The cross-cultural promotion of health: a partnership process?

Principles and factors involved in the culturally competent community based nursing care of asylum applicants in Scotland.

Julia Quickfall

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Abstract

The aim of this study was to investigate the principles and factors underlying the culturally competent nursing care of asylum applicants. Asylum applicants are a highly vulnerable group, whose health is often severely compromised prior to arrival in the UK due to exposure to torture, violence and rape. Although they are entitled to primary health care services whilst their asylum claim is under consideration, their level of welfare support has been significantly eroded over the last decade.

An analysis of the nursing literature revealed mainly US notions of cultural competence, which were based on a private health care insurance system rather than a universal health care system of equitable, accessible and non-discriminatory service provision, such as the NHS. A Five Steps Model of cultural competence (Quickfall 2004) was later revised to provide a theoretical framework for this research study.

Data for this ethnographic study were collected during 2005-2007 with asylum applicants and community nurses within one Health Board in Scotland, using participant observation, individual, narrative and group interview methods. The data were analysed for their categorical content. The findings are presented as vignettes to highlight cultural competence issues.

Three major themes emerge from the study findings, which highlight the intermediary function of community nursing. The provision of equitable, accessible and non-discriminatory services remains pertinent in the 21st century. Secondly, the cross-cultural promotion of health involves a partnership process to ensure effective communication and the negotiation of person centred care. Thirdly, the delivery of socially inclusive services requires the aiding of asylum applicant adaptation to a new host environment. This study contributes to community nursing knowledge in explaining, through synthesis of the literature and study data, a model of cultural competence for the care of asylum applicants. It also provides a set of best practice statements, which require further investigation.

Declaration

I declare that I have composed the following thesis and that it is my own work.

Julia Quickfall

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Glossary of Abbreviations Used

Abbreviation	Description
AD	Adjustment disorder
A&E	Accident and Emergency
ESOL	English for speakers of other languages
GP	General Practitioner
HCSW	Health care support worker
HV	Health visitor
IMC	Interpreter mediated consultation
KSF	Knowledge and Skills Framework
NHS	National Health Service
NMC	Nursing and Midwifery Council
PHC	Primary health care
QOF	Quality and Outcomes Framework
RC	Refugee Council
CNS	Community staff nurse
SNHS	Scotland's National Health Service
SRC	Scottish Refugee Council
TCN	Transcultural Nursing
UK	United Kingdom
UKBA	United Kingdom Border Authority
US	United States (of America)

Acknowledgements

Chapter 1. Introduction

This ethnographic study contributes to community nursing knowledge of cross-cultural care of asylum applicants through an investigation of the notion of cultural competence. Asylum applicants are a highly vulnerable group, who through their refugee experience frequently have complex health and nursing care needs. In this chapter I provide the background, context and rationale for the study, where health is the starting point.

1.1 What is health?

The concept of health is a universally understood but inadequately defined phenomenon; an ambiguous, fluid and relative state, it is a social construction with various cultural meanings (Thompson 2003:114). The humeral theory of health, which Hippocrates considered to be a balance of four elements of blood, phlegm, yellow bile and black bile, has continued to influence medicine and is seen in folk beliefs concerning 'hot' and 'cold' health worldwide (Helman 2007: 28).

Over the last century public health interventions in the United Kingdom (UK) of improved sanitary systems, nutrition and medicine have reduced the incidence of infectious disease, although the overuse of antibiotics may increase prevalence in the longer term (Armelagos et al. 2005:268). An increased population mortality and morbidity from longer term and degenerative conditions (McClymont et al. 1991:127) has now led to a move from treatment to monitoring, curing to caring (Blaxter 2004:88). For example, an analysis of GP Quality and Outcomes Framework (QOF) data shows that the most common conditions seen in primary care are now asthma, depression and hypertension (ISD Scotland 2008).

In considering health within the medical model as the absence of disease, the individual must be able to understand the significance of signs and symptoms in order to seek early treatment (McClymont et al. 1991:85). Women may have no notion of illness until given a diagnosis (Martinez 2005) as the connection between

illness and infection is not always understood (Mull and Mull 1988). Furthermore, health and economic status are closely linked (Graham 2000). Healthy ways of living are not always socially acceptable; unhealthy stressful lifestyles are often financially rewarded (Helman 1987).

A more positive view of health has been adopted as a basic human right (World Health Organization (WHO) 1946). Health as a system in equilibrium (Aakster 1974) was developed further at the International Conference on Primary Health Care (PHC) held at Alma-Ata, in Kazakhstan (World Health Organisation (WHO) 1978). Although the debate continues whether health is a human right (Albrecht 2005:276), it may be a qualified right within the context of equity (Tilki 2006:31). Difficulties arise in measuring health (Smith et al. 2006) due to its ever changing state (Dunn 1959), thus creating challenges in establishing a denial of this right.

People with limited ability to carry out their daily life functions may not necessarily consider themselves as suffering 'illness'; for example, obesity does not automatically qualify as a disease (Taylor 1999:272). The concept of salutogenesis suggests that health is a continuum between being a non-patient, feeling ill and becoming a patient (Antonovsky 1981:41). The link between these states is not static; health may be created through 'a sense of coherence', a mixture of psychosocial assets and social support (Antonovsky 1993). Whilst the concept of salutogenesis is useful in focusing on the resources and capacity to create health (Taylor 2004), other authors have noted that individual freedom to choose a healthy life style is structurally constrained by economic status, educational attainment, interpersonal influences and family kin networks (Ochieng 2006). Although health is a process, health outcomes are not predetermined, but involve a consideration of health belief, individual and family resources to promote health (see later section 7.1) For example, a Canadian qualitative study of the health of Bosnian refugees found that the previous experience of violence and trauma did not necessarily lead to poor health (Kopinak 1999). Health is thus a multifaceted, complex concept, which has a strong cultural component, albeit the relationship between health and poverty requires further clarification.

1.2 The UK National Health Service

The national importance of a healthy population was recognised in the early post war years. The National Health Service (NHS) was established in 1948 to promote and maintain good health (Appleton 1996) and incorporated the following principles (Whitehead 1994):

- Universal entitlement

- Sharing of financial costs

- Free at the point of need

- A comprehensive range of services

- Geographical equality of access

- High standards of care for all

- Access based on clinical need, not the ability to pay

- A non-exploitative organizational ethos

Although these original NHS principles remain pertinent in the 21st century (NHS in England 2000), the underlying concept of equality requires that people are treated with equal dignity and respect (Jayaratnam 1993:11). The above principles have been extended into core values to provide seamless quality services that meet identified population health needs, reduce health inequalities, whilst incorporating client preferences (Department of Health 2000). Equity assumes a notion of fairness, focuses on the distribution of health resources and the non compounding of health issues for those already suffering social disadvantage (Braveman and Gruskin 2003). Horizontal equity assumes equal health care provision for equal need (Hanafin et al. 2002), whereas vertical equity involves an unequal distribution of NHS services, relevant and sensitive to unequal health care needs (Almond 2002, Jan 1995, Whitehead 1990). A tension thus exists between patient treatment choice and the promotion of equity (Bentley and Fletcher 2007).

The original NHS system was based on a tripartite basis. Regional Hospital Boards managed the hospital services, Local Authorities (LA) provided community welfare and public health services, and Executive Councils represented the interests of family doctors, dentists, chemists and ophthalmic services (Jones 1994:439). Successive UK

NHS reorganizations were carried out between 1960 and 1990 to rationalize this immense corporate structure along managerial lines and develop systems of accountability.

The 1974 NHS reform established different managerial structures for England and Scotland. Scotland established two tiers of control: Health Boards and area management structures. General Practitioner (GP) services and community nursing were integrated into Health Boards to further develop Primary Health Care (PHC) teams within the community setting (McTavish 2000).

The NHS aims to improve health and to reduce health inequalities, but the latter have not been tackled effectively (Black et al. 1980); these were highlighted in the Acheson Report (Department of Health 1998). Explanations for health status differences between ethnic groups have centred on a combination of cultural and biological factors (Ahmad et al. 2000:28), but they require corporate responses to promote a NHS culture of equity of access and non-discrimination (Whitehead 1991). Nazroo (2001) identified that class inequalities compounded with material disadvantage to produce a greater risk of poor health. Likewise, Armelagos et al (2005) argue that poor health is directly linked to poverty. Furthermore, a lack of appropriate ring fenced funding for NHS policy directives leads to inequity (Maunder 2007).

1.2.1 The Primary Health Care (PHC) model

The Declaration of Alma Ata set a target of 'health for all' by the year 2000 (International Conference on Primary Health Care 1978). This declaration assumed health could be improved across all nations; universally available, easily accessible and culturally appropriate PHC services would be central to this task (Orr 1985c:5). The World Health Organization (WHO) set major public health objectives of prevention of preventable conditions, the promotion of healthy lifestyles and the provision of rehabilitation and health services. Health visitors operating within primary care are in a prime position to work towards this target (Porter 2005:33).

Although the PHC model has not delivered a significant improvement in health worldwide (Hall and Taylor 2003), it remains the basis of UK health care. GPs, as independent health care practitioners, are contracted by the UK government to provide a single access point for the local community to promotive, preventive, curative and rehabilitation health and nursing care services (Department of Health 1993:6). All UK nationals (including refugees and asylum applicants whilst their claim is under consideration) are entitled to permanent GP registration and to receive primary care services (Aldous et al. 1999, Burnett and Fassil 2002, Health Education Authority's Expert Working Group 1998). Equity of access to PHC services is difficult to measure, but it can be assessed from perspectives of policy, practice and resources. An audit of minority ethnic research in Scotland identified an evaluation of the accessibility of health services for minority ethnic communities as a priority (Netto et al. 2001).

The rising cost of the NHS over the last 60 years has led to greater economic scrutiny; competitive tendering was introduced in 1983 (Jones 1994:517). The 1990 National Health Service (NHS) and Community Care Act introduced the notion of a NHS internal market to provide an element of competition, drive down costs and improve the quality of services. GPs became entitled to manage their own budgets and purchase secondary health care for their patients, but this initiative led to divisions between the NHS purchaser and provider functions as well as the responsibilities for health and social care (Kelly and Symonds 2003).

In April 2004, a new UK contract for General Medical Services (nGMS) came into force (The United Kingdom Parliament 2004) to provide modern flexible primary care services that would enhance patient care (BMA 20003). This contract no longer rests with an individual GP, but within Scotland it is now an agreement between the Health Board and the GP practice as a whole. The QOF sets medical and epidemiological targets for the payment of fees, which promote secondary rather than primary prevention such as travel immunization (Jarvis 2006).

The nGMS contract has also allowed GPs to opt out of providing unscheduled health care services. NHS 24[1] in Scotland, a 24 hour, seven days per week telephone based nurse led advice and medical triage service provides an out of hours access point. Lower GP recruitment had made service provision potentially unsustainable in some Health Board areas (Audit Scotland 2007). A study of those stakeholders providing unscheduled care services has shown that the fast pace of service delivery combined with an increased workload require greater partnership working between health professionals (Haddow et al. 2007).

NHS funding remains a challenge of providing equitable services that are value for money. Although between 2001 and 2007/8, NHS funding increased by 7.8% per annum, tougher nGMS contract thresholds were introduced in 2006/7 to redress the earlier dramatic rise in GP's pay (Thorlby and Maybin 2007). Increased reimbursement has improved GP recruitment (Geue et al. 2009), but nurse-led services have assumed some responsibilities previously carried out by GPs, such as the management of long term conditions.

1.2.2 Community nursing

Florence Nightingale is attributed to laying the foundations of the nursing profession (Kretkowicz 1992). She considered nursing to be a women's vocation and was instrumental in developing community nursing as an educating profession, with health promotion duties rather than task based care (Kelly and Symonds 2003). Although Nightingale suggested that nurses should assist the work of the doctor, Hilton (1997) interprets this partnership working as multi-disciplinary teamwork.

Nursing assumes a different approach from medicine to client health care, but there is no consensus view of the nurse's role and function. The role can be viewed from eight epistemological perspectives: as a vocation; an interpersonal process; an art; a science; a humanistic art and science; a therapeutic intervention and as caring (Hilton 1997). The notion of nursing as the helping of individuals, sick or well, in the performance of those activities contributing to health (Henderson 1966:15), is reliant

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[1] For further details concerning NHS 24 see http://www.nhs24.com/html/content/default.asp.

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upon the interpersonal relationship (Peplau 1988:ix); Peplau defines the concept of nursing as follows:

> "*Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities. In specific situations in which a professional health team offer health services, nurses participate in the organization of conditions that facilitate natural ongoing tendencies in human organisms. Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living (Peplau 1988:16).*"

The Nursing and Midwifery Council (NMC) regulates the registration and practice of nurses, midwives and health visitors in the UK to ensure fitness to practice and client safety. The emphasis on clinical competence is seen in the Code of Professional Conduct (Nursing and Midwifery Council 2004) and the Knowledge and Skills Framework (KSF) (Department of Health 2004). Nurses are responsible for personal professional development and must remain independent of commercial, political or religious interests, avoiding those situations that might compromise their trustworthiness.

The term *community nursing* is used in this thesis to include practice nurses, public health nurses (health visitors and school nurses), family health nurses and district nurses, who together form a core-nursing element of the PHC team. I refer to people in receipt of community nursing services as *clients* rather than patients. Since 1974, most community-nursing services have been organised by GP attachment or alignment, rather than on a geographical basis, whilst maintaining professional autonomy and independent line management. GP employed practice nurses provide PHC services such as family planning (Mackereth 1995) and chronic disease management has also become a major focus of their role (Pollock 2007b). Thus practice nurses play a key role in meeting the QOF standards and financial targets (The NHS Confederation 2003).

1.3 NHS in Scotland

This study was conducted in Scotland, which currently has 15 Health Boards; together with another seven Special Health Boards, these provide equitable health care and health support services for a population of approximately five million people. Scotland suffers a high level of health inequalities, described as those differences of life expectancy or morbidity, which are unnecessary, avoidable, unjust or unfair (Whitehead 1991). Scottish males currently have a life expectancy at birth of 74.5 years compared with 79.5 for females, but this remains poorer than in England and many western European countries by several years (The Scottish Government 2006). Albeit there has been some improvement, deprived communities remain at higher mortality risk from coronary heart disease (The Scottish Government 2008d).

The Scottish Government's health improvement strategy includes the Health of the population, Efficiency and effectiveness, Access to services and Treatment service quality, known as HEAT targets (The Scottish Government 2008d). Although the complex nature of health inequalities limits the impact of NHS initiatives, structural factors are often outside of NHS control. Greater priority should be given to reducing the impact of high levels of stress on health (The Scottish Government 2008a).

Prior to devolution, the Scottish Office directed the Scottish NHS, whilst under the guidance of the Department of Health in England. Improving health and improving health care were major themes of health policy during the 1990s (The Scottish Office 1991:3). *Designed to Care* set out a strategy of involving people in NHS service design and introduced clinical governance as a benchmark of quality (The Scottish Office 1997). In 1997, GP fund holding was replaced by Local Health Care Co-operatives (LHCCs) in an attempt to promote greater equity; there was evidence that GP fund holding could lead to a two-tier system of healthcare (Propper et al. 2000).

Following devolution in 1999, the Scottish Executive's health policy was to improve the nation's health, reduce health inequalities, raise individual responsibility for health and incorporate the user perspective in service delivery. *Our National Health*

laid down a framework to modernise local health facilities to facilitate health improvement (Scottish Executive Health Department 2000). *Caring for Scotland*, sought to improve nursing services for people, for example through the piloting of the Family Health Nurse (FHN) role, Nurse Prescribing and the development of competency based frameworks for nurse education and career pathways (Scottish Executive Health Department 2001a). Family health nursing has been successful in rural communities in addressing public health issues, but has yet to become established (Macduff 2006, Pollock 2007a).

Nursing for Health strengthened the public health nursing role within health visiting and school nursing (Scottish Executive Health Department 2001c). The increased emphasis on community and public health spanned a tension between the state duty and individual responsibility to promote health. The implementation of integrated public health approaches to client care remains limited, perhaps due to a lack of local value placed on the role, as well as a lack of managerial and strategic level support (MacGregor 2006:34).

Community Health Partnerships (CHPs)[2] succeeded LHCCs in 2005, reflecting the impetus for partnership working between the NHS and Local Authority services. CHPs were in their infancy during the time of data collection and only three within Glasgow held a major responsibility for primary care services for asylum applicants. Greater Glasgow Health Board was expanded after the data collection period of this study to include the Clyde area; some CHPs now have responsibility for both health and local social care services (NHS Greater Glasgow and Clyde 2007b).

Health protection and the addressing of health inequalities remains a NHS priority (Anand 2002). A joint approach to address racism in the SNHS (Rooting Out Racism 2001) resulted in '*Fair for All*', a race equality strategy, which highlighted ethnic minority health issues (Scottish Executive Health Department 2001b:10) and

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[2] CHPs are legally constituted bodies with responsibility for local service delivery and decision-making on the priorities for service development.

summarized those faced by asylum applicants and refugees as:

- Difficulties in accessing health care
- Mental health and physical trauma
- Incomplete immunization of minors
- Poor diet and nutrition
- Lack of social support and community development
- Social-economic factors

    (*Fair for All:* 139)

Addressing minority ethnic health inequalities has remained high on the SNHS agenda. Health Board have produced an action plan to meet the gaps identified in the stock take and ensure compliance with the *Race Relations (Amendment) Act 2000* (Scottish Executive Health Department 2001d). Malcolm Chisholm, the Minister for Health and Social Care at the time called for a culturally competent SNHS (Scottish Executive Health Department 2003a:vii). The *Race Equality Advisory Forum (REAF)* report recognized that research was required to identify the health needs of Scotland's ethnic minority groups, including asylum applicants and refugees (Scottish Executive Health Department 2001d).

The Scottish Refugee Integration Forum (SRIF) action plan recognized the need to aid refugee integration in order to address health inequalities; this involved investment in translation and interpretation services, information, advice and community preparation (Scottish Refugee Integration Forum 2002). The National Resource Centre for Ethnic Minority Health (NRCEMH) later implemented the SRIF recommendations, established a national network of asylum practitioners (Scottish Refugee Integration Forum, 2002). Further research was required to gain a greater understanding of the factors affecting the health of asylum applicants (National Resource Centre for Ethnic Minority Health 2005:37). A NRCEMH review in 2005 indicated slow progress; assessment of minority ethnic health needs was still at an

early stage and the development of consultative forums was problematic (National Resource Centre for Ethnic Minority Health, 2006:15)[3].

During the 1990s community nurses were encouraged to audit their service as part of a quality improvement cycle (McKenna 1997:109). NHS Quality Improvement Scotland (QIS) now provides clinical governance guidance[4]. The standard for equality and diversity, based on Fair for All policy, requires Health Boards to provide a diversity induction session for all new employees and to carry out an equality impact assessment of all new policy. Although a range of Best Practice Statements (BPS) and clinical guidelines is available, in 2009 a cultural competence BPS had yet to be published.

Scotland faces major challenges in providing equitable community nursing services with sufficient capacity and the appropriate range of public health and treatment skills. *Delivering for Health* recognised that the additional primary care workload of an ageing population arose from increased morbidity, an inequity of resource allocation and a reduced workforce capacity (Scottish Executive 2005). A major resource transfer from acute to primary care services was required to provide more local PHC services, including preventive care, self-care support, continuous nursing care and greater resource targeting. The requirement to build a nursing workforce with the capacity and educational background to carry out these enhanced roles was outlined in *Delivering Care, Enabling Health 2006* (Scottish Executive 2006a). Community nursing workload has increased substantially over the last decade (The Scottish Government, 2007a). More clients with complex care needs are now living in the community, requiring longer nursing interventions to fulfil these intricate needs (Byrne et al. 2007).

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[3] In 2006, the NRCEMH became a unit within Health Scotland, the national health promotion agency (http://www.nrcemh.nhsscotland.com/).

[4] http://www.nhshealthquality.org

Modernising Nursing Careers heralded a movement towards a more generic community nursing focus (Department of Health 2006:17). Although a generalist public health nursing role may be difficult for the public to understand (Reutter and Ford 1996), *Visible, Accessible and Integrated Care* (VAIC) recommended the introduction of a new Community Health Nurse (CHN) model with a greater generic focus to meet the health needs of people of all ages living in Scotland (Scottish Executive 2006a:16). The CHN function incorporates health visiting, school nursing, district nursing and family health nursing roles and is currently being piloted within four Health Boards in Scotland. Moreover, Glasgow has carried out its own health visiting review (NHS Greater Glasgow and Clyde 2007a), integrating local authority and health services in some CHPs to target families requiring additional and intensive support.

The Scottish Executive remains committed to the provision of culturally competent SNHS services. Services should respond to individual health needs, including age, cultural, ethnicity, disability and diversity issues. *Better health, better care* provides an action plan to address health improvement issues, health inequality and the quality of services, whilst paving the way for a mutual-style organisation where health professionals work in partnership with service users (The Scottish Government 2007a). Thus the SNHS supports the Scottish Government's agenda to develop a more healthy population and a financially viable infrastructure to promote Scottish independence. Moreover, *Equally Well* prioritizes the health needs of children and young people as part of this agenda (The Scottish Government 2008a, e).

1.4 Who is an asylum applicant?

In this study, I refer to people seeking asylum as *asylum applicants*, to overcome the negative images generated by the term 'asylum seeker'. The popular appeal of racism has led some politicians in recent years to use asylum issues for political gain; using terms such as the 'swamping nature' of immigration (BBC News 2002) and in suggesting that only 'genuine' asylum applicants should be welcomed to the UK (Conservative Party 2001a, b). The 'refugee' image has remained as 'bone fide', whereas the term 'asylum seeker' has developed 'bogus' connotations (Moss 2001),

insinuating that asylum applicants may be a threat to British identity, the welfare state and the liberal state itself (Schuster 2003). Thus 'people seeking sanctuary' has recently become a more socially acceptable description (The Independent Asylum Commmission 2008b).

Media reports frequently report a balanced view of asylum issues, but the emphasis is often towards the negative. Exaggerated claims of the scale of asylum health and welfare support (Bailey 2003) are combined with incorrect and misleading terminology (Buchanan and Grillo 2004). A lack of public sympathy was seen in a qualitative study of National Asylum Support Service (NASS) clients in Glasgow, which found that almost all the respondents cited the negative media role in the coverage of asylum issues (Barclay et al. 2003:96). A study of refugee health in Barnet, London in 2000, found that a fifth of the 36 asylum seekers and refugees interviewed considered that health care professionals should demonstrate more sympathetic attitudes, a consequence perhaps of these negative asylum media images (Cowen 2001) or the excessive PHC workload discussed earlier.

Attempts to overcome this media negativity have included Glasgow actively welcoming asylum applicants (COSLA Refugee & Asylum Seekers Consortium 2003). Moreover, an exhibition in London in October 2006 portrayed the courage of Britain's refugees and to refute the image of asylum applicants as a social and financial burden (Milmo 2006). Media guidance on reporting asylum issues in Scotland is now available (Oxfam et al. 2007).

Asylum applicants have not always been regarded so negatively. The UK has a long history of protection of people seeking political asylum. Immigration control is a relatively modern feature; prior to 1905 there were no immigration laws (Cohen 2003:49, Ogden 2004). Refugees only became a major international concern between the first and second world wars, when the League of Nations in 1922 appointed the first High Commissioner for Refugees and introduced a refugee passport (Pirouet 2001:9).

After the Second World War, as many as 40 million people may have become refugees (UNHCR 2003). This large number of displaced people in Europe was an impetus to define the international status of refugees. The United Nations High Commission for Refugees (UNHCR) was established in 1949, in place of the League of Nations, as an international refugee agency. The Geneva Convention (1951) defined a person seeking asylum as someone who:

> *"Owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (1951 UN Convention Relating to the Status of Refugees: Article 1A2).*

The Geneva Convention remains 50 years later as the major instrument of international refugee law (UNHCR 2003). The initial time limitations were removed by the 1967 Protocol to the Convention.

The protection of human rights is also a major issue. The Convention for the Protection of Human Rights and Fundamental Freedoms (known as the European Convention on Human Rights (ECHR)) adopted the UN Declaration of Human Rights in 1950 (Home Office 2007:5). The ECHR aims to establish a fair balance between the rights of the state and the individual. ECHR court cases were held in Strasbourg until 2000. The Human Rights Act 1998 now allows these cases to be heard by the UK courts.

During the post Second World War era, as a member of a Commonwealth of Nations, the UK government responded benevolently to humanitarian crises. Humanitarian acts included the massive airlift in 1973 of 27,000 Ugandan Asians with British passports and the aid for the 20,000 Vietnamese Boat people in 1979 (Pirouet 2001: 19). A liberal asylum policy may have been more politically advantageous at the time (Schuster 2003).

As refugee displacement became a permanent situation, more strategic planning of international medical relief was required (Simmonds 1984). The pathogenic environment of refugee camps, with consequent epidemics of disease, were maintained to encourage repatriation (Dick 1984). At the same time, the number of asylum applicants coming to Europe and the UK increased year on year, rising from 70,000 in 1983 to over 200,000 in 1989. By the 1990s, the refugee crisis in Africa had reached unprecedented proportions; explosive political confrontations arose as a legacy of colonial rule (Kalipeni and Oppong 1998). UK asylum applications trebled, with a net migration into Europe averaging 857,000 per year (UNHCR 2003). The perception that Europe was under siege from asylum applicants grew stronger and resulted in tighter UK immigration control with reduced access to welfare support.

In signing the 1951 Geneva Convention, the UK Government was expected to make health and social welfare services available to asylum applicants on an equal basis as to its own citizens. UK legislation over the intervening 50 years has eroded significantly the entitlements of asylum applicants to mainstream welfare services in Britain. The Immigration Act 1971 limited the entitlement of Commonwealth and non-Commonwealth UK entrants (Moving Here 1971) and became the basis of subsequent asylum legislation. The right to appeal against a negative immigration decision was introduced by the Immigration Appeals Act 1969.

Recent UK asylum policy has strengthened immigration control. The 1999 Asylum and Immigration Act established the National Asylum Support Service (NASS), now known as the UK Border Agency (UKBA). It coordinates a separate asylum welfare support system, including a centralised dispersal system of housing for asylum applicants on a no-choice basis throughout the UK. UKBA welfare support is at subsistence levels and equates to two thirds of income support.

The Nationality, Immigration and Asylum (NIA) Act 2002 introduced controversial asylum induction, accommodation and removal centres, as well as identification cards for asylum applicants. Section 55 of the NIA Act 2002 ended the presumption of welfare support for those who did not claim asylum at the first opportunity. This

policy resulted in an additional financial burden on voluntary organisations (Refugee Council and Oxfam 2004) and ran counter to the Scottish integration policy. The Rough Sleeper Initiative (RSI) had invested heavily to address the problems of homelessness. In June 2004, Section 55 was revised (Refugee Council 2004b).

The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 introduced penalties for people trafficking, unified the asylum appeal system into a single tier and further reduced the welfare entitlement of unsuccessful asylum applicants (Home Office 2005). This legislation did not address the quality of the asylum decision making process, which remains a significant issue (Refugee Council 2004a).

The Immigration and Asylum Act 2006 introduced temporary leave to remain in the UK for five years for recognised refugees and excluded people engaged in terrorism from the right to claim asylum (2006, Refugee Council 2006b). The UK Borders Act (2007) introduced further asylum biometric testing of refugee families.

The status of humanitarian protection has been introduced for those asylum applicants who do not meet the Geneva Convention criteria, but are able to show, under EHCR Article 3, that if they were returned they would face serious threat to life. Humanitarian protection may be granted for five years, whilst discretionary leave to remain, likewise for five years, may be granted to those who do not qualify for humanitarian protection.

UKBA now assigns a case worker to fast track each asylum claim; almost three quarters of claims are heard within the first 2 months (Home Office 2006). By September 2008 UKBA supported 32,170 asylum applicants (Home Office 2008), when 17% of applicants were granted asylum and 11% were granted Humanitarian Protection. The fast tracking of asylum claims may be counter-productive. Missing information may result in the initial refusal of up to 80% of applications and claims being heard on at least two occasions.

Asylum law and entitlement is thus complex and constantly changing, providing difficulties for PHC practitioners to keep up to date. People granted leave to remain, humanitarian protection status or discretionary leave to remain have the same entitlement to health and welfare services as the indigenous population (Home Office 2004a). Albeit NHS charges are waived on production of the HC2 certificate (Quickfall and Sim 2003), the burden of immigrants on NHS services is not as great as is often cited (Hargreaves et al. 2008). There is a greater diversity of UK migrants than ever before (Vertovec 2006), but confusion remains regarding asylum entitlement to health services, both for applicants and health practitioners (Joels 2008, Rhodes and Munton 2002).

If the application for refugee status, humanitarian protection or discretionary leave is rejected, the asylum applicant has a right of appeal to the Asylum and Immigration Tribunal (AIT). Some applicants have a further right of appeal and a Judicial Review in the High Court may be sought. Once all appeal rights are exhausted, welfare support is only provided to those with dependants under 18 years old. Section 4 support, in the form of food vouchers, is given to those unable to return to their country of origin. A deportation order may be carried out without warning. The dawn raids policy has been severely criticised for the impact on the asylum families involved (BBC News 2006) and is evidence of the rift between Home Office and Scottish Government.

The UK voluntary sector provides another tier of services to supplement statutory services (Pirouet 2001:167). The Refugee Council (RC) in England and the Scottish Refugee Council (SRC) are long established advocacy agencies (Refugee Council 2006a) that carry out research, provide asylum support and information in several languages (Scottish Refugee Council 2006). The Red Cross provides an international service to inform families abroad of an asylum applicant's safety in the UK.

A branch of the Medical Foundation for the Victims of Torture operates in Glasgow. It provides holistic medical assessments, practical assistance, psychotherapeutic treatment and support for asylum applicants (Medical Foundation 2006), as well as

practitioner training and public education. Medical reports have been shown to have a positive effect on the success rate of US asylum applications (Lustig et al. 2008). The psychological evaluation is also thought to be therapeutically beneficial to survivors (Gangsei and Deutsch 2007).

1.5 Rationale for this study

The following asylum case study (all names are pseudonyms) was a catalyst for carrying out this study.

V1.1: Asylum applicant case study

Mohammed was an asylum applicant aged 32 years old; a devout Shia Muslim he had suffered religious persecution in Pakistan and was brought to the UK by a courier. On arrival his lawyer had registered but not progressed his asylum claim. The delay was too long to satisfy Section 55 of the NIA Act 2002 and he had no entitlement to welfare support.

When I met Mohammed, he appeared to have learning difficulties. He could not understand advice or read a map. He was homeless, existed on food handouts from Pakistani restaurants and was not registered with a GP. His complex medical history involved an admission from Accident and Emergency for a repair of an unhealed femur fracture, which was pinned and plated. He carried the X-ray of his femur everywhere and showed this proudly to anyone interested! This compound fracture was very painful.

Mohammed spoke English relatively well and requested SRC help in repatriation to Pakistan; he could no longer tolerate his life here. This repatriation request presented several dilemmas. Was it safe for Mohammed to return to Pakistan? Given his cognitive difficulties, could Mohammed make an informed decision about his future?

Asylum applicants are entitled to a social work assessment, to establish special needs and entitlement to Local Authority welfare support. The social work assessment required Mohammed to be registered with a GP, to facilitate a psychological assessment. The latter demonstrated that Mohammed did not have learning difficulties, but his cognitive difficulties resulted from brain injuries received in Pakistan. Mohammed and two of his friends from his hometown in Pakistan had been set upon by a group of Sunni Muslims. Initially, they had fought off their attackers, but later the same day Mohammed was attacked again. He suffered a severe blow to the head and a broken leg and remained unconscious for three weeks.

Although Mohammed's psychologist advised a return to Pakistan, a response to a Red Cross letter some weeks later suggested that it was still too dangerous. Mohammed's disabilities might not have been tolerated in his home community.

There was eventually a satisfactory conclusion to this story. The social work assessment established Mohammed's disability, weekly welfare support was provided and new accommodation found. He has since been given refugee status.

This case study highlighted for me the difficulties of cross-cultural health care for asylum applicants, which included communication, social exclusion and access to NHS services. It also demonstrated the outcomes of a lack of culturally competent NHS care – Mohammed was homeless, not registered with a GP and his only access to healthcare was via Accident and Emergency (A&E) services. Communication was a major issue; although Mohammed understood English, his brain injury had resulted in a changed personality with limited social skills that made him vulnerable to racial abuse and discrimination. Secondly, he experienced discrimination due to his asylum status, his ethnicity and religion, and the lack of welfare support. Thirdly, in common with homeless people, Mohammed found difficulties in GP registration and access to appropriate services.

Several people have questioned why I have carried out a PhD study so late in my nursing career. There were several reasons. I am passionate about community nursing, which has been a major focus of my life for many years. During my experience of working with asylum applicants and refugees I became not only aware of gaps in my community nursing knowledge, but also I had many unanswered questions. This study has been an opportunity to gain a greater understanding of cross-cultural nursing care, to realise a life long ambition and to give something back to my profession.

Secondly, I had witnessed discrimination within the context of asylum PHC care. I wanted to do something about it. Community nurses have a duty to address health inequalities for vulnerable groups (Falk-Rafael 2005b), but I required an understanding of the health implications of the asylum journey.

Finally, I hoped to distil the principles underlying cross-cultural nursing care. The notion of giving and receiving is central to this study and four related concepts of health need, culture, power and community are explored in the next chapter. A major benefit of carrying out this study for me has been to recognise the intermediary function of the community nurse as central to many aspects of care.

1.6 Summary

Health can be viewed from a variety of perspectives; individual and community health beliefs influence the interpretation of this social construct. The NHS was established upon the principle of universal equitable access to services, on the basis of clinical need rather than the ability to pay, to improve the health of all people. Asylum applicants are a disadvantaged group of people, who have fled persecution to seek sanctuary in the UK. Although entitled to PHC services on a similar basis to the indigenous population, asylum applicant entitlement to welfare support over the last 20 years has been eroded. Thus asylum applicants are potentially at high risk of health inequalities, which arise from poverty, poor access to services, racial discrimination and social exclusion. Although it is unclear as to which one predominates (Levin and Browner 2005), poverty and high stress levels are known to be major factors underlying health inequalities.

As an experienced community nurse, I recognised that community nursing faced a major challenge in addressing health inequalities. Thus a greater understanding of cultural influences on health and health behaviour was integral to community nursing practice development and the culturally competent care of asylum applicants in Scotland.

Chapter 2. Concepts underpinning this study

This chapter provides defines the study's underlying concepts of health need, culture, community and power, within a framework of social anthropology. Community nursing knowledge draws heavily on knowledge from other disciplines. Social anthropology is particularly relevant as the cultural context varies between individual asylum applicants, due their experience of a diverse range of societies worldwide.

2.1 The concept of health need

Subsequent to the discussion of health in chapter one, the concept of health need is important as it drives the process to attain health and wellbeing (Torres 1986). It is interpreted differently by clients, professionals and policy makers (Carney et al. 1996:1) and has been described as the "capacity to benefit from care" (Lightfoot 1995); this health need definition sits firmly in the medical model. Alternatively, if health need is seen as a basic social survival requirement (Orr 1985a:72), it may be defined as "a comparative disadvantage" and involving prevention, recovery and rehabilitation processes (Hopton and Dlugolecka 1995).

Health need is relative and has been categorised into normative, felt, expressed and comparative types (Bradshaw 1972). Moreover, four notions of health care need have been identified (Liss 1993); (1) as a medical intervention to address a health deficiency, (2) as a supply notion in that an acceptable treatment exists, (3) the normative notion gives credence that the need exists, and (4) the instrumental notion describes the intervention required to reach the desired goal or state of health. The complex nature of health need suggests that practitioner and asylum health beliefs and consequent health needs will vary as these perceptions are culturally based, (see vignettes V5.8 and V7.2), requiring promotion and negotiation of patient centred care.

2.2 The concept of culture

The notion of culture is central to this study, but there is no accepted single definition (Bauman 1973:1). The term is used within everyday and academic discourse, from describing artistic expression to denoting a socially acceptable learned behaviour. Although culture does not exist in its own right, it is 'a flexible resource for living' *(*Ahmad 1996:190) and embodies a particular way of life (Williams 2003:28). Geertz (2000:75) refers to culture as a 'common sense' body of knowledge.

Historically culture was thought to be unique to man (Herskovits 1938:11). Malinowski and Radcliffe-Brown considered that culture and customs served functions within society to meet its organisational, biological and structural needs (Layton 1997:37). The following definition of 'culture' is based on Kluckholm (1962) and indicates that the term is generally reserved for societies or groups:

> *"The collective programming of the mind that distinguishes the members of one group or category of people from another" (Hofstede 2001:9).*

Culture provides a medium for the cohesive social transmission of norms, values and behaviours. Some authors consider these common customs such as how people dress, marriage and family life, work patterns, religious involvement and leisure activity (Mason and Whitehead 2003) give society a structure (Kluckhohn 1962). They provide stability for individual cultures (Keesing 1958) through a covert, explicit and yet implicit set of guidelines (Hall 1977:14). A hierarchical notion assumes culture to be a 'possession' and a means of reinforcing the normal cycle of destruction and recreation within society (Bauman 1973:6-10). Albeit the shared symbolic structures of language, constitution and abstract rules are a product of consumption (Giesen and Schmid 1989:68-74), cultural awareness is a fundamental element of nurse-client relationships, as discussed later in chapter five.

Effective communication between people relies upon this shared understanding (Cortis 2003b). It is referred to as cultural sensitivity and is discussed further in chapter six. Whereas Geertz (1973) suggests that culture is ideational, Hall's 'Triad of Culture' includes technical or scientific communication (Hall 1982). Whilst a formal culture may perpetuate the customs and accepted rules of behaviour, an

informal culture may arise from unconscious psychological activity (Levi-Strauss 1968). Thus, it may be difficult for clients to explain their cultural ways of life (Dobson 1991:106), which impacts on asylum applicant nursing care. The Iceberg Theory is helpful in understanding how these beliefs and values may be hidden (i.e. underneath the iceberg) whereas rituals, gestures, greetings and dialogue are visible (i.e. above the water line) and open to interpretation (Katan 1999:29); a wink, for example, is not just a movement of the eye, but a meaningful twitch (Peacock 2005:55-56). Culture is not merely an unconscious template for action (Bourdieu 1976), but is a socially inherited lens through which individuals perceive, understand and operate within their social world (Helman 2007:2). Thus, a paradox exists in that culture pervades our everyday lives and influences our individual, group and community actions (Elliot 2003:208), but it rarely intrudes on our consciousness.

Medical anthropology maintains an emphasis on the body (Scheper-Hughes 1994), whilst focusing on disease, illness and healing (Janzen 2002). This understanding of ill-health (Helman 2007:7) conceptualises how disease patterns, social norms and socio-economic status may interrelate (Joralemon 1999). It also links human rights to public health (Lindenbaum 2005). Clients with the same illness, but from different cultural backgrounds, may present with different clinical symptoms (Good and Good 1981). An holistic approach is thus required to ensure that the client understands the cause, treatment and prevention of recurrence of their illness (Katon and Kleinman 1981) as well as address spiritual needs (Patterson 1998).

Whilst reflecting corporate NHS principles, nursing also defines its own values (Drennan 1992:3) to portray its uniqueness and difference from other professional and non-professional groups (Leininger 1997). Status and role are functional elements of nursing culture which define how community nursing provides client care (Burnard 2005), whereas symbols such as words, gestures and dress communicate values and meanings. Rituals are used to initiate, negotiate and conclude an episode of nursing care.

Two major layers of culture are practices and values (Hofstede 1991). The onion rings model places values in the centre, whereas practices that involve symbols, heroes and rituals lie concentrically. This model aids an understanding of NHS health culture (Weidman 1979) and the challenges of implementing core NHS values (described in section 1.2) within a multi-cultural service provision (see vignette 4.14).

Health care is not just the preserve of professionals. Healing systems are thought to be universal across cultures (Kleinman and Kunstadter 1978:1) and three inter-related sectors of health care have been identified (Kleinman 1978:409). The popular health care sector concerns individuals and families, where most minor illness is managed. Secondly, the professional health care sector operates within its own system of formal training, control of practice and enforcement of care standards. A third folk sector provides alternative or fringe medicine that may be used when the western model of medicine fails (Maclean 1977:150).

Cultural norms may deter the use of primary care services. Cultural knowledge of social groups is arguably vital to health promotion activity (Holroyd et al. 2004) and is discussed further in chapter seven. A study of the relationship between sexual identity and health care experiences of HIV positive men in Vancouver, Canada found that health care professionals did not understand their culture; being accepted in a non-judgemental way was an important part of health care (Holton 2001). Thus, although primary care practitioners are frequently working within multicultural environments (Burnard 2005), culture may become a divisive rather than an inclusive concept (Cortis 2003a) and of limited value when ascertaining health inequalities (Hillier and Kelleher 1996). Moreover, Kleinman and Benson (2006) suggest that there is a lack of outcome research evidence to demonstrate the cost effectiveness of culturally informed strategies within clinical settings.

I consider that the complex concept of culture provides a basis for understanding how the notions of health, illness and care are interpreted and applied within society. In this study, the definition of culture is:

"A socially acquired complex set of capabilities and customs needed to operate coherently within society".

When asylum applicants migrate to another social context, it is necessary to re-learn the meanings of social behaviour. Acculturation is a process whereby a person deals with the conflict between two or more cultures through stages of assimilation, integration, separation and marginalisation. Identity is influenced through contact and communication with the host culture (Berry et al. 1987a, Yeh 2003). Adaptation to a new host environment is a huge challenge for asylum applicants. This process is more stressful for some than others (Berry et al. 1987b), but is thought to be conducive to longer term well being (Berry 1997) and is discussed later in chapter seven.

Community nurses require skills of cultural awareness, cultural sensitivity and cultural knowledge to understand how the concept of culture impacts on asylum health. The exchange of benefits between people (Mauss 1969, Molm 2001), the meaning of interpersonal relationships (Barnard 2000:133) and the norms of health and sickness behaviour are relevant to client expectations, as well as the delivery of community nursing care (Cortis 2003a). Nurses are interested to ascertain their clients' cultural beliefs to make treatment and advice more acceptable (Hendry 1999:12), but they need to adopt a transformational culture, which involves three elements of staff empowerment, practice development and an understanding of the workplace situation (Manley 2004: 52-62).

2.3 The concept of community

Most societies consist of an ethnic mixture due to migration or conquest (Harris 1997). A community may be viewed as a geographically, socially or culturally defined group (Kelly and Symonds 2003). The term ethnicity is used to identify people from the same society, who are within a shared culture and speak the same language (Barfield 1997:152), but this grouping is neither pure nor static (Modood 1997:290). The 2001 national census demonstrated that Scotland's minority ethnic population was approximately 100,000 people, two percent of its population

(Scottish Executive 2004). Although this minority ethnic group remains small, it is a growing population, showing an increase of 62.3% on the 1991 census. Glasgow has a population of 578,790, with the largest Black and Minority Ethnic (BME) community in Scotland (NHS Greater Glasgow and Clyde 2005:2).

Social group membership is important for an individual to gain a sense of community (Kelleher 1996), but inclusion also involves exclusion criteria (Jenkins 1997). The concept of community is central to equality; choices have to be made as to whether we base this notion on a national common civil culture, as ethnic community members or as religious group members (Baumann 1999:14). Albeit the term 'community' has an embedded ideal of members looking after each other, there is a consequent lack of individual freedom (Bauman 2001:1-6). Conflict may arise between groups within a community as notions of difference not only provide strength, meaning and boundaries between groups (Nazroo 2001), but may also marginalise and set groups apart (Smaje 1995).

Kelly and Symonds (2003) suggest that historically a community's status was ascribed and related to its locality, occupation and production focus, social class, and gender. A second dimension of community is income based rather than class based, which reflects personal lifestyle and consumption. A mosaic or 'hodgepodge' of co-existing different ways of life may develop, where there is a fracturing of citizenship and a denial of a monoculture (Joppke and Lukes 1999:8-9). Finally, a third dimension involves those marginalised and excluded from the ascribed and elective types of community. The low socio-economic status of asylum applicants makes existence and social integration difficult.

The promotion of racial equality involves a multi-culturalist approach, the sympathetic acceptance of a wide range of cultural values, as well as anti-discriminatory approaches (Rattansi 1992). Turner (1993:414) considers multiculturalism based purely on difference results in the common ground between groups becoming less visible. More importance may be given to the differences than to the similarities between groups (Mulholland and Dyson 2001). Moreover, a single

ethnic group may combine its identity and culture to promote an emotive rather than an objective perspective; consequently, difference multiculturalism risks reification and ascription of homogeneity (Lambert and Sevak 1996).

Contradictory cultural stereotypes arise when it is difficult for one person to appreciate fully another's' culture (Polascheck 1998). As stand alone entities rather than deficiencies (Robinson 1998:58), cultural differences should be nurtured as variety rather than addressed through greater equity of resource distribution (Bauman 2001:107). In perpetuating difference multiculturalism, rather than understanding how cultural identities influence political, ethnic and social class power divides, social inequalities may be legitimised rather than challenged.

Social anthropology employs a critical approach to multiculturalism, which embraces core principles of equal respect for all cultural practices and behaviours (Turner 1993). Turner (1993) proposes that rather than multiple cultures existing within society, a single worldwide culture should be considered that empowers collective action. Social groups do not exist in isolation, but continually influence each other. The complexity of culture is such that it is constantly changing to become a polycentric meta-culture, where collective rights of self-determination can be mobilized. However, a critical approach does not lead to a blanket acceptance of cultural behaviour; practices such as Female Genital Mutilation (FGM) cannot be justified on the grounds of human rights.

Community health should be an inclusive concept, which is equitable rather than built on the premises of difference multi-culturalism. Albeit vertical equity, (see section 1.2), potentially enables individuals to attain the same health status level through health need identification and appropriate service provision (Carr-Hill 1994, Hanafin et al. 2002), minority ethnic populations, including asylum applicants, suffer significant health inequalities (Smaje 1995). A review of 51 diabetic studies in the US and the UK, demonstrated that ethnic differences in diabetic care contributed to more adverse outcomes for diabetic patients from minority groups (Lanting et al. 2005). Coronary heart disease has been shown to be moderately higher in South

Asian groups than in the general population (Aspinall and Jacobson 2004:6). The lack of guiding principles for the equitable allocation of NHS resources and consequent service inconsistencies has been demonstrated (Sassi et al. 2001).

Community nursing faces many challenges in promoting community health. It must meet the distribution of health across populations (Starfield 2002) and effectively address health need within individual and community relationships (Falk-Rafael 2005a, Jan 1995), whilst avoiding a 'colour blind' approach of treating all individuals alike (Cortis 2000). In coming to the UK asylum applicants have lost their home community; the asylum dispersal system of no-choice accommodation may further fragment family groups and lead to social isolation. If community nursing lacks cultural awareness and cultural knowledge, it potentially fails to redress inequity of access to services faced by some minority groups. GP attachment structures may limit the promotion of community health through promoting practice population needs above those of the whole community.

2.4 The concept of power

The NHS is a complex bureaucracy of health service provision; its hierarchy of authority includes a division of labour, standardised activity, formalised procedures and record keeping systems. It uses the appointment and reward of personnel on the basis of merit and responsibility to maintain the status quo (Jones 1994:445). Health professionals also maintain their individual power bases within this bureaucratic structure.

Professional power may be a destructive force. Foucault describes it as the 'clinical gaze', which involves a focus on the body as a machine (Foucault 1973). In *The Birth of the Clinic*, Foucault suggests that professionals make visible the invisible (Rhodes 1993:136), to reconstruct the client's view of health and disease and thereby consolidate their own power (Jones 1994:421). Foucault promotes society as a body of powerless individuals subject to the disciplinary or pastoral power of health professionals (Foucault 1979, Scheper-Hughes 1994, Taylor 1999:273). Thus, the selective application of medical knowledge may reflect the practitioner's rather than the patient's understanding of the health issue (Young 1993).

These power relationships are explored in *Power: A radical View* (Lukes 1974:13). Lukes (1974) identifies the first level of power as one-dimensional and similar to a pluralist position; the conflicting interests of different parties result in an emphasis on decision-making. Individuals test their capacity to influence the outcome through directly promoting conflict to find out who will prevail.

In his two-dimensional view, Lukes explores the two faces of power, where conflict between groups may be either overtly or covertly managed to promote the subjective interests of the dominant party. Both decision-making and non-decision making are seen as alternative modes of action; a decision is actioned through choice, whereas a non-decision maintains the status quo. Whereas hegemony secures compliance through control by one group over another, coercion secures compliance through threat of an individual benefit loss (Lukes, 1974: 20).

The three dimensional or radical view of power incorporates the two previous positions but also embraces the notion that power is exercised in the absence of observable conflict and action (Lukes 1974: 24). Lukes contends that power is independent of conflict to instil authority; power is more effective when conflict is prevented and does not promote a position. The institution's cultural practices may maintain the status quo. Lukes considers that a latent conflict may arise when power is used to maintain individual or corporate interests at the expense of others. Moreover hierarchical power relationships are often unchallengeable (Clare 2003:131). An ethnographic study of Canadian Inuit women showed that hospital based maternity care was implemented in spite of the women's preference for home delivery (Kaufert and O'Neil 1993:50). The QoF standard of GP appointments within 48 hours may suit the NHS's payment mechanisms rather than reflect patient need for routine appointments. Thus, individuals may remain unaware of power domination (Scott 2001:60) as their 'real' interests are ascribed by others (Wicks 1998:22).

Lukes' (1974) conception of power ignores legitimate sovereign power, the right to assume control (Hobbes 1968) as well as the capacity to act (Hindess 1996). Despite

the larger UK nursing workforce delivering clinical care, the medical profession has maintained its NHS powerbase, which is underpinned by epidemiology. Thus the fight for NHS resources results in a tension between the primary, secondary and tertiary sectors. However, health professionals have to abide by UK asylum legislation, even though it may conflict with NHS core values and social justice.

Unequal power relationships between ethnic groups are thought to lead to a tribal mentality of the deserving 'us' and the less deserving 'other' (Miles and Small 1999:137), resulting in discrimination (Ahmad 1996:199, Mulholland and Dyson 2001). As an ex-colonial power, the UK is considered by some authors to be intrinsically racist (Cohen 1992). Evidence of discrimination and institutional racism in the police force came to light in the Macpherson Report (Macpherson 1999), but there was also evidence that minority ethnic people were disadvantaged in the receipt of health and nursing care services (Ahmad, 1993:212). Efforts to address health inequalities must proactively take on board issues of discrimination and racism (Allyne et al. 1994), but progress in challenging racism within the NHS has been limited (Franklin 2007).

Discrimination concerns unfair treatment, often on the grounds of ethnicity and religious group. It is a marker of white power that potentially results in individuals and communities living in anxiety and fear (Arora et al. 2001:144). Whereas racism arose from a belief that some ethnic groups were inherently superior or inferior (Barfield 1997:395), modern racism is more subtle in placing a higher value on ethnic majority beliefs and attitudes (Robinson 1998:39). There are few incentives to be non-racist (Ahmad, 1996; 196) and discrimination continues so long as the attitudes that support it exist (Barry 2001).

The *Fourth National Survey of Ethnic Minority Health (*1997*),* a UK study concerning the general health, socio-economic status and specific illnesses of minority ethnic and white groups, highlighted the existence of health inequalities and found that overt racism was commonplace (Nazroo 1997). There were higher rates of psychosis reported among African Caribbean people than other ethnic groups, which

may be explained by their experience of discrimination and racism (Virdee 1997:287). Nazroo (2001) recognises methodological problems in this study, resulting from a lack of ethnic monitoring data and identification of the variance in health care workers' attitudes to different ethnic groups. Although the study validity has been called into question, it remains important in raising awareness of discrimination and its impact on minority ethnic health inequalities.

An unequal power relationship exists also between health visitors and their clients, controlling client participation in care delivery (Cowley et al. 2004). Social approval for nurses' legitimised role stems from their acknowledged skills and competencies (Claus and Bailey 1977, Department of Health 2004, Walsh and Ford 1989). Secondly, nurses have the power and capability to modify the behaviour of others through health promotion activity and advice (Jones 1994, Maclean 1974:153). Foucault's views may explain this client compliance (Peckover 2002) and the sanctioning of client identified health care needs only if an epidemiologically defined level of risk is reached (Cowley et al. 2004). Community nurses may experience dissonance within the nurse-client relationship. Although empowerment is required to empower asylum disclosure of health needs, to identify with the client they must reduce their power base to Lukes' first level of power. The result may be emotional labour (Hochschild 1983) and the loss of professional esteem.

2.5 Summary

In this chapter I have described four inter-related concepts of health need, culture, community and power that are central to this study. These concepts underpin the giving and receiving of community nursing care. Health need is usually considered on an individual basis, but community nursing serves the whole community who require help to attain equity of access to health and nursing care.

The accurate identification of asylum health need requires cultural awareness, sensitivity and knowledge to promote equitable access to PHC services (see section 3.2). Asylum applicants face a huge cultural challenge in adapting to a new host environment and in navigating the unfamiliar NHS. The result may be the

medicalisation of normal life experiences, such as grief and bereavement (Kleinman 2001). Moreover, at a community level asylum applicants may face racism, reduced access to NHS services and disempowerment in active community involvement.

The NHS has adopted a multi-cultural approach to health care, rather than necessarily confronting discrimination to ensure the collective rights of all NHS users. Community nurses require cultural awareness to understand that stereotyping may reinforce multicultural and professional hierarchies of power. Although a socially inclusive approach promotes equitable access to PHC services, this is not a colour-blind approach, but rather that community nursing should recognize, meet and embrace a range of individual cultural requirements.

Chapter 3. Carrying out the study

I carried out this ethnographic study of community nursing of asylum applicants to ascertain the meaning of cultural competence for both community nurses and their asylum clients. As a novice, white middle aged researcher, a social anthropological approach (Fetterman 1989, Layton 1997:1) enabled me to take forward the study rationale (see section 1.6). I required expert help to carry out this major study, as other authors suggest (Higginbottom 2002) to develop a rigorous approach to researching a culturally diverse and disadvantaged client group (Drennan and Joseph 2005).

3.1 Research aim

My major research aim was to understand how culturally competent nursing and health care appropriate to the health needs of asylum applicants was provided in Glasgow. The major research question was:

- *Based on their experience of primary health care services, what is the meaning and understanding of the concept of cultural competence for community nurses and asylum applicants in Glasgow?*

The subsidiary research questions have been divided into five areas:

1. Equity, access and provision of non-discriminatory services

   - *How does the concept of equity impact on the provision of primary health and nursing care services for asylum applicants?*

2. Cultural awareness

- *How do the health beliefs of asylum applicants and community nurses affect the delivery of primary care nursing?*

3. Cultural sensitivity

   - *To what extent do community nurses see cultural sensitivity as an important aspect of their work with asylum applicants?*

4. Cultural Knowledge

   - *How does the community nurses' understanding of cultural knowledge impact on addressing health inequalities?*

5. The concept of cultural competence

- *What are the major principles underlying the provision of culturally competent care?*

I considered that the study required an interpretive design because cultural competence does not exist in its own right, but is a social construction open to different interpretations and understandings. Thus the cultural context influences the identity and behaviour of the actors (Appleton and King 2002, Denzin and Lincoln 1994, Guba and Lincoln 1994, Hughes 1990).

3.2 Theoretical framework of cultural competence

In developing a theoretical framework for this study, I reviewed the current definitions of cultural competence provided mainly by US authors. With increasing global migration, nurses require an understanding of a range of cultural ways of life (Leininger 2002c:4). Transcultural Nursing (TCN) aims to acquire, learn and understand an academic body of cultural knowledge, to augment cultural competence (Bartol and Richardson 1998) and to predict cultural diversities and universalities (MacLachan 1997).

Leininger (1992) defines TCN as:

> *"A formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned life ways of cultures to provide culturally congruent, meaningful, and beneficial health care to people (Leininger 2002c:5)."*

In Figure 1, I provide an interpretation of the Sunrise Model (Leininger 1992, 2002b:80) which depicts the Theory of Cultural Care Diversity and Universality. This theory assumes that culturally based nursing care, which includes technological, philosophical, kinship, political, economic and educational factors as well as cultural beliefs and life styles, is essential for safe nursing practice.

Figure 1: Pictorial interpretation of the Sunrise model (Leininger 2002b:80)

Worldview

Cultural & Social Structure Dimensions

Cultural values, Beliefs & Lifeways

Kinship & Social Factors

Political and Legal Factors

Religious & Philosophical Factors

Influences

Care expressions patterns and practices

Economic Factors

Technological Factors

Holistic health/illness/ death

Educational Factors

Focus: Individuals, families, groups, communities or institutions in diverse health

Generic (Folk) Care

Nursing Care Practices

Professional Care-Cure Practices

Transcultural Care Decisions and Actions

Code:
(influencers)

Culture Care Preservation/Maintenance
Culture Care Accommodation/Negotiation
Culture Care Repatterning/Restructuring

Culturally Congruent Care for Health, Wellbeing or Dying

A major limitation of Leininger's theory is that it is impossible to know about all aspects of every culture. Her theory does not take account of power relationships, inequalities and racism between different ethnic groups and focuses on life styles rather than life chances (Swendson and Windsor 1996). Although 'colour blind approaches' are considered inappropriate (Burford 2001:201), cultural assumptions can perpetuate difference to result in confusion rather than resolution of cultural care (Gustafson 2005).

Cultural competence enables individuals or organisations to respond appropriately and effectively to people from diverse cultures, languages, religions, ethnic backgrounds and social status. It recognises the values and preserves the dignity of all individuals, families and communities (Earley and Ang 2003); both as an important aspect of care (Papadopoulos et al 2004) and as a professional duty (National Resource Centre for Ethnic Minority Health 2005). Commonalities between cultures form a basis for health promotion (Arora et al. 2001:144), whilst client centred care is an essential element of quality nursing (DeSantis 1994, Leininger 1992). Health inequalities, the quality of US health services and added economic competitiveness were cited as factors underpinning the rationale for promoting cultural competence (Campinha-Bacote 2002), which has been defined as:

> *"A set of congruent behaviours, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals, to work effectively in cross-cultural situations" (Batts 2002:4).*

In this definition, Batts (2002) emphasises institutional responsibility to widen health service access for a diverse range of people, but not purely on the grounds of equity. Although cultural difference is assumed to be the starting point for care delivery, it is integral to US health care marketing strategy to increase service provider profit.

Clinical competence comprises knowledge and technical capabilities (Robotham 2005b:19); cultural competence is an additional skill of understanding the cultural context, obtaining informed client consent and ensuring safe practice (Helman, 2007: 16). The universal principles underlying cultural competence, which include caring, collaboration and creativity (Dobson 1991) have influenced the development of US models (Campinha-Bacote 1994, 2002) and include a sensitivity to spirituality

(Newlin et al. 2002). The US models demonstrate a common emphasis on cultural assessment (Quickfall 2004). The use of cultural competence checklists (Purnell 2005, Seibert et al. 2002) has arisen primarily from the work of Leininger (Giger and Davidhizar 2003). Moreover, culturally competent community nursing care is thought to exist as a continuum (Kim-Godwin et al. 2001).

The application of US cultural competence models to the UK is limited due to major differences between the two health care systems. The US health care service does not provide universal coverage, whereas the NHS focuses on equity, the reduction of health inequalities and countering racism, which have historically received less attention in the US system (Coker 2001:21). The US system has been shown to result in increased health inequalities due to reduced doctor registration and access to medication, when compared to Canada, which has a universal health system (Lasser et al. 2006). Moreover, minority ethnic groups are known to be more likely than whites to perceive bias and a lack of cultural competence in US healthcare provision (Johnson et al. 2004). These limitations prompted me to develop my own Five Steps Model of cultural competence (Quickfall 2004).

The concept of cultural competence is now commonly used within a multi-cultural NHS. Burford (2001:202) summarises its four basic components as the acceptance of difference as normal, the acceptance of the right of all society members to feel part of society, the gaining of cultural knowledge and the taking of a learning stance. Papadopoulos (2006) promotes an equitable, yet multi-cultural NHS approach to addressing health inequalities and access to care in her definition of cultural competence:

> *"The capacity to provide effective health care taking into consideration people's cultural beliefs, behaviour and needs" (Papadopoulos 2006:10).*

A commonality of cultural competence definitions is the notion of '*effective working*', but this requires greater clarity, is dependent to a large extent on values and health belief and whether the outcomes for clients, community nurses or the community are paramount; should these outcomes conflict which one takes priority? As discussed in section 2.2, an emphasis on cultural difference may legitimise rather

than reduce social inequality. Kleinman and Benson (2006) have concerns that cultural competence may assume cultural norms, which lead to stereotyping and hinder the understanding of the client's position.

The Papadopoulos, Tilki and Taylor (PTT) model of cultural competence is arguably more appropriate to the UK and incorporates four major areas (Papadopoulos 2006:10):

- *Cultural awareness* involves understanding our personal value base, including our cultural history, identity and ethnocentricity.
- *Cultural knowledge* includes recognition of both cultural similarities and difference and the structural elements underlying health inequalities.
- *Cultural sensitivity* encapsulates how health care professionals communicate and relate to the people in their care.
- *Cultural competence* is the synthesis of all these three areas to be both clinically competent to assess and diagnose health issues, as well as recognise and challenge discrimination and racism (Papadopoulos et al. 1998).

Cultural competence is cyclical in nature; each aspect informs the next, thereby continuously improving quality of care (Papadopoulos 2006:21). Papadopoulos (2006:22) suggests that cultural competence operates at four levels. A practitioner demonstrates culturally incompetent practice at level one, becomes culturally aware at level two and at level three is providing culturally safe practice. Level four involves the implementation of culturally competent care.

A major limitation of the PTT model is that it puts the onus on practitioners, rather than the organisation, to deliver cultural competent services. The organisation's ability to work in partnership with its service users to provide these services may be as important as the personal competencies of the nurses (Arora et al. 2001:153). The time consuming nature of culturally competent care impacts on workforce and workload planning; NHS managers need to provide adequate community nursing staffing levels to actively address disadvantage (Gerrish 1999).

The concept of cultural safety was developed in New Zealand, where the dominant culture is not that of the indigenous Maori people (Ramsden 1993). It provides an equitable framework and empowers clients to maintain their identity, whilst promoting their own health care needs (Polascheck 1998). Cultural safety also aims to change the attitudes of health service providers towards minority ethnic groups (Richardson and Carryer 2005, Wood and Schwass 1993) to counter structural inequalities (Anderson et al. 2003). NHS culture may blame the victim rather than its policy for the failure to address health inequalities (Nutbeam 1998), which may arise from a lack of cultural safety (Smye and Browne 2002). The concept of cultural safety is applicable to all minority ethnic groups, but for it to become a credible and useful tool, more research on care outcomes is required (Richardson 2004).

3.2.1 The Five Steps Model

At an early stage in this study, I brought the elements concerning the culturally competent health and nursing care of asylum applicants together as a Five Steps Model (Quickfall 2004). An updated version of this model is shown in Figure 2, which employs similar terminology to the PTT model (Papadopoulos 2006:21). In the Five Steps model, responsibility for culturally competent care lies at all levels of NHS organisations. In each benchmarked step there is a continuum between the positive and the negative promotion of cultural competence. These steps are now explored in more detail:

1. Institutional regard

Institutional regard provides a framework of authority for the operation of its cultural values; in this study it refers to ensuring horizontal equity of access to primary care services for asylum applicants in Scotland (see section 1.2). The organisational responsibility for cultural competence exists at strategic and management levels, including national and local policy, together with manpower planning and language support services (Quickfall, 2004). Without these appropriate structures and resources, community nurses are limited in their ability to provide culturally competent care for asylum applicants. Asylum services, whether dedicated or mainstream, should be non-discriminatory and accessible by all ethnic groups; hence, in the updated model, access issues have been incorporated into institutional regard.

2. *Cultural awareness*

Cultural awareness involves respect for individual cultural values of religious belief, diet, family and social organisation, political issues and health belief (Papadopoulos 2006:11), an acceptance of cultural difference as normal (Chenowehm et al. 2006) and is important step towards working effectively both across and within cultural groups (Baldwin 1999). During an initial contact, both the nurse and the asylum client are strangers; each requires an awareness of personal value bases to understand those of the other. In recognising a client's cultural health beliefs, practice can be adapted to meet these cultural norms (McCauley 2004).

3. *Cultural sensitivity*

Effective communication is essential to the culturally competent assessment of health needs and requires language support and translation of health promotion materials. It facilitates the building of trusting relationships between practitioners and asylum clients, but requires an acceptance, adaptation and integration of difference within nursing practice (Bennett 1986). Thus, cultural sensitivity affects primary care access (Bhatia and Wallace 2007) and impacts on the provision of primary care and nursing services (Muecke 1983, Vernon and Feldman 2006:5).

4. *Cultural knowledge*

Cultural knowledge involves an understanding of how structural factors, such as poverty and social exclusion, affect health. It involves the development of agency to address health inequalities; community nurses require self-empowerment for practice development, which involves transformational leadership to promote asylum health.

5. *Cultural competence*

The synthesis of these four elements enables community nurses to carry out culturally competent care. It involves the development of nurse-client relationships to the point where asylum applicants are empowered to access, negotiate person centered care and use PHC services effectively.

Figure 2: The updated Five Steps Model for the culturally competent community nursing care of asylum applicants.

Positive promotion of cultural competence

Strategic NHS Leadership:	Nurse-client relationship	Accurate health & social care needs assessment.	Impact of asylum policy on health.	Client empowerment for equitable access to NHS services
Mainstreaming asylum health issues	Awareness of own value bases and those of others.	Verbal & nonverbal communication issues. Use of interpreters & advocates.	Addressing vertical equity & health inequalities	Individualised & negotiated nursing care
Positive media Influence.	Cultural variation normal regarding: health beliefs, religion, diet, political views, family and social organisation.	Provision of appropriate health information.	Promoting social integration	Signposting & referral to other agencies.
Workforce planning ensure adequate resources. Monitoring horizontal equity of access to services			Maintaining cultural safety	Multi-agency working.

Cultural Competence

Cultural Knowledge

Cultural Sensitivity

Cultural Awareness

Institutional Regard

| Discrimination & reduced asylum access to services

Inadequate workforce planning | Stereotyping Misattribution Nurse- clients remain as strangers | Lack of Language support services

Communication issues not prioritised | Lack of cultural safety

Racism & social isolation not addressed | Colour-blind approach.

Victim blaming & no allowance made for cultural diversity. |
|---|---|---|---|---|

Negative promotion of cultural competence

The pictorial representation of cultural competence in the Five Steps model as the synthesis of institutional regard, cultural awareness, cultural sensitivity and cultural knowledge acknowledges a continuum exits between negative and positive aspects of each step. Although the model provides the theoretical framework for this study, it has its limitations; it neither provides a means for the measurement of cultural competence, nor identifies how cultural competence is carried out in practice. These five steps are considered in the data analysis chapters, to ascertain whether the model accurately reflects identified components of cultural competence and could form the basis for the promotion of best practice within the PHC context.

3.3 Research strategy

Although I had developed a cultural competence framework deductively from the literature, I used an interpretive paradigm to consider cultural competence inductively from the emic perspectives of both asylum applicants and community nurses. An interpretive research design ascribes central prominence to the meanings and interpretations underlying human behaviour (Broom and Willis 2007, Schwandt 1998), which is frequently in response to the social context and how others may interpret behaviour.

Blaikie (2000: 114-118) suggests that an abductive research design is appropriate to the interpretive paradigm, which incorporates the following six principles:

1. The explanations people give concerning their actions and those of others provide a route for understanding how their social world operates.
2. These explanations are provided in lay language that reflects a subjective conceptual framework and understanding of the situation.
3. This understanding of social life is frequently inflective, tacit and taken as read.
4. People ascribe meaning and interpretations to social behaviour when challenged or the situation changes.
5. Fragments of these understandings can be unveiled through the use of appropriate research methods

6. The researcher pieces these understandings together to produce a coherent picture of the situation.

The ontology of the abductive approach examines whether the world exists independently of human thought (Edwards 2001:10). It assumes that people construct their reality through their interpretation of their social world and cultural context (Blaikie 2000:119, Schwandt 1994). Hence, these subjective interpretations vary with the conception of reality (Pawson 1999); they are culturally based whilst adopting local values, concepts and beliefs (Maggs-Rapport 2000). Interpretations of reality are shared through lay language (Hughes 1990:117) and by common agreement on the significance of language and symbols (Geertz 1973:6). I decided that immersion in the social world of asylum applicants and their community nurses was essential to reconstructing how the concept of cultural competence was understood and used in nursing practice.

Epistemology is used to define our social world (Robinson 1985:155). What counts as knowledge should be transparent and open to scrutiny (Blaikie 2000:8), robust, fit for purpose, legal and ethical, as well as accessible and intelligible (Pawson et al. 2003:ix). Nursing builds on an interdisciplinary theory base (Johnson 1999), incorporating commonsense and scientific knowledge (Robinson 1985:156-7). It is further informed through an understanding of the client's experiences (Running 1997). Tacit nursing knowledge is often assumed, intuitive in practice and may be thought of as action (Cook and Brown 2005:53). This study required a broad understanding of organisational knowledge, professional knowledge, user knowledge, research knowledge, policy and community knowledge (Pawson et al. 2003:ix-x). Thus, I considered ethnography was an appropriate methodology for this study.

I had previously used concept mapping methodology (Quickfall 2000), but I chose ethnography because it would provide me with an emic and etic understanding of cultural competence, using an interpretive theory of culture (Geertz 1973:24). Although the use of ethnography to describe social behaviour exposes the relative

objectivity of the writer (Layton, 1997: 184-215), I was integral to the research process and invested my life experiences in the data collection and analysis. My past nursing experience provided interpersonal skills to communicate with the nurse and asylum informants, who came from a variety of ethnic and educational backgrounds with a range of experiences. I had to be wary not to make assumptions in gaining a common understanding of the informants' situation.

Ethnography was quite new to me; it is very descriptive, extending across multiple data sources, with a lesser concern for the theoretical meaning of the observations (Miles and Huberman 1994). It moves beyond description to provide an explanation, a 'translation of culture' (Layton 1997:1). The familiar is seen in a different light and interpreted within the cultural context (Goodley et al. 2004). An ethnography encapsulates this richness of detail concerning people's daily lives (Hendry 1999:20), using similar ways of making sense of the world as the informants (Hammersley and Atkinson 1995). It is described as the both the art and science of portraying a group or a culture (Fetterman 1989), centres on the meanings people give to their cultural experiences (Holloway and Wheeler 1996, Maggs-Rapport 2001) and is suitable for unexplored areas of nursing research (Baillie 1995, Laugharne 1995, Mulhall 2003). My nurse researcher role was to gather the data as lay asylum and professional meanings and piece these together to provide my interpretation of the informants' behaviour.

Language provides a medium for the construction of models and concepts to take account of new personal experiences (Hughes 1990, Layton 1997, Schwandt 1994, Spradley 1979). I considered that a qualitative approach, using words as the basis for exploration (Silverman, 1993:9-10) was appropriate to this ethnographic study. I used simple English when interviewing asylum informants to ensure that my research questions were easily understood and relevant, as miscommunication (see section 6.3) can potentially occur when working through interpreters (Briscoe and Lavender 2009).

Descriptive writing enables culture to become known through text (Geertz 1973:7, Layton 1997:202). The interweaving of thick descriptive layers of the research setting produces an ethnography, which contrasts the emic and etic interpretations of beliefs and behaviour (Barfield 1997:215). It was important to document what was happening as well as what was not happening.

I combined both encyclopaedic (Agar 1996:8) and narrative ethnographic approaches (Holloway and Freshwater 2007:21) to gain an understanding of the informants' social behaviour and produce an ethnography primarily in a story format. Whereas the encyclopaedic approach enables a description of the study context, the narrative approach provides a verbal account of an informant's inner world from several perspectives (Lieblich et al. 1998). Ethnography serves both as a lens to bring disconnected elements together as a whole and as a mechanism for the transmission of cultural values (Polkinghorne 1988:14).

As the main data collection instrument I was responsible for the ethical conduct of this ethnographic study. Medical ethics serve to protect research participants and centres on four principles; respect for individual autonomy, justice, non malevolence and efficacious use of resources (Alderson 2007). The process of obtaining ethical consent was time consuming, but clarity in defining the study conduct was essential to protect the informants' rights and wellbeing. I submitted an on line ethics application. The Greater Glasgow Primary Care Division Research Ethics Committee agreed that the research topic was important and made minor research design changes in their approval letter. It was my responsibility, as the principal investigator to recruit individual informants to take part in the study. I was granted an honorary contract by Greater Glasgow Primary Care Division (see Appendix), which allowed access to the health visitors and district nurses for the period of the data collection. I sought permission from one GP practice to access their practice nurse.

I provided a practitioner and an asylum applicant study information sheet (the latter is provided in the Appendix and was also translated into French). Most informants were able to understand English. I explained the study using simple language to

asylum applicants with a limited ability to read English. An interpreter translated verbally the client information sheet and the consent form for informants unable to read English or French. I asked all informants to sign a consent form and they understood their right to withdrawal from the study at any point.

Some informants were a better data source than others, a recognised complexity of data collection (Spradley 1979). Whenever there was a potential conflict of interest, I prioritised the needs of the informants. I recruited informants able to communicate effectively, with or without an interpreter, to avoid unnecessary duress and to ensure a robust data collection.

The exploration of culturally competent health and nursing care for asylum applicants was a politically and socially sensitive research topic. Sensitive research potentially poses ethical dilemmas (Renzetti and Lee 1993) and requires a political awareness to ensure that findings inform future policy development (Sieber 1993). Sensitivity to an asylum informant's feelings in recalling traumatic events, such as rape, was important. I considered that it was insensitive to record electronically an informant's narrative. Refugees may believe that clinicians are part of the UK government (Tribe 2005). Instead, I recorded observation and interview notes in my journal, jotting down the informants' sentences that succinctly described their experience, rather than making simplified generalisations.

There are ethical implications of writing about others. I did not want to fall foul to voyeurism and gain at another's expense. During the asylum focus group (see section 5.2.1), I became aware of my leadership role in influencing the depth of data collection. Although the exchange of confidences between the group members served mainly to strengthen mutual emotional support, I recognised that control of the discussion should not rest only with the researcher.

A further ethical concern was that asylum informants were not disadvantaged in their future receipt of health and nursing care. A negative experience might have undermined established nurse-client relationships. I always introduced myself as a

nurse researcher, so that informants knew that I was an active observer. The recognised competing moral choices of whether to fully disclose the research agenda (Anspach and Mizrachi 2006) became more apparent in my pushing the boundaries of data collection. In deconstructing clinical practice, I aimed to be sensitive to the nurses' feelings, but also transparent so as not to be thought to be hiding information from them.

There are major challenges of separating the role of nurse and nurse researcher (Gerrish 1997), with consequent divided loyalties (Burawoy 1991, Schiffman 1991). Although as accepted nursing team member I participated in drop in clinics and home visits, I was also aware of ethical issues concerning the need to challenge or report unprofessional nursing practice to a line manager. My loyalties were potentially divided between adopting a critical approach and my allegiance to community nursing; a position noted by others of being betwixt and between an academic and a clinician (Cudmore and Sondermeyer 2007, Walker 1997).

Thus, ethical issues presented throughout this study and these will be considered as they arise in the findings. The two major ethical issues that stand out for me include study informant recruitment decisions and the withdrawal from probing highly sensitive issues. I had to ensure that my research neither harmed asylum nor practitioner informants, but that sufficient study data were gathered.

3.4 Research methods

Ethnographic methods include observation, interviews (individual and group) and examination of texts to produce descriptive accounts (Baillie 1995, Massey 1995). Thick description is created from a fleeting discourse and is interpretive of the normal flow of social interaction (Geertz 1973:21). I triangulated observation and interview methods to investigate the context for community nursing care of asylum applicants (see Table 1 for details) and accessed Reema's case notes on one occasion (see V7.3).

Table 1: Summary of the data collection

Method	Field work dates	Sample	Setting
Pilot study Participant observations followed by individual interviews	3 sessions in June 2005	1 GP 1 Practice Nurse 1 Health Visitor 4 asylum applicants	GP surgery Larger community nurse team base Home visits Drop in clinic
Main study Participant observations followed by individual interviews on one or more occasions	21 sessions during October 2005 – Feb 2007	1 GP 1 Team Co-ordinator 4 Health Visitors 1 Nursery Nurse 2 Staff Nurses 2 HCSW 1 Admin. Assistant 22 Asylum applicants	GP surgery Larger community nurse team base Home visits Drop in well baby clinic. Drop in men's group.
Asylum applicant focus group 1	December 2005	8 English for Speakers of Other Languages (ESOL) class asylum applicants and refugees (includes a HV client)	Community Centre
Asylum applicant focus group 2	March 2006	9 ESOL class asylum applicants and refugees (includes 5 from previous focus group)	Community Centre
Main study part 2 Participant observation individual interviews	4 sessions during August – October 2006	1 GP 2 HVs 1 Staff Nurse 4 Asylum applicants 1 Asylum team co-ordinator	Smaller community nurse team base Home visits Men's clinic
Formal interview	Feb 2007	Manager Interpretation and Translation service (ITS)	Managers office
Community nurse focussed group discussion (1)	March 2007	8 Participants (3 HV, 1 FHN, 3 staff nurses, 1 student and 1 HCSW)	Health Board meeting room
Feedback discussion of study findings	July 2007	4 CHP Senior Management (1 Team Co-ordinator, 1 Manager + 2 CHP Managers)	Health Board meeting room
Community nurse focussed group discussion (2) – Best practice statements	May 2008	9 Participants (3 HVs, 1 FHN, 1 student, 1 Team Co-ordinator, 1 Manager, 2 staff nurses)	Health Board meeting room
Primary care informants total	21 Primary care informants (3 GPs, 8 HVs, 1 FHN, 4 staff nurses, 1 practice nurse, I NN, 2 HCSWs. and 1 admin assistant)		
Management total	5 managers; 1 ITS Manager; 1 Team Co-ordinator and 1 Manager; 2 CHP managers		
Asylum informants total	39 Asylum informants (22 Larger Asylum team clients; 5 Smaller Asylum team clients; 12 focus group participants).		

I observed consultations between community nurses and their asylum clients in both clinic and home settings, to see for myself the challenges of providing culturally competent care. Observation is a recognised nursing skill, which whilst building upon human instincts to 'people watch' (Swanwick 1994) also requires self directed precision to aid accurate health assessment (Parahoo 2006). Participant observation is often undervalued as a nursing research method (Field 1989, Mulhall 2003), but its major strength is to provide a unique perspective, as the description of practice may be as worthy as ascribing meaning (Saks and Allsop 2007:97).

Originally I had drawn up an observation checklist, but as Agar (1996:174) suggests, it was impossible to record everything. I defined the observation data boundaries and recorded those issues that I considered were relevant to my research questions. Issues arising from an observation were discussed during a participant interview and reconsidered during a subsequent observation.

I became integral to the data collection, but it was sometimes uncomfortable being neither a client nor a practitioner. Although I did not overtly intervene, the nurse informants sometimes involved me in their client consultations, where I faced ethical dilemmas of giving advice. It was difficult to establish how reactivity affected the data collection; albeit the asylum informants accepted my presence without question, their care may have been different to the norm. I had also to be aware that parachuting into a research setting on a limited number of occasions did not guarantee an absolute understanding of the context.

In addition to observation, I used formal, informal, narrative and group interview methods; these are the more common research methods (Britten 1999, Holloway and Freshwater 2007:105, Wolcott 1995:105). Wolcott (1995: 106) suggests that the need to ask questions results in combining different types of interviews. I found that an informal interview could lead on to a narrative interview and revert back to being an informal interview. Several formal interviews were conducted and I emailed a summary of these in depth interviews to nurse informants for feedback and comment.

Generally, I carried out individual unstructured interviews as informal conversations to probe the informants' interpretation of their asylum or practice experience. Unstructured interviews have advantages of efficient data collection, flexibility and ease of adjustment of pace (Low 2007), but non-verbal elements may also set the interview tone (Fontana and Frey 1994). Although both asylum and practitioner informants were generally happy to talk about their situation, those less keen to be involved did not maintain eye contact easily.

There are three important elements to the ethnographic interview, including its explicit purpose, an ethnographic explanation, and ethnographic questions. The latter fall into three basic types of description, structure and contrast (Spradley 1979). I explained the study purpose clearly and used descriptive questions to rapidly establish a rapport with the informant and gain a contextual understanding. Open-ended and structural questions during asylum interviews were helpful to find out the past experience of primary care and its significance to current service access. Likewise, I asked structural questions in practitioner interviews to ascertain difficulties of providing transcultural care. Active listening was important to ensuring that the informant had understood the question. I found contrasting questions, which enable the differentiation of shades of meaning, difficult to use with asylum applicants who had a limited understanding of English and is a limitation of my data collection.

I interviewed asylum informants immediately after the participant observation session, using an interpreter if necessary. Most asylum informants were able to speak English, but it was usually inappropriate to make electronic recordings of their interviews. Unless informants wished to speak longer, the asylum interviews lasted 20 minutes. I allowed informants to feel in control of their disclosed information, as they became distrustful if I asked too many questions.

Narrative interviews in this study gave asylum informants a voice. These are a recognised cultural perspective not derived in other ways (Holloway and Freshwater 2007:44-47), but they must be culturally safe (Ogilvie et al. 2008). I was emotionally

involved. Narrative interviews built upon a trusting relationship and some informants were interviewed more than once to clarify issues. I tried to take a balanced view and if I sensed that an informant was becoming distressed, I concluded the interview.

Nursing issues arising from an observation were openly discussed later the same day. I challenged practitioner informants to articulate their practice and interpretation of the context. This method built a deeper relationship; although some nurse informants became defensive concerning their role deconstruction, others found this critical analysis useful, as clinical supervision was not in place during the data collection period. I liked the reflexivity; ethnographic interviews were both challenging and rewarding. As Agar (1996:149) recommends, this process enabled me to build a frame of reference to fully understand the observed behaviour.

I also carried out four focussed group discussions to triangulate my fieldwork data. Focus group interviews have become a more popular method for nursing research (Reed and Payton 1997). Nursing informants often know each other as the discussion is carried out in a familiar setting. Although this method has been defined as a Planned Discussion Group (PDG) interview (O'Reilly 2005), for simplicity I use the term focus group.

A focus group is a relatively unnatural event, where group interaction is managed creatively to develop ideas and generate data (Kitzinger 1999, O'Reilly 2005). The focus group size is recommended to be between six and twelve participants (Freeman 2006); neither too small to stifle discussion, nor too large for the researcher to lose control (Morgan 1997). The benefits of a group interview include the rich data gathered (Lambert and Loiselle 2008), the flexibility to work with hard to reach groups (Barbour 2005), a safe environment for group interaction (Kitzinger 1994) and the participants' willingness to share experiences and co-construct the client view (Lehoux et al. 2006). Group processes help to elicit common beliefs (Freeman 2006) with a subsequent ease of analysis (Greenbaum 2000). A major limitation of focus groups is the validity of the findings; the consensus view of the focus group may be inherently biased (Reed and Payton 1997).

The group interviews were carried out separately for pragmatic reasons. Whereas two sessions were arranged with asylum informants attending English for Speakers of Other Languages (ESOL) classes during initial stages of data collection to gain a broad understanding of their situation, the two nurse informant sessions were held the end of the data collection to confirm the study findings. I recruited participants from established social groups, the eight or nine participants in each focus group were an ideal number and issues of participant payment did not arise. Although I initiated confidentiality ground rules, the informants knew each other and were in a secure environment. The community nurses were members of a professional network and the asylum applicants were an ESOL class group. Thus both groups could speak openly without fear of redress.

Focus groups generally benefit from two researchers being present during data collection (Green 2007). I did not employ a co-researcher, as funding was not available to cover these costs. However, the ESOL teacher was present during both asylum focus groups to safeguard the students' interests, clarify issues and to provide language support (for example in explaining unknown terminology). Likewise the team co-ordinator was present at the two nurse focus groups and took an active role in the discussion.

Although the researcher should remain objective during the focus group discussion (Greenbaum 2000), the method demanded a high skill level to maintain the discussion, read the informants' nonverbal signs, listen to and understand verbal communication, as well as write field notes. I was emotionally involved as both sets of informants becoming totally engaged in the focus groups. When informants disclosed highly personal or practice information, I took an ethical decision to change the course of the discussion. I also aimed to clarify asylum informant statements without appearing to cross-examine.

Later in July 2006, I tried to carry out the same method with an informal men's group at a drop in facility. They were not an established group and were reticent

regarding their health concerns. Consequently, the discussion group did not work, but one informant stated:

"Only women worry about health, I am not interested myself".

This comment suggests that asylum men may view health as a lower priority than their asylum claim.

3.5 Access to research settings

Although Spradley (1979) recommends that research be carried out in an unfamiliar setting, there were difficulties of finding the ideal research context (Hammersley and Atkinson 1995). I chose Glasgow because it has more experience of asylum applicants than elsewhere in Scotland and PHC services for dispersed asylum applicants have been established in a systematic way.

Once ethical consent was obtained, I carried out a small pilot study in June 2005, to test out the suitability of the potential fieldwork sites. Major constraints in choice of the main fieldwork study site included accessibility by public transport and sufficient asylum contact to generate efficient data collection. A limitation of concentrating on an area of high asylum activity was that I might not see the full picture.

V3.1: A comparison of two potential fieldwork sites

The following vignette demonstrates the dilemmas of fieldwork site choice.

Dr Smith was 41 years old and provided asylum primary care services. He had worked previously in Africa and spoke both French and Swahili fluently. I spent a morning observing his GP consultations with asylum applicant clients carried out in French. I chose Dr Smith's GP practice as a pilot site and spent one day in June 2005 observing practice nurse consultations with asylum applicants. I interviewed the clients afterwards.

A colleague helped me to gain access to a second source of fieldwork sites. I was invited to meet both the larger and smaller specialist community nurse teams in early 2005 and we discussed the study. I arranged to spend two days with the larger asylum team as part of the pilot study.

The differences between the two pilot sites were huge. Dr Smith's GP Practice was very busy, the practice nurse worked with a wide range of practice clients requiring a variety of health and nursing care interventions. The larger asylum

team only worked with asylum clients, but did not did not see them on their premises as home visits were made in response to identified needs.

Although Dr Smith's GP surgery was typical of the area, recruitment might have been more difficult due to lower asylum activity and the data collection would have taken longer. The limited space in the GP surgery made observations and client interviews difficult. I had concerns about confidentiality, as asylum applicants would have found difficulty in speaking openly concerning their experience of GP health care. Thus, I decided to access the larger community nurse team for the main data collection. The nurse–client interventions could more easily be observed and interviews carried out within the clinic or home setting.

V3.2: Accessing asylum ESOL class attendees

Sister Mary, at 50 years old, was the manager of a large church community centre. Originally, trained as a nurse, she now combined her nursing and religious training. She agreed in principle to the focus group, but also made clear that electronic recordings were not allowed. I met the English teacher to discuss briefly the proposed discussion group session, which would be undertaken with the intermediate group, as there was no interpreter support available.

Sister Mary had obtained external funding to provide English lessons at novice and intermediate levels at no charge for asylum applicants, with a crèche provided for the children. In addition the community centre provided a drop-in café on several days each week and the provision of donated good quality second hand clothing. White Glaswegian women volunteers staffed the drop-in and also used the crèche facilities for their own children.

When I arrived on both occasions, these women were sitting together drinking tea; they made me feel welcome. I was impressed by their friendliness, which was extended to all people attending the centre. One volunteer, a young local woman with two small children said "I come to the centre three mornings each week. I enjoy coming here as my children are able to attend the crèche and I have some time away from them." The mainly black group of asylum applicants sat together laughing and talking together at another table, obviously a cohesive group at ease in these surroundings and providing mutual emotional support.

For the first focus group session, I had arrived early and nervous. I visited the main church to fill in time, which was bright and had an air of quietness and reflection. The light streamed through the windows. Later I was struck by the contrasting splendour of this building to the drab décor of its huge, high vaulted community wing. Although warm, the community wing was dark and

poorly furnished, reflecting the social deprivation of the local community served.

On the second occasion I noticed that the volunteers were busy making name badges for themselves. The need to tighten up on security had been identified and for all the volunteers to wear a name badge. I felt more comfortable with the surroundings, but was still awe struck by the large space and echoes created in the main hall. I wondered if asylum applicants would also feel as overwhelmed in coming to this centre.

The community centre fieldwork site was familiar to asylum informants, yet unconnected to community nursing services. It enabled the informants to speak freely without risk of retribution. A limitation was that although Sister Mary agreed to the asylum focus group, in advocating on their behalf she refused consent for electronic recordings of the discussion. The cumulative effect of vulnerability on the health of discrete populations has been noted by other authors (Stewart 2005).

The need to establish and maintain group identities was evident. Even though both the volunteers and the asylum applicants used the crèche services, the two groups sat apart. Whereas the asylum applicants were a mutually supportive 'student' group, the volunteers carried out a helping role. These two groups had established individual identities. The asylum experience was a common bond in spite of a broad range of cultural backgrounds, whereas the homogenous Scottish volunteers held a common helping role. Their identity was reinforced on a second occasion by the making of name badges. The vastness of the centre highlighted to me how exposure to an unfamiliar research environment challenged my self-confidence, in spite of years of community nursing experience.

3.6 Study sample

In using an ethnographic approach, the sample size is limited intentionally to collect depth rather breadth of data. The purposeful sampling is continued until no new knowledge is obtained (Patton 1999). I used a strategy of typical case sampling, which was flexible to meet the study needs to provide an insight into how culturally competent nursing care is normally carried out. All the participants in this study were resident in the UK. Whereas the primary care nurses held UK citizenship, the asylum

applicant participants were defined by their asylum status as discussed previously in section 1.4.

The study sample consisted of community nurses and asylum informants; their profiles are provided in the Appendix. The informants all agreed to take part in the study and contributed due to their PHC experience, either as a client or as a nurse. I had known only the team co-ordinator previously.

As summarised previously in Table 1, I selected a total sample of 23 PHC informants. This sample was drawn from management and three PHC teams with the appropriate knowledge, skills and understanding to provide information on the implementation of culturally competent health and nursing care. It included three General Practitioners (GPs), one asylum team co-ordinator, one manager, eight health visitors (HVs) and one family health nurse (FHN), four staff nurses (SNs), one practice nurse, one nursery nurse, two health care support workers (HCSWs) and one admin assistant. Two GPs were partners in separate GP practices and one GP was employed on a sessional basis. The participants had a wealth of experience with the majority having served for longer than 10 years; nine participants had less than 10 years experience, six had between 10 and 20 years experience and seven had over 20 years PHC experience.

Following the fieldwork pilot study, I carried out the main data collection with a large asylum team. There was a snowballing of community nurse informant recruitment, whereby one informant suggested that I contact another colleague. I was directed to meet a GP in the local health centre to complete the picture of primary care for asylum applicants in the locality. I accessed the small asylum team towards the end of the data collection to find out more about asylum men's health. Although I could have recruited more primary care informants, the data collection was already large and saturation was high.

Over the course of the study, I recruited 39 asylum applicant informants, who came from a variety of backgrounds and ethnic origins (see Appendix for details). They

were all adults aged 18 to 60 years of age, generally healthy individuals, although some were experiencing a minor acute physical illness or enduring health condition (e.g. asthma or diabetes). Asylum applicants known to have a terminal illness, a severe mental illness or learning disabilities were not recruited to the study.

The community nurses provided potential informant recruitment opportunities with English-speaking asylum clients; I explained my study and invited their participation. I recruited 28 asylum applicant informants who were single men or women, single parents, married with or without a family; they all routinely received health care from their GP, practice nurse or health visitor. I observed several GP consultations. The community nurse teams helpfully arranged client clinic or home visits for my next fieldwork session, to enable me to observe consultations and carry out post consultation interviews. I attempted to develop some case studies, but frequently informants had moved away before I could see them again.

I arranged two focus groups with asylum ESOL class students provided by a voluntary sector organisation. Twelve female ESOL class attendees agreed to take part in two sessions; eight attended the first group, nine the second one and five attended both sessions. One participant in the second focus group was both an ESOL class member and a health visitor client informant. The focus groups were an economical and effective method of collecting data. The session time was limited to one hour, when the crèche closed and informants had to leave the class promptly to collect their children. Hence it was necessary to hold two asylum informant focus group sessions, but there was a longer gap between the two sessions than was ideal, which could have influenced the quality of the data.

3.7 Conducting the data collection

An important distinction between ethnography and other forms of qualitative research is the relationship between the researcher and the informant. Although they are both ordinary people with individual cultural knowledge (Mackenzie 1994), the data quality depends on an interactive, albeit professional relationship. There are implications for the production of a robust ethnographic account; the researcher has

to be aware of issues of reliability, validity and subjectivity, which together may impact on the robustness and generalisability of the study.

I carried out 32 fieldwork sessions between June 2005 and March 2007 (see Table 1) using ethnographic methods which included six drop in well baby clinic sessions, eleven home visiting sessions, three GP surgery sessions, two men's drop in sessions, two English for speakers of other languages (ESOL) focus group sessions, three health centre clinic sessions, one nurse focus group meetings and four interviews in non clinical settings. A CHP management meeting was attended in July 2008 and another nurse focus group was carried out in May 2008.

Ensuring the reliability and validity of the data collection was important. Reliability is essentially a quantitative notion, which suggests that research instruments should yield similar results on different occasions. The emphasis is on the words used by informants; these are unlikely to be the same on different occasions. Hence the accuracy of data collected may be a more important issue (Parahoo 2006: 326). Validity refers to research data accuracy; Agar (1996) ascribes the researcher with the responsibility for a robust and authoritative account, whilst recognising that the researcher input cannot be ignored. The data validity is relative to the researcher's assumptions (Gomm 2004), but validity can be questioned through examining its plausibility and its credibility (Hammersley 1998). Concerns about the validity of ethnography arise from the epistemology used (Fetterman 1989, Maso 2003); a lack of rigour and transparency of the researcher's position, combined with the methods used to form a single account (Hammersley 1992, Silverman 1993:ix) can potentially impact on the data collection and analysis (Finlay 2003). Secondly, researchers need to be clear which variables are appropriate to include (Stubbs 1993).

A third issue concerning the data collection is subjectivity; the researcher should distance all personal biases (Burawoy 1991). If research is seen to be biased, generalisations from the findings become problematic (Field 1989). I found that an ethnographic approach was challenging in a professional nursing environment; different interpretations of the situation could arise. Moreover, informants may

disclose limited sensitive information, due to a perceived lack of anonymity (Parahoo 206:78). Thus, I had to recognise my subjective involvement and put safeguards in place. I used several strategies to ensure rigour in the carrying out of this study, including the use of different types of knowledge, developing interpersonal relationships, consistency of data collection, the triangulation of methods and personal reflection.

The incorporation of different types of knowledge enables their comparison to highlight disparities and to allow the data to produce its own theoretical framework (Field and Morse 1985, Laugharne 1995, Silverman 1993:1). I required organisational knowledge to understand how the community nurse teams were designed and operated. Although Glasgow was an unfamiliar cultural setting, regular meetings with a colleague enabled my understanding of the organisational issues concerning the local implementation of asylum policy. Whereas my health visiting knowledge of working with asylum applicants was limited (see section 1.5), I had gained an understanding of asylum health issues from the literature. I was keen to ascertain whether similar issues presented in the nursing care of asylum applicants in Glasgow. I arranged a focus group in a non-clinical setting with asylum women attending an ESOL class to find out their views of primary care services (as discussed in section 3.4).

V3.3: Starting the first asylum focus group.

The ESOL class teacher had previously invited her all female class to take part in the first discussion group. I opened each of the focus group discussions by thanking the group for agreeing to participate in my research, informed them of the aims of the research study and explained the study information sheet. The group agreed to sign the consent forms, and provided the requested personal information.

> *I had collected over several weeks about 30 images pasted onto thin card that might suggest 'health' in its broadest sense. These included photographs, postcards and images from magazines, nursing journals and newspapers. These images were selected to represent a range of associations with health, including food and drink (e.g. a nice red apple, a glass of wine), achievement (e.g. a group school photograph), happiness (e.g. happy and smiling faces), beauty (e.g. women in an elegant dresses), activity (e.g. exhilaration of a*

surfer, long distance runner), social and family events (e.g. a family enjoying a meal together), a peaceful or secure environment (e.g. natural scenery from Scotland, buildings such as the White House), as well as medical and treatment images such as immunisation or a plaster of Paris cast.

The images were spread out on a carpet area, situated at the entrance to the classroom. I asked the asylum focus group members to select two pictures: one picture to indicate good health and another to indicate poor health.

Starting a group discussion can be difficult, but an icebreaker was not entirely appropriate, as the members of the group already knew each other. I used a technique of personality association to stimulate discussion and enabled the participants to indicate their individual associations with a concept, service or product (Greenbaum 2000).

The images could be grouped very broadly into three main areas of health. Pictures of people, families and children in happy social occasions such as eating a family meal or a group school photo portrayed a social model of health. Secondly, psychological and mental health was captured through picturesque scenes and beautiful views of the countryside, which generated a sense of contentment and relaxation. Thirdly, there were images that promoted the medical model through positive simple health messages such as an apple for healthy eating, the importance of immunisation. More negative aspects of the medical model were provided through images of hospital clients, departments and equipment.

A second approach was to develop interpersonal relationships with asylum and nurse informants. Immersion in the research setting requires skills of being able to 'fit in' and to 'gain rapport' (Borbasi et al. 2003). Entering the research setting as a 'true stranger' is known to be problematic (Morse 1991), but the notion of rapport is often taken for granted in research texts and has rarely been explored in any depth (McGarry 2007).

My community nursing knowledge resulted from many years of experience; it not only provided a benchmark for comparison, but also enabled my acceptance into the research setting. There were no set rules to help me to understand how others might

interpret my actions, but I realised the importance of developing interpersonal relationships. I shared my professional and personal life experiences to gain acceptance, whilst not becoming too emotionally close. I noted that a shorter time spent with some informants resulted in a less meaningful relationship but ultimately some informants were easier to work with than others.

A consistent approach to data collection made research participation less threatening for the informants. The community nurses and asylum applicants knew what to expect from their colleagues' and peers' respective experiences. This strategy involved seven elements, which included an unobtrusive approach, accessing as representative a sample as possible, obtaining data at first hand, avoiding interviewee bias, recognising interviewer bias, triangulating methods and personal reflection.

An unobtrusive approach to data collection is required in carrying out repeated observations and interviews in similar situations (Mulhall 2003) so as to be courteous and inoffensive (Wolcott 1995). I became a less visible researcher through regular baby clinic attendance. I carried out interviews in a private situation, where nurses could not overhear asylum applicant comments and likewise community nurse interviews remained confidential.

I required a representative sample of informants. To achieve this, I aimed to appear non-judgemental to encourage the nurses to introduce their clients to me with confidence that the research was culturally safe. The community nurses were able to exclude clients that they considered to be unsuitable for inclusion in the study, for example, those clients unable to speak English. To counteract this potential recruitment bias, I arranged to observe several interpreter-mediated consultations and carried out two asylum focus group interviews.

Common understandings did not always cross easily over into another language when using interpreter-mediated interviews with non-English speaking asylum informants. The information obtained was second hand; I had less control and was unsure if questions were asked in the same way as I had intended and there was less

depth to the data collected. I decided to ensure good communication through obtaining data at first hand and recruiting asylum applicants that either had a working knowledge of English or spoke French. This limited range of informants potentially influenced the study validity, but I considered the depth of understanding was more important than a wider range of informants.

Avoiding potential interviewee bias was another element of a consistent approach to data collection. Informants may be tempted to give inaccurate or the 'correct' answers that they think are required (Lee 1993) or even to conceal their personal views (Silverman 1993:114). The richness of ethnographic description provides a defence against this bias (Low 2007:82). I found that the informant narratives delivered a personal, but collective perspective: the themes underlying an asylum applicant's experiences were often common to the whole group. Likewise the community nurses gave common accounts of the issues faced in their everyday work, although they held a range of views regarding the best way to deal with them.

Recognising potential interviewer bias was also essential to this study. It can arise when researching people from other cultures, due to a blindness of the impact of individual cultural knowledge and collecting data specifically to support predetermined categories (Burnard 2004). White racial identities may impose an unscientific basis for research (McKenzie 2003) and perceived cultural stereotypes may influence data analysis (Bibeau and Pedersen 2002). Thus, informants should be encouraged to move the direction of the interview (Fielding 1993, Silverman 1993:107). I tried to set aside my western cultural expectations and be open to the development of new perspectives during the data collection.

The triangulation of research methods has been shown to aid conceptual understanding and improve rigour (Jones and Bugge 2006), as the researcher's interpretation alone can impact on the data collection (Kim 1984). I triangulated methods of participant observation, interview and focus group data (see section 3.4) as part of the iterative approach to ensure the validity of my etic understanding. Figure 3 provides a flow chart of data collection.

Figure 3: Flow chart of data collection

Stage 1. Participant Observation SN/HV/PN/HCSW & client GP & client Nurses & nurses Manager & nurses	Stage 2. Face to face interview data Asylum applicant clients Nurses (HV, SN, PN & HCSWs) GPs & Managers	Stage 3. Focus Group data Asylum applicant & Community nurses. Elaboration of significant issues Confirmation of themes
Observational/Etic Fieldwork data	Narrative/Emic Fieldwork Data	Focus Group Etic/ Emic Fieldwork Data

Stage 4. Feldwork notes

Written up as text in Word files

Stage 5. Data Analysis.

On going literature review
Content analysis of word files
Identification of emerging issues & themes
Vignettes of Etic/Emic data
Triangulation of data

In an ethnographic design the progress is not linear, as the analyses of fieldwork observation and interviews are continually fed back into the sampling frame to ensure the validity of the cases examined (Mackenzie 1994). I repeated observations and interviews, either with the same client or with other clients within the sampling frame, to confirm observations and fill in identified gaps in knowledge. Data gathered from one source were used to inform another; for example, during nurse informant interviews it was possible to discuss not only the current consultation observation, but to contextualise the observation amongst others undertaken and to explore the issues arising. Likewise, interview data were used to inform the focus group discussion. Thus, data gathered were continually fed back into the sampling frame for verification and accuracy.

I was reflexive concerning the data gathered, but was aware that it can obscure the ethnographic picture (Barnard 2000:135) and impact on the interpretation of social behaviour (Fetterman 1989, Geertz 1973, Holloway and Wheeler 1996). This interpretation is influenced by the need to tolerate a degree of uncertainty and ambiguity at times (Hammersley and Atkinson 1995, Kennedy 1999, Pretzlik 1994, Silverman 1993:37, Singleton et al. 1988, Wolcott 1995:92). The researcher needs to be sufficiently involved to understand the situation, whilst remaining relatively detached in order to analyse and understand the situation (Lipson 1991, Vidich and Lyman 1994).

V3.4: The need for personal reflection

Remaining neutral in the observation of the interaction between the asylum applicants and the community nurses was extremely difficult. I became aware of my own conceptions and how these were influenced by my English culture, my emotional state and my own values, as described in the following vignette:

> *Staff nurse Francis and I visited a Somalian family. Yasmin was 21 years old and her husband Memmet was 23 years old. They had three children; Adnan was four years old, Natalie was two years old and baby Mary was nine months old. Memmet had phoned requesting a home visit, as Mary had been ill with a chest infection, she was taking little milk and refusing to eat. The parents were concerned that she was losing weight.*

Francis assessed the baby and told the parents that she was fine, but did not give further advice on weaning or how to encourage the baby to take fluids. She did not ask what types of food were normally eaten in Somalia or how these might be adapted for use as weaning foods. The visit did not come to a satisfactory close. Fortunately Cynthia would make a visit on the following Monday.

My preconceived views of cultural competence potentially influenced my observation of this nurse consultation. Although the staff nurse had carried out her role adequately to check the health of the baby, I expected her to have the appropriate skills to gain Yasmin's confidence and advise her accordingly. The health visitor would visit a few days later, but I considered that a poor service was provided. The staff nurse was not justified in concluding the visit at an unsatisfactory point as the family was left anxiously to care for their baby without adequate advice. I had to remember that the nurse informants had undertaken a range of training, operated at differing levels of competence and that some had significantly less nursing experience than myself.

3.8 Data analysis

Data analysis involves three stages of preparation, organisation and reporting of findings (Elo and Kyngäs 2008). These three stages are shown in Figure 4 and indicate how the analysis was carried out in this study. In preparing for data analysis, I continuously reviewed the literature throughout the study, to acquire a wide knowledge base, including social anthropology, community nursing and asylum legislation.

Field notes were developed during data preparation; these should be written immediately after the event to focus on the collection of robust and relevant data (Kite 1999, Silverman 1993:146, Spradley 1980, Wolcott 1995:99). I found that the writing of key phrases and small direct quotes helped me to recall the situation. The final set of field notes were written up as a Word document, usually within 48 hours. I used a flip chart to record the asylum focus group informants' comments and phrases. This transparent method enabled them to keep track of the discussion, carried out in English as a second language. During the community nurse team focus

group I made more extensive field notes, although when the flow of the discussion was fast, it was hard to keep up with writing it all down.

Efficient and robust research data management is essential (Dey 1993). I gave all informants an alias to safeguard anonymity, which also brought them to life as real people. It was easy to confuse informants; thus I recorded each set of field notes by reference number and date. Once data collection was complete, I printed each set of field notes as hard copy so as to understand the major themes, a known time consuming issue of data analysis (Elo and Kyngäs 2008). I have constantly referred back these notes, which were chronologically ordered, to remain close to the data.

Research texts recommend some initial analysis during data collection to establish that data saturation is complete (O'Reilly 2005) and to layer emic and etic interpretations (Ezzy 2002:61). For example, I identified men's health as a gap in the data collection (see section 3.6). I collected several types of data for analysis, which included:

- Observational data
- Narrative data
- Individual interview data (formal and informal)
- Focus group data

Categorical content analysis is used to deconstruct an account to highlight what happened and why. It may become a basis for theory development (Hammersley 1992, Hammersley and Atkinson 1995, Singleton et al. 1988). Content categories are ascribed according to their similarity or difference (Spradley and McCurdy 1972); a database can help with this process (Ezzy 2002: 87). Narrative analysis is multi-layered and also uses categorical content approaches (Holloway and Freshwater 2007:83-86).

Figure 4: Flow chart of data analysis for the study

Data Preparation

```
                    ┌─────────────────────────────────┐
                    │  Literature search & review     │
                    │  Raw fieldwork data             │
                    │  Informants given an alias      │
                    │  Electronic data management     │
                    └─────────────────────────────────┘
                         │                    │
                         ▼                    ▼
        ┌──────────────────────┐   ┌──────────────────────┐
        │ Category content     │   │ Holistic narrative   │
        │ analysis             │   │ data                 │
        └──────────────────────┘   └──────────────────────┘
                  │                            │
                  ▼                            │
        ┌──────────────────────┐              │
        │ Text segments entered│              │
        │ into File Maker Pro & │             │
        │ ascribed domain codes │             │
        │ (total 44)            │             │
        └──────────────────────┘              │
```

....

Data organisation

```
        ┌──────────────────────┐              │
        │ Single domain files  │              │
        │ collapsed into 27    │──────┐       │
        │ Summary Word Files   │      │       │
        └──────────────────────┘      ▼       ▼
                  │              ┌──────────────────────┐
                  ▼              │ **Vignettes**        │
        ┌──────────────────────┐ └──────────────────────┘
        │ Cover term to 7      │      ▲       │
        │ groups of summary    │──────┘       │
        │ word files           │              │
        └──────────────────────┘              │
                  │                            │
```

....

Findings

```
                  ▼                            ▼
        ┌──────────────────────┐   ┌──────────────────────┐
        │ **Major themes       │◄─►│ **Vignettes selected │
        │ established**        │   │ to support the       │
        │                      │   │ findings & given a   │
        │                      │   │ title**              │
        └──────────────────────┘   └──────────────────────┘
```

I used category-content analysis to break down the all field note data into component parts. A system of 44 domain codes was developed (see Table 2) using a simple File Maker Pro (FMP) database. I attached a domain code to discrete data segments

identified from the fieldwork data; these segments were often attributed to more than one domain; if I used too small a unit of analysis, the number of domain codes became unwieldy, but if the unit of analysis was large the domain was too broad and less focused. These open domain codes emerged during the content analysis. Although I had developed the updated Five Steps model from the literature, I did not set out to test this model in the domains chosen.

To illustrate the analysis process, the following text segment (from the first asylum applicant focus group described in section 3.5) was ascribed to the domain of health (code HEA):

> *In terms of good health, one participant had chosen a person holding an apple. She said: "I chose the picture of the apple because it is was a good colour, clean and is (like) good health."*

This second text segment reflected happiness (code HAP):

> *Another participant chose a family group, with the children of different ages. She stated, "I chose this picture because of the smiling happy faces of (the) children".*

In organising the data, I used the FMP 'find' view to bring together all the segments of text with the same code together into single domain files. In the above examples, I pasted all HEA segments into a Word file entitled Health and all the segments with HAP into a file entitled Happiness. In reading these summaries, I was able to recheck that data were ascribed correctly. A reference code to the original word file remained at the end of each text segment to enable my return to the original field notes.

The next stage was to produce 27 summary Word files through collapsing domains; not all domains contained sufficient data to warrant their own file. Some domains were less important than I had originally considered; for example, I had thought that the legitimacy of an asylum applicant's claim might have been a major issue for the community nurses, but there was little data referring to this.

Table 2 indicates how I collapsed these 27 domains into major themes; for example, health and happiness were brought together under the cover term of meeting health needs. The cover terms were merged into sub themes. I identified major themes of

promoting health, ensuring horizontal access to primary care services facilitating vertical access to services and social inclusion as the major components of cultural competence.

I collected more data than I can include in this thesis. Researcher bias inevitably creeps into choosing which data to present to the reader. Although the advantages of using the database included making the data highly familiar, as well as accessible to other researchers, I found the overall benefits were limited. The data potentially lost its impact and meaning, if it became detached from its context.

I developed vignettes (shown in italics) to bring the findings together into an ethnographical account. The stories, the context and the behaviour of the informants were closely linked. Although I used primarily holistic-content analysis to identify the major themes in Reema's story, her story remains intact as a major asylum thread running through the findings and as a backdrop to the smaller vignettes.

The ethnographic vignettes provide a vehicle for the informants to tell their own story, to illustrate the major identified themes and synthesise a collective story, as well as bring contextual vividness that was difficult to produce in other ways. The vignettes are also a means of separating the data from my analysis and describe my etic understanding of the health and nursing care experience of asylum applicants and how the community nurses provided culturally competent care. This separation is somewhat artificial, as my interpretations are integral to the vignettes, but I hope the reader can gain a clearer understanding of the findings using this approach. Sometimes a vignette requires little explanation, whereas I discuss others in more depth in reference to the literature.

Table 2: Data Analysis Codes for the study

Domain code	Domain Item	Summary Word File	Cover term	Sub themes	Major themes	Over-arching notion
IR	Institutional regard	Institutional regard	Provision of primary care services	Primary Care Context	Promoting horizontal equitable access to services	Cultural Competence
PH	Public Health	Public Health				
MGT	Management	Management				
WL	Workload	Workload				
T	Time					
NC	Nursing Care	Nursing Care				
HEA	Health	Health	Meeting health needs	Promoting health	Promoting health	
HAP	Happy					
HNA	Health needs assessment	Health needs assessment				
TRUST	Trust					
LOSS	Bereavement	Bereavement				
SAF	Safety	Safety				
AD	Advice	Advice				
IC	Infant Care	Infant Care				
EQ	Equity	Equity				
INC	Inclusion	Inclusion				
BH	Bad health	Bad health	Health needs not met			
PNC	Poor nursing care					
EXC	Exclusion	Exclusion				
C	Culture	Culture	Cultural awareness	Aiding adaptation	Promoting vertical equitable access to services	
O	Origin					
PRES	Prestige					
R	Religion					
MC	Multi-cultural	Multi-cultural				
XPT	Expectation					

Domain code	Domain Item	Summary Word File	Cover term	Sub themes	Major themes	Over-arching notion
COM	Communication	Communication	Cultural sensitivity	Aiding adaptation	Promoting vertical equitable access to services	Cultural Competence
LANG	Language	Language				
FE	Further education					
ED	Education					
UND	Understand					
AC	Asylum claim	Asylum claim	Cultural knowledge	Issues of Hegemony		
NON LEG	Not legitimate	Not legitimate				
ISOL	Social isolation	Social isolation	Powerless-ness			
DA	Domestic abuse					
POV	Poverty					
V	Violence					
COMP	Compliance	Compliance	Cultural knowledge			
CON	Confidence	Confidence				
CONT	Control	Control				
CPT	Competence		Power			
LEG	Legitimate	Legitimate				
RES	Resourceful					
RD	Research design	Research design	Robust data collection			
FLEX	Reflection					

3.9 Summary

This chapter has described how I carried out this study. The concept of culture underpins the nursing care of asylum applicants. Although the US notion of cultural competence is limited in its direct application to the NHS, the underlying principles are transferable; institutions have a responsibility for equitable and non discriminatory services to address health inequalities (Burford 2001). The updated Five Steps model for the culturally competent nursing care of asylum applicants included Institutional Regard, Cultural Awareness, Cultural Sensitivity, Cultural Knowledge and Cultural Competence.

A broad range of research questions arose from the updated Five Steps model, which required an understanding of the meaning of cultural competence for primary care community nurses and asylum applicants. An interpretive research design was integral to answering these questions. I chose ethnography to gain an in-depth understanding of the etic and emic perspectives of cultural competence, with an emphasis on narrative ethnography to allow informants to tell their own story. I obtained ethical and Health Board consent to carry out the data collection over a period of two years.

The robustness of the data was ensured through the incorporation of different types of knowledge, the use of a consistent approach to data collection, triangulation of methods and personal reflection. Whilst recognising the possible ambiguity of language and interpretation highlighted in research texts (Fontana and Frey 1994, Silverman 1993:90, Stevenson and Beech 1998) and the difficulties of researching a multicultural context, I found that the triangulation of methods provided a rich source of data, which in turn guided further data collection.

The literature review has enabled comparison within the analysis, although the data were allowed to generate their own theoretical base. Once the data were entered into a simple database to ease content and thematic analysis, I used holistic and categorical content analysis to identify the major domains and brought the data together into summary word files. Through collapsing the summary domains into

cover terms and sub themes, I established the study's major themes. Data vignettes in the findings (shown in italics) provide the reader with triangulated narrative evidence of cultural competence. The theoretical framework of the updated the Five Steps Model provides the structure for the following four data chapters.

Chapter 4. Institutional regard

This is the first of four chapters reporting the findings of this study. It reviews the primary health and nursing care service provision for asylum applicants in Glasgow, within the context of institutional regard as identified in the updated Five Steps model (section 3.2.1). It considers the following research question:

- *How does the concept of equity impact on the provision of primary health and nursing care services for asylum applicants?*

The demographic composition of Glasgow changed significantly with the arrival of dispersed asylum applicants in 2000. During this study, the City Council provided housing and education services for approximately 5,000 asylum applicants, primarily in highly disadvantaged areas. In spite of criticisms that this policy could result in increased risk of harassment and assault for asylum applicants (Anie et al. 2005), Glasgow hosted the largest cluster of dispersed asylum applicants in the UK at the time (Home Office 2006).

Learning from the experience of others was important to ensuring asylum equity of access to primary care services in Glasgow. Although refugees had been reported to access UK services relatively easily (Carey-Wood et al. 1995), *'Unequal Treatment'* (2000) identified a changed situation; refugees and asylum applicants faced difficulties in accessing health care in Barnet, London (Cowen 2001). Cowen (2001) found that although asylum health needs varied, several common themes emerged of communication and language difficulties, refusal of GP registration, and a lack of understanding of the UK PHC system. Furthermore, 20% of the participants considered that their GP displayed offensive or racist behaviour in their health care delivery.

Asylum applicants experience difficulty in accessing and utilising health care services worldwide (Lawrence and Kearns 2005, Silove et al. 1999) and may need more support than health workers often realise (Gammell et al. 1993). Silove et al. (1999) found that Tamil asylum applicants in Australia reported more problems in accessing services than compatriots who were refugees or immigrants.

A series of asylum reports attributed GP registration difficulties in England to under funding (Health Education Authority's Expert Working Group 1998) and to a lack of systems for equitable access to PHC services (Burnett and Peel 2001). The paucity of national asylum planning had led to piecemeal responses in England, where lessons learnt from the Kosovan refugee experience could have been implemented (Ghebrehewet et al. 2002). Language was a major barrier; asylum applicants faced difficulties of understanding and accessing PHC services.

Further investment was required in interpretation services, staff training (Directorate of Public Health Croydon Health Authority 1999) and translated health information (Northern and Yorkshire Public Health Organisation (NYPHO) 2002). *The Health of Londoners Report* (1999) identified that asylum health needs were related not only to the physical effects of war, displacement and torture, but also to the stress of the asylum system (Aldous et al. 1999). *Another Country* (2000) recognised the intensive nature of asylum health care provision, where consultations averaged two to three times longer than for the indigenous population (Audit-Commission 2000). GPs introduced waiting lists due to concerns regarding the quality of primary care provision (London Research Centre 2000). Asylum health deteriorated after a period of time in the UK, due to illness acquisition during the asylum journey, living at UK subsistence levels (Johnson 2003) and a lack of continuity of care (O'Donnell et al. 2007). Improved communication between UKBA and the primary care partners was also required (Scott 2004).

The denial of GP registration for asylum applicants is not cost effective. Albeit it is unethical (Pollard and Savulescu 2004) it may increase the use of pharmacists for health advice (Carey-Wood et al. 1995), potentially impact on public health (Hargreaves 2003) and increase demand on A&E services (Cole 1996, Hargreaves et al. 2006). Health professionals are known to lack knowledge and understanding of asylum health needs (Heptinstall et al. 2004, Rankin et al. 2001). A GP guide on asylum health issues and entitlement to health care (Levenson and Coker 1999) was followed by several PHC publications in a similar vein (BMA 2002; Burnett and Fassil 2002).

An initial asylum health assessment is important, as applicants may not understand PHC provision, only seek health advice when they are ill (Jobbins 1998) which delays further health care and adversely influences an asylum medical report (Audit Commission 2000). A useful asylum health assessment checklist is available (Adams et al. 2004), but few health assessment tools have been culturally tested for use with asylum applicant women (Gagnon et al. 2004), albeit a Swiss cross cultural screening tool for depression has been validated (Eytan and Durieux-Paillard 2007). An Irish survey demonstrated the strong link between psychological illness and frequent GP attendance. Asylum applicants were five times more likely than the indigenous population to be ascribed a psychiatric diagnosis and more likely to be prescribed antibiotics (McMahon et al. 2007).

Asylum applicants frequently require a UK catch up immunisation programme (Dobson 2002). Infectious diseases commonly seen include HIV/AIDS, tuberculosis, hepatitis A, B, C; malaria and other parasitic infections (BMA 2001), but incidence generalisations may be invalid due to sampling difficulties of small asylum populations (Clark and Mytton 2007). A long time may elapse from HIV infection to the development of symptoms (Burnett and Fassil 2002, Martineau 2000). However, it has been noted that infected individuals generally do not delay unduly in seeking treatment (Coker 2003).

Women seeking asylum are known to have complex health issues. They have a poor nutritional status, closely-spaced pregnancies compounded by female genital mutilation and they may present late for ante-natal care (Harris et al. 2006). In addition to suffering rape, the refugee experience for women and children may necessitate high-risk sexual behaviour in order to survive (Executive Committee of the High Commissioners Programme 2001). Depression is often a long-term consequence of rape (Seltzer, 2004). Canadian asylum women have been found to be at higher risk of post natal depression compared to the indigenous population due to a lack of social support (Stewart et al. 2008a). Haemoglobinopathies, nutrition problems and dental health are major physical health issues for the asylum children (Davidson et al. 2004).

During the 1990s routine screening for communicable diseases was managed through mainstream GP services (Audit Commission 2000). Although tuberculosis, a disease associated with poverty and malnutrition, was found more likely to occur one to two years after arrival in the UK (Aldous et al 1999), the rising incidence of tuberculosis in minority ethnic groups (Siddiqi et al. 2001) provided the momentum during 2000 to 2004 to introduce compulsory asylum health checks for tuberculosis and HIV (BMA 2004). The screening was not found to be cost effective (Harling et al. 2007) and was later scaled down.

To recap, asylum applicants are entitled to PHC services, but many experience inequity of access to NHS services, especially in England. Specific mental and physical health care needs arise from a previous lack of health care, their refugee journey and exposure to infectious and parasitic disease, experience of violence and torture, a subsistence standard of living, as well as from conditions less frequently seen in the UK. Local policy is thus required to facilitate equitable access to services.

4.1 Equitable primary care access for asylum applicants

Primary health care, which includes the provision of GP services and community based nursing teams (see sections 1.2.1. and 1.2.2), has historically met raised expectations to address changing community health needs, but has suffered from a lack of financial investment. Joels (2008) suggests that NHS services must be sustainable to ensure equitable access for future generations, but solidarity, a collective sense of charity, is required in providing care for those with additional needs.

V4.1: Implementation of local asylum healthcare policy

In establishing local policy for equitable primary care services for asylum applicants in Glasgow, three broad models of permanent primary care provision were identified from the English experience (Carlisle-Pesic 2001, Houndslow Primary Care Trust 2004):

- Gateway services providing an initial health assessment and subsequent integration into mainstream services

- Integration directly into the mainstream with specialist support such as mental health care and interpretation services

- Dedicated Personal Medical Services (PMS) services providing full GP registration and outreach services

A central Glasgow asylum health referral team to ensure GP registration for newly arrived asylum applicants and their families within 48 hours was set up initially to work alongside education and housing services. The north side of Glasgow developed dedicated Personal Medical Services (PMS), services employing salaried GPs, and specialist asylum health visitor teams. The smaller team provided a gateway registration service with 22 mainstream GPs in their geographical patch for children and families, but also a significant number of single men. A GP rota system designated one practice each week to receive the new asylum applicant referrals.

This vignette describes the asylum policy implementation of GP allocation within 48 hours. Dedicated health visitor teams were established to serve asylum applicants living in the densely populated tower blocks of social housing (von Kaehne 2001). The economy of scale made this system more viable as well as potentially providing a higher quality of primary health and nursing care (Quickfall and Sim 2003). GPs are known to have difficulty in dealing with large numbers of new registrations (Feldman 2006). The smaller asylum team assumed responsibility for GP allocation and registration. Thus, although an allocated horizontal equitable entry point into primary care was established for asylum applicants, this was at the expense of the personal choice of asylum applicants. Some asylum applicants were potentially marginalized as both teams ascribed GP registration, and the choice of GP for consultation was constrained by appointment availability.

V4.2: Lack of policy implementation

This vignette demonstrates that discrimination existed in spite of local asylum policy.

One nurse focus group participant stated: "In one health centre there is a notice on the wall, DO NOT REGISTER ASYLUM SEEKERS."

The community nurse focus group informants considered that they were accorded a similar lower social status to their asylum clients, who were perceived as undeserving of health and welfare services.

The difficulty of implementing NHS equitable policy within primary care arises as GPs are contracted rather than employed. The time consuming nature of asylum health care was perhaps a factor. The community nurses placed a higher value than their colleagues working in mainstream services on their role with asylum applicants.

V4.3: GP gate keeping function

Vertical equity seeks to address health inequalities, but it puts pressure on NHS resources. GPs may consider that they are the gatekeeper to community nursing services (Pollock 2007c:3), as well as access to preventive, curative, palliative and other statutory and voluntary services (Black 1992). The ethical conflict for clinicians between their professional role and the need to advocate on behalf of asylum applicant clients has been noted (Pourgourides 2007).

> *Dr Brook was a 37 years old female German GP, who had been working with asylum applicants for the last five years. She stated: "It is important to maintain control; I cannot let patients dictate treatment and care. Patients play games with me, to put pressure on referral to the acute services. They exaggerate symptoms or pretend to be unable to speak English on the phone, so as to be seen with an interpreter at the surgery." However, she tried to find out the wishes of her patients, or else there was a waste of NHS resources.*

In this vignette, although communication problems sometimes resulted in difficulties of making an accurate medical diagnosis, Dr Brook took into consideration the view of her patients. She assumed professional power to control treatment and NHS resources usage, in line with Foucaultian theory (see section 2.4). Moreover, she embraced Lukes' (1974) third dimension of power to promote the SNHS interests. Expectations of health care access and service provision were mismatched. The GP carried out medical tests on the basis of clinical need, whilst asylum applicants wanted a full medical examination for reassurance.

V4.4: Difficulties of asylum access

The implementation of the UK nGMS GP contract (see section 1.2.1) has resulted in difficulties for asylum applicants, in common with the indigenous population, in obtaining a timely GP appointment (O'Donnell et al. 2007), a significant factor underlying hospital A&E attendance (Congdon 2006). A lack of transport has also

been demonstrated to be a major factor in the use of A&E services (Shah and Cook 2008).

The asylum focus group informants wanted to consult their GP regarding physical health, rather than for emotional or mental health. Single parents stated that they sought reassurance on parenting and health issues.

There was only a short time each day in which to obtain a GP appointment: appointments were difficult to obtain, as they were reserved for children and emergencies only. One participant stated; "When I am unable to get an appointment with the GP at the medical centre, they tell me that the nurse will phone back. If the nurse understands, there is no problem in getting an appointment."

Hortense stated that when her child was ill, the practice nurse had asked her to report back concerning the child's condition. Two hours later the child appeared to have improved; no GP appointment was made, but later that evening the child became very ill. Hortense called an ambulance to take her child to the children's hospital, where the baby was found to have croup. Hortense stated: "The hospital said that this was a dangerous condition. My child should have been seen earlier, as she could have died."

Dr Brook, a GP specialist with over 10 years experience, stated: "Most GP practices in Glasgow have now opted out of providing 24-hour patient care. NHS 24 directs those with urgent conditions to either a walk-in centre within a hospital or to an Accident and Emergency (A&E) department in Glasgow. During normal hours, some GP surgeries have a taxi account to take asylum applicants to hospital in an emergency, as otherwise it is two bus journeys."

In contrast to the GP professional power described in V4.3, this vignette demonstrates the first level of power (Lukes 1974) experienced by the asylum informants, who expressed their frustration in obtaining GP appointments. Moreover, high service expectations, communication issues (see chapter six), limited welfare support and transport difficulties (see chapter seven) also made GP access problematic. The increased asylum use of A&E services was due to GPs no longer providing Out of Hours (OOH) services, as other studies have also shown (Charlton 2005); another example of Lukes' (1974) third dimension of power. Improved nGMS terms and conditions may have increased GP recruitment, but these were also detrimental to OOH services for patients. However, in recognition of the need for equitable access to a local treatment centre, GPs provided taxis to overcome ability to pay for transport costs.

4.2 Specialist community nurse teams

Whereas health visitors often contribute to improving community health through the considerable knowledge gained from their caseloads (Orr 1985b:37), public health led approaches are more systematic and cross reference epidemiological data with social deprivation indices of a known geographical area (Summers and McKeown 1996, Wilson 2001b). Historically, community health profiles have provided an understanding of community health need (Billings and Cowley 1995) and aided the development of specialist health visiting roles to promote equity, through addressing health inequalities suffered by socially excluded groups (Davis et al. 2005). Ease of access to health visiting services is thought to promote child centered care and referral to other agencies (Cernik et al. 2007).

V4.5: Provision of equitable asylum services

Although dedicated services may promote horizontal access to health and nursing care (Prime et al. 2004), ease of service access is not only related to its geography but to its acceptability to the group served. A New Zealand study showed that Maori people preferred dedicated drug and alcohol services (Huriwai et al. 1998), whilst young people used outreach family planning clinics in schools rather than mainstream services (Baraitser et al. 2002). However, the low priority given to some areas of care, may result in less resources to provide them (Hollis and Morgan 2001). For example, school nursing managers have been shown to restrict activity through the gate keeping of resources (Cleaver and Rich 2005).

> *The nurse informants defined cultural competence as involving two major principles; the negotiation and provision of patient centred care and the provision of equitable, accessible and non-discriminatory services. One nurse informant stated: "Our major role is to give our clients an understanding of the NHS and primary health care services."*

> *June considered that asylum applicants should be integrated into mainstream services and the asylum team members dispersed into mainstream services. She stated: "A mixed service delivery is preferable to the provision of dedicated services. Cultural competence involves addressing the needs of clients, taking into account as much as possible our understanding about their cultural background. Although we're not expected to understand all there is to know, it's about accepting difference and making services accessible, equitable and non discriminatory."*

June gave the example of a visit we had undertaken that morning and said: "The visit lasted one hour, as an interpreter was used. It would normally have lasted only half an hour to a member of the indigenous population. The extra time was required to ensure that services were non-discriminatory, that interpreter services were provided and to give clients the opportunity to voice their health concerns,"

Secondly, June considered that asylum applicants arrived generally in Scotland with a very limited understanding of how to use the primary care services and required help to access services. She said: "The health visitor often acts as an intermediary, providing asylum applicants with necessary information, an understanding of how primary care services operate and as a liaison with both hospital and GP services." June thought that effective communication was essential to ensure that the "right information" was transmitted and received.

June stated: "The integration of all asylum applicants into mainstream services requires a more culturally competent model of health visiting to achieve non-discriminatory services and additional training to cascade the necessary knowledge and skills. This knowledge gap might not be as large as it appears, as skills of negotiation and compromise are required in working with other marginalised groups, such as families with drug and alcohol problems. However, negotiation with indigenous clients assumes a common understanding of nursing care in Scotland, whereas an asylum applicant does not necessarily have this understanding."

The focus group nurse informants discussed issues of equity. The generic role of the health visitor was seen as a single access point. One informant commented: "Whoever is first to meet the client is often established as the main point of contact. Clients think more highly of their health visitor than their GP." Continuity of care was equally important; clients tended to only contact their own health visitor, and frequently stated "she knows me best". The nurse focus group informants thought that the asylum applicants did not want to constantly repeat their asylum story.

The informants in this vignette described the three major elements of culturally competent services as equity, access and non-discrimination. The community nurses functioned as intermediaries to facilitate asylum access to services and promote social inclusion; whilst retaining the more vulnerable clients and families on their caseloads until able to use primary care services appropriately, there was a trade off between equity and choice. June placed a higher priority on equity of service provision than on access, but considered that service provision should be equitable to the indigenous population. Although the nurses often considered themselves to be

powerless (see V4.9), they also demonstrated a level of professional power in deciding on the GP registration of asylum applicants.

Although all asylum applicants should ideally be integrated into mainstream services, there were huge training implications for mainstream health visitors to gain the required knowledge and skills. Non-discriminatory services involved the use of interpreters to promote vertical equity and are discussed further in chapter six; disadvantaged clients were enabled to communicate and access services. The smaller team communicated regularly with several GP surgeries to promote continuity of care for the client group.

V4.6: A description of two specialist asylum teams

Effective team management ensures the smooth running of services. Historically, the "unpatterned inequality" of community nursing workforce planning (Powell 1990) has responded more to external pressures of budgets and labour markets than to internal issues of under or over capacity (Procter 1992). CHP managers were faced with a major management challenge of providing sufficient nursing capacity to equitably meet the health needs of the client group, whilst controlling costs.

Workforce planning has often not reflected community health profiles or taken account of public health activity (Brady et al. 2007). Patient centred classification systems have been developed to provide indicators of individual health and nursing need (Fitzpatrick 1994). Although primary care disease registers now provide an improved picture of community health needs (Haddow et al. 2007), community nursing staffing ratios are not necessarily a reflection of indices of multiple deprivation (Pritchard and de Verteuil 2007).

The management of primary care services has relied upon four approaches to workforce planning; professional judgement, a population based assessment of health needs, caseload analysis techniques and patient classification systems to denote nursing activity (Hurst 2004:1). Professional judgement involves managers making a decision concerning staffing ratios. Community health profiles can inform the

staffing need (Billings 1996, Farrington and Clapperton 1996), but the changing demographics and social deprivation indicators within a locality create difficulties in the equitable provision of staffing (Quickfall 1997).

The staffing of specialist nurse teams is complex to ensure the appropriate range of knowledge and skills, as well as the capacity to meet the workload; Feldman (2006) noted that the provision of dedicated community nurses is a problem if asylum numbers reduce, making staff redundant. The community nurse teams were evolving as the following vignette demonstrates:

> *The larger asylum team included four health visitors; June had over 20 years of experience as a midwife and a health visitor. Likewise Isabel had worked as a district nurse, midwife and health visitor for over 20 years. Cynthia had less than 10 years experience as a health visitor. These three community nurses worked solely with asylum applicants registered with the local health centre, which served 6000 patients, of whom 3000 were asylum applicants. Jillian, who had over 10 years of health visiting experience, was attached to large health centre some distance away. She was based with the larger asylum team to reduce her professional isolation, but this arrangement resulted in added stress of working between two sites. Three staff nurses supported the health visitors. Francis, a State Enrolled Nurse with 20 years community experience, Elizabeth, who had worked in the acute hospital sector for over 10 years, but only one year in the community, and later Jessie, with less than 10 years nursing experience, joined the team. The other members of the team included nursery nurse Georgina as well as health care support workers (HCSWs) Caroline, who had less than 10 years experience and Elsie, who had been working for over 10 years in her role.*

> *The smaller asylum team had evolved to respond effectively to a broader range of health needs of asylum applicants. The team included two health visitors Christine with over 20 years experience and Andrea, who had less than 10 years of service. Abigail had worked as a community staff nurse for less than 10 years and Dr Cross, an experienced part-time GP, no longer carried out male asylum applicant medicals but instead provided counseling sessions.*

This vignette provides a description of two community-based teams working with asylum applicants. Although the larger team comprised a greater grade mix, it had no internal leader; six team members had more than ten years experience, increasing the complexity of carrying out leadership roles. The older team members had been trained to work in more traditional ways of working. The smaller team was younger and less experienced as two of its three members had less than ten years experience.

This staffing was typical of the aging community-nursing workforce in Scotland, where between a quarter and a third of staff are due to retire in the next ten years (Scottish Executive 2006c). A recent Scottish study of four Health Boards found that the average age of community nurses was 47 years (Kennedy et al. 2009).

V4.7: Community nursing work base context

This vignette highlights the lack of purpose built premises and reflects the limited investment in community nursing and primary care.

There was insufficient space for the larger asylum team to be based in the same GP surgery as used by their client group. Although the team occupied a spacious open plan office in a pleasantly refurbished business centre building, there was limited interaction between them and other groups based in the centre, resulting in a lack of a sense of cohesion. A security system was in place as a nursery was sited on the ground floor. Access to the building was gained through the intercom system or by a digital keypad. However, I was often able to gain access to the building without calling the office, as people leaving the building would let me into the building without question.

Each team member had her own desk, but shared a computer sited on the administration assistant's desk. Communication was mostly by landline, mobile phones, Royal Mail as well as through an internal mail system. The asylum client group was usually seen at home as the team's office had no private area for consultations.

The smaller asylum team was based in a converted large Victorian house. The centre also hosted a child health clinic and a district nursing team. There were no consulting room facilities. Home visits or other venues were used for these interventions. The friendly staff relationships resulted in an ease of interpersonal communication in spite of close physical proximity and shared IT resources. Client details were faxed to the team as this was considered to be a more secure route than the email system. The GP aligned smaller asylum team was community focused and linked with local advice forums for asylum applicants.

The paucity of email and information technology (IT) resources resulted in communication difficulties for both teams. The larger asylum team remained insular. Their centre was some distance away from their geographical patches and the GP surgery. The community nurses visited clients at home and visiting sessions were planned for several hours for more efficient working. Many of the GP attachment advantages were lost. The lack of a shared environment, a lack of shared access to

patient records and increased difficulty of referral to other services fragmented services, impacted on effective communication and partnership working.

Asylum families could not easily access the community nurse team due to geography and the security of the building. Thus the onus was placed on clients to attend the weekly, outreach well baby clinic.

4.3 Asylum health visiting practice

Primarily 'a women's service for women' (Cowley et al. 2004), health visiting involves a universal service of planned and opportunistic home visits to families with children under five (Wilson 2006) to promote health, prevent disease and reduce health inequalities (Cowley and Frost 2006). Historically, health visiting arose to address the high level of infant mortality (Beine 1996). Its universality has been core to its success, providing care for all members of the community from the 'cradle to the grave' across minority and majority ethnic groups within the community served (Scottish Executive Health Department 2003b). In more recent times there has been an added pressure to target child protection issues and to work with families and individuals most likely to benefit from a health visiting intervention (Appleton 1994b, Cowley and Houston 2003).

Home visiting provides a less visible vehicle for health promotion and is an essential element to gaining a holistic overview of the family's cultural way of life (Jansson and Petersson 2001). Although public health work centers on the cultural-behavioral model (Hawksley et al. 2003), it is thought to be less highly regarded by health visitors than individual case work (Carr 2005), such as vulnerable women and their families experiencing relationship problems (Simons et al. 2003), domestic or sexual abuse in their own homes (Robotham 2005c:261). A US ethnographic study of long-term home visits to families with special needs children highlighted the admiring, familiar, trusting, supporting, reassuring and exchanging sub processes that underpin home visits (Byrd 1998).

Four major underlying principles of health visiting were established in 1977 as part of an initiative to identify the how best to train and teach the profession (Council for Education and Training of Health Visitors (CETHV) 1977:9) and were identified as:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence of policies affecting health
- The facilitation of an awareness of health needs

These principles are related to an underlying belief that health is a valuable attribute, which should be promoted (Robinson 1985:155). Although these were reviewed in 1992 and 2006, there was little change to the underlying philosophy (Cowley and Frost 2006). Health needs have been found to arise in four types of situations; those that are client initiated, those that become visible during the home consultation, those that arise through the 'opening up' of a problem and finally those suspected but hidden by the client (Chalmers 1993).

Health visiting practice involves four major areas of advice giving, environmental control, emancipation and psychological development (Twinn 1991:969). The decision making processes underpinning health visiting assessment are unclear, requiring further investigation (Carney et al. 1996). Albeit health visiting services are set against a background of increasing skill mix to provide improved value for money (Lightfoot 1994), in searching for 'hidden health needs' there are difficulties of measuring service outcomes, which respond to the client's changing agenda (Campbell et al. 1995:23). Community health practitioners (CHP) in Korea have been shown to provide more cost effective services than those of a physician (Lee et al. 2004). Moreover, UK health visitor interventions have been shown to be both clinically effective and cost efficient (Powell 2005:382-387), such as the effectiveness of follow up home visits to those families with babies at high risk of failure to thrive (Hutcheson et al. 1997). The auditing of UK health visiting caseloads to quantify the outcomes of their work within a preventive framework has been promoted (Barriball and Mackenzie 1992), but with little success (Kelsey 1995).

V4.8: Promoting access to services

The following vignette describes a visit to a male asylum applicant to help with GP registration.

> *I accompanied Andrea on a visit to Yusuf, a 35-year-old English speaking single male from Iran, who first language was Farsi, although his English was also very good. Recently Yusuf had been re-housed to this area. The small apartment block owned by an independent housing provider was very modern and there was an entry phone. We walked up to the top floor and Yusuf welcomed us into his minimally furnished flat.*
>
> *Yusuf was keen to tell us his asylum story: "My father, whilst living in Iran, had connections with Jewish families and subsequently he was imprisoned and persecuted. Eventually my father and mother escaped and they are now living in Canada. My sister has been granted UK asylum, she is now married and lives in Glasgow. My asylum application has been refused several times. The court said that as I had not been imprisoned in Iran, I was not at risk of persecution if I returned."*
>
> *Andrea explained that she had come to help Yusuf to re-register with a local GP by completing a GP registration form. She asked him: "Have you had a heart attack or angina, suffered diabetes or any other disease?" She used a translated health needs assessment form to aid communication.*
>
> *Although Yusuf was Muslim, he stated: "I am not a fundamentalist. I enjoy a glass of beer and meeting people in pubs." When Andrea asked about diet, Yusuf stated that he just ate "the same as anyone else". Although there was little evidence of cooking in the flat, Andrea did not pursue the topic. Yusuf stated that he was normally at home each day until about three or four o'clock, suggesting that he was working in the evenings.*
>
> *Yusuf stated: "I only worry about my health when I have symptoms of disease." When completed the assessment tool provided part of a medical record; there was no previous history or record to draw upon. Andrea gave him a list of local dentists, but arranged to make a return visit with an appointment for the practice nurse and directions to the asylum advice drop in. She considered that Yusuf was less typical of the single men that she visited. He had very good English and he was willing to provide the information that she requested.*

Although Yusuf gave a lower priority to health than to his asylum claim, Andrea listened to his asylum story to build a stronger relationship. She used this relationship both to help him with his asylum claim through referral to an asylum advice drop-in service and to facilitate equitable access to health care through GP re-registration. Andrea chose to ignore some areas of the health assessment, for example diet.

Barberia and Canga (2004) also found that health visitors did not see diet as an important health promotion topic, in spite of Scotland's poor health record.

The health needs assessment forms provided an aide memoir and structure for the visit, as well as a tool for documentation, but yielded few health issues that required further investigation. Andrea used conversation to discuss health issues with Yusuf rather than working through the assessment tool line by line. Health needs may remain unmet if check lists alone are used (Cowley et al. 1996). Similarly, a UK study has shown the lack of health knowledge common to both clients and practitioners, in this case concerning cancer, to be a potential barrier for Chinese people in accessing health care (Papadopoulos et al. 2007).

V4.9: Challenges of outreach service provision

Addressing collective health issues requires a local analysis of health needs, working with communities as partners (Forester 2004) and using a community development approach to meet these needs (Grant 2005). Community development programmes, whilst not conflicting with traditional health visiting may be in tension with national policy, local priorities and resources (Hogg and Hanley 2008). Successful community development examples include a Community Mothers Programme to promote good parenting in Australia (Munns et al. 2004), the prevention of failure to thrive (FTT) in remote areas (McDonald et al. 2008) and empowering asylum applicants in Holland to cope with psychosocial problems (Kieft et al. 2008). Other community based initiatives have received resource investment, such as the English Sure Start programme (Harris and Koukos 2007).

The larger asylum team provided an outreach drop-in well baby clinic, which was designed to promote access and reduce travelling to services for asylum applicant mothers and babies. It was housed in a Women's Centre in one of the largest tower blocks in the area. The asylum mothers arrived with buggies and childcare paraphernalia; they were warmly welcomed to the clinic. The mothers visibly relaxed and socialised, sharing parenting knowledge and skills whilst sitting in the clinic waiting area.

As a clinical setting it was less than fit for purpose in terms of health and safety and client confidentiality. The small consultation room was used on other occasions for community education computer classes, with unprotected power sockets and trailing computer leads. Secondly, there was no sink or

hand washing facilities. June and Francis used a liquid hand cleanser between consultations, but the asylum applicant mothers were unable to wash their hands after changing their baby's nappy. It was possible to hear in the waiting room almost every word said in the consultation room, as the door was generally left open, although if there were more private issues to be discussed, arrangements were made for a home visit.

Although I saw no evidence of nurse prescribing, the health visitors made a significant contribution to the health care of asylum applicants, which may have resulted in reducing GP workload. The asylum applicant mothers did not have to pay for prescriptions if they had official exemption documentation (known as the HC2 certificate) and nurse prescribing would have been useful.

The difficulties of providing outreach services was demonstrated when a dance class was authorised to use the clinic facility. Although the problem was quickly resolved, the start of the clinic was delayed until equipment was moved. June considered that the drop-in clinic was not prioritised. She did not feel valued as a health care professional. The drop-in service potentially marginalised asylum applicant families, as exclusion from mainstream provision resulted in less opportunity to mix with new mothers from the indigenous population.

When I asked June if working in such difficult conditions made her angry, she replied: "It does, but I have been working with it for so long that I am kind of used to it now."

Although the clinic situation (see section 2.4) was considered by Foucault to promote a setting for overt professional order and control (Strong 1979), this vignette highlights the challenges of limited SHNS resources and interagency working to provide outreach clinic services. Health and safety issues arose from unsafe electrical equipment left lying on worktops in addition to infection control issues. Hand washing with soap remains a highly effective preventive measure (Cole 2007) and poor hand hygiene leads to cross infection (Beer and Fear 2007). The lack of support for the clinic was reflected in the poor communication between the centre and the asylum team. The overt conflict between the agencies over the use of resources reflected Lukes (1974) one-dimensional view of power.

Access to a local well baby clinic should have been a bonus for the local community, which experienced a high level of deprivation. I did not observe indigenous women using the clinic. A community development approach could have increased the local community's capacity to provide asylum family health support. The women's centre

targeted the local population but no policy initiatives and few resources were provided to integrate asylum health into the women's centre. These second-rate clinic facilities may have been unacceptable to the indigenous population, but also reflected the general marginalisation of asylum applicants during this study.

The community nurses worked in partnership with the asylum mothers to provide them with a space of their own, to relax and meet other asylum mothers. Although the informal nature of the clinic did not lend itself to confidentiality, the development of relationships was seen to be important and these could be further developed through home visits. The asylum applicant parents frequently had no extended family to turn to for advice on childcare and relied on the health visitor at the clinic for advice and information. A possible downside of the clinic was that it potentially created a culture of dependency on the health visiting service.

During this study none of the nurse informants was an active nurse prescriber; the ability to prescribe a basic nurse formulary for asylum applicant clients, would have reduced the need for GP appointments or requests for repeat prescriptions. Moreover, O'Donnell et al. (2007) found that asylum applicants considered the cost of over the counter medicines a barrier to self-care. There were limited training opportunities in Glasgow for nurse prescribing but transformational leadership could have addressed this training issue through promoting access to local university courses. The lack of transformational leadership and disempowerment is also seen in June's statement that she was used to working in difficult circumstances and viewed it as the norm.

The drop in clinic facilities did not provide client confidentiality; home visits were thus vital to giving asylum women an opportunity to discuss sensitive issues, such as rape, in confidence. Hence, the resource limited clinic facilities were more socially than medically orientated. The major benefits for the asylum mothers of attending the clinic were a greater understanding of well baby clinics, an opportunity to make friends with fellow applicants, as well as to keep a check on their child's health. However, the asylum parents were potentially marginalised through reduced

mainstream clinic contact with the indigenous population and access to a wider range of services.

V4.10: A mainstream men's health clinic

Enabling equitable gender access to health care services is important. Men in the UK are known to die at an earlier age than women at all stages of their life (Acheson 1998: section 11) and the need improve men's health is a worldwide issue (Jackson 1991). The tension between sustainability and solidarity has been shown to result in some services, such as men's health, being more highly resourced than others (Hollis and Morgan 2001). However, men's health is frequently a low priority for health care providers (Strange 2007). PHC services have been shown not to promote access or meet the requirements of men (Monaem et al. 2007).

The clinic was usually well attended and was held in an ultra modern centre. The ethos was to bring men's health into a user-friendlier environment. Abigail and Sarah jointly managed the clinic. In addition a massage therapist provided weekly sessions, by appointment, of head, neck and shoulder massage to aid stress relief, at no charge for clients who had been assessed at the clinic. Three volunteers helped at the clinic each week to complete a lengthy client questionnaire to evaluate the effectiveness of the clinic. I was impressed by the support and pleasant manner of the centre staff.

Abigail put on a polo shirt with Glasgow logo with 'WELLMAN CLINIC' written on it; she looked friendly and professional in this outfit. All the clinic equipment was stored at the venue; including electronic weighing scales and height measurement, sphygmomanometer and urinalysis testing kit. There were leaflets on healthy eating, smoking cessation and advice on early signs of prostate cancer, but only the HIV leaflets were printed in different languages.

Abigail had sent out eight appointments to asylum applicants. The appointment letters had been translated into the client's own language[5]. Nicolai, a 35-year-old Russian asylum applicant married with two small children, was the only client who attended the clinic that evening. He stated: "I do not use my GP services unless I have a major problem that I cannot sort out myself. My GP is a busy man and I do not want to bother him with minor ailments."

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[5] A translation facility is available on the Harpweb website

(*http://www.harpweb.org.uk/* Health for Asylum Seekers and Refugees Portal).

The nurse informants stated that often their own priorities were different to those of their male clients. One participant commented: "For asylum applicants, NASS (UKBA) and their asylum claim are the top priorities."

This vignette describes a mainstream men's health clinic, which contrasts sharply with the facilities of the outreach baby clinic described earlier. A high fat diet is thought to be a major factor in the poor health record for Scotland in relation to coronary heart disease (Mainland 1998). Men with excessive weight gain are at high risk, resulting in a greater potential for diabetes and increased morbidity (Harrison 2007). Major investment had been made in this mainstream men's health clinic (MHC) to target hard to reach male groups in south Glasgow. Complementary therapies are thought to play a useful role in relieving stress and may lessen the symptoms of chronic pain, anxiety and insomnia for asylum applicants (Burnett 1999).

When Abigail put on her WELLMAN polo shirt, she assumed a new identity. She was relaxed and welcoming, to make clients feel at home and rapidly develop a close relationship. Spaces between practitioners and clients are not empty voids as such (Purkis 1996). A relaxed and open posture has been shown to signify entry to a private domain, to make clients feel welcomed (Savage 1997).

Only one asylum applicant from eight invitations attended the clinic. This lack of attendance may reflect the nurse informant's view that male asylum applicants considered their NASS application to be more important than their health, due to a lack of understanding of the value of the appointment or perhaps those invited were working. This vignette also demonstrates the challenges of effective resource usage in providing outreach health promotion clinics. The clinic was over staffed on this occasion and its cost effectiveness was questionable.

4.4 Workload management

Emotional labour, as seen in the development of relationships for example, can be viewed as equally demanding as physical work, especially if given a corporate value of mass production (Hochschild 1983:198). Moreover, high workload resulting in

continuous negative stress can lead to burnout (Kaucic 2002). A study to establish health visitors' construction of what was deemed to be 'difficult work' identified client safety as one of the major areas of concern (Chalmers 1994). Corporate, shared caseloads have been shown to lower the stressful nature of health visiting, to develop a shared consensual style of practice and establish a shared portfolio of professional knowledge (Houston and Clifton 2001). They possibly present the way forward to deliver a more flexible responsive service that shares the workload burden.

V4.11: The asylum teams' high level of workload.

The following vignette shows the impact of high workload and limited resources on asylum nursing care.

> There was a similar pattern of health care interventions provided by both asylum teams. A child development check and first immunisation was scheduled at eight weeks old, followed by further immunisations at three and four months of age. Each health visitor had an individual geographical patch within the corporate caseload, to cut down travelling time and acquired approximately eight new babies every month to their caseload.
>
> Jillian stated: "I only visit new asylum applicant families at home for the first six weeks and see clients at the clinic unless there is a serious problem."
>
> A nurse focus group informant highlighted the complexity of service provision in stating: "There is a difficulty of dealing with so many issues at the same time."

The paucity of new client health information resulted in time consuming visits to identify health and nursing needs. Jillian expected asylum applicant clients, once their child was over six weeks old, to attend regularly her baby clinic. This structured approach to workload management provided each client with a similar level of interventions. The high volume of new births resulted in the targeting of the most vulnerable families for intensive visiting and support. This system provided horizontal but less vertical equity of access to care. If the client did not attend the baby clinic, a health problem might go unseen unless the client contacted Jillian. The final comment highlights the workload involved in addressing vertical equity, where there were so many issues to be considered.

V4.12: The difficulties of equalising workload

The next vignette demonstrates the difficulties of equalising workload within a flat management structure.

> *A management meeting was held on the first Wednesday of each month. The team, including health visitors, staff nurses and support workers sat together in the coffee area. Although I was not invited, I overheard the meeting; either the team members trusted me or had forgotten that I might overhear their discussion.*
>
> *The larger asylum team was split into two basic sub-teams. The 'inside' sub-team comprised two health visitors, who formed the core team, made referrals to other team members using their mix of skills efficiently and effectively. The 'outside' sub-team included two health visitors who used predominantly authoritarian styles of intervention. One member was considered by other team members to have the smallest caseload, but was over-visiting her client group and her work focus was the giving of advice. The other member of this sub-team was under confident; she used the clinic situation to maintain her authority, manage a high level of workload and consequently carried out fewer home visits than her colleagues.*
>
> *The outside sub-group was not fully signed up to the meeting and delayed in joining the group. June, as the longest serving health visitor in the team assumed the lead, and used her transactional skills to discuss some mundane issues, such as ensuring that the coffee cups were washed after use.*
>
> *As the meeting progressed tensions between the two subgroups appeared to be bubbling under the surface. The stress of the job resulted in minor conflict as to who was working the hardest. One member highlighted the issue of caseload size stating: "Unless something is done to reduce my workload, something will happen". In order to deflect the conflict, the team agreed to carry out a caseload audit to inform the balancing of workload between the team members.*

Ethical issues arose from data collection of this team meeting, as I was not an official attendee of the meeting, but I could overhear the dialogue. I was unsure as to whether the team wanted me to overhear their discussion and to involve me as a referee in their disputes. However, the data provided an insight into the functioning of the team and I have chosen to include it.

The team meeting centred on transactional housekeeping issues of equitable workload rather than on service development issues. There were two major issues of power and control. In developing a cohesive team there was a need to be able to

assume similar patterns of practice across sub teams to provide continuity of care and client service understanding. Secondly, caseload numbers were meaningless unless clients with similar levels of nursing need were receiving similar visiting programmes. The conflict as to '*who was working the hardest*' highlights that the team members felt undervalued and consequently disempowered. They sought internal gratification from their team colleagues through recognition of the extra duties carried out.

In applying Lukes' (1974:24) dimensions of power (see section 2.1.4), the conflict arising initially in this vignette was two dimensional, as one person was using threats '*of something happening unless something was done*' to gain compliance by the others to reduce caseload size. June employed the third dimension of power in suggesting a caseload audit. This strategy helped her to assume the lead and to avert further conflict. Although the team agreed to this organisational strategy, it was not in everyone's interest to agree to the audit, as some members might have their workload increased. However, the issue of a more consistent health visiting team approach required transformational leadership. Workload was used to subvert any attempt to raise this issue, even though the varying visiting patterns were fundamentality causing the perceived workload inequity.

4.5 Developing services for asylum applicants

Transformational leadership empowers the workforce to promote service development. Manley (2004:77) considers that feeling valued, either as a client or as an employee is as an important attribute of a transformational culture for the development of shared values and practices, flexible patterns of working and effective leadership. Sources of evidence required to inform practice development are thought to come from research, clinical experience and patient experience (Rycroft-Malone 2004:125). Health visitors have been criticised for their lack of leadership and greater concern for autonomy, due to high levels of workload and need for increased training in public health skills (Abbott et al. 2004). Thus, although transactional skills are employed in the everyday running of services,

transformational skills are required to develop practice, enable greater team working and service development (Outhwaite 2003).

Health visitors are reported to have a reduced ability to deliver public health initiatives (McMurray and Cheater 2004). The underlying factors include insufficient health visitor recruitment and retention (Cowley and Frost 2006), large caseloads and low staff morale (Craig and Adams 2007), often combined with inadequate administrative support and poor inter-professional relationships (Winters et al. 2007). Furthermore, the need for greater grade mix in health visitor teams has been noted, but frequently not implemented. Intensive visiting may require grade mix for more effective use of manpower and to reduce the stress of high levels of workload (McKnight 2006).

Although grade mix has been shown to be successful in acute hospital settings (Pearson et al. 2006:1-2), a tension between the use of qualified and unqualified staff in community nursing has been recognised (Crossan and Ferguson 2005). An ethnographic study of district nursing teams in two Health Board areas in Scotland found increased, but ad hoc delegation of nursing duties and raised issues of quality standards, patient safety and the need for staff development (McIntosh et al. 2000). Moreover, a health demonstration project Starting Well, which aimed to provide intensive home visiting services to all new babies born in two geographical areas in Glasgow, successfully implemented grade mix through the development of the health support worker role (Mackenzie 2006).

V4.13: Specialised team roles

The following vignette demonstrates the potential benefit of grade mix for client care.

> *One nurse focus group informant stated, "A mix of skills within the primary care team is useful; some issues important to our clients do not always need a health visitor to sort them out."*

> *I observed that health visitors usually carried out the initial health assessment with a newly arrived family or individual; the larger team carried out an informal assessments of health as clients usually remained on the community*

nurse's caseload, whereas the smaller team used a translated health needs assessment questionnaire to facilitate information gathering and referral.

There was a high degree of flexibility in the larger team. One staff nurse worked specifically with one health visitor and the other staff nurse worked across the whole team. The staff nurses carried out varied clinical roles, including the monitoring of health issues, such as a child with a chest infection, supervising infant feeding or educating the client to ensure medication compliance. They organized services, including well baby clinics, immunization services and a men's health clinic. The nursery nurse encouraged western standards of parenting and promoted social inclusion. The HCSWs helped clients with social integration issues, access to ESOL classes, dental hygiene and emotional support. I observed that the health visitors delegated clinical elements to the staff nurses and supportive elements to HCSWs, but rarely monitored the nursing care provided by unqualified staff members.

In contrast to the larger team, the smaller asylum team worked with adults and single men most of the time. It was more intimate and without the HCSW management responsibilities. A small number of families or individuals requiring additional support were retained on the caseload.

One focus group participant from the smaller team stated: "The goal is to integrate families." However, as soon as a difficulty arose, mainstream health visitors and GPs would phone regarding "Your asylum seeker…" to request advice or a home visit from the smaller asylum team.

Christine stated: "I would like the team to become a specialist team, where complex cases are taken on for a period of several weeks for intensive casework. The team would be a resource for the other health visitors." Her job had changed very much in the last year, previously the team had given immunisations, but this was now the responsibility of the asylum client's GP practice.

Both the asylum community nurse teams in this study had developed a complex set of specialised roles. The major benefit of grade mix was to release health visitors to carry out initial health assessments or other duties. However, in spite of the clear role definition and delegation of duties, workload pressures within the larger asylum team led to a lack of supervision of unqualified staff and further service development. Although the asylum team delegated asylum empowerment working to its HCSWs, it had difficulty with self-empowerment for the required team development, noted in V4.12. The HCSWs had attended Scottish Vocational Qualification (SVQ) courses on diet and dental hygiene, but the lack of monitoring resulted in the HCSWs only

taking forward a structured programme of dental hygiene. Diet and weaning advice remained part of the health visitor role. As Rodwell (1996) suggests, the nurses needed to feel empowered before being able to empower each other.

V4.14: Leadership challenges

The difficulties of taking a leadership role are highlighted in the next vignette.

At an early stage in this study, Georgina the nursery nurse resigned after just seven to eight months. She had provided a play environment for the children attending the drop-in clinic. Secondly, she had carried out an eight months development check with each asylum applicant family at their home, to identify developmental delay and discuss home safety.

June stated: "Georgina found the creation of the new role difficult due to her limited experience. Also the need for help with parenting is not as great as the indigenous population."

Frequently, leadership is provided in the form of role models, but Georgina had no role model to follow directly and limited experience for the development of a new role. She carried out the only formal review of asylum child development. Although this review was culturally based and possibly invalid across a wide range of cultures (Scher and Tirosh 1997), it was a marker of equitable service provision. I observed that the health visitors regularly made informal assessments of child development to compensate for this service lack.

V4.15: Cost effective use of resources

The following vignette highlights the need to contain the costs of community nursing services to avoid inappropriate use of NHS resources, such as Accident and Emergency (A&E) services. A study of ambulatory A&E patients showed that, although many patients could have been successfully treated by their GP, they believed that they should use this service (Walsh 1995). The 2004-05 British General Household Survey also demonstrated a greater use of A&E services by people on lower incomes and without a car (Shah and Cook 2008), suggesting that the lack of transport was a major factor in the use of A&E services.

When I attended a CHP management meeting in Spring 2007 to present the initial findings from this study, I remained in the meeting whilst business was discussed. It was decided to increase the health visiting complement to four

staff, due to an increased use of Accident and Emergency (A&E) services by asylum applicants.

A major concern for the strategic group was the use of resources. The health needs of asylum applicants should primarily be addressed through the primary health care route rather than through accident and emergency services (A&E); A&E services were seen as an expensive use of resources and should be reserved for those with acute and serious illness. The strategic group management committee was currently deciding on a course of action requested by UKBA to provide a speedy health needs assessment as part of the initial asylum assessment service. There was a pervasive attitude by members at the meeting of the need to work closely with UKBA to contain the cost of asylum health care.

The increased asylum use of Accident and Emergency (A&E) services was not fully understood by the management team. Possible explanations such as previous asylum PHC experiences, the reduction in GP Out of Hours services and the difficulties of using telephone based NHS 24 services were not acknowledged. Although an additional health visitor to the team was a welcome resource increase and was thought to be a more cost effective option than inappropriate use of A&E services, this decision did not address the lack of out of hours cover. Thus, cost containment rather than cultural competence was the major objective for the senior management decision.

4.6 Summary

Power was a major theme running through this chapter, especially in regard to the control of NHS resources to maintain professional authority. Institutional regard defined the structures, community nursing capacity and systems for asylum equitable access to services and was the first stage identified in the updated Five Steps model. The GPs and Health Board managers assumed Lukes' (1974) third dimension of power to control asylum primary health care costs (V4.3 and V4.15). The nurses structured their nursing team roles and grade mix (V4.13) to promote efficient working. Although each member was stretched by a heavy caseload and its tension with vertical equity (V4.11), there were inequities between caseloads that resulted in clients with similar needs possibly receiving inequitable programmes of care. The community-nursing services required further resource investment (V4.7, V4.9) to aid

recruitment and retention (V4.6) and address modernization issues (Scottish Executive 2006c).

The identification of service outcomes and demonstration of value for money was important to maintain the level of community nursing resource investment. These outcomes were problematic for specialist asylum community nursing teams to identify due to their less visible, preventive, cross-cultural and time consuming nature. The processes to prioritise the more vulnerable asylum clients were not explicit. Health needs assessment tools alone required client disclosure, but men in particular were reticent about their health needs. Thus the tools did not yield quantifiable outcome measures or the agenda for future health visiting consultations.

The community nurses cited in V4.5 the three major elements of culturally competent care of asylum applicants as equity, access and the provision of non-discriminatory services. Local asylum health care policy facilitated equitable GP allocation (V4.1), but discrimination could still arise (V4.2). Asylum applicants' choice of GP was limited by the allocation system. The asylum applicants found difficulty in obtaining GP appointments (V4.4), frequently lacked confidence in the primary care system and preferred to directly access secondary care. Thus, they were potentially marginalized in accessing services and through less contact with the indigenous population. The nurses promoted equitable access to services for asylum applicants (V4.8 and V4.9) using their limited resources in contrast to the highly resourced mainstream men's health clinic (V4.10). Whereas the flat management community nursing structure impacted on transformational leadership and self-empowerment (V4.12 and V4.14), a consistent team culture to ensure a standardised service was central to promoting equity for asylum applicants. The mainstreaming of asylum applicant PHC would also help to overcome equitable access issues, but had major implications of additional cultural awareness training for community nurses to understand cross-cultural health needs. These are discussed in the next chapter.

Chapter 5. Cultural awareness

Cultural awareness is the second element in the Updated Five Steps model (see section 3.2.1). It involves mutual recognition of individual value bases so as to develop interpersonal relationships and deliver vertical equity of nursing care. This second findings chapter considers the following research question:

- *How do the health beliefs of asylum applicants and community nurses affect the delivery of primary care nursing?*

Reciprocity and gift exchange occur in all societies (Barfield 1997:224) connecting anthropological perspectives with health service delivery. Exchange tracks the way in which things (including services and information as well as objects) move from one person to another (Davis 1992:1). It is an underlying principle of communication (Hendry 1999:53), social interaction (Fajans 1993) and self care support. For example, the care of young people with a long term health condition (Greene et al. 2008).

Mauss (1969) explored the interpretation of gift transactions in an essay entitled *The Gift*. He considered that although the gift at first sight appears spontaneous, voluntary and disinterested, the accompanying behaviour was formal pretence and social deception; the gift transaction was based on economic self-interest and imbued a sense of reciprocity. The gift involved more than goods exchange and involved complex social relationships with implications at many levels (Sykes 2005:75). For Mauss (1969:10), in giving a person gave away part of himself or herself, whilst in receiving the recipient received an essence of someone else's life. The gift involved three obligations: to give, to receive and to repay. Failure to give or to receive involved a loss of dignity, whilst repayment failure debased the recipient, leading to subordination or to a client relationship (Mauss 1969:72).

Three types of reciprocity have been noted (Sahlins 1974); generalised reciprocity concerned no obligation to reciprocate, for example in a family situation. Secondly, balanced reciprocity was where gifts of equal value passed immediately between parties. Thirdly, a negative reciprocity involved an attempt to get something for

nothing. However, this model is tautologous. Layton (1997:99) notes that social relationships are forged through the exchange process rather than existing *per se*. Gifts are never 'free', but in essence are pledges, linked to donors and recipients. These pledges create solidarity between persons of equal social standing (Barfield 1997:224). Reciprocity is required for amicable communication (Hendry 1999:56); the donor's rights in the gift are not extinguished and may become a means of controlling others without resort to violence (Cheal 1988:10). Thus the significance of gift exchange is dependent on the recipient's culture and varies between individuals.

The notion of a gift imbues a sense of altruism through the forgoing of a resource for the benefit of others (Layton 1997:174). Organ donation might be thought to fulfil the Maussian spirit (Sque 1994) but there are limitations. The UK donation of body parts has moral overtones as it involves no monetary exchange, but may not significantly increase cultural capital, as reflected in the current lack of donated organs for transplantation (BBC News 2008). Secondly, the symbolic nature of body parts may impact on the willingness of people to gift blood or organs due to concerns that the donation may take over an individual's identity.

Gatekeepers mediate the giving and receiving of organs, with a consequent lack of spontaneity. The recipient cannot repay the donor for this gift and illegal blood and organ banks operate unethically in some countries (Erwin 2006). Where there may be opportunities for deceit, brokers become part of the exchange process; for example livestock markets and the Internet E-bay service. In paying for an organ transplant, there is no obligation of reciprocation, but donors and recipients may get in touch with each other despite systems to ensure confidentiality (Joralemon 1995).

The paradox of the gift is that at first sight it may appear to include an altruistic element, but few social activities are totally free from social significance, pressure or reward (Davis 1992:15). In giving a blood donation, for example, Davis (1992) considers that the donor is rewarded by a cup of tea, enhanced self-esteem and cultural capital. Thus Davis (1992:20-23) argues that all purposeful action is profit

motivated; altruism is not free but in common with the market economy is bound by moral judgement.

The concept of exchange is an important basis for the development of relationships between people in all societies (Silitoe 1979:282). The significance of the anonymity of the gift has been explored in a UK ethnographic study of ex-donors and ex-recipients of ova (Konrad 2005:22-23). Even though donors and recipients do not know each other, the gift provides a basis of a relationship between the two parties. Konrad argues that anonymity is balanced by the known genetic make up of the ova and recipient and suggests the notion of transilience to denote a non-possessive modelling of personhood.

Nursing care can be thought of as a 'gift'. It is automatic, embedded within practice, universally applied and frequently described as the giving of care or advice. In acting as '*an interpreter*' of health services for the client (Pearce 1967:21), the nurse is a stable element in the unknown social world of multi-professional health care delivery. Clients, as receivers of care, reciprocate through giving freely their time to attend the nursing consultation and to develop the social/professional relationship. Secondly, clients allow access to intimate areas of their body, medical history and social life. Reciprocity involves the grateful acceptance and compliance with nursing care, no matter what the indignity incurred. The lack of engagement of some clients with their nurse or health visitor may be explained by the high price of reciprocity.

Conversely, the notion that nursing care is a gift can be contested. Clients have already 'paid' for health and nursing care services through the national insurance scheme (Godbout 1998:157). Godbout (1998) argues that state services are not gifts but are distributed on the grounds of rights; the welfare state supersedes the market place and takes charge of the gift exchanges. Hence, when the nurse becomes an agent of the NHS, the gift is transformed into a service. Links with the market place are retained, for example through the commissioning or development of services to maintain value for money. The control of NHS resources was shown in chapter four to be important to maintaining professional authority and power. Conflict may arise

between individual and corporate values. For example, health visitors working with asylum applicants may be required to provide care which supersedes the normal expectations of their role (McDonald 2001).

Community nursing uses the mechanism of client relationships, perhaps a vestige of the gift exchange process, to implement its social control function. The building of client relationships is a traditional health visiting role (Robotham 2005a:94) that is carried out at both an individual and community level (McClymont et al. 1991:71). It provides a medium for informal health teaching, social surveillance and child health protection (Cowley et al. 2004). Effective nurse-client relationships operate within the cultural context of the community served (Kelly and Symonds 2003) to promote vertical equity, to provide person centred care and advice (McNaughton 2005); this may also be a major route to raising community health awareness. Peplau's Theory of Interpersonal Relationships (Peplau 1997) provides a useful framework for understanding the development of nurse-client relationships, which includes four phases of:

- Orientation
- Identification of health needs
- Exploitation or empowerment to use resources for health
- Resolution

The data vignettes in this chapter describe these stages of nurse-client relationships in relation to cultural awareness.

5.1 The orientation phase

During the orientation phase, Peplau (1998:44) suggests that the nurse and client are initially strangers. The client requires encouragement to assume an adult approach to face up to health issues and establish how a nurse might help with these felt needs (Howk 2002:382).

I consider that the notion of 'helping' is fundamental to nursing care and treatment. It can be considered to be a form of exchange and a mechanism for increasing social capital. Heron (2001:11) describes helping as "*supporting and enabling the*

wellbeing of others". It has five attributes; namely a warm concern for others, attunement to the other's experiential reality, an understanding of another's needs to achieve their potential, skills to aid the achievement of this potential and finally an authentic or trustworthy presence. This mix of concern, empathy, facilitation and trustworthiness relies upon the inherent cultural values of the individual and suggests a degree of altruism. For the helping to be effective, joint understanding of nursing assumptions and the client's responsibilities is required (De Montigny Korb 1996).

A study of public health nurse interactions found that newly referred ante-natal clients considered that they received appropriate reassurance, but the nurses also helped them with other unrelated issues (Conant 1965). The acts of giving and receiving were seen by Conant (1965) to be significant in the development of trusting relationships. Nurses established the nature of client problems using both verbal and non-verbal communication strategies to achieve this partnership relationship. The exchange of life stories and information is especially important to clients (Forchuk 1994), helping to create interpersonal relationships (Patel and Mahtani 2004: 25) both with individuals and the community as a whole (Vukic and Keddy 2002). Moreover, an opportunity to share traumatic experiences is highly therapeutic (Pennebaker 1993). Reassurance that the way asylum applicants are feeling is a natural reaction to their refugee experience can be comforting (Burnett and Fassil 2002). Moreover, helpful relationships have also been shown to cross cultural boundaries. The importance of nurse–client relationships to overall recovery was demonstrated in a comparison study of psychiatric patients in both Canada and Scotland (Forchuk and Reynolds 2001).

In this study, the data demonstrated that the orientation phase involved:
- The use of empowerment
- Sharing the refugee experience
- Showing mutual respect
- Establishing and testing a trusting relationship.

5.1.1 Empowerment

Empowerment requires non-directive partnership approaches with parents to achieve the full potential of their families and children (Twinn 1991:969). Self esteem is frequently a fundamental need of vulnerable clients (Robotham 2005a:95). A study of the early support needs of Finnish families with small children showed that on average each family was able to identify four to five areas of support need; these included parenthood, childcare, the couple's relationship, and social support networks (Häggman-Laitila 2003). Both the nurse and client must feel empowered to enable the transfer of power from the professional to the client (Rodwell 1996). In utilising scheduled rather than opportunistic visits to clients at home (Robotham 2005a:90), clients make their needs known (Houston and Cowley 2002) and control the health needs assessment process (Cowley et al. 2004). An empowered approach provides clients with an opportunity 'to give back'(Falk-Rafael 2001). Thus, a therapeutic two-way relationship occurs when nurses achieve a counselling role with their clients (Peplau 1988: 67), which relies upon the personal skills and attributes of those involved in the interaction (Mitcheson and Cowley 2003).

The empowerment process involves both authoritative and facilitative approaches, with a gradient between nurse directed prescriptive care and client-directed self-care (Heron 2001:4-7). Mitcheson and Cowley (2003) demonstrated two styles of health visiting practice. A directly controlling style reflected the impact of line management. Secondly, a covert assessment style resulted in the disempowerment of clients. Heron (2001: 7-9) suggests that an authoritative approach impacts on individualised care; the need to elicit information or deliver knowledge may be seen to challenge a client's health behaviour. Studies of interpersonal skills have found that nurses considered that they used authoritative styles more often than facilitative ways of working with clients (Burnard and Morrison 2005), perhaps to assume control and produce order out of perceived chaos (Annandale et al. 1999). Nurses were shown to revert to authoritative styles in spite of training to use non-directive approaches (Buskens and Jaffe 2008).

A facilitative (or reflexive-interactive) approach involves the non-judgemental respect for a client through the caring and sharing of concerns, happiness and grief. It empowers the client to voice individual health concerns and to negotiate individualised care (Bryans 2005). It may involve three additional elements of catharsis for a therapeutic release of emotion, catalytic interventions to enable personal health decision-making, and finally emotional support to validate and confirm health issues (Heron 2001:147-156).

V5.1: The use of authoritative approaches

Health promotion aims to prevent disease through individual and community empowerment and the marketing of healthy lifestyles (Maben and Clark 1995). It assumes a cultural set of values that should include those determinants of health both under and outside the control of the individual to avoid blaming the victim (Nutbeam 1998). Health visitors have the necessary attributes to provide an enabling and mediating function to promote health (De La Cuesta 1994), but the preventive nature of their work makes their effectiveness difficult to demonstrate (Raphael 2000). Although high levels of social capital are thought to be linked to lower mortality and morbidity rates, health education remains an important factor to promoting health (Bolin et al. 2003).

There may be several reasons why an individual decides not to adopt a health promotion message. Although health information is available from many sources, including parenting classes, the media and the Internet, health promotion involves changing cultural health beliefs to affect health behaviour. Poverty and lack of internal resources may prevent adoption of healthy lifestyles. Studies have shown the importance of preparation and pre-contemplation to summon the psychological effort required to achieve a new health behaviour (DiClemente et al. 1991, Prochaska 1994). This vignette demonstrates that health promotion is often one of reinforcing existing behaviour as much as challenging clients to change behaviour.

> *Isabel stated: "I rarely make appointments to see asylum clients, but arrange several potential visits and then if one person is not at home then maybe another person is at home." Her clients were used to these frequent but unexpected visits, which she considered helped to establish relationships.*

She belonged to the 'old school' of health visiting in using a mixture of prescriptive and informative styles of intervention. I noticed that Isabel usually repeated her advice to the client several times to ensure understanding. She started a discussion by eliciting the client's level of understanding of an issue. She did not assume any knowledge, but carried out this intervention skilfully such that the consultation was not seen to be patronising.

Isabel had a working knowledge of Arabic and interspersed the conversation with Arabic words. She said, "God be with you" at the end of each visit. At one home visit the client's six-month-old baby had stopped breastfeeding and was now taking cows milk from a bottle. Irene asked her client: "Are you sterilising the bottles?"

The client replied: "Of course." Isobel replied, "That's great."

Most asylum informants in this study were breastfeeding, either through choice or inability to afford artificial infant milk formula. They were provided with infant feeding sterilisation equipment, either by their midwife or health visitor. Isabel had a working knowledge of Arabic. Isabel's clients appeared to appreciate the attempt to ease communication and accepted her paternalistic and authoritarian approach. She bolstered her client's confidence through praising the sterilising of the infant feeding bottles. In applying Lukes' (1974: 20) second dimension of power (see section 2.4) she challenged her client concerning the sterilisation of feeding bottles to ensure compliance. Isabel thus remained in control. She reinforced compliance with expected social norms of sterilisation of infant feeding equipment. Although Isobel worked with her clients, she maintained the balance of power, did not enter into equitable, reciprocal relationships and used empowerment strategies sparingly. For example, she did not ask how the mother was feeling now that breastfeeding had discontinued. When she stated, "That's great", she praised her client's behaviour. Thus the community nursing role was frequently to gently reinforce rather than radically change health behaviour.

V5.2: The use of a facilitative approach

This next vignette demonstrates the challenge of using a facilitative approach.

Cynthia stated: "When I ask clients for information or give advice, I often turn this information around by asking, how does this feel for you? Or can you take this information on board?"

Nicolai was a 35-year-old Russian man married with two children. At the beginning of the Men's Health Clinic consultation, Abigail asked him a couple of times how he was feeling and if he felt stressed by his asylum claim. Nicolai was very sensitive about these issues and stated: "I will go mad if I think too much about it. I am a Christian and my asylum claim is in God's hands. God will show me the right path to go." Abigail subsequently moved back to an authoritative approach to gain the information she required.

Cynthia recognised that a trusting relationship was required before sensitive issues could be disclosed. Abigail, in trying to adopt a facilitative approach and bring to the surface underlying health issues concerning Nicolai's asylum claim, had insufficiently developed the interpersonal relationship at this point to facilitate discussion of these sensitive issues. Secondly, Nicolai's closure on the discussion of asylum issues was not an unusual response to this confronting style of questioning. Although the community nurses used both authoritative and facilitative approaches with clients, the stage of the nurse-client relationship limited which approach could be used and when.

5.1.2 Sharing the refugee experience

The social and international forces that influence the movements of refugees are complex (Zolberg et al. 1989). Political and economic factors may combine, as violence becomes an expression of competition for finite resources (Schroder and Schmidt 2001) and social upheaval results from the lack of economic development and poverty (Schuster 2003). The decision to flee is usually taken after a prolonged exposure to repression, resulting in fear and tension (van der Veer 1998). Asylum applicants come to the UK to find sanctuary and not through choice (Barclay et al. 2003:13, Robinson and Segrott 2002). There may be little understanding concerning the oppression occurring within the home country (Pirouet 2001:5).

Asylum narratives deserve greater acknowledgement as they provide an opportunity to see refugees as individuals (Malkki 1996), as well as informing the health consequences of forced migration (Coker 2004). Although narratives are accounts of what can be narrated rather than what actually happens, defying the 'cultural anaesthesia' of the denial of chaos caused in violent situations (Feldman 1994), they are essential to gaining an historical view of asylum health needs (Grove and Zwi

2006). For example, a US epidemiological survey of the trauma and torture experiences of Somali and Oromo refugee men and women found a high level of self reported previous exposure to trauma and torture (Robertson et al. 2006).

Reema's story concerns the rape of a young woman. Although sexual violence and rape against women is a worldwide problem, there have been few research studies carried out (Watts and Zimmerman 2002). A study of Chechen female asylum applicant clients found that 16 out of the 19 informants had suffered rape (Granville-Chapman 2004). A review of medico-legal reports found that 17 of the 100 rape cases examined in resulted in pregnancy (Clarke 2004). Rape is a method of torture (Peel 2004), but has only recently been accepted as a war crime (Smith 2004a). Peel (2004) suggests that rape in the context of war serves various purposes, namely as possibly as a reward for victorious soldiers; a mechanism for the social bonding and boosting of male morale; as a way of inflicting terror and subservience on communities; to humiliate male opponents who have been defeated; a means of subverting the culture of the local community; and finally to promote ethnic cleansing through the impregnation of women with offspring of mixed ethnicity. In terms of an asylum claim, the applicant must prove the rape served a purpose rather than being an act of lust; frequently this may only be possible within the European Human Rights legislation (Smith 2004b).

Reema's story[6] is unusual in that she suffered an attempted deportation by the immigration authorities and was able to return and speak about these experiences. In V5.3, I have interwoven the pattern of community nurse team visits and interventions, as identified through the nursing record, to the original story provided by Reema.

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[6] Reema's story is divided into three parts: (1) V5.3 The escape from her home country. (2) V7.3 Claiming UK asylum (page 187). (3) V7.16 The fight against a removal order (page 205).

V5.3: Reema's story part I

Reema was a 23-year-old Muslim woman from the Darfur region of Sudan. She was married to Mohammed and she had one son, Ali aged 14 months old. She spoke English fairly fluently; initially she had only been able to speak Arabic and her local dialect. The story began in Darfur, Sudan, where Reema lived with her parents and her sister. Due to their recent arrival and lack of ability to speak the local dialect, Reema and her sister were rather isolated, with few friends. Their father, a physician's assistant, was rarely at home as he was busy working long hours at the local hospital.

Reema described an incident at her home in Darfur, when Janjaweed militiamen savagely raped both her and her sister. Reema stated: "During the attack, the militiaman held a knife in his hand. When I tried to brush this knife away with my arm, the man plunged the knife into my nose, creating a large hole, which later frequently gave rise to nose bleeds. I called out for my father, who came running into the room. He tried to intervene and stop this from happening, but the militiamen killed him, by shooting him in the head in front of us."

After the attack, the women were taken to separate locations. For four months, Reema lived in a militia compound of three huts, along with nine other women prisoners and three boys under the age of ten years old. Each day, the women were forced to clean the compound huts and cook food for the militia; if they did not carry out the tasks as instructed, Reema stated: "We could be beaten and bad things were done to us." She showed me the scars of cigarette burns on her arm, but I had no way of checking the truth of her statement.

During her imprisonment, the militiamen began to trust Reema and allowed her to go to the bank or collect shopping. On a third occasion she met an old friend of her father and Reema told him her story. In reply this family friend reported that the Janjaweed had also killed his wife, but his daughter aged 15 years and a son aged 13 years had survived. They had been driven out of their village and were homeless. The family friend wanted to help Reema to escape, but at that time she had only 2000 Sudanese Dollars, which was insufficient to pay the agent.

One day when Reema was cleaning in one of the huts she found a hole in the wooden floor. She narrated: "I pulled up the floorboard and found guns and money in a cotton holdall in the hiding place. It was too dangerous to take the money and I put it all back as I had found it. On my next shopping trip I met this friend again and I told him about the money I had found under the floorboards. In four days time I was to be moved to another site; although I did not want to steal the money, I needed to be in a safe country. I said that I could not promise to get the money but would do the best I could."

Reema was instructed to return to the village the next day. She made her escape from the compound by telling the soldiers on guard that she had been

asked to visit the shop again by the person in charge. She reported: "I took a bundle of money from the hiding place, hid it in my underwear and left as quickly as I could. While waiting to be picked up by the agents, I was hidden with three girls and one boy in a small village hut. At eight pm we left, concealed in a lorry with sheep and cows and we travelled for eleven days. There were few stops. I sat on the excrement of the animals and had only biscuits and nuts to eat. We arrived at a village on the Red Sea, where the group remained a further six days."

The next stage of the asylum journey was to take a ship from Port Said. After nine days at sea, Reema was transferred to another ship, which took a further twelve days to reach the UK. She was kept in the bowels of the ship. She was not allowed on deck in case she was seen. Reema said: "I had little to eat, only rice and a few biscuits. I started to vomit, but did not realise that I was pregnant. I was put inside a lorry on the ship."

The lorry drove off the ship and once it had travelled in the UK for about four or five hours, Reema was left stranded on a farm road. She stated: "I had no idea where I was, I did not understand English and I had no money left. Fortunately a car picked me up and the man driving the car spoke Arabic." He drove her to the railway station, where she received help to contact the Scottish Refugee Council (SRC).

The SRC caseworker immediately realised that Reema was very ill and arranged for her to go to a Glasgow hospital, where she found out that she was pregnant. Reema was dehydrated from the vomiting and had eaten very little over a long period. She made a UKBA application (see section 1.4). She was provided with accommodation in a bed and breakfast hotel until she had had an ultrasound scan to check the health of the baby. Reema reported: "I did not want an abortion as it was against my religion." Reema had become an unmarried pregnant asylum applicant.

In becoming an asylum applicant, Reema appeared to have satisfied the three main conditions of the UN 1951 Geneva Convention. She was outside her country of origin and had a well-founded fear of persecution, should she return to Darfur. Thirdly she was in need of protection. Although Reema might have thought that her troubles were now over in reaching a place of safety, as an asylum applicant they were just beginning. She had made her own application for asylum, whereas over two thirds of UK asylum applications (71%) were made by men in 2005 (Heath et al. 2006), and 83% of applications for UKBA support in the second quarter of 2006 were made by single men (Home Office 2006).

In support of Reema's case, the Janjaweed is known to be a Sudanese militia drawn from Darfurian and Chadian Arab tribes. These militiamen became notorious during 2003-4 for massacre, rape and forced displacement of villagers. Darfur is an extremely remote area. Few outsiders have been able to gain access to the area. Two million people are estimated to have been displaced by the conflict and up to one million children raped, wounded or killed (Chaikin 2008). There continues to be limited access to healthcare and the crude mortality rate for people living in the refugee camps may be as high as 20 deaths per 10,000 people per day (Martone 2004). Although the Sudanese government has denied any support for the Janjaweed, anecdotal evidence has refuted this (Koerner 2005).

In listening to Reema's story, I was aware firstly of authenticity issues. Narrators may embellish their story for effect, which cannot be proved or disproved (Holloway and Freshwater 2007:105). Narratives are based on past facts, which are reshaped over time (Polkinghorne 1998: 174). As discussed in section 1.4, the validity of an asylum claim is important to its success. Home Office caseworkers are thought to look for internal inconsistencies, contradictions between objective evidence and the claimant's factual statement and plausibility as reasons for refuting credibility (The Independent Asylum Commission 2008: 19).

Reema's story was well rehearsed. It was as if it was all she had left to give. Although it was very painful at times to describe the events, there was no hesitation over dates or number of days spent in specific places. The rote story learning can be explained in several ways. Asylum applicants may be asked to tell their story numerous times by immigration officials. They may have been instructed by their agents to always tell the same story to protect them from prosecution. A UK oral history study found that most refugee interviewees had escaped from war or persecution in their home country, over half had used agents to come to the UK with little choice of destination (Rutter et al. 2007: 42).

The disclosure of rape is difficult for asylum applicants, due to its associated shame and psychological distress. Late disclosure should not be considered to be a

fabrication of events (Bögner et al. 2007). A UK study found that almost a quarter of people with HIV were victims of rape (Sayers et al. 2006). Seltzer (2004) describes the coping mechanism of switching off subsequent distress as dissociation. It might only be suspected that male or female clients have been raped from their behaviour or other medical signs and symptoms. Rape is rarely openly discussed (Esposito 2006) and frequently has a pathological effect on the whole family such that it is kept secret (Avigad and Rahimi 2004).

There is often difficulty in establishing the validity of an asylum rape claim. Although the applicant's medical evidence may be given a greater weight than the political victimization suffered (Fassin and D'Halluin 2005), asylum caseworkers have also been shown to devalue or ignore medical evidence (Smith 2004c). The time between the occurrence of rape and medical investigation is known to be often lengthy, with little evidence of major physical injury (Kitzinger 2004). The notion of trauma may positively help to access services, but it may negatively affect trust and confirm stereotypes of 'bogus refugees' (Gross 2004:163). Reema stated that she had left her country with only a few items and a little money. She had no official documentation, just a few scars to prove her experiences. An ethnographic Swiss study demonstrated that the medicalisation of the refuge experience has consequences of asylum applicants struggling with ascribed psychological diagnoses and resisting treatment. Asylum applicants may thus misrepresent political suffering in terms of trauma (Malkki 2007), even though there is a limited impact on individual asylum cases (Fassin and D'Halluin 2007).

Poverty was not the major root cause of Reema's migration. Reema stated that her father had held a reasonably well-paid position and the decision to become a refugee had been her own, to escape from the violence and social conflict in Sudan. Rutter et al. (2007: 56) found that adult refugees were more likely to have greater social, educational and economic social capital than those left behind; forced migration selected those with a high potential, which was not always realised in the UK.

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A final issue is inconsistency. Some parts of Reema's story are open to question, such as finding money under the floorboards of a hut in the Janjaweed compound, which although may not be true, does not mean that the whole story is false. The memory of an event is influenced by several factors. A study, which investigated the consistency of autobiographical persecution accounts of Kosovan and Bosnian refugees during 1999 and 2000, found that discrepancies did occur between accounts of the same event even though there was no reason to fabricate the details (Herlihy et al. 2002).

An asylum applicant's experiences may damage memory (Peel 2006). Memory recall has been shown to be inconsistent for people suffering post traumatic stress disorder (PTSD) (Herlihy and Turner 2006). The victim may remember central details at the expense of minutiae (Christianson and Safer 1996). Somatisation of psychological distress can arise from the conflation of previous trauma experiences with current physical illness (Burnett and Peel 2001) in addition to the stigma associated with mental illness (Craig et al. 2007). Although a 'normal response', mental distress is often diagnosed as PTSD (Burnett 2002). It results in a subsequent loss of identity, with high levels of anxiety, depression, guilt and shame. A sense of helplessness, insecurity, lack of trust and alienation has been identified in the sufferers (Rosenbaum and Varvin 2007) requiring individualised care and treatment (Ebert and Dyck 2004).

Interviewers can also influence the detail disclosed (Herlihy and Turner 2007). Van der Veer (1998:21) suggests that the stress associated with the asylum application may constantly remind the applicant of previous traumatic experiences. Hence the applicant creates a different version of events to avoid these painful memories. Thus a story may become a vehicle to make sense of a chaotic life episode, which becomes incorporated into a lived existence (Williksen 2004).

The community nurses never questioned the validity of Reema's story, even though her experiences were beyond their understanding. Asylum applicants have personal strengths to overcome adversity, the nurses had heard many similar stories before

and had no reason not to believe her, whilst recognising that the accounts could not always be taken at face value. In adopting a pragmatic approach, the community nurses recognised that current health issues were most important, but received and accepted these stories in order to establish a nurse-client relationship.

5.1.3 Showing mutual respect

The showing of respect for another's way of life is thought to aid the development of the therapeutic relationship (Masson 2005).

V5.4: Examples of mutual respect

The following vignette provides several examples of showing mutual respect as a first step in the orientation phase; it demonstrates the importance of being polite, to be culturally in tune with the client.

> *Francis stated, "Cultural competence is being aware of different cultures and knowing what to do or what not to do. The first time I met a Somali interpreter I put out my hand to shake hands with him, but I had not realised that I should not shake hands. Although it is important to find out about other cultures, I cannot know everything. If in doubt, I speak to the other nurses for advice."*
>
> *Jillian summed up cultural competence quite succinctly when she stated, "It is to do with keying into the social norms of clients you are seeing." Jillian placed this definition in the context of cultural practices and gave the example of whether to take off your shoes when entering a client's home. Jillian stated that she had once been very annoyed when an interpreter had entered a house with muddy shoes as she thought that this was very disrespectful of clients.*
>
> *One nurse focus group respondent commented: "A client did not turn up for an appointment because it was raining and thought that the family could not go out in the rain."*
>
> *Dr Cross said: "There is a need for the doctor to be on the same wavelength as the client, in order for the client to be able to understand what the doctor is trying to achieve. Mental health needs are particularly difficult to address. Talking therapies are often not understood or thought necessary by asylum applicants and there is often a large amount of groundwork required before therapy can commence."*
>
> *Abigail described cultural competence as: "The non-pursuit of certain questions. Some clients are often very guarded about their immigration status. It's important not to inquire in too much detail about pregnancy or contact with family members. It is much easier to obtain information from the 'more open' indigenous population. Somali clients have a different conception of*

appointments. They are used to going to a clinic and waiting all day to be seen. Hence they do not always arrive on time."

Anba, a 25 years old woman from Pakistan with a new baby daughter, was wearing a brightly coloured traditional outfit. Her partner Pasha was 35 years old and they spoke Punjabi. Anba looked extremely graceful and she appeared to glide in these beautiful clothes, which obviously made her feel good. These signals were not just those of promoting difference. The beautiful clothes suggested that Anba came from a family with high status. She had an inner confidence of her ethnicity, culture and religion.

Cynthia stated: "I only instruct the clients to do things differently, if a child is at risk, for example a health and safety issue of strapping a baby into a high chair."

Both Francis and Jillian viewed cultural competence as a one-way interaction, as part of politeness to initiate a relationship; to be impolite might result in the client refusing future home visits. Francis did not recognise that it was just as culturally inappropriate for the interpreter not to shake hands as for her to want to shake hands. Likewise, the client who could not go out in the rain did not understand how impolite it was not to attend for an appointment. UK PHC systems assume an understanding of monochromic time, where time is linear and has a currency value in that it can be spent, wasted or saved (Helman 2005).

When Dr Cross insightfully referred to nurses as being on the same wavelength as clients, she implied a need to understand both her own culture as well as the client's culture, for reciprocal respect. Abigail also recognised the importance of understanding the boundaries of social discourse and had some insight as to possible reasons for impolite behaviour. Anba wore her traditional outfit as a personal identity statement to show self respect and define her social status in initiating the nurse-client relationship.

Although Cowley et al (2004) showed an unequal power relationship with clients as nurses took control of the home visit agenda, culturally competent practice may actively redress this balance. For example, the nurse may not be able to implement his or her agenda, as to ask insensitive questions at the wrong time may require an authoritative approach and adversely impact on the nurse-client relationship. As

Cynthia suggests, there was a trade off between providing authoritative advice and the initiation of the nurse-client relationship on a partnership basis.

5.1.4 Establishing a trusting relationship.

Trust, the willingness to believe in the strength and goodness of someone or something, is central to health care delivery (Brownlie 2008). Frequently clients take a leap of faith regarding their real benefit from health care (Brownlie and Howson 2005), which may result in raised expectations. Interpersonal activity involves elements of trust, mistrust, abuse and hope (Gilbert 1998) in nurse-client relationships as well as within organisational structures (Johns 1996). Impersonal trust centres on professional nurse authority, in a Foucaultian sense, to actively broker and manage client healthcare expectations (Gilbert 2004).

The concept of trust within nursing has been ascribed four major elements; dependency on an individual, decision making that includes risk, a limited focus of need and the testing of individual trustworthiness (Hupcey et al. 2001). Mollering (2001) considered that trust should not be confused with its outcomes of risk taking, co-operation, reciprocity, interpersonal relationships and social capital. Whilst systems of health care accountability are intended to promote trust, their presence signifies mistrust; trust is engendered through face to face interactions with people rather than from the system itself (Huby 2008). Trust is thus an iterative process (Mechanic and Meyer 2000). It expects an outcome of trust, which builds upon a suspension of the unknown combined with an interpretation of the current situation (Mollering 2001).

V5.5: Establishing trust

The following vignette demonstrates the asylum applicant informants' lack of trust in primary health services.

> *During the nurse focus group one informant stated: "The building of relationships takes time. Asylum applicants consider that their immigration status is of greater concern than their health and are often suspicious at a first visit. Clients think that I am from the government agency, but later, through knowledge gained by word of mouth, realise that I am there to help them." Another nurse informant stated: "Although asylum applicant clients do not understand our individual roles, they pick up on the helping role of nurses."*

Whilst a third participant made the point, "They build trust and want to hold onto it."

Cynthia said; "I use regular home visits to build a trusting relationship with an asylum applicant. Over time I get to know my clients, understand how they are feeling and eventually they begin to describe their past history and its impact on the current quality of life."

Jillian stated: "Asylum applicants look on the health visitor as a friend. For example my clients often asked me to take photos of their children."

Dr Brook stated "Some asylum applicants come from a culture where the need for social exchange is taken for granted. If someone does something for you, you return the favour." She was concerned that GPs could be easily compromised to make unnecessary hospital referrals and gave the following example: "My husband and I were invited to a Kurdish evening of song and dance. The next day the event organiser came to ask for an extension of his sick line, even though he was fit to return to work. I refused to meet his request and now no longer attend any of these events, as I might put myself in a compromised position again."

Their concern was due to potential connections with UKBA, which they considered had authority to influence their asylum application. The community nurses recognised the time investment required to build trusting relationships and empower clients to maintain health. This process is an example of polychromic time, which Helman (2005) considers is less linear than monochromic time and as a point in a relationship. In moving beyond the stage of being strangers, the nurse and the client required an understanding of each other's health beliefs. For example, the gift exchange of photographs helped Jillian to cement client relationships.

The invitation to attend a social event was also a gift. V5.5 highlights the power of the gift to move the power base from the GP to her client. Dr Brook did not want to accept an invitation again, as she considered that there were consequences for her professional power. However, GPs are known to accept other types of gifts, such as free lunches from pharmaceutical companies.

V5.6: Testing trusting relationships

This vignette demonstrates the asylum applicants' use of the reading of letters, ranging from NHS appointments to junk mail, as a mechanism for establishing and testing trusting relationships.

> *Kamil was 34 years old. He had come with his 29 years old wife, Sabat and their five-year-old son with special needs, Hasan, from Pakistan six months earlier to claim UK asylum. Kamil asked Cynthia to look over four letters that he did not understand, even though he had a good level of spoken English. Cynthia had referred their son, Hasan, to several agencies for specialist services. There was a letter from the dietician informing of a 12 week wait before Hasan could be seen; another from the speech and language services advising that Hasan was now on the waiting list; an invitation for Sadaf to attend the GP surgery for a routine smear test; and finally information about their new mobile phone.*

The letters used complex language and were frequently unclear as to what action the parents were required to take. The clients therefore asked the community nurses to help them understand their contents, through using a simpler language register and shorter sentences. Confidentiality might have been an issue, if clients had asked another person to confirm the contents of the letter.

The ritual of letter reading at the consultation close appeared to be an acknowledgement of nurse authority. The clients usually had understood the letter's contents and its interpretation was rarely a surprise: I suggest that in asking the nurses to interpret the contents of the letter, they were reinforcing a trusting relationship in two ways. The nurse-client relationships were cemented through the reciprocal exchange of personal information, which provided a common bond. Secondly, in checking the contents of the letter, the clients were also checking on the reliability and trustworthiness of the nurse. The reading of the letters served to enable a greater understanding of primary care services. For example, Sadaf had little understanding of cervical cytology and Cynthia arranged to return with an interpreter to discuss this preventive service further.

Thus, the orientation phase for clients involved the giving of information concerning their refugee experience. The community nurses received this information to establish a common basis for an interpersonal relationship. This shared

understanding involved processes to establish mutual respect and trust, which were integral to the community nurses' helping role.

5.2 Identification of health needs

As previously emphasized, health visitors have a major role to identify health needs to promote individual and community health (Gott and O.Brien 1990). Peplau (1988:17-42) defines the identification phase as enabling clients to express their health concerns, within three types of responses; participation or interdependence with a nurse, independence or isolation from the nurse, and thirdly through helplessness and dependence on the nurse.

Health visitors have been shown to use the concept of vulnerability to prioritise their workload (Rowe et al. 1995, Williams 1997), to target those families most likely to benefit from a therapeutic intervention (Summers and McKeown 1996) and identify communities experiencing deprivation (Jinks et al. 2003). Vulnerability is difficult to define accurately (Appleton 1994a). There is a lack of consensus as to what constitutes a vulnerable family with potential child protection issues (Appleton 1995). Although health visiting work in this area has remained largely invisible (Newland and Cowley 2003), asylum applicants are highly vulnerable, with multi-faceted and poorly defined complex health needs. The targeting of services to vulnerable and epidemiologically high risk clients has been introduced to address issues of vertical equity (Cowley and Houston 2003, Rowley 2005). Regular home visiting targeted at US low income mothers during the antenatal and early postnatal periods, has been shown to improve parenting as reflected in reduced incidence of child protection issues and improvement in maternal health (Olds 2006).

Cultural awareness is important to understanding a client's health knowledge, beliefs and fears. For example, mental illness may be highly stigmatised and a more acceptable diagnosis is required (Kleinman 2004). Kleinman has termed this understanding an Explanatory Models approach (Kleinman and Benson 2006). A study of Finnish doctors and nurses has shown the nurses to be more in tune with asylum health care needs (Koehn and Sainola-Rodriguez 2005). A qualitative study

of refugee families in London in 2001 found that the health visitors prioritised the children's' immunisation needs above those of cervical cytology for the refugee women (Drennan and Joseph 2005). This may reflect the personal preference of the women to put their children first. In this study the identification of health needs involved four elements:

- An understanding of individual health beliefs
- An accommodation of a range of health beliefs
- The assessment of health needs
- Child health surveillance

5.2.1 Understanding individual health beliefs

Cultural awareness is essential to health promotion activity (Higginbottom 2000) as cultural stereotypes may disadvantage minority ethnic groups in the provision of community nursing care (Cameron et al. 1988). Health beliefs impact on everyday life; male circumcision may be requested for cultural rather than medical reasons (Marsh 2003). These health beliefs may even kill, described as 'voodoo death' (Hahn and Kleinman 1983). Gustafson (2005) suggests that nurse-client relationships should allow for cultural difference and provide an acceptable, workable nursing care plan (Green-Hermandez 2006). Community nurses cannot endorse health behaviour which conflicts with the NMC Code of Professional Conduct (Nursing and Midwifery Council 2004), for example, Female Genital Mutilation. Other authors have also noted that group identity is often considered within the context of risk management rather than its value base (Schilder et al. 2001).

V5.7: A collective asylum view of the concept of health

The asylum focus group described previously in V3.3 (see section 3.7) considered the concept of health:

> *The first person had chosen a picture of a person holding an apple. She thought that the apple was nice, a good colour, clean and represented 'good health'. The open hands in the picture gave an impression of giving, which for her was an important part of health. The group considered that physical health could be promoted. For example, a group member had chosen a picture of a person receiving an immunisation, which she considered to be very important, especially for babies.*

When one participant was asked why she had chosen a picture of very western white woman in evening dress, she stated, "It is the happy face, the woman is laughing". As the discussion continued, another participant described this feeling of health and contentment as "mind happy".

Several members chose pictures that combined the themes of people and food. For example, a family group, a happy group of school children. These images represented a social view of health: the happiness of simply being together, talking and sharing a meal together.

One participant had chosen a beautiful image of the White House in Washington with a lovely blue sky in the background, suggesting health to be an ideal state. She commented: "I want to live in a safe environment with a bright blue sky and no pollution."

The group chose images that reflected physical health as the absence of disease, as a pure and perfect entity, undamaged by the world. Their health belief centred on good health as the original or natural state; the health of children should be prioritised and protected through preventive measures such as immunisation. The current Scottish Government policy is to prioritise children's health to reduce health inequalities in later life (The Scottish Government 2008a).

Secondly, the close association of health and happiness for the asylum applicant participants reflected how psychological issues impacted on mental health. This psychological need to be at ease with the body is seen, for example, by the increased demand for cosmetic surgery (Lawton 2004). The asylum informants considered that health was not just an individual concern, but was connected to the sharing of good fortune within the family and at community level. The group identified another factor as the safety of the home environment, which included freedom from pollution. This was perhaps a reminder of the difficult environmental and political situations from where people had escaped. The impact of the environment on the health of young people and adults is recognised in the policy document, *Good Places, Better Health* (The Scottish Government 2008c).

The construct of health for asylum applicants thus appeared to be culturally defined, linked to a mental, psychological and physical state of fulfilment and happiness and embedded within the family. For a person to be healthy all the major aspects of

health, mental, physical and social aspects of health needed to be in balance, which was an individual responsibility. Helman (2007: 127) also recognises that health is often seen as a balanced relationship between people, between people and the environment and between people and the spiritual world, as well as an internal balance between the physical and the emotional.

The asylum applicant group identified health as a given rather than acquired attribute. Their perceived lack of control over health, which they considered deteriorated over time, had implications for health promotion (see V5.13). Studies have shown how a sense of stoicism and fatalism may impact on pain management (Duggleby 2003) or result in non attendance for breast screening due to a greater priority being given to family commitments (Teran et al. 2007).

V5.8: Community nurse views of the concept of good health

Similar to the asylum applicant group (see V3.3), the first community nurse focus group was asked to choose two pictures from the set of 30 images pasted on thin card.

> The nurse informants chose pictures to represent good health that were similar to those of the asylum applicants. These images included happy, smiling and healthy looking women or children, in what might be called ' a picture of health' – people with bright eyes, nice teeth, clear skin, and attractive bodies who obviously looked after their health.
>
> The nurse informants said that they chose these images because they were the outward signs of good health and showed that people looked after themselves. Other images such as an apple reflected the need to eat healthily and the enjoyment of music represented a psychological aspect of health.

The nurse informants also chose health images that portrayed the human body as beautiful, but conversely they viewed health as under the control of the individual rather than as a balance. This notion of health control is seen in the success of dieting organisations, not only in promoting weight loss but also in improving body image (Weightwatchers 2008). The nurses' emphasis on health assessment also reflected the influence of the medical model; Helman (2007:123) considers that this model is highly reductionist in focusing on individuals rather than the family or the local community.

Secondly, the nurse informants considered health to be more of a commodity. The choosing of the right belief was important. They believed that people who received, accepted and implemented their health promotion messages could acquire health, whereas those who did not take on board these messages were at greater risk of ill health. The community nurses promoted corporate NHS health beliefs as a priority. It was their role to convince their clients of these beliefs. In assuming that individuals made choices to adopt a healthy lifestyle the nurses did not acknowledge family and cultural influences on health behaviour.

5.2.2 Accommodating a range of health beliefs

Although an understanding of a client's health beliefs is integral to providing culturally competent care, these beliefs may not fit neatly into one model (McAllister and Farquhar 1992). Some health issues are difficult to discuss prior to establishing a trusting relationship. For example there is little knowledge concerning the incidence of female genital mutilation, its effects on health or the implications for health professionals (Momoh 2004).

V5.9: Accommodating asylum health beliefs

I noted that cultural awareness involved an accommodation of a range of health beliefs within nursing care provision, as this vignette demonstrates:

> *Beatrice, a middle-aged Scottish practice nurse, registered as a nurse and a midwife stated: "Everyone has a different belief in health and sometimes I get caught unawares."*

> *On the first of many visits to the drop-in, I observed a consultation between June and Andean, a 22-year-old French speaking asylum applicant mother from the Congo. It was Andean's first clinic attendance and her spoken English was limited. June asked her if she wanted to have her one-month-old baby weighed, speaking in a louder, slower but pleasant voice when Andean did not understand. The act of bringing her into the smaller consulting room heralded the beginning of the consultation and Andean undressed her baby. June made Andean feel welcome by giving her a cheery smile and providing an attentive interest in her baby, which instantly pleased Andean. The baby had a dirty nappy. Andean cleansed the baby's skin, before putting her naked baby on the cold scales to check her weight, but was unable to wash her own hands.*

> *Observation was central to the medical health model used in the clinic situation. Francis charted the weight in the parent-held record or 'red book', a useful communication aid. The baby was placed back on the changing mat,*

allowing June to observe the baby for signs of normal growth and development. The baby was breastfed. She looked very healthy and was gaining weight satisfactorily. June noticed that there was a string around the baby's abdomen, tied with a knot underneath the belly and passing around the femoral creases to the loins at the back. Andean stated: "The string is there to help the baby's bottom develop." June checked that the string was not too tight. She reassured Andean that the string was fine. Andean was not anxious about the string, as it was a normal way of caring for babies and would be cut off once it was too tight.

Mohammed was a 30-year-old single asylum applicant from Iran, who was sometimes very depressed. He stated: "I need to be alone for three to four hours sometimes to get out of the depression. If I have a cough or a cold I visit the pharmacist for paracetamol or aspirin type medication. I like to sort myself out. I only see a doctor if a neighbour calls an ambulance, otherwise I do not visit my GP."

Health was central to work of the nurses but the clients did not share it. A nurse focus group informant remarked: "I have to push the health agenda." Another informant commented, "Diversity affects health", whilst another stated: "Asylum applicants have a poor concept of health."

In getting to know each other, Andean and June established Andean's baby as a common focus for their relationship. June acknowledged and reinforced Andean's new motherhood role through showing signs of pleasure when interacting with the child. Andean worked in partnership with June in attending the clinic to gain reassurance that her baby was healthy.

This nurse-client relationship evolved within the multi-cultural context. June maintained her power base through displaying impersonal professional trust in several ways. She observed and weighed the baby to check for normal growth and development, she ensured that Francis recoded her observations in the hand held record and finally she maintained eye contact with Andean during discussion about the baby.

June and Andean quickly moved their relationship through the orientation phase to identifying health needs (Peplau 1988). Although Andean had adapted to expected norms of parenting by attending the well baby as well as the immunisation clinic, she brought her own parenting culture to the consultation. She was breastfeeding well and had tied string around the baby's loins to aid

growth and development. June carried out a risk assessment to consider whether the string was safe. She did not denounce this unusual practice, but advised strongly to make sure that the string did not get too tight.

Although the consultation required interpreter mediation, this was unavailable. June used an authoritative approach throughout the consultation, to overcome the language difficulty; facilitative approaches require an advanced language register. Although in commenting on her own lack of French, June demonstrated reciprocity, Andean was not her client. Thus June could not organise an interpreter-mediated consultation to identify and resolve health needs. A limitation of geographically based services is that several health visitors may be involved in client care. This vignette highlights the importance of hand held records for transfer of information from one health professional to another.

Mohammed demonstrated an individual asylum health belief of self-care responsibility. This vignette shows that applicants frequently preferred to self medicate and did not usually make unnecessary demands on health services. The final part of the vignette however, demonstrates professional power. The community nurses did not always value or understand asylum applicant health beliefs and thought themselves in control of the health agenda.

5.2.3 The assessment of health needs

The assessment of individual and community health needs requires engagement and empowerment of those served to identify the factors influencing the quality of life (Smith et al. 2006). The degree of patient involvement in individualised care varies along a continuum of non-involvement to active involvement (Millard et al. 2006a). For example, district nursing care management assessments were found to be more formal than health visitor assessments, the latter involved acute observation and listening skills to enable clients to disclose sensitive health issues (Cowley et al. 2000). The lack of continuity of care can also create difficulties (O'Donnell et al. 2007).

Assessment tools to identify highly vulnerable families are known to be inadequate. The lack of health visitor engagement in their development (Appleton and Cowley 2004), the lack of research validity and reliance on professional judgement (Appleton 1994b, 1997), as well as the emphasis placed on questioning rather than listening (Cowley and Houston 2003) compound the difficulties of using epidemiologically based tools. Moreover, the use of these tools may result in a medicalisation of health visiting. Although appearing to promote public health, these in reality frequently do not identify needs relevant to the client (Mitcheson and Cowley 2003).

In focusing attention on a pre-determined set of questions, the health visitor sets the agenda, loses the opportunity to listen and heavily influences the potential outcomes. This formal style of health assessment thus potentially causes harm, but does not identify those with the greatest social health need. Houston and Cowley (2003) found that parental understanding of the HV role was more important than the process of identification of health needs. Although action to address health care needs requires the setting of goals, the monitoring and evaluation of care (Liss 2003), in focusing too closely on the epidemiological model of health, public health nurses may remain unaware of the social support needs of parents and families (Häggman-Laitila 2003).

V5.10: A routine men's health assessment

The men's health clinic was described previously in V4.10. The effectiveness of using structured health needs assessment tools for clients with English as a second language is limited. The information gained may not be significant whilst emotional needs may remain unidentified and unmet (Houston and Cowley 2003). Although individuals can be helped to change their health behaviour, they require information, individual support, improved access to services, as well as behavioural skills training to do so (Netherwood 2007).

> Nicolai was introduced in V5.2; his previous experience of health care was poor. When I asked him about the health services in Russia, Nicolai stated: "They are terrible. People require health insurance before they can even be treated." He gave an example of when his wife was pregnant with their first child. She had threatened to miscarry and was bleeding heavily. Nicolai said: "I had to pay both the doctor and the nurse to treat her." When the family moved to Israel they found that the emergency care was satisfactory but other

health services were poor in comparison to the NHS. Nicolai had originally sought asylum in London. The family had been dispersed to Glasgow one year previously and they attended the UKBA office each week. Overall, he thought that primary health care services in the UK were very good.

Abigail used a standardised health questionnaire as a structure for the consultation and asked about his recent medical history. Nicolai stated that his nose had been broken several times in the past and had had difficulty sleeping. His Glasgow GP had referred him to the Ear Nose and Throat department. He had waited seven months for the operation, which had been carried out two weeks previously. Post-operatively his nose was very swollen, but only a slight swelling was still apparent on the bridge of his nose. Nicolai said that his sleeping had improved as he could now breathe more easily.

Next, Abigail weighed Nicolai on electronic scales and measured his height. His body mass index (BMI) was on the upper limit of normal at 25, although he did not look overweight apart from a slight increase in his waistline. Abigail suggested that he should watch his weight. Nicolai stated that perhaps the weighing scales were not accurate as he weighed himself frequently at home. He was always the same weight, a few kilos less than on these scales. However, he had recently given up smoking, which might have caused him to gain a little weight. Nicolai's blood pressure was normal.

Abigail mentioned sexual health briefly and advised on how to seek help if he needed it. He was concerned about a potential susceptibility to prostrate cancer. The urine testing showed no abnormalities. He was reassured and given advice on which symptoms to watch out for. Abigail moved on to ask about diet and methods of cooking. Nicolai appeared to eat sensibly as his family ate plenty of vegetables and soups.

Nicolai was an intelligent man and at times he seemed patronised by Abigail's questions and advice, especially in regard to how much alcohol he drank each week. Although he liked to drink beer, he considered that it made him feel ill. Nicolai pointed to an area around his loins and kidney area, which he stated became painful if he drank too much beer. He preferred to drink whisky and drank about 200-250ml each week. Abigail asked him several times how many glasses this amounted to; Nicolai said it was equivalent to ten shots.

Abigail was dismayed at this amount of alcohol. She explained that the high toxicity of alcohol is known to damage the liver. In response, Nicolai stated: "I am an adult. I know about alcohol and what I am doing." He reported that in Russia he had drunk vodka, but he had concerns that this drink could induce madness and he preferred to drink whisky. Nicolai stated "Alcohol has a cleaning effect on my body and that is why I drank a large amount on a Friday night." He smoothed his hands down his abdomen and body and repeated: "Alcohol cleanses my body."

At the end of the health needs assessment, Abigail thanked Nicolai for coming to the clinic. She reassured him that his health check was satisfactory and left to make him an appointment with the massage therapist. When Abigail returned with an appointment, Nicolai stated that he hoped that some massage therapy would improve his backache.

This vignette demonstrates an emphasis on using diagnostic tests to measure health as the absence of disease. The use of medical technology may be seen as reducing clients to a set of virtual information, enabling a diagnosis to be made almost without their presence (Sandelowski 2002). The stereotyped lifestyle image of Glaswegian men was fundamental to the philosophy of this mainstream health promotion clinic, where diet and exercise were the usual problems identified. It was perhaps less appropriate to the cross-cultural care of asylum applicants, whose health and limited understanding of preventive health care were affected most by the stress of the asylum process.

Abigail asked most of the questions, which impacted on her ability to listen to Nicolai's concerns and build on his existing strengths and family support. Although the questioning of clients has been shown to be frequently concerned with the establishment of the resources for health, the internal capacity for health may not be fully explored (Cowley and Billings 1999). The checklist did not initiate self-management of stress or utilise his internal family health resources, but instead created a defensiveness of health behaviour. There was a greater reliance on external health resources. The massage therapy referral would provide a resource for stress management.

Nicolai and Abigail held very different health beliefs regarding alcohol. Abigail based her alcohol beliefs on the medical model of health. The excessive consumption of alcohol by Russian men, commonly known as Zapoi, reduces male life expectancy to 52 years compared to 72 years for women (BBC News 24 2007, Leon et al. 2007). Nicolai understood the dangers of alcohol, for example, when he stated that vodka could induce madness, he was referring to the production of illicit, home-made vodka produced across Russia (Rodgers 2006). His Friday night drinking was a socio-cultural norm, which reinforced his social identity. In discussing alcohol, the

nurse and client required a common cultural base to agree on what constituted 'normal' and 'abnormal' drinking patterns.

To understand Nicolai's drinking behaviour, the Theory of Planned Behaviour suggests that individual intention and perceived social pressure to conform combine to influence health behaviour (Ajzen and Fishbein 1977). An additional third element of this theory may involve perceived health behavioural control (Roden 2004). For example, Nicolai believed his drinking behaviour was a control mechanism for illness. He planned his drinking behaviour to promote wellness and saw no reason to change his drinking behaviour. A cross sectional study of Thai women also showed that in order to change culturally related health behaviour, such as breast self examination, people needed to believe that they were personally susceptible to a major health condition (Jirojwong and MacLennan 2003).

Similar to Isabel in V5.1, Abigail employed Lukes' (1974) second dimension of power to challenge Nicolai's alternative health belief concerning alcohol. Once Abigail realised that these health promotion attempts were negatively influencing her power base and the inter-personal relationship, she backed down, emphasising the importance of drinking sensibly. Nicolai stated that he was drinking sensibly. They agreed implicitly to disagree on this point, without either making any attitudinal change to alcohol consumption. Thus Abigail gave a higher priority to the interpersonal relationship than to the health message.

This confrontational health needs assessment had raised several health promotion issues, but had identified no physical conditions requiring treatment. Later, Nicolai established backache as a major priority, but he had not mentioned this problem until he was about to leave. The health assessment process had not enabled him to disclose this issue, only when he felt relaxed at the end of the consultation was he able to talk openly about it. Thus, not only its narrow epidemiological base limits the outcome of a formal, medically orientated health assessment, but also by the power ratio within the nurse-client relationship.

V5.11: Examples of mental health assessment

Asylum women are particularly at risk of postnatal depression due to a previous history of rape, violence and the stress of the asylum process. Health visitors often use the Edinburgh Postnatal Depression Scale (EPDS) to identify women at risk or those experiencing symptoms of postnatal depression (Holden 1989, 1991). However, the EPDS has not been developed for use across cultures and is thought to be unsatisfactory for use with non-English speaking women (Adams 2003).

Anxiety is often recognisable through observed cues, even though the client may be unaware (Peplau 1962). Cue acquisition and their interpretation are major elements in the clinical decision making process (Thompson and Dowding 2002:9-10). Intuition also plays an important part in this decision making process; the expert practitioner no longer needs to refer to principles of practice (Benner 1984) but learns from experience concerning what works and what does not work.

> *Kristina, a 27 years old Muslim single parent of one-year-old Kasin, stated: "I was raped, but my family in Somalia do not know that I have a baby son. The feeling of being safe in Glasgow is very important. When I was in Somalia, I always felt anxious and people I knew disappeared." It was too painful for her to talk about the rape. At this point she was a different person; she was very withdrawn and sad, on the verge of tears. Her shame was evident, so long after the event. The memory was obviously still vivid, but too distressing to verbalise, especially in a second language. The conversation moved to talking about her son. Kristina immediately brightened up; she was back in control and regained her normally vivacious and happy self.*

> *June stated: "I often find that the asylum mothers keep the problem to themselves, as their cultural beliefs are not to talk about how they were feeling."*

> *Cynthia remarked: "Observation plays a large part in being able to pick up on health issues. The lethargy and low spirit of postnatal depression, for example. I look for cues and pick up on things." She considered that this approach was easier to carry out if the mother could speak English.*

> *Jillian stated: "I find that that many clients suffer mental health problems, including postnatal depression, but often I cannot get to the bottom of it." She referred her clients to their GP, the Community Psychiatric Nurse, or if the problem was not serious to a local voluntary agency support group. Although Jillian said that she tried to see clients with postnatal depression on a regular basis, she also mentioned that she used the health care support workers to*

monitor a client's mental health on a weekly basis, even though they were
untrained in this area of work.

This vignette highlights that most asylum informants found the discussion of rape very distressing. The shame and the social consequences of rape disclosure were such that Kristina's parents did not know they were grandparents. Even if she had revealed her son's birth, she would have been excluded from the family, as single unmarried women are often not accepted within a Muslim society. There were difficult ethical issues in asking Kristina to talk more about her experience of rape. I had to guard against voyeurism. It was not in the informant's interests to recall events best left buried and forgotten and there was no immediate access to mental health support.

June, Cynthia and Jillian describe various approaches to identification of postnatal depression. Although using different methods, they all acknowledged that asylum women did not initiate their health issues immediately, but as Chalmers (1993) suggests, health issues were identified through the opening up of a problem within a trusting relationship. Whereas June assumed a laissez-faire approach and waited for a client to disclose a problem, Cynthia was more proactive and used her observation skills to identify women with postnatal depression, whilst providing targeted intensive home visiting to address potential vertical inequity. Jillian required additional training to address mental health issues in a multi-cultural situation.

The vignette also shows that the use of untrained HCSWs to provide emotional support was not an unusual occurrence. Although workload was cited as a major reason to delegate these visits, the lack of HV mental health training was perhaps another factor. Thus, the public health emphasis of health visitor training may be detrimental to health needs assessment skills (Appleton & Cowley 2008) and mental health care.

5.2.4 Child health surveillance

The complex relationship between health visitors and their clients may involve a double duty of health promotion and surveillance. The ambiguous health visiting role (Carney et al. 1996:67) involves a policing role as well as responsibility for child

protection issues (Crisp and Lister 2004). This ambiguity may be considered to be a strength. Health visitors respond, without imbuing stigma to their clients, to unpredictable or anomalous situations affecting health (Cowley 1995). Although client centered health visiting services have been shown to be highly relevant to contemporary mothers (Machin 1996), the paucity of health visiting evaluation studies is seen by others as a weakness (While 1997:124).

The pastoral power of health practitioners as described by Foucault (1973, 1979) may be resisted by women (Bloor and McIntosh 1990), resulting in a reluctance to disclose issues such as domestic violence (Peckover 2002). A qualitative study of child health surveillance practice in New Zealand, which used a Foucaultian approach to the analysis, also showed precarious power differentials between the community Plunkett nurse and the client (Wilson 2001a). Whilst not always operating as a true partnership, the nurses maintained relationships through 'gentle surveillance' and the clients through a lack of honesty. Wilson (2001) suggests that not only does the power of the nurse as an agent of social control not go unseen by the client, but that clients engage on their own terms. The high value placed on the nurse-client relationship is such that a reluctance to upset it sometimes results in a lack of honesty. Thus, social surveillance may be achieved through the development of non-judgemental and listening relationships with clients (Cowley et al. 2004). It is frequently carried out in an unsolicited and sometimes covert way (Robotham 2005a:85).

In this study, a major clinic objective was to carry out child health surveillance. Failure to thrive (FTT) is a condition, where the baby's weight falls from the midrange down to the 3rd or lower centile in babies, when using Tanner Whitehouse standards of height and weight velocity, which are designed primarily for use with British children (Tanner et al. 1996). There may be many reasons for this drift in the child's weight. It may be related to parent, parenting, child and social factors (Taylor 2004). Parent factors include relationship difficulties between care giver and child (Benoit et al. 1989), poverty or a lack of family support for parenting (Drotar 1991), parenting styles as well as the maternal educational attainment (Edwards et al. 1994).

Children born to teenage mothers have been shown to be at greater risk of maltreatment than children born to older mothers (Stier et al. 1993). Moreover, infant temperament can be a factor in managing eating difficulties (Skuse et al. 1994) and social factors are highlighted as contributing to the physical or emotional neglect of children (Benoit et al. 1989).

A UK study demonstrated the effectiveness of specialist HV interventions for children with FTT, in prevention of referrals to other agencies (Raynor et al. 1999). Raynor et al (1999) considered that weight gain alone was not the most important factor; the child's eating difficulty, psychomotor development and the maternal mental health status were as important.

V5.12: The challenge of child health surveillance

This vignette describes the challenge of child health surveillance and some of the issues highlighted in the FTT literature.

Ina, an18 years old French speaking single parent from the Cameroon, brought her one year old daughter Serina to the drop-in baby clinic to be weighed. Serina had been born seven weeks prematurely. She had maintained her weight along the 50th centile until about 3 months ago, but the weight had now drifted down to the 3rd centile. June advised Ina to boost the calorie intake through addition of fat to the baby's normal diet. Ina was quite tall, but very slim and elegant. She accepted the advice of the health visitor, although it might not fit in with the economic or cultural constraints on her lifestyle. Later, June stated: "Ina arrived pregnant in the UK as an unaccompanied minor." She thought that the baby had been conceived as a result of rape, but Ina had yet to disclose this information.

I met Ina and Serina again three months later at the drop in clinic. While Ina was waiting to consult June, I played with Serina, who sat on my knee. She snuggled against me, putting her arm around my neck, obviously enjoying the close physical contact. When I placed Serina on the floor to open the clinic door, Serina cried real tears, not just a temper tantrum, but almost as if she felt rejected. During this second consultation, Serina's weight was found to have improved relative to the centile chart. Although tall she remained extremely slim. FTT was no longer a medical problem, but the underlying issues were not necessarily resolved.

June stated; "I think that Ina is depressed and I'm unsure whether she has bonded with her baby. I will keep in regular contact with her."

Serina was at risk of FTT. Her teenage mother lacked local family support to help with parenting issues and potentially there was a maternal-child relationship problem as Serina may have been born as a result of rape. The Tanner Whitehouse centile charts used for weight surveillance were not developed for African children. Although Serina may have been losing weight relative to other UK children of the same age, it was difficult to know if her weight was normal for Cameroonian children, but she did look extremely thin and undernourished. Dutch studies have shown that iron deficiency is common in African asylum children under six years of age, warranting routine screening (Stellinga-Boelen et al. 2007a). Moreover, dietary intake of vitamin D is frequently 80% below their recommended daily intake, requiring supplementation (Stellinga-Boelen et al. 2007c). These African children are taller for their age than indigenous children at all ages (Stellinga-Boelen et al. 2007b) suggesting that the use of European based weight surveillance charts should be used with caution, although continued health surveillance is important.

Albeit the weight issue was important, the maternal-child relationship was more important. 'Gentle surveillance' (Wilson 2001a) was required to identify child protection issues, as psychological trauma may inhibit emotional bonding with a child (Peel, 2004). In monitoring Serina's weight, June carried out a double duty of health promotion and surveillance. This health promotion activity is anticipatory in nature (Scottish Executive 2006c) requiring professional judgement to know when further action is required (Appleton and Cowley 2008, Carney et al. 1996). June had the professional power to monitor maternal-child relationships and potential long-term child protection issues, but did not use it explicitly, preferring instead a philosophy of wait and see.

5.3 Use and exploitation of primary health care resources

Peplau (1988: 37) identifies exploitation as the third phase in nurse client relationships, but a more acceptable term is the use of health resources, as the client explores NHS services to aid recovery. Although priority should be given to actively involving clients in decisions regarding their care (Millard et al. 2006b), asylum

applicants require understandable information on NHS services and primary care (Johnson 2006:67). A major issue of using an empowerment approach with asylum applicant clients is that it assumes an understanding of the social context and ability to use the available options. Facilitating empowerment may itself be a more subtle method of control, whereby the client thinks that they are making a choice, but in reality are complying with the expectations, norms and values voiced by the health visitor. Thus, there are limits as to how far community nurses can empower their asylum clients. The asylum use of primary health care resources involved:

- Previous experience of primary health care
- The negotiation of patient centred care
- Addressing special needs

5.3.1 Previous asylum experience of primary health care

The previous experience of health care impacted on asylum applicant capability to effectively use PHC services.

V5.13: Asylum understanding of primary care services

The following vignette demonstrates three different experiences of health care. Nigeria has been shown to have a poor level of health care provision (Hargreaves 2002), the Bajuni Islanders relied upon traditional medicine, whereas a private health care system operated in Palestine.

Nora, a 25-year-old English speaking asylum woman from Nigeria was 29 weeks pregnant. She was suffering diabetes during her pregnancy. She attended the practice nurse consultation with her two-year-old daughter. Nora was highly anxious and almost tearful. On top of coping alone with her asylum claim, she had additional concerns about her pregnancy, as the twins from her first pregnancy had died shortly after birth. Nora was feeling unwell. She described symptoms of frequency of passing urine, a raised self monitored blood glucose level and extreme tiredness. Initially, Beatrice instructed Nora in the aetiology of diabetes in pregnancy, to which Nora simply said: "OK".

Beatrice was concerned that Nora might have a urine infection, but all the other checks were normal. The diagnosis was reassuring for Nora, who at this point visibly relaxed. Beatrice was able to diffuse the anxiety further by making a joke. She repeated: "You do the measurements (i.e. continue with the blood glucose testing) and we will do the worrying," and Nora laughed.

When Beatrice moved on to health issues of diet and backache, her words were straightforward and implied obedience, giving instructions: "Do not sit slumped, all right?" Beatrice left the consulting room to discuss the case with one of the GPs and returned with a prescription for antibiotics to treat the urine infection. She informed Nora on how to use the medication.

During the post consultation interview Beatrice considered that an asylum client's cultural context was important to appreciating their previous experience and expectations of health care. For example, Beatrice stated; "There is often a need to explain the concept of antenatal care to asylum applicant clients as they frequently do not see the need for it. Many asylum applicants think that it is just hard luck if things go wrong." Although Nora had no previous expectations of antenatal care prior to her diagnosis of diabetes in pregnancy, Beatrice considered that the system had raised Nora's anxiety levels such that she had now seen four professionals from the surgery in one week for a single problem.

Farah also had little previous understanding of primary care services. She was 30 years old and married to 35 years old Iqbal. They had arrived together from Somalia two and a half years ago and now had refugee status. Iqbal was employed and their first child Karim was now 5 months old. She had previously lived in the Bajuni islands, an archipelago situated off the southern coast of Somalia. She stated "My Bajuni tribe use traditional medicine and collect leaves from the trees on the islands to produce our own special medicine. There are no doctors on the islands. I had never seen a doctor before coming to the UK. The women give birth to their babies at home, where birth attendants deliver the babies." Although able to use routine health care services due to good English language skills, Farah stated that she was confused by the conflicting information provided by the hospital and her GP concerning her child's health care.

Shamina, a married 42 year old mother of three children aged 16, 13 and 2 years, stated: "In Palestine you have to pay for the doctor. It is expensive, but you can see the doctor anytime. It is better".

Although the nurse focus group informants stated that they reinforced the message of working with the doctors, they considered that their asylum applicant clients remained unaware of the staff nurse and health care assistant roles.

One nurse informant stated: "Asylum applicants latch on to the HV role as they are fanatical about immunisation and weighing their babies. For example, asylum applicants always bring their child's handheld record to a consultation."

The culture of UK primary care relies upon routine technical assessments to judge antenatal health. Beatrice's formal prescriptive approach to individualised care was

orientated towards the medical model of health, to quickly ascertain Nora's health status and provide treatment. Nora's anxiety was due to her past obstetric history. Although Nora was empowered to manage her diabetes through dietary control and self-monitoring of blood glucose levels, it was unclear as to how much technical information she understood. Beatrice used medial jargon rather than everyday words. Nora's simple response of "OK" suggests that she was overloaded by this large amount of information, even though she spoke English fluently.

In the post consultation interview, Nora stated that she did not feel patronised by this authoritative approach. She had no complaints about the primary care services and found all the staff kind and helpful. Nora had accepted the medical model of antenatal health monitoring. In exchange for compliance with diabetic management regimes, Nora perhaps expected a prompt medical treatment of her symptoms. When Beatrice stated '*you do the measurements (i.e. continue with the blood glucose testing) and we do the worrying*', there was an underlying reciprocal relationship.

Beatrice perceived a sense of fatalism of asylum applicants in regard to antenatal care. This finding is similar to those of a Hong Kong study on uptake of cervical screening (Holroyd et al. 2004), where the participant's culturally based notions of modesty were thought by the researchers to override the need to seek preventive health and nursing care.

This vignette demonstrates that the community nurses perceived the difficulty experienced by their asylum clients in understanding the concept of preventive care and recognised that they found the medical model more acceptable. Farah's previous exclusion from western style health care impacted on her understanding of primary health care. In assuming acute hospitals had a greater authority, she was less confident in primary care services. Shamina also considered that private medicine was superior to the NHS. The community nurses were perhaps unrealistic in expecting their clients to understand the varying roles of the nurse team, but their clients used them to access the medically orientated services they thought that they required. As Peplau (1997) suggests, the client–nurse relationships observed in this

study had progressed to a position where the clients could articulate the services they required.

V5.14: Raised NHS expectations

Many asylum informants in this study had previously received poor quality primary care services and held high expectations of the NHS.

> *Beatrice stated: "For many asylum applicants this is their first experience of quality, primary health care. Some try to take advantage of the NHS, to obtain a full medical screening of X rays, ECG and other tests at no charge. Preventive primary care systems can raise anxieties as well as expectations of asylum applicants."*

> *Jayani stated that her health visitor had been worried about the medical condition of her baby during a home visit, and had tried to get a GP appointment at the medical centre. However, her health visitor was unable to get an appointment. Eventually the baby was seen by the practice nurse and prescribed some antibiotics. The process had taken a long time, too long as far as Jayani was concerned and she stated: "You have to be very ill to get antibiotics."*

> *Dominique, a 38-year-old widow from the Ivory Coast with three children, reported that she asked her cousin, who was a doctor in London, for advice rather than visit her GP. She complained that her GP did not examine her baby properly.*

Beatrice thought that her clients tried to take advantage of the NHS. The lack of understanding of primary health care resulted in asylum applicants seeking access to a familiar style of health care, with prompt access to secondary services. Discrepancy between the expectations of refugees and nurses has been shown in other studies (De Montigny Korb 1996).

This vignette again demonstrates that asylum applicants were not confident in the PHC system. Jayani's cultural expectations of primary care were not met. She preferred to see a GP rather than a nurse for medical conditions and assumed that another health care professional could work the system for her benefit. GPs may not have the time or consider it necessary to fully examine every baby at every visit, as she expected. Jayani used alternative resources when possible. The advice of a cousin in this instance built on the notion of health as a family concern. This lack of

GP confidence is similar in many respects to the findings of a study of Afghan refugees living in the Netherlands during 2000-2003 to find out their experience of healthcare (Feldmann et al. 2007). The informants continued their normal use of herbal remedies prior to seeing the GP. Personal autonomy concerning health was extremely important.

Secondly, Jayani expected her child to receive antibiotics for minor as well as major ailments and viewed the treatment delay as detrimental to her child's health. Whilst antibiotics are commonly available as over the counter medicines in many countries, the over use of antibiotics in the UK is recognised as potentially harmful (Armelagos et al. 2005). Thus there was a tension between the asylum applicant's expectations of primary health care services and the policy/capacity of the service to deliver.

5.3.2 The negotiation of person centred care.

Person centred care is defined as 'a comprehensive approach to disease management' (The Scottish Government 2007a: 42). It assumes that nurses understand the unique care needs of clients (Luker et al. 2000) and relies upon interpersonal partnerships, which are known to take time to develop (Hook 2006). Nurses require background information to interpret and address individual or community health needs (Radwin and Alster 2002) and to understand how nursing actions are perceived and interpreted (Allen 2002). The differing context for these interpersonal relationships has been shown to comprise territoriality, shared perceptions, amicable working relationships, role synchronisation, knowledge and taboo topics (Spiers 2002).

Person centred care is a SNHS policy priority, but a tension remains between public health practice and individualised care. Although people experiencing illness may expect nurses to help them to live normal lives (Escudero-Carretero et al. 2007), ascertaining what matters most in care provision requires an 'elective affinity to the patient' rather than a technical skill (Kleinman and Benson 2006). Whilst public health is promoted at individual and community level, it is frequently misunderstood and applied differently in practice (Gillespie et al. 2004). Health visitors have been criticised for placing a higher value on home visiting and client relationships to promote individualised care (Smith 2004d). I would argue that home visiting does

influence community health, albeit invisibly as informal networks spread health messages delivered in the home in a ripple effect.

Although person centred care is integral to nursing culture, as seen in the nursing process and individualised nursing care plans for patients (Redfern 1996, Reed 1992), conflicts may arise between the individual's personal agenda and the nursing agenda (Rhodes et al. 2006). Although the fulfilment of clients' personal goals is thought to be an important element of health visiting (Chalmers 1992), high levels of workload, the lack of time and training are also considered to be barriers to the delivery of person centred care, especially in hospital situations (West et al. 2005).

V5.15: The provision of person centred care:

The provision of person centred care entails a process of clinical decision making based on a holistic assessment of physical, psychological, social and pastoral needs. When provided across ethnic groups, it must also be underpinned by educational programmes to promote cultural competence (Gerrish and Papadopoulos 1999). Within community nursing person centred care encompasses several areas of dignity, respecting individuality, holistic care, focusing on nursing needs, promoting independence, partnership and negotiation of care, and finally equity and fairness (Gerrish 2000). The concept of dignity is highly valued by both nurses and clients, but remains insufficiently understood (Whitehead and Wheeler 2008). A Swedish phenomenographic study of how women conceive the notion of integrity found that this concept incorporated the need to preserve individual identity, respect for a person as an individual and involved the development of mutual trust with health professionals (Widäng et al. 2008). Gerrish (2000) found that culturally based conflicts existed between some of these ideals. She considered that in South Asian communities, illness is signified by dependence on other members of the family, making the notions of respecting individuality and promoting independence incompatible in the provision of nursing care. The core value of promoting independence could be implemented through developing a triadic relationship with the family as a vehicle for health promotion, but nurses generally have yet to make this cultural shift.

A nursing literature review demonstrated that the culturally competent care of women and children could significantly improve their health status (Callister 2005). Although cultural awareness includes the major elements of individualised care, it also recognises the need to challenge some areas of cultural practice and behaviour, in terms of negotiation of care. Gustafson (2005) criticises this negotiation approach, as she suggests that clients from another culture have neither the knowledge to override the assumed superiority of western medicine nor the power to make a genuine choice concerning health care.

> *Cynthia stated: "Cultural competence is related to how you work in practice. It is respect, taking account of culture and adapting practice to the client's cultural belief, rather than reinforcing your own beliefs. I try to meet my clients in the middle. I get the feel of things and ask clients how they would normally resolve this at home."*

> *For Ailsa, cultural competence was a set of values, standards and practices. Nurses and clients holistically respected each other's values and beliefs. There was a transfer of one's own belief in equal respect to another's values and beliefs. She clarified this definition of holistic care in stating: "Basically, cultural competence is to treat people as we ourselves would like to be treated an intrinsic part of holistic care."*

Cynthia's definition of cultural competence assumed the position that community nurses did not promote their own beliefs, but gained a shared understanding of a client's cultural ways to tailor nursing care. Cynthia's definition, in stating that she tried to see things from the client's point of view was similar to the 'elective affinity' proposed by Kleinman and Benson (2006). In actively taking her own beliefs out of the equation, Cynthia had firstly to be aware of her own health beliefs, as Papadopoulos (2006:10) suggests, in targeting those with the greatest need. This approach relies upon giving clients their own voice and is explored further in chapter six. Although client centred care is integral to SNHS policy, there is a tension with equity. Articulate clients may receive more than equitable access to services, requiring nurses to advocate on behalf of vulnerable clients.

Cynthia in adapting her practice to enable clients to cope with everyday life adopted a counselling role using motivational interviewing techniques. Peplau (1988:17-42) suggests that nurses employ various adult roles in the relationships with their clients.

These roles include a resource person, a teacher, a counsellor, a parent or sibling surrogate as well as a technical expert in the provision of nursing care. Motivational interviewing is based on cognitive behavioural therapy approaches. It has been shown to foster self control and pain management (Turk et al. 2008). Useful in the care of women with post natal depression (Chew-Graham et al. 2008), it is also effective in promoting a healthy diet, whilst taking individual preferences into account (Resnicow et al. 2008). Negotiation in this study was therefore an important aspect of cultural awareness. Cultural practices were not accepted per se, but were discussed with clients in light of current knowledge of health promotion.

Ailsa also considered that people should be treated with dignity and respect, but recognised the two way processes involved in cultural awareness. What one person regarded as respectful behaviour may not be so interpreted by another. Cultural awareness, as a component of cultural competence, thus required a partnership between nurses and clients with equal regard for each other's values.

5.3.3 Addressing special needs

There is no official source of data on the prevalence of impairment and chronic illness among asylum seekers and refugees in the UK. A qualitative study of the experiences of disabled asylum applicants and refugees identified a high level of unmet needs, including a lack of suitable housing, health personal care and disabled equipment (Roberts and Harris 2002).

V5.16: A family with special needs

The following vignette describes the difficulties faced by asylum applicant carers. Microcephaly is an inherited condition where the skull is very small and the bones fuse together at an early age restricting the growth of the brain and subsequent child development (Heaton-Ward 1967).

> *Kamil (introduced in V5.4) stated: "Time is running out. I want the real diagnosis for my son. He needs education to catch up on his development."*

> *The delay in Hasan's development was severe. He had been diagnosed in Pakistan as suffering from microcephaly. At one year of age Hasan had undergone an operation to increase the size of his cranium, but without success. He was two and a half years old before he could walk. Currently,*

Hasan understood very little. He was unable to talk, to eat solid food, to use the toilet or sleep alone at night. Hasan was tall and slim for his age; Sabat was still able to carry him into the sitting room.

Kamil stated: "Everything takes so long, not just appointments with health but with the education authority as well."

Following the assessment by the educational psychologist, Hasan had been given a place at a special school. The bedtime routine needed to change significantly as he had to be ready for the school taxi at 8.15 a.m. each morning. Although Cynthia had been working with the family to encourage Hasan to go to bed earlier and to sleep alone, he had recently reverted to going to sleep at midnight.

Although Sabat and Kamil were unhappy that Hasan had been given a place at a special school, they agreed that it was more appropriate to his needs. Cynthia skilfully moved the conversation to the issues of bedtime and said: "You need to provide Hasan with a firmer bedtime routine. It will give him confidence, and enable him to adapt more easily to going to school."

Kamil and Sabat had come to the UK with high expectations of receiving NHS medical treatment and were frustrated by the delay in service provision. They had hoped that following an educational psychologist appointment Hasan would be able to attend a local mainstream nursery. In reassuring and supporting them to make changes to their pattern of daily living, Cynthia was using a facilitative approach to review of the current situation, examine past experiences and plan future possibilities for living (Heron, 2001:120). In helping her clients, Cynthia implemented an exchange process. If the parents could change the sleeping pattern of their child with special needs, the child would be able to go to school.

The visit enabled the parents to voice their concerns. Sabat and Kamil agreed on the need for Hasan to go to bed earlier, but were daunted by the psychological effort required to enforce this change in behaviour. In addition to the processes identified by Byrd (1998) Cynthia negotiated the cultural norms expected of parents, in that Hasan must be ready for school at the designated time.

5.4 Multi-disciplinary working

Community nurses need to work collaboratively with other disciplines to provide culturally competent services (Green-Hermandez et al. 2004). The previous vignette highlighted that asylum informants in this study required vertical equitable access to a range of services to cope with the demands of caring for a child with special needs. An exploratory study identified three major barriers to effective multi-disciplinary team for nurses working in an acute setting. These included the differing perceptions of team work, the different levels of skill acquisitions to function as a team member and the dominance of medical power influenced team interactions (Atwall and Caldwell 2006).

V5.17: Examples of multi-disciplinary working

The following vignette demonstrates the wide range of issues dealt with by the asylum teams, who functioned as generic specialists.

The generic community nurses had a wide range of skills, but were aware of their own limitations. A specialist health visiting team was able to provide a programme of intensive home visiting, but there was a waiting list for this service. In providing holistic care, community nurses advocated on behalf of their clients. They made referrals to other agencies to address asylum issues, education issues, housing, social care and specialist health service needs. Clients requiring referral to specialist hospital consultants, such as male circumcision, were referred to their GP. The health visitor liaised with the GP on these issues. Blood conditions, for example, Sickle Cell Anaemia and Thallasaemia, were frequently detected during pregnancy or at birth enabling clients to be referred directly to the appropriate clinic. Health visitors were able to refer their clients, who were victims of rape, directly to a specialist psychological service for women. A similar service for men was in the process of development, but was not operational during this study.

The community nurses contacted the local asylum housing facilitator directly to report housing issues. Frequently, dampness was an issue due to the flats' poor condition. Children suffered coughs and colds and asthma was exacerbated by the damp conditions. In extreme cases families were moved, but the process could take some time. The community nurses thought that Angel housing provided higher quality housing than the local authority.

Child protection issues required the involvement of social services. There were similar difficulties of social work case allocation for asylum families as to the indigenous population. I was unaware of a specialist social work team working specifically with asylum applicants. During my fieldwork, although joint

working did sometimes occur, I did not observe a joint consultation of health and social workers with a client.

Clients were signposted to various voluntary organisations. The Scottish Refugee Council (SRC) helped to address asylum or housing allocation issues. If a client required an asylum medical examination and report for legal purposes, the Medical Foundation for the Victims of Torture was contacted. The voluntary sector provided English for Speakers of Other Languages (ESOL) classes. Due to the lack of nursery provision, mother and toddler groups were a useful voluntary sector resource, which facilitated social integration.

In response to the issues of home safety, where accidents are known to be still one of the commonest causes of hospital admission for UK children under five yeas old (While 1997: 127), joint working between the health visitor team and the Fire Brigade had been developed (HM Inspectorate of Education (HMIE) 2007:5). The Fire Brigade carried out a visit to the asylum parents once their child was mobile, usually about 8 months old, to highlight home safety issues and to reinforce expected norms of parenting.

There was regular contact between the different statutory and voluntary agencies working with the asylum applicants, especially where services came together to facilitate a single access point for asylum applicants. Although community nurses were in constant communication with other agencies, where there was a large geographical separation, there was an impact on joint working. The high workload combined with the additional time consuming nature of asylum visits impacted on opportunities for joint working. A client's needs were assessed and referred on to the appropriate agency, resulting in a complexity of care provision for some clients. Ensuring that services provided by other agencies were culturally competent was problematic. Once the community nursing referral was made there was little influence over the case management.

The community nurses used specialised core competencies in working with asylum applicants, but also referred their clients to a wide range of other disciplines and agencies to address vertical equity health issues.

5.5 Summary

In this chapter Peplau's Theory of Interpersonal Relationships (Peplau 1997) has provided a useful framework for an improved understanding of cross-cultural nurse-client relationships, albeit the data collection was limited to asylum applicants. Cultural awareness was integral to developing nurse-client relationships (Peplau 1988) and is thus a major component of cultural competence, as identified in the Updated Five Steps Model in section 3.2.1. Moreover, cross-cultural health

promotion was important to counter the negative impact of asylum policy on asylum health.

Power was a major theme of institutional regard and likewise it impacts on how cultural awareness is applied in practice. The community nurses maintained their power base and functioned as intermediaries or 'NHS culture brokers' (see 5.1.4). They relied upon the giving and receiving of information (V5.1 and V5.2) using authoritative approaches to gain routine information for health assessment purposes and form interpersonal relationships. They used facilitative approaches to facilitate the disclosure of more sensitive information, once mutual trust had been established. The community nursing power base varied according to the stage of their nurse-client relationships. During the orientation phase community nurses initiated client relationships and held the balance of power in setting the health agenda. The importance of understanding the asylum journey of exposure to violence, rape and torture was demonstrated in V5.3. Mutual respect, establishing and testing trust were also shown to be essential elements of nurse-client relationships for partnership working in V5.4, V5.5 and V5.6. Thus, the community nurses' use of facilitative approaches was limited by the phase of the nurse-client relationship and the need for reinforcement of health promotion messages.

In the health needs assessment phase, the nurses maintained control but worked towards empowering their clients to fully disclose their health concerns. Understanding a client's concept of health was fundamental to health needs assessment. V5.7, V5.8 and V5.9 described the differing health beliefs of the asylum applicant and the nurse informants, which had implications for nursing practice. It was important for the community nurses to appreciate that their clients were coming from different value bases to accommodate a range of health beliefs, to understand a wide range of health behaviours and to deliver appropriate health promotion messages.

The difficulty of carrying out health needs assessment was examined in V5.10, V5.11 and V5.12. The assessment of men's health needs using a structured tool

demonstrated that client health issues were not always fully identified by this mechanism. Interpersonal relationships, cemented through regular home visiting and continuity of care, were shown to be more important than the delivery of the health promotion messages. Moreover, they were significant to the disclosure of client health issues.

By the use of resources nurse-client relationship phase, asylum applicants were empowered to negotiate individualised nursing care through partnership working with their community nurse (V5.15 and V5.16). Asylum applicants frequently had previously experienced a lack of access to health care, but were able to access and use primary care services (V5.13 and V5.14). The health priorities for asylum applicants were not the same as the community nurses. Unrealistic expectations and a lack of asylum applicant confidence in PHC services resulted in a preference for secondary care.

The community nurses used their professional power to risk assess health behaviour. Although continued health surveillance was important, they only intervened when health behaviour was considered to be unsafe. The challenges of child health surveillance included the identification of asylum women's difficulties of bonding with children born as a result of rape. The community nurses referred their clients to a range of voluntary and statutory sector organisations (V5.17). Whilst the larger team would have benefited from additional mental health training or a mental health nurse team member, the smaller team was supported by the GP with a counselling responsibility.

In summary, cultural awareness was an essential element of cultural competence for both asylum applicants and community nurses. Asylum applicant lack of confidence in primary health care resulted in greater difficulty of access to services. The nurses operated at many different levels, often within the same intervention, to give and receive information to clients. Moreover, ineffective nurse-client relationships potentially disadvantaged asylum clients in providing a barrier to this flow of

information. The two way nature of interpersonal relationships is further explored in the next chapter, which considers cultural sensitivity.

Chapter 6. Cultural sensitivity

Cultural sensitivity is another major component of cultural competence (see section 3.2), which encompasses how community nurses communicate and interact with their clients. This third data chapter considers the following research question:

- *To what extent do community nurses see cultural sensitivity as an important aspect of their work with asylum applicants?*

6.1 Communicating effectively across cultures

Intercultural communication relates to the transmission of a message produced in one culture that must be processed in another (Porter and Samovar 1994) and is fraught with opportunities for errors to occur. The message should be delivered in accordance with the social context of the health intervention, using an appropriate language register (Hartley 1999). Moreover the lack of an equivalent word, idiom, grammar and syntax may make a literal translation meaningless (Romaine 1994:25). Acknowledging respect for each other's culture (Horn 2002:265) is an integral part and expected outcome of all stages of the communication process (Bremer et al. 1996:16), but the message may be lost due to a lack of understanding of each other's cues (Bremer et al. 1996:9). For example, doctors have been shown to lack flexibility to take account of specific cultural needs in talking to patients (Elwyn and Gwyn 1998:165).

Communication may be technical, formal or informal, but it is always a two way process involving verbal and nonverbal methods of delivery. It starts with the referent or message (Hein 1980:6) and operates within a cultural framework of core values and practice. There is no single definitive style of communication (Leininger 2002a:126), but it has been likened to a dance with mirroring and co-ordination of actions (Hall 1977:71, Hatton 1993). The partners may maintain eye contact, be in tune with each other and able to listen to each others point of view (Heller and Hindle 1998).

Verbal communication relies on the use of language, as a complex set of codes, without language an holistic nursing assessment cannot be conducted (Giger and Davidhizar 1995:23). Communication occurs at simple, advanced and complex levels (Ellis 2003:12). At the most simple level, messages involve only direct statements. At advanced levels secondary meanings are consciously encoded in the message and at complex levels difficult emotional experiences are managed by subconsciously encoding the message.

Rules of address signal the beginning and end of the conversation. An individual may modify their style of speech to indicate boundaries of status, ethnic group, group membership or enforce role or social behaviour (Shepherd 2001:34), using a language register to denote the social context (Montgomery 1986:107). Technical communication makes the communication process not only more economical and efficient for those who understand it (Hartley 1999:127), but it also denotes power and authority. For example, the individual GP's understanding of their professional role, rather than their gender, was shown to be a major factor in the use of cooperative language with patients (Skelton and Hobbs 1999). A regional dialect[7] indicates an individual's identity and social status (Montgomery 1986:81). The use of local dialect is thought to influence a UK doctor's medical diagnosis and teachers' assessment of their pupils' ability (Hartley 1999:133).

In Figure 5, I have brought together the factors involved in the cultural communication framework (highlighted in blue), which include verbal language skills, health beliefs, non-verbal and written communication.

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[7] A language may become the standard to politically unify a geographical area as well as facilitate literacy and cultural identity; a dialect is a subordinate variety of a language but this ascribed status is essentially socially rather than linguistically constructed (Romaine, S. (1994) *Language in society. An introduction to sociolinguistics.,* Oxford University Press, Oxford.
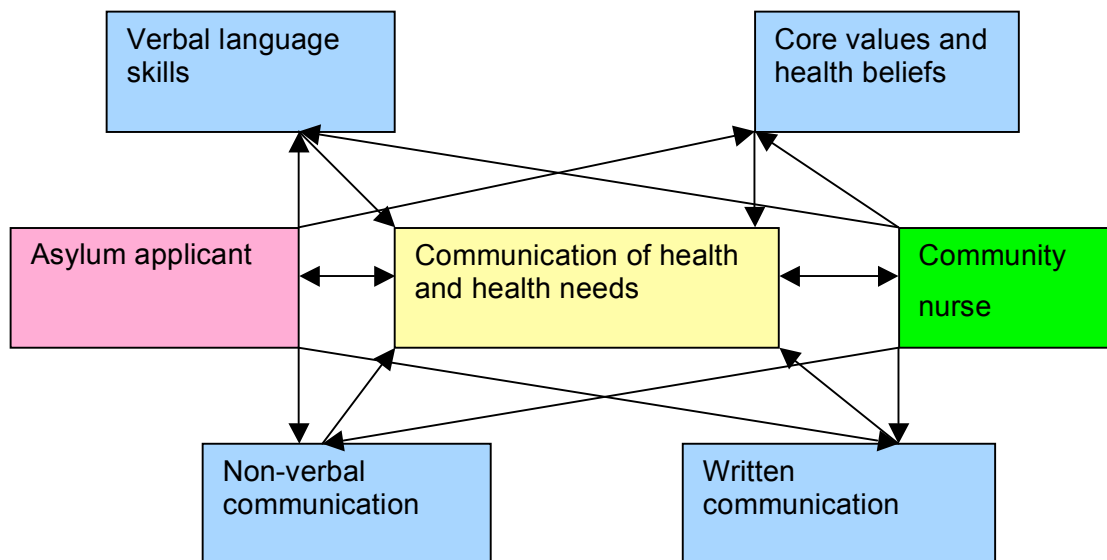
Figure 5: The multi-cultural nature of asylum health interventions

V6.1: The need for good communication

Effective cross cultural communication is essential to quality nursing care (Chong 2002). It enables human beings to relate to each other (Giger and Davidhizar 1995:20), to sustain emotional growth and facilitate internal communication to maintain sanity (Ellis 2003:4). A common language is thought to be essential for asylum applicants to disclose a past experience of violence and consequent medical or psychological symptoms (Bischoff et al. 2003a), to access health services (Woloshin et al. 1997) and to understand their treatment (Gerrish et al. 1996 :37). Woloshin et al (1997) found that women with English as a second language had reduced access to preventive services.

Communication barriers can be very frustrating for practitioners, resulting in difficulties of establishing interpersonal relationships to carry out the nursing role, with subsequently blaming of the client (Muecke 1983, O'Hagan 2001:159). Likewise a UK qualitative study, found that the nurses' ethnocentrism impacted on their ability to provide holistic care and resulted in a feeling of helplessness (Murphy and Macleod-Clark 1993).

An accurate assessment of health requires linguistic as well as the core clinical skills (Bradby 2001). Thus appropriate language concordance is essential for the safe delivery of quality health care (Bischoff et al. 2003b, Jacobs and Shorey 2001, Mesa 2000), the informed consent of a client (Carr 1995 :77) and compliance with treatment (Rivadeneyra et al. 2000).

> *One nurse focus group informant stated: "Communication is one of our biggest challenges; to make sure clients are properly informed, to use an interpreter to get the message across and dealing with unexpected. Visits take so much longer."*

> *Prior to a visit to Lisa, a 33-year-old Congolese asylum applicant woman, the French interpreter met us in the busy reception area of the apartment block. When Jane asked for confirmation of Lisa's address, as the referral information contained two different flat numbers, the receptionist gave her the correct address, but stated that Lisa was at the local children's hospital, visiting her sick premature baby. Although June had sent Lisa a letter to inform her of the planned visit with the interpreter, Lisa was not at home. June asked the interpreter to write a letter in French to Lisa, explaining that another visit would be arranged. Just as we were about to leave, Lisa arrived and it was possible to carry out the home visit after all.*

> *During the consultation, it emerged that Lisa was highly concerned about her asylum claim. Although UKBA was responsible for her accommodation, Home Office papers might be sent to the wrong address. In addition, she required a Glasgow based lawyer as soon as possible to progress her asylum claim. June offered to help her by obtaining her an appointment at the local Women's Centre where they kept a list of approved lawyers.*

This vignette demonstrates the multiple layers of the communication process for community nurses and clients. When Lisa was not available for the consultation, June was feeling very frustrated, but they both had differing cultural knowledge. Lisa might not understand the reason for the home visit, especially as her baby was still in hospital and she had no previous experience of UK preventive health care services. Secondly, English was a language barrier to service provision. June had assumed that Lisa would find someone to translate the letter. Lisa was concerned about her asylum claim and this issue provided a stepping-stone to developing a relationship.

6.2 Communicating through an interpreter

The use of interpreters by community nurses was not straightforward. It involved an understanding of community interpreter services, the multiple roles of the interpreter, knowing when to arrange an interpreter mediated consultation (IMC) and how best to carry one out. The introduction of an interpreter as a third party to a health consultation may result in dynamic changes to interpersonal relationships, thus making additional demands on the nurse (Wadensjö 2001:84).

Although working under the community nurse's direction, the interpreter has a major responsibility in the communication process, as indicated in Figure 6. As the only person who knows both languages, the interpreter must be able to hear everything that is said, remember everything that is said, as well as maintain his or her own speaking space (Dimitrova 1995:147). This stressful combination of roles involves maintaining neutrality and professional distance whilst under pressure to provide an accurate interpretation (Wiegand 2000:207).

Interpreters perform four major roles of transferring a message from one culture into another, promoting understanding, mediation and advocacy. The interpreter acts as a culture broker (Pöchhacker 2000:51). In a conversation the speaker and the hearer both have individual roles and responsibilities (Edmondson 1986:132). Edmondson (1986) suggests that the speaker embodies four roles: *Producer* with responsibility for the sounds, *Encoder* with responsibility for the formation of the words, *Meaner* with responsibility for the meaning of the words and *Responder* with responsibility for the consequences of the communication.

Similarly, the hearer has at least four roles: *Uptaker* with responsibility for listening, *Recorder* or *Sampler* with responsibility for receiving the message, *Understander* in order to derive meaning from the input and *Responder* as the potential next speaker. The Responder roles of both the speaker and hearer may be the most critical.
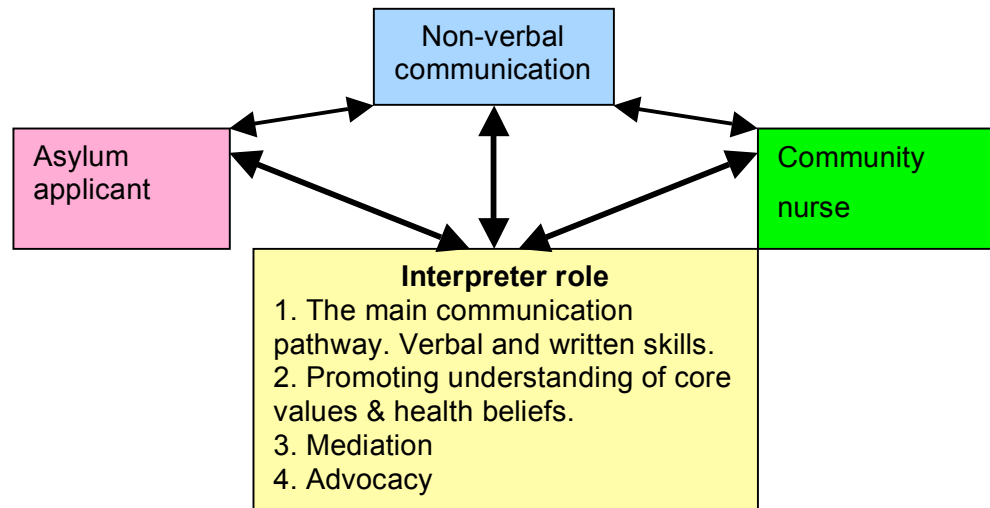
Figure 6: Roles of an interpreter in the multi-cultural setting

An interpreter assumes roles of both *Encoder* and *Producer,* but is not a *Meaner or Responder*. The hearer requires sufficient information to understand the message (Katan 1999:145). As *Encoders*, interpreters are not just producers of text (Wadensjö 1995:36), but constructors of a social context in explaining technical terms (Pöchhacker 2000:53), resulting in omissions, additions or substitutions to the message (Barik 1975).

The interpreter assumes the *Understander* role to capture the gist and cultural context of the dialogue, whilst remaining neutral (Edmondson 1986:132). Although the role has been likened to a language machine (Roy 1993:347), the interpreter picks up a message that is only said once. It is often difficult to amend a previous statement (Gentile 1995:115). Thus, in producing a verbal translation, the interpreter acts as both speaker and hearer at the same time. To facilitate understanding, the interpreter may 'chunk up' or expand renditions (Wadensjö 1993), 'chunk down' to reduce a conceptual term or 'chunk sideways' to use more familiar words (Katan 1999:147). The appropriate cultural framework may be the source culture of the speaker or the target culture of the hearer (Pöchhacker 2000 :53).

The interpreter's mediating role also involves sustaining a common focus for the interaction (Wadensjö 1995:50). The interpreter must be able to non-verbally distribute turns for talking (Wadensjö 2001:83), as well as support the affinity between the client and the health care professional. The advocacy role redresses power imbalances between the health professional and the client. The client is potentially disempowered through lack of awareness of which services are on offer (Garber 2000:19). Thus the interpreter has to balance neutrality with client advocacy to promote the interests of the client rather than those of the health professional (Bot 2003:34).

V6.2: A Community Interpretation Service

The term community interpreting is used to describe interpreting services carried out in health, social work, education and legal settings (Gentile 1995:111). Although formally recognised as a profession[8], community interpretation suffers a lack of social status (Roberts 2000:103) and requires a greater theoretical basis, regulation and registration (Wadensjö 1998:50). Interpreter accreditation is still in its infancy, especially for those languages that are not written down (Fiola 2000:127).

Community interpreting is often incorporated into translation services (Roy 1993:345). This combined service requires the right skills in the right place for the deployment of interpreters (Corsellis 1995:85), as well as an appropriate range of languages, education and training, quality assurance and accreditation (Ozolins 2000:25). Ideally all interpreters should be trained to first degree level (Mikkelson and Mintz 1995), but during the last decade increased demand and lack of capacity has lead to training initiatives drawing on the refugee and migrant populations (Straker and Watts 2003:163). Wadensjö (1998:53) suggests that the low status of community interpreting is seen in the lack of an understanding of the complexity of their role, fluctuations in working patterns and low wages.

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[8] For further details see the Chartered Institute of Linguists http://www.iol.org.uk/

Quality assurance of community interpretation services is highly important (The Independent Asylum Commmission 2008a). Interpreters often operate in an unknown cultural context, where a crisis may be exacerbated, unnecessary resources granted or a required service withheld (Garber 2000:16). A Canadian study of community interpreting service users highlighted the service costs and the importance of neutrality in interpreting dialogue (Mesa 2000:69). Moreover, the use of interpreters untrained in medical terminology has consequences for a consultation and results in the use of common language terms (Meyer 2001:101). It impacts on the sensitivity of the topic for discussion, as well as the issues of confidentiality and objectivity (Phelan and Parkman 1995). The following vignette describes a community interpretation service:

A partnership between NHS Glasgow, Social Work, Education, Police, Community Council and the Asylum Support Group had established the Interpretation and Translation Service in 1981 to provide language support, primarily for community language groups and to contain costs. This service expanded rapidly with the arrival of asylum applicants to the city in 2000, but 75% of the interpreting requests came from NHS practitioners. By 2007, the service had expanded to accommodate 58,000 interpreting requests per year, supporting up to 100 languages with usually 35-40 appointments provided daily. Interpreting services were expensive. Whereas the national average in 2007 was £69 per hour, the Glasgow service charged £39 for each hour of interpreter use.

Interpreter impartiality was an important underpinning value. Interpreters were expected to remain neutral at all times and not advocate on behalf of clients. Hence the service's policy was not to deploy the same interpreter for the same family too often, with the exception of mental health consultations.

Recruitment of interpreters in Glasgow was not straightforward. It depended on the availability of people with the required educational background and range of languages. Interpreter positions were not advertised but were made known through the informal networks of the language group. It was often a refugee's first experience of the job market. Applicants were assessed on text translation, taking note of conceptual areas as well as word accuracy.

A training initiative had been negotiated at a local Further Education (FE) College. Trainee interpreters were schooled in professional issues, including ethical and confidentiality issues. Once completed, the refugee or migrant interpreter was assessed and provided with non-sensitive interpreting experiences. Although all interpreters were routinely monitored, the novice interpreters were more closely observed during this probationary period.

Whilst working, the interpreters continued to prepare for national examinations in three areas of expertise: health, local authority and law.

Asylum applicants were trained through a separate interpreter course. Although only able to work as a volunteer interpreter, they were granted travel costs. Once granted refugee status, they could immediately become employed.

The community interpretation manager reported major difficulties of recruiting interpreters with the qualities and level of professionalism required. Unprofessional behaviour was evident through the submission of false claims, multiple requests for the same interpreter and the discrediting of colleagues. The language recruitment pool was often small, compounded by literacy problems. Secondly, there was no training provided for primary care service users. Training could have increased efficiency in the longer term, for example, by clustering clinic appointments by language group.

Although all NHS staff could request an interpreter, clients were unable to directly access the service. The interpreters required constant monitoring to maintain quality standards and avoid errors, as Wadensjö (1998:51) also notes. The fluid asylum applicant population placed additional pressures on the system to avoid under or over-subscription of each language. Whereas the interpreters required professionalism to adhere to a professional code of conduct, the community nurses lacked formal training in using interpreters, which resulted in experiential knowledge rather than an understanding of interpreter roles.

The lack of interpreter continuity impacted on the community nurses' professional role, resulted in the repetition of personal client information, potentially compromising confidentiality. The inconsistency of contextualising the dialogue could reduce the quality of the interpretation. The differing value bases of the two organisations therefore led to difficulties at times in providing joined up services. These difficulties were overcome at the immunisation clinic managed by the primary care nurses, where the same interpreter attended each week.

V6.3: Cultural sensitivity practice

US studies have demonstrated a lack of health care use of interpreters despite patients wanting this service (Baker et al. 1996). Non-English speaking patients expressed a lower level of satisfaction with emergency health care services

(Carrasquillo et al. 1996). As discussed in chapter 4, asylum informant satisfaction with primary care services is closely linked to effective communication (Cowen 2001). Cowen (2001) found that only 25% of the participants reported routine interpreter provision. Nurses with role autonomy and interpreter-use training were shown to be most likely to use this resource effectively (Gerrish 2004).

I observed that the initial contact visit was frequently conducted to assess the client's level of spoken English. The community nurse returned later with an interpreter, if necessary. Client referral information usually indicated the language(s) spoken, but did not identify the first language or level of English. Although this nursing approach was potentially resource intensive in requiring two home visits, many asylum applicants came to the UK with excellent English language skills. For example, Farah, introduced in V5.13, spoke very good English stated "I studied English for five years in my late teens in a refugee camp in Kenya, before returning to Somalia."

One nurse focus group informant stated, "I prefer to carry out a consultation in a one to one situation. I do not automatically use an interpreter as sometimes, the client can understand the consultation without an interpreter."

Another stated: "Although interpreters are expensive they are necessary and not a lot of work. The interpreter makes communication easier and health interventions more effective."

This vignette demonstrates the importance of individual assessment of spoken English. The community nurses did not consider a home visit that identified language barriers as an expensive waste of time, but rather the opportunity to meet and initiate a nurse-client relationship. The nurses considered that interpreter mediated consultations (IMCs) were part of every day practice in working with asylum applicants.

V6.4: Interpreter mediated consultations (IMCs)

Guidance on providing interpreter mediated consultations (IMCs) recommends that practitioners should request the correct language and appropriate interpreter gender (Global Connections 2005), preferably matching the interpreter to the client's ethnic and political identity (Lears and Abbott 2005). The IMC aims and objectives should be made clear.

Ideally, an IMC takes place in a quiet interview room, where a triangular seating arrangement allows the interpreter to maintain eye contact with both the practitioner and the client (Lago and Thompson 1996:63), but is not so close as to feel too involved with the client (Wadensjö 2001:72). The nurse explains the individual roles, checks for language concordance and talks in the first or second person directly to the client, whilst reversing questions to ensure understanding (Shackman 1985). The nurse and the interpreter work together effectively to share control of the consultation and establish a client communication pathway (Hatton 1993). Misunderstandings must be highlighted as health professionals may assume that there are no communication problems, since an interpreter is present (Meyer et al. 2003:74).

In an emergency, telephone based interpretation services (also known as language lines) provide a wide range of speedily accessible languages. Language line consultations may offer a freer exchange of information, impartiality and confidentiality due to interpreter anonymity (Kim 1988). They are expensive and limited by a lack of non-verbal communication clues (Kim 1988, Pointon 1996). They are thus not an ideal substitution for face-to-face IMCs.

Nursing preparation for conducting IMCs is limited. A national study of pre-registration nursing curricula showed a patchy Higher Education Institute commitment to equipping students with effective intercultural communication skills (Gerrish et al. 1996:72). Experiential learning of IMC skills risks the adoption of inappropriate competence. Standardisation of IMC training is thus required, not only for effective communication, but also to ensure patient safety, as the following vignette also highlights:

> *An IMC in a client's home was usually a formal event. I observed that the three-some nature of the consultation was stressful. The community nurses concentrated hard to ensure that the required information was obtained and advice was delivered appropriately. The asylum applicants were also quite intense and spoke passionately, at length in another language The interpreter sometimes appeared to carry out a private conversation with the client as the rendition often consisted of only a couple of phrases. I was aware that it was more difficult to get a message across a cultural divide if the receiver did not see the need for or want to understand the message.*

A variety of seating arrangements were used during an IMC. The sparsity of furniture often provided little choice of where to sit. Some community nurses maintained eye contact with the client. Sometimes the interpreter sat next to the nurse so that they appeared almost as one, making the body language of the interpreter difficult to see. The nurse could miss a visual clue as to how accurately her instructions were being followed. Other nurses would sit in a triangular shape, to observe the interpreter as well as the asylum applicant.

One nurse focus group informant confirmed these observations and stated: "I aim to see a client and an interpreter together at the same time in a good light. I was told to always sit squarely when talking to the client, but this is not always possible." The nurse informants considered that they sat closer to the client than to the interpreter, moving a chair if necessary. The nurses stated that they needed physical space to emphasise words non-verbally.

The nurse focus groups informants considered that the skill of using an interpreter took time to develop and came with experience. Students should initially observe to learn this skill. Time management was a significant issue. An IMC lasted twice as long as a routine home visit and unexpected issues could extend the visit. Secondly, interpreter gender was important. If a female client was Muslim, it was inappropriate for a male interpreter to be present. There was a shortage of female interpreters in some languages, such as Somali. The use of telephone interpretation services also created difficulties. The interpreter took a long time to ring back to a mobile phone. In the high-rise flats the poor mobile phone reception made these services difficult to use, whereas landline telephones in the clinic situation were less problematic. One asylum applicant focus group informant stated: "Even though NHS 24 service operators can access an interpreter language line service, it's difficult to use telephone-based services without the prompts of nonverbal signals."

This description demonstrates the difficulties of carrying out an IMC within the home situation. Triangular seating arrangements were not always possible and lighting was not ideal. Although efficient, an IMC was not always straightforward and unexpected issues arose. Moreover, the speaker is often unaware that interpreters routinely reform ambiguous dialogue into renditions, which bear no resemblance to the original dialogue (Wadensjö 1998:107). The nurses reinforced their messages to overcome potential miscommunication through nonverbal communication, a safeguard missing in telephone-based services. It was difficult to know for how long to book the interpreter. From my observations, I noted that an interpreter was usually arranged:

- At the request of an asylum applicant
- To overcome nurse identified communication failure

- To give asylum applicant women a voice
- To maintain social roles and status

V6.5: Asylum request for an interpreter

This vignette demonstrates the difficulties faced by asylum women in using maternity services, an area where communication is often taken for granted (Briscoe and Lavender 2009), but it must be effective to ensure patient safety and prevent excessive distress (Houghton 2008).

> *On GP registration, Linda, a 17-year-old single parent from Burundi, was referred for antenatal care at the local maternity hospital. There was no interpreter support present during the first three antenatal consultations, which were a different cultural experience from those of the traditional medicine in her home country. Her anxiety level was high. The consultations were over so quickly that she did not have the opportunity to find how to administer the medication she had been prescribed.*
>
> *Fortunately Linda attended the drop-in clinic. June was able to arrange an interpreter for the next hospital visit and the medication problems were overcome.*

Linda was a pregnant teenager with no UK family support network. The hospital consultant used an inappropriate technical language register, which resulted in poor communication. Secondly, Linda was overwhelmed by the NHS system. She required an interpreter who could chunk down the information appropriately and advocate on her behalf.

V6.6: Nurse identified communication failure

When communication is difficult, an IMC also provides an opportunity for covert child health surveillance, as other authors have noted (Robotham 2005a:85). Following the death of Victoria Climbié in England, child protection policy has been strengthened to ensure greater safeguarding of children (Department of Health et al. 2003). The Protection of Vulnerable Groups Act (2007) placed a responsibility on all agencies to identify and act to help children (The Scottish Government 2007b). The Scottish Government later introduced an initiative entitled *Getting it Right for Every Child* (The Scottish Government 2008b) to protect children from neglect and abuse.

Jasmin, a young Punjabi speaking mother in her mid twenties attended the morning drop-in clinic to see June. Her five months old baby daughter was breastfeeding well in spite of a slight cough, but Jasmin had made an afternoon GP appointment to check the condition. When June asked about the baby's diet, Jasmin replied that the baby sometimes ate 'noki', a sweet biscuit with milk. June was unsure about how suitable the 'noki' biscuit was for such a young infant. She decided that an interpreter mediated visit was required and arranged to send a letter with the visit details.

The focus group nurse informants stated that they used their own professional judgement in knowing when to request an interpreter. One informant stated: "It is important to make sure that clients are properly informed. An interpreter is often required to get the information across."

Jasmin did not officially request an IMC, but June arranged one to observe for potential child protection issues, to discuss the child's diet and offer parenting advice and support. Although "noki" was only a sweet weaning biscuit, it was potentially harmful to children's teeth. June was reinforcing good parenting through promoting dental health, a SNHS priority. The dental health of Scottish children is poor (Health Scotland 2007). During this study, the HCSWs were involved in a successful Glasgow based dental hygiene campaign and informed asylum applicant parents on how to clean their children's teeth. The IMC was an opportunity to ascertain Jasmin's needs for parenting advice and support. Although, Jasmin was not concerned about weaning and using traditional foods, she might have other undisclosed concerns. Thus the identification of weaning issues potentially aided child health surveillance; the double duty of health promotion and surveillance as discussed earlier in section 4.3.

V6.7: Emancipatory care

The notion of emancipation is particularly relevant to asylum women, who may come from countries where women do not have a voice. Twinn (1991:969) considered that emancipatory care involved a collective non-directive community development approach to address social restrictions and discrimination faced by women, as the following vignette describes:

A nurse informant commented: "I request an interpreter when there are concerns that the husband can filter the conversation for his wife."

One female asylum applicant focus group informant reported, "My husband sometimes complains that I no longer do as I am told."

As part of an empowerment approach, the nurses used an IMC to establish female clients' major health concerns and how they were feeling. For example, it was culturally inappropriate for a husband to interpret consultations discussing sensitive sexual health issues. He could misinterpret or use this information inappropriately and effect a barrier to the nurse-client relationship. This vignette demonstrates the impact of empowering asylum women to gain self-esteem and assume more authority within family relationships.

V6.8: Maintaining social status

This vignette presents an insight into the importance for asylum applicants of maintaining social status and roles.

> *Mustafa was a married Turkish asylum applicant in his mid thirties, whose three-year-old son had only one functional kidney. The Renal Consultant had asked Mustafa to phone for an appointment, but Mustafa found the use of the telephone difficult. Mustafa asked June at the drop-in clinic to phone the Children's Hospital on his behalf and she returned with the date and time of the appointment. She had also requested an interpreter, even though Mustafa did not consider that he needed one.*

> *In discussing this scenario later, June stated: "Mustafa's wife has much better English, but Mustafa wants to keep control regarding his son's health care."*

> *A nurse focus group informant suggested: "Clients do not always want an interpreter to be present."*

As head of the family, Mustapha had poorer language skills than his wife, but cultural roles took precedence over linguistic ability, as he wanted to take a lead in accessing services for his son's health problem. Turkey is thought to be a highly patriarchal society, where in spite of greater freedom than in other Muslim countries, women are afforded a lower status in many aspects of social life (Herdman and Badir 2008). Albeit Mustapha had lost social status in seeking asylum, a paradox was that in not wanting an IMC, he potentially risked an ineffective consultation with the renal specialist, with subsequent inequity of access to services.

6.3 Miscommunication issues

Miscommunication issues may arise in communicating through a third party. The inability to hear the message, a lack of understanding to process it or a responder speaking impairment may result in miscommunication (House 2000:146). The client's lack of autonomy in the dialogue may also reduce opportunities for the clarification of issues (Meyer et al. 2003:77). Miscommunication develops from a lack of a shared understanding and is defined as:

> *'A lack of fit between the sense aimed at by one interlocutor, and what is displayed by another as the sense made of the current message' (Wadensjö 1998:198).*

Miscommunication is often sensed through clarification requests, negotiations of meaning, incoherence and hitches in dialogue, as well as verbal and non-verbal signs of uncertainty. Although miscommunication may be mutually known, it may not be noted or the interpreter may keep it hidden (Wadensjö 1998:237). Neutrality and impartiality are essential ethical IMC elements, but confusion may arise as to whom these refer to: the interpreter, one or other of the parties, or the need to mark differences (Wadensjö 1998: 240).

V6.9: Examples of miscommunication

The following vignette highlights some of the miscommunication opportunities during an IMC.

> *Dr Cross stated: "Health professionals should be aware that an interpreter may be unable to deal personally with the sensitive information given by the asylum applicant and unable to translate word for word. It may be too traumatic to even say the words heard." She considered that an interpreter might become so detached that when the information was translated into English, it did not make sense. Hence the information was summarised or paraphrased. Dr Cross stated: "In some instances the interpreter does not believe the information given by the asylum applicant and shows disdain or a lack of respect for the client."*

> *On the previous visit, Wendy had told the interpreter that she thought that her breast milk supply had diminished and was only breastfeeding her baby at night. Wendy had substituted baby 'porridge', made from rice flour, salt and water for artificial infant formula. She thought that this would save her breast milk for the evening feed. The interpreter did not understand the significance of this information and had not informed June accordingly. The infant feeding*

difficulties did not fully emerge until the following week. June then encouraged Wendy to return to breastfeeding the baby at every feed, as the baby had been at risk of dehydration from a high level of salt intake and a reduced number of breast milk feeds.

The focus group nurse informants commented that with experience they knew when the interpreter was not translating word for word. They knew some regularly used words. Major clues were body language, as the interpreter would look uncomfortable, especially if using a different speech dialect to the client. One nurse informant stated: "I use key words and phrases to simplify the message. The interpreter does not always understand the message if I use complex sentences."

Another informant said: "I check the client's understanding by reversing questions, asking the same question in more than one-way and by observing if the client is smiling and maintains eye contact. The client may show a lack of understanding through mild confusion in answering the same question. Often, if a client understands the conversation, she responds before I have finished speaking, but sometimes she does not know the answer and is unable to respond."

Dr Cross acknowledged that renditions were not identical to the original dialogue and that there was a potential for ambiguity in transferring the message from one cultural framework to another. The primary care nurses were not always aware of inaccurate interpreter renditions. The interpreter's lack of medical knowledge impacted on the appropriate 'chunking' of breastfeeding information. Wadensjö (1998:233) considers the interpreter's lack of a shared understanding to be a major source of miscommunication. These examples demonstrate that the community nurses relied heavily upon nonverbal clues, including the flow of the conversation, to check for interpretation accuracy. As Wadensjö (1998) suggests, it was important to ensure the message was unambiguous but sufficiently detailed. If the message was too simple, the interpreter expanded the rendition to make it meaningful to the client.

V6.10: Asylum lack of confidence in interpreters

Accurate interpretation is as important for the client as the nurse, especially in regard to an asylum claim, as this vignette describes:

Sadiq was a 38-year-old Turkish asylum applicant, who was married with 2 children. He stated: "When we first arrived in Scotland, we thought that the city was not used to refugees. I made my asylum statement with my lawyer, but it was not translated properly. My asylum claim was rejected, even though

other members of my family, making a similar claim in London were awarded refugee status. If we had stayed in London, the lawyers and the interpreters were much better and we would not now be facing deportation."

Kurdish asylum applicants have been shown to be potentially disadvantaged in the asylum process due to the physical and psychological effects from previous experiences of torture (Bradley and Tawfiq 2006). The effect of this severe torture could have influenced Sadiq's ability to give a clear report of events. However, this vignette highlights a perceived lack of asylum legal expertise in Glasgow, which may have disadvantaged the initial cohorts of asylum applicants.

6.4 Inter-professional partnership working

Cultural norms influence the rules of communication (Robinson 2001:192), reflecting social expectations of behaviour (Montgomery 1986 :210). For an IMC to be effective, community nurses and interpreters were required to work in partnership and implement common values in their practice.

V6.11: Inter-professional relationships

Some of the challenges of inter-professional partnership working are highlighted in the following vignette.

> *Caroline and I returned to the office to find no sign of the interpreter, who was expected. The interpretation service confirmed that the interpreter had left the building to attend his next appointment. Caroline stated: "This home visit needs an interpreter and it is unprofessional not to await my instructions." Fortunately, the interpreter returned to the office, the client was at home and the IMC went ahead as planned. After the IMC, Caroline gave the interpreter a lift to a bus stop.*

> *The focus group informants discussed interpreter transport issues. They felt vulnerable in giving the interpreter a lift in their car and considered it an extra burden on their busy schedules, which took time away from providing nursing care; interpreters should make their own travel arrangements.*

Caroline considered the interpreter's behaviour of leaving the building before speaking to her as disrespectful and unprofessional. Caroline considered that she was in charge of the IMC, rather than working in partnership with interpreter. Structured professional roles and power relationships resulted in her expecting him to wait for

her at the centre. Although Wadensjö (1998: 287) suggests that the professionalism of interpreters centres on the production of an accurate and fluent discourse, this vignette identifies that the community nurses also judged the competence of interpreters through their cultural behaviour. The lack of respect resulted in the interpreter and the nurse remaining as strangers, which impacted on their professional relationship and is discussed further in the next vignette.

V6.12: A lack of inter-professional trust

The limited inter-professional trust is shown in the next vignette.

Unequal power relationships between the nurse and the interpreter appeared to lead to a lack of trust. Confidentiality, contextualisation and validity of interpreting were not taken for granted by the community nurses. For example, the explanation of the aims, objectives and plan of action for the consultation was short and to the point. It frequently took place as we went up in the lift to the asylum applicant home visit.

Jessie, a thirty-year-old unmarried staff nurse, explained: "Sometimes I do not ask the client to reveal confidential information. For example, when visiting a Somali client I could not ask if she was pregnant because the interpreter was male and also I was concerned about confidentiality."

The community nurse focus group informants considered that there were ethical issues of bringing people from similar communities together in a confidential setting. Client information was given to the interpreter, who could have a relationship with the client beyond that of being an interpreter. Due to an interpreting under-capacity in some languages, there was increased use of certain interpreters, leading potentially to over familiarity.

One community nurse informant stated: "I ask the interpreter to reassure the client regarding confidentiality, but sometimes the interpreter stays behind at the end of a visit to talk to the family and asks to be personally requested for the next consultation." A second area of concern was the lack of neutrality. Both asylum families and community nurses refused to work with certain interpreters. There were concerns that one interpreter was advising against the uptake of the MMR immunisation.

Although the interpreter and the nurse sometimes knew and respected each other through regular professional contact, more often the community nurses did not perceive interpreters as professional equals. Both the community nurses and the interpreters provided opportunities for miscommunication. Time constraints often prevented a long pre-consultation discussion of the community nurse's IMC

objectives, whilst the interpreter's expanded or condensed renditions resulted in information filtering and concerns regarding the interpreter's neutrality.

V6.13: The need for debriefing

A post consultation discussion is considered to be a useful way to address any psychological issues arising for the interpreter or nurse (Global Connections 2005:8).

> *Dr Cross stated: "I always ensure that there is time for debriefing of the interpreter within the allocated consultation time."*
>
> *The community nurse informants did not see debriefing as part of their role. Although they considered that they were responsible for the organisation and implementation of the IMC, there was no routine post-consultation debriefing, only a discussion as to how well the aims and objectives of the home visit had been achieved.*

Dr Cross had gained insight into the psychological impact of the IMC on the interpreter through her counselling work. She considered that debriefing was an essential IMC element and should be integral to the consultation. The nurses thought that they did not have the appropriate debriefing skills for use with interpreters. They were keen to maintain control through achieving the IMC aims and objectives. The interpreter usually had little flexibility and had to leave promptly at the end of the allocated time, regardless of whether all issues had been discussed.

6.4.1 The complexity of interdisciplinary working

The data in this chapter has provided various examples of the complexity of partnership working for the interpreter, the community nurse and the client. In Table 3, I have brought together their power relationships, using Lukes' (1974) theory of power described in section 2.4, and provide a link to the vignette evidence.

Table 3: Power relationships between the interpreter, the nurse and the client

Lukes (1974) level of power	Interpreter	Community nurse	Client
One-dimensional level of power. **An emphasis on behaviour, relationships and in the making of decisions.**	Different interpreter assigned to each IMC to ensure neutrality (V.6.2). Insecure employment. Asks client to request him/her again at next visit (V. 6.2)	Requests repeat interpreter for IMC (V.6.2) Lacks trust in interpreter: concerns re confidentiality (V6.4/V6.11/V6.12/V6.13) Little debriefing (V. 6.13).	Prefers continuity of care using same interpreter (V. 6.5). Empowered to provide own point of view (V.6.7)
Two-dimensional level of power. **Hegemony and securing compliance**	Lack of professionalism to meet expected norms behaviour (V.6.11)	Uses simple language to secure compliance (V.6.9) Pre-consultation briefing short (V.6.4) Knows when interpreter not translating as requested (V.6.9).	Clients do not always want an interpreter; – confidentiality issues, maintaining identity (V.6.8).
Three-dimensional level of power. Power is exercised in the absence of observable conflict & action	Knows all that is said but does not always translate word for word (V. 6.9). Advocates for client rather than professional (V.6.2).	Responsible for organisation and formal control of the IMC (V. 6.4/6.11).	Disempowered by dependence on both professional and interpreter. Lacks confidence in interpreter translation skills (V. 6.10).

The triad worked in partnership within the first dimension of power in V6.2, V6.4, V6.5 and V6.7. The promotion of continuity of care conflicted with the need for interpreters to be neutral and impartial. Although in V6.11 and V6.12 the community nurses judged the competence of interpreters through their social behaviour, they were unable to provide them with a post consultation debriefing (V6.13). The IMC appeared to work best when all triad members operated within Lukes' (1974) first level of power. At this level, there was an emphasis on relationships and behaviour, which confers with the empowered client use of resources (Peplau 1988).

At a two-dimensional level, the community nurses took control of the consultation to counteract the nurse perceived lack of interpreter professionalism. To secure interpreter compliance in translating as directed, the pre-consultation discussion focused on the aims and objectives of the consultation. The nurses used simple language to avoid issues of confidentiality and the giving of unnecessary client information. At the third dimension of power, the interpreters used their power base of knowing all that was said to not always translate word for word and advocate for clients. Conversely, the community nurse considered herself to be in charge of the IMC and that the interpreter should advocate on her behalf. Moreover, the nurses required advanced communication skills to make their messages as clear as possible but adequately detailed to avoid the interpreter taking liberties in the expansion of renditions.

6.5 Communicating without an interpreter

Although the communication process involves primarily verbal communication, nonverbal behaviour also plays a major role (Robinson 2001:201). Nonverbal behaviour presents visual clues in addition to audible information (Poyatos 1987:235) and may enhance or detract its effectiveness (Heller and Hindle 1998). Robinson (1998) categorises nonverbal communication into four broad areas; kinesics or body movements, paralanguage or the way in which language is spoken, proxemics or the interpretation and use of personal space (Hall 1951:107-122) and other factors such as perfume and spectacles. These factors present clues about the behaviour of each person and their interpretation also influences the communication process (Lago and Thompson 1996).

Paralanguage and kinesics can aid the communication process (Poyatos 1987:238). The limitation of words may be overcome through the use of pauses, or by a shrug of the shoulders to complete the sentence. Conversely, the different interpretations placed on nonverbal communication may be a barrier to good communication; for example, some authors consider that Arab cultures value eye contact highly whereas South Asian and Eskimo cultures perceive it to be aggressive and rude (O'Hagan 2001:155).

V6.14: Nonverbal communication

The following vignette provides some examples of the use of nonverbal communication.

> *As Andean redressed her baby, there was a discussion to find out if there were problems with breast-feeding. June used short simple phrases, reinforced by lots of hand signals, June also maintained eye contact with Andean during the discussion, but relieved the tension created through the language difficulty by joking about her lack of French.*

> *Sometimes clients were advised at the drop-in clinic to obtain non-prescription medicines or oil to moisten dry skin. June often used her hands to motion in the air how to massage the oil. If the client appeared to understand, June wrote 'small bottle of olive oil' on a compliments slip and advised her to go to the local supermarket to buy the oil. The HCSW was often asked to visit the family to check that the mother understood how to use the oil.*

> *I observed that community nurses gave out nonverbal signals during an asylum applicant home visit in several different ways. Although on entering the home the nurses immediately took control of the conversation, they also gave clients direction through tone of voice, expressing empathy through reverential body language, nods and pauses between words.*

> *One nurse informant stated: "I smile to show I am friendly and use the word 'nurse' several times. I point to the clock to indicate when I will return the next day." She also showed the client the record file to provide a reason for her return.*

If no interpreter is available, health professionals can use mime and guess work to overcome language barriers (Bradby 2001). This vignette shows that the nurses used hand signals to augment the dialogue through repeating the message in a nonverbal way. Humour and friendliness promoted relationships, in spite of language barriers.

V6.15: Bi-lingual practitioners

Ideally all health professionals should be able to speak two or more languages (Leininger 2002a), but there would still be a need for a community interpreter service. Bi-lingual nurses with the appropriate language skills improve communication for minority ethnic clients (Josipovic 2000) and may reduce interpreter service costs (Tang 1999), but their UK number is small (Phelan and Parkman 1995). Bilingual staff untrained in interpretation encounter similar problems to those of clients' relatives. Some practitioners in this study were bi-

lingual (see also V5.1). A third party interpreter was thus not required as the following vignette demonstrates:

> *Whilst spending a morning with Dr Brook (introduced in V4.3), I met Mr and Mrs Tobias, an older and very frail couple from the Congo. Dr Brook was fluent in both German and French. She spoke to them in French, but when Mrs Tobias did not understand, her husband translated from the French into Swahili for her. They stated that they were very grateful for the health care they received, but they had had to walk to the GP surgery, as they had no money for bus fares. On examination, Dr Brook found that Mr Tobias's blood pressure reading was very high, but did not know if the cause was the stress of the long walk or whether the medication was less effective. Afterwards Dr Brook explained the consultation to me, which appeared to have been conducted at a very simple level to take account of the language difficulties. The hypertension medication for Mr Tobias was increased.*

The humanitarian crisis in Congo is known to have deepened in the last decade (Hargreaves et al. 2003), forcing people of all ages to flee the country. Language acculturation can be highly stressful for older people (Tran et al. 2008). Due to the complexity of working in English, French and Swahili, this consultation remained at a simple level. It was difficult to ascertain the true reason for the rise in blood pressure, suggesting that ineffective communication is potentially dangerous and may impact on patient safety issues.

V6.16: Working without an interpreter

By reducing stress for the client, simplifying language and constantly checking for understanding, the health professional can aid the communication process (Robinson 2001:200). This approach is time consuming and runs the risk of making errors in the health assessment (Bischoff et al. 2003b).

> *Most of the nurse informants were only able to speak English. Although the relaxed style of the drop-in baby clinic was user friendly and welcoming, all consultations took place in English. Those asylum applicants attending at an early stage of motherhood required a larger input of health visitor advice and reassurance. They experienced a double difficulty of communication barriers and a lack of parenting knowledge and skills.*

> *A nurse focus group informant stated: "I use a calm and reassuring tone of voice to reassure the client that there is not a major problem and build a rapport with the client. I use simple words, speaking slowly and clearly, noting which words are understood so that I can re-use these words."*

Deirdre described the difficulties of understanding someone with a poor level of spoken English on the telephone. She stated that sometimes asylum applicants rang the centre, not realising that the asylum team were unable to give a GP appointment. Deidre directed them to their GP, if their baby was ill, but first she tried to find a key word, such as a name or date of birth, in order to inform the relevant health visitor.

It was unrealistic to provide interpreter support for all people attending the drop-in clinic, an open access situation. Reassurance and keeping calm were very important to promoting communication when language difficulties arose. Asylum applicants with limited English speaking skills faced difficulty in accessing GP services. To access the primary care appointment system, they were required to make themselves understood on the telephone, to respond quickly to questions and absorb a large amount of information. Thus asylum applicants used family members to communicate with health service staff.

V6.17: Appropriate use of a child interpreter

An Australian study found that hospital nurses employed a high risk strategy in using relatives as interpreters (Cioffi 2003). Although family members may reassure the client, interpreting is limited to straightforward and non-sensitive health care consultations (Phelan and Parkman 1995). Young people are considered to have inadequate linguistic skills for interpretation (Ledger 2002), but they may choose to interpret for their family and are able to interpret non confidential information to their peers (Bullock and Harris 1995). A qualitative study showed that the success of the consultation depended upon the young person's language skills, the practitioner's communication skills and the nature of the healthcare problem (Free et al. 2003).

A major difficulty of using family interpreters is that routine health care can become unexpectedly complex. Family loyalty may prevent full explanations in cases such as domestic violence or child abuse (Vernon and Feldman 2006:8). A qualitative study of the use of health visiting services by Pakistani and Chinese mothers found the use of family interpreters made health assessment more difficult to carry out (Hogg et al. 2006). Hence family interpreters are usually not recommended for routine healthcare

(BMA 2002:11). The following vignette demonstrates that children may be used appropriately as interpreters in some circumstances:

> *The nurse informants were adamant that they did not involve asylum children as interpreters to discuss health issues, but sometimes they asked local English-speaking asylum children to pass on messages to non-English speaking asylum applicant concerning when a return visit with an interpreter would be made. Overall, it was 'hit and miss' whether the client understood what had been said and a bonus if he or she was at home when the nurse returned with an interpreter for the subsequent visit.*

The nurses used children to pass on a message that they would return later with an interpreter.

6.6 Communication tools

The community nurses used tools to aid communication. These included:

- Hand held records
- Mobile phones
- Written health promotion materials

Hand held records were introduced as a universal child health communication tool in Scotland over 10 years ago. The primary care nurses recorded comments routinely in the record to overcome language barriers, to help parents to understand their child's progress and to aid inter-professional communication. Asylum applicant parents usually remembered to bring their records to the clinic, to ensure that they kept their child's health information up to date.

V6.18: Routine use of mobile phones

The asylum teams had originally been issued with mobile phones in the year 2000 as a health and safety measure. Home visits were a potentially dangerous activity for community nurses working alone. Mobile phones are now used innovatively in nurse-client communication to provide dietary information, smoking cessation support and the monitoring of long-term conditions (Blake 2008). The following vignette demonstrates their usefulness during a home visit.

> *Linda was introduced in V6.4. When her second baby Martha was 10 days old I accompanied June to visit the family. This visit was a day earlier than usual,*

as June knew that I was keen to revisit Linda. June noticed that the baby was rather jaundiced and phoned the maternity hospital on her mobile for advice. She was reassured that the baby was fine. Martha was breast-feeding very well, she was not irritable or crying excessively – these would have been signs that the jaundice required hospital treatment. June had acted appropriately to identify a health problem at an early stage and Linda was pleased that she did not have to make an immediate return visit to the maternity hospital with her two small children.

Isabel stated: "A client was worried about the dampness in her flat, but had been told by her support worker to contact the Scottish Refugee Council. After several phone calls I discovered that the housing had been transferred to another agency and was able to contact them directly."

This vignette demonstrates the transparency obtained through using a mobile phone in the client's home. Linda could hear exactly what was said during the telephone conversation and was reassured that there was no link with UKBA concerning her asylum claim. Secondly, there was an increased speed of obtaining advice and reassurance concerning the jaundice. Thirdly, contact telephone numbers for both statutory and non-statutory services were stored in the phone; referral information could be gathered immediately, thus saving a repeat visit. Thus, June managed her time and workload effectively. The referral was not deferred, although records would be written later.

V6.19: Cross cultural health promotion materials

The provision of written cross-cultural health promotion material is known to be especially difficult. An analysis of translated genetic information leaflets into Urdu found the text was inaccurate, confusing, difficult to understand and culturally insensitive (Shaw and Ahmed 2004). Similarly, surveys of health promotion literature have found the translated materials unfit for purpose (Papadopoulos et al. 2005) and highlighted the need to target the audience's health beliefs to make the health messages meaningful (Higginbottom 2000).

During my fieldwork I noted that there was only a limited supply of translated health promotion materials available and that these were rarely used.

Ailsa reported: "A poster listing all the services provided by the larger asylum team was produced for the local voluntary services. Sexual health and family planning was highlighted in the poster. This information was seen to be highly

offensive by the Roman Catholic Church, which was providing the ESOL classes. Ailsa considered that the team should have been more aware of this.

The limited provision of translated health promotion information for asylum applicants was inadequate. It assumed that clients were literate and able to understand the information. The poster used pictures to promote a range of services, including family planning, but the team had not taken into account how voluntary groups might receive and interpret this information. This vignette demonstrates the team's drive for social inclusion, to enable all asylum applicants to equitably access the services available, but risked the relationship with another voluntary agency.

6.7 Summary

The data vignettes in this chapter have shown that cultural sensitivity is a major aspect of the provision of culturally competent nursing care, as highlighted as a third step in the updated Five Steps Model in section 3.2.1. Cultural sensitivity was one of the greatest community nursing challenges and a pre-requisite to the development of interpersonal relationships. V6.1 demonstrated the need for good communication to empower asylum clients to understand primary care services. Effective communication was a two way process. It involved both verbal and non-verbal routes for the transmission and receipt of a message (V6.14).

There was again a theme of power in this chapter. Community interpreting services were described in V6.2. Their development had been influenced by the increasingly multi-cultural nature of primary care and the need to provide equitable and non-discriminatory NHS services. The arrival of asylum applicants in Glasgow placed additional pressures to provide interpreters with the right language skills and degree of professionalism, but asylum applicants could not directly access this service (V6.8). Neutrality and impartiality were important values to the interpretation service. A policy of providing a different interpreter for each IMC was in place to reduce unprofessional interpreter practice. The community nurse teams were the most frequent NHS service users, but preferred to use the same interpreter for continuity of care. Hence the professional disciplines were working from different value bases.

The community nurses used interpreter-mediated consultations (IMCs) in their everyday practice. They assessed the English language skills of their asylum clients to decide whether to request language support (V6.3). They considered that an IMC made communication efficient and effective. It saved time, energy and money in the longer term. V6.4 provided a summary of best practice in using language support services. The major reasons for organising an IMC were described in V6.5, V6.6, V6.7, and V6.8. These included at the request of an asylum client, identification of communication failure, to promote emancipatory care and to maintain established social roles and identity.

The challenges of inter-professional working were highlighted in V6.11. Table 3 highlighted the power differentials between the interpreter, the nurse and the client. Whereas the interpreter held the balance of power in being the only person who understood both languages, the nurse was in charge of the IMC and asylum clients were not always confident in interpreters (V6.10). Community nurses became aware of miscommunication through checking client understanding and body language (V6.9). Thus for IMCs to be effective all members were required to work in equal partnership, which also involved a level of trust. The community nurses lacked trust in the interpreters (V6.12) and did not see debriefing as part of their role (V6.13).

The community nurses preferred to work in a one to one situation with their clients to maintain their autonomy, avoid the risk of IMC miscommunication and to protect client confidentiality. Although few community nurses could speak another language (V6.15), most had developed skills to work without an interpreter (V6.16). The nurses used children as interpreters only to pass on simple messages (V6.17). Tools to aid communication and transparency of practice included the use of hand held records and mobile phones, as described in V6.18. The dearth of translated health promotion materials and the difficulty of producing in-house materials were highlighted in V6.19.

This chapter has shown the importance of communication within cross-cultural relationships. A lack of cultural sensitivity could potentially result not only in poor

exchange of information but also the delivery of unsafe care. However, the nurses recognised the importance of asylum language support to promote health, to carry out an accurate health needs assessment and ensure the delivery of safe nursing care. Thus the provision of language support within a cross-cultural nursing consultation is highly complex and requires further investigation.

Chapter 7. Cultural knowledge

This final data chapter considers cultural knowledge, which was described in section 3.2.1. It is a fourth step in the Five Steps model, includes an understanding of the effects of poverty and social marginalisation on health and addresses the following research question:

- *How does the community nurses' understanding of cultural knowledge impact on addressing health inequalities?*

The social context for living has a huge impact on people's health. Bourdieu (1977) considered that *habitus,* the meaningful behaviour of people, could only be understood within its social context (Bourdieu 1977, 1990:112). In his Cultural Capital theory, Bourdieu asserts that social prestige is awarded in relation to the acquisition of education, knowledge and cultural symbols of wealth. Cultural capital may be determined by the combination of class and habitus (Cregan 2006:74-75) rather than individual merit and is reflected in the quality of accessed resources (Portes 1998). Social networks as a measure of social capital do not necessarily favour the individual, for example they have been shown to potentially increase HIV incidence (Pronyka et al. 2008).

Poverty is associated with physical and mental illness (Falk-Rafael 2006), especially for those with low educational attainment (Patel and Kleinman 2003). Asylum applicants may not only experience complex health care issues stemming from their refugee journey (Arora et al. 2001:141), but also a loss of social capital compounded by poverty and inequity of access to primary care services (Burnet and Peel 2001a; Barclay et al. 2003: 53). Barclay et al. (2003:32) found in a Glasgow qualitative study of asylum applicants that restrictions on social activities resulted in social isolation. Moreover the social networks of immigrants and refugees have been shown to dwindle in an ethnographic Canadian multi-centre study (Stewart et al. 2008b). Although, the asylum experience should not be medicalised as a pathological event (Kleinman 2008), the psychological impact of poverty and social exclusion should not be under-estimated (Stanciole and Huber 2009). For example, asylum applicants

in Australia were shown to experience a high level of psychological and social health problems (Correa-Velez et al. 2008).

A lack of cultural knowledge, skills and understanding of clients' health or illness behaviour may impact on nursing care provision (Anand and Dolan 2005). In this study, I found that cultural knowledge involved three major areas of asylum nursing care:

- Understanding the stress of the asylum journey
- Aiding adaptation to a new environment
- Health issues for unsuccessful asylum applicants

7.1 Understanding the stress of the asylum journey

Illness is a social construction of an abnormal experience. It may arise due to a failure to adjust to stress (Aakster 1974), be associated with a sense of loss (Helman 2007: 319) or be due to forced migration (McMullin 2005). Whereas disease is a medically and pathologically defined state (Blaxter 2004:21), illness is an imbalance or a feeling of being unwell (Albrecht 2005:268, Miles 1991:3). It is often associated with mental health and is commonly referred to as stress.

Stress was originally conceived as an automatic response to a situation with three stages of alarm, adaptation and exhaustion (Selye 1976). Stress as a purely mechanical process is now refuted. There are many underlying factors, but the social context is highly relevant. Health beliefs concerning stress have been shown to be related to bodily dysfunction rather than pathological processes: symptom explanation may aid recovery significantly (Woloshynowych et al. 1998). The physical environment is integral to emotional well being and impacts on the individual's ability to cope with illness (Shaw 1999). Moreover, economic factors and poverty also impact on stress. Asylum applicants are denied access to labour markets and unemployment may marginalise a previous identity (Perelman 2007). A lack of social support has been shown to affect asylum mental wellbeing and the ability to cope with everyday problems (Ager et al. 2002), although the stress may itself be part of the healing process (Helman 2007: 292).

Personality resources enable individuals to counter high stress levels (Folkman and Lazarus 1988). Hardiness is the ability to deal with stress (Low 1996), it includes self belief, commitment and seeks challenge as an opportunity for personal growth (Kobasa 1979). Resilience encompasses the ability to bounce back from highly stressful situations (Tusaie and Dyer 2004). Thus, people may cope with stress through incorporating life changing events into everyday living (Young 1980) or through adapting to the changes of living in a new environment (Parkes 1971). Enculturation is the process of re-learning how to communicate in a new host environment (Kim 1988:47), which asylum applicants may find stressful (Samarasinghe et al. 2006) due to 'unlearning' or 'losing' some aspects of culture. Over time, an individual adopts a greater proportion of the host culture. Proficiency in the lost language is one indicator of integration (Brahmbhatt et al. 2007:8).

The failure to adapt to changing circumstances is known as adjustment disorder (AD). AD may be a less stigmatising diagnosis than post traumatic stress disorder (PTSD), but there are concerns regarding its use and validity (Strain and Diefenbacher 2008). It has been criticised as the medicalisation of normal life events (Kleinman 2008). The PTSD diagnosis assumes a western model of mental illness (see also section 5.3), but psychological research has shown that it may be better to bury the past and focus on current issues (Patel and Mahtani 2004). Secondly, PTSD does not take account of structural effects. Both the UK asylum and mental health care systems may impact on asylum mental health (Watters 2001).

Treatment is often in the form of counselling, an unknown therapy to many asylum seekers, but is not straightforward. It requires initially the development of trust between the counsellor and the client (Thorne and Robinson 1988), with a consequent increased treatment time and a lengthening of the waiting list for specialist help (Watters 1998). It may be less efficacious when the psychiatric diagnosis is less certain (McColl and Johnson 2006). Moreover, asylum applicants may prefer community or family focused approaches to emotional health and are often unable to influence their treatment or care.

Before returning to Reema's story to understand the stress of the asylum journey, it is useful to compare the nurse and asylum views of the concept of poor health. As I described in section 3.4, both the nurse and the asylum focus group informants chose a picture that represented poor health and explained why it was chosen.

V7.1: Community nursing views of the concept of poor health

This vignette demonstrates that the nurses considered that poor health often arose from people not adopting SNHS promotion messages.

> *The pictures chosen to represent poor health included a mouth full of sugar with poor oral hygiene, a hospital sign, a premature baby in intensive care, someone smoking, stress and poverty, a man in tragedy with dust and dirt on him, the shock and trauma of mothers waiting with babies with a hopeless look on their faces. The informants gave their reasons for choosing these images as those of the consequences of not taking on board health promotion messages.*

The informants blamed the individual's health behaviour for poor health. Likewise a study of the health beliefs of health visitors in Scotland found that the participants rated smoking, drink driving and dental care, all top policy issues, as important behaviours affecting health (Barberia and Canga 2004).

V7.2: Asylum views of the concept of poor health

The lack of self-care was one of the major themes running through the asylum focus group discussion of 'bad health', as highlighted in the next vignette.

> *The asylum informants chose images of people smoking, drinking alcohol, not eating properly or wearing the right clothes, which they described as 'bad health'. One informant stated: "It is when a person does not look after himself properly." Another informant suggested: "This early baby (a picture of a premature baby in an incubator) is the result of a mother not looking after herself properly. May be she does not eat well or perhaps she smokes." None of the group reported that they smoked or drank alcohol.*
>
> *Although homelessness was seen as an individual responsibility, a picture of an unkempt, and possibly homeless, person with a cold and a cough was identified as an example of bad health. In discussing further the relationship between pollution and ill health, another informant stated "There is less pollution in Glasgow than in London, and I prefer to live in Glasgow."*

Although people are known to have multiple understandings of medical terminology (Boyle 1970), the asylum applicant informants viewed the body as a functioning

mechanical entity, a notion which is thought to be reinforced through modern transplant surgery (Helman 2007: 32). The medical emphasis on the body rather than the self may facilitate depersonalisation (Sharp 2000). The asylum applicant informants also included homelessness in the notion of 'bad health'. Health was an individual as well as a community responsibility, as individuals may have less control over health than is thought. Thus, whereas the nurses considered health to be under the individual's control, the asylum applicants adopted a more fatalistic approach.

V7.3: Reema's story part II

Rape was a major health issue for many asylum women, but it does not fit easily into the conventional PTSD framework described above. Seltzer (2004:108) suggests that health professionals can help to diminish its dehumanising long-term effects through continued contact, friendship and empathy. In this second part of Reema's story, the narrative describes the impact of becoming an asylum applicant and the health consequences following rape. I have triangulated the data with information gained from nursing case notes.

> Reema found her life difficult as an asylum applicant and stated: "I stayed in bed and breakfast accommodation for seventeen days, but my allowance barely covered the cost of an evening meal, so I was often hungry." Once provided with her own accommodation, Reema was registered with a GP. An Ear, Nose and Throat (ENT) surgeon later advised her that no further treatment was possible.

> One day, Reema met Mohammed when he helped her to pick up some money she had dropped in the street. Mohammed aged 25 years was also Sudanese. He later asked her to marry him in order to give her baby, Ali, a name. Although now a family, Mohammed and Reema had made separate asylum claims and were entitled to individual case hearings. Reema was refused asylum at her first court appearance and suggested it was safe for her to return to Khartoum. Reema thought that her lawyer's asylum report was inaccurate and said: "The report should have stated that it was unsafe to return to Khartoum. I had no family there to support me. My marriage would not be recognised as I was not a virgin and my son would possibly be killed."

> Ali was born in late March 2005. Jillian's first visit to Reema was delayed as the birth documentation had been sent elsewhere in error. Ali was breastfed, there were feeding difficulties and he had a nappy rash. In the early weeks,

Jillian provided additional breastfeeding and childcare support through visiting Reema twice each week.

At Ali's first routine development check and immunisation in mid May 2005, he was found to have an inguinal hernia and was referred for surgery. His parents were keen for him to be circumcised by a doctor friend who practised in London, which was carried out according to their wishes. Later in May, Ali was found to have an unexplained scald to his wrist. Jillian continued to visit the family weekly. The focus of home visits was childcare, home safety and providing Reema with emotional support. Ali received Hepatitis B immunisations in addition to the routine schedule.

Although Jillian visited regularly, they rarely discussed Reema's asylum claim. Jillian stated: "It does not help to talk about an asylum claim; the client becomes so distraught that it is counterproductive. The client becomes unable to follow instructions or take health advice."

By July 2005, Jillian had concerns that Reema was suffering from PTSD and referred her to a psychologist-led asylum women's group for rape victims. Reema attended regularly and found the group discussion helpful, but her mental distress was not fully resolved.

Additional home visiting support was delegated to Elsie. Home safety remained an issue, for example, a fireguard and safety gate was ordered for the apartment. Elsie also introduced Reema to other young mothers at a mother and toddler group to increase her social network, but without success. Reema asked June at the drop-in baby clinic to chase up the hospital appointment for Ali's hernia operation, which was eventually carried out successfully in September 2005.

Reema was socially isolated. Her child and a legacy of regular nosebleeds constantly reminded her of her rape ordeal. Coping alone with the psychological effects of rape is a high risk factor for PTSD disorder (Seltzer 2004). Similar to the findings of Rutter et al. (2007: 57), this vignette highlights the initial stress for single asylum applicants of arriving in the UK.

A trusting relationship is a pre-requisite to aid PTSD recovery, which is developed through integrated continuity of care (Procter 2006), trauma focused therapy and reconnection with the host community (Maddern 2004). Jillian considered Reema to be highly vulnerable, as she initially visited her twice as often as was usual. A trusting and therapeutic relationship developed, which focused on child health issues and home safety. However, severe mental health issues require long-term therapy.

Jillian required additional mental health training to provide this care (she had stated previously that she found these issues difficult in section 5.2.4). The asylum claim caused Reema great anxiety, but these were difficult issues for Jillian to address.

Once the psychology referral had been made, Jillian delegated Reema's care to Elsie. Although able to provide social support, Elsie was untrained in mental health care. Reema's inability to use the mother and toddler group, suggests that this resource was inappropriate to her needs and she preferred the specialist women's group. Reema was at the stage of exploitation of resources (see section 5.3) as identified by Peplau (1988:54).

Three major health themes emerged from Reema's story and from the asylum focus group discussions of bad health:

1. The legacy of reduced access to health care
2. The continuing health needs to be resolved
3. The anxiety of an uncertain future.

These are now discussed in turn, with examples provided by other informants.

V7.4: The legacy of reduced access to health care

During this study the civil war in Sri Lanka was over 20 years old (Laloë and Ganesan 2002) and Tamils had suffered major human rights abuses for many years (Rajayogeswaran 1997). The long-term denial of quality health care has been shown to result in a lack of prenatal and obstetric health care for Sri Lankan women (Gajanayake et al. 1991). The multi-dimensional health care role of women (Hellman 2007: 83) is highlighted in this next vignette.

> *Jayani, the surviving parent of a Tamil family from Sri Lanka, was 39 years old. Her husband had been killed and she had come to the UK as a widow with her 3 children, who were currently, aged 17, 13 and two years old. Jayani stated: "My life has improved in moving to Glasgow, but I am very stressed. I suffer headaches and am rarely able to sleep the whole night."*

> *Jayani explained that during her first pregnancy she had been advised that she would require a Caesarean Section. Due to the civil war, Tamil access to health care in Sri Lanka was very difficult. When her baby was due to be born,*

there was no medical help available to carry out the operation. Jayani had delivered the baby herself.

The difficult birth had resulted in significant brain damage for her daughter, who was now 17 years old and continued to have special needs. In Sri Lanka she had not been able to go to school, but since coming to Glasgow she had attended a special school. Jayani said: "I carry out personal care for my daughter each morning and evening. My daughter is very happy at school and has learnt to do so many things for the first time."

Jayani coped with additional family health concerns. Her son aged 13 years attended a local school, but had required the insertion of grommets to improve his hearing. Her two-year-old daughter suffered with severe eczema. Both Jayani's elderly parents in Sri Lanka were very ill, but Jayani could not return to look after them.

The asylum experience involves medical, social, political and psychological aspects all at the same time (Desjarlais and Kleinman 1997). Jayani faced huge responsibilities in carrying out her roles as an asylum claimant, as the family's matriarch and as an unpaid carer. Jayani was suffering headaches and insomnia due to the stress of carrying out these multiple roles.

Asylum welfare support did not cover Jayani's additional costs of caring for dependents with long-term conditions. Although Health Boards now have a Carers' Information Strategy in place, there remains a dearth of information concerning carers from ethnic minority groups (Nolan 2001) and their support needs (Scottish Executive 2006b). A study of Tamil refugees in Norway highlighted that their aches and pains were often an embodiment of the tension between their needs for individuality and community engagement (Grønseth 2001). Thus, Jayani's long list of minor family health issues may also have been an indicator of integration difficulties.

V7.5: The continuing health needs to be resolved

The following vignette describes

One of the participants stated: "I have chosen a picture of someone who looks as if she is suffering stress". Some participants did not understand the word "stress". The English teacher entered the discussion to explain that it was a feeling of anxiety and of being under pressure. Most informants had a common understanding, but experienced linguistic difficulty in defining stress. They

described it as "being frightened", "too much thinking"; "nervous" and for one informant it was similar to a feeling she had experienced when her baby was about to be born.

In recalling the stress of leaving her home country, Dominique, broke down in a flood of tears during the first focus group. She stated: "My husband was shot dead in front of me. I escaped from the Ivory Coast with friends of my husband and I have only recently arrived in the UK. I have family in London, but it is very hard to cope with the loss of my husband." The English teacher gave Dominique the option of leaving, as she was so distressed. However, Dominique dried her tears and remained as part of the focus group.

Ines, a 28-year-old Cameroonian single parent with one child, had chosen a picture of a broken foot, which was in a plaster of Paris cast. She said: "I have also suffered a broken femur from a bullet in my leg; it is very painful at times."

These stress definitions centred on the psychological impact of taking personal responsibility for major life events. The loss of control agrees with the initial 'alarm stage' noted by Selye (1976). Ethically, I was concerned that I had overstepped the mark in asking informants to disclose sensitive information. Although I recognised that I should not expect participants to disclose painful experiences without resource to adequate psychological support, I also considered that all the informants should have an opportunity to contribute to the discussion. The informants were mutually supportive. Dominique may have found the cathartic release therapeutic, as she remained for the rest of the session and was a member of the second focus group several weeks later.

The emotional intensity of the focus group discussion increased when Ines also disclosed a broken leg. Both Dominique and Ines had experienced traumatic events beyond their control, which continued to affect their health but these were not visible. The other informants were unaware of their pain and discomfort. Ines needed to feel safe before she disclosed this 'bad health' information.

V7.6: The anxiety of an uncertain future

The fear of being sent home is a significant factor in asylum mental health (Carey-Wood et al. 1995). In a study of Sudanese refugees living in Cairo, Coker (2004) found the refugees described pain as 'travelling' through their fragmented

bodies and that 'thinking too much' was an exacerbating factor for illness. She concluded that these illness stories reflected embodied feelings of political powerlessness and social disintegration. Asylum narratives of their experience often reveal themes of having left the good life behind and demonstrate anxiety concerning the future (Pavlish 2007). Moreover, Rutter et al. (2007:60) found that refugees considered the period of waiting for an asylum decision extremely stressful, whilst an Irish study demonstrated that this psychological distress diminished only in those given refugee status (Ryan et al. 2008). Thus, the anxiety of an uncertain future created a huge tension, as shown in this vignette:

> *One asylum informant recalled: "I did not feel stressed before I had to leave my country, but now I feel stressed all the time." Another participant revealed, "I do not think about things too much – or else my head explodes." Several asylum participants said that they suffered painful tension headaches. One stated: "The Home Office is a big problem. Even our children are stressed as their friends ask when they are leaving." They found free time very difficult to cope with, as it would lead to "always thinking". In keeping busy, activities such as knitting and sewing were helpful to take their minds away from their asylum claim.*

> *Rita, a 24-year-old Albanian from Macedonia was married with a three-year-old son. The family had been in the UK for four and a half years. Although her son had been born here, deportation remained a real concern. Rita could not understand why the authorities wanted to send her home now. She said, "I do not sleep at night because I am so scared of going home. My heart is always racing. All I want is to earn a living and to live my life like other people in Glasgow."*

> *Valma, a widowed 56-year-old Albanian Kosovan, chose an emotive picture of someone placing a hand over the hand of another person to provide comfort.*

Although keeping busy in this study was one way of combating psychological distress and enabling sleep, the asylum applicant participants were often physically as well as emotionally exhausted. Fellow asylum applicants were best placed to understand the stress incurred, which frequently resulted in tension headaches.

For those applicants with a delayed asylum decision, it was a cruel blow to find that they would have to return home. When Rita said that her '*heart was always racing,*' the physical health effects were not outwardly visible but must have resulted from high levels of adrenaline and cortisol. Over time high stress levels may damage the

immune system, increasing susceptibility to virus-associated cancers (National Cancer Institute 2008). I do not think that Rita had high wealth expectations, but wanted to remain as she thought that Glaswegian life was less stressful.

Asylum applicants also described deep sadness as 'bad health'. Valma indicated that she required a helping hand in coming to terms with her violent past experiences to move on to a new life. This request for empathy reflects the major helping role of nursing discussed earlier in section 4.2.

7.2 Social isolation and health

Social exclusion embraces the notion that some groups within society suffer segregation from various activities such as employment, decision-making and cultural practices (Byrne 2005). Although a reluctance by asylum applicants to form new relationships has been attributed to a feeling of disloyalty to family left behind in the home country (van der Veer 1998:20), social isolation is more likely to stem from the asylum process, compounded by language barriers, racism and cultural factors (Barclay et al. 2003:32).

The stigma of being an asylum applicant can have a profound effect on self esteem (Whitehead et al. 2001) and may impact on GP client relationships (Bhatia and Wallace 2007). Asylum applicants experience greater levels of social exclusion than the indigenous population (Palmer and Ward 2007), resulting in disempowerment (Ager et al. 2002) and psychopathology (Laban et al. 2005). The psychological impact of forced migration may be misconstrued as a mental health problem (Maffia 2008). Maffia (2008) cites the seven grieves of exile as those of loss of family, language, culture, land, social status, peer group contact and physical injury (Achotegui 2002). Culture shock may arise from this loss and result in greater mental health morbidity for asylum applicants than the effects of trauma and rape.

Asylum applicants may be more vulnerable to racial attack when living in cities with limited experience of refugees (Refugee Council 2001a). In 2001, Firsat Yildiz, a 22-year Turkish Kurd, was stabbed to death in Glasgow. This unprovoked racial attack

indicated that asylum applicants were at high risk and should not be placed in areas where their basic needs could not be met (Refugee Council 2001b). Racial attacks on asylum applicants in Glasgow continue to occur. In April 2007, a racially motivated sexual assault was perpetrated by four youths on a female Algerian asylum applicant and her one year old son (NEWS.Scotsman.com 2007b).

In this study I noted that social isolation impacted on the mental and physical health of asylum applicant women in several ways, including:

- Difficulties of living on a low income
- Reduced access to services
- The asylum burden
- The loss of family support
- Marginalisation and racism
- Personal safety issues

The following vignettes V7.7 to V7.12 describe the issues that I considered contributed most to the social isolation of the asylum women. These are not the only factors, but the ones of which I became most aware.

V7.7: Difficulties of living on a low income

The following vignette demonstrates the potential health effect of diet poverty and complements vignette 5.12, which discussed issues for underweight children. Likewise, a study of African asylum dietary changes has also included a reduction in the amount of fruit and vegetables eaten (Kruseman et al. 2005). Poor diet and reduced exposure to sunlight may result in undiagnosed Vitamin D deficiency and musculoskeletal pain (de Torrente de la Jara et al. 2006).

I asked the first asylum focus group how they tried to keep healthy. One asylum informant stated: "I buy fruit and vegetables in a local supermarket, but it is not as good as in my home country, less fresh, especially the vegetables." There were no African shops locally, but the informants knew where to find these. They had no major cultural concerns about food and diet, although another stated: "Fish is too expensive to eat on a regular basis."

Wilma, a 35 years old asylum applicant from Liberia lived with her husband, aged 37 years and their three daughters, aged ten years, four years and three weeks old. Similar to other asylum applicant families they lived on a low

income, but resided in a condemned 30 storeys high tower block of apartments, sited in an urban wilderness of broken paving slabs, discarded food waste and deserted cars. Many windows were missing, making the landings draughty and cold. It felt unsafe, dirty and a strong disinfectant smell lingered in the lifts. Once inside, the flat was clean and tidy, well furnished and welcoming, but with few visible children's toys. We sat on a white leather settee. There were little statues and pictures suggesting a strong Christian influence as well as local support and help for this family.

Wilma had been raised in a Catholic Mission in Liberia, where she gained a sense of western culture through learning to speak English. James had been a history teacher, but since arriving in Glasgow, he had been unable to work. Although enrolled on a part-time basis college course, it was the vacation and he was spending a lot of time in bed. James had bought a computer at a car boot sale and met his friends in town occasionally, but frequently had a low mood.

Next, we visited Lo, 33 years old and Wendy, 34 years old and their first baby, Jo aged four and half months old, who were a Mandarin speaking family from Mainland China. The family had arrived in the UK in 2000. They had been in Glasgow for eight or nine months, but their English was poor. They had limited social support and met with their own community in the city centre rather than at home. Lo suffered from diabetes. His left arm had been amputated just below the elbow joint after an industrial accident in 2001. The small one bed-roomed flat was minimally furnished, although Jo had lots of toys, reflecting the parents' child centred priorities. The family appeared quite insecure. I noticed that that they had double locked the front door during our visit.

Wendy and Lo asked June for childcare advice. Lo stated that they wanted to buy a baby walker. June suggested that Jo was rather young and she would benefit more from being on the floor, to develop strong muscles. In discussing the range of toys available, it appeared that floor play was less culturally acceptable. Jo demanded to be constantly held by Wendy. Lo was upset that Jo was rejecting him. With only one arm, Lo had been holding her too tightly and Jo sensed these anxieties.

On a second visit, Jo was almost one year old. Lo had developed a better relationship with his daughter and was able to hold her more comfortably. I noticed that the baby walker was now redundant, as Jo was crawling. A large bright red toy car was taking a prominent place in the small flat. In spite of all these toys the baby was anxious and cried once put on the floor or separated from either parent.

This vignette shows the variation in the material home circumstances for asylum applicants. One family was living in a well-furnished flat and the other living in very sparse conditions. A local church group had helped Wilma to furnish her flat. The

greater social capital and ease of adaptation to western culture had helped the family to acquire improved living conditions.

Irregular migrants have been shown to work frequently in low paid and understaffed manual occupations (Migration and Equalities Team 2006:11). Although Wendy and Lo had worked in the UK for several years before claiming asylum, social integration was difficult as seen by their low level of English and emphasis on home security. Moreover the family received limited local community support as their Chinese community met some distance away.

Both families were experiencing anxieties about family health. Despite the local social support, Wilma was concerned that her husband was suffering from depression, whereas Lo was anxious that his daughter was rejecting him. Both men had lost their previous roles and status; the link between unemployment and ill health has been recognised as a major contributor to health inequalities (Netherwood 2007). Moreover, the wasted skills of a highly educated Zimbabwean asylum population were highlighted in a recent report (Doyle 2009). Reduced social networks can impact on health status. Whilst social capital is often reduced in married couples, it is frequently lower for men than for women (Bolin et al. 2003). Likewise Wilma's husband had few social contacts and often spent his time working alone on his computer.

This vignette also demonstrates variance in childcare beliefs. Whereas June considered that putting babies on the floor helped to develop strong muscles, Wendy and Lo did not share this belief. Although Wendy and Lo had bought the baby walker, it was no longer useful. The toy car was a cultural icon. It was red, a lucky colour for Chinese people. It indicated not only a family commitment to providing the best they could afford for their child, but also an aspiration to acquiring western wealth.

The child's under confidence can partly be explained by John Bowlby's theory of attachment, where a child learns that the presence of a mother is associated with

comfort while the separation from the mother is associated with distress (Bowlby 1973). However, the child was not frequently separated from her mother for any length of time, suggesting that the child's insecurity reflected the parents' anxieties, which probably arose from their asylum claim. Thus, the whole family felt the stress of the asylum claim.

V7.8: Reduced asylum welfare

Asylum applicant families living on a low income found difficulty in accessing both acute and primary health care due to transport costs. The following vignette highlights the difficulties of obtaining reimbursement of bus fares.

> *Lisa, introduced in section 6.2, was anxious about her baby born at 26 weeks gestation two days after arrival in Glasgow. The premature baby had a poor prognosis, as she was very ill. Lisa was taking expressed breast milk to the hospital for her baby two to three times each day. Although the health of her new baby depended on her breast milk, she walked to the hospital because she had no money for bus fares. She had asked the Social Work Department for reimbursement of bus fares, but was referred on to the Scottish Refugee Council (SRC). The SRC had referred her back to Social Work Department, but she had decided not to pursue the issue further. Jane agreed to find out about asylum entitlement to reimbursement of bus fares and advised Lisa to keep her receipts so that she could make a claim at a later date.*

Lisa was walking some distance to the hospital to breastfeed her baby. The going without food at times was detrimental to her health and her breast milk supply. Thus the lack of clarity regarding entitlement to travel costs reimbursement and lack of translated information further disadvantaged Lisa in accessing NHS services.

V7.9: The asylum burden

Domestic abuse is thought to have a profound effect on the victim. The perceived inability to escape and the need to pacify the perpetrator (usually, but not always the husband) results in psychological dependence and a lack of confidence (Wallace 2007). Asylum victims of domestic abuse are entitled to be re-housed (Home Office 2004b), but claiming asylum as a single parent is not easy, as the following vignette describes:

> *Zola was a 33 years old South African asylum applicant, who had originally come with her husband to the UK. Their marriage had broken down, Zola had*

suffered domestic abuse and her husband had deserted her whilst they lived in London. Zola was now pursuing her own asylum claim in Glasgow.

I was struck by the asylum burden that Zola was carrying. Zola stated: "I do not miss South Africa very much. Both my parents are dead; there are no jobs, no opportunities if I return. I feel depressed here, but South Africa can be just as cold as Glasgow in the winter."

It was only 5 weeks since the birth of her baby Annabel, but as a single parent she had attended the immigration department several times in the last two weeks. Zola was breastfeeding with no significant problem, but attended the drop in clinic for advice. She attended a local church on a regular basis, and stated: "I often leave at the end of the church service without speaking to anyone."

Although she said that she lacked support, a friend helped her to make sure that the baby was securely wrapped in a blanket on her back and tied at the front across her chest. Once Annabel was in place and snugly wrapped, she fell asleep and looked very comfortable. It occurred to me, as I observed their departure that the baby was a symbol of the asylum load that Zola was suffering.

Asylum applicants carry a huge burden in pursuing their asylum claim, which sets them apart from the rest of the community. Stress is often conceived as a heavy weight (Helman 2007: 300). Zola was socially isolated. The legacy of domestic abuse resulted in a lack of confidence in meeting other people, as can be seen from her difficulties of integration at the local church. Secondly, she was pursuing her asylum claim whilst only five weeks post partum, which was both physically and emotionally demanding and potentially impacted negatively on her health.

The loneliness of constant childcare created a third aspect of social isolation for Zola, with few friends or relatives in the UK to provide social support. Loneliness, although not pathological in itself, has been shown to be a common problem for unemployed people, single parents or women suffering domestic violence. Community nurses can play a role in augmenting social capital, through the prevention of loneliness (Lauder et al. 2004) and by using strategies of companionship to encourage social contact (Kritsotakis and Gamarnikow 2004).

V7.10: Loss of family support

Asylum women found the lack of UK family members to help with childcare resulted in social isolation and is described in the next vignette.

> *Kristina stated: "I am always alone with no one to talk to. I have little help with childcare in Glasgow; back home there was always a family member to care for children if it was necessary to attend an appointment."*

Thus asylum women often felt bereft, as contact with family living abroad was very difficult. During this study, nursery provision was only available in the pre-school year and contact with children outside the family was mainly through crèche attendance whilst the child's mother was attending a further education class. For those parents not attending college classes, their child was potentially at a disadvantage with a reduced opportunity to attend a preschool learning environment to improve English language skills.

V7.11: Examples of marginalisation and racism

Marginalisation and racism can also negatively affect mental health. A qualitative survey of Lothian refugees in 1994 identified problems related to language difficulties, harassment, isolation, money and welfare rights, as well as lack of access to employment and training (Walsh et al. 1994). Watters (2001) also found in a small UK study that racism affected asylum mental health. Moreover, a UK study of refugee women experiences showed that a high level of psychological stress required treatment or it could lead to depression. A third of the informants felt unsafe and maintained a self-imposed curfew of seven pm at night (Dumper 2002).

> *Wilma (introduced in V7.7) described an incident, which made her cry, even though it had occurred some months previously. She reported that she had been waiting in the local supermarket check out queue and she was ready to be served at the till. Someone put his groceries in front of hers. Wilma said, "Excuse me, but there is a queue." The white person, who was obviously rather drunk replied, "You are just an asylum seeker and have no right to be here."*

> *Likewise Nora, (introduced in V5.13), described how one day on the bus a lady asked: "Where do you come from?" "Nigeria" Nora replied. The lady commented to the bus driver "What are these people doing in our country?" This racist remark had made Nora feel very uncomfortable. On another*

occasion, Nora did not know the way to the GP surgery. She was impressed that someone not only gave her directions but also followed to make sure she went the right way.

Kristina (see V5.11) stated that she felt intimidated by local children, who would spit at her in the street. She said: "If I am going out with the baby and I see these children, I return home for a short time to wait for them to go away and then go out again later in the day."

A nurse focus group informant stated: "Asylum families face a 'tension' in their local community. It is difficult to address racism except in extreme circumstances when it is necessary to move a client to other accommodation."

These examples show that asylum women faced uncertainty as to how other members of the local community in Glasgow, including children, would respond to them. Whilst Wilma had become a valued member of a local Catholic Church, she was made to feel an outsider at other times. Although Wilma was obviously quite assertive in asking someone to refrain from jumping the check out queue, months later she was still emotionally upset by the event. Similarly Nora was given conflicting responses of racism on some occasions and help at other times. Kristina felt intimidated by local children. The final comment suggests that the community nurses were aware of these issues, but felt powerless to do anything about it except in severe cases.

V7.12: Personal safety issues

Although most asylum focus group participants wished to remain in Glasgow, they were also anxious about personal safety, due to drug dealers and their clientele. The following vignette demonstrates how the teenagers' behaviour was intimidating to asylum women.

> *One focus group participant stated: "Sometimes the lift is broken and I have to go up the stairs. It is dangerous, especially with a pram, as you can meet teenagers on the stairs with drugs. There are spots where there are no cameras. I have to walk by quickly, but sometimes they find you alone and it is too difficult to move."*

There were also personal safety risks for professional workers. Whilst community police often patrol in pairs, the community nurses usually worked alone, often missing a lunch break to avoid late afternoon visiting. I can also remember feeling

very vulnerable when leaving the high-rise flats alone on a dark winter late afternoon.

7.3 Aiding adaptation to a new environment

Integration into a new host environment is a two-way process. A key stage in the acculturation process, it involves an individual taking on board the norms and values of the host society without the loss of identity, whilst the host community accepts and welcomes the individual as an equal member of their society (Berry et al. 1987a). Australian studies have shown that community based activity helped Afghan refugees to adjust and cope with a new environment (Omeri et al. 2004). Transformational coping is a concept that includes focused action planning, a positive re-interpretation of events and the seeking of help (Maddi and Hightower 1999). Tailored Australian education and training programmes for asylum applicant children have similarly been shown to aid integration and be effective in improving mental health (Bond et al. 2007).

Community nurses have a role in aiding asylum applicants to adapt to their new environment (Papadopoulos et al. 2003) and re-establish social support mechanisms (Tribe 2005). Adaptation is often hampered by employment and language difficulties. Moreover UK studies have shown that asylum applicants need help to integrate into society (Malcolm 1995) and that improved mental health outcomes result from regular community interaction (Watters 1998:296). Asylum children in Scotland require acceptance by their new school friends (Save the Children and Scottish Refugee Council 2000). The stress of the adaptation process has been shown to result in depression in Ethiopian refugees (Papadopoulos et al. 2004) and social contact may be more important than practical support or the provision of counselling (Ager et al. 2002). In this study, the data highlighted three major health aspects of adaptation, which included:

- Promoting language concordance
- Promoting self help for health
- Cultural expectations of parenting

V7.13: Promoting language concordance

The Scottish Refugee Integration Forum Action Plan (2003) had pledged additional funding for statutory English for Speakers of Other Languages (ESOL) classes (Scottish Refugee Integration Forum 2003). This provision was limited as the voluntary sector provided these services for asylum applicants free of charge. ESOL courses aid social integration (Rutter et al. 2007:183) and promote asylum access to NHS services (Johnson 2006: 61). More recently, the limited delivery of ESOL courses has received national attention (Department for Innovation 2008) and funding has been granted to promote greater social cohesion (Denham 2008) However, these programmes are not the only factors in reducing community tensions (NIACE 2008). The following vignette demonstrates that the community nurses enabled access to ESOL classes to potentially promote language concordance and facilitate effective nurse-client communication.

> *ESOL classes were offered in several local further education centres free of charge. The classes generally were one or two hours long, enabling one parent to provide childcare whilst the other attended the class. Although the asylum women frequently had poorer English language skills than their husbands, they experienced greater difficulty in accessing ESOL classes due to limited availability and a lack of crèche places. Asylum applicants sometimes needed to address literacy problems before they could learn English. The community nurse informants encouraged their asylum clients to attend ESOL classes to improve their English language skills. One nurse informant stated: "My work is so much easier if a client can speak English."*

> *I accompanied Elsie on a home visit to discuss ESOL and other classes at the local centre. Sadaf, introduced in V5.6, had attended university in Pakistan before her marriage, but her English was limited. When Kamil returned from his lawyer's appointment, he translated the consultation dialogue for her. I was unsure as to how much information he passed on to her. Elsie completed the lengthy further education admission forms for the couple. The class teacher tested the asylum applicant's language skills during in a separate interview. As Kamil had good English, Elsie suggested that he might volunteer to be an interpreter, even though he had no previous experience.*

> *For Nicolai, ESOL classes were not a priority. He had learnt English at school. Although he spoke slowly, he had a good grasp of English. He was completing a higher education computing class, but the course afforded few opportunities for English conversation.*

Asylum women were disadvantaged in gaining English language skills, especially if they were a single parent with childcare responsibilities. The HCSWs enabled

asylum access to ESOL classes to address issues of equity, access to health services and social integration and promote future one to one consultations. If clients could be encultured into the indigenous population, the range of cultural behaviour was also reduced.

The benefit for asylum applicants of attending ESOL classes varied. The courses needed to be at the right level and there were longer waiting lists for more advanced courses. Some asylum applicants were able to improve their English language skills very quickly, whilst others took much longer.

V7.14: Promoting self help for health

This next vignette provides examples of adaptation and self help for health.

I began the second asylum focus group discussion with a few questions: "How was the group feeling? Were there any changes?" Shamina reported happily: "I am feeling much better as I am attending a gym in the centre of Glasgow, which is just for women. I only started last week, but I want to be able to go out alone. I hope to lose some weight. My husband looks after the children and I am only away from home for about two hours."

The asylum focus group members stated that in their own country usually only the men attended the gym. The women now did less exercise than previously. Some would have walked two hours each day collecting water from the well. However, the weather was not good enough to walk outside in Glasgow during the winter and the lack of exercise increased their stress.

Although the participants were aware of other support groups, these were thought to be unsuitable. Another participant reported: "The English class is our only chance to talk about the Home Office." Two informants who had attended the first focus group had left the ESOL class, as they had become good friends. Their language skills had developed sufficiently to provide mutual support.

In this vignette, Shamina had adopted western styles of keeping healthy. She wanted to integrate into her new host environment by being able to go out alone. However, attending a gym was not an option for many informants, as they were single parents with childcare responsibilities. The ESOL class provided informal social support to cope with the stress imposed by the asylum system. The group functioned as a self-help group, which Helman (2007: 82) describes as a popular sector health care network. These informal therapeutic encounters enabled the asylum applicants to

give and receive psychological support, thereby reinforcing self-esteem and mental health.

V7.15: Examples of cultural parenting issues

This next vignette describes a range of parenting issues for asylum applicants. Although parents regard health visitor input regarding childcare as helpful (Hogg and Worth 2000), parenting is culturally based and childcare anxieties can exacerbate stress if cultural norms and expectations are not met.

I noted that asylum applicant informants had few extended family members in the UK to turn to for advice regarding parenting issues. The community nurses considered that their role involved providing clients with an understanding of parenting norms and expectations.

June stated: "I try to normalise the minor ailments associated with teething and reassure clients that these problems are an everyday occurrence that will get better in time."

Cynthia stated: "One of the common child protection issues I have encountered is that of leaving children at home alone. For example, an Afghani woman had left her two children, aged five years old and three years old, alone in the flat while she went shopping. On my visit, the children invited me into the flat. I waited with them until their mother returned." She explained to the mother that, although it may be safe to do so in Afghanistan, UK parents are not allowed to leave their children alone at home. The mother had understood the dangers and accepted that she should make appropriate childcare arrangements in future.

Wilma stated: "I could go to prison if I smack my children, but there are many petty quarrels in the small flat."

Lo and Wendy were concerned that their baby might hurt herself on the hot bars of the wall room heater in the sitting room. June agreed to arrange for a fireguard to be fitted.
On a visit to Sandra, a 36 years old full time mother of three children, who was married to Stephen, aged 40 years old, I observed a home safety issue. The family had come from Sri Lanka a year and a half previously. Once given refugee status they had decided to remain in Glasgow. Although a modern baby seat was sitting unused in the corner of the room, Sandra's seven weeks old baby daughter was dangling several feet off the ground in a home made cradle suspended perilously from a short nail in the ceiling. The swinging hammock soothed the child to sleep, but if the nail had given way the child could have been injured in the fall.

The constant parenting responsibility was an additional concern for asylum parents, who were frequently used to extended family support with childcare. Parenting issues involved the management of minor child ailments, adaptation to social norms of behaviour and home safety. Perhaps due to the poor housing and humid Glasgow climate, the asylum children in this study were prone to coughs and colds. The parents did not understand these minor ailments and hence used PHC services more readily than the indigenous population. Secondly, the community nurses reinforced socially expected norms of behaviour regarding chastisement and not leaving children alone. The asylum women found chastisement difficult without resource to smacking. The small apartments were claustrophobic and it was hard work to take the children out to play in the park, especially during cold weather.

Home safety issues were raised in the use of the homemade cradle. An audit of admissions to a paediatric burns unit in Ireland found an over representation of asylum applicant children (Dempsey and Orr 2006). If Elsie questioned the use of the cradle, she risked appearing over-critical of an experienced mother. The situation also presented ethical dilemmas for me, as to whether I should intervene. Elsie decided to inform the client's health visitor and seek further advice.

7.4 Resolution of client care

Peplau (1988:40) describes resolution as the closure of the client-nurse relationship. This involves the strengthening of a client's capability to function independently of nursing support.

V7.16: Reema's story part III

The NIA Act 2002 (see section 1.4) curtailed the asylum appeals process and resulted in asylum detention through a policy of dawn raids (Reoch 2005). The psychological impact of prolonged detention (Silove et al. 2007a) and constant surveillance has been shown in Australian detention centres to negatively impact on mental health (McLoughlin and Warin 2008). Australian asylum applicants suffering PTSD improved significantly when granted refugee status compared to those who were refused asylum and were subsequently detained (Silove et al. 2007b). As many

as 1,500 asylum families in Glasgow were facing forced deportation in 2006 (Gordon 2006). The closure of client-nurse relationships was often abrupt, as unsuccessful asylum applicants were deported or the family went into hiding. Deportations following dawn raids were a common event, but sometimes could be prevented (NEWS.Scotsman.com 2007a).

At five o'clock in the morning in late March 2006 there was a knock at the door of Reema's apartment. UKBA officers came to remove Reema, Mohammed and her baby Ali to a detention centre in Scotland. The immigration officers considered that the asylum case was closed. Although Mohammed had exhausted appeals against his decision, Reema was still entitled to a second hearing.

The immigration officers collected only clothes and nappies for Ali. They forgot to pack any baby milk or food. Before they left, Reema was supervised using the toilet, which she found humiliating. As Reema became highly stressed, her nose started to bleed heavily. Ali and Reema were taken away in one car and her husband in another to a Scottish detention centre.

The family remained in the Scottish detention centre for two days. Reema stated: "The centre staff were pleasant. The nurse gave me a spray to stop my nosebleed, but there was little food that Ali could eat and he was hungry." On the third day, the family was transferred to another detention centre in England. The Scottish solicitor could no longer help the family. Reema contacted a London friend who involved her Glasgow MSP. A London solicitor was found, who promptly contacted a judge to stop the removal. The removal was illegal because the family had not been given the full removal paperwork, giving notice of the date and time of the flight.

The process of deportation continued. The family was given the full removal details by an interpreter and was taken to the airport at four am. Reema demanded not to be sent to Khartoum. In her distress, her nose started to bleed profusely again. Reema stated: "The immigration officers were very rude and racist in their attitudes. They said that I had deliberately picked my nose to make it bleed and to delay the flight." Reema could not remember very much about this time, but once again, the flight to Sudan left without them.

The family was moved to another detention centre and was given a third removal date with the correct paperwork. The immigration officer told them that UKBA officers would hand the family over to the Sudanese government for safekeeping and remain for six hours to check their safety before returning to the UK. Reema considered that the government would probably kill her and possibly her baby as well. Reema tried desperately to contact the London solicitor and for a third time they were taken to Heathrow Airport for the next flight to Sudan.

Meanwhile a high court judge ruled that the deportation should be stopped. Reema was entitled to another asylum hearing. Reema was treated in hospital for anaemia. After three days, the family was given a train travel pass to return to Glasgow. Reema made an appointment to see her new solicitor before she left and has since been in regular contact with him.

There had been no warning of the family's impending deportation to the community nurse team. In early April there was a message that the flat was empty and the family might have been deported. Jillian stated: " I was concerned as I thought that Reema was unsuitable for deportation due to her mental health problems." When the psychologist was informed she also took steps to stop the deportation. One week later the family returned to Glasgow.

Later in this study, Caroline took over Reema's case. I was invited to meet Reema. Caroline said: "An opportunity for Reema to tell her story might be helpful in coming to terms with all that has happened to her." The dawn raid had affected Reema's family, perhaps with long lasting consequences. Although the family had returned to their original Glasgow flat, Reema could not venture out alone as she was highly anxious about detention. Reema stated: "I cannot sleep as I have flashbacks each night concerning the rape and my father's death." Jillian reported that Reema had changed and engaged with the nurses more on her own terms. She was no longer outgoing and expressive. She had lost a lot of confidence. Jillian stated: "Reema now seeks petty things to help her asylum claim." When I spoke to Mohammed briefly after the interview, he said, "If there is a knock at the door, Ali is terrified and hides in a corner of the room."

In July 2006, Ali developed an eczema skin condition. Caroline showed Reema how to apply the prescribed cream to his skin. At a visit in August Ali was only 17 months old but was chewing gum. The parents had not realised the dangers and agreed to stop giving it to him. Reema experienced a racially motivated attack in the local park in September 2006. An eleven-year-old boy deliberately knocked Ali over in the local playground and threw a bottle at Reema. The police had become involved to investigate the racist incident, which had been captured by a surveillance camera. Reema's increasing frustration with the asylum process led to declining mental heath and an inability to cope with life as an asylum applicant in Glasgow. Jillian stated: "Sometimes Reema behaved inappropriately and made herself a target, such as sitting on a bench used mainly by drug users."

By the end of my fieldwork, the future was looking brighter for Reema. It was hoped to move the family to another flat in the near future, to provide a crèche place for Ali and to give Reema some much needed time alone. Caroline considered that over time she had built a meaningful and trusting relationship with Reema, who could now contact her whenever she had a problem.

This final part of Reema's story highlights the potential plight of unsuccessful asylum applicant families. Although the family members were not criminals they were poorly treated and racially abused. UKBA may have moved the family from one detention centre to another to make legal representation more difficult and ease the deportation process. There was no request for a PHC medical report to ensure that Reema was mentally fit for deportation. Moreover, little consideration was given to the child's welfare, which contravenes UK policy of putting the needs of children first (Department of Health et al. 2003) as well as infringing human rights legislation. The family suffered huge psychological effects from the dawn raid and failed deportation. Reema suffered further acute anxiety and flashbacks. These are not only a common feature of PTSD (Seltzer, 2004:104) but also a major consequence of the lack of permanent residency status (Momartin et al. 2006).

High risk health behaviour has been shown to be associated with bicultural stress (Romero et al. 2007). The community nurse team had provided Reema, since the birth of her baby, with regular emotional support, advice on childcare and home safety. These support visits can be thought of as 'gentle surveillance' as Wilson (2001) suggests. Although Reema placed a high value on this nurse-client relationship, where there was a sense of 'give and take', Reema finally used this relationship to further her own asylum cause. The nurse-client relationship eventually became one of adult to adult, when Caroline assumed her care. By the end of the study Caroline had empowered Reema to contact her when necessary, an important stage in nurse-client relationships as suggested by Peplau (1997). Although Jillian provided the case notes' information, Caroline had provided most of the mental health support of this family without access to clinical supervision.

V7.17 Working with unsuccessful asylum applicants

As Reema's story highlighted, the community nurses delivered nursing care to asylum applicants who could suddenly disappear without warning; the following vignette describes the emotional consequences for the community nurses:

"Forced repatriation-it's hard to cope with the emotional loss of the family."

"End stage, there is nothing you can do to help. It is cruel. If the family is to be sent back it should be at the beginning. Sometimes it is after 6 years."

"Asylum applicants grasp at anything, they hope for an amnesty."

"There is often tension in the community. The threat of a dawn raid is difficult to live with. Asylum applicants often do not answer the door."

This vignette shows that when their clients disappeared, the community nurses experienced feelings of a lack of closure of the nurse-client relationship, as well as a sense of powerlessness, unable to intervene, no matter how unjust the circumstances. There were subsequent consequences for their home visiting practice, as asylum applicants did not always answer the door to cold calls, in case it was UKBA officials carrying out a raid. During data collection, in spite of arranging a visit, I also encountered difficulties of gaining access to an asylum applicant's home. I forgot to shout through the letterbox to let the informant know who I was.

7.5 Summary

Cultural knowledge was identified as the fourth step in the updated Five Steps model. The data vignettes have shown that it is a major component of cultural competence. The community nurses required cultural knowledge to understand the additional stress factors affecting asylum health, to aid adaptation to a new host environment and cope with deportation issues. Asylum applicants also required cultural knowledge to understand the stress of the asylum system, provide mutual self help and aid adaptation.

The concept of poor health was explored in V7.1 and V7.2. Whilst the community nurses held the client responsible for not adopting SNHS health promotion messages, the asylum informants considered that poor health resulted from inadequate self-care, but recognised that this was not always under the individual's control. The disempowerment imposed by the asylum system reduced asylum internal resources and individual capacity to deal with these issues. Secondly, as social control agents, the community nurses promoted asylum understanding of primary care services to increase confidence in the system and gave advice based on SNHS priorities. Thus,

asylum participants had a limited self-help capacity, or salutogenesis, and required help and advice to maintain health.

Reema's account in V7.3, demonstrated that asylum women were coping with past experiences of rape. Whilst these issues were central to their need for flight to escape persecution, they were not immediately resolved in coming to a place of safety. Both physical and mental health was already compromised on arrival in the UK. V7.4, V7.5 and V7.6 showed that health issues for asylum informants arose respectively from a legacy of limited access to health care, continuing health needs and the anxiety of an unknown future. Although a specialist psychological service provided group therapy for asylum applicants with PTSD and mental health issues, the treatment took time and a waiting list was in operation.

Social isolation was evident in many ways. Although asylum women wanted to live in Glasgow and integrate into their new community, there were major difficulties of living on a low income. Some asylum applicants had greater access to social capital than others. Moreover, high transport costs impacted on asylum access to health care. The drop-in baby clinic (described earlier in V4.6) provided a local, accessible service to overcome asylum transport poverty.

The loss of family support and the huge burden of the asylum process, when combined with marginalisation and racism, were damaging to self-esteem and mental health. Personal safety was an issue for all people living and working in areas suffering high deprivation. The community nurses reinforced important social expectations, for example, that children should not be left at home alone, or to comply with service access conditions, such as being ready on time for the taxi to take a child to a special nursery. This cultural inclusion approach encouraged asylum applicant clients to become more in tune with the host population.

The community nurses tackled asylum health inequalities through a commitment to promoting social and cultural inclusion. Aiding adaptation to a new host environment concerned facilitating language concordance, self-help for health and host cultural expectations of parenting, as described in V7.13, V7.14 and V7.15. Promoting

language concordance involved encouraging the uptake of ESOL classes. As also discussed in the previous chapter, the community nurses considered it was important to help asylum applicants to improve their English skills to facilitate one to one working, to develop nurse-client relationships (as described in chapter five), to maintain confidentiality and preserve autonomy. The HCSWs helped to reduce social isolation for asylum applicants through facilitating access to ESOL classes, further education courses and mother and toddler groups to increase asylum networks for social capital.

Deportation issues caused major distress to both asylum applicants and the community nurses. The cold-hearted policy of dawn raids did not take account of the fragile mental health of asylum applicants. The account of a failed deportation in V7.16 demonstrates the psychological effects of the dawn raids, the unfair treatment Reema and her family received and how PHC services were often left to pick up the pieces. The strength of the nurse-client relationship is seen in Reema being empowered to contact her HCSW whenever the need arose. V7.17 showed the additional stress for primary care community nurses of their asylum clients unknowingly disappearing or being deported. The community nurses were devastated by the outcomes of the dawn raids and thus continuity of care was compromised by the asylum system.

From my data collection I concluded again that the community nurses acted as intermediaries in taking seriously their community health role to empower asylum social adaptation, thus reducing social isolation and limiting health inequalities. This role was frequently delegated to the HCSWs, due to nursing capacity and the high pressures of workload described in chapter four, along with the non-nursing nature of the role. Although health promotion was a major nursing role requiring facilitative approaches, this function remained epidemiologically defined; the community nurses did not consider social health as less important, but delegated this area to unqualified team members. The HCSWs used their own community cultural knowledge and more authoritative approaches to enable asylum applicants to understand their parental responsibilities in the new social environment. Conversely, a lack of

community nursing cultural knowledge within mainstream services could impact on the priority given to aiding social adaptation, which could potentially increase social isolation for asylum applicants. Thus, an appropriate mix of nursing team skills was important not just to contain NHS costs, but also to provide a range of medical and social nursing care interventions to promote the asylum community's health. Mechanisms for HCSW clinical supervision and monitoring of care were required.

Chapter 8. Culturally competent community nursing care

The previous four data chapters have discussed the findings in relation to the study's research questions and the nursing literature. Whilst recognising the limitations of this study, the findings have given some validity to the Revised Five Steps model of cultural competence (as detailed in section 3.2.1) for asylum applicants. I now present my understanding of the meaning of cultural competence for community nurses and asylum applicant informants. Three major themes emerged from the data vignettes, which included equity, access and provision of non-discriminatory service. Secondly, the cross-cultural promotion of health and thirdly the delivery of socially inclusive services. These themes are not an exclusive list, but are the ones that I considered to be most relevant to community nursing.

8.1 Limitations of this study

This ethnographical study has several limitations. In describing the provision of asylum primary health and nursing care primarily for asylum applicants and their young families living in Glasgow, I located this study in a relatively small geographical area. Whereas the Scottish social context of Glasgow is unique, Scotland also manages its health care system differently to the rest of the UK, as described in section 1.3. I have used a small asylum study sample, which is not necessarily representative of the total UK asylum population, due to Glasgow receiving a higher ratio of families to single males than other dispersal areas. Caution should therefore be taken in generalising these findings to other UK areas.

Secondly, the study is limited by the timing of the data collection. This social snapshot was taken during 2005-2007, but asylum law and entitlements are constantly changing. Since this study was conducted, asylum applicants are now allocated a caseworker to reduce the asylum process time and further reductions to welfare entitlement of destitute asylum applicants are proposed (Refugee Council 2009). The community nurse teams have also undergone a significant restructuring. Effective nurse-client relationships for asylum applicants may be less easily

developed in future due reduced workforce capacity and the shorter period of asylum applicant claims.

A third study limitation is that the informants were in process of or already registered with a GP. I did not access unregistered asylum informants, although there must have been homeless asylum applicants unable to register due to an unsuccessful asylum claim.

As the main data collection instrument in this study, another limitation to the data collection was that I decided which data to record, to analyse and to include in this thesis. Although I aimed to be objective in my observations, I was inevitably influenced by my own previous experience of community nursing, the situations I was privileged to observe and by my relationships with the informants. As has been previously noted in section 2.2, culture is the medium through which we all operate, not just the informants. I too was subject to seeing a situation in my own light. Although I wanted to jump into the shoes of people from diverse cultural backgrounds, I may not have always been on the same wavelength and interpreted the situation as they saw it.

To overcome these restrictions to the production of a valid account, I mixed the research methods and allowed the research informants to tell their own story. I used my observations to contextualise and make the data meaningful. I also triangulated the data to gain a broad perspective and guard against a distorted picture of reality. The vignettes have provided examples that demonstrate concordance between data sources and establish the major themes arising from the observations and the narratives.

8.2 Equity, access and the provision of non discriminatory services

Reema's story, a backdrop to this study, provided an insight into the disempowerment and discrimination experienced by asylum applicants as well as the major mental health issues arising from the asylum journey. As discussed in chapter

1, equity remains a fundamental NHS value but it is not easily achieved (Hanafin et al. 2002). Almond (2002) recognised that equity involved equal opportunity to access services or horizonal equity, universal quality of care and unequal service provision to meet unequal need or vertical equity. Likewise, I identify that equity, access and the provision of non-discriminatory services are important concepts underlying culturally competent community nursing care of asylum applicants. Horizontal access ensures fairness in that all those entitled to primary care services enjoy equal access and do not suffer discrimination, whilst vertical equity may involve inequitable service provision to meet identified physical, mental and social health needs (Jan 1995). I witnessed asylum clients and families receiving equitable access to dedicated and gateway primary care services, but I may not have gained the full picture, as unregistered asylum applicants may not have experienced similar levels of access to GP services. For example, unsuccessful asylum applicants potentially faced limited access to NHS services and consequently discrimination in the receipt of health care.

Braveman and Gruskin (2003) suggest that equity in health care is the absence of systematic disparity. Thus national policy (Scottish Executive Health Department 2001b) and institutional regard were major influences on local policy for the provision of culturally competent primary health care for asylum applicants. Asylum applicants, in coming from diverse backgrounds, required help to override primary care access barriers of language difficulty, lack of understanding of the PHC system (McDonald 2001) and welfare constraints resulting in transport poverty.

Although the allocation system was efficient and provided a first step to understanding primary health care services, asylum applicants were potentially marginalised through reduced mainstream choice of GP and transport poverty. Horizontal equity policy worked fairly well within the dedicated services, but the mainstream GP registration for asylum applicants was not always fully implemented or enforced. In spite of the empowering nature of HV-led outreach services, asylum applicants found difficulty in accessing and were not confident in using GP services, often due to communication difficulties. Likewise Shah and Cook (2008) have noted

that socially disadvantaged people receive poorer access to services and make greater use of accident and emergency services (A&E). Hargreaves (2006) suggests that improved access to PHC services for asylum applicants may reduce use of A&E services. This study suggests that addressing the reduction in out of hours PHC services is required rather than increasing expectations of community nursing.

Franklin (2007) suggests that equality and diversity issues are the responsibility of the practitioner. Similarly, the nurse informants were concerned to provide a similar community nursing service for asylum applicants to that provided for the indigenous population. Promoting vertical equity to NHS services (Almond 2002) required community nurses to use cultural awareness, cultural sensitivity and cultural knowledge skills. Cultural awareness was an essential attribute to understanding the diversity of ways of life. Secondly, language support was integral to vertical equity to facilitate the disclosure of asylum health needs and the provision of non-discriminatory services. The community nurses were the most frequent users of the community interpretation services and employed skills of knowing when and how to use an interpreter mediated consultation. Although an expensive resource, the improved efficiency and effectiveness outweighed the cost implications. Thirdly, equitable access to NHS services required social integration. The asylum applicants wanted to be socially integrated and to function independently within Scottish society. The nurses aided this adaptation to a new host environment through flexible patterns of working, promoting language concordance and reinforcing norms of expected social behaviour.

I observed that culturally competent community nursing services were labour intensive in providing quality care and resulted in high levels of workload. Moreover, workforce capacity, structures and community nursing practice impacted proportionately on vertical equity in the identification of health needs. Srivastava (2008) also recognizes the complexity of delivering culturally competent care. Care pathways have been shown to facilitate a more consistent approach to nursing care (Williams et al. 2005). A care pathway for the prioritisation of vulnerable asylum clients to receive intensive programmes of care could have made health visitor

decision making more transparent and iron out inequities between caseloads. However, the time consuming nature of cross-cultural health care was neither acknowledged nor smaller caseloads allocated to lighten the workload. In spite of the role development within the larger asylum team, the flat management structures negatively impacted on transformational leadership to promote this service development. Although a tension existed between equity and nursing workload, the less structured smaller asylum team maintained a more consistent team culture and was more proactive in working with the local community.

Inspite of the national emphasis on addressing health inequalities (The Scottish Government 2008e), the specialist community nurse teams had difficulty in demonstrating specific outcomes of care. Higginbottom (2000) suggests that health-promoting interventions should be underpinned by an understanding of individual health belief, but the standardised health needs assessment tools in this study were not sufficiently culturally geared to carry this out. Consequently, there was difficulty in demonstrating value for money in service delivery; an important issue for the visibility and sustainability of community nursing (Runciman et al. 2006). This is not surprising as other factors impact on asylum health, such as the temporary nature of asylum status (Momartin et al 2006).

The mainstreaming of PHC for asylum applicants could overcome potential marginalization and inequity of access to services. Asylum applicants in this study received a lower quality of outreach services (see chapter four) and were being rehoused to less densely asylum applicant populated communities. However, community nursing mainstream capacity to provide equitable care for asylum applicants is constrained by limited resources, the time consuming nature of culturally competent care with no explicit care pathway and the difficulties of demonstrating outcomes of care. Moreover, the aging workforce and recruitment issues also impact on capacity (Scottish Executive 2006c). In adopting a mainstreaming policy, the community-nursing workforce requires greater capacity and training across all grades to become culturally competent. The next section

describes the additional skills and knowledge for the cross-cultural promotion of health.

8.3 The cross-cultural promotion of health as a partnership process

Community nurse-client relationships are integral to the delivery of cross-cultural care. The former were shown to progress through the stages of orientation, health needs assessment and use of services, as described by Peplau (1988). Other authors have also demonstrated that Peplau's Theory of Interpersonal Relationships is useful for nurses working with families (Forchuk and Dorsay 1995). Home visiting was used in this study in addition to clinic visits to strengthen nurse-client relationships. The development of a trusting relationship usually takes time to develop (Hook 2006), but this was especially difficult for asylum applicants due to a concern that practitioners were allied to UKBA. Thus gift exchange was used sometimes to cement relationships, perhaps because the relationship phase constrained the community nurses' approach. Whilst a paternalistic approach reinforced indigenous social expectations of health and social behaviour, an empowering approach enabled the client to express individual identity and be involved in care planning and delivery. The latter could only be used once a mutually trusting relationship was established.

In Figure 7, I have brought together the four areas of institutional regard, cultural awareness, cultural sensitivity and cultural knowledge, as detailed in the updated Five Steps model (see section 3.2.1) with the major stages of the nurse-client relationship identified from my data. Although this process is shown at individual level, it could equally be applied at a community level. Cultural awareness, cultural sensitivity and cultural knowledge skills are appropriate throughout the development of the nurse-client relationship, but each has its own focus at different stages for the asylum client and the community nurse.

Figure 7: Cultural competence as a partnership process

Asylum Client *Culturally competent role*	Relationship Phase	Community Nurse *Culturally competent role*
Cultural awareness NHS Expectations Past history Asylum journey	**1. Orientation phase** *Cultural sensitivity* Use of interpreters Authoritarian approaches	**Institutional Regard Cultural awareness** Access
Cultural knowledge Asylum process Social isolation Poverty Discrimination	**2. Identification of health needs** *Cultural sensitivity* Emancipation & Trust Sharing of health beliefs	**Cultural awareness** Child protection Public health agenda
Cultural awareness Identify health barriers **Cultural knowledge** Lack of NHS/social knowledge	**3. Aiding adaptation** *Cultural sensitivity* Empowerment and health advice Facilitative approaches Psychological development	**Cultural knowledge** Risk assessment Specialist referral Social adaptation Social surveillance
Cultural awareness Cultural knowledge Identify personal health care requirements	**4. Use of NHS resources** *Cultural sensitivity* **Negotiation of Person-centred care**	**Institutional regard Cultural awareness Cultural knowledge** Identify person centred care

5. Resolution *Culturally competent care* Client empowerment & independence Self/family care Mainstream GP provision

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Institutional regard was important in phase 1 to provide sufficient nursing capacity to provide community nursing services for asylum applicants. The nurse in representing NHS authority entered the interpersonal relationship with a stronger power base than the asylum applicant. Cultural awareness constrained this power base. The initiation of the nurse-client relationship during the orientation phase was fundamental to the provision of future care and involved the need for politeness to commence the information exchange. Asylum applicants contributed their cultural awareness to this embryonic partnership, which included their previous experience of health care as well as health issues arising from the asylum journey. In moving the relationship towards a partnership footing, the community nurses enabled asylum applicants to understand PHC services. Cultural sensitivity involved appropriate language support to give asylum applicants a voice. This element of practice was central to emancipatory care and gender equality.

In stage two, nurse-client relationships were strengthened further. Cultural sensitivity enabled the development of mutual trust for partnership working and to accurately identify asylum physical and mental health needs. The community nurses carried out their helping role (see V5.5), but also required cultural awareness skills in their public health and child protection roles. The asylum applicants used their cultural awareness skills to gain appropriate family health advice but experienced health barriers of poverty, social isolation and discrimination. Albeit the identification of asylum health needs was culturally based, these health barriers were often outside the sphere of influence of the community nurses.

Nurse-client relationships in stage three evolved with the aim of empowering asylum applicants to adapt to a new host environment. As these relationships developed, the community nurses reduced their power to Lukes' (1974) first level (see V6.11) to empower their clients. Cultural knowledge informed the nurses' risk assessment of cultural health behaviour, child health surveillance and the fostering of social adaptation. Asylum applicants were enabled to identify personal health barriers and to gain an understanding of accessible PHC services. Thus by the third stage of the partnership process all three elements of cultural awareness, cultural sensitivity and

cultural knowledge were involved in the delivery of culturally competent care. As mutual trust was established, the relationship moved to an adult-to-adult footing.

The community nurse negotiated person centred care with their asylum clients in stage four, to facilitate access to NHS resources and/or to change health behaviour. During the negotiation of care clients made their own health needs known and community nurses explained which services were available. Subsequently, asylum applicants accessed those resources they considered to be most appropriate to their individual needs. Thus, the asylum informants used their cultural awareness and cultural knowledge skills within the partnership to understand how community nursing services could help them to maintain health, for example through the acquisition of appropriate child care advice. The community nurses employed cultural awareness skills to facilitate person-centred care and cultural knowledge was essential to asylum health promotion. Institutional regard continued to be important to ensure sufficient nursing capacity, through grade mix teams, to provide asylum applicants with the required emotional support. Stage five concerned the resolution of health issues. Asylum clients were enabled through the provision of culturally competent nursing care to independently use mainstream primary care services and adjust psychologically to the new host environment.

From my data analysis I concluded that the partnership process was central to the cross-cultural promotion of health. It was as important for the nurse to be culturally competent as for the client. Likewise attributes of partnership working have been shown to include a respect for each others' expertise within an equitable and trusting relationship (Bidmead and Cowley 2005). If the client was not culturally competent. it was the role of the nurse to empower the client to have a voice through augmenting communication channels and the use of interpreters. Thus, the nurse-client partnership became the cultural medium for the implementation and delivery of person centred care. Although the community nurses empowered their clients through these interpersonal relationships, the power balance between them shifted as the interpersonal relationship developed. When working well, the initial authoritarian approaches gave way to more facilitative styles as relationships developed. The

community nurses were required to step down from Lukes' (1974) third level to a first level of power (see 2.4), they relinquished their power to empower their client to enjoy an adult-to-adult relationship. Whereas maintaining a client's identity is a major element of maintaining cultural safety (Richardson 200), an amicable relationship is also essential to client negotiation of care (Spiers 2002). Thus when nurse-client relationships were not working well, they remained within an authoritarian and paternalistic framework of nursing care delivery in this study.

The community nurses employed gift exchange mechanisms (see chapter 5) as part of developing and maintaining the nurse-client relationships. I consider that information exchange underpinned gift exchange, which was delivered as part of the intermediary nursing care function. Although a constantly evolving phenomenon, the exchange of information was dependent on the community nurse's skills, knowledge and experience, whilst asylum applicants traded their individual cultural health beliefs and previous experience of health care into the relationship. Moreover, this information exchange enabled the community nurse to understand the asylum informants' expectations of health care and capability to access PHC services. The asylum applicant learnt how help might be provided in a variety of formats. Thus, the partnership process not only provided a medium for the negotiation and delivery of community nursing care, but also paved the way for asylum adaptation to understanding a new system of health care. Chalmers (1992) also found that both community nurses and their clients selectively gave and received care to fulfil their personal goals.

 The community nurses were often more aware of cultural difference than similarity. Although, the Papadopoulos, Tilki and Taylor model suggests that nurses should initially examine their own cultural values prior to understanding other cultures (Papadopoulos 2006), in practice, the community nurses were less aware of their own values due to the subconscious nature of culture, as noted in section 2.2. Secondly, they gave health advice based primarily on SNHS priorities, whilst assessing the risk of cultural health behaviour. Although the examination of difference appeared to be the starting point for the delivery of care, cultural self-

awareness was tacit, but integral to this process as it provided a benchmark for the risk assessment of another's health behaviour.

A major complexity of cross-cultural care was the difficulty of standardisation of community nursing care. Although Williams (2005) demonstrated that care pathways provide a mechanism for standardisation of care, routine evaluation of health promotion activity is also required (Whitehead 2003). Albeit a difference multiculturalism approach underpinned the identification of individual health care needs in this study, a lack of cultural awareness could lead to colour blind approaches to the delivery of care. Thus the trade off between standardisation and person centred care (Daniels 2004) was also evident in this study. The stage of the nurse-client relationship limited the incorporation of cultural health needs into a care plan. Moreover over-standardisation of care could lead to a rigid and unsafe health needs assessment, prescriptive or stereotyped responses to health need and delivery of inappropriate care.

8.4 The delivery of socially inclusive services

The delivery of socially inclusive services was a third major element of cultural competence identified in this study. The mental and physical health of asylum applicants was compromised by UKBA imposed reduced welfare entitlement, resulting in relative poverty regarding diet, transport and home comforts. Mental health was at further risk of deterioration due to loss of family support, the asylum journey and the experience of racism. The community nurses were acutely aware of the need of asylum applicants for social inclusion to promote language concordance, self-help and to aid adaptation to a new social environment. Cultural awareness, cultural sensitivity and cultural knowledge together provided an enabling of social adaptation and equitable access of primary care services.

Cultural sensitivity has been a major consideration in this study. The challenges of providing affordable community-interpreting services to overcome language barriers were noted in chapter six. Interpreters were part of the community nurses' everyday practice. The nurses routinely assessed asylum language skills, made professional

decisions as to when to employ an interpreter and had developed through experience skills of building nurse-client relationships, often via a third party. This triadic work style required mutual trust for success. Miscommunication was an inherent risk, which could arise from the interpreter's inability to translate the dialogue as the speaker intended, due to a lack of medical knowledge or contextual understanding. The community nurses preferred to work in a one to one situation, to avoid miscommunication, to develop interpersonal relationships and reduce confidentiality concerns. Thus, ensuring good communication was a community nursing responsibility and an inherent tenet of the intermediary function. The promotion of ESOL classes was not only part of the drive for social integration, discussed in chapter seven, but also addressed the nurse's preference to work in a single partnership with clients.

Chapter seven described the challenges of overcoming the impact on asylum health from poverty and the stress of the asylum process. Rather than identifying individual cultures as separate entities, the community nurses adopted a socially inclusive approach to reduce the impact of cultural diversity on care delivery. This approach promoted vertical equity (Jan 1995) through providing clients with a cultural knowledge of PHC services and reinforced the social expectations of asylum families living in Glasgow. For example, the outreach baby clinic and immunisation system provided opportunities for asylum applicants to access care and improve their understanding of how PHC operated.

This socially inclusive approach limited the 'cultural field' of nursing practice. By cultural field, I refer to the diverse ways of living enjoyed by asylum applicants. Whilst cultural awareness and cultural sensitivity were integral to providing person centred care, social adaptation was an element of cultural knowledge that enabled the fostering of shared health beliefs to promote health. Nursing care became less time consuming to carry out once it could encompass some shared health beliefs within the partnership process. These shared health beliefs were cultural assumptions, but were not stereotypes of how patient centred care was thought to be required. Rather these embodied the partnership approach described in section 8.3 of 'how we do this

together' within the social context of Glasgow. Thus, the community nurse informants reduced their cultural field for nursing practice through negotiating person centred care. This negotiation took account of client health beliefs and the health behaviour expected of asylum applicants by the indigenous population. Moreover, this socially inclusive approach enabled asylum informants to slowly adapt and potentially integrate into a new host environment, but it also impacted on their individual identity.

The helping and social control roles of community nurses underlie social inclusion activity. Examples of the giving and receiving of social nursing care (Chalmers 1992) included the procurement of childcare to enable an asylum mother to attend a college course, the facilitation of access to ESOL classes and other education courses to aid integration. Again these roles are part of the intermediary nursing function. Asylum informants developed social networks, improved their language skills and gained an insight into the social values of the host society through attendance at higher education and ESOL classes. Access to education was thus a major element in aiding the adaptation process and in promoting the expected social norms of the host society.

Providing socially inclusive services was thus very important. A lack of community nursing cultural knowledge potentially perpetuated the social isolation experienced by asylum applicants through not addressing communication difficulties. Secondly, this deficiency could increase the nurse's workload, as asylum clients were less aware of the host cultural norms and social expectations. Consequently, a socially exclusive community nursing service could potentially result in an increased need for child protection monitoring and surveillance.

8.5 Cultural competence in the provision of community nursing

Three major principles of culturally competent community nursing care of asylum applicants have been distilled from the findings of this study:

- The provision of equitable, accessible and non-discriminatory services

- The cross-cultural promotion of health as a partnership process
- The delivery of socially inclusive services

How different are the principles of culturally competent care identified in this study to traditional health visiting practice? In section 4.3, the underlying principles of health visiting (Council for Education and Training of Health Visitors 1977) were provided as:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence of policies affecting health
- The facilitation of an awareness of health needs

These health visiting principles do not spell out the need for equitable, accessible and non-discriminatory services, but do identify the need to influence health policy development, which could be interpreted as promoting equity and non-discrimination within community health services. The cross-cultural promotion of health as a partnership process can be thought of as the mechanism underlying the search, stimulation and facilitation of health needs. Likewise, the delivery of socially inclusive services is not singled out within the health visiting principles, but is implicit to health policy development. Thus the three principles of culturally competent community nursing care identified in this study not only build upon the basic principles underlying health visiting practice, but also provide further understanding of the application of health visiting principles to providing care in a multi-cultural setting. I define culturally competent community nursing care for asylum applicants as:

> *"The working in partnership with clients to deliver culturally appropriate, culturally sensitive and effective community nursing care to promote health within a socially inclusive framework of equitable, accessible and non-discriminatory services."*

This definition of culturally competent nursing care encompasses the notion of health, which requires horizontal access to services and treatment to promote cross-cultural health at individual and community level. Secondly, it acknowledges the importance of working in partnership to achieve vertical equity and the accurate

assessment of health needs. Finally, the delivery of socially inclusive services enables people to gain the knowledge and skills to function as members of society.

Community nurses in this study functioned as intermediaries to promote asylum health in several ways. The nurses mediated equity by facilitating an understanding of PHC services for asylum applicants and providing services equitable to those of the mainstream. Moreover, the two-way nature of cross-cultural health care required asylum applicants to be as culturally competent as the nurses themselves. If asylum clients were not culturally competent, the nurses enabled them to become so through language support to ensure effective communication. The nurses also mediated social adaptation to the host community for their asylum clients.

Positive promotion of cultural competence

				Provision of equitable services **Cross-cultural promotion of health as a partnership process** **Delivery of socially inclusive services**
			Impact of asylum policy on health. Addressing vertical equity & health inequalities Promoting social integration Maintaining cultural safety	**Cultural Competence**
		Accurate health & social care needs assessment. Ensuring good communication Use of interpreters & advocates to promote partnership working Provision of appropriate health information.	**Cultural Knowledge**	
	Nurse-client relationship Awareness of own value bases and those of others. Cultural variation normal regarding: health beliefs, religion, diet, political views, family and social organisation.	**Cultural Sensitivity**		
Strategic NHS Leadership: Mainstreaming asylum health issues Positive media Influence. Workforce planning to ensure adequate staffing & resources. Monitoring horizontal equity of access to services	**Cultural Awareness**			
Institutional Regard				
Discrimination & reduced asylum access to services Inadequate workforce planning	Stereotyping Misattribution Nurse- clients remain as strangers	Lack of Language support services Communication issues not prioritised	Lack of cultural safety Racism & social isolation not addressed	Colour-blind approach. Victim blaming & no allowance made for cultural diversity.

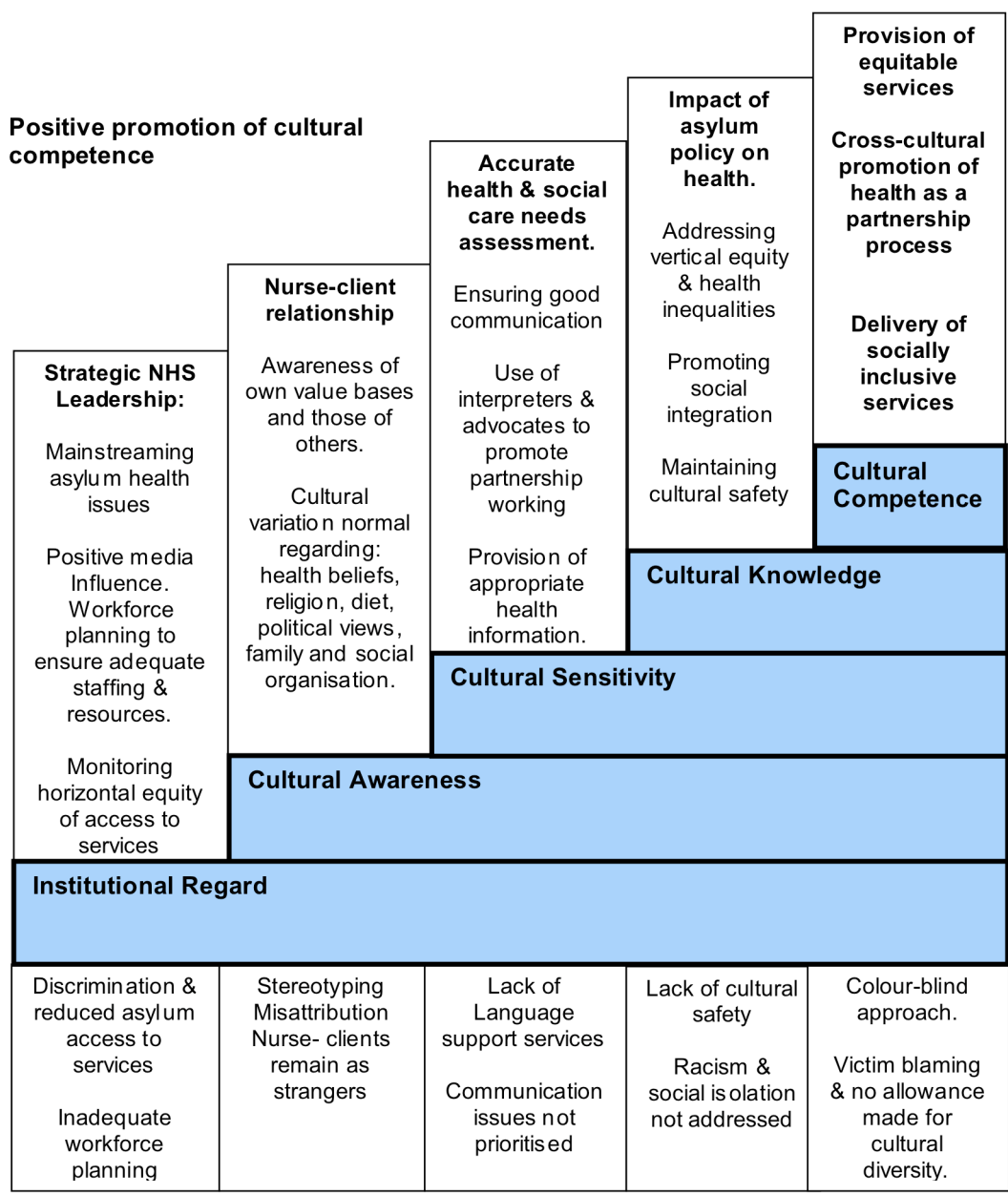**Negative promotion of cultural competence**

Figure 8: The Revised Five Steps Model for the culturally competent community nursing care of asylum applicants.

In Figure 8, I have revised the model to include the major principles of cultural competence, which comprise the equitable provision of services, the cross-cultural promotion of health, and the use of socially inclusive approaches. The major change

to the theoretical framework centres on the importance of developing an empowered partnership approach to the delivery of cross-cultural healthcare.

The five steps in the revised model have been validated to a limited extent through the study findings. Institutional regard was shown in the data to be an initial step of providing an infrastructure for horizontal equity. This infrastructure included mechanisms for routine GP registration, language support services and community nursing services; without these systems in place, asylum applicants would not have had equitable access to primary care services.

Cultural awareness can be considered as a second step. It is integral to the development of nurse-client relationships, which in turn are the corner stones of person centred community nursing care. The third step of cultural sensitivity has also been shown to be essential to enable asylum applicants to become partners in care and for the accurate assessment of health needs. Cultural knowledge was a fourth step of promoting socially inclusive approaches to community nursing care to empower asylum applicants to overcome the damaging health effects of the asylum journey. Finally, cultural competence has been shown to be a combination of all these threads of equity, cross-cultural promotion of health and socially inclusive approaches. Thus an empowering partnership approach is an essential element of culturally competent community nursing care of asylum applicants.

There are limitations to the revised Five Steps model. Further work is required to identify other steps that have yet to be described in the nursing literature. Although I remain convinced concerning the need for equity in the provision of culturally competent care to provide asylum applicants with primary care services similar to the indigenous population, there are resource implications. Albeit economic constraints exist, NHS inequity remains in spite of national policy for resource transfer from the acute sector to primary care services (The Scottish Government 2007a). Whilst horizontal equity can be more easily measured in terms of access to services, vertical equity is more difficult to achieve (Hanafin et al. 2002) and requires more sensitive measures for evaluation.

Secondly, in applying the partnership process to the Five Steps model, interpersonal relationships did not always progress sequentially through all the five stages described by Peplau (1988). The nurse-client relationship might not move forward. The nurse's authoritarian work style or high level of workload prevented the empowerment of asylum applicants to influence health care delivery. The emotional health of an asylum applicant might require a backward step, for example when new health issues were disclosed. Finally, relationships could end abruptly due to the departure of a client or family for whatever reason. These resulted in emotional difficulties for the community nurses, who had not completed a programme of care.

Cultural sensitivity required inter-disciplinary working. These were challenging as community nursing and interpretation services arose from different value bases. Although continuity of care was not an issue for the interpreter services, it was highly important to the community nurses to establish effective nurse-client relationships. Thus cultural competence can have different meaning for different professional groups, with a trade off between continuity and neutrality.

The community nurses used their cultural knowledge to aid social adaptation and promote social integration, but this was an area where they had least influence. Asylum applicants could not be forced to learn English or attend education courses. The community nurses intervened in extreme cases of discrimination and racism to seek alternative asylum accommodation, but had little impact on the everyday occurrences of racist behaviour by the indigenous population that impacted on asylum mental health.

A culturally competent community-nursing workforce is required to meet the health needs within Scotland's growing multi-cultural context in the 21st century. The review of community nursing in Scotland has raised major issues concerning greater efficiency and effectiveness in working with long-term conditions (Scottish Executive 2006c). The government proposed modernisation agenda includes the need for community nursing to boost its public health activity and to match

knowledge and skills to the identified health needs of individuals, families and the community. Cultural competence remains a taken for granted notion that receives little attention or funding. Moreover, social health and child protection issues are long-term conditions that impact on community health.

8.6 Summary

This study has considered a range of factors involved in the delivery of culturally competent community nursing care for asylum applicants in Glasgow. The data collection was influenced by my understanding of the research setting, as well as by the geographical setting, timing and access to a small sample of study informants. Whilst recognising these limitations, the in-depth description of observed interventions between community nurses and their asylum clients has provided an insight into the asylum experience as well as the challenges faced in delivering PHC services for this vulnerable group of people.

The data have indicated that culturally competent nursing care was based upon the provision of equitable, accessible and the non-discriminatory services. These fundamental NHS principles remain pertinent to the 21st century. Although spiralling costs may make future NHS sustainability an issue, asylum applicants are entitled to services on a similar basis to the indigenous population. Horizontal equity involved helping asylum clients to access and understand primary health care services. Vertical equity involved nurse awareness of asylum health issues, the provision of language support, the enabling of access to treatment or care and the provision of psychological support. The future capacity of community nursing to deliver cultural competent care is a major issue.

The delivery of culturally competent nursing care secondly involved the development of nurse-client partnerships for the cross-cultural promotion of health and the negotiation of person centred care. Interpersonal relationships provided a medium for the development of person centred care. It was important for the community nurses to understand asylum health beliefs to negotiate care within their client's cultural framework.

Thirdly, the delivery of socially inclusive services incorporate an understanding of cultural sensitivity and cultural knowledge, to enable asylum applicants to adapt to living in their new host environment and use health services effectively. Communication issues arose at many different levels. The use of interpreter services promoted effective communication, but miscommunication could still occur. The community nurses negotiated nursing care to combine asylum cultural preferences, the health beliefs and the expected health behaviour of the host community. The nurses thus worked as intermediaries, to provide their client with a broad understanding of the rights and responsibilities of being a NHS client. In facilitating an inclusive understanding of NHS culture, the community nurses made their role easier, as expectations and the cultural field of operation was reduced.

These three principles underlying cultural competence build upon the underlying principles of health visiting practice and can be applied to the nursing care for all sectors of the community. Although asylum applicants come from a greater diversity of ethnic backgrounds than the indigenous population, people within any community employ a variety of health beliefs and health behaviours in their everyday lives and thus have a range of nursing care needs.

Cultural competence was thus a two way process. It was as important for the asylum client to be culturally competent as the community nurse. Community nurses used their intermediary function to help asylum applicants to adapt to a new environment. If clients experienced difficulties in this regard, the nurses empowered them through language support, the provision of health information and an improved understanding of primary health care services. A lack of cultural competence may result in nurses adopting a colour-blind approach, in the mistaken view that equity involves all people receiving the same care package regardless of their cultural health beliefs and health care needs.

Cultural competence underpins and is central to the delivery of community nursing services. It is a skill required by all clients as the receivers of care as much as by

nurses involved in the promotion of community health. The example of asylum applicants has highlighted a broad context for the delivery of cross-cultural nursing care, but equally the underlying principles apply within a cultural group as across groups.

My final point is that cultural competence is as much a corporate responsibility as an individual one. The SNHS makes its value base known through the development of structures and roles to support the nurse-client relationship. The community nurse and the asylum client use the medium of partnership working to promote cross-cultural health and adaptation to the new host environment. This thesis has demonstrated the importance of providing asylum applicants with culturally competent nursing care, but equally all ethnic groups within Scotland should receive this quality of care.

Chapter 9. Conclusion

Cultural competence is a skill required by all nurses, whether working with predominantly majority or minority ethnic groups. It is the tacit understanding of the importance of culture to the delivery of nursing services. In chapter eight, The Five Steps Model was shown to centre on three major principles underlying the culturally competent community nursing care of asylum applicants:

- The provision of equitable, accessible and non-discriminatory services
- The cross-cultural promotion of health as a partnership process
- The delivery of socially inclusive services

Whilst building on the traditional principles underlying health visiting practice, these principles add a 21st century dimension to the helping role of community nursing. They reflect the importance of promoting equity for all groups in the delivery of community nursing services. Secondly, the promotion of health for an increasing diversity of ethnic groups within communities requires a partnership approach between community nurses and their clients. Thirdly, whilst the promotion of social inclusion reduces the potential for health inequalities, it also requires standardisation in the delivery of nursing care. Thus, this study has several major implications for community nursing, including the challenges of developing nurse-client relationships in a multi-cultural setting and the implementation of the concept of multi-culturalism in the development of community health services.

The helping role to enable people to stay healthy remains central to health care provision (Professor the Lord Darzi of Denham 2008) and community nursing in particular. I consider that gift exchange (see section 5.1.4) is a major element of nurse-client relationships, but the gift of information exchange to promote health also requires cultural competence skills. As an additional layer to clinical competence, cultural competence aids health promotion through facilitating social inclusion and addressing to a limited extent the health inequalities faced by asylum applicants. In the blurring of professional boundaries, the community nurse may became more of a friend than a health care professional; the commitment to promoting asylum health

went frequently beyond the usual NHS remit of working with the indigenous population and was seen in the complexity of addressing communication difficulties, health issues and nursing care needs.

There are many challenges in developing nurse-client relationships across individual and community cultural boundaries; cultural competence is an important skill in partnership working with the whole community and its minority ethnic groups. The enabling of clients to operate coherently within society can be applied to several sectors of the community, where social exclusion and health inequalities exist.

A second major implication from this study is that the use of the concept of multiculturalism, as discussed in chapter 2, within the NHS requires a move from one of centring on difference to a more inclusive approach. I have found the ideas proposed by Turner (1993) as most useful in this regard; an inclusive primary care culture empowers the provision of equitable asylum health and nursing care. A culturally inclusive approach involves promoting social integration through the mainstreaming of services, the routine use of interpreters to reduce language barriers and the establishment of a cross-cultural value base for care delivery. I suggest that in addition to person centred care, a culturally inclusive approach ensures both horizontal and vertical equity of access to services. Thus the term cultural inclusion, rather than cultural competence, may be more appropriate to community nursing in Scotland.

9.1 Recommendations

A main recommendation of this study is that further research is required to develop the following quality standards for cultural competence generated from the data. The culture of nursing governs clinical practice; a transformational culture is required which facilitates practice development to ensure that services are patient centred (Manley 2004:51). Although models of cultural competence are useful in representing relationships between the underlying concepts in a meaningful way, their use is limited in terms of practice development.

In relation to promoting horizontal and vertical equity of access to health care services, all nurses working in the community should be able to respond to the health needs of asylum applicants; best practice statements are required to ensure that cultural issues of health care are addressed at strategic as well as at grass roots level. I have developed the following Best Practice Statements (BPS) from my fieldwork data. The principles underlying the BPS are adaptable to other cross-cultural nursing situations; community nurses require self-empowerment to implement these in their everyday work.

The knowledge and skills in working with people from a range of cultures should be a major part of pre and post registration nursing curricula. Once embedded into nursing practice, these additional benefits to clients would be no longer considered as a gift, but as a right and a duty of care.

9.1.1 Best Practice Statements

1. The provision of equitable, accessible and non-discriminatory services

National and local policy to ensure the provision of equitable, accessible and non-discriminatory services is integral to the culturally competent care of asylum applicants. Cultural sensitivity was shown to be all stages of nurse-client relationships in this study.

Key Challenges
- An understanding of the impact of the asylum journey on health
- The facilitation of horizontal and vertical equity of access to PHC services for asylum applicants
- The development of a national strategy for the provision and use of community interpreting services
- The promotion of effective nurse-client communication
- Workforce capacity to provide culturally competent services

Statement	Reasons for statement	How to demonstrate statement is being achieved
Asylum applicants are entitled to equitable, accessible and non-discriminatory service provision.	Core NHS value to provide equitable services. Scottish Government 'Fair for All' policy.	Health Board/CHP responsibility. Audit of GP register and nursing caseloads profiles.
Community nurses require an understanding of asylum health issues.	The asylum journey has a major impact on health	Education and training courses for all staff
Appropriate language support enables equitable asylum access to NHS services.	Asylum applicants without English as a first language should not be disadvantaged in accessing services.	Monitoring of interpretation services usage to overcome language and cultural barriers.
Community nurses require manageable caseloads to provide culturally competent care.	The provision of culturally competent care is resource intensive.	Nursing care plans and records Staffing and workload monitoring Management of stress.

2. The cross-cultural promotion of health

The cross-cultural promotion of asylum health and wellbeing requires effective communication, the development of a trusting nurse-client relationship, and an understanding of health beliefs and health behaviour for the robust assessment of health needs.

Key Challenges
- The understanding of a range of health beliefs and health behaviour
- The development of effective nurse-client relationships to work in partnership to promote health
- The accurate assessment of health needs
- The negotiation and delivery of person-centred care
- The need to challenge discriminatory cultural health practices

Statement	Reasons for statement	How to demonstrate statement is being achieved
Community nurses understand the importance of effective communication.	Effective cultural sensitivity is essential to establishing a trusting relationship and a robust health needs assessment.	Training in use of interpreters for all community nurses.
Community nurses use empowering approaches to develop effective nurse-client relationships to promote health.	An understanding of cultural awareness is integral to the development of trusting nurse-client relationships.	Care plan/ record audit of client assessment and support.
Community nurses work in partnership with asylum clients to identify health needs.	Clinical health needs are identified at an early stage for prompt referral to the appropriate agency.	Cultural awareness training Audit of referrals
Community nurses risk-assess cultural health practices.	Child protection issues, Promotion of home safety.	Monitoring of home safety incidents Provision of home safety equipment
Community nurses negotiate with asylum clients regarding the delivery of person centred care	Nurses provide a therapeutic relationship that is person centred.	Nursing care plans and records

Statement	Reasons for statement	How to demonstrate statement is being achieved
Multi-disciplinary team working. Community nurses refer asylum clients to other agencies and services.	Complex asylum case management requires multi-disciplinary team working and specialist referral.	Joint assessment Specialist referral monitoring Nursing care plans and records audit Access to English tuition
Community nurses challenge discriminatory cultural health practices.	Need to protect vulnerable individuals, e.g. female genital mutilation	Nursing care plans and records audit.

3. The delivery of culturally inclusive services

The delivery of culturally inclusive services is important to facilitate asylum access to PHC services and to enable asylum applicants to understand social expectations of living in Scotland.

Key Challenges
- The aiding of asylum adaptation to an unfamiliar environment
- Facilitation of access to NHS services

Statement	Reasons for statement	How to demonstrate statement is being achieved
Asylum applicants should be integrated into mainstream services with appropriate levels of professional support.	Social isolation is known to be damaging to health. Promotion of asylum access to mainstream services may reduce social isolation.	Liaison mechanisms to facilitate access to mainstream GP services. System monitoring of access to mainstream PHC services.
Community nurses understand the need to help asylum applicants to adapt to the social norms of the host environment.	Adaptation to the host environment is stressful.	Nursing care plans and record audit.
Promotion of ESOL classes to aid social adaptation and understanding of NHS services.	English language skills facilitates social inclusion & reduces the need for interpreter-mediated consultations	ESOL provision Monitoring of ESOL referrals
Community nurses use cultural knowledge to provide asylum applicants with social support to promote health and wellbeing.	Effective use of skill mix teams requires adequate training to the required level of cultural competency.	Care plan and record audits to ensure that staff are not given inappropriate referrals.

4. Education, training and supervision in acquiring and using cultural competence skills

Cultural competence is a major skill that should be nurtured in pre-registration nurse training and further developed as part of specialist nurse training programmes.

Key Challenges
- Clearer national guidance for the delivery of culturally competent services for asylum applicants
- Increased awareness of asylum health issues
- Promoting cultural competence in the workplace
- Training in use of interpreters for all NHS staff
- Mentoring/role models to develop communication skills and practice
- Use of debriefing/clinical supervision to prevent burn out
- Skill mix supervision to ensure client safety

Statement	Reasons for statement	How to demonstrate statement is being achieved
Pre-registration nursing courses in Scotland include cultural competence training.	Widening ethnicity base of Scotland	Review of nursing course curricula.
Community nurses are trained in: Cultural awareness Cultural sensitivity Cultural knowledge	All primary care staff should be culturally competent.	Training is available for all NHS staff at varying levels of competence.
Community nurses demonstrate culturally competent care in their practice.	Culturally competent community nurses should be role models and share their expertise and knowledge.	Systems in place for practice development. Nursing care plans and record audit.
Mentorship, clinical supervision and mechanisms for debriefing should be in place.	NMC and NHS Education for Scotland Quality standards. Occupational health.	Evidence from induction programme Monitoring of clinical supervision.

Bibliography

One of the major challenges of carrying out this study has been the management of the literature review. The Internet has created both an ease of access to research information as well as a mushrooming of articles to review. I have reviewed texts concerning cultural competence and its related concepts, written in English primarily between 1990 and 2009, but also included pertinent academic texts written prior to this period. I have considered UK and worldwide research studies to inform my understanding of the complex concept of cultural competence.

The Edinburgh University Library electronic search facilities enabled access to several databases, including BNI plus, CIANAH, HMICDH (Data and Kings Fund database) Nursing and Allied Health Collection, and HMIC – HELMIS. I input key words of asylum seeker; refugee; cultural competence; transcultural care; primary care; nursing and health. Although these electronic searches were useful, the search results often listed too few or too many references. I found that following up the references used by other writers was sometimes more useful. Whenever possible, I downloaded the full text version of the journal article and made a reference to it in my Endnote library, which included an electronic copy of the abstract; this strategy saved printing out every article and aided my recall of the study. I would urge all new PhD students to adopt this method to avoid the volumes of printed copies of journal articles. The electronic article URL address enabled instant return to a document. However, a major frustration of the literature review has been the denial of access to some journals, such as the Journal of Transcultural Nursing.

In addition, regular newsletters have been useful to highlight the publication of new reports; asylum legislation is constantly changing and it is important to keep up to date. Although I have visited key web sources regularly to download reports and documents, it has also been very useful to know when new information has become available.

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Appendix

1. Research Permissions

NHS Greater Glasgow – Primary Care Division
3rd Floor, Administration Building
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW G12 OXH
Telephone 0141 211 3600
www.show.scot.nhs.uk/ggpct/
Date 15 March 2005
Your Ref Our Ref EL/ECM
Direct Line   0141 211 0367
Fax   0141 211 3790
Email   Elaine.Love@glacomen.scot.nhs.uk

Julia Quickfall
Nurse Director
Queen's Nursing Institute
31 Castle Terrace
Edinburgh
EH1 2ER
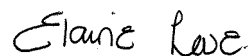
Dear Julia

I have been passed your email describing your research proposal.

I am happy for you to contact community nurses within NHS Glasgow Primary Care Division and would suggest the best way of doing so would be via LHCC Lead Nurses. I have attached for you their names and contact details.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Elaine Love

Elaine Love

Assistant Director of Nursing

Primary Care Division

Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Tel: 0141 211 3600
www.nhsgg.org.uk

NHS

**Greater
Glasgow**

Mrs Julia Quickfall	Date	16 May 2005
Nurse Director	Your Ref	
Queen's Nursing Institute Scotland	Our Ref	
31 Castle Terrace		
Edinburgh	Direct line	0141 211 3824
EH1 2EL	Fax	0141 211 3814
	E-mail	anne.mcmahon@gartnavel.
		glacomen.scot.nhs.uk

Dear Mrs Quickfall

Full title of study: *An exploration of the factors involved in the delivery of culturally competent primary care nursing services for asylum applicants and refugees in Glasgow*
REC reference number: *05/S0701/42*
Protocol number:

Thank you for your letter of 20 April 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 12 May 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

D161181

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Document Type:	Version:	Dated:	Date Received:
Application	one	15/03/2005	21/03/2005
Application	two	20/04/2005	21/04/2005
Investigator CV		15/03/2005	21/03/2005
Protocol		15/03/2005	21/03/2005
Covering Letter		15/03/2005	21/03/2005
Letter from Sponsor		09/03/2005	21/03/2005
Interview Schedules/Topic Guides	Scottish Patient Control Group	15/03/2005	21/03/2005
Interview Schedules/Topic Guides	Primary Care Nurse Group	15/03/2005	21/03/2005
Interview Schedules/Topic Guides	Asylum Applicant Group	15/03/2005	21/03/2005
Letters of Invitation to Participants	Invitation to GP	15/03/2005	21/03/2005
GP/Consultant Information Sheets		15/03/2005	21/03/2005
Participant Information Sheet	Patient Info. Sheet	15/03/2005	21/03/2005
Participant Information Sheet	Primary Care Nurse Info Sheet	15/03/2005	21/03/2005
Participant Information Sheet	Patient Information Sheet two	21/04/2005	25/04/2005
Participant Information Sheet	Information Sheet for Nurses - two	21/04/2005	25/04/2005
Participant Consent Form	Patient Consent Form two	20/04/2005	21/04/2005
Participant Consent Form	Nurse Consent Form	15/03/2005	21/03/2005
Participant Consent Form	Patient Consent Form	15/03/2005	21/03/2005
Response to Request for Further Information		20/04/2005	21/04/2005
Other	Supervisor CV	15/03/2005	21/03/2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

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Statement of compliance
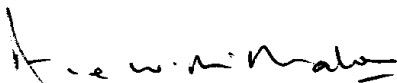
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/S0701/42	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

A W McMahon
Research Ethics Manager on behalf of Dr Paul Fleming, Chair

Enclosures   *List of names and professions of members who were present at the meeting and those who submitted written comments*

Standard approval conditions

Site approval form (SF1)

2. Patient Information sheet

Study of community nursing services for asylum applicants and refugees in Glasgow.
Information Sheet for Patients

My name is Julia Quickfall, and I am a PhD student in the Nursing Studies Department at the University of Edinburgh. I have worked as a nurse for many years in the community, and now I am carrying out a research study of nursing services for asylum applicants and refugees in Glasgow. I would like to invite you to take part in the research study. Before you decide, please read this information so that you can understand why the research is being done and what it will involve. If you do not understand anything or have any questions, do not be afraid to ask. Take time to decide whether or not you want to take part.

What is the study about?
The nurses working in your GP practice see asylum seekers and refugee patients on a regular basis. The study will look at how the nurses provide care for patients, who are asylum seekers or refugees and come from a range of nationalities and cultural backgrounds.

Why am I being asked to take part in the study?
The study needs to find out what you think about the nursing services provided by your GP practice.

What will the study involve?
I am the only person carrying out the research study. Your GP surgery has agreed to take part in the study, which will involve these stages: You will be asked if you are willing to meet with me to find out more about the research study, and I will answer your questions. An interpreter will be available if necessary. If you are willing to take part in the study, I will arrange to accompany the nurse at your next appointment. This appointment may be either at your home or at the GP surgery, as part of the nurse's routine work. In a private interview afterwards, you will be asked what you think about the nursing service. An interpreter will be available if necessary. All the information gathered in the study will be made anonymous, so that an individual person cannot be recognised. The information will remain highly confidential, kept securely, and will not be passed on to another person.

What will the results be used for?
The results from the study will be used to help other nurses to improve their nursing care of asylum seekers and refugees. Anyone taking part in the study will be sent a summary of the results, in an easy to read format. A full report can be sent on request.

What if I do not want to take part?

You should only agree to take part if you are happy to do so. If you decide not to take part, that is not a problem and will not affect your health and nursing care in any way.

Can I stop taking part?

You are free to leave the study at any point.

Quotations

Quotations of your views obtained during the research study may be used to make the final report more interesting. The quotations will remain anonymous and any identifying features removed.

Further Information

If you would like further information about the study, please contact the following person:

3. Patient Consent Form

Patient Identification Number

PATIENT CONSENT FORM

Title of Project: An exploration of the factors involved in the delivery of culturally competent primary care nursing services for asylum applicants and refugees in Scotland

Name of Researcher: Julia Quickfall

Please initial box

1. I confirm that I have read, or have had explained verbally, and understand the information sheet dated………………for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being affected.

3. I understand that if there is a query about my medical history, which is relevant to this research study, my medical notes may be looked at by an authorised individual from my GP practice. I give permission for this individual to have access to my records.

4. I understand that there will be an opportunity to see and read quotations obtained during the data collection prior to publication of the study report. I give permission for quotations to be recorded.

5. I agree to take part in the above study.

_____   _____   _____

Name of patient   Date   Signature

_____   _____

_____

Researcher   Date   Signature

1 for patient, 1 for researcher, 1 to be kept with GP notes

4. Primary Care Nurse Consent Form

Primary Care Nurse Number**:**

PRIMARY CARE NURSE CONSENT FORM

Title of Project: An exploration of the factors involved in the delivery of culturally competent primary care nursing services for asylum applicants and refugees in Scotland

Name of Researcher: Julia Quickfall   **Please initial box**

I confirm that I have read and understand the information sheet dated……………

for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any

time, without giving a reason.

I agree to take part in the above study.

_____   _____

_____

Name of nurse   Date   Signature

_____   _____

_____

Researcher   Date   Signature

1 for nurse, 1 for researcher,

5. Interview Topic Guide Examples

Community nurses

General health
- How would you describe the health of the asylum applicant patient you saw today?
- What are the biggest problems for asylum applicants in keeping healthy in Glasgow?
- How do you assess the health beliefs of the asylum applicants?
- What do you think are the major differences between the health care asylum applicants receive in Scotland and their home country?
- What do you think are the major differences between the nursing care provided in Scotland and the asylum applicant's home country?

Communication
- How easy or difficult is it for you to understand what the asylum applicant is saying to you?
- How much do you think the asylum applicant understands what you say to him/her?
- What would help you to understand better the health needs of the asylum applicant?
- How often do you use an interpreter during a consultation with an asylum applicant? If not, why not? How easy is it for you to obtain an interpreter?
- What are the major difficulties in using an interpreter?

Culture
- In what ways are the cultures of asylum applicants different to the culture of the people of Glasgow?
- In your opinion, how easy or difficult is it for asylum applicants to practice their religion; eat the right foods; wear the preferred dress etc.
- Which other aspects of the culture of asylum applicants are you aware of, that they find it difficulty in expressing?
- Does the primary health service in Glasgow cater for cultural/religious preferences of asylum applicants, for example the gender of the nurse/interpreter?
- Are there implications for their health?

Primary Health Care
- To what extent do asylum applicants understand the National Health Service (NHS) in Scotland in your opinion?
- In your opinion, do asylum applicants consider the cost of healthcare to be important?
- Which treatments have you found that asylum applicants have used in the past that are not available in Scotland?
- To what extent do asylum applicants use treatments that are not prescribed by the GP or nurse?
- To what extent do asylum applicants understand the term Primary Health Care?

Community nursing
- How do you inform asylum applicants about health and nursing services?
- If an asylum applicant has a health problem, whom do they usually contact first?
- When would an asylum applicant contact the nurse rather than the doctor?
- How many asylum applicants are on your caseload?
- What is the nursing care plan for the asylum applicant seen today? How often do you intend to see/visit them?
- How easy or difficult is it for you to have confidence that you as a nurse are giving appropriate advice to asylum applicants?
- How easy or difficult is it for asylum applicants to use the advice you give to them? How do you know the advice make sense to them?
- How do you help asylum applicants to keep healthy, e.g. diet, exercise, how to take their medicine?

Asylum Applicant Focus Group Interview Topic Guide

1. General health
- Ice breaker: What is health? Describe how you feel when you are not healthy?
- What are the biggest problems for you in keeping healthy in Glasgow?
- What do you think are the major differences between the health care you receive in the Scotland and your home country?
- What do you think are the major differences between the nursing care you receive in the Scotland and your home country?

2. Communication
- When you go to see the nurse at your GP surgery, how easy or difficult is it for you to understand what the nurse is saying to you?
- What would help you to understand better what the nurse says to you?
- Do you use an interpreter when you see the nurse? If not, why not?

3. Culture
- How is the culture here in Glasgow different from your own experience?
- Does Glasgow feel like home to you?
- How easy or difficult is it for you to practice your religion; eat the right foods; wear your preferred dress?
- Which other aspects of your culture do you find it difficult to express?
- Does the primary health service in Glasgow cater for your cultural/religious preferences, for example the gender of the nurse? How does this affect your health?

4. Primary Health Care
- Do you know what the National Health Service (NHS) is?
- Do you think the cost of healthcare is important?
- What do you understand by the term Primary Health Care?
- Would you like to find out more about health services?

- What treatments have you used in the past, that are not available in Scotland?
- What treatments do you use that are not prescribed by the GP?

5. Primary care nursing
- If you had a health problem, whom would you contact first?
- When would you contact the nurse rather than the doctor? Do you know how to contact the nurse? Do you feel included in the health care for you or your family?
- How easy or difficult is it for you to have confidence in your nurse, that he/she will give you the right advice?
- How easy or difficult is it for you to use the advice the nurse gives you? Does the advice make sense to you?
- How can the nurse help you to keep healthy, e.g. diet, exercise, how to take your medicine?

6. Primary health care informant profiles

Male or Female	Name	Role	Age Group	Qualifications	Years of experience	Ethnicity
1.Female	Abigail*	Community SN	21-35 years	RGN	>10 years	Scottish
2.Female	Ailsa	Team Co-ordinator	50-65 years	RGN, HV, Tropical Dis. Cert	20 years +	Scottish
3.Female	Andrea	Health Visitor	36-50 years	RGN, HV	>10 years	Scottish
4.Female	Annette*	Family Health Nurse	21-35 years	RGN, FHN	>10 years	Scottish
5.Female	Beatrice	Practice Nurse	36-50 years	RGN, SCM	20 years +	Scottish
6.Female	Caroline*	Health Care Assistant	51-65 years	SVQ III	>10 years	Scottish
7.Female	Christine*	Health Visitor	51-65 years	RGN, HV	20 years +	Scottish
8.Female	Cynthia	Health Visitor	36-50 yrs	RGN, HV	>10 years	Scottish
9.Female	Deidre	Admin. Assistant	36-50 years	Health CareAssist.	>10 years	Scottish
10.Female	Dr Brook	GP	36-50 years	GP specialist	10-20 years	Scottish
11.Female	Dr Cross	GP	51-65 years	GP specialist	20 years+	Scottish
12.Male	Dr Smith	GP	36-50 years	GP Specialist	10-20 years	Scottish
13.Female	Elizabeth*	Community SN	36-50 years	SEN, RGN	10-20 years	Scottish
14.Female	Elsie	Health Care Assistant	36-50 years	SVQ IIII	10-20 years	Scottish
15.Female	Francis*	Community SN	36-50 years	SEN	20 years+	Scottish
16.Female	Georgina	Nursery Nurse	21-35 years	Nursery Nurse	>10 years	Scottish
17.Female	Isabel	Health Visitor	51-65 years	RGN, HV, DN, SCM	20 years +	Scottish
18.Female	Jessie	Community SN	21-35 years	RGN	>10 years	Scottish
19.Female	Jillian	Health Visitor	51-65 years	RGN, HV	10-20 years	Scottish
20.Female	June	Health Visitor	36-50 yrs	RGN, HV, SCM	20 yrs +	English
21.Female	Sarah*	Health Visitor	21-35 years	RGN, HV,	>10 years	Scottish
22.Female	Susan*	Health Visitor	36-50 yrs	RGN, HV	10-20 years	Scottish

*Attended the nurse informant focus groups

7. Asylum applicant and refugee informant profiles

Sex	Participant Name	Age	Country of Origin	First Language	Status	Family unit in UK
1. Female	Andean	22	Congo	French	AA	Single parent. Child 1 month
2. Female	Asha§	27	Sri Lanka	Tamil	AA	Married. Child 2 years. New baby expected
3. Female	Asya	25	Pakistan	Punjabi	AA	Lives with partner. Child 2 months
4.Female	Aurore§	16	Chad	French	Refugee	Single parent. Child 3.5 months
5.Female	Dominique	38	Ivory Coast	French English	AA	Widow. 3 children (1 in UK)
6. Female	Farah	30	Somalia	Somali	Refugee	Married. Child 5 months old
7. Female	Francine	27	Somalia	Somali	AA	Married. 3 childen 4 yrs, 2 yrs and 5 mths
8.Female	Françoise*	25	Congo	French Lingala	AA	Separated. 3 childen aged 6yrs, 3.5 yrs & 8 months
9. Female	Hortense	25	Guinea	French English	Refugee	Separated. 2 children, 4 yrs and 7 mths
10.Female	Ina	18	Cameroon	French	AA	Single parent. Child 1 yr
11.Female	Ines*	28	Cameroon	French	AA	Single parent. 1 Child
12.Female	Jayani	39	Sri Lanka	Tamil	AA	Widow. 3 children, 17, 13, 2 years
13.Female 14.Male	Judy Muhammed	41 26	Pakistan Pakistan	Punjabi Punjabi	AA	Married. 2 children, 5 yrs and 5 months
15. Male 16.Female	Kamil Sabat	34 29	Pakistan Pakistan	Punjabi English Punjabi	AA	Married. One child 5 yrs (special needs)
17.Female	Kristina*	27	Somalia	Somali	AA	Single parent. Child 1 year old

Sex	Participant Name	Age	Country of Origin	First Language	Status	Family unit in UK
18.Female	Linda	17	Burundi	French	AA	Single parent. 2 children under 2 yrs
19.Female	Lisa	33	Congo	French	AA	Single parent. Child premature.
20.Female	Maduka§	37	Sri Lanka	Tamil	AA	Married. 2 children 7yrs and 3.5 yrs
21. Male	Mohammed	30	Iran	Arabic	AA	Single male
22.Female	Margot	18	Uganda	English	AA	Single parent .twins 16 months.
23. Male	Nicolai	35	Russia	Russian	AA	Married. Two children 4 and 2 years
24.Female	Nora	25	Nigeria	English	AA	Married. Child 2 yrs.
25.Female 26. Male	Reema Mohammed	23 25	Sudan Sudan	Arabic Arabic	AA	Married. Child 1 yr
27.Female	Rita§	24	Macedonia	Albanian	AA	Married. Child 3 years
28.Female 29. Male	Sadiq Nafisa	38 40	Turkey Turkey	Turkish Turkish	AA	Married. 2 children 17 yrs and 5 years
30.Female 31. Male	Sandra Stephen	36 40	Sri Lanka	Tamil	Refugee	Married. 3 children 13yrs, 2yrs & 2 mths
32.Female	Shamina	42	Palestine	Arabic	AA	Married. 3 children 16,13, 2.5 yrs
33.Female	Valma	56	Kosovo	Albanian	AA	Single. 1 son 29 yrs
34.Female 35. Male	Wendy Lo	34 33	China China	Mandarin Mandarin	AA	Married. Child 4 months
36.Female 37. Male	Wilma James	35 37	Liberia Liberia	English English	AA	Married. 3 children, 10 yrs, 4 yrs and newborn
38. Male	Yusuf	35	Iran	Farci	AA	Single male
39.Female	Zola	33	South Africa	English	AA	Single parent. Child 5 weeks old

* Focus group 1 only participants (3)

§ Focus group 2 only participants (4)

Both Focus groups participants (5)

PhD. Dissemination and Conference Presentations

February 2004 - The Transcultural Nursing Society Conference. Glasgow
Concurrent Presentation: Developing a Primary Care Model of Culturally Competent Care for Asylum Seekers and Refuges

21-23 October 2004 – CPHVA Annual Conference: Going Upstream. Harrogate
Poster presentation: The provision of culturally competent health visiting care of asylum applicants and their families in Glasgow

April 2005 – Scottish School of Primary Care Conference. Dundee
Poster presentation: A five steps model for culturally competent primary care nursing for asylum seekers and refugees in Scotland.

January 2006 – Nursing Research Group Edinburgh University
Work in progress seminar: An exploration of the factors involved in the delivery of culturally competent primary care nursing services for asylum applicants and refugees in Glasgow.

6 October 2006 – CRNA Annual conference: Cultural influences on health. London
Concurrent Presentation: The influence of culture on the delivery of primary care services to asylum applicants and their families.

18 October 2006 CPHVA Conference – The health jigsaw making it fit! Bournemouth
Poster presentation: The provision of culturally competent health care of asylum applicants and their families in Glasgow

21 September 2007 – 33rd Annual Conference of The Transcultural Nursing Society Bournemouth University
Concurrent Presentation: Interpreter-mediated consultations between primary care nurses and asylum applicants.

27 March 2009 – RCN International Research Conference, Cardiff, Wales
Concurrent Presentation: How do community nurses learn skills of cultural competence?

25 May 2009 – Nursing Research Group Edinburgh University.
Seminar Presentation: Interpersonal relationships: An integral component of culturally competent community nursing care of asylum applicants in Scotland.

18 August 2009 ICCHNR Conference. Adelaide, Australia
Concurrent Presentation: Interpersonal relationships; an integral component of culturally competent community nursing care of asylum applicants in Scotland