks to you for this treatment.*

Nurse returns to Ayşe:

Nurse: *Okay, Ayşe, your surgery is on August 31st at 09:00. It will take about 2–3 hours. You should arrive the day before the surgery and be admitted to the clinic, and you will be prepared for the surgery the night before. These include various blood tests. In addition, a doctor from the anesthesia team will come to visit you and examine you. Due to the pandemic, it is not possible for anyone to accompany you. In a moment I will explain how to perform deep breathing and coughing exercises, as well as how to use a patient-controlled analgesia device, as you will be semi-dependent for a while after surgery. If no complications develop, you will stay in the hospital for about 5–7 days. During this period, you will learn how to walk, turn, climb stairs, sit on the toilet, and perform various extremity exercises. I also must ask if you have any chronic illnesses that may prevent possible respiratory and circulatory system complications?*

Ayşe: *"Hemşire ne diyor Muhammed?" (What does the Nurse say Muhammed?)*

Muhammed explains it to his mother:

Muhammed translation: *"Ameliyat sonrasında yapılması gerekenleri anlatıyor, Birazdan sana ameliyat sonrası yapman gereken solunum egzersizlerini öğretecek." (She explained what will happen after the operation. She will teach you the breathing exercises you should do after the surgery.)*

Ayşe: *"Muhammed ameliyattan sonra sen yanımda kalacak mısın? Ben çok korkuyorum." (Muhammed, will you stay with me after the operation? I am so afraid.)*

Muhammed translation: *"Hayır anne pandemi sebebiyle refakatçi kabul etmiyorlarmış"*

(No, mom, they won't allow me to accompany you because of the pandemic.)

Ayşe: *"Olmaz o zaman kalamam ben yalnız Muhammed çok korkuyorum." (No, then I can't stay alone, Muhammed, I'm so scared.)*

Muhammed translation: *"Anne doktor ameliyatını onayladı artık vazgeçemeyiz. Bu ameliyat için insanlar çok para ödüyor ve aylarca sıra bekliyor sorun çıkarma." (The doctor approved your surgery. We can't give up now. People pay a lot of money for this surgery and wait in line for months.)*

Nurse: *Is everything okay?*

Muhammed: *Yes, you go ahead please. My mother only has hypertension and is on medication for it and has no other chronic diseases.*

Speaking to his mother:

Muhammed translation: *"Değil mi anne başka hastalığın var mı?" (Do you have any other diseases, mother?)*

Ayşe: *"Gelmeden önce doktora gitmiştim şeker hastalığın da var demişti onun için de ilaç içiyorum. (Before I came here, I went to the doctor and she had said that I have diabetes. I am taking medicine every day for that.)*

Muhammed translation: *"O önemli değil fazla yüksek değil şekerin. Hemşire hanımın kafasını karıştırmayalım." (It's okay, your blood glucose isn't too high. Let's not confuse the nurse.)*

Nurse: *Is there anything Ayşe would like to add?*

Muhammed: *No, she is ready for the operation, you go ahead.*

Nurse: *Okay After the operation, the most important issue for Ayşe to address is pain control. She may feel pain on the first day after surgery. For this reason, we will give her intravenous painkillers, which will be patient-controlled. Using a machine, she will take painkillers at regular intervals and when her pain becomes unbearable, she will be able to reduce the pain herself by pressing the button on the machine. We will check on her often and ask about her pain. I'm taking notes here so that an interpreter will be scheduled for her.*

Muhammed translation: *"Anne ameliyat sonrası ağrın olacakmış ama hemşireler sana bir düğme verecekmiş kendi kendine ağrı kesici yapacakmışsın." (Mom, you will have pain after the operation, but the nurses will give you a button and you will give yourself painkillers.)*

Ayşe: *"Olamaz nasıl yapacağım? Ben beceremem Muhammed? Ne olur vazgeçelim."*

No, how can I do it? I can't do it Mohammed.

Nurse: *I think Ayşe has a question, doesn't she?*

Muhammed: *No, everything is fine. I will explain everything to her in detail later.*

Nurse: *Ok……*

Case 2 (A small part from a nurse-patients -professional interpreter communication scenario)

Selim is 40 years old and was hospitalized with a diagnosis of pancreatitis. He is married and has two children. He's not with his family. Only with his cousin, who is also his business partner. While going abroad for business, he got sick and was brought to the hospital by his colleagues. The nurse will communicate with Selim using an interpreter.

At first, the nurse and interpreter meet in front of the nurses' room.

Interpreter: *Hi, I am Deniz Polat. I am here to help the patient (Selim) who is Turkish.*

Nurse: *Hi! I am Sophia. Welcome. I have been waiting for you. Do you want to ask anything about the patient?*

Interpreter: *Could you please briefly explain his situation?*

Nurse: *Ok. He is 40 years old and he came here for business. His colleagues and his cousin brought him to the hospital. His symptoms included sudden abdominal pain, fatigue, blurred vision, diarrhea, and the avoidance of food. He was hospitalized with a diagnosis of pancreatitis from the emergency department.*

The interpreter took notes and added:

Interpreter: *When we go into the room, let's introduce ourselves and I will ask him for permission to translate for him. Please ask one question each time and answer the questions step by step.*

They knocked on the door and went in. The nurse stood in front of the patient and made eye contact and the interpreter stood near the patient. The patient's cousin was sitting by the bed.

Interpreter: *"Merhaba Selim Bey ben Deniz Polat, burada sizin sağlık personeli ile aranızdaki iletişimi sağlamak için bulunuyorum. Profesyonel sağlık çevirmeniyim. Nasılsınız?" "Hello Selim. I'm Deniz Polat. I'm here to provide communication between you and your healthcare professionals. I am a professional medical interpreter. How are you?"*

Selim: *"Teşekkür ederim. Hoş geldiniz Türkçe konuşuyorsunuz çok şükür!" Thank you. Welcome. Thank God, you speak Turkish!*

Nurse: *Hi, I am Sophia, I am a nurse and I am responsible from your care.*

Interpreter translation: *"Selim bey hemşireniz sizi selamlıyor, adının Sophia olduğunu söyledi. Sizin bakımınızdan kendisi sorumluymuş."*

Selim: *Thank you.*

Interpreter: *"İzin verirseniz sağlık durumunuz ile ilgili iletişim kurmanıza yardımcı olacağım. Özellikle sormak istediğiniz herşeyi sormaktan çekinmeyin ve çevirmemi istemediğiniz şeyleri çevirmeyeceğim." (If you give permission, I will help you to communicate about your health status. Feel free to ask anything you want to specifically ask, and I won't translate anything that you don't want me to translate.)*

Selim: *"Tamam izin veriyorum."*

Interpreter translation: *I give permission. OK. Thank you, then we can start.*

Nurse: *Do you want your cousin here while we are speaking? Otherwise, we will ask him to please wait outside.*

Interpreter translation: *"Biz konuşurken kuzeninin burada olmasını ister misin? Aksi halde lütfen dışarıda beklemesini rica edeceğiz."*

Selim: *"Kalmasını isterim."*

Interpreter translation: *I want him to stay with me.*

Nurse: *OK. As the doctor stated before, you have pancreatic inflammation. Have you had such a situation before?*

Interpreter translation: *"Daha önce doktorunuzun da belirttiği gibi pankreas inflamasyonunuz mevcut." Daha önce böyle bir durumla karşılaştınız mı?*

Selim: *Hayır hiç olmadı! Şimdi hastanede bana ne yapacaklar?*

Interpreter translation: *No, it never happened! What will happen now?*

Nurse: *We will take blood sample from you to evaluate your blood tests results and inflammation daily. I will also give you medicine 3 times a day to relieve your pain and reduce inflammation. We need to minimize your fluid loss with the fluid given through your vein. For now, I it is important that you don't eat or drink anything. You must rest your digestive system. Do you want to ask something?*

Interpreter translation: *"Günlük kan testi sonuçlarınızı ve iltihaplanmayı değerlendirmek için sizden kan örneği alacağız. Ayrıca ağrınızı dindirmek ve iltihabı azaltmak için size günde 3 kez ilaç vereceğim. Damarınızdan verilen sıvı ile sıvı kaybınızı en aza indirmemiz gerekiyor. Şimdilik sizden hiçbir şey yememenizi ve içmemenizi rica ediyorum. Sindirim sisteminizi dinlendirmelisiniz. Bir şey sormak istiyor musunuz?"*

Selim: *Anladım. Yemek yemeye başladığımda domuz eti/yağı yemediğimi belirtmek istiyorum. Hastaneden ne zaman taburcu edileceğim?*

Interpreter translation: *Understood. I would like to point out that when I started eating, I didn't eat pork meat, ham, or pork fat. When will I be discharged from the hospital?*

Nurse: *Yes, I will note that about your diet. As for your other question, first, we will evaluate your blood tests, vital signs, and other inflammation symptoms regularly so that you are discharged from the hospital. When your tests results are within normal limits, your doctor will start your discharge procedures and inform us. If you have no further questions, and while the interpreter is here, I'll get a few medical devices and do a physical exam and take your blood sample. I'll be back in a few minutes.*

Interpreter translation: *"Evet, bunu diyetinizle ilgili not edeceğim. Diğer soruya geldiğimizde, öncelikle kan tahlillerinizi, yaşamsal bulgularınızı ve diğer iltihap belirtilerinizi düzenli olarak değerlendirip hastaneden taburcu olmanızı sağlayacağız. Test sonuçlarınız normal sınırlar içinde olduğunda doktorunuz taburculuk işlemlerinizi başlatacak ve sizi ve beni bilgilendirecektir. Başka sorunuz yoksa, tercüman buradayken; Fiziksel muayene yapmak ve kan örneğinizi almak için birkaç tıbbi cihaz getirmek için iki dakika içinde döneceğim."*

Selim: *OK. Thank you Nurse.*

CONCLUSIONS

The language barrier puts a strain on nurses who spend a lot of time with patients. This challenge also affects the quality of care and patient satisfaction. Nurses who have not received training in transcultural nursing care and have no experience in communicating through an interpreter will fail to manage this process. For this reason, nurses should know the best practices in this regard. In addition, interpreters should work as a team, and cultural factors should not be allowed to create gaps in care. The lack of education on this subject should be eliminated during undergraduate education. Information should be updated with post-graduation trainings.

Review Questions

1. In which situation can a member of the family act as an interpreter?
2. Which position is appropriate when communicating with the patient via interpreter?
3. What are the advantages of using an interpreter in communication with patient/families/caregivers?
4. What are the disadvantages of communicating via a medical interpreter?
5. When should the first meeting with the interpreter take place?
6. Why is it important that the interpreter be of the same sex and similar age?
7. How can there be an ethical problem during communication through Medical Interpreter?

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CHAPTER VII

CULTURALLY SENSITIVE HEALTH ASSESSMENT and CULTURALLY CONGRUENT NURSING CARE

A) CULTURALLY SENSITIVE HEALTH ASSESSMENT

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Key Points

1. Culturally competent care begins with a cultural assessment, which forms the basis for the nursing care plan.
2. Culture is perceived as a set of values, norms, and behaviours shared by a particular social group.
3. Cultural awareness means questioning oneself, discarding prejudices against foreign cultures, and developing the right attitude to provide the best possible health care to all patients.
4. Cultural knowledge means seeking information about patients' culture and beliefs in order to better understand and interact with them.
5. Cultural competence means being able to gather and process relevant data to engage in meaningful cross-cultural interaction with the patient.

INTRODUCTION

Culturally sensitive care is an important component of professional and patient-centred care. Therefore, efforts must be made to improve nurses' cultural competences, as this is the only way they can provide quality care to patients. In this process, they need to reflect on how their relationships are influenced by their own culture as well as the culture, values, and beliefs of their patients. At the same time, they also need to understand how patients' bio-psycho-social needs and cultural backgrounds relate to their healthcare needs. In delivering culturally competent nursing care, nurses need to be aware of the fact that cultural beliefs, values, and nursing practice have a strong influence on how individuals perceive health and illness and how they believe health problems should be managed. Nurses need to be aware of the fact that health and well-being are culturally defined concepts and that patients can only achieve a sense of health and well-being when their cultural needs have been addressed (Narayan, 2003). Today, nurses are conscious of the existence of differences between patients, and this forms the basis for culturally compatible care. Certainly, this should not be seen as a patient privilege, but as a basic human right of all users of the health system (Ličen et al., 2021; Prosen, 2015).

In recent decades, nurses have delivered care to an increasing number of culturally and linguistically diverse patient groups. At the same time, problems related to linguistic and cultural issues have been perceived as a threat to patient safety and quality of care. The concept of cultural competence has therefore gained attention as a strategy for providing equitable and quality healthcare services to culturally diverse patient populations (Kaihlanen et al., 2019). While cultural competence is a multidimensional construct, it can be defined as a continuous process of striving for greater self-awareness, appreciation of diversity, and knowledge of one's cultural strengths (Alizadeh & Chavan, 2016; Ličen et al., 2017). However, cultural competence is also defined as an understanding of how social and cultural factors influence patients' health beliefs and behaviours and how these factors are taken into account at different levels of health care in order to provide patients with quality care (Alizadeh & Chavan, 2016; Narayan, 2003). In other words, as explained by Purnell (2012), cultural competence is about learning how cultural differences can affect health decisions and how care can be adapted to the patient's culture. In nursing scholarship, however, the concept of cultural competence dates back to Leininger's work on transcultural nursing. Leininger has long referred to the moral and ethical responsibility of nurses to be sensitive and respond appropriately to cultural care and other patient needs (Ličen et al., 2021; Singleton, 2017). Leininger's (2002) theory of culture care diversity and universality is based on the fundamental premise that culture influences not only people's experiences of health and illness, but also nursing care.

Developing self-awareness is the first step towards cultural competence. This requires nurses to examine how their own behaviours, attitudes, and beliefs can facilitate or impede interactions with patients and their families. Far more difficult than self-awareness is the issue of attitudes, prejudices and beliefs. While no one is immune to harbouring prejudices, in this context, it comes down to being aware of those prejudices and the ways in which they can affect patient care (McGee & Johnson, 2014).

THE CONCEPT of CULTURE

Prior to addressing how to assess patients' cultural needs, we need to reflect on why culture is important in the context of nursing assessment.

In the contemporary literature, there are many different definitions describing the concept of cultural competence and the concept of culture (Shen, 2014). Among the many experts who have proposed a definition for culture, Purnell (2002) defines culture as the socially transmitted behaviours, beliefs, arts, customs, values, lifestyles, and other products of human labour and thought characteristics of a particular population. Culture can also be understood as the dimensions in which a group of people engage in overt and verbal behaviour which reflects the shared learning histories that distinguish one group from another. In this regard, a culturally diverse context encompasses social diversity, which may take many forms, such as age, gender, sexual orientation, or socioeconomic status. It is not limited to race and ethnicity (Garneau & Pepin, 2015; Ličen et al., 2021). Fundamentally, one's culture can have a significant impact on how individuals define health or what they consider illness, when and where they seek medical help, and how they perceive overall health and the healing process (Roberts et al., 2014).

Definitions of culture have also been provided by anthropologists. Perhaps the most famous is Tylor's definition, which states:

> "Culture is the complex whole comprising knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of a society." (Helman, 2007, pp. 2-3)

It is clear from these various definitions that culture can be understood as a set of guidelines inherited by individuals as members of societies, on the basis of which they perceive the world, experience it emotionally and also behave towards other people. In a sense, culture can be seen as an inherited "lens" through which individuals perceive and understand the world they inhabit and learn how to live in it. Through this cultural "lens", however, the world and the people in it are divided into different categories, such as men and women, children and adults, young and old, relatives and strangers, upper and lower class members, disabled and non-disabled, normal and abnormal, beautiful and ugly, healthy and ill, etc. (Helman, 2007).

CULTURALLY SENSITIVE COMMUNICATION

Appropriate and effective communication with patients and their families is an essential element of nursing practice and is also crucial for assessing a person's cultural needs. Therefore, in assessing cultural needs, the basic questions of "What?", "When?", and "How?" are of equal importance (Allen & Crouch, 2016).

In the literature, the use of culturally sensitive communication is described in different ways: developing an understanding of a person's cultural attitudes, values, practices, and beliefs; communicating openly and sensitively; and developing strategies for working with patients and their families to provide optimal care (Claramita et al., 2016; Douglas et al., 2011). The most important step in learning about other cultures is to become aware of one's own cultural attitudes, values, practices, and beliefs. This awareness is necessary because cultural attitudes, values, practices, and beliefs can vary greatly and nurses need to accept and respect these differences (Brooks et al., 2019). However, sensitivity and adaptability to individual cultural differences also depend on nurses' self-awareness and reflection, which can have a positive impact on patient and family satisfaction (Gallagher and Polanin, 2015). Through knowledge and understanding of other cultures, cultural attitudes, values and beliefs, nurses are able to provide individualised and culturally sensitive care to their patients (Bellamy & Gott, 2013; Friganović et al., 2016). Nurses also need to be aware of the fact that different approaches are required to care for different patients. Assessing a person's ability to communicate in a culturally sensitive manner is important for nurses to gain patients' trust (Brooks et al., 2019).

Open and sensitive communication involves active listening and respect for each other's cultural practices and beliefs. Active listening and respect refer to interactions that are transparent and promote a therapeutic relationship between a caregiver and patient (Douglas et al., 2011). Achieving cultural sensitivity requires an exploration of how patients and families from different cultural backgrounds communicate, including verbal and nonverbal cues, and how this exploration may differ within and across cultures (Brooks et al., 2019). Culturally sensitive communication is also essential for working with patients and their families in healthcare decision-making processes. There are numerous barriers which can interfere with the nurse's ability to work with the patient, including language barriers, cultural values and beliefs. As a result, family members may feel powerless when it comes to their role and skills in caring for and supporting an ill relative (Parisa et al., 2016). Nurses who use culturally sensitive communication can show their understanding of the values, goals, and beliefs of patients and their families. This approach

incorporates family-centred care, which involves respectful and supportive interactions with the patient's family, promotes partnerships, and supports continuity of care (Brooks et al., 2019). Recommended initiatives for increasing family involvement in patient care include listening to the family and encouraging family members to speak up first and contribute to care planning and decision making, even before healthcare professionals. Other initiatives include familiarising the family with the hospital environment to help them to interpret the clinical setting in a culturally meaningful way and reduce fears and uncertainties related to the hospital setting and the health care provided (Johnstone et al., 2016).

Culturally competent care means that a health professional is sensitive to the context in which questions are asked. We all know that physical proximity and eye contact can be interpreted differently in different cultures. How do you know when to respond correctly? Cultural competence also means respecting patients' wishes when it comes to how they are addressed and whether the use of first names or other names is appropriate (Allen & Crouch, 2016). Professional behaviour of nurses in terms of cultural competence means that the nurse does not impose their cultural norms on the patient. They know that patients will only accept and follow the plan of care if it is consistent with their own cultural understanding of health and illness (Leininger, 2002). Some authors (Helman, 2007) also believe that meaningful care means moving away from traditional, "we have always done it this way" approaches such as providing the right food, finding an interpreter, and knowing what to do when someone dies, although these important factors do need to be included in the nursing process. For people to thrive spiritually even in the context of a life-threatening illness, nurses need to possess the interpersonal skills with which they can reinforce the importance of communication rather than diminish it by not taking into account the cultural needs of patients and their families.

CULTURALLY SENSITIVE HEALTH ASSESSMENT

The first step towards delivering culturally competent care is to conduct a cultural assessment as part of the comprehensive assessment which includes physical, psychosocial, functional, and environmental assessment. As part of cultural assessment, the nurse should determine the patient's cultural understanding of the health problem and how cultural norms may affect the plan of care, as well as identify the patient's beliefs, values, and practices that may support or hinder nursing interventions. In this way, cultural assessment helps nurses to better understand the patient and their health- or illness-related circumstances (Narayan, 2003). Madeleine Leininger defines cultural assessment as (Leininger, 1999):

> »The systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served«.

Based on the cultural assessment, the nurse develops an acceptable plan of care for each individual patient, which should also be based on the patient's information pertaining to their beliefs.

It is common knowledge that it is easier to ask questions than to listen to the answers. Nurses should reflect on whether they are actually able to actively listen to the patients they are working with. Are they paying attention to their body language; are they listening to what they are not saying as much as to what they are saying, are they thinking about the emotional consequences of

admitting to an illness (Allen & Crouch, 2016; Narayan, 2003)? Assessing the needs of patients in a multicultural society requires a partnership between the nurse and the patient. It is often assumed that the lived experience in the prevailing culture is a positive one.

Guidelines for Health Assessment for Patients from Different Cultures

In a chapter entitled Cultural Health Assessment, Anderson et al. (2010) outline several approaches to conducting a holistic culturally sensitive health assessment.

Ethical and cultural considerations are important components for nurses to take into account when assessing a patient's health. In terms of mitigating health inequities, the development of professional values, such as social justice, is an ongoing and long-term process which begins with nurses' professional education and continues throughout their years of work in clinical practice (Table 1) (Habibzadeh et al., 2021).

Table 1. Ethical, cultural, and social justice considerations (Anderson et al., 2010)

Ethical, cultural, and social justice considerations according to Anderson et al., 2010
1. *Conduct self-reflection regarding your personal beliefs, life experiences, explanatory models, and potentially biased attitudes:*
a) *Learn how to use these beliefs in ways that will help you respect the belief systems of patients and families.*
b) *Monitor your reactions to people and situations.*
2. *Maintain your personal and professional integrity which is essential for building trust, demonstrating respect, and being sincere in your intentions.*
3. *Determine the patient's ethnolinguistic orientation before your first meeting:*
a) *If you anticipate barriers to effective communication, seek available translation/interpretation options.*
b) *Review available documentation/records for relevant cultural and linguistic information before initiating contact.*
4. *Ethical approaches to clinical assessment require appropriate management of the power imbalance between the provider and patient/family.*
a) *Vulnerable populations (such as underrepresented minorities, people with disabilities, homeless people, and/or people living in poverty) may have difficulty communicating with providers as they may be aloof or disinterested due to their power status and prestige.*
b) *Some patients are reluctant to disclose personal information if they fear discriminatory treatment.*
c) *These patient concerns often lead to miscommunication and misdiagnosis, especially for those with mental health problems.*
5. *Show respect:*
a) *Introduce yourself by name and clinical function.*
b) *Greet patients and/or their family members by their last name(s).*
c) *Look for signs of comfort:*
▪ *Distance between self and patient/family member*
▪ *Eye contact*
▪ *Touch (ask permission before any touching, including shaking hands).*
6. *Build mutual trust:*

Table 1. Ethical, cultural, and social justice considerations (Anderson et al., 2010) (cont.)

Ethical, cultural, and social justice considerations according to Anderson et al., 2010
a) *Use techniques of active listening.*
b) *Show interest.*
c) *Provide reassurance.*
d) *Provide confidentiality.*
e) *Consider the possibility that the patient may have experienced stigma, discrimination, and/or racism.*

Methods for Conducting Health Assessments for Patients from Different Cultures

To conduct a culturally sensitive health assessment, nurses must be aware that although there are differences between cultural groups, there are also many differences between people of the same culture. Therefore, it is necessary to carry out an individual health assessment in order to plan and implement culturally appropriate care. Table 2 shows how to conduct an interview with patients from different cultures.

Table 2. Conducting interviews with patients from different cultures (Anderson et al., 2010)

Conducting the interview according to Anderson et al., 2010
1. *When you ask questions:*
a) *First determine the appropriate person with whom to begin the interview:*
▪ *Usually this is the patient.*
▪ *In some ethnic and cultural groups, a man or an older member of either gender is designated as the authority for all communication.*
b) *Start with general questions.*
c) *Avoid intrusive questions (if they must be asked, establish rapport with less intrusive questions first).*
d) *Avoid coercion.*
e) *Use verbal and behavioural cues from the patient as signals for more personal questions.*
f) *Provide opportunity but avoid directive style to ask for personal information.*
2. *Types of general information to request:*
a) *Explanatory models in patient and family.*
b) *Make an effort to learn the patient's and family's strengths before asking about their weaknesses.*
c) *Consider the possible connections with religion and spirituality when asking questions about cultural and ethnic orientation.*
3. *Ethical considerations in assessment fit well with the concept of a functioning partnership between the clinician and patient/family.*
4. *The environment, including socioeconomic and political factors, has a significant impact on the response of patients and families, as well as their dynamic interactions with healthcare providers in institutional settings, which have implications for health disparities.*
5. *Behaviours of healthcare providers that may be responsible for inequities in health outcomes:*
a) *Ineffective communication*
b) *Poor service delivery*

Table 2. Conducting interviews with patients from different cultures (Anderson et al., 2010) (cont.)

Conducting the interview according to Anderson et al., 2010
c) *Inefficiency*
d) *Cultural incompetence*
6. *Patient recommendations:*
a) *Provide opportunities to empower patients throughout the nursing process.*
b) *Train providers and staff in effective communication.*
c) *Consider alternative models of patient care.*
d) *Explore accessible mechanisms for monitoring quality of care.*
e) *Build partnerships with patients and their families.*

Cultural Assessment Tools, Instruments, Guidelines

In the existing literature, there is a lack of research on how nurses incorporate the principles of culturally sensitive care into the health assessment of patients from culturally diverse backgrounds and the planning of care based on that assessment. However, research has shown that many nurses, even those who have been trained in cultural competence, feel uncomfortable, uncertain, or even incompetent when they need to incorporate their cultural sensitivity and knowledge into health assessment and care planning (Narayan & Mallinson, 2021). Today, however, nurses can use several cultural assessment tools, instruments, and guidelines for transcultural nursing assessment. Table 3 shows an example of such guides for effective health assessment.

Table 3. The Transcultural Nursing Assessment Guide (Anderson et al., 2010)

The Transcultural Nursing Assessment Guide according to Anderson et al., 2010
1. *Biocultural variations and cultural aspects of disease incidence:*
a) *Some common diseases such as diabetes and cardiovascular disease occur more frequently in certain cultural groups.*
b) *Socioeconomic conditions may contribute to the incidence of disease.*
c) *There is increased resistance to specific diseases in certain cultural/ethnic groups.*
2. *Communication*
a) *Language:*
▪ *Language spoken at home.*
▪ *Preferred language with the healthcare provider.*
▪ *Other languages spoken by the patient and their family members.*
b) *Selection of an interpreter:*
▪ *Consider family and patient preferences.*
▪ *Culturally inappropriate interpreters may include members of the opposite sex, persons older or younger than the patient, members of a rival tribe, ethnic group, or nationality.*
c) *Rules and style of patient's communication.*
d) *Vary the techniques and style of communication to meet the patient's cultural background:*
▪ *Pace and intensity of conversation.*
▪ *Eye contact may be culturally important or taboo.*

Table 3. The Transcultural Nursing Assessment Guide (Anderson et al., 2010) (cont.)

The Transcultural Nursing Assessment Guide according to Anderson et al., 2010
▪ *Sensitivity to certain taboo topics.*
▪ *Norms regarding confidentiality.*
▪ *Styles of nonverbal communication.*
▪ *The patient's and the family's feelings and views toward healthcare providers who do not share the same cultural or religious background.*
3. *Cultural affiliation:*
a) *The patient's cultural affiliation.*
b) *Differences and similarities with other family members.*
c) *Country of origin.*
4. *Cultural sanctions and restrictions:*
a) *Expressions of emotions, feelings, spirituality, religious beliefs.*
b) *Culturally defined expressions of modesty, male-female relationships.*
c) *Restrictions related to sexuality, exposure of various body parts, or certain types of surgeries.*
5. *Developmental considerations:*
a) *Distinct growth patterns and characteristics vary by cultural background.*
b) *Factors such as circumcision, growth rates, culturally accepted age for toilet training, duration of breastfeeding, gender differences, discipline, and socialisation into adult role.*
c) *Beliefs and practices related to developmental events such as pregnancy, birth, and death.*
d) *Cultural beliefs about aging and practices related to elderly care.*
6. *Economics:*
a) *Primary earner and income level; other sources of income.*
b) *Insurance coverage.*
c) *Impact of economic status on lifestyle and living conditions.*
d) *Patient's and family's experience with the healthcare system in terms of reimbursement, cost, and insurance coverage.*
7. *Educational background:*
a) *Patient's highest level of education.*
b) *Value of educational attainment.*
c) *Impact of education level on patient's health literacy and health behaviours.*
d) *Patient's preferred learning style: written materials, oral explanations, videos, and/or demonstrations.*
e) *Patient's and family's preferences for intervention environment:*
▪ *Community venues such as churches and schools are conducive to open discussion, demonstration, and reinforcement.*
▪ *Home environment provides privacy, convenience, and personalised learning.*
8. *Health-related beliefs and practices:*
a) *Beliefs about causing illness and disease*
▪ *Divine wrath.*

Table 3. The Transcultural Nursing Assessment Guide (Anderson et al., 2010) (cont.)

The Transcultural Nursing Assessment Guide according to Anderson et al., 2010
▪ *Imbalance between heat and cold.*
▪ *Yin-Yang.*
▪ *Punishment for moral transgressions, past behaviours.*
▪ *Soul loss, hexes.*
▪ *Pathogenic organisms.*
b) *Beliefs about ideal body size and shape; concept of body image in relation to this ideal.*
c) *The terms used by the patient to express health conditions, such as the way they express pain and discomfort.*
d) *Beliefs of the patient and family members regarding health promotion:*
▪ *Eating or avoiding certain foods.*
▪ *Wearing amulets for good luck or to ward off evil (red earrings, bracelets, hats, etc.).*
▪ *Sleeping, resting, or napping for children.*
▪ *Stress reduction techniques such as exercise, yoga, meditation, prayer, ancestral rituals.*
e) *Patient's religious affiliation and involvement in religious practices and activities; similarities and differences in religious beliefs and practices between patient and family members.*
f) *Reliance on cultural healers such as curanderos, shamans, spiritual advisors:*
▪ *Types of cultural healing practices used by the patient.*
▪ *Patient and family members' perceptions of biomedical or scientific healthcare providers.*
g) *Family's arrangements for patient's home care.*
h) *Patient's and family's views of mental disorders.*
9. *Kinship and social networks:*
a) *Patient's social network such as family, friends, peers, neighbours.*
b) *Composition of a "typical" family compared to the composition of the patient's family.*
c) *Role of family members and social networks during episodes of health and illness.*
d) *Decision makers in the family who make decisions about health and healthcare.*
e) *Involvement of family members in health promotion, e.g., lifestyle changes in diet and/or exercise.*
f) *Involvement of family members in caregiving activities such as bathing, feeding, touching, being present when the patient is sick.*
g) *Influence of cultural, ethnic, or religious organisations on patient's lifestyle and quality of life.*
h) *Gender issues within cultural groups, such as adherence to traditional gender roles where women care for the household and children while men work outside the home and have the primary responsibility for decision-making.*
10. *Nutrition:*
a) *Cultural influences on nutrition; meaning associated with eating or sharing meals for the patient and family.*
b) *Eating disorders such as obesity, bulimia, anorexia, or lactose intolerance:*
▪ *Eating disorders of family members.*
▪ *How the patient and family members view eating disorders.*

Table 3. The Transcultural Nursing Assessment Guide (Anderson et al., 2010) (cont.)

The Transcultural Nursing Assessment Guide according to Anderson et al., 2010
c) *Overview of patient's and family's eating behaviours:*
▪ *The patient's definition of »eating«.*
▪ *What is considered a »healthy« diet.*
▪ *Consistency of beliefs with what the patient eats.*
d) *Family members who purchase food and/or prepare meals.*
e) *How family members are involved in dietary choices, values, and decisions about food.*
f) *How foods are prepared at home.*
g) *Nutritional practices of the patient and family members such as vegetarianism and abstinence from red meat or alcoholic beverages.*
h) *Influence of religious beliefs on the patient's and family's diet:*
▪ *Religious observances or holidays that require abstinence or avoidance of certain foods, such as kosher diets, observance of Ramadan, fasting on certain occasions.*
▪ *Observance of fasting practices within the family, periods of fasting, and exceptions to fasting.*
i) *Home remedies or special foods used to treat illnesses.*
11. *Religious affiliation:*
a) *The ways in which the patient's religious affiliation and religious beliefs influence health and illness.*
b) *Special rites or ceremonies related to healing, recovery, illness, and/or death:*
▪ *Who performs the special religious ceremonies.*
▪ *Preparations the nurse must make before performing these rituals.*
c) *The role of religious representatives in health and illness.*
12. *Values orientation:*
a) *Attitudes, values, and beliefs of the patient and family regarding health and illness.*
b) *How attitudes, values, and beliefs influence behaviour related to health and illness.*
c) *Stigmas associated with the patient's illness.*
d) *Reactions of the patient and family to changes associated with illness or surgery.*
e) *Views of the patient and family about biomedical healthcare.*
f) *Other cultural views that may influence behaviour related to health and illness.*

Other Strategies for Conducting a Culturally Sensitive Health Assessment

Nurses can obtain comprehensive cultural assessment data also through other efficient strategies (Narayan, 2003). Perhaps the simplest way is to ask the patient or family members to share their understanding of the health problem and how they think it should be treated, or to consult cultural resources to gain insight into the cultural patterns that need to be considered when assessing the patient's needs, and to integrate relevant questions into pain, nutrition, and medication assessments, as well as functional, and psychosocial assessments, so as to evaluate the impact of cultural norms on these components of the comprehensive assessment (Narayan, 2003).

Table 4 presents Spector's Heritage Assessment interview (Spector, 2016) as a useful tool for cultural assessment.

Table 4. Cultural Assessment Interview (Spector, 2016)

Cultural Assessment Interview according to Spector's Heritage Assessment Tool
▪ *Where were you born? Where were your parents born?*
▪ *What pronoun do you use (he, she, they)?*
▪ *In what language are you most comfortable speaking and reading?*
▪ *Did you grow up in a city or a town or a rural setting?*
▪ *When you were growing up, who lived with you and your family?*
▪ *Are your friends from the same cultural background as you?*
▪ *What is your religious preference?*
▪ *Do you have any dietary preferences related to your religious or cultural beliefs?*
▪ *In your culture, how do you celebrate the birth of a baby? A wedding?*
▪ *When a woman is pregnant, are there any special customs she needs to follow? Any special foods?*
▪ *When someone in your family is ill, who cares for them? What foods are prepared? Is there anything the ill person should avoid or refrain from doing?*
▪ *What home remedies might be used if someone is ill?*
▪ *As a family member is approaching death, what actions do you find comforting?*
▪ *After a loved one dies, what rituals are performed?*
▪ *What do you think a nurse should know about your culture if a family member is hospitalised?*
▪ *Who makes the decisions in your family?*
▪ *How are elders viewed in your culture?*
▪ *Are there any special beliefs regarding organ donation or blood transfusions that are held in your culture?*
▪ *Is your culture known for any special customs (e.g., rites of passage, foods, holidays, etc.)?*

The main strategy of cultural assessment is to actually ask questions about the patient's interpretation of a health problem under the influence of culture (Table 5) (Narayan, 2003):

Table 5. Patient's understanding of the health problem (Narayan, 2003)

Patients Understanding of the Health Problem
▪ *What do you call this illness? (Diagnosis)*
▪ *When did it begin? And why? (Onset)*
▪ *What do you think caused it? (Etiology)*
▪ *How does the disease work? What does it do to you? (Progression)*
▪ *How long will it last? Is it serious? (Prognosis)*
▪ *How have you treated the disease? How do you think it should be treated? (Treatment)*

These questions can be further expanded to address specific issues that the problem poses for the patient. These questions make the patient feel heard and understood, thus promoting their

trust in the nurse. With this information, a mutually acceptable nursing plan can be created that is consistent with the patient's cultural understanding of the problem (Narayan, 2003) (Table 6).

Table 6. Cultural Assessment Checklist (Narayan, 2003)

Cultural Assessment Checklist according to Narayan, 2003
Degree of acculturation
▪ *How strictly does the patient/family adhere to the beliefs/values/practices of their culture of origin?*
▪ *Is the patient/family traditional (holds to the customs of their culture of origin)? Acculturated (understands and is able to navigate the old/new culture)? Assimilated (has internalised the norms of the new culture)?*
Religion/spiritual needs
▪ *Are there spiritual practices that nurses can help the patient observe (e.g., special prayer times)?*
▪ *Are there religious items that the patient likes to use, wear, or have with them?*
▪ *Are there special rites/blessings for the ill? Are there spiritual guides/healers that the patient finds helpful?*
▪ *Are there dietary restrictions or rules that should be followed?*
Language and communication
▪ *What is the best language for the patient to speak?*
▪ *The patient has a right to a medical interpreter. Does the patient request one?*
▪ *Is the patient able to read in English or preferred language?*
Patient's explanation of the health problem
▪ *What do you call the problem you have? (Use the patient's term instead of "the problem" for the rest of the questions).*
▪ *When and how did your problem start? Why do you think the problem started?*
▪ *What do you think caused this problem? Why do you think you developed this problem and not someone else? What might others in your family/community think is wrong with you?*
▪ *Do you know anyone who has had this problem? What happened to that person? Do you think this will happen to you as well?*
▪ *What are the main problems this disease has caused you? What problems has it brought into your life? What do you think will happen?*
▪ *What do you fear most about this problem? How serious is this problem? Do you think it is curable?*
▪ *How have you treated the problem so far? What have you done to feel better? Have you tried remedies such as herbs or remedies from your home country?*
▪ *How do you think the problem should be treated by you, your family or those around you? Who in your family/community/religious group can help you? Do you turn to other healers for help?*
Nonverbal communication patterns
▪ *Is eye contact considered polite or rude?*
▪ *Is personal space larger/smaller than usual in your country?*
▪ *When, where, and by whom may the patient be touched?*
▪ *What is the significance of certain facial expressions and hand/body gestures?*
▪ *Is special importance given to loud or whispered conversations?*
Etiquette and social customs
▪ *How would you like to be greeted and addressed by our staff?*
▪ *What behaviours are expected of guests? Take off shoes?*

Table 6. Cultural Assessment Checklist (Narayan, 2003) (cont.)

Accepting food/drinks?

- *Is punctuality important?*
- *Is it polite to make "small talk" before getting "down to business"?*
- *Should discussions be direct and blunt or subtle and indirect?*
- *What topics are not acceptable? Is it appropriate to talk about emotions and feelings? To discuss reproductive, sexual, or elimination issues? Should we discuss the possibility of negative consequences?*

Health/disease problems

- *Are there health problems that have a stigma attached to them in the culture? Are there culture-bound diseases (i.e., diseases that are only recognised within the culture)?*
- *Are there tests/procedures/treatments that violate cultural norms?*
- *What has the patient found helpful in previous experiences with the healthcare system? Offensive? Confusing?*

Lifelong rituals/practices

- *What beliefs, values, and practices accompany life events (birth, childcare, aging, death)? Ask depending on the patient's situation.*
- *If the patient has a terminal illness, should one "tell the truth" or "hold out hope"?*

Biophysical variations/risk factors

- *Are there genetic variations or endemic diseases that are common in the patient's group?*
- *Do members of the culture frequently engage in harmful practices?*

Assessment of pain

- *Is the patient more stoic or expressive when in pain?*
- *What is the significance of pain to the patient?*
- *Is pain generally described quantitatively or qualitatively?*
- *Is the numerical scale confusing?*
- *What is the patient's attitude toward taking pain medication?*
- *What is the worst pain you have ever had? How have you dealt with it? How did you treat it? How well did the treatment work?*

Nutrition assessment

- *What is eaten and when is it eaten? Complete a 2-day dietary record.*
- *Are there any dietary habits that might conflict with the plan of treatment (e.g., fasting)?*
- *Is there a possibility of food-drug interactions with traditional foods?*
- *Which foods are considered beneficial to health? Which foods are considered good for sick people?*
- *Does the patient subscribe to the cold-warm theory of illness and treatment?*
- *Are there religious dietary rules and restrictions?*

Medication assessment

- *What is the patient's attitude toward Western medications? Does he appreciate them or distrust them?*
- *Could there be genetic differences in the way the patient responds to medication?*
- *Are there traditional remedies, such as herbs, teas, or ointments, that the patient uses?*

Daily (health) practices and routines

- *Are there any special rituals/practices related to bathing, toileting, hair/nail care?*
- *Are there restrictions based on gender/age/social class on who can help a person with daily tasks?*
- *How important is modesty? How is modesty demonstrated?*
- *Are there particular morning/evening rituals or practices that are important to the patient?*

Table 6. Cultural Assessment Checklist (Narayan, 2003) (cont.)

Psychosocial assessment
▪ *Who is considered "family"? What is the impact of the illness on the family?*
▪ *Who is the head of the family? Who makes the decisions for the patient?*
▪ *Who should we discuss your care with? Is there someone to help you make decisions?*
▪ *How are family members involved in the patient's care?*
▪ *Who will help you when you are sick? How do they help you? How would you like them to help you?*
▪ *What health/support services are available in the patient's cultural community?*

CONCLUSION

Culturally competent nurses provide culturally competent care when they seek to understand a health problem from the patient's perspective through a culturally sensitive health assessment. By incorporating non-harmful cultural practices into the nursing plan, they create a consensual plan that is culturally acceptable to the patient and can achieve the good outcomes that both the nurse and the patient ultimately seek.

Review Questions

- *Try to describe your culture? In addition, try to rank the following items in order of importance: Religion, ethnicity, family, food, and future? Do you think the patients you care about have the same priorities? Do you think these values impact your relationships with them?*
- *What does your body language say about you? How might a patient from another culture interpret your body language? Could your body language express something different than your words?*
- *Active listening is the key to good communication. Active listening requires you to listen carefully to patients, understand what they are saying, respond to it, and think about what they are saying. Are you an active listener? Explain why yes and why you are not.*

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B) CULTURALLY SENSITIVE NURSING CARE

Sandra Tricas-Sauras, Ann Claeys

Key Points

1. Transcultural nurses may find it challenging to deliver transcultural nursing care in a consistent manner. Using specific tools or models to guide their practice may assist them daily care.
2. The ACCESS framework by Narayanasamy (1991) brings a European (UK) perspective to transcultural care and assessment. It provides a structure for nurses on how to deliver transcultural care (which is culturally sensitive and considers their culture, beliefs, and values while providing tailored care).
3. The ACCESS model has six main elements, which comprise assessment, communication, cultural negotiation, and compromise, establishing respect and rapport, sensitivity, and safety.
4. The ACCESS model is an example of how a straightforward approach may help students, nurses, and researchers to improve practice within a multicultural setting.

THE ACCESS MODEL: A TRANSCULTURAL NURSING PRACTICE FRAMEWORK

Despite a vast number of studies and scientific literature currently emerging on the topic of transcultural nursing, nurses often struggle to deliver transcultural nursing care in a consistent manner. As seen in the previous chapters, many researchers have focused on clarifying specific aspect of transcultural care, providing cultural assessment tools, or leading specific research on how to deliver excellent care to culturally diverse patients and families (Journal of Transcultural Nursing, 2010; Sagar, 2012; Sagar & Sagar, 2018). Most of those investigations have roots in the USA, although the most recent scientific literature provides a wider view on other contexts, such as the Australian, European, Middle East, or Southeast Asian perspectives.

In 1988, Leininger postulated that "cultural care provides the broadest and most important means to study, explain, and predict nursing knowledge and concomitant nursing care practice" (Leininger, 1988, p. 152). However, to date, slight differences regarding the concept of culture/s can widely influence care provided by nurses in very diverse contexts and practices. For instance, in the case of mental health care. Nowadays, certain bodies, such as The Join Commission International (TJC, 2010), advocate for nurses to be compliant, not only with culturally and linguistically appropriate services but to widely disseminate resources in order to facilitate training at all levels.

The key to delivering good care appears to be intimately related with how well nurses assess the needs of their patients, families, and significant others. Sometimes, the assessment may be thorough but complex and onerous, and therefore pragmatic options also seem to be essential, such as the UK-based assessment, communication, cultural negotiations and compromise, establishing respect, sensitivity and safety (ACCESS) model proposed by Narayanasamy in 1998.

This subchapter will present the origins and the key elements of the ACCESS framework, as originally described by researcher Aru Narayanasamy, in 1991. Some examples of the use of ACCESS will be provided by the main author, and also by the recent literature.

Narayanasamy's framework to deliver transcultural nursing care brings a UK perspective, and has been extensively used in England, particularly by the University of Nottingham, where it originated and was embedded in the nursing curricula. The ACCESS model is a good example of how a straightforward approach may help students, nurses, and researchers to improve practice within the multicultural setting.

This chapter supports the systematic use of a transcultural approach to care. The latter may be assisted by the use of straightforward tools (or frameworks such as ACCESS) that provide nurses with the structure to guide their care process in a sensible manner.

EN ROUTE to the ACCESS MODEL

Aru Narayanasamy is a former Associate Professor of Nurse Education at the University of Nottingham (UK). He developed most of his remarkable work on spirituality and cultural diversity at the Faculty of Medicine and Health Science, Queens Medical Centre, University of Nottingham. He was also an advisor to various agencies and the co-editor for the Open Nursing Journal. His innovative work produced several models, which translated in notable teaching innovations such as the actioning spirituality and spiritual care education and training (ASSET) model (Narayanasamy, 1999c) and the focus of this subchapter: the Transcultural ACCESS model for nursing. Both examples have been adopted in the UK, Europe, USA, Australia, Canada, Hong Kong, Taiwan, India, and Turkey, among many other countries.

Narayanasamy equally focused on e-learning education and developed various resources on diversity for teachers and students. Most of his work has focused on diversity and healing and spiritual/cultural care. One of his initial publications appeared in Lyttle's mental health and disorder reference book, where he presented a chapter exploring the concepts of spiritual care and mental health competence (Narayanasamy in Lyttle et al., 1994; Thompson, 2000).

Later, a series of articles appeared in 1999 in the British Journal of Nursing (BNJ) with a focus on Transcultural Mental Health Nursing (Narayanasamy 1999a; Narayanasamy 1999b) and where the ACCESS model was initially mentioned (Narayanasamy, 1998), although it had not yet been published as such. These two articles explored the benefits and potential limitations of using a transcultural approach within the mental health setting, and as well reviewed key concepts to the field of study, such as race, ethnicity, and culture. Narayanasamy (1999b) insisted on the importance of clarity when it comes to the use of those three terms, particularly in the case of transcultural nurses. He revisited the work by Fernando (1991, 1995), and he underlined the lack of precision in the above-mentioned concepts (which were naturally also dependent on socio-political considerations and history). In fact, those three terms continue to evolve, and it can be seen that they are often revisited by academics in trying to nuance previous definitions.

In his work, Narayanasamy insisted on the need for using research to advance knowledge, and to therefore tailor nursing interventions to eliminate differences for specific minority groups. The concept of ethnic minorities is still controversial today and in the work of Fernando (2010, 1995, 1991), he discussed the pertinence of utilizing specific terminology (see Table 1).

The UK-based Law Society (2020) suggested a careful assessment when choosing a specific term to refer to the origin of a particular patient or family. Additionally, careful consideration and awareness[1] should go into the fact that certain denominations may change depending on a specific country, region, and time frame, with rapidly evolving terms across the globe. Although the use of specific denominations may not yet be extended, professionals working in the field of transcultural health should be aware of the importance of using language properly. An adapted summary of the definitions by Narayanasamy at the time, can be found below in Table 1.

In his first paper published in the BJN, he provided an overview of key concepts regarding transcultural nursing, as well as assumptions, concerns, and criticisms regarding this discipline (already identified throughout this book, and therefore will not be further explored herein). Narayanasamy warned against generating stereotypes, unwittingly and despite well-intended objectives, while working with cultures, in an attempt to oversimplify them. This is key within the mental health context, for instance, where both culture and mental health disorders may be intrinsically related in terms of manifestation, acceptance, or even presentation of the symptoms (Galanti, 2018). Narayanasamy, also warned against leaning towards potential generalizations and stereotypes, encouraging nurses to look critically and challenge their own labels, which may determine future work with individuals and their families. Galanti (2018) also urged nurses to identify the core causes for "cultural disconnects" among professionals and healthcare users. In this sense, Narayanasamy equally justified and encouraged the importance of employing a transcultural approach within the psychiatric setting. However, to date, much work remains to be done in order to develop a real insight into the cultural dimensions of mental health and illness (Narayanasamy (1999a)).

1 "Awareness is needed when choosing specific terminology, such as ethnic minority, minority ethnic, or minoritized ethnic. Additionally, consideration should be paid to certain language nuances, as it is in the case of US and UK denominations, or similarly when using (for instance) Hispanic terminology depending on Latin-American countries contexts or in Spain. When speaking of nuances and new denominations, emerging terminology such as the acronyms BAME (Black, Asian and minority ethnic) or BME (black and minority ethnic) may also pose problems, since those could be seen as labelling individuals as well as excluding those of who have a mixed ethnicity" (The Law Society, 2020).

Table 1: Key definitions: Adapted from Narayanasamy (1999 b)

	Nuances	Definitions
• **Race**	Pejorative connotations. Primarily physical component. Race and ethnicity often used and interchangeably.	Race: categorization mainly based on physical attributes or traits, assigning people to a specific race simply by having similar appearances or skin color (i.e., black or white). The categorization is rooted in white supremacy and efforts to prove biological superiority and maintain dominance over others. Today: recognition that race is a social construct. However, racial identity is important to many and can be a basis for collective organizing and support for racially minoritized individuals (Gov.UK, 2019).
• **Ethnicity**	Preferred use to race. Used as a reference to minority racial groups. Psychological connotation. Ethnic minority communities were often subject to hostility and rejection because of racist attitudes in the dominant population (Wright, 1991).	Emergent ethnicity: ethnicity that evolves and becomes well established as a result of social factors acting as a psychological safety mechanism against a dominant culture (Yancey et al, 1976). Ethnicity: broader than race and has usually been used to refer to long shared cultural experiences, religious practices, traditions, ancestry, language, dialect, or national origins (i.e., African-Caribbean, Indian, Irish). Ethnicity can be seen as a more positive identity than one forged from the shared negative experiences of racism. Ethnicity: commonly used and asked about within diversity questionnaires in the UK, not so often across EU (Gov.UK, 2019).
• **Equality Act, 2010-UK**	In the Equality Act 2010, (UK) the protected characteristic of 'race' is defined as including color, ethnic or national origin, or nationality.	There is some overlap with the characteristic of religion or belief too with Jews and Sikhs considered to be ethnic groups under the act, although Muslims are not considered an ethnic group but a religious group only under the act's definitions.
• **Culture** The term "culture" is not defined by Narayanasamy in his 1999 BNJ series.	Nursing is not culturally free but embedded in a specific culture which permeates all aspects of care. Attention to imbalances between team members.	Not a single or simple definition of culture exists, with many layers and manifestations shaping this conversely widely used term. Culture (from the Latin cultura stemming from colere, meaning "to cultivate") usually refers to patterns of human activity and the symbolic structures that give such activities significance and importance (Airhihenbuwa, 1995). Culture: considered an umbrella term, that considers the social norms and traditions present in societies. It comprises also the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals' specific groups at a particular time that provide a sense of belonging. (Adapted from Government of Ireland Department of the Environment 1995 in Tuohy, 2019; The Cambridge Dictionary, 2021. The feeling of belonging may be defined as the comprehension of specific cultural forms and in sharing values and identity. Culture is the way we learn to think, behave, and do things' (Government of Ireland Department of the Environment 1995 in Tuohy, 2021).

In his second paper on transcultural mental health, Narayanasamy (1999 b) reflected on the double discrimination that people usually face while receiving a mental health diagnosis and at the same time belonging to an ethnic minority, or simply being a migrant. Aspects such as racialization and misdiagnoses for specific communities were similarly underlined. In his paper, he discussed, for instance, the differences regarding admission rates when it comes to specific communities. This remains an ongoing and real debate (Pérez-Rodríguez et al., 2006; Polling et al., 2021), as well as how the origin of a particular client, may multiply the chances of being diagnosed or even admitted to a psychiatric unit through, for example, involvement of the police, as in the case of some minorities or specific ethnicities (Crawford et al., 1998; Gary, 2005; Pérez-Rodríguez et al., 2006; Lawlor et al., 2012; Halvorsrud et al., 2018; Barnett et al., 2019; Delanerolle et al., 2021).

A mental health diagnosis and psychiatric conditions may be severely affected by cultural perceptions and or religious orientation, as noted by Fernando (1991 in Narayanasamy, 1999b). Hence, a diagnosis may be delayed or not disclosed every so often (Crawford et al., 1998; Gary, 2005; Pérez-Rodríguez et al., 2006; Lawlor et al., 2012; Halvorsrud et al., 2018; Barnett et al., 2019; Delanerolle et al., 2021). For instance, in certain cultures, mental illness is often associated with a supernatural cause, or as a punishment for previous actions. Moreover, the way in which mental suffering is expressed may vary from one region to another (Marsella in Narayanasamy, 1999b; James & Prilleltensky, 2002; Ang, 2017) with specific patterns of behavior modulated by culture, as noted earlier. Consequently, variations within culture and origin may have broad implications both for patients and professionals. This may include their own relationship with concepts such as wellbeing, disease processes, treatments, and acceptable alternatives, not to mention individual aspects regarding racism or discrimination (Pérez-Rodríguez et al., 2006; Gopalkrishnan, 2019; Delanerolle et al., 2021).

Cultural and social factors can also play a key role in the origin and progression of mental illness, although this may vary depending on a specific diagnosis (Pérez-Rodríguez et al., 2006; Gopalkrishnan, 2019). Equally often, people who leave their roots behind may be more vulnerable to experiencing mental health problems. In some dramatic cases, migrants are forced to leave their homes due to famine, war issues, or persecution, leading to traumatic experiences that will have an important impact in their daily lives (López et al., 2017; Kadir et al., 2019; Gatt et al., 2020; Bendavid et al., 2021) and future development.

Narayanasamy (1999b) briefly discussed the potential discrepancies in the experience of mental health across different origins. Moreover, the way in which culture-related factors may challenge the universal categorization regarding mental health illness, such as, for example, the case of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013), where it specifically notes that conditions from non-Western countries are considered as “culture-bound”. Despite great interest in this stimulating topic, it exceeds the purpose of this subchapter, but further information can be found in the original article series presented by Narayanasamy, as well as in recurrent academic discussions.

In his second BMJ paper (Narayanasamy, 1999b), he finally introduced his original ACCESS model (1998) and its application within the mental health setting while providing specific culture related examples for the reader. The humble approach of ACCESS seems perfect for professionals practicing mental health nursing from a transcultural perspective. This framework offers the structure and attention points needed for professionals to remain observant when working with this dual perspective (transcultural care and mental health).

THE ACCESS MODEL by NARAYANASAMY

As mentioned, the ACCESS model was first developed in 1998 by Narayanasamy, but was not addressed until 1999 in his BJN series on Transcultural Health and Mental Health (Narayanasamy, 1999a; Narayanasamy, 1999b). He later evaluated its usefulness as a transcultural practice framework (2002) and the nurses' response to cultural needs, as well as their need for further education in the UK context (2003). Since then, Narayanasamy's research has focused on a variety of topics, but mostly with a focus on transcultural aspects and spiritual care in the mental health setting, as well as innovation in education, to cite a few (Narayanasamy, 2004; Narayanasamy et al., 2004; Narayanasamy, 2006; Narayanasamy & Narayanasamy, 2006; Narayanasamy & Narayanasamy, 2008; Narayanasamy et al., 2010; Nixon & Narayanasamy, 2010; Narayanasamy, 2014).

The concept of transcultural nursing has been consistently revisited across this book and therefore, no further description will be provided in this subchapter. Nevertheless, it should be noted that the concept of culturally appropriate and sensitive nursing care (intimately related to the core concept of transcultural nursing) has flourished over the past three decades, and it will evolve as societies do. In his publications, Narayanasamy has explored the work from contemporary researchers, particularly focusing on the issue of working with ethnic minority groups and perceived health needs (Gerrish et al., 1996; Fletcher, 1997; Le Var, 1998; Papadopoulos et al., 1998; Gerrish and Papadopoulos, 1999; Serrant Green, 2001; Narayanasamy, 2002). It should be also underlined that at the time that ACCESS was being developed, key actors in the field of transcultural nursing where also presenting their models, such as Purnell (1998 in Purnell, 2019; 2002), Campinha Bacote (1991, 2007); Giger & Davidhizar (1990, 2002); Davidhizar & Giger, (2004), and Spector (2002), who underlined the importance of the topic and the shared interest around the world.

Narayanasamy's work is rooted in Britain, which has traditionally been considered as a multi-ethnic and multicultural society with growing percentages of the population belonging to black or other minority ethnic groups (2002). According to the Office for National Statistics (ONS), at the time of writing this chapter, the latest survey figures from 2019 would suggest that people from ethnic minority backgrounds accounted for up to 14.4% of the UK population (16.1% for England, 5.9% for Wales, 5.4% for Scotland, and 2.2% for Northern Ireland). It is not possible to predict how societal changes will evolve, particularly after Brexit, but it is still clear that health providers in the UK must in any case, always be ready to respond to cultural and ethnic diversity while also providing culturally adjusted and sensitive care. This point has been strongly encouraged by Narayanasamy and he underlined the fact that "fairness and justice" should be foundational (Narayanasamy, 2002) in the care process. With regard to the data on ethnicity in the European region, the very diverse methodologies (data protection, data restriction, etc.) used across the EU states hinder the ability to obtain a clear picture of the genuine situation or simply establish further comparison with other regions (European Commission, 2017). However, the 2015 edition of a special Eurobarometer (n.437, 2015) explored ethnic origin-based discrimination in the EU, which suggested that this type of bias was heavily perceived across the EU population. Data from the Centre for International Crisis Management and Conflict Resolution at University of Nottingham (Wolff, 2008) indicated that similar to the UK, the total number of national minorities populations in Europe would account for about 14% of its citizens (Wolff, 2008). As an ethnically diverse continent, Europe still experiences important differences from country to country with ethnic identities and its presence largely related to geography.

This point is particularly relevant for transcultural nurses, since care and the dominant culture within countries will undoubtedly be influenced by tradition and local practices. Certain intrinsic hazards would therefore exist, and an attentive eye is thus required.

In his work, Narayanasamy acknowledged Leininger's (1959 in 1998) model, as well as other relevant researchers and their contributions to this field, but at the same time he voiced important concerns regarding the lack of appropriate culturally competent care in general, and particularly in the UK, despite the vast amount of existing knowledge and theories to support competent care (Gerrish et al., 1996; Polaschek,1998; Royal College of Nursing, 1998; Gerrish & Papadopoulos, 1999; Henley and Schott,1999; Narayanasamy, 1999a in Narayanasamy). Similar concerns prevail, even today, in many countries, despite promising examples such as those highlighted throughout this book. Nevertheless, it should be noted that the scenario has noticeably evolved recently and encouraging signs can be seen locally and internationally. In the UK, the Middlesex University Research Centre for Transcultural Studies in Health has developed a leading role in creating awareness and establishing networks to take this field further. The work conducted by Papadopoulos et al. is inspiring, and it is in constant evolution. For instance, one of their latest research developments, the CARESSESS project, incorporates artificial intelligence and robots to deliver culturally competent care (in specific settings) (Papadopoulos et al., 2020; Papadopoulos et al., 2021). Equally, the work conducted by Pezzella et al. at Middlesex, on LGBTQA+ issues and transcultural aspects of health (Baiocco et al., 2021; Hafford-Letchfield et al., 2021; Papadopoulos & Pezzella, 2015; Pezzella, 2016 and 2018), opened interesting new avenues for improving transcultural work with populations that may have been traditionally rather invisible or unfairly treated. These initiatives underlined the need for collaborative work, with wider and bolder visions to be conducted in the coming future on a global basis. As an example, the BENEFITS Project (Tosun et al., 2021) will positively provide a European curriculum (and evaluating tools) that should assist nursing schools in delivering quality education on transcultural nursing in a coherent and comprehensive manner. This EU partnership (Erasmus+ Program of the European Union, 2019) underlined the significance of international collaboration in developing quality materials, inspired by collaboration and intense exchange of multicultural teams. In this case, representatives from Belgium, Czech Republic, Hungary, Slovenia, Spain, and Turkey collaborated actively towards the design and implementation of such a curriculum, which encourages nurses to put theory into action.

The work of Narayanasamy also pursued the active practice of nurses, and this is one of the reasons why the ACCESS model was doubly welcomed, due to its usability and its action-centered approach. ACCESS naturally enhances the planning and subsequent implementation of congruent care, and most importantly it is compassionate from the start.

The next section will describe Narayanasamy's ACCESS model and its key elements in detail.

ACCESS FRAMEWORK

The ACCESS model focuses on planning and implementing congruent care in a respectful, sensitive, and compassionate manner. ACCESS is an acronym for Assessment, Communication, Cultural negotiation (and compromise), Establishing respect and rapport, Sensitivity and Safety, as described by Narayanasamy in 1998 and 1999. Those elements will be breifly presented in Table 2, and later described in detail.

Table 2. ACCESS Elements (Adapted from Narayanasamy, 1999)

• *Assessment*	Cultural aspects, health beliefs and health practices
• *Communication*	Verbal and non-verbal (variations)
• *Cultural negotiation and compromise)*	Awareness of other culture's and understanding individual views and own explanations
• *Establishing respect and rapport*	Therapeutic approach displaying genuine respect for other cultural beliefs and values
• *Sensitivity*	Culturally sensitive care delivery
• *Safety*	Empowering cultural safety

Assessment:

As in other transcultural models, a thorough evaluation of all cultural aspects of an individual way of life, health values, and health practices, will assist nurses in reviewing and planning subsequent care interventions. A correct cultural assessment (Narayanasamy, 1998) will increase our understanding of the individuals we care for, their beliefs, and subsequent practices, even when those traditions that may seem remote to our own backgrounds. Narayanasamy's model includes specific questions that may help professionals to guide their interviews with patients regarding health beliefs. An adapted version of those queries can be found in Table 3, which can be adapted depending on the specific scenarios. It is important to carefully listen to patient's accounts as to what is causing their disease, what their relevant symptoms are, or the patients' opinions regarding potential treatments. Narayanasamy referred to the seminal work and "explanatory model" of illness by Kleinman et al. (1978; 1980). For the record, explanatory models refer to "notions about an episode of sickness and its treatment that are employed by all of those engaged in the clinical process" (Kleinman, 1980 in Lloyd et al., 1998). Those valuable accounts will provide unique insight into the patient's perspective (from the origin of their affliction to the actions that may be taken forward to improve their situation at a given moment).

A key aspect of the ACCESS model is the emphasis it places on the necessary "conscious and sustained" efforts from professionals, to identify crucial factors that may influence the patients' reaction to a specific condition or diagnosis. Patients' accounts and descriptions of their journey should be encouraged to help professionals to identify what values and attitudes are associated with the impact of the disease/illness in their lives. Careful planning and specific interventions should emerge from those narratives to assist patients, families, and significant others throughout this journey.

Communication:

The concept of communication is transversal in nursing care, as well as in everyday life. As noted in the previous subchapter (Claeys & Tricas-Sauras, n.d.), nurses communicate in a non-stop basis. Occasionally those exchanges could also be the origin of conflictual situations due to an inaccurate reading of conversations, or unsatisfactory interpretation of the former.

Transcultural care and communication are therefore no exception to the equation of nursing and excellent care. Appropriate cultural communication is in itself a passionate adventure since many elements converge. For that reason, nurses must develop their skills in recognizing essential aspects that may have an impact on their daily exchanges with patients, families, or significant others. Some of those elements have been previously cited, such as body posture, distance,

Table 3. Examples of questions about Patients' Health Beliefs (Adapted from Narayanasamy, 2002).

• *What do you think could have caused your problem (adapt as needed)?*
• *Why do you think it happened at that specific moment in time?*
• *What effects if this (...complete as by case) problem having on you?*
• *What type of treatment would you expect? What type of treatment do you think you should receive?*
• *Do you believe your (health problem/complete as necessary) can be serious? Why?*
• *Do you think your condition will last over a long period of time?*
• *What are some of the problems that your condition (adapt as needed) has caused?*
• *Some persons forget to take daily medication. Do you think this could ever happen to you?*
• *What have you done (if necessary) to take your medication?*
• *What specific aspects of your condition (adapt as needed) make you worry?*

gestures, use of language, listening styles, eye contact, time and punctuality, or touch modalities, among others. For instance, Spaniards may feel uncomfortable when their interlocutor does not address them or look straight into their eyes, so they may insist on gazing at the professional. This could be the opposite in other contexts, where cultures may find direct eye contact unprofessional and intimidating (Galanti, 2018). Touching a child's head can be interpreted as a sign of affection or warmth for Mediterranean cultures, but it would be an absolute shock or even an offense for some Asian cultures, which regard the head as the most important part of the body (D'Avanzo, 2008).

Another essential aspect of every day communication is the use of correct language and how its fine use, or misuse, may have a certain impact, for instance, on finding the adequate treatment for a patient and/or subsequently delaying recovery (when language barriers prevail). This has been largely documented by the scientific literature (Origlia Ikhilor, 2019; Grylka-Baeschlin et al., 2020; Le Neveu et al., 2020; Bains et al., 2021) and often, the use of interpreters or members of the family as translators is often encouraged. Nevertheless, nurses should be wary when using family members as interpreters, since patients may often feel shy, uncomfortable, or simply embarrassed to share certain details in front of their relatives. This may end up being a larger challenge for professionals, since they may end up, ultimately lost in translation, with all the already mentioned consequences for the correct assessment and impact of subsequent treatments.

In multicultural and ever-changing societies, as it is the case nowadays (in many places around the world), it may be difficult to be aware of the small nuances involving verbal and/or non-verbal communication. Additionally, an important aspect in multicultural societies is the use of languages in a proficient manner, or in a colloquial one. Societies become naturally diverse (although this may not be the case in smaller provinces or specific regions) and nurses also migrate, for different reasons, to countries where they can practice their profession. However, the process of acquiring proficiency in a different language may take years of practice (Ho & Chiang, 2015; Lundin et al., 2018; Nortvedt et al., 2020). Recent work has been conducted on how to support nurses in enhancing effective language training (Nortvedt et al., 2020); however, aspects such as identifying certain subtleties during communication exchanges may take much longer

for non-natives. On a promising note, a variety of tech resources exist that can assist nurses, at a given moment, in developing their practice in a professional manner (Schloman, 2000; Bischoff & Hudelson, 2010; Henderson et al., 2016; Mikkonen et al., 2016; Hagqvist et al., 2020; Müller et al., 2020; Noack et al., 2021). The challenge sometimes is using those resources without getting lost in the vast array of existing options, such as those on paper, online, or available as e-applications. Particular options are also being developed by certain universities, or as part of collaborative research projects, that may not be yet widely available. For instance, the Erasmus Hogeschool Brussel alliance with HoGent, both based in Belgium, are currently working on the development of a training module for the use of digital aids in communication with non-Dutch speaking patients (Van Landschoot et al. (n.d.). Similarly, the interesting TransCocon project completed in 2020 (funded by the EU), focused on creating Re-usable Learning Objects for Trans-cultural Collaboration and Competence in Nursing. Those are simply two local examples of stimulating opportunities to enhance communication in multicultural settings that may escape wider audiences. It is suggested to use available networks and keep an interested eye on developments that will lead professionals in the right direction. Some of those resources will probably be inspired by a particular context, region, or countries where specific nuances may also apply.

Cultural negotiation and compromise:

Nurses practice their diplomacy on a daily basis, and many researchers (Papadopoulos et al., 1998; Leininger, 2002; McFarland et al., 2012; McFarland & Wehbe-Alamah, 2014) have insisted on the importance of avoiding the use of forcefulness during practice. However, a key to cultural negotiation, as described by Narayasanamy, is the active role embraced by professionals. Nurses in general (but particularly those working on transcultural nursing, and ideally those working in diverse settings) must ensure that they actively try to be aware of other cultures. This does not mean that professionals should be skilled in dealing with all cultures, but they should at least have the basis (the will) and the resources to quickly understand key information that will guide them in their care processes. An example of a facilitator in this context is the pocket guide developed by Galanti on Cultural and Religious Sensitivity (Galanti, 2018). Her work is available both as a booklet and as a mobile application, making it easy to access during daily practice. Another comprehensive resource, The Facilitators Guide, a guide to help professionals in deepening in their cultural negotiation (Office of Minority Health US Department of Health and Human Services, n.d.), was designed by the US government. Similarly, the popular Pocket Guide to Cultural Health Assessment by D'Avanzo (2008) is a great way to approach working with a patient from a culture that nurses are not fully competent in. This guide provides a rather comprehensive insight (from over 170 countries) on key aspects regarding culture and clinical aspects that may be influenced by the origin/s of the patients. Becoming familiar with patients' backgrounds will facilitate negotiations but will also require compromises to be made with patients and families while showing a sensitive approach. For instance, patients may favor the use of complementary therapies, or be assisted by traditional healers, shamans, or coaches throughout their illness process (D'Avanzo, 2008). Equally, patients or families may ask for specific ceremonies to be arranged (such as daily communion for Catholics during their hospital admissions) or request that the furniture in the room face toward Mecca in the case of Muslim patients. Nurses must reinforce patients' values and negotiate, when possible, aspects of care that will be beneficial to them and their significant others (Galanti, 2018).

Establishing respect and rapport:

First impressions count, and the initial contact with the patients may influence the whole relationship that is developed throughout the care process, given that initial feelings may determine the professional interactions. This is particularly relevant for transcultural care processes, where small signs may be wrongly perceived either way, if not addressed properly and politely. Respect is a key element of the ACCESS model, since a respectful relationship will enhance the caring dynamics facilitating exchanges and beneficial discussions. Narayanasamy (1999) noted that patients often feel vulnerable when admitted to a hospital, but also because of the specific cultural connotations that "being a patient" may have for them. Self-esteem may thus be affected, and hence, competent professionals should acknowledge it and reinforce a good rapport. This point has been proven to enhance patients' own self-respect and strengthen therapeutic relationships (Narayanasamy, 1999). For instance, in her research, Lo (2012) reflected on the importance of establishing respect and rapport in the case of Chinese oncological patients. She suggested that Chinese culture may be rigid in the type of communication behaviors that are expected, particularly in the case of foreigners. This aspect of communication would have a marked effect on Chinese and non-Chinese (nurses or patients) relationship. Lo (2012) noted that, for example, Chinese patients may avoid offense by remaining courteous, but they could then be consequently perceived as submissive by professionals. She noted that in this case, nurses need to be especially attentive to subtle changes, such as facial expressions or body positioning. Inside and outside (of the patients' own family) rules may equally apply, and as noted by Yeo et al. (2005), implicit communication is regarded as a common rule in Chinese culture. This may lead to ambiguous communication, which is often overlooked by cultures that may rather use direct communication styles, as is the case in North America or the Netherlands, to cite a few contexts.

Lo's (2012) example is particularly relevant when, for instance, using interpreters to convey sensitive information, such as bad news regarding a specific oncological treatment. In this case, transmitting details in a clear manner, may be considered extremely offensive, and have a disruptive effect, not only for the patient, but also for the family system. In other cultures, such as Latin or Mediterranean, some families still may prefer to be the warrant of bad news, perpetuating a "silence's conspiracy" (Reich, & Mekaoui, 2003; Munoz Sastre et al., 2011; Nasrabadi et al., 2020).

On another level, paying attention to the level of familiarity gained during interactions with patients and families is also important. This could often be beneficial, but misunderstandings may appear as well, as part of these exchanges. Fostering trust in all exchanges will enhance mutual respect and increase rapport in professional relationships.

Sensitivity:

For Narayasanamy, "the key point of care is recognizing and delivering diverse culturally sensitive care to diverse cultural groups" (Narayasanamy, 2002). Lo (2012) also suggested that cultural sensitivity and negotiation must be embedded within the care process, yet this care should be met through culturally adapted processes. Nowadays, a fast-paced work environment is often present and impregnates the routines of nurses. Realistically speaking, a crucial element in ensuring that appropriate care is delivered depends on nurses' intrinsic motivation to create the time and safeguard places to effectively communicate with patients and families (Kersey-Matusiak, 2019). Fundamental matters, such as how nurses introduce themselves (or not) and the way they do it, may shape future interactions. However, simple introductions appear unexpectedly neglected but should not be forgotten if the aim is to perform in a sensitive way. It is no surprise

that constant advocates can be found to remind professionals about presenting themselves in a suitable manner (Guest, 2016; Chiatti, 2019; Wilson & Waqanaviti 2020; Ferris-Day et al., 2021; Hutton et al., 2021), no matter how brief these interactions may be. In addition, it should be remembered that interactions may be even more challenging in specific contexts, such as in mental health care or aging; hence, particular attention should be paid (Jensen et al., 2020). This point is not only a matter of courtesy and professionality, but it is also the nurses' responsibility as sensitive individuals. Again, the issue of language in this subsection is paramount, and nurses ought to acknowledge the relevance of using specific terms or concepts, inherent to the mother tongues of the patients being cared for. It is also important to consider how sometimes those terms may translate into the common language used during the nursing process. For instance, as suggested by Narayasanamy (2012), the use of indigenous language, ethnically related expressions, or specific culture-related terms may be used to express feelings or simply make a point. Again, a deeper understanding of how communication is used by this diverse clientele is essential to move forward. No magic recipe exists, but nurses should be aware of the many microcosmos existing within societies and in the care setting. Those spheres may determine the strategies used to communicate effectively, despite language and/or linguistic barriers, and therefore an attentive eye appears to be essential for this task.

Safety:

The final element of the ACCESS model focuses on providing a culturally safe atmosphere so that the patients and families feel at ease. Narayasanamy (2012) was inspired by the seminal works of Ramsden (1993) and Polaschek (1998). The concept of cultural safety has its roots in the late 1980s, when New Zealand (NZ) Maori nurses examined nursing practices and incorporated the points of view of indigenous minorities. This term was not exempt from controversy, but it was adopted by the NZ Nursing Council as part of their core curriculum for nursing training in 1996 (NZ Nursing Council, 1996) and since then, it has become an influential concept in major health institutions in NZ (Polaschek, 1998). Polaschek critically contrasted the concept of cultural safety with Leininger's influential work, who had initially addressed the issues of race relations in nursing (leading to the notion of culture differences to go beyond a marked ethnocentrism) (Polaschek, 1998). A key point is that often, during the care process, individuals are labelled as "patients or clients" suggesting a powerful attempt to reshape them into nursing culture (Polaschek, 1998; Narayanasamy, 1999b). This issue may be more obviously marked when caring for foreign patients or individuals coming from specific cultures who may be unfamiliar to the customs of others, as is the case of certain minorities or indigenous groups. In those cases, a certain power struggle may be present, and that may subsequently jeopardize the feeling of safety. Narayasanamy (2002) advocated enhancing practices that promote actions towards "recognizing, respecting, and nurturing" and whose aspects are inherent to unique cultural identities displayed by the individuals being cared for. This is essential, so that individuals feel safe regarding respect of their rights, and also to meet their own care prospects. When individuals and families feel that the environment they are in seems alien and that their needs are disregarded in terms of service of attitude, for instance, these lead to culturally unsafe practices (Narayasanamy, 2002). Therefore, much work is needed to ensure environments that favor cultural acclimatization and common understanding, to ultimately enhance a sense of cultural safety. As highlighted throughout this chapter, therapeutic relationships will benefit from such an approach, inspired by trust and respectful care.

A crucial point in developing this sense of cultural safety is intimately connected with dealing with aspects such as discrimination and/or racism. Narayasanamy (2002) specifically pointed

out the need to eradicate all forms of obstacles and barriers and promote equal access to services and practices, such as in the case of black and minority ethnic communities. Similarly, it is important to highlight the importance of paying attention to other additional, and perhaps more recent "-isms" that challenge present societies, such as ageism, sizeism, heterosexism, or LGTBIQA+-ism, among many others. In order for nurses to guarantee safety while delivering tailored culturally competent care, it is necessary for them to stay relentlessly motivated and incorporate new knowledge on a constant basis, while remaining attentive to how societies evolve (Papadopoulos & Omeri, 2008). Keeping this in mind will help professionals to move forward in their practice, avoiding deterring manners and adapting their care and evolving as societies do.

USING ACCESS: SOME RECENT EXAMPLES

The ACCESS framework is probably not as widely known as other popular models within transcultural nursing, such as those by Leininger (1982), Papadopoulos, Tilki and Taylor (1998), Campinha-Bacote (2002); Giger & Davidhizar (2002), or Purnell (2002, 2019). However, ACCESS has always been a preferred reference for Nottingham University's nursing curricula. Interestingly, in recent years, researchers have also revisited its application outside the UK (for instance in China, Israel, Spain, Belgium, and other EU countries) and also in a variety of contexts, such as mental health, oncology, spiritual care, academia, and most recently in the context of COVID-19, to cite a few (Cang-Wong et al., 2009; Albarran et al., 2011; Higginbottom et al., 2011; Lo, 2012; Antón-Solanas et al., 2021; Romem et al., 2021).

The next section will quickly describe some examples of how professionals use this framework to guide their practice.

The first example is the work of Lo (2012), who explored the emotional vulnerability of cancer patients. Her paper used a down to earth approach about how the ACCESS model could be used to improve everyday practice in a very delicate context. Lo shared numerous practical examples of how holistic nursing care can be overlooked when cultural barriers exist, but also when a serious diagnosis is on the table. The author pointed out that anxiety and vulnerability can be more prominent for patients who are unaccompanied, and whom for particular reasons may not yet be integrated in a certain culture. In the case of Lo's analysis, she reflected on caring for a young foreign student from China and living the UK, but with a limited command of English language. Lo tried to bridge the existing cultural gap, as suggested by Narayanasamy's work, to actively seek a deeper understanding of potential cultural discrepancies that may influence transcultural care in this case. She actively took the reader into "experiencing" active cultural respectful care. Lo's work reflected on differences in the care provided by staff that may be influenced, and in some cases, defined by the inability to communicate with patients. This may happen when languages and/or cultures are extremely different. Professionals may be frustrated when this happens, or they may simply rely on other colleagues who may be more acquainted with certain cultures, or who may simply be able to exchange in a mutual language. The question of whether care should be reliant on only those who may be able to communicate in a given language was stirred by Lo's research. She advocated for teamwork and giving the group the chance to contribute to comprehensive nursing care by facilitating therapeutic conversations as often as possible. In her paper, the concept of patient empowerment was also underlined. This aspect is key for oncological patients so they can regain a sense of control

and management of their often-medicalized journey. The ACCESS model assisted Lo et al. in providing congruent care of a sensitive and compassionate nature in a complex context.

On a more theoretical level, Higginbottom et al. (2011) revisited the scientific literature, examining nursing assessment models or tools that had been proven suitable for clinical practice, and its use with diverse ethno-cultural groups. This integrative review, yet again identified the ACCESS model as a very suitable option underlining communication as the crux of cultural care (as noted by Narayanasamy). Higginbottom et al. insisted on the fact that nurses must actively seek awareness of the cultures of others "by negotiation and compromise, while establishing respect and rapport and showing sensitivity to all aspects of the patients' needs" (2011, p7). The authors praised the ACCESS model as a valuable framework that nurses can use to positively implement transcultural care.

Romem et al. (2021) recently used the ACCESS model to examine the response of authorities in the city of Beit Shemesh (Israel) in caring for specific communities due to high COVID-19 infection rates. Coronavirus cases were particularly marked for the large ultraorthodox community during the first wave of the outbreak (through early May 2020). In this case, ACCESS proved effective in structuring a response during this health care crisis, and in shaping and delivering care for this specific community. According to the researchers, using the clear framework of ACCESS helped professionals to increase compliance with COVID-19-related measures in this population, and ultimately lowered the community's morbidity rate. A particularly interesting aspect of the research of Romem et al. (2021) was that they showed how Narayasanamy's model can equally be used outside of the clinical setting. In the case of the ultraorthodox community, the assessment of the cultural background of this group posed interesting challenges. In most cases, the ultraorthodox lived in small flats hosting large families, favored the use of public transport, and access to smartphones or computers was limited. This last point would hinder children from working remotely, particularly during the time where schools were closed due to lock-downs (Waitzberg et al., 2020), but it would also prevent access to important health-related preventive information facilitated by Public Health Institutions. Another key aspect of this community was that from a religious point of view, rabbinical validation should be provided. This point was particularly important when State regulations were opposed on religious beliefs (Ashkenazi, 2020; Libman, 2020; Malchi et al., 2020). A slow embracement of measures to prevent the contagion and dissemination of COVID-19 would translate into increased mobi-mortality for this group, and therefore quick action was needed, as described by Ashkenazi (2020) and Waitzberg et al. (2020). Another interesting issue of the study by Romem et al. (2021) was the usage of adapted communication to the orthodox community, such as adapting the language used by the media to convey key messages. The study described how media used "breaking news" outlets or even loudspeakers on the streets to deliver important information during the COVID-19 crisis. Hebrew and Yiddish languages were employed, and familiar scriptural and religious references were equally used to enhance the attention of the community. Pashkevilim (posters usually situated on public walls within the Orthodox Jewish community) were equally used to reinforce key health-related messages, but actively working with the Department for Health Advocacy was also used to support the community.

Cultural Negotiation and Compromise were particularly crucial for the case of Romem et al. (2021), and this was ensured by engaging numerous authority players (from the municipality to higher health authorities) who could understand the delicate boundaries of the community as well as its intrinsic relationship to religious life. Equally, considering "sensitivity and safety",

as described by the ACCESS model, were essential in this crisis. As an example, ultraorthodox leaders were asked to intercede in the use of coronavirus hotels so that the community would understand and accept their use during this important period. The work of Romem et al. (2021) is an excellent example of how clear steps can help in guiding good and systematic and efficient practice (even outside of the hospital) inspired by a comprehensive approach.

CONCLUSION

The ACCESS model, as presented by Narayasanamy in his original work, but also in later contributions (1998, 1999a, 1999b, 2002, 2003, 2014), suggests a useful framework to assist nurses (and probably other healthcare professionals as well) in assessing and implementing transcultural care. The force of ACCESS resides in its core elements, as reflected by its acronym, by providing a straightforward model to consciously guide nurses towards the application of transcultural care in a systematic manner (while easily remembering the different components of its foundations).

Nevertheless, the ACCESS model has equally faced some detractors who underline its humble approach to transcultural care, such as not being specific enough to identifying particular barriers to good quality care, including power struggles, coercion, discrimination, or racism (as well as other "isms"). It is considered that using ACCESS is a straight move toward setting the basis for transcultural care. Similarly, professionals can use this framework to guide their practice so that gaps can be identified and later adapted or corrected, when necessary. No perfect model exists but using a reference model should assist graduates (but also junior nurses or even students) in organizing their care in an orderly manner, which will naturally evolve in complexity as experience is gained. Nevertheless, nurses must remain attentive, particularly when it comes to educational needs, as is the case of transcultural aspects of care, diversity, and evolving societies. As such, further research is needed to examine the suitability of the ACCESS model in certain settings that pose particular challenges to holistic care. However, the use of pragmatic tools that enable the implementation of transcultural care in a natural manner is advocated. Undoubtedly, as professionals become more experienced, they may decide to incorporate other models or tools encompassing a higher level of complexity to their practice, but the latter should not prevent nurses from having a friendly start when it comes to transcultural care assessment and practice.

Review Questions

- What is the ACCESS Model?
- What are the key elements of the ACCESS Model?
- How can this model help you in guiding your practice?
- Why is it important to use such a model during your daily practice?

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CHAPTER VIII

CULTURAL SAFETY in HEALTH CARE ORGANIZATIONS

Emel Bahadır Yılmaz, Betül Tosun, Eda Şahin, Ezgi Dirgar, Ayla Yava

Key Points

1. Health care organizations should include culturally safe care and an environment for people with different cultures.
2. A culturally safe environment contains health care professionals who are receptive, use culturally appropriate resources, and provide an environment that supports Indigenous peoples.
3. Culturally safe health initiatives consist of working together, responsibility for decision-making, taking an in-depth look at patient's life, creating a safe atmosphere, deliberation at institutional and personal levels, and education for healthcare professionals.

INTRODUCTION

A culturally competent healthcare system recognizes the effect of culture on health care, includes evaluating intercultural relationships, accepts positive or negative outcomes of cultural differences, enlarges cultural information, and makes adjustments to satisfy culturally special demands. Cultural differences between healthcare providers and patients, such as language and communication can affect the quality of health care and delivering equitable care and create unsafe and inappropriate situations (School of Public Health and Tropical Medicine, 2021). There are social, health, and business benefits of becoming a culturally competent health care organization, such as healed health care indicators, increased patient regard and satisfaction, and improved Indigenous people participation (American Hospital Association, 2013).

Health care organizations should include culturally safe care and an environment for people with different cultures. Culturally safe service is characterized by an actual association between a client and health professional: power-sharing, contacting with them, and being respectful of their beliefs and opinions (Gadsden et al., 2019). A culturally safe environment also includes healthcare professionals who are receptive, use culturally appropriate resources, and provide an environment that supports Indigenous peoples. Culturally safe health initiatives consist of working together, responsibility for decision-making, taking an in-depth look at patient's life, creating a safe atmosphere, deliberation at institutional and personal levels, and education for healthcare professionals (Brooks-Cleator et al., 2018). It is essential to identify cultural components and safe organizations for safe cultural care and health service.

This chapter defines and explaines the importance of cultural safety, barriers to cultural sensitivity care environment, and challenges working with the multicultural healthcare teams in creating culturally component health care organizations.

CULTURAL SAFETY

Cultural safety is an effective nursing practice for individuals or groups from another culture. It emerged in nursing and midwifery training in New Zealand. A dangerous approach in cultural care is the practice of humiliating Indigenous individuals or groups (Wikipedia, 2021). Cultural safety has different definitions. According to Oxford Languages (2021), it is the policy of providing sensitivity to cultural and social characteristics in health care delivery.

According to Williams (2008), it is a safe environment that offers trust for people. This environment does not include any attack, challenge, or denial of their identity and requirements. It is sharing respect, knowledge and experience. It is to be together by respecting human dignity in all areas of social life. Walker et al. (2010) also underlined the concept of Cross-Sectional Patient Safety (CCPS). The CCPS gives safe and successful care to cultural communities despite the obstacles to perception and identifying cultural needs.

First Nations Health Authority (2021) states this as an output based on a non-discriminating target that seeks to identify and eliminate the inequalities found in the structure of health institutions. It tries to create a climate of trust and an atmosphere free of prejudice and inequity while providing care services. It is different from recognizing different cultures and caring for individuals who receive health care. It makes a working environment that evaluates the cultural identities and values of employees and service recipients and provides transparency in their behavior towards an individual with a different culture. It also includes understanding their attitudes or experiences to analyze their troubles.

FRAMEWORK for CULTURAL SAFETY

Cultural safety has several goals: to eliminate inequalities of both individuals and institutions, to prevent alienation from care services, to show consideration everyone's cultural characteristics, and to take into account their personal or cultural needs. It introduces terms such as cultural difference, cultural awareness, cultural sensitivity, and biculturalism to define Maori health concepts and practices and remove barriers to their access to health care (Australian Human Rights Commission, 2018).

The National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) in 2013 defined that cultural safety consisted of eight areas (Australian Human Rights Commission, 2018). Figure 1 shows these areas. These domains are (NATSIHWA, 2013):

1. *The Country & Community domain is necessary for the delivery of culturally safe and sensitive care and treatment practices for Indigenous people*
2. *The Local Cultural Contextuality area recognizes and acknowledges the importance of engaging with the local Aboriginal and Torres Strait Islander community to gain insight into and understand the impact of contact history and how it has shaped and influenced the life experience of peoples.*
3. *Recognizing and valuing the role of Indigenous employees is critical. They are often the first point of contact with the local community who seek to access healthcare services, and also play a pivotal role in undertaking and/or advising on local community engagement strategies.*

4. *The Individual Reflection area is to explore characteristics of cultural safety. It requires the health professional to engage in deep personal reflection as a core component of demonstrating professional competence in areas of cross-cultural understanding and respect.*
5. *The Systemic Reflection area supports health organizations and providers in assessing culturally safe practices and regulations and encourages them to take action.*
6. *The equity & sustainability area aims to improve and perform cultural safety in the organizations and health care environments equally for all.*
7. *The Collaboration and Cooperation area strengthens to provide culturally safe practices and encourages partnership and working together.*
8. *The Monitoring and Evaluation area underlines the significance of following and evaluating procedures, functionings, and health institutions to give culturally safe, sensitive, and standard care practices.*

PRINCIPLES of CULTURAL SAFETY

Cultural safety also takes into account that people from different cultures may not feel safe while using health care. In this direction, cultural safety principles are guiding. Cultural safety

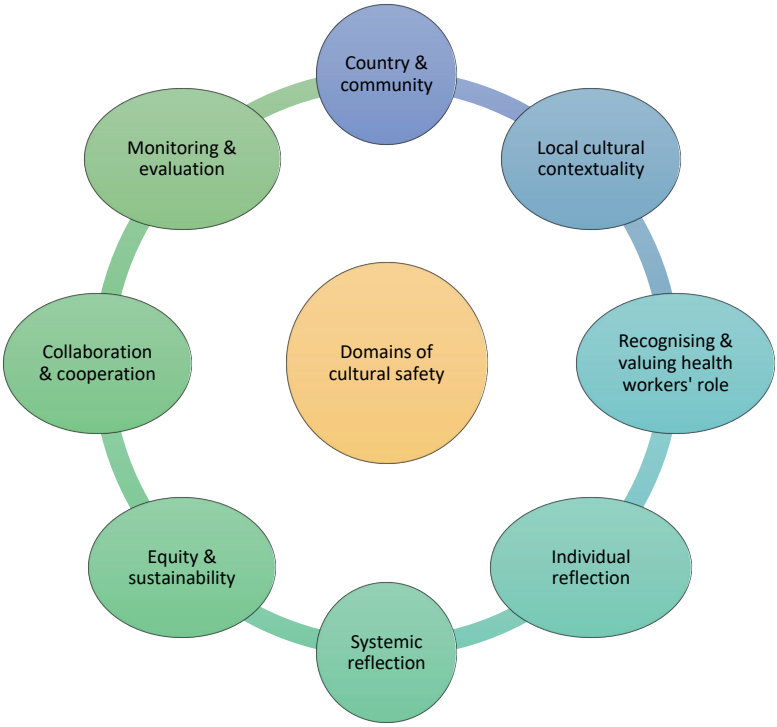

Figure 1. Areas of cultural safety

principles can also be used when providing nursing care to people from cultural groups who use illegal substances (Harris, 2020).

There are five principles necessary for cultural safety (Brascoupé & Waters, 2009): 1) Protocols – a high regard for cultural participation, 2) Personal knowledge – knowing the individual's cultural background and expressing their cultural characteristics and awareness to form the equality and confidence, 3) Process – participating in the learning process from each other, assessing the individuals' cultural safety perception, 4) Positive purpose – maintaining and supporting the caregiver' beliefs, wishes, and daily routines, and 5) Partnerships – improving partnership in delivering health care.

Tremblay et al. (2021) define four principles for cultural safety. The first principle includes the components or factors that make up the core of different cultural groups or people of health professionals. Understanding the essence of different cultures requires considering all kinds of sociocultural factors and their consequences that affect people's health. The second principle seeks to establish objective and fair cooperation with these communities or people and mobilize their support resources. The third principle is safe communication. This communication includes both learning and understanding people's speech features or dialects and establishing a healthy communication that they can understand. Medical terms are not used too much in this communication. The last principle is that the practices of different cultural groups or peoples should be legally accepted and respected to be practiced in healthcare settings.

BARRIERS for CULTURALLY SAFETY CARE

According to Walker et al. (2010), the Cross-Cultural Patient Safety (CCPS) covers the elimination of factors that hinder the execution of proposed corrective or supportive initiatives. The CCPS includes a safe, person-centered service, recognizing that culture contains many factors that risk the individual's health. Thus, cultural safety covers defining and preventing movements that make individuals' cultural identity and well-being less powerful in diverse conditions. Defining and highlighting barriers or obstacles for culturally safe care is vital.

Tremblay et al. (2021) determined obstacles in providing the cultural safety of an Indigenous individual with diabetes in the health institution. They gathered these barriers under four headings; social determinants, health service institution, speech, sending or receiving information, conventional practices, and cultural appearances of health (Figure 2). Social determinants consisted of awareness of inequity or knowledge of racial discrimination in the health system and suggestions for not unsuitable to individuals' cultural backgrounds. Health care organizations, the difficulty of taking into account the culture and beliefs of individuals during the planning and implementation of patient care, a service delivery that makes trust-based therapeutic communication difficult, and the disruptions in the flow of service prevent the delivery of individual-centered care. Language and communication include the inability of healthcare professionals to understand the language of Indigenous individuals, their use of medical terms, and their inability to find clues of interpersonal interaction.

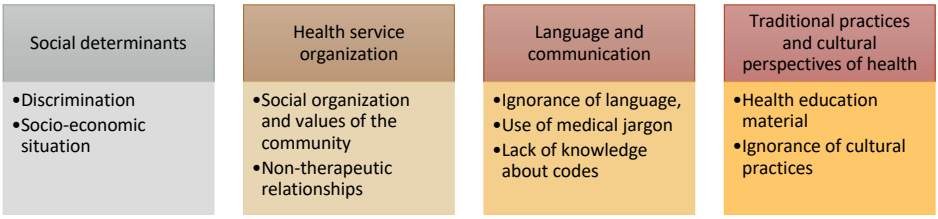

Figure 2. Barriers for culturally safety care (Tremblay et al., 2021)

Russell et al. (2018) identified several significant barriers for First Nations when accessing culturally safe end-of-life care services. These were feelings of isolation, treated with a non-culturally sensitive approach, stereotypes, misconceptions about First Nations clients, a lack of public transportation to urban healthcare services, a lack of awareness of and funding for the rehabilitation equipment.

Effective communication with patients is an essential part of cultural safety. Thus, determining the barriers to culturally safe communication is also important. According to Taylor et al. (2013), there were five barriers to cross-cultural communication in health care: 1) language, 2) lack of literacy, 3) Lack of comprehension, 4) Traditional practices, behaviors, and faiths, and 5) Storing the data.

DEVELOPING CULTURAL COMPETENCE

Cultural safety is related to cultural competence. Cultural competence is necessary for safe, individual and family-oriented, scientific research results-based, and equitable care for every individual from different cultures. In addition, it is an essential ability of health managers, institutions, and workers to provide a quality health service (Douglas et al., 2014). Understanding of cultural competence is crucial for nurses. Cultural competence is composed of five components: cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire (Duke et al., 2009). Nurses should have cultural awareness, knowledge, and skills by transcultural nursing education.

Douglas et al. (2014) improved Implementing Guidelines for Culturally Competent Nursing Care. It covers recognizing the patient's cultural background, training, having critical thinking skills, intercultural communication, providing culturally adequate care, observing and advocating for the patient's rights, leading, structuring care according to the results of scientific studies, and evaluating the results of the care given. This guideline highlights adequate and appropriate healthcare for people from different cultures and can be a resource for nurses at all levels working in various positions.

Cultural competence consists of seven components; 1) Values and attitudes; 2) Communication types; 3) Patient participation; 4) Physical environment, materials, and resources; 5) Policies and procedures; 6) Health service delivery techniques for the community; 7) Training and professional development (Walkers et al., 2010). Health services to be planned by focusing on these seven components can ensure the delivery of culturally safe care.

CULTURALLY SAFE ENVIRONMENT

Cultural safety is a safe environment for individuals from different cultures. It consists of spiritually, socially, emotionally, and physically safe components (Smith, 2019). For this reason, creating a culturally safe environment is essential. Therefore, it is necessary to know the power of the environment and to be able to manage it. Understanding the culturally safe environment is essential to think about its kind of environment and make critical evaluations. At this point, it will be a necessary step in creating a culturally safe environment for the nurse to empathize and think about the question of "what kind of environment would she feel safer in if she were in the patient's place." In addition, the nurse's acceptance and respect that the patient she cares for has a different cultural perspective is another crucial step in creating a culturally safe environment (Bahadır-Yılmaz, 2014).

Safe and culturally sensitive nursing care confirms, regards, and draws outs differences and contains cultural education, plan of actions, and other converting workplace instruments (Smith, 2019). According to Brooks-Cleator et al. (2018), a culturally safe environment provides effective communication, and an accepting approach applies to supportive cultural practices and provides a culturally supportive and fostering environment for Indigenous individuals. Culturally safe physical and emotional environments present a warm reception and an intimate relationship. These environments decrease feelings of rejection and any behavior that prevents the patient from feeling safe.

CULTURALLY COMPETENT HEALTH CARE SYSTEMS and ORGANIZATIONS

Health organizations should be culturally safe, facilitating, and understanding to the people, and they should create the infrastructure for them. Community participation is essential in facilitating access to health services, identifying and giving cultural health needs, and creating an interaction based on trust and partnership between patients and staff (Douglas et al., 2014).

Along with implementing more culturally competent service delivery models, organizations should assess cultural competence, their lack of cultural care capacities, or the robust features of health care professionals. Cultural competence should have been assessed as individual and organizational. The personal assessment includes health care professionals and evaluates their cultural behavior, notice, and abilities to present ethical and sufficient health care to culturally different communities. Organizational assessment includes appropriate behaviors, interventions, procedures, and constructions. These characteristics make it possible for health organizations and providers to work in collaboration and harmony (Cherner et al., 2014).

Culturally competent healthcare systems that offer culturally competent health care can prevent inequalities arising from cultural backgrounds. These inequalities can be decreased by performing and continuing culturally safe care practices, struggling with cultural care obstacles and providing effective communication. The most necessary step for health service giving to culturally different communities is to build culturally competent health organizations. Culturally capable health organizations present culturally competent care to maintain reasonable care and diminish medical mistakes because of cultural differences (Anderson et al., 2003).

CULTURALLY SAFETY HEALTH CARE SYSTEMS and ORGANIZATIONS

Culturally safe health initiatives for Indigenous peoples should include (Brooks-Cleator et al., 2018); 1) Community collaboration, including confidence, regard, and information about cultural communities; 2) Power-sharing between Indigenous people and health care providers; 3) Addressing the broader context of the patient's life regarding cultural attitudes, faiths, and experiences, supportive relationships, and using health care interventions; 4) Safe environment, including being accepting and applying culturally supportive sources; 5) Self-reflection among health care professionals and institutions about power-sharing, cultural opinions, and past events or experiences; 6) Culturally competent education for health care professionals (Figure 3).

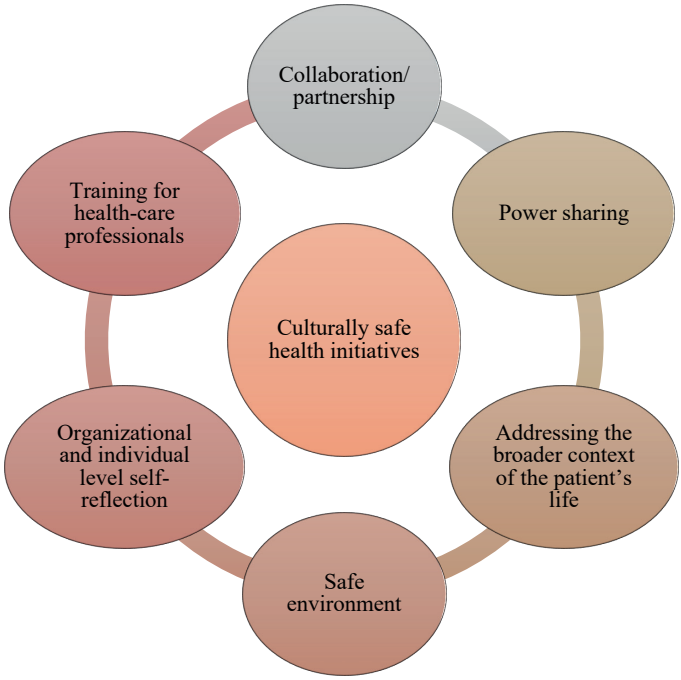

Figure 3. Culturally safe health initiatives (Brooks-Cleator et al., 2018)

Australian Institute of Health and Welfare (2020) developed a monitoring framework for cultural safety. This framework encompasses a culturally competent care service, the care practices of Indigenous people, and reach to culturally safe care initiatives. Health care organizations and professionals should be sensible and sensitive to the outlooks of people from different cultures. All practices and procedures in the health organizations should deliver culturally respectful health care. Culturally safe health practices contain institutional collaboration to service culturally safe care, appropriate communication techniques and methods, education, and cooperation between institutions. Cultural safety includes open and respectful communication and therapy, the participation of family members, and improvement in judgment. Inequalities in health care services are the state of being distant from something else, inexpensiveness, and not providing cultural safety.

Russell et al. (2018) defined three key strategies to culturally safe practice (Figure 4). These strategies included educating healthcare providers, delivering services using telehealth and

social media, sharing information about resources, and building community awareness. Education should consist of cultural safety awareness training, self-exploration and self-reflection techniques, and holistic care to balance spiritual, physical, emotional, and mental health. Delivering services using telehealth and social media focused on quality of life and family education. Training techniques should include written and electronic documents, storytelling, and communicationg with interpreters.

Health care systems and organizations should create a culturally safe environment and cultural safety policies. Policy guidelines can include developing and displaying sensitivity to cultural knowledge, being sensitive and respectful to different cultures, using verbal and non-verbal communication that is respectful, clear, and understandable, and encouraging the exploration of different experiences and cultural backgrounds. Employees are responsible for contributing to a culturally safe work environment by being aware of all organizational policies about equality, attending ongoing training programs to support cultural awareness and safety, providing support to new employees on culturally safe practices, refraining from unsafe cultural practices, and interactions, and conducting themselves in a culturally safe manner (Bega Garnbirringu Health Service, 2018).

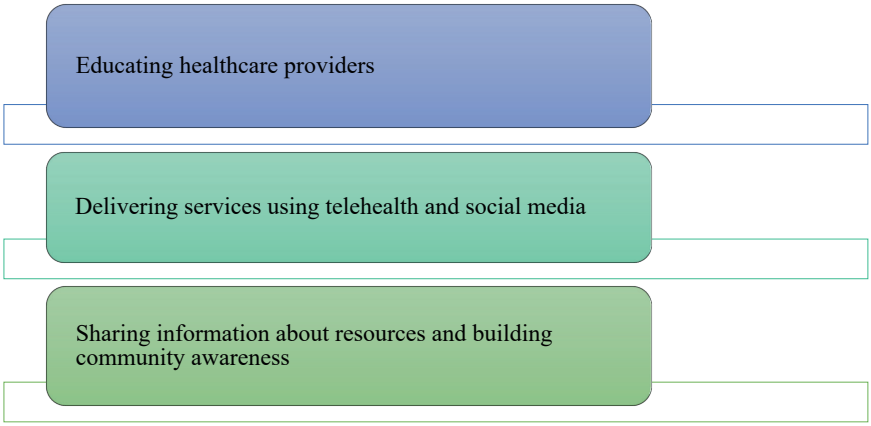

Figure 4. Key strategies to culturally safe practice (Russell et al., 2018)

Review Questions

1. Briefly explain cultural security.
2. Explain the Cultural Safety Principles.
3. Explain the Barriers to Culturally Safety Care
4. What are the dimensions of a culturally safe environment?
5. What are the key strategies for culturally safe practice?

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CHAPTER IX

CULTURALLY SENSITIVE ENVIRONMENT and MULTICULTURAL TEAM

Ayla Yava, Betül Tosun, Ezgi Dirgar, Eda Şahin, Emel Bahadır Yılmaz

Key Points

1. All people have the right to receive care in culturally sensitive health care settings.
2. Measures should be taken to overcome institutional, physical, psychosocial, and individual barriers in receiving culturally sensitive health care.
3. It will be useful to raise the awareness of nurses, avoid prejudices, take institutional measures for language and communication barriers, and inform the health care team about this issue, in order to ensure that individuals and groups receive culturally sensitive care.
4. The multicultural health care team is becoming commonplace in health care settings.
5. A team's cultural diversity has a dual effect on team performance:
   - By setting up barricades, it may adversely affect performance or
   - Through innovation and creativity, it can allow various perspectives and increase its performance.

A) BARRIERS to a CULTURALLY SENSITIVE CARE ENVIRONMENT

INTRODUCTION

Culturally sensitive health care is defined as "care *that reflects the ability to respond appropriately to the attitudes, feelings or conditions of groups of people who share a common and distinct racial, national, religious, linguistic or cultural heritage"* (OMH, 2001). A *culturally* sensitive health care environment is a care environment that includes *the legal, administrative, physical, and educational conditions of the care given to people or groups of people with different or similar cultural heritage, optimized for the characteristics of individuals or groups with different cultures.*

People from different countries, and individuals and groups belonging to different cultures, come together for various reasons and have to live together. Reasons such as economic conditions, political attitudes, and the desire to receive education, worsening living conditions in the country of residence, social interactions, and employment opportunities are the most important reasons that bring people from different cultures together. This unity does not always result in mutual acceptance, as displacements and migrations caused by compulsory conditions cause people to experience a different socio-economic and cultural lifestyle.

Global migrations appear as a result of globalization. These migrations continue from rural areas to urban areas, east to west, south to north, and are not only for reasons such as marriage, education, employment, and economic conditions, but also with the hopes of wars, civil wars, ethnic or religious conflicts, poverty or better living conditions, resulting in increased human mobility. Other situations that differentiate the cultural texture arise depending on the lifestyle, sexual identity preferences and religious preferences of the individuals, which differ from the majority, despite being a part of the same society.

Different cultural textures and lifestyle preferences, which arise for various reasons and are a dynamic process, affect all areas of life, including health, and this leads to the emergence of different health problems. Local, national, and global migration negatively affects access to and benefiting from health services and brings inequalities in access to health care. Differences in sexual identity preferences and lifestyles also make it difficult to receive safe and equal health care. The universality of the right to equal, safe, and culturally sensitive health has been accepted by many national and international health institutions, and especially by the World Health Organization. However, the differences that are increasingly taking place, especially in western countries due to migrations, socio-cultural, economic, political, and other reasons, cause difficulties when individuals and groups try to receive culturally sensitive care in terms of health care (Gahlert et al., 2008).

It is necessary to create conditions for all individuals and sub-groups of society to receive care in culturally sensitive health care environments, and to receive health services that are not ethnocentric, and are free of prejudices and sensitive to culture. Providing culturally sensitive health care will be a professional and moral responsibility and obligation for health institutions and caregivers in the future as it is today (Chevannes, 2002). Health professionals, who are aware that the values and behaviors of society and individuals are affected by their cultures, should be able to evaluate the planning and delivery of health services in this context in order to increase the effectiveness of health services.

Barriers need to be recognized and overcome in order for all components of the health system to develop an understanding of culture and its relationship to diseases and health, and to offer care access and equal care-receiving practices. Health professionals may encounter differences in patient communication styles, attitudes, and beliefs towards their health behaviors, language, and ethnicity. The patient's cultural values, beliefs and practices are also an important part of holistic nursing care. Culturally adequate nursing care enables individuals to benefit from health services and reduces inequalities in access to health services by integrating the patient's cultural beliefs into patient care (Douglas et al., 2014; Yilmaz et al., 2017).

Despite the relevant legislation and regulations, the provision of culturally sensitive care is not universal. This section summarizes the common barriers to creating culturally sensitive care environments and the challenges faced when working with a multicultural health care team.

BARRIERS to the CULTURALLY SENSITIVE CARE ENVIRONMENT

Barriers in accessing health institutions (the right to health care) Individuals living in the society have equal rights in accessing health institutions and receiving health care services. Health inequalities negatively affect groups of people who experience systematically greater barriers to health based on their race or ethnic group or other culturally related characteristics (Healthy People, 2010, 2020). In order for individuals and groups with different cultures, ethnicities,

and social life to have equal access to health care, they must have sufficient financial means or be registered with the health insurance system. In addition, it has been stated that "*most of the individuals with different ethnic communities or cultural backgrounds do not work in a job that generates sufficient income to meet their health expenditures, and in connection with this, they cannot benefit from the health insurance system adequately*" (World Health Organization, 2017).

Compared to members of the majority society, ethnic minorities, culturally diverse groups, immigrants face more barriers to accessing health care, including lower rates of health insurance, lower rates of regular doctor visits, and lower use of health care. There is evidence in many countries that ethnic minority populations differ from majority populations in access to health care, health outcomes, and mortality rates. Inequalities in access to health services also create an obstacle to the creation of a culturally sensitive environment (Drewniaka, Kronesab, & Wildac, 2017).

Inequalities in health include systematic differences in the health status of different population groups. These inequalities have significant social and economic costs for both individuals and societies. Another important issue in accessing health insurance systems is that these people must be accepted as a part of society and have obtained their rights as citizens (Philbin, Flake, Hatzenbuehler & Hirsch, 2018). For various reasons, individuals and groups may encounter problems in accessing the health system of countries due to lack of language and knowledge. This situation may prevent individuals who have not yet benefited from rights, such as residence and work permits, from having access to health institutions for their simplest health care needs (Snyder, Cunningham, Nakazon & Hays, 2000). The recognition of ethnic groups, minorities or individuals, and groups with different social life standards and informing society about legal regulations on health rights may aid in benefiting from the unique health systems of countries (Anderson et al., 2003).

Language and communication barrier Effective communication is essential for patient safety, compliance with treatment and care, accurate diagnosis, and maintenance of health. Language and literacy barriers in healthcare adversely affect clinical effectiveness, medical decision-making, medication adherence, and the patients' understanding and access to services. However, most people, including health professionals, do not consider language and literacy problems as barriers to health care **(**Taylor, Nicolle, & Maguire, 2013).

Individuals who do not know a language that is different from that in their own culture and are widely spoken have problems in terms of accessing health institutions, exercising their right to health, and communicating with health personnel more than they do in social life. The terminological language used by the health care team becomes an important barrier that makes it difficult for foreigners to understand and respond. Health and illness and concepts are the areas where individuals want to feel the most secure. Feeling safe in health institutions; understanding what is said to him in order to fulfill the requirements related to his health can be possible by giving the right answer. Feeling safe is also important in terms of evaluating the suitability of health care settings for their own cultural, religious, social life, and understanding. Individuals who do not feel that they are in a culturally sensitive health care environment cannot provide the necessary information for diagnosis, cannot understand treatment options, and cannot adapt to their treatment and care properly. Language barriers can be considered as the most important reason why individuals feel insecure and anxious in health care settings.

From the point of view of physicians, nurses, and other health personnel, the language barrier may not be perceived as significant of an obstacle as it is by patients and their families. In fact, this may cause more problems arising from the language barrier. Good and effective communication

is the most important and key step for healthcare professionals to provide culturally sensitive care. Failure to obtain an adequate medical history from the patient and their family will reduce the effectiveness of treatment and care services, as well as contribute to ineffective health care delivery and increase health care costs. In order to know the attitudes of individuals and groups from different cultures towards illness and health care, it is essential to resolve the language barrier and establish good communication with the patient.

In recent years, there have been increasing developments in the application of interpreters for the resolution of language barriers. Interpreters are not only dependent on language barriers, but also people who are expected to translate to individuals with an understanding appropriate to their own cultural structure and to be a bridge between healthcare personnel and the patient/family (Ngo-Metzger, Massagli, Clarridge et al., 2003). However, since individuals from different countries and societies apply to health institutions, interpreters who speak only one foreign language may not be sufficient. For example, immigrants from different countries may apply to a hospital to receive health care. In this case, it may be necessary for the hospital to employ more than one interpreter who has knowledge of different languages and cultural characteristics. This can be seen as a factor in increasing hospital costs. However, despite the significant resources spent in this area, language barriers remain an ongoing barrier in healthcare. New approaches are needed to deal with language and literacy barriers to improve the patient experience (McKinn, Linh, Foster, & McCaffery, 2017).

The difficulties experienced by new immigrants in adapting to their newly adopted culture are an issue that health services should be sensitive to and responsible for (Taylor, Nicolle & Maguire, 2013). Some ethnic minority families may lack awareness of the role of professional interpreters and certain health professionals and the need for certain procedures. Providing information about these areas prior to patient admission can help to prevent misunderstandings and patient anxiety and establish a more effective communication.

The language barrier exacerbates all of the other challenges faced by nurses caring for a culturally diverse patient. It is necessary for the nurse to establish good communication with the patient in order to ask questions, perform a physical examination, and provide education in order to obtain a patient's past health history. The language barrier that makes communication difficult must be overcome somehow in order to communicate through an interpreter or help must be sought from another patient or patient's relative who can still speak the patient's language.

Barriers Due to a Lack of Knowledge and Education The patient's cultural values, beliefs, and practices are an important part of holistic nursing care. Culturally sensitive nursing care optimizes individuals' use of health services and ensures that the patient's cultural beliefs and attitudes are a part of patient care. Thus, it also increases compliance with health care and strengthens communication with the health care team. However, studies have shown that the members of the health care team, especially doctors and nurses, are quite inadequate in recognizing different cultural attitudes, lifestyles, and beliefs, including their own cultures. It is very important to recognize cultures, beliefs, and values, and traditional practices in order to manage health services and ensure their effectiveness (Weech-Maldonado, et al., 2012).

A lack of knowledge about cultural differences can lead to a misunderstanding or lack of understanding of the patient's needs. In addition to language difficulties, a nurses' lack of knowledge about a patient's culture can be an important obstacle to culturally sensitive care practices (Henderson, Kendall & See, 2011).

In studies conducted in different countries and societies, it was stated that various socio-demographic characteristics of patients and a lack of knowledge by nurses prevented cultural sensitivity. Nurses should also be aware of their own values, beliefs, and cultural heritage in order to have an awareness of how these qualities and issues can affect culturally compatible nursing care (Douglas et al., 2014). In addition to institutional measures to ensure that nursing and health care settings are culturally sensitive, the education of the health care team about transcultural care and different cultural understandings of health should be provided (Delgado et al., 2013).

The International Council of Nurses (ICN, 2012) supports the view that education should be given on transcultural care at all levels of nursing education in order to develop the cultural competencies of nurses. It will be beneficial for nurses to gain intercultural communication skills during their graduate education and lifelong learning programs so that they can understand and communicate with people from different cultures.

Health Care Barriers Based on Traditions Many cultures have very different thoughts and attitudes about health care, treatment, medications, and caregivers. They may have traditions that contradict their own culture and the culture they are in and later joined to their medical approaches. For example, there may be contradictions between the traditional practices of an Asian family regarding babysitting and the recommendations of Western medicine. They may think that herbal mixtures are more effective than the treatment of a disease with modern drugs, or they may not mind using herbal mixtures with drugs. Another example is that the relatives of a patient whose death is approaching may think that death at the home of the patient's relatives is more in line with their religious traditions, no matter how much intensive care treatment is needed. Health care providers who are unfamiliar with the cultural traditions surrounding medical care may also have difficulty communicating with the patient. Such situations may cause the patients and their families to exhibit an attitude that is felt/expressed or not but has negative effects on health care. The exclusion of the patient and their family may make it more difficult to comply with treatment for individuals who already do not feel safe (Majumdar, Brown, Roberts, & Carpio, 2004; Chang, Yang & Kuo, 2013).

Prejudices Foreigners, refugees, individuals, and groups with different ethnic origins and cultural backgrounds in health care settings want to receive care in sensitive environments where the understanding of care for their own cultural attitudes is felt. The lifestyle, clothing, food, family relationships, beliefs, and social communications of these groups may differ from those of the health care team.

Although the health care team focuses on the health status of groups and individuals from different cultures, they may not always be able to make an unbiased interpretation of the conditions. In other words, they may unconsciously criticize the health behaviors, lifestyles, eating-drinking, dressing styles, religious beliefs, perceptions of health, and illness of the patients and their families. This critical attitude may pave the way for patients and their families to perceive the health care environment as unsafe in terms of their own cultural life, cause disruptions in communication with the health care team, and result in failure to provide the expected benefit from treatment and care.

It has been emphasized that there is an increasing prejudice against immigrants from Eastern societies, especially in Western societies. This situation is considered to be a factor in the development of prejudices against Eastern cultures, especially due to the beliefs of immigrants that reduce the job opportunities of the local people, as well as their religious beliefs. Prejudices can appear in health care settings, as well as among health professionals.

Among the most common stereotypes is that immigrants take jobs from local people, abuse social resources, and put the healthcare system into a difficult position (Jiménez-García & Jimenez-Vicioso 2019). Attitudes towards prejudiced minorities and religious communities can sometimes be an important obstacle for these groups to receive effective health care and culturally sensitive care. Leininger (1997) suggested that prejudices and issues of ethnocentrism are barriers that limit nurses' attainment of cultural competence. He stated that in order to be culturally competent, nurses should have constructive critical self-reflection in affective domains such as the emotions, values, attitudes, and beliefs of the society they care for, as well as certain knowledge and skills. It has been suggested that removing all negative beliefs and attitudes, including prejudice, bigotry, discrimination, and racism, can be achieved through nursing education and postgraduate education (Leininger, 1997). These training programs will enable nurses and other health personnel to evaluate not only other people but also their own cultural attitudes and beliefs. Thus, an increase in the ability to empathize for effective communication can also develop.

CONCLUSION

The ICN Code of Ethics requires that the need for nursing is universal and that nursing should provide an equal understanding of care to all people, regardless of their nationality, language, religion, gender, age, political opinion, or social status (ICN, 2012). It was seen that nurses are knowledgeable and sensitive about health-related thoughts, perspectives, traditions, values, practices, and family systems of culturally different individuals, families, communities, and individuals under their care (Douglas et al., 2014).

Review Questions

1. How does being a new resident in a country, belonging to a culture different from the majority culture, or being a refugee in a country affect the right to health care?
2. What does a culturally sensitive health care environment mean for those who are members of a minority group or to refugees or who have a different lifestyle or gender identity?
3. How does the language obstacle create a barrier between health care personnel and care recipients with regard to communication?
4. What is the connection between the language barrier and communication?
5. What are the roles and responsibilities of nurses in creating culturally safe and sensitive health care environments?

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CHAPTER X

NARRATIVE PHOTOGRAPHY

This chapter was planned and organized by:

Juan M. Levya-Moral

Students and faculty participating in the BENEFITS Intensive Program held in Giresun (Turkey) in July 2021 were invited to reflect on the multicultural learning experience and to represent their feelings using a self-made picture and a short reflection. The instructions provided were: "Think about the knowledge, skills, and attitudes developed during the Intensive Program you have just finished and create an image that represents an idea related to the contents of the course. Add a brief reflective footnote explaining the meaning of your picture (why did you take it, what does it mean…?). Remember, do not show people's faces to preserve privacy".

Photographs and expressions used in the part of the book "TRANSCULTURAL NURSING: Better and Effective Nursing Education to Develop Intercultural Nursing Skills (BENEFITS)" are used with the permission of the owners.

ARIADNA CABRERIZO (SPAIN)

Despite having different cultures, traditions, languages... There is something that brings us together; the art of caring, the art of being a nurse, the art of looking after the patient in a genuinely way. Even if the room is empty, it will always be full of the life we have created inside, it will always be full of memories.

LAURA CAÑERO (SPAIN)

To me, this picture represents diversity and unity. It represents diversity because it shows five people, all with unique and different features, whether it is the hair, the glasses or the smile. Diversity is what we as students experimented every day during the week of the BENEFITS Program, because we were 28 students of seven different countries, and we were so different and had so much to learn from the others.

However, we were not that different, we also had things in common, and we realized that the more and more we talked and spent time with each other. There are things common in many cultures, for example: the desire of belonging to a group, the tired we all got when we had lectures during all day, the excitement of visiting new and beautiful places in Turkey, the cultural shocks we got from Turkey… Therefore, at the end, we had differences between the cultures, but we were not that different from each other. That is why this picture also represents unity for me.

KÜBRA ÇETINDAŞ (TURKEY)

A Spanish and a Turkish came together and realized that their common subject is from South Korea, this sign means I love you in Korean culture.

DAINA PARELLADA (SPAIN)

We complete each other like puzzle pieces. Together we are better, stronger, more colorful, more joyful.

DEJAN FILIPOVIC (SLOVENIA)

My picture is about unity in diversity! Even if I don't speak same language, we find the way to extend the hand of friendship and to go through cultural barrier! Turkish tea is a strong message of friendship in Turkey!

AZRA KOVAČEVIĆ (SLOVENIA)

The point of this picture is that everything such as our knowladge and human body are composed of many small things and even we dont or we cant see them at the first sight – the foundations are built on them and without them – without these small things – the whole will be never created. This iron nail shows how these all small things are very important for buildings or human cells for our body or our opinions and thoughts for our knowladge.

The point of this picture is that if you see only these dirty hands, you can say to yourself, that the person has to be poor or homeless or just somebody who hasn‘t money. But we want to say through this picture, that a lot of people have prejudices about others, because of their look but they don‘t know nothing about them – how much money they have, nothing about their health, about live situation, etc.

NIKA BORŠTNER (SLOVENIA)

This picture for me represents our whole trip because we were learning about different cultures and how to accept them. As foreign students we tried to fit in and learn as much as possible about Turkish nationality and culture. We are all in this pandemic together, so the masks are sadly our meeting point, but we are trying to see the positive in everything we encounter.

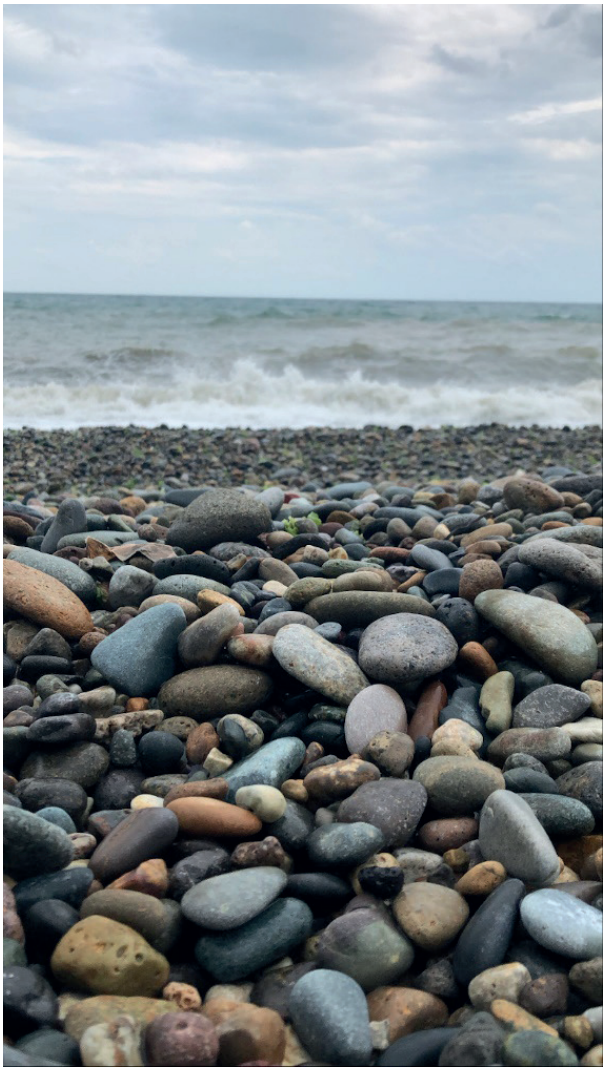
ZEHRA BOZTEPE (TURKEY)

While feeling the warmth of people…

MARIA DOLORS BARNABEU TAMAYO (SPAIN)

People intersect with their history and culture. I go out and meet my peer, and think how much unites us and how little separates and differentiates us. We are lights, clouds, rays…. that intersect to complement and equalize. All different, unique, singular but we should be equal, plural, reflecting the interculturality as the phenomenon that occurs naturally.

BETÜL TOSUN (TURKEY)



Since the world has existed, many stones of various colors, sizes and contents stand together in harmony on the beach. Sometimes the waves or winds pick them up and toss them to the other side of the beach. But we don't know when that stone was thrown there and what kind of story it has. I stood on the beach and thought that people are like these stones. The most important thing is to accept these diversities, try to understand its stories and stand together in a harmony like these stones.

HALIL IBRAHIM KARACAN (TURKEY)

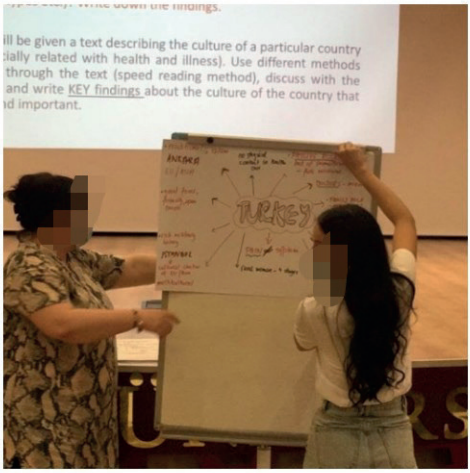
We got together in the Black Sea, and we all got wet in the Black Sea rains. That's why this picture sums up us. In cultural interaction, green nature is us, clouds are our cultures.

In this picture the culture is the sea, and the islands are the people we care for in different cultures. We student nurses are the boat in the sea (TAKA), our first goal is to reach the nearest island because the main theme of this photo is like islands in the sea, separate on the surface but connected in the depths

DEJAN ETEMAJ (SLOVENIA)

Although there are differences among us, we can still get along, and we're all going the same way'

AREZOO AZANAKHARI (TURKEY)



You will see the entrance celebration and welcome for all professors and students here, and I was very curious about what I will learn in this program, as you can see, we guessed about the culture and customs of other countries. And it made us understand each other's cultures better, and in the end, I came out of this program very productively, and this part of the program was a way to get to know each other's cultures and how to be a transcultural nursing‹ focuses on global cultures and comparative cultural caring, health, and nursing phenomena. The transcultural nurse looks to respond to the imperative for developing a global perspective within the nursing field in an increasingly globalized world of interdependent and interconnected nations and individuals. And I learned that the primary aim of this specialty is to provide culturally congruent nursing care. To be an effective transcultural nurse and we should possess the ability to recognize and appreciate cultural differences in healthcare values, beliefs, and customs. Transcultural nurses shouldn't only be familiar with the religious customs, values, and beliefs of patients, but also how someone's way of life, their modes of thought, and their unique customs can immensely affect them in how they deal with illness, healing, disease, and deaths.

KEVSER YILMAZ (TURKEY)

For the memory of this project that unites cultures, gifts reflecting Turkish culture and reminding us of today.

A shot from the day we drank Turkish tea and tasted local delicacies against the green landscape of the Black Sea. A moment when nature embraces us and makes us feel its warmth.

JUAN M. LEYVA (SPAIN)

People have different ideas, feelings, beliefs, and priorities. The meaningful and respectful interaction of such different realities is what makes our lives unique. As Paul McCartney once sang '*Ivory and ebony live together in perfect harmony'*. As nurses we must promote respect and tolerance for many reasons, especially if excellent care is aimed.

EZGI DIRGAR (TURKEY)

The Skyline...

Despite the differences in gender, race, language and culture, it is the turning point where the body and mind are intertwined, and all the feelings of peace and hope that surrounds the soul meet.

Dinner table gains meaning, beyond eating, when it is crowned with people sitting together, shared moments, laughter and sometimes the sharing of cultural heritage.

EMEL BAHADIR YILMAZ, TURKEY

This photograph tells us the story of a transcultural trip. There are people from different cultures on the way. Their goal is to achieve culturally congruent nursing care. They all have the same goal, concern and expectation. Traveling together will strengthen the bond between them.

IGOR KARNJUŠ (SLOVENIA)

In many situations, we still look at the differences between skin colours and forget to see the inner colour of a person. In the current global situation we live in, we need to start looking deeper, cooperating and helping each other.

URŠKA BOGATAJ (SLOVENIA)

Acquiring knowledge is a long and never-ending process. The learning process brings many similar and at the same time different stories of peoples. The goal and purpose is to accept everything that we are and that we bring to this world and to the relationships between us everything that determines us and creates us as we are, different and equal ... and in caring for each other in different ways ... always. it is the most precious thing humans can achieve.

BOOK REVIEWS

Angela Kydd, Professor

Joint post with Robert Gordon University and NHS Grampian, Aberdeen, Scotland.

This is an important book for nurses who wish to gain an understanding in transcultural nursing. The ten chapters cover cultural issues in care and include transcultural nursing, diversity, ethics, health and illness, communication, sensitivity and the environment. The book concludes with a visual chapter in which students have been asked to provide a picture that embodies for them the meaning of transcultural care.

The book is easy to navigate, with each chapter starting with key points and ending with review questions, giving the reader time to reflect on the content of the chapter. The chapters also give short case studies, so I would recommend this as not only a text book for students, but as a teaching text. This book was compiled by the academics from six countries involved in developing and delivering a European Transcultural Nursing programme and this text is a testament to their expertise in the subject.

Candan ÖZTÜRK, Professor

Near East University, Faculty of Nursing, Nicosia / TRNC, Mersin 10 - Turkey

Culture; one's thinking, behavior, self-expression, communication, what to eat and drink, perception of time, decision mechanism to "whom/where, when, how to apply in health and illness, how to react to illness, how to name his child, how to care for him, how to discipline him" In short, it is a key concept that gives meaning to every value created by human beings and accumulates by filtering.

In today's world, where human mobility and cultural diversity have increased, it is one of the paradigms of nursing to provide care with cultural competence by seeing people as a whole with their culture. This book will contribute to the training of nurses on this subject.

Sara Nissim, RN, PhD

Former Director of Wolfson Academic Nursing School,
Transcultural Nursing Expert, Lecturer, Tel Aviv University, Tel Aviv, Israel

Being an expert and teacher of Transcultural Nursing for more than 30 years, it was an honor and privilege for me to be among the first readers of this excellent and unique book aimed at serving as a guideline for Transcultural Nursing Educators, which was much needed and awaited. This European Collaboration of Nursing Experts in TCN, has produced a comprehensive, well structured, clear and easy to follow, methodology, for developing a core curriculum for Nursing Students globally. With all its chapters, this is a book that provides a solid foundation of knowledge to support and enhance Transcultural Nursing Practice, and can be considered as an essential body of knowledge so needed in the Nursing Discipline. Because European countries face many demographic challenges and similarities due to migration and nursing shortages, TCN educators can use this book to develop their own way of teaching and teaching techniques. Besides providing basic theoretical knowledge about the development and modeling of TCN, the book is also packed with various teaching methods and content. The goal of TCN practice is to promote health and wellbeing of culturally diverse population by reducing health disparities, health inequalities and promote culturally competent care. Therefore, there is a much need for this unique book "Benefits" to serve as guidance and even be considered as basic standards for the delivery of such care.

The authors offer in the book, for Nursing Educators, tools exercises and examples of case studies, designed to increase understanding about culture, ethnicity and diversity and at the same time expose the readers to the various Transcultural Nursing Models, all of them aimed to help students gain awareness, sensitivity and basic TCN skills. As nurse educators, our responsibility is to prepare the future nurse with a wide range of thinking tools and intervention skills that will allow them to provide safe, quality and culturally appropriate care in a global environment. All that, while taking in consideration that the nursing students we are educating, reflect themselves the rainbow of cultures, ethnic background and various groups that consists our world. In addition, we need to be aware that the nursing students we are helping to educate need to recognize and be proud of their own cultural background. Students today, are eager to have a comprehensive, simple to understand and easy to apply methodology, for the huge responsibilities we are demanding from them providing culturally competent care for culturally diverse patients, in most occasions, culturally or ethnically different from themselves.

Personally, I am grateful to the authors and editors for this very professional book, convinced that "Transcultural Nursing: Better & Effective Nursing Education For Improving Transcultural Nursing Skills (Benefits)" book will become an integral part of my references in my teaching, and relay on its content, while creating my TCN courses as well as referring students to it.

Alfonso Pezzella MSc, BSc (Hons), FHEA

Lecturer and Programme Leader in Mental Health, Department of Mental Health and Social Work
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The book Transcultural Nursing: Better & Effective Nursing Education For Improving Transcultural Nursing Skills (Benefits) provides a summary of key knowledge for students, and healthcare professionals, on the topic of transcultural nursing and culturally competent care. The book offers several topics to help students to improve their skills and knowledge on the subject of transcultural nursing as well as adding on the literature in the field of transcultural nursing. With the increase of migration across the globe, societies are becoming culturally diverse and healthcare professionals are supporting patients from different cultures. Understanding the cultural background and needs of patients are of vital importance to make sure the care provide is culturally appropriate. To bridge the gap between healthcare professional and patients, healthcare staff need to be learning about transcultural nursing to become culturally competent practitioners and this book supports and facilitate students and professionals in their learning on the topic.

There are a variety of chapters from an introduction to transcultural nursing to the history of this, ethics and cultural care, cultural diversity, and cultural sensitivity communication. The transcultural element of the book, which is a product of a cross-collaboration project, and with authors from various countries offers a real-life view of transcultural nursing and the important this has in the nursing care for patients and healthcare professionals.