

Bridging Cultures

A Guide to the Diverse Cultures in Australia
for Aged Care Service Providers, 2016 3rd Ed.

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Partners in Culturally Appropriate Care (PICAC) NSW & ACT

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FOREWORD

Multicultural Communities Council of Illawarra (MCCI) is a community based, not-for-profit, organisation which seeks to represent the broad interests of people from culturally and linguistically diverse (CALD) backgrounds.

Established in 1975, MCCI contributes to the development of a society which is culturally diverse and values and promotes this asset.

MCCI strives to enhance the capacity of CALD communities by assisting them in accessing a just and equitable place in society. We do this through our evidence-led advocacy, service delivery and the building of community capacity; underpinned by innovation, collaboration, professionalism and cultural expertise.

MCCI supports the aged care services sector to deliver care which is appropriate and sensitive to the needs of older people from CALD backgrounds, through programs, such as Partners in Culturally Appropriate Care (PICAC) NSW & ACT.

On behalf of MCCI and PICAC NSW & ACT, we are pleased to be able to share with you *Bridging Cultures*, 2016 3rd Ed.

Ken Habak OAM

Chairperson

Multicultural Communities Council of Illawarra





*Partners in Culturally
Appropriate Care*

Partners in Culturally Appropriate Care (PICAC) NSW & ACT is pleased to publish *Bridging Cultures 2016*, 3rd Ed. This updated resource includes cultural information regarding Australia's culturally and linguistically diverse ageing populations in over 30 communities in Australia.

This book is intended to enhance the readers' understanding of the cultural diversity of many people seeking aged care services or who are currently receiving services from aged care service providers. It is also intended that students who are involved in learning to care for people aged 65 and over from CALD backgrounds will find this resource to be a useful guide.

Included in this third edition is information on carers in CALD communities. Extra features include demographical information on each cultural group, information to assist professionals who are required to

undertake a home visit to homes of diverse cultures, key events and dates, some case studies and an interesting cultural facts. The case studies will assist aged care staff and students to understand some of the complex issues that may arise when engaging with older people from diverse backgrounds. Some of the case studies are intended to highlight the challenges which can confront the service provider when dealing with sensitive end-of-life care and dementia.

The Australian culture chapter has material included which will assist the many diverse cultures which are currently employed in the Australian aged care sector to better understand the language and the prevailing values and attitudes which exist in our society.

In preparing this 2016 third edition, PICAC NSW & ACT would like to acknowledge the resource Demographic Data for Australia's

Older CALD population by State and ACPR Funding Regions from the Australian Population and Migration Research Centre at The University of Adelaide. The PICAC team look forward to the results of the 2016 Census which will underpin the information provided for future editions of Bridging Cultures.

The primary objective of the PICAC NSW & ACT project is to equip and support residential and community aged care service providers to deliver culturally appropriate care to older people, from culturally and linguistically diverse communities. The project also aims to represent the interests of people aged 65 and over from CALD communities in alignment with the principles of the National Ageing and Aged Care Strategy, for people from culturally and linguistically diverse backgrounds.

PICAC NSW & ACT can assist service providers in identifying and addressing the unique needs of these communities.

PICAC NSW & ACT work with service providers to develop and provide culturally specific:

- Strategic partnerships
- Training and professional development
- Quality resources
- Demographic data

A partnership with PICAC NSW & ACT will enable your organisation to deliver services which are responsive, inclusive and sensitive to the individual.

The Partners in Culturally Appropriate Care program is a national initiative funded by the Australian Government.

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THE ROLE OF THE CARER IN THE CALD CONTEXT

The Carer Recognition Act of 2010 defines a Carer as being an individual who provides personal care, support and assistance to another individual who has a disability, a medical condition, a mental illness or is frail and aged. This role is not conducted for payment, education or in a volunteer capacity.

The term carer is not always easily translated into different languages. For many culturally and linguistically diverse families, caring is ingrained into their cultural practices and everyday living. Caring is a matter which bears no special treatment or accolade. For many, it is simply an activity without reason for distinction or merit.

The Australian Bureau of Statistics has estimated that 30% of carers are from culturally and linguistically diverse backgrounds. However, they state that this figure could be an underestimate of the real picture, as difficulties in translation can exist with the term, or that questions pertaining to caring are not always answered correctly.

The Australian Government is committed to providing support for carers as they contribute greatly to the welfare and longevity of large sections of our society. Their daily activities in assisting, supporting, medicating, treating and looking after their person in need, greatly alleviates the burden of care from being a government funded exercise.

Carers from CALD backgrounds are sometimes unaware that services exist to support their roles as carers. Low literacy and language skills act as barriers for the process of information retrieval. Many people from CALD backgrounds are identified as 'hidden carers'. These carers do not identify themselves as carers and are not recognised as carers by the government, community or staff working in the aged and health care sector. Networking with government agencies such as Centrelink, hospitals, primary health providers, and local government will assist in identifying 'hidden carers'.

Carers from CALD backgrounds face many cultural and language

barriers on a daily basis. Some of the barriers can include low literacy and language skills which mean that they may have limited means of accessing information about what services are available to them to assist in their caring journey.

For older carers, low levels of education in their birth countries means that they may not be literate in their language of origin. Therefore, translated materials can be of little or no use, if available.

Cultural barriers at times play a role as a misconception can exist that adult family members of CALD older people will assist them with translating and interpreting areas when they are in need. It must be considered that the offspring of ageing migrants may not always speak their heritage language well, or in fact are able to understand the language or able to read the written word.

To live in a dominant culture and to be expected to carry out the norms of an inherited culture can sometimes cause family issues. The older generations can feel that they have failed in their parental duties if they do not witness their children mirroring their cultural values and attitudes.

Many people who are carers from CALD backgrounds are not able to consider leaving their care recipient out of an inherent feeling of 'duty' towards them. They will often experience a feeling of guilt if they are seeking to take 'time out'. CALD carers can experience family pressures to maintain the current situation of the frail person living at home.

Some CALD carers do not seek Government subsidised care or obtain support payments for several reasons. This may include their suspicious perceptions of financial assessments. This stems greatly from experiences of living in oppressive regimes and experiencing trauma in the past. Some also are not aware of subsidised assistance as there is a lack of appropriate information which is provided to them. Some cultures seek information from ethnic-specific services only.

The Australian aged care system is not understood by many CALD carers. Perhaps in their country of origin there was no age care system in existence. Many countries have limited or indeed no specific aged care framework.

Some CALD carers are not able to access translating and interpreting services as they are unaware that these services are available. CALD carers may have little or no confidence in establishing the initial communication. The use of the telephone to communicate with people other than family members is not considered an option for them. Communication in some situations must be initiated by other family members. Many carers from CALD backgrounds have a low uptake of technology and low computer literacy levels. The current trend towards providing online information can disadvantage CALD carers.

Trust is an important factor for many people from CALD backgrounds. This important value must be established from the outset when interacting with them on any level.

Carer support groups are not always appropriate for CALD populations, as discussing personal aspects of one's lives is not always culturally appropriate, even with cohorts of the same culture. Carer support frameworks will need to work collaboratively with the cultures involved and understand that it will take time for trust to develop.

Sending a family member to an organised care scenario such as respite or residential care is not seen as a favourable option. It is often only considered when the caring situation reaches a crisis point.

Planning for aged care is not considered amongst many people from CALD backgrounds. It is expected that the family will take care of the needs of the ageing parent or family member. This is a complex issue which is exacerbated when one is ageing in a foreign country, where cultural norms are augmented by negotiating two separate and unaligned cultural contexts.

There is generally little or indeed no contemplation for advanced care directives in CALD communities. Advance care planning appears to be an unfamiliar concept for many people from CALD backgrounds.

Further information on providing care in Australia from a CALD background can be obtained from the Carers Australia 2013 comprehensive report, Culturally and linguistically diverse carers in Australia: background report. Please visit www.carersaustralia.com.au

CULTURAL ATTITUDES TOWARDS DEMENTIA

There are more than 100 different disorders which cause dementia. Dementia is a term which encompasses a variety of conditions including Alzheimer's disease, Vascular Dementia, Dementia with Lewy Bodies and Fronto-temporal lobe Dementia.

Dementia is a leading cause of death and burden of disease in Australia for which there is no cure. For people aged over 65, dementia was the second leading burden of disease in 2011 and the leading cause of disability burden. For culturally and linguistically diverse (CALD) populations living in Australia, the prevalence of dementia is projected to escalate to around 120,000 by 2050. This will inevitably place a great stress on the supply of CALD trained dementia care providers and on the demand for culturally appropriate care.

There are unique challenges regarding managing dementia within cultural contexts. These include identification of the disorder, treatment

régimes, support mechanisms, including aged care service provision and CALD community acknowledgement.

Subsequently, one of the greatest challenges faced by CALD community members, when diagnosed with dementia, is social isolation. These challenges can lead CALD older people to under-utilise available community services. Typically, these populations have a lower than average uptake of dementia respite services.

There exists a research gap in the area of cultural nuances in regards to dementia. Many cultures understand dementia to be a normal part of ageing. Additionally, they comprehend that the suitable treatment is to be conducted via medication. In some communities, dementia is hidden where the overwhelming attitude is considered to be one of 'disgrace'.

Generalisations regarding perceptions and beliefs of dementia within diverse communities can assist care providers with an overview of the prevailing attitude

The information in this directory about the diverse attitudes to dementia care is for general guidance only and does not encompass all views of the various languages, cultural and religious groups mentioned.

towards dementia in CALD communities. However, every individual with dementia is unique and generalisations should merely serve as a technique to initially evaluate an individual. A person-centred care approach to caring for a person with dementia should be engaged at all times.

Alzheimer's Australia Victoria produced a report in 2008, following their project, *Perceptions of Dementia in Ethnic Communities*. This important project and report has contributed greatly to the information in this section of Bridging Cultures.

ARABIC

The Arabic-speaking community in Australia is diverse and includes communities from 22 countries. The most prevalent being the Lebanese community. Since 1960, Arabic-speaking people from Egypt, Iraq, Jordan, Palestine and the Arab Peninsula have migrated to Australia. Large numbers of Arabic-speaking people practice Islam. It is generally accepted among

those who practice this faith that dementia is God's will which is to be accepted. However, treatment for dementia can still be sought by the community as this fits into the Islamic belief that God has enabled such approaches to assist his followers. It is common to find a stigma attached to dementia within this community, due in part to the terminology used to describe the condition. The interpretation of the dementia equivalent word in the Arabic language carries negative implications, akin to 'losing one's mind'. The causes of dementia are not well understood and therefore can be subject to personal interpretation. This generally involves the person being involved in a particular event which was shameful or an incidence of misfortune.

CHINESE

Dementia knowledge and perceptions vary within the Chinese community. Some consider dementia to be associated with old age where even minimal instances of memory loss are associated with

the condition. Other perceptions are broader where a wider range of issues, such as wandering, language problems, confusion and incontinence are recognised as being signs of the condition.

Dementia is not a topic which is openly discussed in the Chinese community. Hence, a family may not willingly admit that they have a family member with dementia. This can lead to a person being excluded from their community and potentially will become socially isolated. Medical support will be sought and family members will attend, especially if the doctor is from a non-Chinese background. The community will accept western medical treatments; however, they will combine this with traditional Chinese medicine. Acupuncture and cupping may be used in the treatment of many conditions and should not be confused with elder abuse.

Some Chinese community members will embrace a healthy lifestyle in order to prevent dementia. Activities such as *Mahjong* which combines memory exercise and calculations will be encouraged, as is a healthy diet and exercise.

ITALIAN

Many attitudes towards dementia in Italian communities reflect attitudes which were prevalent at the time of their emigration. This includes terminology used for this condition. The word *demenza* in Italian is a medical term which is aligned with mental health disabilities. Some older Italians may use the term *sclerosis* which was frequently used in the past. It is important for Italians to understand the causes of dementia. They sometimes draw conclusions about the condition, blaming over or under use of the brain, poor nutrition and physical inactivity.

Many Italians develop some knowledge of dementia as they witness their friends' experiences with the condition. As there are significant numbers of ageing Italians in Australia, the incidence of dementia is quite high. Generally, Italians do not realise the condition is a progressive and terminal illness. It is common for carers to absorb the burden of care and therefore not seek assistance from aged care services. The community holds quite clear expectations that the family, in particular the eldest daughter, will take care of the needs of the ageing family member, including those with dementia. It is

important to stress to members of the Italian community who are in dementia caring roles, the benefits of respite care and carer support groups.

SPANISH

The greatest numbers of Spanish-speaking people in Australia are from mainland Spain, Chile, Argentina and Uruguay. There is little knowledge and understanding of dementia in Spanish-speaking communities. Some people believe that dementia is caused by stress and excessive worrying. The most common translation of the word dementia is *loco* or crazy.

VIETNAMESE

Most Vietnamese people arrived in Australia after the end of the Vietnam War as refugees. Many endured a traumatic journey to Australia on fishing boats to escape the communist government who took power at the end of the war.

There is little knowledge of dementia in this community. The terms dementia and Alzheimer's disease are recognised by younger community members, however a deeper understanding of the condition is not common. As is the case in other CALD communities, the Vietnamese consider dementia

to be a normal part of ageing. Additionally, they consider that it is caused by too much worry and stress. Commonly it is considered that someone with dementia has 'lost their mind.' These pre-conceptions lead to a diagnosis being made far too late which does not allow people to finalise their affairs in the manner that they would prefer. Vietnamese culture holds their elderly family and community members in high esteem. This can negatively impact on securing a timely diagnosis of dementia as it is perceived as being disrespectful to inform them of such a debilitating condition. As dementia is not considered an illness, it is difficult for this community to understand that the condition is terminal and there is no cure. Prayer, Chinese herbs and acupuncture are all accepted modes of treatment which are used alongside modern medicine.

GREEK

The Greek community is a large CALD group in this country. Literacy levels amongst elderly Greek people is quite low, however, they have good community support networks across the country due to their organisations' demonstrating commitment to preserving the Greek culture and heritage.

Nevertheless, there is still a low level of understanding of dementia. Most community members describe dementia in terms of its symptoms. The causes of dementia are associated with some sort of trauma, shock or constant worrying. Some believe that dementia is associated with stroke.

Greek spouses are the main carers of people with dementia. Carer fatigue is well recognised in the community, which can lead to compromised health for the carer. The Greek community relies heavily on the family structure to support their aged. It is of concern to them that the younger generations may not have strong Greek language skills and therefore they cannot provide the traditional extended family support.

The Arabic-speaking, Chinese, Italian, Spanish-speaking, Greek and Vietnamese communities all have preconceptions that their children will provide care for their elders when it becomes necessary. Many older community members believe it is appropriate to spend their last days at home. It is becoming more common to see people from these communities in care, as the economic pressures of modern living no longer enable children to provide personalised

care for their elderly family members.

EASTERN EUROPE

Eastern European cultures include Polish, Russian, Hungarian and Ukrainian ethnicities. Many of these migrants were subjected to torture and were victims of oppressive rule. Some communities have a prevalence of Post-Traumatic Stress Disorder which can exaggerate the symptoms of dementia. Certain memories can cause challenging behaviours amongst the elderly with dementia.

Dementia can be seen as a normal part of ageing within these communities. When the dementia becomes advanced it can be regarded to be a mental illness. Dementia in the Polish community is highly stigmatised and it is commonly denied. This ultimately leads to social isolation which is evidenced by fewer friends and family members visiting and less participation in social activities. The Polish community refers to dementia as *sclerosis*.

Russian community members prefer to seek treatment from their doctor and they have faith in modern medicine. They believe in preventive health measures. The perception of dementia in this

community depends on which area of Russia they originated from, and when they came to Australia.

MACEDONIAN (FYMR)

There is a lack of awareness of dementia in the Macedonian community. Some sections of the community regard dementia as a mental illness and that it is a punishment for mistakes of the past. In some instances, dementia is thought to be a curse placed upon a person. This is where the community relies on spiritual guidance to assist them with the condition. Family members are embarrassed to discuss dementia with friends and the community at large. Many Macedonian elderly refer to dementia as a *sclerosis*. Low literacy levels impact a heightened understanding of the condition.

The Macedonian spouse is the main carer for the elderly with dementia. Families are the main support mechanism as there is a reluctance to seek outside assistance.

It is important to remember that every person is an individual and the perceptions and beliefs pertaining to dementia may differ between individuals in a specific culture. It is also essential that elderly CALD consumers receive support from aged care service providers in a responsive, inclusive and sensitive manner which takes into consideration their cultural foundations.

CULTURAL ATTITUDES TOWARDS PALLIATIVE CARE

A palliative approach aims to improve the quality of life for individuals and their families, with a life-limiting illness or who are becoming progressively frailer because of advanced age.

This is carried out by identifying, assessing and addressing their holistic treatment of pain, physical, psychological, social, cultural, and spiritual needs. The underlying philosophy of a palliative approach is a positive and open attitude towards death and dying with an emphasis on improving quality of life.

Education about cultural diversity is recommended for aged care teams to enhance an understanding of care preferences of individuals from different cultural backgrounds. Efforts to accommodate these preferences promote individualised care which benefits individuals and their families.

It is important to understand that there are a number of religions that cross language and cultural boundaries. When working with a person facing a life-limiting illness,

a carer will need to understand the role religion plays in their end-of-life choices.

WESTERN EUROPE

In some Western European countries such as Austria, Germany and The Netherlands, palliative care is a recent concept. It was introduced into Germany in 1985 and was relatively unknown in the Netherlands prior to 2001. Therefore, it is likely that elderly people born in these countries will be unaware that such services exist or what it entails.

INDIAN

There is a general acceptance of Western medical practices, home hospice and hospital care by the Indian community. Health professionals are seen to minimise discomfort and are therefore welcomed in the family home by the Indian-born population. Culture demands that there is close family involvement in the care of the aged.

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CAMBODIAN

In the Australian Cambodian community, there is a lack of understanding of palliative care and many people will feel more comfortable to be treated in their home as aged care facilities do not exist in Cambodia. Health professionals are expected to clarify with the family, the diagnosis and prognosis of an illness. Giving news to the family first or telling both the patient and family are acceptable. The guarantee of confidentiality is important within the Cambodian community. Decision-making about illness is likely to involve the client and the family.

CHINESE

Not every Chinese person wants to die at home as they believe that death can bring negative energy to the house. Chinese values draw upon many influences such as Confucianism, Taoism and Buddhism. Values such as loyalty, filial piety, the maintenance of social order, and superiority of men over women, self-restraint,

self-respect, and self-blame, are embedded in Chinese culture and have a lot of implications for health choices during end-of-life care. The open discussion of terminal illness and end-of-life issues are not considered appropriate in Chinese culture.

ARABIC

Doctors and qualified medical people are well accepted and respected by Arabic speaking community members from countries such as Egypt, Iraq and Lebanon. The expectation by people from these communities is that information about a patient's diagnosis and prognosis will be told to the family first, and the family will decide whether or not to tell the patient.

FIJIAN

The approach to inform a Fijian born person of a diagnosis, depends on the individual. Generally for an aged Fijian born person who has not fully adopted Western culture, it would

be appropriate for their son or daughter, or another older close relative to tell them. This 'buffering' of the impact of the news is very important, both to the person, and to his or her family.

INDONESIAN

In Indonesian culture, family and spiritual leaders are involved in caring for the dying person. The concept of palliation is not known.

FINNISH

Options in palliative care are not yet well known among Finnish people. However, when this stage of life is reached, they are keen to know more about alternative medicines, even though they may initially show resistance. Information on pain management is especially valued.

GREEK

Many Greek-born people are very sensitive about death and dying issues so it is very common that Greek families do not want the dying person to be told of their diagnosis and prognosis, believing it will only burden the dying person further. Greek families prefer to be informed first of the diagnosis and then decide if the ill person should

be told. Sometimes it may be the eldest son that would tell his parent of the diagnosis. There is fear of cancer and often the word 'cancer' is not used, instead many use an alternative word, such as 'the terrible illness'.

EASTERN EUROPEAN

In Eastern European countries such as Hungary, Czech Republic, Poland, Ukraine, Estonia, Latvia, Lithuania, Slovakia, Slovenia, Croatia, Macedonia and Serbia, palliative care is a fairly new concept. Elderly people from these countries may not be aware that such services exist or what it entails. Traditionally, the diagnosis of a terminal illness would not be communicated to the person concerned but rather to their families who then decide when and how, or if at all, to tell the patient. Families, relatives and friends may wish to 'protect' the person from diagnosis and prognosis of a terminal illness. Often family members believe if the prognosis is communicated to the patient, they may lose the will to live. A direct approach is not recommended for these cultures. Individuals from these countries may be reluctant to accept palliative care, as this is perceived as a sign of imminent death. People from these

communities believe it is important for relatives to be with a person who is dying to provide emotional and spiritual support to the dying person and family.

ITALIAN

For elderly Italians, treatment at home is preferred but hospital or hospice is becoming increasingly acceptable. Family-centred care is always preferred. The family needs to be involved at all stages of decision-making. The family may try to 'protect' the dying person by withholding information and a diagnosis in order to maintain hope. A charade is often played out with family members and friends' pretending the illness is not terminal. There are high expectations that doctors and/or nurses will relieve symptoms and pain. Some Italians may accept morphine whilst others may express fears associated with its use and be reluctant to use it. It is important that the effects of morphine are communicated to all concerned. Italian carers have a strong sense of duty. Roles are dictated by family hierarchies and by gender. Emotions are openly displayed, including anger and grief. Carers may encourage the patient to eat unnecessarily believing this to be good for the patient.

MALAYSIAN

In Malaysia, many are not aware of what palliative care is and certainly even if they knew, may not be aware of where they could access it. Palliative care has only been an option in Malaysia since 1991. To talk about death and dying is a huge taboo in this culture.

MALTESE

It is important for people of Maltese background to die at home. As people from this culture age, they have a tendency to revert to speaking Maltese. It's difficult for health professionals to understand the needs of the Maltese community when it comes to health, palliative care, death and dying, as there is an expectation within this community that family is the primary support option.

FILIPINO

In the Philippines during times of illness, the extended family provides support and assistance. Important values that might affect interactions between providers, patients and families in the context of terminal illness, include a strong respect for elders, reliance on family as decision-makers in the case of illness, and high expectations of care by the family.

PORTUGUESE

For Portuguese people, dying and death is accepted as a fundamental part of life by most. Presence of a priest is important for Catholic Portuguese to provide support to the dying person and family. Medication is accepted to reduce suffering.

SPANISH

Traditionally, Spanish speaking people, from countries such as Spain, Uruguay and Chile, prefer to die at home. It is important for family members and close friends to see their loved ones during their final hour. Family needs to be involved at all stages of the decision-making process. The role of the family has a strong influence on anything relating to their loved one's health care and they prefer to be given the diagnosis or prognosis before their patient.

SRI LANKAN

Sri Lankan born people are usually familiar with government provided services and resources for the elderly. General barriers to accessing services for the elderly may not be as significant within the Sri Lankan community as English language proficiency is generally

higher than in other groups. This is also because similar services are provided by the government in Sri Lanka.

TURKISH

For the Turkish community, the preferred place of treatment is at home, if possible. Staff should give the diagnosis or prognosis to close family members first, since some patients will not be able to cope with the news. Some families would like to be the ones to decide how the patient should receive news of impending treatment.

VIETNAMESE

Traditionally, Vietnamese people prefer to die at home. It is important for relatives and friends to see the face of their loved one in the last minutes of life. Organ donation may be seen as meritorious in future lives, creating good karma.

Where possible, provide information about a palliative approach to individuals from culturally and linguistically diverse backgrounds in their own language, as this enhances cultural sensitivity for individuals and their families, and ensures adequate and appropriate care.

CULTURAL ATTITUDES TOWARDS CONTINENCE

The information in this directory about the diverse attitudes to continence is for general guidance only and does not encompass all views of the various languages, cultural and religious groups mentioned.

It is also important to understand that the religion of the individual may impact greatly on the health and self-management behaviours relevant to the prevention and management of incontinence.

Continence is the capacity to pass urine or faeces in socially and hygienically acceptable circumstances. Incontinence is the accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence).

Incontinence and continence problems affect people of all ages, gender, cultures and backgrounds. Despite popular opinion, older people are not the only ones affected by these conditions. It's important to understand that bladder and bowel control problems are not an inevitable part of ageing. The problems associated with incontinence have a considerable impact on a person's quality of life and many people do

not seek help. Embarrassment often prevents people talking about their bladder and bowel problems.

Incontinence is one of the least spoken about health conditions. It's estimated that 70% of people affected by incontinence don't talk about it, according to the Continence Foundation of Australia, which is the peak national organisation for Australians affected by bladder and bowel control problems.

Discussing such a sensitive issue is even more challenging if you don't speak English. As well as the lack of language skills; attitudes and social taboos common to many culturally and linguistically diverse groups, make the topic a particularly difficult one to address. In fact, in some languages there is no direct translation for the words, continence and incontinence.

The Victorian Continence Resource Centre (VCRC) undertook a project in 2011, titled 'Awareness of Incontinence in Ethnic Communities',

working in collaboration with various organisations and ethnic communities. The report highlighted a lack of research in Australia. Twenty ethno-specific focus groups were also surveyed to explore general attitudes and awareness of people from various ethnicities to incontinence.

In Eastern European countries such as Hungary, Czech Republic, Poland, Ukraine, Estonia, Latvia, Lithuania, Slovakia, Slovenia, Croatia, Macedonia, Serbia and Western European countries such as Austria, Germany and the Netherlands, continence issues are not openly discussed as it is not regarded as an appropriate topic. There is no wide interest to improve an understanding about its causative factors, treatment and management. As a consequence, it is often ignored or minimised. Medical treatment is rarely sought, and the affected individuals use their own coping strategies to manage the problem, like herbal remedies, hot spas or avoiding active participation in a social life.

Quite often, incontinence problems are hidden from the family and are considered a taboo. When it is unbearable, health professionals may then be involved in the treatment. Medical aids are not widely used, until the condition has progressed so

much that the individual affected can no longer cope.

The Maltese, Greek and Cypriot communities in Australia have minimal knowledge of incontinence treatments. There is a tendency to restrict fluids amongst older members of these communities to manage their problem, which can have its own negative health effects such as dehydration and the risk of falling.

Individuals from countries such as Portugal, Spain, Uruguay and Chile, may lack understanding about incontinence as a health issue and may not seek professional health care. It is perceived as an embarrassing and shameful matter which is not openly discussed.

There is advancement in various Asian countries such as the Philippines, India, Sri Lanka, Indonesia, Malaysia, Cambodia, China, Vietnam and Korea, in continence awareness. The diversity in the socioeconomic, cultural and political backgrounds has generated diverse and unique problems for individuals with continence related issues. Low levels of knowledge and an understanding of incontinence, and little awareness about the causes and treatments has, led to a poor understanding of the

illness and can result in a barrier to seeking help. In large or densely populated countries, particularly India and China, promoting continence awareness is difficult with limited resources. For the predominantly Islamic countries like Malaysia and Indonesia, where urinary incontinence is equated with uncleanness, there is a huge barrier of denial and concealment.

In principally Islamic countries such as Turkey, Lebanon, Iraq and Egypt, urinary incontinence has a devastating effect on an individual's quality of life. For Muslims, praying is seen as a relationship between the person and God, and leaking urine is a barrier. Ablution is a cleansing ritual carried out by every Muslim prior to prayers. The passing of stool, flatus or urine whilst in the act of ablution necessitates carrying out the ritual again, as cleanliness during prayers is required. Prayers are performed five times a day at different intervals, and it requires a Muslim to stand, bend and sit while reciting the verses of the Quran. These actions can cause a leakage for a person who is incontinent. The general association of being unclean with incontinence leads to feeling sinful and increases a person's fear about not being able to fulfil religious obligations. This

can often escalate to serious mental stress and anxiety.

Italian-Australian attitudes to continence related issues are similar to those of other European ethnic groups. Generally there is a low understanding of health problems and treatments. Continence is often seen as part of the normal ageing process and not discussed to avoid embarrassment or shame. Women prefer to discuss the problem with a close female relative, and typically not outside the family.

Many Pacific Islander communities such as Fiji, Tonga and the Cook Islands are not aware of continence related services available to them. In general, Islanders are only aware of general practitioners and the hospitals when they require medical assistance. Individuals from these communities do not access medical services, partly due to language barriers and limited knowledge of health related services and how to access them.

Where possible, provide information about continence related issues to individuals from culturally and linguistically diverse backgrounds in their own language, as this enhances cultural sensitivity for individuals and their families, and ensures adequate and appropriate care.