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IO2 – E-Learningcourse

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Content

Module 1 – Intercultural competence

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1. Intro

2. Course introduction

Welcome to the e-learning course "Intercultural competence in ambulance services".

This course shall assist you in reducing interculturally related in-service stress.

It provides knowledge about

1. Intercultural comptencies
2. Cultural background knowlegde
3. Methods and strategies for competence in action.

3. Fear of the unknown

Flight and expulsion can affect anyone and has affected also Europeans in the past. And also they were discriminated against and faced hostility, like the displaced Germans after WW II in their actual home country by their fellow countrymen.

Asylum seekers in their new or temporary home often are met with anxiety and even hostility. Mostly, this is due to lack of experience with other, perceived as alien cultures.

Since the beginning of time, people have been afraid of the unknown.

Fear and uncertainty in dealing with strangers leads to avoidable conflict.

Our course aims to help reduce the potential for conflict and thus lead to a reduction of job-related stress for ambulance staff.

4. Intercultural in-service-situation

I can not take my shoes off.
We're here to help! The patient can be not treated by our female doctor.
The whole family is there. Why is everything so loud here?
Why do they all interfere?

What drugs?
What do they want from us?
Must everyone watch ...?
This area of town is notorious.

The man won't let me through to his wife?
Why is he gesticulating so wild with his hands?
How is that meant?
Who is in pain? ALL?
If we do not act quickly, someone dies!
Why are the children here?
She doesn't understand me!
Please calm down! Why are they all screaming?
What are they thinking actually?
Please not so aggressive!
Do we need the police as reinforcement?

STRESS!!!

5. Intercultural In-Service stress reduction

Intercultural In-Service stress

Reduced handling confidence during the rescue mission is a stressor, which negatively affects the quality of the work of the ambulance team.

This may cause a threat to the professionalism of the rescue Service.

In order to avoid this, it is helpful to increase the intercultural competence of the staff.

Increased intercultural competence

increased handling confidence

less stress in action

increased quality of care

increased work satisfaction

prevention of mental exhaustion.

6. Cultural diversity

Our European societies have long been characterized by cultural diversity. (For more information about the migration history of the UK, click here)

Foreign citizens made up 7.5% of persons living in the EU Member States on 1 January 2017. (Source: Eurostat)

Due to demographic trends, the proportion of people with an immigration background is increasing thoughout Europe, because of shrinking birth rates.

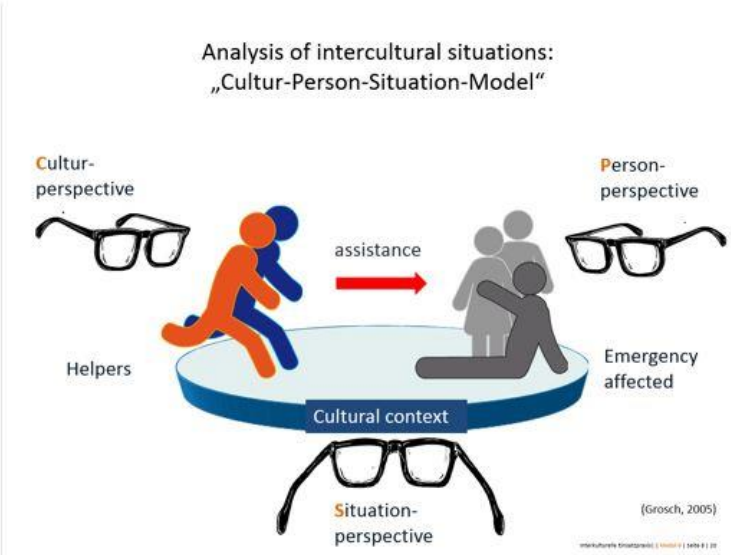
Cultural differences can increase stress potential on both sides (aid recipients and providers) particularly in emergency situations.

Many people generally experience fear, powerlessness and insecurity in threatening situations. How do you thus deal with emergency situations, when often additonally to cultural differences, language barriers are added and different expectations with regard to the tasks of the ambulance services exist? How do you ensure a mutually satisfactory service?

7. Intercultural competence as key competence

The necessary competencies for a safe and constructive handling of conflicts in intercultural situations can be described as follows:

8. Cultural socialisation



Our words, our gestures, our actions can be interpreted completely differently by someone with a different cultural background. Like us, every human being sees the environment, the fellow human beings, oneself through the spectacles of ones cultural socialization. How intercultural interaction succeeds depends on intercultural understanding and the intercultural competence of the participants.

9. Identity & Culture

Before dealing with the other, the stranger, one should be aware of one's own culture and its peculiarities [...].
(Payer, 2005)

10. My cultural identity

So lets take a closer look at our own cultural idenity. Are you a typical representative of your culture/nation/country? Why? What does that mean? What is important to you? What is your identity? How would you describe yourself?

Please, take some time to ponder about these questions and answer them in a written way for yourself.

Illustration: **Lena Steinke (https://lena-steinke.de/photography/people_portraits)**

11. Self-image

Every person is a unique, distinctive subject with its own characteristics, attitudes, experiences, abilities and behavior patterns. When we describe our characteristics, we speak of our "subjective identity" or of our "self-image".

Identity can be divided into three areas:

Personal Identity: Attitudes that remain largely stable - despite all the experiences and developments (for example, age-gender or body identity).

Social identity: formed by experiences with people and organizations, e.g. social roles: parent, worker or 'foreigner';

Cultural Identity: Attitudes and behaviors influenced by the sociocultural environment in which we grow up (for example, language, religion, customs and customs, rituals).

12. Model of identity

According to this three-legged model by Karl Stanjek, belonging to one or more cultures or to sociocultural groups is (only) one important factor for a stable identity. The constellation of the three pillars allows the explanation of human behavior, especially the stabilization of identity, for example, when the cultural (e.g. religious or ethnic) affiliation is emphasized, if the social identity is or becomes unstable (e.g. by a lack of access to socially recognized roles and positions).

Through experiences before and during the flight and the new living environment, especially the legs "personal identity" and "social identity" are weakened.

The third leg "cultural Identity" then becomes of great importance in order to bear and maintain one's own identity. This can lead to self-ethnization*.

* Self-ethnization: compensatory emphasis on one's cultural-ethnic identity among individuals or groups.

13. Threats to identity

Identity ...

is important for personal development and health,

may contain parts from different cultural backgrounds (so-called "patchwork identity" or "hybrid identity")

can be questioned partly or in total during conflict and crisis situations (e.g. discrimination or expulsion). Human beings try to preserve, strengthen and defend their subjective identity when they see themselves threatened (for example, by aggressive behavior, withdrawal, or stressing of certain identity areas).

Examples of threats to the different areas of identity:

disability, loss of function in old age (→ personal identity),

loss of relatives, friends or the workplace, leaving a (professional) group (especially → social identity),

living in a foreign environment, difficulties spreaking your mother tongue or exercising your religion (→ cultural identity.)

14. Every person...

...is in certain areas like

any other human,

some other people,

no other human being.

(Kluckhohn & Murray, 1953, cited Bertelsmann Stiftung, 2006)

15. What is culture?

Identity can not be explained independently of culture. But what is culture and what does it do with us?

Culture is "mental software", which is "programmed" in a socialization process. In the course of this socialization and especially in childhood (the primary socialization), the individual acquires certain patterns of thought, feeling and trade, which are described as values and attitudes.

Culture is an important part of human life. It affects our views, our values, our humor, our hopes, our loyalties and our worries and fears.

When we work with people and build relationships with them, it helps to have a perspective and an understanding of their culture.

But it is also important to remember how much we have in common.

We are all human beings. We all have hopes and dreams and pain and fear.



There are about 300 different definitions of culture, eg: "Culture is the orientation system, which is made up of specific symbols and traditions in the respective society, organization or group. Culture influences the perception, thought, values and actions of all its members and defines their belonging to society. The orientation system enables the members of the society to manage their own environment, facilitate rapid communication, facilitate orientation in complex social fields and promote smooth and effective interpersonal cooperation."

(Straub / Thomas, 2003)


For example, spatial perception is culturally conditioned. Spatial perception is not neutral-mathematical: Large halls are impressive, cellar vaults cozy or oppressive. The sensation that spaces evoke is also culturally influenced and not determined evolutionarily.

16. Cultural standards I

Another practical term for assessing human behavior are "cultural standards". They are acquired in the course of socialization and lived unconsciously. They form the basis for their own behavior and the benchmark for the assessment of foreign behavior.

As a central feature of a cultural orientation system, they contain "**all kinds of perception, thought, judgment, action, which are regarded by the majority of the members of a particular culture personally and others as normal, self-evident, typical and binding.** " (Thomas, 2003).

Cultural standards are acquired in the course of socialization and lived unconsciously. Different cultures produce different identities.

It is very important to understand that not all people share our views (cultural standards). This results in different, initially perhaps strange behaviors. But if you understand that these are based on different cultural standards, it is perhaps easier to deal with them.

17. Cultural standards II

Many intercultural misunderstandings and problems result from "... unconciousness about the cultural boundaries of one's own and the specific mode of perception of one's foreign culture partner:

Things and facts are assumed as " normal ", but are not at all for the perceptual habits of the other person

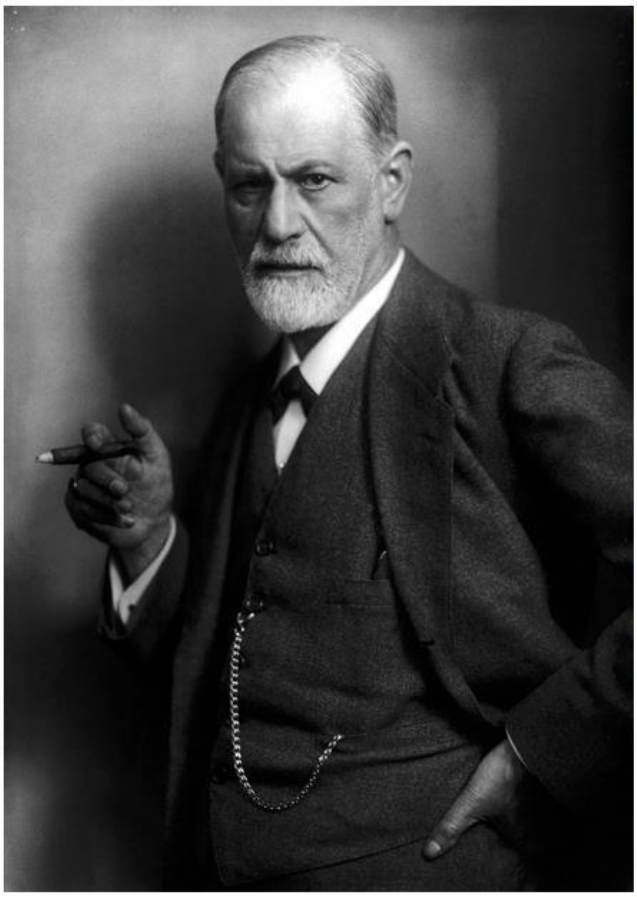
If this lack of plausibility is not addressed, or if the state of affairs is "reinterpreted" until it appears plausible from one's own point of view, all further interactions between the parties are based on the deceptive assumption, one has a common basis of reasoning.

In fact, one argues, however, on very different levels (without noticing). If mutual misunderstanding becomes obvious then the real cause is usually no longer known, which makes it all the more difficult to recover a neutral relationship. (Source: IKO - Interkulturelle Kompetenz Online (2004))

Have a look at the table below, it shows different cultural standards in different countries/societies. They can be a source of misunderstanding.

cultural standards					
	Germany	USA	Peru	India	China
People are striving for	Self-realization and personal responsibility	Individualism, equal opportunities, personal initiative	Social recognition, mutual help	Family orientation, recognition by certain persons	Social recognition and group affiliation
Areas of life	Separation of work and private life	Identification with work, connection with the private	Mixing of work and private	Mixing of work and private	Unity and community building in all areas of life
First contacts	distant, stiff, matter-of-factly, impersonal	(pretended) cheerful, sociable, approachable, "overbearing"	friendly, but suspicious*, appraising, wordy	polite, respectful, emotional, easily vulnerable	polite, respectful, humorous, harmonious
Behavior in conflicts	Direct address, sincerity	indirect dealing, harmony	indirectly, search for third-party fault, suffering	indirect dealing, harmony	indirect handling, "saving face"
Rules and principles	give clear orientation, are irrefutable	are handled flexibly, non-interference more important	are measured by the situation, serve only as a rough guideline	not significant, are beneath the cosmic order	are measured by the situation, serve only as a rough guideline
Relationship with authorities	critical, skeptical	patriotic, loyal	suspicious, stubborn	submissive, ambitious	submissive, appreciative
Thinking and Acting	goal-oriented, planned, analytical, not spontaneous	pragmatic, planned, analytical, risk-taking, spontaneous	passive, mythical-holistic, flexible, spontaneous	adaptable, holistic, innovative, flexible, spontaneous	improvising, holistic, flexible, spontaneous
Work ethics	Performance only for payment or recognition, impatience, short-term goals	Performance *only for* payment *and* recognition, serenity, action orientation	Community achievement, generous support, patience, diligence	Obedience for caring, mutual help obligations, readiness for change	Obedience for caring, mutual help commitments, patience, long-term goals
Dealing with time	strictly planned and leisure-oriented	loosely planned and performance oriented	unplanned and present	everything simultaneously	everything simultaneously
Collective self-image	"We are popular, but ..."	"We are the world power."	"Together we are strong."	"It will go on."	"All others are barbarians."
* These cultural standards in Peru clearly show the mixing of indigenous culture with European. The centuries-long oppression and exploitation					
The model of cultural standards is often used to prepare employees who go abroad to prepare them for the local mentality. However, it should					
source: wikipedia					

18. Structural model of the psyche



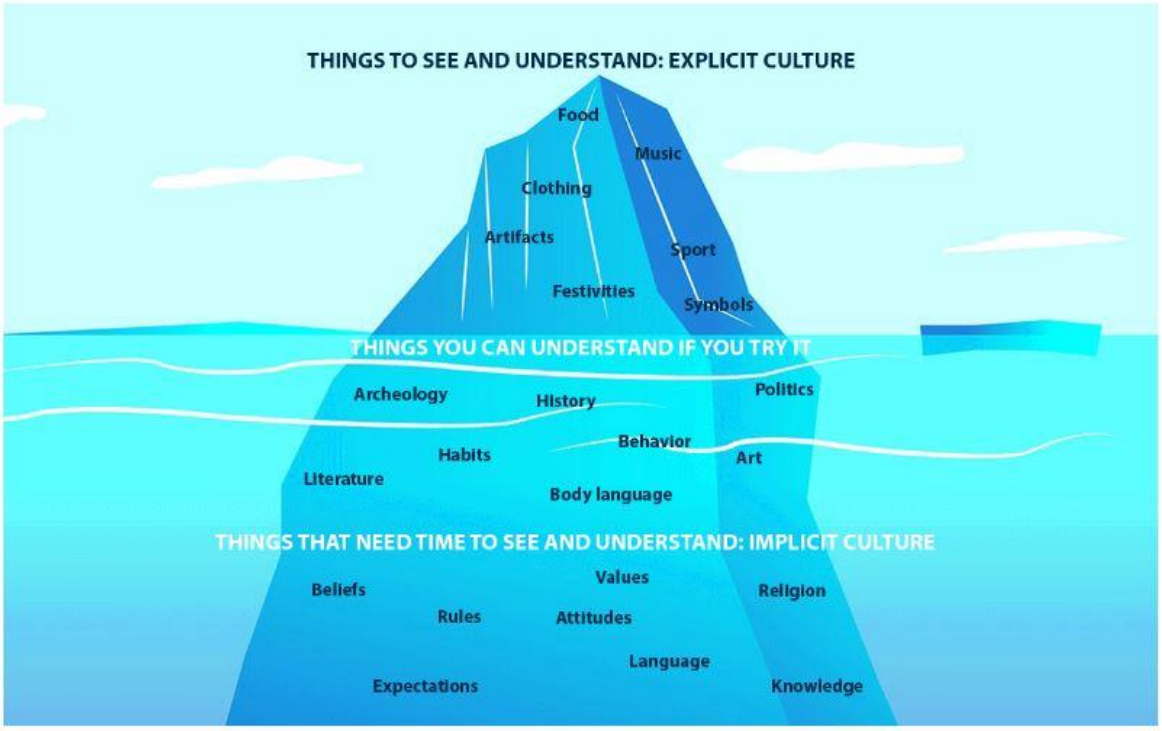
To understand the influence of culture on humans, it is helpful to use the iceberg model. This goes back to Siegmund Freud and his structural model of the psyche.

Freud observed his patients and assumed that human action is consciously determined in daily situations only to a small extent. This contradicted the previous view that behavior can only be traced back to conscious thinking and rational action.

Freud divided the psyche in his structural model of the psyche into three instances and argued that the conscious parts of the *ego* (reality principle) only decide which parts of the *id* (the pleasure principle) and the *superego* (the morality principle) can be realized in the perceptual world, which we experience as true. Thus, he points to the overpowering significance of the unconscious for human action and supplements it with the areas of hidden subjectivity (personality, feelings, conflicts).

Most of the content of the psyche is anchored in the preconscious and unconscious. Only a small part of the content is at the same time conscious to humans. The iceberg model serves as an illustrative analogy for this relation. It is not clear who first attributed the image of an iceberg to Freud's layering model. However, various authors later attributed to his concept of ego, i.e. the conscious areas of the personality, the smaller, visible part of a fictional iceberg above the surface of the water and the unconscious areas, *id* and *superego* , the bigger but hidden under water part.

19. Iceberg model



Visible culture: Language, appearance, etc. are visible elements of cultural affiliation. Everything an individual knows and shows about his/her cultre. Everything we immediately recognize as belonging to this specific culture. But, the visible phenomena of culture are just the tip of the iceberg.

Invisible culture: The majority of the cultural elements creating identity is not visible on the one hand and partly unconscious on the other. The invisible part of the iceberg, the hidden, is the mighty base of the visible manifestations. Below the surface of the water lies the much larger part of the iceberg, the non-visible, not immediately recognizable part. This unknown area of culture must first be "explored" so that any "dangers of collision" can be counteracted.

20. Identity of others

Let's get to the identity of others.

What does this woman do for a living?

Solution

21. Solution

She is a qualified pedagogue and trained child and adolescent psychotherapist.
She is 26 years old, German, married and has a child.
Her parents were born in Turkey.

22. Stereotypes

The way others are perceived is often shaped by stereotypes* . They belong to the implicit knowledge of an individual and a culture, they work without being aware of them. Especially stereotypical alien images can therefore be extremely hindering for successful intercultural action. They diminish the space one gives to the other person to negotiate the relationship, assuming that they have stereotyped positions.

Those who want to counteract the negative flip side of stereotypes must first become aware of them, i.e. transfer them to the area of explicit, self-reflexively observable knowledge.

"With schemes in the head, we not only face the entire reality, but also its sub-areas: the strangers." (See Erll, A., Gymnich, M .: Intercultural Competence - Successful communication between cultures.) 4. Aufl ., Stuttgart 2010.)

*Stereotypes are generalized attributions of attributes and behaviors to members of a social group or category.

23. Stereotypes as pseudo knowledge

Stereotypes are primarily mental processes and are based on (pseudo-) knowledge, which is shared within a group.

Here is an example: A cruise ship with an international audience on board rams a huge iceberg and slowly begins to sink. As the lifeboats jam, the captain orders that the passengers immediately put on the life-jackets and jump off board.

After ten minutes, the first officer returns desperately and announces: "Nobody is ready to jump, what should we do?" The captain himself leaves the bridge, and after another ten minutes all the passengers are off. "How did you do that?" the first officer asks in astonishment. "Quite simply, my dear," says the captain,

I told the Englishmen that it was unsportsmanlike not to jump,

the Italians, that jumping off the ship was strictly forbidden,

the Scottish that the life-jackets were for free,

the Americans, they were insured,

the Russians, it was sad but romantic,

the French, the Englishmen were against it,

the Germans, this was an order and

the Japanese, it is good for the potency.

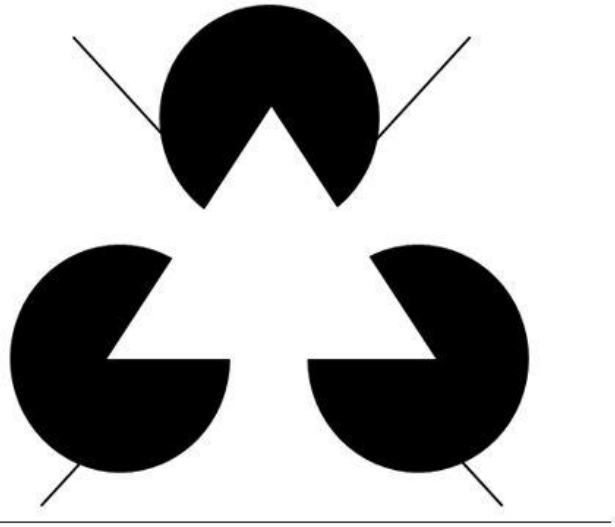
24. Stereotypes for orientation

In everyday life and especially in complex situations, stereotypes act as 'guidance aids' in information processing and action control, because human perception is a mostly unconscious but active process.

The brain as 'organ of meaning' follows the principle of 'cognitive economy'. The following example shows, how this unconscious perception works.

25. Cognitive economy

You may also see a white triangle on three circles on this image, which is a perceptual error, because the triangle does not physically exist, but because the three-dimensional structure appears simpler, more logical, and more familiar, most people here see a white triangle.
This reduction in complexity runs automatically, that is, unconsciously, and can only be temporarily suppressed by conscious control.



The principle 'speed before accuracy' is an evolutionarily advantageous and especially for everyday coping necessary process, which is also error-prone.

These mistakes are mostly meaningless in everyday life and remain without consequences.

In complex activities such as the care of those affected by an emergency, however, they can have considerable consequences (see St. Pierre, Hofinger & Buerschaper, 2011, pp. 89 ff.).

26. Pigeonholing

Also social perception (the perception and thinking about other people) uses social categorization (stereotyping). The most commonly used in meeting strangers are age, gender and ethnicity.

Pigeonholing (stereotyped thinking) feeds on unquestioned generalizations, unreflective stereotypes and thus provides an ideal breeding ground for discrimination.

Stereotypes are a part of our thinking that is schematized for practical reasons. They do not depict reality, because there is no (regular) matching of the folders with their actual content, therefore, stereotypes are also relatively resistant.

It makes sense to review about ones stereotypes from time to time.

27. Checking your stereotypes

What does this man do for a living?

Solution

28. Solution

He is a lieutenant and a student officer. He is 26 years old and his parents are from Mozambique and Germany.

29. Prejudices

Prejudices are blanket and usually negative reviews of other groups (members). Like stereotypes, they are based on insecure but socially shared knowledge, but are more associated with feelings and behavioral tendencies (such as discrimination).

Prejudices often persist despite contradictory information and serve less for orientation than to stabilize one's own identity and the positive assessment of one's own person or group. Prejudices arise e.g. through culturalization, i.e. a reinterpretation and reduction of behavior and perceived differences to cultural characteristics.

Prejudices reduce the complexity of backgrounds, contexts and processes. As a result, these appear easier to explain, but important other aspects are not taken into account.

For example if school failure is associated with ethnic background instead of acutally cramped housing conditions, which don't allow for undisturbed homework.

In addition, it is often associated with 'blame' for (interaction) problems. Essentially cultural ideas are often instrumentalized to legitimize one's own culture and existing relationships of domination.

For example American ethnologist Laura Nader has found in comparative studies in Western Europe, the US and Middle Eastern countries that women are often played off against each other in the struggle for social equality with cultural arguments. Islamic women are considered oppressed in the Western public; while Islamic media, in turn, spread stereotypical images of Western women as sexual objects, rape victims and elderly women deported to retirement homes. The culturally conditioned, supposedly far more problematic situation of women in the other cultural sphere is often used in public discourse to relativize the social ills existing in both regions. In the West, as well as in Islamic countries, women should be reassured by the message: "Compared to women in other societies, you are fine."

30. Ethnocentrism

Prejudices can also be based on ethnocentrism. The term ethnocentrism "is a primarily psychological one, but it is also used in various social science and political science studies to describe the bias of an individual or a group towards foreign groups. The characteristics of one's own group to which an individual belongs are assumed to be the basis of evaluation and superior to those of outgroups. "The sense of superiority may refer to culture, lifestyle, belief or religion." "The phenomenon of ethnocentrism is based on believing that one's own patterns of behavior and those of the ethnic group to which one belongs are always normal, natural, good, beautiful or important.

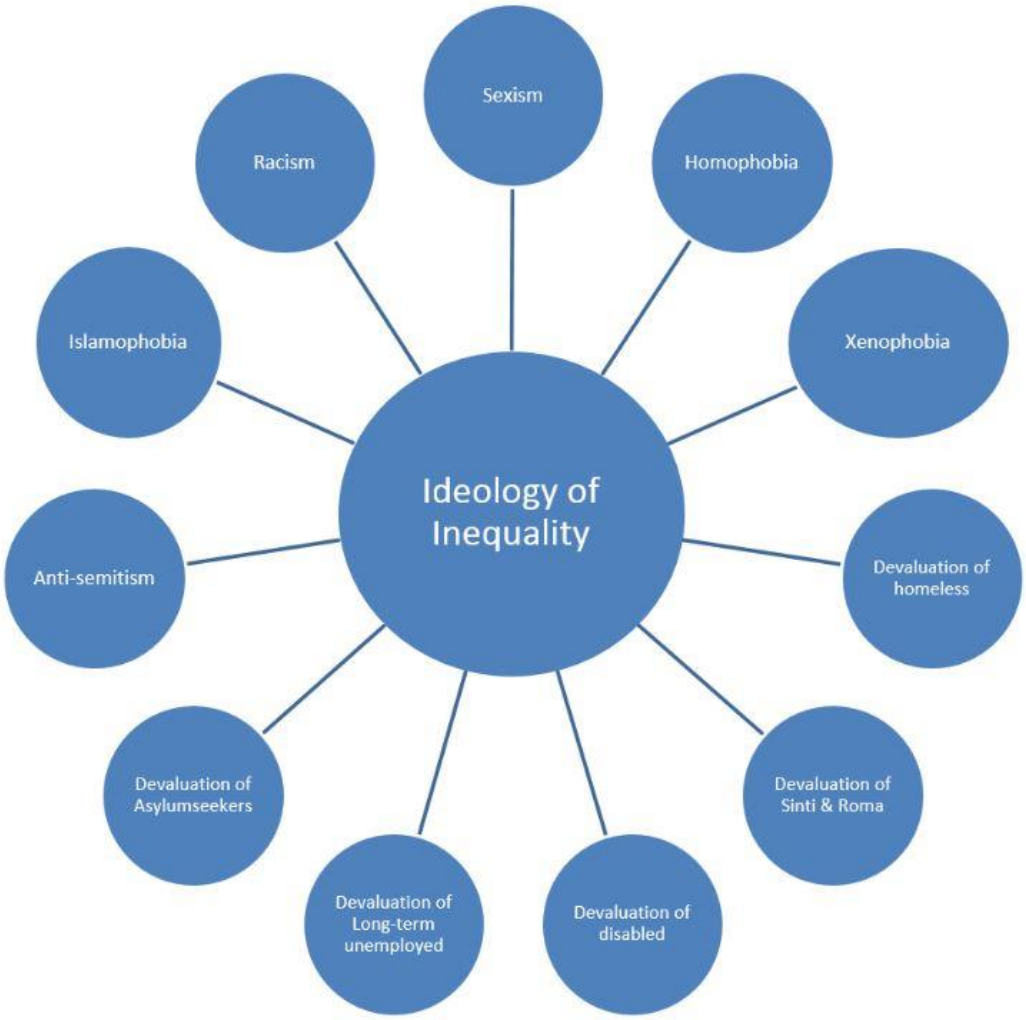
Before this normative scale, strangers - whose culture differs significantly - can be judged as wild, inhumane, disgusting or irrational. "This way of thinking can make dealing with foreign cultures considerably more difficult. And even lead to....

(Cf.: Ulrich Schneckener: Ethnocentrism, in: Dieter Nohlen (ed.): Encyclopedia of Politics, Vol. 7 (Political Terms), CH Beck, Munich 1992ff, 156; LeVine, RA & Campbell, DT (1972). Theories of Conflict, Ethnic Attitudes, Group Behavior, New York: John Wiley.)

31. Group-focused enmity

THE foreigners, THE asylum seekers, THE Muslims, THE homeless, THE Jews, THE gays - whenever people are divided into groups for a common feature and they are devalued and marginalized, it is called group-focused enmity. If people are labeled as somehow 'different', 'foreign' or 'abnormal' because of their assigned affiliation with a social group, then 'diverse' easily becomes 'unequal'.

Prejudices against a group - e.g. Immigrants - are usually not alone, but the devaluation of a group goes hand in hand with the devaluation of other groups. Gordon Allport, the father of modern prejudice research, noted this: "One thing we're pretty sure of is that people who reject an outsider group also tend to reject other outsider groups, when someone is against Jews 'he's probably against Catholics, Blacks and any other outsider group.' Those who generally advocate hierarchies between social groups tend to be more likely not only to devalue a specific group, but generally to devalue a whole range of groups; and so xenophobia, anti-Semitism and homophobia often go hand in hand. The goal is always to maintain or establish social hierarchies.



Not surprisingly, it has been empirically confirmed that the following ideological attitudes are particularly important factors for Group-focused enmity: The tendency of a person to authoritarianism, meaning an exaggerated positive attitude to law-and-order and at the same time the willingness to obedience, the social dominance orientation, i.e. the explicit endorsement of social hierarchies, and the general rejection of cultural and religious diversity, with a higher acceptance of all elements of group-focused enmity, e.g. also related to homophobia and sexism.

Group-focused enmity is also promoted by an economic value system that judges people according to their usefulness. In addition, those in the modern world who are disoriented tend to have more group-focused enmity.

On the other hand, a protective effect against enmity has contact with those who are considered to be "different". This protection, which is remarkable, is not limited to the group to which contact exists, but also has a positive effect on attitudes towards other social groups. Those with contact to immigrants tend not only less to xenophobia, but, e.g. less to homophobia.

32. Prejudices and operation

In the field of operations, the most diverse people are to be provided according to their needs and the applicable ethical and legal standards. If there are significant prejudices among helpers, these must regulate the associated negative emotions in action in order to remain able to act. This inner process binds resources that are then missing for a professional care of those affected.

As a result, stress is generated or increased - during and possibly also after work(see Intercultural in-service stress reduction). It is therefore recommended that helpers review their own assumptions, categorisations and attitudes regarding certain people (groups) and, if necessary, edit them in order to be able to provide these people with complete professional support.

Sharpening one's intercultural competence is thus very useful.

33. Summary intercultural competence

What is intercultural competence?

There are many different answers to this question. Being aware of one's own cultural values, stereotypes and prejudices is a start.

Other elements include awareness and acceptance of cultural differences. e.g. sociocultural differences in how people deal with pain and stress.

It is important to understand that different cultures express and interpret information differently. (more in module 2)

For everyday working life it helps to acquire working knowledge about various health and disease-related beliefs, customs and practices of different groups.

Similarly, flexibility is needed to be able to respond to cultural differences. For example, the linguistic adaptation of information.

The following characteristics of intercultural competence can be summarized:

Attitudes, mindset and characteristics

- Motivation and interest in intercultural contact
- Respect for the customs and traditions of other people
- Impartiality, abstain from negative evaluation
- Courtesy, friendliness and diplomacy
- Patience and tolerance
- Accept and tolerate contradictions (ambiguity tolerance)

Skills

- Communication skills (e.g., listening and capture important concerns)
- Calm and controlled behavior in case of difficulties (impulse control)
- Conflict resolving skills
- Reflecting own stereotypes

Knowledge and proficiency

- General knowledge and awareness about cultural differences
- Knowledge of certain cultures
- Linguistic proficiency

34. Conclusion

Intercultural competence in action helps to implement work/mission tasks in an intercultural context as completely as possible and to better and more successfully provide emergency patients with a migrant background.

Intercultural competence thus also contributes to the job satisfaction and stress reduction of the rescue service personnel.

Intercultural competence is a key competence - now and in the future.

35. Diversity

However, intercultural competence is only a partial aspect of a generally necessary diversity sensitization. To explain this word, we chose the following movie instead of using many words.

36. Digression - Intercultural opening

The claim of civil protection is the best possible preparation and supply as far as possible of all population members and groups. The socio-cultural and ethnic diversity of the population poses a challenge to planers and civil society actors.

In other culturally diverse countries, such as the USA, Australia or New Zealand, as well as in global humanitarian and disaster relief, the need for a fitting of aid measures with socio-cultural characteristics of the affected people and societies is being addressed increasingly.

37. Mission statements

Rescue service workers are not only committed to general ethical principles, as they are formulated in laws, but also to the mission statements of their employers.

Our vision for the future

The next five years for NEAS are going to be exciting as we drive and lead major system reform. This period is also going to be challenging as the reforms are critical to our success and our financial sustainability.

Our mission

Why we wear our badge.

Safe, effective and responsive care for all.

The pride we place in delivering these services marks us out as second to none in terms of reliability, professionalism and compassion. People rely on us for the responsive services we provide all day, every day, throughout the areas we serve.

Our vision

Where our badge will take us.

Unmatched quality of care, every time we touch lives
Even in the most challenging situations we will strive to perform to the highest professional standards in a spirit of collaboration and team work. We will be acknowledged as the leading specialty care provider when looking after the patients in our care.

Our promise

Our badge stands for unmatched quality of care for every life we touch.

For Life

"This is a start of an exciting new journey for NEAS. The setting of a new mission and vision is a line in the sand, marking a time for change for the better."
Yvonne Ormston, CEO

Our values

Respect.
We work in challenging environments and situations. We will treat all our patients, colleagues and customers alike, with the same respect we'd expect to be shown ourselves. We will act as one team and will appreciate one another in facing the future together.

Take responsibility and be accountable.
We will make sure we do what we commit ourselves to, and take responsibility for our actions. In doing this, we will support each other in delivery, and react quickly to lessons learnt along the way. Be only critical of ourselves, not others.

Compassion.
To deliver our services effectively, care alone is not enough. We care for our patients and staff with compassion and empathy that marks us out as special. We listen intently to those whose lives we touch, so that our provision is considered to be above and beyond the call of duty.

Pride.
This is more than a job, and it's a privilege to serve the patients in our care. We've made a true commitment to our vocation as part of the overall NHS healthcare system. This will drive us with integrity at every turn to help others. In return, we will commit to the recognition, training and development of our team so that they can perform their duties to the best of their abilities.

Strive for excellence and innovation.
We will always do our very best. We will learn and constantly innovate wherever we can by embracing change to enhance our service. We will listen to, and collaborate with, our colleagues throughout the NHS, fellow emergency services and patients. This will enable us to remain at the forefront of specialist responsive care, as a dynamic, integrated and sustainable service.

Make a difference - day in day out.
We touch people's lives on a daily basis. How we do that can be life-saving or life changing. We will always aim to make a positive difference to those people's lives. And we will show the same respect to our colleagues as our patients.

Our strategic aims explained

Our strategic aims underpin our activities over the life of this strategic plan and summarise what we want to achieve.

Do what we do well
1. Achieve sustainable service delivery and ongoing improvements, whilst protecting best practice and quality standards through optimum use of all available resources.

Look after our employees
2. Nurture a consistent culture of compassion that values and supports employees to deliver exceptional care to patients.

Develop new ways of working
3. Drive and shape the future of urgent and emergency care services through effective integration and collaboration.

38. International examples

Internationally, the USA, New Zealand and Australia are pioneers in terms of intercultural opening. Background for the intercultural opening was evidence of unequal treatment of minority groups in the health system ("Unequal Treatment"), especially during disasters (by Hurricane Katrina, 2005)

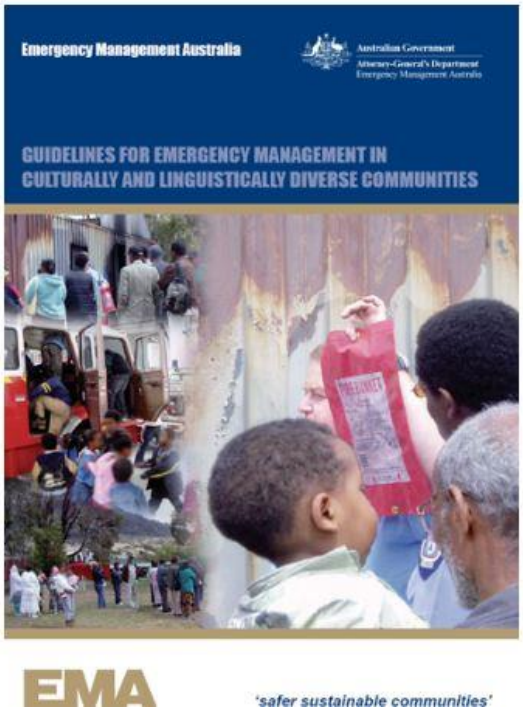
In response, the US developed the "National Standards for Culturally and Linguistically Appropriate Health Care (CLAS)" and the "Think Cultural Health" program, which provides online resources and e-learning for medical personnel and civil protection.

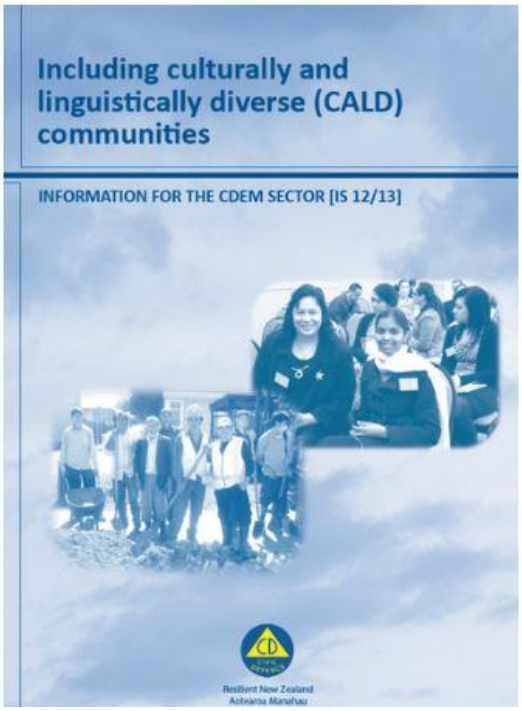
More

Community-based approaches

Aim: to increase the sensitivity of the response and task forces as well as the resilience (including participation) of the entire population

Key message: Build a relationship with communities based on respect, mutual trust and understanding before disaster strikes.





39. Humour connects

Now to finish this first module, we want to have a humorous view on stereotypes and prejudices. Enjoy the change of perspective!

- Asian Network Comedy
- Maz Jobrani
- British Citizenship Test - Stand Up Comedy Imran Yusuf
- Laugh Factory

Module 2 – Migrants & Health

TABLE OF CONTENTS

1. Migration - Why?

In the first module, you dealt with intercultural competence and questions of identity. In the second module we want to deal with the other, the stranger. Who are they and what is there to consider when dealing with them from a professional point of view. But first let them speak for themeselves.

Why do people leave their home?

"Would you leave your home if it would save your life?"

Would you leave if another country offered a better life for your family?"

"Would you leave your home if you were being persecuted?"

"Would you move to another country if you couldn't find work?"

"Would you leave everything behind, all your friends, all your family, all your belongings, everything you played with, everything that you grew up with?"

(Sajwaa) "I left Iraq in 2006 with my three children due to the escalated situation back there. There was a civil war in Iraq and due to my background and my husband's, we were subject to persecution and threats by different parties".

(Shakeeb)"I left India in search of more experience and because I wanted to get more exposure in my job; I wanted to learn about different cuisine and I had always heard about Europe; that there's more work and better working environments, more job security and that people are more accepting of people from other parts of the world".

(Alain) "I left Congo because of political problems. In our country especially things are not going well; people are starving every day, students are not going to school, there's no freedom, you can't even express yourself and I thought that if I went back to that country I would die, or maybe be persecuted".

(Ines) "My name is Ines, I come from Portugal, and I came to the UK because of work. At the time it was not as bad as it is now, but I still couldn't find any sort of work for two years. For some time I was doing temporary jobs and these started to become fewer and fewer until I had nothing".

(Priyanga) "I came here simply for a better life. My parents and I, we left Sri Lanka when I was twelve years old, and we had to flee the country because civil war had broken loose, and the lives of both my parents were in danger. When we came to the UK it was the year 2000 and several locations – asylum applications – were originally rejected and we had to keep putting in fresh claims".

What is it that would make you leave your own home, what is it that would make you leave everything you have, all your friends, all your family, everything that you own and go to a different country?

Project „Positive Images"

2. Migration - how?

How do people leave their homes?

"Given the opportunity I don't think that anyone would want leave their country".

"It was terrible to leave my family behind".

"The best part is just to be in a secure country where people are free to say what they want to say".

(Sajwaa)"We had to leave Iraq without telling anyone. During the journey, on the road to the Syrian-Iraqi border there was an American tank in front of our car. First of all the soldier on that tank waved a red flag, so we stopped. And then, after a while, the same soldier raised an orange flag. This orange flag should logically be interpreted as get ready, just like the traffic lights, but the driver who was driving the car started going forward. That was a really life threatening move because at that minute the tank opposite us started shooting towards our car".

(Ebrahim) "I'm Iranian-Kurdish. I had political problems in my country and one day I had to leave the country very urgently. We spoke to the driver and then we had to go to the back of the lorry. There was a space in the middle so we went in so that it looked like we disappeared, no one could see us if they opened the door. Sometimes the lorry stopped and the driver said "I want to have a rest" and then he'd sleep for about ten hours and then we'd start moving again. But when I came out from the lorry I didn't know where I was. I asked the driver, he said "it's the UK". I just wanted to go somewhere safe, I couldn't even speak English, I was very hungry, I hadn't slept for about four or five days".

(Glenda) "I left the Philippines in January 2002 and we were in a group, about fourteen of us. When we reached Paris I said to my friend "Can you pinch me?" I couldn't believe I was there!"

(Priyanga) "It was very hard to make friends at the start. They wouldn't talk to you because you were different and if they were seen talking to you they would be different and they were conscious about that"

(Ines) "I don't know if you know but in Portugal there are also a lot of migrants. We create an opinion when we are in our own country, looking at migrants, but coming here you can imagine that my perspective changed a lot. I can see and understand the reasons why people do it and how fragile those people are, simply because they are not in the place that works the way they know it. They can't see people they know every day. Now when I go to Portugal, whereas before I had huge prejudice towards the migrants there, now I look at them and I just wish them the best luck".

Projekt „Positive Images"

3. Migration - who?

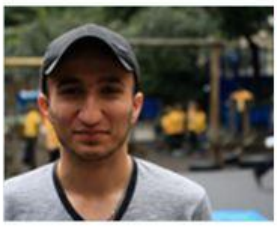
Who are the migrants?

(Glenda) "I'm not an asylum seeker, I'm a migrant worker, I came here for work legally.

I'm a nurse, I'm a Filipino, I'm a hard worker, and I am very good and very friendly".

(Sajwaa) "I'm not an economic migrant, I'm a refugee. The government has agreed to let me stay legally in the country because I was persecuted in my country

I'm a teacher, I'm a mother of three. All three of my children study, and I am your neighbour".



(Ebrahim) "I'm not a refugee but I'm an asylum seeker which means the government hasn't decided whether to accept me as a refugee or not".

(Priyanga) "I'm a refugee".

(Shakeeb) "I'm a migrant worker".

"An asylum seeker is just a status, but beyond an asylum seeker there's a person".

(Ines)"I am a woman. Like every woman in the world I am a daughter, a sister, a mother, worker. I'm resilient, I'm passionate and I smile when I'm nervous!"

Project "Positive Images"

4. What happens when humans migrate?

5. Phases of migration

Migration is usually described and researched as a positive option for Lifestyle, but also as a potentially harmful stress experience for people (groups) (Borde & David, 2007). The heterogeneity of migrants and migration contexts hardly makes generalizing statements possible.

However, it can be expected that this experience will be more negative if the migration was not voluntary, triggered and/or accompanied by traumatic circumstances and its outcome (e.g., integration in the destination country) is considered unsatisfactory.

Preparation and actual migration

Dealing with the question of whether migration or not□decision□

Redistribution of roles□

Attempt to estimate loss and profit□

Can lead to feelings of guilt towards those who are left behind

Escape/Flight: often no preparation - shock

Arrival and first time in the new country

Euphoria - shock - confusion□

Cultural similarities are explored□

Behavioral values are examined for their acceptability and "usability" in the new environment

Predominant feelings: grief, fear, longing, rejection of the new, idealization of the former environment□

Rituals of farewell and arrival are missing

Loneliness - members of the same ethnic group are important

Overcompensation - strong adjustment efforts

Stress is not consciously perceived

Great vulnerability, good and bad experiences are experienced very intensively

Experiences with representatives of the host society are formative□many practical challenges

Decompensation – Phase of regeneration

Vulnerability to conflicts

Crises□

Physical symptoms□

New role allocation required

This phase is very difficult, but can lead to considerable development steps

Susceptibility to depression and identity crises in the case of a lack of integration possibility - also extreme idealization of one's own cultural character

Reorganisation

The mourning process still lasts, but does not influence the ability to act in the present so much anymore

□New culture is checked in detail□□

Partial merging

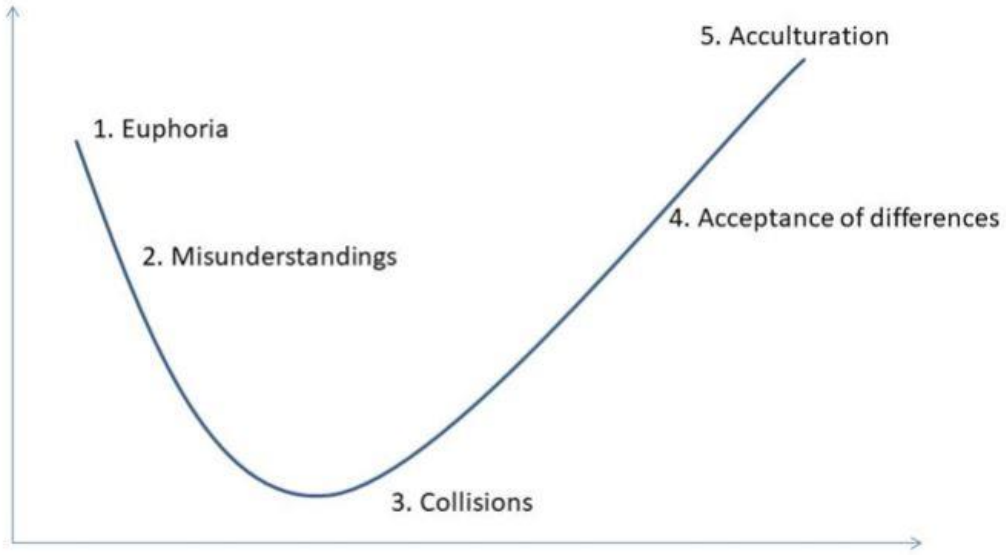
□Realistic view of both worlds□

Next generation has an important mediating role□

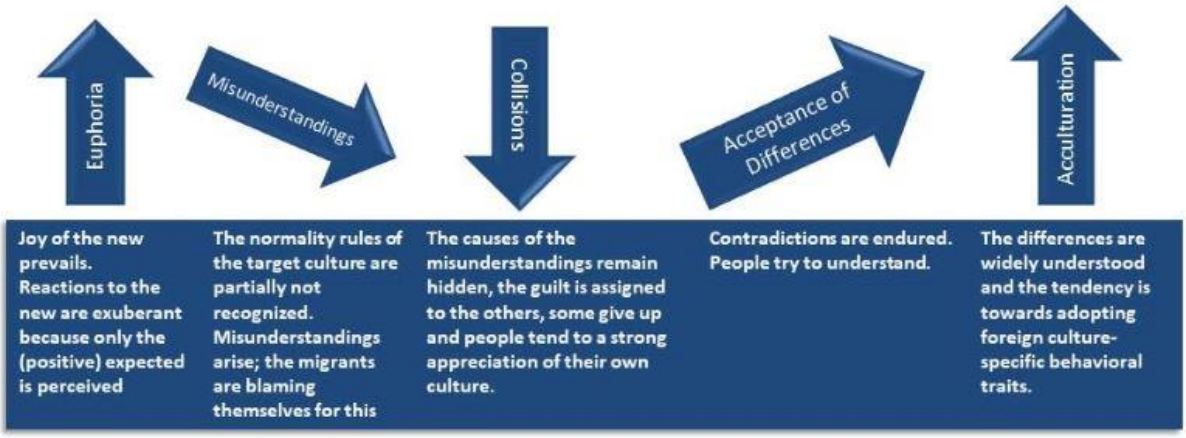
Work is particularly important for the location in the new society□

Stable relations with the country of origin and the host country can now be built up and maintained

6. Phase model of Sluzki

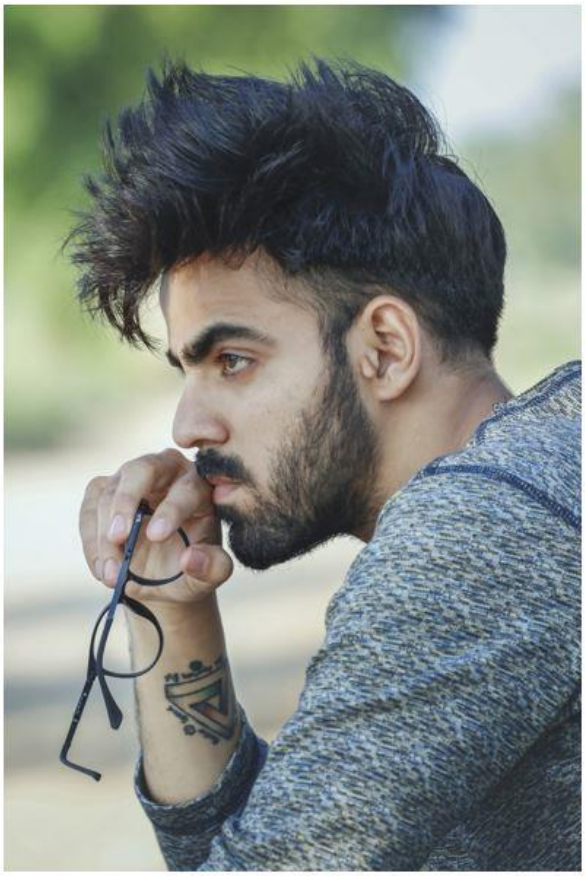


The phase model of migration according to Sluzki (2001) describes the functionality (and thus indirectly the well-being) of migrants.



For psychosocial emergency care, this may mean that migrants affected by emergencies are emotionally pre-stressed differently depending on their current stage and thus have more or less resources to cope with the current situation (Schouler-Ocak, 2012).

7. Migration-specific risks



Psychosocial stressors:

- separation from family and country of origin
- unclear residence status
- experience of persecution and torture in the country of origin
- xenophobia in the country of immigration
- possible loss of status
- unpredictable future prospects
- multiple loads and communication problems.

8. Special problem situations

Apart from the general burdens of the migration process, migrants can also be in special migration-related problematic situations.

Knowledge about these holds valuable background Information for emergency care.

We consider the following groups of people

- asylum seekers
- people without legal residence status
- unaccompanied minor refugees
- people with mental illnesses
- genital mutilation

9. Asylum seekers

Asylum seekers themselves are basically at risk from the same infectious diseases as the resident population. However, due to a possible lack of or incomplete immunization protection and the tight spatial situation in the reception facilities, this group of people is more susceptible to infections. Thus, asylum seekers are more a vulnerable group than one that is dangerous to others.

They are more likely to suffer from vaccine-preventable pathogens. Measles, chickenpox, mumps, whooping cough, influenza and hepatitis A should be mentioned in this context, including with regard to possible outbreaks in collective housing.

Overview of epidemiologically relevant infectious diseases in connection with asylum seekers

	vaccine-preventable diseases						gastrointestinal diseases	parasitic diseases	respiratory diseases
	Hepatitis A	Influenza	whooping cough	Measles	Mumps	chickenpox	Norovirus	Scabies	tuberculosis
transmission	fecal-oral contact infection as well as contaminated food or drinking water	inhalation of infectious droplets	inhalation of infectious droplets	inhalation of infectious droplets as well as contact with infectious nose and throat secretion	inhalation of infectious droplets and direct saliva contact	inhalation of infectious droplets and contact with virus-containing vesicles			
incubation period	15 - 50 days usually 25 - 30 days)	1 - 8 days	9 - 10 days (6 - 20 days are possible)	8 - 10 days until the beginning of the catarrhal stage, 14 days until the eruption of the rash	16 - 18 days (12 - 25 days are possible)	8 - 28 days (usually 14 - 16 days)	10 - 50 hours	first infection: 4 - 5 weeks, reinfestation: 1 - 2 days	Latency to the disease: months till several years
most common symptoms	mostly without symptoms - especially in children. unspecific symptoms: slight increase in temperature, loss of appetite, nausea, vomiting, performance kinking and pressure pain in the right upper abdomen; in the later phase of the disease: jaundice	Sudden onset of illness with pronounced disease in the whole body, high fever, chills, headache and fatigue, body aches. full screen only occurs in a proportion of cases, depending on the patient's age and virus subtype.	flu-like symptoms such as a runny nose, a mild cough, seizures (staccato coughs), followed by inspiratory withdrawal, no or only moderate fever	Fever, conjunctivitis, runny nose, cough, Koplik patches, maculopapular masernexantheme	painful or double-sided inflammatory swelling of the parotid with possible involvement of the submandibular or sublingual salivary glands, respiratory symptoms possible	itchy rash, fever, skin lesions from papules, blisters and scabs in various stages of development ("starry sky")	pronounced malaise with abdominal pain, nausea, headache, myalgia, exhaustion, giddy vomiting and severe diarrhea	slight burning of the skin, itching, pin-sized vesicles, erythematous papules and pustules	Coughing with or without sputum, general disorders, lack of appetite, weight loss, mild fever, increased sweating (especially at night), tiredness, general weakness or flu-like symptoms, nonspecific symptoms, also asymptomatic diseases
potential for outbreaks	medium	high	high	high	medium	high	high	medium	medium

Source: asylum seekers and health in Germany: overview of epidemiologically relevant infectious diseases

Dtsch Ärztebl. 2015; 112(42): A-1717 / B-1423 / C-1395

10. People without legal residence status

An undocumented life may also appear to be a better option or "lesser evil" than what people would expect following their forced return to their home country, which they eventually choose.

The term "illegal" refers to the fact that a person resides without residence rights in a country and therefore makes himself punishable under the Residence Act.

People without a legal residence status can, among others, be:

- Rejected asylum seekers obliged to leave the country
- Persons who, after a divorce, do not have a residence permit from a person who has the right of residence, but who wish to stay or can not return
- Victims of trafficking and forced prostitution who are forced to stay or are in other mental and financial dependencies.
- relatives of migrants living in the host country who have not applied for their own residence permit after entry, e.g. second wives
- Persons whose tourist visa, student, employment contract or au pair visa expired
- Others have entered without valid, with forged or without documents.

The problems and deficits in health care, which are often found among migrants, are particularly applicable to people without a legal residence status.

To make matters worse, they are exposed to increased health risks due to their life and work situation. At the same time, they are not granted access to health care by the state. Exceptions are the diagnosis and, to a limited extent, the treatment of communicable diseases covered by the Infection Protection Act.

Medical treatment is delayed and illnesses are delayed to worsening, chronification or even death. Other phenomena include physician hopping and discontinuity in treatment.

One of the reasons for this is the fear of discovery and resulting deportation - "Survival stress" has negative effects on health risks and health behavior, ad hoc medicine is often the result.

11. Unaccompanied minor refugees

Unaccompanied minor refugees are a particularly burdened and vulnerable group (UNHCR, 2106). International studies show that they have a higher number of traumatic experiences compared to other underage and adult refugees and that they often suffer from mental disorders.

In addition to the post-traumatic stress disorder as a classic trauma disorder, occur, among other things, anxiety, depression, suicidality and psychosomatic complaints.

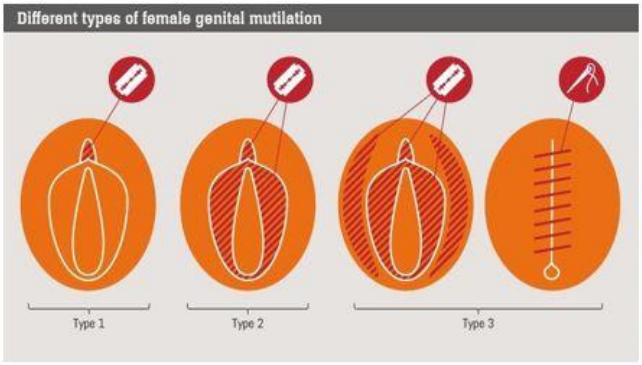
UMRs not only have to deal with the fate of the flight and the experiences made in this context alone, without the protection and support of their parents or other caregivers, but are also in a phase of life in which they deal with the particular mental, social and physical challenges associated with growing up.

For all decisions normally made by parents for their minor children, an unaccompanied minor refugee needs a guardian. The reason: their legal capacity to act is limited. They, for example may not engage in legal transactions (such as signing contracts) etc. and are not allowed to consent to medical examinations and treatments.

The guardian has to act solely in the interest of the unaccompanied minor refugee. The focus is on the well-being of the child. The guardian is the personal contact person for the adolescent.

The guardian has the right to stay, provides the application for assistance to education, to ensure the adequate care, housing, education, linguistic support and care of the minor and is responsible for the health care.

12. Genital mutilation



Even in Europe many thousand girls are threatened or affected by genital mutilation. Responding to this situation appropriately is a major challenge for society. Many refugees come from countries where genital mutilation is practiced, especially from African countries, but Iraqi Kurdish women are also 80% affected by genital mutilation. It may well happen that you are confronted with patients whose health problems were caused by genital mutilation. These include: Acute effects of female genital mutilation.

Acute complications

Infection	Problems with urination	Injury	Bleeding
Local infection, abscess formation, general infection, septic shock, HIV infection, tetanus, gangrene	Urinary retention, edema of the urethra, dysuria	Injury to neighboring organs, fractures (femur, clavicle, humerus)	Hemorrhage, anemia, shock, death

Chronic somatic complications

Chronic nfections	Sexuality/menstruation	Problems with urination	Complications of scar tissue
Chronic vaginitis, endometritis, pelvic inflammatory disease	Dyspareunia/apareunie, vaginalstenose, infertility/sterility, dysmenorrhea, menorrhagia	Recurrent urinary tract infection, prolonged urination, incontinence, vaginal crystals	Abscess, keloid formation/dermoid cysts/neuromas haematocolpos

Link

13. Mental illnesses

Mental health examinations of refugees in 'western' host countries show taht this population is up to ten times more likely to have post-traumatic stress disorder (PTSD) than the native population (Fazel, Wheeler & Danesh, 2005). Investigations in Germany also provided evidence of higher levels of mental health problems such as depression and anxiety (Lindert, Brähler, Wittig, Mielck & Priebe, 2008). Those with an immigrant background tend to be at increased risk of pre-existing mental health problems. This is especially true in experiences of persecution, violence, loss, flight and discrimination.

General intercultural aspects of Psychosocial emergency care situations

• Every intercultural encounter involves challenges - in emergency situations, these challenges increase normally for all involved.

• The behavior of those affected by an emergency (stress and crisis management strategies / coping strategies) is determined by their situational, personal AND sociocultural aspects.

• All these aspects should be taken into account in the emergency care of those affected in order to ensure the quality of care.

• Culture-specific knowledge (for example, about dealing with death in different cultures) is helpful, but it does not provide absolute security - flexibility and clarifying as well as focusing the provisioning mandate are therefore always required.

• Contacts with (representatives of) the local socio-cultural groups / communities and their involvement in planning for psychosocial emergency care increases efficiency in an emergency.

• A (stronger) sociocultural diversity of the professionals in psychosocial emergency care (intercultural opening of the relief organizations) facilitates the need-based care of those involved in the mission.

Action-related intercultural aspects of psychosocial emergency care

• Uncomfortable or inappropriate appearing behavior (coping strategies) of those affected may lead to confusion, irritation and excessive distancing. The management of one's own emotions is then particularly important.

• Mental stress can be expressed more through physical sensations and complaints (in part as culture-specific expression strategies).

• In general, a culturally sensitive rather than a culture-specific approach to understanding the expression and coping strategies of people in emergencies makes more sense, as these strategies are complex and people sometimes use different ones in parallel or alternately.

• The five principles of psychosocial emergency care according to Hobfoll , which are also recommended by different federal departments for disaster relief and civil protection, are also suitable as a guideline for a culture-sensitive psychosocial care.

14. Five essential elements according to Hobfoll

Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention:

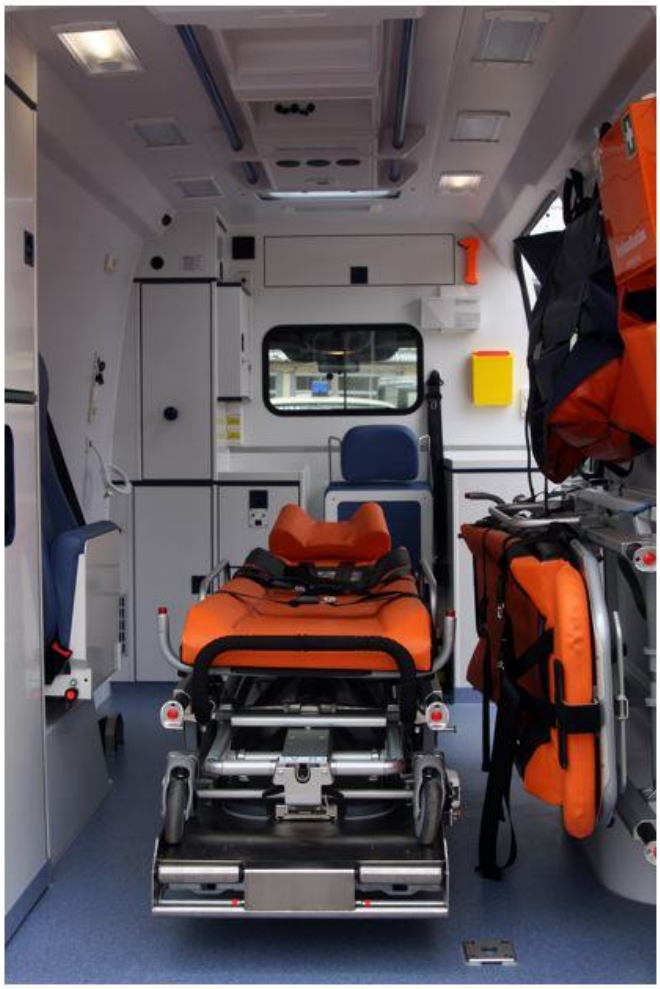
- Promote sense of safetey
- Promote calming
- Promote sense of self- and collective efficacy
- Promote connectedness
- Promote hope

Link to article

15. Access to health services

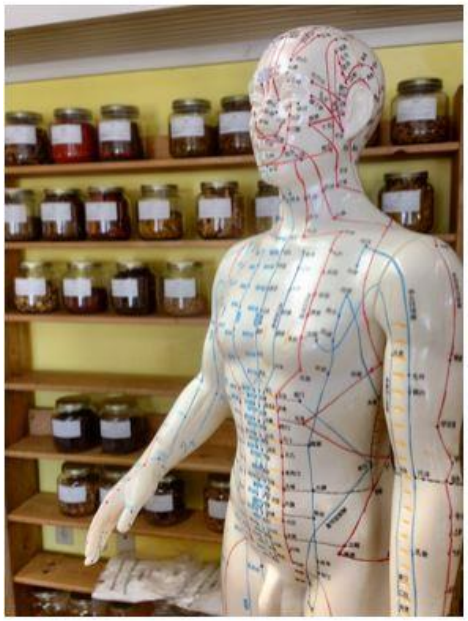
Health, illness, causes of disease and their prevention are culturally, socially and subjectively shaped. Behavioral patterns, values, norms, terms, attitudes and expectations are thereby influenced. Access barriers to health care can be linguistic and/or cultural as well as gender specific. Migrants often have poorer access to health care than European citizens, and this is especially true for preventive versus curative services. For example, a lower vaccine coverage of migrant children contrasts with the high use of emergency outpatient clinics (Razum/Geiger 2003: 689). The increasing use of rescue services by certain groups of the population (including migrants), in recent years, is shown in different studies from different countries. It is likely that emergency services will be used as basic health care for specific groups of the population.

16. Rescue service as basic care



The explanations for this may be related to the particular healthcare system, e.g. the health care by ambulances is free. Other aspects may be: the location of the ambulance in the city in relaton to the Location of residential districts with a higher proportion of migrants, the rescue center as a low-threshold offer especially for those people who have no family doctor and their usability also at night and on weekends and the relatively anonymous treatment. Rescue centers are an unbureaucratic alternative for asylum seekers and refugees, as they do not need to apply for a treatment certificate from the Social Welfare Office in advance (Borde / Braun / David 2003: 43ff). Experiences of relatives and friends with treatment in emergency rooms may also play a role.

17. Medicine as a cultural system



Medicine is closely linked to the prevailing religion, philosophy and practice of life and socio-economic backgrounds. This context has always (co-) determined what and who was healthy (normal) or sick (abnormal).

"Medicine" can also be seen as a cultural construction - that is, as a "system" that is closely linked to the socio-cultural background from which it originated and in which it exists. Humans can use various systems to treat diseases (e.g., biomedicine, homeopathy, or traditional Chinese medicine). Sometimes they also do this in parallel (Greifeld, 2003). The (emergency) medicine practiced in Europe is based on a biomedical, anatomical-organ-related understanding.

Basic knowledge of different medical concepts is useful for health professionals and also for emergency aid workers, as differences in the understanding of medicine between them and those affected by the emergency can lead to irritations and misunderstandings as well as to incorrect diagnoses and treatments.

18. Body concepts

Sociocultural backgrounds also shape the perceptions people have of their bodies.

Biomedicine	Holistic body concept	Social body concept
Anatomical-organ-related idea of the body. Presentation of the body as a (well-tuned) system of parts	Disease of a body part or organ without being affected by the whole body and human being difficult or even impossible to imagine.	Human bodies as part of a larger organism (e.g., the family) connected and communicating.
(Miss) sensations are usually directly associated with anatomical structures (e.g., organs). Mental states are described organically (for example, "That hit me on the stomach.").	Symptom descriptions are correspondingly comprehensive ("The pain is everywhere.").	Members of a group also react physically to diseases of other group members

19. Concepts of health and disease

For the medical profession, the *disease* as such is the basis of communication with the patient.
For the sick, on the other hand, personal *illness* is the basis of interaction.
In other languages, German for example, there is only the term illness, which means both.

Being ill/ feeling ill (illness)	Disease
Individual perspective of the patients, including mental, social and cultural level.	Perspective of biomedicine. Illness is diagnosed on the basis of history and physical examinations (manual or apprative).
Symptom-bound – if such are missing, no sense of illness is experienced.	Disease without symptom possible.
Feeling ill, feeling sick/ill without physical findings.	Diagnosis made due to scientific factors. Experience of the patient plays a minor role.

20. Causes of illness

Medical systems contain explanations for physical processes, sensations and complaints. These include the "disease concepts," which in turn assume causes of disease at one or more levels.

Individual level	Natural world	Social world	Supernatural world
e.g. Illness as a result of own lifestyle or carelessness	e.g. Illness as a result of infection, weather or environmental damage	Illness as a result of the action of others, e.g. Conflicts, bullying or 'evil eye'	Illness on the basis of Providence as well as examination or punishment

- These assumptions also lead to ideas and expectations regarding the treatment.
- It makes little sense to apply the 'Western' biomedical explanatory model to all humans, as different models can lead to different treatment approaches.
- In an approach that is completely alien to him, the affected person will not feel understood and consequently will not (or not completely) cooperate in his treatment.

21. Explanatory model according to Kleinman

The "explanatory model" of Arthur Kleinman assumes that people try to explain symptoms in their cultural context. In this model, people who are affected by symptoms are asked the following questions (cited in Zielke-Nadkarni, 2007):

1. How do you describe your problem? What name do you give your illness?
2. What do you think is the cause of your problem?
3. Why did it start when it started?
4. What does the disease do to you? How does it work?
5. How serious is your illness? Will it take a long or short course?
6. What do you fear most about your illness?
7. What are the main problems that have brought you the disease?
8. What type of treatment should you receive? What are the most important results that you expect from the treatment?

22. Grief and Culture

A good example of the similarities and differences between people and how they cope with stress and crisis situations is the phenomenon of "sadness".

"Grief" can be understood, on the one hand, as a feeling or a physical condition that arises when someone or something significant is lost. Second, the term describes a process of saying farewell and the behavior of individuals and groups in the context of that process.

The feeling ("sadness") and the physical condition are usually considered universal, e.g. cross-cultural. This is supported by interculturally comparable facial expressions of feeling and related body reactions (such as crying).

23. Socio-cultural background of mourning

In contrast, the behavior of people in response to loss and sadness is strongly influenced by the socio-cultural backgrounds and contexts of those affected. Therefore, there is an almost unmanageable variety and diversity of ideas about human life, dying and what follows. The (socio-cultural guidelines for) rituals and behaviors associated with death and grief are correspondingly diverse (Stubbe, 2005, p. 494 ff.).

In Eastern cultures, the family is usually subject to precisely defined duties that it has to fulfill. Unlike in the frosty western hemisphere, the eastern cultures are often expected to experience intense feelings, regardless of whether or not they feel these feelings of grief and pain. By expressing strongly these feelings, the respect for the dead person is expressed again.

24. Dealing with death in different cultures

Consistent with our own preconceived notions, we do not describe grief as a ritual social or physical condition, but as a state of emotional turmoil that may require a therapeutic intervention.

At the same time, ethnologists have argued that at Chinese funerals, the predominant feeling is not grief but barely concealed fear of the corrupting influences of death.

In many cultures, where death is the result of other people's evil actions in the form of witchcraft, anger can be the dominant emotion.

The sexes may be expected to react in different ways, the man with anger, the woman with tears.

25. Grief in intercultural service

For intercultural emergency missions, this may mean that helpers are confronted with unfamiliar and possibly inappropriate or 'dishonest' emotional expressions and behaviors of mourning emergency victims (Przyrembel, Jonas & Knaevelsrud, 2011, p. 22 f.). The result can be irritation, insecurity and excessive distancing from those affected.

26. Conclusion

- To understand the information provided by patients it is helpful to know that their view of their illness can contain foreign, irrational elements.
- Lack of understanding of these elements or the culture-based presentation of (pain) symptoms can lead to culturalising stereotypes such as 'mamma mia syndrome' and the like.
- These stereotypes carry the risk of hastily and wrongly assesing the situation of those affected and of acting accordingly.
- The culture-related need for sympathy and support of the relatives and caregivers of sick people can be irritating and stressful for helpers, but should be respected in principle.
- If care is too difficult because of a too big crowd, this needs to be communicated constructively.
- Relativizing one's own understanding of the body, illness, and appropriate treatment can help reduce stress levels for all those involved and maximize quality of care.
- Missunderstandings and unfavourable communication processes between emergency aid workers and those affected can be prevented by a greater understanding of culture-related different body, health and desease concept.

27. Disgression - victims of trafficking

What is human trafficking?

Human trafficking is the exploitation of people against their will by use of force and it is the one of the fastest growing crimes in the world.

Trafficking is the buying and selling of people. It happens not just in Asia or Africa, but increasingly also in Europe. However, there are no reliable figures about the true extent. The dark figure is supposedly higher than the registered victims.

Trafficking human beings is closely linked to terms such as smuggling, illegal migration and modern slavery. The transitions are flowing. According to the law, "trafficking human beings" is difficult to prove because e.g. the first step in the migration is often "voluntary" and because the victim has to testify against his offender (person proof).

There are several manifestations of trafficking:

forced Prostitution,

labor exploitation on construction sites, meat industry, agriculture, freight forwarding, as carers and domestic workers,

forced marriage

compulsory adoption and

organ trade.

Some countries include child labor and child soldiers and slavery in the textile industry.

Most people are "acquired" into slavery through traffickers worldwide involuntarily and from a great need (debt, poverty, lack of education).

Those affected are uprooted, extremely traumatized, stigmatized and threatened. A way out seems hopeless.

How do I recognize human trafficking?

It is very difficult - even for experts - to recognize victims of trafficking and modern slavery. The perpetrator works with perfidious influence and threat, the victim keeps silent and smiles so as not to lose the job. The traumatization leads to a person becoming more and more isolated and only functioning. Many victims have already been abused in their homeland, are mostly completely unaware of their rights and the legal system / language.

Start asking question and showing interest, to gain the trust of the person or any effidences of trafficking.

Signs of trafficking can be:

- External signs of physical / mental violence
- Malnutrition and insufficient body hygiene and clothing
- Strong fright, evasive look
- Passport not available or fake
- Often accompanied by strange male watchers ("interpreters", "good friends"), strong submissiveness to these persons
- Extremely long working hours (without pay or time compensation)
- Miserable working conditions, equipment and housing
- If an agency is involved and frequent changes of jobs occure (so that client does not build relationship or do not ask too many questions)
- Disproportionate debt
- No medical care / insurance (do not go to the doctor, although injured)
- Memory gaps and no space-time feeling
- No will to integrate
- The person is rarely allowed to speak alone or the answers seem like they are memorized, they seem artificial
- Mostly small children in the home (strong emotional / financial pressure)

Link

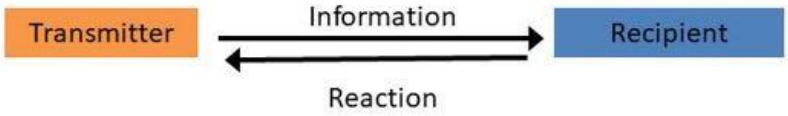
Module 3 – Development of intercultural competencies

TABLE OF CONTENTS

1. Communication

After having raised awareness for own cultural conditioning and migrant related health issues, we now want to find ways of dealing with difficult intercultural situations. The third module therefore deals with action competences - methods, tools and strategies related to intercultural communication.

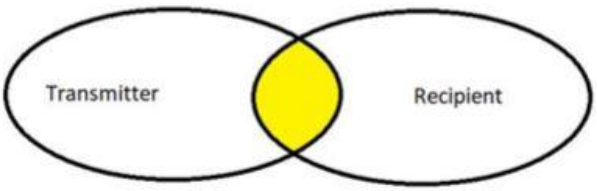
- By "communication" is generally understood the exchange of signals or messages.
- Communication is NOT a one-way street



2. Forms of communication

Forms of Communication

- Verbal: language, dialect, forms and choice of words
- Paraverbal: The 'background music' of speech: pitch, 'melody', pauses or non-linguistic sounds
- Nonverbal: The classic 'body language': facial expressions, gestures, posture and movements



→ Important for successful communication is a shared set of symbols.

3. Nonverbal communication

That the set of Symbols must not naturally be shared, shows the table of different meanings of hand signs.

Nonverbal Communication

- (Hand) sign language

- „okay“
- „Perfect!“
- vulgar insult

- „okay“
- „one“
- „Take me with you!“
- vulgar insult

- „Victory!“
- „Frieden“
- „Two“
- vulgar insult (when the back of the hand points forward)

- Prayer
- Greeting
- „Thank you!“
- „Sorry!“

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4. Meaning of nonverbal communication

People intuitively attach more importance to the message interpreted from nonverbal behavior because it appears 'more genuine'.
It is therefore important to pay attention to para- and non-verbal communication behavior, especially when dealing with language barriers.

For example, are non-linguistic sounds culturally coded: In Turkish, the sound "Tz" is used as "no" - Germans often associate with the sound a disapproval or admonition, from above 'like' Tztztz! "

5. Recommendations for communication

Introduce yourself with your name. Address your counterpart by using the formal form his/her name (try to pronounce the name as correctly as possible).

Speak slow, quiet and use simple sentences, but don't exaggerate, don't speak too simple.

If available, use multilingual / non-verbal communication tools (e.g. tip doc emergency or the BICAS APP).

Seek direct eye contact only if it is also sought. Caution with physical contact (especially in woman-man constellations, this includes the body distance). The use of hand signals can lead to misunderstandings.

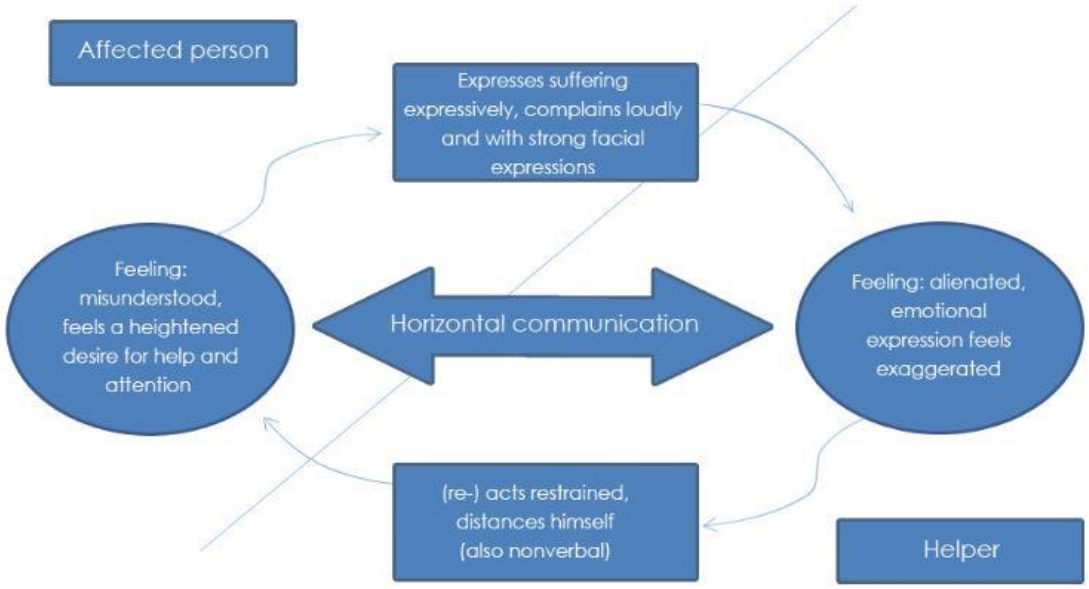
6. Vicious cycle model

Human communication is complex and therefore prone to failure. One way to understand and correct such disruptions is through the vicious circle model.

It describes the communication of two participants and shows what the participants think or feel and what they say or do.

As an example, an interaction between an emergency patient and a helper is described here:
It is assumed that the helper regards the sufferings of the person concerned as strange and exaggerated. He (re-) acts with more restrain or distancing. The patient in turn feels (even more) misunderstood and wants more support, which is why he reinforces his statements. As a result, the negative feelings continue to rise in the helper and he behaves even more distanced. The 'vicious circle' is thus a spiraling of the negative feelings of the participants and their corresponding behavior. This can lead to escalations that jeopardize the objective (the professional and best possible care of the patient).

The vicious circle model (Schulz von Thun)



In order to prevent this dynamic, "horizontal communication" (or "meta-communication") can be used between the participants. This refers to the open but appreciative exchange with regard to the respective intimations (perspectives, feelings).

In emergency use, this is certainly only possible to a limited extent, especially because there is no symmetrical relationship between the participants and mostly time pressure.

Nevertheless, helpers can try to address the feelings of those affected (for example, "I see you are feeling bad - I'll take care of it.") In order to signal understanding and positively influence the behavior of those affected.

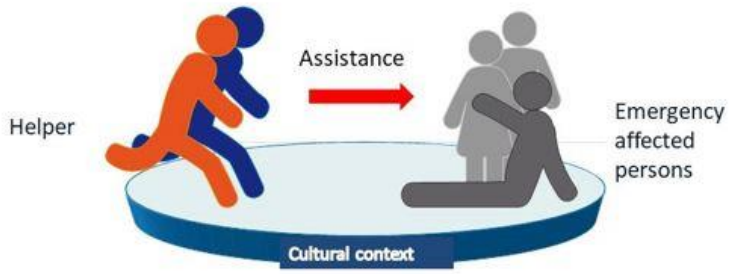
7. Definition of intercultural in-service situation

A typical example of the first constellation "Helpers act in a foreign cultural context" are deployments of civil protection personnel to help with major disasters abroad.

The second constellation is "Helpers belong to culturally diverse groups", which is on the one hand a feature of international cooperation in foreign missions. On the other hand, it can be present in joint missions of professionals from organizations with different organisational culture (for example, emergency service and the firefighters) as well as in the cultural-ethnic diversity of the members of a civil protection organization. Finally, the third constellation is "helping and affected people belong to different socio-cultural groups".

All three constellations can exist alone or in combination.

Although the focus of this training is on the third constellation, this explanation should also increase the awareness of (organizational) cultural differences between helpers and the potentially resulting problems. The term culture is used here in an understanding beyond national and religious affiliations.

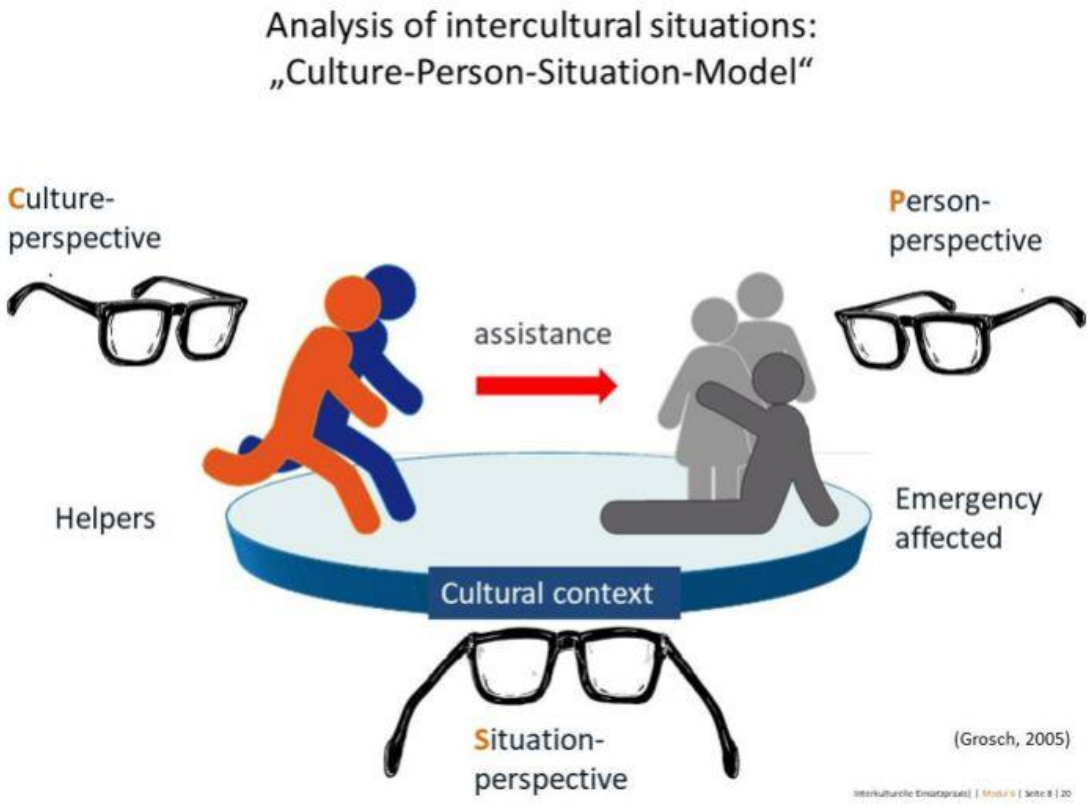


- Helpers act in a foreign cultural environment **and / or**
- Helpers belong to culturally diverse groups **and / or**
- Helping and affected people belong to different (socio) cultural groups

FOTO: Nils Raake

8. Situation analysis

A useful tool to analyse intercultural situations is the Culture-Person-Situation Model.



This model was developed by a group around Prof. Leenen and used in various intercultural training courses for police commanders and officers.

The aim of applying this model is to obtain a complete and differentiated picture of intercultural encounters and interactions and to avoid two 'typical interpretation errors' ('ethnocentrism' and 'culturalisation').

9. Cultural perspective

CPS-Model
(Leenen et al., 2005)

Culture-
perspective

The consideration of the intercultural in-service situation through the "culture glasses" uses questions like:

How much (pre-) knowledge is available to the participants about each others cultural background?

- What role do religious or other ideological characteristics of the participants play (e.g., commandments, values and norms related to illness and death)?

- What is the role of differences between the participants in terms of communication (in particular language, but also non-verbal expression of emotions)?

- What role do different perceptions about authority and respect (such as women, men, or elders) and the appropriate behavior between people with different social status play?

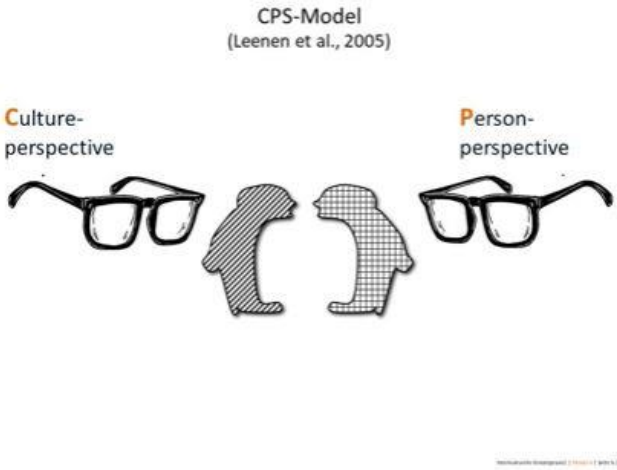
- What is the role of group-related perceptions of the participants (for example, to hold together within the family, the religious community or the ethnic group)?

- What role do strategies of the participants play in direct handling of emergencies and crises and their subsequent management?

- What formal and social status do 'uniformed emergency services' (of the rescue service, but also of the police and the military) have in the country of origin of the migrants involved?

10. Person perspective

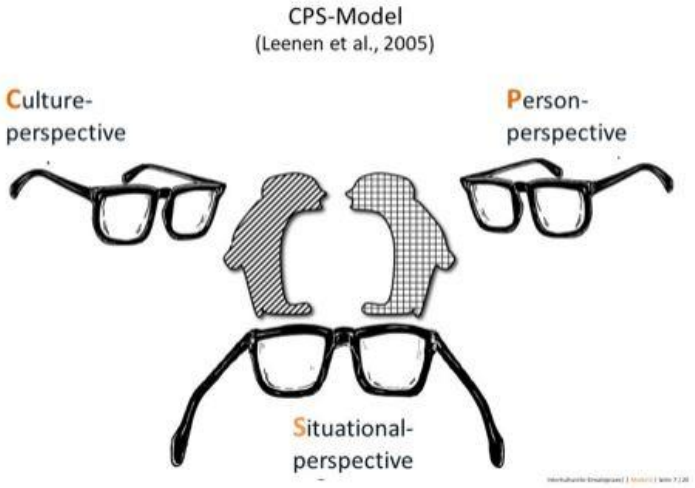
The examination of the intercultural in-service situation through the 'personal glasses' uses questions such as:



- Which 'biological characteristics' do those involved have that may be relevant to other perspectives (for example, gender, age and physical appearance)?
- Which experiences relevant to stress and emergency do the participants bring to the situation (for example emotional exhaustion or traumatic experiences or from the context of migration)?
- Which general intercultural experiences do the participants bring with them (e.g. from encounters with migrants in everyday life or with everyday discrimination)?
- Which emergency-related intercultural experiences do the participants bring with them (e.g. with migrants as emergency victims or with rescue and security forces in Germany or in the countries of origin or transit countries)?
- Which general attitudes and assumptions (in particular stereotypes or prejudices) do the participants have regarding each other or the respective socio-cultural groups?
- Which self-images (e.g., 'noble savior in need' or 'eternal victim') and public images (e.g., 'grateful help recipients' or 'arrogant posers') have those involved?
- Which social role do the participants have or claim in their own group (e.g., executive or family leader) and how do these role concepts work in the given situation?

11. Situation perspective

The consideration of the intercultural in-situation through the "situation glasses" finally uses questions such as:



- What kind of emergency is this?
- Is the situation associated with acute danger to those affected and/or emergency services?
- Are strong emotional reactions from those involved due to the cause of the incident (for example, child reanimation or sudden death) possible?
- Where does the mission take place (e.g., in a domestic context or in public space)?
- At which (day)time and under which external conditions (for example, heat, cold, noise or confined space) does the mission take place?
- Who is involved (e.g., which task forces and organizations) and how is the numerical relationship between those involved?
- What is the socio-emotional relationship of the participants with each other (also between possibly existing groups within the task force or the emergency victims)?
- What is the 'form of the day' of the participants (e.g., duration of the previous service and amount of work or restrictions due to physical or mental complaints)?
- What result is foreseeable for the Mission (e.g., loss of life or property, serious injuries or need for psychosocial acute and follow-up care)?

12. Example

You are called as ambulance (with male and female crew) with the mission statement "unclear abdomen" to the apartment of a southern family.

There you will find, lying on the sofa, an approximately 60-year-old woman. She moans with tightly closed eyes, holding her stomach and has no cyanosis.

About 10 more people are standing around the sofa, some of them talking excitedly.

When the emergency assistant addresses the woman, she does not answer and keeps her eyes closed. As he prepares to lift one of her hands, he notices restlessness among the bystanders.

13. Application CPS model to the example

This case study prototypically depicts the use of the Rescue Service in a 'foreign cultural' home environment.

As potentially important aspects can be mentioned:

Culture glasses

The religious affiliation of those affected is not named - the reactions of the bystanders may indicate special features in the interaction of people of different sexes.

Relatively many people are present - this could be an indication of strong involvement of the parties with their own family or group.

Formally, the man in the Rescue Service team is the chief of operations.

Person glasses

The Rescue Service team consists of a man and a woman.

The patient is older and therefore possibly a person of authority and respect within the group affected by the emergency.

The patient may have negative experiences with emergency or general health care.

Situational glasses

At first, no acute danger to life is recognizable, so the procedure can be done with peace of mind.

The utterances of the patient (groaning and facial expressions) indicate pain and can generate pressure for action in the ambulance team.

The patient does not communicate directly with the paramedic - the reason is not clear at first.

There are significantly more affected than emergency personnel present.

If it's a Muslim household, how about you say at the door? "I know you usually take your shoes off, but I'm not allowed to do that now. Would it be okay if I wipe off my shoes befor entering? "

How much time would that cost you?

What do you show with it and how could it affect the people affected by the emergency?

14. Conflict avoidance in action

Preparation

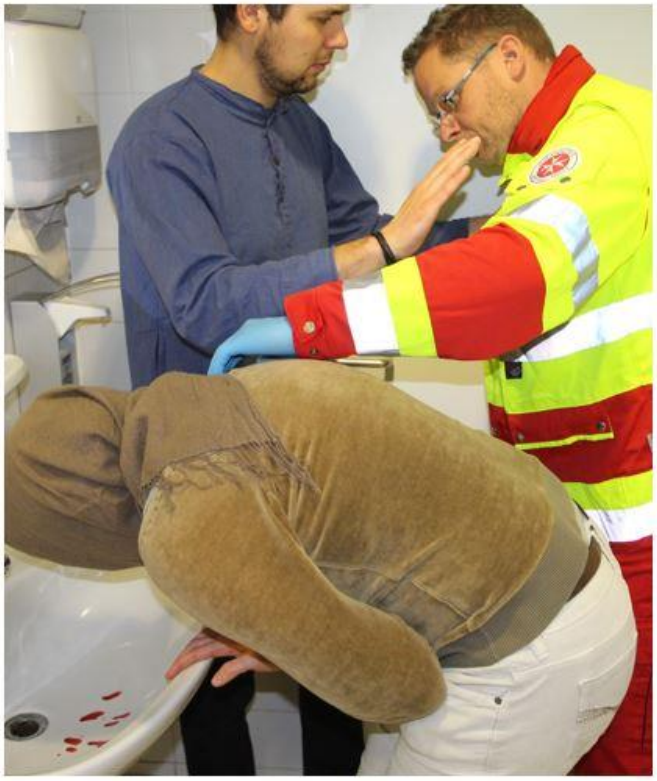
To know your own attitude to conflicts and 'typical' behavioral styles.
Basic attitude: "We want something good!"

And generally start with a willingness to cooperate among all participants.
Develop culture-specific knowledge about the population in the area of operation.

In-Service - conflict prevention

- Observe self-protection as a team, while remaining in the role of the helping one
- Respectful and confident appearance
- Explain technical competence and show it through actions, taking into account as far as possible socio-cultural particularities
- Explain the task, goals and (planned) procedure, consider options for compromise in the procedure and offer them if necessary
- Emphasize the importance of co-operation of those affected / involved, in groups seek and integrate allies with influence

15. Conflict management in action



•Consider sociocultural, personal and situational aspects of conflict development in coping (see CPS model)

•Do not accept 'cultural reasons' for problematic behavior, clarify common interests (especially make help possible)

•Pay attention to de-escalating body language (avoid 'threatening gestures')

•Verbal de-escalation, stay in touch, explain your own behavior / procedure

•Stay as calm and factual as possible when facing provocative behavior, regulate emotions (for example, by focusing on the assignment)

•Demonstrate consequences of problematic behavior (e.g., cancellation of assistance by withdrawal or compulsory use of police)

•Fix mentally ill patients as gentle as possible

•If you neet to retreat, then together, as safely as possible and without violence

•If retreat is impossible or team members or third parties are acutely threatened, use gentle defensive / liberation techniques as far as possible

16. Conflict management in action - follow-up

- Fully document the mission, report any damage and impairment
- Discuss the assignment promptly with the colleagues involved, thereby promoting an open, appreciative and error-free discussion culture
- Be on the lookout for stress, be honest with yourself and others, and demand follow-up offers
- Make reflected experiences available to the 'learning organization'
- If necessary, make experience available for the overall system of civil protection and research

17. Critical Incidents Analysis (CIA)

In order to avoid critical situations (critical incidents), it is useful to analyze these situations in the past in order to learn from them and derive behavioral changes.

Working with critical incidents can be summarized as the collection of situations that are considered either problematic or particularly successful with the aim of solving practical problems and contributing to the development and promotion of competencies.

A *critical* situation is considered to be a situation when negative consequences arise for one of the participants. It is *particularly successful* if very positive consequences arise for one or more participants.

An accurate analysis of the critical situations allows insight into coping and processing strategies of those involved. This makes events visible that have a strong influence on the respective activity. A collection of such events can be studied in a structured way and conclusions can be drawn to promote desired processes and prevent unwanted processes.

(Source: Kerstin Göbel: Critical Incidents - Learning from Difficult Situations Lecture within the framework of the "Lernnetzwerk Bürgerkompetenz" conference, 17-18. December 2003 in Bad Honnef.)

18. Critical Incident Reporting System

Error reporting systems - Critical Incident Reporting Systems or CIRS® - have been used successfully in aviation as instruments of learning and system improvement for decades.

They are also used in medicine as instruments for detection of safety-relevant events in health care. They are supposed to analyze critical events in terms of their causes and the development of avoidance strategies. At the same time, they should spread knowledge among the relevant professional groups and institutions in the health sector, to increase the quality of care and overall patient safety.

CIRS contributes significantly to risk management, which encompasses the entirety of structures, processes, instruments and activities which support employees in a healthcare facilities to identify the risks in patient care, to reduce and Control
them.

The benefits of CIRS and its opportunities can be described as follows:

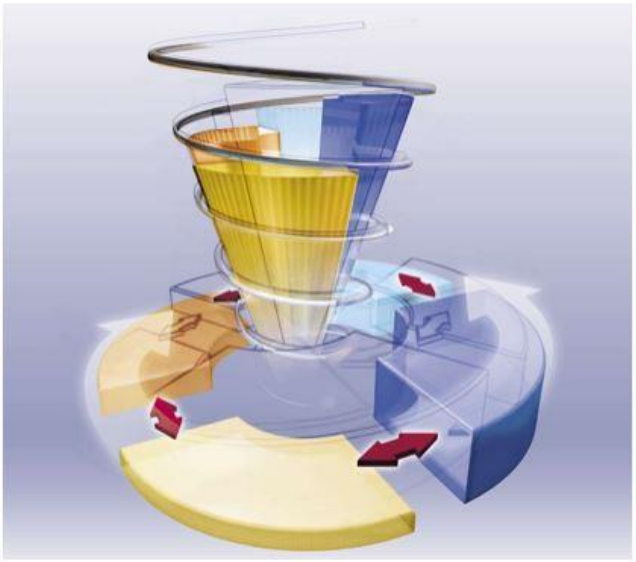
- CIRS is suitable for supporting local risk management.
- CIRS shows abnormalities (frequencies). CIRS is particularly well suited to discover everyday critical events in typical routine actions. Reports therefore often concern "trivialities".
- CIRS helps identify hot spots.
- CIRS helps detect "trivial" mistakes rather than complex mistakes.

General information about the CIRS:

- CIRS grows from the bottom.
- CIRS thrives on role models.
- CIRS needs training.
- CIRS needs remembrance.
- Every report needs an answer.
- CIRS needs protection (from anonymity to legislation).
- CIRS needs permanent support from the management.
- CIRS needs a "just culture"*.
- CIRS is not already risk management.
- Use other available information systems as well. Only then does it become a functional one Risk management.

* "Just Culture" is a culture in which [employees] are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. (Source: http://www.eurocontrol.int/articles/just-culture)

19. Conclusion



Intercultural competence is neither a static condition nor the direct result of a single learning experience. Language control or explicit, e.g. learnable knowledge about cultural peculiarities alone does not make anyone interculturally competent.

Still one neither acquires intercultural competence by a journey abroad or ad hoc by a further education.

If the assumption is true that culture is constantly in flux, people need to learn and master skills for processes. The development of intercultural competence is therefore complex and multi-dimensional depending on the intercultural situation. For the acquisition of intercultural competence this means a continuous dynamic process, which takes place in different dimensions and spirally enriches and develops.

The acquisition of intercultural competence requires lifelong learning and is part of ongoing personality development.

(Source: Bertelsmann Foundation)