Intercultural Approach: Aspects of Immigrants and Roadblocks to Participation in Health Care (Part 2)

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With the exception of Aboriginals, who can speak of immigration in this new land, America, in which we are all, more or less, newcomers?

Introduction

This document is the second part of a series on interculturalism. It covers the migration process, the adaptation modes of newcomers, and the intercultural approach in care delivery. The series is intended to inform nurses about the immigrant clientele with whom they occasionally work.

This second part covers the challenges faced by immigrants in our society as well as the main aspects which hinder their integration to and participation in our health care system. The customs and values of immigrants during lifetime events such as maternity, death and eating habits will be explored. The third part of this series will also provide information on essential communication and intervention tools used in the intercultural care approach.

Problems which influence the adaptation and health of immigrants

It is essential to understand the main problems faced by immigrants if we are to help them upon their arrival and in their subsequent integration into their host society. These problems affect all spheres of life – economic, values, displacement, emotions, customs and habits of the host society – and, in spite of all the efforts of care providers and CLSCs, these still need to be overcome.

Economic status upon arrival and employment level

Economic status is one of the single most important dimensions to fully grasp the condition of immigrant patients. Finding work and the means to offer their family a decent quality of life facilitates the integration process into the host society. The ability to find work is influenced by academic level and knowledge of one of the official languages of Canada.
In spite of a high level of education and advanced language skills, some recent immigrants have a hard time finding work.\textsuperscript{1} Underemployment and unemployment are widespread, in particular among young adults.

"On the whole, immigrant youths who had been in Canada for five years or less had an unemployment rate of 17.2\% in 2006, well above the rate of 11.2\% for their Canadian-born counterparts."\textsuperscript{2} A study conducted by Statistics Canada indicated that family class immigrants “found a job fairly rapidly, but 15\% did not work during their first four years.” High unemployment engenders serious economic hardships which affect nutrition, housing and overall health.

**Women Face Even Harder Conditions**

Women face particularly difficult conditions. Even though they represent 50\% of the immigrant labour force in Quebec, the employment rate of immigrant women is 7\% lower than that of their Quebec counterparts.\textsuperscript{3} The unemployment rate of recent immigrants in the 15 to 24 age category is 19.9\%, double the 9.8\% rate for young Canadian-born women.\textsuperscript{4}

In spite of having an education level that is higher than that of Quebec-born women and equal to their Quebec counterparts, those who lack specific training are mostly women. Furthermore, lack of recognition of academic credentials and lack of integration into their field of study explains their lower income.

“Immigrant women do not have revenues which correspond to their level of education. The average income of a female Arab university graduate is approximately $22,000, whereas Canadian-born women and men earn $41,400 and $47,100 each respectively.”\textsuperscript{5} Furthermore, family conditions, pregnancies and raising children are additional factors which make them vulnerable and affect their employability.

**Poverty Is Part of the Lot**

Poverty is the lot of many newcomers in Quebec, especially refugees and economic class immigrants. Their financial woes are often factors which underlie health problems, in particular among children. These problems are more noticeable in the Montreal area, where most immigrants are located.

“A study conducted by Statistics Canada shows an 18% unemployment rate among immigrants who have been living in Montreal for five years or less. That is three times more than the 5.9% rate for Canadian-born residents. The problem is especially noticeable among Maghribian youths whose unemployment rate is 28%.”

Montreal is demonstrably the Canadian city in which newly arrived immigrants have the hardest time finding work. Finding decent housing is also a challenge. Economic conditions, potential discrimination among certain immigrant groups, and the presence of children can complicate their efforts to find housing.

**Language Barrier**

In addition to the problems enumerated above, some immigrants must also confront the language barrier. Immigrants from French or English-speaking countries do not face this obstacle, but it is a serious problem for others. It inhibits their ability to find work and adequate housing, and to provide for their families decently while integrating into the host society without experiencing some form of ghettoization.

In spite of the language barrier, the quality of the reception can make a huge difference in the level of comprehension between the caregiver and the patient.

It also creates a communication gap between the care provider and the immigrant, thereby inhibiting care delivery. It is essential to show understanding in order to grasp the patient’s problem and related complications in order to provide assistance effectively. That being said, establishing communication is easier said than done. Certain notions which underlie the communications approach help to avoid obstacles and potential disruptions.

**Transition and Isolation**

The problems enumerated above are not the only ones faced by immigrants. Displacement and value disorientation are also sources of destabilization and suffering. Many immigrants are used to living in distinct social and religious contexts. They often experience loneliness and disorientation compounded by economic hardship – in itself a significant source of stress.

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It is essential to understand that everything has changed for the immigrant, including: social networks, geography, the urban layout, transportation modes, nutrition, and the distribution of services. For example, an African or South American immigrant mother from the countryside takes the subway in Montreal for the first time. She is taking her child to the hospital. Can we imagine her disorientation in executing this daunting task? Do we realize that this immigrant is unfamiliar with this transportation mode, the medical environment, and the language in which staff are attending her child, her most precious relative?

The immigrant impregnates his past with nostalgia for the warmth of his community, for the safety of the traditions of his homeland, as well as for the landscapes, colours and odours that were familiar to him. It is human nature to seek relations with one’s past and to look deeply into one’s roots. The immigrant who is displaced may feel alienated in a strange land in which others are indifferent to his plight.

In addition to having problems dealing with his present situation and to imagining his future in a distinct society and culture, the immigrant continues to be haunted by his past. For many, the melancholy will accompany them for quite some time.

“Migration is one of the most defining moments in a person’s life. Emigrating and leaving behind people who are important to him as well as the known social, physical and cultural environment constitute a series of losses which the immigrant will mourn.”

Culture Shock

- Emotional feeling of awe, shock and worry and physical distress experienced by a person diving into another culture.
- Culture shock is caused by being removed from family, friends and a familiar environment and plunging into a setting in which all points of reference are different and unknown.
- Most immigrants experience culture shock to varying degrees.
- They can no longer rely on their normal perceptions, knowledge, mechanisms and reactions.
- They no longer have access to their traditional, family, social and cultural points of reference.
- They often experience economic precarity in their host country.
- They have trouble conciliating their personal values with those of the host society.

Intergenerational Conflict

Newcomers often face problems dealing with certain aspects of their values and customs. Upon their arrival, they seek to integrate to the host society while maintaining ties with their language, traditions and religion. Their offspring, who were born here or who arrived at a young age, are confused, disoriented or indifferent to the values of their parents. These children are influenced by the socio-economic, cultural, and academic environment in which they grew up. Their friends also play a role.

The children of immigrants often end up having a different perception of their parents' culture; hence the weakened affiliation to culture and religion. There might be a divide between generations that is greater than under normal circumstances. Youths and their parents may be

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unable to understand each other, which puts a strain on their relations. Elders may be pained by this reality whereas the youths may feel lost and unable to establish bonds. They in turn may become vulnerable to manipulators who incite them to break the law, pushing them into marginalization.

**Loose Values of the Host Society**

Walking in the shoes of displaced immigrants allows one to realize that they have a different set of values. For example, some immigrant parents are shocked by the attitudes Quebecers adopt towards education. Many immigrants rank conduct, education, family unity and female modesty high up in their values. To many immigrants, Quebecois values concerning the education of children, the confinement of religion to the private sphere and the liberalization of women are simply unacceptable.

<table>
<thead>
<tr>
<th>Evolution of Impressions</th>
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<tbody>
<tr>
<td><strong>At First</strong></td>
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<tr>
<td>• All is new, lovely and impressive.</td>
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<tr>
<td>• Customs and values of host society are fascinating and impressive.</td>
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<td>• Everything can be tried and discovered.</td>
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<td>• Traditional values are put into question and new values are experienced, especially among youth.</td>
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<td><strong>Gradually</strong></td>
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<td>• Cultural differences are hard to bear and nostalgia for homeland arises.</td>
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<td>• Occasional discrimination.</td>
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<td>• Challenges in everyday life appear: language differences, non-recognition of academic achievements, poor economic conditions, and so on.</td>
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Adaptation occurs over the course of time. Living conditions improve. A social network is developed. That is the integration process.

In addition, Quebec society is not always very welcoming. Without realizing it, Quebecers are extremely individualistic and focused on their relatives, friends and acquaintances. Foreigners may find family and professional circles to be practically impenetrable. Quebecers are often indifferent to the feelings and experiences of immigrants. Even neighbours may ignore them completely.

Immigrants try to integrate to an impersonal and cold society. They miss the support network of their friends and relatives, especially when they come from cultural communities in which the extended family plays a prominent role and in which social contacts are essential.

**Harsh Climate**

A further problem faced by immigrants is the harsh reality of our climate. It should be mentioned that “75% of immigrants who arrived in Quebec last year came from warm-climate countries.” In addition to culture shock, they must deal with climate shock. Some immigrants who arrive in winter may be fascinated by the beauty of the frigid landscape, whereas others are frightened by the brutal climate. Frosty the Snowman is not really a friendly character for many African and Mexican immigrants. Newcomers often don’t have the financial means to purchase appropriate winter clothing. Their adaptation is thus further complicated.

**Administrative Initiatives**

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For immigrants who lack knowledge of both official languages, the socio-political organization, and the immigration laws in Canada and Quebec, the initiatives required to normalize their citizenship, immigrant or refugee status remain daunting tasks. Some file a request before arriving, which simplifies the procedure. Other newcomers, in their search for a better life and displaced by tragic events in their homeland, arrive unprepared and without any idea of what initiatives they must undertake. They know nothing of the numerous government ministries and departments.

Arriving is only the first step. Then come the paperwork, finding a job, studies, registering children at a school, and so on. Newcomers face the same challenges when they need to consult services intended for immigrants that are provided by health care professionals, hospitals and CLSCs.

Bureaucracy plays a prominent role in our society. For example, forms need to be filled out when applying for a health insurance card. It should therefore come as no surprise that immigrants are often overwhelmed by the complexity of our system. By informing them whenever possible, we help to improve their access to services.

Better Knowledge of the Particularities of Immigrants and of the Obstacles They Face in Participating in Health Care

There is always an underlying challenge in establishing relations with others because of differences, even more so if these persons in question come from different cultural or ethnic origins and have another set of values and customs. Relational problems are noticeable and even clearly obvious when disease, suffering or death is involved. Establishing relations with strangers in such a context is not always easy, regardless of their origin, physical appearance, language, religion, and beliefs concerning health matters. That is the challenge that health care professionals must overcome in order to develop intercultural care competence.

They first need to reach out to immigrants, to provide support and to show understanding. Then, in spite of all existing constraints, they must help the immigrant to understand the proposed preventive and therapeutic measures. It should therefore come as no surprise that problems can arise in the patient-care provider relations in such circumstances.

Care providers must make a greater effort to show understanding to the immigrant, and to factor in his apprehensions, dietary taboos, repulsions, tradition-based insecurity regarding certain interventions, religious concerns, and

so on. It is impossible to know everything about the culture of the immigrant, but asking questions and listening to him is a great way to find out. It is essential that care providers obtain information about a few elements which concern the identity and lifestyles of immigrants. How can they be effective if they don’t know their subjects?

**Awareness of the Role of Beliefs and Attitudes towards Disease**

One of the first conditions for working with immigrants is to find out about their beliefs regarding disease and its associated symptoms. Care providers must attempt to understand the immigrant's interpretation of these beliefs because they may interfere with the care and treatment process.

It is well known that ethnicity is a health factor. By ethnicity, we mean a set of characteristics and elements which are specific to a culture with which the immigrant has forged his identity. These factors are centred on tradition, beliefs and even superstitions. For us, disease and its ravages are the result of a pathogen or degenerative condition which can be explained by scientific evidence. In certain cultures, beliefs concerning the cause of disease may be more obscure.

It is not uncommon for people from remote or even more advanced locations to believe they are haunted by an evil spirit, are possessed by the devil, are the focus of an "evil eye" or are even the subject of a spell cast by someone who hates them. They may resort to traditional witchdoctors, exorcists, and spell breakers. These immigrants may also use amulets and fetishes, practices which are more widespread than commonly thought and which we may find troubling.

Care providers may feel powerless when facing such phenomena and this in turn can affect the relationship with the patient. How must a care provider react to a Haitian woman who believes in the power of a voodoo doll? Or how about the Algerian patient who carries the hamsa (hand of Fatma) to avoid spreading contagion?

Above all, it is essential that the use of superstitions or traditional methods be identified to avoid adversely affecting the care process. For example, certain beliefs held by Filipino or other Asian mothers, such as putting sand on the umbilicus of a newborn and cutting his umbilical cord with a natural object rather than scissors, are not recommended.

It is often difficult to identify the dangerous influence of these beliefs on care provided at home to children and sick persons. Without denying the merits of certain traditional medicines, it is important to identify risky treatments such as medications or bandages composed of strange substances which may be more dangerous than therapeutic. It may always be explained politely that other, more conventional means are applied here.

The patient should also be reassured if he believes occult forces are behind his condition. Immigrants may apprehend our judgement and omit mentioning their practices, but their fears

should be taken seriously as they are a source of stress. It is up to the care providers to earn the trust of these persons and to allow them to express themselves.

Core beliefs are deeply rooted in the traditions of certain cultures. They should be neither dismissed nor ridiculed. Care providers should show understanding of their fears and alleviate them by mentioning that these spirits, who are far from their ancestral land, have less sway here.

“Pain is a disagreeable physical and emotional sensation associated with real or perceived tissue injury. Suffering is often associated with moral pain.”

Attitudes of Certain Immigrants towards Adversity and Disease

Fatalism and stoicism, which are the norm in certain Asian cultures, are disconcerting for Quebecers. What is an apparent detachment of certain families from their child or relative may be wrongly perceived as constituting indifference. Care providers should not be misled by the behaviour of certain individuals. They may wish to avoid attracting the attention of evil spirits to their sick relative.

In spite of seeming cold and indifferent, the families also experience great sorrow. Finally, whereas composure is expected in certain cultures, others may demonstrate their affliction through tears, crying and lamentations. Regardless of the reaction of others in the face of adversity, the nurse must always show compassion and support.

Understanding How Immigrants Express Themselves and Their Pain

The way people from different cultures express their pain varies considerably. This can lead to misunderstanding between the nurse and the patient. In addition to individual perceptions of pain which vary greatly from one person to the next, cultural origins and gender play a role in these perceptions are expressed. Without casting stereotypes, it is well known that men are generally more reluctant than women to express their suffering.

In some cultures, people will complain more readily. For example, it is commonly said that Mediterranean patients find it easier to talk about their pain more overtly (beware of stereotypes), whereas Asians are often more discrete. Beyond culture, it must be repeated that each person is unique and that they must be treated as such without falling into the trap of prejudice and stereotype.

Culture and preconceptions must never dictate how readily care providers control or provide access to analgesics in response to complaints by the patient. The role of care providers is to take physical pain into consideration, to evaluate it and to try to detect the presence of psychological suffering as best as possible, regardless of whether the signs are subtle or overt.12

Another very important aspect of the treatment of pain is the detection and understanding of certain prejudices harboured by people from different cultures or religions regarding the use of narcotics. The desire by some people to remain stoic or their fear of losing control over

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their faculties if they use analgesics often leads them to refuse their administration and results in prolonged suffering. Simple explanations or adapting the prescription often does the trick in convincing them to accept relief.

**Cultural and Religious Aspects of Pain**

Language, religion, and the logic of the cultural group to which a person belongs play a significant role in the construct of pain and in the manner of expressing it. Nursing interventions should factor in the patient’s culture, language and level of education. A patient with a limited vocabulary, who does not master the dominant language or who has limited instruction may find it difficult to express his pain. As a result, he may not be taken as seriously as a person who has a fluent and refined manner of speaking.

Such bias should be avoided when interpreting the complaint of an immigrant patient. The care provider should demonstrate interest in the cultural and religious dimensions behind the expression of pain in order to “match” it to the patient’s reality and to relieve him. Below is some practical information on how pain is perceived in a few religious contexts.

**In Islam:** Islam recommends calm, a kind of stoicism when dealing with a trial, suffering or death. It encourages patience, endurance and submission in the face of pain and adversity. A Muslim must not rebel. “All good and evil, like life and death, is decreed by Allah. Assuming pain and suffering is an expression of faith.”

**In Judaism:** Pain is a trial inflicted by God to reinforce the spirit of men. For most Jews, there is no spiritual value in pain and suffering. In other words, in Judaism there is no asceticism in mortification as in Christianity. Judaism authorizes rebellion against pain at any cost.

**In Buddhism:** Human misery is not divine punishment but the result of man’s ignorance. The sum of all pain is associated with the consequence of past and present misdeeds. Pain purifies the misdeeds accumulated in past lives. “All existence is pain. Do not rebel against your condition, because it is a punishment for past deeds (sermon de Buddha).”

**The Influence of Religious Duty on Everyday Life**

Religion assumes a set of values, beliefs, behaviours, taboos and rituals which creates expectations that affect the way nurses must deal with certain adherents when providing care to them. Nurses may feel dismayed or in conflict with the influence of religion on

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14 Asceticism: rule of conduct.


interventions and treatments. It may be difficult to grasp the essence of the duties imposed by certain unfamiliar religions in matters of nutrition, prayer or mortification.

Nonetheless, it is important that adherents be respected in their faith and that nurses avoid casting stereotypes. The care provider must listen to the patient and ask him to specify his objections or requests regarding the treatment. Listening, although not perfect, is a simple way to show respect that can lead to dialogue.

**Right to Refuse Treatment**

It is not up to care providers to discuss religion, but rather to expose the need for treatment or care. It is easier for the patient to accept treatment if he understands its nature and the risks associated with his health problem. A spiritual advisor belonging to the patient’s religion or cult may bear sufficient authority to help the patient deal with his dilemma resulting from the nature of the treatment. On occasion, refusing treatment may bear no serious consequence. Alternatives may even be found and proposed to the patient.

That being said, there are times when refusing treatment may endanger the patient’s life or may have a significant, adverse effect on his quality of life. Under such circumstances, care providers may consult their codes of ethics and the Charter of Human Rights for guidance. These clearly state that patients have the right to refuse treatment and that their right to autonomy and self-determination must be respected.

"If a patient is able to give enlightened consent, he is also able to refuse consent; otherwise, the rules of consent would be meaningless. Respecting the integrity of the patient and his right to integrity shed light on the fact that none may intervene when he refuses treatment."¹⁷

Care providers may experience a feeling of failure if the patient continues to refuse treatment in spite of all prior attempts to convince him otherwise. Nonetheless, his decision must be respected. The patient must sign the form intended for refusals, and his refusal must be appended to his record. When a third party refuses treatment (i.e. for a child) and this decision is irrevocable and endangers the patient, the final decision is beyond the scope of the care provider. It requires the intervention of a judicial authority to confirm or deny the refusal.

"If the parents (or tutor) refuses to have treatment administered to the child, if an agreement cannot be reached on the therapeutic measures to be administered, if the physician deems that the care is absolutely necessary given the state of the child, and the parents refuse these treatments, a court order may be required to administer treatment."¹⁸

**Prescriptions and Dietary Taboos**

Many dietary accommodations are made for cultural and religious reasons. It is often said that cultural origins and religious affiliations are to be found in a plate.

**Judaism**


Many care providers are unfamiliar with Judaism’s numerous sanitary taboos. According to the Torah, fish must have fins and scales in order to be fit for consumption (kosher) and to prevent gastro-intestinal problems that were believed to arise from eating molluscs and crustaceans. Only animals with cloven hooves which chew their cud (ruminant) are fit for consumption. Certain animals which have one characteristic but not the other such as hare and pork are deemed unfit. Pigs is also believed to be a source of parasites. The holiest of Judaism’s books, the Torah, provides guidelines for these restrictions.

Birds of prey are not kosher; however domestic birds such as chicken, quail, duck and geese are considered to be pure. Drinking the milk of pure animals is permitted. Grape products must be prepared under the supervision of a qualified rabbi. The same applies to oil and vinegar. Dairy and meat products must be kept separate, even when handling pans and plates. There is an obligation to eat kosher (or kashrut) food which conforms to the Torah and which is prepared according to the instructions of the rabbi.

Islam

Like Judaism, Islam forbids the consumption of pork and products which are made with pork fat. On the other hand, most meats are deemed fit, with the exception of those of animals which are fanged (i.e. wolf, monkey). Even hare is permitted. The term used for permitted food is halal. Like Jews, Muslims require that animals be slaughtered according to a specific set of rituals.

Just like Jewish scripture, Islamic writings require that animals that are to be slaughtered suffer as little as possible. Sunnis can accept meat slaughtered by non-Muslims; Chiites cannot. Intoxicating beverages such as alcohol are also forbidden, which can be explained by the obligation to pray five times per day, the point being that in order to communicate effectively with Allah, one must have a clear mind.

Vegetarians

People from all cultures and origins may choose to be vegetarian. Listening is the best tool available to care providers. Hospital kitchen staff are usually quite aware of vegetarian practices and have menus prepared to avoid any inconvenience.

**Hinduism**

Practicing Hindus also have dietary rituals. They must make five daily offerings or sacrifices: an offering of some food from a meal to a God; an offering of water mixed with sesame seeds to the spirits of ancestors or other deceased persons; a simple offering to all beings; an offering of hospitality to anyone or to all; and a recitation from the Veda, the sacred scriptures of Hinduism.

Hindus generally avoid eating beef. Bovines are considered to be sacred. Many Hindus practice vegetarianism. This practice is not universal. Vegetarianism is often the exclusive privilege of upper castes, such as the Brahmans. Meat consumption is associated with blood and the slaughter of animals. As such, it falls within the realm of the common castes. Many Hindus who are not vegetarian nonetheless abstain from consuming beef, pork, eggs and meat derivative products.

**Fasting and Religion**

For both spiritual and hygienic reasons, practically all religions recommend fasting, meaning to voluntarily abstain from consuming food. Christians, Jews, Confucianists, Hindus, Taoists and Jains belong to groups which engage in fasting rituals.

**Judaism**

Fasting is recommended on specific days, such as Yom Kippur, the first day of the Jewish calendar, as well as the Fast of Gedeliah, the Fast of Esther, and so on. The objective of fasting is to enhance the spiritual experience. The fast is observed from sunset to sunset the following day.

**Islam**

Observant Muslims fast during Ramadan, thus respecting the fourth of the Five Pillars of Islam. Ramadan is the ninth lunar month of the Islamic calendar. Muslims commemorate the revelation of the Koran, the sacred book of Islam, during this period. Fasting is mandatory and lasts from dawn to sunset. When fasting ends, Muslims share a special meal and traditional treats with their friends and families. Non-obligatory fasting days are also provided for during the year.

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Fasting is important for Hindus, but is practiced in different ways depending on regional, local, and personal beliefs and customs. Many Hindus fast on specific days or celebrations. In Northern India, Hindus fast on Thursdays. Dietary restrictions may range from practicing total abstinence to avoiding certain foods (i.e. meat and eggs) or limiting consumption to one meal per day. Fasting is frequently observed on the new moon. Observant Hindus may fast partially or prolong it for 24 hours or abstain from consuming solids. Fasting is not a universal practice. It is considered to be an act of devotion, a sacrifice and a means to assist meditation.

Sexuality and Birth Control

Religion and tradition play a significant role in sexuality, in particular in matters which concern birth and birth control. Many couples - women in particular - adhere to religious precepts and fear using birth control methods. Birth control, abortion, sterilization and ligating the uterine tubes are disavowed in many cultures.

Women who are sick or tired of repeated pregnancies and who would be more open to these methods are often undermined by their husband's authority, religious convictions and machismo. The only possible avenue for care providers is to inform the woman or couple of these options in a warm, welcoming, non-judgemental manner.

The goal of many Muslims is to have as many children as possible and to give them a good education. There is no single position on birth control. As such, couples are not forbidden from seeking ways to control their fertility. Family planning must nonetheless be conducted within an Islamic framework and guiding principles.

All life is considered to be sacred in Islam, from conception to natural death. Certain contemporary Islamic scholars have reached the following conclusion:

“An embryo is a living organism from the time of conception, and its life must be respected at all stages (...). Any aggression against the embryo, in the form of abortion, is prohibited except under absolute necessity. Some believe, however, that abortion before the 40th day, especially when justified, is legal.”

Judaism

Ancient writings state that only men have the obligation to procreate. Women therefore have better access to contraceptives than men. The diaphragm, pill and intrauterine contraceptive

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device (IUD) are authorized; however, abortion is not. Men are not permitted to wear condoms.

India

Birth control is a controversial topic in India and is generally viewed as undesirable; however, it is not forbidden. No contemporary and binding position has been taken on this subject. Opinions may differ according to personal belief. It is up to each individual to decide whether abortion is good or evil, in spite of the fact that it is often associated with bad karma.

For Buddhism, which is widespread in Asia, there is no reason to oppose birth control, so long as there is no fertilization and thus no living being at stake. Birth control methods which result in abortion are not accepted. 29 30 31

Paradoxically, abortion rates among immigrant communities which do not belong to these religious groups are quite high. Lack of awareness of birth control practices, of contacts with the nursing and medical communities, and of financial resources to purchase birth control products often lead to this result. Unfortunately, the husband’s decision prevails in some cases. Abortion thus often ranks as the first choice before other birth control options.

The role of the nurse is to inform the couple of the risks associated with repeated abortions and to convince the husband of the practicality of using birth control methods. Information should be provided about contraceptive methods which are adapted to the budgets and level of understanding of the couple.

Pregnancy and Childbirth

For cultural and religious reasons, birth rates among recent immigrants are by far much higher than those of Quebec-born residents. It is important to reach out to women belonging to these communities in order to inform them about preventive measures and essential care during pregnancy and breastfeeding. Many immigrant women used to obtain such information from other women (friends and relatives) in their communities, whereas here they often find themselves isolated and desperate. Single parenting is common in certain cultural communities. This increases feelings of solitude among these women and the need to communicate with health care professionals. Single parenting is also one of the leading factors of poverty.

These women need help and compassion. Care providers should be well-intentioned with them and "monitor" their steps in order to accept their differences and to identify their hygiene and care needs. These women often do not have any person whom they can trust or who can lend them a helping hand. The nurse is often their only contact outside of their families. That is why relations with these immigrant women must be warm and empathetic.

Receiving advice, encouragement, recognition and respect means a lot to them. A few simple words can go a long way. For example, a care provider could say that they have a beautiful

baby, especially when nobody else is there to do so. This responds to a human need which appears simple to us, but which means the world to them.

Cultural and religious traditions as well as superstitions often play a role during pregnancy and childbirth. In some cultures, women avoid wearing any accessory which resembles the umbilical cord (i.e. collar, chain or necklace) in order to avoid choking the baby. In other cultures, women insist on wearing amulets at all cost, even on the delivery table. Irrational beliefs are expressed in many shapes and forms.

For example, some women demand that the umbilical cord or placenta be returned to them so that they can bury it or burn it. The objective is to avoid a curse being cast upon their child. Another example involves women who during their pregnancy only listen to positive comments about their babies to avoid the risk of malformation. For some women, to be in contact with somebody who is dead can provoke spontaneous abortion or the premature death of the newborn. In some cases, certain women ask that a coin be placed on the newborn's umbilicus; others avoid crossing their legs to prevent a painful delivery. The number of false and senseless ideas or beliefs associated with childbirth is limitless.

What is troubling is that many immigrant women refuse care, consultations with obstetricians, and pregnancy follow-up for fear of being examined by a man or of having to remove their clothes. Muslim women are especially apt to deprive themselves of essential preventive and therapeutic measures. As a result of fear or superstition, they often refuse to accept an epidural anaesthesia, a c-section or an episiotomy.

Certain cultures require specific positions for labour: squatting, sitting or standing. Care providers are always surprised when they encounter these standards. These traditions can date back centuries and have proven to be functional in the cultures which apply them. It should therefore come as no surprise that women from these cultures find it difficult to accept the locally prescribed gynaecological position, which has been the accepted standard for barely two centuries.

Showing understanding and kindness when faced with reluctance can help immigrant women vanquish their apprehensions. The nurse is often in the best position to inform these women and to negotiate care which conforms to modern obstetrical necessities, in spite of the traditions and beliefs of these women. In addition to providing support, whether working in home care or in the hospital, the care provider must observe the behaviour of the parturient woman (woman undergoing labour), get her to talk, and obtain information regarding her beliefs, traditions, and apprehensions. Certain harmless changes may be permitted; however, the nurse must always exercise her leadership during interventions and adhere to the care, hygiene and sterilization principles in effect here.

Nurses are not always able to respond to certain expectations. In such circumstances, the client may feel understandably disappointed. The nurse must provide simple, concise explanations and

reassurance to help the immigrant woman overcome this challenge. In spite of these surprising cultural difficulties, the nurse must avoid casting stereotypes and remain focused on the well-being of the parturient woman and of the unborn child.

In some cultures, pregnancy and childbirth are considered to be female problems. The husband provides little or no support at all to his wife, leaving this role to female relatives or to his local community.

The immigrant mother does not have access to this kind of support here. She often ends up left on her own. The nurse must provide as much support as possible and understand this situation without getting exasperated or blaming the husband who is simply following his cultural standards. That being said, the nurse can explain that things work differently here, invite the husband in a warm, friendly manner to get involved in his wife’s pregnancy while telling him that he can behave differently without being judged by his community.

**Different Notions and Perceptions of Hygiene**

Hygiene is often the source of misunderstanding between care provider and patient. Our Westernized culture puts a high value on cleanliness. We generally have all of the tools at our disposal to clean our environment, which is not the case of all homes and societies. Certain immigrants may not adhere to our code of hygiene, which creates problems in service delivery. Imposing hygienic care can result in conflict. Keeping an open mind, showing understanding and exercising common sense can result in compromise and adaptation without neglecting hygiene.

Cleanliness is highly regarded in certain cultures. In Islam, ablutions are recommended before each of the five daily prayers. Baths are required after certain events, such as sexual relations, menstruation or childbirth. It is also recommended to keep nails cut short and to wash hands after going to the bathroom.

Judaism also has purification rituals. It is recommended that the hands be washed before the morning prayer, and before blessing each meal. A ritual bath is prescribed for women who have given birth. Circumcision is required for all male babies aged eight days for religious and sanitary purposes. These rituals are associated with religion are extremely important to immigrants as they are often applied in everyday life. As such care providers need to show an understanding of these rituals and respond to the hygienic requirements of the immigrant whenever feasible.

**Euthanasia and Futile Medical Care**

**Euthanasia:** act of deliberately and swiftly putting an end to the suffering of a patient by ending his life. - *Translated from Renaud Perronnet*

Most religions oppose euthanasia; however, as societies have evolved, certain life-shortening methods are increasingly tolerated. The purpose of this article is not to debate the pros and cons of euthanasia and the ethical
questions surrounding this issue, but rather to inform nurses of certain religious practices and perceptions regarding life so that they can better understand the requests and objections of immigrant families.33

Islam

In Islam, “Allah is responsible for life and death and the timing and circumstances of the latter. Man has no right to kill or to encourage the death of others. Thus, giving life to someone is like giving life to all of humanity, and killing someone is tantamount to killing all of humanity.”

For some contemporary scholars, “so-called passive euthanasia is permissible according to advanced scripture.”34 It is perhaps better to practice this form of care than to keep the patient alive artificially and prevent him from responding to the call of Our Lord (Glory Upon Him).

Active euthanasia, on the other hand, is absolutely forbidden in Islam. It is tantamount to homicide, even when confronted with a desperate situation. Under such circumstances, allowing the patient to die naturally is the only option. In effect, this implies the prohibition of futile medical care.

Judaism

One of the fundamental principles of Judaism is that all life is sacred, inviolable and infinite. “Thou shalt not kill” is one of the Ten Commandments inscribed on the stone tablets.

“Euthanasia, whether active or passive, is in contradiction with Jewish doctrine, which indicates that any action taken to speed up the death of a patient is considered murder. Even if death occurs just a few moments before natural death and even if the motives are honourable and constitute an act of charity or love, euthanasia remains murder.”35

It is also forbidden to prolong the life of a dying patient when it causes additional pain and suffering. Jewish scholars have focused on a few clearly defined principles regarding end-of-life care.

1. In principle, all patients, regardless of their condition, must be treated with nutrients, liquids, oxygen and other elements which maintain life, even if these elements must be administered in an uncustomary manner."

2. Patients who suffer from severe chronic diseases and who are not at the end of their lives must be treated exactly like any other patient.

3. Terminal patients must also be treated like all other patients. If one of them suffers heart or respiratory failure or any other complication which requires intensive care and which could make his situation even worse, the guidelines are:

   a) In the event of heart or respiratory failure which is the normal trajectory of a fatal disease, it is not necessary to reanimate the patient as this might even constitute an error;

   b) In the event of sudden heart or respiratory failure (or any other complication) which occurs independently of a fatal disease, treatment must be provided to the patient as it would be provided to any other person. This rule is valid only if it does not enhance the suffering of the patient in his fight to stay alive.36

These principles can be summarized as avoiding death when possible, but not prolonging life.

**Eastern Religions**

[Our translation] Some scholars of Hinduism and Buddhism have stated the following principle: "Treat others as you would like them to treat you." Euthanasia may then seem like an act of compassion, a "final blow" administered to the dying person to help him achieve the highest level of human destiny – liberation.


Non-violence, compassion and acceptance of suffering are values of Eastern religions which have influenced the reflection on death and euthanasia in modern societies and even in monotheistic Western religions. “[Our translation] Buddhism considers that life is the most precious asset of all beings, and based on causality, it postulates that what happens to an individual is necessarily the result of karma – what he has done, said or especially thought in his former lives. As a result, Buddhism, which admits the existence of reincarnation, formally advises against euthanasia. This religion does not cast a moral judgement on this practice. It neither condemns the person who requests euthanasia nor the person who carries it out if done through compassion.”37

As regards passive euthanasia, Buddhism teaches that death is a special moment in which a person may achieve awakening. That is why it is necessary, whenever possible, to instil an ambience of calm, quiet and well-being - in essence to avoid any form of suffering which can

36 Nordmann, Y. Euthanasie: le point de vue de l’éthique médicale judaïque (M. Werner Trans.). Retrieved on June 30, 2009, p. 438 from http://www.bullmed.ch/k2/pages/support/iew.asp?k2dockey=C%3A%5CInetpub%5Cwwwroot%5Csaez%5Cpdf%5C2002%5C2002-09%5C2002-09-077.PDF%40saez_d&serverSpec=schwabe03:9920&querytext=vue&OriQuery=&QueryParser=Internet_Basic&logTitle=Euthanasie%3A+le+point+de+vue+de+l%C3%A9thique+m%C3%A9dicale+juda%C3%AFque&dtype=3

be provoked by futile medical care. On the other hand, analgesics which dim consciousness may hamper this awakening.

For Hindus, death induced by euthanasia or suicide can prevent the person from achieving karma. Euthanasia and suicide are therefore forbidden practices. That being said, Hindu and Buddhist scholars have found arguments in their traditions which back active euthanasia by reflecting on the meaning of death as a door to liberation. According to this logic, it is unacceptable to prolong suffering unnecessarily.

**Mortuary Rituals and Mourning**

Every human dies one day or another, regardless of origin. Death is a time of suffering for the patient as well as his friends and family. It is also a critical moment for the dying person to express his religious and cultural values as well as the manner in which he is to be accompanied through his ordeal. Understanding the rituals surrounding death allows the nurse to better accompany the suffering patient and to provide support to those who are grieving the death of a loved one in a manner which is suitable to their culture and religious values. In order to grasp the final moments and behaviour of the patient and what it means to him and his relatives, a few religious notions need to be understood. Some religions are so different from what we know that it is best to reflect on their practices.

The role of care providers is to accompany the patient, provide support to his family at the time of death, and to allow rituals that are practiced by them to be held whenever possible.

**Judaism**

Judaism forbids letting someone die alone. As soon as an extremely ill person is on the verge of death, the *chevra kadisha* (holy society),

**Objectives of Funeral Practices**

- Softening the blow to families through accounts of affection and solidarity.
- Providing support to the families and making it easier to accept the departure of their loved one.
- Solving past and present conflicts with the deceased.
- Allowing individuals to express their sorrow, their appreciation and their love for the deceased.
- Gathering a group, the family or the community.
- Becoming aware of new roles (i.e. eldest son assuming the role of the father).
- Influencing the future role of the deceased (i.e. praying for salvation, to facilitate his arrival into the ancestral homeland, etc.).

Each culture is defined by specific mortuary rituals. In our society, death has been hidden and entrusted to hospital staff and funeral parlours. The customs of the families of certain patients may therefore be surprising. Their request to have the body may shock certain care providers who are unfamiliar with their customs.

**Cleaning the Corpse**

In many cultures, cleaning the corpse is considered an act of respect towards the deceased. The body is deemed a sacred envelope. This act is also a symbol of separation: separation of the soul from the body, separation of the being from his family, social and cultural background. It is also a rite of passage between here and the afterworld (or elsewhere).

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which is present in all major cities, is called upon. Male or female members are sent to oversee the dying person. The duty of these volunteers is to pray for and to comfort the patient and his family. When the person dies, everyone recites the prayer with the verse "Listen Israel, the Lord Our God. The Lord is One."

The eldest son normally closes the eyes and mouth of the deceased. Great respect is shown to the corpse of the deceased. Volunteers wrap the corpse in a white shroud so that nobody sees it. The feet are positioned in the direction of the door. Candles are placed at the head and feet. A mortuary purification ritual is performed. The corpse is then wrapped in the prayer shroud.

In Quebec, the corpse is usually cleaned at the funeral parlour. The corpse must be buried as soon as possible so that the deceased finds the path to God as soon as possible. The family of the deceased stays at home for seven days of bereavement and to receive the condolences of friends and relatives. Family members must pray, recite passages of the Torah, and follow a specific ritual during this period. They are not allowed to work and they can only take care of themselves for hygienic purposes.

The seven-day period is followed by another 30-day period of bereavement. There is no bereavement period for stillborns or children who die within 30 days of birth because they are considered to be pure and therefore have no need of mourning rituals.

Islam

Islam has religious values which are similar to Christianity and Judaism. Death is not a time for anguish. The corpse, if respected, is not a source of terror. That is in spite of the sadness felt by individuals. For Muslims, death is the journey from the material to the spiritual world - to Allah. Death is accepted with serenity.

The funeral must be held shortly following the death, which is not always possible due to delays in obtaining a death certificate and to other administrative measures. The request for an autopsy may be problematic as it is forbidden in Islam.

The dying person is warmly and dutifully surrounded by his family. Koranic verses extolling the mercifulness of Allah and resurrection are recited. Relatives seek serenity in these prayers to accept the death of their loved one. The corpse is then washed with soap. The family or another person is responsible for ablutions. The body is cleansed, bathed and rinsed. While ritual prayers are recited, the body is anointed with perfumes and spiced ointments. The body

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is positioned facing eastward, the head westward. The imam arrives as soon as possible to recite traditional prayers. The physical integrity of the corpse must be maintained: cremation is therefore not permitted in Islam. Muslims bury their dead directly in the soil, but in Quebec, the body is placed in a coffin with the head facing towards Mecca. Rudimentary wooden coffins are apparently used. The lid is removed before the corpse is buried. The role of care providers continues to provide understanding and support to the dying person and his relatives according to his culture and religion.41

India

India has a wide array of religions which, although different, share many points in common. Jainism, Hinduism and Buddhism are three major religions practiced in India. Jainism is a philosophy without the concept of an Almighty Creator God which proclaims that the world has always existed. Hinduism has a number of divinities. Many practicing Hindus are nonetheless monotheistic and believe that a single God assumes the form of Shiva, the God of creation; Kali, the mother goddess; Vishnu, the protector of the universe, and so on. Rama and Krishna are the two most important human forms adopted by Vishnu. The sacred texts are known as the Vedas.

Belief in reincarnation affects the experience of death and bereavement, conferring upon it a sense of hope and serenity. In Hinduism, death is a cycle which is followed by birth. Traditional funeral processions are aimed at encouraging the transitions of the soul to another life, especially through cremation. Many Westerners are dismayed by the fact that Hindus may worship more than one God.

Hindu philosophy is based on the concept of a divine law of cause and effect which regulates the natural and eternal cycle of creation and destruction. The destiny of man depends on karma. It is the sum of his thoughts and actions. As such, each person creates his or her own destiny. The objective of believers is to exit this painful cycle of reincarnations, in which the soul may assume a human, animal or other form. Karma is achieved by leading an ethical life and by believing in the eternal truth. Hinduism allows for blood transfusions and organ transplants.

Hindus prefer to die in their own homes. The family undertakes the ritual ablutions of the corpse, which is then bathed, dressed in white clothes (or occasionally red for women), and covered with flowers. The family makes immediate preparations for the cremation. Make-up, embalming and autopsies (unless absolutely necessary) are forbidden in order to permit immediate cremation. The corpse may also be adorned with personal effects such as jewels until the final moment. They are removed to facilitate the passage to the next stage of transformation. White is the colour of bereavement among men.

The funeral is celebrated between the eleventh and thirty-first day following death. Parents and ancestors are also honoured during the funeral ceremony, which is intended to help the migration of the soul to its next incarnation. The ceremony can be repeated once every year. Hindus prefer to eat vegetables during the period of mourning.42

The serenity surrounding death may be misleading to nurses. It does not mean that Hindus do not suffer from the death of their loved one. They still require comforting, empathy and respect for their beliefs. According to her personal beliefs, the nurse may pray in silence with the dying person in her own religious tradition, but she should inform him that it is a bhajan – a common prayer.43

**Chinese and Far East Cultures**

In order to understand mourning among Chinese or Far Eastern immigrants, it is necessary to look at three religious influences: Taoism, Confucianism, and Buddhism. Taoism is marked by the influence of the cult of ancestors, which is based upon the idea that man descends from a divinity through a chain of ancestors in which he is participating through progenitors. This theory is used to maintain communications between the living and the dead. Achieving immortality is the ultimate goal pursued by Taoists. This religion is polytheistic and contains many rites and rituals to achieve salvation.

Confucianism is an ethical and moral system which has no God. Its objectives are family piety and harmony within the family and society by balancing yin and yang. The influence of Confucianism is felt in rites of passage from birth to marriage to death.

Buddhism preaches impermanence. Death is only a stage in the cycle of rebirth, not reincarnation, which confers upon death an aura of hope. The success of Buddhism can be attributed to the concepts of awakening, rebirth and karma, which is the moral law of cause and effect which encourages people to assume responsibility for their destiny through the path of salvation - meditation, ritual and the study of Buddhist scriptures. According to this religion, the soul of a deceased person is reborn according to the cumulative karma of his actions and thoughts. Rebirth can be warm and welcoming, but also miserable. Buddhists seek to attain nirvana, the end of the cycle of rebirth.44

Buddhists do all that they can to maintain the serenity of the dying person. The accompanying recitations are believed to create a state of mind favourable to rebirth. The deceased is positioned on his right side in the sleeping lion position in which the Buddha died. Traditional

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funeral rituals include cleansing and the preparation of the corpse, which is surrounded by candles and incense. The corpse is usually cremated.

Offerings are made and ceremonies are held in honour of the deceased and to encourage a favourable rebirth. The family can also call upon the Buddhist clergy to transmit the religious accomplishments of the deceased to the after world. Funerary tablets on which the names of ancestors are inscribed are used to honour them. They shelter their souls and are piously maintained on the family alter on which incense is burnt. Mourners wear white clothes to show that the deceased has achieved enlightenment.45

“Speaking of death is taboo in most Asian countries. Speaking openly about or even alluding to a deceased person can bring bad luck. That is one of the reasons why Chinese people avoid expressing their feelings or shedding tears when a loved one passes away, and rely on themselves to alleviate their suffering.”46 The death of a child is considered to be “shameful because the parents blame themselves for not receiving the blessing of the gods. That is also why parents do not attend the funerals of their own children.”47 This attitude may seem disconcerting and be misinterpreted by us. The parents nonetheless require that understanding and respect for their beliefs be shown.

Traditional Religions of Africa

“[Translation] Religious plurality in contemporary African societies means that monotheistic, aboriginal, polytheistic and animistic religions occupy a common space with ancestor worship being the commonly shared element. Even if Islam and Christianity are the two major religions in Western Africa, funeral rituals and aboriginal religions continue to coexist along with the religions of the Book.48 Such religious diversity has deep historical roots. The obligations imposed by Christian, Muslim and animist death rituals differ.49

Social relations are tightly knit in African communities. When a person is about to pass away, family, friends and neighbours are in attendance so that the dying person does not feel abandoned. Death is a collective issue rather than a personal matter. “It is experienced neither like a drama unfolding nor a natural phenomenon, but often as the result of spells cast by sorcerers.”50 The dying person is treated attentively by the women. As death approaches, families often settle their quarrels

48 These religions are all derived from the Old Testament.
quietly. Once the person has passed away, he assumes the status of ancestor. According to popular belief, he can protect the family and ensure its continuity.

**Haiti**

The family structure of Haitians is quite "supportive". Haitians also have a fatalistic philosophy of life. Many are Christians; many also use Voodoo rituals to find solace. The death of a Haitian relative in our asepticized and impersonal care environments is often trying for family members. They nonetheless accompany their relative and give him as much of their time as possible.

**Rituals and Their Goals**

In all cultures, death is marked by tradition and ritual. Most ceremonies, prayers, ablutions, and songs are intended to support the deceased in his time of suffering and to facilitate his passage to the other world – paradise or the home of his ancestors. The final good-bye is also the time for friends and family to express their feelings to the dying person and to pay tribute to him. The rituals also bring out expressions of affection and solidarity to the bereaved family. Acts and words which appease the mourning family allow both it (and sometimes the community) to improve their ties. Being supportive helps the living to overcome their trial.

**Conclusion**

It is not an easy task for nurses to accompany persons of another culture in their disease or bereavement. In addition to the suffering brought about by the disease on the patient, his family and even the caregivers, cultural, religious and linguistic differences complicate the relationship even further. As such, nurses must take into consideration certain differences. Recognizing them is greatly appreciated by persons belonging to cultural communities. The imminent death of a relative is traumatic for any person, regardless of cultural origin, religious affiliation or attitude. The soothing words and respect shown by nurses are always welcome.

The way foreigners deal with pain and suffering, and the way they mourn may be off-putting to us. Nonetheless, they must be welcomed and their differences accepted without casting judgement. Sadness and suffering are intimate matters which are deeply conditioned by culture, tradition and religion. Even within a unified social group, individual reactions to disease and mourning will differ. There is no single way to experience suffering and death in the wake of a serious disease.
The role of the nurse is to help the patient, to listen to his friends and relatives, and to provide support whenever appropriate. The nurse must remember that intercultural care is an enlightened manner to comprehend what others experience and to provide assistance with an open mind without losing site of her own personal values. Enlightened care is a means to welcome others and their differences, to listen to them, to understand their needs, and to provide responses which are adapted and free from prejudice and stereotype.

Please consult the third part of this document which provides information on essential aspects of communication and care within the intercultural approach: *Intercultural Approach: Open-Minded Care and Communications*

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