Health, Faith and Equality

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**Prepared for the Health Research Board
through a
Building Partnerships for a Healthier Society Research Award**

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Foreword

In recent years the role of religion in the public square has once again re-emerged as a key concern. Whereas in the twentieth century the working assumption was that religion was becoming ever-more marginal to political life, the events of the last decade suggest that, world-wide, the presence and political significance of religion is being re-established. Thus the once dominant secularization thesis, with its confidence that as societies become more developed they would abandon the naïve superstitions of faith, has had to be re-thought with a view to recognizing this global phenomenon. It would be wrong to conclude simply that secular world-views are under threat, while religious ones are again on the rise. Rather what characterizes this age is not that the religious or secular world-view has triumphed, but rather that the conditions of belief have changed, so that believers and unbelievers alike live with the fact of religious pluralism; with the recognition that 'even for the staunchest believer, faith is only one option among many.'[1]

Our world is both secular and religious at the same time, with the political implications of this complex reality being played out in social policy debates on issues such as health, education, and family law. In Europe these questions take on a particular hue because of the multiplicity of institutional arrangements between individual states and the various majority and minority faiths represented therein. Moreover the construction of the EU as a political entity has also provided the occasion for a re-energized debate about the role of religion in the liberal polity.[2] In liberal societies the fact of religious pluralism poses two different, though related questions: the first being the question of extent to which a society should adapt its existing laws to accommodate religious practices that are not typical of those of the host communities; the second being the question of the extent to which the common good requires the regulation of particular religious practices (especially those that may be regarded as discriminatory or repressive of individuals within the community in question). States deal differently with these fundamental political questions, and in Europe two distinctive approaches are in evidence: the assimilationist approach, most strongly associated with France, with its republican ideal of laïcité; and various versions of a multiculturalist approach, typical of Holland, Belgium, and the United Kingdom.[3]

In the Irish context the demographic developments of the last decade have changed the political landscape utterly. Although statistically small in number, the diverse religious traditions that are increasingly present enrich Irish society in manifold ways.

Ireland is now a multi-religious society, and this fact poses crucial challenges for politicians and policy-makers alike, as they create and implement just, equitable and inclusive law and policy. Although cultural diversity has increasingly manifested itself in public debate, the intellectual framework within which the issues and implications can be properly aired is not sufficiently developed. There are many major policy issues to be considered, and this study seeks to make a contribution to the public discussion of the significance of religious pluralism by focusing specifically on the healthcare context. In the clinical context, healthcare professionals are encountering this religious diversity, and the challenges it poses, on a daily basis; yet there has been no sustained analysis of the implications of this new reality, either in the clinical setting or at the level of healthcare management and policy formulation. Furthermore such limited study of cultural diversity in Ireland as has been undertaken has paid very little attention to the variable of religion.

For some minority communities religious affiliation is a highly significant articulation of their identities. Religion and culture are so intertwined that it is impossible to appreciate the nature of such identities without paying attention to religious factors. Ireland's new experience of the presence of immigrant communities calls for an integrated effort to understand and engage with the newly arrived global religions like Islam and Asian religions as a prerequisite for shaping respectful and fruitful public policies, particularly in the healthcare context. How can debate about healthcare be respectful of and inclusive of these newly arrived religious minorities? How should religious voices contribute to public debate in civil society on healthcare issues? Should the practices of religious minorities be respected in all circumstances? Are there limits to tolerance? If so who should set them and how?

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[1] Charles Taylor, A Secular Age, (Cambridge Mass.: Harvard University Press, 2007) 3

[2] See for example "Degré de Modernité des États en Europe," Revue d'éthique et de théologie morale "Le Supplément" 226 (September 2003), "Religions et Nations," Revue d'éthique et de théologie morale "Le Supplément" 228 (March 2004) and Jürgen Habermas, "Vorpolitische Grundlagen des demokratischen Rechtsstaats?" in his Zwischen Naturalismus und Religion (Frankfurt: Suhrkamp 2005) 106–18.

[3] See the various essays in Pluralism in Europe? One Law, One Market, One Culture? Proceedings of the Annual Conference of the Societas Ethica in Ljubljana, August 2004, ed. Stefan Heuser and Hans Günter Ulrich (Münster: Lit, 2006), Marie-Jo Thiel, Europe, spiritualités et culture face au racisme, (Münster : Lit, 2004) and Islam and Enlightenment: New Issues, Concilium 2005/5 (London: SCM, 2005).

Ireland's learning curve towards becoming a genuinely multicultural society is proving to be both short and steep. Understandably, the policy priorities so far have been largely reactive, and have tended to concentrate on improving the capacity of the relevant statutory agencies to adapt their existing mechanisms for delivering social support to the needs and requirements of our new minority communities, and to sensitise the general public and the social partners towards positive attitudes to ethnic diversity. However, we have now entered a phase in which this reactive policy stance needs to be complemented by strategic, sector-specific policy formation. Moreover such policy needs to be informed by systematic reflection on the manner in which the diversity of religious identities now present in the state challenge the norms, assumptions and practices of existing health policy and healthcare delivery.

It is our hope that this study on Health, Faith and Equality can make a contribution to the state's capacity to deliver a health service that is genuinely respectful of religious difference. We are grateful to the organisations that have supported this research initiative, namely the Health Research Board, the Adelaide Hospital Society, the Adelaide and Meath Hospital, Incorporating the National Children's Hospital, Tallaght and the Irish School of Ecumenics Trust.

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Executive Summary

In 2005, the Health Research Board (HRB) the Adelaide Hospital Society (AHS), the Adelaide and Meath Hospital, incorporating the National Children's Hospital, Tallaght (AMNCH) and the Irish School of Ecumenics Trust commissioned the Irish School of Ecumenics (ISE) to research issues arising in relation to health care provision and policy formation for religious minorities within a Christian culture.

The research aimed to identify key issues as they arise in the Irish context and to consider policy options in light of the experiences of other jurisdictions.

Action-based research was conducted between August 2005 and December 2006, a period of transition for the Health Service Executive (HSE), which came into operation on the 1st January 2005. Field sites included the Adelaide and Meath Hospital, incorporating the National Children's Hospital, Tallaght; Balseskin and Mosney Refugee Reception Centres; and the offices of a variety of non-governmental organisations (NGOs) and faith/religious organisations throughout Ireland.

During the fieldwork period, the HSE National Social Inclusion Steering Committee began implementation of an inter-cultural health care strategy as part of programme of reform in response to the Department of Justice, Equality and Law Reform's (DJELR) National Action Plan Against Racism (NPAR). The development of this process in part influenced the direction of this HRB research.

Eleven key findings and six recommendations emerge from the primary research:

Findings

1. For those from minority faiths, health promotion, tackling ill health and its prevention is not solely the domain of the Department of Health and Children (DHC) or the HSE. Rather, it is the collective responsibility of many government departments. There are key roles to be played by all government departments in partnering with NGOs and religious organisations to fulfil their obligations.

2. In attempting to accommodate religious belief, there is a tendency for health care providers and practitioners to assume a one-size-fits all approach which does not reflect the diversity, varieties and cultural sensitivities within individual faith communities.

3. There is a need in any new or existing cross border health policy forum or integrated working for a sustained and dedicated focus on diversity and equality aimed at creating networks to promote research, education and advocacy in relation to the impact of faith within healthcare settings.

4. There are currently no national protocols and guidelines relating to faith in a health care setting that are accessible in a variety of languages and formats. Staff are frustrated and their professionalism compromised by a lack of codes of conduct in relation to balancing legal/medical requirements with cultural expectations in, for example, post mortems, blood transfusions, provision of specific medication and death and funerary practices.

5. Many factors mitigate against a successful uptake of services and service delivery by those from diverse backgrounds, including language and communication. There is an identified need for a national regulatory body to standardise medical interpretation practices. This should explicitly and de facto take into consideration the micro-dynamics occurring when engaging with a diverse set of religious and faith practices.

6. There is a recognised need to develop a framework to co-ordinate the involvement of those from diverse religious backgrounds for both the DHC and the HSE as part of their Intercultural Strategy.

7. Many service users and health care providers consider that core to successful health care delivery is the provision of adequate training for all those working within health care settings to ensure an informed understanding of how religious belief and practices impact on areas of birth, death, diet and ritual behaviour and to the mainstreaming of inter-culturalism as theory into practice.

8. Teaching resources and the training of future medical and nursing professionals do not focus on aspects of religiosity that are pertient to health care provision in a diverse Ireland.

9. There is currently a poor evidence base of service users' religions and limited guidelines available from the HSE/DHC within health service delivery. This can be seen to impact on service delivery standards. National and local research into health promotion and prevention, different medical models and specific cultural practices, including cultural circumcision, is required to address the rights and needs of those from minority faiths.

10. The majority of facilities relating to religious worship currently available through the HSE cannot be seen as shared spaces promoting inclusivity. Many from non-Christian religions would welcome a revision of the protocols for Hospital chaplaincy services and of the arrangements made for public events that contain religious components.

11. Religious belief is often seen as synonym for race or ethnicity in Government analysis. It can therefore be seen to be merely 'smuggled into' policy discourse.

Recommendations

1. A framework be developed to explicitly co-ordinate the involvement of those from diverse faith backgrounds for both the DHC and the HSE as part of any Intercultural Strategy. In addition to addressing existing or any potential systemic racism, the remit should incorporate capacity building, information dissemination about and access to appropriate services, the resourcing of cultural mediators, bi-lingual health advocacy and link and outreach workers. In any new or existing cross border health policy forum and integrated working partnerships, a sustained and dedicated focus should be placed on diversity and equality. This should aim to create networks to promote research, education and advocacy in relation to the impact of faith within healthcare settings.

2. Any development of national protocols and guidelines relating to faith in a health care setting need to be accessible in a variety of languages and formats. This might include guides or codes of conduct in relation to balancing legal/medical requirements with cultural expectations in the key thematic areas addressed in Section 4.

3. A more comprehensive approach to training for all those working within health care settings is essential to ensure an informed understanding of how faith impacts on areas of birth, death, diet and ritual behaviour and to the mainstreaming of inter-culturalism as theory into practice.

4. Teaching resources and the training of future medical and nursing professionals should be developed to ensure that the religious idiom and mode, as well as ethnicity, informs the syllabus and induction process of university hospitals and the inter-institutional collaboration of 3rd level educational establishments.

5. National and local research into health promotion and prevention, different medical models and specific cultural practices including cultural circumcision is required to address the rights and needs of those from minority faiths.

6. The way in which ethnic and religious monitoring data can be captured from primary and secondary care needs to be revisited with a commitment made to include information on birth and death certificates.

The following is a proposed set of overarching policy objectives with suggestions for key outputs and performance indicators.

Over-arching Policy Objectives	Outputs	Key Performance Indicators
Engage with issues pertinent to those from minority faiths by developing a framework for co-ordinating involvement of those from MEFLOs	• Policies developed through community engagement based on principles of equality, diversity, dignity and respect. • Long-term strategic planning based on demographic changes.	• Resource capacity building programmes within MEFLO and communities to develop needs assessments and community audits. • Develop gender sensitive guidelines for use in hospitals. • Monitor the mainstreaming of minority faith/ethnicity issues into work plans. • Formation of consumer panels to encourage communities to participate in information sharing. • Stronger links with patients' organisations needed to assess the quality and appropriateness of services.
Address the lack of data relating to faith.	• Undertake long-term strategic plan cognisant of demographic changes. • Link census attributes to other information to exhibit the health history of members of minority faiths.	• A longitudinal study looking at both the behaviour, context and composition of individuals' health. • The development of health promotion and prevention projects designed to address the rights of those from minority faiths.
Adequately train all those working in healthcare provisions to ensure equality of care and opportunity in diverse work/service environments.	• Mandatory anti-racist cultural awareness, equal opportunity and diversity training for all medical and non-medical staff.	• Delivery of anti racist, equality and discrimination training throughout organisations with induction programmes for new staff/students/service providers carried out in partnership with MEFLO . • Dedicated programme in Health Executive of a roadshow of training/resources/programmes relating to faith/health. • Training and information for staff communicating how death is handled cross-culturally and what legislation is in place elsewhere that may impact on expectations. • National programme to raise communication and cultural competency standards in hospitals.
Raise the profile of the rights and needs of those from minority faiths in healthcare provision.	• Develop good practice guides and positive action programmes where appropriate.	• Positive action plans developed within departments/organisations and the appointment of faith champions. • Develop a community cultural mediation service that is able to provide support to all stages of the life cycle experienced throughout the health care system. • An organisational undertaking to update and widely disseminate material resources used in hospital in relation to community organisations and their practices. • Practical, culturally sensitive support services and rights-based information for grieving family members and dependents.

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Acknowledgements

Abbreviations

AHS	Adelaide Hospital Society
AMNCH	Adelaide and Meath (Incorporating the National Children's Hospital)
DFA	Department of Foreign Affairs
DHC	Department of Health and Children
DJLER	Department of Justice, Equality and Law Reform
DSFA	Department of Social and Family Affairs
EHRA	Eastern Regional Health Authority
GNIB	Garda National Immigration Bureau
HSE	Health Service Executive
HRB	Health Research Board
IMO	Irish Medical Organisation
INO	Irish Nurse Organisation
ISE	Irish School of Ecumenics
MEFLO	Minority Ethnic and Faith Led Organisation
NPAR	National Action Plan Against Racism
NESC	National Economic and Social Development Office
NCCRI	National Consultative Committee on Racism and Interculturalism

Tables

1. Population Classified by Religion, 2002 and 2006

2. Models of integration as suggested by Mac Éinrí, 2006

1 INTRODUCTION

1.1 Background

In 2005, the Health Research Board (HRB) the Adelaide Hospital Society (AHS), the Adelaide and Meath Hospital, (incorporating the National Children's Hospital, Tallaght (AMNCH)) and the Irish School of Ecumenics Trust commissioned the Irish School of Ecumenics (ISE) to research issues arising in relation to health care provision and policy formation for religious minorities within a Christian culture. The research aimed to identify key issues as they arise in the Irish context and to consider, in the accompanying report, potential policy recommendations in light of the experiences of other jurisdictions.

This report is presented within the context of fluctuating national demographics. It is written in light of changing policy and legislative environments locally and internationally in relation to both health and migration. It has been produced at a time when the Catholic Church remains the largest and most dominant tradition within Irish health care, with a written code of prescriptive ethics for all its hospitals that mitigates against honouring the pluralism and multi-denominationalism of Ireland, including the minority Christian Churches. The report implicitly acknowledges the prevailing position of the Catholic Church and the challenges that this has created for some of the minority churches seeking to deliver or access public health services. It is the contested and opposing perspectives from within the Christian Churches in the main that resulted in the formation of some public and voluntary hospitals.

The research is situated within a theoretical framework which privileges models of integration through an exploration of inter-culturalism over the consideration of either multi-culturalism or assimilation. The thrust of this report is to argue that it is now timely for health care providers to mainstream inter-culturalism as a norm within the Health Service, and in doing so, attempt to treat each individual as they would wish to be treated, within the parameters of international conventions and legislation.

This report has as its focus not the pathogenic issues to be found at the core of any biomedical enquiry, though it recognises that within the hospital setting, hierarchical and competing power relations are dominated by medicalised models and perspectives (cf Lindenbaum 1993). Rather, the discussion has been shaped by anthropological methodologies and social policy developments, and considers the wider, 'chronic', psycho-social determinants of physical and mental well-being and health inequalities, including social networks and social capital.

Woven into the fabric of this work are case narratives aimed at illustrating the experiences, responses and reactions of those individuals and their families (in particular those from 'minority faiths') who engage with health care systems both as service users and as service providers. These vignettes are drawn both from long-term residents and citizens of Ireland and from more recent migrants.

Primary research took place within the first year of the formation of the HSE (following the enactment of the Health Act of 2004), whose establishment continues to determine acute hospital and healthcare rationalisation and a radical restructuring of the health service. A significant part of this process has to date been the development and strategic implementation of an initiative on Intercultural Health Care in 2006 through the National Social Inclusion Steering Committee which, at the time of writing is undertaking a process of national consultation. The timing also coincided with an acceleration of cross-border bodies and inter-agency work, and the consultation on the form of any regional translation service.

This paper distils the lessons from the research concluding with a series of recommendations.

1.2 Aim of Study

This study has been written in recognition of the shift in policy thinking in favour of a more managed approached to equality and diversity in health (in train with similar initiatives in relation to immigration). Both the DHC and the HSE are keen to ensure that the democratic entitlement of individuals from black and minority ethnic and faith led organisations (MEFLOS) and communities are upheld and issues that impact directly on their lives are centre-staged in policy review and practice development.

Yet, there remains relatively limited evidence to substantiate some of the claims, needs and rights made by those from 'minority' faiths in an environment where the Christian Churches remain an ever present and contributory force within health care. In light of inextricable practical and symbolic links and influence wielded in particular by Catholicism within statutory service provision

(Barrington 1987, Wren 2003), this study aims to contribute explicit empirical material to that which is currently available relating to minority faith issues in Irish health care and healing.

There are implicit questions raised here as to the ethical and moral currency drawn on to debate the need for change. Based on cultural expectations, answers need to found as to:

• How are we best able to ensure that individuals are treated as people not just as patients from a specific ethnic/religious background?

• What are the benefits to be gained by investing in the provision of cultural mediators[1], particularly in emotionally charged hospital situations and where bereavement occurs?

• How and by whom should any potential conflict between diverse religious and cultural practices with an existing ethos within a health-care setting be addressed?

• How do we ensure that the wishes of patients or families are adhered to when we balance cultural/religious prescriptions with legal/medical requirements, for example in the areas of post mortems or life-saving drugs containing porcine components?

This study aims to stimulate further debate on issues of health policy formation in relation to religious minorities in a society where Christian cultures, and explicitly the Roman Catholic church, dominate service provision.

1.3 Methodology and Outputs

The process undertaken for this study included documentary and qualitative research.

Desk research and a literature review revealed a myriad of policy documents throughout the island of Ireland and in Great Britain relating to health inequalities and racial and ethnic discrimination, experiences and social change. However, few explicitly investigate the interface between health service provision and religious diversity[2] despite this being a growing tendency within the United States and the United Kingdom. In Europe, such studies have tended to focus on the epidemiological connection to specific ethnicities (Gill et al 2006) and the different biological predispositions new and older established migrant communities can demonstrate.

Data in relation to faith, is hard to obtain. One of the problems in attempting to profile religious identity is that it is generally absent from health monitoring systems. None of the forms used to record information of the following datasets gather information on ethnicity and religion: National Mortality Dataset, Perinatal Reporting System, National Psychiatric In-Patient Reporting System, Hospital In-Patient Enquiry, National Drug Treatment Reporting System.

The first stage of the study saw the development of relationships on a number of different field-sites.

• AMNCH Tallaght provided the principal site and opportunity to target two specific constituencies working in the health sector in a public, voluntary teaching hospital:

   • 25 medics, administrators and practitioners

   • 150 service users and patients and, where appropriate, their families and carers

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[1] Cultural mediators are distinct from translators and interpreters. Whilst also being able to fulfill crucial roles in facilitating communication between service users and services providers by working in two or more languages or dialects, cultural mediators provide a more integrated and holistic connection between health and education services and their clients. Their role is to represent individuals more holistically than translators and interpreters are able to do by seeking out a wider, often medium to long-term first hand knowledge of the individuals, their family history, family dynamics and the cultural and community networks and context in which they live.

[2] For a brief discussion within the British context see Weller, Feldman and Purdam 2001

- A series of 30 clinical observations in outpatient and A&E departments, consultations, focus groups and interviews were carried out within this acute hospital setting. There was no reliable method of ascertaining patient's faith other than if they chose/were able to record it on admittance which in turn was passed to the chaplaincy. Shadowing members of the hospital's chaplaincy team on ward rounds on a bi-weekly basis over a 12 month period provided additional opportunity to meet with patients and discuss religious beliefs.

- Attitudes and experiences were examined within highly charged emotional environments, at times of communal and private worship, and with people who could be identified as being in the process of moving through different life stages. The legacy of an ecumenical service provision developed from the ethos of its foundation hospitals and subsequently enshrined in the current Hospital's charter enabled a broad range of faith-based practices to be observed.

- Appendix 1 lists those organizations that were visited and consulted as part of the research with service users and policy developers. These include non-governmental and community based organisations involved in inter-cultural work, governmental organisations or state supported agencies involved in intercultural work, regionally based minority ethnic health forums, key specialists in intercultural healthcare provision, health planners/policy makers and religious, faith and community leaders.

- A third set of sites where interviews, focus groups and participant observation occurred were in the Balseskin and Mosney refugee reception centres and with asylum seeking women in Dublin and Athlone living in a variety of accommodations under direct service provision. This provided a more detailed exploration of issues relating to pregnancy, child-birth, child-rearing and mental health and well-being.

The second stage of the fieldwork process drew on a broad range of expertise in a specific and focused environment. Policy formation is a dynamic and ongoing process and, with this in mind, ISE convened a one day symposium in April 2006 which brought together stakeholders from Ireland North and South as well as Great Britain already actively working in the area of health policy formation. These included government officials, key ngos, senior HSE management, health care providers, service users and the leaders of religious organisations. They discussed and explored the development of policies and protocols in relation to faith, equality and health. Two workshops in relation to cultural competency and death and dying provided the framework for informed discussions on the day.

The third stage of this process saw the ISE proffer a successful tender to carry out a consultation process on behalf of the HSE on the contents of an existing draft of the Intercultural Interfaith Resource Pack. This consultation provided the opportunity to observe the debates and concerns of a wider range of service users and providers in different sites throughout Ireland (see Appendix 3). Issues raised at earlier stages of the study within Dublin were observed being rehearsed within these additional geographical locations.

Recurrent themes are considered in Section 4, by way of ethnographic example.

1.4 Value Base

Methods of interviewing and modes of recording information were tailored to meet the needs of individuals and groups. This aimed to ensure that as wide a set of responses as possible were accessed in light of the added complexities and sensitivities that arise in relation to individuals' beliefs and cultural expectations. Such practicalities included the scheduling of meetings, the gender-representation of participants and the need for translation and interpretation services. All of these elements were factored into how the research might be conducted equitably. As it became apparent that a number of contributors to the research had competing agendas and expectations when working for the shared goal of equality of service provision and access to services, the narratives chosen to illustrate some common themes in this study are positioned so as to draw attention to the basic standards of local and international legislation.

The ethics committee of the AMNCH gave approval for conducting the research on site. Informed consent and permission to participate through clinical observations were sought from service users and their families, as well as from ward and departmental staff. Oral consent was obtained in the presence of an independent witness (usually medical or administrative staff). In some instances, where bereavement had or might potentially occur within the hospital, permission was sought on a separate occasion from the families by either Chaplaincy or by the Mortuary technicians. This was initiated to provide participants

with a further opportunity to decline to participate. All personal and medical information obtained relating to the research participants has been treated as confidential.

1.5 Structure of Report

That the Catholic Church has been inextricably linked with health care provision in Ireland is indisputable (Barrington 1987, Wren 2003). However the role that other Christian Churches and other religions and faiths can and increasingly do play in the health sector is less well charted.

Section 2 considers faith and ethnic diversity and the changing demographics in Ireland within the context of current policy and legislation and patterns of migration. It highlights some gaps within current evidence and sets out a definition (for the purposes of this report) of the role of faith within hospital and other health care provisions.

Section 3 examines the theoretical framework which underpins the integration of those from minority faiths into Irish society. At a macro level, it unpacks the concepts of interculturalism, multiculturalism and assimilation, reviewing the international evidence by drawing on European and North American experiences. It considers the role played by the third sector, recognising that voluntary and community organisations are well placed to act as a bridge to mediate between the statutory service providers and the individuals for which they are responsible. At a micro level, the section also includes a more abstract consideration when looking at individuals' faith by considering how the body can be interpreted as a site of symbolic integration. This aims to re-insert the individual back into any discussion about issues of religious significance.

Section 4 uses ethnographic examples by way of field-case studies to look at recurrent thematic areas of concern to participants. These correspond to different stages within the life cycle as well as to specific cultural and faith-based practices.

The report concludes with Chapter 5. Here, a number of policy recommendations are made based on the findings of the research, with suggestions as to how Ireland might best benefit by recognition of the diversity within the health service. They might be considered a signpost for future discussions into the desirability and the appropriateness of policy development.

2 HEALTH ISSUES

2.1 Current Health and Ethnicity Policy Interventions in Ireland

The following developments provide a recent background to the core shaping and formation of health policy in Ireland.

Following the European Year Against Racism (1997), the Irish Government established the National Consultative Committee on Racism and Interculturalism (NCCRI) as an independent expert body to advise the government on all relevant matters.

In 2003, NCCRI were advisors to the former Eastern Regional Health Authority (EHRA) on the production of a Regional Health Strategy for Ethnic Minorities (intended to be implemented in parallel with the already-existing Traveller Health Strategy). This outlined an overview of issues associated with cultural diversity. Recommendations on service issues included:

- the need to develop a formally accredited interpretation service

- the need to resource non-governmental community-based organisations working with MEFLOs and other minority ethnic and faith groups

- the provision of cultural awareness and anti-discrimination training for health service staff

Development and implementation of these recommendations was overtaken by the major programme of re-structuring in the health services, which in 2005 resulted in the establishment of the Health Service Executive, answerable to the Department of Health and Children.

Simultaneously, to address the rights of vulnerable citizens, Planning for Diversity: National Action Plan Against Racism outlined the Government's willingness to further formulate a debate about the need for structures to support integration into mainstream society. As if by way of response, a number of schemes were initiated from within the Department of Justice and these are currently being advanced, it might be assumed, with the expectation in part of pre-empting the types of inter-ethnic unrest experienced by citizens in Britain and France in 2004.

In 2005, in anticipation of social partnership discussions, a critical review of the health care system was commissioned by the Irish Congress of Trade Unions (ICTU) that identified 'anomalous and dysfunctional' economic incentives in the public hospitals perpetuating inter-hospital and inter-regional inequity, including an incremental annual budget which does not reflect social and demographic changes (Tussing and Wren 2005:12). While the study did not pay specific attention to MEFLOs, the National Action Plan Against Racism, also published that year and steered and developed principally by NCCRI, had identified health care as an area where those members of and represented by MEFLOS remain vulnerable to social exclusion and in need of 'culturally appropriate services' that should be provided by 'an informed and culturally aware workforce'.

To address their responsibilities and obligations raised therein, the HSE's National Service Plan 2005, identified the development of a National Intercultural Health Strategy, including an Intercultural and Interfaith Resource for health service staff in all settings. Preliminary consultations that the researcher observed as part of that consultation process appear to indicate that the level of public debate into awareness of religious diversity and specific health needs in Ireland is low.

It is noteworthy that these initiatives are taking place within the broader context of both a national anti-poverty strategy and a developing general social and economic framework where increased attention is paid to international equality and human rights standards (outlined below) and policies operating within a common EU social inclusion framework.

Overview of the broad legislative context and specific initiatives for minority groups and current human rights frameworks:

- The Irish Human Rights Commission was established in 2001 within the context of the Belfast/Good Friday Agreement 'to promote and protect human rights as defined in the Constitution and in international agreements to which Ireland is a party'.

- Ireland is generally considered to have strong equality/ anti-discrimination legislation, contained primarily in the Employment Equality Act 1998 and the Equal Status Act 2000. The Equality Act 2004 updated the two original Acts by incorporating provisions of the European Directive 2000/43/EC and covers discrimination in relation to employment and the provision of goods and services including health care and social protection on nine grounds (gender, marital status,

family status, sexual orientation, religion, age, disability, race and membership of the Traveller Community).

- The EU Directive 2000/43/EC (known as 'the Race Directive') contains measures for implementing principles of equal treatment of all persons, irrespective of racial or ethnic origin.

- Ireland is signatory to the International Covenant on Social Economic and Cultural Rights adopted by the UN General Assembly in 1966 (and entered into force 10 years later). Among its provisions, it commits party States to 'recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and to 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness'.

- The statement of goals in the introductory overview of the latest National Partnership Agreement Towards 2016 is aspirational in its assertion of 'more successfully handling diversity, including immigration' (p.5)

- The Nationality and Citizenship Act of 2004 restricted for the first time the right of a person born in Ireland to hold Irish citizenship (applying to all babies born after 1Jan 2005). At the time of writing, the imminent Immigration, Residence and Protection Bill, (currently under consideration), is expected to replace all existing legislation on asylum and on immigration namely: the Aliens Act of 1935, the Refugee Act of 1996, and the Immigration Acts of 2003 and 2004, as well as current asylum determination procedures and the institutions administering them, in particular, the Office of the Refugee Applications Commissioner (ORAC) and the Refugee Appeals Tribunal (RAT). A single, centralised body, the Irish Naturalisation and Immigration Service (INIS) will handle all applications for residency in Ireland (including those from asylum seekers), and issue residence permits of all types.

- Ireland is signatory to both The UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the United Nations Convention on the Elimination of Racial Discrimination (CERD) but these are not directly enforceable in Irish law. It is noteworthy that the Government's account of its track record in combating racism and discrimination, in its first and second reports to the CERD Committee was challenged in 2004 on a number of grounds in a detailed 'Shadow Report' compiled by a group of NGOs.

2.2 Demographic Implications for Health

Given the rapidly changing demographics of Ireland, a policy related discussion on health issues can only be of benefit if preceded by a brief consideration of the impact of long-term migration and immigration in Ireland. Current policies and legislation concerning immigration have been recorded elsewhere as 'piecemeal' (NSEC 2006:3) with the government acknowledging that Ireland 'has had the most open economic migration system in Europe' (DJLER, 2005: 60). While the DJELR remit to regulate admission and residence accords the Department the overall responsibility for immigration policy, there are many other government agencies involved in the integration process, including, but not exclusively, the Department of Foreign Affairs (DFA), the Garda National Immigration Bureau (GNIB), the Department of Social and Family Affairs (DFSA), and of particular relevance to this report, the Department of Health and Children (DHC) and the Health Service Executive.

Recently, academic and practical expertise has been developed and honed in relation to migrancy in specific areas. These include racism and discrimination (Farrell and Watt 2001, Lentin and McVeigh forth.), asylum and refugee status (Fanning et al 2000, Feldman et al 2002, Hughes 2005), integration (MacEinri 2005, 2006) immigration policy (Ruhs 2005) and the labour market (Barrett et al 2005). Also, Cotter (2005) provides an overview of published and unpublished research into 31 areas of civic life and the direct relation to refugees, asylum seekers and immigration. But to date, little has been written about the role religion and faith might play in these circumstances, nor in the role religion and faith have to play in the lives of those who are long term or second and third generation residents in Ireland. As Rawls (1997) has argued in other jurisdictions, there is limited attention paid to or co-ordination that addresses how access to and the uptake of state services are impacted on by religious diversity. Of particular relevance to this report, is how this might impact on mental as well as physical well being.

It is widely acknowledged in much of this literature, that the composition of migration and changing demographics poses both opportunities and challenges in relation to an increase in pressure on health service provision, infrastructure and human resources. Key challenges for those from non-Christian communities wishing to utilise services are often the same as they are for those working within the sector who wish to deliver these services equitably. Namely, an increased pressure of numbers, language difficulties, attitudinal barriers (on both sides of the couch), lack of cultural understanding between those in a medical

system and those in a social system, and an inadequate understanding of and responses to medical conditions rarely encountered in Ireland (Watt and McGaughey 2006:117). Tensions surrounding these areas often manifest themselves in practical terms through the scheduling of appointments, hospital diet plans, catering, compliance with medical regimes, and communication between individuals that cross cultural and gendered norms. Furthermore there are concerns raised by some in relation to the material culture associated with the Catholic Church. These issues can be seen to precipitate further considerations in relation to appropriate social integration not just in the health sector but in the wider societal acceptance of cultural diversity. In Ireland, North and South, there is little public debate about the processes through which stronger community involvement in all aspects of service provision (through education, housing, employment, health) might best be achieved to support processes of social cohesion.

However, it is the health sector which provides a principal loci/site where the ramifications of the tensions between theory and policy, between policy and practice, and between individuals from minority faith communities and the majority Christian communities, are often most consistently played out. This can be seen to occur principally when attempting to understand and accommodate religious observances during specific stages of the life cycle. It is at the time when people are at their most vulnerable, for example at times of pregnancy, birth, ill health and death when heightened adherence to religious prescriptions, rituals, and diets are called on by many to support bio-medical healing processes. And it as at these times when the conflict between individual needs, group rights and organisational structure can come into play most.

2.3 Migration to Ireland

Economic pulls have resulted in a growing migrant workforce. This is in part as a result of Ireland moving from receiving "final demand" notices from the International Monetary Fund in the late 1980s to becoming one of the fastest growing economies in Europe per ratio of the population. Ireland was one of the only three 'old' EU 15 member states which imposed no transition arrangements concerning admission to the labor market in 2004 (although it did introduce restrictions to welfare benefits by imposing a two year habitual residence rule). It also made changes to the categories of work for which it was possible to apply for work permits and this in turn might be considered to have had an impact on the nationalities and the ethnic and religious background of those filling these skill shortages.

In relation to the rapidity and size of this growth, a brief cross-border comparison is of relevance. From May 2004 to Sept 2005, while 293,000 workers moved to UK, (14,395 of whom applied for the Workers Registration Scheme in Northern Ireland) (Beatty et al 2006), in the Republic, 133,258 individuals obtained PPSN (personal public service numbers). In the period January 2005 to November 11th 2005, a further 128,702 PPSN numbers were issued in respect of former EU accession countries (O'Brien 2007). While it is vital to acknowledge that these figures do not record the number of those who have returned home, to put them into perspective, Ireland has a population 15 times smaller than that of the UK yet it has attracted more migrant workers per capita in the period 2003-2005 than the US and the UK have had to in the past 30 years (Frawley 2006:44).

In addition, the Irish figures do not include those who migrated to Ireland from outside EU, international students, the non-economically active spouses and families in Ireland on the grounds of family reunification. While the work permit system has acted as a gateway to access the labour market and has been principally regulated by the Employment Permits Act 2003, other employment-related policy challenges have occurred outside this system. The number of foreign students, for example, has doubled since 2002. This has all occurred within a health system which does not monitor or indicate the nationality and faith of migrant workers, students or those relocating for the purpose of family reunification and it is indisputable but often unacknowledged, that there have been Jews, Muslims and Hindus who have contributed to life in Ireland for a number of generations.

By the end of 2005, 48,632 applications had been processed on behalf of asylum seekers. A total of 6,814 (principally Nigerian and Romanian) were granted full refugee status. In addition, 16,727 were granted leave to remain under a special application process for the parents of Irish-born children after the Supreme Court ruling in 2003 (through the Lobe and Osayande cases) overturned the status quo ante where the parents of Irish-born children acquired indefinite residency rights. There are now at least 27,000 people legally resident in Ireland who originally arrived as asylum seekers and there are currently 167 languages in use among members of these communities. Yet, there is no specific data available in relation to the faith of those granted leave to remain or asylum seekers.

Figures below comparing the 2002 and 2006 Census, reveal an 8.2% increase in the overall population of Ireland from 3,917,208 to 4,172,013 with a 6.3% increase in the majority Roman Catholic communities from 3,462,606 to 3,681,446. However, further examination indicates that of those resident and eligible to complete the census, there has been a significant growth in the percentage of many individuals who self describe as non-Catholic.

Table 1. Population Classified by Religion, 2002 and 2006

Population	2001	2006	% Increase
Total Population	3,917,203	4,172,013	8.2
Roman Catholic	3,462,606	3,681,446	6.3
Church of Ireland	115,611	125,585	8.6
No Religion	138,264	175,252	34.8
Muslim	19,147	31,779	69.9
Other Christian Religion	21,403	29,206	36.5
Presbyterian	20,582	23,546	14.4
Eastern Orthodox	10,437	19,994	99.3
Methodist	10,033	12,160	21.2
Jehovah's Witness	4,437	5,152	16.3
Buddhist	3,894	6,516	67.3
Jewish	1,790	1,930	7.8
Hindu	3,099	6,082	96.3
Lutheran	3,068	5,279	72.1
Evangelical	3,780	5,276	39.6
Baptist	2,265	3,380	47.4
Pantheist	1,106	1,691	52.9
Agnostic	1,028	1,515	47.4
Latter Day Saints/Mormons	833	1,237	48.5
Aethiest	500	929	85.8
Quaker/Society of Friends	859	882	2.7
Lapsed Roman Catholic	590	540	-8.5
Baha'i	490	504	2.9
Brethern	222	365	64.4
Apostolic/Pentecostal	3,152	8,116	157.5
Other Stated Religions	8,920	8,576	-3.9
Not Stated	79,094	70,322	-11.1
Source: Central Statistics Office, Ireland Census 2006 Volume 13 Table 5			

It is, however, unquestionable that the census is a blunt and cumbersome tool. For the purposes of this report it provides a flawed and incomplete picture. As an overview of the significance of faith, not only are these figures now grossly outdated, they are also unable to provide any analysis of the net inward and outward migration of those in Ireland ineligible to register. The census has no part in unpacking how the practice of religion is contextual and that the challenges and expectations of practising Christianity in Ireland, (for some congregants in from Sub-Saharan African countries to give but one example), differs significantly from those whose experience of the Christian Church has been rooted in a Western European interpretation of Christianity.

'When I came here, I didn't know how I could worship with people, prayer was so different, what people expected of one another through the church was very new to me!'

Furthermore, the census does not capture the complexities and fluidity of how those 138,264 who describe themselves as having no religion might find that they have recourse to call on it at particular stages of the life cycle.

Currently the breadth of the policy focus within the Irish health care system that is debated in the media and repeated in 'water cooler' discussion relies on a very narrow agenda. Faith is sometimes found to act as a synonym for race or ethnicity in Government analysis and it can be seen to be merely 'smuggled into' policy discourse, (Lowndes 2005). Here the crisis in A&E, bed shortages, the consultants' contracts and the private 'choice' agenda is endlessly rehearsed and to the fore of discussions. These issues are only occasionally supplemented with consideration of matters of particular interest to those with a religious rights agenda when tragic incidents occur such as the issue of the abortion ruling sought by 'Miss D' and presided over by Justice Liam McKechnie and of the death from haemmoraging and shock of four week old Callis Osaghae in August 2003 after a home circumcision. With an official emphasis on the outputs of a system, consideration of its outcomes or the lack of service provision for service users with minority needs are often crowded out of the equation. It is noteworthy to recall the adage that 'targets can be good servants, but they are poor masters'.

It is increasingly noticeable that services are being delivered within a system where the sharing of information through new media and technology is limited and where, in keeping with the suggestions in Mackenbach et al. (2002), the policies and interventions aimed at reducing inequalities in health, are in reality, limited to achieving equal access to healthcare. A preventative approach to service delivery as well as a service which is 'appropriate and sensitive' is necessary (Siggins 2006). This is particularly so in light of:

- the restricted attention paid to preventative health for those from MEFLOs

- the creation of healthy environments through social cohesion measures in housing, transport

- the promotion of social and economic opportunities through education and employment

- the valuable role that meflos might play in supporting this work (Marmot and Wilkinson 1998)

Gaps in Evidence –comparisons from elsewhere

The current Inter-Cultural Health Strategy provides a timely opportunity for the HSE to universalise good practice in relation to health and faith. The HSE, like the NHS currently functions as a large top-down, Fordist system where, it might be suggested, the central imposition of targets can tend both to reduce staff morale and to depersonalise the service for users (Wilson and Oliver 2007:17). Both organisations talk of the need to ensure that citizens and practitioners 'have an effective voice in planning and evaluating services' (DHSSPS 2005:14). And in keeping with mortality, morbidity and utilisation statistics, responsiveness to the patient experience is a key indicator to evaluate a health system's performance. According to WHO 2003, responsiveness is operationalised in the eight domains of:

- respect and dignity for persons

- autonomy to participate in health-related decisions

- confidentiality

- prompt attention

- adequate quality of care

- communication

- access to social support networks

- choice of health care provision

While the mix of policy and governance developments are clearly not yet fully coherent in relation to responsiveness within the Irish health care system, there appears to be a keen recognition of the importance of tailoring a holistic approach to health care. Yet, despite government signalling its intention to address current anomalies in the system in relation to confronting systemic racism and to recognising the needs of those wishing to access culturally specific services there remains the danger that:

- in responding to new legislation, actions referred to in policy and protocols focus on existing commitments by organisations and result in box-ticked responses rather than innovative and creative ones which have been mutually developed with service users

- there is no significant quantitative or qualitative research available or being undertaken from which to address the current, weak evidence base of operationalised 'responsiveness'

- the existing structures in relation to current training provision are not equipped to support staff wishing to respond to the needs of those from minority faith communities

- an insurmountable barrier to inter-agency work remains with the current culture of poor information exchange and dissemination. Outdated IT systems, limited electronic methods of recording/sharing patient information and the independent status of both general practitioners and consultants who continue to work both within and without the system are all seen to impede and obstruct conversations between the statutory services and voluntary organisations working at neighbourhood level on behalf of service users

Furthermore, the management of individual and group rights and the direction the State intends to travel in relation to religious practices remains unresolved despite numerous conventions, policies and protocols to ensure individuals are free from discrimination, irrespective of whether or not they choose to be associated with a minority group. This can, perhaps be best evidenced in the high profile case in 2006 of Ms K—a 27-year-old French-speaking Congolese woman, a non-Irish citizen and Jehovah's Witness—who, speaking through an interpreter, presented compos mentis at the Coombe Hospital for the birth of her child. After an emergency ruling by the High Court in Dublin it was deemed to be in the best interests of her child that Ms K was able to be physically restrained and forced to have a blood transfusion against her will and in violation of her spiritual beliefs. The cry of medical paternalism was raised by some, of injudicious judicial intervention by others. Still others wondered at the morality of the patient choosing to enter into a medical system when, in this worse-case scenario, professional carers were then expected to compromise their own ethics.

2.5 Data and Religious Monitoring in Health Care

Within the various outworkings of the health service, there is little data collection of any quality in relation to the ethnic monitoring of patients and even less in relation to their religious beliefs—therefore prudence is advised when interpreting any material currently available. The British Medical Journal (1996:1094) suggests it is good practice to collect a range of information about patients, including religion.

It might be suggested that fuller religious coding clauses than currently exist within health service contracts (accompanied by the training of staff to collect and interpret this material) would be advantageous. This would also be so for both interpreting material in relation to generic equality issues, and in relation to the cost and cost-effectiveness of specifically tailored services, as well as for a better understanding of specific epidimeological predispositions and issues.

As data collection on ethnicity and faith is not currently seen to be a priority, any change will be dependent on long term strategic planning. New IT systems and programmes are currently under consideration and have been implemented in other jurisdictions. Within the NHS in Scotland, records relating to Travellers are hand-held by the patients. If data on faith were to be collated on admission to hospital and was routinely fed through to the religious/faith centres, there might be better relationships established

between those offering chaplaincy services in the hospital setting and others who could support them from outside.

2.6 Defining Faith in Health Care Provision

At a micro-level, the inevitable restriction that is imposed by a lack of emphasis on and transparency in relation to faith within current policies and protocols, has meant that the demands and practicalities of dealing with the day's routine can sometimes limit the staff's opportunities to provide the level of emotional support that they would wish to families in need of non-medical support (Herbert et al. 2001). This can be seen to be particularly so in relation to religious and faith-based need. Of the 150 hospital patients spoken to for the purposes of this research, all indicated that their requests for religious support were responded to on an ad hoc basis dependant on staff capacity, inclination and resources.

Gerry Ireland the mortuary technician is on the phone on behalf of a patient who has died in the hospital. He is asking the Nigerian embassy to contact the next of kin in Lagos with a view to repatriating the body. The embassy appear unwilling to help. This is the fourth call from Gerry in half as many weeks. Despite the 'case' taking up more time than Gerry has allocated in his schedule, Gerry is reluctant to let it drop; 'the way I see it, the family have a right to know he's died. Now what they want to do about it is up to them, but I do think that it's my responsibility to help in that process, but it's proving very, very hard.' Outside his office waits a man from the Chevre Kadishe, the Jewish burial society. He has been outside for the 30 minute duration of the phone call, waiting to take a body from the fridge to the synagogue for preparation for burial within the 24 hour period designated by halacha (Jewish law). There is no formal arrangement between the Jewish community, the coroner's office or the hospital, but a tacit understanding and working relationship is facilitated by the men in what they describe as 'good faith'. Gerry hangs up the phone and beckons the other in, they greet one another warmly. 'Im sorry to see you so soon', says one. While they talk Gerry opens the drawer of a filing cabinet which contains different religious icons including interchangeable Protestant and Catholic crosses for use in the viewing room. He picks up a challis in which he will robe the body of a Bosnian construction worker whose chest and skull had been crushed by a concrete block the week before. Unsure of the man's religion, he pulls the Velcro'd image of Jesus off the front of the fabric. The family are due in an hour to view the body in the mortuary chapel and Father Michael, one of the chaplaincy team who administered to the family when they arrived in the country, waits to talk with Gerry to bring him up to speed on the family. He tells of the communication difficulties that Gerry will have as none of them speak English and there is no interpretation service available today. Both seasoned communicators, the men nevertheless find themselves concerned about the boundaries they may unintentionally cross when communicating across cultures and religions. 'I'm never sure how appropriate it is for me to work with people when I have no experience of their Church and when we can't speak together,' says Michael, 'But I work from the premise that it is better that I stay with them than they are alone and frightened and sad. It's frustrating though. I could run around all day long, not listening at all and just flipping from one bed to another doling out the eucharist. But I think that my role is to develop a meaningful relationship with people, staff, patients and families—I want to be able to encourage people to touch their family member, to pray. It's these things, irrespective of who you are, that help people to call on the spiritual aspect of their lives that they may not have been in touch with for a while. Many people find they need the spiritual to help them to think about getting better. It is all of these things that come naturally to me at a time like this. And then, after a person has gone, I stay with them so that their families know I am trying to support them in whatever limited way I can'. Gerry agrees, saying, 'I'm no counselor and no counselor could be expected to take on 12 hours of solid counseling. But sometimes that's what you have to do in this job and that's really hard when you're working with people who are scared because they haven't got a notion of what the system expects of them. I've had people in here with no families to support them, burying their only relatives in an alien country away from their own faith, and then it'll turn out that they have over 20 different agencies to deal with in a different language– and there's nothing really I can do to help that. It was particularly after my own father died, that I began to think about how it must be just a very, very hard place to be for people from a different religion living in Ireland'.

Evidenced in the preceding narrative, and for the purposes of this report, religion and faith within the hospital setting is deemed to occur in three distinct areas:

- the spiritual – where the healing process is understood to be facilitated and mediated by the inner ethos and the holistic resources of the believer in an holistic body-mind-soul triad

- the pastoral – where visiting, support and counseling is provided to individuals and their families, in a partnership between the biomedical and the chaplaincy teams

- the liturgical – where culturally appropriate services are developed alongside access to iconography and material culture

However, the process through which the requirements and demands of religion and faith can be organisationally facilitated and scheduled into the work plans of staff members is not so clear. With a broadening of the religious constituency, hospital administrators recognise the tensions and challenges that an increased focus on religion and religious diversity will bring to individuals and to organisations. According to Fergus O'Ferrall, Director Adelaide Hospital Society, 'The difficulty currently facing Tallaght, ten years after its move and amalgamation is how to cater for all faith-based needs within a Christian culture without diluting the ethos of the hospital as laid out in its charter and how to do this without creating a secular space'.

Given that there has not yet been any discussion about the benefits and shortfalls of a secularization of the health service in Ireland, one way in which this debate might begin to be introduced is through the recognition that the need for access to faith and religious support is not exclusively within the domain of patients and their families. But rather, with an increasingly diverse workforce, and with a growing public recognition of rights-based culture, there is a mounting need to consider the level of organisational support required to address those demands being made by staff of faith. Their concern is to have their religious needs acknowledged and accommodated both in the context of the provision of services, and also in their conscientious objection to the carrying out of particular medical procedures which challenge their personal and professional value base.

As we walk through the A&E corridor (only 40 on trolleys today), I listen to a conversation between a non-Muslim CNM and a Muslim registrar (both white and Irish born). Their discussion reveals a rumour that the contract of a recently employed colleague, a paediatric consultant, has been negotiated to enable his schedule to allow him to adhere to religious observances in relation to Eid. Both are sympathetic to their new colleagues needs and discuss it within the context of the time-tabling concessions they feel they have to make to their faith because of their working contracts and that of their colleagues. Clinicial Nurse Managers are not able to holiday over Christmas, or the week after, which means that many overseas staff (for whom family reunification in Ireland is not an option) are rarely able to spend any time with their families over that period.

The hospital in which they work is currently serviced exclusively by a Christian pastoral care team comprising an administrator and five full-time and five part-time Roman Catholic Chaplains, one full-time and one part-time Church of Ireland minister, one part-time Methodist minister and a number of Eucharistic ministers who visit wards three times each week, excluding the Psychiatric and Children's Wards. There are no chaplains from other faiths. Daily mass and weekly communions are celebrated in a beautifully designed and equipped chapel open at all times to all staff, patients and visitors. Connected to the chapel by sliding doors is a room (without the obligatory washing facilities for ritual ablutions) that has been made available to Muslims staff, students and in-patients for Friday prayers Situated at the opposite end of the hospital with a separate access, the mortuary has two contemplation rooms where Protestant and Catholic icons are inter-changeable and removable.

In Canada, a wave of health care reform and restructuring took place during the 1990s and there, as in Great Britain, there is a growing tendency for the public provision of multi-faith prayer and contemplative spaces. Like in Ireland, the health care system prides itself on providing quality health-care regardless of socio-economic status (Spitzer 2004:490). Yet the Canadian system also shares another and less reputable legacy in keeping with the Irish experience: In Ireland, those from minority faiths (alongside indigenous Travellers), have long-been marginalised within health care provision (Pierce 2003) and so too can it be demonstrated that in Canada members of First Nation communities, as well as those from visible minority communities, are seen as presenting challenges to assumption that there is an equality of provision in health care services (Anderson and Kirkham 1998). 'Canadians are among the healthiest people in the world; however this good health is not enjoyed equally by everyone' (Anisef and Kilbride, 2003). It has been argued that despite legislation enshrining multi-cultural norms (see section 3), the public-private funding structures in both the Canadian and the US healthcare systems, in effect, ultimately work to preserve and reinforce white (and de facto Christian) values and sensibilities in many public hospitals. These are considered to result in linguistic barriers, culturally inappropriate diagnoses and treatments, inflexible hours of operation and lack of access to services (Page and Thomas 1994).

The challenges and the certainties provided by religious hospitals within an overall health service provision can be unpacked to indicate particular learning from a North American experience. Within the United States, a number of Jewish and Catholic hospitals have merged successfully without diminishing their individual ethos and mission. Whether they were driven to do so by shared financial or shared clinical ethical issues is a matter for debate elsewhere. Yet it is worth noting that, the bioethical guidelines of secular hospitals can be seen to draw on what might be described as 'floating parameters' which change due to legal and professional precedents and case-law. Whereas in 'religious' hospitals and those amalgamated hospitals whose traditions are grounded in religious traditions, the norms and teachings of the respective theological bodies provide a shared and over-arching moral code. And there, the religious 'right' is often accepted as ultimate authority in place of the guidelines in state law and professional medical-ethical standards.

Community-based resistance to merging secular hospitals with the religious, or creating inter-faith hospitals, is most often framed within a discourse of reduced consumer choice in accessing life-extending medical treatments and to reproductive health care services, in particular to sterilization and prohibiting terminations. A recent case in Ireland can be found in relation to participation in clinical trials when the Mater Hospital refused to accept women for trials of a lung cancer drug if they were using artificial birth control methods, despite this being named as a pre-requisite for participation by the drug manufacturers. It is noteworthy that while the matter was well-covered in the media, there was a silence on the issue by the Irish Nurses Organisation (INO), the Irish Medical Organisation (IMO) and others with relative influence who were able to and might be expected to speak out on how the hospital's position impacted on both the practical as well as the ethical and human rights issues.

Also noticeable in the discussions about the matter was the insignificant attention paid in the debate to the disproportionate affects on women of low-incomes unable to access services. The impact of poverty on health care choices cannot be sidelined. The practice in the United States and Canada, again like Ireland, is that due purely to financial expediency, many citizens go to hospital emergency rooms as their first port of call for routine health problems and those who are most vulnerable to ill health often only chose to 'enter the health care system at end stages of disease' (Aroian 2005, Geiger 2003). Yet it is in the A&E where culturally competent service provision is often less well developed.

My most difficult moments when dealing with racist colleagues was not the times I saw them turn away from me with sidelong glances, not the lack of Halal food in the hospital, but when I watched them interacting with patients and I suppose that as a Muslim I'm particularly keyed into the dynamics between Muslims and non-Muslims. Even when there is an emergency there are certain cultural sensitivities that should be understood. That doesn't mean that who and how a patient is addressed should determine the level of service they should expect to get, but it does means that all health care practitioners should be aware of how they might impact on the patient in the context of their religious and ethnic background.

Given the punch that might potentially be packed on the health service were it to accommodate all requests for adherence to religious traditions, it is perhaps surprising that outside the literature grounded in the sociology of religion, analysis of faith in western health care has been of sporadic medical interest and received little academic attention (Cotton et al 1999, King 1994). There remain many theoretical and practical conceptual points to be debated that are only just beginning to be asked: does religion affect the choice of a physician or maintenance of the doctor-patient relationship (Koenig et al 1991), what might be learned from the particular and nuanced changes towards spirituality found in medics when, as patients they are faced with their mortality (Klitzman et al 2005). Responses to enquiries made for this study suggest that religion is perceived as unimportant in medical treatment by many health service providers, just as it is by many service users. However, there is a significant body within both groups who see religion and faith within the health care setting as critical and crucial to the emotional well-being of staff and patients alike, as well as to the structural and operational running of health-care institutions (Sloan et al 1999).

2.6.1 Adapting Kleinman

In order to better understand and avoid a clash of orientations and expectations between the domains of professional health carers and the informal healing networks in which patients are also enmeshed, Kleinman's (1988) model (developed to understand patients and carers' health beliefs in the clinical encounter) could be adapted and extended. In doing so, information can be elicited that allows for insight into the role that religion might be expected to play in the patient's 'healing realm'.

1. *What do you call your problem, what name does it have?*

2. *What do you think caused your problem?*

3. *Why do you think it started when it did?*

4. *What does your sickness do to you? How does it work?*

5. *How severe is it? Will it have a short or long course?*

6. *What do you fear most about your disorder?*

7. *What are the chief problems your illness has caused for you?*

8. *What kind of treatment do you think you should receive?*

9. *What are the most important results to achieve from this treatment?*

Supplementing the framework of questions above with specific enquiries aimed at ascertaining the need to incorporate the religious beliefs of patients could broker the biomedical and lay worlds with a view to maximizing communication and collaboration between the patients and their professional carers.

1. *Is this a common illness within your faith and community?*

2. *How has your faith helped you deal with it so far?*

3. *Have you discussed it with any religious leaders and would that be helpful?*

4. *Are there any references to this illness in any religious texts?*

5. *Can you think of any rituals, ceremonies or offerings that might help your recovery?*

6. *Are there any people outside the hospital who might aid in your recovery?*

7. *How might your spiritual well-being be supported at this time?*

3 DEFINING INTEGRATION AND RACISM

3.1 Lessons from Britain, France and North America

It is government's vision to create a common vision and sense of belonging for all society's citizens: one where the inescapable plurality of affiliation, diversity of background and circumstances of life are positively valued and where relationships are forged irrespective of ethnicity, nationality, culture and faith. This generic process and neutral descriptor are, for the purposes of this report, being used to signify the ideal of integration. It is understood that implementing such a concept militates against the hardening of lines of ethnic division (Sen 2006: xiii-xiv).

Mainstreaming integration as a normative process of social cohesion recognises that civic associations, including meflos and religious institutions from the voluntary and community sector, have a powerful role to play in partnering with the state to address areas of potential social exclusion and discrimination. However this aspiration might be considered mere rhetoric when considered alongside the significant anecdotal evidence of racism demonstrated from bedside to boardroom that was either witnessed by the researcher or reported by participants to this research. The lack of instruments or a formal process to evidence and monitor this within the health sector might in itself be considered a form of institutional racism when measured by the marker of Macpherson (1999:216) whose report into the Police's handling of the Stephen Lawrence murder defines its persistance:

'because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation'.

Political philosophies, concerned with the nature and limits of liberalism and the tolerance of difference question whether liberalism can authentically claim to be responsive to individuals and their communities of interest when the stress points which occur in respect of group rights (ie gender/faith) come to the fore. When this interface arises, it brings with it the question of whether secularity or multi-religiosity should be the ideal of the state. Within institutions responsible for health care, there is a debate to be had not just about the autonomy and requirements of individuals in a patient-centred environment, but one that engages with the ethics of the state's principles which guide the formation of organisational policy. Namely, how to consider tolerance, equality and group rights in a multi-ethnic and pluralist society.

The challenge becomes that of finding an appropriate model for furthering the needs of Irish society in the short, medium and long term. Some have suggested that , the unresolved 'quarrel' simultaneously perplexing assmiliationists and multiculturalists, appears to be whether either are able to 'manage a diverse society while maintaining a sense of common identity' (Malik 2007). Yet the question remains, are faith and culture components that policy makers should considering as core to a process of community cohesion?

If we are to take assimilation and multiculturalism as two distinct approaches, a potential third way presents in the form of interculturalism. As theory and practice, it is defined in Ireland by the National Consultative Committee on Racism and Interculturalism (2006) as the 'development of strategy, policy and practices that promotes interaction, understanding, respect and integration between different cultures and ethnic groups on the basis that cultural diversity is a strength that can enrich society, without glossing over issues such as racism' (see also Gundara 2000). Malabotta (2005:177) sees the model as being based not just on the plurality of communities, but on the presence of those communities and their constituency as individual subjects, citizens, and human beings. It is, therefore, to be seen as an archetype that enables the meeting and exchange of discourse and ideas within acknowledged shared public space rather than one which allows for discrete and bounded groups to co-exist with little or no interaction. It is the 'we' as opposed to the 'them and us'.

The theory and the approach gain much from Bhikhu Parekh (2000:56) whose influential report outlined how community cohesion derives from 'core values both between communities and within them: equality and fairness; dialogue and consultation; toleration, compromise and accommodation; recognition of a respect for diversity and… a determination to confront and eliminate racism and xenophobia', Conversely, those values which are not cohesive can be found to 'engender intercultural conflict through a lack of trust at inter-group levels' (Gundara 2002:12).

3.2 Britain, France and Canada a lack of Cultural Cohesion

For the purposes of considering how Ireland's health service might best develop its own model of integration, the table below (drawn from Mac Éinrí 2006), outlines a spectrum of approaches.

Table 2. Models of integration as developed by Mac Éinrí 2006

Ideology	Process	Exemplar Countries
Formal Multiculturalism	Multiculturalism through positive action is enshrined in legislation, policy and practice with minority rights communally defined and protected.	Canada Australia
Assumptive Multiculturalism	A degree of protection for minorities is legislated for but with limited integration policies resulting in communities' reliance on internal structures and social networks.	USA GB India
De Facto Assimilation	The State acts to remove discrimination but does not otherwise promote an integrated agenda	Most Western Countries
Assimilation	The State pro-actively encourages active compliance with national and majority mores.	France Switzerland
Exclusion	Economic drivers act as an incentive for tolerating the presence of migrant workers; little done to provide for integration. Religious minorities face persecution/discrimination.	Japan

It is appropriate here to further unpack the approaches taken by our closest European neighbours. The inter-ethnic unrest experienced by citizens in Britain and France in 2001, 2004 and 2007 articulated the feelings of marginalisation experienced by the children and grand-children of indentured labour and colonised migrants. Not just in the grand gestures of blue collar and unemployed youth in the street riots and the emergence of native-born suicide bombers (both, perhaps to some extent attributable to competition for limited social resources and capital as well as to a legacy of colonialism), but also in the media-led 'Cross and Veil' debates which emerged in discussions in white collar working environments. There, crude distinctions made between mission and proselytising, between public and private were used to both underpin and undermine the flawed and loaded, now largely discredited ideological models of assimilationism and multiculturalism.

In Britain, the influence of the enlightenment can be found in the remnants of multiculturalism which as a lived experience is enriching. Yet its political ideology, the critics argue, has helped to create a 'tribal Britain with no political or moral centre'. (Malik 2005). Legislation to support 'race relations' has been developed within a framework that has allowed for what has been described as 'boutique multiculturalism' (Mac Éinrí 2006) where despite rhetoric to the contrary, a white, Christian hegemony remains embedded in the structure of society. Following the civil disorder which occurred in Northern England in 2001, a series of papers were published and through the Cantle and Denham reports, the State announced its intention of making 'community cohesion' a stated aim of both central and local government. But this aim was never fully defined. Politics of identity were to the fore as the government's policy formation cart was placed before civic society's discursive horse and questions still remain unanswered as to the relationship between cohesion, equality and faith (Gundara 2002:9). It might be suggested that the Anglo Saxon model does not take seriously its relationship with the EU or the Council of Europe.

The scramble for local level political influence acts to the detriment of common interests, suggests O'Cinneade (2004) and 'could set Sikh against Muslim and Hindu' to the detriment of common interests'.

France's secular approach is historically based on the premise that it is the individual and not the community that must be integrated. The position can be seen beginning to emerge in French consciousness in a debate on Religious Minorities and Questionable Professions (namely acting and executioning!) in 1879, when the Count of Clermont-Tonnerre spoke on the eligibility of Jews for citizenship spelling out the terms on which they might be included in the new political dispensation. 'The Jews', he said, 'should be denied everything as a nation, but granted everything as individuals… It is intolerable that the Jews should become a separate political formation or class within the country. Every one of them must individually become a citizen; if they do not want this, they must inform us and we shall then be compelled to expel them' (cited in Bertossi (2002). For some this represents the formation of civic Republicanism at its finest, for others it represents the birthing of der Judenfrage, the 'Jewish question', which arguably gave rise in 1941 to the Endlosung, the Final Solution.

And as a result of the research carried out by Nazi doctors, the standards of medical ethics were radically reconsidered.

The secular approach taken in France opens up for debate the question, how can a universalist doctrine in France address racism and exclusion, and monitor discrimination, when it does not officially recognise ethnic differences? Clearly the response by the authorities has been sought in the creation of the North African sink estates. There, residents' restricted and dispproportionate representation in French civic life more broadly, has left the concept and value of liberté, egalité and fraternité for all, as aspirational, rather than a reality.

French politics of citizenship then simply ignores probable ethnic, regional or religious minorities. Only individuals are citizens, citizens are equal, therefore all individuals are equal citizens'. (Bertossi (2002:72). Such assimilation, when viewed through a conformist lens, implies that the rules and standards already set in a particular geography are the ideal to be emulated by new citizens. Its adherents argue that contrary to a simplistic interpretation, the process does not de facto outline a process of structural hegemony arguing that when seen in a transformational sense, assimilation permits the altering of community norms with neutral rules and obligations (Young 1990:165).

Further afield, in New Zealand, Canada and Australia, attempts at bi-cultural integration have been able to focus to different degrees on the protection of the rights of the indigenous populations in education and language through case-law and policy. Trudeau's social engineering through Canada's Multi-Culturalism Act (1971) had the intention of ensuring the successful co-existence 'of communities whose members share a common origin and their historic contribution to Canadian society' promising to 'promote the understanding and creativity that arise from the interaction between individuals and communities of different origins'. Those with a more cynical view look less favourably at the societal mosaic-making, with Bissoondath writing of the

'fetishisation' of identity encounters as 'folkloric Disneyland' where patrimonial identities and cultural practices are preserved and essentialised, irrespective of whether or not they are compatible with wider society.

For exponents of multiculturalism, Canadian thinkers (Kymlicka (1995) and Taylor (1994), draw on the learning from Quebec's political participation, official language acquisition and inter-marriage rates in a contested space to argue for the acknowledgement of minorities' rights as collectives. Yet those advocating for the 'politics of recognition' by means of a multicultural society have been criticised for inadequately addressing the gap in relationships between groups. This disjuncture remains unable to account for the predisposition to fix and reify cultures. The tendency to reinvent traditions to justify and bind imagined communities (as outlined by Anderson 1993), clearly provides intra-community challenges, and this can be found to occur from within an inter-generational and gendered context. The ascriptive nature of some communities (through birth as opposed to affinity) can counter certain democratic norms and it is the perpetatuion of inequality when bolstered by doctrinal argument that is of relevance in this instance.

Chryssochoou has argued that assimiliationism and multiculturalism are two sides of the same similarity/difference coin. They both assume bounded, majority/minority cultures with the former demanding the subsuming of one into the other and the latter forcing a separatist agenda (Council of Europe 2004:55). The problematics of the theories in practice and their lack of significant social synthesis can be seen most clearly in light of the tragic events in Britain in 2001 and in France. Consequently, there needs to be a distinction made in Ireland between diversity as lived experience and diversity as political process and ideology. The political failure of assimiliation is that it acts as a sanitising agent and that of multiculturalism is that it hermetically seals, essentialises and reifies individuals into bounded group identities. Whereas the lived experience can be seen to provide opportunities through social milieus (including health) for a level of inter-connectedness and inter-faith dialogue.

Adopting an intercultural model for Ireland might be seen in part as a fusion of some of the desirable elements of both concepts of assimilation and multiculturalism now no longer perceived as primary tools to integration. The questions posed within the British context by Malik (2005) are applicable in Ireland in relation to how central the state is to the process of integration and to what extent should it proactively be developing partnerships with migrant community led organisations to develop policy.

Mac Éinrí (2006) suggests that one route to mainstreaming interculturalism, might be through the framework of the Common Basic Principles (CBPs), adopted 19 November 2004 at an EU Council of Ministers when chaired by the Dutch Presidency (Council of European Union 2004) (See Appendix B). It is through the CBPs that the principle of integration as a two way process is affirmed both by supporting migrants to engage with the history and culture of host culture and by affirming diversity in identity in service provision. These are understood to be progressed within the context of a set of core values aimed at tempering and underlining any process of interaction between citizens and between the State and civil society. The EU Commission proposals for the adoption of the CPBs references and builds on the Handbook for Integration (produced in 2004) which references the work of NCCRI. It is anticipated that a specific section within the second edition of this will focus on health and social services.

Might it then be appropriate to revisit the narrow French expression of civic republicanism referred to earlier? Refocusing on it in the light of the CBPs as a non-denominational concept of common good can see it aim to give full citizenship in practice to all Ireland's various identities, cultures and faith. And when this is carried out in that most public of arenas, namely healthcare, civic republicanism can be found as an ethos of liberty and freedom as articulated in the work of Irish political theorist and philosopher Philip Pettit.

3.2 Voluntary/Community Sector

Some non-Christian religious and faith-based organisations are often subsumed under a general rubric of race and ethnicity in the third sector and under these circumstances there may be limited understanding of the value placed by some on their religious identity. This is a cause for regret since the 2001 British Home Office Citizenship Survey found that for Muslims, Jews, Sikhs, Hindus and Buddhists (but not, interestingly for Christians), religion was a more important marker of identity than ethnicity and nationality (O'Beirne 2004:20). The issue of religious identity is often 'lost' in the arguments of sectoral politics which dominates discussions of diversity and that are frequently translated into exploration of secular concerns based on ethnicity and national identity.

If the diversity of Irish society is to be actively considered and involved in developing the direction of public services, it should be recognised that the voluntary and community sector has a particularly valuable role to play (O'Ferrall 2000). The Task Force on Active Citizenship (and its working papers) might be drawn on to broker the gap between the policy rhetoric and statutory service providers' practice in this area. This is particularly pertinent when considering the role that faith-based organisations play in providing a strong volunteering focus for existing and emerging communities (O'Mahony and Prunty 2007), and this in turn is relevant when considering the centrality of religion to a sense of community and acknowledging the role of community and sense of connectedness in health recovery and support processes.

Given the nature of religious organisations, faith-based community and voluntary groups are often best-placed to provide additional human and practical resources and services to those in need of support due to health issues. However many of these are working under capacity and are under resourced. In exploring the role of I/MELOs (immigrant and minority ethnic-led organisations) in civil society, Feldman et al (2005:67) comment on the need to build up structures and resources to support common struggles to address social exclusion and social cohesion.

In a small, dusty hall attached to a Church of Ireland parish, two Brigidene nuns are preparing the room for the drop in session to begin. Children's toys are laid out, (black and white dolls and story books). Coffee cups and scones are ready. Today the women are going to be continuing work on a quilting project – where the stories of their respective homelands and their journeys are stitched and woven together. The programme was set up specifically to befriend new migrants and in particular those who are asylum seekers into this area. Its reach has been wide. 'We found increasingly that we have had to change our way of working and consider if what we set out to offer people is appropriate. One of the things that we are increasingly being asked to do is to accompany women to their doctors and to hospital to help them with their needs and that would certainly include things related to their religious background. I see this work increasing in particular in relation to those who are at risk of social isolation who don't have the usual support networks like family to call on. Some people might think it is ironic that it is a project that was initiated within a Christian context, but that is our mission, and there are no similar projects run by other religions to the best of my knowledge, certainly not in this area, that have the resources to do what we do.'

The Interim Statement of the British Commission on Integration and Social Cohesion (2007) (paragraph 56), identifies that 'Faith Communities… have a key role to play in providing locally delivered, responsive, flexible services that respond to local need'. For the purposes of this report, it is recognised that a key strength of the faith sector is its centrality to much of its constituents' lifestyles and consequently its ability to act as a broker between the statutory service and service users and their families and carers. However, while the statutory sector might indicate an increasing intention to partner with that sector, both 'community' and 'voluntary' can prove to be weasel words. There are resourcing and capacity issues in relation to how and who within the sector are in a position to partner most appropriately. Although there are an increasing number of thriving voluntary and community organizations within the religious and faith sector it might be argued that some are unable to provide the degree of support their members/congregants may require due to insecure funding (Atkin and Rollings 1993). Furthermore, there is also an urgent debate to be had in relation to the representativeness of some faith-based community groups as a key and recurring issue of concern is with their constitutional position in relation to local and international equality standards.

'I can only draw on my experiences as an Algerian woman who grew up in France. I cannot speak for the experiences of women who are Muslim in Ireland, just as I would not expect any man to speak about how I feel in certain situations. I do not think I should discuss or be expected to comment on matters about female circumcision just because I am a Muslim woman active in the community. It is not part of my cultural background. What I do know is that the spirit of community is recognised in the Koran. When, for example the Koran says women are weakened by birth and need to stay at home for 40 days. The practice is about recognising the stresses born by a new mother and how the community can alleviate and support her by helping her with the ordinary tasks of life. But that is my interpretation of one aspect, I cannot speak for others.'

3.3 Faith-Based health services

Father Michael's shift this evening was not atypical. It began with reference to a list identifying those patients who on admission requested a visit from the chaplaincy team and those who will be operated on the next morning. The chaplains are the sole recipients of this material which contains the faith of in-patients. We wander through the wards, most people, staff, patients and visitors, irrespective of their ethnicity or faith greet the Priest warmly and appear to be genuinely pleased when he stops to chat. We begin a visit to a woman, recently admitted, whose husband's funeral the Priest had officiated at some months previously. She takes his hand in hers and talks about the funeral arrangements they had made, 'You sustained me in saying "take your time", Father. Our arrangements must have changed 50 times those first days – I'm glad we didn't rush things.' On our way through the ward Michael pauses at the bed of an elderly Chinese woman who is moaning loudly. There are no cards by her bed, no personal effects in the room that might offer a connection to an outside world or an indication of her faith. She is unable to acknowledge our presence as the Priest puts the palm of both hands on her forehead. Tenderly he pushes her hair behind her ear and whispers, 'You're safe here now, don't be afraid to sleep and I'll say a prayer for you, so.' As we walk down the corridor he smiles as he is approached by a Hindu patient, identifiable by his tilaka, and hands over a new toothbrush retrieved from his jacket pocket. The man nods and smiles back. Neither men attempt to converse any further with one another. 'He doesn't speak English,' Michael tells me 'But when I was on yesterday he let me know he needed a toothbrush'. He smiles, 'There's not a lot else I can do for him!' I ask who will look after his spiritual needs and the Priest makes an apologetic shrug and raises his eyebrows. 'It just depends on whether he's got anyone to tell that he's coming in here and if we can contact someone on his behalf'. He pauses and laughs 'I think you'll find its usually the Methodist who has the responsibility for the other faiths in a hospital chaplaincy'. 'What do you do to provide support for staff who want closure on the death of a patient?' I ask. 'That's a very important part of Chaplaincy work'. he acknowledges, 'We always have a good turn out from staff at the services.' I ask, 'What about those who practice other faiths?' Again he shrugs and raises his eyebrows 'I do what I can, I wish I could do more, sometimes all I can do is offer a greeting and the hope that 'your faith will make you well'.

Muslims have the poorest health profile in Britain; there is no comparable data available for Ireland. That there are a small number of faith-centred initiatives to improve health outcomes there reflects a failure by clinicians, policy makers and academics to appreciate the centrality of faith to Muslim identity suggests Sheikh (2007). However it can be argued, following, Esmail (2007:334) that such service provision enhances stigmatism and stereotyping and that by pointing to the homogeneity in religious identity we are not in a position to translate faith-based needs into what is actually required from a competent faith-centred service.

Important moral, political and legal arguments underscore how the equitable delivery of public services is achieved. Through the monitoring of religious identity in healthcare settings, there is an opportunity to challenge the inequalities of service provision from an informed evidence base while benchmarking and evaluating the effectiveness of service delivery. It has been argued elsewhere (Aroian 2005, Anderson 1995, Lurie 2002), that cultural beliefs represent preferences and, therefore, developing services that accommodate them may not be appropriate indicators of equality in health care delivery. With a willingness to universally meet all demands for services based on a religious identity, there are two risks:

- that of essentialising identities
- that of attempting to justify the provision of practices which may be morally and ethically unacceptable and which result in decisions being made for or about patients based on fixed ethnic assumptions

3.3.1 Essentialising Identities

Without self-ascription, efforts to monitor and collect data for the purposes of developing best practice in relation to minority ethnicity relies on essentialising particular groups.

In relation to patient support, information about faith as well as ethnicity is beneficial when attempting to acknowledge the predisposition to and understanding of the coping mechanisms employed by some in relation to specific bio/psycho/social medical conditions (See Gill et al 2006).

But essentialising groups, reifying cultures and stereotyping, necessitates making assumptions about individuals and on basing expectations on crudely determined and fixed ethnic traits. This can have negative effects on patient-staff relationships and plays some part in providing inaccurate diagnosis.

Religious identity is not homogeneous – all faiths are sub-divided into sects that place a different emphasis on particular tenets of their religion. All sects comprise individuals with multiple identities informed by a variety of components including gender, age social class and ethnicity. To expect service users to comply with an assertion of a singular identity, based on religion and ethnicity, is to undermine the complexity of both categories, and their concomitant value systems. One contributor to this research, a Christian Palestinian woman, defined this process as 'treatment by assumption' in relation to suppositions and suggestions made about her requirements.

> 'It would be a good thing if they would just get round to asking. I do get so tired of people assuming that I'm Muslim when I tell them that I'm Palestinian'.

3.3.2 Unethical Discrimination?

During the latter part of the 20th Century, theologians, hospital chaplains and church leaders were considered in a unique position to contribute meaningfully to health care provision as pioneers of medical ethics. But in an increasingly litigious society, contemporary medical ethicists are less likely to be philosophers than drawn from the corpus of academic lawyers who bring what is perceived to be more clarity to the discipline through a neutral, secular lens. A judicial system then becomes the final arbiter in cases which require moral judgements not jurisprudence alone.

There is no agreed understanding of secularisation in biomedical ethics. Gill (2006) argues that for some, the marginalisation of religion in today's health care can be traced back to the seminal Principles of Biomedical Ethics (Childress and Beauchamp 2001) which offers no meta-ethical justification in its four principles for health care (autonomy, justice, non-maleficence and beneficence) and which some suggest privileges secular moral reasoning. Others, Gill suggests, see the work as a triumph of melding sacred and secular perspectives and what can be argued as an implicit inter-culturalism in the collaboration between authors, neither of whom cede to the other's stance providing a complementary inherent Christianity and a 'principled utilitarianism'. The principle theoretical novelty of the text is its focus on what it describes as a 'common morality' (Childress and Beauchamp 2001:3), loosely defined as 'the set of norms that all morally serious persons share' and which is explicity linked to a human rights discourse.

At one level, a rights-based approach supplements what appears to be increasing international moves towards affirmative action measures. Such processes recognise that inequality requires engagement beyond merely avoiding discrimination. This is perhaps best exemplified in the wider concept of 'reasonable adjustment' used in international disability discrimination legislation. The European Court of Human Rights has found that measures aimed at treating everyone equally, without taking into account the needs of particular groups, amounts to unlawful discrimination. In 2000, European Court of Human Rights found in Thlimmenos v. Greece that the prohibition of discrimination is violated when States fail to treat differently those whose situations are significantly different without an objective and reasonable justification. The case relates to a Jehovah's Witness imprisoned for being a conscientious objector and whose imprisonment resulted in his being refused admittance to the Greek Institute of Chartered Accountants. The decision was based on discrimination that occurred because of the failure to recognise that the applicant's conviction was a result of his religious beliefs.

However, ethical and moral pronouncements in the name of rights remain a matter of subjective interpretation. Refusal of treatment due to religious conviction (autonomy) has led to the advancement of science through the development of new medical procedures (beneficence). And this in turn brings the avoidance of risks related to, for example transfusion (non-maleficence). However a conflict with religious belief might occur when an unfair or excessive allocation of resources (justice) is requested or when treatment demands are made where the outcome of intervention is known to be futile, for example in the case of some life-sustaining support systems. It is, at this time, suggests Brett (2003), that clinicians are obliged to work with clergy and chaplaincy where appropriate, to reach consensus on treatment.

3.3.3 Children—religious liberty and freedom of choice

In relation to decision making on behalf of children and young people, the law has traditionally set its benchmark with the intextricable links that form the weft in the weave of individuals' right to practice both their own religion and to raise their children within a specific moral and value base. However, the ascriptive nature of religious identity, interprets this entwining as problematic by those who, for example, see the decision to circumcise infants as stemming from unreasonable doctrine. Substantive legal arguments calling on international instruments including the UN International Covenant on Civil and Political Rights, Universal Declaration of Human Rights and the UN Convention on the Rights of the Child have been used in relation to the violation of rights and freedoms in respect of autonomy, expression, thought, determination, dignity, identity and discrimination. But the water remains muddied in a variety of procedures where autonomy and the assigning of rights to children are central.

Medical philosopher Adrian Viens (2004) suggests that in relation to infant circumcision, the argument that the procedure is morally impermissible is in 'the wrong justificatory class… advocating a substantive moral position, instead of using public reason' to arrive at a fair and justifiable policy. This line of reasoning is followed by the American Academy of Paediatrics, the British Medical Association, the Canadian Paediatrics Society, the Royal Australian College of Physicians, all of whom subscribe to the validity of the practice yet chose not to subscribe unreservedly to its appropriateness through a policy of universal recommendation, with their decisions being made principally on the medical value of the process.

Viens asserts that fair and sustainable public policy must be secured using politically and societally shared 'liberal' values that allow parents to make decisions concerning what procedures are in their child's interest not because parental autonomy is the principal value that should be upheld but rather because it represents, as Ainslie (2002:14) maintains, 'the terms for our living together in a society despite our different moral commitments ... the only way to allow each of us to subscribe to our own moral doctrines and yet still live together'.

3.4 The body as a site of integration

How then do these aspirational conditions play out when reality changes and the lived experience is one where patients, parents or children have little agency due to the disempowerment that comes with hospitalization? There the gaze of medics objectifies and dehumanizes and there hierarchical power structures mitigate against patients influencing decisions about their well-being and treatment despite rhetoric to the contrary. In these circumstances, the body, it might be suggested, becomes the last bastion of cultural resistance to assimilation.

It is through guarding the boundaries of the body, its entrances and exits, by its handling at times of death or during the menstrual cycle, through circumcision and other rituals inscribed into it and in the prohibition of particular foods as well as the prayers and rituals centered around washing and excretion, that religions guard their membership against the threat of assimilation and in the process maintain their internal structures of power. Littlewood (1997:171) (citing Turner (1984)) suggests that the body represents 'a series of homologies between the self and the external world'. Subscribing to religious prescriptions is no easy task for those already facing emasculation by virtue of their patient status within the medical system. Many are reluctant to challenge or question the voice of authority. Not only because of their subordinate ranking in the micro-social dynamics of the patient/doctor/carer triad (where the patient's body is the axis), but also exacerbated, on occasion, by circumstances such as their immigration status, their economic status and cultural and gendered expectations of their norms. Having been assigned and assumed an objectified position, the patient becomes less able to play an active part in their own healing process, an expectation that may be an essential component within their traditions, practices or belief system.

As both a cultural construct as well as the site of competing medical knowledge and hypothesis, the body has long been the subject of anthropological investigations (Scheper-Hughes and Lock 1987, Turner 1984, Lock 1993, Littlewood 1997). All patients, irrespective of their ethnicity, faith or immigration status temporarily relinquish the social expectations of personal responsibility for their bodies becoming ambiguous, compliant figures in the medical treatment. Those unwilling to follow the advice of medics are seen to be 'non-compliant', and 'non co-operative'.

4 SPECIFIC THEMATIC AREAS

Social exclusion is understood to be found in the structures and processes of inequality that mitigate against peoples' ability to engage fully with services. There are specific areas in health care delivery where social exclusion prevails and some of these can be directly found as a response to or in relation to individuals' religion and faith.

Along with the provision of Halal meats and Kosher diets, the timetabling of appointments and operations so that they do not clash with religious holidays and the demand for single-gender facilities, dress codes remain at the fore of the agenda when competency is being discussed in relation to the provision of culturally appropriate services. A number of these issues will be addressed in this section.

Furthermore, if social inclusion is understood to be the reduction of inequalities between the least advantaged groups and the rest of society, there are specific relationships and responses which go some ways in addressing the perception and experiences of segregation that arise due to religion and faith within health care provisions. It has already been suggested that it is crucial to consider the potential and actual dynamics for change in these liaisons and affiliations and they will be considered further below. Short vignettes and case study examples are used to introduce or to illustrate the key issues under discussion in each sub-section and to personalise any consideration of the topic.

In the first instance, this chapter will give consideration to the challenges facing institutional chaplaincies who acknowledge their responsibility to address the needs of those seeking spiritual support within an inter and multi-faith context.

4.1 Multi-Faith Chaplaincy

Transparency in relation to long term strategic planning about the role of chaplaincy in hospitals and hospice, and explicit guidance in relation to the use of shared and multi-faith worship spaces is currently scant within the health service and further clarity would be beneficial. Practitioners and patients alike are unclear as to the Health Service's commitment to how religious beliefs are to continue being accommodated and supported within public and shared spaces at a time when the equality and rights agenda is higher in the public consciousness than previously. Irrespective of the outcome of such public deliberations, further consultation on this matter might go some ways towards strengthening links with different communities and, in doing so, could explore mechanisms by which to reduce the load on in-house pastoral care which chaplains currently report to be taxing. This could also serve the purpose of identifying the extent of the lack of fit between what organisations and authorities consider to be ecumenical space and what is the perception of those seeking spaces for contemplation that are not dominated by a Christian ethos or where icons are prevalent.

Father Michael is concerned – there is only a very little time left to address his item under 'any other business' at the hospital's weekly chaplaincy meeting. They are running late today and proceedings are being rushed to ensure that the room is vacated in time for Muslims wishing to attend Friday prayers. All the more poignant given that Father Michael's point is to raise an issue in relation to grief support he has wants to avail of for a non-Christian patient whose wife has died since he was admitted to hospital. The room in which the meeting is being held is joined by a sliding door to the chapel and it serves as an overflow space for the chapel's larger Christian services at Easter, Christmas and on particular Saint's Days, such as St Luke's. As a partitioned room, its priority use is as a space for meetings by chaplains and other hospital staff from Saturday through Thursday, but on Fridays at lunchtime it is hospital policy to leave it open for the rest of the day to medics, students and in-patients for the purposes of prayer and contemplation. The room is without washing facilities and only has a window recess where prayer mats and copies of the Koran are stored. Technically it shouldn't be accessed by families and visitors and, despite requests, it remains unavailable to patients attending out-patient clinics or A&E. It is not a dedicated space for Muslims. The hospital has designated it a space for prayer and contemplation that is to remain free from any one faith's religious iconography. However there has been no demand for use of the space by Jews, Hindus or Sikhs and the hospital has yet to admit any Bahá'ís.

The current chaplaincy practice is to consider it the domain of the Methodist to minister to 'other' faiths. However, that part-time post is stretched and Father Michael's query begins a defensive and speedy debate about how to deliver a multi-faith chaplaincy service within the current structures. 'The difficulty for all of us is getting round everyone. We all recognise that

people of course need to be prioritised in an emergency, and that can be open to accusations of detracting from the quality of service we are able to provide to those who require other levels of pastoral support'.

The conversation opens up with the fact that other neighbouring hospitals have appointed 'cultural' officers to support departments in this area of work because religion and pastoral support are seen to span a variety of departments. With his eye on the clock, Michael tries to steer the conversation back to his point about how best to access a culturally appropriate grief and loss support system for non-Christians where there are no dedicated chaplains. Michael introduces the possibility of this being provided by cultural mediators. However the concept is unfamiliar to the other chaplains and is quickly parked by a consensus that such an exploration would require more time to discuss than the meeting permits. It is not tabled for the next meeting and the chair calls the meeting to a close with an ecumenical prayer and the suggestion that 'Time is at a premium in health care, therefore it is not easy to respond appropriately to all circumstances'.

4.2 Pastoral Support

It is uncontested that hospital chaplaincy units in Ireland show a bias towards Christianity. However, the pressures on how pastoral services are developed, as well as currently delivered, might also be recognised as being dependant on the clinical facilities and expertise available as much as they are on the jurisdiction and constituency served by particular hospitals. For example, demands and services change as patients move from assisted living to long-term care facilities, from medical units to intensive care or from curative to palliative care. Chaplaincy teams who may have ministered for some time to the long-term ill may not be available to them at the final and end of life stages. While this clearly has implications to those from all faiths, it may be particularly pertinent to those whose religious beliefs are not currently catered for within some settings and have to be accessed from and supported by spiritual guides working in the community or from within other hospitals.

Faith and ethnicity, as well as economic status, family membership and gender, may all play a part in disadvantage and multiple forms of discrimination. When these forms of social exclusion are coupled with sudden or chronic ill health or with restricted mobility, individuals can find themselves with cumulative obstacles to overcome that may in turn impact on their life course circumstances and expectations. And at these times of increased stress and vulnerability, it is not unusual to find people articulating an increased need to draw on their faith to provide a spiritual component to support a variety of other healing mechanisms.

How belief systems can be found to intersect with choices made in health care provision might provide an alternative narrative to the macro-level debates and discourses surrounding multi-cultural and integrationist practices. By looking at the micro-level at how individuals require or attempt to provide pastoral support to one another when at their most vulnerable, it is possible to demonstrate active organisational inter-culturalism by means of spiritual connectedness.

On Ruttle, (a general medical and neurological ward), the Sanctuary is a well-appointed light filled room with comfortable chairs where the nurses retreat for tea breaks. It was, however, specifically named to signpost its availability for families and carers who need space for reflection and sensitive decision-making. Osman, a cultural mediator, is alone in the room waiting for the Doctor to reappear after examining Javeed. They are both Pakistani Muslims. Javeed has been working in Ireland for over a year now sending money to his wives and children who currently live in Northern India. Javeed has been diagnosed with Hepatitis C, he requires dialysis and is in need of a liver transplant. Having poor English and now unable to work, he was signposted to Osman from a migrants' support centre. Osman has, with limited success, spent the past week liaising with the hospital's social work team, the Islamic Cultural Centre and mosque in South Dublin to try and piece together a network of support for Javeed that will fulfill his articulated need for practical, emotional and spiritual support both in hospital and in the community. There appears to be fear of duplication as well as eligibility of services. Javeed has been living in temporary shared accommodation in Longford when he was placed in a hostel after his last release from hospital. His relationships there are strained, having opened a hospital letter by mistake addressed to another migrant worker. Javeed had denied and then concealed his illness for sometime, both concerned about his precarious work situation, and immigration and health status, but also because he considered his illness to be 'unclean'. Consequently Osman is as concerned about Javeed's mental well

being as much as his practical needs. 'In times gone by', he says 'a person was never alone in hospital, there was always someone by their side – pastoral care does not necessarily have to be religious, a good carer should be able to minister to any patient's needs regardless of their religious convictions. A hospital should make it a priority to source pastoral workers who can be flexible and approachable but who understand the value of religion to people'.

There is some debate as to who is best placed to enquire of and deliver pastoral care (Handzo 2004, 2006). There is currently very limited attention in the syllabus for the training and induction of medical, nursing and associated professions on the inter-cultural and religious needs of patients and staff. Clearly there is a great potential for nursing, social work and related disciplines to bridge lay and medical worlds. While this is perhaps most evident and most often requested as a reaction to the rituals and norms of behaviour most evident at end of life care, the provision of pastoral support is a daily necessity required to promote integration into health care team working. Health practitioners are sometimes expected to understand the need for a holistic spiritual evaluation which marries the medical and psycho-social dimensions of patients lives with their spiritual and emotional experiences and expectations. However the success of any such appraisal must recognise and incorporate the patient's understanding of the need for authority and guidance in relation to belief, meaning, ritual and practice. An understanding attuned to this need might enable carers to have a better understanding of ritualistic performances that might reasonably be demanded of both chaplaincy and of those from teams with whom they are working in partnership.

Yet the micro-understanding of particular faiths that this requires is a discipline within itself. In a working environment where the pressure of time is paramount and one where there is limited understanding of religions which are not Christian in foundation, it is unclear who is best placed to carry out such an assessment. Further investigation into how the voluntary and community sector might support this work and develop the understanding of cultural mediators would be worthwhile. There is the potential here to establish protocols in partnership that would enable proactive integration by a method of pastoral and spiritual assessment within health-care systems that might go some ways towards stopping current gaps for patients.

4.3 Cultural Competency Procedures and Protocols in Pastoral Care, Birth and Death

In addition to pastoral support work, the role to be played by the voluntary sector and MEFLOs in defining the way in which cultural competencies are mainstreamed into health care delivery is currently under utilised. As agents of understanding of the ways in which faith shapes and constrains individuals' propriety, modesty and autonomy, meflos are able to point to the myriad ways in which the relationship between practitioners and those from non-Christian faiths are currently challenged. This include:

- touch practices
- proxemics
- the use of physical space
- violations of modesty
- privacy
- cultural reactions to pain (both psychological and physical)
- understanding the religious significance of food, daily prayer rituals and ablutions

But it is at the key life stage periods of birth and death, as well as in the provision of appropriate palliative care, when cultural competencies and expectations are often most explicitly challenged and where a brokering role between communities and medics might help develop relationships based on trust and mutual respect.

When they knew they were having their first son, Amir and his wife Selma were clear that they both wanted to be present at the birth and for Amir to whisper the name of Allah into the child's ear. The community midwife was supportive of their wishes. However when Selma went into labour six weeks early, Amir was out of the country on business and the midwife was on leave. Contrary to the family's expectations, Selma was taken to hospital and an emergency Caeserian was performed by a male doctor with other male medics in attendance. When Selma recounts the story, she describes her distress within the context of shame and modesty. She feels that it would have been preferable to have had someone there to advocate for her wishes even though her case was considered to be an emergency situation. Speaking through a translator she describes how her expectations of the process were 'shattered' with the experience dominated by the clinical and she uses words such as 'abandonded', 'ashamed' and 'alone' to express her distress at the time.

Given the public context in which the intimacies of birth and death occur in hospitals, namely in proximity to others also facing mortality and in the presence of strangers, there is often a need for staff to deritualise and rationalise birth and death as rapidly as possible. Therefore, at the point of both birth and death, there is more often than not the minimal ecclesiastical gestures, an absence of any formalised rituals and an active discouragement of those wishing to animate any celebration or grief and mourning process. Cathartic crying, weeping, prayers or ritual songs are discouraged.

With the clinical rather than psycho-social needs dominating at such times, Euro- and andro-centric presumptions sometimes arise when staff and family members clash over how a patient's body might best be respected in life and in death. Considerations into how someone is dressed and decorated, touched or viewed, how they are washed, cut or inscribed to achieve a state of purification and what they require by means of nourishment, take on an even greater significance for carers and patients alike at the time of death. And it is also signficiant as to how the course of mourning should take place with expectations of ceremony, ritual and tradition in relation to the handling of bodies after death.[3]

Lohmann (2005) defines death specifically in social terms contextualised by cultural models of reality and social interaction. For some, he suggests, it is precisely at the points of birth and death that identity is conferred and confirmed by the specificity of spiritual rituals. The implementation of this process is frequently dependent on webs of kinship and community as much as being rooted in the cultural practices of the medical or death attendants.

Death remains a taboo subject for both carers and patients alike. Consequently, it is helpful for staff to have easy and immediate access to a written summary of what the preferred procedures should be when someone dies with easily accessible contact details for cultural mediators and spiritual leaders. This information needs to be regularly updated and the procedures to follow, integrated into staff induction as a matter of course. Furthermore, there is a need to customize information for neighbourhood level. However, providing a culturally competent pastoral care service for those from non-Christian faiths is not about handbooks, tickboxes and accessing all available information about a particular religion. Background information may provide a general awareness of some of the rituals and traditions that might be expected to occur for some patients, however, quantifying and measuring this knowledge is no benchmark of appropriate care. Cultural competency is, however, a measure of the ability to function effectively in the context of diversity. This is only achievable by a combination of awareness, motivation, knowledge and skill base and the implementation of adequate protocols and procedures—all indispensable factors to ensuring the pastoral needs of individuals are catered for inside and outside of regular business hours.

'I'll never forget the first words that I heard when I got to the hospital after she died. We went in the back entrance and were greeted by a man in a suit who said "Hello, my name is Brian, I'm the mortuary technician and I'm here to take care of Soha. Would you like to tell me how I can do that best?" I can't describe to you how comforting that felt. He was such an ambassador for the hospital and a comfort to us because it came across as that the hospital system really respected and cared for her'.

A group of practitioners who have at some stage in their career had responsibility for caring for those who are recently bereaved, have come together with former patients and carers to discuss the challenges they face when dealing with cultural and religious traditions and expectations. At the start, their conversation is dominated by some individuals wanting to

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[3] Metcalf and Huntington's (1979) consideration of North American approaches to death discusses the series of illusions created through the embalming process and the roles of professional death attendants to negate the finality of death.

demonstrate their knowledge ('don't cut Sikh hair' 'Jews make sure the feet are pointing to the East and that someone stays with the body until it's buried' 'There's a special ring that Bahá'ís wear'). But after a while more meaningful and personal challenges begin to be explored. One social worker is still concerned about an incident that happened early in his career some 10 years previously. With no clear protocols and procedures in place to draw on at the time, he remains unclear as to whether his actions at the time were appropriate. He tells his experience to the group of how he attempted to facilitate a Buddhist family who had flown from Vietnam to wash and prepare the body of a family member who had died of an AIDs related illness: 'I would be frightened to accommodate someone in this way again. There was a clear conflict of interest between staff needing to think of infection control procedures and a family, highly charged emotionally, needing and expecting to carry out death rituals in situ. In the end, no-one was happy with the way the situation deteriorated'. It transpired that the family had brought oils and wraps expecting to spend some time washing and preparing the body in ICU in preparation for a same-day cremation and unbeknownst to staff they began this process when left alone with the body. However, the ICU staff was keen to place the body in a sealed bag for immediate transport to the mortuary. As the family became 'agitated' and insistent on ministering to the body where it lay, the social worker mediated between family and staff and arranged to have the family members wishes adhered to. They were gowned, but their activities took longer than the social worker expected it to: 'Over the space of a half an hour the body began to release significant quantities of fluid because of the high doses of steroids she had been treated with. That should really have been what forced us to stop them. But in fact it was because ICU staff were also having to shield the distressed relatives of other patients from the noise and activity and it was these relatives' comments that prompted me to call a halt and their relative was placed in a body bag and taken away to what we considered the more appropriate location, that is the Mortuary'.

In addition to caring for families and patients, there is an imperative on employers to look after all staff requiring leave and pastoral support in relation to loss. Many people in this situation are principally comforted by extended faith and family groups. However there is often also a desire by colleagues from diverse backgrounds to seek out appropriate ways to support one another. Employers might consider workplace protocols for the provision of aid in particular for those who are distanced from other forms of mutual support.

An Irish-born, Catholic housekeeper begins to recount the story of a funeral she attended for the son of a Muslim porter. "I went to a mosque once - my head was totally melted by the experience, it was away with it all – none of us knew what to do to show him we were in sympathy, nobody here knew. So in the end we decided just to do what we'd have done for one of our own. The hospital gave us a couple of hours off and three of us took a bunch of flowers to the mosque and sat with his wife but we hadn't met her before. None of us knew what was going on, the men took over and the mother didn't appear to be a part of what was going on at all. It made no sense to any of us, so we came away with the flowers still in the car. I don't even know if he knew we came – he never came back to work after that. I think they went back to Pakistan'.

With an acknowledgement of the pastoral support that colleagues can provide to one another also comes an explicit need for hospitals, hospices and other facilities to make clear their obligations and responsibilities in relation to 'caring for the carers'. There is a requirement to address the needs of those nursing, chaplaincy and mortuary staff who persistently face death (both peaceful and traumatic) and whose role it is to provide levels of support to those confronting their own mortality or that of others.

'It's part of the job of course, but it can be a very hard part of this job to support one person after another after another. Some days you know that it's just going to be like that and you have to respect that every person in every family responds differently to death. It can be difficult if you're trying to connect with someone and then you have to bear in mind that their expectations at a time like this might be different because of their culture. It's easy for me to signpost on families who have been bereaved through cancer, but there are very limited support services for those who have been bereaved through suicide and it can be especially hard if the religion of the people you're dealing with see suicide as a shame, or a sin, or something that is not acceptable within their community and that can get in the way of their grieving. We really need a dedicated room for grieving that people can go to before they enter the mortuary. And we also need someway that those of us who are dealing with it day after day can process our own thoughts'.

The provision of culturally competent care requires an unconditional openness to the experiences, expectations, perceptions and realities of diverse individuals and communities. The failure to communicate empathy or a willingness to demonstrate flexibility brings the multiple risks of frustration, social exclusion, perceived discrimination and potentially perilous practices.

4.4 Communication

In addition to beliefs about illness and appropriate methods of treatment, communication in relation to attitudes, behaviour and the expectations of outcomes of service delivery all impact on the success of any encounter between service user and service provider. While all personal communications are approached and influenced by individuals' unique styles, ineffective communication methods are exacerbated in cross-cultural situations due to:

- fear

- embarrassment

- lack of clinical or cultural knowledge

- a pre-occupation with the medical condition

- time constraints

- the level of interpersonal connection in the language used

Down in the mortuary, the mortuary technician is trying to reach the Nigerian embassy on the phone about the repatriation of a body. Father Michael waits to talk with him about the events of last night. Rosary beads in his hands as he speaks, he talks about his New Year's Eve which he spent trying to contact and arrange for the next of kin to be informed about the deterioration of a construction worker in ITU whose chest and skull had been crushed by a concrete block the day before. Within 48 hours some had arrived from two different locations on mainland Europe, knowing that they would return with a body rather than a family member. Their distraught state was increased by the hospital not being able to source a translator. The Chaplain, responding to the family's isolation, remained with them throughout the time in hospital and through a process of non-verbal communication indicated that he was asking their permission to carry out last rites: 'I wasn't sure if it would be appropriate to work with them given that I have no experience of the Orthodox Church and we couldn't speak together at all. But I figured it was better that I stayed with them than they were alone. So, with my gestures, I encouraged them to touch the body and pray - all the things that come naturally to me at a time like that. And then, after he had gone, I stayed with them so that they knew I was trying to support them in whatever limited way I could. Sometimes I think that you do not need a translation service when you are connecting with people of faith, the intimacies get lost in a situation like that'.

There is an immediate barrier to be surmounted within healthcare provisions with the fact that there is no national policy regulating standard medical translation and interpretation practices. This shortage underlines the poor practice of habitually and inappropriately relying on family members, including children, and hospital staff from particular ethnic backgrounds for day to day interpretation and translation services. The use of unskilled and untrained translators can result in exploitation and unrealistic expectations.

Equally, it is important to recognise that the provision of a universally accessible translation service will bring challenges for the expectations of some people's gendered norms of behaviour.

Mahmood is concerned that his wife has been offered an interpreter when he always makes sure he is free to attend appointments with her. He describes it as 'disappointing' that a husband who is used to 'protecting' his wife finds that the hospital should suggest that there is someone more appropriate than he to act as a mediator between her and the medics wishing to treat her.

The HSE's current consultation with the NCCRI to both find an appropriate means to address this deficit and to support this development in partnership with MEFLOS is one indication of a willingness to tackle some of the challenges and miscommunication about hospital practices and procedures that are currently unintelligible to patients.

On a plastic seat half way down the long corridor sit three young Bosnian women in long skirts, their dark hair is covered by scarves. One pre-masticates a biscuit and then places it on the lips of a chatty toddler while the other two try to decipher the hanging signage thick with medicalised language pointing to the outpatients' clinics: podiatry, colposcopy, genito-urinary, endoscopy, dermatology. A small, ten-year old boy compares the words on the signs with an appointment letter that has key words underlined for him by the receptionist. The practicalities of the small group's hospital visit are severely compromised due to the adult women having limited understanding and use of the English language. One of the women is pregnant, and the boy is accompanying her specifically to discuss a complication that has arisen in her pregnancy. He approaches a desk and for the third time since entering the hospital, is greeted by a shaking head, a shrug and a hand signal by way of redirection. With no pre-booked translation or interpretation service, both patient and staff are unable to communicate adequately.

In the hospital setting, communication highlights the bi-polarities that exist in the 'them and us' debates of social inclusion and reinforces power imbalances and hierarchies. Hospitals are peopled by initials, senior nurses are CNMs, patients with no long-term autonomy are PVS and individuals remains unclear as to whether their status is as client, customer, service user or patient. Poor communication exacerbates the difficulties faced by those who are trying to realise their rights when their faith, ethnicity and culture are central tenets of their being.

'Your diagnosis is in the history 90% of times – and if you can't take a good history, then it's trying to do a jigsaw with a third of the pieces. If there is a need for a translation service this should be made explicit in GPs letters. I can give you many examples of women waiting for female doctor and using/family members for translation purposes, of small children being asked to consider gynecological problems, of staff who just happen to come from a patient's country of origin irrespective of their tribal or religious or ethnic background all being brought into opportunistically translate for someone. These aren't isolated incidents. I also find there are increasing numbers of overseas students and part time workers who want to talk about the range of contraception, for example – but communication is more than handing somebody a leaflet. Real communication would be about a patient having the confidence to challenge a clinical decision based on grounds of religious identity'.

There are a number of practicalities and cultural misconceptions to be overcome in relation to successful interaction and consultation. Essential to understanding basic problems of communication between service users and providers is a need to explore the social ramifications of linguistic diversity and of the agreed lingua franca for some ethnic groups in addition to the literacy challenges they may face. The lack of historical data collection and the existing narrow focus of information that is captured within the health service reveals a systemic failure of inadequate recording mechanisms with a limited capacity to cross

reference between different structures. As well as considering how information is monitored and data collected within healthcare settings, there is increasingly a need to describe and explain the use of complex naming systems and titles in discussions about appropriate forms of address and communication. South Asian names, for example, are distinctive relating largely to religion where endogamy is the norm (Nicoll, Bassett and Ulijaszek 1986).

4.5 Diet and Medicine

Some service planners are already cognisant of the need to provide food that suits patients' cultural as well as nutritional needs. Staff at St Vincent's Hospital, for example, report purchasing two hundred Kosher meals at a time with a view to sharing them with neighbouring hospitals (NSHSP 2005:21).

There is a need for health care provisions and planners to undertake an on-going assessment of the quality and appropriateness of hospital meals and to commit to all staff having a broader understanding of why the preparation and components of specific, derivative and processed foods may cause concern for some.

Religious dietary restrictions and their implications for nutrition during times of fasting need to be explicitly addressed by health care teams as well as by those providing pastoral care, housekeeping support and those decision makers able to give approval for specific courses of action in relation to patients' care.

The canteen is relatively quiet with the breakfast rush over. The smell of fried bacon lingers appetizingly for some, but not for Firouz, the Persian, Iranian-born registrar picking over a yoghurt and fresh fruit salad. His morning began by negotiating to reschedule next week's shift so that he could attend prayers at Clonskeagh Mosque, exchanging gifts and food with other Irish Muslims and symbolically joining with those making Hajj on that day to Mecca. His Jewish consultant was sympathetic and has restructured the roster. They have 'an understanding' - both previously having acknowledged privately to one another and collectively to senior management in the hospital the importance of their respective religions when requesting that Kosher and Hallal meals be available to them. The hospital explored options to accommodate this, but consensus was reached in the end by agreeing a more extensive vegetarian menu. However this also proved problematic on one occasion when Farouz was informed by one of the kitchen porters that some vegetables could be considered Haram as utensils and water used to prepare them had also been used in the preparation of meat products. In the kitchen, Diarmuid the catering manager is ploughing through invoices. He explains that 'the cost per patient per meal is between 1.55-1.60 Euros, 'but if I need to access Hermolis UK (for Kosher food) – well that's coming in at between 4.50 – 6.00 Euros a meal and you're having to buy it in bulk and with little demand and a short shelf-life. So as I can buy emergency supplies in from (a Kosher facility in) Church Town at 9.30 euros a meal and a taxi ride. That's usually what has to happen because there's never usually more than thirty patients a year demanding it.' Figures from the chaplaincy records indicate that during the previous month the hospital had three elderly Jewish patients brought in from nursing homes to be in patients for a combined total of 66 nights. However with no system of recording religion or request's for religious dietary requirements on the canteen's daily dietary menu pages for patients, neither housekeeping nor catering were aware of the potential demand for Kosher food and none of the patient's brought requests to the hospital's attention with all three opting for vegetarian food. Up on the orthopaedic surgery ward I sit with Jacob. He is 72 and has a black arrow drawn on his left leg to indicate where a tennis accident has necessitated a knee replacement. It's lunchtime – 'Would you like my milk?' he asks me. 'They've brought me milk. I'm not a frummer (religiously observant) and I don't mind that the meat isn't Kosher, but it's just that I would never mix milk and meat, that's just my way of keeping Kosher'.

Given the acknowledged need for protocols in relation to the accessibility and provision of halal, kosher and vegetarian food, there comes an additional imperative in relation to medication and medical procedures involving animal bi-products. Consequently, it would be good practice to develop an appropriate labelling system for those concerned about animal food products and derivative foods such as jelly used in the production of medication, as well as those products developed using methods such as embryonic and stem-cell research or those which contain blood. An indication that these are approved by religious authorities and guidelines for their use would be a source of valuable information and should also be accompanied by clear statements for prescribers and dispensers about the conditions under which 'forbidden' medication might be used. There

are currently no centralised sources of information for health practitioners as to how to readily access by means of electronic and printed formats the names of approved alternatives. It has been argued that national and local services need to be in place and able to provide advice on potentially problematic medication or suitable alternatives (Gatrad 2005). There is a need for care providers to understand the right of Jewish and Muslim patients to have access to non-porcine derived drugs, and for Muslims and some Christians to have alternatives to alcohol derived drugs.

4.6 Dress Codes

Dress codes provide a symbolic representation of fields of order, status, control and power. In health care provisions, they can present a marker that ascribes the roles of the professional within the system and they can create distance between the medics and the patients and their visitors. While this might once have reinforced distance based on ethnicity and class (white doctor = white coat, black patient = black burka), the changing demography of health care workers and the 'hijab and turban' disputes about employment dress requirements have begun to break down that simplistic 'them and us' notion.

Dress codes at work have been the subject of a number of workplace management challenges that have been mediated by professional regulatory bodies in both Ireland and Great Britain. Internal policies, in relation to Sikh and Jewish male headwear for example, have been the subject of accusations of systemic and institutional racism. There are frequent debates within the media as to whether or not it is appropriate for employers to isolate the professional from the demands of his or her cultural practices. For some, regulating dress codes might be interpreted as a form of post-colonial colonialism, feeding into the replication of power imbalances between colleagues, employers and citizens, church and state and consequently religious and democratic liberties.

Becoming a patient means that individuals are often separated from the communities in which their networks of support function and the human and personal associations they value. Infrequently discussed, (perhaps because it is ambiguous and hard to measure), is the issue of how the distance between practitioner and patient might be successfully brokered and connections forged through the use of material culture and dress.

> 'I remember one situation very vividly. A Muslim woman had been admitted to A&E. She had no English and had been put into a hospital gown (which of course opened at the back). She was waiting on a trolley for her family to arrive and was being tended to by a male nurse. She was full of grief, crying, crying. When I arrived, and she could see by my dress that I was Muslim, even though I was a male doctor, she became visibly more comfortable and able to feel that her concerns were being understood. It appeared that the staff had no comprehension whatsoever of the concept of shame, no insight into her life or interest in addressing what it was that was making her so unhappy. It really shocked me as a professional'.

Dress and dress codes are a metaphor for the bi-polarities that exist in the debates of social inclusion and inter-culturalism in health care settings. When potential points of reference are removed that might facilitate connections between the practitioner and the patient, the patient from a minority faith (sometimes with limited communication opportunities and already passive or principally reactive within the medical setting) is further weaned away as an individual from complex social demands brought about as a result of their ethnicity, faith and community-based commitments. This process is a factor in individuals' dehumanization as the balance tips their status from person to patient.

> JP Singh is feeling uncomfortable. He has been allocated a non-gender specific green gown that no matter how hard he tries, simply 'doesn't work'. He is reluctant to put it on. 'It's just not going to happen without a fight' his wife tells me her voice somewhere between joking and nervous. The radiographer shrugs and mutters something about health and safety issues. She has already capitulated on JP's refusal to yield to requests to remove his turban—'I'm not here for an MRI scan – leave it on' he remonstrates.

Finally, as lifestyle is recognised to be a major determinant of health, it is important that dress and adornment are not overlooked when understanding aspects of health promotion. A strong sense or cultural expectation of modesty for example, might potentially affect Vitamin D deficiency as well as reluctance to consent to physical examination in some circumstances.

New leaflets, depicting not the naked back of white woman this time, but the partially robed back of a South Asian woman, are being distributed by the hospital in community centers and other spaces used by members of Muslim, Sikh and Hindu women. The exercise is an attempt to engage with communities and indicates a change in strategy where awareness of services is being actively directed at groups and individuals who previously have had a low uptake of breast screening services. The redesign of the leaflet has been based on research indicating a previous reluctance of the target group to engage with the service based on perceived issues of modesty.

4.7 Male Cultural Circumcision

Mustafa Mahmood is a paediatric surgeon who has been working out of three Dublin-based hospitals for 10 years, infrequently performing what he described as 'social' circumcisions through the Health Service but carrying out at least two a month in a private capacity mostly for those from Muslim families with links to the Middle-East and Arabic-speaking countries. He is rarely called on by Nigerian's who, he says 'have a well-established network of community circumcisers that they prefer to use'. Despite these practitioners not being regulated, they receive much support from those unwilling to have the procedure being carried out under general anesthetic. At a social gathering of sub-Saharan African women, Yennis, a Nigerian from the Delta State, describes her experience in the hospital system: 'I was not happy with the way this thing was when it happened for my baby. Back home they use rings—but here, they are very rough, you should see the way they cut it. Even now you see that the stitching is no good. When they take him to theatre, my tears were just coming, I couldn't hold them because I could see how my baby was frightened before he went to sleep. Then, after the operation, I could see how he was struggling to come to life. And later, when he wanted to wee, it was very hard. Everyone wants a professional, hygienic job for their child but I would rather it was not done in a hospital'. Yennis' used a community practitioner for her second and third children. 'I was happy to pay him the 200 euros. This guy, he calls himself the best circumciser in the world and if he was supported to do it, he would do it well for the health service. He is quick and is doing at least 30 or 40 a week. There are others in Dublin, in Ballinasloe and we have a woman in Athlone who has done it with never any problem. But there is a danger there that if the Government do not recognize that people want to go and have it done, there will be problems, like what happened in Waterford even though it was just an accident'. Yennis explains that she is referring to the death of a 4 week old boy, Callis Osaghae, the son of Nigerian citizens Idehen and Mabel who was admitted after a home circumcision to Waterford General Hospital on 17th August 2003 and found by the state pathologist to have died the next day as a result of both haemmoraging and shock due to bleeding. Judge Kevin Haugh felt compelled to ask jurors not to bring their 'white western values to bear' prior to the circumcisor's trial and subsequently Osaghie Igbinedion's was cleared of 'recklessly engaging in conduct in and about the circumcision in a manner which created a risk of serious harm or death'. After Callis' death, the Gill report was compiled following discussion and soundings with some religious organisations. However, Yennis and her friends are concerned that, as community activists, they were not consulted 'what is the point of ignoring us?—as African women responsible for our sons— we will be requiring this service more and more and more'.

Callis' death prompted a flurry of discussion and activity around the subject of male cultural circumcision. Both Temple Street and Crumlin Children's hospitals in Dublin record an increase in the number of procedures carried out for cultural reasons and growing anecdotal evidence from statutory services and non-governmental organisations of the demand and use of community-based services. Government's response was for the commissioning of the Gill Report (2005) which recommended that the HSE provide a regional service capable of performing the requested number of cultural male circumcision. Based on figures made available to the Committee it was estimated that currently between 1,500 and 2,000 cultural male circumcisions could be required annually. The Committee also recognised that there was a need for the Health Service Executive to quantify regional demands and to identify hospitals, facilities and resources required to provide the service in individual regions. It was recommended that the procedure should ideally take place within the second six months of the child's first year of life and be performed as a day case procedure by appropriately trained surgeons and anaesthetists with pre and post-operative assessment and observations. The Committee was satisfied that the practice as carried out by Orthodox Rabbis (mohels) should be regularly reviewed but permitted to continue in Ireland. Detractors suggest that while it is inappropriate for the public to have to resort to

poorly regulated male circumcision services, the moral imperative should be questioned as to whether statutory service providers should be expected to prioritise making available such a service. They point to the documented cases of complications arising which have resulted in death due to loss of blood, systemic infection from the circumcision wound, hypovolemic shock and complications from use of anaesthesia (Williams 1993). Conversely, the NCCRI (Watt 2006) see the Gill Report as a prime example of the state targeting and mainstreaming diversity issues and exemplifying 'a service has been initiated and provided not on the grounds of formal equality, but to reflect the specific needs of particular communities of interest'.

4.8 Gender

Sensitivity to the context and cultural specificities in which those from minority ethnic and faith-based communities seek health interventions is key to developing appropriate policy and services. When making the case for same gender chaperones or same gender practitioners for intimate procedures, it has become routine to draw on equality arguments. The Women's Health Council, amongst others, have specific concerns about issues raised earlier in this report in relation to women patients' autonomy and are keen to ensure that they are kept to the fore in any discussion and considered within the context of international human rights.

While some from faith-based and religious communities unconditionally support the role that the family can and does play in working within a medical model to aid patients, others argue that the family might sometimes be found to compromise patient's independence. Care and support clearly requires a humane response irrespective of gender issues (Ahmead 1989), but there is also a need for appropriate legislation to mediate and resolve issues between competing value systems.

Women's payments and entitlement to benefits when inpatients, their travelling and child-care costs when attending for themselves or as carers (for example for radio therapy and other specialists treatments) outside their areas of residency, is a key concern for many. There is a key role to be played by MEFLOs and the NGO sector in supporting those women for whom there is an additional pressure based on obligations and expectations in relation to religious holidays, festivals and commitments. Health advocacy projects and other interventions can and are beginning to help address the concerns of women in these circumstances.

One emerging challenge, previously not the norm within Irish society, and increasingly present for health care professionals (in particular those working within gynecological and maternity service provision), is the issues of female genital mutilation.[4] While, according to the European Council for Fatwa and Research, this is a custom for which there are no prescriptive fatwas supporting the practice, it is a routine procedure in some predominantly Muslim states and Sub-Saharan African countries. In addition to a higher risk of complications in birthing, genito-urinary infection and permanent scarring and local desensitisation, the physical condition can also bring with it psychological complications and the emotional expectation that women who have not undergone the procedure are unmarriageable. Consequently, for some, there is an imperative for inter-generational compliance with the custom.

Amina, a Somalian Muslim chose to 'hide from a husband' before coming to Ireland. That is, she decided not to marry into her tribe for fear of being forced to undergo FGM (Female Genital Mutilation). 'The way they do it is so barbaric, the equipment they use is crude and they do not sterilise it. Discussing it is not even on the agenda with men, not even with my father or my grandmother'. Amina is now 20 but she made her decision to move away from her family (which she is well aware will be a permanent form of self-exclusion) when she was only 15. It was based on witnessing her oldest sister's experience when visiting their father's mother's village. The paternal grandmother arranged for 'huge men to come and hold her, and then they made her sit on her chair and one hold her chair, one hold her head, and one hold her leg and they just use razor blade then to do it—it was a mistake for my sister, she couldn't walk properly she bled in the night, she had to sit down in hot water for a long time and she got a bad, bad fever'. Within a few months her sister had married, 'But because I would not do it, they do not regard me as somebody who is in the family. What they believe is that if you do not do it, you will be moving from one man to another and that you won't stay with your husband, you will be like a prostitute'.

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[4] Female Genital Mutilation is the term used by World Health Organisation (Fact Sheet 124) for practices often referred to as Female Circumcision and which comprise procedures involved in the partial or total removal of external genitalia and other injuries to genitalia for cultural/religious or non-therapeutic reasons.

4.9 Racism

In his investigation into the death of Stephen Lawrence, Macpherson (1999:216) referred to institutional racism as 'a corrosive disease', delineating the various forms of direct and indirect discrimination, which it comprises and citing it as 'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes or behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people'.[5] The Lawrence report added momentum for discussion within the National Health Service (McKenszie 1999), but was not a catalyst for change with the HSE.

Recent research by Watt and McGaughey (2006) outlines the need for appropriate data collection so as to avoid institutional racism within statutory service provision in Ireland and as a means by which diversity might be measured, mainstreamed and benchmarked with appropriate services, outputs and outcomes targeted. And given reports and quotations in the recent press of one senior health official describing Ireland as a 'haven' for bogus doctors,[6] the recommendation is timely and aimed at addressing racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and institutionalised practices.

Currently mitigating against the HSE's intention to address institutional racism is the lack of research and data collection pertaining to racist incidents occurring within the health care settings perpetrated by and on patients and health care workers.

Furthermore, there is fragmentary material currently held in relation to the ethnicity or religious persuasion of staff and patients. When addressing this deficit, it is pertinent to recognise the significant civil liberty concerns that arise in relation to any information technology system that will record patients' personal details, such as religion and belief, birth date, gender, ethnicity,disability status and sexual orientation. Yet, the collection of such information is relevant when used to further and adapt services to meet and anticipate demands.

To address racism in the form of religious discrimination, cultural awareness and anti-racist training is needed throughout the health service. There is at best confusion and at worst a reluctance to engage and debate the impact of specific religious beliefs on service provision by many practitioners. But there is a particular need to do so in areas where new migrant communities have recently presented. Such engagement will work to eradicate comments such as 'it's not necessary in our hospitals' and 'it's a waste of resources', which were frequently expressed by health care professionals during the course of this research. Flexible working practices, inter-agency work and enhanced communication are practical and operational issues that can play a significant role in changing the organisational culture to mainstream an ethos of how the needs of diverse cultural groups are respected and met without diluting or compromising what are an institution's ethos and norms. Doing so enables the routine and habitual inter-cultural engagements between employers, employees and members of the public to become good practice and to eradicate the ignorance and unawareness which might be interpreted and experienced as covert racism.

[5] The most authoritative definition of racism can be found in Article 2(a) and (2) of the UNESCO Declaration on Race and Racial Prejudice, 1978
[6] Dr Maruice Geuret a member of the Eastern Regional Health Authority reported in http://www.cirp.org/news/munsterexpress08-23-03/ sourced 10/10/2006

It is St Luke's day in the hospital. The Pastoral Care team have invited staff, patients and visitors to join in a celebration programme, including mass in the chapel and ecumenical prayer services in both the psychiatric and age related units. St Luke's Day is one of a number of exclusively Christian celebrations that the team organise throughout the year. Marie, a nurse who hails originally from the North West and who nursed for years at Letterkenny General Hospital, has brought two patients down to attend the mass. Both Christians, both black Africans and one a lay preacher. As they enter the chapel they are greeted effusively and with a stage whisper by a member of the pastoral care team 'you're very welcome, have you been here before'? As they begin to sit down, another worshipper in the same pew gives them a sideways glance, gets up, and moves to another seat. Marie previously worked in New York and has recently returned to Dublin, first to take up a post in the community and now working in a hospital. She finds her job challenging; 'For me there is something very real about the "we're white, we're right, and we've always done it this way" mentality'. It's perhaps not so surprising to find this attitude back home but it's also prevalent in Dublin in a way that it just isn't evident in the States. I overheard a couple of the housekeepers joking wit' one of the caterers about 'the little fella who they brought in to bless the buns' when they were talking about the Rabbi. Marie talks about the difficulties that some of her new colleagues, who are Irish born, seem to find when working with those from new migrant communities—she covers things such as their reluctance to timetable appointments and the lack of consideration given to religious holidays, she talks of the reticence the majority of staff have to actively recognising religion as a core component of some people's identity. Marie thinks that while most of this is unintentional, some is due to their feeling challenged and threatened with what they see as 'national dilution' by those from other faiths. She tells of an experience she had when working in the community. 'A lot of people want you to sit down and chat when we go into their homes and even though I'm sure it contravenes some policy or other, we tend to do that as a way to build relationships. People always want to offer you something to eat and drink at those times. One Hindu woman I had to visit always said a blessing over food before she offered it. I remember the nurse I was working with would refuse to eat after it had been blessed. She didn't see her actions as racist nor that it might be offensive to talk about 'idol worshipers'—but unless we start to recognise that this is particularly important for some cultures we can end up offending them and being racist without realising it'.

4.10 The Asylum Process

The role religion plays in the lives of some asylum seekers warrants specific attention. It is noteworthy that existing and newly presenting psycho-social problems are exacerbated for many by their immigration status and attempts at cultural integration. Religious organisations can and do play a significant role in how physical and mental health is managed and supported for asylum seekers.

I'm sitting on Simi's floor. Crammed into her tiny room which she shares with her child, are three other Nigerian women, one Cameroonian, one Kenyan and a Somali, all aged between 20 and 40. Makwena, a Kikuyu, has been here for the shortest time, 3 months, and Cherish, whose English is very limited, has been in Ireland for two years. Cherish nurses a six-month-old baby. She lived for a few months in the community in Dublin and at that time had been housed at the top of a three story Victorian building in the city centre. But as a single parent to a ten-year-old son living with Spina Bifida, she found the accommodation to be unmanageable: 'I am here, alone and fearful now about what the future will hold. Sometimes I feel it in my body, sometimes in my head'. She has recently been accepted back at the refugee reception centre, a theatre of temporary buildings on an 4 acre compound half an hour outside Dublin comprising a medical unit, accommodation units, a canteen and external play facilities for children and internet and computer access for adults.

The women all have diverse professional backgrounds, one was a photo-journalist, another a social worker, a third a farmer and all have been educated at least until the age of 18. They are volunteer members of a pan-African women's support group and come together specifically to develop strategies to raise awareness about mental well-being and to address issues of social exclusion faced by asylum seekers. Cherish talks of the suicidal thoughts she had during the first weeks after her second child was born and considers that this was rooted in her being under stress brought on by living with the children in inappropriate accommodation. While the reception centre is not ideal, there she is supported by other women in the centre. They, in turn, have been befriended by a religious order attempting to connect the women with a wider network of spiritual support and it was through these connections that Cherish began to recognize that she had post-natal depression. She was then able to seek out and access the statutory support her condition warranted. But the process was not without complications, she resented the early response from the centre's GP to her situation—'The doctor just would come into the room and listen to what I had to say, and then he just says OK, OK, OK and writes out prescriptions'.

Gerard, now an on-site clinical nurse specialist with a particular interest in traditional medicines and scarification processes, was formerly a development worker connected to a Catholic mission in Sub-Saharan Africa. He acknowledges that a full clinical examination of asylum seekers is not undertaken, and consequently, complications in pregnancy or potential concerns that might be raised earlier are sometimes not addressed until women present in labour at the Maternity Hospital. Yet, he is obliged to screen residents for HIV, TB, Hep B&C, and chicken pox because the reduction of public health risks is very much the focus of service delivery. Gerard is frustrated particularly because the medical centre is ill-equipped to deal with the pschyo-social needs of those in trauma: 'I don't have the opportunity to examine as thoroughly as I'd like to here and so issues relating to people's emotional state and their mental well being are not always detected. There's some kind of mentoring programme that needs to be urgently put into place for young men and boys at risk of suicide, particularly when they're lost or been separated from their families. I have about 20 at the moment who I've referred onto CCST'. (CCST - The Centre for the Care of Survivors of Torture a specialist service operated under the auspices of the Spiritan Asylum Service Initiative, Spirasi.)

Currently, the Psychological Service for refugees and asylum-seekers at St Brendan's Hospital and the Centre for the Care of the Survivors of Torture, based at the Spirasi centre, provide the only specialist services in Ireland (both are in Dublin) and the organisations' exemplary work is frustrated by the long waiting list for referrals.

Asylum seekers' anxiety and fear are rarely accompanied by the power to act as a catalyst for change. Rather they are about being reactive to and dealing with the practicalities faced as individuals often at their most vulnerable. Without the usual networks of support from affines and kin, many asylum seekers suggest that they are reluctant or unable to address their problems, as they feel they inhabit a world populated by potential enemies in the guise of doctors, social workers and teachers with control over resources (housing, financial help, access to health, legal status). Statutory agencies with whom there has been no trust-building are often perceived to be potentially malevolent.

'I didn't know who to speak with when Joshua died. I didn't know who to turn to. People talk about community this and community that and you think that you must belong to some community groups, but when you are faced with something like this, you realize just how empty those words are. It is at this time you want your religion to be there for you in very practical ways'.

It would be presumptuous to consider the emotional challenges which accompany the questions and practicalities that asylum seekers face here, usually in isolation: Am I going to be here for much longer? Will I be able to source the retro-viral drugs that brought me here in the first instance? Who do I turn to for child care support when I have to go to hospital for my new baby to be born? How will I get a message to let them know that the baby has died? Gone are the formalised rules that regulate interaction between individuals. New rules of reciprocity are tentatively negotiated and formulated within the confines of the migrant status. It remains a certainty, however, that many look to networks of spiritual support to address social and psychological, as well as practical needs, seeking out those whose answers are believed to have the power and potential to heal rather than to those who are bureaucratically problematic. 'Community', therefore, is as paradoxical as migration, transience and displacement, with spiritual and physical estrangement directly affecting any sense of belonging.

The experience of the asylum seeker allows no room to essentialise individuals or groups. The lexicon and syntax normally used as shorthand to unpack the norms of particular nationalities and ethnicities is redundant in reception centres. Accepted assumptions and meanings defy use in relation to the points of reference sought in neighbourhood ties, kinship networks, residency units and patterns and in ritual behaviours with social life structurally weak, lacking 'endosociability' (Gay y Blasco 2005:167). In reception centres, all is subject to reinterpretation and distortion and all actions need to be negotiated and taken 'in good faith' when filtered through the lens of undetermined status and of being an undocumented migrant.

4.11 Mental Health and Well-being

Mental health services continue to have Cinderella status within the Irish health care system despite there appearing to be a growing demand for appropriate service provision for a variety of needs. There would appear to be something of a tendency not to discuss mental health issues in Ireland, and therefore, to focus specifically on this within the context of minority faith/ethnicity might reinforce stigmas and stereotypes surrounding both mental health and diversity issues. Mental well-being is both gender and culture specific and requires specialist expertise as well as more compassion and understanding from society and communities at large. Support services have been systematically developed, but for some there is inadequate information and services. And for those whose lives have been affected by depression or who have been bereaved through suicide, this is particularly pertinent and a matter for service planners in light of the the number of people in Ireland who come from areas dealing with conflict and where gender based torture, for example, has been used as a weapon of war.

Some empirical evidence indicates that patients are most satisfied with their treatment (and de facto more compliant with a medical regime) when mental health practitioners share their model of understanding of the patients' distress and condition (Callan and Littlewood 1998, Bhui and Bhugra 2002). However, while this remains a contested issue, any brokerage between the patients' and the practitioners' explanations of the model of illness or distress might be expected to aid the treatment of culturally complex clinical presentations.

A recent on-line debate in the British Medical Journal in relation to a controversial article about spiritually sensitive health cares services (Aziz 2007) highlights that no medical school in the UK or Ireland teaches spiritual history-taking (Stammers 2007). This might be considered to be somewhat surprising given the widespread acknowledgement of religions' profound influence on patient compliance (Koenig 2004) and the significance of religion in relation to those living with mental health problems. The following narratives aim to illustrate this.

As suggested in the previous section (4.10), there is a growing imperative to recognise the specific mental health needs of those who are seeking asylum as well as to support those who are refugees or migrant workers employed within the health service.

Ayishi, is ready to go home and retrieve her baby daughter from her husband, who in turn is scheduled to begin his shift after lunch. He is also a trained nurse but has not yet found employment in that capacity and so works as a kitchen porter. They both come from the Christian-dominated Southern Indian state of Kerala from where the majority of Indian-born nurses in the hospital have been recruited by an agency that specifically targets nurses in the region. While Ayishi is often called on to translate or provide support to both Hindu and Muslim Indian patients—these patients experiences are often further removed from her own than those of Irish born Catholics. Like all other nurses recruited from overseas undertaking employment in either the public sector or in private nursing homes, she was required to spend a period in a Dublin teaching hospital as part of her registration process. She and her husband have settled well into Ireland and attend a church close to their home, which in turn is well attended by other nurses from the hospital. Last year she and her husband agreed with the Human Resources Department that she would temporarily make a spare room available to another nurse undergoing registration who came from the Karnataka Province. However that nurse had found it increasingly difficult to settle during the registration period. She was profoundly lonely and began to demonstrate a complexity of negative psycho-social behaviour despite Ayishi's family's attempts to make her welcome and she began to develop a large array obsessive/compulsive tendencies. A devout vegetarian Hindu who felt she had no-one with whom she could share a language and culture, she felt she was unable to tap into any support network from within her own faith as all other Indian nurses she met were Christian. She was unable to develop good relationships on the wards or in any of the teams with which she was placed. Her condition led her to her stopping eating and this severely impacted on her general and mental well-being. Over a series of weeks, she became increasingly absent from work and she was forced to return to India.

The lack of dedicated service provision to address the needs of children and young people in some hospital provisions clearly warrants a study in and of itself and within that there is clearly a need to address the rights of those for whom culturally sensitive and competent care is a growing concern.

Sana is a 15 year old Muslim girl with suicidal ideation due to an alleged sexual assault—she is an inpatient on an adult psychiatric ward. Over a period of two and a half months, she has refused to return home and has continued deliberate self harming. The community care social workers who were informed and involved were surprised by her parents seeming denial of the sexual assault and that their family's focus seemed to be on ensuring that she was not eating hospital food but that she was given food that was being prepared and brought from home. The social workers were unfamiliar with Muslim culture; 'I'd never met anyone from that culture before' and had no insight into the families fears of the damage that any public acknowledgement of sexual violation might bring. What was perceived to be the family as a lack of support from their social circle during Sana's hospitalisation was in effect a tacit stepping back by friends and neighbours to avoid causing a disgrace to the family. The social workers and nursing staff were not aware of the competing cultural expectations that were adding tensions to Sana's already fragile and vulnerable state.

Finally, there is particular need for the mental well being of older people to be considered in light of the widely accepted position that geriatric services are resource-input heavy. Given that Ireland has an increasing elderly population, and that most health care is end of life care, it is essential that health policies respond to projected demographic changes. Consequently, the development of a mid- to long-term strategy for the aging population is essential. This will contribute to the elimination of disparities in the health of people of diverse ethnic, racial, cultural and religious backgrounds. It is of equal importance for those for whom the consequences of medical treatment represents an unfamiliar environment and for whom succumbing to a medical model represents a degree of personal submission, capitulation and spiritual conflict.

Gareth is living with age-related dementia, he has been diagnosed as suffering from Alzheimers. Increasingly frail, he fractured two ribs, his elbow and wrist in a fall at his home. This condition is additional to the chronic asthma with which he has lived for most of his 76 years and which is increasingly causing him to be hospitalised for short periods. Gareth is a Christian Scientist who came to his faith as a young married man, some 50 years ago. Despite concern about his advancing dementia and the increased support he requires for everyday activities, his wife Caren wants as much as possible to respect Gareth's wishes for prayer-based healing, recognising it as paramount to his belief system and to his sense of self. As she no longer attends their church, she is reluctant to revisit relationships there to explore any support that the church would normally expect to provide. Furthermore, there is no local Christian Science house within 200 miles of their home where Gareth might be cared for in a supported environment by senior Christian Science practitioners and nurses who are trained in the practical care of bandaging and cleaning wounds. When he was last hospitalised, Caren spent some considerable time talking with Gareth's consultant, who in turn called on the chaplaincy to talk with the nursing staff and to liaise between the clinicians and the family. The intervention helped the practitioners understand that the emotions based on disappointment, and expressed as anger by Gareth, specifically related to his finding himself alienated from peer support and in what he considered to be an 'undesirable environment'. The clinicians responded by ensuring that Gareth's therapeutic interventions were kept to a minimum. And, at the request of Caren, Gareth's condition was re-evaluated after he was given a period of time for prayer and reflection before any decision making took place about the need for medication.

4.12 Blood Transfusion, Organ Transplantation, Post Mortem

A number of procedures considered routine within the Irish health care system, including organ transplantation and post mortems, present as problematic for those whose religion indicates a need to maintain the body inviolate at a time of burial. The Muslim, Jewish and Bahá'í obligations to undertake burial of within 24 hours of death presents challenges in the current systems, where the issuing of death certificates is often slow. Similarly, the specific prohibitions of some religions in relation to blood donation and transfusions raises ethical questions for medics. So to do the responses provided by observant religionists. Of particular note is the role to be played by Hospital Liaison Committees as advocates and educators in the support and provision of bloodless surgery as well as for those who see prayer-based spiritual healing from God as more appropriate than engagement with health-based medical services.

Conducting non-invasive autopsies using MRI (magnetic resonance imaging) is not common practices in Ireland. However, the issuing of national and local standards in relation to its use might go some way to addressing the needs of those for whom infringing these observances contravenes doctrinal and theological direction. This is an issue in which the coroner might wield significant influence but has so far been reluctant to do so.

Mrs Selig had been in a nursing home for four and a half years before she died in hospital five weeks after admission. In keeping with their cultural expectations as Orthodox Jews, members of the family had expected to stay with her body at the hospital mortuary until she would be taken for burial within the subsequent twenty four hours. However they were distressed when informed that the body would not be released until an autopsy had been performed in keeping with standard practice and could not understand why such a procedure was necessary given the circumstances of her death. Discussing their experiences some months after their mother's death, her sons explained: 'You can't expect everyone to have the wisdom of Solomon in these situations, but what would have been helpful would have been an acceptance that while the medical ethos and state legislation is unfamiliar to us as families it is not acceptable that the professionals steering the process along should be unfamiliar with our needs when they are so clear cut. We felt then as now that it is their professional duty to support us, rather than expect us to fit in with their systems.'

5 CONCLUSION

'The settlement and integration 'infrastructure' of virtually all countries relies heavily on migrant organisations for service delivery, advocacy and representation. Consequently, there is an interest by the state in the capacity of these organisations to serve their constituents. Communities that are rich in human capital tend to produce more effective settlement organisations than do poorly endowed communities'. (NESC/IOM 2006:159)

Patterns of health and disease are profoundly bound to genetic, cultural, socio-economic and environmental factors with religion and religious expectations connected to all of these.

Healthcare reform is seen to be the lynchpin of a number of complex progressive social justice issues. Shaping something as intangible as the needs of faith into policy and applying that in the form of good practice can only be achieved when all the actors are prepared to address the language (both form and content) and protocols aimed at changing organisational culture.

To date, there has not been any meaningful public discussion as to the continuation of the role of the Christian church in healthcare provisions and policy direction in Ireland. Given the changing demography of Irish society, the imperative to address this is growing. To further that agenda, there is much to be learned from the programmes of equality and diversity in health care that have been developed in other jurisdictions, not least from the strengths of the practical and theoretical approaches that privileges social integration through inter-culturalism over that of separatism and assimilation.

Systemic culture, like community and faith, is organic, dynamic and constantly changing. It cannot only emerge as a construct based on legislative obligations. It is a way of being in the world that can provides a conduit to a democratic society. In this instance, to assume that intercultural and inter-faith issues are ones for 'them' as opposed to 'us' is unhelpful. Rather, it would be more productive, sooner rather than later, to acknowledge that these concerns and how we deal with them are our collective responsibility and core to how Irish health care and society develops. Therefore a major challenge exists for health care providers in how to engage in partnership with different religious and faith based communities.

This report suggests that there is an urgent need for an integrated cross-sectoral action plan for those wishing to develop a meaningful health service accessible to all those from minority faiths. While identifying that measurable outcomes and targets are essential to this process, the report illustrates that it is not sufficient to rely solely on quantifiable material in delivering holistic and person-centred care and services. It is suggested that qualitative data provides a unique insight and perspective. It is argued that whilst appropriate responses might be systemically addressed through the language of policy commitments, it is only through exposure and practice that respecting diversity becomes embedded in individual and organisational cultures. Priority areas identified in this paper include an expansion of policies, programmes and services targeting those from religious organisations and communities, and the development of policies, programmes and services that retard or reverse the cumulative disadvantage currently experienced by those seeking health care provision within the context of a service which is faith-based.

There is an urgent need for public awareness programmes which will identify specific health needs and provide educational programmes for medical staff addressing factors such as human rights violations, social justice issues, trans-cultural healthcare and migration trends. It is anticipated that this will enhance both the health and well-being of the growing population of citizens whose religion falls outside that of the Christian church, which by correlation, will benefit Irish society as a whole.

The needs of all Irish citizens and those accessing and delivering health care in Ireland will benefit from being addressed in a concerted, collective and co-ordinated way, so that the voices of some community gatekeepers and well-connected policy makers and informers do not marginalise and dominate without appropriate consultation with service users and the medical providers.

Focus should be on how a patients' religious and ethnic background can be sensitively and positively used to improve their health and to provide an individualistic service to the patient.

In acknowledging this, it is important to recognise that:

- Faith is often seen as synonym for race or ethnicity in Government analysis. It can therefore be seen to be merely 'smuggled into' policy discourse (Lowndes 2005).

- People have multi-dimensional identities and work needs to be undertaken to explore relationships between faith and ethnicity.

- Faith communities are heterogeneous, comprising individuals with competing needs, social obligations and equality issues that can sometimes be addressed most successfully under the auspices of a broad collective banner that understands the centrality of faith in individuals' lives.

- Ad hoc inter-faith work needs to be strengthened and sustained across the public sector by appropriate partnerships between the public sector and voluntary groups.

- There are resourcing issues to consider particularly as some religious and faith-based organizations that are considered attractive to partner with are primarily being approached because they do not charge for their services.

- There are currently limited citizen participation mechanisms, from consultation to co-governance, that factor the relevance and value of inter-faith into their working.

- Tackling ill health and health promotion and prevention for those from minority faiths is not solely the domain of the Department of Health and Children (DHC) or the HSE. Rather, it is the collective responsibility of many government departments. There are key roles to be played by all government departments in partnering with NGOs and religious organisations to fulfil their obligations.

6 RECOMMENDATIONS

This report recommends that consideration be given to:

1. A framework be developed to explicitly co-ordinate the involvement of those from diverse faith backgrounds for both the DHC and the HSE as part of any Intercultural Strategy. In addition to addressing existing or any potential systemic racism, the remit should incorporate capacity building, information dissemination about and access to appropriate services, the resourcing of cultural mediators, bi-lingual health advocacy and link and outreach workers. In any new or existing cross border health policy forum and integrated working partnerships, a sustained and dedicated focus should be placed on diversity and equality. This should aim to create networks to promote research, education and advocacy in relation to the impact of faith within healthcare settings.

2. Any development of national protocols and guidelines relating to faith in a health care setting need to be accessible in a variety of languages and formats. This might include guides or codes of conduct in relation to balancing legal/medical requirements with cultural expectations in the key thematic areas addressed in Section 4.

3. A more comprehensive approach to training for all those working within health care settings is essential to ensure an informed understanding of how faith impacts on areas of birth, death, diet and ritual behaviour and to the mainstreaming of inter-culturalism as theory into practice.

4. Teaching resources and the training of future medical and nursing professionals should be developed to ensure that the religious idiom and mode, as well as ethnicity, informs the syllabus and induction process of university hospitals and the inter-institutional collaboration of 3rd level educational establishments.

5. National and local research into health promotion and prevention, different medical models and specific cultural practices including cultural circumcision is required to address the rights and needs of those from minority faiths.

6. The way in which ethnic and religious monitoring data can be captured from primary and secondary care needs to be revisited with a commitment made to include information on birth and death certificates.

Over-arching Policy Objectives	Outputs	Key Performance Indicators
To engage with issues pertinent to those from minority faiths by developing a framework for co-ordinating involvement of those from bmef groups.	• Policies developed through community engagement based on principles of equality and diversity, dignity and respect. • Long-term strategic plan based on demographic changes.	• Resource capacity building programmes within meflo communities to develop needs assessments and community audits. • Development gender sensitive guidelines for use in hospitals • Monitor the mainstreaming of minority faith/ethnicity issues into work plans • HSE take a lead in the formation of consumer panels to encourage communities to participate in information sharing • Stronger links with patients' organisations needed to assess the quality and appropriateness of services.
To address the lack of data relating to faith.	• Undertake long-term strategic plan cognisant of demographic changes. • Link census attributes to other information to exhibit the health history of members of minority faiths.	• A longitudinal study looking at both the behaviour, context and composition of individuals' health. • The development of health promotion and prevention projects designed to address the rights of those from minority faiths.
To adequately train all those working in healthcare provisions to ensure equality of care and opportunity in diverse work/service environment.	Mandatory anti-racist in addition to cultural awareness/equal ops/diversity training for all medical/non-medical staff.	• Delivery of Anti racist, equality, rights and anti-discrimination training throughout organisations with induction programmes for new staff/students/service providers carried out in partnership with bmef communities. • Dedicated programme in Health Executive to develop a roadshow of training/resources/programmes relating to faith/health. • Training and information for staff in communication about how death is handled cross-culturally and what legislation is in place elsewhere that may impact on expectations. • National programme to raise communication and cultural competency standards in hospitals.
To raise the profile of the rights and needs of those from minority faiths in healthcare provision.	Develop good practice guides and positive action programmes where appropriate.	• Positive action plans developed within departments/organisations with bmef champions • Develop a community cultural mediation service that is able to provide support to all stages of the life cycle experienced throughout the health care system. • An organisational undertaking to update and widely disseminate material resources used in hospital in relation to community organisations and their practices. • Practical support services and rights-based information for those grieving as family members and dependents.

Over-arching Policy Objectives	Outputs	Key Performance Indicators
Treat racism faith discrimination as serious disciplinary matter.	Develop a reporting/monitoring system to capture racist incidents	Implement reporting system and monitor information produced against base-line data.
Ensure that all new facilities relating to worship, commissioned by Dept Health and Children are seen to be shared spaces promoting inclusivity.	Decisions relating to shared places of worship should offer equality, welcome and facilities to all faiths.	An increased uptake in services
Formation of a national regulatory body to standardise medical interpretation practices	Creation of a national interpreting project.	• Development of a set of national protocols and guidelines relating to faith in a health care setting, to be accessible in a variety of languages and formats • Bilingual advocacy interpretation project.
Address the taboos relating to death and grieving within health care provision.	Provision for further discussions to be had about the need for a mechanism whereby clinical decisions can be questioned on religious grounds.	• Make available existing HSE guidelines on sudden/unexpected deaths and in relation to repatriation for terminally ill clients. • Support services for staff who grieve. • Conduct research, including a needs assessment, of those who experience loss and grieving within hospitals. • Counselling and support services to be provided for those working in hospitals and dealing with loss and bereavement • Given the tensions for some faiths in relation to post-mortems, there should be guidance issued which has been developed in consultation with faith-based organisations.

Appendix 1:
Consultees

Access Ireland

Adelaide Hospital Society

AMNNCH

Africa Centre

AkiDwa

Bahá'í Council for Northern Ireland

Balseskin Refugee Reception Centre

Cairdre

Christian Science Committee on Publication

Comhlamh

Congregation of Jehovah's Witnesses

Department of General Practice NUI, Galway

Department of Health and Children

Department of Health, Social Services and Public Policy

Ethnic Minority Health Forum

Equality Authority

European Council for Fatwa and Research

Female Genital Mutilation Coalition

Friends of the Western Buddhist Order

Galway Refugee Support Group

Global Ladies, Waterford

Greek Orthodox Church of the Annunciation

Guru Nanak Darbar Sikh Gurdwara

Health Service Executive

Immigrant Council of Ireland

Integrating Ireland

Irish Family Planning Association

Institute of Public Health in Ireland

Irish Council of Bioethics

Irish Nurses Organisation

Irish Refugee Council

Islamic Cultural Centre of Ireland

Jewish Burial Society

Lutheran Church in Ireland

Migrant Rights Centre

National Bahá'í Centre

National Consultative Committee on Racism and Interculturalism

National Women's Council of Ireland

Office of the Chief Rabbi of Ireland

Public Health Alliance

Reception and Integration Agency

Religious Society of Friends, Northern Ireland

Residents Against Racism

Rigpa Dublin Centre

Romanian Orthodox Church

Romanian Society of Ireland

Royal College of Surgeons

Seventh Day Adventist

Spirasi

St. James' Hospital

Tallaght Intercutural Action

Vincentian Refugee Centre

Women's Health Council

Appendix 2

Summary of Common Basic Principles

1. Integration is a dynamic two way process of mutual accommodation by all immigrants and residents of Member States

2. Integration implies respect for the basic values of the European Union by every resident.

3. Employment is a key part of the integration process and is central to the participation of immigrants, to the contribution immigrants make to the host society, and to making such contributions visible.

4. Basic knowledge of the host society's language, history and institutions is indispensable to integrations enabling immigrants to acquire this basic knowledge is essential to successful integration.

5. Efforts in education are essential in preparing immigrants, and particularly their descendants, to be more successful and more active participants in society.

6. Access for immigrants to institutions, as well as to public good and services, on an equal basis to national citizens and in a non-discriminatory way is an indispensable foundation for better integration.

7. Frequent interaction between immigrants and citizens of the Member States is a fundamental prerequisite for integration.

8. The practice of diverse cultures and religions is guaranteed under the Charter of Fundamental Rights and must be safeguarded, unless practices conflict with other inviolable European rights or with national law.

9. The participation of immigrants in the democratic process and in the formulation of integration policies and measures especially at the local and regional levels, is a key to effective integration.

10. Mainstreaming integration policies and measures in all relevant policy portfolios and levels of government and public services is an important consideration in public policy formation and implementation. The principal of engaging civil society is also endorsed.

11. Developing clear goals, indicators and evaluation mechanisms are necessary to adjust policy, evaluate progress on integration and to make the exchange of information more effective, so as to transfer good experience.

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