



North East Regional Migrant Health Conference June 14th 2010

**How does the Cultural Competency of health
workers impact on the health needs of Refugees
and Asylum Seekers?**

**Presentation by Joy Nyadete and Maria Chikara,
Regional Refugee Forum North East**



Hearing the Voice of Refugees in Policy and Practice

Joy and Maria spoke on behalf of the membership of the Regional Refugee Forum North East. They prepared this presentation based on their own knowledge of supporting refugees and asylum seekers and evidence contributed from across the membership, who are Refugee-led community organisations – RCOs - working in the North East region.

If your organisation would like to discuss how the Regional Refugee Forum can help with staff or student training in cultural competence, or to progress issues raised in this presentation by working directly with refugee led community organisations in your area, please contact our Project Manager, Herbert Dirahu, on herbert.dirahu@refugeevoices.org.uk or call 07918765658.



Hearing the Voice of Refugees in Policy and Practice

JOY NYADETE

EXECUTIVE COMMITTEE MEMBER, REGIONAL REFUGEE FORUM NORTH EAST

CHAIR OF '*VOICES FOR CHANGE*', TEES VALLEY

Joy had a professional career in enterprise in Zimbabwe, and came to the UK in 1997 to explore business links with the UK. Unable to return to Zimbabwe she was granted asylum here. She grew increasingly concerned about the health of asylum seekers which led to her setting up an HIV support group in Middlesbrough which now holds weekly drop ins giving support and information to those infected and affected. She also decided to pursue a career in health and is now in the final year of a Public Health degree at Teesside University. She contributed evidence about HIV support needs to the 2008 conference and participated in research with Durham University.

MARIA CHIKARA

MEMBER OF REGIONAL REFUGEE FORUM NORTH EAST

CHAIR OF '*WOMEN'S WORTH*', TEES VALLEY

Maria came to the UK from Zimbabwe in 2001 and was employed within the health sector in Bedfordshire as a hospital support and care worker. Unable to return to Zimbabwe, and having experienced Health services as both a worker and customer, she remains passionate about health and is now also completing her degree in Public Health at Teesside University. Her final year dissertation is on the lived experiences of refugees and asylum seekers in accessing health services. She founded the community group *Women's Worth* to provide support for single mothers, which delivers counselling, activities and information sessions to otherwise isolated individuals.



Experience Prior to Exile

oppression
 persecution
 harassment
 torture
 conflict
 combat
 imprisonment rape
 famine
 death of family and friends

Journey/ Migration

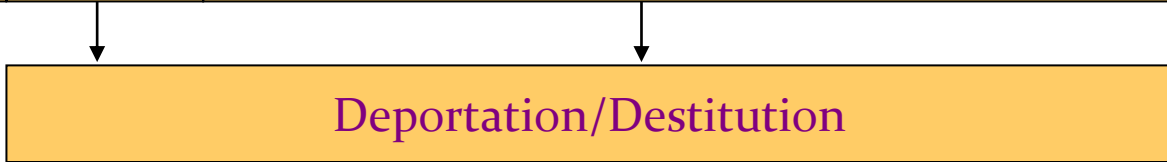
fear of capture
 threat of death
 deprivation
 sexual and physical abuse
 threat of separation from loved ones

Asylum Process

Imprisonment
 threat of being returned
 Safe haven? hostility within UK
 not being believed
 isolation, home sickness
 uncertainty
 memories of trauma
 physical health problems
 communication problems fears for family/friends
 dependence on state
 loss of status/role
 'cultural bereavement'

Refugee Status Granted

As before but also including.....
 Perception of exile as temporary
 possibility of 'return?'
 'integration'
 'identity'
 generational strain
 political situation in country of origin
 Inability to 'settle'





What is Culture?

- Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behaviour, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation
- “Culture” refers to the shared attributes of a group of people. It is broadly defined as a common heritage or learned set of beliefs, norms, and values



Culture and Competence

- As previously defined in this section, the word “culture” refers to the shared attributes—including beliefs, norms, and values—of a group of people
- The word “competence” implies the capacity to function effectively, both at the individual and organizational levels. “Competence” is associated with “culture” to emphasize that being aware of or sensitive to the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culturally diverse population groups.
- Cultural competence is not a matter of being politically correct or of assigning one person to handle diversity issues, nor does it mean simply translating materials into other languages. Rather, it is an ongoing process of organizational and individual development that includes learning more about our own and other cultures; altering our thinking about culture on the basis of what we learn; and changing the ways in which we interact with others to reflect an awareness and sensitivity to diverse cultures.



Cultural Competence

• Culture isn't a list of 'ingredients' to include 'dress', 'food', 'customs' it is much more subtle

• It is important to respect a person's cultural context but practitioners can only gain knowledge of this context from the person who is the real 'expert' on their own cultural context:

• *"Culture is not the possession of black people only, nor is it the sum total of who we are. Culture obviously plays a part in how we understand, explain and experience mental and emotional distress, but this is only one part of the jigsaw - other life circumstances and experiences such as racism often times have far more devastating emotional consequences. In these circumstances culture is often a source of strength."* (Keating, Sainsbury Centre for Mental Health)

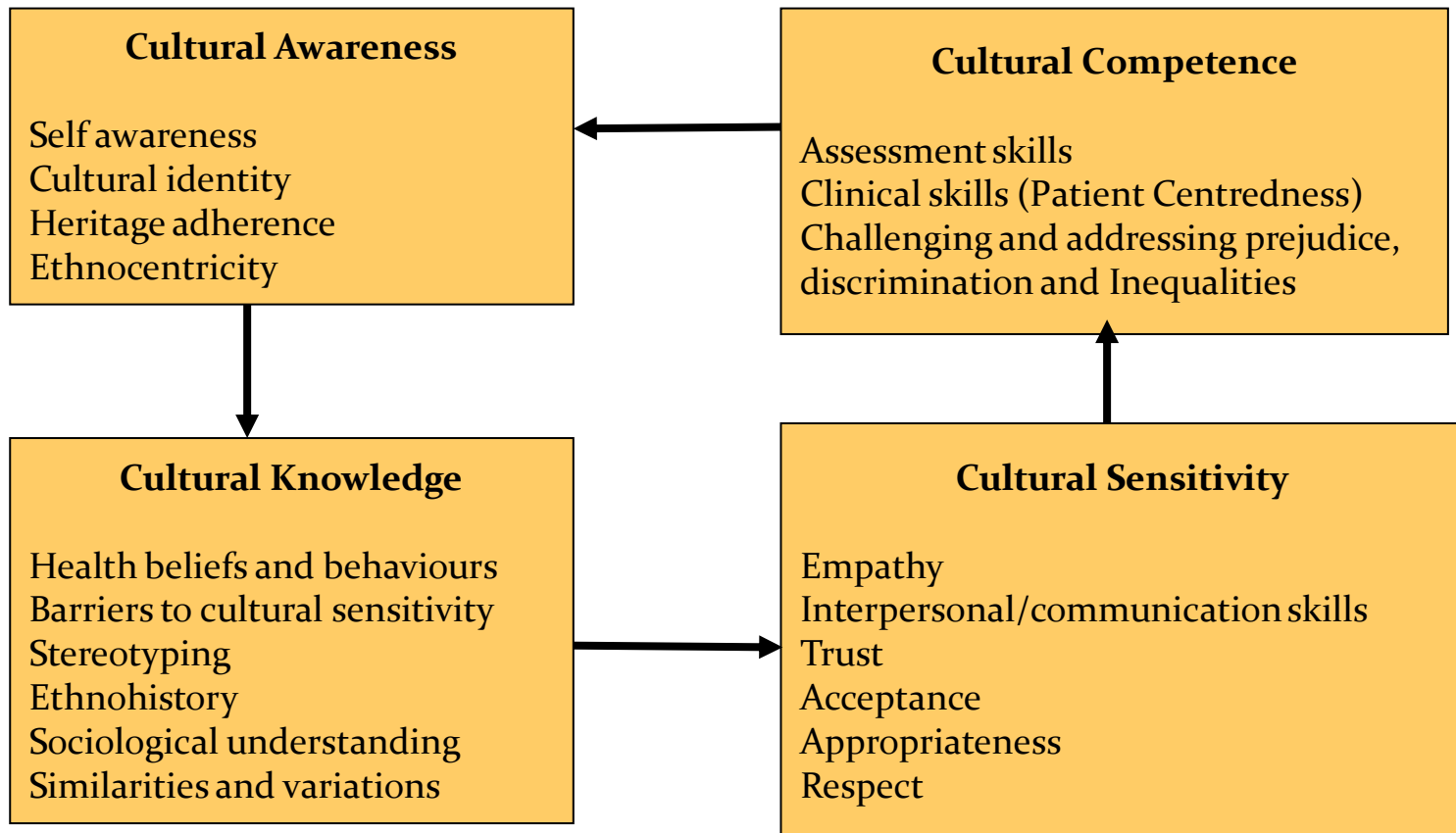


Cultural Competency is a lens through which healthcare workers may gain deeper understanding of their patients' perceptions regarding health, and also a way of service provision that systematically incorporates cross-cultural sensitivity.

It is a method of bridging different traditions to improve the quality of care, not a way of bringing the patient into line with the biomedical model. It is important to remember that.



Model for developing 'Cultural Competence' (Papadopoulos, Tilki and Taylor, 1998)





Ethnocentrism

Ethnocentrism is actually and potentially a major barrier to cultural competency in health care. Ethnocentrism is:

"The view of things in which one's own group is the centre of everything and all others are scaled and rated from it" (W. G. Sumner 1906)

- One man's meat is another man's poison'
- "When in Rome" syndrome. Assimilation is not the aim

"Seek First to Understand, Then to be Understood" (Stephen R. Covey 2005)



"If staff, WHATEVER their cultural background, make assumptions based on their own cultural norms and values, without taking into account that their patients may not share these values, it will be difficult to deliver good health care" (Jones 1994)

"Ethnocentric beliefs by healthcare professionals have resulted in misdiagnosis, alienation of patients, failure to adequately provide pain relief and arrest of parents accused of child abuse because of culturally based practices" (Andrews 1992)



Gender issues





Language and Communication



köszönöm תודה dekuji
mahalo 고맙습니다
thank you
merci 谢谢 danke
Ευχαριστώ شكرا
どうもありがとう gracias





Conclusion

- There may be different expressions of 'illness' or 'help seeking behaviours'
- Practitioner 'anxiety' can affect engagement and lead to clients 'falling through the net'
- There may not be equivalent words in the persons language for 'stress', 'anxiety', 'depression' etc.



Part 2: Personal journeys

We want to talk a bit about our experience as refugees or asylum seekers living here in the north east, about this issue of cultural diversity and how it has impacted on our ability to look after our own health or access appropriate health interventions. I want to ask you to step into our shoes, just for 5 minutes. We are in our shoes 24/7, but in 5 minutes I want to try and take you into our lives.

I would like to take you through a journey of a single mother of 3 children, but hold on a minute; this is not just any single mum. This is a stigmatised single mother, who has fled their country, suffered a bereavement both with family and culture, been raped and witnessed multiple traumatic experiences, and waiting to know what is going to happen to my asylum case. I could receive a letter of refusal any day, whether I am given sanctuary or forced to return to danger, or at any time a knock on the door by uniformed guards coming to take me and my kids into detention.

The level of tension and anxiety I live with on a daily basis is far in excess of an average white British single mother. I survive on food tokens and vouchers, not allowed to find work, can't afford to take the kids to Sure Start care, can only access 2.5 hours at a nursery, and so cannot attend classes in the college, can't have a break from the kids or feel I want to achieve something in life. I am trapped inside, with my thoughts and fears, and the children are screaming in the background I am stressed all day. Signs and symptoms of post traumatic stress set in, I can't sleep, my physical and mental health deteriorates, and therefore I become withdrawn. I find it hard to relate to health visitors who do not understand my culture or my experience and what I am currently going through.



In the community I reside in, you are constantly judged, you almost instantly can feel someone's perception of you. If you admit to feeling overwhelmed, depressed, in need of any support, you feel twice judged – they are thinking “look at all these kids and where is the father?” Or you are a threat because you may steal someone else's husband. Then comes a health professional “look at what she is doing – she is letting her 3 week baby drink water” as though if it was wrong. That's the way I was brought up in Zimbabwe and find it normal in my culture. So you are judged instantly not fit to be a good mother. So you lose trust and know that health workers, want to impose things on you, and seem to expect us to fail as parents. We feel looked down upon, constantly watched as if we are on Channel 4's Big Brother, judged and damned. This then brings fear, therefore I tend to seclude myself, not access health services and suffer in silence because the health professionals do not understand my experiences or my culture and they appear unwilling to learn from women like me.

Meanwhile I feel more tired, stressed and less able to cope on a daily basis. Children are confused with one message inside the home that I teach them and another that they learn from outside the home. This is especially around the issue on discipline and boundaries – such as when I consider them too young to go out late at night, but they complain because other children seem to be allowed to, even at the age of 16. The children are deeply frustrated and humiliated by their own lack of material things or cool clothes, I cannot buy them the things other children have or provide a home they are proud of.

The children absorb the sense of my disempowerment and vulnerability, were I am trapped by the asylum system – controlled and limited by a system that determines what I can and cannot do which leaves me in extreme poverty. And as all children wish to do sometimes, they resist, challenge or seek to escape authority from me by appealing to what they identify as greater authorities outside the home.

And at that time I realise what power the health workers have over us. They can undermine our role as the parent. We have learned this from the experience of other women like us, who have had their children taken into care often without good reason. How can we trust and put our faith in those agencies that have done this to my children, my community and my sisters.



How can we admit to health services our health needs, our need for support, when it might mean our children are taken away from us and that we are open to judgement? So we learn to avoid all contact with agencies as much as possible. We learn to see them as people with authority and power over us, rather than people who can offer support and a service to us. So people do not seek help for their health needs. They prefer to suffer in silence. To be left alone in a degree of safety

How do you cope with this on top of everything else? How do you trust the people you get referred to for support who don't understand your culture and your experiences as a refugee or asylum seeker? I need to find support from people who know me, who understand my experiences and my culture.

I need someone who understands when I am at a low point and need uplifting, and to be empowered in the right direction. Not someone who makes me feel lower looked down upon or judged because they don't understand my experience or my culture and they don't even bother to ask me.

So what I need to know when a health worker comes to my house, or when I visit a health service, is whether the information or support being delivered / offered to me

- Is it advice or is it a legal obligation?
- Are we being told to do something with some kind of threat of a penalty if we don't do it?
- Or are you giving us an informed choice?
- Are you giving health advice or moral guidance?
- Are you offering scientific knowledge or a cultural approach?

There is great need to remove the culture from the science.



We need to feel confident that health workers do not see asylum seekers as people who are unskilled and lacking of knowledge. We have our own indigenous knowledge which we are willing to share if you are willing to listen. We need to have confidence in your desire and ability to support us, to treat us, rather than feel the powers you have to intervene when an asylum seeker has no knowledge of how to question or challenge things or what our rights are.

We know there is a superiority of cultural models in the way in which health messages are delivered with the west being seen as the best, which is often not the case. It makes people feel humiliated, that they are somehow brutal or uncivilised.

If this is how someone feels, then they are not likely to be receptive to new ideas, on which they could make an informed choice. They will listen and simply carry on doing what they were raised to believe is the best way to, and try to avoid further contact with the services.

It is important that health workers to listen first and try to understand the situation and not the other way by prescribing first, before they diagnosed.

It is important that they seek first to understand and then be understood, I warn you, giving out advice before having empathized and understood and engaged with a person and their situation will likely result in the advice being rejected. Thoroughly reading out your own autobiography will decrease the chance of establishing a working communication.



Does Cultural Competency training offer a person a structured opportunity to achieve insight – to reflect on their own cultural upbringing and how it has affected their understanding or approach to health and health care? Does it give them an appreciation of historical change in their own culture, and how sometimes it has been legislation that has forcibly changed culture and how that transition was complex? And this relates to all health workers, from whatever cultural background – white British, Asian British, Italian, Indian, Chinese, from different African nations - because we all carry culture within us.

Ladies and gentlemen I leave you with these questions to bear in mind:

- Does cultural training include awareness about the context or situation faced by RAS – such as physical, historical, economical and psychological consequences of circumstances of exile, of translocation, of isolation, traumatisation, poverty and exclusion from work or higher education, worries about and responsibilities to relatives back home, and culture clash - and the impacts this has for health? My belief is that it currently does not.
- Do cultural trainers understand that people need a chance or support to manage cultural change and find a balance?
- Cultural trainers need to broaden the insight of health workers into the power they are exerting in their role when working with disempowered and vulnerable people like the RAS?
- And if the health professionals are suggesting change, then are they also offering support to manage that change?
- Don't offer a judgement on someone and then just leave someone to struggle with the transition on their own.
- Or have we just adopted the tick a box culture. Am I the token black, female, asylum seeker in your cultural diversity and equality exercise?

THANK YOU!

(c) Joy Nyadete and Maria Chikara, Regional Refugee Forum North East



The Regional Refugee Forum North East

is an independent membership organisation which:

- Unites the region's 50+ refugee led community organisations to produce their Collective Voice to inform and campaign on policy and services
- Supports RCOs to build their capacity to deliver unique integration support to their communities
- Supports RCOs to build their ICT functions
- Supports Refugee artists to participate in and contribute to the cultural and artistic life of the region
- Networks with other emerging refugee led Forums across the UK

RRF Constitution March 2003:

To provide a mechanism for hearing the voice of asylum seekers and refugees by bringing together in council representatives of Refugee Communities in the North East

Executive Committee 2010

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