

Foreword

The Race Relations (NI) Order (1997) and The Northern Ireland Act (1998) sets a legal imperative on all public sector agencies to address the needs of all their minority ethnic groups. They reinforce the need for all service users, including those from minority ethnic groups, to receive health and social care in a manner, which is reflective of their needs e.g. provision of an interpreter/translator. Specifically, in relation to children, The Children (NI) Order (1995) places an obligation on childcare agencies to consider 'the child's religious persuasion, racial origin and cultural and linguistic background' in their dealings with families.

In order to assist staff and to aid understanding of the various cultures prevalent in Northern Ireland, particularly those from the minority populations, this handbook has been jointly produced by the following organisations as a guide for all health and social care staff:-

Armagh and Dungannon Health and Social Services Trust

Craigavon Area Hospital Group Trust

Craigavon and Banbridge Community Health and Social Services Trust

Newry and Mourne Health and Social Services Trust

Southern Health and Social Services Board

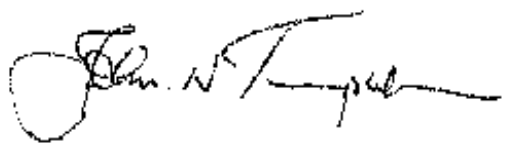
Southern Health and Social Services Council

The handbook is designed to provide a starting point for an understanding of the cultural and health issues of selected communities in Northern Ireland. It provides information on cultural needs and an understanding of selected ethnic groups based on their cultural and religious affiliation, for example, in relation to dietary requirements, religious observances, care of the dying, childbirth etc. However, it is worth noting that within the various cultures, some people may be more, or less, observant of religious norms than others and credence would need to be taken of this.

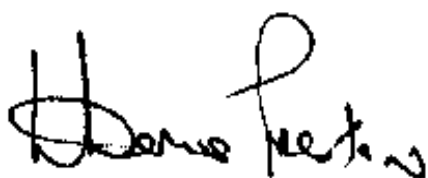
We would ask that those staff involved in direct patient care or, indeed, have any contact with patients and clients take time to read this handbook - not only to become familiar with the various cultures, but also to ensure that our organisations continue to provide a high quality, accessible and equitable service to **all** of our users.



Miss Pauline Stanley
CHIEF EXECUTIVE
Armagh & Dungannon H&SS Trust



Mr John Templeton
CHIEF EXECUTIVE
Craigavon Area Hospital
Group Trust



Mr W Denis Preston
CHIEF EXECUTIVE
Craigavon & Banbridge
Community H&SS Trust



Mr Eric Bowyer
CHIEF EXECUTIVE
Newry & Mourne H&SS Trust



Mr Colm Donaghy
CHIEF EXECUTIVE
Southern H&SS Board



Mrs Delia van der Lenden
CHIEF OFFICER
Southern H&SS Council

[Alternative formats](#)

This Multi-Cultural Handbook will be made available on request in formats such as Braille, disc and audiocassette and in minority languages to meet the needs of those who are not fluent in English.

Acknowledgements

The Trusts, Board and Council would like to take this opportunity to express sincere thanks and appreciation to Mr Robert Moore, Ulster Community and Hospitals Trust on whose comprehensive publication the material in this staff handbook is taken from.

In addition, we would also like to thank the following people for their valued input on the contents of the handbook:-

Ada Graham, Armagh Philippine Association

Daniel Holder, The Multicultural Resource Centre, Belfast

Inez Keenan, Craigavon Traveller's Support Group

Mark Donohoe, Belfast Travellers Education and Development Group

Najla Loughlin, Banbridge Bahá'í Community

Tanja McKee, STEP, (South Tyrone Empowerment Programme),
Dungannon

Bernadette McAliskey, STEP, (South Tyrone Empowerment
Programme), Dungannon

Eleanor McKnight, The Equality Commission NI

Anna Manwah-Watson, The Chinese Welfare Association

Catherine Moustafa, AL-NUR Asian, Arabic & Muslim Association

Mr Tsang, Vietnamese Association, Craigavon

Paul Yam, Wah Hep Chinese Community Association, Craigavon

Patrick Yu, The Northern Ireland Council for Ethnic Minorities

Karima Zahi, The Northern Ireland Council For Ethnic Minorities

Edwin Graham, Bahá'í Council for Northern Ireland

Language Line, London

Des McCabe, NI Interfaith Forum

The Trusts, Board and Council also acknowledges the work undertaken by the Equality Commission for NI, the Department of Health, Social Services & Public Safety in their document "Racial Equality in Health" and also the British Medical Association's publication entitled "Asylum Seekers, Meeting their Healthcare Needs" which is also reflected in this handbook.

Table of Contents

| | <u>Page No.</u> |
|--|-----------------|
| Section One: Culturally Sensitive Health and Social Care Checklist | 1 |
| Section Two: General Guidelines when Dealing with Cultural Diversity | 3 |
| Section Three: Guidelines for Treating a Patient/Client With Different Religions & Cultural Beliefs:- | 29 |
| 1. The Bahá'í Faith | 30 |
| 2. The Buddhist Community | 33 |
| 3. The Chinese Community | 37 |
| 4. The Christian Community | 42 |
| 5. The Filipino Community | 47 |
| 6. The Hindu Community | 50 |
| 7. The Lithuanian Community | 56 |
| 8. The Muslim (Islamic) Community | 58 |
| 9. The Jewish Community | 65 |
| 10. The Portuguese Speaking Community | 71 |
| 11. The Rastafarian Community | 74 |
| 12. The Sikh Community | 77 |
| 13. The Vietnamese Community | 82 |
| 14. The Irish Travelling Community | 85 |
| Section Four: Information on other Religious Groups | 87 |
| 15. Brethren | 88 |
| 16. Christian Science | 89 |
| 17. Humanism | 92 |
| 18. Jainism | 94 |

Table of Contents (Cont..d)

| | <u>Page No.</u> |
|---|-----------------|
| 19. Jehovah's Witnesses | 96 |
| 20. Mormons | 98 |
| 21. Paganism | 99 |
| 22. Quakers | 101 |
| 23. Scientology | 103 |
| 24. Seventh Day Adventists | 104 |
| 25. Spiritualism | 105 |
| 26. Unitarians | 106 |
| 27. Zoroastrianism | 107 |
| | |
| Section Five: Accessing An Interpreter/Translator & Guidelines for Using an Interpreter/Translator | 109 |
| | |
| Section Six: Useful Contacts | 116 |
| | |
| Section Seven: 2001 Census - Ethnic Group Statistics | 119 |

SECTION 1: CULTURALLY SENSITIVE HEALTH & SOCIAL CARE CHECKLIST

The following issues should be recorded when addressing the health and social care needs of patients/clients:

Naming: Preferred Name/Form of address:

This may also be used to record name of significant relative(s) if, for example, the marriage partner's name is very different. Ask both the individual and partner for their official name and 'what you would like us to call you'.

Language: (spoken and written)

A selection of the most likely options should be offered.

Interpreter Need:

This should be recorded along with the preferred gender of the interpreter.

Diet Options:

Again, key preferences will be suggested: some patients/clients will want the option to choose from the 'English' menu as well as special diets. Note that for religious reasons it may be insensitive to use cutlery or plates used by other cultures or for non-approved foods. Many communities may wish to bring in items of food for their members: some of these have religious value, others provide essential nutrients. Permission should rarely be refused, unless there are clear medical reasons (e.g. special diet treatments).

Prayer Observation:

Times and requirements (e.g. washing, privacy, pray mat).

Significant Dates:

Key dates of major festivals, fasts, etc. should be noted.

Activities of Daily Living:

Hints about other culturally significant preferences should be checked in case they are of personal significance to the patient/client. This includes attention to questions of modesty clothing and skin and hair care.

Birth Issues:

Major traditional practices (if known) – this may be very personal.

Death and Dying:

Guidance on some traditional responses and needs at such times: Do not remove jewellery, sacred threads or significant religious items of clothing.

Religious Representative:

Record which particular place of worship or religious worker (Priest, Imam, etc.) should be notified, if necessary.

Medication:

Any medications pharmaceutical or otherwise.

SECTION TWO: GENERAL GUIDELINES WHEN DEALING WITH CULTURAL DIVERSITY

Patients/clients and their relatives all have a set of beliefs which guide their daily life. Some will have strong religious beliefs, whilst others may have limited contact with religion in terms of formal worship, but will have strong beliefs in a god or gods, or in moral principles which are based on religious beliefs. While for some, these beliefs may mean little obvious difference in their lives, illness and death can highlight these beliefs.

For some cultures, their religion is very much woven into their way of life. This is particularly the case with the Jewish and Islamic faiths whose religious instruction covers eating practices and ways of prayer, as well as other aspects of life. However, for all patients/clients a recognition and willingness to respond to their cultural and religious needs is important to overall care.

Language

Every language is part of a culture and has its own cultural features. Interpreters are an important resource in providing a voice for patients whose proficiency in English is poor or insufficient for the situation.

To decide whether the patient needs an interpreter, assess whether their English language ability is adequate for the situation. In certain circumstances it is crucial that the patient has full understanding and there are no misinterpretations by patient or staff.

As a general 'rule of thumb', a patient who has been in an English-speaking country for less than two years will need an interpreter.

English comprehension at social level does not necessarily mean that the person will be able to understand medical terminology.

It is possible to overestimate a person's English skills. In stressful situations, it is usual for the person's command of English to decrease.

Repeat important information, make things very clear and simple, focused and direct and avoid jargon, confusing phrases, double negatives and rhetorical questions, such as "you don't want any more painkillers, do you?"

Time needs to be well managed when using the interpreter service. If possible all questions should be planned in advance before arranging for an interpreter. (See Section 5 - Guidelines for Using and Interpreter/Translator)

If there is the need for an interpreter, either because the situation is one of those mentioned above or a need is expressed by the patient/client, organise

an interpreter if at all possible. Under the Race Relations (NI) Order 1997, one could find oneself legally liable if one has not taken reasonable steps to facilitate meeting this need. It is advisable to make a note in the chart/records if the patient/client refuses to have an interpreter although you think it is necessary.

Communicating Effectively

Health and social care involves basic principles that apply to all patients/clients irrespective of cultural or linguistic background. However, any health care system is necessarily based on the predominant culture and medical system. All of us, including health professionals, often make assumptions based on our own culture. These assumptions influence practice and interactions with patients.

When a professional is caring for someone from an ethnic minority background, it is important to be aware of your own values, beliefs, expectations and cultural practices and consider how these impact on the care you give to people from cultures different from your own.

Factors that influence interactions include socio-economic status, politics, urban/rural origin, educational level, language proficiency, age, gender and personality.

In many cultures, the patient/client and his/her family make up a single client group with which you need to interact.

SOME PRINCIPLES TO REMEMBER WHEN COMMUNICATING WITH SOMEONE FROM AN ETHNIC MINORITY BACKGROUND:

Do not assume English proficiency

Even if a person speaks English fluently, all information is subject to misinterpretation. This has been evident in all our professional experiences when someone has misinterpreted what we have asked them to do in English.

Remember, poor English skills are not a reflection of a hearing disorder or level of intelligence. You don't need to raise your voice, as this will not solve the problem!

Do not make assumptions about patient/client levels of understanding

Lack of comprehension will affect a patient's commitment to adhering to a treatment plan, or their competency to carry out or follow the treatment plan. For example, a clinician may advise a patient/client to go on a "low fat diet". This will be insufficient without some knowledge or understanding of what a normal diet is in the patient/client's culture, or knowledge of what the patient/client regards as "low fat". For example, does this include olive oil, or

does it refer only to animal fat? Is "high fat" food that which makes you fat and does it include food with high sugar content? Take time to discuss the illness and treatment. This allows you to explore the patient/client's own beliefs and understanding and will help you assess their comprehension and understanding of the advice or procedure. Taking time to get it right now will eliminate the time and resources wasted if the patient/client gets it wrong.

Don't patronise! Making assumptions about poor levels of comprehension and skill can result in a patient/client feeling patronised if they have some knowledge of English, medical terminology or hospital practice.

Respect beliefs and attitudes

We all have different reactions towards illness, life and death. These are built up over a lifetime and cannot be dismissed without creating a barrier in the communication process.

Asking a patient/client "Could you tell me what would happen to you if you were in your former country?" or "I don't have a great understanding of this" or "I am interested to know more". These are ways to encourage intercultural dialogue and by doing this, you are acknowledging to the patient your understanding of his or her different perspectives and experience.

Take the time to explore any issues

Patience, respect and extra time can resolve the potential for miscommunication. Cultural or linguistic issues may affect the acceptance or rejection of medical treatment or social help. Other members of the family may be involved in decision making as well as or instead of the patient and this may influence patient/client behaviour.

Taking extra time to explore such issues may be difficult. In addition, there is a need to balance cultural appropriateness (from the patient/family's perspective) with medical procedures to ensure the patient's survival, especially in an A&E or intensive care setting. It may help if key issues are identified and prioritised. Patient/client and family confidence in medical and social decisions increase if you take the time to talk and ensure good communication.

Effective communication is the key to addressing many of the cross-cultural issues that arise in hospitals and health and social care facilities.

Speak clearly and slowly

Communication is a two way process. The service must give patients/clients the information they want and need. In addition, the service must listen and respond. Communication enables patients/clients to understand more fully, participate in their care and to feel more confident.

Communication enables professionals to offer information, to offer support at the right time and to be sensitive to clients/patients needs.

Insensitive communication alienates patients/clients, increases stress and can have adverse physical as well as emotional effects.

It is important to ascertain that you understand the patient/client and that the patient/client understands you.

Ask the patient/client to let you know if he/she does not understand your accent, would like you to speak more slowly or would like clarification e.g. writing down words that are not clear.

If you use complicated terms, speak rapidly, or mumble, it is unlikely that you will be understood. The information you give may need to be broken down further than usual, or rephrased, to avoid confusion.

Ask the patient/client to tell you what he/she understands to check comprehension.

Self-awareness is important and staff should be wary of sounding condescending.

Listen and observe

Be sensitive to body language and take cues from it. Sometimes the patient's demeanour will give you clues to comprehension.

Body language in different cultures expresses different messages. For example, maintaining eye contact may be a sign of respect and smiling may be a sign of apprehension.

Be aware of eye contact, facial expressions, head and body movements, posture, gestures, touch and the physical distance from the other speaker.

Note differences in meanings of words

Some words or phrases have different meanings in different cultures.

Most Northern Ireland people use "yes" as an affirmative, but in some cultures "yes" can be a form of acknowledgement rather than an indication of agreement. Eliciting responses such as "I understand" or "that is correct" may be helpful.

Common euphemisms tend to be culturally confined. For example, women from the Philippines may not be familiar with the use of the word "period" to

describe menstruation. They may say they do not experience painful periods, even if they suffer from dysmenorrhoea. It is best to give several synonyms for these euphemisms.

Clarify choices and options. Make sure that patients/clients understand they have choices and are clear about their options.

Patients/clients often need to be reassured that one option includes the refusal of a treatment and that they can ask questions if they are not certain they comprehend what they are being offered.

Exercise sensitivity when using interpreters

Sensitivity is required when asking patients to reveal intimate details through a third party, especially regarding 'taboo' subjects such as sexual behaviour, contraceptive use, abortion, or menstruation etc.

The interpreter may be a member of the patient's/client's community, so issues of confidentiality may be of concern.

Section Five within this handbook provides information regarding the use of interpreters.

Diet

The availability of food products, culture, life experience and religion determines one's diet. Food has cultural significance in terms of gaining and maintaining health and strength.

In some cultures, including some Asian and Latin American cultures, people believe in the hot and cold theory of food and disease. According to such beliefs, certain foods may be classified as "hot" or "cold". This refers not necessarily to the temperature at which food is served, the spiciness nor its energy value but to its effect on the body.

Various diseases and health states may also be classified as hot or cold and this affects the kind of foods that can be eaten. We all know the saying 'feed a cold and starve a fever'.

In Asia, the traditional belief is that women lose heat during delivery and so prefer to eat only "hot" foods during the postpartum period in order to recover quickly and avoid longer-term health problems.

Hot/cold classifications may sometimes be extended to medicine, resulting in conflict in a patient's mind where they are required to take "hot" medicine for a "hot" condition. These beliefs vary among individuals as well as from culture to

culture, hence you should not assume that this is the basis of refusal to eat or reluctance to adhere to medication.

Patients/clients should be asked about their preferred diet. It is good practice to remember that dietary preferences also extend to eating implements and where food is actually eaten. Some people may prefer to eat with spoons or their fingers rather than a fork. Others may require privacy when they are eating and on an open ward, this may mean drawing the screen around the patient/client.

The best way to check on patients' dietary and eating requirements is to ask them directly.

Dietary restrictions may make it impossible for some patients to eat hospital food unless arrangements have been made.

For example, Halal or Kosher food may be obtained from an agent in Belfast. It can then be stored in a separate fridge. Alternatively, if the patient/client is on a special diet, storage facilities should be available in every ward so that the hospital diet can be complemented where necessary by bringing food in from outside.

Fasting is required by some religions during particular times (e.g. during Ramadan among Muslims and during March for Bahá'ís). The sick are usually exempt from fasting, but this is generally a decision of the individual patient/client. This may need discussion between the staff and patient/client.

In some cases all that may be required is assistance in filling out a menu if the patient/client is unfamiliar with the names of the dishes.

The condition of the patient/client may deteriorate simply because of inappropriate food or because they do not understand imposed dietary restrictions. This is particularly important when visitors bring food in and it may be necessary to ask them politely to take it back home. Some think that if they are healthy, they should eat as much as they want and therefore need advice on how much to eat.

As with all individual patients/clients please check what their requirements are.

The table overleaf may be used as a general guide to the food preferences of followers of the major religions. Some foods may not be acceptable to the patient because of the method of preparation.

| FOOD | HINDUS/ BUDDHISTS | SIKHS | MUSLIMS | JEWS |
|---------------------------------|---------------------------------|--------|---------|----------|
| Beef | Hindus no Buddhists some* | No | Halal # | Kosher + |
| Butter/ghee | Yes | Yes | Yes | Yes |
| Chicken | Some* | Some | Halal # | Kosher + |
| Cottage/curd cheese | Yes | Yes | Yes | Yes |
| Eggs | Some* | Yes | Yes | Yes |
| Fish | Some* | Some | Yes | Yes |
| Margarine/vegetable oils | Yes | Yes | Yes | Yes |
| Milk & Yoghurt | Yes | Yes | Yes | Yes |
| Mutton | Some* | Some | Halal # | Kosher + |
| Pork | Some* | Rarely | No | No |

* Very strict followers avoid this.

Halal meat must be killed, dedicated and prepared in a special way.

+ Kosher meat for Jews requires special rituals and butchering procedures in preparation.

Family, Community and Medicine

Many people from ethnic minorities come from societies where the community is more important than the individual. There are a number of different family structures ranging from the grandmother taking the role of head of household to young boys being responsible for older female siblings. This may be a function of the culture, but it may also be due to circumstances created by restrictions in family members able to migrate.

It is important to ascertain the family roles of both the patient/client and support people. This is particularly necessary because decision-making, receiving and disclosure of news to the patient/client and orchestration of care may not be individual, but group, responsibilities.

Some patients may wish to have relatives or friends accompany them for support and to relieve anxiety at all stages of the hospital experience.

Families play an important role in decreasing isolation and increasing hope for the patient. Faith in the supporter can be a very important addition to faith in the healer. Very often, the family needs to be involved in discussions and treatment which can be to a greater extent than you may expect. Communication with the family is very important. Check out if the patient is comfortable with family members being present and if so, whenever possible, allow members of the family to accompany the person and if this is not possible, explain tactfully why.

Visiting the sick person is a must in many cultures and large numbers of visitors may arrive. Be sensitive to the importance of this, particularly if it is necessary to restrict the number of visitors at any one time (Intensive care, cardiology, post surgery etc.)

It is also worthy of note that "family" means different things to different cultures. Be sensitive to who is considered to be immediate family and next of kin. Also a number of patients have no family in Northern Ireland, so friends may play the role of relatives.

Ask the patient/client who they would like to know about their situation and the level of detail. It may be helpful to explain the Trust regulations about giving information over the telephone.

Do not assume that the family is always supportive - there can be conflicts within the family, either interpersonal or with respect to treatment, management and care of a particular illness.

It may be possible occasionally to involve community members in the care of a patient and family - ask if the patient would like to speak to someone from their own community (see the 'Useful Contacts', Section 6 this handbook.)

Gender Issues

Gender is a very important factor in health and social care. Gender determines the roles one has in most societies and response to illness and recovery. It is a major issue in cross-cultural health and social care.

In many cultures, a woman should be attended by a female health professional and a male by a male health professional.

This is important for gynaecological, urological, lower gastrointestinal and sexual health problems. Women from some cultures believe that they can become sick from male staff seeing their genitals.

For some Muslim women it is perceived as not only uncomfortable but also a great shame to have a male doctor.

If no female staff member is available for women, an acceptable alternative may be to offer the option that their husband or a female nurse be present during the consultation or examination. Some men do not find it appropriate to be looked after and given advice by women if they come from a male dominant society. Within the limits of practicality, try to arrange carers of the same gender. (This also applies to the use of interpreters.)

Having a female doctor may be especially important for vaginal examinations. If there is no female doctor available, how the situation is handled is important. Explain the available options and their right to give or refuse consent. Explain the procedure, the instruments and the reasons for the examination/test. Some may think they are also being screened for sexually transmitted diseases. (This scenario may be reversed to male patients with 'male health' problems.)

Middle Eastern men and men from other cultural backgrounds too, may not allow examination of their wives, so treatment has to be based on the history alone.

In some cultures, it is taboo to talk about the body and exposing parts of the body such as the breast can be very embarrassing. It is difficult for women from these cultures to have mammograms or breast procedures.

Exposure of the chest during an ECG needs to be handled sensitively. Similar issues relate to the management of cervical and other gynaecological cancers and to treatments such as colposcopy.

Muslim and Asian women in particular may have issues with undressing or changing into short gowns for procedures or operations. Explore alternatives which also protect the women's modesty. It is important to respect the patient's wishes to have the curtains drawn and to remain covered at all times.

Privacy is, of course, important for all patients/clients from all cultures.

Western Medicine and Traditional Medicine

All cultures have their own approaches to diagnosis and treatment and many, if not all, cultures have herbal remedies and medicines. Whilst some rely on 'modern' Western medicine, others believe that traditional medicines are more effective.

Western medicine may be unfamiliar or may not inspire as much confidence as some traditional forms of medication, which may therefore be taken concurrently with what has been prescribed.

It is useful to ascertain all forms of medication that the patient is taking. There may be duplication of medications because doctors have not checked what other Western medications the patient is taking before prescribing a new one.

The contents of Traditional/Eastern medicines can interact with Western medicines. e.g. many Indians in Southall in London visit their Hakim for treatments before approaching Western doctors.

It is crucial to communicate through an interpreter if the patient's English is not adequate, so that he or she thoroughly understands the purpose, dosage and timing of the medication/s.

There are other issues around medicines such as compliance and these need to be carefully explored. Other family members may need to understand how and when the patient's medication needs to be administered.

It has been known for people to swallow suppositories. Some may take a double dose if they forget a tablet, or if they believe that this will speed up the cure. Others may have difficulty accepting certain medications. These issues need to be addressed thoroughly and the patient and family need to be encouraged to discuss any concerns they have about medication.

For example:

Injections may be problematic if the patient is uncomfortable with having their skin pierced (e.g. some Buddhists).

Some people prefer injections to oral medication because they perceive the former is more effective.

Followers of religions that prohibit the use of alcohol or certain animal products may object to medicines containing alcohol or gelatine. Where possible, use substitute alternative brands or formulations.

During Ramadan, fasting Muslims may not take oral medications in general or those that have to be taken with food. (In this situation, some patients will consider injections if it is important not to miss doses.) There are provisions in Islam for such situations and staff are advised to liaise with the Islamic religious leader.

"Take until finished" is a phrase that has been found to mean "take until you die" to some people, who would not take the last tablet in the packet. A better phrase is "take until all taken".

Models of Health and Illness

Not everyone believes in the biomedical model. The acknowledgement of different beliefs is important. People differ in what they perceive as a symptom. Some cultures do not believe in X-rays, the germ theory of disease, or injections.

Some religions propose that sickness and death are caused by past life events. For example, some religions explain the occurrence of cancer and other diseases in terms of the philosophy of karma, which attributes life events to the accumulation of good or bad deeds. Beliefs such as these may be an underlying

issue when a patient is unwilling to adhere to a given treatment or adopt a health promoting behaviour.

The concept of prevention may be a novel one to some people. For example, some people who settle in Northern Ireland come from poorly resourced countries where the health system is barely able to provide adequate clinical, curative care and where public health budgets are so low as to preclude attention to health promotion and prevention of life-style diseases.

Ascertain the perceived cause of a health problem, the usual treatment within the culture and the extent to which the patient is prepared to accept an alternative form of treatment.

Note that beliefs often, but do not always, affect practice.

Pain and Disability

Pain tolerance, experience of pain, outward expression of pain and communication about pain are very different across cultures. Some cultures may place a lot of emphasis on the need to save face (e.g. Chinese, Filipino) and some are very expressive of pain (e.g. in general, Mediterranean cultures).

In some religions, pain is valued as a pathway to Heaven. In others it is viewed as a karmic return for past misdeeds. Different belief systems also influence attitudes to pain relief. Failure to vocalise pain does not mean that the patient has a "higher threshold". As well as asking the patient how much pain they have, it may be helpful to ask the family. This is particularly relevant to the labour ward.

Attitudes to drugs differ and techniques, other than medicines, for pain should be explored. Pain can create increased dependence and therefore significant others must be included in planning the care of the patient.

As with past Western culture, some cultures perceive disability as a shame and a punishment for past sins. There are also different attitudes to dependence. In some cultures the emotional wellbeing of a patient is related to the provision of care by loved ones and this is given greater value than independence and autonomy. For others, including Anglo-Australians, independence is highly valued and this is emphasised in rehabilitation programmes. A compromise may need to be negotiated with the person and family, as rehabilitation may be an unfamiliar concept.

It is not appropriate in many cultures to tell a person directly of a poor prognosis as this removes all hope. Approaching the family about how best to break the news would be appreciated.

A Specific Note on Refugees

Identification of refugees and survivors of torture and trauma is difficult, but this can be important. The detrimental impact of the asylum process on the health of asylum seekers is a recognised concern. Knowing the country of origin will give some indication of whether a particular patient is likely to have experienced war and physical or psychological abuse. Certain health problems are common among asylum seekers and some are specific to them. The threats to health are mostly posed by diseases linked to poverty and overcrowding, whether communicable, degenerative or psychological. However, a great deal of tact is required when trying to ascertain information which may not be volunteered if the interpreter or the health provider is not trusted. Figures of authority can represent annihilation and therefore refugees may not want to reveal themselves for fear of being betrayed. The most important barriers to healthcare are language and cultural differences and the fact that some asylum seekers may be illiterate. Asylum seekers have difficulty in finding information on health services, in particular primary care. Further, the hospital system can re-traumatise by triggering memories of patients who have previously undergone traumatic experiences. Triggers may range from specific experiences with doctors and nurses, to having to wait in a closed waiting area and this can complicate staff-patient interaction. Depending on the level of proficiency in English, interpreter-assisted communication is essential in order to facilitate discourse and develop a relationship based on trust.

In 2002 the Department of Health in England set up a small team to coordinate health and social care policy for asylum seekers whose aim is to keep all those who work with asylum seekers informed of developments within the department and elsewhere. Initial work includes the publication of a resource pack in partnership with the Refugee Council for those who work with asylum seekers in healthcare, social care and mental health settings. For further information, please see the 'Section Six: Useful Contacts on page 116 of this handbook.

Religion

In general, religion plays a major role in people's lives. There are some very useful resources, which provide extensive guidelines for the management of patients from different religions. (see Section 6 Useful Contacts).

Religious beliefs have a major impact on attitudes toward many procedures in the hospital, e.g. organ transplantation, birthing practices, death and dying, diet, gender issues, abortion and modesty, to name a few.

Certain religions require prayer at certain times of the day, so being sick or hospitalised can be very disruptive to an important routine. Prayer rooms are a valuable resource and patients need to be informed about them. In addition, hospital chaplains can sometimes co-ordinate visits from the appropriate priest,

monk, rabbi, imam or other religious leader. This may speed up the healing process.

Avoid making negative comments about faith - some staff have said, "prayers will never work". Allow room for prayers even if you do not believe in them yourself.

The Staff – Patient Relationship

In many countries, health workers are figures of authority and patients/clients play a passive role. The notions of choice and informed consent, as well as the opportunity to question treatments and procedures available in the Northern Ireland health system, may therefore be new to many.

Complaints are seldom made because of concerns that staff will think them unappreciative and that future care may be affected. In addition, many people are afraid of doctors and hospitals and their fear is magnified if they do not understand what is wrong with them. Hospital is often the last resort and the decision to have what may be considered by medical staff as an urgent operation may be taken only after trying other non-medical treatments first.

Attitudes towards hospitals and hospital staff depend largely on the patient's previous experiences and expectations. If, for instance, a patient expects that a particular treatment should result in an instant cure, a step by step treatment process will need to be explained very clearly.

Staff attitudes to patients also affect interactions within the hospital system. The interview to collect data on the patient's history may be perceived as very threatening and daunting depending on previous experience.

Some patients/clients do not expect or understand the depth of questioning that is normal in a health care or hospital culture. Disclosure of personal information including current symptoms or health history may not always be appropriate at the first meeting. Some people from specific cultural backgrounds or who have been tortured/traumatised may have difficulties in disclosing personal information.

You need to be patient and make an effort to establish a trusting relationship with the patient/client.

A list of guidelines to assist in improving the relationships between hospital staff and patients from culturally and linguistically diverse backgrounds is given below.

Identify yourself clearly with a readable identification badge, which helps to make you more approachable.

It is helpful for doctors/nurses/social workers/ AHPs in particular to write down their names so patients/clients can remember unfamiliar names more easily.

A smile and a friendly attitude is an important way of communicating non-verbally with patients/clients who cannot communicate in English. It is not always possible for them to learn to speak English, but this need not be an insurmountable barrier to communication. Your tone of voice, body language and actions can convey reassurance. Taking time and being patient and gentle are very important.

Be aware of your own attitudes. These are clearly transmitted both verbally and non-verbally. Awareness of your own expectations and recognition that they are simply expectations based on your own culture and experience is helpful.

A preliminary step in the process of developing a culturally appropriate service is the willingness to engage in some self-analysis to establish your own beliefs, attitudes, expectations and practices, which can then be affirmed or modified as appropriate.

Explore ways of accommodating different requests and cultural practices. For instance, in some situations it may be possible to allow a woman concerned about modesty to wear pyjamas to surgery rather than a hospital gown.

Allied Health Professionals (AHPs)

Not all people are familiar with AHPs. The approaches and roles of different therapies in the management and care of the patient's/client's condition should be explained. Further, these types of services are offered both in the hospital and a community setting and care should therefore be taken to ensure patients'/clients' needs are taken account in arrangements for making appointments and home visits.

Physiotherapy

Physiotherapy is not provided in all health care systems and so not all patients/clients will be familiar with its approaches to healing and care. Physiotherapeutic advice and practice, such as early ambulation after surgery or childbirth, may be inconsistent with traditional attitudes to healing and recovery.

The advice of a physiotherapist may not be seen to be as good as that of a specialist. For successful treatment, there needs to be close communication between the patient/client and the physiotherapist. For assessments that require undressing, it may be preferable to have a family member present.

Speech and Language Therapy

Organise an interpreter if necessary and take into account that English is not the first language. It may be possible to arrange a referral to a bilingual speech therapist. It is worth noting that some questions in the language assessment tool may not be appropriate.

When an electrolarynx is used, the monotone obscures the meaning of tonal languages such as Chinese, which creates difficulties in understanding.

Occupational Therapy

People have different attitudes towards dependence. In some cultures the emotional wellbeing of a patient is related to the provision of care by loved ones and this is given greater value than independence and autonomy. For others, independence is highly valued and this is emphasised in rehabilitation programs. A compromise may need to be negotiated with the person and family, as rehabilitation may be an unfamiliar concept.

For staff referring to the occupational therapy team it is best to advise early that the person will be going home so the team can make preparations for discharge, which may take longer than for people without cultural and language issues.

Social Work

The concept of social work does not exist in some countries. It is not appropriate in many cultures for individuals to admit to social, personal or interpersonal problems because of the disgrace this might bring to the family. Those in need may not ask for help directly, therefore assistance should be offered sensitively. Immediate rejection may not necessarily indicate total rejection either and it might be useful to revisit issues with patients/clients once they have had a chance to think about such services.

Hospital Admission Procedures

Preparing to go into hospital is anxiety provoking for most people. Admission to a hospital here can be quite a traumatic experience, especially for the first time.

For routine admissions, it is vitally important for the patient/client to be contacted prior to admission (where practicable). This contact may be made by post or over the telephone, or in some cases, via the family doctor.

Inquiries should be made to establish the need for an accredited interpreter and also about special needs, such as preference for a particular gender of interpreter and so on. This will reduce anxiety. Find out who is regarded as

next of kin and establish how much family involvement they would like. This contact can also provide information/instructions from the hospital.

For non-routine admissions it is essential to organise an interpreter (if needed) as soon as possible. The patient's medical record should indicate his/her ability to communicate in English. Sometimes the patient/client may not be accompanied by anyone at admission (interpreter or advocate). The patient's/client's expectation is that an interpreter or someone bilingual will be present on admission. A patient/client who is unable to speak English at a sufficient level will have a sketchy and possibly inaccurate understanding of his/her medical condition without the presence of an interpreter.

If new to the system, the non-English speaking patient will need information in his/her own language about the hospital. There are considerable variations in expectations as far as hospital admission is concerned.

Expectations and understanding of hospital admissions may need to be clarified. For example, if they have to wait for a bed, this needs to be explained, as the time lapse before a bed may be available may be confusing. Ideally, there should be someone from their background to explain these things. Assistance may be required with filling out forms.

The admission staff must be satisfied that the patient has sufficient information and fully understands the information presented on admission.

The quality of the communication between admission staff and patient/client has a major bearing on the information both parties obtain and thus on the quality of care received during the admission.

Emergency Departments

Emergency departments are generally stressful both for staff and patients. A lack of understanding of procedures and poor English language skills can exacerbate this and reassurance is needed.

Without an interpreter, the person may not be able to express himself or herself and can be sent home even if quite ill. It is important to give the consultation as much time as practicable.

Language issues are more crucial in an emergency which makes it very important to arrange an interpreter.

The communication styles and time pressures of people working in the emergency department will greatly influence the quality of the interaction and it is worth explaining this to the patient. Long waits for medical attention are a problem and may be particularly distressing if the person cannot speak English and does not realise that cases are seen in order of priority, not arrival. Many

may not realise that the emergency department is not for minor problems. Lack of, or delay in, attention may be perceived as racism.

It can be awkward to have spouses together with the patient and staff in small cubicles, but for the reasons mentioned in the Family and Community section (on page 9), this is especially important for some people.

Investigations

The potential problems with investigations among patients from culturally and linguistically diverse backgrounds are inadequate explanation of the procedure and lack of understanding of the results. It is crucial therefore, that communication in these areas is accurate.

Pathology

People from some cultures are hesitant to give blood or have blood tests because the purpose of this has not been properly explained. Some people interpret the common weakness experienced after a blood sample is taken as a removal of part of their life force. Others who are not familiar with such processes may fear what will happen to their blood and in some communities there is a belief that witches take other people's blood and this is an indication of imminent death.

Providing a faecal sample may also cause difficulty if an explanation of how this is done is not given.

Radiology

Experience has shown that Muslim women may not wish to tell male staff they are pregnant and as such are not aware of the dangers of an x-ray in this situation. Further, the difference between scans and x-rays may be confusing. Explain that scanning a baby is not an X-ray and is not dangerous for the baby. Interpreters may not know this either. It is important to explain procedures adequately beforehand.

Most know they will have an X-ray if they have a broken bone, but not necessarily for other problems. CAT scans can be frightening because of the confined space, which is more anxiety provoking if unexpected. Bad experiences may be remembered and the procedure may be particularly traumatising because patients often do not have a support person with them.

Childbirth

Most women who access health services do so during the reproductive years and particularly for the purpose of childbearing. All countries have maternal and child health programs and antenatal care and supervision during birth are routine

primary health care provisions. As a result, virtually all women in Northern Ireland will have some expectation of medical care during pregnancy, although their expectations of the nature and frequency of care will certainly vary.

Pregnancy and childbirth are important events in the life of a woman and the experience is strongly affected by the culture and level of knowledge of the women and her support people.

Consider these issues:

Antenatal clinics should identify women from culturally diverse backgrounds and identify which language they speak at home. Is an interpreter required?

People have strong and complex beliefs about different cultural practices in relation to birth. Important differences exist in relation to bathing/showering, the mother's diet, how much and for how long she rests after the birth, how the baby is dressed, what should happen to the baby and specific practices to encourage healing of her body. The ultimate consideration is that the mother's health is of the utmost importance.

Women may feel that they cannot say what they want, so help them to feel comfortable to talk about cultural issues. Ask what practices and traditions they are familiar with and make out a care plan involving the woman and appropriate family members/support people. It helps if you understand particular behaviours and practices of women from various cultures, e.g. some cultures believe that women will experience arthritis and bladder problems if exposed to anything cold after childbirth.

Cultural concepts of family, breastfeeding and maternity hospital admission also vary. In most societies, women learn about mothering from family and wider community, rather than antenatal classes. Having a baby is an important event in every culture and older people usually come to help, support and encourage. This resource may not be available when one finds oneself in a foreign country without extended family support. Childbirth may become an even more isolating experience and may affect the mother's risk of postnatal depression. It may be necessary to provide assistance in identifying support within the community, although not all women will want or accept this. In either case, support from community midwives may be helpful.

In some cultures, a husband is not expected to be present on the labour ward and would feel embarrassed to be with his wife during labour. The support of other women may be preferred, but if there is no other support person, having the husband present may become a matter of necessity.

Although women have the option of a "birthing plan" it is just as important for them to understand what is realistically possible in the hospital under the public

health care system. For example, some people are surprised and apprehensive when there is no doctor present at the birth.

Women need to understand that the placenta will be disposed of, so they can ask if they want something different.

Some women may not appreciate the importance of breastfeeding for the first few days after birth. They may believe that colostrum is not good for the baby and come from backgrounds where women express colostrum and only commence breastfeeding with the letdown of "proper" milk. Other women may supplement colostrum or rely on artificial feeds in the first few days because they believe they do not yet have "enough" milk for their baby. Artificial feeding is also a sign of status in some culture. Explain the physiology of lactation to encourage the establishment and duration of breastfeeding.

Asian and African women tend not to eat many dairy products and may be lactose intolerant and need to be encouraged to eat other sources of calcium, particularly when breastfeeding.

It is important to tell women about child health clinics and the role of health visitors because they may not be aware that these exist. In addition, house calls made by community midwives and health visitors to women who have recently given birth need to be explained before discharge, otherwise it may be misinterpreted as a "check up" on the mother or her family. This may discourage future presentation to the clinic, access to immunization and other vital support for mothers and their infants.

Paediatrics

Hospital routines need to be carefully explained. For example, increasingly, parents have a choice in the care and activities of daily living of the hospitalised child. In other countries, there is little difference between paediatric and adult care and this may result in parents being reluctant to become involved in the care of their child.

Elsewhere, in countries with acute staff shortages, there may be too few trained staff to provide routine, non-medical care of patients. In these circumstances, parents typically stay in hospitals with their sick child; not only to provide reassurance to the child (and to the parent his/herself), but also to provide basic nursing care.

Parents need to be reassured that their involvement on the ward is to enhance quality of care, but that the child's wellbeing will not be compromised in their absence. It may be impossible, in any case, for a parent to stay with the child, particularly when they have other care responsibilities (other children, ageing parents) or when they are unable to take time off work for this purpose.

In some countries, children are warmed when feverish to "sweat out the fever". They are thought to be "cold", so are kept well wrapped and given hot drinks. Conventional cooling treatments for fever need to be explained. Similarly, some cultures tend to overfeed children, as it is a sign of status and health to have a fat child. If restrictions are required in the child's diet, this needs to be carefully explained. If further information is needed about childrearing in a particular culture, confidential enquiries could be made to specific organizations representing ethnic minorities.

Very occasionally, major conflict may arise in the care of a sick child, regardless of cultural background. If the situation occurs that parents refuse lifesaving treatment for their child, although all attempts have been made to overcome cultural and language barriers, the child can become a ward of the state.

Child Abuse

Child abuse varies in its definition because of cultural differences in raising children. For example, in some cultures, it can be a cultural norm to shout at the child as a disciplinary measure and this is not regarded as abusive behaviour. Some physical punishment may be usual, at home and at school. Social class differences within cultures also need to be taken into account when assessing for child abuse.

Do not confuse bruises resulting from coin therapy of Chinese/Vietnamese traditional healing with bruises due to physical child abuse. If there are marks on a child's body, which you do not understand, ask the parent or carer for his or her explanation before taking any other action.

Remember, also, that infants with dark pigmented skin characteristically have "Mongolian spots" which look like bruises. These are typically on the lower back and disappear over time. They are normal and are not an indicator of how the child is handled. These Mongolian spots can also be present on a child whose mother is Irish but the father is from a country such as Iran.

Professionals are responsible to meet the requirements of The Children's (NI) Order 1995 and Trust policies.

Surgery and Intensive/Critical Care

Operations, especially when urgent, are very frightening for both the patient and relatives because of the perception of a high risk of death.

Doctors should clearly explain the procedure and post-operative care to the patient and close family members, using an interpreter and diagrams or models, where appropriate. People need to be given the opportunity to express their fears.

It may be necessary to have a professional interpreter in theatre for procedures that do not require a general anaesthetic.

Informed consent is a major issue. It is very difficult to be sure that even patients/clients who speak English as their first language fully appreciate the nature of a condition, the procedures that might be involved and the risks entailed and are therefore in a position to give true informed consent.

For those who do not speak English as their first language, the difficulties are magnified and fear may also inhibit language facility at this time. Patients or guardians (e.g. parents) may create the impression of understanding when they do not have full comprehension of the procedure. This includes operations and ECT.

If the person is not competent in English, make sure you get an interpreter who can explain the procedure, the risks and the benefits, in the person's own language.

It may be helpful to ask if patients would like you to talk to someone in their family to help with the decision about the procedure.

People may not ask questions and may say they have understood, even if they have no or only partial understanding. If it becomes a legal issue in a court of law, it is important to have checked comprehension. How would you prove that they have understood?

Most people entertain fears of dying if they have an operation. Signing the consent may create the impression that the operation is very risky and the doctor is evading responsibility by getting them to sign. So explain that it is standard for all patients to sign and explain why they need to sign the consent form.

In some countries, procedures such as endoscopies are done without sedation. Make sure the patient understands that in Northern Ireland hospitals, some form of sedation is usually used, otherwise they may be needlessly anxious.

On the other hand, various procedures are now done in Northern Ireland as day surgery and often with local anaesthesia only, whereas patients may be familiar with such operations occurring for inpatients with a general anaesthetic.

Again, a comprehensive description of the procedures with sufficient time for the patient to ask questions and clarify their own worries and uncertainties is essential.

Organ Transplantation

Each culture has a unique view of organ donation, often based on religious beliefs and sometimes reinforced by state law. For example, organ donation is not

allowable in Japan. It is helpful to be aware of cultural/religious attitudes, but of course individual preference is all-important. Muslims or Buddhists for instance, may be offended at being asked about organ transplantation. For some Muslims, the attitude may be that if Allah has ordained them to die, they have to die and no one has the right to interfere with the will of Allah by receiving a transplant.

Some people believe that by even talking about dying, one is doing wrong, because this is a negative attitude. Discussions about removing organs after death may be offensive. Some may be distressed if it is suggested that they donate body parts for transplantation procedures, because their body belongs to Allah/God, not to them. On the other hand, some have the attitude that if the donation of their organs can save another person's life or sight, that is of great religious merit.

Intensive Care/Coronary Care

It is important to explain the purpose of intensive or critical care units to reassure patients and family, who may assume the patient will die. Monitoring systems can be threatening, especially to people who are not familiar with medical technology and it should be remembered that patients/families might not have a clear understanding of the implications or consequences of initiating life support.

Taking patients off life support also raises cultural as well as personal issues. People hold very different attitudes to patient autonomy and self-determination and some may find the idea of terminating life support offensive. Different value systems relating to the role of medical practitioners in life decisions may lead to conflict. As a result, it is important that issues of life support be discussed fully and sensitively. Treat patients/clients as individuals first and members of cultural groups second. People making life-and-death decisions draw on a lifetime of experiences and their cultural traditions are not the only factors involved. Each person has a unique belief system, with cultural background forming only part of the picture.

Resuscitation

Before discussing resuscitation or 'do-not-resuscitate' orders, the concept may need to be explained, as it may be unfamiliar to some patients. When discussing these orders with patients from any culture, explore the following:

What is the patient's/family's attitude to resuscitation?

What is their understanding/perception of life support?

What is their definition of death?

What is their religious background and how active are they currently?

What do they believe are the causal agents in illness and how do these relate to the dying process?

What is the patient's social support system?

Who makes decisions in the family? Care of Older People

When carrying out assessments, remember that people come from diverse backgrounds and different medical and health care systems. Many people may be unfamiliar with the concepts of palliation, geriatric assessment and/or rehabilitation.

For many, the idea of nursing homes can be very upsetting and can be considered insulting. Most older people expect to stay with their family until they die. The elderly are the children's responsibility, are looked after mainly by their daughters and are rarely put in nursing homes.

There is a need for special sensitivity to the traumas of the aged, who can be totally isolated. Elderly people often do not vocalise their fears and discomfort and may try to pretend they are well, as they do not want to upset their family or prevent them from going to work. They may avoid calling their children at work to take them to the doctor or hospital. There may be language barriers with children and grandchildren.

Aged people need to receive adequate information about appropriate community services before discharge as they may not receive the community services they need after discharge, such as domiciliary care, care packages, 'Home from Hospital', 'Cook Chill Meals' and so on, because often there are no culturally appropriate services. It may be important to have people from the same background and religion to assist them at home (if the family is unable to), to inform family carers of additional community support and to recognise the isolation of home carers of the aged. Very elderly patients and young patients with certain conditions, may experience considerable confusion complicated by their migration and may lose language facility.

Oncology/Palliative Care

As palliative care acknowledges and values the uniqueness of the individual, it must allow for great variability on the part of patients and families in the degree of autonomy and control they wish to maintain in terminal care. The sensitive professional who listens carefully, seeks to understand the needs, offers help and allows choices, will be deeply appreciated by persons of all cultures at this highly stressful time in their lives. One's cultural heritage can impact on terminal illness in various ways including:

Values and ethics of good pain control.

Acceptability of and comfort from various analgesics.

Decision-making around treatment issues e.g. cessation of treatment, use of intravenous fluids, artificial feeding etc.

Degree to which truth (e.g. diagnosis, future outcome) is valued and spoken openly.

Degree to which one is a member of one's culture, or is modified by other influences.

Management of dying care - care at home or in hospital - which model is most acceptable.

Specific practices that surround death, funerals, burial etc.

Manner of grieving and types of community supports available.

In some cases, families may expect that patients are not to be told directly their diagnosis or prognosis, particularly in the event of disease such as cancer or terminal illness. This is common in the Mediterranean, South America, Asia, the Middle East and former USSR. It is usual in these cultures for the physician to advise close family members and they choose whether to tell the patient, based on their perceptions of how such knowledge will affect the person's mental state, if they are told news which takes all their hope away. This needs to be balanced with the legal requirements that the person needs to know their situation in order to give informed consent to their procedures. Also they may want to change their will.

However, even within the same community, individuals have different preferences about this. A person may not want their relatives to know. There is a need for clinical judgement on this difficult issue of balancing the different perspectives. One compromise is to ask the family how and when to tell the person and work with the family to tell them. People generally appreciate being told an unpleasant diagnosis subtly and gently and in a diplomatic way based on culturally appropriate protocol.

Issues of quality of life, amputations and fluid loss have different meanings to different cultures and these topics also need to be explored in individual cases.

Autopsy

Where relevant, involve the appropriate religious leader if an autopsy is necessary. Autopsies need to be negotiated with Muslims who want to bury their dead early. They may also believe that death is God's will and there is no need to find a reason. Buddhists generally do not like the skin to be pierced. For Bahá'ís it is forbidden for the body to be moved more than one hour's travel time after death. Therefore a post mortem examination should be arranged as close to the place of death as possible.

Dying and Death

Death is a cultural as well as a biological event. This includes arrangements for spiritual support. Even people who do not practise any religion may return to the religion of their upbringing when dying.

Health professionals need to be aware of the cultural and religious beliefs of their dying patients and their families. The behaviours surrounding death are

especially robust and adherence to cultural practice provides grieving families and communities with a script that offers them essential support.

Traditional practices regarding who should touch the body or move it, what direction the body should face etc. should be acknowledged and respected. The following points may be useful:

It is usually important to involve a priest, rabbi, monk, imam or other religious leader and this can be arranged through the appropriate nursing staff, head of department or Chaplain's office. If it is the wish of the patient or family, a religious leader can provide support or prayers, whether the person is conscious or unconscious.

Explain the physiological changes that occur as a result of the dying process. For instance, a dying person's lack of appetite can be distressing to family members to whom it is important to show caring by bringing food.

Check with the family first regarding their special needs and how they would like things done when a loved one has died, especially in sudden death.

Staff need to know how to look after the grieving family and how to access bereavement groups.

Discharge From Hospital

The importance of discharge planning lies in its potential for reducing readmission. According to bilingual community workers, people from diverse cultural backgrounds are still being discharged from hospital or Trust facilities without understanding their follow-up plans. Sometimes, even at the time of discharge, the patient/client is not sure why they were in hospital or what operation was done. Many patients who are not familiar with the Northern Ireland system or recent developments in patient care do not expect early discharge and assume that they will remain in hospital until they are well. They need to understand the reasons for early discharge and what support will be arranged.

Develop a plan for post-hospital care of the patient, centred on his or her individual problems and needs. This must involve the patient, the family and a co-ordinated multidisciplinary team of health professionals with established lines of communication, which considers the patient's medical and non-medical (social etc.) needs during both the hospital and post-hospital period.

Multidisciplinary discharge planning is especially important for older people whose problems tend to be more complex and chronic. These issues are even more important when the patient is not proficient in English. The discharge plan may need to be discussed with the patient and his or her family through an interpreter. Sometimes just before discharge, people are visited by a number of health staff in

sequence to maximise interpreter efficiency, but it can be overwhelming for both interpreter and patient to have a single two hour session.

Discharge planning as a process must begin on admission to hospital and continue throughout the hospital stay, to ensure continuity of care in the post-hospitalisation phase. Appropriate services must be identified as early as possible by the discharge planning team to establish an ongoing working relationship with them and to ensure that appropriate referral is made for people from diverse cultural backgrounds. Where possible, referrals must be made well before the patient is discharged, to give service organisations sufficient time to pick up the referral.

Discharge planning teams need to be aware of intermediaries in each ethnic community with whom they can liaise, both to establish linkages with appropriate community-based services and to be guided in a more general sense about critical cultural factors. After consultation with the person, specific ethnic minority organisations and other community resources can be involved.

Volunteer visitors from their community may be available to help a recently discharged patient shop and undertake other tasks, provide company and provide personal support etc.

In summary, the following points should be considered essential to comprehensive discharge planning and are particularly important for patients from diverse cultural backgrounds:

- Start planning as early as possible in the hospitalisation period, as preparations for discharge may take longer than for people without cultural and language issues.

- Consider the patient's medical and non-medical (social) needs.

- Employ a multidisciplinary approach involving a range of health professionals.

- Allow patients and their families considerable self-determination in the process of planning for their care and needs.

- Check that the patient, family and care providers fully understand the proposed care plan.

Ensure that post-hospital care involves co-operation and collaboration between the hospital and relevant home and community care services.

SECTION THREE: RELIGIONS AND CULTURES IN NORTHERN IRELAND

The main minority faiths in Northern Ireland are listed below. The following pages provide a history on each of these faiths as well as detailed information on the traditions and cultures of each one.

| | Page No. |
|---------------------------------------|-----------------|
| 1. The Bahá'í Community | 30 |
| 2. The Buddhist Community | 33 |
| 3. The Chinese Community | 37 |
| 4. The Christian Community | 42 |
| 5. The Filipino Community | 47 |
| 6. The Hindu Community | 50 |
| 7. The Lithuanian Community | 56 |
| 8. The Muslim (Islamic) Community | 58 |
| 9. The Jewish Community | 65 |
| 10. The Portuguese Speaking Community | 71 |
| 11. The Rastafarian Community | 74 |
| 12. The Sikh Community | 77 |
| 13. The Vietnamese Community | 82 |
| 14. The Irish Travelling Community | 85 |



The Bahá'í Community

The Bahá'í Faith is an independent world religion which was founded in Persia (Iran) during the mid-19th century. In 1844 the Báb taught that a Divine Messenger was about to be sent into the world. Within a few years the Báb had attracted many followers, however His followers suffered great persecution – many thousands were martyred in a short space of time and in 1850 the Báb was executed in Tabriz for heresy. Before His execution the Báb had identified Bahá'u'lláh as the Promised One foretold by all the world's religions. His followers became known as Bahá'ís. Bahá'u'lláh suffered greatly and spent the remainder of His life in imprisonment and exile. He was finally exiled to Palestine (Israel) and His remains are buried near Mount Carmel. Mount Carmel has become a place of pilgrimage for Bahá'ís from all over the world.

The Bahá'í Faith is the youngest of the world's independent religions. Over the past 150 years the Bahá'í community has spread across the globe to become the second most widespread religion. It has over 5 million followers worldwide.

Bahá'ís believe in the essential unity of the great world religions and that God has revealed Himself to humanity through a series of Divine Manifestations including Abraham, Buddha, Jesus, Krishna, Moses, Mohammed, Zoroaster, the Báb and Bahá'u'lláh. Bahá'ís also believe in the unity of humanity, the elimination of extremes of wealth and poverty, the need for universal education, equality between women and men and harmony between science and religion.

The Universal House of Justice, based on Mount Carmel in Israel, is the global governing body; elected National Spiritual Assemblies supervise affairs in each country, Bahá'í Councils organise affairs at the regional level and local Spiritual Assemblies administer local affairs. Bahá'u'lláh set out the basic principles and systems for administration and forbade the establishment of a priesthood. Thus Bahá'ís have no clergy although religious leaders are appointed by the administrative institutions described above. Bahá'ís pray each day, observe 9 major holy days and fast for 19 days every year. They regard their work as a form of worship and are dedicated to the abolition of prejudice. Sacred texts include the writings of the Báb and Bahá'u'lláh including The Most Holy Book, The Book of Certitude, The Hidden Words and The Seven Valleys. The scriptures of other religions are also regarded as sacred texts by Bahá'ís. Followers are required to say an obligatory prayer each day and read from the scriptures of the Faith each morning and evening. In illness they are exempted from the obligatory prayer. In Northern Ireland there are Bahá'ís present from many different cultural backgrounds and so there may be particular cultural considerations that might be important for some patients.

Special Considerations

Bahá'ís believe that we are placed in this world to grow and develop spiritually. Illness, like other “tests”, may be a means to such growth and it should be approached on both the material and the spiritual planes. Thus they believe in the power of prayer but have no objection to medical practice, seeing them as different aspects of the same God-given healing process. Bahá'u'lláh instructed his followers: ‘Whenever ye fall ill, refer to competent physicians’

Under normal circumstances Bahá'ís abstain from alcohol (and from other harmful or habit-forming drugs) but it is permitted when prescribed as a bona fide part of treatment. Narcotics would similarly be permitted for medical reasons like the control of pain, as prescribed by a doctor.

Diet

Bahá'ís have no special requirements as far as food and diet are concerned. Some are vegetarians, but this is a matter of individual choice. The abstention from alcohol is strict and extends to cooking as well. Wine sauces, sherry trifle, etc. are forbidden. Such items do not usually form part of the hospital diet.

Fasting

Members of the Faith observe a period of fasting each year. The ill are exempted, as are children, the elderly and expectant and nursing mothers.

Modesty

As for all men and women. There are no special points to be noted in this area, but there may be cultural needs.

Family Planning

The rearing of children is regarded as one of the main reasons for the institution of marriage, but the details and extent of contraceptive practice are left to the conscience of the couple. Many Bahá'ís will not use the intra-uterine device for contraception as they regard it more as an abortifacient than a contraceptive.

Birth

As Bahá'ís believe in the essential unity of the world's faiths, its members will welcome for themselves and for others, the dedicated efforts of clergy and lay people of other religions. They believe that the grounds for co-operation and mutual understanding, especially in a place like a hospital, far outweigh differences of doctrine and practice.

Blood Transfusions

There is no objection to the giving or receiving of blood transfusions.

Donation of Organs

There is no objection to the giving of organ transplants. Donations of organs after death for transplanting to others in need are regarded as praiseworthy.

Abortion

Termination of pregnancy is permitted only where there are strong medical grounds such as risk to the life and health of the mother. It is not regarded lightly and is not permitted as a social or contraceptive measure. Whether it is acceptable in any specific case is for consultation between the patient and her medical attendant in the light of this guidance.

Care of the Dying

There are no specific Bahá'í teachings on withholding or removing life support in disabling or terminal illness where this support is being given merely to prolong life. It is also left to the conscience of the individual whether or not to subscribe to a "living will."

Last Offices

Bahá'ís believe that after death the body should be treated with respect. Embalming is not allowed. It is customary for Bahá'ís to place a ring on the finger after death. In such circumstances it should not be removed. It is forbidden for the body to be transported more than one hour's journey after death.

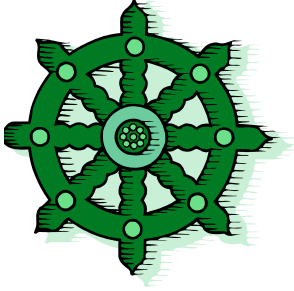
Post Mortems

There is no objection to necessary post-mortem examination provided these stipulations surrounding last offices and the funeral are met.

Funeral

Cremation is not permitted and burial should take place as near as reasonably possible to the place of death, certainly within the distance of an hour's transport.

The Buddhist Community



Buddhism derives from the teaching of Siddhartha Gautama who was born into a princely family near the border with Nepal in India during the 6th century BC. Leaving a life of luxury to seek an answer to the question of human suffering, Siddhartha found enlightenment through meditation. He became known as Buddha or enlightened one. Buddhism means the teachings of Buddha and this is a way of life. The term Buddha is derived from budh, meaning to be awakened.

Over the centuries, Buddhism has spread widely and has main divisions into northern and southern types. There are over 300 million Buddhists world-wide and there are many variations of Buddhism; while most Buddhists have been born into a Buddhist family or culture, many Buddhists in the UK have consciously converted to Buddhism.

Buddhist Beliefs

The enlightenment which Buddha found was the middle way between extremes of luxury and self-torture and, for the lay-follower, a Buddhist way of life involved the pursuit of morality and generosity, the keeping of special festivals, pilgrimage to Buddhist sacred places and social responsibility.

Buddhists 'take refuge' in the 3 principles known as the 3 Jewels:

The Buddha -the historical Buddha and the spiritual idea of human enlightenment.

The Dharma - teachings and practice which lead to human enlightenment.

The Sangha - the spiritual community (monks and nuns practising the Dharma).

The eight-fold path of Buddhism is the framework to be followed, encompassing understanding of life, the right motives, right speech, perfect conduct, right livelihood, self-discipline, right-mindedness, perfect meditation.

Buddhists believe in Rebirth and that their behaviour in this life will influence the quality of the next and, therefore, accept responsibility for their actions at all times. They believe that through Rebirth, all human beings reap good or evil consequences of their actions.

Because there is no 'God' but instead the act of 'Puja' or worship (to respect) is a way of acknowledging a human ideal.

Buddhists meet in simple temples, call Viharas or a meeting house which is frequently a large room in a house. The room will be carpeted and bare of

furniture, except for cushions. Buddhists worship there whenever they can and attached to the building may be accommodation where monks and others may stay.

There are many forms of Buddhism. The main split is between the Theravada stream, which continues a more strictly traditional practice and the Mahayana, which allows for more variety and the absorption of other practices such as:-

Shinto – Japanese sects

Chinese meditative practice – Ch'an/Zen

Tantoism, occult, Tibetan Bon – Vajrayana/Lamaism/Tibetan Buddhism.

The philosophy of Buddhism has also had a considerable impact in the West. The Buddhist Society of England was formed at the beginning of the 20th Century.

Because of its emphasis on self-redemption rather than redemption through God, a Buddhist's personal actions and way of dealing with life are important in his own progress and reincarnation.

WESSEK - a celebration of the Enlightenment of Buddha – is held on the full moon of May.

Scriptures - A copy of 'The Teaching of Buddha' will be held in the Night Co-ordinators office, Chaplain's office or Administration Department. Any scriptures brought in by the patient or borrowed must be treated with respect and other things must not be placed upon them.

Special Considerations

Peace and quiet for meditation and chanting would be appreciated and they will also welcome visits from other Buddhists. There is a particular need for a Buddhist priest from the patient's own tradition to be contacted in the case of death. It would be good practice to obtain a contact name and telephone number from the patient or family on admission.

Diet

There are no special requirements relating to food. However, many are vegetarians because of their respect for all life.

Fasting

There are a number of days when a Buddhist may wish to fast, generally occurring at the time of a New Moon or a Full Moon. On such days, eating is required at regular times. If a patient wishes to undertake a fast, staff should discuss needs and any medical problems with the patient and their family and make appropriate catering provision.

Modesty

As for all men and women. There are no special points to be noted in this area, but there may be cultural needs. Ordained nuns and monks wear different coloured robes depending on the tradition they are from.

Family Planning

Normally Buddhists disapprove of any method of family planning, seeing the size of a family as dictated by destiny. If a couple do resort to family planning, it should be a method which does not endanger the development of the baby if conception does take place.

Birth

Before the birth, the parents would visit the temple to receive blessings from Sangha. When the baby is born, it is taken to the temple to receive such blessings. The monks at the temple may be consulted for suitable names for the child. Sometimes when a baby is about a month old its head is shaved and sacred threads are tied around its wrists. A very high-class baby would have these special ceremonies performed for him/her, but normally there are no special rites.

Blood Transfusions

No religious objections.

Donation of Organs

Normally no religious objection as helping others is fundamental to Buddhist belief. Some Far Eastern Buddhists may object.

Abortion

All Buddhist traditions condemn abortion, which is seen as a much greater wrong than family planning.

Care of the Dying

A SIDE ROOM IS ESSENTIAL

Buddhists believe that the physical body comes to an end but life energies carry on with some change into a new life.

Buddhists would like to have very full information about their imminent death to enable them to make their own preparation for death. Whilst it may be very difficult for both medical and nursing staff to give an accurate prediction about

when a patient will die with many illnesses, as death approaches, it is normally appreciated if staff will discuss the patient's imminent demise in an open, honest and frank manner. Buddhists consider that dying is a very important part of life and that it should be approached positively and in as clear and conscious state of mind as possible. This may mean a reduction of certain types of medication and the patient should be fully involved and consulted at all stages.

A priest from the patient's tradition should be contacted as soon as possible and the body should not be moved too much before the priest arrives. Depending on the tradition, prayers could take an hour. It is possible that the priest will decide to recite prayers where he is or in a temple rather than come to the ward. In this case, last offices can continue as normal.

Last Offices

Normal procedures are usually acceptable, but check with family.

Post Mortems

No religious objections.

Funeral

Generally, cremation is preferred. Ceremonies vary according to cultural circumstances. Following cremation, the ashes are usually scattered in a garden or buried.

In the Tibetan tradition the body can be kept for up to 49 days while prayers for the deceased are said.

Relatives often arrange for a memorial service at home or in the temple after the death and then on an annual basis with gifts of books, money or other things required by the temple in memory of their departed.



The Chinese Community

As previously stated the Chinese, as an ethnic group within Northern Ireland, do not have an institutional religion. This handbook has information on Christianity and Buddhism, please refer to these sections if you are working with a Chinese patient who practices these faiths.

Chinese Beliefs

These are influenced by a variety of beliefs i.e. Buddhism, Christianity, Confucianism and Taoism. (See section on Buddhism and Christianity). Taoism perceives life as a balance between fire, earth, water, metal and wood. Illness occurs when these elements are imbalanced. Chinese traditional medicine seeks to address the imbalance. Confucianism is an ethical code respecting authority and perceiving law as essential in order to make life possible.

Every traditional Chinese home has a shrine, which will contain tablets listing each of their ancestor's names. Nowadays, photographs often accompany these names. The shrine usually is placed in a prominent position and will also contain statues of the various deities. Small red electric lights or candles illuminate the shrine. Offerings of fruit, rice, wine or burning incense are made frequently and often before making important family decisions, the ancestors may be consulted.

Festivals

These represent important days in the Chinese lunar calendar, which is based upon the phases of the moon. Therefore the dates of these festivals change each year.

Chinese New Year This usually falls in January or February. Celebrations last 3-15 days. This is celebrated with fireworks, dancing and the giving of gifts. Red symbolises good luck and gold symbolises prosperity. On New Year's Eve everyone must take a bath and put on new clothes – this represents self-purification and renewal.

Dragon Boat Festival Falls on the 5th day of the 5th lunar month in the Chinese lunar calendar, somewhere around midsummer's day. The festival is also known as Poet's Day because it commemorates the poet Qu Yuan.

Ching Ming & Ching Yang These festivals occur in April & October. It is the time when homage is paid to ancestors.

Moon Festival Held in August or September each year and is a celebration of the new moon. 'Moon' cakes filled with lotus paste and lighting lanterns are key elements to this festival.

Health and Medicine

The influences of the West upon the Chinese living in Northern Ireland have resulted in an acceptance of Western medicine. However, some individuals may still prefer traditional Chinese medicine, which addresses the relationship of the whole person with the environment and culture. Exercise, herbal treatments, diet and acupuncture may be prescribed. It is important to establish the individual's views on this.

Their use of hospitals is low and the use of doctors is very low especially by women. A doctor of the same sex is preferred by most Chinese, this is particularly true for women. The Chinese will expect to be given a prescription and the whole idea of attending the GP for a 'check up' when not ill will be perceived as strange. They may not be aware, like other minority ethnic groups, that this service is available to them.

If a member of the Chinese Community say they have a problem with their heart, they may mean a psychological problem. It may not necessarily be a heart attack but rather, an emotional problem.

Language

The Chinese language has three spoken forms:-

Cantonese: Relates to people from Hong Kong, China, Kwongtung Province of China and, the New Territories, Malaysia and Singapore.

Hakka: Largely spoken dialect of the New Territories. This is spoken by most elderly Chinese living in Northern Ireland

Mandarin: The first language spoken by people originating in China and Taiwan. (The official Chinese language.) This is understood to a greater or lesser extent by the vast majority of the Chinese people especially the young and educated.

Chinese is a tonal language. Therefore, a word in Mandarin can have four different unrelated meanings depending on the tone in which it is spoken. Within Cantonese, one can have up to eight tones.

In relation to the written word, during the Cultural Revolution in the 1960s, the written language was simplified to encourage literacy. However, Chinese people from Hong Kong China use the traditional form. The average educated Chinese person knows between 5,000 and 10,000 characters.

Communication

Lack of eye contact, shyness and passivity are cultural norms and are not necessarily a sign of emotional disturbance. Many Chinese do not want to talk to an outsider about their problems, especially psychosocial ones. Many consider saying "No" as impolite. This means they may go to considerable lengths to avoid saying "No". In some cases a professional's assertiveness may be interpreted as aggressiveness or hostility. Some Chinese may be hesitant to reject an offer of help or suggestion – so as not to offend.

Naming conventions

In the written form, the surname usually comes first, followed by the family generation name (if used) then finally the personal name.

In the spoken form (unless addressing a young child) the personal name is made up of two names – generation and then personal. Sometimes a hyphen is used. e.g. Kwok-Wing, Lai-Yee.

Chinese Names

| | |
|----------------|----------|
| Shek Kwok Wing | Father |
| Shek Lai Yee | Mother |
| Shek Gai Wai | Daughter |
| Shek Gai Ming | Son |

Breakdown

| | | |
|-------|-----------------|------|
| Wing | Personal Name | Yee |
| Kkwok | Generation Name | Lai |
| Shek | Surname | Shek |
| Wai | Personal Name | Ming |
| Gai | Generation Name | Gai |
| Shek | Surname | Shek |

Diet

This is influenced by cultural beliefs with health being related to the balance of the physical elements in the body. 'Yin' and 'Yang' is the balance of 'cold' and 'hot' energies within the human body. The Chinese believe that foods are important to 'heat', 'cool' or 'neutralise' the body and achieve a balance in one's health. A sick person should not eat cold food e.g. salads.

Rice or noodles are the traditional components of the staple Chinese diet. Meat, fish, cereals and soya bean products are the main forms of proteins. Tea is the common beverage. There are no dietary restrictions except for the preferred choice of the individual. Well-boiled soups are believed to cleanse the body and speed recovery. The older generation hold the belief that rice is the only staple food which can give them energy and vitality.

Fasting

No specific requirements. Dependent on the individual's own beliefs.

Modesty

Open discussion about sexuality is 'taboo'. Same sex doctors are preferred.

To many, the Chinese often appear expressionless or 'faceless'. Children learn from an early age to hide their personal feelings for the sake of politeness and to avoid disputes that could disrupt social harmony. To lose face is to lose one's dignity and in Chinese terms, we are human because we have a 'face' or reputation to protect.

Chinese women are comparatively shy and modest. They are more relaxed when being attended to by a female health and social care professional. As with any patient/client, reassurance and explanation by health and social care professionals on treatments or procedures is essential to gain co-operation and trust. Fear is often generated through ignorance or lack of understanding of what is going on around them.

Women and Child Health

After childbirth, the mother may not bathe or shower for the first few days and usually will not drink tap water - water has to be boiled. A bedwash is acceptable, however it is tradition that the mother does not wash her hair for seven days and would prefer to bathe in Ginger skin as per Chinese traditional medicine.. It is also a wide belief that the woman should rest for up to one month and hence, she may be reluctant to go out during this period.

The birth is celebrated with gifts of red dyed eggs, chicken soup and new clothes. Money is often given in red envelopes to celebrate the birth of a child. A dinner party is held when the baby is one month old to celebrate the birth and this is often a larger scale party when the baby is a male.

Most Chinese women prefer to bottle feed due to issues surrounding modesty and the almost compulsory inclusion of rice wines and ginger soups within the post natal diet – this will affect the breast milk but this does not mean that they cannot breastfeed. Women may have difficulty with breastfeeding because of lack of family support and language difficulties and may give up sooner than otherwise.

Most mothers follow certain traditional practices advocated by older relatives. However, a practical approach is often adopted combining practices from both Western and Chinese culture. There is no age of independence and elderly parents have considerable influence over adult children.

The Chinese accept family planning devices and abortion as they now place more emphasis on the quality of the upbringing of their children. Family planning matters should not be mentioned in the presence of other Chinese.

Blood Transfusions and Organ Transplants

Generally, the Chinese have no objections to these. Check individual preferences.

Mental Health

Mental Health problems are often related to social and psychological stress and can be exacerbated due to financial insecurity. Problems of this nature are often viewed as a 'taboo' subject within the Chinese community because mental health issues may be seen as a spiritual problem i.e. 'bad spirits'. Therefore anyone experiencing mental health problems would be extremely reluctant to come forward for help for fear of bringing 'shame' on the family, so much so, that by the time they do seek help their condition would have deteriorated significantly.

Care of the Dying

The presence of the family is important at the time of death. After the death, talking to the deceased is part of the grieving process and may not be hallucinations. The Chinese do not see death as an end, but merely a move into a new but not unconnected sphere where the concerns of the material and the spiritual well-being remain paramount and affect those left behind. The Chinese rites of mourning are a great source of comfort.

Funeral

As per Buddhist or Christian beliefs.

When interacting with more recently arrived Chinese clients:

Learn to pronounce your client's name correctly. Find out what language and dialect they would like to speak and offer them the opportunity to have an interpreter (preferably the same gender). As far as possible, avoid using family members as interpreters. Your client may have traditional beliefs, or follow both traditional and biomedical beliefs, or be in the process of integrating two cultures. Try to elicit your client's own understanding of their illness. Listen to and accommodate their explanation of their illness even if it seems unusual to you. Avoid the use of jargon. Many Chinese will have learned some English. Communicate with family members and involve them in the treatment plan. Ask your client to let you know if you say or do something that upsets them. Provide information about relevant community resources and explain how to access them.



The Christian Community

Christianity grew from Judaism. It accepts the Old Testament of the Jewish people but believes that the promised Messiah has already come in the person of Jesus around 6BC. Christians see God as one but within that oneness, God expresses himself in 3 persons, Father, Son and Holy Spirit. Jesus is seen as the Son of God, both human and divine and the Holy Spirit is the invisible guide showing people the truth of God's way. It is believed that Jesus died on a Roman Cross and then rose 3 days later and gave further teaching to his disciples before returning to his Father. Christians believe in life beyond this world. For most Christians baptism with water is the basic sign of commitment to the Church founded by Jesus. Baptism is often given at a young age but in some parts of the Christian Church, baptism is only administered to adults.

There is one Church and Christians are those who accept Jesus Christ as the divine Son of God and accept God as Father, Son and Holy Spirit. Within that basic unity, however, there is a wide variety of ways of practising the faith.

Down the centuries a huge number of churches have grown which reflect these variations of practice and understanding. These are not separate religions, however and these different parts of the universal Church such as Methodism, Roman Catholicism, Anglicanism, Presbyterianism, Free Presbyterianism, Baptists etc. are called denominations. Easter and Christmas are the principal festivals.

Christian - Roman Catholic & Protestant Churches

Christian - Roman Catholic

The Roman Catholic Church in common with other Christian denominations has its roots within the person of Jesus Christ and the Judaeo-Christian Scriptures. It is characterised by a doctrine and structure which traces its history to the Apostles of Jesus Christ in the 1st century AD.

Roman Catholics believe in the resurrection of Jesus from the dead and in the existence of the Holy Trinity; God the Father, the creator of the world, God the Son who is Jesus Christ and God the Holy Spirit. A recent Catechism (guide-book) for the Catholic Church presents the tradition as being based upon - faith as expressed in the great Creeds, the sacramental life, the spiritual and moral life and Christian prayer.

The Roman Catholic Church recognises seven sacraments. These are sacred rites, which pass on the principles of the Church and assist people in living their Christian lives. They are Baptism, Confirmation, the Eucharist, Reconciliation,

Anointing of the Sick, Marriage and Holy Orders (whereby priests are ordained to minister the faith).

There are around 600 million Roman Catholics in the world today concentrated in Southern Europe, Latin America and the Philippines. Roman Catholics try to live their lives as proposed by Jesus in the New Testament responding to the message of love and unity contained there. Following on from this attitude of caring and service, the Roman Catholic Church has established many schools, hospitals and relief organisations throughout the world.

Increasingly lay people are becoming more involved in the running of the parish and in the liturgy contained in religious services. In addition to the diocesan and parish structures, religious orders of men and women have had an important role within the spiritual life of the church for hundreds of years. Sunday Mass is an important part of the religious life of the individual Roman Catholic and a number of feast days celebrating various aspects of the life of Jesus and the saints are celebrated throughout the year.

According to the 1991 Census, there are about 600,000 members of the Roman Catholic faith living in Northern Ireland. It is the largest Christian denomination in Northern Ireland and Ireland as a whole.

[Christian - The Protestant Churches](#)

In Northern Ireland the three numerically largest Protestant denominations are Presbyterian, Church of Ireland and Methodist.

[The Presbyterian Church](#)

Presbyterianism came to Ulster with the Scottish settlers in the 17th Century; Irish Presbyterianism traces its formal origins to the establishment of the first presbytery at Carrickfergus in 1642. Presbyterians place an emphasis upon the Sovereignty of God, the Kingship of Christ and the authority of the Bible. Prayers, hymns, Scripture readings and preaching are central within worship. Nearly 337,000 members of the Presbyterian Church were recorded at the 1991 Northern Ireland Census.

[The Church of Ireland](#)

The Church of Ireland is part of the worldwide Anglican Communion and in the 1991 Northern Ireland Census numbered about 280,000 members. It describes itself as 'Catholic, Protestant and Reformed' and traces its roots to the earliest days of Irish Christianity as well as to the early apostles. The sacrament of Holy Communion (the Eucharist) is central to its worship and two main Prayer Books are used - The Book of Common Prayer and the Alternative Prayer Book.

[The Methodist Church in Ireland](#)

Methodist teachings are very similar to those of the other larger Protestant denominations, with an emphasis on the Bible as the supreme authority for faith and the need for personal faith. Baptism is normally of infants and communion services are usually held monthly. Set liturgy is not often used in Irish Methodist churches and the climax of worship is normally the sermon, with much hymn singing. Each local congregation normally has a Minister and some lay people serve as Local Preachers. According to the 1991 census about 60,000 people in Northern Ireland identify themselves as Methodists.

Northern Ireland's Protestant communities are diverse and as well as the three numerically large denominations there are many smaller ones. Those indicated here give some flavour of that diversity.

[The Baptist Union of Ireland](#)

There are around 20,000 Baptists in Northern Ireland. Baptists emphasise the need for believers' baptism by total immersion in water on profession of faith in Jesus Christ and there is a baptismal tank at the front of most Baptist churches.

[The Christian Brethren](#)

See section on 'Information on Other Religious Groups'

[The Free Presbyterian Church of Ulster](#)

This Church was established in the early 1950s under the leadership of the Reverend Ian Paisley and has grown steadily since that time to a membership of around 13,000. Free Presbyterians describe themselves as fundamentalist, emphasising 'the absolute authority and divine verbal inspiration of the Old and New Testaments as the Word of God' and great importance is attached to evangelism. The Free Presbyterian Church has consistently opposed ecumenism.

[The Pentecostal Churches](#)

Several Pentecostal denominations are found in Northern Ireland, with broadly similar beliefs and practices, especially the Elim Pentecostal Church, the Assemblies of God and the Apostolic Church.

[The Salvation Army](#)

In the 1860s and 1870s William Booth, a Methodist minister in East London, established a new mission to the poor which became known as the Salvation Army. By 1880 the Army had arrived in Ireland, where it currently has about 1,000 members.

The Society of Quakers

See section on 'Information on Other Religious Groups'

Special Conditions

Patients may wish to see a chaplain if they are in hospital for very long or if they are very ill, worried, or about to undergo surgery. Relatives are likely to ask for a chaplain for a dying patient or for prayers with a patient who has died. In hospital, patients are normally willing to meet with a chaplain but often they will prefer contact with their own clergy. Patients may be open to prayers and readings from the Bible at the bedside. They also may avail of the services held in the hospital chapel.

Diet

There are no particular dietary needs. The ethnic background is likely to be important in dietary choice.

Fasting

This varies with individuals, but some will wish to abstain from meat on Fridays (often eating fish instead) and on Ash Wednesday at the start of the season of lent. Some of the patients/clients see fasting as important to bring themselves closer to God. It is often an individual decision.

Modesty

No particular religious needs, but some patients may be particular about dressing modestly and may find mixed wards difficult.

Family Planning

This is normally acceptable but within limits depending upon individual conscience and belief. Roman Catholics who follow their church's teaching strictly will only accept limited options, which do not interfere with the possibility of conception.

Birth

There are no particular ceremonies normally, but where a baby is very sick the parents should be asked whether they want their baby baptised. Roman Catholics and Anglicans are particularly likely to request this. The appropriate chaplain should be called but, if time is too short, a nurse can administer emergency baptism.

Blood Transfusions

No religious objections.

Donation of Organs

No religious objections. Chaplains may be called where the family feels it would be helpful.

Abortion

This will vary, but there are general objections to abortion except where essential for the mother's health. There is a greater acceptance of termination for foetal abnormality.

Care of the Dying

This varies with individuals, but many will ask to see their own minister or a chaplain. Often the request will come from the family towards the end, but it is also appropriate for staff to offer to call a chaplain. This is normally appreciated even if the family does not wish to take up the offer. This offer can also be appropriately offered when a diagnosis of a terminal condition is communicated or it is suggested that treatment be withdrawn.

Where a chaplain has been particularly caring for a patient, staff should contact that chaplain when the patient deteriorates and is expected to die. Roman Catholic patients and their families would particularly expect to see a priest before the patient dies. Staff would normally contact the Roman Catholic Chaplain unless the patient has specifically asked not to see him.

Last Offices

Routine Last Offices are appropriate.

Post Mortems

No religious objections.

Funeral

Both burial and cremation are acceptable generally.



The Filipino Community

Beliefs

See section: The Christian Community

Special Considerations

Filipino culture has two particularly important traits. One is hiya, which can be roughly translated as "embarrassment", "shame" or "face". It has been described as "a kind of anxiety, a fear of being left exposed, unprotected and unaccepted". Having hiya means that people may feel very sensitive to social slight and as a result are very careful of the feelings of others.

Related to hiya is amor proprio, "self esteem". Loss of self-esteem can cause withdrawal.

There are cultural differences both inside and outside the home. In the Philippines, women are responsible for managing household finances and affairs. This differs from the situation in many Northern Ireland households, where men often expect to be in charge of the finances.

Food

Rice is the central feature of the Filipino diet, which tends to be high in refined carbohydrates (treacle, sugar), high in fat (cooking with oil or adding coconut cream), high in salt (used in food preserving) and low in fibre. Eggs, meat, fish and most vegetables are eaten. Filipinos use sauces, based on fish or shrimp, which have a strong, salty taste. Food is often not spicy, although there is regional variation.

Modesty

Women prefer female doctors but may see male doctors for certain conditions because of ease of access. In this case the presence of a female attendant may be important. (As with all patients/clients.)

Complaints such as thrush may be untreated, because women are afraid to mention them to male doctors, but do not feel a special visit to a female doctor is warranted. For similar reasons male interpreters are not always acceptable. However, most women speak English well.

Women and Child Health

Home visits will be unfamiliar for many newly arrived Filipinas. In general they are not used to unsolicited offers of help and may feel that they are being singled out for attention, or that the offer puts them under some obligation. It may be necessary to explain that the service is offered to all mothers.

Women often have children within a year of getting married. Traditional custom in the Philippines dictates that women should not bathe for about ten days after giving birth and during menstruation. Bathing during these times is seen as a cause of ill health and complaints such as rheumatism during old age. Sponge baths, herb poultices and sitting in the smoke from a herbal fire or steam bath are used as alternatives. Many women do not fully subscribe to these beliefs but they still may impact on the acceptability of health care practices. For example, women may object to having a shower immediately after giving birth.

Many women would be familiar with some traditional practices, which may include bed rest for at least one week, or even a whole month, after birth.

Women fear what is referred to as a "relapse" (bughat/binat) if they become active too soon. This involves extreme tiredness, weakness and chronic headache. Traditionally a healer would treat this.

New and lactating mothers are given rice porridge (rice boiled soft to a consistency halfway between soup and puree). This may be served with sweet, salty or spicy accompaniments. Soup made of meat and vegetables is also believed to help promote lactation.

Breast feeding on demand is normal practice for rural Filipinas. However, in Northern Ireland women may adopt mixed feeding because of the demands of work outside the home.

Some mothers may be reluctant to feed colostrum to their newborn. Some mothers believe that a mother's mood could be transmitted through breast milk and therefore do not feed if they feel sorrow or anger. Breast feeding may also cease if the child contracts diarrhoea, in case the illness becomes worse.

Many women have difficulty coping with the daily routine of looking after a baby in a country where generally they do not have the support of an extended family. In the Philippines when a woman has a baby she rests while her relatives do all the housework and cooking.

In the Philippines, both rural and urban mothers are aware of the risks associated with diarrhoea. Colds and rashes may be accepted as natural in young children, although some are regarded as serious. In rural Philippines women will often take a child with a cough to a traditional healer.

Filipino adults are typically very tolerant with young children and include them in all adult activities. Small children attend social gatherings at night as these are considered family activities. Respect for parents and elders is stressed with older children.

Health Beliefs and Practices

In the Philippines, biomedical services are supplemented by herbalists and other healers who specialise in herbal remedies, massage or healing by spiritual means, through power derived from devotion to Christian saints. Women in both rural and urban settings may seek treatment from both healers and modern health centres.

People may use concepts of "hot" and "cold" to classify and explain illnesses. Foods, medicines and temperature/weather conditions are classified according to their "heating" or "cooling" quality and their effects on the body. Sudden changes in body temperature may be perceived as harmful. Beliefs about the relationship of water and bathing to health differ substantially. Bathing can be associated with a draining of strength from the body, particularly if a person is already ill.

Mental Health Issues

It has been proven that accessing mental health services is an area in which a number of Filipinas experience difficulties. It is not uncommon for them to have symptoms of postnatal depression, because of social isolation or domestic violence, but they are often reluctant to talk about this with outsiders.

Communication

Visitors to a Filipino home are customarily offered food and/or some kind of beverage. It is usual to accept and this signifies acceptance of the giver and her household.

Filipinos consider it impolite to stare or look directly at people with whom they are talking. This should not be mistaken for mistrust or lack of confidence. Filipinos usually speak good English.

Funeral

Both burial and cremation are acceptable generally.



The Hindu Community

Hinduism is the oldest living religion, originating in India about 5,000 years ago. Indeed the word Hindu is the Persian for 'Indian' and was given to believers by invading Muslims in the 11th Century. Believers themselves prefer to speak of their belief as the eternal teaching and their beliefs are very much entwined with their way of life.

Hinduism is an umbrella-term covering different philosophical schools of thought and systems of belief. There is a wide diversity in belief and practice but a key belief is that there is one Supreme God, who is unlimited and therefore can manifest in unlimited forms, both male and female. There is also a belief in a number of demi-gods and demi-goddesses. Hindus believe that the atman, spirit, of a person is separate from their physical body and that this energy leaves the body at death and goes on to another life. It is the actions of the person in their life, which determine the nature and circumstances of their next life. The ultimate aim is to escape the cycles of birth and death and achieve union with the Supreme Spirit.

Hindu Beliefs

As already indicated, the Hindu faith covers a wide range of belief and practice; indeed some see it as an umbrella covering a large number of more distinct beliefs. While most Hindus believe in God, some do not.

For most Hindus, the one God is understood either as the all-pervading, unknowable Brahma or as the Supreme Person. In either understanding, Hindus also believe in the existence of higher beings. The three main gods and their consorts are:

God

Brahma – The Creator

The lord of all creatures

Vishnu – The Preserver

The controller of human fate

Shiva – The Destroyer

The source of good and evil who destroys and re-creates

Consort

Sarasvati

The goddess of knowledge and truth

Lakshmi

The goddess of fortune and beauty

Kali/Durga

The symbol of judgement and death.

These gods can be seen in incarnations or avatars who have appeared in history and some who are yet to come.

A major belief is that of the transmigration of the abman (soul) in this world until it is sufficiently enlightened to transcend this process and become an eternal

servant of Brahma by merging into the Supreme Spirit. This ultimate goal of all living beings is called moksha.

The Caste System

Please note: this is being addressed currently by the Indian Government at world level.

The Hindu faith and social order are particularly combined in the Caste system. The system is justified by Scriptures and the idea of karma, whereby a person's actions in their life (lives) determines their progress in the cycle of rebirth. A caste combines the family grouping with particular forms of work and traditionally people were expected to both mix socially and marry someone of the same caste.

The four major castes are:

| | |
|------------------|-----------------------------------|
| Brahmins | Priest |
| Kshatryas | Rulers and Soldiers |
| Vaishyas | Businessmen, Artisans and Farmers |
| Shudras | Manual Workers |

These are not straightforward, however and there are many subcastes as well as people belonging to a caste which does not seem to reflect their occupation.

Religious Festivals

Diwali/Deepavali

The Festival of Light. A celebration of the victory of Rama over Ravanna and the homecoming of Rama and Sita. Candles and lights are lit in all houses to guide Lakshmi, the goddess of good fortune and prosperity to bless the house. Gifts are exchanged and fireworks are lit. The Festival celebrates the victory of light over evil.

Holi

Again celebrates the victory of good over evil. It also signifies the end of winter and the beginning of spring. Celebrations involve coloured water and coloured powder, which is thrown at family and friends. Some people may choose to fast. People meet in their homes, temple or community centre to sing religious songs.

Janamashtami

This is a celebration of the birth of Lord Krishna. Plays may be presented to depict the life of Lord Krishna. Again, many people will attend their local temple where religious songs are sung. Hindus may fast all day until midnight and some people may fast during the following day.

| | |
|-------------------------|---|
| Mahashivratri | A celebration of the birth of Lord Shiva. |
| Nanaratri | The 'festival of nine lights' leading up to Dussehra. Dedicated to Mother Goddess Durga or Amba. Hindus dress up and dance around deities for nine days. |
| Dussehra | The tenth day after Nanarati. Celebrations of Mother Goddess Durga – the female principle of energy and motherhood. Family celebrations occur and presents are exchanged. |
| Raksha Bandhan | A celebration of the bond between brothers and sisters. |
| Rama Navami | Celebrates the birth of Rama, the incarnation of Vishnu and the hero of the epic poem, the Ramayana. A day of fasting and prayer. |
| Ganesh Chaturthi | The celebration of the god of prosperity and good fortune – Ganesh. This god is revered as the remover of obstacles and is perceived as the symbol of happiness. |
| Saraswati | A celebration of Saraswati, the goddess of learning and art. |

The Panchang is the Hindu lunar calendar and is the basis of all religious festivals. Festivals do not fall on the same date annually.

Special Considerations

Female patients prefer female doctors and consideration should be given to their modesty. Hindus are accustomed to having running water or a jug in the same room as the toilet and, if a bedpan is used, a bowl of water must be offered afterwards. Showers are preferred to baths.

Women may wear wedding jewellery and some men and boys may wear a white sacred thread over the right shoulder and around the body. These must not be removed without the patient's agreement as these are normally worn day and night.

A Hindu patient is likely to have three names; the personal name first, followed by a complimentary name and then a family name last.

Diet

This will need to be checked with each individual. Hindus uphold the sacredness of life, including animal life. Devout Hindus will not eat meat or fish and rarely eggs. Most Hindus will not eat beef (they consider the cow to be sacred) or pork.

Strict vegetarians will be unhappy about eating vegetarian items if they are served from the same plate or with the same utensils as meat. Hinduism forbids the consumption of alcohol. Strict Hindus and Hare Krishnas do not eat garlic or onions.

Strict Orthodox Hindus will not eat food prepared by someone not practising to the same religious standard. Some Hindus regard as unclean any utensils touched by non-practitioners.

Some Indians have traditional views on when to take certain foods; e.g. they may consider it unwise to drink milk or eat citrus fruit when they have a cough.

Fasting

It is unlikely that a Hindu would insist on fasting while in hospital (if they do, guidance will be needed from the patient and their family). At the end of the period of fasting, visitors may bring in a little food (possibly sweets) which has been offered to God in thanksgiving so that the patient can join in the celebration. Fasting may occur associated with the festivals already mentioned.

Modesty

All Asian patients are likely to be unhappy about being in a state of undress in public. As well as having a strong preference for a doctor of their own sex, Asian women are likely to find mixed wards unacceptable except for emergency situations.

The traditional clothing for men is the kameez or kurta (long tunic). Women wear a sari shalwar (loose fitting trousers) or kameez (a loose fitting long shirt) and a chuni/dupatta (a long scarf covering the head). Married women sometimes wear a bindi (a red spot on the forehead) and sometimes a red streak in their hair parting.

Family Planning

There are no religious objections but there may be strong social pressure on the woman, particularly if no son has been born. Any discussion of family planning should normally involve the husband. Women who have difficulty bearing children can be put under a great deal of pressure in a traditional family.

Birth

Relatives are likely to expect the mother to have complete rest for 40 days after the birth, to the point where they may worry about her getting up to bathe in the first few days. Mothers may find it difficult to accept the baby being kept in a separate room.

It is traditional for relatives to bring new clothes for the baby and they may need some persuasion to simply leave the clothes with the baby rather than putting them on the baby immediately. Sometimes a member of the family will write 'OM' on the baby's tongue with honey or ghee (clarified butter).

A baby's head is shaved in the first, third or fifth year. When a boy reaches the age of seven, a sacred thread ceremony is performed.

Abortion

Reverence for life means that abortion is not really approved of and, where this is the case, a woman will only accept abortion in a desperate situation. In practice, however, attitudes vary and individuals may take a very different stance.

Care of the Dying

A member of the family may read to the patient from the Hindu Scriptures. Before death a Hindu desires to offer food and other articles for the use of the needy, a religious person, or to a temple. These may be brought by relatives for the patient to touch. Offering a female calf is very important for a dying Hindu; this can symbolically be represented though kusha grass. A small piece of this sacred grass may be placed under the bed of a dying patient by relatives.

A Hindu may like to have the leaves of the Sacred Tulsi plant and Ganges water put into his mouth before death. Relatives are able to collect these items from their local temple.

Some families may call a Hindu priest, a pandit, to perform holy rites. He may tie a thread around the shoulder down to the waist or round the neck or wrist of the dying person. Do not remove this thread or any other religious items before or after death without the family's agreement. When a Hindu dies, a priest is called to invoke blessings on the corpse.

Last Offices

After death the patient's body should be left uncovered. Consult the family about what they wish to be done and whether they wish to wash the body themselves before taking it from the hospital. Often, elders in the family wash and prepare the body for the funeral. Non-Hindus handling the body can cause distress. Disposable gloves should be worn for necessary procedures not performed by the family.

Religious items such as sacred threads and perhaps jewellery should not be removed except with the family's permission and, if possible, in their presence.

Funeral

A Hindu is cremated. Families prefer funerals to take place within 24 hours. The corpse is taken to the crematorium by relatives; the eldest and the youngest son must be present for the required rituals to be carried out effectively. The ashes are sprinkled into flowing water as soon as possible after the cremation.



The Lithuanian Community

Lithuania has a population of 3.7 million people with the country's area being 25,212 sq. miles (slightly smaller in size than the Republic of Ireland with slightly larger population). 80% of the population are Lithuanians. The remaining 20% are Russian (8.7%), Polish (7%), Belarusian (1.6%) and Ukrainians (1.2%). The average life expectancy of Lithuanians 63 years for men and 75 years for women.

Religion

The largest of the Christian faiths is the Roman Catholic Church, but many other Christian, Jewish and Muslim Faiths have active congregations in Lithuania. There are also significant numbers of persons of no religion.

Culture

Lithuania is the largest, by population, of the Baltic Countries. The first language is Lithuanian, one of only two surviving Baltic languages of Indo-European origin. There are four main dialects, the most common of which is 'high' Lithuanian. Before the 18th century the Grand Duchy of Lithuania stretched through Russia and the Ukraine to the Black Sea. The modern Lithuanian State has been an independent republic since 1991. Agriculture is still the mainstay of the economy, with cattle, dairy foods, vegetables and sugar beet the main products.

Traditional Lithuanian cooking makes innovative use of the humble potato and includes cepelinai (meat cooked inside a ball of potato dough, served with a special sauce), vedarai (cooked meat and potato sausage) and kugelis (potato pudding with a sour cream sauce). Smoked sausage, various cheeses, local fruit and vegetables are traditional fare and soups are also popular. Western European culture has permeated the larger urban and youth culture to a considerable extent.

Family

The average family has one or two children. The father is generally recognised as head of the family. There is a longer tradition of both parents working outside the home and actively sharing parental responsibilities than in Northern Ireland.

Health and Medicine

Lithuania is not yet a member state of EU, although it is one of the countries to be accepted as a new member. Many Lithuanians needing health care will therefore be unsure of their position and rights in relation to health care provision. Some may be fearful of refusal or deportation if they fall ill. Services for women may

include prenatal care, reproductive care, infant care, nutrition, family planning and geriatric care, as well as health education on prevention and detection e.g. mammograms. The most commonly cited barriers to health access include lack of professional interpreter services, unfamiliarity with the health care system and the concept of prevention and primary care.

Mental Health

Resettlement is a stressful process and personal losses connected with resettlement may result in severe depression. These losses may include a decline in status due to non-recognition of skills and credentials, insufficient language skills to transfer performance standards to new context. Racist attitudes and behaviour from the host community contribute to mental health problems, particularly where there is little community structure and relatively few numbers of people 'from home'.

Language and Communication

The most commonly spoken languages are Lithuanian, Russian, Polish and Yiddish.

Diet

Lithuania is a modern Baltic state and enjoys a range of dietary choices common to most Baltic states (see Culture). The availability of local market produce is greater than in our society. Lithuanians may therefore be particularly affected by the high cost of fresh food and dairy produce in Northern Ireland.

Women and Child Health

Domestic violence, as in our own society, is more common than openly acknowledged. Women may not be aware of support structures like Women's Aid, or their legal rights in this country to protection.

Lithuanian Community in Southern Area

The numbers of Lithuanian citizens in the Southern Area is currently relatively small and there are no formal independent community structures with which individuals can identify. Most Lithuanians will be here on specific work permits or as family members/spouses of visiting workers, UK residents or UK Citizens. Some persons are without documents and these are the most vulnerable to health and social problems.



The Muslim (Islamic) Community

There are approximately 3000 Muslims in Northern Ireland, most of which have settled from Europe, the Far East, Gulf States, India, Iran, Malaysia, the Middle East, North Africa, Pakistan and Turkey. The majority of Muslims are Sunni (90% Sunni, 10% Shiite). Most Muslims live in the Belfast area, although many live in Ballymena, Coleraine, Craigavon and Londonderry. The Belfast Islamic Centre is the mosque and place of worship for Muslims in Northern Ireland and also acts as a social and community centre. There are also a few local mosques i.e. the Ballymena Islamic Cultural Centre and the Bangladeshi Islamic Centre, Newtownards and in Craigavon the community have their own Imam and temporary mosque. The main languages spoken, in addition to English, include Arabic, Malay, Urdu Punjabi, Sylheti and Bengali. In the Southern Area the most common languages would be Punjabi-Urdu and Arabic. There is a strong link between the universities within the Province and the Islamic Centre which was founded in the early 1980s. The Arabic language, the Quran and Islamic history classes are run at the centre along with study circles for women on Sundays with discussion focusing on Islamic history, poetry, language, careers advice and parenting. The Islamic community has a part of Glengormley cemetery allotted to them.

The literal meaning of Islam is considered to be 'peaceful submission to Allah'. Makka (Mecca), Saudi Arabia is the place of pilgrimage and the birthplace of the prophet Mohammed (peace and blessing on him). Muslims face the Kabba (shrine) within Mecca when praying, so may ask the direction of Kabba or Mecca.

The Holy Quran is the Holy Book of the Muslims who believe it to be the Word of God; this is particularly the case for the Arabic version. The Islamic faith is not just a pattern of religious behaviour, but a way of life with strict standards in many areas. The faithful are called to pray five times a day, although these can be joined together when necessary. Times of prayer vary because they are based on the times of dawn and dusk and Muslims follow the Lunar calendar.

Islam is a multi-racial faith and all languages may be found to some extent within the Muslim following. In Northern Ireland, the most prominent languages amongst the Islamic community are Arabic, Malay and Urdu.

Islamic Beliefs

The foundations of the Islamic Faith go as far back as Adam and Eve and Islam is a continuous chain from the Torah through the Gospels and on to the final book the Quran. This Faith developed rapidly during the Prophet's lifetime and from the 7th Century became a potent force first in the Middle East and then further afield.

While all religions have some impact on the way a follower conducts his or her life, Islam lays down a distinct regime for devout followers both in public and private life. Islamic law is based on:

1. The **Quran** (Koran) revealed gradually to Mohammed by the angel Gabriel. (The Arabic text is regarded as the only authentic version).
2. The **sunna** or practice of the Prophet as recorded in tradition.
3. The **ijma** or consensus of the Muslim community and Islamic scholars.
4. **Qiyas** – deductions from the first three sources.

There are a number of strands of the Islamic faith, which have their own views on practice and some are more conservative than others. There is a common agreement on the basic foundations. They believe in one God (Allah) and reject any idea that God comprises any person other than Allah the Creator. They reject the Christian view of God as one, but comprising Father, Son (Jesus) and the Holy Spirit. They do acknowledge Jesus as a prophet but see Mohammed as the final and most important prophet whose message was universal rather than for a particular nation or people.

Islam is built on 5 Pillars (duties) which are considered the practical side of Islam.

Declaration of Faith (SHAHADAH)

By verbally using the following words, 'I bear witness that there is no God but Allah and that Mohammed (peace and blessing upon him) was his prophet and messenger'.

The mandatory five daily prayers (SALAT).

Fajr - at dawn

Zuhr - in the early afternoon

Asr - late afternoon

Maghrib - sunset

Isha - late in the evening. The believer must perform ablutions before prayers can commence. Muslims are obligated to attend midday congregational prayer on Fridays in a communal setting.

Fasting during Ramadan

One lunar month of abstaining from food, drink and sex from just before dawn to sunset. Ramadan occurs 11 days earlier each year and is the 9th month of Islamic lunar calendar.

The giving of alms (ZAKAT) is a duty of giving charity to the poor every year. Sadqa is charity given anytime.

Pilgrimage to Mecca once in life (HAJJ).

Muslims reject any image of God and would not wish to pray where there are symbols of other religions. Some will refuse to pray where other symbols are around. There is also variation in attitudes over men and women praying together; some will be happy to pray in different areas of the same room, while others will wish to be in a different room or screened from each other.

It is normal for Muslims when mentioning 'Mohammed' or the 'Holy Prophet' to insert a phrase 'peace and blessing on him' either in their native tongue or in Arabic. (We have used this phrase in the text both out of respect for this tradition and as an example of a practice you may hear and find strange; it is not incumbent on non-Muslims to use this.) This is part of their prayer and reverence for the Prophet who was instrumental in showing the world Allah's message. It should also be noted that many Muslims find it difficult when in modern Western society people make jokes about God. They will certainly find criticism or satire about Allah or Mohammed unacceptable and may be deeply offended.

Islamic Date of Significance.

These festivals are calculated by the lunar calendar.

| | |
|----------------------------|--|
| Al Hjarh | Commemorates the migration of Mohammed from Mecca to Medina. The Muslim calendar starts on this day. |
| Ashura | Commemorates the death and defeat of Hussain, son of Ali and grandson of Mohammed. Shiite Muslims will fast, mourn and re-enact the historic events. Sunni Muslims will imitate the Prophets own fast on this day. |
| Muharram | The first day of the first lunar month - New Year. |
| Mohammed's Birthday | The twelfth day of the third lunar month. |
| Lailat Al Miraj | This is the original of the five times a day ritual. It marks the ascent of the prophet to the throne of God to receive messages for the guidance of mankind. |

| | |
|-----------------------|--|
| Ramadam | Muslims practice self-discipline through fasting in order to achieve tolerance, love, sacrifice and equality, by desisting between dawn and dusk from eating, sexual activity or quarrelling. The fast is broken at dusk with special meals. |
| Lailat UI Qadr | A celebration of the night (the night of power) when the Quran was first revealed. This is equivalent to 1,000 nights of worship. Prayers are said either at home or at the mosque. There is additional reading of the Quran. |
| Hajj | The pilgrimage to Mecca. Each Muslim should make one trip to Mecca within their lifetime. The employer may expect the individual to be away for at least three weeks. |
| Eid UI Fitr | The celebration day at the end of Ramadam. Gifts are exchanged and there is a special feast. Prayers are said at the Belfast mosque. |
| Eid UI Adha | A commemoration of when Ishmael and Abraham were tested by God. Eid prayer is said at the local Mosque. |

NB: The two 'Eids' above are the only two festivals in Islam.

Special Considerations

With regards to general cleanliness, e.g. the provision of water in the toilet area or a jug/container would be helpful. There is a duty of performing ablution before prayers (WUDU) for which running water and privacy is needed. If the patient has a copy of the Holy Quran, it must be treated with respect and staff should not place anything on top of it.

Prayer is very important and, where possible, a Muslim patient would like to offer prayer at the appropriate times. The prayers offered at Dawn and Forenoon can be particularly important. Facilities for washing before prayer and a prayer mat are important where patients are well enough to offer the formal prayers. However, if a patient is very unwell, prayer may be offered sitting or even lying down. If water is harmful from ablution, the patient may require a simple smooth stone with which to purify themselves for prayer.

Diet

In Islam, all food is classified as halal (lawful) or haram (harmful). Muslims cannot eat ordinary meat and will normally not eat pork or pork products or blood (e.g. Black pudding). Alcohol is forbidden.

For a short stay of 2 or 3 days they may prefer vegetarian food, but for longer stays they should certainly be offered ritually slaughtered meat (Halal meat) which can be provided through an agent in Belfast by liaising with the Catering Department.

An animal should not be stunned before slaughter; a quick deep stroke of a sharp knife across the throat is required. (This resembles the Jewish preparation of ritually prepared meat.) This is dependent on the patient being willing to accept our Halal food. Sometimes families will prefer to bring food in because they are not confident we will serve the genuine article or because they find the hospital food too bland.

Make sure utensils are washed before using to serve halal food - there is no need to use different utensils.

Fasting

Arrangements should be made during Ramadan for food to be available before dawn and after sunset for any patient wishing to fast. Should fasting be medically inadvisable, staff should explain that to the patient and family.

Essential drugs and medicines can be administered during Ramadan. It is not compulsory for children under 10 years of age or ill people to fast.

Modesty

Both men and women are very modest in their dress and outlook. Due consideration should be given to this important factor, especially during medical examinations and investigations, it is not uncommon for a Muslim woman to request that her husband be present during medical examinations, especially with a male doctor. Women often are covered so that their face and hands are only visible and wear headgear known as a Hajib. But in some cases women may choose to cover their entire face or reveal only their eyes. Normally women will only shake hands with men if they are relatives.

Family Planning

Openness to this will vary from individual to individual and any advice should be given in strict confidence to the patient without any form of pressure being applied. It should not be raised before visiting relatives and friends.

Birth and Circumcision

Upon birth, a member of the family will recite a short prayer to the baby – this officially brings the child into the Muslim faith. The Adhan are said into the right ear and then the left ear. A male child is required to be circumcised as soon as possible, for the sole purpose of facilitating cleanliness but this will not normally be while he is in hospital.

Blood Transfusions

No religious objection.

Donation of Organs

Muslims have declared organ donation acceptable, but this may not be acceptable to all Muslims.

Abortion

Abortion or termination of pregnancy is only allowed if there is a serious medical condition for the mother. The older the pregnancy the more difficult the ethical issue and days 40 and 120 of pregnancy as important. The health of the mother is a priority and guidance from a religious leader should be sought to seek clarification.

Care of the Dying

Family and friends may sit with the patient quietly reading the Holy Quran or making supplication. The patient may also feel the need for a visit from an Imam (leader) for comfort and making supplication. Reading the Holy Quran when one is ill is to bring about some spiritual healing and also as a means of feeling close to Allah. There is no need to hold the Holy Quran while performing any of the 5 daily prayers.

Last Offices

DO NOT WASH THE BODY OR CUT NAILS AND HAIR

Wrap in a plain white sheet. Do only the practical essential tasks following death and wear disposable gloves. The family and Muslim undertakers will carry out all Islamic requirements and you could distress the family by carrying out normal last offices. Muslims believe that the deceased retains some awareness until he/she is buried. Talk to the family and be guided by them on what is acceptable or helpful to them in carrying out the last offices.

It is normal practice for relatives of the deceased to wash the body. The body is dressed in a Kaffon (white shroud).

Post Mortems

Muslims, like many faiths, may oppose post mortems, but there are no religious restrictions if it is required by law. The family is likely to want all the organs returned to the body before burial.

Funeral

Muslims are always buried within twenty-four hours after death.

The family who will handle all procedures including the washing of the body (know as gusel) and prayers at the Mosque normally contacts a Muslim undertaker or a Mosque. Immediate burial (next day) is preferred but this is not always possible due to weekends and public holidays in Great Britain and Northern Ireland.

The body is buried with the deceased's head facing the holy city of Mecca. Cremation is forbidden.



The Jewish Community

The foundations of Judaism and the earliest stories of the Jewish people are found in the Hebrew Bible (i.e. the 'Old Testament'). The essential belief is that there is One spiritual God who cannot be represented in any shape or form. Since Biblical times the land of Israel has been considered a Jewish homeland. Following the re-establishment of Israel in 1947 many Jews have chosen to live there, others to live in many other countries.

The Jewish Faith

The Jewish religion dates back several thousand years and is the oldest of the three major monotheistic religions. Indeed Christianity and Islam both build on the revelations contained in the Hebrew Scriptures largely recognised by Christians as the Old Testament. The Jewish Faith sees God as the Creator and Ruler of everything, both knowing all things and eternal. The Jewish people see themselves as having special obligations as God's chosen people particularly under his Law. People are born Jewish rather than choosing Judaism; although some people do convert to Judaism. It is not a faith, which actually seeks converts. The Jewish bloodline comes through the mother rather than the father.

The Jewish Law is found in the Torah, the first 5 books of the Hebrew Bible/Old Testament. This Law is summed up in the Ten Commandments, but other regulations are also contained in the Torah and Talmud and have been further amplified by Jewish scholars.

The major branches of Judaism are:

Orthodox – strict observance of the Law is taught and conforming one's daily life to the classical regulations. Because of this, most Orthodox will feel unable to travel to see patients on the Sabbath however serious the situation. However, patients may travel if it is a matter of life and death.

Progressive/Reform/Liberal – these branches take a variously less orthodox viewpoint, being prepared to adapt tradition to the needs of modern society without losing the central faith in God and his adoption of the Jewish people as his chosen.

Jewish people believe that the Messiah is yet to come into the world. They expect the Messiah to be a divinely appointed perfect man who will lead the Jewish people to that foretold in prophecy.

The Rabbis are experts in the Law and give guidance in Jewish practice. They are involved in teaching and preparing boys (and in the liberal and reform tradition, girls) for the ceremony of adulthood at age 13. The Rabbis also conduct worship in the synagogue. There are religious leaders who have not achieved the

rabbinical standard of scholarship, but who may assist in the pastoral care of members of a synagogue. There is wide variation in the degree to which individual Jews observe religious requirements.

Sabbath and Festivals

The Sabbath begins at sunset on Friday and lasts until sunset on Saturday. Some patients will want to follow the tradition of lighting two candles at the onset of the Sabbath and to greet the Sabbath with a small glass of wine with special bread. We can assume that if this is required, the relatives or Rabbi will provide these necessities.

On the Sabbath work is prohibited. Practice varies widely but may include certain everyday tasks like writing or switching on lights. The patient or relative should be consulted as to what that person can or cannot do.

Religious Festivals

| | |
|-------------------------|---|
| Pesach | The Passover (celebrated in March or April) is an eight day celebration marking the exodus of the Jews from Egyptian slavery. The four middle days are treated as ordinary workdays. Special Passover meals are made and food must not contain any yeast or anything that is fermenting. Only unleavened bread and other special food is eaten. |
| Yom Hashoa* | Remembrance Day for the victims of the Nazi Holocaust. It is marked by lighting memorial candles and the holding of special services. |
| Yom Ha'atzma'ut* | Marking the foundation of Israel. |
| Lag B'Omer Omer* | The period of 49 days between Passover and Pentecost. Lag B'Omer is the 33 rd day. It is the celebration of the end of a plague that occurred during Roman times and it is the only day during Omer when weddings can take place. |
| Shavuot | Pentecost – a celebration of the revelation of the Torah on Mount Sinai. It also celebrates the wheat Harvest. |
| Tisha B'Av* | A day to fast and to mourn the destruction of the 1 st and 2 nd Temples in Jerusalem. |
| Rosh Hashanah | New Years Day – the anniversary of the world's creation and the marking of the ten days when Jews are judged by God. |
| Yom Kippur | The Day of Atonement (celebrated in September or October) marks the end of the ten days. It is a day of fasting. The dangers of fasting when ill will be taken into account by |

even the most orthodox patient on medical advice.

| | |
|----------------------|--|
| Sukkot | A nine day harvest festival. The middle five days are treated As weekdays. It begins five days after Yom Kippur and commemorates the forty years spent in the wilderness after the Jewish flight from Egypt. |
| Simchat Torah | This follows Sukkot celebrating one annual cycle of reading the Torah and the beginning of another cycle. |
| Hanukkah* | The re-dedication of the Temple by the Macabees. An eight-branched candlestick is used to celebrate the eight evenings of this festival – one candle is lit each evening. |
| Ti B'Shevat* | This is a New Year for trees. Trees are planted and fruit from Israel is eaten. |
| Purim* | A celebration of deliverance of the Jews from Persia. The giving of gifts to family and friends and charity to the poor takes place on this day with a day of fasting preceding it. |

Not all these festivals are of the same religious significance. The ones, which are not restrictive as to work, writing or switching on lights, are marked with an asterisk '*'. .

Further Religious Observances

For some ultra-Orthodox Jews, it is considered immodest for men to touch women other than their wives. For such patients thought needs to be given about what contact is necessary between nurse and a patient of the opposite gender.

Some Jewish men will need to keep their heads covered at all times, some while praying, others not at all. Some ultra-Orthodox Jewish women will wish to dress modestly at all times (i.e. no bare arms) and some married women may be wearing a wig or will keep their hair covered at all times.

Special Considerations

Judaism is not just a system of worship but a system of life. Patients will vary in how strictly they observe the Jewish code and may also be prepared to relax some observances in hospital. Where a patient wishes to follow their religious and cultural practices in hospital though, staff should do all they can to enable this. Some needs are described below:

Diet

Many Jews will ask for Kosher food. In essence, this means that specially prepared meat (and only lamb, beef or chicken; definitely no pig-meat) and only true fish (i.e. with fins and scales) can be eaten and that milk and meat products are not mixed. Pigs, rabbits and birds of prey are not kosher.

At home strict Jews will keep separate dishes and cutlery for meat and dairy foods. Meat and milk/dairy must not be mixed in a dish, but also they must not be mixed at the same meal. Some will require that strictly kosher meals be ordered, others will simply refrain from eating forbidden foods like pork or shellfish.

All fruit and vegetables are kosher, but only cheese produced under the supervision of the Rabbi may be eaten. Kosher foods should only be prepared with dishes, utensils, cookers and equipment reserved for kosher food.

The patient should obviously be consulted over his/her level of dietary observance. Kosher food can be obtained through an agent in Belfast if specially ordered through the Catering Department and must not be mixed with non-kosher food or served with the same utensils.

Fasting

This will vary with the strictness of the individual patient. The most likely time when a Jewish patient may wish to fast is Yom-Kippur, the Day of Atonement, which usually falls in late September/October. When the patient observes this fast, they would also wish for quiet so that they can pray.

Modesty

Views will vary but generally attitudes are not very different from the general run of women coming into hospital (see Special Considerations above). Some observant Jews wear a beard all year and may have sidelocks. During certain periods of the religious calendar, Jews may not shave at all.

Family Planning

Mechanical methods of contraception are not strictly acceptable, but most Jewish families will use some method of family limitation.

Birth

The birth of a child is a joyful time for the family, so there could be plenty of visitors. Normally a baby boy will be home before the time of circumcision on the eighth day after birth. This is delayed if there is any doubt about the health of the child. A specially trained practitioner called a mohel carries it out in the home.

Language

The main languages are English and Hebrew, the latter being the language of worship rather than everyday conversation

Judaism is very much part of life and culture. People are born Jews (through the maternal line) rather than coming to faith. It should be stressed that many Jews do not belong to a synagogue and that even those who might call themselves Orthodox do not always follow the strict dietary code of Judaism, so it is important to check needs with the patient or their family.

Abortion

Not normally acceptable, but views will vary with strictness of the family.

Care of the Dying

Judaism has always believed in life after death. For Orthodox Jews this takes the form of bodily resurrection at the future time of the coming of the Messiah. For Progressive Jews, it takes the form of a spiritual afterlife. However, Judaism does not stress such beliefs and rather puts the emphasis on this life and the importance of leading a good life on this earth.

According to Jewish law and tradition a dying person should not be left alone and many families will wish to sit with their relatives during the last days/hours.

Traditionally a Jew before dying should have the opportunity of saying a special prayer or confession vidui and to receive the Affirmation of Faith (the Shema). These prayers can be said on their behalf by a relative or Rabbi, but it should be stressed that a Rabbi is not essential and that if these prayers are not said nothing untoward has occurred.

If a patient or his/her relatives wish to see a Rabbi, then the patient's own Rabbi should be the first call. If this Rabbi is not available or cannot be contacted, then you should ask if the person was Orthodox or Progressive and then contact the local Rabbi as appropriate. The Rabbi or relative may wish to say a prayer after the patient has died, but again this is not essential.

Last Offices

In some cases the son or nearest relative (if present) may wish to close the eyes and mouth. The arms should be extended by the side. The body is cleaned and wrapped in a plain linen shroud in preparation for burial.

Some Orthodox Jews will wish the deceased's body to remain where it is until their funeral director can come to take it away, but most will be happy for the body to be taken to the hospital mortuary until it can be collected. If the patient dies on the Sabbath, this, in any case, will be necessary, as they cannot be collected on that day.

Mourners, if not sure what to do, should be instructed to contact their Synagogue/Rabbi who will put them in touch with the Funeral Director used by their Synagogue. If they are not members of a Synagogue they should contact the local Synagogue/Rabbi.

Orthodox Jewish families will probably want watchers to stay with the deceased until collection. In this situation, necessary arrangements will need to be made with the Mortuary.

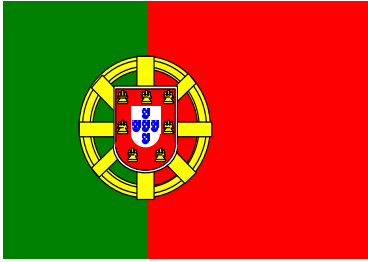
Post Mortems

No religious objections.

Funeral

Orthodox Jews can only be buried (cremation is forbidden) and the funeral should take place as soon as possible – usually within 24 hours. Progressive Jews allow cremation as well as burial and, again, would require the cremation to be as soon as possible.

After the funeral, the immediate family of the deceased mourn for a week. This is the Shiva ceremony during which the immediate family stays at home, saying prayers and receiving condolences from visitors.



The Portuguese Speaking Community

The Republic of Portugal is a member state of the European Union with a population of 10 million and an area of 36,000 sq. miles. The average life expectancy of the Portuguese is 71 years for men and 78 years for women.

In common with several other Western European Countries, Portugal has a long Colonial history which is reflected in the diversity of its citizens e.g. some may be of Black African descent. In 1974, all former Portuguese colonies were granted independence although many citizens of these countries retain Portuguese citizenship.

Religion

The major Portuguese population is Roman Catholic and Catholic traditions continue to influence life in Portugal. Minority religions include Protestants, Jews and Muslims. Church and state were separated under the Constitution of 1911.

Culture

Portugal was a major world power in the 15th and 16th Century, losing much of its wealth and status following an earthquake in 1755 which destroyed Lisbon, the occupation of Portugal in the Napoleonic wars and the independence of Brazil in 1822. The monarchy was deposed in 1910 and until 1974 the country was run by dictatorship. A left-wing military coup installed democratic reforms and elected government in 1974 and the following year Portugal granted independence to all its African colonies.

Not all persons, therefore who speak Portuguese as a first language have a shared culture, or a common national flag. Portuguese is spoken in South America, Africa, East Timor and Macau (off the coast of China) and is one of the most common spoken languages in the world. Therefore, it should be noted that not all of the Portuguese speaking community are actually 'Portuguese'.

Portugal has a rich and diverse culture which embraces Celtic, Moorish, Roman, African and Latin American influences in architecture, art, music and food.

Health and Medicine

Before the 'Carnation Revolution' in 1974, Portugal did not have National Health Provision or National Health Service. The poor were cared for by private charitable organisations and the Church. Those who could afford to, bought health services when required. By comparison our Health Service was created in 1947 and the Portuguese National Health Service more than 25 years later.

In Portugal, very few drugs/medicines can be secured without medical prescription, whereas we have a culture of self-prescription of over-the-counter drugs. This can create a misperception that locally the Portuguese are 'running to the doctor looking for prescriptions they don't need'. Health providers are simply not exposed to the unneeded self-medication of the local population.

Similarly, an assumption that because Portugal is part of Western Europe and therefore 'the same as us' can potentially lead to misdiagnosis, for example sickle cell disease is found in the South of Portugal. Portuguese women often present themselves with *agonias*, described as chest palpitations, shortness of breath and a general feeling of anxiety.

Barriers to Health

The most commonly cited barriers to accessing health services include the lack of professional interpreting services, unfamiliarity with the health care system, the concept of prevention, primary care and health support services.

Mental Health

Given the relative youth of the National Health Service in Portugal, people do not readily understand our concept of Mental Health support, self-help or access to psychology. Care should be taken with terminology as a diagnosis in relation to Mental Health may be confused with 'insanity' and lead the patient to expect and fear removal to an institution, loss of authority over their own affairs etc.

Language and Communication

While many of the Portuguese community have a second language (other than Portuguese), English is most often acquired as a third language. Older persons may not have good reading skills in their first or second language and some Afro-Portuguese use French as their formal language.

Family involvement is important in arriving at decisions and this should be taken into account when dealing with individual patients who may need the matters explained to relatives. When using interpreters, due care should be taken of language, cultural and ethnic differences and tensions within the Portuguese speaking community.

Diet

The Portuguese eat significantly higher proportion of fresh fish and fresh fruit/vegetables in their diet than is eaten in Northern Ireland. The comparatively

high cost of these foods here may impact on the capacity of the local migrant workers to eat properly.

Gender

There is often a preference for same sex physicians for pelvic and breast examinations.

Maternal/Child Health

Given that mental health is an area where misperception is common, care and sensitivity should be exercised in dealing with post-natal depression or special needs diagnosis with children. The difference in service provision can also lead to misconstruing support services as a criticism of the mother/family capacity to provide proper care.

Death and Dying

As with any individual, from any cultural background, the question of death and dying poses difficult issues. It should never be a generalised 'race' or 'culture' issue, (see palliative care).



The Rastafarian Community

Rastafarians are followers of a growing movement, which began in the West Indies, mainly in Jamaica and Dominica in the 1930s. The movement is linked to the roots of resistance to slavery (Campbell 1985) amongst the descendants of the black African slave families and the identification with Africa is central to the principle of Rastafari.

The philosophy of Marcus Garvey gave birth to the Rastafarian philosophy. He promulgated that man must know himself and led the 'Back to African Movement' which raised consciousness and self-respect.

The accession of Ras (Prince) Tafari, as Emperor of Ethiopia (Haile Sellassie) in 1930 was seen as fulfilment of the belief that a ruler would emerge in Africa and lead all black people to freedom.

Various groups have contributed to the Rastafarian Movement, which has, in many ways, rejected Jamaican-European culture and the Christian Revivalist Religion predominant in Jamaica. The result is a distinct entity. The Old and New Testaments are still regarded as Scriptures, but Rastafarians do not consider themselves ordinary Christians. For them Christ's spirit was reborn in Ras Tafari, the true Messiah.

Rastafarian is a personal religion and it's culture has a puritan ethic, which assists personal dignity and this may mean rejecting Western medical treatment. For some, legal marriage is unnecessary and thus extended families may be complex.

Rastafarians are easily identified by their distinctive hairstyles i.e. dreadlocks. The hairstyles or locks are a symbol of faith and a sign of black pride. Orthodox members may not permit their hair to be cut. Rastafarians may be unwilling to wear hospital garments which have been worn by others. If this is the case, disposable theatre gowns may be the best answer.

Religious Festivals

Christmas is celebrated on the 7 January.

Haile Selassie's birthday is on the 23 July.

The 2 November is the celebration of his imperial majesty's coronation.

Marcus Garvey's birthday is on the 17 August.

Special Considerations

Rastafarians may have an antipathy to Western medicine and be reluctant to take treatment, which they fear will contaminate the body, preferring alternative therapies such as herbalism, homeopathy or acupuncture. There may be large numbers of people wishing to visit the patient – visiting the sick is seen as important. Rastafarians may also have extended families with complex relationships, as legal marriage is not seen as important.

Diet

All pork and pork products are forbidden. Only natural foods are eaten, so canned and chemical food is unacceptable. Some fish such as herring and sardines are also unacceptable, so the patient and family should be consulted about what is permitted. Some will follow a vegetarian diet.

Modesty

Traditionally, Rastafarian women dress modestly.

Birth Customs

The new arrival is celebrated by a ceremonial Nyiahbinghi drumming along with the offering of libations and prayer. The naming of the child takes place during a gathering of the broader community.

Care of the Dying Patient

Rastafarians have a deep love of God and believe that wherever people are, God is present and that the Temple itself is within each individual.

Family members may pray at the bedside of the dying person but there are no rites or rituals before or after death. There may be a considerable number of people wishing to visit.

Last Offices

Routine Last Offices are appropriate.

Post Mortems and Organ Donation

Post Mortems will be intensely disliked by most Rastafarians. Families are most unlikely to donate a body for research, organ transplant or for teaching purposes.

Funeral

The wishes of the individual are respected, but burial is preferred. The funeral is not the elaborate affair as seen in other Afro-Caribbean groups and the body is accorded little ceremony. Only the deceased's family and friends will attend and there is no special mourning ritual. Rastafarians may be flown back to the country of origin.



The Sikh Community

Sikhs believe in one God and in many cycles of rebirth. They respect equality of all people, regardless of caste, colour, creed or sex.

The birthplace of Sikhism was in the Punjab, India in the last 15th Century. They took on the Hindu view of rebirth.

In most towns, there is a GURDWARA (Sikh temple) which is the rendezvous chosen by Sikhs for meeting, speaking about God and for public worship. It is a place for meditation, divine knowledge, bliss and tranquillity. Unlike other temples which contain altars and idols, a Gurdwara has as its focal point the HOLY GRANTH SAHIB (Sikh Holy Book) wrapped in a costly cloth placed on a platform under a canopy.

Prayers are read during the day; orthodox and baptised Sikhs try to keep a stricter routine and may wish to pray 5 times daily.

Tobacco and alcohol are officially forbidden, although many younger and less devout men do take alcohol. Tobacco is more strictly banned.

Sikh Beliefs

Sikhism is one of the newer faiths of the World, having its origins in the life and teachings of Guru Nanak in the Punjab in Northwest India in the late 15th and early 16th Centuries.

The Sikh religion was founded by Guru Nanak, born in Talvandi (1469-1538), Guru Nanak envisaged a society in which every member would work for the common good; Sikh means 'Disciple'. He and the nine other Gurus who followed him sought to set an example in the way of living spiritually, while at the same time taking an active part in the World.

Guru Nanak was opposed to religious practices taking the form of superstitions and ritual acts, which he saw as barriers rather than aids to worship. He spoke against the Caste System, against the custom of 'Purdah' (veiling) and 'Sati' (Widow burning) and gave women not only equal but rather higher status than men. He emphasised the oneness of God and his presence; and he stressed the virtues of truthfulness, kindness and generosity and the equality of men. Nine more Sikh gurus followed his teachings over a period of 200 years.

The tenth guru, Gobind Singh, knit the Sikhs into a Saint and Soldier nation with a common loyalty and a common purpose and at the same time introduced a more democratic form of organisation, with less reliance on a single man. He introduced Sikh Baptism in 1699: all baptised Sikhs adopted and wore five symbols of Brotherhood.

These are known as the five Ks and are:

| | |
|---------------|--|
| Kesha | Uncut hair of head, face and body. |
| Kangha | The comb which keeps hair tidy and in place. |
| Kara | The steel bangle wrist band. |
| Kirpan | A short sword or dagger. |
| Kachha | White shorts, worn as an undergarment. These have important religious significance and should not be removed unnecessarily. If they must be removed this must be discussed with the patient. |

The Guru also instructed the Sikhs to rise early and say prayers in the morning, at sunset and before returning to bed; to abstain from tobacco, drugs and alcohol; to avoid eating meat, to refrain from adultery and to contribute to religious purposes or for the needy in the community.

There are no priests in Sikhism; any competent person from the community can lead the service. Before Guru Gobind Singh died he declared that the Book of Scriptures, 'Guru Granth Sahib' should be his successor and it is through this Holy Book that Sikhs now approach the 'Wagerguru', meaning the Wonderful Lord.

The Sikh Temple is called the Gurdwara, where the Granth Sahib is kept with utmost respect. The Gurdwara is more than a place of worship; it is a Community Centre – the focal point of the Sikh Community.

The kitchen attached to the Gurdwara is called a Langer. Worshippers meet after the service to prepare food and eat together. People take it in turn to supply the food.

Langer is the free provision of food for everyone, regardless of religion, race, sex or class. It is a distinctive feature of Sikhism and served twice a day in major Gurdwaras.

To provide food and to serve the prepared meal are both considered great honours.

Turban

Sikhs are probably best known for two things, their turbans and their inner spirit. The turban is more than a covering for the head. It is regarded as part of one person's personality, not merely a garment. The hair of Sikh children will not be cut as it grows longer, that of boys will be tied up in top knot and secured with a handkerchief.

It is the way in which the Sikh man identifies himself with the Gurus, especially the tenth, who, when he commanded his followers to be like him, was understood to

be referring to outward appearance as well as spiritual and ethical conduct. As the Guru wore the turban, so should their disciples. The turban is made out of muslin material, which is wound round the head and is six to seven yards in length and about thirty inches in width. There are different ways of wearing a turban and different shapes and colours. Younger men will wear it in different colours. Some older men and men who are widowed wear white. Not all women wear a turban but there are some that do. If they do, they will also cover a turban with the 'dupatta' scarf that is worn with Shalwar (trousers) and Kameez (tunic top).

Religious Festivals

These are divided up into Melas and Gurburbs. A Gurburb is a religious celebration associated with the anniversary of the birth or death of a Sikh guru. The festivals of Baisakhi, Diwali, Sangrand and Hola Mohalla are important melas.

Baisakhi New Year's day falls on 13 April commemorating the foundation of the Sikh Order of Khalsa known as the five Ks. It is preceded with three days of prayer.

Hola Mohalla Falls in the spring when Sikhs are supposed to visit Gurdwaras in the vicinity.

Birthday of Guru Nanak A complete reading of the Guru Granth Sahib which begins two days before the birthday and is scheduled to finish on the morning of the birthday itself. Hymns and sermons celebrate the work of Guru Nanak and food is shared amongst the congregation.

Diwali The traditional Hindu Festival of Lights which is significant for Sikhs. The 6th Guru Hargobind was released from prison and arrived in Amristar on Diwali Day

Diet

Many Sikhs are basically Lacto-Vegetarian. Those Sikhs who eat meat will not normally eat beef and pork and many will not accept fish, eggs and meat. **NB. Sikhs will not eat halal or kosher meat.**

Fasting

There is no fasting tradition in the Sikh Faith, but some may keep some form of fasting from Hindu influences. In such circumstances fasting normally consists of abstinence from some foods but not all. This should be checked with the patient where they want to keep a fast.

Modesty

Women prefer to be examined by female doctors, but where this is not possible, a female member of staff should be present and vice versa.

Orthodox male and female Sikhs wear short underpants which should not be removed; the patient may prefer to shower with them on. Any removal or replacement must be done with the patient's agreement.

A request to remove the turban in public will cause embarrassment.

Both female and male patients are likely to find nudity, even in front of the same sex, offensive. Conservative Sikh men will wish to keep themselves covered from the waist to the knees.

Do not ask a Sikh to remove their KARA (worn by men, women and children) unless surgery or X-ray to be performed on right wrist or arm. For other operative procedures, secure with tape.

NB. A MRI (Magnetic Resonance Intensifier) scan may not be performed unless the patient agrees to remove their KARA.

Sikhs normally use the right hand for eating and the left for washing. Wherever possible the right hand should be free for eating.

Family Planning

Sikhs have no objection to family planning.

Birth

There are no religious ceremonies on birth but relatives will wish to visit the mother and there will be rejoicing with the distribution of sweets to celebrate. Relatives will be anxious that the mother completely rests for forty days after the birth.

Abortion

This is generally disapproved of, although many will consider abortion in a desperate or shameful situation, particularly less orthodox Sikhs.

Care of the Dying

Reciting hymns from Guru Granth Sahib will comfort a dying Sikh. The family will normally be present and will say prayers and recite hymns, especially if the patient is too weak to recite.

Taped hymns and prayers can be placed in the patient's room to console and comfort the patient and the family members.

Last Offices

Routine procedures may be performed but **DO NOT REMOVE 5 K'S**.

KESH - DO NOT CUT HAIR, BEARD OR REMOVE TURBAN
KANGHA - comb
KARA - Sikh bracelet
KACHHA - special shorts/underwear
KIRPAN - sword.

NB. If, for any reason, the patient's **KACHHA** has to be removed, they should be replaced by another pair.

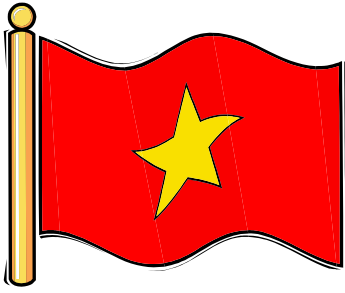
It is normal procedure for the family to wash and dress the body at the Funeral Directors.

Blood Transfusions, Post Mortems and Donation of Organs

No religious objections to any of these.

Funeral

Sikhs are always cremated and their ashes scattered in running water.



The Vietnamese Community

The majority of Vietnamese people living in Northern Ireland arrived as refugees in the late 1970's via refugee camps via Hong Kong as a result of the Chinese invasion of Vietnam. The majority have originated from North Vietnam and most are ethnic Chinese.

Religion

Vietnam has no official religion. Confucianism, Taoism and Buddhism are three philosophies, which influence the lives of Vietnamese people. However, the vast majority of Vietnamese are Buddhists with 20-30% Catholics.

Health and Medicine

Traditional and Chinese medicine play an important role in health care and people may express a preference for herbal remedies rather than Western medicines. However, most ethnic Vietnamese prefer Western medicines.

Language

The Vietnamese people speak one or both of two languages:

| | |
|------------|---|
| Vietnamese | This may be the only language spoken by ethnic Vietnamese. Ethnic Chinese can often speak Vietnamese too. |
| Cantonese | All Vietnamese of Chinese origin will speak Cantonese. |

In spite of reading and writing English well, many Vietnamese don't speak English fluently.

Communication

Traditionally, in social as in family life, hostility, aggression and other negative feelings are suppressed. Respect, self-control, flexibility and a readiness to compromise are also highly valued traits

Smiling is a common social response which can be used to mark a variety of reactions, such as anger, frustration, embarrassment, disappointment, lack of knowledge, lack of understanding, happiness or unhappiness. Smiling is therefore open to misinterpretation from our cultural perspective.

Similarly ambiguous is the answer "yes": it may be used to indicate that the listener is paying attention and does not necessarily indicate agreement. People may say "yes" because they try to avoid disagreement while privately disagreeing.

Festivals

Those associated with Buddhism and Catholicism.

Diet

The staple food is rice and there is usually a clear soup taken with each meal. Dietary restrictions result from an individual's own choice. Milk and dairy produce is not to be found within the traditional diet. Lamb may be treated with suspicion basically because it is not widely available within Vietnam.

Fasting

There are no particular periods of fasting.

Modesty

Vietnamese prefer the same sex health care providers.

Family Planning

Often, knowledge of family planning will depend on when the person arrived in Northern Ireland. It can be perceived as 'hot' medicine that can cause handicapped babies and may (particularly Catholics) also constitute too much interference with pregnancy.

Recent arrivals are more likely to be familiar with family planning due to government policy to move to 'the two child family'.

Naming Conventions

Many first names can be used for either gender, not unlike "David" or "Liam", this is not, however, universally true. Vietnamese people list their family name first, then their middle name, with their first (given) name listed last. Family members use different given names (first names aren't passed down). For example, if the name is Nguyen Van Hoa, Nguyen is the family name and Hoa is the person's given name.

Women and Child Health

Members of the family provide the mother with strong ginger soups, which are consumed twice a day for at least two weeks, twenty-four hours after the baby is

born. These are believed to purge the mother of any traces of infection. Other foods may be unacceptable during this time.

A special meal is prepared one month after the birth to celebrate the arrival of the baby into the community.

Vietnamese mothers bottle-feed their babies. It is uncommon to wean the baby on to a cup before the first birthday. In addition, drinks are often given via a bottle until the child is three years old or even older. This can have a disastrous effect on dental health.

When a child is ill, the first recourse may be to a folk or family remedy. A common remedy is rubbing the location of the illness with a spoon or a coin and some kind of ointment, such as Tiger Balm or "heating" oil, until bruising results. This kind of cure is called cao gio ("rubbing off the bad wind"). It is reputed to work by getting rid of the "wind" (gio or phong), which has caused the cold, sore throat, stomach or back pain, headache or flu. Since bruising is an effect of this, it can be mistaken for child abuse.

Blood Transfusions/Donation of Organs

Normally no religious objection as helping others is fundamental to Buddhist belief. Some Far Eastern Buddhists may object.

Abortion

The termination of pregnancy is perceived as an enormous step to take because the foetus is considered to have a soul or spirit. This is capable of remaining with and troubling the family concerned. This is of less concern to recent arrivals from Vietnam.

Care of the Dying

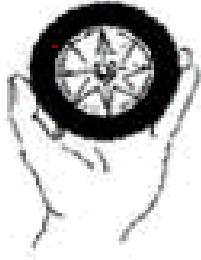
Those associated with Buddhism and Catholicism.

Last Offices

Normal procedures are usually acceptable, but check with family.

Funeral

Those associated with Buddhism and Catholicism.



The Irish Traveller Community

Irish Travellers often confused with Gypsies are a lesser known culture in Northern Ireland. Travellers are indigenous to Ireland whereas Gypsies have their origins in Northern India. Irish Travellers live in extended family groupings and have their own customs, traditions and language. Gamin, the language of the travellers has its origins in 'Old Irish or even a pre-historic Celtic parent language'.

Travellers are identified by the Race Relations (NI) Order 1997 as a racial or ethnic group; "A community of people commonly so called who are identified as a people with a shared history, culture and traditions including historically nomadic way of life on the island of Ireland."

Travellers identified as a distinct ethnic group situates them within the context of the social relations engendered by the interaction between dominant and subordinate ethnic groups. The oppression of the Travellers is seen as a human rights issue with implications for legal protection against discrimination and equality of access to the full range of service provision including accommodation, education, training and employment and health care.

Beliefs

See section: The Christian Community

Health

The health needs of many of the Irish Travellers can be equated with that of the wider community in the 1920's:-

Adult life expectancy is between 11 and 15 years below that of the settled community.

Infant mortality rates are high.

Levels of childhood immunisations are generally poor.

A further factor impacting on the health of Travellers is the fact that Travellers historically have not had equal access to education leaving many members of the community with low literacy skills. This problem leads to some Travellers not knowing what services and information is available to them through the usual channels of health promotion. This information rarely takes into consideration the lifestyle and culture of the Travelling Community and often uses inaccessible language and jargon. Low literacy skills can also lead to failure in keeping hospital appointments and inability to follow instructions when taking medicine and for hospital procedures.

Refer to page 3 - principles to remember when communicating with someone from an ethnic minority background.

Modesty

Many Traveller women prefer female doctors but may see male doctors for certain conditions because of ease of access.

Health Beliefs and Practices

Many Irish Travellers have a strong belief in Faith Healers alongside bio-medical services. It is important to try to accommodate their wishes, where possible. Visiting the sick person in hospital is a must in the Traveller community so large numbers of visitors may arrive. It is important for hospital staff to be sensitive to the sick person's and extended family's needs. If visitors need to be restricted, staff must take time to explain why in a culturally sensitive way.

SECTION FOUR: INFORMATION ON OTHER RELIGIOUS GROUPS

The following pages provide information on each of the religious groups listed below:-

| | Page No. |
|-----------------------------------|-----------------|
| 15. Brethren | 88 |
| 16. Christian Science | 89 |
| 17. Humanism | 92 |
| 18. Jainism | 94 |
| 19. Jehovah's Witnesses | 96 |
| 20. Mormons | 98 |
| 21. Paganism | 99 |
| 22. Quakers | 101 |
| 23. Scientology | 103 |
| 24. Seventh Day Adventists | 104 |
| 25. Spiritualism | 105 |
| 26. Unitarians | 106 |
| 27. Zoroastrianism | 107 |



Brethren

Originating in the mid-19th Century, the Brethren - sometimes known as 'Plymouth Brethren'- are not really a denomination as such but rather a loose fellowship of autonomous local churches. Some would fit into the general Free Church category but others do not fit well with mainstream Christianity. Guidelines from the patient and their family are particularly important. Their buildings are often known as the Gospel Hall or Evangelical Church.

Special Considerations

Some Brethren have strict restrictions on their association with people outside fellow Brethren. This is particularly true of Exclusive Brethren who cannot eat or drink with others. In this case, nursing staff will need to draw curtains around the patient for them to eat and drink in peace. Interrupting such a patient while they are eating or drinking will also cause embarrassment and staff need to be sensitive to this. Many Brethren are modest in dress and attitudes and may be apprehensive about mixed wards.



Christian Science

The Church of Christ, Scientist, was founded in 1879 by Mary Baker Eddy (1821 -1910). Though she suffered much physical ill health, eventually this led her to the question of God's responsibility for human suffering. She experimented with various alternative-healing methods and eventually experienced personal healing after reading of the healing power of Jesus Christ in the New Testament. This episode, in 1866, marked the point of her founding of Christian Science.

In 1875 she published 'Science and Health', later revised as 'Science and Health with Key to the Scriptures'. The Bible and this work formed the textbooks of the Faith, which grew rapidly in America and elsewhere. There are over 200 congregations in the UK.

The Church aims to 'reinstate primitive Christianity and its lost element of healing'. To most people, it is probably best known for its reliance on prayer alone for the healing of sickness. Adherents believe such healing is in direct line with that practised by Jesus Christ and the early Christian Church and is an integral part of the overall ministry of Christianity and the natural result of drawing closer to God in one's thought and life.

Christian Scientists are free moral agents and the Church does not control the actions of its members. It does not rebuke those who defer to family or legal pressures to undergo conventional medical treatment. However, when someone joins the Church, it is understood that there will be reliance on God for healing, rather than on medicines or surgery. Christian Science treatment must be purely spiritual, calling for a deeper understanding of man's relationship with God.

Christian Scientists will not normally be treated in hospitals but will seek treatment in a Christian Science Nursing Home or House. They may be admitted as the result of an accident or as a result of family or legal pressures, however and they will undergo medical treatment during pregnancy. Christian Scientists will allow medical treatment for their children in accordance with UK Law.

Special Considerations

If in hospital voluntarily, the Christian Scientist is likely to accept conventional but minimal medical treatment. However, he/she may ask for drug therapy to be kept to a minimum. Christian Scientists not in hospital voluntarily, e.g. after accidents, would normally wish to be completely free of medical treatment. They will normally wish to contact a Christian Science practitioner to ask for treatment through prayer and will appreciate privacy for any such treatments. He/she would probably request that, as soon as possible, a transfer will be effected to a

Christian Science Nursing Home, where treatment can be given in accordance with religious convictions.

Access to the Bible and Christian Science published works would be appreciated. Privacy would also be greatly appreciated.

Diet

No special considerations. Alcohol and smoking are prohibited.

Fasting

No set pattern.

Modesty

Individual views.

Family Planning and Abortion

Individual views.

Birth

No special needs.

Blood Transfusions

Christian Scientists have no specific objections to blood transfusions as such but, as it is a material method of treatment and their desire is to rely on spiritual means alone for healing, they would not wish to participate either as a donor or recipient. Parents comply with the requirements of the law in the UK that a doctor should be called to attend a child at a time of illness. If, in accordance with this requirement, the child of Christian Scientist parents were under medical care, the parents would not normally object to a blood transfusion, if the doctors considered it was essential.

Donation of Organs

Christian Scientists would wish to maintain the body inviolate and would not normally wish to donate or receive any organ as this represents a material method of treatment.

Cremation is usually chosen in preference to burial, but it is entirely a matter of family choice.

Care of the Dying

Worship is kept free from ritual and there are no last rites. Female staff should handle females after death (so far as possible).

Post Mortems

Christian Scientists wish to be free from post mortems, unless required by law.



Humanism

Humanism originated in the Greek secular contribution and was formalised in the UK in the Ethical Union, which was founded in 1896. The British Humanist Association was formed in 1963, under the Directorship of Sir Julian Huxley. Humanism is the outlook of goodwill and reason for those who do not accept God or a Divine Plan and see the highest good as what is best for mankind.

Humanism is concerned with morality and having faith in man's intellectual and spiritual resources, which it is believed will bring knowledge and understanding of the world and how to solve the moral problems which arise in using that knowledge. They believe strongly in the individual's freedom of choice.

Humanism respects man regardless of class, race or creed. It is also believed that the solution to a person's problems lies within themselves.

Humanism considers freedom and tolerance to be basic moral principles and looks to achieve happiness for all.

Humanism accepts that everything in the universe is the result of naturalistic processes. Humanism aims to give vision to inspire people and guidelines from which moral judgements can be built. There is a belief that the ideals of co-operation and tolerance, the use of the constitutional process and reasoned persuasion can win through and form the best framework for the Open Society.

Special Considerations

Care will need to be taken to ascertain the patient's individual attitudes and requirements. Only general principles apply to humanists, so a variety of cultural preferences and customs may influence the needs of a patient.

Diet

There are no dietary restrictions but many humanists will be vegetarian. Many humanists have objections to intensive farming methods and the pollution of food by chemical additives.

Care of the Dying

A humanist counsellor may be requested. There are no special rituals or practices, but it may be useful to be aware that humanists are more likely than most to believe in euthanasia.

Post Mortems and Transplants

There should be no objections.

After Death

Routine last offices are appropriate.



JAINISM

Jain philosophy arose in India and is distinctive from Buddhism and Hinduism. The universe is believed to have existed for all time and no Creator is seen as necessary. Each soul is eternal and the ultimate goal of existence is to gain release from a cycle of death and rebirth and achieve eternal rest in the highest heavens called nirvana.

Jainism is an ascetic philosophy, which sees the world as a place of sorrow, which can only be escaped by distancing oneself from the world through the Three Jewels, right knowledge, right faith and right conduct. The central vows, which assist in reaching the salvation of nirvana, are non-violence, truthfulness, non-stealing, chastity and non-attachment to possessions and worldly goods.

Special Considerations

The Jain patient may want to pray with their Brahman.

Diet

Jains are vegetarians and some may prefer not to eat after sunset. Some Jains may refuse potatoes, garlic and onions.

Fasting

The most important time when a Jain may wish to fast is the Festival of Paryushana-Parva. On the last day, the Jain makes an effort to be reconciled to relatives and friends and may wish to fast.

Modesty

Females may wish a doctor of their own sex.

Blood Transfusions

No religious objections.

Donation of Organs

May be willing to both give and receive. Individuals will make their own decision.

Care of the Dying

The patient may wish to fast and may wish spiritual support from his or her own community. This can be problematic from a health perspective.

Last Offices

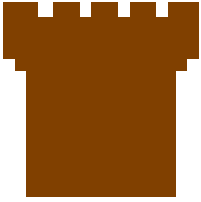
The family may provide a white gown or shroud for the dead patient. They may also wish to be present and assist; this should be checked with the family.

Post Mortems

This tends to be seen as disrespectful to the body, but attitudes vary.

Funeral

Will be arranged by the Jain community.



Jehovah's Witnesses

Jehovah's Witnesses believe in Almighty God, Jehovah, Creator of the heavens and the earth, but not in a way acceptable to Christians or Jews.

Their scriptures vary from the Bible used by Christians.

EARTH.....

created by Jehovah...
cared for by man...
to be inhabited forever

Jehovah's Witnesses believe in making a positive effort to reach the public with their message, which varies from traditional Christian teaching. Scriptures and literature are offered to householders.

Witnesses conduct meetings in Kingdom Halls on a weekly basis and also assemble in private homes for Bible Studies each week.

The only festival celebrated is the annual memorial of the death of Christ, the date of which varies, being calculated to the Biblical formula.

Blood Transfusions and Use of Blood Products

Jehovah's Witnesses believe, with absolute conviction, that the Bible forbids blood transfusion, or the taking of blood in any form. For the doctor who is faced with a patient who may die without transfusion, this is an important ethical and moral issue. It must be remembered, however, that it is an equally important ethical and moral issue for the patient and respect must be shown for their beliefs.

For the medical staff faced with this dilemma there are two considerations:

1. If the patient is an adult, is he/she conscious, able to understand the implications of refusing a blood transfusion and in a fit mental state to express his/her wishes clearly.
2. Is a blood transfusion essential in the treatment of the patient?

If the answer to both parts is 'yes' and the patient is refusing a blood transfusion, staff must refer to the Trust's policy on Consent to Examination or Treatment which details what should happen when an adult or competent young person refuses treatment. This section particularly refers to the refusal of blood, detailing what should happen.

As with all policies, the Trust reviews these at prescribed intervals and staff must be sure that they are adhering to the current policy.

Burial and Cremation

Jehovah's Witnesses may either be buried or cremated, depending on personal or family preferences and local circumstances.

There are no specified funeral rites, though a simple, personal service will likely be held at the deceased's Kingdom Hall or at the graveside or crematorium.



Mormons

(Also known as the Church of Jesus Christ of Latter-day Saints)

The origins of the Mormon religion began in 1820 in Palmyra, a family area in Western New York, USA. Today there are estimated to be 300,000 converts annually and the headquarters of the Church is in Salt Lake City, Utah, USA.

Mormons worship using the King James Version of the Holy Bible and the book of Mormon. Mormon missionaries crossed the Atlantic in 1837 and began preaching and the first Mormon baptisms in England took place in the River Ribble at Preston on the 30 July 1937.

Mormons believe that God (the Father), Jesus Christ (the Son) and the Holy Ghost are separate personages, although united in purpose. They believe in continuing Revelation and that there is a living prophet, a man who receives revelations from God and who directs their church here on earth. They also believe that we are living in a time just before the Second Coming of Christ and that the Gospel should be taken through missionary work to the whole of the world. They believe in self-sufficiency, in honouring, upholding and sustaining the Law and in being of service in the community. Mormons follow a very strict health code, known as the Word of Wisdom, which counsels against the use of tea, coffee, alcohol and tobacco and advocates healthy living.

Missionary work is mainly done by young people between the ages of 19 and 22 who travel in pairs serving full-time without pay. They go out into the Community visiting homes and spreading the word of their Church. Most rely on their own savings or are supported by family and friends. Their term of service is two years for men and 18 months for young women and missionary couples.

Special Considerations

Some Mormons, who have been through a special Temple ceremony, wear a sacred undergarment which may be a one piece or two piece garment and may be made of different fabrics. It is only removed for hygiene and laundering, but may be removed for surgical operations. It must at all times be considered private and treated with respect.

Diet

Mormons try to take care of their body and eat a healthy diet, take proper rest and exercise. They eat meat sparingly and avoid eating blood products (i.e. Black Pudding). They may request visits from members of their church called 'Teachers'

who may pray, anoint and give sacraments. They do not use stimulants or drugs, so milk, water and fruit juices are alternatives to tea or coffee.

Care of the Dying Patient

There are no rituals for dying, but spiritual contact is important and active members of the church will know how to contact their Bishop. The church has home teachers who are charged to offer support to the needy and make visits to hospital. The family should be consulted about needs.

Last Offices

Routine last offices are appropriate. The sacred garment previously mentioned must be replaced on the body, following last offices.

Post Mortems, Blood Transfusions and Donation of Organs

There are no religious objections.

Funerals

Burial is preferred. Cremation is not encouraged because of the important symbolic references to burial in the doctrine of the church, but this is the responsibility of the family to decide. Services are held at the church meeting houses and will follow the pattern of the Sunday Service which is simple and dignified and a brief sermon will take place centred on the Gospel of Jesus Christ.



Paganism e.g. Wicca [witchcraft], Druids, Odinists

In these guidelines, Paganism is used to describe a particular religious group. It is not being used in a pejorative sense.

Beliefs

These tend to include:

- 'A respect for the Sanctity of Life'
- 'A respect of the Welfare of Children'
- 'A particular respect for Women'
- 'A feeling of closeness to and reverence for Nature'
- 'That Deity can be seen in terms of male and female'
- 'That Deity can be found and approached both within and without one's Self'
- 'Reincarnation'
- 'The need to work for good ends'

For many pagans, the position of a goddess as a major source of their inspiration is the most distinctive aspect of paganism.

Special Considerations

Generally no particular needs but Pagans may wish to have a small candle and simple holder or a small figure of a god and/or goddess.

Diet

Many are vegetarian or vegan and some may want to keep to a raw food diet – in this situation it will be necessary to liaise with the Catering Department.

Blood Transfusions

No religious objections.

Care of the Dying

It is important that Pagans have the name and telephone number of their Spiritual Adviser to attend them in the same way as other ministers/religious leaders. Pagans have a network of volunteer contacts for those wanting a Pagan approach as they or their loved ones approach death.

Post Mortems and Organ Donation

No objections, they believe that they may help others in this way.



Quakers

Also known as the 'Society of Friends'

Quakers are best known for their pacifist principles and their silent and spontaneous worship. Founded by George Fox in the 17th Century, Friends believe that there is a Divine Light present in every person.

Quakers believe the whole of life is sacred and the experience of God is available to everyone. Quakerism is a group of insights, attitudes and practices, which together form a way of life, rather than a dogma or creed. It rests on a conviction that by looking into their innermost hearts people can have direct communication with their Creator. This experience cannot ultimately be described in words, but Quakers base their whole lives on it. The Religious Society of Friends (Quaker) movement arose in the mid-seventeenth century. Its followers called themselves 'Friends of Truth' or simply 'Friends'. There are no ministers or pastors. Elders and Overseers are appointed to oversee spiritual and pastoral well being of Quakers meetings and their members.

In their meetings for worship Quakers do not sing hymns or use set prayers, but wait on God in silence, with a member occasionally speaking briefly about insights they have received, praying or reading from the Bible or other religious works.

Quakers are pacifists.

Special Considerations

A Quaker may like to be visited by another Quaker.

Diet

No special considerations. Some Quakers are vegetarian and a few are vegan.

Care of the Dying Patient

There are no special rituals or practices for the dying. Patients will appreciate a visit from an Elder and other Quakers who may sit in silent worship.

Last Offices

Normal procedures apply. A number of people are appointed to support and advise families after a death and to assist with practical arrangements.

Post Mortems, Blood Transfusions and Donation of Organs

No religious objection.

Funeral

The wishes of the deceased are respected.

A Quaker funeral is like a meeting for worship and is based on silent reflection or prayer with no visible leader. Anyone is free to speak if they feel it appropriate or helpful. It is likely that several people may put into words the experience of the moment; the mystery of life and death, the human longing for consolation and the qualities of the one who has died.



Scientology

The American L Ron Hubbard founded scientology in 1950. It describes itself as an 'applied religious philosophy' and rejects the idea that Man is simply a higher animal and the materialism of modern society, which it believes to be destructive.

Scientists describe a person's inner spiritual being as the thetan, the essence of a person. This is not a separate part of a person but the person. They consider that people are made up of the 'thetan', mind and body and that a person can be helped to take control of themselves. The mind is seen as having two parts – the 'analytical' and the 'reactive'. The reactive part of the mind records everything even when we are unconscious and is 'charged' with energy in the memories it contains. Neutralising that energy allows people to be in control of themselves.

Scientists are concerned with the whole of life and have advice for their followers on a whole range of problems.

Special Considerations

A Scientist may well wish to see someone from the Church of Scientology to discuss his or her spiritual condition. They are unlikely to welcome the attention of psychologists or counsellors unless they are working alongside advisors from their own church.



Seventh Day Adventists

The 7th Day Adventists grew out of a worldwide religious revival, which expected the imminent return of Christ. The Church was organised formally in 1863 and began its mission to the world. They believe the Bible is infallible and have a strict lifestyle.

Special Considerations

Saturday is observed as the Sabbath for rest and worship and is considered to be a day of communion with God and one another. The Sabbath is from Friday sunset until Saturday sunset.

Diet

As a result of the Church's long-standing health programme, many Adventists adhere to a vegetarian diet but that practise is not incumbent on their members. The Church does, however, accept and practise the Levitical Food Code of eating only certain 'clean' or Biblically permitted meats, where members prefer a meat diet.

Care of the Dying Patient

No special rituals, but visits from local pastor if required.

Funerals

Burial is preferred but there is no religious objection to cremation.



Spiritualism

In itself a religion, in that it embodies the main ideas of all religions that there is life after death, immortality and the existence of a God. The difference is that Spiritualism claims the ability through Medium-ship to prove that man survives the grave. The philosophy of Spiritualism is based on seven fundamental principles.

'The Fatherhood of God'

'The Brotherhood of Man'

'The Communion of Saints and the Ministry of Angela'

'The Continuous Existence of the Human Soul'

'Personal Responsibility'

'Compensation and Retribution for all the Good and Evil Deeds done on Earth'

'Eternal Progress Open to every Human Soul'

Special Considerations

Spiritualists in institutions may request a Healer for treatment alongside medical treatment. This can be performed by the laying on of hands, backed by prayers of spiritual guidance and can be carried out without any dramatisation.

Diet

There are no special dietary requirements.

Care of the Dying

Death to Spiritualists means the beginning of a new and fuller life and the certainty of eternal progress. The rate of their own particular advancement will depend upon their desire to do so, remembering that they will have free will, as they have in this life. They believe that those in the Spirit world will come and meet them and take them to their new home.

Last Offices

Routine last offices are appropriate.

Blood Transfusions, Post Mortems and Donation of Organs

No objections to blood transfusions, transplants or post-mortems.



Unitarians

This is a dissenting movement, which carried many overtones of Christianity but rejects a number of important Christian doctrines such as the Trinity and the Incarnation of Jesus Christ. Baptism is in the name of God (the Father) only.

No particular requirements, but a patient may require their own minister rather than a Christian chaplain.



Zoroastrianism

A descendent of the old Indo-Iranian beliefs, the modern Zoroastrian faith has an emphasis on personal religion and choices. God is seen as the good Creator of all things physical and spiritual and has no responsibility for evil. Evil comes from the Destructive Spirit (Angra Mainyu) whose nature is destructive and violent. The world is the battle ground for good and evil.

Zoroastrians believe in life beyond death and judgement which consigns a person to heaven or hell.

Special Considerations

Children are given sacred garments on initiation, a shirt (sadra) and girdle (kusti) which are worn at all times and must be treated with great respect. The girdle is tied and untied during the recital of daily prayers.

Zoroastrians have very high standards of hygiene. Running water is preferred for washing but a bowl of freshly drawn water is an acceptable alternative.

Diet

No particular restrictions though some may not eat pork or may prefer a vegetarian diet.

Blood Transfusions

Orthodox Zoroastrians may consider blood transfusion a pollution of the body.

Donation of Organs

Like transfusions these may be seen as a pollution of the body and the orthodox may be unwilling to donate or receive.

Last Offices

The body should be washed before being placed in white clothing. The family may provide a special shirt to be worn under the clothing with the girdle. They may also wish for the head to be covered by a cap or scarf.

Post Mortems

Religious law forbids these and a Coroner's legal requirement is the only way a post-mortem is likely to be accepted.

Funeral

Burial and cremation are both acceptable and are likely to be wanted without delay. The family may prepare the body but generally they instruct a funeral director. If there is no family, attempts should be made to contact a fellow Zoroastrian.

SECTION FIVE: ACCESSING AN INTERPRETER/ TRANSLATOR

The Role of the Interpreter

Interpreters are an important and expensive resource in providing a voice for patients/clients whose proficiency in English is poor or insufficient. The interpreter is used solely for the purpose of conveying information between health and social care staff and patients/clients, in a language that the staff member and the patient/client can both understand. The interpreter's role is **NOT** to analyse information, or to decide what should and should not be conveyed. He or she is also bound to keep patient/client confidentiality.

Staff should not expect the interpreter to be a cultural expert, to counsel the patient/client, or to calm the person down. The interpreter is simply there to repeat what the staff member and the patient/client say to each other.

Assessing Interpreter Needs

It is essential to use professional interpreters, especially in sensitive situations or if there is any possibility of misinterpretation

How can you tell if an interpreter is required especially if the person can speak some English? Some people cannot communicate in English at all or will have such minimal English that the decision is obvious. Some will bring an 'I need an interpreter card'. As a general 'rule of thumb', a patient/client who has been in an English speaking country for less than two years will need an interpreter.

When a patient/client with poor or insufficient English skills approaches Health and Social Care staff for an appointment or help, the member of staff needs to determine if an interpreter is required.

On Presentation, Observe the Following Steps

Identify the language spoken by the patient/client and establish whether an interpreter is needed. This may be done through an accompanying relative or friend or by the patient/client or by staff presenting the patient/client with a card with translations of the following statement:

“POINT TO YOUR LANGUAGE. WE WILL GET AN INTERPRETER ON THE TELEPHONE.”

Determine whether an 'on site interpreter' or a 'telephone interpreter' is required. As a basic principle, the more complex the communication the more likely an 'on-site interpreter' is required while the more urgent the need the more likely a 'telephone interpreter' is the best option.

Establish whether the patient/client has any preferences regarding the interpreter e.g. gender and obtain their consent.

A family member or friend may be used to interpret in immediate situations where decisions may have to be made quickly. This may however raise issues of confidentiality and does not reflect 'good practice'.

Seek approval for the engagement of an interpreting service from the Head of Department then proceed to contact the appropriate interpreting service outlined on pages 109-110 of this handbook. For future reference, record that an interpreter is needed and the language required in the patients/clients core information with their file for future reference.

Translation of written communication

If there is a requirement to have written correspondence translated, whether from English to a particular language or vice versa, there are a number of ways these can be done. For example through the Southern Area Interpreter Service, Language Line, NICEM and FLEX. Please see contact details below.

Useful Contacts to Access an Interpreter/Translator

| Name | Service | Costs |
|--|--|--|
| <p>Southern Area Interpreter Service</p> <p>Chinese Interpreter - 028 3834 7162</p> <p>Wah Hep Chinese Drop-in Centre, Unit 5 Legahory Centre, Legahory, Craigavon, BT65 5BE, Tel: 028 3834 7162, Fax: 028 3834</p> <p>Urdu and Punjabi Interpreters - 028 3834 6607 or 07876 675221</p> | <p>Three interpreters employed - 1 full time Chinese Interpreter, 2 part time Asian Interpreters for Urdu and Punjabi</p> | <p>Part of contract.</p> |
| <p>Languageline Swallow House 11-21 Northdown Street</p> | <p>Telephone Interpreting Service. Based on a contract</p> | <p>Cost: £2.85 per min (8am-6pm). £3.25 per min other</p> |

| | | |
|--|---|---|
| <p>London N1 9BN Tel: 0845 310 9900</p> <p>Web: www.languageline.co.uk</p> | <p>and only accessible via ID codes allocated to specific Directorates within the Trust.</p> | <p>times. Sliding scale depending on length of time. Costed to the Directorate or Programme of care using the service. Primarily designed for 'urgent/critical' situations.</p> |
| <p>FLEX (Foreign Language for Export). University of Ulster at Jordanstown Shore Road, Newtownabbey Co Antrim.BT37 0QB</p> <p>Tel 028 9036 6546 Fax 028 9036 6316</p> <p>Email: M.McCurdy@ulst.ac.uk R.McCullough@ulst.ac.uk</p> | <p>FLEX is helping the Health and Social Services by providing interpreters for patients, doctors and health visitors, by dealing with international correspondence and telephone calls, by translating literature on health and other issues and by advising on cultural issues when hospitals are dealing with patients from abroad. Languages are provided for all sections of the community in Northern Ireland and beyond.</p> | <p>Current Rates are: 8 a.m.-8.p.m. £32.00 8.p.m.-8.a.m. £42.00 Saturday/Sunday/Bank Holidays £42.00</p> <p>Please note, the Trust is charged travel costs and time.</p> |
| <p>Regional Health & Social Services Interpreting Service for Black & Minority Ethnic Communities Project - More than Words</p> | <p>Aims to significantly improve the access to health and social services of members of ethnic communities who do not speak English either as a first or competent second language. Will provide written translation and spoken interpreter services.</p> | <p>Currently being developed.</p> |

Staff Guidelines For Working with Interpreters (Face-to-Face)

1.0 INTRODUCTION

- 1.1 Interpreters are an important resource in providing a voice for patients whose proficiency in English is poor or insufficient for the situation.
- 1.2 These guidelines refer to utilising the services of an interpreter in a face-to-face situation.
- 1.3 The Trust has access to a telephone interpreting service via Language Line and staff in a number of departments are being trained each year to use this service in urgent situations. A training video is also available.

2.0 IDENTIFYING THE NEED FOR AN INTERPRETER

- 2.1 As a general guide, a patient who has been in an English-speaking country for less than two years will need an interpreter.
- 2.2 In stressful situations such as illness and hospitalisation, it is usual for the person's command of English to decrease. It is crucial that the patient has full understanding and there are no misinterpretations by patient or staff.
- 2.3 As with native English speakers, English comprehension at social level does not necessarily mean that the person will be able to understand medical terminology. It is possible to overestimate a person's English skills.
- 2.4 To decide whether the patient needs an interpreter, assess whether their English language ability is adequate for the situation.
- 2.5 Some people can not communicate in English at all or will have such minimal English proficiency that the decision is obvious. Some will bring an 'I need an interpreter' card naming the language required.
- 2.6 You may need to seek this information out from the person or via an accompanying relative. However, if there is any doubt, here are some simple tests to help you make your decision.

Ask a question that requires the person to answer in a sentence. Avoid questions that can be answered with a 'yes' or a 'no' or a very familiar question such as 'Where do you live?'

Ask the person to repeat a message that you have just given in his/her own words.

- 2.7 If you do not know which language is required, Language Identification Cards are available in various departments within the Trust and these are also available via your Equality Schemes Co-Ordinator. Discuss your interpreting needs with your manager.

3.0 ARRANGING FOR AN INTERPRETER

- 3.1 If you consider that an interpreter is required then arrange one following the procedure as outlined on page 109 of this handbook.
- 3.2 It is very important to find out which language and dialect is appropriate. For example, Taiwanese people sometimes get confused by the terms the interpreter uses if the interpreter is from China, Hong Kong or Malaysia.
- 3.3 The ethnicity of the interpreter is important. Some patients may not want to have interpreters from specific communities, for political reasons or because of confidentiality fears in small communities. For example, it may be inappropriate to provide a Serbian interpreter for a Bosnian Muslim.
- 3.3 Remember the interpreter is there to enable you to do your job completely, not only for the patient/client.
- 3.4 Ensure that the Claim for Travelling and Hours Worked form is completed and forwarded to finance for payment. A copy is forwarded by the Finance Department to the Equality Schemes Co-Ordinator for reference.

4.0 THE INTERPRETER'S ROLE

- 4.1 The interpreter is used solely for the purpose of conveying information between health and social care staff and patients/clients, in a language that the staff member and the patient/client can both understand. The interpreter's role is **NOT** to analyse information, or to decide what should and should not be conveyed. He or she is also bound to keep patient/client confidentiality.

When deciding if an interpreter is required, try to explain their right to an interpreter and the interpreter's role, if they are not already aware of this. Also explain the interpreter's professional obligation to preserve confidentiality.

- 4.2 Do not expect the interpreter to be a cultural expert, to counsel the patient, or to calm the person down. They are simply there to repeat what you and the patient say to each other in a language that you can both understand.

5.0 HOW TO COMMUNICATE WITH THE PATIENT/CLIENT WITH AN INTERPRETER PRESENT

5.1 Before the discussion

Arrange a place where the discussion can be conducted in private.
Allow for extra time.

Arrange the seating to allow for easy communication: in a circle or triangle or place the interpreter to the side and just behind you.

Brief the interpreter prior to the discussion, where possible.

Ask the interpreter for any cultural factors that may affect the discussion but remember that interpreters do not consider themselves to be cultural experts.

5.2 Introduction and set up

Introduce yourself and the interpreter.

Explain both your's and the interpreter's role.

Stress that both you and the interpreter are bound by code of ethics to maintain the confidentiality of the discussion.

Explain the purpose of the discussion and how it will proceed.

5.3 During the discussion

Sit facing the patient/client.

Look at the person and maintain awareness of body language. Avoid looking at the interpreter unless you are directly addressing him/her.

Speak directly to the patient/client as you would with an English speaker.

Always use the first person e.g. 'How are you feeling?' (to the interpreter).
Not, 'Ask her how she is feeling?'

Do not try to save time by asking the interpreter to summarise.

Be aware that it may take more words than you have spoken to convey the message.

Do not let the interpreter's presence change your role in the discussion. It is not the interpreter's role to conduct the discussion.

5.4 Discussion style

Speak a little more slowly than usual in your normal speaking tone.
Speaking louder does not help.

Use plain English where possible.

Pause after 2 or 3 sentences to allow the interpreter to relay the message.

Start speaking when the interpreter signals by raising a hand.

Summarise periodically when complex issues are involved.

If the person does not understand it is your responsibility (not the interpreter's) to explain more simply.

Seek the patient/client's permission if you need to obtain cultural information from the interpreter.

Avoid long discussions with the interpreter. If you need to talk to the interpreter directly then the interpreter should explain to the patient/client about the nature of the conversation.

5.5 **Ending the discussion**

Check that the patient/client has understood the key messages in your discussion. Ask for any questions.

Thank both the patient/client and the interpreter. Say goodbye formally.

Debrief the interpreter if the discussion was emotionally taxing and clarify any questions you have arising from the discussion. This may need to happen later, as it may make the patient/client uncomfortable if you are seen to be in a detailed conversation with the interpreter.

For most people, it is important to engage an interpreter of the same gender as the patient. If this is not possible, ask the patient if they are willing to accept the opposite gender before engaging an interpreter.

6.0 GUIDELINES REVIEW

- 6.1 These guidelines will be reviewed on a yearly basis as local interpreting services are developed in consultation with agencies representing minority ethnic groups.
- 6.2 Staff are requested to highlight any issues with these guidelines to the Equality Schemes Co-Ordinator to ensure that they are effective.

Review Date: March 2004

SECTION SIX: USEFUL CONTACTS

| | |
|--|--|
| <p>AL-NUR Asian, Arabic & Muslim Association Room G65 Brownlow Health Centre 1 Legahory Craigavon, BT65 5BE Tel: 028 38 346607</p> | <p>Wah Hep Chinese Community Association, C/o Brownlow H&SS Centre Legahory Centre, Legahory, Craigavon, BT65 5BE,</p> <p>Tel: 028 3834 7162, Fax: 028 3834 7603</p> |
| <p>Craigavon Travellers Support Committee Moylinn House Legahory Craigavon</p> <p>Tel: 028 3834 2089</p> | <p>Early Years Worker - Traveller Community Craigavon Travellers Support Committee Moylinn House Legahory Craigavon</p> <p>Tel: 028 3834 2089</p> |
| <p>South Tyrone Empowerment Programme (STEP) C/o Dungannon Enterprise Centre 2 Coalisland Road DUNGANNON</p> <p>Tel: 028 8772 9002</p> | <p>Bahá'í Council for Northern Ireland 64 Old Dundonald Road Belfast BT16 0XS Tel: 028 90 480500 E-mail: bcni@bahai.org.uk</p> |
| <p>Belfast Hebrew Congregation The Wolfson Centre 49 Somerton Road Belfast, BT15 3LH</p> <p>Tel: 028 9077 7974</p> | <p>Latinoamerica Unida C/o Multicultural Resource Centre 12 Upper Crescent BELFAST BT7 1NT</p> <p>Tel: 028 9024 4639</p> |
| <p>Belfast Travellers Education and Development Group 13A Glen Road Belfast BT11 8BA Tel: 028 90 203337 E-mail: info.b-e-t-d @ireland.freeseve.co. uk</p> | <p>Belfast Travellers Support Group Unit 12 Blackstaff Complex 77 Springfield Road Belfast BT12 7AE Tel: 028 90 205330 Fax: 028 90 205330</p> |

| | |
|---|--|
| Traveller Movement NI 30 University Street BELFAST BT7 1FZ Tel: 028 3020 2727 | Traveller Movement (NI) 30 University Street Belfast BT7 1FZ Tel: 028 90 202727 |
| Chinese Lay Health Project 100 Lisburn Road Belfast BT9 6AG Tel: 028 90 668766 | Chinese Welfare Association 133-135 University Street Belfast BT7 1HQ Tel: 028 90 288277 Fax: 028 90 288278 |
| Chinese Chamber of Commerce 133-135 University Street Belfast BT7 1HQ Tel: 028 90 288277 | Oi Kwan Chinese Women's Group C/O 100 Lisburn Road Belfast BT9 6AG Tel: 028 90 681604 |
| Oi Yin Bangor Chinese Women's Group C/O 8 Beechville Drive Conlig BT19 7ZW | Belfast Islamic Centre 38 Wellington Park Belfast BT9 6DN Tel: 028 90 664465 |
| Indian Community Centre 86 Clifton Street Belfast BT13 1AB Tel: 028 71 288858 Fax: 028 90 278922 | Northern Ireland Pakistani Cultural Association C/O 8 Braniel Park Belfast BT5 7JL Tel: 028 90 836704 |
| Bangladeshi Welfare Association 24 Greenwell Street Newtownards BT23 7LN Tel: 028 9042 1218 | Pakistani Community Association 7 Casaedona Gardens Belfast BT6 9RQ Tel: 028 9079 7671 |
| Sikh Community Project 163 Cavehill Road BELFAST BT15 5NB Tel: 028 9028 4400 | Multi-Cultural Group Windsor Womens Centre 136-144 Broadway Belfast BT12 6HY Tel: 028 90 230684 |
| Northern Ireland Filipino Association C/O NICEM See Details below. | Northern Ireland African Cultural Centre 60 Lisburn Road Belfast BT9 6AF Tel: 028 90 238742 |

| | |
|--|---|
| <p>NICEM (Northern Ireland Council for Ethnic Minorities) 24 - 31 Shaftesbury Square Belfast BT2 7DB</p> <p>Tel: 028 9023 8645</p> | <p>Multi-Cultural Resource Centre 12 Upper Crescent Belfast BT7 1NT Tel: 028 90 244639 E-mail: mcrc@dnetco.uk</p> |
| <p>NI Interfaith Forum C/o Stranmillis College Stranmillis Road BELFAST BT9 5DY</p> <p>Tel: 028 9038 4328</p> | <p>Languageline Swallow House 11-21 Northdown Street London N1 9BN Tel: 0845 310 9900</p> <p>Web: www.languageline.co.uk</p> |
| <p>Refugee One Stop Service C/o NICEM</p> <p>Details as above.</p> | <p>National Asylum Support Service 58 Howard Street Belfast BT1 6PD</p> |
| <p>O Centro para Portugues Feeney's Lane Dungannon Tel:028 8775 0212</p> | <p>Equality Commission NI Equality House 7-9 Shaftesbury Square Belfast. BT2 7DP.</p> <p>Tel: 028 9050 0600 Fax: 028 9031 5993</p> |
| <p>FLEX (Foreign Language for Export). University of Ulster at Jordanstown Shore Road, Newtownabbey Co Antrim.BT37 0QB</p> <p>Tel 028 9036 6546 Fax 028 9036 6316</p> <p>Email: M.McCurdy@ulst.ac.uk R.McCullough@ulst.ac.uk</p> | <p>HARPWeb - Health for Asylum Seekers and Refugees Portal. This website provides a major new resource for both professional and voluntary agencies working with asylum seekers and refugees.</p> <p>www.harpweb.org.uk</p> |
| <p>Law Centre (NI) 124 Donegall Street Belfast. BT1 2GY</p> <p>Tel: 028 90 244401</p> | <p>British Medical Association</p> <p>Various publications re. asylum seekers that health care staff may find of use.</p> <p>www.bma.org.uk</p> |

SECTION SEVEN:2001 CENSUS

ETHNIC GROUPS IN THE SOUTHERN AREA

| | C'AVON | B'BGE | ARMAGH | D'GNON | NEWRY & MOURNE | SHSSB | NI |
|---------------------------|--------------|--------------|--------------|--------------|----------------|---------------|----------------|
| TOTAL | 80670 | 41392 | 54260 | 47735 | 87057 | 311119 | 1685267 |
| White | 79863 | 41218 | 54010 | 47363 | 86543 | 309003 | 1670942 |
| Chinese | 226 | 33 | 54 | 57 | 96 | 467 | 4213 |
| Mixed | 145 | 58 | 60 | 67 | 96 | 436 | 3371 |
| Irish Traveller | 129 | 25 | 81 | 153 | 235 | 622 | 1685 |
| Indian | 89 | 12 | 16 | 24 | 17 | 156 | 1517 |
| Other Ethnic Group | 56 | 17 | 22 | 24 | 26 | 156 | 1348 |
| Pakistani | 121 | 8 | 0 | 14 | 17 | 156 | 674 |
| Black African | 16 | 4 | 5 | 10 | 9 | 31 | 506 |
| Other Black | 16 | 4 | 5 | 14 | 9 | 62 | 337 |
| Black Caribbean | 8 | 4 | 5 | 5 | 9 | 31 | 337 |
| Bangladeshi | 8 | 0 | 0 | 5 | 0 | 31 | 169 |
| Other Asian | 0 | 4 | 5 | 5 | 0 | 0 | 169 |

Notes: Census Figures were provided in percentages, hence the above figures have been rounded to the nearest decimal point. These figures may be understated, in particular, the Chinese Community due to language barrier.