Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

MODULE 1. SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY
Unit 2. INTERCULTURAL COMPETENCE AND SENSITIVITY TO DIVERSITY
GUIDELINES

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Migrants & Ethnic Minorities Training Packages

Escuela Andaluza de Salud Pública
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Reggio Emilia

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MEDICAL COLLEGE

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Module 1: Sensitivity and Awareness of Cultural and Other Forms of Diversity

Unit 2: Intercultural Competence and Diversity Sensitivity

1. Objectives and Methods

1.1. Objectives

Objectives of the presentation:

- Introduce the concepts "multiculturalism", "interculturalism", "cultural competence", "intercultural competence" and "diversity sensitivity", and the shifts in their use.
- Provide the key elements for understanding the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.
- Introduce the concepts of "health promotion", "health education" and relate them with cultural diversity and interculturality.

Objectives of the activities:

- Reflect on different concepts related to the topic.
- Reflect on the application of the different approaches in the concrete, context-specific professional practice.
- Introduce the concept of *"Cultural Awareness"* and apply **"***The Process of Cultural Competence in the Delivery of Healthcare Services Model".*
- Identify aspects related to the positive contribution of interculturality and sensitivity to diversity.

1.2. Methods

Time	Objectives	Activities	Sources
15 min.	• Reflect on different concepts related to the topic.	**Activity 1** "Brainstorming" • Presentation of the methodology • Brainstorming in plenary. *(Slide 4)*	Projector, laptop, screen. M1_U2_Presentation
15 min.	• Introduce the concepts "multiculturalism", "interculturalism", "cultural competence", "intercultural competence" and "diversity sensitivity", and the shifts in their use.	**Presentation** "From Intercultural Competence to Diversity Sensitivity" and questions. *(Slides 5 - 9)*	Projector, laptop, screen. M1_U2_Presentation M1_U2_Additional_Document
Time	**Objectives**	**Activities**	**Sources**
50 min.	• Reflect on the application of the different approaches in	**Activity 2** "Experiences related	Projector, laptop, screen.

	the concrete, context-specific professional practice	to interculturalism, intercultural competence and diversity sensitivity” • Presentation of the methodology • Small group work • Wrap up in plenary *(Slide 10)*	M1_U2_Presentation M1_U2_Activity_1_Template_1 M1_U2_Activity_1_Template_2 M1_U2_Activity_1_Template_3
15min.	• Provide the key elements for understanding the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.	**Presentation** “Influence of cultural background on health professionals’ and patients’ perceptions and behaviours” and questions. *(Slide 13-16)*	Projector, laptop, screen. M1_U2_Presentation
30 min.	Introduce the concept of “Cultural Awareness”, • Apply **“***The Process of Cultural Competence in the Delivery of Healthcare Services Model”*	**Activity 3** “Cultural assessment tool for professionals” • Presentation of the methodology • Work individually • Wrap up in plenary *(Slide 17-21)*	Template, Projector, laptop, screen.
20 min.	• Introduce the concepts of “health promotion”, “Health education” and relate them with cultural diversity and interculturality.	**Presentation**” and questions.	Projector, laptop, screen. M1_U2_Presentation

MODULE 1:
Sensitivity and Awareness of Cultural and Other Forms of Diversity

From Intercultural Competence to Diversity Sensitivity

PREPARED BY:
Amets Suess,
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From Intercultural Competence to Diversity Sensitivity

1. Presentation

Slide 1: Title page, Module 1, Unit 2.

Slide 2: Outline of the session.

Slide 3: Title page "From Intercultural Competence to Diversity Sensitivity".

2. Activity 1: Brainstorming

Slide 4:

- Presentation of the methodology
- Brainstorming in the plenary:
    - What comes into your mind when you hear the following concepts?
        - "Multiculturalism"
        - "Interculturalism"
        - "Cultural competence"
        - "Intercultural competence"
        - "Diversity sensitivity"?

Slide 5: A broad theoretical discussion[1,2,3,4,5] related to **"multiculturalism"** and **"interculturalism"** is ongoing. Some authors[6,7] conceive both concepts as differentiated. They understand "multi-culturalism" as the co-existence of different cultures in a concrete geographic and sociopolitical context, based on mutual recognition and respect of specific cultural needs. A focus on the interaction, dialogue and mutual influence of different cultures is observed In relation to the "intercultural concept". At the same time, some shared aspects are identified, such as the respect for cultural diversity and concerns with social inequalities. Other authors[8,9,10] highlight the overlapping meanings and a lack of clear differentiation between both concepts. Furthermore, context-specific differences in their use are observed. Recently, prior models of assimilation or multiculturalism have been replaced by intercultural approaches.

For facilitating a consultation of the definitions of the quoted concepts, please share M1_U2_Additional_Document with the trainees.

[1] Barrett M. Introduction – Interculturalism and multiculturalism: concepts and controversies. In: Barrett M (ed). Interculturalism and multclturalism: similarities and differences, p. 15-42. Strasbourg: Council of Europe Publishing, 2013.
[2] Council of Europe. White Paper on Intercultural Dialogue. "Living Together As Equals in Dignity". Strasbourg: Council of Europe, 2008. http://www.coe.int/t/dg4/intercultural/source/white%20paper_final_revised_en.pdf (retrieved: March 5, 2015).
[3] Levey GB. Interculturalism vs. Multiculturalism: A Distinction without a Difference?, Journal of Intercultural Studies 2012;33:2:217-224.
[4] Meer N, Modood T. How does Interculturalism Contrast with Multiculturalism? Journal of Intercultural Studies 2011:1-22. http://www.bristol.ac.uk/media-library/sites/ethnicity/migrated/documents/interculturalism.pdf (retrieved: March 5, 2015).
[5] Sarmento C. Interculturalism, multiculturalism, and intercultural studies: Questioning definitions and repositioning strategies. Intercultural Pragmatics 2014;11(4):603-618.
[6] Barrett 2013, op. cit.
[7] Council of Europe 2008, op. cit.
[8] Levey 2012, op. cit.
[9] Meer, et al. 2011, op. cit.
[10] Sarmento 2014, op. cit.

Slide 6: Providing health care in intercultural contexts, the relevance of specific professional competences and institutional policies can be observed. In the recent bibliography[11,12,13,14,15,16,17,18], different approaches and concepts can be identified, including the concept of **cultural competence, intercultural competence, sensitivity to difference** and **diversity sensitivity.**

The next slides describe the differences and shared aspects between these approaches and concepts are described, as well as paradigm shifts and tendencies.

Slide 7: According to the reviewed bibliography[19,20], the model of **cultural competence** focuses on the relevance of the professionals being aware of culturally specific habits, beliefs and needs in health care, as well as having knowledge of the specific cultural and ethnic background. In consequence, health policies should be focused on providing specialized health care services for migrants and ethnic minorities.

The model of **intercultural competence** is presented as focused on the interaction and dialogue between different cultures. According to this model, health policies should focus on addressing health care needs in intercultural contexts.
An overlapping use of both concepts can be seen when these differences are identified.

Slide 8: Over the last years, the concept of **"cultural diversity"** is increasingly being used. A model of health care oriented towards cultural diversity is based on the recognition of diversity as a positive social contribution. The development of health policies therefore focuses on addressing health care needs from a diversity perspective. Furthermore, the concepts of **"cultural sensitivity", "difference sensitivity"** and **"diversity sensitivity"** have been introduced. These are based on the relevance of health professionals and health organizations being aware of different forms of diversity, as well as the intersectional character of social inequalities. Health policies are thus aimed to reducing transversal and interconnected social inequalities. A slight conceptual difference between the concept of "difference sensitivity" and "diversity sensitivity" can be observed. There is a

[11] Papadopoulos I (ed). Transcultural Health and Social Care: Development of Culturally Competent Practitioners. Churchill Livingstone Elsevier: Edinburgh, 2006, quoted in: IENE, Intercultural Education of Nurses in Europe, 2014, n.p. http://www.ieneproject.eu/glossary-term.php?termID=11 (retrieved: March 5, 2015).

[12] UNESCO, United Nations Educational, Scientific and Cultural Organization. Intercultural Competences. Conceptual and Operational Framework. Paris: UNESCO, 2013.
http://unesdoc.unesco.org/images/0021/002197/219768e.pdf (retrieved: March 5, 2015).

[13] UNESCO, United Nations Educational, Scientific and Cultural Organization. UNESCO Universal Declaration on Cultural Diversity. Paris: UNESCO, 2001.
http://unesdoc.unesco.org/images/0012/001271/127162e.pdf (retrieved: March 5, 2015).

[14] WHO, World Health Organization. WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance. Health and freedom from discrimination. Health & Human Rights Publication Series Issue No. 2, Geneva: WHO, 2001.
http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf (retrieved: March 5, 2015).

[15] Council of Europe. Recommendation Rec2006(18) of the Committee of Ministers to Member States on health services in a multicultural society, 2006. https://wcd.coe.int/ViewDoc.jsp?id=1062769&BackC (retrieved: March 5, 2015).

[16] Renschler I, Cattacin S. Comprehensive 'difference sensitivity' in health systems. In: Bjorngren-Cuadra C, Cattacin S (eds). Migration and Health: difference sensitivity from an organizational perspective, p. 37-41. Malmo: IMER, 2007.

[17] Chiarenza A. Developments in the concept of 'cultural competence'. In: Ingleby D, Chiarenza A, Devillé W, Kotsioni (eds). Inequalities in health care for migrants and ethnic minorities, Vol. 2, p. 66-81. COST Series on Health and Diversity. Antwerp: Garant Publishers, 2012.

[18] Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015.

[19] Papadopoulos (ed) 2014, op. cit., n.p.

[20] UNESCO 2013, op. cit., p. 16.

differentiated focus on “difference” versus “diversity”, at the same time as both concepts are used as synonyms.

The concept *“difference sensitivity”* is based on the intersectoral character of social inequalities, the recognition of diversity and the aim of improving equity in health care[21]. This is in contrast to focusing only on specific individual experiences related to migration and ethnicity, and a static and essentialist conceptualization of culture.

Slide 9: In conclusion, over the last years a **conceptual shift** can be observed from **cultural competence** and intercultural competence towards **cultural diversity, cultural sensitivity, difference sensitivity** or **diversity sensitivity**[22,23,24,25,26,27,28,29]. In the **framework of cultural competence***,* a specific consideration of the knowledge regarding the specific cultural and ethnic background of migrants and ethnic minorities is evident. This is accompanied by health policies focused on providing specialized health care services. The **intercultural competence approach** focuses on the dynamics of interaction between different cultures and a health care provision aimed to address health care needs in intercultural contexts. The **cultural diversity model** is based on the recognition of diversity as a positive social contribution. Therefore, health policies are focused on addressing health care needs from a diversity perspective. The concepts of **cultural sensitivity, difference sensitivity** or **diversity sensitivity** prioritize the awareness of diversity and the intersectional character of social inequalities. These are accompanied by health policies aimed at reducing transversal and interconnected social inequalities.

3. Activity 2

Slide 10: Activity “Experiences related to interculturalism, intercultural competence and diversity sensitivity”

- Presentation of the methodology

- Discussion in small groups

Each small group is invited to complete the templates (M1_U2_Activity_2_Template_1, M1_U2_Activity_2_Template_2, M1_U2_Activity_2_Template_3) and to select a spokesperson for presenting the small groups in the plenary.

  - Group 1

[21] Cattacin S, Chiarenza A, Domenig D. Equity standards for healthcare organisations: a theoretical framework. Diversity and Equality in Health and Care 2013;10:249-258.
[22] Papadopoulos 2006, quoted in IENE 2014, op. cit.
[23] UNESCO 2013, op. cit.
[24] UNESCO 2001, op. cit.
[25] WHO 2001, op. cit.
[26] Council of Europe, op. cit.
[27] Renschler et al. 2007, op. cit.
[28] Chiarenza 2012, op. cit.
[29] Mock-Muñoz 2015, op. cit.

  - Please describe practical experiences with **interculturalism** in your professional practice.
  - Which difficulties can you identify? Which positive contributions?

- Group 2
  - Please describe practical experiences with **intercultural competence** in your professional practice.
  - Which difficulties can you identify? Which positive contributions?

- Group 3
  - Please describe practical experiences with **diversity sensitivity** in your professional practice.
  - Which difficulties can you identify? Which positive contributions?

- Presentation of the small group results in plenary

Slide 11-12: References

4. Readings

Recommended readings:

Barrett M. Introduction – Interculturalism and multiculturalism: concepts and controversies. In: Barrett M (ed). Interculturalism and multclturalism: similarities and differences, p. 15-42. Strasbourg: Council of Europe Publishing, 2013.
Cattacin S, Chiarenza A, Domenig D. Equity standards for healthcare organisations: a theoretical framework. Diversity and Equality in Health and Care 2013;10:249-258.
Chiarenza A. Developments in the concept of 'cultural competence'. In: Ingleby D, Chiarenza A, Devillé W, Kotsioni I (eds). Inequalities in health care for migrants and ethnic minorities, Vol. 2, p. 66-81. COST Series on Health and Diversity. Antwerp: Garant Publishers, 2012.

Complementary readings:

Council of Europe. Recommendation Rec2006(18) of the Committee of Ministers to Member States on health services in a multicultural society, 2006. https://wcd.coe.int/ViewDoc.jsp?id=1062769&BackC (retrieved: March 5, 2015).
Council of Europe. White Paper on Intercultural Dialogue. "Living Together As Equals in Dignity". Strasbourg: Council of Europe, 2008.
http://www.coe.int/t/dg4/intercultural/source/white%20paper_final_revised_en.pdf (retrieved: December 8, 2015).
Levey GB. Interculturalism vs. Multiculturalism: A Distinction without a Difference?, Journal of Intercultural Studies 2012;33:2:217-224.
Meer N, Modood T. How does Interculturalism Contrast with Multiculturalism? Journal of Intercultural Studies 2011:1-22. http://www.bristol.ac.uk/media-library/sites/ethnicity/migrated/documents/interculturalism.pdf (retrieved: December 8, 2015).
Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015.
Papadopoulos I (ed). Transcultural Health and Social Care: Development of Culturally Competent Practitioners. Churchill Livingstone Elsevier: Edinburgh, 2006, quoted in: IENE, Intercultural Education of Nurses in Europe, 2014, n.p. http://www.ieneproject.eu/glossary-term.php?termID=11 (retrieved: March 5, 2015).
Renschler I, Cattacin S. Comprehensive 'difference sensitivity' in health systems. In: Bjorngren-Cuadra C, Cattacin S (eds). Migration and Health: difference sensitivity from an organizational perspective, p. 37-41. Malmo: IMER, 2007.
Sarmento C. Interculturalism, multiculturalism, and intercultural studies: Questioning definitions and repositioning strategies. Intercultural Pragmatics 2014;11(4):603-618.
UNESCO, United Nations Educational, Scientific and Cultural Organization. Intercultural Competences. Conceptual and Operational Framework. Paris: UNESCO, 2013.
http://unesdoc.unesco.org/images/0021/002197/219768e.pdf (retrieved: March 5, 2015).

UNESCO, United Nations Educational, Scientific and Cultural Organization. UNESCO Universal Declaration on Cultural Diversity. Paris: UNESCO, 2001.
http://unesdoc.unesco.org/images/0012/001271/127162e.pdf (retrieved: March 5, 2015).
WHO, World Health Organization. WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance. Health and freedom from discrimination. Health & Human Rights Publication Series Issue No. 2, Geneva: WHO, 2001.
http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf (retrieved: March 5, 2015).

MODULE 1:

SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY

Influence of cultural backgrounds
on health professionals' and patients' perceptions and behaviours

PREPARED BY:
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1. Presentation

Slide 13: Title page.

Slide 14: Influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients (understanding individual values, beliefs, behaviours and basic assumptions)

In order to be **culturally competent**, a professional needs to understand his/her own views of the world, as well as those of the patient, while avoiding stereotyping and misapplication of scientific knowledge. Cultural competence, as we defined before, includes *"both a process and an output, and results from the synthesis of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding."*[30] Therefore, it consists both of obtaining cultural information and then applying that knowledge.

All forms of knowledge are cultural, including scientific and medical practice, so much so that biomedicine can be seen as a specific form of ethnomedicine. "Culture is not something that irrationally limits science, but is the very basis for value systems on which the effectiveness of science depends"[31].

To be able to be culturally competent, we need to think that it is part of our job, given that we will have patients (people) and that the patient population changes. This process implies **cultural awareness.** Such awareness allows one to see the entire picture and improves the quality of care and health outcomes.

Cultural awareness is understood as the degree of awareness we have about our own cultural background and cultural identity. This helps us to understand the importance of our cultural heritage and that of others, and makes us appreciate the dangers of ethnocentricity. Cultural awareness is the first step to developing cultural competence and must therefore be supplemented by cultural knowledge.[32]

Adapting to different cultural beliefs and practices requires flexibility and a respect for other view points. Cultural competence means to really listen to the patient, and to find out and learn about the patient's beliefs of health and illness. To provide culturally appropriate care, we need to know and understand culturally influenced health behaviours, as well as be aware of our own culture.

Slide 15: There are several aspects of cultural competence that we have to take into account:[33]

- Working with patients is a cross-cultural initiative.
- Becoming culturally competent is a process, not an endpoint.
- Being aware of our personal cultural filters is a central part of effective work across cultures.

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[30] Papadopoulos (ed)2014, op.cit.n.p.
[31] Lancet Commission Report on "Culture and Health", Vo. l384 November1, 2014: 1630.
[32] From: "IENE-Intercultural education of nurses and medical staff in Europe". http://www.wedo-partnership.eu/resource/iene-intercultural-education-nurses-and-medical-staff-europe. (retrieved January 21, 2015).
[33] The Red ISIR/Migration and Health Network. Regional Ministry of Equity, Health and Social Policies. Andalusia. Spain.

- Specific information on each group can be used as a starting point to explore individual experiences.

- Stereotypes are a natural part of human perception, but we must be aware of them and challenge them.

Slide 16: Therefore, cross-cultural practice encourages the discovery of the differences between people. It represents having an empathic relationship, being able to communicate effectively, offering sensitive and competent actions, and acquiring cultural knowledge with adequate tools.

The concept of health professional-patient relationship is a basic concept on health services provision.

The principles of cultural competence encourage the discovery of people's differences. This can be achieved in accordance with:

- Having an empathetic relationship
- Communicating with skill
- Acquiring cultural knowledge
- Providing responsive and competent actions

Therefore, the individual **values, beliefs, behaviours and basic assumptions of health professionals and patients** influence all the aspects of health care demand and provision. Language (same words can have different meanings). The concept of time (relativity of time), the disease model or reasons why the concept can also be different (illness, loss, punishment, gain, normal part of life). Finally, perception and expectations about a treatment or the effectiveness of an intervention also vary.

Readings:

Recommended readings:

Papadopoulos I (ed). Transcultural Health and Social Care: Development of Culturally Competent Practitioners. Churchill Livingstone Elsevier: Edinburgh, 2006, quoted in: IENE, Intercultural Education of Nurses in Europe, 2014, n.p. http://www.ieneproject.eu/glossary-term.php?termID=11 (retrieved: March 5, 2015).
Lancet Commission Report on “Culture and Health”, Vo. l384 November1, 2014: 1630.
“IENE-Intercultural education of nurses and medical staff in Europe”. http://www.wedo-partnership.eu/resource/iene-intercultural-education-nurses-and-medical-staff-europe. (retrieved January 21, 2015).

MODULE 1: SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY

Addressing one's own identity and prejudices

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Addressing one's own identity and prejudices

Slide 17: Title of the Unit

Slide 18: Addressing one's own identity and prejudices

Knowing and being aware of oneself is a necessary exercise for all persons, but maybe more for those who are working in the health services. It is particularly important for those who work with migrants and people from ethnic minorities.

In this unit, we seek to increase the awareness of health professionals´ own identity and prejudices in order to provide the most culturally competent practice.

Training of health professionals as well as migrants and ethnic minorities, can help to reduce direct discrimination and mistrust, by raising awareness of the prejudices people have that they are not aware of, and equipping them with the knowledge and skills needed for diversity-sensitive health care.[34](…).

The awareness of one´s own identity and prejudices need to go beyond the health professionals but also to health and social services which is more broad, including the administrative support services.

Important changes have taken place over the last 30 or 40 years in the way 'culture' has been understood. During much of this period, 'cultural differences' (conceptualised in a certain way) have been considered to be the main barrier standing between MEM patients and health service providers.[35] In this conceptualisation, 'culture' is a relatively fixed and homogeneous set of characteristics that migrants bring with them, like baggage, from their country of origin.

This view of the role of culture in health services for MEM has increasingly come under fire since the 1990's. Rather than labelling and stereotyping patients according to simplistic conceptualisations of culture, attention has been drawn to the diversity within cultures, the fluid and many-layered nature of culture, and migrants' interactions with the host country culture – which gives rise to new, 'hybrid' cultures and identities.[36]
At the same time, given the increase in the number and diversity of sending countries, becoming a culturally competent health provider has become increasingly difficult for those who try to follow the traditional text-book approach. A different approach has come to the fore, which proposes that little of use can be learned about a patient's culture from books. Instead, the first task is seen as understanding one's own culture: in this way one can become better able to accept and understand that of others. As in 'patient-centered care', the way to overcome cultural barriers is to take the time to get to know the patient better.[37] *The appropriate attitude for health professionals is therefore one*

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[34]Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a, p. 13. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).
[35] This section draws on Ingleby, D. (2012). Introduction by series editor. In: D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity, Volume II* (pp. 9-28). Antwerp/Apeldoorn: Garant.
[36] Tervalon, M., & Murray-García, J. (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), 117–125.
[37] Saha, S., Beach, M.C., Cooper, L.A. (2009). Patient centeredness, cultural competence, and healthcare quality. *Journal of the National Medical Association*, 100 (11): 1275-85

of 'cultural humility' - "a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" [38].

We would like to note that text books approach does not mean that sometimes a text books reading can be useful for references to acquire cultural knowledge and learn about specific health problems.

Slide 19: Examination of the Cultural Aptitude of the Professional[39]

To prevent conflicts and establish optimal relations with the migrant or the person from an ethnic minority, a professional should examine her beliefs and ways of thinking about ethnicity, as well as his or her attitudes toward cultural pluralism, replanting those attitudes, if necessary. Cultural awareness, is very necessary to achieve this goal.

Campinha-Bacote[40] defines **cultural awareness** as ***"****the self-examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one's own cultural or professional values, there is risk that the health care provider may engage in cultural imposition. Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behavior on another culture (Leininger, 1978)."*

Slide 20: Cultural awareness talks about cultural awareness and sensitivity. It can be defined as *"the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self awareness, knowledge of a patient's culture, and adaptation of skills"* [41]

Slide 21: Therefore, sometimes we need to start by assessing the cultural aptitude of the professional, focusing on different aspects in order to have culturally competent practice.

- Professional-user relationship
- Transference: feelings and behavior of the user towards the professional
- Counter-reference: feelings and behavior of the professional towards the user

Counter transference, unconscious or conscious, is not often suitable for a user -professional normalised relationship and prevents horizontal and collaborative decision- making.

This could lead to the appearance of:

- Denial of differences
- Excessive cultural curiosity
- Superidentification
- Complicity (rage, guilt, shame)

The appropriate cultural counter transference entails:

[38] Tervalon, M., & Murray-García, J. (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), 117–125.
[39] Adapted from training materials of Red Isir. Network of Migration and Health. Andalusian Ministry of Health. 2014.
[40] Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. J Transcult Nurs. 2002 Jul;13(3):181-4;discussion 200-1. Review. PubMed PMID: 12113146. http://tcn.sagepub.com/content/13/3/181.full.pdf+html
[41] Fleming M, Towey K. Delivering culturally effective health care to adolescents. Chicago (IL): American Medical Association; 2001. Available at: http://www.ama-assn.org/ama1/pub/upload/mm/39/culturallyeffective.pdf.

- Breadth of view
- Flexibility
- Curiosity and desire to recognise and explore the intercultural components of transference and counter transference

Appropriate cultural counter transference means not falling into the errors of inadequacy. This means being aware of cultural influences.

Slide 22: Activity

Several tools exist to assess the cultural competence. A summary, prepared by Dr. Josepha Campinha-Bacote,[42] is included in the additional readings**.**

As an activity we propose to take into account the model "The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 1998a)" "The model views cultural competence as "the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)." This model requires health care providers to see themselves as *becoming* culturally competent rather than already being culturally competent. The process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire."[43]

The model is based on the following assumptions:
1. Cultural competence is a process, not an event.
2. Cultural competence consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

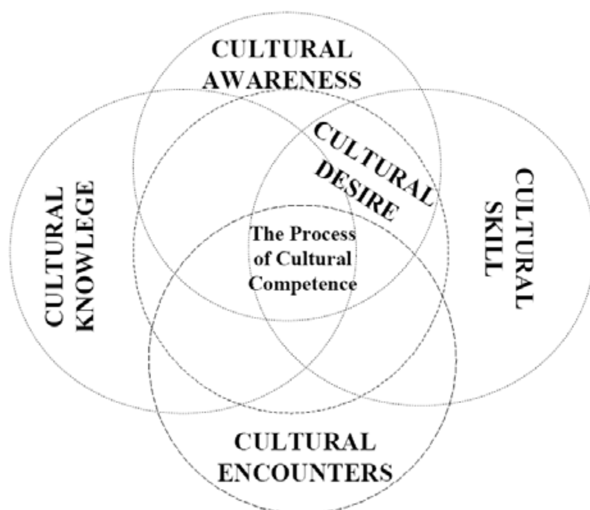

FIGURE 1. The Process of Cultural Competence in the Delivery of Health Care Services.
SOURCE: Transcultural C.A.R.E. Associates. Reprinted with permission.

3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).
4. There is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive health care services.

[42] http://www.transculturalcare.net/
[43] Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. J Transcult Nurs. 2002 Jul;13(3):181-4;discussion 200-1. Review. PubMed PMID: 12113146. http://tcn.sagepub.com/content/13/3/181.full.pdf+html

5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients.

Cultural assessment tool for professionals. ASKED[44]

The self-assessment tool, ASKED, is an informal tool. It works as a guide for reflection and assessment of cultural competence and helps us to explore and organize our ideas.[45]

Awareness	***Are you aware of your own prejudices and prejudices towards other cultural groups and racism in the health services ?***
Skill	**Do you know how to make a cultural assessment?**
Knowledge	***Can you describe the differences between various cultural groups?***
Encounter	***Do you try to conduct clinically efficient interviews with individuals from other cultural groups?***
Desire	***Do you really want to be culturally competent?***

In this activity, professionals are asked to consider these five constructs and then assess themselves, using the table below. The definition that we have used for the different concepts are taken from the model.[46] They will then discuss their self-analyses in groups of three:

44 Campinha-Bacote, Josepha; A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*; Thorofare; May 199. http://tcn.sagepub.com/content/13/3/181 (retrieved: December 17, 2014).

46 ***Cultural awareness*** is defined as the process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in healthcare delivery. ***Cultural knowledge*** is defined as the process in which the healthcare professional seeks and obtains a sound educational base about culturally diverse groups. In acquiring this knowledge, healthcare professionals must focus on the integration of three specific issues: health-related beliefs practices and cultural values; disease incidence and prevalence (Lavizzo-Mourey, 1996). ***Cultural skill*** is the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment. ***Cultural encounters*** is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible

Awareness	
Skill	
Knowledge	
Encounter	
Desire	

Slide 23: Readings

Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. J Transcult Nurs. 2002 Jul;13(3):181-4;discussion 200-1. Review. PubMed PMID: 12113146. http://tcn.sagepub.com/content/13/3/181.full.pdf+html

Campinha-Bacote, Josepha; A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*; Thorofare; May 199. http://tcn.sagepub.com/content/13/3/181

Fleming M, Towey K. Delivering culturally effective health care to adolescents. Chicago (IL): American Medical Association; 2001. Available at: http://www.ama-assn.org/ama1/pub/upload/mm/39/culturallyeffective.pdf.

International Organization for Migration (IOM) Equi-Health project to address Roma, migrant health issues in Europe. PBHLM Increasing Public Health Safety alongside the New Eastern European Borderline. http://www.iom.int/cms/en/sites/iom/home/news-and-views/press-briefing-notes/pbn-2013/pbn-listing/equi-health-project-to-address-r.html

Ingleby, D. (2012). Introduction by series editor. In: D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity, Volume II* (pp. 9-28). Antwerp/Apeldoorn: Garant.

Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. Work package 1 MEM-TP project. Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2014. http://www.mem-tp.org/pluginfile.php/233/mod_resource/content/1/MEM-TP%20WP1%20Synthesis%20Report%20171014.pdf

Saha, S., Beach, M.C., Cooper, L.A. (2009). Patient centeredness, cultural competence, and healthcare quality. *Journal of the National Medical Association*, 100 (11): 1275-85

Tervalon, M., & Murray-García, J. (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), 117–125.

stereotyping. ***Cultural desire*** is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters; not the "have to." Cultural encounters is the pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence.

MODULE 1:

SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY

Identifying aspects related to the positive contribution of interculturality and sensitivity to diversity

PREPARED BY:
Ainhoa Ruiz Azarola,
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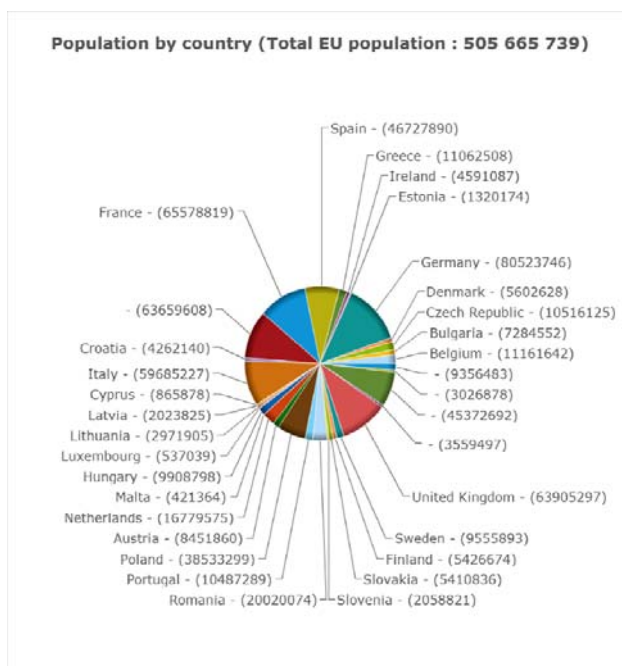
Identifying aspects related to the positive contribution of interculturality and sensitivity to diversity

Slide 24: Title of the Unit

Slide 25: Figures with demographic data

Europe is composed by millions of people, including migrants and ethnic minority populations. At the beginning of 2015, the total EU population is around 505 hundred millions.



Based on Eurostat latest statistics[47]**, *d***
uring 2012, there were an estimated 1.7 million immigrants to the EU-27 from countries outside the EU-27. In addition, 1.7 million people previously residing in one of the EU Member States migrated to another Member State. Thus, about 3.4 million people immigrated to one of the EU-27 Member States, while at least 2.7 million emigrants were reported to have left an EU-27 Member State.

The EU-27 foreign population (people residing in an EU-27 Member State with citizenship of a non-member country) on 1 January 2013 was 20.4 million, representing 4.1 % of the EU-27 population. In addition, there were 13.7 million persons living in an EU-27 Member State on 1 January 2013 with the citizenship of another EU-27 Member State.

There were 33.5 million people born outside of the EU-27 living in an EU-27 Member State on 1 January 2013, while there were 17.3 million persons who had been born in a different EU-27 Member State from their country of residence.

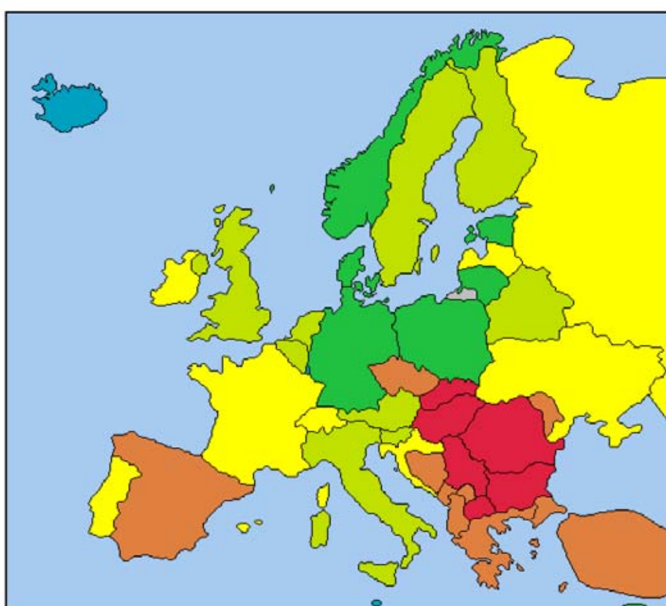
[47] Source: Eurostat [migr_pop3ctb]

	Total immigrants	Nationals		Non-nationals					
				Total		Citizens of other EU-27 Member States		Citizens of non-member countries	
	(1 000)	(1 000)	(%)	(1 000)	(%)	(1 000)	(%)	(1 000)	(%)
EU-27	1 693.9	:	:	:	:	:	:	:	:
Belgium	147.4	17.3	11.7	129.7	88.0	64.9	44.0	64.8	44.0
Bulgaria	*14.1*	*5.0*	*35.2*	*9.1*	*64.7*	*4.1*	*29.3*	*5.0*	*35.4*
Czech Republic	34.3	6.8	19.7	27.6	80.3	12.1	35.2	15.5	45.1
Denmark	54.4	18.6	34.3	35.8	65.7	19.8	36.4	16.0	29.3
Germany	592.2	87.2	14.7	503.6	85.0	298.5	50.4	205.1	34.6
Estonia	2.6	1.5	58.1	1.1	41.9	0.1	2.7	1.0	39.3
Ireland	54.4	16.5	30.4	37.9	69.6	22.3	40.9	15.6	28.7
Greece	110.1	42.6	38.7	67.6	61.3	24.8	22.5	42.7	38.8
Spain	304.1	31.6	10.4	272.5	89.6	100.3	33.0	172.2	56.6
France	327.4	115.8	35.4	211.7	64.6	90.8	27.7	120.9	36.9
Croatia	9.0	4.2	47.0	4.8	53.0	1.3	15.0	3.4	38.1
Italy	350.8	29.5	8.4	321.3	91.6	104.1	29.7	217.2	61.9
Cyprus	17.5	1.3	7.3	16.2	92.6	10.2	58.3	6.0	34.2
Latvia	13.3	9.6	72.4	3.7	27.6	0.5	4.1	3.1	23.5
Lithuania	19.8	17.4	87.5	2.5	12.5	0.7	3.7	1.7	8.8
Luxembourg	20.5	1.0	5.1	19.4	94.7	15.6	76.0	3.8	18.8
Hungary	33.7	13.4	39.6	20.3	60.3	10.4	30.7	10.0	29.6
Malta	7.1	1.8	24.7	5.4	75.3	2.5	34.6	2.9	40.7
Netherlands	124.6	36.4	29.2	83.0	66.6	51.2	41.1	31.8	25.5
Austria	91.6	8.3	9.0	83.2	90.9	51.9	56.7	31.4	34.2
Poland	217.5	135.9	62.5	81.5	37.5	24.4	11.2	57.1	26.2
Portugal	14.6	9.3	63.9	5.3	36.1	1.3	9.2	3.9	26.9
Romania	167.3	155.6	93.0	11.6	6.9	3.5	2.1	8.2	4.9
Slovenia	15.0	2.7	18.2	12.3	81.8	2.2	14.5	10.1	67.2
Slovakia	5.4	2.5	45.7	2.9	54.3	2.4	44.6	0.5	9.6
Finland	31.3	7.9	25.4	22.8	73.0	10.3	32.9	12.6	40.1
Sweden	103.1	20.5	19.9	82.3	79.8	25.3	24.6	56.9	55.2
United Kingdom	498.0	80.2	16.1	417.8	83.9	157.6	31.6	260.3	52.3
Iceland	5.0	2.3	46.6	2.7	53.4	1.8	36.6	0.8	16.9
Liechtenstein	0.7	0.2	25.5	0.5	74.5	0.2	37.1	0.3	37.4
Norway	69.9	6.7	9.6	63.2	90.4	36.8	52.6	26.4	37.7
Switzerland	149.1	24.0	16.1	125.0	83.9	90.1	60.5	34.9	23.4

(¹) The values for the different categories of citizenship may not sum to the total due to rounding and the exclusion of the category 'unknown citizenship' from the table.
Source: Eurostat (online data codes: migr_imm1ctz and migr_imm5prv)

Map showing density of Roma population (%) in the European area

Based on data from the Council of Europe (2010)



Key to colours:

> 5%	
> 1%	
> .5%	
> .2%	
> .1%	
unknown	

Migrants and people from ethnic minorities, as well as the other European citizens in the European Union, are protected by the fundamental principles of the EU[48], there ensure the free movement of

[48] Communication from the Commission: Free movement of workers – achieving the full benefits and potential.

persons as one of the fundamental freedoms guaranteed by Community law and includes the right to live and work in another Member State.

Migrants and ethnic minority populations have been differentiated because of their personal and cultural habits, and only sometimes because of their economic value. Their contribution in personal and social dimensions has, however, not been recognised or valued in the same way.

Slide 26: The European Network against Racism (ENAR)[49] has published a document addressing "*this mismatch of information about migrants and ethnic and religious minorities by showing evidence of the many talents they contribute to European society – culturally, socially, politically and economically. It also highlights, by contrast, the uncalculated losses incurred by failing to recognise and value these innumerable talents – which further impact Europe's resilience in times of crisis, its lack of collective creativity and well-being."*

Slide 27: *The main **contributions of migrants** to the European society **are summarized as**:*

*Contributions to the **social, cultural and political** aspects have an **economic value.***
*Contributions to the **European economy**.*
*They **fill** specific **labour market gaps**, taking **jobs that the general population often refuses**.*
*They are not only innovating but **their presence is enabling others to create and innovate**.*
*They contribute significantly, directly and indirectly, to **GDP (gross domestic product)** and to the **trade of European countries.***

The ENAR publication sets out to raise awareness of the many talents of migrants and ethnic and religious minorities in Europe by demonstrating that they contribute significantly, directly or indirectly.

Slide 28 and 29: The Europe 2020 Strategy[50] and the Stockholm Programme[51] fully recognise the potential of migration for building a competitive and sustainable economy. They set out, as a clear political objective, the effective integration of legal migrants, underpinned by the respect and promotion of human rights[52].[53]

On the other hand, we can talk about aspects related to the positive contribution of interculturality and sensitivity to diversity**. *WP 1*[54]** describes the factors undermining quality and good practices. The authors conclude that *cultural competence or diversity sensitivity may have a positive impact on the following barriers to quality:*

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http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52002DC0694&from=EN (retrieved: March 6, 2015)
[49] Lynch, C;Pfohman, S.: Hidden talents, Wasted Talents? The real cost of neglecting the positive contribution of migrants and ethnic minorities" .ENAR (European Network Against Racism).
http://cms.horus.be/files/99935/MediaArchive/publications/20068_Publication_HiddenTalents_web.pdf
[50] Conclusions of the European Council, 25/26 March 2010, EUCO 7/10, CO EUR 4, CONCL 1.
[51] The Stockholm Programme - An open and secure Europe serving and protecting citizens, OJ 2010/C 115/01.
[52] The Annual Growth Survey 2011 brings together different actions which are essential for the EU to move towards its Europe 2020 objectives. This survey has shown the need for urgent reforms to promote skills and create incentives to work both for the national and migrant population,. COM(2011) 11 final, Annex 2, Macro economic report.
[53] European Commission. COM(2011) 455 final, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, European Agenda for the Integration of Third-Country Nationals. Brussels, 20.07.2011.
[54]Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a, p. 13. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).

It may facilitate communication about different frames of reference regarding health.
It may help professionals to overcome deeply-rooted prejudices.
It may help to bridge the gap between widely differing understandings of health and illness in general, as well as the nature, manifestations, causes, effects and social meanings of particular illnesses.
It may help to reconcile conflicting expectations concerning appropriate behaviour for doctors and patients.

Therefore *"Promoting cultural competence or diversity sensitivity at the level of both organisations and individuals is seen as a central component of the changes which have to be made in order to adapt services to users with widely varying beliefs, expectations, needs and social positions. It is also important for targeting health promotion interventions for migrants, so as to take into account the different ways in which people perceive and experience a health problem."*[55]

Many of positive contributions and hidden talents of migrants cannot be measured. Nonetheless, they contribute to the wellbeing in Europe. ENAR´s publication estimates and describes the economic value of such talents. It therefore highlights the importance of the main intention of the publication: to change the common discourses on migration in Europe. This reality can also be applied to different ethnic minorities living in Europe nowadays.

A population's wellbeing and health are the result of the interaction between all the different population groups. If these populations are not integrated, their positive contributions to the common good will be lost.

Some of the most important findings from the ENAR study are included in the additional readings. As the study points out, migrants and ethnic minorities contribute positively to European society in social, cultural, political and health aspects, and not only in the economic aspects.

Slide 30:

Recommended readings

Conclusions of the European Council, 25/26 March 2010, EUCO 7/10, CO EUR 4, CONCL 1.
European Commission. COM(2011) 455 final, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, European Agenda for the Integration of Third-Country Nationals. Brussels, 20.07.2011.
Lynch, C;Pfohman, S.: Hidden talents, Wasted Talents? The real cost of neglecting the positive contribution of migrants and ethnic minorities". ENAR (European Network Against Racism). http://cms.horus.be/files/99935/MediaArchive/publications/20068_Publication_HiddenTalents_web.pdf
Netto, G. *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International.*
The Stockholm Programme - An open and secure Europe serving and protecting citizens, OJ 2010/C 115/01.

[55] Netto, G. *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International.*

European Commission. European Migration Network - Impact of Immigration on Europe's Societies - March 2006European Migration Network. Impact of Immigration on Europe's Societies. http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/illegally-resident/0._final_pilot_study_booklet_27mar06_en.pdf

MODULE 1:

SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY

Developing strategies for health promotion and health education based on cultural diversity and interculturality.

Prepared by
Ainhoa Ruiz Azarola,
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Developing strategies for health promotion and health education based on cultural diversity and interculturality

Slide 31: Title of the Unit

Slide 32:
Developing strategies for health promotion and health education based on cultural diversity and interculturality

Related to the issue of developing strategies for health promotion and health education in general, **it is important to stress these** are services for the entire population, not just for those in need of care., WP1 authors conclude that *whereas it is the individual who seeks the health care provider, preventive and educational programmes go in search of the individual. If they succeed in finding him or her, the individual has access to them*.

Slide 33: Regarding health promotion:

The World Health Organization defines health promotion as "the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions."[56]

It is very important to take into account that if services and interventions are not specifically targeted to migrant and an ethnic minority population, *research demonstrates that their success may be limited*. This is especially the case for very vulnerable groups such as the Roma, who experience a great number of barriers to accessing health services compared to non-Roma. This is despite the fact that most of them are national citizens of a Member State and thus should be entitled to these services.[57]

Therefore, in order to develop strategies for health promotion based on cultural diversity and interculturality, we need to:

- Identify tools for health promotion in migrant and ethnic minority populations.
- Identify health practices that can be enhanced.
- Apply strategies for working with the community.
- Search for experiences of health promotion.

[56] http://www.who.int/topics/health_promotion/en/
[57] Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a, p. 13. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).

Slide 34 and 35: Different factors concerning health habits and health promotion need to take into account:

Macrostructural factors	Microstructural factors
Economy	Family
Policy	Social Networks
Globalization	
Communication	

A new social context could appear for migrants in the new host country. At the same time, the standard health habits adopted by ethnic minorities might not be appropriate.

People have customs, beliefs, different health systems and different health practices in the migrants' countries of origin. To make a healthy adaptation to the new environment, migrants may need to acquire new, healthy habits regarding the food they consume or the use of alcohol, tobacco or other drugs.

What are the key elements of effective health promotion?

• Schools, workplaces, and local communities all provide opportunities to promote health.
• In order to be effective, people must be the focus of promotional programs and the processes of decision making.
• Providing real access to education and information, with an appropriate language and style, is crucial.
• Health promotion is a key investment in economic and social development.

The main objective of health promotion is to make it easy for people to have access to healthy choices. For this, it is essential to take into account these outcomes in planning health promotion programms.

• Social outcomes: quality of life, functional independence, and equity.
• Health outcomes: morbidity, avoidable mortality, and disability.
• Intermediate health outcomes [modifiable (or adaptable) determinants of health]:
- **Healthy lifestyles:** diet, exercise.
- **Effective health services:** delivery of preventive services, access to health services and their suitability.
- **Healthy environments:** a safe physical environment, economic and social conditions, food supply, drug and alcohol restrictions.

In terms of the individual, health promotion needs to focus on dealing with the life cycle: pregnancy, birth, childhood, adolescence, old age, and death. These moments have different meanings, lived experiences or even needs.

In most health systems, several health promotion programmes have been designed and put into place for these life moments. There may be many reasons, however, for migrants and persons from ethnic minorities not to follow health programs, which the health services have established. These include lack of information and their own parallel health systems. It is very important to be aware of these groups' habits and needs.

Adapted health education is also an important issue for promoting the health of migrants and people from ethnic minorities. Health education can be implemented at an individual, group, or community level. Many resources are available on the Internet for health professionals[58] that can help to improve their daily work.

We will be able to give all these population groups the best attention by sharing best practices and being aware of cultural diversity and interculturality, and by taking into account the different needs, customs and values of these groups.

Slide 36: Regarding health education / health literacy:

Health education is defined by the World Health Organization as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.[59]

This is define as "the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and [access] services needed to prevent or treat illness"[60].

Poor health literacy implies a lack of knowledge about health, illness and the health care system[61]. It leads to the following difficulties in accessing healthcare: not knowing the connection between risky behaviours and health, not being able to locate providers and services, not knowing the meaning of application forms, notices, and brochures, not being able to fill out complex health forms, or to share medical history with providers[62]. Sometimes, low language proficiency can be an important factor preventing migrants from improving their health literacy.

Often, however, migrant and ethnic minority users are regarded as having 'low health literacy' when the root of the problem may be simply that they have not been provided with adequate information. Such information needs to address the following issues:

Entitlements and the procedures necessary to claim them.
How to use the health system (e.g. whether specialist care can be accessed directly or only through a 'gatekeeper').
Health maintenance in specific conditions (living with diabetes, cancer etc.).

[58] E.g.: http://www.saludinmigrantes.es/
[59] http://www.who.int/topics/health_education/en/
[60] U.S. Department of Health and Human Services (2013, December). *About Health Literacy.* Health Resources and Services Administration. Retrieved from http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html
[61] Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a, p. 13. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).

[62] Institute of Medicine (2004). *Health Literacy: A Prescription to End Confusion.* Washington DC: Institute of Medicine.

Health education and health promotion: how to recognise problems, when to seek help, how to look after one's own health.

A great deal of research, much of it supported by the EU, has been carried out in the last decade on shortcomings in the information available to migrants as well as 'good practices' to overcome them. An important finding is that such information often needs to be targeted: the language used, the means of dissemination, and the content may all have to be adapted in order to reach migrants effectively.[63,64,65] *Some of these interventions also call for intersectoral and intersectional approaches, requiring the engagement of policy makers and key stakeholders outside the health sector and at all levels of health organisations, and looking at health inequalities through a wider 'diversity' lens. Other interventions involve front-line health professionals who come into contact with the target group in their daily work, and representatives of the communities they serve.*

Slide 38: Readings

Institute of Medicine (2004). *Health Literacy: A Prescription to End Confusion.* Washington DC: Institute of Medicine.
Priebe. S. *et al* (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC Public Health*, 11:187.
Mladovsky, P. *et al* (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.
Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. Work package 1 MEM-TP project. Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015. http://www.mem-tp.org/pluginfile.php/233/mod_resource/content/1/MEM-TP%20WP1%20Synthesis%20Report%20171014.pdf
Netto, G. *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, 25: 248-57
U.S. Department of Health and Human Services (2013, December). *About Health Literacy.* Health Resources and Services Administration. Retrieved from
http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html

European Commission. Synthesis Report Migrant access to social security and healthcare: policies and practice European Migration Network Study 2014. http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/emn_synthesis_report_migrant_access_to_social_security_2014_en.pdf

[63] Priebe. S. *et al* (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC Public Health*, 11:187.
[64] Mladovsky, P. *et al* (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.
[65] Netto, G. *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, 25: 248-57