Alexander Bischoff

sfm
SWISS FORUM FOR MIGRATION
AND POPULATION STUDIES

Caring for migrant and minority patients in European hospitals
A review of effective interventions

Social changes in European societies place migration and cultural diversity on the European political agenda. The European initiative Migrant Friendly Hospitals (MFH) aims to identify, develop and evaluate models of effective interventions. It has the following objectives: To strengthen the role of hospitals in promoting the health of migrants and ethnic minorities in the European Union and to improve hospital services for these groups.

This report reviews models of effective intervention in the medical literature and provides the background information needed to enable partner hospitals taking part in the MFH initiative to select and implement suitable interventions. The interventions reviewed in this study are grouped in four areas: Communication, Responsiveness Empowerment of migrant and minority patients and communities. Monitoring of the health of migrants and minorities and the health care they receive.

Caring for migrant and minority patients in European hospitals

sfm
SWISS FORUM FOR MIGRATION
AND POPULATION STUDIES

SFM Studies 43

Alexander Bischoff

This report reviews effective interventions intended to improve the quality of health care for migrants and minorities in hospitals.

Author: Alexander Bischoff, PhD, MPH, RN, for the Swiss Forum for Migration and Population Studies, Neuchâtel, and the Institute of Nursing Science, University of Basel

Editor: Alix Henley, writer (Basel, London)

SFM Studies 43

Alexander Bischoff

Caring for migrant and minority patients in European hospitals

A review of effective interventions

Contents

Towards diversity competent care

The European initiative "Migrant friendly hospitals" (MFH) was launched in 2001 as professionals in the health sector and management of health care organisations became increasingly aware of the impact of migration and ethnicity on their everyday work.

The project (2002-2005) was sponsored by the European Commission, General Directorate Health and Consumer Protection and co-financed by the Austrian Federal Ministry for Education, Science and Culture. The project focuses on the influence of hospitals on health and health literacy of migrants and ethnic minorities. Pilot hospitals from 12 member states of the European Union, a wide range of experts and several international organisations and networks collaborated under the auspices of the Ludwig Boltzmann Institute for the Sociology of Health and Medicine of the University of Vienna which acted as co-ordinator. The project aimed at drawing attention on the issue of migrant-friendly, culturally competent health care and health promotion, and at attributing this matter high priority on the agenda of hospitals and within health policy in Europe. At the same time, the project compiled knowledge and instruments relevant to everyday practice to support hospitals in their quality development.

The project had three main objectives: Firstly, to select three common problem areas on the basis of a systematic needs assessment in the 12 pilot hospitals. Secondly, to implement and evaluate specific evidence-based interventions identified from a systematic literature review. A last objective was to monitor the overall organisational development process towards "migrant friendliness" initiated by the project, using the Migrant Friendly Quality Questionnaire. This instrument was especially developed within the project. These three objectives resulted in three subprojects: *Improving interpreting in clinical communication*, *Migrant-friendly information and training in mother and child care* and *Staff training towards cultural competence to enable hospital staff to better handle cross-cultural encounters*. Experiences and results were presented at the Final Conference "Hospitals in a Culturally Diverse Europe" in Amsterdam from December 9 to December 11, 2004. European recommendations regarding policy, hospitals and other stakeholders were published as the "Amsterdam

Declaration towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe".[1]

With this study, a wider public is finally offered an insight in the review that provided the scientific basis for selecting and further developing the subprojects of the MFH-project. It presents the state of the art institutional initiatives on "migration, ethnicity and health". Written two years ago, the text already circulated influencing an important number of decisions and researchers. Also, as it contributed to the proliferation of a multidimensional view on how organisations in general and hospitals in particular can deal with health issues related to migration and ethnic minorities, it initiated important discussions on potential initiatives within a comprehensive framework.

The study points out the transformation of policies on migrant health which began in the 1980 in different European countries. In some of these countries, increasing awareness of health inequalities between migrants or ethnic communities and the indigenous population provoked a political reaction. Particular hospitals were challenged by the increasing demand for adequate care for minorities. As a consequence, coherent policies were implemented; for pragmatic reasons first at local level and later (more systematically) at national level.

But organisations do not like transformations: their survival is based on structural stability. It is hence not surprising that the initial reaction of hospitals the challenge of socio-demographic changes due to migration and pluralism of ethnic belonging was rather conservative: core actors and management were often reluctant to change their philosophy. However, based on the hospital's daily practice, a pragmatic way to deal with cultural diversity was developed. Members of the cleaning staff were used as interpreters. This example shows us, that the adaptations at the margins of the organisation mask an institutional blindness.

Policy makers thus identified changing the philosophy of hospitals as the main challenge. Only a management which is aware of the implications of its philosophy can incorporate cultural sensitivity. Otherwise, the gap between marginal adaptations and general policies will always lead to short-term solutions. Success and survival of initiatives regarding sensitivity for ethnic and migrant differences will only be possible, if it is integrated conceptually

in a new way of thinking about organisations. Bischoff's text is not only a collection of good models, but provides a solid knowledge base. It can be a powerful instrument to change a system of enforced standardization of patients to one that is sensitive to their diversity.

The next step is to bring organisations to a higher level of self-observation, so they become aware that, instead of standardizing patients, understanding and using their diversity is the key to efficiency. If we take claims from migrants and ethnic communities as well as gender issues into consideration, we realise that nowadays normality means difference. Hence, hospitals need to shift from cultural competent care to competent care in the framework of a pluralized world.

Sandro Cattacin

Department of Sociology

University of Geneva

Karl Krajic

Ludwig Boltzmann Institute for the

Sociology of Health and Medicine

University of Vienna

---

[1] For detailed information about research instruments and outcomes see the final project report by Krajic K., Karl-Trummer U., Novak-Zezula S., Wirtenberger M., Pelikan J.M. "Migrant-Friendly Hospitals in an ethno-culturally diverse Europe. Experiences from a European Pilot Hospital Project", Vienna, 2005 at http://www.mfh-eu.net/public/home.htm.

Executive summary

Background

With the constant global flows of information, money, products, cultures and people at the beginning of the 21st Century, European populations are becoming increasingly diverse. Social changes in European societies, such as the ageing population and the enlargement of the European Union, also place migration and cultural diversity on the European political agenda. Health and migration are closely linked: most migrants leave inadequate living conditions, their journey to Europe often creates significant health risks, and life in European societies can impose additional stressors. Adequate health care and health promotion, as well as equal access to health services, are therefore particularly important for migrants and members of minority ethnic groups.

The European initiative **Migrant Friendly Hospitals** (Schulze 2003) aims to identify, develop and evaluate models of effective interventions. It has the following objectives:

- To strengthen the role of hospitals in promoting the health and health literacy of migrants and ethnic minorities in the European Union

- To improve hospital services for these groups by defining measures of quality, developing migrant- and minority-friendly routines for service provision, and creating migrant- and minority-friendly hospital settings.

This report reviews models of effective intervention in the medical literature and provides the background information needed to enable partner hospitals taking part in the MFH initiative to select and implement suitable interventions. The interventions reviewed in this study are grouped in four areas:

1. **Communication** This is certainly the most urgent, obvious, straightforward and frequently mentioned area in which interventions are needed.

2. **Responsiveness** to the socio-cultural backgrounds of migrant and minority patients, focusing on hospitals' positive responses to their needs. Responsiveness includes the adequacy of health care facilities in relation to the needs of migrant and minority patients, and covers both structural aspects of hospitals and training for health professionals.

3. **Empowerment** of migrant and minority patients and communities. Empowerment is similar to responsiveness but goes further in enabling patients to participate fully in decision making.

4. **Monitoring** of the health of migrants and minorities and the health care they receive. This involves investigating and evaluating problems and what has been done to address them.

There are a number of approaches to improving health care for migrants and ethnic minorities and increasing migrant- and minority-friendliness in hospitals:

Quality of care There are many generally accepted methods of measuring and improving the quality of health care. These can also be applied to measuring and improving the quality of health care received by minority groups. Quality of care is defined here as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'. Within this general definition, the classical distinctions between structure, process and outcome are widely used and accepted. To put it simply, the quality of health care is not adequate if it is not provided to all patients.

Responsiveness to cultural needs Another way of increasing migrant- and minority-friendliness is to improve health services' responsiveness to diverse needs (cultural, linguistic, minority or migration-specific) and to provide care that is more culturally competent.

Health literacy is a relatively new concept. It has been defined as the capacity to use the health care system appropriately and to live a healthy lifestyle. Increasing health literacy improves the quality of migrant and minority health care. It also increases empowerment.

Equality and equity Health disparities between migrant and minority populations and the majority are not only an issue of quality of care, but are also issues of equity, equality and even ethics.

Selected examples of effective interventions

Our research has identified many examples of effective interventions in each of the four areas mentioned above: Communication, Responsiveness, Empowerment and Monitoring. A small sample of the most effective interventions is summarised here:

Effectiveness of a professional interpreter service Jacobs and colleagues (2001) are, to our knowledge, the first researchers to report on the effectiveness of professional interpreter services in improving the delivery of health care to a population of allophone patients. (The term allophone is used in this review to describe patients who do not share the language of the professionals caring for them.) The researchers took advantage of the introduction of a new interpreter service in a large HMO (Health Maintenance Organisation) in the USA to conduct a retrospective cohort study to find out whether interpreters affected the quality of health care provision. Two patient groups were observed for two years, one consisting of Portuguese and Spanish-speaking patients, (the 'interpreter service group'), and a control group (a sample taken from all other eligible HMO members). Patients who used the interpreter services had a significantly higher number of consultations, prescriptions and rectal examinations than the control group. This study makes a valuable contribution to research into language access. It shows that professional health-care interpreting increases the provision of ambulant and preventive care and thus enhances, the authors conclude, allophone patients' access to care.

Australian translation services (Gagnon 2002). There are currently six Health Care Interpreter Service Centres covering the State of New South Wales in Australia. These offer professional interpreting services free of charge in more than 50 languages to people who use public health services (ie, most people) in areas around Sydney. In metropolitan areas, these services are available 24 hours a day, seven days a week, depending on urgency. In some areas, interpreters are also available for telephone consultations.

Culturally-competent diabetes education (Brown 1999). This is a detailed and very useful description of a truly community informed, community based program. It took place in a Texas county that is 97 per cent Mexican American, in which 50 per cent of people over 35 years old have diabetes. The authors have done programme planners a great service in chronicling the different phases of development of this programme.

During the early stages, researchers conducted extensive focus group and in-depth interviews with a wide variety of community members and practitioners. They presented 19 messages which they felt that the programme had to respect, all generated through the early involvement of the community. For instance, one message reflected the resentment that community members felt toward health workers from outside the area who came in and advised people with diabetes that they should no longer eat Mexican food. Bicultural and bilingual health professionals, community liaison workers, and support staff were hired. They, along with family members, provided an important dimension of social support for participants. A video was developed in Spanish and English, featuring community members and local practitioners whom participants in the programme were delighted to recognise.

About 250 participants went through the programme, half of them receiving the educational intervention immediately and half of them serving as study controls. Those in the intervention group had a substantial decrease in average blood glucose that was maintained over the course of the year. Glycosylated haemoglobin, a measure of long-term blood glucose control, also decreased in the intervention group, compared to an increase in the control group.

Cross-cultural primary care: A patient-based approach (Carrillo 1999) These authors describe a cross-cultural curriculum at New York Presbyterian Hospital and Cornell Medical School that explicitly attempts to avoid the oversimplification and stereotyping that can accompany some 'cultural competence' curricula. The programme provides 'practical cross-cultural skills' that providers can use to interview individuals within their unique and multi-faceted social contexts. The curriculum consists of 'five thematic modules that build on one another over four two-hour sessions.' The article contains an extensive and helpful list of questions adapted from medical anthropology sources, that can be used in medical interviews. The curriculum includes an important component involving reflection about one's own cultural background as well as about the culture of medicine and medical care.

An example of a comprehensive empowerment project (Rowe 1987) The Refugee Health Volunteer Project is a case study in cross-cultural health care delivery. Beginning in 1979, Fresno County received a second dramatic influx of Southeast Asian refugees. Altogether, Southeast Asian refugees comprise nearly 10 per cent of the population of Fresno. These figures provide the background for significant problems in health care service delivery. Some of the barriers that the refugees face in accessing health care include: 1) the stress, loss, dislocation, poverty, illness, and unemployment that are part of the refugee experience; 2) language differences; 3) cultural isolation; and 4) cultural beliefs and practices whose spiritual, holistic, and natural forms of care often run contrary to the West's scientific, specialised, and technological treatment modalities.

The Health Department began to recognise some of the difficulties related to providing health services for refugees and developed a strategy to combat these. This was called the Refugee Health Volunteer Project and its goal was to enable individuals, families, and community groups to better meet their own health care needs. This was to be achieved by first creating a community-based health promotion network to 1) identify health needs; 2) communicate health information; 3) train community health volunteers; and 4) build a greater capacity for self-care that would last beyond the end of the programme.

This project demonstrates the effectiveness of networking in improving service delivery to minority ethnic communities which face language and cultural barriers to health care. The project staff served as catalysts for community initiatives which helped to make the broader health delivery system more accessible to refugee clients. What emerges is an approach to health empowerment that builds on the strengths, skills, knowledge, and experience of people in the community and of those organisations which support their efforts.

HIV sexual risk reduction intervention (Di Clemente 1995) This article examines the effect of educational sessions on HIV-risk reduction with African-American women aged 18-29. This was the first randomised controlled trial of community based HIV sexual-risk reduction for economically disadvantaged young adult African-American women. Two intervention groups were created; one received five sessions of education, the other received the same educational material but all in one session. The material covered the following topics: gender and ethnic pride, knowledge of HIV and risk behaviour, sexual assertiveness and communication training, proper condom-use skills, and cognitive coping skills. Those women who received the education in one session showed similar changes in behaviour to women who did not receive the intervention. However, the women who participated in the prolonged intervention were significantly more likely to have better cognitive skills, interpersonal skills, partner norms, and consistent condom use than their counterparts.

Interactive group education to help refugees reduce oil consumption (Kruseman 2003) This study reports on an effective intervention which aimed to reduce cooking oil consumption by a group of refugees. The main goal of the dietary counselling programme was to decrease dietary fat consumption by refugees from former Yugoslavia living in Geneva, Switzerland. Cooking oil was highly valued in participants' representation of health. Since one-to-one counselling was unsuccessful, a pilot intervention was developed to explore the potential of participatory workshops for identifying and implementing appropriate behaviours. Four series of three workshops were held. Participants identified and practiced ways of reducing fat consumption. Knowledge and skills were measured on completion of the workshops and some months later. The average reduction in oil used per recipe was 58 per cent. The use of oil-reducing techniques increased nine-fold.

This project piloted a participatory approach in which participants were placed at the centre of the change process and required to take an active role in identifying culturally appropriate motivation which might change their behaviour. Hands-on practice and exchanges of ideas and experience within the group on applying the new cooking techniques reinforced participants'

skills. This approach, which includes a patient-empowering component, may be an alternative to one-to-one dietary counselling.

Monitoring interpreting among uninsured patients Andrulis (2002) and colleagues report on a survey of 4,161 uninsured respondents who received health care in 16 US cities. They compared the perceptions and experiences of uninsured adults who needed and got an interpreter, with those who needed but did not get an interpreter, and with other uninsured adults who did not need an interpreter. Three out of four respondents who needed and got an interpreter said that the facility they used was 'open and accepting', compared to 45 per cent of those respondents who did not get an interpreter. 27 per cent of those who did not get an interpreter said that they did not understand the instructions for taking their medication, compared to only 2 per cent of those who got an interpreter. Among those who reported needing help to pay for their medical care, more than half of those who did not get an interpreter said that staff 'never' asked if they needed financial assistance, while only one third of those who got an interpreter said they were never asked. The Community Access Monitoring Survey project was designed to help local organisations increase their effectiveness in promoting better access to health care for uninsured people. The present survey is good example of what effective monitoring can achieve.

Comments

To conclude, a plea for a focus on the quality of care. A useful definition of quality of care is **'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'**. Note that this definition includes both individuals and populations, and implies both an individual (patient-centered) and a public health perspective. 'Desired health outcomes' includes the outcomes desired by those who are most involved, patients. Desired health outcomes may vary considerably depending on people's socio-cultural background, origins and experience.

Improving the quality of health care encompasses six aims: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. The last aim, equity, is crucial. A health care system or institution is not providing quality care if it is not providing quality care to all its patients. Quality in terms of equality is thus a key issue in migrant and minority health care. It is also a political issue, because a national health care system is supposed to provide health care equally well to all its citizens. Finally a double recommendation, adapted from 'Quality and Culture – Joining the Levers' (Smith 2002): **'Frame migrant and minority health care issues as quality issues'** and **'Include migrant and minority health care issues in quality monitoring'**.

> 'Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations' (Tervalon 1998).

1 Introduction

As a result of the continuing global flows of information, money, products, cultures and people at the beginning of the 21st Century, European populations are becoming increasingly diverse. Other social changes, such as ageing populations and the enlargement of the European Union, also place migration and cultural diversity on the European political agenda[2].

Health and migration are closely linked. Most migrants leave inadequate living conditions, the journey itself can pose significant health risks, and life in European societies can impose additional stressors. Adequate health care and health promotion, including equal access to health services, are therefore particularly important for migrants and members of minority ethnic groups.

Health care and health promotion for migrant and minority patients are not always successful. In minority ethnic and migrant communities, people's health literacy (capacity to use the health care system appropriately) and understanding of local health care systems may be limited, and health services are not usually tailored to accommodate cultural diversity. Hospitals, where minorities often first access health care, are a particular focal point. The increasing diversity of their patient populations poses new challenges, but it also offers them an opportunity to improve overall service quality and patient orientation.

The European initiative, Migrant Friendly Hospitals (MFH), aims to identify, develop and evaluate models of effective interventions. It has the following objectives:

(a) To strengthen the role of hospitals in promoting the health and health literacy of migrants and ethnic minorities in the European Union. Migrants and ethnic minorities using local hospital services should be supported in three areas:

- Using health services appropriately

- Collaborating successfully with health professionals in the management of acute and chronic illness

---

[2] Schulze, B., K. Krajic, U. Trummer and J. M. Pelikan (2002). Migrant-friendly hospitals. A European Initiative to Promote the Health and Health Literacy of Migrants and Ethnic Minorities. Project Summary. http://www.mfh- eu.net/public/resources/mfh-summary.pdf. Vienna, LBISHM.

- Living a healthy lifestyle, using the health resources of the society in which they live, and being able to combine them with cultural patterns which reflect and take into account their own background.

(b) To improve hospital services for these patient groups by implementing quality measures, developing migrant- and minority-friendly routines for service provision, and creating migrant- and minority-friendly hospital settings.

The MFH initiative is a project which involves establishing a network of European pilot hospitals to take part in a quality development process with the aim of becoming 'migrant-friendly hospitals.' The experience and results gained in this project will form the basis for policy recommendations on how European hospitals can move towards meeting health needs in their culturally diverse societies.

2 Rationale

2.1 Objectives of the review

The MFH project aims to build upon existing knowledge and experience of developing migrant-friendly hospitals. This review, therefore, looks at models of effective interventions in both published and unpublished literature as well as at information on the Web. Its aims are:

(a) To present a systematic overview of current interventions intended to increase the migrant and minority friendliness of hospitals, and at improving the health and health literacy outcomes of migrants and ethnic minorities. The overview will include contacts and sources of further information for the models that are identified. Particular attention will be given to those areas that are identified as being of special interest to the pilot hospitals.

(b) To identify both evidence- and experience-based models, and to evaluate and rate them. The evaluation criteria will include: adequacy of the theoretical framework, acceptability, feasibility, quality of implementation, effectiveness, efficiency and sustainability.

2.2 Review

A preliminary inquiry into the main difficulties that European hospitals experience in providing health care to migrants and minorities identified the following problem areas: communication, cultural differences, inadequate provision to meet the health care needs of migrants and minorities, lack of

documentation and research on this issue, and lack of adequate information for patients.

At the first meeting of the MFH hospital representatives, this list of issues was refined and grouped into four main areas:

- **Communication** This is certainly the most urgent, evident, straightforward, and the most frequently mentioned area in which interventions are needed.

- **Responsiveness** to the socio-cultural backgrounds of migrant and minority patients, focusing on hospitals' positive responses to their needs. Responsiveness also includes the **adequacy** of health care facilities in meeting the needs of migrant and minority patients, including both structural aspects of hospitals and training for health professionals.

- **Empowerment** of migrant and minority patients and communities. Empowerment is similar to responsiveness but goes further in enabling patients to participate fully in decision making.

- **Monitoring** of migrant health and migrant health care. This is the final and vital aspect which closes the quality cycle: observing what is going on, what measures have been taken, how successful they were, and measuring the resulting changes. Monitoring also includes looking at other research topics which may help identify further areas where intervention is required ('need for further research').

The literature review looked at a range of data sources. These included electronic databases, collections of journal articles on communication barriers, annotated bibliographies, meta-analyses, monographs, and books dealing with migrant and minority health care, as well as unpublished literature (reports, statistics, policy papers). The key words used for information retrieval in computerised databases were: *migrant health care, ethnicity, minority, cultural competence, quality of care, evidence-based medicine, patient-centred care, health literacy, patient education, empowerment, community health, intercultural communication, language barriers, patient-provider communication, interpreting*. The research papers in this review use qualitative, quantitative and mixed research methods[3].

The information collected was grouped into three categories within each of the four key areas:

---

[3] Creswell, J. W. (2003). *Research Design: qualitative, quantitative and mixed methods approaches*. London, Sage.

1. **Concerns:** an overview of the problems identified in the literature (*What problems have been identified?*)

2. **Policies:** references in the literature to what health providers intend to do (*What should and could be done?*)

3. **Interventions** that were reported to be effective (*What was done that was effective?*).

Table 1 below lists the main sources used to compile this review.

Table 1: Main published sources used in this review of effective interventions

Multicultural Health 2002, an Annotated Bibliography[4]

Cultural Competence Works[5]

Improving Healthcare Quality for Minority Patients[6]

Can Cultural Competency Reduce Racial and Ethnic Disparities?[7]

Responsiveness of the Canadian Health Care System towards Newcomers[8]

Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care[9]

Culture, Religion and Patient Care in a Multi-Ethnic Society[10]

Language Barriers in Access to Health Care[11]

---

[4] Murray-Garcia, J. L. (2002). Multicultural Health 2002. An annotated bibliography. Woodland Hills, The California Endowment.

See also http://www.calendow.org/reference/publications/pdf/disparities/TCE0222-2002_Multicultural_.pdf

[5] HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

[6] NQF (2002). Improving healthcare quality for minority patients. Washington, The National Quality Forum.

[7] Brach, C. and I. Fraser (2000). *Can cultural competency reduce racial and ethnic disparities? A review and conceptual model*. Medical Care Research and Review 57(1): 181-217. and Brach, C. and I. Fraser (2002). *Reducing disparities through culturally competent health care: an analysis of the business case*. Quality Management in Health Care 10(4): 15-28.

[8] Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

[9] Smedley, B. D., A. Y. Stith and A. R. Nelson (2003). *Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington, The National Academies Press.

[10] Henley, A. and J. Schott (1999). *Culture, religion and patient care in a multi-ethnic society - a handbook for professionals*. London, Age Concern Books.

[11] Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

2.3 Conceptual framework

There are a number of approaches to the way in which migrant and minority health care can be improved, and migrant- and minority-friendliness in hospitals be increased:

Quality of care: There are many generally accepted methods of measuring and improving the quality of health care. These also apply to care for minority populations. Quality of care is defined here as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'[12]. Within the general definition, Donabedian's[13] distinctions between structure, process and outcome are widely used and accepted. To put it simply, the quality of health care is not adequate if care is not provided to all patients[14].

Evidence-based medicine: The concept of evidence-based medicine is generally accepted as the underlying philosophy for quality of care. However, in the context of quality of care for migrant and minority populations, there is also the question of whether scientific conclusions based on research in majority populations can be generalised to minority populations.

Patient-centred care: Patient-centred interviewing is associated with greater patient satisfaction and better medical outcomes than are traditional encounters[15]. The patient-centred approach is also recommended as helpful in avoiding the stereotyping that can arise when the focus is provider-based[16]. However, measuring patient-centred care has proved difficult and is even more complicated in cross-cultural patient-provider interactions.

Responsiveness to cultural needs: Another way of increasing migrant friendliness is by improving responsiveness to diverse needs (cultural, linguistic, minority or migration-specific) and providing culturally competent care. A tentative definition of cultural competence is: the ability to provide

---

[12] Nerenz, D. R. (2002). *Quality of care measures of special significance to minority populations*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

[13] Donabedian, A. (1988). *The quality of care: how can it be assessed?* JAMA 260(12): 1743-1748.

[14] NQF (2002). Improving healthcare quality for minority patients. Washington, The National Quality Forum.

[15] Rivadeneyra, R., V. Elderkin-Thompson, R. C. Silver and H. Waitzkin (2000). *Patient centeredness in medical encounters requiring an interpreter*. Am J Med 108(6): 470-4.

[16] Kai, J. and J. Spencer (1999). *Learning to value ethnic diversity - what, why, how?* Medical Education(33): 616-623.

effective health care services, taking into consideration the individual's gender, sexual orientation, disability, age, and religious, spiritual and cultural beliefs. It requires staff to have a working knowledge of the diverse spiritual and cultural needs of service users. Furthermore, in order to provide culturally competent practice, it requires staff to support cultural values and beliefs, but, where this is not possible, explains the reason in a respectful way. It enables patients to feel respected by and confident in their health care providers.

Cultural competence in relation to employment is the ability to recruit staff who are free from any bias or prejudice, and to ensure that systems are in place to enable equality of access to training and development, promotion, and career progression. It also includes the ability to manage and support staff, taking into account their gender, sexual orientation, disability, age, and religious, spiritual, cultural and individual needs, and enabling them to provide culturally competent care[17].

While cultural competence has been seen as a major force in improving minority health care, it can be somewhat paternalistic (the providers are competent, they know; the patients are in a receiving, humble position). Thus, responsiveness seems to be a more appropriate term when describing how the needs of migrants and minority patients should be addressed from the health professional side[18].

Health literacy is a relatively new concept and has been defined as the capacity to use the health care system appropriately and to live a healthy lifestyle. Increasing health literacy improves the quality of health care and increases patients' empowerment. First, however, health literacy must be measured. There are a number of assessment tools available[19]. Most of these were developed in English-speaking contexts, and a few have been translated and adapted for Spanish speakers[20].

Equality and equity Health disparities between migrant and minority populations are not only an issue of quality of care, they are also issues of

equity, equality and even ethics. These lie only partially within the scope of hospitals, but migrant and minority health care could be greatly improved if equity and equality were used as levers[21]. Reducing *health care* disparities can reduce *health* disparities[22].

While all approaches that help improve hospitals' migrant- and minority-friendliness are of great value, the most effective approach in our view is to focus on the *quality of care*[23]. In presenting models of effectiveness and good practice in each area, priority will be given to examples which fulfil quality of care criteria[24]. It should also be noted that several examples of effective interventions in this report involve some of the approaches listed above since the best interventions cover more than one area.

[17] Adapted from the definition proposed by Dilshad Khan (Email 4/6/2003)

[18] Brach, C. and I. Fraser (2000). *Can cultural competency reduce racial and ethnic disparities? A review and conceptual model*. Medical Care Research and Review 57(1): 181-217.

[19] Davis, T. C., R. Michielutte, E. N. Askov, M. V. Williams and B. D. Weiss (1998). *Practical assessment of adult literacy in health care*. Health Educ Behav 25(5): 613-24. Davis, T. C., S. W. Long, R. H. Jackson, E. J. Mayeaux, R. B. George, P. W. Murphy and M. A. Crouch (1993). *Rapid estimate of adult literacy in medicine: a shortened screening instrument*. Fam Med 25(6): 391-5.

[20] Parker, R. M., D. W. Baker, M. V. Williams and J. R. Nurss (1995). *The test of functional health literacy in adults: a new instrument for measuring patients' literacy skills*. J Gen Intern Med 10(10): 537-41.

[21] Smedley, B. D., A. Y. Stith and A. R. Nelson (2003). *Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington, The National Academies Press.

[22] Brach, C. and I. Fraser (2002). *Reducing disparities through culturally competent health care: an analysis of the business case*. Quality Management in Health Care 10(4): 15-28.

[23] Smith, M. (2002). *Culture and quality: joining the levers*. Advancing effective health care through systems development, data and measurement, Chicago.

[24] Nerenz, D. R. (2002). *Quality of care measures of special significance to minority populations*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

3 Findings of the review

This section sets out the results of the review of health-related literature. Most of the sources are published papers, a few are unpublished. Anecdotal evidence is not included. Those examples which we consider most relevant to the MFH project are set out in text boxes.

3.1 Communication

In the preliminary assessment of problem areas in the selected (MFH project) hospitals, communication was the most prominent area of concern, as it is in many reviews and evaluations in this field undertaken in Western countries. At the same time, communication is probably both the best researched and the most highly developed area in the context of providing quality health care for migrants. Consequently, this first section of the review findings is the most comprehensive.

3.1.1 Communication: areas of concern

The literature presented in this section provides substantial evidence that language barriers have adverse effects on the accessibility of care, the quality of care received, patient satisfaction, and patient health outcomes. Speakers of minority languages and patients who do not share the language of the professionals caring for them (referred to in this review as allophone patients) are at double risk: the risk of receiving less than optimal care because they are part of a migrant or minority community, and the additional risk posed by language barriers.

Diagnostic testing

Two studies have investigated the impact of language barriers on diagnostic testing. Waxman & Levitt[25] showed that significantly more tests were ordered for allophone patients with abdominal pain than for English speakers. This research was conducted in a US emergency department and compared English-speaking patients with non-English-speaking patients whose first languages included Spanish, Cantonese, Hindi and Arabic. Different kinds of interpreters were present: in 80 per cent of the encounters an untrained interpreter (family member, house staff, nurse etc.) was used; in 20 per cent a

professional, trained interpreter was used. However, no sub-analysis was performed based on the type of interpreter.

Hampers and colleagues[26] found similar trends: in a paediatric emergency department, language barriers were associated with a higher level of resource use for diagnostic testing and with increased visiting times. This study reports that an interpreter was involved in only 6 per cent of the patient visits analysed, but does not specify whether the interpreter was a trained professional interpreter. Whether there was a connection between the higher level of resource use or the increased visiting times and the use of an interpreter is also not clear.

Medication

Several studies show that allophone patients are less likely to receive adequate medication. Comparing hormone replacement therapy among African-American, Asian, Latin-American, Soviet and white US women, Brown et al. found significant differences in prescription patterns[27]. Soviet women, few of whom spoke English, were less likely to be prescribed hormone replacement therapy (7 per cent, compared to 33 per cent of other white women). This large difference may reflect communication barriers, although there is also a possible difference in cultural beliefs. For some of the Asian and Latin-American women, language barriers may have also been a factor, but neither the language used nor the patient's mother tongue were included as variables in the study design.

The findings of a questionnaire survey into hormone replacement therapy among Swiss and non-Swiss women in Geneva[28] revealed similar trends and suggest lower use of hormone replacement therapy among the non-Swiss women when compared to the population in general.

In a clinical trial evaluating the prescription of analgesics for minority patients with cancer, researchers[29] found that only a third of minority patients received analgesics as recommended in the prescribing guidelines, compared

---

[25] Waxman, M. and M. Levitt (2000). *Are diagnostic testing and admission rates higher in Non-English-speaking versus English-speaking patients in the emergency department?* Annals of Emergency Medicine 36(5): 456-461.

[26] Hampers, L. C., S. Cha, D. J. Gutglass, H. J. Binns and S. E. Krug (1999). *Language barriers and resource utilization in a pediatric emergency department*. Pediatrics 103(6 Pt 1): 1253-6.

[27] Brown, A. F., E. J. Perez-Stable, E. Whitaker, S. Posner, M. Alexander, J. Gathe and A. Washington (1999). *Ethnic differences in hormone replacement prescribing patterns*. J Gen Intern Med 14: 663-669.

[28] Rieder Nakhile, A., A. Morabia, J.-P. Humair, S. Antonini and H. Stalder (2001). Utilisation de l'hormonothérapie substitutive: comparaison entre une consultation de premier recours et la population générale. Genève, Médecine Communautaire HUG.

[29] Cleeland, C. S., R. Gonin, L. Baez, P. Loehrer and D. Pandya (1997). *Pain and treatment of pain in minority patients with cancer*. Ann Intern Med 127: 813-816.

to half the majority patients. In addition, more Hispanic than Black patients were inadequately medicated (69 per cent vs. 54 per cent). This suggested that patients' proficiency in English played a role in assessing their pain. However, language issues were not directly assessed, and there is no information as to whether interpreters were used. The authors suggest a number of explanatory factors, including difficulties in assessing pain due to differences in language and culture, as well as cultural differences in willingness to use analgesics.

In another study[30], Hispanic ethnicity was a strong predictor of poor pain management, but language was a risk factor of only borderline significance. (No information is available as to whether interpreters were used).

Another study[31] showed that pain management in a palliative care unit was inadequate for allophone patients. The authors conclude:

> 'The results suggest that patients not fluent in English received less optimal palliative care. Communication of the diagnosis and prognosis requires the cooperation of the patients' families as well as the use of professional interpreters.'

While the above studies show that allophone patients receive *less* medication, Hampers[32] came to a different conclusion: allophone patients in a paediatric emergency department were *more* likely to be given intravenous fluids than English-speakers. However, an important limitation of this study was that all the allophone patients (more precisely all the allophone families of the children attending the emergency services) were lumped together in one group, irrespective of whether an interpreter of any kind was used. Because there may have been trained or ad hoc interpreters to facilitate communication in many cases, the effects of language barriers were probably underestimated.

Medical follow-up

Language barriers can affect medical follow-up. Manson[33], who was one of the first to explore language barriers and who introduced the term 'language concordance' as a determinant of health care outcomes, found that allophone

patients were more likely to miss follow-up appointments. They were also more likely to skip medication, as well as to use hospital emergency rooms.

In a cohort study comparing allophone patients with English-speakers after visits to an emergency department[34], the allophone patients were significantly less likely to have been given a follow-up appointment. Interestingly, both categories of allophone patients (those who used an interpreter, and those who did *not* use an interpreter but felt that an interpreter was needed) were less likely to have been given a follow-up appointment. It should be noted, however, that a trained interpreter was used with only one out of ten patients, while ad hoc interpreters (mainly family members) were used with many of the others.

Language was also found to be a barrier to the use of preventive services[35]: allophone women were less likely to receive mammograms, breast examination and pap testing.

One study[36] found clear evidence of the benefits of using trained interpreters: the quality of diabetes management and follow-ups was *better* for allophone patients than for English-speakers. However, this study is not easily comparable with the previous ones, as it is to our knowledge the only one where all allophone patients were systematically provided with trained interpreters, a fact that, as the findings suggest, had an important effect on addressing language barriers to health care.

Hospital visits and admissions

Pitkin and Baker[37] interviewed patients who attended a hospital with non-urgent medical problems and found that the allophone patients (Latinos) reported fewer hospital visits than the English-speakers. The authors, re-analysing a data set from an earlier study[38], hypothesised that patients' self-reported proficiency in English might be a more direct and accurate measure of language barriers. They did not consider the presence or absence of interpreters.

[30] Todd, K. H., N. Samaroo and J. R. Hoffman (1993). *Ethnicity as a risk factor for inadequate emergency department analgesia*. JAMA 269(12): 1537-1539.

[31] Chan, A. and R. K. Woodruff (1999). *Comparison of palliative care needs of English- and non-English- speaking patients*. J Palliat Care 15(1): 26-30.

[32] Hampers, L. C., S. Cha, D. J. Gutglass, H. J. Binns and S. E. Krug (1999). *Language barriers and resource utilization in a pediatric emergency department*. Pediatrics 103(6 Pt 1): 1253-6.

[33] Manson, A. (1988). *Language concordance as a determinant of patient compliance and emergency room use in patients with asthma*. Med Care 26(12): 1119-28.

[34] Sarver, J. and D. W. Baker (2000). *Effect of language barriers on follow-up appointments after an emergency department visit*. J Gen Intern Med 15(4): 256-64.

[35] Woloshin, S., L. M. Schwartz, S. J. Katz and H. G. Welch (1997). *Is language a barrier to the use of preventive services?* Ibid. 12(8): 472-477.

[36] Tocher, T. M. and E. Larson (1998). *Quality of diabetes care for non-English-speaking patients. A comparative study*. West J Med 168(6): 504-11.

[37] Pitkin, K. and D. W. Baker (2000). *Limited English proficiency and Latinos's use of physician services*. Medical Care Research and Review 57(1): 76-91.

[38] Baker, D. W., R. M. Parker, M. V. Williams, W. C. Coates and K. Pitkin (1996). *Use and effectiveness of interpreters in an emergency department*. JAMA 275(10): 783-8.

In another study, the authors[39] wanted to measure the association between physician-patient language discordance (defined as no shared language, no interpreter) and increased hospital admission. They found evidence, strongly contrasting with that of the previous study, that the probability of allophone patients as against English-speaking patients being admitted to hospital were 1 to 7. These authors considered that hospital admission was more likely when patients could not communicate effectively.

In a study comparing levels of service use by English and non-English speakers in Australia, the researchers[40] found longer median stays among allophone than among English-speaking inpatients in psychiatric services. In an attempt to explain this difference, the authors speculate that it takes longer to establish a firm diagnosis in allophone patients because of communication barriers. Other important findings were shorter face-to-face clinic contacts for allophone patients (explained by the researchers as due to the generally low use of trained interpreters), and significantly lower rates of voluntary hospitalisation. Thus, the authors concluded, where clients have a choice, allophone patients stay away in large numbers, which suggests that it is the acceptability, accessibility or perceived relevance of voluntary hospitalisation that is problematic for allophone potential clients.

In our research on the effects of language barriers on referral rates[41], an analysis of 723 interviews with asylum seekers conducted by a team of nurses in Geneva suggests that language discordance and the poor quality of communication (as perceived by the nurses who conducted the interviews) led to low referral rates for psychological care. The assessment, a crucial stage in the nursing process, could not be done properly, and subsequent treatment was hampered. Symptoms suggesting post-traumatic stress may have been under-reported. In contrast, the researchers found that adequate language concordance and the use of interpreters increased the likelihood of asylum seekers being referred for mental health care.

Patient adherence

In a study of access to primary care[42], Hispanic patients were asked, after their consultation, to rate their proficiency in Spanish and English, and to say whether an interpreter had been present at the consultation, and whether they had received information about medication during the consultation. Only half of those patients who spoke only Spanish felt that the side effects of treatments had been explained to them, compared with 84 per cent of the controls (patients with good English). In addition, the lack of explanation about medication correlated significantly with later non-adherence and with patients' dissatisfaction with the care they received.

In another study using exit interviews[43], Spanish- and English-speaking patients were asked to recall their diagnoses and follow-up instructions. The Spanish-speaking patients performed significantly worse than the English-speaking patients. It should be noted that in both this and the previous study, the interpreters used in some of the medical consultations had had no formal interpreting training.

In another investigation, Karter[44] conducted a cross-sectional survey of how language barriers affect self-monitoring of blood glucose. Multivariate analysis revealed that language barriers were significant predictors of non-adherence (along with a number of other factors including less intensive therapy, male sex, age, ethnicity, education, and income). The study compared English-speaking patients with allophone patients, mainly Hispanics, Asians and Pacific Islanders. No mention is made of whether interpreters were used.

Patient information

The Berlin study[45] compared health care provision for Turkish women with that for German women in gynaecological services in Berlin. While 90 per cent of the German women understood well the medical information provided by health staff, this applied to only half the Turkish women. The Turkish women's understanding of the medical information provided by

[39] Lee, E. D., C. R. Rosenberg, D. M. Sixsmith, D. Pang and J. Abularrage (1998). *Does a physician-patient language difference increase the probability of hospital admission?* Acad Emerg Med 5: 86-89.

[40] Trauer, T. (1995). *Ethnic differences in the utilisation of public psychiatric services in an area of suburban Melbourne*. Aust N Z J Psychiatry 29(4): 615-23.

[41] Bischoff, A., P. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan (2003). *Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral rates*. Soc Sci Med 57: 503-512.

[42] David, R. A. and M. Rhee (1998). *The impact of language as a barrier to effective health care in an underserved urban Hispanic community*. Mt Sinai J Med 65(5-6): 393-7.

[43] Crane, J. A. (1997). *Patient comprehension of doctor-patient communication on discharge from the emergency department*. J Emerg Med(15): 1-7.

[44] Karter, A., A. Ferrara, J. Darbinian, L. Ackerson and J. Selby (2000). *Self-Monitoring of Blood Glucose*. Diabetes Care 23(4): 477-483.

[45] Borde, T., M. David and H. Kentenich (2000). Probleme der Kommunikation und Aufklärung im Krankenhaus aus der Sicht deutscher und türkischsprachiger PatientInnen sowie des Klinikpersonals. Berlin, Charité Campus Virchow-Klinikum.

physicians was considerably hampered by the kind of interpreting they received. *Ad hoc* interpreting, arranged as needed when the women arrived (*Notlösungen*), was considered unsatisfactory by both patients and health professionals. This suggests that medical information as currently provided is most useful for patients who are proficient in German and who have a high level of pre-existing knowledge, and less useful for patients who have fewer skills in German and a greater need for information.

Patient understanding

Baker et al.[46] conducted a cross-sectional survey in a US emergency department and assessed Spanish-speaking patients' understanding of diagnoses and treatments. Patients were grouped into three categories: those who used an interpreter, those who thought they needed an interpreter but did not get one, and those who said that they did not need an interpreter. Sixty-seven per cent of patients who said that they did not need an interpreter rated their understanding of their disease as good to excellent, compared with 57 per cent of those who used an interpreter, and 38 per cent of those who thought that they should have had an interpreter. Looking at patients' understanding of their treatment, the figures were 86 per cent, 82 per cent, and 58 per cent respectively, also with statistically significant differences. A limitation of this study was that different types of interpreters were used, and that in only 12 per cent of cases were these trained interpreters. The authors conclude:

> 'Interpreters are often not used despite a perceived need by patients, and the interpreters who are used usually lack formal training in this skill. Language concordance and interpreter use greatly affected patients' perceived understanding of their disease, but a high proportion of patients in all groups had poor knowledge of their diagnosis and recommended treatment.'

In research into patient-centred consulting, a cross-sectional sample of patients was video-taped during visits to physicians[47]. Spanish-speaking patients made fewer comments and were less likely to receive encouragement to speak from their physicians. Furthermore, they were more likely to have their comments ignored, while English-speaking patients usually received an answer or acknowledgement to their questions even if the physicians did not encourage further discussion on the topic. These communication difficulties may have resulted, the authors conclude, in lower adherence and poorer medical outcomes among Spanish-speaking patients. Unfortunately, the impact of interpreters was not investigated. However, the interpreters used were bilingual nurses, who had had no training as interpreters.

Patient reporting

Our own study into language barriers between nurses and asylum seekers[48] suggests that patients in language-discordant interviews were less likely to report symptoms (including headache, abdominal pain, backache, as well as psychological symptoms including insomnia, nervousness and sadness). In relation to the detection of traumatic events, the differences found in multivariate analysis were even more significant: patients' reporting of war situations, violence, detention, deaths of relatives and missing relatives increased with adequate language concordance. Their reporting of traumatic events decreased drastically in interviews with no language concordance.

Patient satisfaction

Patient satisfaction is the most well-recognised and widely used measure of the effectiveness of provider-patient communication[49]. It is also an outcome of health care and is highly correlated with quality of care[50]. It is therefore particularly important in relation to improving health care for migrants and ethnic minorities to measure satisfaction among allophone patients. Several patient satisfaction studies do indeed show that allophone patients are less satisfied than other patients with the care provided:

Carrasquillo[51] studied allophone patients' satisfaction and willingness to return to an emergency department. In a cross-sectional survey which included over 2,300 patients, multivariate analysis showed that allophone patients were significantly *less* likely to be satisfied and significantly *less* willing to return to the same emergency department. They were also significantly *more* likely to report overall problems with care, communication and diagnostic testing. Only half of them reported satisfaction with their care. The data did not indicate whether interpreters were used in any of the interviews. The authors conclude that patient satisfaction could be improved

[46] Baker, D. W., R. M. Parker, M. V. Williams, W. C. Coates and K. Pitkin (1996). *Use and effectiveness of interpreters in an emergency department*. JAMA 275(10): 783-8.

[47] Rivadeneyra, R., V. Elderkin-Thompson, R. C. Silver and H. Waitzkin (2000). *Patient centeredness in medical encounters requiring an interpreter*. Am J Med 108(6): 470-4.

[48] Bischoff, A., P. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan (2003). *Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral rates*. Soc Sci Med 57: 503-512.

[49] Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

[50] Donabedian, A. (1988). *The quality of care: how can it be assessed?* JAMA 260(12): 1743-1748.

[51] Carrasquillo, O., E. J. Orav, T. A. Brennan and H. R. Burstin (1999). *Impact of language barriers on patient satisfaction in an emergency department*. J Gen Intern Med 14(2): 82-7.

by the appropriate use of trained interpreters and by increasing language concordance between patients and providers.

Another cross-sectional survey assessed interpreter use and patient satisfaction with interpersonal aspects of care[52]. Patients were divided into three groups (as in the other study by Baker et al. 1996, see above): those who were able to communicate without an interpreter, those who communicated through an interpreter, and those who felt that an interpreter should have been used but who communicated directly with the physician. Those who communicated through an interpreter rated their provider as less friendly, less respectful, less concerned for them as a person, and less likely to make them comfortable than those who communicated adequately without an interpreter. This indicates that, whenever it is possible, direct communication between patient and professional is most desirable.

Surprisingly, among the two groups of patients who needed an interpreter, those who actually had one did not understand any more of their consultation than those who did not. However, it should be noted that the type of interpreter used in each consultation was not assessed, and that trained interpreters were used in only 12 per cent of the consultations. This explains the authors' final suggestion that further efforts are needed to ensure interpreter availability and proper interpreting techniques.

Another study[53] comparing patient satisfaction with communication with providers, divided the patients into three groups: Latinos responding *to* questionnaires in Spanish, Latinos responding in English, and non-Latinos responding in English. An analysis of 7,000 questionnaires showed that the first group (Latinos responding in Spanish) was significantly more dissatisfied with communication than the other two groups, even after multivariate analysis adjusting for age, gender, education and insurance status. Language concordance was found to have a greater impact on patient satisfaction than any other variable. However, as in many of the studies reviewed here, there was no record of whether or when interpreters were used, nor of whether any interpreters used were trained or untrained.

Finally, several studies which focus on aspects of health care other than language also report lower patient satisfaction due to language barriers[54].

Using family members as interpreters

Using family members as untrained interpreters is the most frequent method of trying to solve the problem of language barriers[55]. Family members do not cost health services anything, and health service providers feel no responsibility for their proficiency as interpreters. In contrast, allophone patients often feel that it is their duty to bring along someone who can make communication possible.

In our Swiss survey[56], the use of family members was particularly frequent among Kurdish, Albanian, Tamil and Turkish patients. However, migrants, especially refugees from war-torn countries who are likely to experience post-traumatic disorders, often feel unable to talk about traumatic experiences and their consequences if they have to use relatives or friends to interpret for them. The use of relatives is frequently highly problematic, both for the patients themselves (who have to reveal extremely sensitive and distressing personal information that they may not want family members or friends to know) and for the relatives or friends who are interpreting (who may learn and have to interpret things that are very distressing). Although it is often important to integrate the family into a patient's therapy, trained interpreters are definitely needed in their own right and fulfil a completely different function.

A few papers favour relatives acting as interpreters[57], arguing that patients like continuity and familiarity in an interpreter and also prefer relatives

[52] Baker, D. W., R. Hayes and J. P. Fortier (1998). *Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients*. Med Care 36(10): 1461-70., Pitkin Derose, K., R. D. Hays, D. McCaffrey and D. W. Baker (2001). *Does physician gender affect satisfaction of men and women visiting the emergency department?* J Gen Intern Med 16: 218-226.

[53] Morales, L. S., W. E. Cunningham, J. A. Brown, H. Liu and R. D. Hays (1999). *Are Latinos less satisfied with communication by health care providers?* J Gen Intern Med 14(7): 409-17.

[54] including those by Madhok, R., A. Hameed and R. Bhopal (1998). *Satisfaction with health services among the Pakistani population in Middlesbrough, England*. J Public Health Med 20(3): 295-301., Hu, D. and R. M. Covell (1986). *Health care usage by Hispanic outpatients as function of primary language*. West J Med(144): 490-493. and Perez-Stable, E. J., A. Napoles-Springer and J. M. Miramontes (1997). *The effects of ethnicity and language on medical outcomes with hypertension or diabetes*. Medical Care 35(12): 1212-1219..

[55] Bonacruz_Kazzi, G. and C. Cooper (2003). *Barriers to the use of interpreters in emergency room paediatric consultations*. Journal of Paediatrics and Child Health 39(4): 259-63. See also Ginsberg, C., V. Martin, D. Andrulis, Y. Shaw-Taylor and C. McGregor (1995). *Interpretation and Translation Services in Health Care: a survey of US public and private teaching hospitals*. New York, National Public Health and Hospital Institute. Poechhacker, F. (1997). *Kommunikation mit Nichtdeutschsprachigen in Wiener Gesundheits- und Sozialeinrichtungen*. Wien, Dezernat für Gesundheitsplanung.

[56] Bischoff, A., C. Tonnerre, A. Eytan, M. Bernstein and L. Loutan (1999). *Addressing language barriers to health care, a survey of medical services in Switzerland*. Soz Praventivmed 44(6): 248-56.

[57] Xuo, D. and M. J. Fagan (1999). *Satisfaction with methods of Spanish interpretation in an ambulatory care clinic*. J Gen Intern Med 14(9): 547-50.

because they are easily available. However, the literature provides ample evidence of the adverse consequences of relatives acting as ad hoc-interpreters, eg, the child who was asked to communicate to her mother that the foetus the mother was carrying was dead[58], the child in distress after being asked to interpret for a dying sibling[59], the misinterpreting of family history in paediatric care, and the lack of confidentiality[60].

A growing body of evidence also suggests that the use of informal, untrained interpreters can lead to inadequate care due to serious miscommunication[61]. Untrained interpreters may be proficient in both languages but may still not know how to interpret; poor interpreting leads to misunderstandings[62], wrong diagnoses and low adherence[63]. Untrained interpreters who do not understand both cultures cannot provide the necessary cross-cultural mediation. Relatives, especially children (Jacobs, Kroll et al. 1995), are also at high risk of stress disorders themselves if they have to translate emotionally charged interviews (eg, about their parents experiences of violence or forced migration)[64]. However, despite their obvious disadvantages, informal interpreters are still widely used.

Surveys in Vienna which specifically assessed the use of children as interpreters[65], and studies among Swiss private practitioners[66], confirm the above findings. In the latter study, two-thirds of the physicians interviewed said that language was the most important communication problem they faced with refugees. However, 75 per cent thought that friends and family members would do well as interpreters. Only half of those interviewed found it problematic that children were used as interpreters, and almost the same proportion said that the migrants themselves normally 'solved' the interpreter problem by bringing someone with them[67].

There are times, however, when the presence of a family member as an interpreter during a consultation cannot be avoided. For some patients, it is inconceivable to visit a doctor on their own; it is customary for them to be accompanied by one or more members of their family. This is especially true for women in some minority communities, whose husbands are often present during a consultation and serve as interpreters.

Experience shows that when a relative is interpreting, he or she almost invariably speaks *on behalf of* the patient rather than transmitting the health professional's questions to the patient and the patient's replies back to the health professional. A husband, for example, may reply on his wife's behalf about her expectations, her fears or her symptoms without actually asking her. This can lead to misunderstandings and serious misdiagnoses. It is important to be quite clear about the potential and the limitations of such an arrangement and, once a basic level of trust has been established, to suggest a trained interpreter for future consultations. A number of authors, while cautioning against the use of family members as interpreters, provide guidelines for working with informal interpreters, see for example the table in the handbook, *The Medical Interview*[68].

Quality of communication

Good patient-provider communication has been shown to have lasting positive effects over time[69] and directly to improve adherence and health outcomes[70]. The quality of patient-provider communication is therefore a strong indicator of the quality of the health care provided.

[58] Haffner, L. (1992). *Translation is not enough. Interpreting in a medical setting*. West J Med 157(3): 255-9.

[59] Jacobs, B., L. Kroll, J. Green and T. J. David (1995). *The hazards of using a child as an interpreter*. J R Soc Med 88(8): 474P-475P.

[60] Holden, P. and A. C. Serrano (1989). *Language barriers in pediatric care*. Clin Pediatr (Phila) 28(4): 193-4.

[61] Ebden, P., A. Bhatt, O. J. Carey and B. Harrison (1988). *The bilingual consultation*. The Lancet 1(8581): 347.

[62] Launer, J. (1978). *Taking medical histories through interpreters: practice in a Nigerian outpatient department*. Br Med J 2(6142): 934-5.

[63] David, R. A. and M. Rhee (1998). *The impact of language as a barrier to effective health care in an underserved urban Hispanic community*. Mt Sinai J Med 65(5-6): 393-7.

[64] Westermeyer, J. (1990). *Working with an interpreter in psychiatric assessment and treatment*. J Nerv Ment Dis 178(12): 745-9.

[65] Poechhacker, F. (1997). *Kommunikation mit Nichtdeutschsprachigen in Wiener Gesundheits- und Sozialeinrichtungen*. Wien, Dezernat für Gesundheitsplanung.

[66] Bloechliger, C., T. Junghanss, R. Weiss, C. Herzog, P.-A. Raeber, M. Tanner and C. Hatz (1998). *Asylsuchende und Flüchtlinge in der hausärztlichen Praxis: Probleme und Entwicklungsmöglichkeiten*. Soz Praventivmed 43: 18-28.

[67] Bloechliger, C., M. Tanner, C. Hatz and T. Junghanss (1997). *[Asylum seekers and refugees in ambulatory health care: communication between physician and patient]*. Schweiz Rundsch Med Prax 86(19): 800-10.

[68] Hardt, E. J. (1995). *The bilingual interview and medical interpretation*. In: The medical interview: clinical care, education and research. M. Lipkin, S. Putnam and A. Lazare. New York, Springer.

[69] Simpson, M., R. Buckman and M. Stewart (1991). *Doctor-patient communication: the Toronto consensus statement*. BMJ 303: 1385-1387.

[70] Stewart, M. (1995). *Effective physician-patient communication and health outcomes: a review*. Can Med Assoc J 152(9): 1423-1433.

Our Quality of Care study in (French-speaking) Geneva[71] demonstrated that the quality of communication in medical interviews was rated unfavourably in consultations with allophone patients. Both providers and patients perceived the following aspects of communication as less satisfactory in language-discordant consultations: meeting patients' needs, giving explanations, showing respect, the consultation process, and giving follow-up information. In this study, the presence or absence of interpreters and the type of interpreter were included in the study design and assessed in detail through multivariate analysis. The analysis showed that the use of trained interpreters significantly improved the quality of communication with allophone patients.

3.1.2 Communication: policies

There are three main strategies for addressing language barriers in health care. All three enable language concordance between the two speakers (health professional and patient):

- *The health professional speaks the allophone patient's language.* Increasing the number of health professionals who speak other languages, ie, the languages spoken by allophone patients.

- *The patient speaks the health provider's language.* Increasing the number of foreign-language patients who speak the local language(s).

- *A third party acts as mediator between two people who do not share a common language and relays messages from each person's language into the other person's language.* Increasing the number of interpreters who can translate the speakers' messages in both directions

Strategy 1. The health professional speaks the allophone patient's language

Here the first individual (the health care provider) *moves towards* the second individual (the minority patient). The health care provider gives up the isolated position in which she[*] cannot communicate with her interlocutor. She creates a shared 'area of communication' with the patient by speaking, or learning to speak, the patient's language (or one of the patient's languages).

This strategy involves initiatives which aim to increase the number of health professionals who speak and work in other languages[72]. A common approach in large hospitals with health professionals from diverse backgrounds is to compile lists of bilingual health professionals on whom other health professionals can call when in need. This is the main way of addressing language barriers in many hospitals in Switzerland[73].

A more pro-active strategy is to encourage the recruitment and professional education of members of different ethnic groups, for example as physicians and nurses[74]. Many hospitals, however, still appear to find it difficult not to discriminate against minority ethnic staff in employment and in selection for training. Another way of trying to implement Strategy 1 is to facilitate the licensing of foreign-trained staff. However, the cumbersome procedures involved in accrediting foreign diplomas are often a major obstacle.

A final approach to Strategy 1 is to encourage health professionals to learn the languages of local minority groups[75]. The effectiveness of this has so far not been adequately evaluated. However, research has emphasised the risks of 'false fluency' among health care providers who try to communicate without an interpreter although they have only limited proficiency in the minority language. While the provider may believe that he understands the patient and that the patient appreciates the efforts he is making in speaking a 'foreign' language, serious miscommunication can result, with potentially dangerous consequences[76].

At the same time, our research into language barriers at a Geneva outpatient clinic shows that the bilingual abilities of the physicians working there during the survey were remarkable and were an important reason for high levels of patient satisfaction[77]. In the survey of nurses' interviews with asylum seekers mentioned earlier, language concordance resulting in adequate symptom

---

[71] Bischoff, A., T. V. Perneger, P. Bovier, H. Stalder and L. Loutan (2003). *Improving communication between physicians and patients who speak a foreign language*. British Journal of General Practice 53: 541-546.

[*] The provider is described as 'she' in this review and the patient as 'he' for reasons of grammatical simplicity.

[72] Betancourt, J. and R. King (2000). *Diversity in health care: expanding our perspectives*. Arch Pediatr Adolesc Med 154: 871-872.

[73] Bischoff, A., C. Tonnerre, A. Eytan, M. Bernstein and L. Loutan (1999). *Addressing language barriers to health care, a survey of medical services in Switzerland*. Soz Praventivmed 44(6): 248-56.

[74] Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

[75] Swartz, L. and G. Drennan (2000). *Beyond words: notes in the 'irrelevance' of language to mental health services in South Africa*. Transcultural Psychiatry 37(2): 183-199.

[76] Flores, G., M. Abreu, M. A. Olivar and B. Kastner (1998). *Access barriers to health care for Latino children*. Arch Pediatr Adolesc Med 152(11): 1119-25.

[77] Bischoff, A., L. Loutan and H. Stalder (2001). *Barrières linguistiques et communication dans une policlinique de médecine*. Bulletin VALS-ASLA 4.

reporting and referrals was often achieved through the nurses' own ability to speak different languages[78].

A couple of provisos should be considered in relation to using bilingual health professionals as a solution to language barriers: the recruitment and use of bilingual health professionals is generally a long-term strategy, but most language problems arise in communicating with those groups of migrants who have arrived most recently[79]. In general, a migrant community only produces bilingual professionals once it has been settled in a country for some time and is more integrated. As a result, most bilingual professionals are members of those longer-settled minority communities where language barriers are less serious. Unfortunately those communities with the greatest language-access needs are generally also the most recently arrived, often with large numbers of refugees and asylum seekers who have experienced uprooting and violence.

Bilingual staff who are asked to communicate directly in the patients' own language need to have an excellent command of both the local and the patients' language, including knowledge of and facility with the terms and concepts relevant to the type of health-care setting. Ideally, this command of both languages should be checked by formal testing[80].

Programmes which encourage the use of bilingual staff are only successful if the health professionals are *both* bilingual *and* bi-cultural, and if they receive training to ensure that they are not only proficient in the necessary areas in both languages, but also in cultural consultancy (the ability to explain cultural issues to patients and to other staff). In addition they must understand the community in which the allophone patients they treat live.[81]

Finally, Mitchell and colleagues[82] present the results of research that explores the roles of bilingual professionals in community mental health services in the Sydney metropolitan area of New South Wales. Bilingual health professionals were found to have at least four important roles: the direct provision of clinical services to allophone patients; mental health promotion and community development; cultural consultancy; and service development. Respondents reported that the latter three roles were seriously underdeveloped compared to the provision of clinical services. Mitchell and colleagues conclude: 'It is critical that service managers implement strategies to make better use of the linguistic and cultural skills of bilingual professionals. In addition to their role in clinical service provision, ways must be found to facilitate the community focused, cultural consultancy and service development roles of bilingual professionals employed in mental health services.'

Strategy 2. The patient speaks the health provider's language.

The second strategy involves movement from the other side: the minority patient moves towards the health professional. The patient is the one who gives up his* isolated position, and learns to speak the health professional's language. Language classes for allophone migrants are seen almost as a cure-all in integration policies in Switzerland[83]. While it is always useful to encourage foreign-language speakers to learn the local language, it is easily forgotten that this can only be a long-term solution. Providing classes for all is not only an expensive measure for the receiving country, there is also much more to learning a language than attending classes. Research in Sweden has shown that only people who are well settled, and are 'rooted' in their mother tongues can learn other languages[84]. In Sweden, migrant children are entitled to education in their home language, which is seen as a prerequisite for managing well in Swedish. There are even programmes which encourage adult migrants to become more proficient in their mother tongues. The idea behind these is to provide people with a framework of their native language and culture which will later enable them to master Swedish more effectively and without losing their own language or culture. This method of addressing

---

[78] Bischoff, A., P. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan (2003). *Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral rates*. Soc Sci Med 57: 503-512.

[79] Widstrom, E. (1985). *Dentists' experiences of immigrants as patients*. Swed Dent J 9(6): 243-7.

[80] OMH (2000). National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, Office of Minority Health, US Department of Health and Human Services (www.omhrc.gov/clas).

[81] Mitchell, P., A. Malak and D. Small (1998). *Bilingual professionals in community mental health services*. Australian and New Zealand Journal of Psychiatry 32(424-433). See also the bilingual nurses' own concerns and their need for adequate training: Cioffi, R. N. (2003). *Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences*. International Journal of Nursing Studies 40(3): 299-306.

* The provider is described as 'she' in this review and the patient as 'he' for reasons of grammatical simplicity.

[82] Mitchell, P., A. Malak and D. Small (1998). *Bilingual professionals in community mental health services*. Aust N Z J Psychiatry 32(3): 424-33.

[83] EKA (1999). Die Integration der Migrantinnen und Migranten in der Schweiz: Fakten, Handlungsbereiche, Postulate. Bern, Eidgenössische Ausländerkommission (EKA).

[84] Janson, S., P. G. Svensson and S. Ekblad (1997). *Migration and Health in Sweden*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

language barriers, however, does not solve the urgent problem of access to health care for new arrivals, the group with the greatest needs[85].

It can be argued that once new migrants are settled and 'well' (in terms of health, occupation, social networks etc.), they will no longer want to depend on help (interpreters, special health programmes) but will want to communicate directly with local people: they will want to learn the local language. While it remains important at a higher governmental level to implement integration policies and to increase the number of migrants who speak the local language, it is unlikely that health care institutions will make the provision of language courses one of their priorities. Long-term integration programmes are needed which combine both aspects: interpreter provision at the time of entry in the host country, and language learning later, together with other measures to facilitate interaction with the host community.

Strategy 3. A third party acts as mediator between two people who do not share a common language, and relays messages from each person's language into the other person's language.

Strategy 3 involves bringing in an interpreter. While in Strategies 1 and 2 one of the two parties has to learn or speak a 'foreign' language, the third strategy does not imply any (additional) foreign language proficiency. An interpreter intervenes between two people who do not share a language in order to bridge the communication gap and to bring them together.

This kind of interpreting, which aims to enable (in most cases) members of minority communities to communicate and achieve full access in public service settings such as hospitals, courts, schools etc is often referred to as community interpreting, though the name varies in different countries: for example 'contact interpreting' (in Scandinavia), 'liaison interpreting' or 'dialogue interpreting' (Australia), 'public service interpreting' (UK), '*interprétariat en milieu social'* (France), '*Kommunaldolmetschen'* (Austria), '*Sprachmitteln'* (Switzerland).

Community interpreting

Interpreting plays a major role in all aspects of community life where people with different language backgrounds interact. '*Community interpreting is probably the kind of interpreting undertaken most frequently in the world at large*'[86]. Wadensjö, a Swedish researcher and interpreter, and other

researchers into interpreting have contributed to a clarification of the specific features of community interpreting. These are summarised in Table 2[87].

Table 2: Characteristics of community interpreting

Community interpreting generally takes place:
- in face-to-face encounters between officials and lay people (with a likely status differential and information gap between the two)
- with a single trained interpreter interpreting for the people who need to communicate: usually a 'provider' (eg, health professional) and a 'receiver' (patient/client)
- in two directions, with the interpreter translating what is said into both languages
- consecutively (as opposed to simultaneous translation as in conference interpreting)

arising out of some sort of need or crisis in the life of the patient/client.

In interpreter-mediated consultations, the health professional is no longer the only specialist involved. A third party, the interpreter, has been inserted into the relationship. The health professional loses some or all of her direct contact with the patient, and communication becomes a joint enterprise. At times, the health professional is bound to feel disturbed and hampered by the presence of the interpreter, who, if nothing else, tends to slow the course of the consultation. But she can also make use of the opportunities offered by a partner who is also (ideally) a trained interpreter, who can facilitate the accurate transmission of information, and whose presence may also give the patient a sense of being valued and supported.

High quality care can only be ensured if there is a careful exchange of information about the state of the patient's health. Moreover, patients may be

[85] Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

[86] Wadensjö, C. (1998). *Interpreting as interaction*. London, Longman.

[87] Adapted from different sources including

- Gentile, A., U. Ozolins and M. Vasilakakos (1996). *Liaison interpreting, a handbook*. Melbourne, Melbourne University Press.
- Roberts, R. P. (1997). *Community interpreting today and tomorrow*. In: The Critical Link: Interpreters in the community (papers from the first international conference on interpreting in legal, health and social service settings, Canada, June 1-4, 1995. S. E. Carr, R. Roberts, A. Dufour and D. Steyn. Amsterdam, John Benjamins Publishing.
- Garber, N. (2000). *Community interpreting: a personal view*. In: The Critical Link 2: Interpreters in the community. R. Roberts, S. E. Carr, D. Abraham and A. Dufour. Philadelphia, John Benjamins Publishing Company. 31.

more likely to tell their stories, express their needs more freely, and answer the health professional's questions more readily in the presence of a professional, trained interpreter whom they can trust to maintain confidentiality even if they live in a small community.

Research shows that the quality of care depends largely on good patient-provider communication[88]. According to 'The Art and Science of Bedside Diagnosis'[89], 90 per cent of all diagnoses are still made on the basis of the patient's history (9 per cent on the basis of physical examination and only 1 per cent by laboratory analysis). A study of the diagnostic value of medical history-taking found that, despite the increasing emphasis on diagnostic technology, physicians continue to view a patient's history as the main source of diagnostic information[90].

Since communication is a very important factor in health care provision, the value of overcoming communication and language barriers cannot be overestimated. The interpreter is therefore the vital link in all health care communication with allophone patients.

It is often overlooked that interpreters, in order to do a good job, need not only language skills, but also communication skills. And the sensitivity of communication in health care requires an interpreter to be able to adapt their communication style to meet the needs of both 'clients', the health professional and the patient[91].

Adapting interpreter services to special health care settings

In recent years there have been a number of publications which provide advice and guidance on the use of interpreters in different health care services. The function and role of interpreters are likely to vary according to the context in which care is given. The health care contexts covered in these publications include:

- nursing care services[92]

- emergency departments[93]
- rehabilitation[94]
- paediatric services[95]
- paediatric emergency rooms[96]
- private practice[97]
- research design[98].

Using bilingual health professionals as interpreters

In two Swiss national surveys[99], many hospital staff members indicated that they most wanted help with language access for patients from Kurdistan/Turkey, Kosovo and Sri Lanka, countries which are currently characterised by unrest, war and instability. The use of bilingual staff as interpreters is often suggested as the best solution in this kind of situation. However, bilingual staff do not always have the necessary skills to interpret in complex situations for allophone patients who are suffering from the post-traumatic stress and psychosomatic troubles which are frequent among recently arrived refugees.

[88] Bensing, J. (1991). *Doctor-patient communication and the quality of care*. Soc Sci Med 32(11): 1301-1310., Campbell, S., M. Roland and S. Buetow (2000). *Defining quality of care*. Soc Sci Med 51: 1611-1625.

[89] Sapiro, J. D. (1990). *The art and science of bedside diagnosis*. Munich, Urban & Schwarzenberg.

[90] Rich, E. C., T. W. Crowson and I. B. Harris (1987). *The diagnostic value of the medical history: perceptions of internal medicine physicians*. Arch Intern Med 147(11): 1957-1960.

[91] Beltran Avery, M. P. (2001). The role of the health interpreter - an evolving dialogue. Chicago, National Council of Interpretation in Health Care NCIHC.

[92] Dias, M. R. and E. O'Neill (1998). *Examining the role of professional interpreters in culturally-sensitive care*. The Journal of Multicultural Nursing & Health 4: 27-31.; Poss, J. E. and T. Beeman

(2000). *Effective use of interpreters in health care: guidelines for nurse managers and clinicians*. Semin Nurse Manag 7(4): 166-71.; Bernstein, J., E. Bernstein, A. Dave, E. J. Hardt, T. James, J. Linden, P. Mitchell, T. Oishi and C. Safi (2002). *Trained medical interpreters in the emergency department: effects on services, subsequent charges, and follow-up*. Journal of Immigrant Health 4(4): 171-176.

[93] Zimmermann, P. G. (1996). *Use of interpreters in the emergency department*. J Emerg Nurs 22(3): 225-7.

[94] Smart, J. F. and D. W. Smart (1995). *The use of translators/interpreters in rehabilitation*. Journal of Rehabilitation April/May/June 1995: 14-20.

[95] Leanza, Y. (2001). *Pédiatrie et culture: entre impuissance et volonté d'accueil de la diversité culturelle*. ARIC, Genève.

[96] Bonacruz_Kazzi, G. and C. Cooper (2003). *Barriers to the use of interpreters in emergency room paediatric consultations*. Journal of Paediatrics and Child Health 39(4): 259-63.

[97] Flubacher, P. (1994). *Eine Uebersetzerin der Hausarztpraxis, Kommunikation mit fremdsprachigen Patienten*. Soziale Medizin 6: 20-22.; Flubacher, P. (1999). *Quelques suggestions pratiques d'un médecin de famille pour éviter les problèmes liés à la communication "transculturelle"*. Psychothérapies 19(4): 257-265.

[98] Temple, B. (2002). *Crossed wires: interpreters, translators, and bilingual workers in cross-language research*. Qual Health Res 12(6): 844-54.

[99] Bischoff, A., C. Tonnerre, A. Eytan, M. Bernstein and L. Loutan (1999). *Addressing language barriers to health care, a survey of medical services in Switzerland*. Soz Praventivmed 44(6): 248-56.; see also Eytan, A., A. Bischoff and L. Loutan (1999). *Use of interpreters in Switzerland's psychiatric services*. J Nerv Ment Dis 187(3): 190-192.

When bilingual health professionals are used to interpret for health professional colleagues, they often find it difficult to navigate between their two roles: health professional and language mediator. It can be almost impossible to interpret accurately and objectively and not to allow their own professional expertise to intrude, especially if they are interpreting in fields in which they are experienced and in which they would normally be providing care themselves. Their colleagues face a similar dilemma in deciding whether to ask them to interpret. The following study shows that using bilingual staff to interpret is not an easy, inexpensive or sensible alternative to professional interpreter services. In a project in South Africa, the use of bilingual hospital staff was shown to be too expensive since they have to be called away from their normal work on a ward to do language-related work, creating considerable management and staffing problems for the ward [100].

Many publications are opposed to the systematic use of bilingual health professionals as interpreters. A study investigating the quality of interpreting provided by bilingual nurses concluded that untrained nurse-interpreters make frequent errors when interpreting, with the result that the conditions of allophone patients are often misunderstood by their physicians[101]. There are no publications demonstrating the effectiveness of using bilingual health professionals as interpreters, but there is at least consensus that anyone who is used as an interpreter should have training and supervision, whatever their other qualifications or training[102].

Setting up interpreter services: organisational aspects

Many publications deal with the use of interpreters, but there are few accounts of how interpreter services have been set up. To our knowledge, there are no scientific articles which examine the actual impact of interpreter services. There are a few reports on how interpreter services are organised, and these services could be contacted when considering the implementation of such a service[103]. In contrast, papers about interpreter training programmes abound[104].

Financial implications of interpreter services

How health care interpreting should be financed is, as yet, by no means clear. It is up to individual health services (ie, to a large extent, hospitals) to decide whether or not to pay interpreters, and if so, how much. In the US, some HMOs include allowances for interpreters in their budgets[105]. However, while there seems to be some indication that German health insurance companies will recompense interpreter costs, Swiss health insurance companies categorically refuse even to discuss this matter.

---

[100] Drennan, G. (1996). *Counting the cost of language services in psychiatry*. S Afr Med J 86: 343-345.

[101] Elderkin-Thompson, V., R. Cohen Silver and H. Waitzkin (2001). *When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting*. Soc Sci Med(52): 1343-1358.

[102] Musser-Granski, J. and D. F. Carrillo (1997). *The use of bilingual, bicultural paraprofessionals in mental health services: issues for hiring, training, and supervision*. Community Ment Health J 33(1): 51-60.

---

[103] Ginsberg, C., V. Martin, D. Andrulis, Y. Shaw-Taylor and C. McGregor (1995). *Interpretation and Translation Services in Health Care: a survey of US public and private teaching hospitals*. New York, National Public Health and Hospital Institute.

[104] See for example the following:

London: Shackman, J. (1984). *The right to be understood: a handbook on working with, employing and training community interpreters*. Cambridge, National Extension College.

Massachusetts: Massachusetts Medical Interpreters Association (MMIA) Background: With over 350 members from all over the USA and from Canada, MMIA became incorporated in 1991. Membership benefits include a free copy of the MMIA Interpreter Standards of Practice, which have been revised and accepted by the National Council on Interpreting in Health Care in May 1998. Contact information: John Nickrosz, President MMIA, phone: 617-636-5479, fax: 617-636-6283. Or Massachusetts Medical Interpreters Association Address: New England Medical Center 750 Washington St NEMC Box 271 Boston, MA 02111Fax: 617-636-1845

Bern: INTERPRET', Switzerland: Different papers can be found at the website of Interpret', Bern
- Report in German: http://www.inter-pret.ch/pdf/bericht_bag.pdf
- Report in French: http://www.inter-pret.ch/f/ofsp.htm
- For training video and guide http://www.inter-pret.ch/f/trialog.htm
- Manual for health professionals working with interpreters: http://www.inter-pret.ch/f/guide.htm

Minnesota: Benhamida, L., B. Downing and Z. Yao (1993). Professional standards and training for interpreters in mental health for refugees and others. Minnesota, Refugee assistance program - mental health: technical assistance center at the University of Minnesota.

Seattle: Community Health CentersCommunity Health Services Program, Seattle, WA. Shelley Cooper-Ashford, Executive Director, Center for Multicultural Health, 105 14th Avenue, Suite 2C, Seattle, WA 98122. Phone: 206-461-6910. Fax: 206-461-4890. E-mail: shelleyc@cschc.org

Boston Interpreter Services. Please contact them directly for more information': Boston Medical Center Interpreter Services Boston Medical Ctr Pl, Dowing 4 South, Suite 4501,Boston, MA 02118-2393, (617) 414-7204, Tel. (617) 414-5017, Fax. Email: Oscar.arocha@bmc.org.

[105] Riddick, S. (1998). *Improving access for limited English-speaking consumers: a review of strategies in health care settings*. Journal of Health Care for the Poor and Underserved 9(Supplemental 1998): 40-61. See also Jacobs, E. A., D. S. Lauderdale, D. O. Meltzer, J. M. Shorey, W. Levinson and R. A. Thisted (1999). *The impact of adequate interpreter services on health care delivery to limited English-speaking patients*. 16th Annual Meeting AHSR.

To our knowledge, no economic evaluation examining the costs and benefits of using interpreters has yet been undertaken. Drennan[106], in a study which examined the costs of language services in psychiatry in South Africa, showed that there was a small financial cost involved in using bilingual staff but that the indirect costs of *not* providing adequate language services were enormous: clinicians noted interviews that had to be repeated, important additional information that could not be obtained, and uncertainty about diagnostic questions as fundamental as whether or not the patient was psychotic.

Hornberger[107] in his sophisticated research which attempted to compare the costs of consecutive face-to-face interpreting with simultaneous telephone interpreting, came to the conclusion that 'the data are currently insufficient on the economic consequences of communication failures in health care encounters with non-English-speaking patients to warrant a strong recommendation in favour or against a particular type of interpreter service'. Nevertheless, he provides a framework for estimating the costs of language access programmes which could prove useful in future evaluations.

Hampers, in a recent study on the effects of trained interpreters on resource use, found that the most encouraging aspects of his findings were the beneficial effects that interpreters had on physicians' assessments and treatment decisions.

> 'A decrease in resource utilisation does not necessarily indicate an increase in efficiency. However, the fact that the presence of an interpreter was associated with utilisation similar to that in the English-speaking population does not suggest a compromise in quality. It appeared that interpreters improved communication and increased physician assurance to a degree that approximated to cases in which no barrier existed.'[108]

Legal implications of health care interpreting

What about the rights of allophone patients to access to an interpreter? While this right is often appealed to, at least in the literature on community interpreting, it is not always clear whether the laws in different countries allow people to claim a legal right to language access. Bowen, in her review of language barriers to health care in Canada, concludes that there is little

provision to support the enforcement of language access[109]. In the USA, however, there is a trend towards enforcing the legal rights of individuals with limited English to gain access to services provided by public institutions (including, therefore, hospitals)[110]. A new federal law in the US also requires health care organisations to provide appropriate interpreting services[111].

In the UK, the Race Relations Act (1976) permitted interpreter services to be set up as part of policies to combat racial discrimination. Under this act 'it is illegal knowingly to provide an inferior quality of care to a particular racial minority group…the failure to provide interpreters for a minority group many of whose members are known to speak little English could be construed as unlawful'[112].

In Sweden, a law in force since 1975 stipulates that people who do not understand or speak Swedish well enough have the right to an interpreter during court trials and in other encounters with public institutions. The law states that an interpreter should be called upon if needed. In this case, responsibility for calling upon an interpreter clearly lies with the institutions[113]. This law provides the basis on which government-funded interpreters are provided to everyone who does not speak Swedish[114].

In conclusion, it should be clearly stated that allophone minority patients have a right to be understood by the health professional caring for them, and to be informed in a language they understand. The implications of this are

[106] Drennan, G. (1996). *Counting the cost of language services in psychiatry*. S Afr Med J 86: 343-345.

[107] Hornberger, J. C., C. D. Gibson, Jr., W. Wood, C. Dequeldre, I. Corso, B. Palla and D. A. Bloch (1996). *Eliminating language barriers for non-English-speaking patients*. Med Care 34(8): 845-56.

[108] Hampers, L. C. and J. E. McNulty (2002). *Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization.* Archives of Pediatrics & Adolescent Medicine 156(11): 1108-13.

[109] Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

[110] see also the following papers : Puebla Fortier, J. (1997). *Interpreting for health in the United States: government partnership with communities, interpreters and providers*. In: The Critical Link: Interpreters in the community (papers from the first international conference on interpreting in legal, health and social service settings, Canada, June 1-4, 1995. S. E. Carr, R. Roberts, A. Dufour and D. Steyn. Amsterdam, John Benjamins Publishing, Puebla Fortier, J., C. Strobel and E. Aguilera (1998). *Language barriers to health care: federal and state initiatives, 1990-1995*. Journal of Health Care for the Poor and Underserved 9(Supplemental): 81-100. Perkins, J. and Y. Vera (1998). *Legal protections to ensure linguistically appropriate health care*. Journal of Health Care for the Poor and Underserved 9(Supplemental): 62-80. Woloshin, S., N. A. Bickell, L. M. Schwartz, F. Gany and H. G. Welch (1995). *Language barriers in medicine in the United States*. JAMA 273(9): 724-8.

[111] OCR (2000). Office of Civil Rights: Title VI of the Civil Rights Act of 1964; Policy guidance on the prohibition against National origin discrimination as it affects persons with limited English proficiency.

[112] Henley, A. and J. Schott (1999). *Culture, religion and patient care in a multi-ethnic society - a handbook for professionals*. London, Age Concern Books.

[113] Wadensjö, C. (1998). *Interpreting as interaction*. London, Longman.

[114] Niska, H. (1993). A new breed of interpreter for immigrants: contact interpretation in Sweden. Stockholm, Institute for Interpretation and Translation Studies.

important: health providers must provide professional health care interpreting. In addition, providers (and not patients) should incur the costs of interpreters, since it is their duty to give information to patients in a form that patients can understand.

3.1.3   Communication: effective interventions

Effectiveness of a professional interpreter service

Jacobs and colleagues[115] are, to our knowledge, the first researchers to report on the effectiveness of professional interpreter services in improving the delivery of health care to a population of allophone patients. They used the introduction of a new interpreter service in a large HMO (Health Maintenance Organisation) in the US to conduct a retrospective cohort study to find out whether interpreters affected the quality of health care provision. Two patient groups were observed for two years: one consisted of Portuguese and Spanish-speaking patients (the 'interpreter service group'), and the other consisting of a sample of all other eligible HMO members (the 'control group'). Patients who used the interpreter services had a significantly higher number of consultations, prescriptions and rectal examinations compared to the control group.

The study makes a valuable contribution to research into language access. It indicates that professional health care interpreting increases the provision of ambulant and preventive care and thus, the authors conclude, improves allophone patients' access to care.

Effectiveness of care for allophone patients through using interpreters: the quality of diabetes care for non-English-speaking patients[116]

Clinical and administrative databases were used to gather data on 622 English-speaking and non-English-speaking patients with Type II diabetes who used the primary and specialty care clinics of the University of Washington (Seattle) Medical Center and its affiliated county hospital.

Twenty-four languages were represented in the study. Both clinical facilities have a well-developed, nationally regarded interpreter service, in which only interpreters who have passed both written and oral certification examinations can participate. In multivariate analyses, controlling for patient age, gender, new patient status and insurance status, allophone patients were more likely than English-speaking patients to meet American Diabetes Association guidelines for two or more glycol-haemoglobin blood tests (a measure of long-term blood glucose control), to have made two or more physician visits per year, and to have received at least one dietetic consultation. There were no differences between English-speaking and allophone patients in glycol-haemoglobin levels, serum lipids, kidney function, or degree of retinopathy, despite significantly greater percentages of allophone patients who were elderly, from ethnic minorities, or covered by Medicaid. Investigators were pleased that in this ethnically and linguistically diverse patient population, 'The care at these institutions appeared to be as good as, if not better than, care for English-speaking patients.' They suspected that the high quality and comprehensiveness of the interpreter service contributed to this finding.

> 'A major implication of this study is that with a commitment to make professional interpreters available to all patients, health care institutions can provide diabetes care to non-English-speaking patients that appears to be of comparable quality to that provided to English speaking patients.'

---

[115] Jacobs, E. A., D. S. Lauderdale, D. O. Meltzer, J. M. Shorey, W. Levinson and R. A. Thisted (2001). *The impact of interpreter services on delivery of health care to limited English proficient patients*. J Gen Intern Med 16: 468-474.

[116] Tocher, T. M. and E. Larson (1998). *Quality of diabetes care for non-English-speaking patients. A comparative study*. West J Med 168(6): 504-11.

Effectiveness of a training intervention intending to improve communication between physicians and allophone patients

The aim of this quality of care project was to assess the effectiveness of an intervention to improve the communication skills of French-speaking physicians caring for allophone patients[121]. The research was designed as a before-and-after intervention study in which both allophone and Francophone

---

[117] Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

[118] http://www.moh.govt.nz/moh.nsf

[119] Kizito, H. (2001). *Refugee Health Care: A Handbook for Health Professionals*. New Zealand, Folio Communications Ltd.

[120] http://mhcs.health.nsw.gov.au/

[121] Bischoff, A., T. V. Perneger, P. Bovier, H. Stalder and L. Loutan (2003). *Improving communication between physicians and patients who speak a foreign language*. British Journal of General Practice 53: 541-546.

patients and their physicians filled in visit-specific questionnaires assessing the quality of communication. The intervention consisted of four training sessions carried out after the first set of questionnaires and before the second:

Training sessions

1. Introduction on how to work with interpreters: planning and scheduling interpreter-assisted consultations; structuring consultations in five steps (preparing the consultation before the patient arrives, beginning the consultation, managing communication during the consultation, finishing off the consultation; feedback after patient leaves); information on available interpreter services (languages, specialties), practicalities, payment of interpreters.

2. Working with interpreters: the role and functions of health care interpreters (verbatim mediation, cultural mediation, advocacy mediation); role play, group discussions, working out guidelines with participants; code of ethics; background information on language barriers, migration and health; introduction of the manual on interpreting '*Open Words, Guide to the Bilingual Medical Interview for Health Professionals and Interpreters*'[122].

3. Managing emotional stress in interpreter-assisted interviewing: interpreter-assisted medical interviews with patients with post-traumatic stress disorder; improving the therapeutic partnership; coping with stress in triadic communication; the need for supervision.

4. Group discussion with physicians and interpreters on the merits and drawbacks of interpreter-mediated consultations, including confidentiality issues, initial mistrust, group dynamics in triadic communication, and the negotiating skills necessary in cross-cultural communication.

This study showed that communication between primary care physicians and allophone patients, at least as perceived by the patients themselves, can be improved by providing specific training sessions for physicians on working with interpreters. Following the training, allophone patients gave somewhat higher scores for the respect they were shown by the physician, the quality of communication during the consultation, and for the overall consultation process. This improvement was most probably due to the health professionals' greater ease in working in partnership with interpreters, in

---

[122] Bischoff, A. and L. Loutan (1998). *A mots ouverts - Guide de l'entretien médical bilingue à l'usage des soignants et des interprètes*. Genève, Hôpitaux Universitaires de Genève.

handling the three-way relationship, and in a patient-centred approach to minority ethnic patients. (The patient questionnaire used in the above study was originally developed in French, then translated into ten languages and pre-tested with patients who spoke the different languages. It appeared to be culturally and linguistically acceptable; however no formal assessment of its psychometric performance was carried out.)

In addition, after the training the physicians themselves became more self-critical about communication, especially when dealing with allophone patients. The training modules appear to have raised their awareness of their own communication skills and the effects of language barriers. This may explain why the physicians in the study did not perceive a significant improvement in the quality of their communication. The most important visible change in the physicians' behaviour was an increased demand for assistance from trained interpreters. During the baseline survey physicians booked interpreters for fewer than half their consultations with allophone patients. Following the training, interpreters were booked for two-thirds of consultations with allophone patients. It seems that that the physicians' use of interpreters in their consultations with allophone patients became more systematic.

A similar trend was observed in other programmes intended to improve health care provision for minority patients. The decrease in consultations using *ad hoc* interpreters, where confidentiality and consent cannot be properly ensured, was encouraging.

This study demonstrates that training health professionals in dealing with allophone patients, including skills in using interpreters, can result in better professional-patient communication.

In view of the difficulties faced by health professionals in communicating with allophone patients, and based on our observations, we recommend that the mother tongue and language proficiencies of each patient be systematically recorded in patients' files, with information about whether an interpreter was used and the name of the interpreter (to ensure continuity where possible). Training modules on working with interpreters should be an integral part of the postgraduate and continuing education of health professionals working in multicultural primary care settings.

Remote-simultaneous interpretation

Hornberger[123] reports on a study of a new language service in which interpreters are trained in the skills of simultaneous interpreting (more commonly used at international conferences). The interpreters are based at a different site and are linked via land lines and headsets to both the clinician and the patient. This method is called 'remote-simultaneous interpretation,' in contrast to the traditional method in which an interpreter is physically present at the interview and interprets consecutively, known as 'proximate-consecutive interpretation.'

The aim of this study was to assess, using a randomised protocol, the quality of communication and interpreting, and the levels of satisfaction among patients, interpreters, and physicians with these two different ways of providing interpreting services. The findings suggest that both the patients and the physicians significantly preferred the remote-simultaneous interpreting service to the proximate-consecutive service. The interpreters stated that they thought the patients and the physicians understood each other better using the remote-simultaneous service, although the interpreters themselves preferred to work in the proximate-consecutive service. The authors conclude that using remote-simultaneous interpreting to improve the quality of communication in discordant-language encounters seems likely to improve the delivery of medical care for allophone patients.

We have included this example of an effective intervention, firstly because it shows that the impact of interpreting can be measured using scientific methods, and secondly because it illustrates that there are other techniques, such as telephone interpreting, which can be used as well as, or instead of, face-to-face interpreting, and which could play a role in making hospitals more migrant- and minority-friendly. Telephone interpreting is already used, for example, in the MFH hospitals in Bradford[124] and Amsterdam.

---

[123] Hornberger, J. C., C. D. Gibson, Jr., W. Wood, C. Dequeldre, I. Corso, B. Palla and D. A. Bloch (1996). *Eliminating language barriers for non-English-speaking patients*. Med Care 34(8): 845-56.; see also Hornberger, J. (1998). *Evaluating the costs of bridging language barriers to health care*. Journal of Health Care for the Poor and Underserved 9: 26-39.

[124] Khan, D. (2003). Equality & Diversity in the NHS - the Bradfort Experience. Bradford, Bradford Hospitals NHS Trust.

An exemplary integrated interpreter service[125]

When the Family Healthcare Center (FHC) in Fargo, North Dakota, began to serve a large new and diverse refugee community, it became a catalyst in the development of a programme to provide and train medical interpreters. The interpreting programme now operates independently, with many agencies and organisations using its services. Developing such a service, in an area whose population had previously consisted of a large Scandinavian-American population and smaller Native-American and Spanish-speaking migrant populations, enabled local agencies to build an infrastructure that can be continually adapted to serve the many new refugees now settling in the area.

FHC was the first health service agency in this largely Anglo, Scandinavian-American region to use paid interpreters for all appointments with patients who speak languages other than English. Clinic staff participated in a task force to establish a community interpreter centre, which runs a formal training programme for all interpreters. The clinic is the largest user of interpreter services in the community and has encouraged most other social service providers to use interpreters. Interpreting is built into the job descriptions of bilingual staff, and training and competence are assessed through the community interpreter programme. The costs of interpreters and a Refugee Coordinator position, initially covered from local grants, are now built into the clinic budget. Clinic staff also participate in planning an annual conference on meeting the health care needs of refugees, provide health

---

[125] Taken from HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

Contact: Family Healthcare Center (FHC), 306 Fourth Street North, Fargo, ND 58102

Contactperson: Sherlyn Dahl, Tel: (701) 239-2283, E-mail: sdahl@medicine.nodak.edu

Website: http://www.med.und.nodak.edu/depts/fpcfar/home.htm

Additional information: The Family Healthcare Center (FHC) is a community health center and residency programme providing primary care to underserved populations in Cass County, North Dakota, and Clay County, Minnesota, where 45,000 people live below poverty level. Thirty-five percent of clinic patients are members of a racial/ethnic minority group. Clinical services and programmes, including dental care, are targeted to special populations including homeless, refugee, migrant, and Native American clients. FHC is the primary care provider for refugees resettled in the community each year from Europe, Asia, and Africa by the Office of Refugee Resettlement, the US Department of Health and Human Services, and local agencies. In collaboration with the University of North Dakota School of Medicine, WIC, Migrant Health Services, Head Start, public health, Lutheran Social Services Refugee Programmes, and area mental health agencies, the FHC successfully recruits minority providers and clinic staff, and maintains cultural diversity with attention to the unique needs of its patient population. The FHC/University of North Dakota Medical School Family Practice Residency Collaboration enables family practice physicians to train in a culturally diverse environment. The residency actively and successfully recruits minority physicians, including Native Americans.

education/orientation to new refugees, and act as consultants to the local cultural diversity programme. They organise and conduct focus groups with minority communities, and share health assessment materials and experiences with other clinics that serve minority populations.

3.2 Responsiveness

By responsiveness we mean both being responsive to the socio-cultural backgrounds and needs of minority ethnic patients (at an individual level), and achieving institutional adequacy (at a structural level). Responsiveness is also linked to communication and empowerment[126]: most effective interventions which improve communication, such as the introduction of interpreter services, also achieve greater responsiveness (in this case to language needs and cultural expression) and thus empowerment.

3.2.1 Responsiveness: areas of concern

Difficulties in responding to diverse minority populations

Responding to the characteristics and health needs of migrant and minority populations is often complicated. In the past, health care services have not always responded appropriately to the needs of these groups in their areas. These needs may vary depending on, for example, peoples' migration history, their political and legal status (eg, asylum seekers, refugees), their possible experience of violence, different levels of literacy and health literacy, different language proficiencies, different religious backgrounds, different food traditions, different use and experience of the mainstream health-care system, and different use of traditional health care.

Health services can react in two ways to the complexity of a diverse population. They can either adopt a *universalist* approach (services the same for everybody, no targeted interventions), or a *particularist* approach (targeted interventions aimed at different groups and communities).

There are a number of books which describe the health beliefs and practices, immigration histories, birth and death rituals, family dynamics, and other

---

[126] See websites:

http://www.ethnomed.org/

http://www.xculture.org/index.cfm

http://www.diversityrx.org/HTML/ESWEL.htm

Address:

Resources for Cross Cultural Health Care

8915 Sudbury Road, Silver Spring, MD 20901

cultural aspects of different groups of people. In one example[127], the authors state that 'the wise use of [this book] would be a starting point to individualised nursing care'. However, books of this kind can too easily be used to stereotype individuals, becoming kind of quick-fix cookbooks. Unfortunately, Leininger's[128] model of transcultural nursing, developed in the 1960s, is still very influential even though it easily leads, even where health care providers intend to be responsive, to 'cultural pigeon-holing'[129].

Related to the issue of responsiveness to particular groups is the definition of culture that underlies the response. The following definition has the advantage of being inclusive (ie, not only minority ethnic groups have cultures). However, it assumes that culture is more homogeneous and more stable than is the case:

> 'Any group of people who share experiences, language, and values that permit them to communicate knowledge (not necessarily shared by those outside), may form a culture. Health professionals reflect many individual cultural attributes, but they also participate, to some extent, in the culture of medicine, with its special shared language, values, and experiences.'[130]

Such a definition would require the creation of a series of parallel institutions for different, apparently homogeneous, patient groups (for example, different minority ethnic groups). The following critique of the whole concept of culture, formulated by Kuper, may also be useful when considering responsiveness:

> 'The difficulties become most acute when (...) culture shifts from something to be described, interpreted, even perhaps explained, and is treated instead as a source of explanation in itself. This is not to deny that some form of cultural explanation may be useful enough, in its place, but appeals to culture can offer only a partial explanation of why people think and behave as they do, and of what causes them to alter their ways. Political and economic forces, social institutions, and biological processes cannot be wished away, or assimilated to systems of knowledge and belief.'[131]

A different and also more critical definition is proposed by Baumann:

'Ethnographers' uses of the word culture have established one essential point of consensus: culture is not a real thing, but an abstract and purely analytical notion. It does not cause behaviour, but summarises an abstraction from it, and is thus neither normative nor predictive. As a deliberate abstraction it is there to help the anthropologist conceptualise that ever-changing 'complex whole' (Tylor 1871) through which people engage in the continual process of accounting, in a mutually meaningful manner, for what they do, say, and might think. Culture thus exists only insofar as it is performed, and even then its ontological status is that of a pointedly analytical abstraction.'[132]

As a preliminary conclusion we can say that genuine responsiveness involves institutions abandoning the idea of culture as a range of separate closed systems and adopting an open approach which caters for diversity in terms of a range of possible and changing differences[133].

In the following sections we list studies which aim to improve transcultural responsiveness through training programmes for health professionals, as well as reports of interventions related to specific health problems.

3.2.2 Responsiveness: policies

Clinical strategies for conducting culturally sensitive medical interviews[134]

The authors of this book discuss the main ways in which patients' cultural backgrounds may influence their illness beliefs and behaviours, and present strategies for determining which patients are likely to have health beliefs and behaviours that differ from those of biomedical practitioners. They then offer a list of questions to elicit patients' explanatory models of their symptoms based on Kleinman's explanatory models of illness[135]. These questions are designed to help professionals communicate responsively with migrant and minority patients[136]:

[127] Lipson, J. and S. Dibble (1996). *Culture and Nursing Care: A Pocket Guide*. San Francisco, UCSF Nursing Press.

[128] Leininger, M. (1997). *Future directions in transcultural nursing in the 21st century*. International Nursing Review 44(1): 19-23.

[129] Murray-Garcia, J. L. (2002). Multicultural Health 2002. An annotated bibliography. Woodland Hills, The California Endowment.

[130] AMA (1999). *Cultural competence compendium*. Chicago, American Medical Association.

[131] Kuper, A. (1999). *Culture. The Anthropologists' Account*. London, Harvard University Press., pp XI

[132] Baumann, G. (1996). *Contesting Culture. Discourses of Identity in Multi-Ethnic London*. Cambridge, Cambridge University Press., p11

[133] Soner, T. (2001). *Die Bedeutung von Familienzentriertheit und Individuumzentriertheit im Migrationskontext*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

[134] Johnson, T. M., E. J. Hardt and A. Kleinman (1995). *Cultural factors in the medical interview*. In: The medical interview: clinical care, education and research. A. Lazare. New York, Springer.

[135] Kleinman, A. (1978). *Concepts and a model for the comparison of medical systems as cultural systems*. Soc Sci Med 12: 85-93, Kleinman, A. (1978). *Culture, illness and care: clinical lessons from anthropologic and cross-cultural research*. Ann Intern Med 88: 251-258.

[136] For a French version see Loutan, L., S. Durieux, L. Subilia and L. Toscani (1999). *La médecine des migrants: illustration d'une médecine communautaire*. Médecine & Hygiène 57(2270): 1821-1824.; for a discussion in German, see in Weiss, R. (2003). *Macht Migration krank? Eine transdisziplinäre Analyse der Gesundheit von Migrantinnen und Migranten*. Zurich, Seismo-Verlag.

- What do you call your problem?
- What causes your problem?
- Why do you think it started when it did?
- How does it work – What is going on in your body?
- What kind of treatment do you think would be best for this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and its treatment?

Patient-centred approach to medical care for migrant and minority patients[137]

Migration, particularly when associated with refugee and asylum-seeker status, poses a range of challenges to the health system of the receiving country. This project, undertaken in Basel, Switzerland, is concerned with the impact of migration history on illness experience, the meaning of the illness experience, and the help-seeking strategies used by two groups of migrant patients: from Bosnia and Turkey. The study makes clear the potential of the patient-centred approach in general medical care, especially when treating patients with underlying psycho-social problems. The study found that patients' individual migration history had an impact on their illness experience, indicating that it is important for health care providers to find out about their patients' social circumstances[138].

This study also showed that it is important for health providers to understand how patients perceive the causes of their illness, since this shapes their illness experience and influences their help-seeking behaviour and their expectations of the outcome of treatment. The most important finding was the high number of psycho-social and psychological causes of illness in both patient groups which were only revealed after probing.

All the patients reported using a combination of biomedical treatment, self-help and social support. The main difference between the two groups was in their use of specific additional treatment options. The authors recommend:

> '...that the wide range of help-seeking strategies employed by the refugee populations need to be supported as important therapy options. They also need to be recognised as resources which could be used and mobilised more effectively, contingent upon an adequate infrastructure. The results of this study show the nature and the impact of migration history on illness experience. Migration-specific history-taking, which is too often neglected, as well as consequent probing of both the psycho-social and the somatic dimensions of health problems, is essential. The interaction between patient and clinician should incorporate both the practitioner's and the patient's agendas. Training in migration-specific issues is crucial for health professionals at all levels to ensure they acquire the necessary skills and responsiveness.'

Migration-specific history-taking in health care for minority patients[139]

The team of researchers involved in the study mentioned above also developed a history-taking questionnaire especially for migrant patients as an essential step to increase physicians' 'responsiveness to migrant patients' needs'[140]. In a similar attempt, Domenig developed a transcultural medical history to be used in nursing care[141].

Transcultural care medical history[142]

The aim of the transcultural care medical history is to elicit the patient's perspective (individual, biography centred, anti-pigeon-holing, inclusive of social processes, context-related, situation-related, holistic, resource-oriented, system-oriented, interactive, self-reflective).

The following items should be covered in a transcultural care medical history:

- Life history *(Place of birth? Childhood, where? In urban or rural area? Lived in other places? Origin? Social level? Social position? Lifestyle in original country? Other important biographical events?)*

---

[137] Gilgen, D., D. Maeusezahl, C. Salis Gross, E. Battegay, P. Flubacher, M. Tanner, M. G. Weiss and C. Hatz (2003). The impact of migration on illness experience and help-seeking strategies of patients from Turkey and Bosnia in primary health care in Basel. Basel. and Gilgen, D., D. Maeusezahl, C. Salis Gross, E. Battegay, P. Flubacher, M. Tanner, M. G. Weiss and C. Hatz (2002). *Klinische 'cultural epidemiology' von Gesundheitsproblemen ambulant behandelter Migrantinnen und Migranten aus der Türkei und aus Bosnien.* In: NFP39. NFP39. Bern.

[138] Salis Gross, C., C. Moser, B. Zuppinger and C. Hatz (1997). *Die Arzt-Patienten Interaktion aus der Sicht von MigrantInnen: Vorschläge für die ärztliche Praxis.* Praxis(86): 887-894. ; Flubacher, P. (1999). *Praktische Empfehlungen zur Überwindung "transkultureller" Verständigungsprobleme aus der Sicht eines Hausarztes.* Ars Medici 5.

[139] Domenig, D. and Y. Stauffer (2001). *Transkulturelle Pflegeanamnese.* In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

[140] Salis Gross, C., C. Moser, B. Zuppinger and C. Hatz (1997). *Die Arzt-Patienten Interaktion aus der Sicht von MigrantInnen: Vorschläge für die ärztliche Praxis.* Praxis(86): 887-894.

[141] Domenig, D. (2001). *Professionelle transkulturelle Pflege.* Bern, Verlag Hans Huber.

[142] Domenig, D. and Y. Stauffer (2001). *Transkulturelle Pflegeanamnese.* In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber., p 231

- Nursing care *(Perceptions of role and tasks of care-givers? Local traditional care practices? Reservations regarding particular care practices? Gender-specific reservations? Expectations of care provision?)*

- Health and illness *(Illness explanatory models? Relationship between mind and body? Stigma of illness? Attitude towards biomedicine? Experience with health system? Knowledge of the local health system? Religious healing practices? Decision-making in the illness process?)*

- Nutrition *(Food customs? Main food? Spices? Drinks? Meal Times? Religious influence on food traditions? Fasting?)*

- Pain *(Expression of pain? Pain behaviour? Role of family in addressing pain? Pain as communication?)*

- Communication *(Mother tongue? Proficiency of local language? Foreign language proficiencies? Literacy? Communication rules and modes? Non-verbal communication forms? Modesty? Meaning of touching and distance? Expression of emotions? Wish for interpreter? Wish to have information in own language?)*

- Religion *(Religious commitment? Practicing religion? Religious influence on lifestyle such as food? Dying? Gender etc.? Religious healing rituals? Contact with religious leaders? Use of spiritual and ritual symbols? Wish for religious rooms?)*

- Work, occupation, training *(In country of origin? In host country? Professional perspective? Professional satisfaction and recognition? Wish for professional training? Economic situation?)*

- Environment *(Household situation – size? living standards etc. –? Way of living – single? Family? Extended family? Friends? Contacts with neighbours? Neighbourhood network?)*

- Social network *(Family system? Relationship with family? Family support? Family visiting? Social network in host country? Membership of religious group? Political or ethno-specific associations? Trans-national network? Trans-national communication (letters, visits, telephone)? Contact with country of origin?)*

- Residence status *(Foreigner status? Uncertainty? Threat of forced return? Irregular or permanent status? Naturalisation?)*

- Women *(Image of women? Role concept? Woman-specific conflicts? Experience of violence? (rape? marital violence? genital mutilation?) Concepts regarding pregnancy? Birth? Family planning?)*

- Migration history *(Reasons for migrating? History of flight? Experience of war and violence (traumatisation)? Expectations with regard to migration? History of integration? Experience of discrimination and racism? Plans to return? Situation in country of origin? Lifestyle changes due to migration?)*

- Group membership *(Origin? Nationality? Group membership(s)? Child of migrants? Bi-national marriage?)*

Teaching health professionals to care for culturally diverse populations[143]

This project aims to enable health professionals to provide better care for diverse populations and to become more responsive. Three topics outside the traditional medical curriculum are presented to students: cultural competency, public health, and community-oriented primary care.

> 'The goal is to have physicians go beyond addressing the needs of individual patients to partnering with the community and on the community level to improve the health of many individuals.'

The three topics overlap, though each has its own set of challenges in teaching physicians. For instance, the authors see effective public health intervention as limited by financial constraints, saying, 'Imagine if primary care residents could refer to a community health worker as easily as they could order an x-ray or refer to a cardiologist!' They are very clear about their expectations of physicians' competencies:

> '…an overall sensitivity to the influence of the patient's culture and the willingness to try to understand the patient's perspective, no matter how different, and no matter how little the physician knows of the patient's culture, is both realistic and necessary for good care.'

Learning to value diversity[144]

This discussion of diversity education in medicine places the focus of change on the trainee health care providers. A patient-centred approach is recommended as helpful in avoiding the stereotyping that can result from such training. Discussing patient-centred interviewing, the authors write honestly about the tension that can arise in proposing provider-focused diversity training which encourages self-reflection and awareness of providers' own racism and cultural bias:

> 'To interact effectively with people in our multicultural society we need to be willing to accept the discomfort of unfamiliarity and uncertainty.'

---

[143] Zweifler, J. and A. Gonzalez (1998). *Teaching residents to care for culturally diverse populations*. Academic Medicine(73): 1056-1061.

[144] Kai, J. and J. Spencer (1999). *Learning to value ethnic diversity - what, why, how?* Medical Education(33): 616-623.

The authors criticise the existing literature on diversity training as lacking discussion of racism and prejudice among providers. Their article contains important sections on planning strategically for institutional change. It includes: the dangers of over-reliance on one individual as the 'champion' of the programme; the importance of evaluating and documenting experiences, particularly in small-group teaching and reflective exercises; and managing resistance and discomfort. They are especially concerned about stereotyping individual patients and missing opportunities for providers to confront their own racism. They stress the importance of institutional change that integrates 'valuing diversity' at the core of good patient care. See also Canales' paper on the understanding of difference[145].e

Strategies for working with diverse communities and clients[146]

This publication is designed as a workbook to help health care providers increase their understanding of cultural aspects of health and illness so that they can work effectively with individual clients and families in culturally diverse communities. It provides tools for providers both to assess their own cultural heritage and to learn about the cultural values, beliefs and practices of the communities they serve. The manual also provides guidelines for working with minority ethnic community groups and for using interpreters and other means to improve cross-cultural communication. There is also a bibliography and various appendices containing additional assessment tools and resources.

Culturally competent health care[147]

Chin addresses the current profile of cultural competence training from a business and organisational perspective. She rightly states:

'The focus of cultural competence initiatives has been on the provider-patient relationship with little attention given to whether the systems of care in which they function are culturally competent.'

Measurable evidence of the cultural competence of an organisation includes patterns of use and disparities in health status. Chin discusses the need to formulate quality indicators for organisational cultural competence and accountability and how this can be done. She stresses the need to break data down by racial and ethnic group. This paper is a straightforward, strong, and much needed statement containing specific guidelines and suggestions for achieving organisational accountability. It is important for managers and others in health care institutions to be reminded that responsiveness is not simply an attitude or skill to be possessed individual health professionals, but should run through the whole health care institution.

Mandatory curricula in diversity and cross-cultural medicine[148]

Welch details the paucity of multicultural training in medical training programmes across the USA. She reviews the principles and objectives of such training, including getting physicians to examine their own biases and values. She presents an excellent review of several training programmes, including their broad theoretical approaches, instructional techniques, and evaluation strategies. In addition to stressing the importance of avoiding the stereotyping that can result from teaching about diversity if it is not done well, Welch states that

'...the greatest challenge of cross-cultural training in residency programmes is the necessary changing of attitudes at all levels of the institution. Lack of attention to power dynamics, cultural differences, and gender bias among peers and faculty parallel the inattention given to these issues in the patient-provider interaction. Accordingly, curricula must simultaneously address faculty and institutional cultural sensitivity'.

The struggle for equality in health care[149]

This excellent article is written in the language of health care executives, imploring institutional leaders to respond to diversity before it becomes an issue of damage control following an embarrassing situation.

'Complex health care institutions cannot afford to deal with potentially challenging problems only when a crisis or an embarrassing situation comes to light. Doing so is a serious violation of their public trust.'

---

[145] This author offers a dense piece on the process of 'othering,' a process which she calls 'othering' which for her can be negative, positive, or possibly both, depending on the situation and the person assigning the label of 'Other.' The clinical experiences and teaching practices of Latina faculty are used to exemplify these concepts: 'Negative othering' involves exploiting power imbalances in relationships for one's own gain at the expense of others. 'Inclusionary othering' is a process which 'attempts to utilise power within relationships for transformation and coalition building.' Nurses must take the role of 'the other' in patient care in order to avoid applying negative myths and stereotypes to individuals and groups. Several suggestions are offered about how to stay engaged in 'inclusionary othering', including choosing the option of 'inclusionary othering' when the opportunity arises (Canales, M. (2000). *Othering: Toward an understanding of difference*. Advanced Nursing Science 22(4): 16-31.) This piece of work deals with what has been conceptualised in French-speaking countries as '*altérité*, see for example Horisberger, D. and K. Disler (2000). *Soins interculturels: rencontrer l'Autre*. Krankenpfl Soins Infirm(9): 69-71.

[146] Randall-David, E. (1997). Strategies for working with culturally diverse communities and clients. Washington, Hemophilia Program, Maternal and Child Health Bureau, Department of Health and Human Services.

[147] Chin, J. (2000). *Culturally competent health care*. Public Health Rep 115: 25-33.

[148] Welch, M. (1999). *Required curricula in diversity and cross-cultural medicine: The time is now*. Journal of the American Women's Association 53: 121-123.

[149] Rutledge, E. (2001). *The struggle for equality in healthcare continues*. Journal of Healthcare Management 46: 313-324.

The article discusses how the institutional environment and moral structure of a health care institution can encourage or discourage racism and other dysfunctional behaviour related to diversity among its employees. The author proposes legal programmes and the establishment of accreditation standards that explicitly address the development and implementation of institutional diversity plans.

Reproductive health

Pregnancy outcomes for minority ethnic groups are worse than for majority group women, as, for example, Lehmann[150] has shown in Switzerland. Perinatal mortality rates (per 1,000 births) are 9.4 for women of Swiss heritage and 17.5 for women of Turkish heritage, that is, 50 per cent higher for women of Turkish heritage (these are mainly recently arrived migrants who are unfamiliar with the language and health system in Switzerland). For women of Spanish heritage, perinatal mortality rates are 9.3 and, for women of Italian heritage, 11.3. These women have similar perinatal mortality rates to Swiss women, reflecting the fact that many of their families have lived in Switzerland for two or three generations. (No data are available on women of Former Yugoslavian or Portuguese heritage.)

Differences in infant mortality rates are similar: 8.2 per 1,000 births among women of Swiss heritage, 7.2 per 1,000 births among women of Spanish heritage, and 8.6 per 1,000 births among women of Italian heritage, as compared to the infant mortality rate among the more recently arrived Turkish immigrants: 12.3 per 1,000 births. Similar findings are reported in other European countries, as Carballo has shown in his analytical review[151].

Accounts of programmes intended to improve minority health in maternity services in different countries suggest that many health professionals have concluded that the best way to identify individual needs is to ask and to listen to people[152]. But there is also an awareness that members of some minority ethnic groups may be hesitant in talking about the difficulties they face in accessing services.

A study on the cultural and social meanings of childbearing, comparing women of Chinese and Scottish heritage in Scotland[153], came to interesting conclusions. This study does not support the transcultural nursing model[154]; instead it suggests that a culture that is in contact with other cultures undergoes a continual process of change. Health service managers should understand that providing culturally sensitive care demands thought, self awareness, and additional resources in terms of time, flexibility, training for staff at all levels, support and facilities. Midwives' supervisors have a major part to play in encouraging their staff to reflect on issues of accountability and the eradication of racial discrimination in the care they give to women:

'In practice, the health providers should be aware of the substantial differences in the notion of health, social and cultural expectations between the different patient groups. This may be reflected in their choice of medication, food, bodily cleansing and contacts, and mobility. For example, Scottish women would choose to use folic acid, vitamins and iron tablets in pregnancy and analgesia for pain control in labour. In contrast, most Chinese women would avoid doing so, when they could. The health worker should be aware of this and help them choose the appropriate food according to these beliefs. This means the food provided for them in the NHS should be suitable to their needs in terms of choice, quantity, quality and concept of balance. The hospital dietitians and catering staff need to find out a good range of acceptable and feasible menus in order to meet the needs of their clients. For most Chinese women, maternity hospitals in Scotland are better organised and equipped than those they know of in their home country. Therefore, for them, as with most Scottish women, hospitalised childbirth is not the problem. But many Chinese women know little about the routines, practices and personnel of Scottish maternity wards. More explanation is needed for Chinese women before their admission.'

Another paper by the same author highlights the potential for choice and control by minority women in childbearing[155].

Responsiveness to specific subgroups among migrants and minorities

The International Rehabilitation Council for Torture Victims (IRCT)[156] is an independent, international organisation of health professionals which promotes and supports the rehabilitation of torture victims and the prevention of torture worldwide. It works with 200 rehabilitation programmes

[150] Lehmann, P., C. Maboury and C. Minder (1990). *Health and social inequalities in Switzerland*. Soc Sci Med 31(3): 369-386.

[151] Carballo, M., J. Divino and D. Zeric (1997). Analytic review of migration and health and as it affects European Community countries. Antwerp, International Centre for Migration and Health.

[152] Schott, J. and A. Henley (1996). *Culture, religion and childbearing in a multiracial society*. Oxford, Butterworth Heinemann.

[153] Cheung, N. F. (2002). *The cultural and social meanings of childbearing for Chinese and Scottish women in Scotland*. Midwifery 18(4): 279-95.

[154] Leininger, M. (1997). *Future directions in transcultural nursing in the 21st century*. International Nursing Review 44(1): 19-23.

[155] Cheung, N. F. (2002). *Choice and control as experienced by Chinese and Scottish childbearing women in Scotland*. Midwifery 18(3): 200-13.

[156] www.irct.org/about_the_irct_0.htm

internationally, monitors torture throughout the world and intervenes in conflict situations. It is supported by the European Union, the United Nations Voluntary Fund for Victims of Torture, and the Oak Foundation. The IRCT is mentioned here because its strength is a comprehensive approach to all torture survivors (rather than, as is discussed in the rest of this review, a comprehensive approach to all patients). The IRCT is an important organisation since a considerable proportion of migrant patients in European hospitals are likely to have experienced violence which can only be detected and treated with competent support. Hospitals planning MFH programmes could collaborate with these specialist centres (as an example, the Kolding hospital in Denmark is already working with the IRCT in Copenhagen). The IRCT also has long-standing experience of using and training interpreters[157].

A similarly specialised institution is The European Union Networks on Reception, Integration, and Voluntary Repatriation (EU Networks), a project financed by the European Union which focuses on improving the integration of refugees in member countries (EU Networks on Integration of Refugees 2002). EU Networks aims to develop networks on issues such as education, language and vocational training, health, reception, and voluntary return. Its activities so far have included: maintaining an inventory of integration activities, developing guidelines for good practice, and publishing reports of interviews with refugees in all 15 member countries.[158]. Both the IRCT and EU Networks are mentioned as examples of best practice in the Canadian report on responsiveness to newcomers[159].

The ageing migrant population[160]

Over time, an increasing need for medical, rehabilitation and social welfare services must be expected among ageing minority patients. Research also shows that minority populations have a higher risk of mortality than the mainstream population. In particular, it has been found that members of

---

[157] Bentsen, E., A. Hermansen, I. Hojgaard Knudsen and V. Pentz-Moeller (1990). Interpretation in the rehabilitation of torture victims. Kopenhagen, RCT.; Pentz-Moeller, V. (1992). *The ethics and techniques of interpreting*. Torture 1(Supplementum): 17-19.; Pentz-Moeller, V. and A. Hermansen (1991). *Interpretation as part of the rehabilitation*. Torture 3(1): 9-12.; Pentz-Moeller, V. and A. Hermansen (1991). *Interpretation as part of rehabilitation, part II*. Torture 1(2): 5-6.

[158] see the following web pages:

www.refugeenet.org/pdf/health_guide.pdf

www.unhcr.ch

[159] Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

[160] Salman, R. (2001). *Zur Gesundheitsversorgung von MigrantInnen*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

---

minority groups 'age' earlier than the majority population by about ten years. The expected increase in the need for health care among minorities points to the need for new models of care in long-term care facilities, for example the 'transcultural nursing home', as proposed by Koch[161].

Responsiveness to dietary needs of minority and migrant patients

Hospitals often find it difficult to produce adequate food for minority patients. The booklet Celebrating Diversity[162] looks at first sight like a recipe book, but its main message is that food is something that should be discussed between providers and patients. Perceptions about foods and diets vary from group to group and may also change over time, depending on the degree of integration of a minority group in the host country. Since food is a delicate issue and is linked to cultural ideas about health and illness, time must be invested in discussion and negotiation if patients' needs are to be met. Communication about food and diet can also lead to generally improved patient-provider interaction because these topics touch on underlying cultural issues which must be addressed if the provider is to respond to the client's needs: for example, tradition, family ties, and community and health beliefs. Celebrating Diversity explicitly recommends the use of interpreters when discussing food.

Dietary representation and negotiation

Greenhalgh and colleagues[163] studied beliefs about diabetes mellitus, including diet, among a group of Bangladeshi immigrants in London. While some of these beliefs overlapped with the Western medical model, others were very different. All the members of the group recognised the importance of diet in diabetes control, and believed that one of the main causes of diabetes was too much sugar. However, they divided foods into two symbolic categories in terms of their perceived strength ('nourishing power') and 'digestibility'. The group believed that the onset and control of diabetes depended on the balance between food entering the body and emissions from the body. An excess of any of these emissions was believed to cause illness and weakness, as in diabetes. Because communal feasts, festivals and social occasions are common in the Bangladeshi community, and usually involve the consumption of sweets and rich foods, a calculated compromise had to be

---

[161] Koch-Straube, U. Ibid.*MigrantInnen in der Altenpflege*.

[162] Graves, D. E. and C. W. Suitor (1998). *Celebrating diversity - Approaching families through their food*. Arlington, National Center for Education in Maternal and Child Health.

[163] Greenhalgh, T., C. Helman and A. M. Chowdhury (1998). *Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study*. Bmj 316(7136): 978-83.

made between social obligations and dietary compliance by both diabetic patients and their families.[164]

Visits by extended families

Different definitions of the family are another issue for hospitals dealing with minority patients. For hospital staff, visits by large families can be difficult, apparently hampering care on a ward. Tensions between the families of minority patients and health staff can arise if assumptions about normal family size (extended vs. nucleus family[165]) differ, as well as other assumptions, for example about visitors' roles and responsibilities (how often they should visit a patient, whether they should stay overnight, bring in food etc).

One continuing education programme which focused on transcultural patient care discussed this issue with different groups of health professionals[166]. The main problems that the professionals mentioned were lack of space in wards and corridors, noise disturbing other patients, too many 'people from the street' (allegedly 'not complying with hygiene standards in the hospital'), and large numbers of visitors obstructing busy health professionals. Several solutions were suggested, for example, providing larger visiting rooms for larger groups of visitors, discussing their involvement with family members, and introducing dividing screens to shield other patients from large numbers of visitors. Finally, staff may need to help patients and relatives who are unfamiliar with the way things are organised by offering sensitive explanations (eg, about doctors' rounds, mealtimes, visiting hours, the availability of social workers) and giving them opportunities to ask questions. To quote Henley and Schott:

'Try not to assume that seemingly "inappropriate" behaviour is intentional'.

For a discussion on family-centeredness and individual-centeredness in the context of migration, see Soner 2001.

---

[164] see also the chapter on diet and nutrition in Helman, C. G. (2000). *Culture, Health and Illlness*. Oxford, Butterworth-Heinemann.

[165] Henley, A. and J. Schott (1999). *Culture, religion and patient care in a multi-ethnic society - a handbook for professionals*. London, Age Concern Books.

[166] Binder-Fritz, C. (1997). *Transkulturelle Patientenbetreuung in Oesterreich. Ein aktuelles Thema in der Fortbildung für Krankenpflegepersonen*. In: Transkulturelle Pflege. C. Uzarewicz and G. Piechotta. Berlin, VWB Verlag für Wissenschaft und Bildung. 10.

Increasing responsiveness in maternity services[167]

Midwives in a Bradford maternity hospital have been pro-active in re-assessing traditional practice and have become more creative in order to try to meet the needs of women in the community. All staff attend a cultural awareness session, with input from Muslim, Hindu and Sikh participants from the local community. Staff also ensure that all women have access to parent education and information, and that these are provided in an equitable, accessible and appropriate manner. 'Sari' meetings have also increased the number of women attending maternity education sessions: staff from diverse ethnic backgrounds hold meetings in local health service locations, eg, clinics, doctors surgeries, bringing support workers who speak the clients' language. The service also offers an all-female team and long dressing gowns to meet the needs of women for whom it is important to keep their legs covered.

Transcultural organisational development

According to Domenig's handbook on professional transcultural care[168], transcultural organisational development in a hospital requires increased transcultural awareness and competence among care-givers, plus increased awareness at management level. Her recommendations include:

- a task force on care for migrants and minorities at management level
- a hotline for migration-specific questions for health professionals
- increased employment of staff from local minority groups
- a professional interpreter service
- the modification of policies, guidelines, standards of care and other documents to ensure that the needs of minority and migrant patients and their families are met
- the provision of adequate financial resources and personnel
- networking on migrant and minority issues within the institution as well as with external institutions
- collaboration in, and the promotion of, science and research on migrant and minority issues

---

[167] Khan, D. (2003). Equality & Diversity in the NHS - the Bradfort Experience. Bradford, Bradford Hospitals NHS Trust., p 8

[168] Domenig, D. (2001). *Professionelle transkulturelle Pflege*. Bern, Verlag Hans Huber.

- the development of information material for health professionals about the needs of minority and migrant patients and their families
- discussions of relevant clinical case studies
- cross-service nursing care groups
- continuing education on cross-cultural health care and minority-specific topics.

3.2.3 Responsiveness: effective interventions

In this section, examples of effective interventions which have improved responsiveness to the needs of migrant and minority patients are divided into clinical issues (programmes dealing with cancer, diabetes, HIV, AIDS etc.), and the development of cultural competence and training activities.

Particularly interesting examples that are relevant to MFH are displayed below in text boxes.

Culturally sensitive weight loss programme[169]

Sixty-two African-American women participated in an eight-week weight reduction programme using a culturally-informed adaptation of the 'Rice Diet.' Culturally relevant modifications to the programme included reduced menu costs, culturally suitable recipes, specific culturally-informed ideas about exercise, and the encouragement of participation by family members. An African-American instructor conducted most of the training sessions. Seventy-nine per cent of the women completed the programme.

After eight weeks, the averaged pooled data indicated statistically significant decreases in weight, systolic and diastolic blood pressure, and cholesterol. All eight measures of health-related quality of life scores increased, five at a level of statistical significance. Control measures were unchanged. Notably, four hypertensive women were able to decrease their medication, and five others had their hypertension controlled without medication by the end of the programme. Ninety-six per cent of the women were very satisfied with the programme, and 90 percent felt that it 'suited their needs as African Americans'. The authors explain the rationale for their cultural emphases in the discussion, concluding,

> 'A culturally appropriate approach to weight loss for African Americans can lead to safe weight loss and risk factor modification.'

Factors preventing minority women from attending their general practitioners for cervical screening[170]

This paper presents the results of a study that examined the factors that deter ethnic minority (Bengali, Kurdish, Turkish, Urdu-speaking, Punjabi and Chinese) women living in London from visiting their general practitioner for a pap smear. The study used 11 focus groups, each containing between six and ten women. In the focus groups, the women reported that administrative and language barriers were more significant in deterring them from attending for a pap smear than anxiety over the results of the test.

The findings have several practical implications: 1) Many ethnic minority women are more likely to accept cervical cancer screening once they understand the procedure; 2) Poor administrative procedures and language are potential barriers to screening; 3) Concerns about poor surgery hygiene, non-sterile equipment, and lack of childcare facilities may deter women from treatment; and 4) focus groups using the patients' own language are an effective way of consulting minority ethnic community groups.

Improving mammography in the inner city[171]

Researchers randomised 376 female patients from different urban practices. Patients received either a letter from their physician stating that they were due for mammography, or a letter from their physician *plus* care from a community health educator. The ethnicity of the community health educators was matched to the predominant ethnicity of the patients at each clinical site. In addition, community health educators provided culturally sensitive educational materials, counselling about empowerment and self-efficacy, and a 'street-wise personal touch.' Women who received culturally sensitive care from a community health educator were 2.87 times as likely to have a mammogram than women who received only the letter from their physician.

Encouraging cancer screening[172]

This article describes the development of a culturally sensitive, cost-effective documentary video on cervical and breast cancer targeted at the Latino population. Recent studies have demonstrated that videos are effective in

[169] Ard, J., R. Rosati and E. Oddone (2000). *Culturally-sensitive weight loss pro-gram produces significant reduction in weight, blood pressure, and choles-terol in eight weeks*. Journal of the National Medical Association(92): 515-523.

[170] Naish, J., J. Brown and B. Denton (1994). *Intercultural consultations: investigation of factors that deter non- English speaking women from attending their general practitioners for cervical screening [see comments]*. BMJ 309(6962): 1126-8.

[171] Weber, B. and B. Reilly (1997). *Enhancing mammography in the inner city: A randomised trial of intensive case management*. Arch Intern Med(157): 2345-2349.

[172] Yancey, A. K. and L. Walden (1994). *Stimulating cancer screening among Latinas and African-American women. A community case study*. J Cancer Educ 9(1): 46-52.

increasing knowledge and promoting health-protective behaviour in low-income minority populations, especially when they are specifically designed to address the cultural beliefs of specific groups. This study used a focus group of Latinas to develop an understanding of the attitudinal barriers related to screening for breast and cervical cancer. Two Spanish-language videotapes on cervical cancer prevention and one on breast cancer prevention were then produced. These emphasised relevant cultural issues and included entertainment and music, information comprehensible to people with little formal education, and a short, moving, minimally didactic presentation.

The article also presents a case study describing the increased demand for cervical-cancer screening that occurred as a direct result of one video screening. After the video was shown to 27 Latina mothers, all 27 requested pap smears. Soon after, 60 more requests came from women who had been informed about pap smear screening by word of mouth. The monthly mean number of pap smears requested during the following few months was nearly twice that in previous years.

A similar study by the same author[173] on the same topic showed that the proportion of women who received pap smears was approximately one-third higher among those who had seen the video than among those in the control group at each clinic who had not.

Another paper describes another effective intervention in cancer screening[174]. It summarises the findings of a study designed to determine the degree to which an intensive nursing intervention, consisting of education and on-site cervical cancer screening, increased the rate of cervical cancer screening in elderly women. The authors point out that ethnicity is often a predictor of the stage at which cervical cancer is diagnosed as elderly black and Hispanic women have lower rates of cervical cancer screening.

This study found that educational intervention increased awareness of the need for routine pap testing among the elderly women but left unanswered questions about the most effective and efficient approaches to such interventions.

The effects of ethnicity and language on medical outcomes in patients with hypertension or diabetes[175]

This study compares the well-being and functioning of patients from different ethnic backgrounds who have chronic medical conditions. It addresses the question of how cultural factors may affect a patient's communication with their physician and so influence health outcomes. The researchers conducted a cross-sectional study of 226 general medicine patients with hypertension or diabetes, in order to compare the effects of ethnicity and language concordance on physical health outcome measures, use of health care services, and clinical outcomes. Their main observation is that patients whose primary care physician spoke their language (language concordance) reported increased well-being and functioning. Language concordance was associated with 10 out of 14 health status measures.

In another study related to diabetes[176], researchers looked at the barriers to providing care for Type II diabetes among Hispanic women. The article suggests several culturally sensitive methods which could increase treatment adherence among Hispanic women with Type II diabetes, although it does not provide evidence of their effectiveness. These methods include: finding out whether the patient is using any alternative forms of health care; maintaining open communication with the patient and her family; asking direct questions during follow-up visits about treatment adherence and barriers to adherence; and discussing possible solutions to difficulties with the women themselves.

Culturally competent diabetes education[177]

This is a detailed and very useful description of a truly community-informed, community-based programme. It took place in a Texas county that is 97 per cent Mexican American, and in which 50 per cent of the people over 35 years old have diabetes. The mortality rate from diabetes in this county is the highest in Texas. The authors have done programme planners a great service in chronicling the different phases of development of the programme.

[173] Yancey, A. K., S. P. Tanjasiri, M. Klein and J. Tunder (1995). *Increased cancer screening behavior in women of color by culturally sensitive video exposure*. Prev Med 24(2): 142-8.

[174] White, J. E., L. Begg, N. Fishman, B. Guthrie and J. Fagan (1993). *Increasing cervical cancer screening among minority elderly: education and on-site services to increase screening*. Journal of Gerontological Nursing 19(5): 28-34.

[175] Perez-Stable, E. J., A. Napoles-Springer and J. M. Miramontes (1997). *The effects of ethnicity and language on medical outcomes with hypertension or diabetes*. Medical Care 35(12): 1212-1219.

[176] Oomen, J. and L. Owen (1999). *Culture counts: why current treatment models fail Hispanic women with Type II diabetes*. Diabetes Education 25(2): 220-225.

[177] Brown, S. and C. Hanis (1999). *Culturally competent diabetes education for Mexican Americans: The Starr County Study*. Diabetes Educator 25(2): 226-236.

During the early stages, the researchers conducted extensive focus group and in-depth interviews with a wide variety of community members and practitioners. They present a table containing 19 messages which the planners that felt that the programme had to respect, all generated through this early involvement of the community. For instance, one message reflected the resentment that community members felt toward health workers from outside the area who came in and advised people with diabetes that they could no longer eat Mexican food. Bicultural and bilingual health professionals, community liaison workers, and support staff were hired. They, along with family members, provided an important dimension of social support for participants. A video was developed in Spanish and English, featuring community members and local practitioners whom participants in the programme were delighted to recognise.

About 250 participants went through the programme, half of them receiving the educational intervention and half of them serving as study controls. Those in the intervention group had a substantial decrease in average blood glucose that was maintained over the course of the year. Glycosylated haemoglobin, a measure of long-term blood glucose control, also decreased in the intervention group, compared to an increase in the control group.

AIDS awareness: the benefits of culturally sensitive education programmes[178]

This study evaluated the effectiveness of using culturally sensitive 'train the trainer' type activities to increase knowledge and change attitudes regarding AIDS in culturally diverse populations. The intervention involved training volunteer facilitators from different community groups, and providing them with knowledge about HIV and with the skills to facilitate larger groups. Each facilitator then convened sessions through their own organisations. Different facilitators used different facilitation techniques, varying according to cultural appropriateness. This programme exposed participants in different communities to new information and changed their attitudes towards people living with AIDS.

Promoting cultural competence in HIV/AIDS care[179]

This article suggests specific training strategies to increase cultural competence, and offers a broad conceptual framework for teaching and learning about the issues involved in cultural competence, with specific examples relating to HIV/AIDS. According to the authors, gaining cultural competence is a developmental process that involves first, self-awareness and second, a change of attitude by the group, peers, and staff concerning acceptance and flexibility. The article suggests that optimal, accurate and effective cultural assessment must be carried out not just at community or group level but also on a case-by-case, person-by-person basis. The article also addresses the constant need for providers, especially nurses, to negotiate relationships and encounters, and to understand the paradox of respecting people's values and the customary behaviours that support those values while at the same time working to change them. The paper concludes with a brief discussion of the process of creating cultural competence through workshops and training.

Ensuring health care use by diverse families affected by HIV/AIDS[180].

This article illustrates how an interdisciplinary group was formed to work in partnership with indigenous providers responded to an HIV crisis in a rural community. The author describes how he developed the model and its application to an outbreak of the AIDS epidemic in Belle Glade, Florida. The culturally specific health care model, which serves as a bridge between research and practice, linking providers and consumers, has four features: 1) a description of the target community; 2) a culturally sensitive approach to assessment and intervention; 3) interdisciplinary collaboration between providers, and 4) the use of key indigenous providers. The model is suggested as a guide for health and social workers in assessing and working with rural, ethnically diverse families.

Mental health interventions with minority patients

An analysis of mental health services for Mexican Americans suggests three areas for improvement[181]:

---

[178] Majumdar, B. and J. Roberts (1998). *AIDS awareness among women: the benefit of culturally sensitive education programs*. Health Care for Women International 19(2): 141-153.

[179] O'Connor, B. B. (1996). *Promoting Cultural Competence in HIV/ AIDS Care*. Journal Association of Nurses of AIDS Care 7(1): 41-53.

[180] Goiceochea-Balbona, A. M. (1997). *Culturally specific health care model for ensuring health care use by rural, ethnically diverse families affected by HIV/AIDS*. Health and Social Work 22(3): 172-180.

[181] Bechtel, G. A., R. Davidhizar and C. M. Tiller (1998). *Patterns of mental health care among Mexican Americans*. J Psychosoc Nurs Ment Health Serv 36(11): 20-7.

1. When health providers are aware of cultural issues beyond language, this improves the take-up of mental health services and enables patient and health providers to agree on a plan of care.

2. When health providers understand cultural characteristics, this helps them understand patients' behaviour, family and social dynamics, and patterns of adaptation to stress, and how these can empower clients to work towards their goals. It helps validate the impacts of patients' emotions and behaviour on others.

3. The provision of culturally appropriate mental health care requires a synthesis between communication, space, social organisation, time, environmental control and biological variables.

Another study[182] evaluated the outcomes of a treatment programme that attempted to introduce cultural issues into therapy for Puerto Rican patients. The programme targeted anxiety symptoms, acting-out behaviour and self-concept problems. An evaluation of the outcomes confirmed the positive impact of culturally sensitive modelling therapy on anxiety symptoms and other selected target behaviours, but negative effects of the treatment were also evident. This suggests that new approaches to psychotherapy for special populations, such as Hispanic children and adolescents, should be supported by a programme of research which would provide a comparative evaluation of treatment outcomes, and would take into account the importance of mediating between traditional health care culture and Hispanic culture in therapeutic processes.

Comprehensive interdisciplinary care: making a difference to pregnancy outcomes for Hispanic women[183]

This article reports on a cohort study that looked at the antenatal care received by 113 Hispanic women in a north-eastern city in the US. The outcomes of the study demonstrate the need for a model of care that is comprehensive and culturally sensitive, and that encourages women's self care during pregnancy. The authors cite their study as supporting the work of other researchers who recommend that cultural variations in women's view of antenatal care should be considered when developing programmes.

Raising awareness of breastfeeding[184]

Breastfeeding offers the healthiest start to a baby's life, yet the UK has one of the lowest rates in Europe. The educational video 'Breastfeeding – a gift for life' was produced in Bradford, England. It aims to show that breast-feeding is normal and socially acceptable. It stars local people who have passed through the local hospital trust's maternity unit. These people come from all walks of life and represent the culturally diverse community. The trust's breastfeeding policy includes giving information to mothers about the benefits of breastfeeding, staff training, and providing a welcoming environment for breastfeeding mums. According to the report, 'now 65 per cent of women who give birth in Bradford are choosing to breastfeed compared to 53 per cent two years ago'.

Diversity leadership and organisational transformation: performance indicators for health service organisations[185]

This paper attempts to design criteria for evaluating the cultural competence of health care organisations, especially in terms of 'behaviourally based performance indicators'. The author sees organisational change as a *process* with five stages: discovery, assessment, exploration, transformation (resulting in a change in institutional ethos and climate) and revitalisation. Change should occur at all levels of the institutional hierarchy. Before presenting the performance indicators, the author states:

> '...Diversity leadership entails revisioning differences…Consequently, no checklist of concrete behaviorally-based performance indicators can ever fully capture the essence of diversity leadership.'

Finally, the author presents an extensive and detailed list of performance indicators designed to help organisations determine whether diversity leadership and processes are in place (though not necessarily whether the desired end point has been reached).

[182] Malgady, R. G., L. H. Roglet and G. Costantino (1990). *Culturally sensitive psycho-therapy for Puerto Rican children and adolescents: a program of treatment out-come research*. Journal of Consulting and Clinical Psychology 58(6): 704-712.

[183] Pearce, C., J. Hawkins, D. Carver-Chase, R. Ebacher, S. Matta, A. Sullivan, V. Vawter, C. Vincent and K. Windle (1996). *Comprehensive interdisciplinary care: making a difference in pregnancy outcomes for Hispanic women*. Public Health Nurs 13(6): 416-424.

[184] Khan, D. (2003). Equality & Diversity in the NHS - the Bradfort Experience. Bradford, Bradford Hospitals NHS Trust.

[185] Dreachslin, J. (1999). *Diversity leadership and organizational transformation: Performance indicators for health service organizations*. Journal of Healthcare Management 44: 427-439.

Cross-cultural primary care: A patient-based approach[186]

The authors describe a cross-cultural curriculum at New York Presbyterian Hospital and Cornell Medical School that explicitly attempts to avoid the oversimplification and stereotyping that accompany some 'cultural competence' curricula. They provide 'practical cross-cultural skills' that providers can use to interview individuals within their unique multifaceted social contexts. The curriculum consists of 'five thematic modules that build on one another over four two-hour sessions.'

The article contains an extensive and helpful list of questions, adapted from medical anthropology sources, that can be used in medical interviews. The curriculum includes an important component involving reflection about one's own cultural background as well as about the culture of medicine and medical care.

In search of cultural competence in psychotherapy and counselling[187]

This article is an attempt to identify more specifically what it means to be a culturally competent provider. The author reviews several of his own studies that have documented the beneficial effects of ethnic concordance in client-therapist encounters. He proposes three characteristics which he believes describe the culturally competent provider:

1. *'scientific mindedness*, which involves actively gathering appropriate information about clients and testing hypotheses so that theories or assumptions are not applied inappropriately.
2. *dynamic sizing*, 'knowing when to generalise and be inclusive and when to individualise and be exclusive… [This] allows one to avoid stereotypes of members of a group while still appreciating the importance of culture', and
3. *culture-specific elements or expertise* that allow practitioners 'to translate interventions into culturally consistent strategies'.

The author shares his extensive experience both as a researcher into minority ethnic issues, and as a person whose research findings have been used to justify, against his intentions, racial segregation in provider-client encounters.

Cultural audits: introduction, process and results[188]

This case study documents the process of organisational change to achieve cultural competency within a school of dentistry. A list of components to be assessed, as well as appropriate methods of change are included plus the timeline of the cultural audit. Insightful lessons are offered including, for example, the importance of administrative leadership responding appropriately to people who are resistant or feel 'spied upon'. The recommendations fall into six main groups, which are then linked to several more specific recommendations, each relating back to the original findings of the audit. One of the recommendations reads:

'Conducting a cultural audit is difficult work, often discouraging and frustrating, but always interesting and personally challenging. It must become an ongoing effort for every organisational unit that prepares providers for their professional lives in the next century of this country.'

A curriculum for multicultural education in family medicine[189]

This excellent and concise article describes a multicultural curriculum in a continuing education programme for physicians in Minnesota. The broad goals of the programme were to help physicians gain insight into: how culture affects a practitioner's personal and professional life; how culture might influence patient's perspectives; and how communication skills can be developed. The programme used lectures, case discussions, community presentations, videotapes, role-plays with simulated patients, and one-to-one evaluation of the physicians' videotaped clinical encounters. The evaluation showed that the physicians felt the latter to be most helpful. In a self-assessment, the physicians' knowledge and skills increased significantly, as did their level of 'cultural competence.' There was a high correlation between trainees' and trainers' assessments of final levels of competence. The authors have done educators a great service in presenting both positive and negative comments from participants, as well as programme planners' challenges in overcoming participants' resistance to learning about the cultural dimensions of clinical practice. For example:

[186] Carrillo, J. E., A. R. Green and J. Betancourt (1999). *Cross-cultural primary care: a patient-based approach*. Ann Intern Med 130: 829-834.

[187] Sue, S. (1998). *In search of cultural competence in psychotherapy and counseling*. American Psychologist April(440-448).

[188] Inglehart, M. and C. Quiney (1997). *Cultural audits: Introduction, process and results*. Journal of Dental Education 61: 283-288.

[189] Culhane-Pera, K. and C. Reif (1997). *A curriculum for multicultural education in family medicine*. Fam Med 29(10): 719-723.

'[Physicians] wanted culture to be packaged into concrete bits of information that could be arranged into lists of do's and don'ts for clinical encounters…We resisted creating lists that could support a reductionist view of culture, undermine a contextual view of health and reinforce stereotypes. Instead, we encouraged physicians to generate hypotheses from general information and then ask patients about health beliefs and cultural needs.'

Improving cultural awareness and sensitivity training in a medical school[190]

The authors describe a series of sessions on diversity for first-year medical students at the University of Michigan. The sessions included videotapes, small group discussions and other exercises. The goals of the programme were increased introspection, self-awareness, and understanding of the connection between culture and patient care. The activities were specifically designed to reduce the resistance among the medical students which had been documented earlier by programme planners following the presentation of other multicultural material.

In an intriguing evaluation strategy, Likert ratings of sessions were stratified by whether the participants were 'minority men', 'minority women', 'majority men' or 'majority women'. Consistently, across eight points of evaluation, the sessions were rated lowest by majority men. Focus group data showed that the majority men 'felt under attack' during the programme. In the following year, when participants' suggestions for more clinically-oriented examples were incorporated, and facilitators with clinical experience were added, ratings increased significantly. The majority men apparently became much more engaged in the programme than they had been in the previous year.

This is an important and rare example of the implementation and evaluation of specific instructional techniques in multicultural medical education.

Increasing awareness and implementation of principles of cultural competence[191]

This article provides a brief review of the importance and timeliness of cultural competence initiatives in health professional education. The current lack of and urgent need for 'outcomes' and evaluation data about such initiatives is reiterated. The authors also ask pointed questions about the lack of comprehensive institutional or organisational systems of accountability 'by which managers and individuals are held responsible for programme results.'

There is a helpful list and description of training and accreditation requirements from health professional accreditation bodies, including medical and other health professional trainees.

Assessment of medical students' cultural attitudes after training[192]

The authors describe the psychometric properties of a survey tool for assessing 'students' openness to developing cultural awareness and competence'. Ninety per cent of the students completed this 26-item assessment instrument. Researchers found the tool reliable and valid for several groups of cultural attitudes. It could help programme planners to design and implement more effective cultural competence programmes by measuring students' initial interest in and/or resistance to learning about the principles of cultural competence.

Self-evaluation (in cultural competence training)[193]

The authors publish a self-assessment questionnaire (10 questions) which practitioners and service providers can use to determine their potential for unintended biases and prejudices against certain groups. Though the researchers did not assess the psychometric properties of the questionnaire, its internal consistency was high. Face validity was demonstrated when each group of participants got the best score (lowest potential for prejudice) for their own ethnic group. The researchers state that clinicians can direct their own learning with this instrument, and service agencies can use it to assess the educational and training needs of their staff.

3.3   Empowerment

Migrant friendliness in hospitals should mean more than just patient satisfaction with services that may only minimally meet their needs (cultural, linguistic, migration-specific). Programmes that are truly minority friendly involve minority patients and community members in identifying the needs, assets, resources, and barriers within their community[194]. In this kind of participatory approach, patients (clients) and community members play an active role in needs assessment, programme development, implementation

[190] Robbins, L. and J. Fantane (1998). *Improving cultural awareness and sensitivity training in medical school*. Academic Medicine 73: 31-34.

[191] Donini-Lenhoff, F. and H. Hedrick (2000). *Increasing awareness and implementation of cultural competence principles in health professions education*. Journal of Allied Health(29): 241-245.

[192] Robbins, L. and G. Alexander (1998). *Development and evaluation of an instrument to assess medical students' cultural attitudes*. Journal of the American Women's Association 53(3): 124-129.

[193] Paniagua, F. and M. O'Boyle (2000). *Self-evaluation and unintended biases and prejudices*. Psychological Reports(87): 823-829.

[194] HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

and evaluation. As a result, patients are more likely to be empowered. While communication is the most urgent area to be addressed by specific interventions, and responsiveness is an important step in moving towards minority patient populations, empowerment goes a step further: it makes patients 'move', gives them power, and enables them to take charge of their own health.

While responsiveness includes what the provider side can do (training, change in attitudes, inclusion of members of minority groups in health professions etc.), *empowerment* covers activities on the patient's side, such as communicating effectively with providers, receiving and understanding useful health education, understanding explanations of treatments and being able to ask questions and discuss implications, being a pro-active patient, and dealing well with professional dominance.

Ideally, empowerment should enable people to become pro-active partners in the processes of healing and therapy. In the Health Promotion Glossary[195], empowerment is included as a strategy for health promotion and is defined as follows: 'Empowerment is a process through which people achieve more control over decisions and actions which influence their health'. Research has shown the effects of lack of control or powerlessness in causing disease and, conversely, the effects of empowerment in improving health[196]. Empowerment can also be understood as 'a social action process that promotes the participation of people, organisations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice'[197]. Patient education is an essential feature of empowerment. This is defined as 'an educational process designed to help patients develop the knowledge, skills, attitudes, and degree of self-awareness necessary to take effective responsibility for their health-related decisions'[198].

In this section we highlight a number of policies and interventions intended to enable and empower minority patients.

3.3.1   Empowerment : areas of concern

Patient empowerment and education in diabetes care

The traditional model of medical treatment often ignores the emotional, spiritual, social, and cognitive aspects of living with a chronic disease such as diabetes. Empowerment programmes address these areas by helping individuals to develop skills and self-awareness in goal setting, problem solving, stress management, coping, social support, and motivation. Although many diabetes educators have been taught to use an empowerment curriculum to facilitate patients' self-management, there is minimal research on the actual process of carrying out such programmes with patients. One research group investigated the impact of empowerment programmes on diabetes outcomes and was able to show in a randomised controlled trial that the group who did not receive the empowerment/education programme showed no improvements in self-efficacy, in diabetes attitude scales, or in blood glucose levels[199].

Other areas of concern in empowerment are easily identified. Whenever patients are disenfranchised, and whenever there is an imbalance of power, empowerment is needed. Reports of effective interventions in empowerment are in short supply. Most are listed in the Annotated Bibliography on Multicultural Health[200] (though this only covers the USA). The policy section below summarises articles that deal mainly with increasing diversity in employment as a way of giving power to minorities.

The 'Practice of Medicine in California'[201]

This is an extensive profile of (Californian) physicians, including the racial, ethnic and gender composition, practice structures, physicians' perception of practice, and the continued maldistribution of physicians. Most urban areas designated as Primary Care Health professional shortage areas, such as East Los Angeles, are low-income neighbourhoods with large minority populations. The report points out that physician workforce is actually 'losing ground in terms of its racial and ethnic diversity'. With regard to the supply

[195] Trummer, U., P. Nowak and J. M. Pelikan (2002). *Empowerment von chirurgischen PatientInnen - Modelle, Interventionen, Effekte, Erfolgsbedingungen*. Oesterreichische Zeitschrift für Soziologie 27(4): 97-114.

[196] Wallerstein, N. and E. Bernstein (1988). *Empowerment education: Freire's ideas adapted to health education*. Health Educ Q 15(4): 379-94.

[197] Wallerstein, N. (1992). *Powerlessness, empowerment, and health: implications for health promotion programs*. Am J Health Promot 6(3): 197-205.

[198] Feste, C. and R. M. Anderson (1995). *Empowerment: from philosophy to practice*. Patient Educ Couns 26(1-3): 139-44.

[199] Anderson, R. M., M. M. Funnell, P. M. Butler, M. S. Arnold, J. T. Fitzgerald and C. C. Feste (1995). *Patient empowerment. Results of a randomized controlled trial*. Diabetes Care 18(7): 943-9, Arnold, M. S., P. M. Butler, R. M. Anderson, M. M. Funnell and C. Feste (1995). *Guidelines for facilitating a patient empowerment program*. Diabetes Educ 21(4): 308-12.

[200] Murray-Garcia, J. L. (2002). Multicultural Health 2002. An annotated bibliography. Woodland Hills, The California Endowment.

[201] Dower, C., T. McRee and K. Grumbach (2001). The Practice of Medicine in California: A Profile of the Physician Workforce. San Francisco, California Workforce Initiative at the UCSF Center for the Health Professions.

of nurses, the authors calculated in a projection[202] that to keep up with population growth, California needs 43,000 additional nurses by 2010. The paper describes California's nursing workforce: 'All racial and ethnic groups are under-represented among nurses but the gap is most pronounced for Hispanics, who account for 30 per cent of California's population but for only 4 per cent of the state's nurses.' To our knowledge no similar surveys have been undertaken in European countries.

Instructional responses to ethnically diverse nursing students[203]

Researchers conducted interviews with 43 nurses (including nurse educators) of colour who graduated from Californian nursing programmes. Yoder describes five patterns of faculty response to minority students' needs:

> 'a *generic pattern*, in which faculty assume that the needs of minority students are no different than majority students;
>
> a *mainstreaming pattern*, in which students are expected to relinquish their own cultural identity and adopt values and behaviors of mainstream (White) culture;
>
> a *culturally non-tolerant pattern*, in which faculty pose barriers for minority students because of their (the faculty members') impatience and intolerance with issues of diversity;
>
> a *struggling pattern*, in which faculty are in flux, trying out different approaches to achieve a culturally sensitive stance to minority students; and
>
> a *bridging pattern*, characterised by highly 'culturally adaptive instructional responses to students… in which students are encouraged to maintain their ethnic identity and to function biculturally.'

The first three, at least, of these responses are likely to have negative consequences for minority students, including a sense of invisibility, devaluing of their cultural perspectives, and pressures to conform. Indeed, 'the majority of the ethnic student participants perceived that they had encountered prejudice, discrimination, or racism in their nursing education programmes or clinical practices'. The author concludes that it is critical for faculties to understand their particular styles of interaction with

disenfranchised students and to develop, or be trained to develop, strategies that have positive rather than negative consequences for these students.

Lack of advocacy

Failure to ensure patients' full informed consent to treatment (including surgery and invasive diagnostic or treatment procedures) can negatively affect the quality of care. It is therefore particularly important to empower minority patients in this sensitive area. Kaufert and his colleagues, in a large amount of ethnographic research over many years, provide compelling evidence that informed consent procedures for allophone patients are less than optimal. True consent requires health professionals to gain patient's trust in advance. Consent may also have different meanings in different cultures. These can only be elucidated if the language barrier is overcome. Negotiating consent may also involve, for example, decision-making strategies (eg, individual vs. family), taboos on the sharing of bad news, and contrasting explanatory models of illness and healing. Furthermore, although obtaining consent is one of the areas where ad hoc interpreters are most used, it also contains the greatest risk of misinformation and distress for all those involved, including the patient, the health professionals and the interpreter. Research into the negotiation of informed consent makes the importance of interpreters clear, and also the importance of health advocacy and cultural mediation. Kaufert et al. underline the fact that the interpreter's role in discussions on informed consent is not only to translate but also to be a cultural broker, mediator, and advocate:

> 'Interpreters may play a significant role in mediating consent agreements between clinicians and clients. They link clinician's messages with the client's personal framework for interpretation. Consent was negotiated by drawing on the trust relationship between the patient and interpreter. The interpreter's intervention as a culture broker introduced a third perspective which influenced the course of the decision…The briefing for informed consent in cross-cultural setting may be influenced by the extent to which the translator is able to function as a patient advocate.'[204]

[202] Coffman, J. and J. Spetz (1999). *Maintaining an adequate supply of RNs in California*. Journal of Nursing Scholarship 31(389-393).

[203] Yoder, M. (1996). *Instructional responses to ethnically diverse nursing students*. Journal of Nursing Education 35: 315-321.

[204] Kaufert, J. M., J. D. O'Neil and W. W. Koolage (1991). *The cultural and political context of informed consent for Native Canadians*. Arctic Med Res (Suppl.)(Suppl): 181-4.

See also : Kaufert, J. M. and R. W. Putsch (1997). *Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power*. J Clin Ethics 8(1): 71-87, Kaufert, J. M., R. W. Putsch and M. Lavallee (1998). *Experience of aboriginal health interpreters in mediation of conflicting values in end-of-life decision making*. Int J Circumpolar Health 57 Suppl 1: 43-8, Kaufert, J. M., R. W. Putsch and M. Lavallee (1999). *End-of-life decision making among Aboriginal Canadians: interpretation, mediation, and discord in the communication of "bad news"*. J Palliat Care 15(1): 31-8.

3.3.2 Empowerment: policies

Empowering minority communities by increasing the minority workforce

An initiative intended to increase the racial and ethnic diversity of America's physician workforce was launched in 1991 to provide a 'long-term solution for a very complex, multi-factorial, recalcitrant social catastrophe', that is, the under-representation of ethnic minorities in US medical schools. Cohen[205] argues that achieving greater diversity within the nation's physician workforce will achieve:

> '...just and equitable access to a rewarding careers...improved access to health care for the underserved;...culturally competent care...a comprehensive research agenda, [and] use...the rich and diverse pool of the nation's talent to better manage the health care system.'

In a similar vein, the Paediatric Workforce Committee in the US stresses the importance of increasing the ethnic diversity of the paediatric workforce. This article provides a clear argument for increasing the diversity of the paediatric workforce nationally[206]. Committee members see diversity as directly increasing access for diverse populations to effective clinical care, as well as a means of improving the education of all paediatricians. They do, however, warn that 'More data are sorely needed on the relationship between the paediatric workforce diversity and satisfaction, access, quality and outcomes of paediatric care'.

Advocacy as a means of empowerment

Communication between a physician and a patient is inherently cross-cultural, because the 'illness experience' of the patient is different from the 'disease process' that is the natural province of the physician[207]. Research in medical anthropology has shown that there are always two different systems at play: the illness system (the patient's perspective) and the disease system (the health professional's perspective)[208]. Thus every medical encounter is a negotiation, with the goal that both sides (provider and patient) should find a common ground of understanding. In a medical encounter, every transfer of 'stretches of language' is also a 'shuttle', shuttling backwards and forwards in the process of trying to bring about a consensus or, at least, a compromise between the two systems.

Several differences are characteristic of cross-cultural and cross-language patient–physician interactions: different cultural expectations and concepts; different understandings of lay knowledge and shared concepts; different knowledge of medical language; different knowledge of types of conversations; different proficiencies in both languages; different notions of negotiation; and different power potentials in the negotiation for consent (the patient's informed choice may be reduced). In these situations, the contribution of intermediaries acting as advocates[209] is indispensable if patients are to be empowered.

Until recently, for most health professionals working with allophone patients, the sole function of the person called in to translate was passing messages. The interpreter was seen as an instrument (unobtrusive, neutral, non-personal, non-relational), a black-box 'language-switcher' into which messages entered in one language and came out in another. The interpreter did not have a role, because she was not seen in a social context. An important focus now is on the roles of interpreters in community settings in strengthening (empowering) patients.

> 'Role is a social science construct used to explain behaviour and examine attitudes between at least two participants in any social situation. The concept of role is inextricably tied to the idea of a reciprocal relationship; thus dyads exist such as doctor/patient, teacher/pupil, lawyer/client, etc. The essential point is that each of these roles exists only in relation to the other. Thus a teacher can only be a teacher when there is a pupil to be taught; the role of a doctor only becomes evident in the presence of a patient. (…) This construct is useful in liaison interpreting situations to describe not only the relationship and attitudes of the clients to each other but also the relationships between the interpreter and each client in turn.'[210]

Informed consent

Informed consent is a pivotal 'event of trust' in the doctor–patient relationship. Genuine informed consent requires 1) full information about risks, benefits and alternative treatments; 2) patient competence; 3) patient understanding; and 4) the patient's ability to act on his/her own behalf. Fully informed consent from minority patients requires two-way communication (just information given by the health provider alone is not enough) in which the patient can ask questions and be fully re-assured. The presence of an

[205] Cohen, J. J. (1997). *Finishing the bridge to diversity*. Academic Medicine 72: 103-109.

[206] Pediatric Workforce Committee (2000). *Enhancing the racial and ethnic diversity of the pediatric workforce*. Pediatrics 105: 129-131.

[207] Kreier, R. (1999). Crossing the cultural divide. *American Medical News*, American Medical Association (AMA).

[208] Helman, C. G. (2000). *Culture, Health and Illlness*. Oxford, Butterworth-Heinemann.

[209] Kaufert, J. M. (1990). *Sociological and anthropological perspectives on the impact of interpreters on clinician/client communication*. Santé Culture Health 7: 209-235.

[210] Gentile, A., U. Ozolins and M. Vasilakakos (1996). *Liaison interpreting, a handbook*. Melbourne, Melbourne University Press.

intermediary (interpreter, intercultural mediator, cultural broker, community health worker) may be necessary. Depending on the patient's socio-cultural background, informed consent may also have to be negotiated in the presence of other family members. Kaufert and colleagues, in their research with Canadian aboriginal patients, concluded (among other things) that in order to establish meaningful communication the interpreter must mediate between the clinician's biomedical explanations of illness and proposed treatment, and the culturally-based framework which the minority patient uses to interpret their problem[211]. The Boston Medical Center has on its internal website a whole catalogue of consent forms for the various interventions in different languages[212]. These forms can be printed out and discussed with patients.

Empowerment through religious involvement

The review 'Religious involvement, spirituality and medicine: implications for clinical practice'[213], which includes 146 references, documents the association of health benefits with religious involvement and/or spirituality. These benefits include reductions in overall mortality, cardiovascular disease including hypertension, depression, anxiety, substance abuse, suicide, and an increase in health-promoting behaviours. Though causality is difficult to demonstrate conclusively, benefits are apparently associated with religious involvement even after controlling for socio-demographic factors and social support. Since most people in the US report having some kind of spiritual life, the authors propose ways in which clinicians might support this aspect of patients' identity without proselytising or 'prescribing' religious activities. Besides being aware of the mind-body disconnection that characterises bio-medically oriented practitioner training, authors suggest ways of taking a brief spiritual history, suggesting that 'on its own, the spiritual history can be a form of spiritual care.'

Spirituality and health care organisations[214]

The authors discuss a greater role for spirituality in health care organisations, including one that influences relationships between co-workers, and between clients and service providers. They review the secular trend towards reductionism and objectivity that has led to a rift between the technical aspects of service provision and open caring and compassion towards patients. This trend is perhaps most easily seen in the training and behaviour of physicians. The authors also review the constructive role of faith (a positive risk factor) in health outcomes, and society's recent demands for a more caring organisational environment. They discuss the obvious and more subtle organisational barriers to spirituality in health care institutions, including respect for employees' privacy and a potential lack of shared beliefs. They caution:

> 'Programmes that promote spirituality should be a natural reflection of the true core values of the organisation, and the organisation's leaders must already be respected for their values and honesty…Unless this has been realised, the organisation has not achieved the moral maturity to embark on this path…With proper consideration and caution by clinicians and managers, a truly 'spiritual' health care organisation can be developed: one that supports patients' expressions of faith; provides guidance and direction to staff on how to discuss faith, health, and meaning in illness; encourages staff and clinicians to be warm, caring, and sensitive, and supports individuals' search for meaning and fulfilment.'

Community involvement in population-based research

Lythcott[215] argues that in population-based research, 'it is crucial to broaden the traditional research paradigm to effectively include community involvement.'

She offers five useful suggestions: 1) Know the community 'beyond the data'; 2) involve the community *before* funding requests and before crises arise; 3) build trust through accountability; 4) use multi-disciplinary research teams for valid research; and 5) 'be accountable to the community'. This latter includes communicating the results of the research and future plans to the community.

---

[211] Kaufert, J., M. Lavallee, W. Koolage and J. O'Neil (1996). *Culture and informed consent: the role of aboriginal interpreters in patient advocacy in urban hospitals*. Issues in the North 1: 89-93. See also Kaufert, J. M. and J. O'Neil (1998). *Culture, power and informed consent: the impact of Aboriginal health interpreters on decision-making*. In: Health and Canadian society: sociological perspectives. D. Coburn, C. D'Arcy and G. Torrance. Toronto, University of Toronto Press.; Kaufert, J. M., J. O'Neil and W. Koolage (1990). *The cultural and political context of informed consent for native Canadians*. Circumpolar Health 90: 181-184.

[212] http://www.bmc.org/about/facts02.pdf

[213] Mueller, P. and D. Plevak (2001). *Religious involvement, spirituality and medicine: Implications for clinical practice*. Mayo Clin Proc 76: 1225-1235.

---

[214] Graber, D. and J. Johnson (2001). *Spirituality and healthcare organizations*. Journal of Healthcare Management 46(1): 39-50.

[215] Lythcott, N. (2000). *Changing the research paradigm: Community involvement in population-based research*. Cancer 88(5): 1214-1216.

Power differentials between an evaluator and the community[216]

Much has been written about community empowerment and collaboration, begins Wallerstein, 'yet many of the challenges and contradictions of our role, especially related to our positions of power as health researchers and evaluators, remain unexplored'. Wallerstein provides a thorough review of such concepts as action research, community empowerment, and empowerment evaluation, all seen as ideal and overlapping ways of bringing about the kind of social change that leads to healthier communities by empowering their members. She then provides a very personal case study from New Mexico, where she served as the evaluator for a state-wide initiative which lasted several years and which, at its inception, was intended to engage communities in their own development and public health improvement. Wallerstein describes how her role often went wrong in this endeavour, despite the 'sincerest' of desires to be an ally with disenfranchised communities:

> 'Although I believed in a participatory evaluation design, …I did not realise from the beginning my own positions of power in relation to communities. This lack of recognition of my own power served to sabotage genuine community ownership of the evaluation endeavour, which made the interpretation and use of the findings by the communities problematic. '

3.3.3 Empowerment: effective interventions

An example of a comprehensive empowerment project

Refugee Health Volunteer Project: a case study in cross-cultural health care delivery[217]. Beginning in 1979, Fresno County received a second dramatic influx of Southeast Asian refugees. It now has approximately 20,000 refugees, including 14,000 Hmong, the largest population of Hmong in the US. There are also about 2,000 Cambodians, and 4,000 Lowland Lao. Altogether, Southeast Asian refugees comprise nearly 10 per cent of the population of Fresno. These figures provide the backdrop for significant problems in health care delivery. Some of the barriers that these people faced in receiving health care included: 1) the stress, loss, dislocation, poverty, illness, and unemployment that are part of the refugee experience; 2) language differences; 3) cultural isolation; and 4) cultural beliefs and

practices whose spiritual, holistic, and natural forms of care often run contrary to the West's scientific, specialised, and technological treatment methods. The Fresno Health Department recognised some of the difficulties related to providing health services for refugees and developed a strategy to combat them.

This strategy was named the Refugee Health Volunteer Project. Its goal was to enable individuals, families, and community groups to better meet their own health care needs. This was to be achieved by first creating a community based health promotion network which would 1) identify health needs; 2) communicate health information; 3) train community health volunteers; and 4) build a greater capacity for self-care that would last beyond the end of the programme.

The programme's goal would also be met by overcoming problems of access to services, encouraging broad participation among service providers in designing more accessible approaches to service delivery, and improving coordination between service providers.

Significant progress was made in a very short time. This project demonstrates that a fairly ordinary bureaucratic organisation can respond to highly unique community needs. It also demonstrates the effectiveness of a networking approach as a model for service delivery to minority ethnic communities which face language and cultural barriers to health care. The project staff served as catalysts for initiatives which made the wider health delivery system more accessible to refugee clients. What emerges is an approach to health empowerment that builds on the strengths, skills, knowledge, and experience of the people in the community and of those organisations which support their efforts.

Interactive group education for refugees to reduce fat consumption[218]

This study reports on an effective intervention intended to reduce cooking oil consumption by refugees. The main goal of the dietary counseling programme was to decrease fat consumption by refugees from former Yugoslavia living in Geneva, Switzerland. Cooking oil was highly valued in participants' ideas of health. Since one-to-one counselling was unsuccessful, a pilot intervention programme was developed to explore the potential of

---

[216] Wallerstein, N. (1999). *Power between evaluator and community: research relationships within New Mexico's healthier communities*. Soc Sci Med 49: 39-53.

[217] Rowe, D. R. and H. P. Spees (1987). *The Fresno County Refugee Health Volunteer Project: a case study in cross-cultural health care delivery*. Migr World Mag 15(4): 22-7.

[218] Kruseman, M., B. E. Stoll and H. Stalder (2003). *Interactive group education for refugees from the Former Yugoslavia to reduce their oil consumption.* Patient Education and Counseling 49(2): 171-6.

participatory workshops in identifying and implementing appropriate behaviours. Four series of three workshops were held. Participants identified and practiced ways of reducing fat consumption. Knowledge and skills were measured both at the end of the workshops and several months later. The average reduction of oil used per recipe was 58 per cent, and the use of oil-reducing techniques increased nine-fold. This study piloted a participatory approach in which participants were placed at the centre of the change process and required to take an active role in identifying motivation to change behaviour in a culturally appropriate way. Hands-on practice and exchanges of ideas and experiences for applying the new cooking techniques within the group reinforced participants' skills. This approach, which includes a patient-empowerment component, may be an alternative to one-to-one dietary counseling where this has been ineffective[219].

Faith-based cardiovascular health promotion[220]

Researchers enrolled 529 older African-American women, members of 16 predominantly Black churches in Baltimore. The design of the content and process of the programme were crucially informed by focus-group information obtained from the pastors and ministers of several non-participating Black churches within the same community.

267 randomly selected women attended weekly nutrition and exercise education classes, as well as exercise sessions, all with explicit attention to spiritual principles (spiritual intervention). 188 other women received all of the above but without the explicit spiritual component. However, the women in the latter group, both under the direction of the lay leaders and of their own accord, added an explicit spiritual dimension to all the activities on the courses, with the result that the content of their courses was indistinguishable from the content of the courses attended by the 'spiritual intervention' group members. The results of these two groups were similar and are therefore reported as a single combined group.

Seventy-four other women were part of a 'self-help' control group, and received only educational materials and a one-off educational retreat. After one year, the 'spiritual intervention' group (n=455) had favourably significant, although modest, changes in weight, body mass index, waist measurement, percentage body fat, systolic blood pressure, energy intake, total fat intake, percentage energy from fat, and sodium intake. The control group only experienced a decrease in the percentage of energy intake from fat. The differences in favourable changes between the intervention and control group were significant for weight loss, body mass index, and energy, total fat and sodium intakes. Desirable changes in behaviour within the group were statistically significant for the intervention group for consumption of fruits and vegetables, fibre, fat, daily kcals, and sodium. The programmes continued in most churches after the research study was concluded.

HIV sexual risk reduction intervention[221]

This article examines the effect of educational sessions on HIV-risk reduction among African-American women aged 18-29. This was the first randomised controlled trial of a community-based HIV sexual risk reduction programme for economically disadvantaged young adult African-American women. Two intervention groups were created: one received five sessions of education; the other received the same educational material but all in one session. The material covered: gender and ethnic pride, knowledge about HIV and risk behaviour, sexual assertiveness and communication training, proper condom use skills, and cognitive coping skills. Those women who received the education in one session showed similar changes in behaviour to those women who did not receive the intervention. However, the women who participated in the prolonged intervention were significantly more likely than their counterparts to have better cognitive skills, interpersonal skills, partner norms, and consistent condom use.

A local health department's role in catalysing community development[222]

This interesting article demonstrates the rich texture of community health and the vitality that are possible when a neighbourhood is given 'full control over setting its agenda.' With innovative, dedicated personnel and courageous leadership from county staff, a Health Department launched an initiative to improve the well-being of residents in a diverse public housing complex in Pittsburgh, California. County personnel refrained from defining a health

---

[219] Contact: Maaike Kruseman, Département de médecine communautaire, Hôpitaux Universitaires de Genève, 1211 Genève 14, Suisse ; email : maaike.kruseman@hcuge.ch

[220] Yanek, L. (2001). *Project Joy: Faith-based cardiovascular health promotion for African American women*. Public Health Rep 116: 68-81.

[221] DiClemente, R. J. and G. M. Wingood (1995). *A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women*. Jama 274(16): 1271-6.

[222] El-Askari, G. and J. Freestone (1998). *The Healthy Neighborhoods Project: A local health department's role in catalyzing community development*. Health Educ Behav 25(2): 146-159.

agenda for residents, concentrating instead on overall community development. This led to residents using their own talents and building relationships within the community, quickly deciding upon the unlikely health promotion strategy of installing speed bumps and better street lighting to discourage neighbourhood drug trafficking.

> 'Residents felt that improving public safety and reducing the ability for drug transactions to occur were crucial first steps in bettering the neighbourhood and uplifting the residents.'

With the development of coalition-building and advocacy skills, the residents then went on to tackle, under their own direction, more traditional public health issues in their neighbourhood, such as billboard advertising with negative health messages. The programme was built on the following assumptions:

1. as a matter of strategy, urban communities should highlight the assets and underdeveloped potential and strengths that their members possess

2. addressing the immediate needs of a community and improving overall well-being increases subsequent receptiveness to health messages as well as participation in preventive health activities

3. an increased sense of control may, in itself, lead to better health outcomes

4. individuals who take part in initial community driven activities later become involved in broader city and regional policy-making initiatives.

In the light of the programme's success, the authors note the dilemma of community based initiatives from whom funders often require 'funding deliverables' to be spelled out up front. This 'dictates that a pre-existing agenda be imposed on a project, thus hindering the ability of organisers to turn over true decision-making power to residents.' The article describes the leadership strategies used to justify funding for non-traditional public health activities.

Outcomes of training paediatricians to serve the underserved

Ozuah[223] describes a physician training programme in social medicine. Among the components of the programme's multidimensional mission is the goal to

'train excellent primary care physicians grounded in the biopsychosocial model who are effective advocates of social change…and to maintain and enrich the physical, spiritual, intellectual, emotional, and material resources necessary for these tasks.'

In the 25 years of the programme, 46 per cent of graduates have been members of minority ethnic groups and 79 per cent have worked in poor, minority or underserved communities. Ozuah attributes the programme's success to several factors, including the 'shared vision' of the faculty, carefully selected trainees, continuity of experiences at community health centres in under-served areas, and a population- and community-based curriculum which is based on the bio-psychosocial/family systems model.

Patient empowerment through providing ethnically diverse health staff

Murray-Garcia's study[224] details the service patterns of paediatric physicians at a children's hospital. They found that African-American, Latino and Asian patients were respectively 1.2, 4.6, and 1.9 times more likely to see physicians of their own race/ethnicity than they were to see physicians from other races. White patients were neither more nor less likely to be seen by white physicians. These findings were obtained after controlling for physicians' gender and level of training, and patients' health insurance status. After controlling for physicians' second language proficiency, Asian and Latino patients were still respectively 2.4 and 1.6 times as likely to see Asian and Latino physicians as they were to see physicians from another ethnic group. Among other conclusions,

> 'the contributions that racially, ethnically and linguistically diverse house staff make to their training institutions and surrounding communities should not be understated'.

Effective health advocates[225]

Depending on the context, goal and content of a patient-provider encounter where the two parties do not speak the same language, an intermediary may play different roles in the communication triangle, moving between them as necessary[226]:

---

[223] Ozuah, P. (2001). *Outcomes of training pediatricians to serve the underserved: social pediatrics*. Journal of the National Medical Association 93: 444-445.

[224] Murray-García, J. and J. García (2001). *The service patterns of a racially, ethnically, and linguistically diverse housestaff*. Academic Medicine 76: 1232-1240.

[225] Verrept, H. and F. Louckx (1998). *Health Advocates in Belgian Health Care*. In: Health & Social Services among International Labor Migrants, a comparative perspective. A. Ugalde and G. Cárdenas. Texas, Center for Mexican American Studies.

[226] Weiss, R. and R. Stuker (1998). Interprétariat et médiation culturelle dans le système de soins. Neuchâtel, Forum Suisse pour l'étude des Migrations.

- A faithful translation focuses on the spoken words of both patient and health professional, with the interpreter remaining more or less in the background.

- A culturally illuminating translation places verbal statements in the context of their cultural and social background: here the interpreter becomes a kind of cultural mediator.

- An advocating translation emphasises the patient's concerns and supports the patient's standpoint: the interpreter becomes the patient's advocate and supporter.

- Alternatively the interpreter may act as the health professional's close collaborator and thus as a participant in the therapeutic process: here, in addition to translating, the interpreter may also actively intervene as a mediator.

In the 'black box model'[227] discussed earlier, the interpreter is seen merely as a kind of static switching point ('language converter') between the statements of the patient and those of the health professional. She has no social role and no social relationships. In contrast, the multiple role outlined above acknowledges that the interpreter is a social presence who cannot be ignored. The process whereby the interpreter adapts their role depending on the context and the changing needs of the patient has been labelled 'incremental intervention':

> 'To achieve such (communication) clarity, it may be necessary to provide linguistic clarification, cultural brokering, and limited advocacy while respecting the goals of the individual participants and the community. In doing so, the interpreter must also keep in mind the programmatic and institutional context in which she is interpreting as well as the cultural and political context of the patient's community. (…) Movement across the boundaries of different roles is determined by the demands of the situation. Examples of these contextual variables are the provider's skill in working with an interpreter and his overall cultural competence, the degree of cultural distance between patient and provider, and the experience of the patient in a western medical environment. The interpreter role expands incrementally to bridge the gaps between patient and provider, so for different patients, different providers and in different interactions, the interpreter may assume different roles.'[228]

This paragraph discusses advocacy in the context of interpreting. Advocacy is crucial in providing health care for minority patients because of the power differentials (asymmetry) that exist in health care systems. Although advocates can be interpreters, they need not be. The health advocacy service, set up at the Royal London Hospital, provides health advocates (called linkworkers) who defend, support and empower minority clients[229].

Empowerment through community involvement, client participation, community health workers and incorporating community members in the health care system

The Comprehensive Family AIDS Project[230] has clients taking active roles as peer educators or consumer advocates. The participation rate is high and clients often also take charge of events. The job referral network currently operated by the project also grew out of a need which was both recognised and addressed by clients on their own. In addition to having community members on boards of directors and community advisory boards, and clients participating in focus groups, most programmes make efforts to hire individuals from the community or from similar cultural, economic, and linguistic backgrounds as local community members. These programmes hire office staff, community health workers, outreach workers and all levels of nursing and provider staff, as well as providing residency and training opportunities for minority ethnic health professionals. Community members serving in any of the above capacities may provide direct services, act as

---

[227] Westermeyer, J. (1990). *Working with an interpreter in psychiatric assessment and treatment.* J Nerv Ment Dis 178(12): 745-9.

[228] Beltran Avery, M. P. (2001). The role of the health interpreter - an evolving dialogue. Chicago, National Council of Interpretation in Health Care NCIHC.

---

[229] White, V. (2000). *Health advocacy in medicine.* In: Language, labour and migration. A. Kershen. London, Centre for the study of migration.

[230] HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

Contact: Comprehensive Family AIDS Project, Children's Diagnostic & Treatment Center, 417 St. Andrews Avenue, Fort Lauderdale, FL 33309. Contact person: Susan M. Widmayer, PhD, Telephone: (954) 728-8080, Fax: (954) 779-1957.

Additional information provided in the HRSA publication: The Comprehensive Family AIDS Project (CFAP), of the Children's Diagnostic & Treatment Center, is a coordinated system of primary and specialty medicine, clinical research, financial assistance, support groups, peer education programmes, and linkages to community providers for children and families infected with and affected by HIV/AIDS in Broward County, Florida. CFAP's goal is to provide quality services to underserved children and families living with HIV/AIDS. Broward County has the third highest incidence of HIV among minorities in the U.S. Most families are supported by single, minority, unemployed, HIV-infected women with two or more dependent children. The majority of clients are members of ethnic and minority populations, and the programme provides documents in English, Spanish, and Creole. CFAP uses Family Resource Assistants who are full-time staff who are infected with or affected by HIV/AIDS and represent ethnic groups served by the Center. They work closely with social work staff assisting with case management, delivering medicines and food, and co-facilitating support groups.

cultural brokers, facilitators and interpreters between staff and clients, and serve as resources for training other staff.

Many programmes also find it advantageous to employ bilingual/bicultural people from the local community (as office staff, for example) both to facilitate communication and to help make clients feel more comfortable since they can speak to a member of their own community.

Other programmes incorporate community members into the health care system by using the community health worker model. This is a particularly effective way of bridging the gap between the service delivery system and the community: community health workers act as intermediaries, relaying the community's concerns to the programme, and educating the community on health concerns based on their own value system.

Empowering immigrant and refugee communities in Canada

The Canadian report on responsiveness towards newcomers[231] highlights as an example of best practice the advocacy and networking activities undertaken by MOSAIC, a multilingual non-profit organization dedicated to addressing issues that affect immigrants and refugees in the course of their settlement and integration into Canadian society[232]. MOSAIC's mandate is to support and to empower immigrant and refugee communities, helping them to address critical issues in their neighbourhoods and workplaces, and assisting them with multilingual services. MOSAIC's programmes and services are constantly evolving and developing in response to the needs of the community. Their tools are 'advocacy, public education, community development, coalition building, and bridging with the broader community'.

3.4   Monitoring

3.4.1   Monitoring: areas of concern

In plural societies with substantial minority and refugee populations, interactions between patients and health professionals from different cultures are becoming routine. However, there is little baseline data documenting this fundamental change. In fact, there is a real dearth of demographic and epidemiological data altogether about minority and migrant patients, with the result that the debate on the exclusion vs. the integration of minorities in health care provision is fed largely by anecdotal and unsystematic data.

---

[231] Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

[232] http://www.mosaicbc.com/

Research is sorely needed. It should begin when interventions are first planned and should continue after they have ended in order to measure their long-term impact and effectiveness. Such research should not be an objective in itself but should aim to achieve change. For this reason we prefer to use the more practically oriented term, monitoring, in this review.

The changing demographic characteristics of minorities vary across European countries. In 1995, experts in most EU countries prepared reports on migration and health in their own countries, providing useful data[233]. In

---

[233] Huismann, A., C. Weilandt and A. Geiger (1997). Country reports in Migration and Health in Europe. Bonn, WIAD. The following reports are included in this (unpublished) volume. (Copies of the country reports are available from the author of this review):

- Anderson, E. M. (1997). *Migration and Health in Denmark*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Carchedi, F. and A. Picciolini (1997). *Migration and Health in Italia*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- De Muynk, A. (1997). *Migration and Health in Belgium*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- de Jong, J. and R. Wesenbeek (1997). *Migration and Health in the Netherlands*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Gliber, M. (1997). *Migration and Health in France*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Huismann, A., C. Weilandt, A. Geiger, L. Joksimovic, J. Korporal, B. Dangel and A. Salomon (1997). *Migration and Health in Germany*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Karmi, G. (1997). *Migration and Health in the United Kingdom*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Kokko, S. (1997). *Migration and Health in Finland*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Janson, S., P. G. Svensson and S. Ekblad (1997). *Migration and Health in Sweden*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Matuschek, H. (1997). *Migration and Health in Austria*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Moreira, B. (1997). *Migration and Health in Portugal*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

- Solas Gaspar, O. and D. Silès (1997). *Migration and Health in Spain*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

relation to hospital performance, research in recent years provides compelling evidence of inadequate care for migrant and minority patients. Even when socio-economic and related factors are taken into account, minority and migrant patients still receive inferior care compared to their majority counterparts. Table 3 lists a number of research findings in this area. These point to an urgent need to tackle inadequate service provision for migrant and minority patients.

Table 3: Minority and migrant patients (MMPs) are less likely...

- MMPs with colorectal cancer are treated less aggressively than majority patients[234].
- MMPs with prostate cancer are treated less aggressively than majority patients[235].
- MMPs with cardiovascular disease receive less specialist cardiovascular care[236].
- MMPs with mental illness are more likely to be misdiagnosed and to receive inadequate treatment[237].
- MMPs with abnormal mammograms are less likely to receive adequate diagnosis and treatment[238].
- MMP children are less likely to be up to date with recommended childhood immunisation[239].
- MMP women who are pregnant are less likely to start antenatal care in the first trimester, and less likely to receive adequate information during antenatal care on risk factors like cigarette smoking and alcohol use[240].
- MMPs are less likely to receive analgesia in emergency departments[241].
- MMPs are less likely to receive bypass surgery[242].
- MMPs are less likely to receive antidepressant therapy[243].
- MMPs are less likely to receive adjuvant chemotherapy for breast cancer[244].
- MMPs are less likely to receive preventive medication in asthma therapy[245].
- MMPs are less likely to receive dental health care[246].
- MMPs are less likely to receive curative surgery for lung cancer[247].
- MMPs are less likely to undergo a hysterectomy[248].
- MMPs receive fewer anti-retrovirals for HIV infection[249].
- MMPs receive less appropriate management of congestive heart failure[250].
- MMPs receive fewer paediatric prescriptions[251].
- MMPs receive fewer admissions for chest pain[252].
- MMPs receive fewer bone marrow transplants[253].
- MMPs receive fewer orthopaedic procedures[254]
- MMPs have fewer pap smears[255].

– Bischoff, A., L. Loutan and D. Burgi (1997). Migration and Health in Switzerland. Bern, BAG.

[234] NQF (2002). Improving healthcare quality for minority patients. Washington, The National Quality Forum.

[235] Klabunde, C. N., A. L. Potosky, L. C. Harlan and B. S. Kramer (1998). *Trends and black/white differences in treatment for nonmetastatic prostate cancer*. Med Care 36(9): 1337-48.

[236] Canto, J. G., H. A. Taylor, Jr., W. J. Rogers, B. Sanderson, J. Hilbe and H. V. Barron (1998). *Presenting characteristics, treatment patterns, and clinical outcomes of non-black minorities in the National Registry of Myocardial Infarction 2*. Am J Cardiol 82(9): 1013-8.

[237] Fiscella, K. (2002). *Using existing measures to monitor minority healthcare quality*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

[238] Frazier, E. L., R. B. Jiles and R. Mayberry (1996). *Use of screening mammography and clinical breast examinations among black, Hispanic, and white women*. Prev Med 25(2): 118-25.

[239] CDC (1997). *Vaccination coverage by race/ethnicity and poverty level among children aged 19-35 months -- United States, 1996*. MMWR Morb Mortal Wkly Rep 46(41): 963-9.

[240] Hansell, M. J. (1991). *Sociodemographic factors and the quality of prenatal care*. Am J Public Health 81(8): 1023-8. and Kogan, M. D., M. Kotelchuck, G. R. Alexander and W. E. Johnson (1994). *Racial disparities in reported prenatal care advice from health care providers*. Am J Public Health 84(1): 82-8.

[241] Todd, K. H., N. Samaroo and J. R. Hoffman (1993). *Ethnicity as a risk factor for inadequate emergency department analgesia*. JAMA 269(12): 1537-1539.

[242] Ramsey, D. J., D. C. Goff, M. L. Wear, D. R. Labarthe and M. Z. Nichaman (1997). *Sex and ethnic differences in use of myocardial revascularization procedures in Mexican Americans and non-Hispanic whites: the Corpus Christi Heart Project*. J Clin Epidemiol 50(5): 603-9.

[243] Sirey, J. A., B. S. Meyers, M. L. Bruce, G. S. Alexopoulos, D. A. Perlick and P. Raue (1999). *Predictors of antidepressant prescription and early use among depressed outpatients*. Am J Psychiatry 156(5): 690-6.

[244] Nerenz, D. R. (2002). *Quality of care measures of special significance to minority populations*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

[245] Zoratti, E. M., S. Havstad, J. Rodriguez, Y. Robens-Paradise, J. E. Lafata and B. McCarthy (1998). *Health service use by African Americans and Caucasians with asthma in a managed care setting*. Am J Respir Crit Care Med 158(2): 371-7.

[246] Vranjes, N., B. Bisig and F. Gutzwiller (1996). Gesundheit der Ausländer in der Schweiz. Bern, Bundesamt für Gesundheit.

[247] Bach, P. B., L. D. Cramer, J. L. Warren and C. B. Begg (1999). *Racial differences in the treatment of early-stage lung cancer*. N Engl J Med 341(16): 1198-205.

[248] Vranjes, N., B. Bisig and F. Gutzwiller (1996). Gesundheit der Ausländer in der Schweiz. Bern, Bundesamt für Gesundheit.

[249] Moore, R. D., D. Stanton, R. Gopalan and R. E. Chaisson (1994). *Racial differences in the use of drug therapy for HIV disease in an urban community*. N Engl J Med 330(11): 763-8.

[250] Ayanian, J. Z., J. S. Weissman, S. Chasan-Taber and A. M. Epstein (1999). *Quality of care by race and gender for congestive heart failure and pneumonia*. Med Care 37(12): 1260-9.

[251] Hahn, B. A. (1995). *Children's health: racial and ethnic differences in the use of prescription medications*. Pediatrics 95(5): 727-32.

[252] Johnson, P. A., T. H. Lee, E. F. Cook, G. W. Rouan and L. Goldman (1993). *Effect of race on the presentation and management of patients with acute chest pain*. Ann Intern Med 118(8): 593-601.

[253] Mitchell, J. M., K. R. Meehan, J. Kong and K. A. Schulman (1997). *Access to bone marrow transplantation for leukemia and lymphoma: the role of sociodemographic factors*. J Clin Oncol 15(7): 2644-51.

Monitoring is urgently needed to look at:

- the health needs of specific minority ethnic groups (including needs for information and interventions) in order to improve both health promotion and the quality of care.

- the impacts of interventions on the health system (including differences and changes over time).

- the quality of care in relation to the specific needs of different groups.

- psycho-social treatment and support for minority patients.

- the adequacy of different concepts of treatment and support in relation to the needs of minority patients.

In aiming to improve the quality of care, health care services can get the leverage they need by using measurement, accountability and public reporting. They can give patients a voice and listen with confidence to their views.

Public reporting involves 'assisting patients when they choose and use health care; giving decision makers the information to make a variety of decisions; equipping providers with benchmarks, performance targets and a focus for quality improvement; tracking the value of the "social good" of health care.'[256]

3.4.2   Monitoring: policies

In most European countries there is a lack of health care data that take into account the ethnic diversity of the population, or that focus on the needs of specific minority ethnic groups. Collecting and reporting health care information by patient ethnicity (and other relevant variables, eg, demographic characteristics, length of stay, legal status) would be an important step towards monitoring and eliminating disparities in health between ethnic groups. In addition, routine statistics on health status and mortality rates should include legal status, eg, asylum seeker. Data on treatment and support for ethnic minorities (not only in public health institutions, but also among private doctors and welfare institutions) are also

needed. Such data would help identify the most common health problems experienced by migrants and minorities and enable decisions about priority interventions[257].

Inequality in quality: Addressing socio-economic, racial and ethnic disparities in health care[258]

This article is one of many, though (perhaps deservedly) the most frequently referenced, that includes an extensive literature review on health care disparities. The authors' goal is to bring

> 'health care disparities into mainstream quality assurance and continuous quality improvement discussions, and discussions of report cards.'

The authors propose significant roles for the (US) National Committee for Quality Assurance and the Health Care Financing Administration (which administers Medicaid and Medicare). They offer a set of measures for addressing disparities: recognising disparities in health and health care as a significant and urgent problem; increasing the collection of data and their reliability; identifying performance measures stratified by race and ethnicity; setting out population-wide performance measures; and taking into account both socio-economic and race/ethnicity disparities. Barriers to implementing these measures include: the difficulties of mobilising leadership, the current lack of demographic data, concerns about the privacy and misuse of data, inertia, and resistance among health care organisations. However, such measures could achieve substantial progress in eliminating disparities in health status by eliminating disparities in health care delivery.

Approaches to eliminating socio-cultural disparities in health[259]

These authors point out that descriptions of racial/ethnic disparities in health care abound, but solutions and demonstrably successful programmes to eliminate these disparities are scarce. They describe three broad areas of intervention aimed at:

1. health care providers (eg, through cultural competence training)

2. individual patients and communities, and

[254] Ronsaville, D. S. and R. B. Hakim (2000). *Well child care in the United States: racial differences in compliance with guidelines*. Am J Public Health 90(9): 1436-43.

[255] Calle, E. E., W. D. Flanders, M. J. Thun and L. M. Martin (1993). *Demographic predictors of mammography and Pap smear screening in US women*. Ibid. 83(1): 53-60.

[256] Smith, M. (2002). *Culture and quality: joining the levers*. Advancing effective health care through systems development, data and measurement, Chicago.

[257] Maggi, J. and S. Cattacin (2003). Needed research in "Migration and Health" 2002 - 2006. Neuchâtel, Swiss Forum for Migration and Population Studies.

[258] Fiscella, K., P. Frank, M. R. Gold and C. M. Clancy (2000). *Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care*. JAMA 283: 2579-2584.

[259] Horowitz, C. and M. Davis (2001). *Approaches to eliminating sociocultural disparities in health*. Minority Health Today 2(2): 33-43.

3. health systems and policies, including the use of federal civil rights legislation.

Rigorous evaluation of these programmes has been missing so far, for reasons that the authors detail in their discussion. They offer ways to maximise research and evaluation efforts.

Counting accountably: Implications of new approaches to classifying race/ethnicity in the 2000 US Census[260]

Krieger discusses some of the research and policy issues that emerged when the Census Bureau devised new racial and ethnic categories and offered respondents, for the first time in US history, the option of ticking more than one racial/ethnic category. Krieger sees as unwise the popular move to take race out of public health data collection, a move which is proposed by those who argue that since race is no longer seen as a biological descriptor, it should not matter:

'Without race and ethnic data, we cannot monitor progress or setbacks in addressing racial/ethnic inequalities in health.'

Disaggregating minority population data[261]

This is an important article, strongly advocating the disaggregating of data and public health considerations for the group of heterogeneous peoples usually lumped together as 'Asian/Pacific Islanders' or 'Asian Americans'. The authors point to these communities' disparate health status (eg, Vietnamese women have the highest rates of cervical cancer of any racial or ethnic group), different health care up-take, different immigration and socio-political histories, and the socio-demographic distinctiveness of 'Asian' ethnic groups (eg, six per cent of Filipinos versus 63 per cent of Hmong have incomes below the poverty level). The authors make a compelling case for overcoming the invisibility of Asian Americans and Native Hawaiian/Pacific Islanders that has led to assumptions about their homogeneity. They put forward a case for urgent data collection:

'There are several gaps in our knowledge of the health needs of Asian Americans and Native Hawaiians/Pacific Islanders, and of the illnesses from which they suffer, because of the lack of group- or ethnicity-specific data.'

Although the authors are writing about a specifically US situation in relation to minority groups, their conclusions apply equally in Europe.

Improving the wording of questions in surveys of culturally diverse populations[262]

This study provides an excellent reference on the challenge of carrying out research surveys among culturally diverse populations. Examining the tasks that respondents must perform when completing a survey – interpreting, memory retrieval, judgment formation, and response editing – the authors review the literature on how different cultural orientations towards these tasks may systematically influence patterns of response, introducing bias and uncertainty into research findings. The principles illustrated here have profound implications for the surveys of patient satisfaction and other quality indicators which are so prominent in public health research and institutional and organisational accountability strategies today.

These are some of the methodological issues in quality of care programmes which must be taken into account in patient-centred surveys whose respondents include migrant and minority populations[263]:

- 'Surveys must be adapted to address the needs and concerns of diverse populations.

- The comparability of the content of surveys in several languages must be evaluated.

- The reliability and validity of administering standard surveys to diverse populations must be tested.

- Migration and minority specific, ethnic-specific, and language identifiers must be added to surveys and administrative databases.

- Existing metrics must be used as levers to highlight problem areas.'

---

[260] Krieger, N. (2000). *Counting accountably: implications of the new approaches to classifying race/ethnicity in the 2000 census*. Am J Public Health 90(11): 1687-9.

[261] Srinivasan, S. and T. Guillermo (2001). *Toward improved health: Disaggregating Asian American and Native Hawaiian/Pacific Islander data*. American Journal of Public Health 90: 1731-1734.

[262] Warnecke, R. B., T. P. Johnson, N. Chavez, S. Sudman, D. P. O'Rourke, L. Lacey and J. Horm (1997). *Improving question wording in surveys of culturally diverse populations.* Ann Epidemiol 7(5): 334-42.

[263] Smith, M. (2002). *Culture and quality: joining the levers*. Advancing effective health care through systems development, data and measurement, Chicago.

Quality of data in multi-ethnic health surveys[264]

This is an extensive discussion of the challenges involved in developing and validating a survey of a multi-ethnic sample of women. The authors describe the process of surveying a large sample of women in California, and then returning to these women about problems, inconsistencies, or difficulties with selected questions in the survey. Having identified 'problem' questions using response patterns or interviewers' reports, the researchers conducted focus groups, test-retest sessions, think-aloud sessions, and different kinds of interviews, the latter in order to formulate alternative questions. For example, the question about 'the members of one's household' exposed issues of mistrust and fear about immigration status, general concerns about the invasion of privacy, and confusion about definitions, for example, how to classify older children who contributed financially but were not physically present in the house.

These are important issues in research and in attempting to hold health care planners and providers accountable for the quality of services delivered to diverse populations.

Addressing racial inequalities in health care: civil rights monitoring[265]

Smith chronicles in detail the history of civil rights monitoring of health care institutions in the United States. Under Title VI of the Civil Rights Act of 1964, in order to receive newly allocated Medicare funds, hospitals had to demonstrate compliance with civil rights standards that made segregated wards and other racist practices illegal. The author states that, perhaps because there was so much funding attached, 'few efforts to eliminate racial segregation in the United States moved as smoothly and as quickly'. Smith advocates the aggressive monitoring of clinical data on equitable service delivery in a health-care environment that has been transformed by the organisational strategies of risk avoidance and cost containment which have placed the disenfranchised at risk. He proposes several clinical indicators that have some national precedent in monitoring:

> 'A variety of report card approaches are now being proposed to assure accountability, consumer choice, and goal-directed action. Most have undergone extensive review and development. Only minimal changes in reporting formats would be necessary for civil rights monitoring purposes.'

Research agendas in communication issues

Language barriers are associated with differences in diagnostic testing, mediation, medical follow-up, hospital admission, referral rates, service use, patient compliance, patient information, patient understanding, patient reporting, and patient satisfaction. The quality of care provided to allophone patients is often poor. Since language barriers often prevent health systems performing effectively they can lead to high costs in the long term. Studies demonstrating the effects of language barriers are summarised earlier in this review.

Further research on the effects of language barriers on other aspects of health care provision would be useful. Since the number of allophone patients needing health care is likely to increase in Europe, two routine monitoring measures could prove useful:

- including information about patient's language proficiencies and mother tongue in routinely collected health data, and

- routinely including language as a variable in research proposals.

While the first would contribute to identifying possible risk factors affecting the quality of care, the second addresses a current gap in the research, the language factor[266]. Language access programmes currently involve the recruitment of bilingual staff, language training for allophone patients, or interpreter services[267].

Increasing interest in whether allophone patients could challenge health care providers to provide interpreters on the basis of patients' rights has triggered a number of papers[268]. All patients have the right to confidential care and to informed consent. However, these rights are often breached for allophone patients. Discussion on how to enforce these rights and ensure ethical

[264] Passick, R. and S. Stewart (2001). *Quality of data in multi-ethnic health surveys*. Public Health Reports 116: 223-243.

[265] Smith, D. B. (1998). *Addressing racial inequalities in health care: Civil rights monitoring and report cards*. Journal of Health, Politics and Law 23: 75-105.

[266] Bindman, A. (1993). *Collecting data to evaluate the effect of health policies on vulnerable populations*. Fam Med 25: 114-119, Frayne, S. M., R. B. Burns, E. J. Hardt, A. K. Rosen and M. Moskowitz (1996). *The exclusion of non-English-speaking persons from research*. J Gen Intern Med 11: 39-43, Hazuda, H. (1996). *Non-English-speaking patients a challenge to researchers*. J Gen Intern Med 11: 39-40, Taira, A. (1999). *Improving the health and health care of non-English-speaking patients*. J Gen Intern Med 14: 322-323.

[267] Prodolliet, S. (2000). *Interkulturelle Kommunikation. Eine Einführung in die Praxis*. Luzern, Caritas-Verlag., Gelzer, D. (1994). *Interkulturelle Kommunikation im Gesundheitsbereich*. Soziale Medizin 21(7-9).

[268] Flubacher, P. (1994). *Eine Uebersetzerin der Hausarztpraxis, Kommunikation mit fremdsprachigen Patienten*. Soziale Medizin 6: 20-22, Dussaussois, E. and H. Mosimann (1998). *Das Recht verstanden zu werden - Der Umgang mit Fremdsprachigkeit im institutionellen Rahmen*. Bern, Edition Soziothek, Lin, M. and K. Mutter (1999). *Vom Recht, verstanden zu werden. Elterngespräche mit Dolmetscherinnen und Dolmetschern*. Thema, Basler Schulblatt 10: 6-8.

standards of care for all patients is to be encouraged. This should involve not only health professionals, interpreters and patients, but also lawyers with expertise in human rights, patients' rights and health legislation. Implementing these rights is likely to have important implications, possibly leading, for example, to a solution to the problem of finance for interpreter provision.

Health providers perceive communication with allophone patients as an important barrier to health care and express the need for professional interpreter services[269]. Furthermore, the evaluation of interpreter provision has increased policy makers' awareness. In future, a double strategy might be useful: to pursue the promotion of language access programmes in health care, and to develop national strategies for health care interpreter training, including financing mechanisms, curricula development, professional ethics and an accreditation system. There will be a long-term continuing need to monitor language access.

Surveys show high levels of patient satisfaction with communication when professional interpreters are used[270]. Research on the effects of communication skills training on interpreter-mediated consultations also shows allophone patients' increased satisfaction with care. The development of research protocols to investigate the cost-effectiveness of trained interpreters in health care could draw on research evidence which indicates that high quality communication is an important part of the overall quality of care.

It is important to note that health professionals need systematic training on working with interpreters: this includes raising their awareness of the effects of language barriers on health care provision. Training modules for health

professionals should be included in all basic professional education, continuing education and post-graduate programmes. Communication between health professionals in primary care and allophone patients should also be monitored.

3.4.3   Monitoring: effective interventions

Can we monitor socio-economic inequalities in health?[271]

Krieger et al. surveyed 55 US states and a number of district public health departments about the socio-economic data they provide to the National Centre for Health Statistics. The departments were asked whether they collected data on income, education, occupation, employment status, health insurance, carrier status and receipt of public assistance on birth and death certificates, and in cancer, AIDS and TB registry data. The researchers' concern was that data sources which only look at age, gender and race lead to disparities in health status being incorrectly attributed to these demographic descriptors. They found that none of the 55 vital records bodies or disease registries surveyed collected data on income, and few others collected much data on other socio-economic indicators. Moreover, socio-economic information was for the most part not included in routine publications. The most commonly mentioned barriers to collecting more socio-economic data were the lack of resources and concerns over data privacy. The researchers strongly urge an addition to current data collection to link data to 'census-based socio-economic data at the block group level.' They emphasise the importance of enriched data collected at the local level and including region-specific sub-populations,

> 'to be used to monitor socio-economic inequalities in health and to illustrate links between public policy and public health.'

Monitoring language barriers

Until recently, there was little research on the effects of language barriers, nor on the impact of language access programmes, including interpreter-mediated communication. Jacobs et al.[272] are, to our knowledge, the first researchers to report on the effectiveness of professional interpreter services in improving health care delivery to a group of allophone patients.

---

[269] see the studies undertaken in Swiss hospitals:

Bloechliger, C. (1997). Institutionsbasierte Erhebung der ambulanten medizinischen Grundversorgung und der gesundheitlichen Situation von Asylsuchenden und Flüchtlingen in der Schweiz. Swiss Tropical Institut. Basel, University of Basel, Bloechliger, C., M. Tanner, C. Hatz and T. Junghanss (1997). *[Asylum seekers and refugees in ambulatory health care: communication between physician and patient]*. Schweiz Rundsch Med Prax 86(19): 800-10, Bloechliger, C., T. Junghanss, R. Weiss, C. Herzog, P.-A. Raeber, M. Tanner and C. Hatz (1998). *Asylsuchende und Flüchtlinge in der hausärztlichen Praxis: Probleme und Entwicklungsmöglichkeiten*. Soz Praventivmed 43: 18-28, Bloechliger, C., J. Osterwalder, C. Hatz, M. Tanner and T. Junghanss (1998). *Asylsuchende und Flüchtlinge in der Notfallstation*. Soz Praventivmed 43(1): 29-38, Bloechliger, C., N. Ries, M. Gonon, L. Loutan, K. Mark, S. Vetterli, M. Tanner, C. Hatz and T. Junghanss (1998). *[Asylum seekers and refugees in the medical polyclinic: a comparison between the Basel, Bern and Geneva polyclinics]*. Soz Praventivmed 43(1): 29-38.

[270] Bischoff, A., P. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan (2003). *Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral rates*. Soc Sci Med 57: 503-512.

---

[271] Krieger, N., J. T. Chen and G. Ebel (1997). *Can we monitor socioeconomic inequalities in health? A survey of U.S. health departments' data collection and reporting practices*. Public Health Rep 112(6): 481-91.

[272] Jacobs, E. A., D. S. Lauderdale, D. O. Meltzer, J. M. Shorey, W. Levinson and R. A. Thisted (2001). *The impact of interpreter services on delivery of health care to limited English proficient patients*. J Gen Intern Med 16: 468-474.

As described in Jacobs et al above (cf. 3.1.3 communication: effective interventions), they took advantage of the implementation of a new interpreter service in a large HMO in the US and conducted a retrospective cohort study to determine whether interpreters affected health care provision.

However, this study had important methodological limitations: for example, limited generalisability because of the sophisticated HMO model in which the research was carried out, and the selection of only Portuguese and Spanish speakers (other language groups with different levels of acculturation were excluded). Most importantly, in our view, an *increase* in the number of health care services delivered does not necessarily mean an *improvement* in quality or better outcomes. Given concerns about cost containment, the research evidence could even be interpreted counter-productively, leading to the conclusion that using interpreters leads to unnecessary or unjustified costs ('migrants' "over-consumption" of health care services'). This is an important area for future research. Nevertheless, the study makes a valuable contribution to research into language access. It indicates that professional health care interpreting increases the provision of ambulant and preventive care and thus enhances, the authors conclude, allophone patients' access to care.

Andrulis and colleagues report on a survey of 4,161 uninsured respondents who received health care in 16 US cities. They compare the perceptions and experiences of a group of adults who needed and got an interpreter with a group who needed an interpreter and did not get one, and with a third group, also of uninsured adults, who did not need an interpreter. Three out of four respondents who needed and got an interpreter said that the facility they used was 'open and accepting', compared to 45 per cent of respondents who needed but did not get an interpreter. Twenty-seven per cent of those who needed but did not get an interpreter said that they did not understand the instructions for taking their medication, compared with only two per cent of those who had an interpreter.

Among those who reported needing help to pay for their medical care, more than half of those who needed but did not get an interpreter said that staff had 'never' asked if they needed financial assistance, while only one third of those patients who got an interpreter said that they had never been asked. The Community Access Monitoring Survey project was designed to help local organisations promote better access to health care for uninsured people in their communities[273]. This survey is a good example of what effective monitoring can achieve.

[273] The Access Project 30 Winter Street, Suite 930, Boston, MA 02108; telephone (617) 654-9911, facsimile (617) 654-9922, email website@accessproject.org, website http://www.accessproject.org

4 Comprehensive strategies

The previous section, 'Findings', presented effective interventions intended to improve health care for migrants and minorities in hospitals. The interventions are grouped under the headings: communication, responsiveness, empowerment and monitoring. This section looks first at comprehensive programmes which combine and integrate different types of interventions. Although we realise that MFH-initiative hospitals will have to choose a small number of specific interventions to implement, it is important that they also bear in mind a more comprehensive view of possible intervention strategies. It should also be noted that not all strategies for implementing models of good practice are mutually compatible.

The second part of this section concludes with a strong claim for interventions that are oriented towards and based on quality of care.

4.1 Strategies

4.1.1 'Best Practice Guidelines for Health Services Delivery for Newcomers'

The Canadian Council for Refugees has published *Best Settlement Practices* which provides guidelines for services (Canadian Council for Refugees 1998)[274]. Services should:

1. 'Be accessible to all who need them.
2. Be offered in an inclusive manner, respectful of, and sensitive to, diversity.
3. Empower clients.
4. Respond to needs as defined by users.
5. Take account of the complex, multifaceted, interrelated dimensions of settlement and integration.
6. Be delivered in a manner that fully respects the rights and dignity of the individual.
7. Be delivered in a manner that is culturally sensitive.
8. Promote the development of newcomer communities and newcomer participation in the wider community, and develop communities that are welcoming of newcomers.
9. Be delivered in a spirit of collaboration.
10. Be made accountable to the communities served.

11. Be oriented towards promoting positive change in the lives of newcomers and in the capacity of society to offer equality of opportunity for all.
12. Be based on reliable, up-to-date information.'

Comment: These guidelines are included in a recent report entitled 'Responsiveness of the Canadian Health Care System towards Newcomers', which, like this present report, reviewed interventions intended to improve the health of and health care for 'newcomers'. 'Newcomers' (as opposed to settled immigrants) correspond, in the European situation, to refugees, asylum seekers and recently arrived migrants. The report reviewed not only interventions in Canada, but also those in other countries including Australia, New Zealand, Sweden, the Netherlands and the UK. It is also available in French[275] and is likely to be a valuable resource for assisting decisions about MFH interventions.

4.1.2 'Culturally and Linguistically Appropriate Services'

CLAS (Culturally and Linguistically Appropriate Services) contains recommendations for national standards and an outcomes-focused research agenda. These standards were developed on behalf of the US Department of Health and Human Services Office of Minority Health, with input from a national advisory committee of policy makers, providers and researchers. They have been circulated widely for comment and are available on the OMHR website[276]. Since culture and language have a considerable impact on how patients access and respond to health care services, the CLAS standards suggest a number of measures to ensure equal access to quality health care for diverse populations[277]:

1. 'Health care organisations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organisations should implement strategies to recruit, retain, and promote at all levels of the organisation a diverse staff and leadership that are representative of the demographic characteristics of the service area.

---

[274] Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

[275] Gagnon, A. J. (2002). La réceptivité du système canadien de soins de santé à l'égard des nouveaux arrivants. Montreal, McGill University.

See also websites:

http://www.hc-sc.gc.ca/francais/soins/romanow/index.html and

http://www.hc-sc.gc.ca/english/care/romanow/index.html

[276] www.omhrc.gov/clas

[277] Corbie-Smith, G. (2000). Toward cultural competence in health care. *SGIM Forum*: 4-5.

3. Health care organisations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Health care organisations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency (LEP) at all points of contact, in a timely manner during all hours of operation.

5. Health care organisations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organisations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpreting services (except on request by the patient/ consumer).

7. Health care organisations must make available easily understood patient-related materials and signposting in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Health care organisations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organisations should conduct initial and ongoing organisational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organisations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organisation's management information systems, and periodically updated.

11. Health care organisations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organisations should develop participatory, collaborative partnerships with communities and utilise a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.

13. Health care organisations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organisations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Comment: These policy recommendations focus on diversity, rather than on minority groups or migration issues; diversity includes cultural as well as linguistic diversity. Four of the 14 standards deal explicitly with 'language access services'. They provide valuable principles for further policy development and for planning interventions. Among the other standards, three deal with culturally competent care, and seven with organisational support for cultural competence.

The CLAS standards are quoted in most recent papers on migrant and minority health issues (see 'Unequal treatment'[278]); they appear to reflect a broad consensus in the US and are widely accepted. The applicability of the CLAS standards in Europe may be hampered by their US focus, including the term LEP (Limited English Proficiency) which makes them difficult to use in multilingual European countries; the focus on managed care; and finally the definition of 'culturally appropriate' which may seem to indicate a bottom-down (and perhaps somewhat paternalistic) approach.

4.1.3 'Migration & Health in Europe'

Setting out its health policies for Europe, the WHO stated as a primary target that differences in health status between countries, as well as between population groups within countries, should be reduced by 25 per cent by improving the health status of disadvantaged populations and minority ethnic groups[279]. Several *courses of action* can help in pursuing this target[280]:

'**Health services. Adapting existing health services** to migrants' needs is essential, by increasing awareness of cultural and ethnic specificities, by providing adequate information on administrative procedures of the health services available (in migrants' mother tongues), as well as by making interpreter services routinely available. There is also a need for implementing **specific interventions**, especially for recently arrived migrants (asylum seekers, for example). Areas of particular concern include women's health, mother and childcare, and victims of torture and violence. The **mental health needs** of minority ethnic communities, including refugees and asylum seekers, should be recognised and responded to by the psychosocial and mental health agencies at a national and international level. This must include the particular needs of people from second-generation groups, children, adolescents and elderly people. **Strategies for disease control,** primarily TB and AIDS, should include measures aimed at migrant populations not by targeting high-risk groups but by integrated approaches.

[278] Smedley, B. D., A. Y. Stith and A. R. Nelson (2003). *Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington, The National Academies Press.

[279] WHO (1991). Ziele zur Gesundheit für alle. Die Gesundheitspolitik für Europa. Aktualisierte Zusammenfassung September 1991. Kopenhagen, WHO Regionalbüro für Europa.

[280] Bischoff, A., L. Loutan and D. Burgi (1997). Migration and Health in Switzerland. Bern, BAG.

Health data. National and local health authorities should gather epidemiological data, surveillance data and ethnographic (qualitative) data to provide specific information on migrant health issues, in a differentiated, but not in a discriminatory way. National health surveys or studies into health of the population need always take into account the variables 'migrants' and 'ethnic minorities'. The aim is not stigmatisation, but the development of adapted and adequate information, health promotion and improved access to health care.

Health promotion and training. The same access to information and protection (*eg* immunisation) should be guaranteed to the native and to the migrant populations. **Training** on migration topics (*eg* multiculturalness, forced migration, anthropology, bi-cultural provider-patient relationship) should be set up for health and social professionals, as well as for non-professional native speakers in their migrant communities. Areas: curricula of nursing schools and medical schools (pre- and postgraduate training), courses for refugee health care workers, workshops for intercultural community workers. The final goal of training is 'improving the responses of the health services to the needs of ethnically and culturally different people.

Health promotion programmes should target (at both national and local levels) areas including AIDS prevention, addiction, nutrition, occupational health, sports and other health behavioural aspects, with a view to empowering migrant communities. Again: These programmes should be aimed at the native and the migrant populations at the same time and equitably, especially as regards the use of adequate and acceptable information channels and community empowerment.

Policy implications. Migrant and ethnic health issues should be put high on the agenda of policy makers. The questions of health and well-being of migrants and ethnic minorities should be an essential component of immigration policies of the European countries and cannot merely be delegated to the responsibility of the health authorities of these countries. As health sector reforms are underway in many European countries, the 'migrant factor' can contribute to better understanding and development of health policies compatible with equity. [281]'

Comment: These recommendations provide a useful policy framework for decision-makers at governmental level. Although they were compiled about eight years ago, they are unfortunately still valid, since many have not yet been implemented. Compare also the excerpts from the Swiss policy paper 'Migration and Public Health: The Confederation's strategic orientation 2002-2006', which provides a comprehensive overview of a package of interventions intended to improve migrant public health (see Appendix, 6.1.4).

4.1.4 'Cultural Competence Works'

'Cultural Competence Works'[282] presents good practices carried out mainly in managed care settings (some of which have already been included in this review). These were identified by the HRSA (Health Resources and Services Administration) in the US, which sponsored the Cultural Competence Works competition, a nation-wide search to recognise and highlight programmes which provide culturally competent care for diverse populations. The programmes nominated can be found on the HRSA's website[283]. Overall, those which provide culturally competent services most successfully tend to:

1. define culture broadly

2. value clients' cultural beliefs

3. recognise complexity in language interpretation

4. facilitate learning between providers and communities

5. involve the community in defining and addressing service needs

6. collaborate with other agencies

7. professionalise the hiring and training of staff, and

8. institutionalise cultural competence.

These points are explained here by quotations from the report:

'Define Culture Broadly. Most people understand culture in its broadest sense, and usually interpret it as something that groups possess. But health care is generally dispensed to individuals, and there are other things in addition to race, language, and ethnicity that contribute to a person's sense of self in relation to others. These may be more specific or more general cultural sub-categories based on shared attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, occupation, or homelessness). It is the convergence of multiple memberships in various cultural and subcultural groups that contribute to an individual's personal identity and sense of their own 'culture.' Understanding how these factors affect how a person seeks and uses medical care, as well as their culture group's historical relationship to the medical establishment, is an integral part of providing culturally competent care. For many of the nominated programs, employing this broad understanding of culture has enhanced programme success.

[281] Bourdillon, F. and R. L. Bennegadi (1992). *Migration and Health - what does the future hold?* In: Migration and Health in the 1990s. IOM. Geneva, International Organisation for Migration. 30: 199-205.

[282] HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

[283] http://www.hrsa.gov/financeMC/

Value Clients' Cultural Beliefs. Another way in which cultural competence is demonstrated is the extent to which a programme is able to learn about and value its target community's knowledge, attitudes, and beliefs about health care. Competence is also reflected in the extent to which that information is applied to programme areas to improve access to and quality of care while respecting cultural health beliefs and practices. In order to communicate effectively with clients, providers need to understand how to talk about sensitive issues such as sexuality, drug use, and personal violence, among others. In many cases, the provider must be willing to explore the individual life experiences of a client to find the underlying causes of their behaviors, which may not be readily apparent.

Recognise Complexity in Language Interpretation. In the experiences of the nominated programs, being able to speak a client's language is essential, but it does not always guarantee effective communication between the client and the provider. Communication is more than simply shared language; it must also include a shared understanding and a shared context as well. As explained by several nominated programs, there are three overarching concepts to consider when providing culturally and linguistically appropriate health care: (1) Recognising the linguistic variation within a cultural group; (2) Recognising the cultural variation within a language group; and (3) Recognising the variation in literacy levels in all language groups. Because not all programmes can afford to hire full-time staff, most need to use multiple strategies to meet their language needs. Contracting with commercial telephone interpreter services, though somewhat costly, has been very useful to smaller programs, especially those who have seen a rapid increase in the number of languages spoken by new clients. Other programs, recognising a larger need, were proactive in creating services where none existed before. Many programmes (…) address not only language and race/ ethnicity, but also literacy, since some individuals may not be literate in their native language. Creating environments where learning can occur is crucial to improving the health of both individuals and communities. (…). Several nominated programmes have made concerted efforts to create and sustain a 'learning loop' between their providers and their client community. In some cases, cultural competence is also a matter of understanding that one's collaborating agencies and organisations are groups that have their own organisational cultures.

Involve the Community in Defining and Addressing Service Needs. Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. Programmes that are truly culturally competent involve clients and community members in identifying community needs, assets, and barriers, and in creating appropriate programme responses. In this approach, clients and community members play an active role in needs assessment, programme development, implementation, and evaluation. Some organisations institutionalise this relationship by making individuals from the community voting members of their governing boards. Others ensure input and recommendations by using community advisory boards, client panels, task forces, or town meetings. Still others sponsor locally based community research (interviews, focus groups, etc), and integrate the results into programme design. Some programmes integrate clients and community members into programmes by using volunteers from the target community in a variety of programme areas, serving as peer advocates who help new clients negotiate the system. Most of the nominated programmes also try to hire individuals from the community, or from

cultural, economic, and linguistic backgrounds that complement those of community members.

Collaborate with Other Agencies. A number of the programme nominees have been proactive in their communities to expand culturally competent services by combining forces with other local agencies and organisations. Some programs, for example, have built strong collaborative relationships with medical school residency programs, and described the benefits of these staffing arrangements to the provision of culturally competent care.

Professionalise Staff Hiring and Training. Many of the nominated programmes suggested ways to professionalise hiring and training practices. Among these are: Establishing specific hiring qualifications and mandated training requirements for all staff in language, medical interpretation, and cultural competence as their positions necessitate; Producing a comprehensive and replicable training curriculum and qualifying factors; and allocating the budget and time for staff training including training for new staff, annual updates and review, as well as testing and job application criteria. Many of these programmes approach training in cultural competence and medical interpreting with the same seriousness as training in other essential clinical skills.

Institutionalise Cultural Competence. Nominated programmes made several suggestions for institutionalising cultural competence in a health delivery system. These include: 1) making it an integral part of strategic planning at all levels; 2) making staffing and activities for cultural competence an integral piece of a sustainable funding stream; and 3) designing cultural competence activities with replicability in mind (both for other cultural groups and for other health care programs). Critical to the long-term survival of culturally competent service delivery is sustainable funding for staff, training and other essential activities. Of all of the goals, this may be the most difficult to achieve. Some of the nominated programmes demonstrated how they have moved toward more sustainable funding for culturally competent services.'

Comment: This report is a useful compilation of programmes, projects and interventions and is worth reading when looking for models to improve Migrant Friendly Hospitals. There may again be a problem with the definitions of culture and of cultural competence. In compiling this review, we opted for the term 'responsiveness' in order to avoid the potentially arrogant and professional-centred term 'competence'. (Note however the HRSA's definition: Cultural and linguistic competence are 'a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.').

4.1.5 'Reducing ethnic health disparities'

This article develops a conceptual model of the potential of cultural competence for reducing racial and ethnic health disparities[284]. The need for cultural competence in interactions between patients and health professionals is frequently discussed. But since health professionals are part of a system, that system too must change if cultural competence is to be achieved. In Brach & Fraser's initial review they found that much of the literature on cultural competence discusses the importance of cultural awareness, knowledge, attitudes, and skills in individuals but does not describe how a whole health system can become culturally competent. Although the literature as a whole identifies a wide range of cultural competence techniques, most articles also discuss only a single approach, making it difficult to gain an overview. The authors describe the techniques most frequently discussed in the literature on cultural competence, grouping them into nine categories (summary of pp. 184 ff):

1. **Interpreter services**, as the most common way to improve communication among persons who speak different languages.

2. **Recruitment and retention** of minority staff or, more generally speaking, staff who reflect the demographics of the patient population.

3. **Training** in cultural competency, aimed at increasing cultural awareness, knowledge and skills, leading to changes in staff (both clinical and administrative) behaviour and patient-staff interactions.

4. **Coordinating with traditional healers** Health professionals needing to coordinate with these healers as they would with any other care provider. In addition, presenting patient education in a conceptual framework concordant with traditional healing practices may increase the chances that patients will concur with treatment recommendations.

5. **Use of community health workers.** Because they are known and respected by the community, these workers service as guides to the health system. Their advocacy and empowerment function is important.

6. **Culturally competent health promotion.** This can take several forms: health professionals' screening tools, brief interventions, public information campaigns. The health promotion messages can be made more culturally competent and specific.

7. **Including family and/or community members.** While patient autonomy has become a core principle of Western health care, some minority groups involve family members in health care decision-making.

8. **Immersion into another culture.** Immersion enables participants (health professionals) to overcome their ethnocentrism.

9. **Administrative and organisational accommodations.** A variety of administrative and organisational decisions related to clinic locations, hours of operation, network membership, physical environments and written materials can also affect access to and use of health care.

Comment: This paper provides a highly useful framework which should be kept in mind when planning MFH interventions.

4.1.6 'Planning services and quality standards'

In 'Culture, Religion and Patient Care in a Multi-Ethnic Society - A Handbook for Professionals'[285], Henley & Schott set out quality standards, pulling together the key policy and management issues developed and discussed in their handbook (essential reading when planning interventions in this field), and proposing standards to 'ensure that services enable people of all communities benefit equally'. Selected standards are summarised[286] and listed in Table 4:

Table 4: Quality Standards (Henley & Schott 1999)

- There will be a policy on equal access to services, and steps will be taken to ensure that all staff, including clerks and receptionists, understand the policy and its implications for their works. The rest of the standards outlined below could be incorporated in this equal access policy.
- Procedures will be in place to ensure that clients' names are accurately recorded and used, and can be retrieved correctly. Computer systems and all charts, forms, and labels will accommodate differing naming systems.
- Care plans will be used as vehicles for discussing and recording specific cultural and religious needs.
- Privacy will be provided in all clinical areas. Full-length, long-sleeved gowns with adequate ties, and full-length dressing gowns, will be available in all departments where patients are asked to undress.
- Patients for whom modesty is a particular issue will, whenever possible, have access to staff of the same sex.
- A range of foods will be offered and menus will include details of ingredients so that all patients can choose foods to suit their religious or cultural needs. Relatives will be free to bring in food from home. Adequate storage and heating facilities (within appropriate health and safety guidelines) for such food will be provided.
- Privacy and space for families to pray or spend time together or to perform religious ceremonies will be provided. Religious items including religious and wedding jewellery will be treated with respect and not removed without the consent of the patient or their next of kin.

---

[284] Brach, C. and I. Fraser (2000). *Can cultural competency reduce racial and ethnic disparities? A review and conceptual model*. Medical Care Research and Review 57(1): 181-217.

[285] Henley, A. and J. Schott (1999). *Culture, religion and patient care in a multi-ethnic society - a handbook for professionals*. London, Age Concern Books.

[286] Ibid., pp 232 ff; abridged text of pp 232ff; all points are discussed at length in the handbook.

- Both showers and baths will be provided in all wards.Low level taps will be available to enable Muslims to wash their feet before prayer. Bidets or hand basins will be available in the lavatories. Alternatively patients who clean themselves with running water will be offered their own jug for this purpose.
- The preferences and needs of dependent patients in relation to modesty, personal hygiene and hair care will be identified and met.
- People's cultural obligations in relation to visiting will be acknowledged and accommodated whenever possible, especially when a patient is critically ill or dying.
- Discharge procedures will be planned jointly with patients and their families and will take account of religious festivals and possible constraints.
- Written information will accommodate differing religious and cultural issues and will be available in languages appropriate to local community needs, as a back-up to verbal information. This will include: letters and appointment cards; hospital and clinic direction signs; health education material; and patient information leaflets.
- Professional trained interpreters who speak the main local languages will be available, especially for important discussions (for example, taking a history, discussing treatment options, and obtaining informed consent), and will be on call on a 24-hour basis. Arrangements will be in place for contacting interpreters who speak languages that are less frequently needed. Interpreters will receive training on the psychological as well as the practical aspects of optimum care.
- Procedures and practices for last offices will accommodate religious and cultural preferences and needs. The religious needs of the family will be identified and catered for.
- There will be an accessible, responsive and well-publicised complaints procedure. Information about the complaints procedure will be available in all languages relevant to the local communities.

4.2   Conclusion

There is now sufficient research to judge the effectiveness of interventions to improve migrant and minority health care. This review presents examples of effective interventions and provides a database which hospitals can use when choosing the areas in which they will take action.

There are several perspectives on which health care interventions can be based. These include; the quality of care, evidence-based medicine, patient-centred care, cultural competence, health literacy and equality. The most practical and useful perspective is the quality of care.

The quality of care is usefully defined as 'is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'[287].

Selecting interventions that focus on the quality of overall care enables health care providers to look at both individuals and populations, and contains both an individual (patient-centred) and a public health perspective. 'Desired health outcomes' include the outcomes desired by those people who are most affected, the patients. Patients' desired outcomes may vary considerably depending on their socio-cultural background, origins and life experiences.

Focusing on improving the quality of care for all patients helps to avoid cultural stereotyping (which can be a danger when the focus is on cultural competence). It benefits everyone and is not directed solely at specific groups such as minority ethnic groups.

To end, we should like to make a plea for the quality of care movement as the most effective and the most likely to be successful in creating migrant- and minority-friendly hospitals. Mark Smith[288], in his keynote speech at the Conference on Quality Health Care for Culturally Diverse Populations (Chicago, October 2, 2002) advocated uniting the quality of care movement and the cultural competence movement: 'There are six aims for improving the quality of health care: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.'

Smith's final aim, equity, is crucial. A health care system or institution is not providing genuine quality of care if it is not providing quality care to all its patients, including migrants and minorities. This is, furthermore a political issue: a national health care system is supposed to provide health care equally well to all its citizens.

Two final recommendations, also adapted from Smith's speech:

Frame migrant and minority health care issues as quality issues.

Include migrant and minority health care issues in all quality monitoring.

Addressing migrant and minority health issues can help improve health services generally. This is because migrant and minority health issues make explicit what is important in health care in general: the patient's point of view on health care and health[289].

We end this review of effective interventions that could be used to improve migrant and minority friendliness in hospitals with a quote from Tervalon[290]:

[287] see the IOM 1990 report, as quoted in Smedley, B. D., A. Y. Stith and A. R. Nelson (2003). *Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington, The National Academies Press.

[288] www.diversityrx.org/CCCONF/02/CultureandQuality

[289] Sullivan, M. (2003). *The new subjective medicine: taking the patient's point of view on health care and health*. Soc Sci Med 56(7): 1595-604.

[290] Tervalon, M. and J. Murray-Garcia (1998). *Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education*. Journal of Health Care for the Poor and Underserved 9(2): 117-25.

'Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations'.

5 Bibliography

AMA (1999). *Cultural competence compendium*. Chicago, American Medical Association.

Anderson, E. M. (1997). *Migration and Health in Denmark*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Anderson, R. M., M. M. Funnell, P. M. Butler, M. S. Arnold, J. T. Fitzgerald and C. C. Feste (1995). *Patient empowerment. Results of a randomized controlled trial*. Diabetes Care 18(7): 943-9.

Ard, J., R. Rosati and E. Oddone (2000). *Culturally-sensitive weight loss pro-gram produces significant reduction in weight, blood pressure, and choles-terol in eight weeks. Journal of the National Medical Association*(92): 515-523.

Arnold, M. S., P. M. Butler, R. M. Anderson, M. M. Funnell and C. Feste (1995). *Guidelines for facilitating a patient empowerment program*. Diabetes Educ 21(4): 308-12.

Ayanian, J. Z., J. S. Weissman, S. Chasan-Taber and A. M. Epstein (1999). *Quality of care by race and gender for congestive heart failure and pneumonia*. Med Care 37(12): 1260-9.

Bach, P. B., L. D. Cramer, J. L. Warren and C. B. Begg (1999). *Racial differences in the treatment of early-stage lung cancer*. N Engl J Med 341(16): 1198-205.

Baker, D. W., R. Hayes and J. P. Fortier (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Med Care 36(10): 1461-70.

Baker, D. W., R. M. Parker, M. V. Williams, W. C. Coates and K. Pitkin (1996). *Use and effectiveness of interpreters in an emergency department*. JAMA 275(10): 783-8.

Baumann, G. (1996). Contesting Culture. Discourses of Identity in Multi-Ethnic London. Cambridge, Cambridge University Press.

Bechtel, G. A., R. Davidhizar and C. M. Tiller (1998). *Patterns of mental health care among Mexican Americans*. J Psychosoc Nurs Ment Health Serv 36(11): 20-7.

Beltran Avery, M. P. (2001). The role of the health interpreter - an evolving dialogue. Chicago, National Council of Interpretation in Health Care NCIHC.

Benhamida, L., B. Downing and Z. Yao (1993). Professional standards and training for interpreters in mental health for refugees and others. Minnesota, Refugee assistance program - mental health: technical assistance center at the University of Minnesota.

Bensing, J. (1991). *Doctor-patient communication and the quality of care*. Soc Sci Med 32(11): 1301-1310.

Bentsen, E., A. Hermansen, I. Hojgaard Knudsen and V. Pentz-Moeller (1990). Interpretation in the rehabilitation of torture victims. Kopenhagen, RCT.

Bernstein, J., E. Bernstein, A. Dave, E. J. Hardt, T. James, J. Linden, P. Mitchell, T. Oishi and C. Safi (2002). *Trained medical interpreters in the emergency department: effects on services, subsequent charges, and follow-up*. Journal of Immigrant Health 4(4): 171-176.

Betancourt, J. and R. King (2000). *Diversity in health care: expanding our perspectives*. Arch Pediatr Adolesc Med 154: 871-872.

Binder-Fritz, C. (1997). *Transkulturelle Patientenbetreuung in Oesterreich. Ein aktuelles Thema in der Fortbildung für Krankenpflegepersonen*. In: Transkulturelle Pflege. C. Uzarewicz and G. Piechotta. Berlin, VWB Verlag für Wissenschaft und Bildung. 10.

Bindman, A. (1993). Collecting data to evaluate the effect of health policies on vulnerable populations. Fam Med 25: 114-119.

Bischoff, A., P. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan (2003). *Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral rates*. Soc Sci Med 57: 503-512.

Bischoff, A. and L. Loutan (1998). A mots ouverts - Guide de l'entretien médical bilingue à l'usage des soignants et des interprètes. Genève, Hôpitaux Universitaires de Genève.

Bischoff, A., L. Loutan and D. Burgi (1997). Migration and Health in Switzerland. Bern, BAG.

Bischoff, A., L. Loutan and H. Stalder (2001). Barrières linguistiques et communication dans une policlinique de médecine. Bulletin VALS-ASLA 4.

Bischoff, A., T. V. Perneger, P. Bovier, H. Stalder and L. Loutan (2003). *Improving communication between physicians and patients who speak a foreign language*. British Journal of General Practice 53: 541-546.

Bischoff, A., C. Tonnerre, A. Eytan, M. Bernstein and L. Loutan (1999). *Addressing language barriers to health care, a survey of medical services in Switzerland*. Soz Praventivmed 44(6): 248-56.

Bloechliger, C. (1997). Institutionsbasierte Erhebung der ambulanten medizinischen Grundversorgung und der gesundheitlichen Situation von Asylsuchenden und Flüchtlingen in der Schweiz. Swiss Tropical Institut. Basel, University of Basel.

Bloechliger, C., T. Junghanss, R. Weiss, C. Herzog, P.-A. Raeber, M. Tanner and C. Hatz (1998). *Asylsuchende und Flüchtlinge in der hausärztlichen Praxis: Probleme und Entwicklungsmöglichkeiten*. Soz Praventivmed 43: 18-28.

Bloechliger, C., J. Osterwalder, C. Hatz, M. Tanner and T. Junghanss (1998). *Asylsuchende und Flüchtlinge in der Notfallstation*. Soz Praventivmed 43(1): 29-38.

Bloechliger, C., N. Ries, M. Gonon, L. Loutan, K. Mark, S. Vetterli, M. Tanner, C. Hatz and T. Junghanss (1998). *[Asylum seekers and refugees in the medical polyclinic: a comparison between the Basel, Bern and Geneva polyclinics]*. Soz Praventivmed 43(1): 29-38.

Bloechliger, C., M. Tanner, C. Hatz and T. Junghanss (1997). *[Asylum seekers and refugees in ambulatory health care: communication between physician and patient]*. Schweiz Rundsch Med Prax 86(19): 800-10.

Bonacruz_Kazzi, G. and C. Cooper (2003). *Barriers to the use of interpreters in emergency room paediatric consultations*. Journal of Paediatrics and Child Health 39(4): 259-63.

Borde, T., M. David and H. Kentenich (2000). Probleme der Kommunikation und Aufklärung im Krankenhaus aus der Sicht deutscher und türkischsprachiger PatientInnen sowie des Klinikpersonals. Berlin, Charité Campus Virchow-Klinikum.

Bourdillon, F. and R. L. Bennegadi (1992). *Migration and Health - what does the future hold?* In: Migration and Health in the 1990s. IOM. Geneva, International Organisation for Migration. 30**:** 199-205.

Bowen, S. (2001). Language barriers in access to health care. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.

Brach, C. and I. Fraser (2000). Can cultural competency reduce racial and ethnic disparities? A review and conceptual model. Medical Care Research and Review 57(1): 181-217.

Brach, C. and I. Fraser (2002). Reducing disparities through culturally competent health care: an analysis of the business case. Quality Management in Health Care 10(4): 15-28.

Brown, A. F., E. J. Perez-Stable, E. Whitaker, S. Posner, M. Alexander, J. Gathe and A. Washington (1999). *Ethnic differences in hormone replacement prescribing patterns*. J Gen Intern Med 14: 663-669.

Brown, S. and C. Hanis (1999). Culturally competent diabetes education for Mexican Americans: The Starr County Study. Diabetes Educator 25(2): 226-236.

Calle, E. E., W. D. Flanders, M. J. Thun and L. M. Martin (1993). *Demographic predictors of mammography and Pap smear screening in US women*. Am J Public Health 83(1): 53-60.

Campbell, S., M. Roland and S. Buetow (2000). *Defining quality of care*. Soc Sci Med 51: 1611-1625.

Canales, M. (2000). *Othering: Toward an understanding of difference*. Advanced Nursing Science 22(4): 16-31.

Canto, J. G., H. A. Taylor, Jr., W. J. Rogers, B. Sanderson, J. Hilbe and H. V. Barron (1998). Presenting characteristics, treatment patterns, and clinical outcomes of non-black minorities in the National Registry of Myocardial Infarction 2. Am J Cardiol 82(9): 1013-8.

Carballo, M., J. Divino and D. Zeric (1997). Analytic review of migration and health and as it affects European Community countries. Antwerp, International Centre for Migration and Health.

Carchedi, F. and A. Picciolini (1997). *Migration and Health in Italia*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Carrasquillo, O., E. J. Orav, T. A. Brennan and H. R. Burstin (1999). *Impact of language barriers on patient satisfaction in an emergency department*. J Gen Intern Med 14(2): 82-7.

Carrillo, J. E., A. R. Green and J. Betancourt (1999). *Cross-cultural primary care: a patient-based approach*. Ann Intern Med 130: 829-834.

CDC (1997). Vaccination coverage by race/ethnicity and poverty level among children aged 19-35 months -- United States, 1996. MMWR Morb Mortal Wkly Rep 46(41): 963-9.

Chan, A. and R. K. Woodruff (1999). Comparison of palliative care needs of English- and non-English- speaking patients. J Palliat Care 15(1): 26-30.

Cheung, N. F. (2002). Choice and control as experienced by Chinese and Scottish childbearing women in Scotland. Midwifery 18(3): 200-13.

Cheung, N. F. (2002). The cultural and social meanings of childbearing for Chinese and Scottish women in Scotland. Midwifery 18(4): 279-95.

Chin, J. (2000). *Culturally competent health care*. Public Health Rep 115: 25-33.

Cioffi, R. N. (2003). Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. International Journal of Nursing Studies 40(3): 299-306.

Cleeland, C. S., R. Gonin, L. Baez, P. Loehrer and D. Pandya (1997). *Pain and treatment of pain in minority patients with cancer*. Ann Intern Med 127: 813-816.

Coffman, J. and J. Spetz (1999). *Maintaining an adequate supply of RNs in California*. Journal of Nursing Scholarship 31(389-393).

Cohen, J. J. (1997). *Finishing the bridge to diversity*. Academic Medicine 72: 103-109.

Corbie-Smith, G. (2000). Toward cultural competence in health care. SGIM Forum**:** 4-5.

Crane, J. A. (1997). Patient comprehension of doctor-patient communication on discharge from the emergency department. J Emerg Med(15): 1-7.

Creswell, J. W. (2003). Research Design: qualitative, quantitative and mixed methods approaches. London, Sage.

Culhane-Pera, K. and C. Reif (1997). *A curriculum for multicultural education in family medicine*. Fam Med 29(10): 719-723.

David, R. A. and M. Rhee (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. Mt Sinai J Med 65(5-6): 393-7.

Davis, T. C., S. W. Long, R. H. Jackson, E. J. Mayeaux, R. B. George, P. W. Murphy and M. A. Crouch (1993). *Rapid estimate of adult literacy in medicine: a shortened screening instrument*. Fam Med 25(6): 391-5.

Davis, T. C., R. Michielutte, E. N. Askov, M. V. Williams and B. D. Weiss (1998). *Practical assessment of adult literacy in health care*. Health Educ Behav 25(5): 613-24.

de Jong, J. and R. Wesenbeek (1997). *Migration and Health in the Netherlands*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

De Muynk, A. (1997). *Migration and Health in Belgium*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Dias, M. R. and E. O'Neill (1998). *Examining the role of professional interpreters in culturally-sensitive care*. The Journal of Multicultural Nursing & Health 4: 27-31.

DiClemente, R. J. and G. M. Wingood (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women. Jama 274(16): 1271-6.

Domenig, D. (2001). *Professionelle transkulturelle Pflege*. Bern, Verlag Hans Huber.

Domenig, D. and Y. Stauffer (2001). *Transkulturelle Pflegeanamnese*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

Donabedian, A. (1988). *The quality of care: how can it be assessed?* JAMA 260(12): 1743-1748.

Donini-Lenhoff, F. and H. Hedrick (2000). Increasing awareness and implementation of cultural competence principles in health professions education. Journal of Allied Health(29): 241-245.

Dower, C., T. McRee and K. Grumbach (2001). The Practice of Medicine in California: A Profile of the Physician Workforce. San Francisco, California Workforce Initiative at the UCSF Center for the Health Professions.

Dreachslin, J. (1999). Diversity leadership and organizational transformation: Performance indicators for health service organizations. Journal of Healthcare Management 44: 427-439.

Drennan, G. (1996). Counting the cost of language services in psychiatry. S Afr Med J 86: 343-345.

Dussaussois, E. and H. Mosimann (1998). Das Recht verstanden zu werden - Der Umgang mit Fremdsprachigkeit im institutionellen Rahmen. Bern, Edition Soziothek.

Ebden, P., A. Bhatt, O. J. Carey and B. Harrison (1988). *The bilingual consultation*. The Lancet 1(8581): 347.

EKA (1999). Die Integration der Migrantinnen und Migranten in der Schweiz: Fakten, Handlungsbereiche, Postulate. Bern, Eidgenössische Ausländerkommission (EKA).

El-Askari, G. and J. Freestone (1998). The Healthy Neighborhoods Project: A local health department's role in catalyzing community development. Health Educ Behav 25(2): 146-159.

Elderkin-Thompson, V., R. Cohen Silver and H. Waitzkin (2001). When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. Soc Sci Med(52): 1343-1358.

Eytan, A., A. Bischoff and L. Loutan (1999). *Use of interpreters in Switzerland's psychiatric services*. J Nerv Ment Dis 187(3): 190-192.

Feste, C. and R. M. Anderson (1995). *Empowerment: from philosophy to practice*. Patient Educ Couns 26(1-3): 139-44.

Fiscella, K. (2002). *Using existing measures to monitor minority healthcare quality*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

Fiscella, K., P. Frank, M. R. Gold and C. M. Clancy (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. JAMA 283: 2579-2584.

Flores, G., M. Abreu, M. A. Olivar and B. Kastner (1998). *Access barriers to health care for Latino children*. Arch Pediatr Adolesc Med 152(11): 1119-25.

Flubacher, P. (1994). Eine Uebersetzerin der Hausarztpraxis, Kommunikation mit fremdsprachigen Patienten. Soziale Medizin 6: 20-22.

Flubacher, P. (1999). Praktische Empfehlungen zur Überwindung "transkultureller" Verständigungsprobleme aus der Sicht eines Hausarztes. Ars Medici 5.

Flubacher, P. (1999). Quelques suggestions pratiques d'un médecin de famille pour éviter les problèmes liés à la communication "transculturelle". Psychothérapies 19(4): 257-265.

Frayne, S. M., R. B. Burns, E. J. Hardt, A. K. Rosen and M. Moskowitz (1996). *The exclusion of non-English-speaking persons from research*. J Gen Intern Med 11: 39-43.

Frazier, E. L., R. B. Jiles and R. Mayberry (1996). Use of screening mammography and clinical breast examinations among black, Hispanic, and white women. Prev Med 25(2): 118-25.

Gagnon, A. J. (2002). La réceptivité du système canadien de soins de santé à l'égard des nouveaux arrivants. Montreal, McGill University.

Gagnon, A. J. (2002). Responsiveness of the Canadian Health Care System towards Newcomers. Montreal, McGill University.

Garber, N. (2000). *Community interpreting: a personal view*. In: The Critical Link 2: Interpreters in the community. R. Roberts, S. E. Carr, D. Abraham and A. Dufour. Philadelphia, John Benjamins Publishing Company. 31.

Gelzer, D. (1994). Interkulturelle Kommunikation im Gesundheitsbereich. Soziale Medizin 21(7-9).

Gentile, A., U. Ozolins and M. Vasilakakos (1996). *Liaison interpreting, a handbook*. Melbourne, Melbourne University Press.

Gilgen, D., D. Maeusezahl, C. Salis Gross, E. Battegay, P. Flubacher, M. Tanner, M. G. Weiss and C. Hatz (2002). Klinische 'cultural epidemiology' von Gesundheitsproblemen ambulant behandelter Migrantinnen und Migranten aus der Türkei und aus Bosnien. In: NFP39. NFP39. Bern.

Gilgen, D., D. Maeusezahl, C. Salis Gross, E. Battegay, P. Flubacher, M. Tanner, M. G. Weiss and C. Hatz (2003). The impact of migration on illness experience and help-seeking strategies of patients from Turkey and Bosnia in primary health care in Basel. Basel.

Ginsberg, C., V. Martin, D. Andrulis, Y. Shaw-Taylor and C. McGregor (1995). *Interpretation and Translation Services in Health Care: a survey of US public and private teaching hospitals*. New York, National Public Health and Hospital Institute.

Gliber, M. (1997). *Migration and Health in France*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Goiceochea-Balbona, A. M. (1997). Culturally specific health care model for ensuring health care use by rural, ethnically diverse families affected by HIV/AIDS. Health and Social Work 22(3): 172-180.

Graber, D. and J. Johnson (2001). *Spirituality and healthcare organizations*. Journal of Healthcare Management 46(1): 39-50.

Graves, D. E. and C. W. Suitor (1998). *Celebrating diversity - Approaching families through their food*. Arlington, National Center for Education in Maternal and Child Health.

Greenhalgh, T., C. Helman and A. M. Chowdhury (1998). Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study. Bmj 316(7136): 978-83.

Haffner, L. (1992). Translation is not enough. Interpreting in a medical setting. West J Med 157(3): 255-9.

Hahn, B. A. (1995). Children's health: racial and ethnic differences in the use of prescription medications. Pediatrics 95(5): 727-32.

Hampers, L. C., S. Cha, D. J. Gutglass, H. J. Binns and S. E. Krug (1999). *Language barriers and resource utilization in a pediatric emergency department*. Pediatrics 103(6 Pt 1): 1253-6.

Hampers, L. C. and J. E. McNulty (2002). Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Archives of Pediatrics & Adolescent Medicine 156(11): 1108-13.

Hansell, M. J. (1991). *Sociodemographic factors and the quality of prenatal care*. Am J Public Health 81(8): 1023-8.

Hardt, E. J. (1995). *The bilingual interview and medical interpretation*. In: The medical interview: clinical care, education and research. M. Lipkin, S. Putnam and A. Lazare. New York, Springer.

Hazuda, H. (1996). Non-English-speaking patients a challenge to researchers. J Gen Intern Med 11: 39-40.

Helman, C. G. (2000). *Culture, Health and Illlness*. Oxford, Butterworth-Heinemann.

Henley, A. and J. Schott (1999). Culture, religion and patient care in a multi-ethnic society - a handbook for professionals. London, Age Concern Books.

Holden, P. and A. C. Serrano (1989). *Language barriers in pediatric care*. Clin Pediatr (Phila) 28(4): 193-4.

Horisberger, D. and K. Disler (2000). *Soins interculturels: rencontrer l'Autre*. Krankenpfl Soins Infirm(9): 69-71.

Hornberger, J. (1998). *Evaluating the costs of bridging language barriers to health care*. Journal of Health Care for the Poor and Underserved 9: 26-39.

Hornberger, J. C., C. D. Gibson, Jr., W. Wood, C. Dequeldre, I. Corso, B. Palla and D. A. Bloch (1996). *Eliminating language barriers for non-English-speaking patients*. Med Care 34(8): 845-56.

Horowitz, C. and M. Davis (2001). *Approaches to eliminating sociocultural disparities in health*. Minority Health Today 2(2): 33-43.

HRSA (2001). Cultural Competence Works. Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Merryfield, HRSA Health Resources and Services Administration US Department of Health and Human Services.

Hu, D. and R. M. Covell (1986). Health care usage by Hispanic outpatients as function of primary language. West J Med(144): 490-493.

Huismann, A., C. Weilandt and A. Geiger (1997). Country reports in Migration and Health in Europe. Bonn, WIAD.

Huismann, A., C. Weilandt, A. Geiger, L. Joksimovic, J. Korporal, B. Dangel and A. Salomon (1997). *Migration and Health in Germany*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Inglehart, M. and C. Quiney (1997). *Cultural audits: Introduction, process and results*. Journal of Dental Education 61: 283-288.

Jacobs, B., L. Kroll, J. Green and T. J. David (1995). *The hazards of using a child as an interpreter*. J R Soc Med 88(8): 474P-475P.

Jacobs, E. A., D. S. Lauderdale, D. O. Meltzer, J. M. Shorey, W. Levinson and R. A. Thisted (1999). *The impact of adequate interpreter services on health care delivery to limited English-speaking patients*. 16th Annual Meeting AHSR.

Jacobs, E. A., D. S. Lauderdale, D. O. Meltzer, J. M. Shorey, W. Levinson and R. A. Thisted (2001). *The impact of interpreter services on delivery of health care to limited English proficient patients*. J Gen Intern Med 16: 468-474.

Janson, S., P. G. Svensson and S. Ekblad (1997). *Migration and Health in Sweden*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Johnson, P. A., T. H. Lee, E. F. Cook, G. W. Rouan and L. Goldman (1993). *Effect of race on the presentation and management of patients with acute chest pain*. Ann Intern Med 118(8): 593-601.

Johnson, T. M., E. J. Hardt and A. Kleinman (1995). *Cultural factors in the medical interview*. In: The medical interview: clinical care, education and research. A. Lazare. New York, Springer.

Kai, J. and J. Spencer (1999). *Learning to value ethnic diversity - what, why, how?* Medical Education(33): 616-623.

Karmi, G. (1997). *Migration and Health in the United Kingdom*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Karter, A., A. Ferrara, J. Darbinian, L. Ackerson and J. Selby (2000). *Self-Monitoring of Blood Glucose*. Diabetes Care 23(4): 477-483.

Kaufert, J., M. Lavallee, W. Koolage and J. O'Neil (1996). Culture and informed consent: the role of aboriginal interpreters in patient advocacy in urban hospitals. Issues in the North 1: 89-93.

Kaufert, J. M. (1990). Sociological and anthropological perspectives on the impact of interpreters on clinician/client communication. Santé Culture Health 7: 209-235.

Kaufert, J. M. and J. O'Neil (1998). *Culture, power and informed consent: the impact of Aboriginal health interpreters on decision-making*. In: Health and Canadian society: sociological perspectives. D. Coburn, C. D'Arcy and G. Torrance. Toronto, University of Toronto Press.

Kaufert, J. M., J. O'Neil and W. Koolage (1990). *The cultural and political context of informed consent for native Canadians*. Circumpolar Health 90: 181-184.

Kaufert, J. M., J. D. O'Neil and W. W. Koolage (1991). *The cultural and political context of informed consent for Native Canadians*. Arctic Med Res (Suppl.)(Suppl): 181-4.

Kaufert, J. M. and R. W. Putsch (1997). Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power. J Clin Ethics 8(1): 71-87.

Kaufert, J. M., R. W. Putsch and M. Lavallee (1998). Experience of aboriginal health interpreters in mediation of conflicting values in end-of-life decision making. Int J Circumpolar Health 57 Suppl 1: 43-8.

Kaufert, J. M., R. W. Putsch and M. Lavallee (1999). End-of-life decision making among Aboriginal Canadians: interpretation, mediation, and discord in the communication of "bad news". J Palliat Care 15(1): 31-8.

Khan, D. (2003). Equality & Diversity in the NHS - the Bradfort Experience. Bradford, Bradford Hospitals NHS Trust.

Kizito, H. (2001). *Refugee Health Care: A Handbook for Health Professionals*. New Zealand, Folio Communications Ltd.

Klabunde, C. N., A. L. Potosky, L. C. Harlan and B. S. Kramer (1998). *Trends and black/white differences in treatment for nonmetastatic prostate cancer*. Med Care 36(9): 1337-48.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. Soc Sci Med 12: 85-93.

Kleinman, A. (1978). Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med 88: 251-258.

Koch-Straube, U. (2001). *MigrantInnen in der Altenpflege*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

Kogan, M. D., M. Kotelchuck, G. R. Alexander and W. E. Johnson (1994). *Racial disparities in reported prenatal care advice from health care providers*. Am J Public Health 84(1): 82-8.

Kokko, S. (1997). *Migration and Health in Finland*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Kreier, R. (1999). Crossing the cultural divide. American Medical News, American Medical Association (AMA).

Krieger, N. (2000). Counting accountably: implications of the new approaches to classifying race/ethnicity in the 2000 census. Am J Public Health 90(11): 1687-9.

Krieger, N., J. T. Chen and G. Ebel (1997). Can we monitor socioeconomic inequalities in health? A survey of U.S. health departments' data collection and reporting practices. Public Health Rep 112(6): 481-91.

Kruseman, M., B. E. Stoll and H. Stalder (2003). Interactive group education for refugees from the Former Yugoslavia to reduce their oil consumption. Patient Education and Counseling 49(2): 171-6.

Kuper, A. (1999). *Culture. The Anthropologists' Account*. London, Harvard University Press.

Launer, J. (1978). Taking medical histories through interpreters: practice in a Nigerian outpatient department. Br Med J 2(6142): 934-5.

Leanza, Y. (2001). Pédiatrie et culture: entre impuissance et volonté d'accueil de la diversité culturelle. ARIC, Genève.

Lee, E. D., C. R. Rosenberg, D. M. Sixsmith, D. Pang and J. Abularrage (1998). *Does a physician-patient language difference increase the probability of hospital admission?* Acad Emerg Med 5: 86-89.

Lehmann, P., C. Maboury and C. Minder (1990). *Health and social inequalities in Switzerland*. Soc Sci Med 31(3): 369-386.

Leininger, M. (1997). *Future directions in transcultural nursing in the 21st century*. International Nursing Review 44(1): 19-23.

Lin, M. and K. Mutter (1999). Vom Recht, verstanden zu werden. Elterngespräche mit Dolmetscherinnen und Dolmetschern. Thema, Basler Schulblatt 10: 6-8.

Lipson, J. and S. Dibble (1996). *Culture and Nursing Care: A Pocket Guide*. San Francisco, UCSF Nursing Press.

Loutan, L., S. Durieux, L. Subilia and L. Toscani (1999). *La médecine des migrants: illustration d'une médecine communautaire*. Médecine & Hygiène 57(2270): 1821-1824.

Lythcott, N. (2000). Changing the research paradigm: Community involvement in population-based research. Cancer 88(5): 1214-1216.

Madhok, R., A. Hameed and R. Bhopal (1998). Satisfaction with health services among the Pakistani population in Middlesbrough, England. J Public Health Med 20(3): 295-301.

Maggi, J. and S. Cattacin (2003). Needed research in "Migration and Health" 2002 - 2006. Neuchâtel, Swiss Forum for Migration and Population Studies.

Majumdar, B. and J. Roberts (1998). *AIDS awareness among women: the benefit of culturally sensitive education programs*. Health Care for Women International 19(2): 141-153.

Malgady, R. G., L. H. Roglet and G. Costantino (1990). Culturally sensitive psycho-therapy for Puerto Rican children and adolescents: a program of treatment out-come research. Journal of Consulting and Clinical Psychology 58(6): 704-712.

Manson, A. (1988). Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Med Care 26(12): 1119-28.

Matuschek, H. (1997). *Migration and Health in Austria*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Mitchell, J. M., K. R. Meehan, J. Kong and K. A. Schulman (1997). Access to bone marrow transplantation for leukemia and lymphoma: the role of sociodemographic factors. J Clin Oncol 15(7): 2644-51.

Mitchell, P., A. Malak and D. Small (1998). *Bilingual professionals in community mental health services*. Australian and New Zealand Journal of Psychiatry 32(424-433).

Mitchell, P., A. Malak and D. Small (1998). *Bilingual professionals in community mental health services*. Aust N Z J Psychiatry 32(3): 424-33.

Moore, R. D., D. Stanton, R. Gopalan and R. E. Chaisson (1994). *Racial differences in the use of drug therapy for HIV disease in an urban community*. N Engl J Med 330(11): 763-8.

Morales, L. S., W. E. Cunningham, J. A. Brown, H. Liu and R. D. Hays (1999). *Are Latinos less satisfied with communication by health care providers?* J Gen Intern Med 14(7): 409-17.

Moreira, B. (1997). *Migration and Health in Portugal*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Mueller, P. and D. Plevak (2001). Religious involvement, spirituality and medicine: Implications for clinical practice. Mayo Clin Proc 76: 1225-1235.

Murray-García, J. and J. García (2001). The service patterns of a racially, ethnically, and linguistically diverse housestaff. Academic Medicine 76: 1232-1240.

Murray-Garcia, J. L. (2002). Multicultural Health 2002. An annotated bibliography. Woodland Hills, The California Endowment.

Musser-Granski, J. and D. F. Carrillo (1997). The use of bilingual, bicultural paraprofessionals in mental health services: issues for hiring, training, and supervision. Community Ment Health J 33(1): 51-60.

Naish, J., J. Brown and B. Denton (1994). Intercultural consultations: investigation of factors that deter non- English speaking women from attending their general practitioners for cervical screening [see comments]. BMJ 309(6962): 1126-8.

Nerenz, D. R. (2002). *Quality of care measures of special significance to minority populations*. In: Improving healthcare quality for minority patients. NQF. Washington, The National Quality Forum.

Niska, H. (1993). A new breed of interpreter for immigrants: contact interpretation in Sweden. Stockholm, Institute for Interpretation and Translation Studies.

NQF (2002). Improving healthcare quality for minority patients. Washington, The National Quality Forum.

O'Connor, B. B. (1996). *Promoting Cultural Competence in HIV/ AIDS Care*. Journal Association of Nurses of AIDS Care 7(1): 41-53.

OCR (2000). Office of Civil Rights: Title VI of the Civil Rights Act of 1964; Policy guidance on the prohibition against National origin discrimination as it affects persons with limited English proficiency.

OMH (2000). National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, Office of Minority Health, US Department of Health and Human Services (www.omhrc.gov/clas).

Oomen, J. and L. Owen (1999). Culture counts: why current treatment models fail Hispanic women with Type II diabetes. Diabetes Education 25(2): 220-225.

Ozuah, P. (2001). Outcomes of training pediatricians to serve the underserved: social pediatrics. Journal of the National Medical Association 93: 444-445.

Paniagua, F. and M. O'Boyle (2000). *Self-evaluation and unintended biases and prejudices*. Psychological Reports(87): 823-829.

Parker, R. M., D. W. Baker, M. V. Williams and J. R. Nurss (1995). The test of functional health literacy in adults: a new instrument for measuring patients' literacy skills. J Gen Intern Med 10(10): 537-41.

Passick, R. and S. Stewart (2001). *Quality of data in multi-ethnic health surveys*. Public Health Reports 116: 223-243.

Pearce, C., J. Hawkins, D. Carver-Chase, R. Ebacher, S. Matta, A. Sullivan, V. Vawter, C. Vincent and K. Windle (1996). *Comprehensive interdisciplinary care: making a difference in pregnancy outcomes for Hispanic women*. Public Health Nurs 13(6): 416-424.

Pediatric Workforce Committee (2000). Enhancing the racial and ethnic diversity of the pediatric workforce. Pediatrics 105: 129-131.

Pentz-Moeller, V. (1992). *The ethics and techniques of interpreting*. Torture 1(Supplementum): 17-19.

Pentz-Moeller, V. and A. Hermansen (1991). *Interpretation as part of rehabilitation, part II*. Torture 1(2): 5-6.

Pentz-Moeller, V. and A. Hermansen (1991). *Interpretation as part of the rehabilitation*. Torture 3(1): 9-12.

Perez-Stable, E. J., A. Napoles-Springer and J. M. Miramontes (1997). *The effects of ethnicity and language on medical outcomes with hypertension or diabetes*. Medical Care 35(12): 1212-1219.

Perkins, J. and Y. Vera (1998). *Legal protections to ensure linguistically appropriate health care*. Journal of Health Care for the Poor and Underserved 9(Supplemental): 62-80.

Pitkin Derose, K., R. D. Hays, D. McCaffrey and D. W. Baker (2001). *Does physician gender affect satisfaction of men and women visiting the emergency department?* J Gen Intern Med 16: 218-226.

Pitkin, K. and D. W. Baker (2000). *Limited English proficiency and Latinos's use of physician services*. Medical Care Research and Review 57(1): 76-91.

Poechhacker, F. (1997). Kommunikation mit Nichtdeutschsprachigen in Wiener Gesundheits- und Sozialeinrichtungen. Wien, Dezernat für Gesundheitsplanung.

Poss, J. E. and T. Beeman (2000). Effective use of interpreters in health care: guidelines for nurse managers and clinicians. Semin Nurse Manag 7(4): 166-71.

Prodolliet, S. (2000). Interkulturelle Kommunikation. Eine Einführung in die Praxis. Luzern, Caritas-Verlag.

Puebla Fortier, J. (1997). *Interpreting for health in the United States: government partnership with communities, interpreters and providers*. In: The Critical Link: Interpreters in the community (papers from the first international conference on interpreting in legal, health and social service settings, Canada, June 1-4, 1995. S. E. Carr, R. Roberts, A. Dufour and D. Steyn. Amsterdam, John Benjamins Publishing.

Puebla Fortier, J., C. Strobel and E. Aguilera (1998). *Language barriers to health care: federal and state initiatives, 1990-1995*. Journal of Health Care for the Poor and Underserved 9(Supplemental): 81-100.

Ramsey, D. J., D. C. Goff, M. L. Wear, D. R. Labarthe and M. Z. Nichaman (1997). Sex and ethnic differences in use of myocardial revascularization procedures in Mexican Americans and non-Hispanic whites: the Corpus Christi Heart Project. J Clin Epidemiol 50(5): 603-9.

Randall-David, E. (1997). Strategies for working with culturally diverse communities and clients. Washington, Hemophilia Program, Maternal and Child Health Bureau, Department of Health and Human Services.

Rich, E. C., T. W. Crowson and I. B. Harris (1987). *The diagnostic value of the medical history: perceptions of internal medicine physicians*. Arch Intern Med 147(11): 1957-1960.

Riddick, S. (1998). Improving access for limited English-speaking consumers: a review of strategies in health care settings. Journal of Health Care for the Poor and Underserved 9(Supplemental 1998): 40-61.

Rieder Nakhile, A., A. Morabia, J.-P. Humair, S. Antonini and H. Stalder (2001). Utilisation de l'hormonothérapie substitutive: comparaison entre une consultation de premier recours et la population générale. Genève, Médecine Communautaire HUG.

Rivadeneyra, R., V. Elderkin-Thompson, R. C. Silver and H. Waitzkin (2000). *Patient centeredness in medical encounters requiring an interpreter*. Am J Med 108(6): 470-4.

Robbins, L. and G. Alexander (1998). *Development and evaluation of an instrument to assess medical students' cultural attitudes*. Journal of the American Women's Association 53(3): 124-129.

Robbins, L. and J. Fantane (1998). Improving cultural awareness and sensitivity training in medical school. Academic Medicine 73: 31-34.

Roberts, R. P. (1997). *Community interpreting today and tomorrow*. In: The Critical Link: Interpreters in the community (papers from the first international conference on interpreting in legal, health and social service settings, Canada, June 1-4, 1995. S. E. Carr, R. Roberts, A. Dufour and D. Steyn. Amsterdam, John Benjamins Publishing.

Ronsaville, D. S. and R. B. Hakim (2000). Well child care in the United States: racial differences in compliance with guidelines. Am J Public Health 90(9): 1436-43.

Rowe, D. R. and H. P. Spees (1987). The Fresno County Refugee Health Volunteer Project: a case study in cross-cultural health care delivery. Migr World Mag 15(4): 22-7.

Rutledge, E. (2001). *The struggle for equality in healthcare continues*. Journal of Healthcare Management 46: 313-324.

Salis Gross, C., C. Moser, B. Zuppinger and C. Hatz (1997). Die Arzt-Patienten Interaktion aus der Sicht von MigrantInnen: Vorschläge für die ärztliche Praxis. Praxis(86): 887-894.

Salman, R. (2001). *Zur Gesundheitsversorgung von MigrantInnen*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

Sapiro, J. D. (1990). *The art and science of bedside diagnosis*. Munich, Urban & Schwarzenberg.

Sarver, J. and D. W. Baker (2000). Effect of language barriers on follow-up appointments after an emergency department visit. J Gen Intern Med 15(4): 256-64.

Schott, J. and A. Henley (1996). *Culture, religion and childbearing in a multiracial society*. Oxford, Butterworth Heinemann.

Schulze, B., K. Krajic, U. Trummer and J. M. Pelikan (2002). Migrant-friendly hospitals. A European Initiative to Promote the Health and Health Literacy of Migrants and Ethnic Minorities. Project Summary. http://www.mfh- eu.net/public/resources/mfh-summary.pdf. Vienna, LBISHM.

Shackman, J. (1984). The right to be understood: a handbook on working with, employing and training community interpreters. Cambridge, National Extension College.

Simpson, M., R. Buckman and M. Stewart (1991). *Doctor-patient communication: the Toronto consensus statement*. BMJ 303: 1385-1387.

Sirey, J. A., B. S. Meyers, M. L. Bruce, G. S. Alexopoulos, D. A. Perlick and P. Raue (1999). *Predictors of antidepressant prescription and early use among depressed outpatients*. Am J Psychiatry 156(5): 690-6.

Smart, J. F. and D. W. Smart (1995). *The use of translators/interpreters in rehabilitation*. Journal of Rehabilitation April/May/June 1995: 14-20.

Smedley, B. D., A. Y. Stith and A. R. Nelson (2003). *Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington, The National Academies Press.

Smith, D. B. (1998). Addressing racial inequalities in health care: Civil rights monitoring and report cards. Journal of Health, Politics and Law 23: 75-105.

Smith, M. (2002). *Culture and quality: joining the levers*. Advancing effective health care through systems development, data and measurement, Chicago.

Solas Gaspar, O. and D. Silès (1997). *Migration and Health in Spain*. In: Country Reports on Migration and Health in Europe, compiled on behalf of the Commission of the European Communities. A. Huismann, C. Weilandt and A. Geiger. Bonn, WIAD.

Soner, T. (2001). *Die Bedeutung von Familienzentriertheit und Individuumzentriertheit im Migrationskontext*. In: Transkulturelle kompetente Pflege. D. Domenig. Bern, Verlag Hans Huber.

Srinivasan, S. and T. Guillermo (2001). Toward improved health: Disaggregating Asian American and Native Hawaiian/Pacific Islander data. American Journal of Public Health 90: 1731-1734.

Stewart, M. (1995). Effective physician-patient communication and health outcomes: a review. Can Med Assoc J 152(9): 1423-1433.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American Psychologist April(440-448).

Sullivan, M. (2003). The new subjective medicine: taking the patient's point of view on health care and health. Soc Sci Med 56(7): 1595-604.

Swartz, L. and G. Drennan (2000). Beyond words: notes in the 'irrelevance' of language to mental health services in South Africa. Transcultural Psychiatry 37(2): 183-199.

Taira, A. (1999). Improving the health and health care of non-English-speaking patients. J Gen Intern Med 14: 322-323.

Temple, B. (2002). Crossed wires: interpreters, translators, and bilingual workers in cross-language research. Qual Health Res 12(6): 844-54.

Tervalon, M. and J. Murray-Garcia (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved 9(2): 117-25.

Tocher, T. M. and E. Larson (1998). Quality of diabetes care for non-English-speaking patients. A comparative study. West J Med 168(6): 504-11.

Todd, K. H., N. Samaroo and J. R. Hoffman (1993). *Ethnicity as a risk factor for inadequate emergency department analgesia*. JAMA 269(12): 1537-1539.

Trauer, T. (1995). Ethnic differences in the utilisation of public psychiatric services in an area of suburban Melbourne. Aust N Z J Psychiatry 29(4): 615-23.

Trummer, U., P. Nowak and J. M. Pelikan (2002). *Empowerment von chirurgischen PatientInnen - Modelle, Interventionen, Effekte, Erfolgsbedingungen*. Oesterreichische Zeitschrift für Soziologie 27(4): 97-114.

Verrept, H. and F. Louckx (1998). *Health Advocates in Belgian Health Care*. In: Health & Social Services among International Labor Migrants, a comparative perspective. A. Ugalde and G. Cárdenas. Texas, Center for Mexican American Studies.

Vranjes, N., B. Bisig and F. Gutzwiller (1996). Gesundheit der Ausländer in der Schweiz. Bern, Bundesamt für Gesundheit.

Wadensjö, C. (1998). *Interpreting as interaction*. London, Longman.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: implications for health promotion programs. Am J Health Promot 6(3): 197-205.

Wallerstein, N. (1999). Power between evaluator and community: research relationships within New Mexico's healthier communities. Soc Sci Med 49: 39-53.

Wallerstein, N. and E. Bernstein (1988). *Empowerment education: Freire's ideas adapted to health education*. Health Educ Q 15(4): 379-94.

Warnecke, R. B., T. P. Johnson, N. Chavez, S. Sudman, D. P. O'Rourke, L. Lacey and J. Horm (1997). *Improving question wording in surveys of culturally diverse populations*. Ann Epidemiol 7(5): 334-42.

Waxman, M. and M. Levitt (2000). Are diagnostic testing and admission rates higher in Non-English-speaking versus English-speaking patients in the emergency department? Annals of Emergency Medicine 36(5): 456-461.

Weber, B. and B. Reilly (1997). Enhancing mammography in the inner city: A randomised trial of intensive case management. Arch Intern Med(157): 2345-2349.

Weiss, R. (2003). Macht Migration krank? Eine transdisziplinäre Analyse der Gesundheit von Migrantinnen und Migranten. Zurich, Seismo-Verlag.

Weiss, R. and R. Stuker (1998). Interprétariat et médiation culturelle dans le système de soins. Neuchâtel, Forum Suisse pour l'étude des Migrations.

Welch, M. (1999). *Required curricula in diversity and cross-cultural medicine: The time is now*. Journal of the American Women's Association 53: 121-123.

Westermeyer, J. (1990). Working with an interpreter in psychiatric assessment and treatment. J Nerv Ment Dis 178(12): 745-9.

White, J. E., L. Begg, N. Fishman, B. Guthrie and J. Fagan (1993). *Increasing cervical cancer screening among minority elderly: education and on-site services to increase screening*. Journal of Gerontological Nursing 19(5): 28-34.

White, V. (2000). *Health advocacy in medicine*. In: Language, labour and migration. A. Kershen. London, Centre for the study of migration.

WHO (1991). Ziele zur Gesundheit für alle. Die Gesundheitspolitik für Europa. Aktualisierte Zusammenfassung September 1991. Kopenhagen, WHO Regionalbüro für Europa.

Widstrom, E. (1985). *Dentists' experiences of immigrants as patients*. Swed Dent J 9(6): 243-7.

Woloshin, S., N. A. Bickell, L. M. Schwartz, F. Gany and H. G. Welch (1995). *Language barriers in medicine in the United States*. JAMA 273(9): 724-8.

Woloshin, S., L. M. Schwartz, S. J. Katz and H. G. Welch (1997). *Is language a barrier to the use of preventive services?* J Gen Intern Med 12(8): 472-477.

Xuo, D. and M. J. Fagan (1999). Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. J Gen Intern Med 14(9): 547-50.

Yancey, A. K., S. P. Tanjasiri, M. Klein and J. Tunder (1995). Increased cancer screening behavior in women of color by culturally sensitive video exposure. Prev Med 24(2): 142-8.

Yancey, A. K. and L. Walden (1994). Stimulating cancer screening among Latinas and African-American women. A community case study. J Cancer Educ 9(1): 46-52.

Yanek, L. (2001). Project Joy: Faith-based cardiovascular health promotion for African American women. Public Health Rep 116: 68-81.

Yoder, M. (1996). Instructional responses to ethnically diverse nursing students. Journal of Nursing Education 35: 315-321.

Zimmermann, P. G. (1996). *Use of interpreters in the emergency department*. J Emerg Nurs 22(3): 225-7.

Zoratti, E. M., S. Havstad, J. Rodriguez, Y. Robens-Paradise, J. E. Lafata and B. McCarthy (1998). *Health service use by African Americans and Caucasians with asthma in a managed care setting*. Am J Respir Crit Care Med 158(2): 371-7.

Zweifler, J. and A. Gonzalez (1998). *Teaching residents to care for culturally diverse populations*. Academic Medicine(73): 1056-1061.

6 Appendix

6.1.1   List of Tables

Table 1: Main published sources used in this review of effective interventions

Table 2: Characteristics of community interpreting

Table 3: Minority and migrant patients (MMPs) are less likely...

Table 4: Quality Standards (Henley & Schott 1999)

6.1.2   Abbreviations

CLAS	Culturally and linguistically appropriate services
SFM	Swiss Forum for Migration and Population studies
LBIMGS	Ludwig Boltzmann-Institut für Medizin- und Gesundheitssoziologie
MFH	Migrant-friendly hospitals
MMP	Migrant and minority patients
WHO	World Health Organisation

6.1.3   Websites

www.accessproject.org
www.ahrq.gov/research/minorix.htm
www.bag.admin.ch/sucht/migration/mg_strategie/MG_kurz_e.pdf
www.bmc.org/about/facts02.pdf
www.calendow.org/reference/publications/pdf/disparities/TCE0222-2002_Multicultural_.pdf
www.diversityrx.org/CCCONF/02/CultureandQuality
www.diversityrx.org/HTML/ESWEL.htm
www.ethnomed.org/
www.hc-sc.gc.ca/english/care/romanow/index.html
www.hc-sc.gc.ca/francais/soins/romanow/index.html
www.hrsa.gov/financeMC/
www.hrsa.gov/financeMC/
www.diversityrx.org/CCCONF/02/CultureandQuality
www.inter-pret.ch/f/ofsp.htm
www.interpret.ch/f/trialog.htm
www.inter-pret.ch/pdf/bericht_bag.pdf
www.irct.org/about_the_irct_0.htm
www.med.und.nodak.edu/depts/fpcfar/home.htm
www.mosaicbc.com/
www.refugeenet.org/about/index.html
www.refugeenet.org/pdf/health_guide.pdf

www.stat.gouv.qc.ca
www.omhrc.gov/clas
www.unhcr.ch
www.xculture.org/index.cfm

6.1.4 Excerpts from 'Migration and Public Health'

The Swiss policy paper 'Migration and Public Health, the Confederation's strategic orientation 2002-2006'[291] is the result of a broadly based expert investigation and extended consultation process[292].

The background and starting point for the Strategy is an analysis of the state of health of migrants. The living and social welfare conditions of migrants differ significantly from those of the native population. These differences can be explained by the fact that migrants are often exposed to specific disadvantages, affecting several levels, for example:

The majority of migrants come from lower social classes or disadvantaged sectors of the workforce, which has harmful effects on their health. The gender segregation of the labour market often gives migrant women the lowest status in the hierarchy of income, qualification and professional status. The consequences of this situation are increased health risks and a limited perception of their own interests. The uncertainty about residence status is a key factor in the increased health risk among asylum seekers and sometimes also among people with a limited right of residence. Foreign wives' lack of a residence permit in their own right creates a dependence on their Swiss husbands that is often harmful to their (physical and mental) health. Migrant women are over-represented in women's refuges. This uncertainty about residence status particularly affects unauthorised residents who have a job and possess limited social rights. As well as their living circumstances, migrants' contacts with social institutions in the host country are marked by their cultural outlook and by the extent to which they have mastered the language (problems of making themselves understood, understanding of roles, values, religion). The perception of migrants also plays a role here (exclusion, discrimination). Migrants often work in sectors with lower social recognition. These conditions have deleterious effects on health. For example, the health of migrant women is considerably worse than that of migrant men. The causes and consequences of the migration process (displacement, trauma, flight, experience of torture) can also significantly influence the living and health conditions of migrants.

---

[291] http://www.bag.admin.ch/sucht/migration/mg_strategie/MG_kurz_e.pdf (apart from German, French, Italian versions, the summary report is also available in Albanian, Arabic, Croatian, Portuguese, Russian, Serbian, Spanish, Tamil and Turkish).

[292] commissioned by the Swiss Federal Office of Public Health to the SFM

These problems should not mask the fact that migrants also exhibit specific resources that may sometimes compensate for other disadvantages (social networks, the generally better health of people who emigrate). But we must assume that health hazards increase significantly if the factors 'class', 'language-dependent access barriers', and 'precarious situation' – quite apart from possible traumatisation through war – reinforce one another. Experts in the health care sector therefore agree that we should assume a generally high vulnerability to disease among the migrant population, and this calls for appropriate measures.

The longer-term objective of this 'Migration and Public Health' Strategy is a health care system whose institutions are in a position to give care to a society and clientele whose nature and needs have changed as a result of migration. For example, the understanding and professional handling of the specific needs of a heterogeneous clientele in a pluralistic society should be encouraged during both basic and advanced training of medical personnel. This can only be achieved within the framework of a longer-term revision of health care education. The practical experience and research findings on which we have based this Strategy enable priorities to be set in five areas of intervention for the period 2002–2006: education (basic education, advanced and continuing training), public information, illness prevention and health promotion, health care provision, therapy for traumatised asylum seekers, research (basic research, evaluation and monitoring). If access to the health care system is to be improved, and if specific services are to be provided, it is necessary to start on these five levels. The areas of intervention listed contain measures intended to achieve a range of goals. Their order follows the priorities of implementation and financing. These principal areas of intervention are presented briefly below, listing individual elements of the strategy. However, successful implementation of the programme requires them to be implemented in combination and with a potential for interaction.

Education. Based on equal opportunities and adequate service provision, three aspects are foremost in the education sector: An officially recognised training programme for interpreters will be established in the health care and social sectors. Objective: improvement of understanding in health care through professional interpreting services. An officially recognised training programme for intercultural mediation will be established in the health care and social sectors. Objective: improvements in communication and public information, prevention and health promotion within the migrant population through professional interpreting and intercultural mediation. Possibilities for advanced training and continuing education in the health care professions will be developed to enable sufficient attention to be given to situations that are specific to migration and gender. These educational possibilities will involve doctors, nursing staff and management of service providers in the health care system. In addition, the feasibility of incorporating sensitisation to these issues into basic professional health care training should be investigated. Objective: an improved understanding of migrant issues within the health care system.

The Confederation's main goal in the educational sector over the next five years is to establish professional basic and advanced training and recognised certification for interpreting and intercultural mediation (in the health care and if possible the social sector). In addition, regular advanced and continuing education courses in 'Migration and Public Health' should be provided for all health care professions, ensuring that training is provided in all parts of the country and that access is flexible through open approval procedures.

Public information, prevention and health promotion. In the field of intervention that relates to public information, prevention and health promotion, two areas focusing on the values of personal responsibility, equal opportunities and adequate service provision should be developed: Within the migrant population, health care sector initiatives to mobilise relevant self-help resources should be promoted. This should improve the general impact of preventive measures and health behaviour. Objective: health promotion and empowerment. The second area concerns service providers in the health care sector, who should be made aware of the need to aim their services towards a heterogeneous audience, and to exploit possibilities for further training in this field. Objective: to promote understanding for concerns that are specific to migration and gender, as a basis for implementing measures.

The Confederation's goal over the next five years is the systematic promotion of interventions that help to convey information about the health care system, prevention and health promotion within the migrant population. The optimum design of measures and activities requires suitable instruments and procedures. The Confederation is committed to presenting successful projects to the wider public and recommending them for imitation. The key service providers in Switzerland will also be sensitised to the subject of migration and health.

Healthcare provision. Three packages of measures are announced for health care provision. The orienting values are equality of opportunity and adaptation of the service to the specific needs of the migrant population. Easily accessible services will be promoted in areas with a high density of migrants. Objective: Removal of access barriers to health care and more targeted mediation. In addition, mediation and coordination services will be promoted to offer various services and improve coordination between service providers, and between providers and the migrant population (reference services). Objective: better allocation of services, better collaboration between service providers, targeted provision of care. Interpreters should increasingly be employed in the health care sector. Objective: Improvement of communication between service providers and their clientele.

The Confederation's objective in terms of health care provision is to promote the establishment of easily accessible services in areas, particularly in existing institutions. These should provide help with health problems without red tape. In all regions and at national level the aim in the final analysis is to establish mediation and co-ordination services for the health care sector, if possible for the social sector as well. These institutions provide interpreting services in all regions; their funding has yet to be finalised. The entire health care system should be opened up to these interpreting services.

Therapy for traumatised asylum seekers. In the trauma therapy field, the focus of attention is on two aspects which are primarily geared towards adequate service provision and equal opportunity. Services for people who have been traumatised by war or are victims of torture must be adapted both to this unique problem and to specific needs. Additional support should therefore be given to the specialised services and their efficacy regularly evaluated. Objective: Improvement of existing provision, particularly for traumatised people with a longer-term residence perspective. At the same time there are an inadequate number of low threshold services for asylum seekers who have been traumatised (and here women and children are the particular targets of the relevant services). Objective: Establishment of easily accessible decentralised services for traumatised people, particularly for those whose long-term residence status is unclear.

In the therapeutic sector, the Confederation's objective is to provide services for traumatised people that are differentiated, rapidly accessible and decentralised. Temporary and short-term solutions are to be particularly promoted. Furthermore, the possibility of supporting needs-related projects for treating trauma as part of a returnees' programme to particular countries of origin should also be investigated.

Research. Three areas of research are inadequately covered. Overcoming this is a higher-level task, since adequate and appropriate measures can only be implemented if they have the necessary scientific foundations and support. Problem-oriented basic research should be used to analyse specific issues (including gender issues) from medium-term perspective. Objective: To offer aid based on research that allows measures to be appropriately directed. Monitoring the health of the migrant population will provide epidemiological information as a starting point for developing migration- and gender-specific measures. Objective: Identification of new problems and development of aids to setting future priorities. The implementation of the measures will be accompanied by regular evaluations of their efficiency and efficacy. Objective: Measurement of efficiency and efficacy, so that lessons can be learned from projects.

Over the next five years, problem-oriented basic research and the evaluation of measures should systematically support the development of measures in 'Migration and Public Health'. The establishment of a monitoring system for the health and health behaviour of the migrant population is of prime importance.

Latest publications of the series
« Social Cohésion and cultural plurality »

Janine Dahinden (2005). Prishtina-Schlieren. Albanische Migrationsnetzwerke im transnationalen Raum.

Gianni D'Amato, Brigitta Gerber (Hrsg.) (2005). Herausforderung Integration. Städtische Migrationspolitik in der Schweiz und in Europa.

Hans Mahnig (Ed.) (2005). Histoire de la politique de migration, d'asile et d'intégration en Suisse depuis 1948.

Etienne Piguet (2005). L'immigration en Suisse depuis 1948. Une analyse des flux migratoires.

Janine Dahinden, Etienne Piguet (Hrsg.) (2004). Immigration und Integration in Liechtenstein.

Josef Martin Niederberger (2004). Ausgrenzen, Assimilieren, Integrieren. Die Entwicklung einer schweizerischen Integrationspolitik.

Pascale Steiner; Hans-Rudolf Wicker (Hrsg.) (2004). Paradoxien im Bürgerrecht. Sozialwissenschaftliche Studien zur Einbürgerungspraxis in Schweizer Gemeinden.

Brigitta Gerber (2003). Die antirassistische Bewegung in der Schweiz. Organisationen, Netzwerke und Aktionen.

Christin Achermann, Stefanie Gass (2003). Staatsbürgerschaft und soziale Schliessung. Eine rechtsethnologische Sicht auf die Einbürgerungspraxis der Stadt Basel.

Claudio Bolzman, Rosita Fibbi, Marie Vial (2003). Secondas – Secondos. Le processus d'intégration des jeunes adultes issus de la migration espagnole et italienne en Suisse.

For more information about these publications, please visit the SFM website http://www.migration-population.ch or the editor's one http://www.seismoverlag.ch.

These publications can be ordered at Seismo: buch@seismoverlag.ch.

Latest SFM's research reports

42 : Paola Bollini, Philippe Wanner en collaboration avec Sandro Pampallona, Urszula Stotzer, Alexis Gabadinho, Bruce Kupelnick (2006). Santé reproductive des collectivités migrantes. Disparités de risques et possibilités d'intervention.

41 : Christin Achermann, Milena Chimienti unter Mitarbeit von Fabienne Stants (2006). Migration, Prekarität und Gesundheit. Ressourcen und Risiken von vorläufig Aufgenommenen und Sans-Papiers in Genf und Zürich.

40 : Rosita Fibbi (2005). Mesures de lutte contre les discriminations à l'embauche.

39 : Gianni D'Amato (Hg.) (2005). Die Bedeutung des Wissenstransfers bei migrationspolitischen Fragen. Erfahrungen aus Frankreich, Deutschland, Österreich und der Schweiz.

38B : Roger Besson, Etienne Piguet (2005). Trajectoires d'asile africaines. Répartition des demandes d'asile en Europe et effets des politiques.

38A : Denise Efionayi-Mäder avec la collaboration de Joëlle Moret et Marco Pecoraro (2005). Trajectoires d'asile africaines. Déterminants des migrations d'Afrique occidentale vers la Suisse.

37 : Gianni D'Amato, Brigitta Gerber, Martina Kamm (2005). Menschenschmuggel und irreguläre Migration in der Schweiz.

36 : Janine Dahinden, Chantal Delli, Walter Grisenti (2005). Nationale Machbarkeitsstudie Projektmodell „Migration und Sucht".

35 : Janine Dahinden, Alexandra Felder, Gianni D'Amato (2004). Aufbau einer Koordinationsstelle für interkulturelle ÜbersetzerInnen und VermittlerInnen.

For more information about the SFM publications, please visit the website http://www.migration-population.ch.

These reports can be downloaded free of charges or ordered at the SFM.