Mig-HealthCare Roadmap & Toolbox

Language, Culture & Communication Issues

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Language, Culture and Communication issues

1. Magnitude of the problem

Language and Communication

The World Health Organisation (WHO) states that globally only an estimated 600 to 700 million people use English as a second language, in addition to 335 million native English speakers. This leaves most of the world's population, around six billion people, with little or no access to a large wealth of public health information because it is in English.

Language is considered as a significant barrier to accessing high quality health care. "In public health, the linguistic disconnect between those providing health information and those who need that information affects everyone from clinicians and patients to public health managers and policy-makers" (WHO, 2015, p.365).

Communication is key to quality health care and a central feature of every interaction (White et al., 2015). One of patients' biggest needs is to communicate their symptoms and situations to healthcare professionals. Effective doctor-patient communication can result in better outcomes, which contributes to the overall health of the community.

Multiculturalism and multilingualism have become extremely common in Europe, resulting in language barriers in the healthcare setting. Patients whose first language is not the same as that of the healthcare service they attend will most likely experience poorer health outcomes (Divi et al., 2007). Although many large healthcare institutions have access to interpreter services which has strongly been associated to improved patient satisfaction and positive communication, the availability of interpreters is not sufficient to ensure high-quality health care. An in-depth survey of 39 immigrant Somali women at a London obstetric centre demonstrated that the availability of translators alone is insufficient to overcome cultural barriers (Binder et al., 2012).

Ensuring high-quality health care access to all has also been included in the 2030 agenda of sustainable development goals - Goal 3: Ensure healthy lives and promote well-being for all at all ages.

Cultural issues

The concept of cultural competence was introduced in the 1980s to address a gap in healthcare providers' ability to promote equitable and non-discriminatory care for diverse populations. Since then, a range of cultural competence frameworks have emerged focussing on various issues including knowledge of minority cultures, attitudes to minorities and newly arrived immigrants and skills for providing health care via translators and in collaboration with cultural mediators. The concept of cultural competence has evolved over time to include not only the interaction between healthcare providers and users but also organisational and systemic cultural competence (Truong, Paradies & Priest, 2014). Although a range of articles have looked and

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reviewed cultural competence in healthcare (Pearson et al., 2007) and advocated for its importance (Casillas et al., 2014; Pearson et al., 2007; Truong et al., 2014), no unanimous definition exists. Various terms such as cultural appropriate care and education, multicultural education and transcultural care, cultural sensitivity, cultural responsiveness are used in conjunction with cultural competence, which contribute to the lack of clarity as to what the concept entails (Truong et al., 2014). Broadly speaking cultural competence is used to encompass a wide range of interventions in healthcare aimed at improving the accessibility and effectiveness of healthcare services for different ethnic, cultural and religious groups.

The most commonly cited definition is from Betancourt and colleagues which defines cultural competence as:

> "The ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003).

Addressing culture, but no other dimensions of diversity, the World Health Organisation defines cultural competence as:

> "Knowledge, skills and attitudes that a health-care worker needs in order to provide adequate and appropriate health-care services to all people in a way that respects and honours their particular culturally-based understandings and approaches to health and illness" (WHO, 2011).

Health Literacy

Health literacy was introduced in the 1970s (Sørensen et al., 2012), and has been extensively researched over the years (Van den Broucke, 2014).

Health literacy has been used generally to describe the ability to seek, read, understand and use health information by an individual (Committee on Health Literacy for the Council on Scientific Affairs, 1999; Schillinger et al., 2002; Jordan et al., 2010). These definitions emphasize personal ability to handle words and numbers in a medical setting (Sørensen et al., 2012). However, the concept also involves complex personal skills, such as communication and decision making processes (Kickbusch, Maag & Wait, 2006; Paasche-Orlow, & Wolf, 2007; Freedman et al., 2009; Adkins & Corus, 2009; Sørensen et al., 2012).

According to Sørensen et al. (2012) health literacy concerns the knowledge and competencies of persons to meet the complex demands of health in modern societies:

> *"Health literacy is linked to literacy and entails people's knowledge, motivation and competencies to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course."*

For Parker and Ratzan (2010):

> *"Health literacy occurs when the skills and ability of those requiring health information and services are aligned with the demand and complexity of information and services."*

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Another approach to the study of health literacy comes from understanding social context. More specifically what occurs at home, the workplace, the health system, the community and across the population, and also including cultural influences (Kickbusch, 2002; Baker, 2006; Nutbeam, 2008). In this regard, Nutbeam (2000) emphasizes a new element of health literacy which is the empowerment of individuals and communities and overcoming structural barriers to health.

According to Sørensen (2012) the core competencies of health literacy related to accessing, understanding, appraising and applying health-related information, are individual knowledge, competence and motivation. These individual processes progressively enable the person to navigate in three domains of the health continuum:

- Being ill or as a patient in the healthcare setting
- A person at risk of disease in the disease prevention system
- A citizen in relation to the health promotion in different environments

Moreover, the model takes into consideration the changes in the context, and the adaptive capacity to navigate the health system based on the individual:

- Cognitive and psychosocial development.
- Previous and current experiences.
- The skills and competencies of health literacy develop during the life course
- Lifelong learning.

2. Reference to the problem concerning migrants/refugees

The UN's Covenant on Economic, Social and Cultural Rights, article 12.1 states "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN 1966). In the European context, the Charter of Fundamental Rights states that everyone should have the right to access preventive health care and to benefit from medical treatment. Still, problems in health care access for migrants and refugees exist. As an example, a study of data from 2008-2011 found that 16 European countries declined to cover the costs of secondary healthcare and most drugs for asylum-seekers and migrants (Rechel et al., 2013).

Language and Communication

In a 2018 study of migrants and refugees in 10 countries across Europe within the Mig-HealthCare project, nearly 15% of participants reported needing healthcare services in the past year and not accessing them. Among the most frequently reported barriers to healthcare access was language, with 30.1% of immigrants reporting a lack of communication and understanding of physicians and their instructions. The participants of this study demonstrated the vast diversity of language and communication skills among the migrant and refugee populations in Europe: 50.5% had communication skills in Arabic, 46.5% in English, 19.1% in French, 13.6% in Italian, and smaller percentages had communication skills in Spanish, German, Swedish, Bulgarian, Greek and Maltese.

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Cultural issues

With the increase in the population of migrants in Europe, cultural competence has been advocated as a way to ensure equity in access to healthcare and to provide responsive healthcare to migrants and refugees (Jongen, McCalman & Bainbridge, 2018). Evidence from the literature review conducted by the Mig-HealthCare consortium on migrant and refugee access to healthcare shows that inequalities between migrants and non-migrants in health and in access to health care services persist. Inequalities are the results of legal barriers that exist in many EU MS in accessing care among migrants, refugees and asylum seekers and especially undocumented migrants, but they are also due to the economic situation of migrants who may lack the means to access or to pay for health services. Inequalities are also the result of language barriers, discrimination and what is referred to in many articles as lack of cultural competence from healthcare providers (Lebano et al., 2018).

Health Literacy

Limited health literacy is more common among patients who have low educational attainment and among older patients, and ethnic minorities and immigrants. In this regard, a wide range of adverse factors play an important role to access the services and information by the immigrant population in the host country. According to Zanchetta and Poureslami (2006) health literacy in newcomer communities with diverse ethno cultural backgrounds is less understood, rather than other factors such as language and cultural differences hindering health information, the access to healthcare services and information available to them. This study points out how health information usually does not reach the immigrant population with low health literacy.

3. Reference to issues of particular interest

Effective communication - Working with an Interpreter

The British Psychological Society (2008) provides key recommendations in terms of working with an interpreter:

- Undertake a language needs analysis for the population which your service covers and consider how you will best meet this need.
- Check that the interpreter is qualified and appropriate for the consultation/meeting.
- Allow 10–15 minutes in advance of the session to inform the interpreter about the purpose of the meeting and to enable them to inform you about any cultural issues which may have bearing on the session.
- Be aware of confidentiality issues and trust when working with someone from a small language community as the client may feel anxious about being identifiable and mistrustful of an interpreter's professionalism.

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- Create a good atmosphere where each member of the triad feels able to ask for clarification if anything is unclear and be respectful to your interpreter, they are an important member of the team who makes your work possible.
- Match an interpreter with the patient in terms of gender and age. Do not use a relative and never use a child.
- At the end of the session allow 10 minutes to debrief the interpreter about the session and offer support and supervision as appropriate.

According to the Australian Psychological Society (2013) facilitating effective communication via an interpreter should be done as follows:

- Speak to the person, not the interpreter, and maintain culturally appropriate eye contact with the client, even when the interpreter is interpreting. When speaking or listening watch the client rather than the interpreter so nonverbal messages can be observed. Speak to the client directly using first person "I" and second person "you", rather than "he" or "she", to elicit a more accurate understanding of the words and emotions being expressed.
- Avoid using technical language, metaphors and acronyms.
- Repetition can be effective in assisting understanding.
- Use short, simple sentences.
- Pause after one or two sentences to allow the interpreter to relay the message.
- The psychologist may wish to use diagrams or pictures to increase understanding.
- Ask the client whether you are speaking at an appropriate pace or if any clarification is required.
- Ask for feedback during the consultations to ensure that the client is satisfied with the interpreting process.

Improving Cultural competence

Culture is defined as the "patterns of ideas, customs, and behaviors shared by particular people or society. These patterns identify members as part of a group and distinguish members from other groups" (How Culture Influences Health, 2017). Improving cultural competence is therefore crucial as it enables a physician to provide effective health care without relying on stereotypes. According to a report on health challenges for refugees and immigrants (Bischoff, 2003), providers must consider cultural factors when they:

- Take a medical history and physical exam. Patients' individual migration history has an impact on their illness experience, showing that it is important for health care professionals to find out about their social and life circumstances. Aspects such as life history, experience of pain, traditional/religious healing practices, nutrition (food customs), proficiency of local language, meaning of physical contact, work and residence status, status of women, experience of violence, migration history (reasons for migration, experience of trauma, history of flight and integration).

- Assess care needs: The health care provider should view illness in a broader social context, rather than as an individual concern. This involves differentiating between cure and treatment, sharing knowledge of

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health and wellness information, and involving the patients' family and community in medical decisions (Burgess, 204).

Additionally in order for health care providers to become more culturally competent it has been suggested (Bernd, 2011) that they should:

- elicit patients' language, culture and ethnic group
- be aware of cultural stereotypes
- avoid using patients' families as interpreters
- familiarize oneself with culturally specific expressions of distress
- maintain confidentiality
- avoid religious and social taboos
- use same-sex chaperones
- remember potential prescribing pitfalls
- allow culturally specific rituals, for example, after death
- not make assumptions.

Increasing health literacy among migrants/refugees

The literature includes numerous studies on increasing health literacy for migrants/refugees. Nevertheless, to date there is no systematic assessment or meta-analysis we can propose in the way of promising practices. A new Cochrane review is being conducted currently titled Interventions for improving health literacy in migrants (Cochrane Systematic Review – Intervention- protocol, 2019). The results will show which interventions are successful in increasing health literacy among migrants/refugees.

The Ophelia (OPtimising HEalth LIterAcy and Access) is an approach to health system strengthening through a) optimising the health literacy of individuals and, b) optimising the health literacy responsiveness of organisations (Beauchamp et al., 2017). The figure below details the Ophelia process.

Phases of the Ophelia approach:

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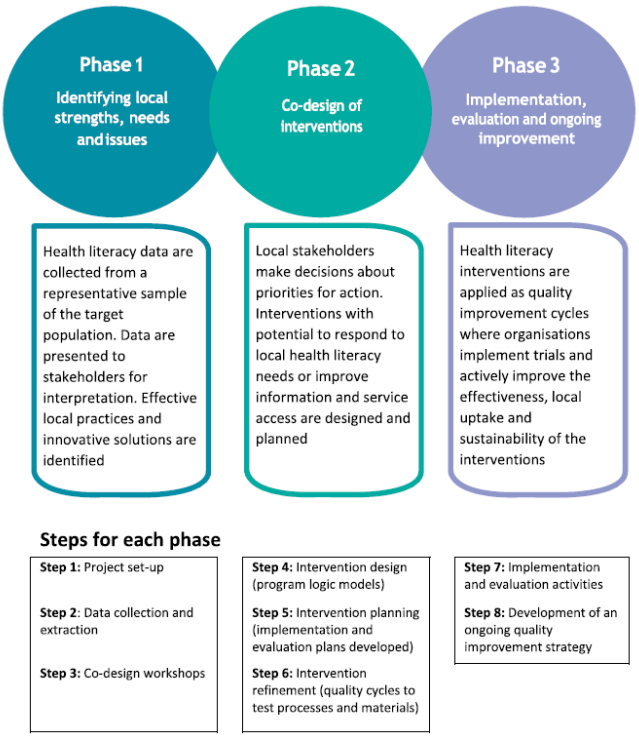

Results of a study that implemented the Ophelia approach showed that it can be used for the purpose of health services' improvements that improve health outcomes and healthcare access inequality (Beauchamp et al., 2017).

4. Important steps for the Health care sector

An article titled "Good practice in health care for migrants: views and experiences of care professionals in 16 European countries" explored the experiences of healthcare professionals to identify what they consider constitutes good practices for overcoming difficulties in delivering quality health care to migrants and refugees.
As has been adapted from Priebe et al. (2011) below is a summary of the most emphasized themes of good practices relating to communication:

- **Organizational flexibility with sufficient time and resources**

This was emphasized to ensure that migrant patients were heard and understood. Respondents also advocated for the importance of regular staff meetings to deal with problems arising in healthcare to migrants.

- **Good interpreting service using professional interpreters**

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However, it is important to note that some interviewees preferred using relatives or friends as interpreters instead due to their ability to provide comprehensive information about the patients, as well as having the patient's trust.

- **Cultural awareness of staff**

Some respondents viewed the training of staff in different cultural and religious practices as core to the delivery of satisfactory and respectful care to migrant patients. They further suggested obtaining information on migrant specific diseases, cultural understanding of illness and treatment, and information pertaining to cultural and religious norms and taboos. According to the respondents, such knowledge enabled them to reach more accurate diagnoses and provide appropriate treatments, while meeting patient needs for cultural acceptance and understanding.

- **Positive and stable relationships with staff**

Over a third of all respondents pointed towards positive relationships between staff and patients, and continuity of care as components of good practice. They discussed the necessary features for a positive relationship, which included respect, warmth, being welcoming, listening and responding effectively. Some respondents spoke of having welcoming policies in place, which ensured that patients are given individual attention and eased processes for them where possible.

A review of interventions in regards to cultural competence showed the existence of particular processes that would contribute to the development of a culturally competent workforce. The following processes were identified as key in the review (Pearson et al., 2007):

a) Appropriate linguistic services. This can be done through displaying pictures, posters and other information materials in healthcare receptions in a variety of languages.
b) Intercultural staff training and education. This can be done through training workshops, lectures, using case studies, videos and films as well as other media resources.
c) Establishing cooperation with organisations that can address needs of culturally diverse groups of patients by healthcare providers is important. These organisations should offer support in cultural competence in decision-making support systems and staff education.
d) Using cultural competence skills when formulating patient information brochures and educational materials.

Combining patient-centered approach and cultural competence: An article highlighted the importance of combining cultural competence and patient-centred method. Patient-centred care is defined as putting the patient in the centre to care and being responsive to the individual patient's needs, values and preferences. Through patient-centred care, care providers can avoid homogenising patients in regards to their ethnicity, culture and religion (Saha, Beach & Cooper, 2008). Moreover, although there is no evidence that patient-centred care reduces health inequalities, it has been argued that it contains the theoretical underpinning and potential (as it aims to equalise power-relations between healthcare providers and patients) to address these inequalities as it addresses racial/ethnic and cultural bias which healthcare professionals may have.

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Both patient centeredness and cultural competence are movements in healthcare that aim to improve healthcare quality and access but focus on various aspects. While patient-centered care aims to individualise care, cultural competence aims to balance quality, to improve equity and access to healthcare focussing on ethnic minorities and other disadvantaged groups. However, the article argues that by combining patient centeredness and cultural competence approaches, individualising care can take into account the diversity of patient values and perspectives. At the same time, cultural competence must take into account the wide variety in values and norms within a given group i.e., understanding the dynamic nature of culture so as not to fall into the trap of homogenising a group of people such as Muslims or African etc (Saha et al., 2008).

Addressing health literacy through healthcare services is challenging (Lee, Arozullah, & Cho, 2004; Nielsen-Bohlman et al., 2004). Interventions addressing factors such as adherence to treatment (Van Servellen et al., 2003, 2005), the adoption of preventive behaviour such as screening and the reasonable use of antibiotics (Stockwell et al., 2010), are influenced by health literacy. Moreover, training on communication issues for instance training patients for clinical interviews have been found to be effective too (Van Servellen et al., 2003, 2005). In this regard, the incorporation of skills to navigate the healthcare system has shown efficacy (Soto-Mas et al., 2015 a,b; Yung-Mei et al., 2015).

On the other hand, a greater understanding of the capacities and needs of patients with limited health literacy is needed in order to develop strategies to establish effective means to communicate with them (Paashe-Orlow & Wolf, 2007). In this regard, healthcare providers and health systems will be able to accommodate the needs of patients with limited health literacy being more aware of their needs.

5. Examples of best practices

The Mig-HealthCare project reviewed and evaluated relevant interventions offered to migrants and refuges. We include in this roadmap some examples that can be used in different settings based on the evaluation process of the systematic review that was conducted by the Mig-HealthCare partners. More information about these and other promising practices can be found on the project's website http://www.mighealthcare.eu/ by accessing the report titled 'D5.1: Report on models of community health and social care and best practices'.

Language and communication

- Good Practice Guide to Interpreting (Arabic, Bengali, Chinese, English, Somali)
  The guide was produced by Migrants Organise as a way of raising awareness on the importance of interpretation and its correct use in the healthcare setting. It gives tips on good practice for medical professionals and users. The guide can be accessed here: http://www.migrantsorganise.org/?p=21539
- Returning with a Health Condition. A toolkit for counselling migrants with health concerns (International Organization for Migration, 2014).
  This toolkit involved the active participation of IOM specialists in migrant and health issues. It offers practical tools and theoretical background to assist healthcare professionals who work with migrants. The toolkit can be accessed here:

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https://publications.iom.int/system/files/pdf/toolkit_for_counselling_migrants.pdf

- Picture Communication Tool (Mid Essex Hospital Services, UK)
  This website is comprised of sets of drawing that can be used in the healthcare setting with people whose first language is not in English. The drawings are free to download and ready for printing. The tool can be accessed here:
  http://www.picturecommunicationtool.com/

Cultural competence

A review focused on the types of interventions aimed at developing cultural competence including training, workshops and programs for health practitioners, culturally specific or tailored education or programs for patients, as well as interpreter services, peer education, patient navigators and exchange programs. Most of the articles that were reviewed examine interpersonal cultural competence focusing on healthcare providers while a few looked at cultural competence from an organisational perspective such as employing a diverse staff and making cultural adaptations to health programmes. Although positive effects of these interventions were reported, it was unclear which types of intervention are most effective and why (Truong et al., 2014).

Cultural competence training for healthcare providers often focuses on developing skills and knowledge to deepen understanding of diversity, and respond to cultural differences. Moreover, training involves, facts about minority patient cultures or may include interventions such as intercultural communication skills training, examination of potential barriers to care, and institution of policies to provide care that is optimal for the needs of culturally and linguistically diverse patients (Horvat, Horey, Romios & Kis-Rigo, 2014). Given, the significant variation in workforce cultural competence strategies, measures and outcomes reported in various studies makes comparison of such interventions' effects problematic. The two main workforce intervention strategies that were identified by a review on cultural competence interventions were (1) cultural competence training and (2) other professional development interventions including other training and mentoring (Jongen et al., 2018).

Although cultural competence continues to be developed as an important tool to address health inequities, assessment of the effects of these strategies is lacking. A Cochrane review conducted in 2014 (Horvat et al., 2014) concluded that although the assessment of healthcare professionals' cultural competence training was positive in regards to patient-related health outcomes, the quality of the evidence of these assessments was low. Improved cultural understanding and skills among healthcare providers' can be demonstrated by measuring increased levels of knowledge (using various methods, including questionnaires, randomised control trials, quasi experimental, and qualitative reviews) (Casillas et al., 2014; Horvat et al., 2014; Truong et al., 2014). However, there are few studies that set out to address adverse outcomes by improving health outcomes, patient satisfaction and compliance to treatment. Additionally, the variation in interventions with regards to scope, design, duration, implementations as well as outcomes chosen, makes it difficult to draw any conclusions (Horvat et al., 2014).

Some other examples of cultural competence practices and tools include:

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- Cultural competence Training and Performance Reports to Improve Diabetes Care for Black Patients. A Cluster Randomized, Controlled Trial. (2010). Thomas D. Sequist, Garrett M. Fitzmaurice, Richard Marshall, Shimon Shaykevich, Amy Marston, Dana Gelb Safran and John Z. Ayanian.

This was a cultural competence intervention conducted in the USA between 2007 and 2008 focussing on increasing clinician awareness of racial disparities between blacks and whites in the USA as well as improving communication between black patients and healthcare professionals in regards to diabetes care.

The intervention involved cultural competence training of nurses, physicians and physician assistants, at the primary care level in eight healthcare centres. The cultural competence training entailed using a specific training curriculum designed to understand attitudes of trust and bias, increasing awareness in regards to health inequalities as well as gaining skills to improve transcultural care. The training was delivered in form of lectures, group discussions and community activities in which healthcare professionals met with black diabetic patients. The intervention was evaluated through a cluster randomised control trial conducted between 2007-2008. The total amount of healthcare providers involved in the trial was 124. Clinician awareness of racial differences in diabetes care and rates of achieving clinical control targets among black patients was measured at 12 months. The results showed that intervention clinicians were significantly more likely than control clinicians to acknowledge the presence of racial disparities (Sequist et al., 2010).

- Cultural competence in Health Care: Evaluating the Outcomes of a Cultural competence Training among Health Care Professionals. (2009). Khanna SK, Cheyney M, Engle M.

This intervention was conducted in the USA where 60 health care providers (nurses and physicians) and health care administrators were selected to participate in a four-hour cultural competence-training workshop in 2007. The training included defining cultural competence, ethnic and racial health inequalities, the relationship between culture and health beliefs and how cultural competence can improve communications between patients and healthcare providers.

The intervention was evaluated using a pre-post method of self-reported evaluation in order to answer the question of whether cultural competence training produce a measurable change in knowledge in regards to caring for patients from diverse cultural and ethnic backgrounds. The study results show that there are statistically significant changes in the participants' self-report of knowledge and skills related to cultural competence (Khanna, Cheyney & Engle, 2009).

- Cultural Competence Assessment Tool (Ccatool) http://cultureandcompassion.com/wp-content/uploads/2015/04/CCTool-article-Marios-6-Original-Paper-Vol-6-Issue-1.pdf

- List and description of cultural competence tools http://transculturalcare.net/cultural-assessment-tools/

- The PTT tool https://link.springer.com/article/10.1186/s40639-016-0019-6. This model, named after the researchers who developed it (Papadopoulos, Shea, Taylor, Pezzella, & Foley, 2016), is a model of transcultural nursing and cultural competence that is made of four important parts:

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1) Cultural awareness: This is defined by the researchers as "The degree of awareness we have about our own cultural background and cultural identity". The idea behind this awareness is that through a critical understanding of one's own culture, one will tend to appreciate other cultures more as well as move away from an ethnocentric and essentialist understanding of others.
2) Cultural knowledge: This entails through developing one's own knowledge as a professional in terms of having a broader knowledge that is not only limited to medicine rather to other disciplines such as sociology, anthropology etc. A way to develop this through having a multidisciplinary team when constructing a cultural competence training intervention.
3) Cultural sensitivity: This construct stems from developing an ability to view patients as true partners in order to develop good relations with them.

These three parts lead to the fourth construct:

4) Cultural competence: This final goal is achieved, as per the model, through developing the aforementioned constructs and requires not only an understanding of the variety of people's cultural beliefs but also racism. A cultural competence element developed in the model entails therefore both multi-culturalism but also antiracist perspectives (Papadopoulos et al., 2016).

Health literacy

- Mental Health Literacy Inventory (MHL). (2008). Hong, Kim, Sohn, Ha and Rho.

This instrument was developed to assess the mental health literacy of Korean adults. It comprises 39 items including factors of knowledge, attitude, stigma, and utilizing services regarding mental health and mental health problems. Cronbach's alpha of the instrument was 0.93 in this study.

- Effects of a Program to Improve Mental Health Literacy for Married Immigrant Women in Korea. (2017). Choi, Y. J.

This study aimed to develop and evaluate a mental health improvement program for the acculturative stress and mental health literacy of married immigrant women using bilingual gatekeepers. Bilingual gatekeepers were recruited from multicultural centers and trained to provide 8-week structured mental health improvement services to the women in the experimental group using a mental health improvement guidebook developed in 8 different languages. The program was effective in improving mental health and mental health literacy scores as well as reducing the degree of acculturative stress. This study offers a model of effective mental healthcare for multicultural communities (Choi, 2017).

- Integrating Principles of Positive Minority Youth Development with Health Promotion to Empower the Immigrant Community: A Case Study in Chicago (2017). Ferrera, M. J.

Growing vulnerabilities among immigrant families are further complicated by the context of US health care. This article discusses the critical need for health promotion initiatives that integrate principles of positive minority youth development. Mixed methods, including a CBPR (community-based participatory research) approach, are used to highlight narratives of immigrant youth who have participated in a health-promotion program infused within their high school curriculum. These narratives underscore contributing contextual influences and pathways to conscientization, civic action, how programming can effectively facilitate positive

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minority youth development, as well as individual and community-level empowerment that leads to increased health literacy (Ferrera, 2017).

- Development and pilot test of pictograph-enhanced breast health-care instructions for community-residing immigrant women. (2012). Choi, Y. J.

The aims of this study were to develop breast health-care instructions enhanced by pictographs (simple line drawings representing health-care actions) and pilot test the instructions in a sample of six immigrant women with limited literacy skills. Based on the Mayer's Cognitive Theory of Multimedia Learning, pictographs were developed in addition to low-literacy text. The text and the pictographs were then pilot tested with six immigrant women in community health centers for clarity, comprehension and acceptability through face-to-face interviews. Participants perceived that the drawings were engaging and enhanced clarity of the intended health-care messages. The black and white simple line drawings were well received by participants of varying race and ethnicity. The pictograph-based approach might be an effective tool in developing health-care instructions for immigrant women with limited literacy skills. Future research is needed to compare the effect of pictograph-enhanced instructions with written text-based instructions on adherence to instructions and health outcomes (Choi, 2012).

- CARE – Common Approach for REfugees and other migrants' health

The project "CARE – Common Approach for REfugees and other migrants' health" (Ref. 717317), which received funding from the European Union's Health Programme (2014-2020), aimed to promote a better understanding of refugees and migrants' health condition as well as to support the adaptation of the appropriate clinical attitude towards refugees and migrants' health needs and in particular towards the health needs of fragile subgroups, such as minors, pregnant women and victims of violence. Overall, the CARE project focused on promoting and sustaining the good health of migrants and populations in Member States experiencing strong migration pressure. More specifically, the CARE project met the following objective: Promote migrants' health literacy with emphasis on the right to access public health care services in MSs aiming to facilitate delivery of services to migrants, according to their age.
http://careformigrants.eu/the-project/

- Meeting the health literacy needs of immigrant populations - MEET

MEET aims at adapting and developing an innovative Community Health Education model and a professional development program for social and health service providers. The project aims to enhance the cultural and interpersonal competences of health and social service providers to develop health literacy skills and deliver a more effective service to immigrant users. Another goal of the project is to strengthen health literacy skills among migrants by promoting information, guidance and access to health care services and expand inter-sectoral coordination in designing and developing training program for health professionals, in particular between health, education and social service sectors. http://migranthealth.eu/index.php/en/

6. Toolbox

Please access our toolbox for additional tools related to Language, Culture and Communication issues among migrants and refugees.

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7. References

Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, A. M. A. (1999). Health Literacy. Report of the Council on Scientific Affairs. *Journal of the American Medical Association*, *281*(6), 552–557. Retrieved from V:\LBI\EA\PDF\EA-PDF_00053.pdf

Al-Hasaniya Moroccan Women's Centre, BME Health Forum, Chinese National Healthy Living Centre, Midaye Somali Development Network, Migrant and Refugee Communities Forum, Queens Park Bangladeshi Association & WSPM Agape Community Project (2010). Good practice guide to interpreting (Arabic, Bengoli, Chinese, English, Somali). Retrieved from https://www.migrantsorganise.org/?p=21539

Australian Psychological Society (2013). Working with Interpreters: A Practice Guide for Psychologists. Retrieved from http://www.mhima.org.au/pdfs/APS-Working-with-Interpreters-Practice-Guide-for-Psychologists2013.pdf

Baker D. W. (2006). The meaning and the measure of health literacy. *Journal of general internal medicine*, *21*(8), 878–883. https://www.doi.org/10.1111/j.1525-1497.2006.00540.x

Baumeister, A., Aldin, A., Chakraverty, D., Monsef, I., Jakob, T., Seven, Ü. S., … Woopen, C. (2019). Interventions for improving health literacy in migrants. *Cochrane Database of Systematic Reviews*, *2019*(4). https://doi.org/10.1002/14651858.CD013303

Beauchamp, A., Batterham, R. W., Dodson, S., Astbury, B., Elsworth, G. R., McPhee, C., ... & Osborne, R. H. (2017). Systematic development and implementation of interventions to OPtimise Health Literacy and Access (Ophelia). BMC public health, 17(1), 230.

Bernd R., Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M. (2011) Migration and health in the European Union. European Observatory on Health Systems and Policy Series. Accessed February 2019 from: http://www.euro.who.int/__data/assets/pdf_file/0019/161560/e96458.pdf

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302. https://doi.org/10.1016/S0033-3549(04)50253-4

Binder, P., Borné, Y., Johnsdotter, S., & Essén, B. (2012). Shared language is essential: Communication in a multiethnic obstetric care setting. *Journal of Health Communication*,*17*(10), 1171–1186. https://doi.org/10.1080/10810730.2012.665421

Bischoff, A. (2003). Caring for migrant and minority patients in European hospitals A review of effective interventions. *MFH – Migrant Friendly Hospitals, a European initiative to promote health and health literacy for migrants and ethnic minorities.* Retrieved from http://mfh-eu.univie.ac.at/public/files/mfh_literature_review.pdf

Burgess, A. Health Challenges for Refugees and Immigrants. Refugee Reports. 2004; 25: 2. http://reliefweb.int/sites/reliefweb.int/files/resources/ACB7A9B4B95ED39A8525723D006D6047-irsa-refugee-health-apr04.pdf. Accessed June 2017.

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

CARE – Common Approach for REfugees and other migrants' health. Retrieved from http://careformigrants.eu/the-project/

Casillas, A., Paroz, S., Green, A. R., Wolff, H., Weber, O., Faucherre, F., … Bodenmann, P. (2014). Cultural competence of health-care providers in a Swiss University Hospital: self-assessed cross-cultural skillfulness in a cross-sectional study. *BMC Medical Education*, *14*(1), 19. https://doi.org/10.1186/1472-6920-14-19

Choi, J. (2012). Development and pilot test of pictograph-enhanced breast health-care instructions for community-residing immigrant women. *International Journal of Nursing Practice*, *18*(4), 373–378. https://doi.org/10.1111/j.1440-172X.2012.02051.x

Choi, Y. J. (2017). Effects of a Program to Improve Mental Health Literacy for Married Immigrant Women in Korea. *Archives of Psychiatric Nursing*, *31*(4), 394–398. https://doi.org/10.1016/j.apnu.2017.04.012

Cultural Assessment Tools. (n.d.). Retrieved from http://transculturalcare.net/cultural-assessment-tools/

Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M. (2007). Language proficiency and adverse events in US hospitals: A pilot study.*International Journal for Quality in Health Care*,*19*(2), 60–67. https://doi.org/10.1093/intqhc/mzl069

Ferrera, M. J. (2017). Integrating Principles of Positive Minority Youth Development with Health Promotion to Empower the Immigrant Community: A Case Study in Chicago. *Journal of Community Practice*, *25*(3–4), 504–523. https://doi.org/10.1080/10705422.2017.1354241

Freedman, D. A., Bess, K. D., Tucker, H. A., Boyd, D. L., Tuchman, A. M., & Wallston, K. A. (2009, May). Public Health Literacy Defined.*American Journal of Preventive Medicine*. https://doi.org/10.1016/j.amepre.2009.02.001

Hong, Kim, Sohn, Ha & Rho, (2008). *Mental Health Literacy Inventory* [Measurement instrument].

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews*, (5). https://doi.org/10.1002/14651858.CD009405.pub2

How Culture Influences Health (2017). Kidsnewtocanada.ca. Retrieved from http://www.kidsnewtocanada.ca/culture/influence.

Jacobson, H. E., Hund, L., & Soto Mas, F. (2016). Predictors of English Health Literacy among U.S. Hispanic Immigrants: The importance of language, bilingualism and sociolinguistic environment. *Literacy & numeracy studies : an international journal in the education and training of adults*, *24*(1), 43–64. https://www.doi.org/10.5130/lns.v24i1.4900

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competence interventions: a systematic scoping review. *BMC Health Services Research*, *18*(1), 232. https://doi.org/10.1186/s12913-018-3001-5

Jordan, J. E., Buchbinder, R., & Osborne, R. H. (2010). Conceptualising health literacy from the patient perspective. *Patient Education and Counseling*, *79*(1), 36–42. https://doi.org/10.1016/j.pec.2009.10.001

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Khanna, S. K., Cheyney, M., & Engle, M. (2009). Cultural competence in health care: evaluating the outcomes of a cultural competence training among health care professionals. *Journal of the National Medical Association*, *101*(9), 886–892.

Kickbusch, I. (2002). Health literacy: A search for new categories. *Health Promotion International*, *17*(1), 1–2. https://doi.org/10.1093/heapro/17.1.1

Kickbusch, I., Wait, S. and Maag, D. (2006) Navigating health: The role of health literacy. Alliance for Health and the Future, International Longevity Centre, London. http://www.ilcuk.org.uk/files/pdf_pdf_3.pdf

King, M. (n.d.). Picture Communication Tool: Home Page. Retrieved from http://www.picturecommunicationtool.com/

Lebano Adele, Hamed Sarah, Bradby Hannah & MigHealthCare Consortium (2018). Migrants' access to healthcare in Europe: A literature review

Lee, S. Y. D., Arozullah, A. M., & Cho, Y. I. (2004). Health literacy, social support, and health: A research agenda. *Social Science and Medicine*, *58*(7), 1309–1321. https://doi.org/10.1016/S0277-9536(03)00329-0

MacFarlane, A., Glynn, L. G., Mosinkie, P. I., & Murphy, A. W. (2008). Responses to language barriers in consultations with refugees and asylum seekers: A telephone survey of Irish general practitioners. *BMC Family Practice*, *9*. https://doi.org/10.1186/1471-2296-9-68

Meeting the health literacy needs of immigrant populations – MEET. Retrieved from http://migranthealth.eu/index.php/en/

Nielsen-Bohlman, Lynn & Panzer, Allison & Kindig, David. (2004). *Health Literacy: A Prescription to End Confusion*. Washington (DC): National Academies Press (US)

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, *15*(3), 259–267. https://doi.org/10.1093/heapro/15.3.259

Nutbeam, D. (2008). The evolving concept of health literacy. *Social Science and Medicine*,*67*(12), 2072–2078. https://doi.org/10.1016/j.socscimed.2008.09.050

Paasche-Orlow, M. K., & Wolf, M. S. (2007). The causal pathways linking health literacy to health outcomes. *American Journal of Health Behaviour*, *31* (Suppl. 1), 29-26. https://www.doi.org/10.5993/AJHB.31.s1.4.

Papadopoulos, I., Shea, S., Taylor, G., Pezzella, A., & Foley, L. (2016). Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare. *Journal of Compassionate Health Care*, *3*(1), 2. https://doi.org/10.1186/s40639-016-0019-6

Parker, R., & Ratzan, S. C. (2010). Health literacy: A second decade of distinction for Americans. *Journal of Health Communication*. *15 (*Suppl. 2), 20-33. https://doi.org/10.1080/10810730.2010.501094

Pearson, A., Srivastava, R., Craig, D., Tucker, D., Grinspun, D., Bajnok, I., … Gi, A. A. (2007). Systematic review on embracing cultural diversity for developing and sustaining a healthy work environment in healthcare. *International Journal of Evidence-Based Healthcare*, *5*(1), 54–91. https://doi.org/10.1111/j.1479-6988.2007.00058.x

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., … Bogic, M. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. *BMC Public Health*, *11(187)*. https://doi.org/10.1186/1471-2458-11-187

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P., & McKee, M. (2013). Migration and health in an increasingly diverse Europe. *The Lancet*. Lancet Publishing Group, *381*, 1235-45. https://doi.org/10.1016/S0140-6736(12)62086-8

Rodenburg, J. & Bloemen E. (2014). Returning with a health condition: A toolkit for counselling migrants with health concern. *International Organization for Migration.* Retrieved from https://publications.iom.int/system/files/pdf/toolkit_for_counselling_migrants.pdf

Ross Adkins, N., & Corus, C. (2009). Health literacy for improved health outcomes: Effective capital in the marketplace. *Journal of Consumer Affairs*, *43*(2), 199–222. https://doi.org/10.1111/j.1745-6606.2009.01137.x

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient Centeredness, Cultural Competence and Healthcare Quality. *Journal of the National Medical Association*, *100*(11), 1275–1285.

Schillinger, D., Grumbach, K., Piette, J., Wang, F., Osmond, D., Daher, C., … Bindman, A. B. (2002). Association of health literacy with diabetes outcomes. *Journal of the American Medical Association*, *288*(4), 475–482. https://doi.org/10.1001/jama.288.4.475

Sequist, T. D. (2010). Cultural competence Training and Performance Reports to Improve Diabetes Care for Black Patients: A Cluster Randomized, Controlled Trial. *Annals of Internal Medicine*, *152*(1), 40. https://doi.org/10.7326/0003-4819-152-1-201001050-00009

Sørensen, K., Van Den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., & Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. https://doi.org/10.1186/1471-2458-12-80

Stockwell, T., Zhao, J., Naimi, T., & Chikritzhs, T. (2016). Moderate Use of an "Intoxicating Carcinogen" Has No Net Mortality Benefit—Is This True and Why Does It Matter? *Journal of Studies on Alcohol and Drugs*, *77*(2), 205–207. https://doi.org/10.15288/jsad.2016.77.205

Tribe, R. & Thompson, K. (2008). Working with Interpreters in Health Settings*. The British Psychological Society.* The Leicester: UK. Retrieved from https://www.ucl.ac.uk/dclinpsy/training-handbook/chapters/handbook-pdf/SECTION_8_Appendix_9_BPS_guidance_on_working_with_interpreters_June_2013. Accessed June 2017.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competence in healthcare: a systematic review of reviews. *BMC Health Services Research*, *14*(1), 99. https://doi.org/10.1186/1472-6963-14-99

United Nations Human Rights (1966). International Covenant on Economic, Social and Cultural Rights. Retrieved from https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

Van den Broucke S. (2014). Health literacy: a critical concept for public health. *Archives of public health = Archives belges de sante publique*, *72*(1), 10. https://doi.org/10.1186/2049-3258-72-10

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Van Servellen, G., Carpio, F., Lopez, M., Garcia-Teague, L., Herrera, G., Monterrosa, F., … Lombardi, E. (2003). Program to Enhance Health Literacy and Treatment Adherence in Low-Income HIV-Infected Latino Men and Women. *AIDS Patient Care and STDs*, *17*(11), 581–594. https://doi.org/10.1089/108729103322555971

Van Servellen, G. V., Nyamathi, A., Carpio, F., Pearce, D., Garcia-Teague, L., Herrera, G., & Lombardi, E. (2005). Effects of a Treatment Adherence Enhancement Program on Health Literacy, Patient–Provider Relationships, and Adherence to HAART among Low-Income HIV-Positive Spanish-Speaking Latinos. *AIDS Patient Care and STDs*, *19*(11), 745–759. https://doi.org/10.1089/apc.2005.19.745

Vasiliou, M., Kouta, C., & Raftopoulos, V. (2013). The use of the Cultural competence assessment tool (Ccatool) in community nurses: The pilot study and test-retest reliability. *International Journal of Caring Sciences*, *6*(1), 44–52. Retrieved from https://cultureandcompassion.com/wp-content/uploads/2015/04/CCTool-article-Marios-6-Original-Paper-Vol-6-Issue-1.pdf

White, R. O., Eden, S., Wallston, K. A., Kripalani, S., Barto, S., Shintani, A., & Rothman, R. L. (2015). Health communication, self-care, and treatment satisfaction among low-income diabetes patients in a public health setting.*Patient Education and Counseling*, *98*(2), 144–149. https://doi.org/10.1016/j.pec.2014.10.019

World Health Organization (2011). Definitions of Key Concepts from the WHO Patient Safety Curriculum Guide (2011), Retrieved from https://www.who.int/patientsafety/education/curriculum/course1a_handout.pdf

World Health Organisation (2015). Bridging the language divides in health. Bulletin of the World Health Organization, 93, 365-366. Retrieved from https://www.who.int/bulletin/volumes/93/6/15-020615/en/

Yung-Mei, Y., et al. (2015) Health empowerment among immigrant women in transnational marriages in Taiwan. *Journal of Nursing Scholarship*, 47 (2), 135–142

Zanchetta, M. S., & Poureslami, I. M. (2006, May). Health literacy within the reality of immigrants' culture and language. *Canadian Journal of Public Health*. https://pdfs.semanticscholar.org/8d23/54b5d02a57bcdf62a3b64945fda3ac5aa6bc.pdf

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).