Migrant Friendly Hospital

A Literature Review

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ABSTRACT

Migration is the movement of population and it is increasing all over the world. This movement also affects the health care. Nowadays there are more migrant patients in health care than before and nurses have limited experiences in caring for people who come from different cultures. In order for the health care services to be equal for everyone, the needs of the migrants need to be considered as well.

The purpose of this final project was to describe and to clarify the concept of a migrant friendly hospital. Needs, interventions and effectiveness of interventions were described. By exploring projects, publications, and research articles, this paper aimed to answer the following questions: What are the main needs and interventions in the health care of migrants? What is a migrant friendly hospital?

A literature review was performed by using two well-known electronic databases CINAHL and OVID. In addition, a search in Google was performed in order to locate information concerning the topic. Altogether 21 scientific articles, eight different publications, and project reports were analyzed. All the data answered to the purpose and aims, were written in the English language, and were published between 1999-2010. The collected data was analyzed using inductive content analysis as a method and six themes emerged from the articles. The publications located through Google were described separately.

The main findings in the articles show that obstacles in communication are the most pressing area of concern for migrant patients. Interventions concerning communication include the use of professional interpreters. Professional interpreters increase the patients' access to health care and overall improve the care of migrant patients.

Additionally, recognizing diversity and difference should be seen as a positive element and having culturally competent health care professionals is an important step towards developing migrant friendly services. Cultural competence training is the most important intervention in achieving culturally competent care.

In conclusion, the needs of migrant population are various and responding to them requires extensive development in the health care sectors.

Keywords

migrant, migration

Metropolia

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TIIVISTELMÄ

Migraatio viittaa ihmisten muuttoliikkeeseen ja se kasvaa koko ajan. Muuttoliike vaikuttaa myös terveydenhuoltoon. Tänä päivänä terveydenhuollossa on kasvavassa määrin maahanmuuttajia ja näiden potilaiden hoidossa hoitohenkilökunnalla on rajallinen kokemus. Jotta terveydenhuolto palvelut olisivat tasavertaisia kaikille myös maahanmuuttajien terveys tarpeet tulee ottaa huomioon.

Tämän kirjallisuuskatsauksen tarkoituksena oli kuvata ja selkeyttää käsitettä maahanmuuttaja ystävällinen sairaala. Tarpeet, interventiot ja interventioiden vaikuttavuus on ilmaistu. Perehtymällä projekteihin, julkaisuihin ja tutkimus artikkeleihin tämä päättötyö pyrki vastaamaan seuraaviin kysymyksiin: Mitkä ovat maahanmuuttajien terveyteen liittyvät tarpeet ja niihin liittyvät interventiot? Mikä on maahanmuuttaja ystävällinen sairaala?

Kirjallisuuskatsauksen tiedonhakumenetelminä käytettiin tunnettuja elektronisia tietokantoja (CINAHL, OVID) ja Googlea. Kaiken kaikkiaan aineistoksi valittiin 21 englanninkielistä artikkelia ja kahdeksan erilaista julkaisua ja projektiraporttia, jotka oli julkaistu vuosina 1999-2010. Aineisto vastasi työn asettamiin tarkoituksiin ja pyrkimyksiin. Aineisto analysoitiin induktiivisen analyysin avulla ja artikkeleiden pohjalta nousi kuusi teemaa. Googlen kautta hankitut julkaisut kuvailtiin erillisenä kokonaisuutena.

Tutkimustulokset osoittivat, että esteet kommunikaatiossa on suurin huolenaihe maahanmuuttaja potilaiden terveydenhuollossa. Hoitohenkilökunnan ja potilaiden väliseen kommunikaatioon liittyviä esteitä ja ongelmia voitaisiin helpottaa käyttämällä tulkkia. Ammattitaitoisen tulkin käyttö lisää potilaiden hoitohakuisuutta ja kaiken kaikkiaan parantaa maahanmuuttaja potilaiden terveydenhuoltoa.

Lisäksi erilaisuuden tunnustaminen ja monimuotoisuus tulisi nähdä positiivisena elementtinä ja ammattitaitoisen hoitohenkilökunnan tulisi omata kulttuurillinen kompetenssi.

Johtopäätöksenä maahanmuuttajataustaisten potilaiden tarpeet ovat monenlaisia ja niihin vastaaminen vaatii laajamittaista kehitystä terveydenhuolto alalla.

Avainsanat

maahanmuuttaja, maahanmuutto

CONTENTS

1. INTRODUCTION

Migration is the movement of population and it can be either voluntary or forced. The number of migrants is increasing all over the world. It includes population movements over international and domestic borders. In 2007, United Nations estimated that there are 175 million migrants worldwide. (WHO 2007.) According to their status, they have a different access to basic social services. These different statuses are migrant workers and their families, long-term and short-term immigrants, internally displaced people, asylum seekers, refugees, those who have gone back to their country of origin or return, illegal migrants and victims of human trafficking. (WHO 2007.)

The topic of this paper is a migrant friendly hospital and it is a part of a developmental project in the degree programme in nursing (DPN). A developmental study is "A type of study of nonexperimental research design that is concerned not only with the existing status and interrelationship of phenomena but also with changes that take place as a function of time" (LoBiondo-Wood 2006: 562). The aim of the DPN-project is to have a local influence in promoting migrant friendly hospitals.

By the end of 2008, the amount of foreign citizens in Finland was 2.7% (143,256) of the overall population; the biggest population growth took place in Uusimaa (Tilastokeskus 2009). Migration and health care are closely linked together as migrants often suffer more from a poorer health status than the average population. This is due to their lower socio-economic status or that they do not seek help early enough or because of traumatic migration experiences. At this moment, health care services cannot answer the needs of migrants sufficiently.

Since Finland is moving towards a more multicultural society, this also affects the health care. Nowadays there are more migrant patients in health care and nurses have limited experiences of caring for people who come from different cultures. In order for the health care services to be equal for everyone, the needs of the migrants need to be considered as well.

The purpose of this final project is to describe and to clarify the concept of a migrant friendly hospital. Needs, interventions, and if possible, effectiveness of interventions will be described. By exploring projects, publications, and research articles, this paper aims to answer the following questions: What are the main needs and interventions in health care of migrants? What is a migrant friendly hospital?

2. MIGRANT, MIGRATION, CULTURE, AND CULTURAL COMPETENCE

For the benefit of this final project, the key concepts culture, cultural competence, migrant, and migration are described as follows. According to WHO (2007) a migrant is a person who moves from one region or a country to another and is seen as somebody who is a foreigner in a country including refugees. Reasons for migration can be economic, family, legal status, conflicts, environment, political persecution, and combination of these. Migration is the act of movement and it contains space and time. Space involves the place of departure and of arrival. Most commonly, migration is international where one crosses at least one national border and changes his/her country of residence. (WHO 2007.)

"Culture is our social legacy. It includes many facets about the way of life of people who share a common learned tradition which is transmitted from one generation to the next." (Leininger 1994: 112). Apart from the transmission within the family, it can also be learned from other social organizations where it is shared by the group's majority. It guides in decision-making, facilitates self-esteem and self-worth, and includes an individualized worldview (Giger, Davidhizar, Purnell, Harden, Philipps & Strickland 2007). Cultural competence is having knowledge, understanding and skills about different cultural groups. This allows the health care professional to provide culturally sensitive care. Cultural competence is not something which one acquires at once, but it is a continuing process. It includes being aware of one's own worldview and not letting it interfere with those that are different, having a positive attitude towards cultural diversity (Giger et al. 2007).

3. METHODOLOGY

In this study, literature review is used as methodology. Literature includes all written sources, which are significant for the selected subject (Burns & Grove 2001 : 107). This literature review was conducted by using a search engine and databases. Databases are used for retrieving scientific articles on the selected topic. A search engine is used to explore and gain knowledge about different organizations and projects, who concentrate on improving health services for migrants. Their actions and discoveries cannot be found through scientific databases. "The overall purpose of a review of the literature is to develop a strong knowledge base for the conduct of research and evidenced-based practise" (LoBiondo-Wood 2002 : 79). By conducting a literature review one determines unknown and known information about a chosen topic. It also reveals findings of evidence-based practise and uncovers inconsistencies, consistencies, and gaps in chosen subject.

3.1. Data collection

To retrieve information internet searches were performed, using the Google search engine, in early December 2009 and in March 2010. The following search terms were used migrant friendly hospitals, migrant, migrant and healthcare, migration, migrant and health, and culturally friendly hospital. The terms produced six relevant web pages from different organizations, projects, and reports, refer to APPENDIX 3. Two research papers were found through the search in Google. Krajic, Straßmayr, Karl-Trummer, Novak-Zezula, and Pelikan, (2005) was a vital source for finding additional material from its reference list. It provided a systematic literature review conducted by Alexander Bischoff (2003).

A supervising teacher supplied the web page of Migrant Friendly Hospitals project, which turned out to be of great importance for this final project. In addition, the supervisor also provided the web page of The Norwegian Centre for Minority Health Research (NAKMI).

The publications and projects were included based on whether they were relevant according to their title, which have been published between 1999-2010, which were written in English, and answered to the purpose of the study.

To look for scientific articles three database searches were conducted, one in October 2009 and two in March 2010. The first, tentative search was carried out using CINAHL database with the following keywords: patient-friendly, minority ethnic AND nurses, and minority ethnic AND nurses AND attitudes. The limitations were full text and publications from 1999-2009. Two relevant articles were chosen from this tentative search.

Another database search was conducted in March 2010 after reading through the gathered materials from the first search. The search was done in databases CINAHL and OVID. The limitations in all the searches were publications from 1999-2010 and English language. Refer to APPENDIX 1 and 2 for a complete description**.** Altogether 12 relevant articles were found, three through CINAHL and nine through OVID. Additionally, five articles were found by performing a manual search.

Altogether 21 articles were included based on whether they were relevant according to their title and/or abstract, which have been published between 1999-2010, which were written in English, and answered to the purpose of the study.

3.2. Data Analysis

According to Elo and Kyngäs (2007) content analysis is a method of describing and analysing data in a systematic way. The data can be either in written or in verbal form. In order to analyze findings of the review an inductive content analysis was performed. Inductive content analysis is a technique for analyzing data by starting from the details and moving toward the general picture. The process was divided into three phases: preparation, organising, and reporting.

Firstly, both writers of this final thesis read all the articles, publications, and projects and ensured that the inclusion criteria's were met. Secondly, two tables were created; one for the articles and one for the reports of projects, to aid in the analyzing process (APPENDIX 3 and 4). Information was transferred from the materials to the tables in the purpose of having all relevant findings in a smaller and manageable form.

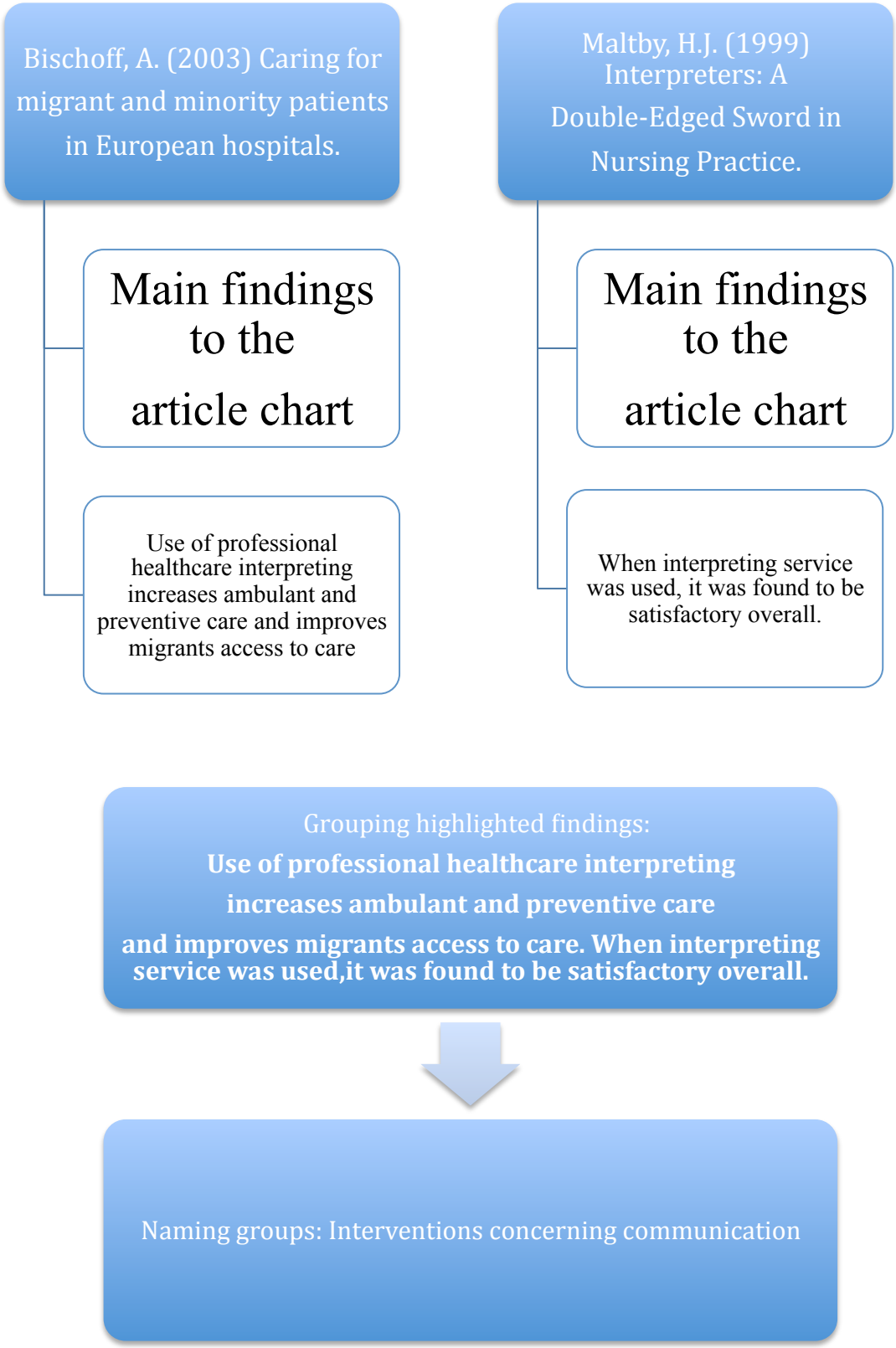
From the findings similar words, combination of words, and fragments of text were grouped together. Comparable groups were then put into broader categories in order to minimize the number of groups and to increase understanding on the subject. Thirdly, all the categories were named in relation to the content.

These categories are:

- communication barriers
- interventions concerning communication
- cultural competence
- interventions concerning cultural competence
- responsiveness and empowerment and interventions concerning them
- monitoring and interventions concerning it

The different publications, projects, and organizations are described as a separate entity in the findings.

- Diagram 1: Example of the analysis process



4. FINDINGS

The purpose of this final project is to describe and clarify the concept of a migrant friendly hospital. Needs, interventions, and if possible, effectiveness of interventions will be described. By exploring projects, publications, and research articles this paper aims to answer the following questions: What are the main needs and interventions in health care of migrants? What is a migrant friendly hospital? This chapter illustrates findings from the data collected for this final project.

4.1. Different Projects

As already mentioned before, the need for a migrant friendly hospital is nothing new. Health care professionals are confronted with it on a daily basis, either while having personal experiences, reading the news, following current discussions in health care or exploring relevant research. There is a lot of discussion on the needs of migrants mostly from the perspective of the nurses' experiences while caring for a migrant patient. To get some background information, the authors wanted to know what already existing research provides, what has been initiated so far, and what kind of projects are currently ongoing. Relevant projects, involving different European countries, were found while exploring the topic.

TABLE 1 SUMMARY OF PROJECTS

NAME OF THE PROJECT/ORGANIZATION	DESCRIPTION/AIM/PURPOSE
Migrant Friendly Hospital (MFH)	The aim was to place migrant-friendly, culturally competent health care and health promotion into a higher position on the European health policy agenda and to support other hospitals with practical knowledge and instruments so that they could become more migrant friendly.
Task Force on Migrant Friendly and Culturally Competent Health Care (WHO-HPH TF MFCCH	To guarantee the sustainability of the MFH initiative. It aims to develop ways of improving the delivery of high quality, linguistically appropriate, culturally sensitive**,** equitable and accessible health care services for migrant and ethnic minorities.
Good/Best Practices -Conference	A conference called "Health and Migration in the EU: Better health for all in an inclusive society" was held in Lisbon, Portugal where Good Practices on Health and Migration in the EU were discussed.
Norwegian Centre for Minority Health Research (NAKMI)	The aim is to become a meeting point for minority health issues in Norway, especially for competence concerning somatic and mental health care of immigrants and refugees.
Health Service Executive (HSE)	HSE is a mixture of staff from different departments in health services and other offices which deal with the public. The HSE came up with a plan called "The National Intercultural Health Strategy 2007-2012". This strategy focuses on all minority-ethnic groups in Ireland.
Swiss Forum for Migration and Population Studies (SFM)	It is an institute which does teaching, training and research at the University of Neuchâtel. It was founded in 1995 with the aim to contribute to pragmatic discussions on migration issues.
Health Promoting Hospitals and Health Care (HPH-HC)	It is a centre which collaborates with WHO and its mission is to support hospitals and other health care institutions in Europe and other regions of the world in order to develop into healthy and health promoting settings and organizations.
Migration and Health: Difference Sensitivity from an Organisational Perspective Publication of the results from three different workshops from the University of Malmö.	To show the organizational challenges which health systems are facing with the new migration trends.

4.1.1. The Migrant-friendly hospitals (MFH) project

The European "Migrant-friendly hospitals" (MFH) is a project sponsored by the European Commission, General Directorate Health and Consumer protection from 2002-2005. It consisted of 12 hospitals from 12 European Union (EU) countries, several experts, the Ludwig Boltzmann Institute for the Sociology of Health and Medicine at the University of Vienna as co-ordinator, and national and regional networks of the World Health Organisation Network (WHO) of Health Promoting Hospitals (HPH). The aim was to increase the importance of migrant-friendly, culturally competent health care and health promotion on the European health policy agenda and to support other hospitals with practical knowledge and instruments so that they could become more migrant friendly. (Krajic et al. 2005, Migrant-Friendly Hospitals 2009.)

The goal was to select three common problem areas from the 12 pilot hospitals through a systematic needs assessment. Language barriers in communication with patients, patient education, and the cultural competence of staff members were the most common issues. In 2003, the Ludwig Boltzmann Institute commissioned the Swiss Forum for Migration and Population Studies to conduct a literature review to gather knowledge related to problems and possible solutions of health and healthcare concerning migrants (Karl-Trummer & Krajic 2007). Alexander Bischoff (2003) conducted the literature review and came up with four groups of interventions communication, responsiveness, empowerment, and monitoring. He as well pointed out the effectiveness of the interventions.

Shortly after that the Migrant Friendliness Quality Questionnaire (MFQQ), a generic assessment instrument to assess the overall migrant-friendliness of a health care institution, was developed. Refer to APPENDIX 5. This questionnaire was used twice (2003 and 2004) within each of the participating hospitals to monitor the projects progress (Karl-Trummer & Krajic 2007.) The experiences of the European hospitals strengthen the case for investing in training towards cultural competency as a solution for tackling tensions and difficulties experienced in encounters between staff and a diverse patient population.

Experiences indicate that it is advisable to distinguish two aspects of this issue: on the one hand cultural competence training as a short, generic, basic workshop, and on the other hand the systematic inclusion of cultural competence aspects into the regular quality management routines on the level of hospital departments.

In December 2004, experiences and results from the MFH project were presented at a Final Conference in Amsterdam. The goal of the conference was to bring together experts to discuss specific models and different approaches to address cultural diversity in hospital care. A list of recommendations/criteria was developed which is called "The Amsterdam Declaration Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe". A summary of the recommendations:

- The success of becoming a migrant friendly hospital depends on the complementary contributions of several different stakeholders
- Hospital owners/management, quality management: the quality of the services has to be put on the hospitals agenda
- Staff/Health Professions: acknowledgement that the issues are relevant and willingness to achieve competency
- Users (patients)/Representatives of community groups: making contributions to the process by putting diversity, health and health care on their agenda
- Health sciences: Expertise and scientific knowledge can be helpful in the process.
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A large number of European and international organizations have endorsed the declaration. (The Amsterdam Declaration 2004.)

4.1.2. Task Force on Migrant Friendly and Culturally Competent Health Care (WHO-HPH TF MFCCH)

The Task Force (TF) was created out of a desire to continue working on the themes, which were concluded from the MFH project, and to build on the gained experiences. The aims and objectives of the TF are to develop improvements in the delivery of high quality culturally competent health care services for migrant and ethnic minorities. The TF meets twice a year to discuss and exchange knowledge, and it organizes conferences. The conference Good/Best Practices, which was hold in Lisbon, is an example of TF's efforts (Further MFH Activities, Task Force MFCCH 2010.)

4.1.3. Good/Best Practices

In 2007 a conference called “Health and Migration in the EU: Better health for all in an inclusive society” was held in Lisbon, Portugal where Good Practices on Health and Migration in the EU were discussed. Several EU countries shared their knowledge on the effectiveness of interventions to improve migrant health and healthcare in the field, and as well to talk about the obstacles each country is facing. Problem areas showed once more that they were very similar to the ones that were brought together in the Amsterdam Declaration. Good/Best Practices can assist others in dealing with similar issues and through that provide a link between research and policy-making as it provides model projects and successful initiatives. (Good Practices on Health and Migration in the EU 2007.)

Finland took part in the conference and presented how the problem of communication issues is taken care of by using interpretation services. Interpretation services in Finland are offered in health care and preventive services whenever needed. The goal of interpreting services in Finland is to guarantee that migrants have the same rights as the other residents do. Finnish Ministry of Labour proposes that interpreter services should mainly be used in the initial stage of migration because everyone should learn Finnish or Swedish as quickly as possible. If there is a learning barrier, the local language interpreting services in these instances can be used for a longer time. There is no set time limit. (Koskenkorva 2010.)

The interpretation service has been developed as the need for the service is constantly growing. There are several Acts which regulate the service and gives the migrants the right to the service. Arranging and supplying interpreting services are the tasks of municipalities. The law provides the health care personnel and clients the right to request interpreting service when they think it is a necessity in assuring the quality of the care. The state funds interpreting and translation services to immigrants with refugee status, and to Ingermanland Finns from the former Soviet Union. In addition, the state finances the use of social welfare services, health departments, and for adaptation during the early phase of immigration. The municipalities are responsible for reimbursing interpreting services to all other immigrants living in the municipality area. (Koskenkorva 2010.)

The current interpretation services include different forms of interpreting; via telephone, on-screen, and face-to-face interpreting. There are in total eight regional interpretation centres in Finland provided by the public sector. In addition, there are private interpretation and translation service companies. (Koskenkorva 2010.)

4.1.4. Norwegian Centre for Minority Health Research (NAKMI)

NAKMI's aim is to become a meeting point for minority health issues in Norway, especially for competence concerning somatic and mental health care of immigrants and refugees. The organization surveys the needs of migrants in the public health care and initiates different projects concerning migrants and health. One of their projects coordinates a network for migrant-friendly hospitals in a multicultural Norway. The network consists of six hospitals from all over Norway. Twice a year meetings are held to share information and to develop lasting practices. (NAKMI 2010.)

4.1.5. Health Service Executive (HSE)

The Health Service Executive (HSE) is a mixture of staff from different departments in health services and other offices which deal with the public. The HSE came up with a plan called "The National Intercultural Health Strategy 2007-2012". This strategy focuses on all minority-ethnic groups in Ireland. The strategy was developed in order to deal with the barriers and inequalities that exist in the health system. The information in the strategy was gathered from meetings, discussions, workshops, organizations that work with asylum seekers, individuals, and through questionnaires. New developments have been initiated since the start of the strategic plan. For example, training and support provided to hospital staff, identification of local health information that requires improvement, and the MFH initiative is ongoing in some of the hospitals. (Intercultural Health Strategy 2007.)

Another development, which resulted from the HSE National Intercultural Health Strategy, is a guide that profiles the cultural and religious needs of 25 diverse groups. It was developed in reaction to a need expressed by health care staff and designed to increase the capacity in providing cultural competent care in Irish health settings. (McGuane 2009.)

4.1.6. Swiss Forum for Migration and Population Studies (SFM)

The Swiss Forum of Migration and Population Studies (SFM) is an institute which does teaching, training and research at the University of Neuchâtel. It was founded in 1995 with the aim to contribute to pragmatic discussions on migration issues. Since then the SFM has completed over 200 studies. The SFM offers services in the form of research and its expertise lies in integration, asylum and refugees, migratory movements, racism and discrimination and demography. It works with several prominent European research institutes that are dealing with migration issues. (UNINE 2010.) An example of SFM work is a literature review conducted by Alexander Bischoff, as mentioned above. The results from this literature review "Caring for migrant and minority patients in European hospitals" have been of great importance for the MFH project.

4.1.7. Health Promoting Hospitals and Health Care (HPH-HC)

HPH-HC is a centre who collaborates with WHO and its mission is to support hospitals and other health care institutions in Europe and other regions of the world to develop into healthy and health promoting settings and organizations. It pursues its mission through providing scientific/technical support like: organizing facts, promoting communication through conferences, workshops, newsletters, and a website. It initiates and coordinates developmental projects and research and publishes concepts, strategies for implementation and experiences. The centre is following the principles of thorough scientific research and it is also committed to a model of applied science for evidence-based quality improvement in health care. An example of a project where HPH-HC was part of it is the above mentioned MFH project and the WHO HPH task force "Migrant friendly and culturally competent hospitals". (WHO Collaborating Centre for Health Promotion in Hospitals and Health Care 2010.)

4.1.8. Migration and Health Project from Malmö University

The University of Malmö organized workshops on the subject of Migration and Health in autumn 2005. The titles of the workshops were: Barriers to Health Care Access; Migrant Friendly Hospitals; Health Strategies of Marginalized Groups; and Migration and Health Policies. Information from presentations, ideas from discussions and texts from participants were gathered and made into a volume. The results of the volume

show the organizational challenges which health care systems are facing with the new migration trends. The four chapters are: Understanding difference sensitivity in organizations; Barriers and learning processes in organizations confronted by difference; Coping with precarious health systems; and Discourses forming realities in health systems. The booklet could be used as a starting point for reflection in health care staff or to inspire further research on the subject. It could be used in education programs for future staff in the health care sector or other social sectors. (Björngren Cuadra & Cattacin 2007.)

4.2. Findings from articles

4.2.1. Communication barriers

According to the material collected for this final project, obstacles in communication are the most pressing area of concern for migrant patients (Aries 2004; Bischoff 2003; Cortis 2003; Maltby 1999; Nielsen & Birkelund 2009; Peckover 2007; Poon 2003;Tuohy 2008). Barriers in communication present a variety of problems for both, the migrant patients and the health care workers. According to Bischoff's literature review, these problems lower the quality of care, patient satisfaction, and patient outcomes. In addition, Bischoff (2003) noted that due to communication barriers patients were more anticipated to miss follow-up appointments, were more likely to use emergency rooms, received less than best possible care, were positioned to added risk, and were less expected to get adequate medication. Additionally Bischoff (2003) stated that language obstacles make migrant patients not to seek help early enough. Maltby (1999) stated the same in her study.

Other harms, caused by obstacles in communication, are linked to interpreting. Maltby (1999) concluded that health care providers decide whether to call an interpreter rather than automatically doing it as a matter of policy. The same was also said in a study by Nielsen and Birkelund (2009) and Gerrish, Chau, Sobowale and Birks (2004). Lack of interpreters and having unqualified interpreters, according to Maltby (1999), are major barriers in trying to communicate with the migrant patients. Maltby (1999) also stated that health care providers often misevaluate clients' ability to understand medical terms if the patients could communicate in everyday English. Health care providers easily assume that if a client had printed information in their native language, they were able to access health services (Maltby 1999).

In studies by Gerrish et al. (2004) and Maltby (1999) staffs' lack of knowledge, on how to use interpreting services, was listed as a problem. The Swiss Network of Health Promoting Hospitals and Health Services (HPH) stated the same in a presentation of criteria for Migrant Friendly Hospitals, in Berlin 2008 ().

Using family members, especially children, significant others, and bilingual staff as interpreters is seen as an obstacle (Aries 2004, Bischoff 2003). An article by Nielsen and Birkelund (2009) studied Danish nurses' experiences in meeting the minority ethnic patients and discovered that nurses paid attention to difficulties in communication. The nurses felt that circumstances dictated the use of interpreter. For example if a patient arrives late at night they use children as interpreters because the use of a professional one is expensive for the hospital, although they knew that using children was not beneficial (Nielsen & Birkelund 2009). The nurses expressed irritation that the care takes far more time if the patient does not speak Danish (Nielsen & Birkelund 2009).

4.2.2. Interventions concerning communication

Although it was earlier stated that the use of bilingual staff as interpreters is not beneficial, in some studies it was seen as a solution to addressing the language barrier in the absence of an interpreter (Aries 2004; Bischoff 2003; Brooks et al. 2000; Goertz et al. 2007). Maltby (1999) noted in her literature review that employing bilingual nurses from different ethnic communities is much better than working through an interpreter. In the literature review majority of the nurses are unilingual and people with culturally and linguistically diverse backgrounds are underrepresented in nursing (Maltby 1999).

The use of professional interpreters was seen as an effective intervention in several studies (Aries 2004; Bischoff 2003; Brooks et al. 2000; Gerrish et al. 2004; Goertz, Calderón, & Goodwin 2007; Maltby 1999; Poon et al. 2003; Tuohy et al. 2008). The most preferred method was telephone translation (Aries 2004; Bischoff 2003). Although, most of the staff in Aries' (2004) study experienced the use of telephone translation services as very impersonal because the patients had to share their private issues with someone they could not see and did not know. Bischoff (2003) noted that professional health care interpreting increases patients' access to care and enhances the circumstances of ambulant and preventive care. Karliner, Jacobs, Chen, and Mutha, (2007), also found similar results. Karliner et al. (2007) examined 21 articles in their

systematic literature review and discovered that professional interpreters improve the care of patients who have limited English proficiency (LEP). In addition, they learned that professional interpreters are more effective in clinical care when comparing to ad hoc interpreters. Furthermore, Karliner et al. (2007) approximated that professional interpreters raise the quality of care and reduce disparities in the care of LEP patients.

Additionally, Bischoff and Hudelson (2010) discovered similar findings. In their study, they examined health professional's attitudes and practices related to health care interpreting. 114 questionnaires were completed and the results indicate that interpreters have a positive effect on their ability to provide quality of health care and that they are beneficial to migrant patients. 99% of the respondents stated that health care providers understanding is improved when using an interpreter, 97% stated that using an interpreter helps to communicate more effectively when giving instructions to patients, 98% stated that interpreters helped them to better understand their patients, and 68% felt that it helped to reduce conflicts with their patients. The study also revealed that there is an increase in using interpreters but that the first choice is still the use of ad hoc interpreters even though professional interpreter services are now more available in Switzerland. The same phenomenon also occurs in other countries. There is a tendency to use bilingual staff to lower the costs and it can be more easily integrated in the daily routines. There should be the awareness of invisible costs as the bilingual staff cannot be in two places at once, and they should receive training in interpreting, as it is not enough to be bilingual to ensure adequate interpreting skills. Even though professional interpreter services are available, that does not automatically mean that the use of ad hoc interpreters decreases. The awareness needs to be raised of the risks and benefits of different interpreting services. (Bischoff & Hudelson 2010.)

Interventions to tackle the obstacles in communication also included having English lessons and tutoring for migrants since increasing ability to speak English means improvement in their health status (Goertz et al. 2007; Maltby 1999). Furthermore, providing information manuals, to health care workers, on available language services help to tackle the obstacle (Maltby 1999; Tuohy 2008). In addition, translating health information into different languages and using of videos for patients who cannot read is seen as a sufficient intervention (Goertz et al. 2007; Maltby 1999; Poon et al. 2003).

The Swiss Network of Health Promoting Hospitals and Health Services (HPH) presented criteria for a Migrant Friendly Hospital in Berlin 2008. In the presentation, criteria for communication issues received a big focus. They stated that in order to have a migrant friendly hospital, research questionnaires and satisfactory surveys need to be in primary language of a patient and that it is a necessity to have the informed consent form in the patient's primary language or if not possible, an interpreter needs to be present. The institution should offer the possibility of translating important information from the patient's file into English. The HPH also said that patients reading competence and comprehension needs to be evaluated and signage adapted for migrant and illiterate patients. (Diserens, C., Bühlmann, R., Hudelson, P., Kjellström, F., Stauffer, Y., Ullman, F., Doninelli, M. and Bodenmann P. 2008.) Aries (2004) also pointed out that signage in different languages is possible intervention in tackling communication barriers.

Gerrish et al. (2004) examined the utilization of interpreting services by a range of primary care nurses from the perspectives of the nurses, interpreters, and minority ethnic communities and suggested that training of both, health care professionals and interpreters, would improve the quality of interpreting interaction. Having qualified interpreters was also of relevance in studies by Brooks et al. (2000) and Maltby (1999).

4.2.3. Cultural competence

Due to the changing world and the movement of people, the patient population has become more varied. Recognizing diversity and difference should be seen as a positive element for organizations. Migrant patients do not only bring their culture to the care but also their experiences which are often tainted with inequalities (Cortis 2003).

In another study by Cortis (2004), the experiences of nurses caring for hospitalized Pakistani patients in the United Kingdom, revealed that nurses had a poor understanding of the concept of culture. It was also noted that applying the concept of culture need to be re-conceptualized as a dimension of nursing practice, since the lack of knowledge in matters related to culture results in health disparities of migrant patients.

Peckover and Chidlaw (2007) revealed similar findings in their qualitative study. They studied 18 district nurses' understanding and practices in relation to discrimination and inequalities issues and found out that the nurses seem to be unused to talking about issues of cultural diversity at their work place and that there is a need for more education in the matter (Peckover & Chidlaw 2007).

Poon et al. (2003) studied the barriers of health care of Latino paediatric orthopaedic patients and identified several obstacles. Folk traditions often serve as a barrier since Latinos health beliefs often differ from those of the model of illness in medicine. Lack of formal education in the Latino community presented another problem because deficiency in ability to read can be a cause of medical errors, poor treatment compliance literacy has been shown to, and unnecessary and expensive complications. According to Poon et al. (2003), another problem was Latinos ranking of physicians in high worth. This prevents them from voicing worries or asking questions out of the admiration for the doctor. Role of the family is different in the Latino culture as they consider the group concord and mutual decision-making more important than an individual. For Latino patients getting time off from work and transportation to the hospital or health centre are major hindrances to accessing medical care. In the study physicians stereotyping, attitudes, and biases sometimes served as barriers of health care of Latino patients (Poon et al. 2003).

It has been widely studied and endorsed that while caring for migrant patients, the health care staff should be culturally competent (Cortis 2003). The following chapter provides results of interventions regarding cultural competence from the materials collected for this literature review.

4.2.4. Interventions concerning cultural competence

According to the materials collected for this final project structuring cultural competence trainings is one of the most important interventions in improving migrant's health care (Aries 2004; Giger & Davidhizar 2007; Krajic et al. 2005; Maltby 1999; Taylor 2005). The most critical factor in implementing cultural competence training is support by management (Aries 2004; Krajic et al. 2005). Aries (2004) states that in creating a workforce that is culturally competent the involvement of the management is significant, especially if members of the staff are not considering the issue important.

Aries (2004) also concluded that for senior managers cultural competence would be achieved by having good relations with the local communities. Aries (2004) also argues that some managers had come up with different reasons that diversity in staff can also create problems, others pointed out that the problems are individual in nature and not cultural and some told about ethnic/racial conflicts.

Another critical factor is that training should aim at solving the real specific problems of everyday practice (Krajic et al. 2005). Recruiting competent trainers is important in cultural competence trainings. A good training model starts with a short generic introduction and it provides information on cultural diversity which can be adapted into the routines of departments (Krajic et al. 2005).

Taylor (2005) also talks about cultural competence training for health care professionals. According to her literature review, cultural competence training contains the following core concepts: examining one's own cultural beliefs, exploring the influence of culture on health and health behaviours, information for specific cultural groups and cultural assessment tools.

Another finding in determining interventions is hiring culturally diverse staff (Aries 2004; Maltby 1999). Aries (2004) argues in her study that whoever gives or receives care prefers it to be with people similar to themselves. Diversity could have good effects in covering the needs of diverse patients as the workers have different views to a problem (Aries 2004). Migrant patients assessed the hospitals with culture as a screen. To face a hospital, which has a different set of beliefs and health practices than themselves, causes difficulties. To be treated by people from similar cultural background was the preference as well as to use their native health practices. In all the migrant groups, which were involved in the study, was an opinion that workers gave favoured treatment to patients like themselves (Aries 2004). A result was that the workers stated that their cultural background does not interfere with their work ethic but they rather felt that the co-workers ethnic preferences caused discrimination. Migrant workers mentioned that they felt prejudice from the non-migrant patients and that some of the patients even refused to be cared for by the migrant workers (Aries 2004).

According to Aries (2004) and Giger and Davidhizar (2007) having culturally responsive policies could work as an intervention in providing culturally competent care. They also concluded in their studies that hospitals should create environments to accommodate diverse patients (Aries 2004; Giger & Davidhizar 2007). One of these environmental changes could be changing visiting hours to suite different family's desire.

In a study by Aries (2004) it was also pointed out that new potential workers should be asked about their cultural competence. Similar suggestion was given in a presentation by HPH (2008). The HPH argued that staff's files should contain information on their cross-cultural competence and that staff should receive introductory information on staff's obligations and available resources concerning cultural competence upon employment. They also said that language classes should be offered for migrant staff (Diserens et al. 2008).

Poon et al. (2003) and Narayan (2002) state in their studies that obtaining background information on patient's culture, is a significant intervention in ensuring individualized care. Narayan (2002) speaks of the steps that the clinicians could take in providing care that meets the cultural needs and expectations of patients from diverse populations. A first step is possessing four attitudes: caring, empathy, openness, and flexibility. These are the core attitudes of clinicians who provide effective cross-cultural health care. Secondly, when clinicians are knowledgeable about the different ways and how deeply culture affects health care decisions and practices, they decrease the risk of cultural miscommunication, cultural misunderstanding, and cultural imposition. The potential areas of cultural misunderstanding are communication patterns and social etiquette, health beliefs and values, and social values. A third and fourth step are to conduct a cultural assessment, it is just as important as medical and physical information, and create a care plan. Giger and Davidhizar (2002) present an assessment model, which assesses patients according to six cultural phenomena communication, space, social organization, time, environmental control, and biological variations. According to Narayan's (2002) study, a fifth step is to avoid defensiveness and to recover from cultural mistakes by adopting social etiquette norms, seeking to get on the same side of the problem as the patient is, be alert to the patient's cultural needs, preferences, and expectations, when making recommendations try to do it from the patient's cultural frame.

Hilgenberg and Schlickau (2002) reported training in transcultural knowledge being efficient. They described a learning strategy where students from two different nursing schools collaborated in studying transcultural issues. During this collaboration, students were taught to integrate culture into the care and study an unfamiliar culture. After the implemented strategy, students reported having increased knowledge on the unfamiliar culture and having more in-depth knowledge in providing culturally congruent care (Hilgenberg & Schlickau 2002).

Additionally, Camphinha-Bacote's (2002) model for cultural competence could be a useful intervention in confronting culturally responsive health care services. The model views cultural competence as a continuous process in where the health care provider strives to achieve the ability to effectively work within the cultural context of the client (Camphinha-Bacote 2002).

4.2.5. Responsiveness and Empowerment and interventions concerning them

In Bischoff's (2003) literature review, the second area of concern is the responsiveness. Responsiveness refers to responding to the features and health requirements of migrant populations. Health care services have had difficulties in appropriately responding to these needs. There are many affecting factors which shape the needs of a migrant patient. These can be for example, patients' migration history, their political and legal status, religion, tradition, and level of education. According to Bischoff (2003), these factors present a difficulty for the health care system, and there are two ways of reacting. Health care systems can either implement same services to each patient or apply distinct interventions for different groups of people. The goal is towards individualized care.

Bischoff (2003) argues that while responsiveness includes what the provider can do, empowerment involves the patient into the care process. He points out that the areas of concern, when it comes to empowerment of patients, are disenfranchisement, and inequity of power. In addition, Bischoff (2003) reveals that there is very little research on carrying out empowerment programs.

According to Bischoff's (2003) literature review, if the health care facilitators can appropriately answer to the needs of migrants, the migrant patients are more likely to become empowered. In the literature, there were many examples of effective interventions programs, which significantly improved migrant's awareness, well-being, and functioning. The examples utilized culturally sensitive approaches, meaning the groups and individual's needs were considered in a culturally appropriate manner and targeted services were created (Bischoff 2003). In addition, many of the examples outcomes were significantly improved if health educator's ethnicity matched the communities' predominant ethnicity.

In Bischoffs (2003) study, effective interventions concerning empowerment included placing the participants in the middle of the change process rather than telling them what was healthy or unhealthy. Culturally diverse staff members were also seen as a vital contributor to the empowerment process since migrants are more likely to see doctors of their own race/ethnicity (Bischoff 2003). Maltby (1999) suggest that holding promotion/education classes on client's/migrants terms is a part of culturally competent health and another intervention is developing health related strategies in collaboration with the communities.

In attempt to improve migrant's access to health care services Hesselink, Verhoeff, and Stronks (2009) introduced health care advisors into four districts in Amsterdam. These health care advisors had an ethnic background, which corresponded to the main migrant groups in the districts. The two-year intervention resulted in an empowerment of the migrant groups, it helped migrants to understand and to gain trust in the health care system and the professionals working in them, and it improved knowledge and health literacy. The ethnic background of the health care advisors helped to remove both, language and cultural, barriers.

4.2.6. Monitoring and interventions concerning it

In Bischoff's (2003) extensive literature review, monitoring is the fourth and final major area of concern. He explains monitoring being a vital part of the care cycle. It entails viewing and evaluating what is going on, what actions have been taken, and the results. Bischoff (2003) also explains that monitoring includes looking into relevant literature and identifying areas where further research is needed. He also states that monitoring should not be an aim itself but it should intend to accomplish change.

Bischoff (2003) notes that gathering and reporting information on patients' ethnicity is a vital step towards monitoring inequalities in health between ethnic groups and eliminating them. Routine statistics on health condition should contain patient's legal status, data about treatment and support for ethnic minorities. Such data would help to identify the most common health problems experienced by migrants and minorities and facilitate interventions concerning them.

According to Diserens et al. (2008) set criteria for migrant friendly hospital institutions must self evaluate on regular basis. Institutions should also identify needs and resources of staff and migrant patients, create an action plan, which objectives are to be attained, and create a network for ensuring adequate responsibility is taken for migrant patients (Diserens et al.2008).

The findings gathered from the articles provided vast amount of knowledge concerning the migrant's needs and interventions in health care. The publications and projects portrayed initiatives taken in exploring and improving the health care of migrant's. Neither the findings from the articles nor from the publications and projects produced sufficient evidence about the effectiveness of interventions.

5. DISCUSSION

The purpose of this final project was to define and clarify the concept of migrant friendly hospital, and to describe needs, interventions, and if possible, effectiveness of interventions. This literature review aimed to answer the following questions: What are the main needs and interventions in the health care of migrants? What is a migrant friendly hospital? The literature searched for this final project was productive in providing us the answers to our questions and in filling our purpose.

The findings revealed many important issues concerning the needs and interventions of migrants in the health care systems. One of the most important issues that arose from this literature review is communication between migrant patients and their caregivers. Barriers in communication have significant and broad effects to the migrants' well-being and access to health care services. It starts with the fact that some migrants do not even consider to consult a health care provider because they do not share the same language. Because of that, the outcome is often that these patients do not seek help early enough. Another result showed that even when the migrants do dare to visit a doctor, they might not understand the diagnosis and the doctor's orders. This can lead to poor treatment compliance and management of the patient's health problem. To address these problems the literature review exposed different interventions in dealing with communication issues. The main intervention, revealed in this literature review, is the use of unprofessional interpreters (family members, children and bilingual staff) and professional interpreters. The results show that using family members for interpreting can cause problems and that it is inappropriate. To make use of bilingual staff is one-step forward in solving the problem but the first choice should always be a professional interpreter. Furthermore, the training of health care professionals and interpreters is needed in order to improve the quality of interpreting interaction.

Cultural competence was another revelation of this literature review. With society becoming increasingly multicultural the need for culturally competent health care providers is rising. Many educational institutions have already endorsed the issue and transcultural nursing studies are part of the nursing curriculums. Hiring culturally diverse staff and providing cultural competence training for health care staff are also interventions discovered in this review. The most critical factor in implementing cultural competence is the support of the management, if the management does not

think it is important than the staff will adopt the same attitude. Recognizing diversity and difference should be seen as a positive element and having culturally competent health care professionals is an important step towards developing migrant friendly services. Cultural competence training is one the most important intervention in achieving culturally competent care.

According to the findings gathered from the different projects, publications and organizations the criteria of a migrant friendly hospital could include:

- It ensures the availability of professional linguistic assistance to aid patients who speak a foreign language and staff who knows the procedure to resort to an interpreter. The organization avoids resorting children and family members for interpretation. Policies for using interpretation services and the quality of the services are regularly evaluated.
- Evaluation of the patients reading and understanding skills of received information concerning his/her health status. Important information (procedures, brochures, signage, research questionnaires, satisfaction surveys and the declaration of consent for certain procedures) are available in the patients language.
- New staff is asked about their transcultural nursing skills and it is noted in their files, they receive information about staff obligations and available services. Cultural competence training is offered to the staff and language training to the culturally diverse staff member to be able to interact with patients and work colleagues
- There are three partners in the migrant friendly hospital criteria which are all interlinked: Institution’s policies, patient (needs and resources), and staff (needs and cross-cultural competences)

5.1. Implications for clinical practice

According to the results, there are numerous implications for clinical practice. The quality of health care services for migrants is dependent on the hospitals agenda. Leaders of health care organizations play a major role in enhancing services and they should initiate, support, and monitor change. One way to start could be to use the Migrant Friendliness Quality Questionnaire (MFQQ, APPENDIX 5**)** which assesses the overall migrant friendliness of an establishment. The organizations could also include information on patient's culture in the background inquiry. This could include data on religion, language, and food preferences.

Another implication is the integration of transcultural nursing studies in all nursing school curriculums and the education of health care staff on transcultural nursing subjects. The results also show that it would be important to ask people about their transcultural nursing skills upon hiring. To hire culturally diverse/bilingual staff could aid in meeting the needs of migrant patients and as well help in situations where an interpreter is not available. Professional interpreter services should be used on a daily basis to guarantee quality care and equal rights for patients with culturally diverse background. Additionally, the findings indicate that the awareness of available interpreter services among health care professionals needs to be increased. For example drafting a guide on how and when to access interpretation services could raise the awareness.

5.2. Suggestions for further research

There is a need for more studies on the effectiveness of interventions concerning migrant's health care services. Since this paper is the first step of the DPN migrant friendly hospital developmental project the next phase would be to study these matters in a local context.

5.3. Ethical considerations and trustworthiness

This final project is a literature review therefore there is no direct data collection from individuals and ethical considerations concern the articles and publications which were reviewed for this project. Ethical matters were taken into consideration while collecting and analyzing data. It was guaranteed that all research articles and publications maintained the privacy of the participants. At no point was there any mentioning of names or personal information which may lead to the recognition of the participants. In addition, proper accreditation was given to authors of articles and publications. This was done by marking quotations accordingly in text. Proper accreditation was also shown by making it evident to the reader where text was gotten from by having every source in the reference list. This paper has followed the Metropolia University for Applied Sciences guidelines for writing papers.

The author's inexperience in recognition, evaluating, and analyzing information limits this final project. Another limitation of the study is that some articles were not accessible without paying a fee therefore they were left out even though the content described in the abstracts was relevant. Furthermore, the performed internet search through Google may have left out important information since it cannot be done in a systematic way. Additionally, neither of the author's mother tongue is English therefore interpretation of the data maybe hindered.

The trustworthiness of the publications and the projects were judged on whether they answered to the purpose/aims and whether they met the inclusion criteria. The chosen publications and projects were judged as trustworthy when the sources or supporters behind them were well known organizations like World Health Organization (WHO), Health Promoting Hospitals Network (HPH), Migrant Friendly Hospital Project (MFH), Swiss Forum for Migration and Population Studies (SFM), and International Organization for Migration (IOM).

Trustworthiness is established by including the four elements which are credibility, auditability, fittingness, and confirmability. Credibility refers to the truth and validity of the data (LoBiondo-Wood and Haber 1998). This was achieved by the authors reading through all the gathered material and agreeing on the context. According to LoBiondo-Wood and Haber (1998) auditability is met when the reader can follow the researcher's

steps and conclusions. In this final project this was realized through performing and documenting the data recording and analysis in a step by step method. Fittingness is seen when the study is described in enough detail so that the readers can evaluate whether findings are applicable in their own practice (LoBiondo-Wood and Haber 1998). Confirmability was achieved through applying creditability, auditability and fittingness and is shown in the findings (LoBiondo-Wood and Haber 1998).

Throughout the data collection process, it was important to ensure that the selected research articles answered to the purpose/aims of the study and that they met the inclusion criteria. To guarantee the compliance with these criteria's scientific databases were used (CINAHL, OVID). The chosen articles were up to date (1999-2010) and published in well-known scientific journals. Refer to APPENDIX 6 for the list of used journals in this final project.

The data recording and analysis was performed and documented in a step-by-step method and visualized with an example of the content analysis. To increase the trustworthiness between the results and the data two charts (APPENDICES 3 & 4) were created. The publication and projects charts contain information on title, participants, year, aim of the projects, the process of the projects and the findings of the projects. On the article charts author, title, journal, purpose of the study, sample size, data collection and analysis, and main results are presented. The use of 21 scientific articles and eight different documents for this project makes it a wide-ranging review.

6. CONCLUSION

There is a need for improvement in providing migrant friendly health care services. Obstacles in communication and cultural competency are seen as significant barriers. The main interventions include the usage of interpreters and having trainings for health care professionals on transcultural matters. A migrant friendly hospital has to identify the linguistic and cultural needs of its patients, to respond effectively and to ensure access to quality healthcare for all patients. In conclusion, the needs of migrant population are various and responding to them requires extensive development in the health care sectors.

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APPENDIX 1 DATABASE SEARCH CINAHL MARCH 2010

Keywords	Total hits	Relevant articles	Chosen articles
Migrant AND Need	84	0	0
Migrant AND Intervention	59	1	0
Migrant AND Communication	42	3	0
Migrant AND Empowerment	7	2	1
Migrant AND Monitoring	7	0	0
Migrant AND Communication AND Need	7	0	0
Migrant AND Empowerment AND Need	1	0	0
Migrant AND Monitoring AND Need	1	0	0
Migrant AND Communication AND Intervention	5	1	0
Migrant AND Empowerment AND Intervention	4	1	0
Ethnic AND Minority AND Need	369	0	0
Ethnic AND Minority AND Intervention	172	0	0
Ethnic AND Minority AND Communication AND Need	47	3	1
Ethnic AND Minority AND Empowerment AND Need	6	0	0
Ethnic AND Minority AND Monitoring AND Need	11	0	0
Ethnic AND Minority AND Responsiveness AND Need	2	0	0
Ethnic AND Minority AND Communication AND Intervention	16	0	0
Ethnic AND Minority AND Empowerment AND Intervention	4	1	1
Ethnic AND Minority AND Monitoring AND Intervention	6	0	0
Ethnic AND Minority AND Responsiveness AND Intervention	1	0	0

Altogether three articles from this data search were chosen.

APPENDIX 2 DATABASE SEARCH OVID Your Journals@Ovid MARCH 2010

Keywords	Total hits	Relevant articles	Chosen Articles
Migrant AND Communication AND Need	250	12	5
Migrant AND Empowerment AND Need	65	2	0
Migrant AND Communication AND Empowerment AND Need	38	0	0
Migrant AND Responsiveness AND Need	31	2	0
Migrant AND Empowerment And Intervention	46	0	0
Migrant AND Responsiveness AND Intervention	19	0	0
Minority Ethnic AND Empowerment AND Need	30	3	1
Minority Ethnic AND Monitoring AND Need	71	4	0
Minority Ethnic AND Responsiveness AND Need	8	2	1
Minority Ethnic AND Communication AND Intervention	65	4	2
Minority Ethnic AND Empowerment AND Intervention	15	0	0
Minority Ethnic AND Monitoring AND Intervention	44	0	0
Minority Ethnic AND Responsiveness AND Intervention	48	2	0

Altogether nine articles from this data search were chosen.

APPENDIX 3 PUBLICATIONS AND PROJECTS CHART

TITLE AND PARTICIPANTS AND YEAR	**AIM OF THE PROJECT**	**THE PROCESS (WHAT WAS DONE)**	**FINDINGS**
-Caring for migrant and minority patients in European hospitals A review of effective interventions- Swiss forum for migration and population studies SMF Alexander Bischoff	To explore effective interventions	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)	<u>Communication:</u> Use of professional healthcare interpreting - increases ambulant and preventive care - improves migrants access to care Trainings between physicians and migrants - improved communication between - increased migrants respect toward physicians - raised physicians self awareness - increase in the demand of interpreters by the physians Remote interpreting (via phone) - improved quality of communication <u>Responsiveness</u> - health care services have had difficulties in appropriately responding to migrants needs. - many factors, which shape the needs of migrants f.ex. patients' migration history, their political and legal status, religion, tradition, and level of education - factors present a difficulty for the health care system, - two ways how the health care system can react either implement same services to each patient or apply distinct interventions for different groups of people <u>Empowerment</u> - empowerment involves patients - areas of concern when it comes to empowerment: disenfranchisement, and inequity of power. - if the health care facilitators can appropriately answer to needs of migrants, the migrant patients are more likely to become empowered - utilizing culturally sensitive approaches helps empowerment - empowerment programs work better if health

			educator's ethnicity matches to the communities' predominant ethnicity and if patients are placed in the middle of the change process rather than telling them what is right or wrong - Culturally diverse staff members are vital contributor to the empowerment process since migrants are more likely to see doctors of their own race/ethnicity <u>Monitoring</u> - monitoring is a vital part of the care cycle - monitoring entails viewing and evaluating what is going on, what actions have been taken, and the results. - monitoring includes looking into relevant literature and identifying areas where further research is needed. - gathering and reporting information on patients' ethnicity is important in monitoring inequalities in health between ethnic groups and eliminating them.
Diversity and Equal Opportunity What criteria for Migrant Friendly Hospitals?- Diserens, C., Bühlmann, R., Hudelson, P., Kjellström, F., Stauffer, Y., Ullman, F., Doninelli, M. and Bodenmann P. HPH Conference Berlin, May 2008	To present Migrant Friendly Hospital-criteria		<u>Communication</u> - research questionnaires and satisfactory surveys in primary language of a patient - informed consent in patients primary language or interpreter present - patient's reading competence and comprehension is evaluated - important information available in patients primary language - signage adapted for migrant and illiterate patients - institution offers the possibility of translating important information from the patient's file into English - institution ensures qualified linguistic assistance - staff is informed of the procedures for resorting interpreters - institution avoids resorting to children under 18 and immediate family <u>Staff and cross cultural competence (ccc)</u> - staff files contain information on their ccc

			- staff receives introductory information on staff's obligations and available resources upon employment - ccc training is offered - language classes are offered for migrant staff <u>Institution</u> - institutions self evaluation - needs and resources of staff and migrant patients are identified - action plan, which objectives are to be attained - network for ensuring adequate responsibility is taken for migrant patients
Good Practices on Health and Migration in the EU Final Draft Conference: "Health and Migration in the EU: Better health for all in an inclusive society" Editors: Portugal, R., Padilla, B., Ingleby, D., de Freitas, C., Lebas, J. and Pereira Miguel, J. Lisbon, 2007	To discuss issues of health and migration with reference to some of the interventions that EU member states have found to be effective in the field. With the ultimate goal to improve migrant health and health care in member states through sharing different experiences and to identify problems in health systems when accounting for migrant health.	-Defining Good Practices -From Best to Good Practices -Good Practices Matrix -Criteria for selecting a "Good Practice" -Analysing the Good Practices: 1) Diversity, 2) Commitment, 3) Competency -Limitations of the Good Practice approach 55 good practices were collected by the editors and after analysing these with the set criterias 35 good practices were selected.	Good practices are innovations which point out: 1) diversity: like pointing out different fields and ways to how health care systems can be improved, 2) commitment: the assurance that both at an individual and collective level human resources can be activated to undertake action in favour of a better system, 3) competency: they show the existence of a substantial bulk of knowledge and skills for implementing change. Good Practices are excellent, practical and creative solutions designed and implemented by NGOs, individuals or the state to solve problematic issues in the field of migrant health.
NAKMI Promoting Migrant Friendly Hospitals in a multicultural Norway Project co-ordinator Claire Mock-Munoz de Luna Since 2006 ongoing	To become a meeting point for minority health issues in Norway, especially for competence concerning somatic and mental health care of immigrants and refugees.	Different projects concerning immigrants/refugees and health. For ex. Since 2006 NAKMI has been coordinating the Norwegian Network for Migrant Friendly Hospitals. The Network consists of 6 hospitals from all over Norway. Their bi-annual meetings provide space for information sharing, collaborative effort, and the development of sustainable practices.	The whole findings are just available in Norwegian but each project has a short statement in English.
Intercultural Health Strategy 2007-2012 Health Service Executive (HSE) It is a mixture of staff from	It's a detailed plan of the HSE on how the health systems and services could be improved to provide for its diverse users.	The information in the strategy was gathered from meetings, discussions, workshops, organizations that work with asylum seekers, individuals, and through questionnaires.	Findings were: lack of access to information, language and communication, lack of standard interpreting services, lack of access to services, service delivery, changing the organisation (meaning to have a more

different departments in health services and other offices who deal with the public. Ireland	To deal with the barriers and inequalities that exist in the health system.		diverse staff), to work in partnership with ethnic minority communities. -Out of these results recommendations were made like: providing training to use qualified interpreters, equal access to GP services, the HSE to work together with other departments in the best interest of the service users, the HSE to work together with other departments like education, training, employment, housing and social welfare, to employ more ethnic minority staff, to integrate cultural competent training for staff and to develop an Ethnic Identifier. -New developments have been initiated since the start of the strategic plan like: Training and support provided to hospital staff; Identification of local health information that requires improvement and the MFH initiative is ongoing in some of the hospitals.
Health Service Executive (HSE) Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings 2009 The Guide was developed under the HSE National Intercultural Health Strategy 2007 to 2012 as part of a framework of initiatives	To build capacity to deliver culturally competent care in Irish health settings. .	This Guide was developed in response to an expressed need by healthcare staff across a range of cultural backgrounds for knowledge, skills and awareness in delivering care to people from backgrounds other than their own.	The Guide profiles the religious and cultural needs of twenty-five diverse groups who are being cared for in healthcare settings. These groups comprise twenty-one religious groups, 3 ethnic/cultural groups and people without religious belief
The Amsterdam Declaration Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe	To invite all European hospitals to implement the Amsterdam Declaration and through that become migrant-friendly and culturally competent organisations and develop individualised, personal services from which all patients will benefit.	In December 2004, experiences and results from the MFH partners were presented at a Final Conference in Amsterdam. The goal of the conference was to bring together experts to discuss specific models and different approaches to address cultural diversity in hospital care. A list of recommendations/criteria was developed which is called “The Amsterdam Declaration Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe”.	The success of becoming a migrant friendly hospital depends on the complementary contributions of several different stakeholders: -Hospital owners/management, quality management: the quality of the services has to be put on the hospitals agenda -Staff/Health Professions: acknowledgement that the issues are relevant and willingness to achieve competency -Users (patients)/Representatives of community groups:

			making contributions to the process by putting diversity, health and health care on their agenda -Health sciences: Expertise and scientific knowledge can be helpful in the process.
Migration and Health: Difference Sensitivity from an Organisational Perspecitve Editors: Björngren Cuadra, C. and Cattacin, S. University of Malmö, 2007	To show the organisational challenges which health systems are facing with the new migration trends.	The publication is a result from a series of workshops concerning migration and health. The titles from the different workshops were: -Barriers to Health Care Access -Migrant Friendly Hospitals -Health Strategies of Marginalized Groups: Migrant Prostitutes, Illegal Workers and Asylum Seekers -Migration and Health Policies	Organisational challenges which health systems have to face when dealing with migration: 4 Chapters -Understanding Difference Sensitivity in Organisations - Barriers and Learning Processes in Organisations Confronted by Difference -Coping with Precarious Health Systems -Discourses Forming Realities in Health Systems A tool that could be used as a starting point for reflection in health care staff or to inspire further research on the subject. It could be used in education programs for future staff in the health care sector or other social sectors.
Migrant-Friendly Hospitals (MFH) 12 hospitals from 12 European (EU) countries, several experts, the Ludwig Boltzmann Institute for the Sociology of Health and Medicine at the University of Vienna as co-ordinator, and national and regional networks of the World Health Organisation Network (WHO) of Health Promoting Hospitals (HPH). 2002-2005	The aim was to put migrant-friendly, culturally competent health care and health promotion higher up on the European health policy agenda and to support other hospitals with practical knowledge and instruments to become more migrant friendly.	-Each of the hospitals came up with the 3 most important migrant groups, 3 most important health problems and the 3 most important problems when caring for migrant patients. -Through a systematic needs assessment 3 common problem areas were selected from the 12 hospitals. - In 2003, the Ludwig Boltzmann Institute commissioned the Swiss Forum for Migration and Population Studies to conduct a literature review to gather knowledge related to problems and possible solutions of health and healthcare concerning migrants. -After that 3 subprojects were introduced: Improving interpreting in clinical communication', 'Migrant-friendly information and training in mother and child care' and 'Staff training towards cultural competence: enabling hospital staff to better handle cross-cultural encounters'	The 3 common problem areas were: -Language barriers in communication with patients -Patient education -The cultural competence of staff members The experiences of the European hospitals strengthen the case for investing in training towards cultural competency as a solution for tackling tensions and difficulties experienced in encounters between staff and a diverse patient population. Experiences indicate that it is advisable to distinguish two aspects of this issue: on the one hand cultural competence training as a short, generic, basic workshop, and on the other hand the systematic inclusion of cultural competence aspects into the regular quality management routines on the level of hospital departments

		-An instrument called Migrant Friendly Quality Questionnaire (MFQQ) was developed during the project and was used to monitor the overall organisational development process towards migrant friendliness. Each participating hospital used it twice during the projects period, in the beginning and at the end..	
Health Promoting Hospitals and Health Care (HPH-HC) (ongoing)	It is a centre who collaborates with WHO and its mission is to support hospitals and other health care institutions in Europe and other regions of the world to develop into healthy and health promoting settings and organizations.	It pursues its mission through providing scientific/technical support like: organizing facts, promoting communication through conferences, workshops, newsletters, and a website. It initiates and coordinates developmental projects and research and publishes concepts, strategies for implementation and experiences. The centre is following the principles of thorough scientific research and is also committed to a model of applied science for evidence-based quality improvement in health care.	HPH-HC is part of many different projects, interesting for this final project is that it was/is involved with the MFH project and the WHO HPH task force "Migrant friendly and culturally competent hospitals".
Task Force on Migrant Friendly and Culturally Competent Health Care (WHO-HPH TF MFCCH 2005- ongoing	To continue working on the themes which were concluded from the MFH project and to build on the gained experiences.	It tries to develop improvements in the delivery of high quality culturally competent health care services for migrant and ethnic minorities. The TF is meeting twice a year to meet and exchange knowledge, and it organizes also conferences.	The TF is meeting twice a year to meet and exchange knowledge, and it organizes also conferences. One example is the conference Best Practices which was hold in 2007 in Lisbon or the HPH conference in Berlin.

APPENDIX 4 RESEARCH ARTICLE CHART

AUTHOR, TITLE AND JOURNAL	PURPOSE	SAMPLE	DATA COLLECTION AND ANALYSIS	MAIN RESULTS
Aries, N. R. (2004) Managing Diversity: The Differing Perceptions of Managers, Line Workers, and Patients. *Health Care Manage Rev.* 29 (3), 172-180.	To assess how hospital managers, line workers, and patients understand the impact of patient and workforce diversity on the delivery of hospital care.	23 Managers, 66 Patients and 32 Employees from 5 different hospitals in New York City	Open-ended interviews at each of the hospitals with managers, line workers (6 groups were conducted), and patients (focused on 7 groups). Interviews were taped and then transcribed, focus group interviews also taped and prepared detailed summaries. As focus group interviews were done in different languages a second person reviewed the tape and summaries. Content analysis of the transcripts and summaries was performed inductively.	3 Findings emerged, first: **Cultural competence** is critical to the provision of quality care. Second: **language** remains an exceptional problem for patients and staff. Third: **Diversity** is perceived to be a problem more by staff and patients who see cultural biases embedded within the ongoing operation of the hospital than management.
Bischoff, A. and Hudelson, P. (2010) Access to Healthcare Interpreter Services: Where Are We and Where Do We Need to Go? *International Journal of Environmental Research and Public Health* 7, 2838-2844.	To examine health professionals' attitudes and practices related to healthcare interpreting.	114 out of 205 questionnaires were completed by head doctors and nurses.	Self-administered questionnaire with 23 questions in German and French. 205 questionnaires were sent to all head doctors and nurses of ten clinical hospital departments in the canton of Basel Stadt Switzerland. 56% of the questionnaires were completed, 114. Descriptive analyses (frequency distributions and cross-tabulations) were carried out	54% of the respondents reported that they are using interpreters (ad hoc or professional ones) only a few times a year. 15% stated to use interpreters more than once a month, 13% used them about once a month and 16% said that they have never used an interpreter. Depending on the language in question different solutions were used to overcome the language barrier. The respondents felt that

			using SPSS.	interpreters had a positive effect on their ability to provide quality of health care even though the use was relatively infrequent. 99% stated as “somewhat true or perfectly true” that the providers understanding is improved when using an interpreter. 97% stated that using an interpreter helps to communicate more effectively when giving instructions to patients, 81% agreed that they help them to better understand their patients, and 68% felt that it helped to reduce conflicts with their patients. Majority of the group felt that professional interpreters are beneficial for migrant pat. 90% were rating that it is “somewhat or perfectly true” that it ensures that the clients are well informed and 72% that it helps them to know their rights. 22% agreed that it helps them to integrate into society. 31% rated that “somewhat or perfectly true” that they could become too dependent on interpreters and 36% thought that it prevented the clients from learning the local language. The first choice of using

				interpreters is still ad hoc interpreters even though professional services are now more available in Switzerland. Same phenomena in some other countries. But bilingual staff was more used than family members/relatives. To use bilingual staff can lower the costs and can be more easily integrated in the routines. But there are also invisible costs as the bilingual staff cannot be in two places at once, and they should receive training in interpreting, as it is not enough to be bilingual to ensure adequate interpreting skills. That there are professional interpreter services available does not automatically mean that the use of ad hoc interpreters is decreased. The awareness needs to be raised of the risks and benefits of different interpreting services.
Brooks, N., Magee, P., Bhatti, G., Briggs, C., Buckley, S., Guthrie, S., Moltesen, H., Moore, C. and Murray, S. (2000) Asian patients' perspective on the communication facilities provided in a large inner city hospital. *Journal of Clinical*	-Evaluate current communication provision in terms of whether this was meeting the needs of minority ethnic patients on the wards -Clarify the views of minority ethnic patients with regard to improving the communication service;	277 patients 34% spoke and understood English fluently, 35% spoke and understood limited English and 31% did not speak or understand English.	Questionnaire with closed questions and open ended questions	When interpreting service was used, it was found to be satisfactory overall. Participants gave suggestions on how to improve the service: -59% suggested more interpreters -increasing patients' awareness of the service

Nursing 9, 706-712.	-Identify service strengths, areas for improvement and recommendations for practice; -Provide information knowledge for other service providers/ healthcare personnel.			-Asian nurses and doctors working on the wards -interpreters linked to the wards -increased availability and accessibility over 24 h -appropriately qualified and friendly interpreters
Campinha-Bacote, J. (2002) The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing* 13 (3), 181-184.	To present Camphinha-Bacote's model of cultural competence in health care delivery			**It's a model that health care providers can use as a framework for developing and implementing culturally responsive health care services.** It is a model that 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.
Cortis, J. (2003) Managing society's difference and diversity. *Nursing Standard* 18 (14-16), 33-39.	The author argues that there needs to be better understanding of equality, more value placed on diversity, better recognition of racism and active challenging of racism and where it occurs in health care.		Literature review	The management of diversity has more to offer than many traditional aspects of equality practice. Recognising diversity and difference should be seen as positive attributes of an organization. **Culture as a concept needs to be studied formally, understood and applied.** Minority ethnic patients do not only bring their culture to care but also their experiences, which are often tarnished by inequalities. **To deliver culturally sensitive**

				care nurses need to be culturally competent.
Cortis, J. (2004) Meeting the needs of minority ethnic patients. *Journal of Advanced Nursing* 48(1), 51–58.	To investigate the experiences of nurses in caring for hospitalized Pakistani patients in West Yorkshire (UK).	30 registered nurses from three different clinical settings (acute care, critical care and rehabilitation). All participants were educated at a minimum of diploma level, had nursed a Pakistani patient within the previous 3 months and had a minimum of 1 year post registration experience.	Semi-structured interviews and supplementary questions to follow-up leads and seek clarification. The author himself transcribed the interviews so that he became immersed in the raw data. Each transcript was checked for accuracy against the audiotapes and adjustments were made after the participants have read it and ensured it that it was accurate. Transcripts were then coded, and themes and patterns were identified, these were then tested or reaffirmed, and finally confirmed. Another person checked the codes identified from a random selection of interview transcripts, no discrepancies emerged.	The results confirmed already known topics as: **inequality in health linked to ethnicity, communication barriers, health education related to minority ethnic groups.** New findings through this study: Registered nurses deficit in knowledge about Pakistani patients in the UK, **poor understanding of the concept of culture and how it is applied in practice settings, the need to re-conceptualize and re-affirm "holism" as a dimension of nursing practice.**
Gerrish, K., Chau, R., Sobowale, A. and Birks, E. (2004) Bridging the language barrier: the use of interpreters in primary care nursing. *Health and Social Care in the Community* 12 (5), 407-413.	To examine the utilization of interpreting services by a range of primary care nurses from the perspectives of the nurses, interpreters and minority ethnic communities.	Focus group were undertaken with 5 separate groups of district nurses, health visitors, practice nurses, community midwives and specialist nurses, three groups of interpreters from different interpreting services, and five groups of participants from the main community languages in the locality where the study	Focus group discussions were tape-recorded and subsequently transcribed. Data analysis drew upon the principles of "framework" analysis.	The study confirms that **Interpreter services are not adequately provided and used and that there is heavy reliance placed on family members to interpret.** The findings highlight that nurses occupy the position as gatekeepers for interpreting services. The study suggests that **training of both health**

		was undertaken (Arabic, Bengali, Cantonese, Somali and Urdu)		**care professionals and interpreters would improve the quality of interpreting interaction with patients and raise awareness of the importance of using interpreters.** Nurses need to be more proactive in meeting the needs of their patients who are disadvantaged as a result of language barriers.
Giger, J. N. and Davidhizar, R. (2002) The Giger and Davidhizar Transcultural Assessment Model. *Journal of Transcultural Nursing* 13 (3), 185-188.	The Giger and Davidhizar Transcultural Assessment Model to provide a tool for nursing students to assess and provide care for patients that are culturally diverse.			The model states that each individual is culturally unique and should be assessed according to six cultural phenomena: **Communication, space, social organization, time, environmental control, and biological variations.**
Giger, J., Davidhizar, R. E., Purnell, L., Taylor Harden, J., Phillips, J. and Strickland, O. (2007) American Academy of Nursing Expert Panel Report: Developing Cultural Competence to Eliminate Health Disparities in Ethnic Minorities and Other Vulnerable Populations. *Journal of Transcultural Nursing* 18 (2), 95-102.	To assess current issues related to closing the gap in health disparities and achieving cultural competence. To discuss a beginning plan of action from the Expert Panel on Cultural Competence for future endeavors and continued work in these areas and to provide clearly delineated recommendations to assist the Academy to plan strategies and to step forward in taking the lead in reshaping health care policies to eliminate health care and health disparities.		The American Academy of Nursing (AAN) has the mission to advance health policy and practice through the generation, synthesis, and dissemination of nursing knowledge.	Recommendations of the Expert Panel on Cultural Competence. **Education:** Eliminating health disparities requires the development of knowledge, skills, basic competencies, and abilities among health care professionals. It should be integrated in health care curricula. **Practice:** All practice settings must be culturally sensitive and all institutions must assure that culturally competent care is rendered. **Research:** It is crucial to success in reducing

				and ultimately eliminating health disparities. **Policy:** The academy must take a proactive lead in proposing policies that can focus funds and care in areas that will change health outcomes to eliminate health disparities. **Advocacy**: Health care professionals and the Academy must promote efforts that advocate for diverse groups and vulnerable populations who cannot advocate for themselves. It is the responsibility of every health care professional and must be championed by powerful groups like the Academy to ensure that change can occur.
Goertz, H. D., Calderón, A. J. And Goodwin, S. (2007) Understanding Health Needs of Migrant Workers in America's Heartland. *Urologic Nursing* 27 (5), 429-436.	To facilitate discussion regarding health needs of migrant workers living in America's heartland. To identify health needs of Hispanic agricultural workers, discuss barriers to health services and to suggest possible solutions to the barriers.	40 Participants of Hispanic origin who have worked in agricultural-related occupations in Nebraska or Iowa	Qualitative study was performed using focus group methodology and narrative analyses.	Participants' needs: **health information printed in Spanish, provision of education on nutrition and personal hygiene,** improving parenting education, **increasing English as a second language program**, provision of education on sexual disease prevention, and dental care. **The results of the study were used to develop Hispanic nursing education at a Midwestern college**. **Through increasing the**

				number of Hispanics in health care professions the health care disparity might decrease for this population.
Hesselink, A. E., Verhoeff, A. P. and Stronks, K. (2009) Ethnic Health Care Advisors: A Good Strategy to Improve the Access to Health Care and Social Welfare Services for Ethnic Minorities?. *Journal of Community Health* 34, 419-429.	To improve the access of ethnic minorities to health care and welfare services through the introduction of healthcare (HC) advisors in four districts in Amsterdam, the Netherlands. HC advisors work for all health care and welfare services and their main task is to provide information on health care and welfare to individuals and groups and refer individuals to services.	11 Healthcare advisors were appointed in the four participating districts. Their ethnicity corresponded with the main migrant groups in the districts. There were Moroccan and Turkish HC advisors in three districts and Ghanaian and Surinamese HC advisors in one district. The pilot period started in two districts in 2003 and in the other two districts in 2004	Action research was carried out over a period of 2 years to find out whether and how the HC advisors function can contribute to improve access to services for ethnic minorities. Data were gathered using mixed methods, including quantitative data from registrations and qualitative data from semi-structured interviews, observations of group classes, analyzing reports, and attending meetings. Results were issued on an annual basis. For every year of the pilot, similar information was collected, analyzed, and published in a report. The researcher also conducted interim presentations and consultations. Each district received one or two interim reports and one final evaluation report.	**HC advisors were able to reach ethnic minority groups, obtain insight into their problems and inform them about health care and** welfare services **and topics. They helped them to understand and gain trust in health care and** welfare services **and professionals and so improved knowledge and health literacy. The ethnic background of the HC advisor helped to reach the ethnic minorities it helped to remove both language and cultural barriers.**
Hilgenberg, C. and Schlickau, J. (2002) Building Transcultural Knowledge Through Intercollegiate Collaboration. *Journal of Transcultural Nursing* 13(3),	To build transcultural knowledge of nursing students through collaborative learning between two different nursing programs.	Two faculties from two different nursing programs. One of the faculties was located in an area that served a large Mexican-American population and the other	Since the two schools were geographically located far apart, a learning activity was implemented that incorporated the use of use of information technology for student	Students reported increased knowledge about the two cultures. Classroom discussions indicated students had a more in-depth understanding of

241-247.		served a large Amish population in another state	collaboration. The two faculties implemented four case studies, which integrated transcultural care needs within the existing course content. The case studies focused on transcultural care in the context of maternal/child, mental health, and medical/surgical nursing care needs. Then groups were made by grouping students studying the same culture in one school with those studying the same culture at the other school. Afterwards students evaluated their learning experience through verbal comments and anonymous, short, open-ended evaluation forms distributed to class participants in each program. Responses from three semesters were analyzed.	nursing decisions and actions essential to providing culturally congruent care to these two cultural groups. Students' learning was enhanced by the collaboration with students in other geographical areas who had actual experience interacting and caring for clients in a specific cultural group. The technology was mainly effective but it had few limitations. Students' reflection of emotional and physical problem holistically was promoted due to the case studies. Using the Internet for collaboration and retrieval of information gave students valuable experience with information technology as a nursing resource.
Karliner, L., Jacobs, E., Chen, A. and Mutha, S. (2008) Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Research and Educational Trust* 42(2), 727-754.	To determine if professional medical interpreters have a positive impact on clinical care for limited English proficiency (LEP) patients.	21 articles	Literature review	- professional interpreters care for LEP patients - professional interpreters improve clinical care more than ad hoc interpreters do - professional interpreters raise the quality of clinical care for LEP patients to match or approach that for patients without a language barrier - professional interpreter

				services can reduce disparities in care for LEP populations
Krajic, K., Straßmayr, K., Karl-Trummer, U., Novak-Zezulah, S., and Pelikan, J.M. (2005) lmproving ethnocultural competence of hospital staff by training: experiences from the European 'Migrant-friendly Hospitals' project. *Diversity in Health and Social Care* 2, 279-290.	To contribute to the cultural competence training by presenting experiences from hospitals in 8 states in the European Union. These experiences were collected as a part of the 'Migrant Friendly Hospitals' project which aimed to improve the impact of hospitals on the health of migrants. In the part of the project reported in this paper, cultural competence training was provided for all types of hospital staff, primarily with the intention of providing support for staff.		Data was collected through staff questionnaires before and after cultural competence training.	Seven of the eight pilot hospitals managed to implement cultural competence training. Acceptance of the training among staff, measured in terms of participation, varied considerably The training had a positive impact on staff perceptions of their knowledge, skills, and comfort levels in transcultural situations. The training was also considered to be cost-effective The most critical factors for implementing cultural competence training were: (l) support by management (2) time and energy are needed to convince staff of the relevance of the training (3) training should aim at solving the real specific problems of everyday practice (4) a skills-oriented design including experiential learning is useful (5) recruiting competent trainers is (6) splitting the integrated training model into a short generic introduction combined with the inclusion of cultural diversity issues into the normal quality

				improvement routines of departments should be tested.
Maltby. H. J. (1999) Interpreters: A Double-Edged Sword in Nursing Practice. *Journal of Transcultural Nursing* 10(3), 248-254.	To explore relevant literature in relation to communication issues in the Australian context and to give potential solutions for transcultural nursing practice.		Literature Review RESULTS: Communication issues: Inability to speak English leads to pressed access to health services Majority of the nurses are unilingual and people with culturally and linguistically diverse backgrounds are underrepresented in nursing Health care providers decide whether to call an interpreter rather than automatically doing it as a matter of policy Lack of interpreters Unqualified interpreters Health care providers misevaluate clients ability to cope with medical interviews if the client could communicate in everyday English Assumption: if a client had printed information they were able to access heath services. Too simplistic	Potential resolutions: English lessons and tutoring for migrants, increasing ability to speak English->improvement in health status Constant evaluation of immigration and multicultural affair policies Teaching on transcultural health care issues for all health professionals Working through an interpreter is essential Provide information manuals, to health care workers, on language services (when an interpreter should be called, how to access interpreting services etc.) Translating health information into different languages and using of videos for patients who cannot read When holding promotion/education classes doing it on the clients terms. Developing strategies in collaboration with the communities
Narayan, M. C. (2002) Six Steps Towards Cultural Competence: A Clinician's Guide. *Home Health Care Management & Practice*	To explore six concrete steps clinicians can take to provide care that meets the cultural needs and expectations of patients from diverse		Literature review	Step 1: Four attitudes—caring, empathy, openness, and flexibility—are the core attitudes of clinicians who provide effective cross-cultural

14(5), 378-386.	populations.			health care Step 2: When clinicians are knowledgeable about the different ways and how deeply culture affects health care decisions and practices, they decrease the risk of cultural miscommunication, cultural misunderstanding, and cultural imposition. The potential areas of cultural misunderstanding are: communication patterns and social etiquette, health beliefs and values, and social values Step 3: Obtain background information about the patient's culture to ensure individualized care Step 4 & 5: Perform a cultural assessment, it is just as important as medical and physical information, and create a care plan Step 6: Avoid defensiveness and recover from cultural mistakes by adopting social etiquette norms, seeking to get on the same side of the problem as the patient is, be alert to pt cultural needs, preferences, and expectations, when making recommendations try to do it from the patients cultural frame of reference, be aware

				of signs of cultural pain, apologize when you've made a cultural error and try to learn from it
Nielsen, B. and Birkelund, R. (2009) Minority Ethnic patients in the Danish healthcare system - a qualitative study of nurses' experiences when meeting minority ethnic patients. *Scandinavian Journal of Caring Sciences* (23), 431-437.	To investigate nurses' experiences in caring with patients with an minority ethnic background.	4 nurses in a hospital.	Qualitative interviews were conducted with 4 nurses in a hospital and combined with observations. The interviews and observations were analyzed according to phenomenological methodology.	Three phenomena showed up: **problems in communication, patients' level of pain and the patients' food.** The result indicated that nurses need resources, such as more support in dealing with patients with a minority ethnical background to give caring. And it revealed that nurses have different attitudes within the same phenomena.
Peckover, S. and Chidlaw, R. G. (2007) The (un)-certainties of district nurses in the context of cultural diversity. *Journal of Advanced Nursing* 58 (4), 377-385.	To explore district nurses' understanding and practices in relation to discrimination and inequalities issues.	18 district nurses employed in two primary care organizations in England.	Methodology was a qualitative approach. Semi-structured interviews were used to explore understanding and practice experiences of discrimination and inequalities issues in district nursing work. The interviews were audio-taped and transcribed. Analysis was undertaken by both authors.	3 themes were presented in the findings: district nurses' **awareness and acknowledgment of diversity and discrimination issues, inequalities in care provision, and communication issues.** The nurses seemed to be unused to talking about how issues of cultural diversity were addressed in their work. The language and communication needs of clients were sometimes inadequately met. There is a **need for more education and support to ensure that nurses develop a critically reflective approach to their practice with clients**

				from culturally diverse groups.
Poon, A. W., Gray, K. V., Franco, G. C., Cerruti, D. M., Schreck, M. A. and Delgado, E. D. (2003) Cultural Competence: Serving Latino Patients. *Journal of Pediatric Orthopaedics* 23, 546-549.	To identify barriers to health care for Latino pediatric orthopedic patients and to propose culturally competent strategies to overcome these barriers.	570 Latino patients in pediatric orthopedic practices in California. The sites included an academic tertiary hospital, a county hospital, and several outreach clinics.	Method: literature review, interviews, and patient demographics. Demographic information was collected over a period of 1 month from the patient population. Information about patient ethnicity, country of origin, education, and payer status were obtained. Several patients and their families were randomly interviewed and asked to comment on the quality of care received and to discuss difficulties in obtaining health care. Information from the U.S. Census Bureau was reviewed, as were several articles from various fields, including family medicine, pediatrics, and public health, regarding Latino health care.	Barriers: **Folk and popular traditions of health care; Communication, language, and education; Norms of interaction; Role of the family; Access and logistics; Physician-derived barriers. Strategies for improving cultural competence:** 1) showing a genuine interest forms the foundation to the other strategies. To have an active interest in a group of people is a main element in culturally competent care. 2) Researching a groups' background. 3) Communicating with patients, asking questions about their difficulties in accessing the care. 4) Facilitating communication, using interpreters to translate information, having materials available in different languages. 5) Identifying barriers to health care. Through integrating information gathered through researching a groups' background and from direct communication with patients' representative of a group. 6) Addressing barriers to health

				care. Identified barriers can be addressed by coming up with solutions that are goal-directed and practical.
Taylor, R. (2005) Addressing Barriers to Cultural Competence. *Journal for Nurses in Staff Development* 21 (4), 135-142.	To explore the barriers to cultural competence forced by nurses and to examine the role of staff development in addressing these barriers.	Literature review		Addressing barriers through training. Training for cultural competence-> 5 modules: **the relevance of cultural competence, culture and health culture, intercultural communication, language issues, and skills application**
Tuohy, D., McGarthy, J., Cassidy, I. and Graham, M. (2008) Educational needs of nurses when nursing people of a different culture in Ireland. *International Nursing Review* 55(2), *164-170.*	To explore nurses' educational needs when nursing multicultural patients in Ireland.	7 participants	Data was collected through semi-structured interviews and the data was thematically analyzed.	**Language barrier**: Being understood, and being able to understand was significant to the delivery of optimum care. **Accessing and using interpreter services:** Participants identified the importance of having the same interpreter coming to the patient so that relationship was established. Nurses considered carefully before using informal interpreters f.ex. family members **Planning and taking action (suggestions from nurses):** staff education, protocols, resources, and increased access and use of interpreter services

migrant-friendly hospitals

Migrant-Friendliness Quality Questionnaire (MFQQ)

Developed by:

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migrant-friendly hospitals

Migrant-Friendliness Quality Questionnaire (MFQQ)

Introduction

This questionnaire serves as an instrument to monitor and assess migrant-friendly quality development of hospital services, enquiring

- the availability of migrant-friendly services responsive to the needs of patients with different ethnic and cultural backgrounds and
- the presence of a support system for realising migrant-friendliness as a specific dimension of service quality at the hospital

In this questionnaire, „MF“ (migrant-friendly/migrant-friendliness) is used as a general label for cultural diversity and/or culturally adequate services, or however you term this approach in your local context (e.g. cultural competence, equality and diversity, working group „euro-migrants”, etc.). “MF” refers to patient orientation and quality development of the hospital organisation, especially focussed on users who have a different ethic or cultural background from the majority culture of the country in question.

Background

The MFQQ is a further development of the MF Checklist which was improved using two strategies:

1. Consulting experts within the MFH project and beyond
2. Investigating the relevant literature on quality development for diverse populations, the WHO project “Health Promoting Hospitals”, and on established quality systems such as the EFQM, with the aim to validate the MF indicators used (see attached reference list).

Criteria for MF reflect the current state of the debate on improving the quality of healthcare for diverse populations, i.e. face validity is ensured.

Use

It is recommended that the local focal person takes charge of completing the questionnaire – involving the project steering group and the top hospital management in the assessment process. The MFQQ will be used at two points in time: for a baseline assessment early in the mfh project (May 2003) and a final assessment at the end of the project period (June 2004). We would encourage you to give a realistic assessment of the status quo – especially if you are at the beginning of developing migrant-friendliness at your hospital. In this way, improvements through the mfh project will become more clearly perceivable and thus enhance the visible success of your project.

Hospital: ……

Questionnaire filled in consultation with

Project Steering Group ☐

Top Hospital Management ☐

Other (Please specify:) ☐

Contact for questions

If you have difficulties in understanding or answering specific questions, please contact Uschi Trummer (uschi.trummer@univie.ac.at, phone: ++43-1-4277 48296)

Part A: MF Characteristics of Services

Please give estimated degree of implementation of the named MF quality assurance/ improvement measures in the relevant units of hospital, using a scale from 0% to 100% with the following response options:

0% - (not at all)
up to 25% - (e.g. in some units, erratically)
up to 50% - (in several units)
up to 75% - (widespread, rather reliable)
up to 100% - (full coverage, good quality, reliable, fast..)

Please give your estimate by checking the relevant box.

	General resources to facilitate communication and information	0%	up to 25%	up to 50%	up to 75%	up to 100%
	Communication - Interpreting services available at the hospital					
	Kind of professional interpreting service					
1.	Interpreting service implemented at hospital	☐	☐	☐	☐	☐
2.	Telephone interpreting service	☐	☐	☐	☐	☐
3.	Co-operation with external interpreting service	☐	☐	☐	☐	☐
	Who can request an interpreter?					
4.	Interpreting service available on request of staff	☐	☐	☐	☐	☐
5.	Interpreting service available on request of patients and/or relatives	☐	☐	☐	☐	☐
6.	Utilisation of language and cultural competencies of staff members with migrant and/or diverse backgrounds	☐	☐	☐	☐	☐
7.	Cultural mediation services	☐	☐	☐	☐	☐
8.	Other (please specify, e.g. informal or proxy interpreters):	☐	☐	☐	☐	☐
	Information					
9.	Patient information translated in the local community languages	☐	☐	☐	☐	☐
10.	Patient information prepared in the appropriate form (culturally specific, pictographs, audiotapes) -(Please specify:)	☐	☐	☐	☐	☐
11.	Visual orientation systems at the hospital (signposts, pictographs, etc.)	☐	☐	☐	☐	☐
12.	Other (please specify):	☐	☐	☐	☐	☐

	Accessibility, pre-entry and entry into hospital	0%	up to 25%	up to 50%	up to 75%	up to 100%
13.	Action programmes to improve access and ensure adequate service utilisation by migrants/all service users (please specify):	☐	☐	☐	☐	☐
14.	Hospital information for prospective patients available in places in the community easily accessible for people with a migrant/ethnic minority background (e.g. community centres, pharmacies, mosques, etc.)	☐	☐	☐	☐	☐
15.	Hospital information for prospective patients translated into the local community languages /	☐	☐	☐	☐	☐
16.	Hospital information for prospective patients prepared in the appropriate form (culturally specific, pictographs) (Please specify)	☐	☐	☐	☐	☐
17.	Written process regulations[1] for reception of migrant patients	☐	☐	☐	☐	☐
18.	Written process regulations for admission of migrant patients	☐	☐	☐	☐	☐
19.	Written process regulations for anamnesis of migrant patients	☐	☐	☐	☐	☐
20.	Bilingual questionnaires on medical history in the most important migrant languages as part of (medical + nursing) anamnesis	☐	☐	☐	☐	☐
21.	Other (please specify):	☐	☐	☐	☐	☐

	Whilst in hospital	0%	up to 25%	up to 50%	up to 75%	up to 100%
	Hotel services					
22.	Written process regulations for hotel services for migrant patients	☐	☐	☐	☐	☐
23.	Provision of adequate food (culture, religion)	☐	☐	☐	☐	☐
24.	Provision for patients to practice their religion within the hospital	☐	☐	☐	☐	☐
25.	Provisions for spiritual carers from diverse religious groups	☐	☐	☐	☐	☐
26.	Arrangements/facilities for family visits (more than 2 visitors per patient) Please specify:	☐	☐	☐	☐	☐
27.	Written process regulations for caring for deceased patients and their relatives according to their different cultural and religious backgrounds	☐	☐	☐	☐	☐
28.	Other (please specify):	☐	☐	☐	☐	☐
	Medical / nursing treatment					
29.	Provisions for patients to be treated by a doctor and nurse of same gender (if they choose)	☐	☐	☐	☐	☐
30.	Culturally competent nursing service	☐	☐	☐	☐	☐
31.	Transcultural mental health service	☐	☐	☐	☐	☐
32.	Written process regulations for diagnosis of migrant patients	☐	☐	☐	☐	☐
33.	Written process regulations for therapy of migrant patients	☐	☐	☐	☐	☐
34.	Services for migrant-specific health problems (e.g. sickle cell disease, thalassemia), (Please specify:)	☐	☐	☐	☐	☐
35.	Services accessible for irregular and/or undocumented (”illegal”) migrants (please specify):	☐	☐	☐	☐	☐
36.	Service to care for traumatised refugees (refugee trauma, war experiences, torture, etc.)	☐	☐	☐	☐	☐
37.	Culturally specific travel clinic for migrants returning to their country of origin	☐	☐	☐	☐	☐
38.	Provision for ensuring that patients are able to consent to treatment in a language they understand	☐	☐	☐	☐	☐
39.	Provision for ensuring that patients are able to read/ understand their medical and nursing record to be oriented about their progress	☐	☐	☐	☐	☐
40.	Other (please specify):	☐	☐	☐	☐	☐

	Discharge	0%	up to 25%	up to 50%	up to 75%	up to 100%
41.	Provision of information regarding treatment and post discharge care in appropriate language and format	☐	☐	☐	☐	☐
42.	Provision of culturally adequate recommendations and health information at discharge	☐	☐	☐	☐	☐
43.	Other (please specify):	☐	☐	☐	☐	☐
44.	Written process regulations in place for discharge of migrant patients	☐	☐	☐	☐	☐

	Discharge (ct.)	0%	up to 25%	up to 50%	up to 75%	up to 100%
45.	Written process regulations in place for transfer of migrant patients to other health care and/or social service institutions	☐	☐	☐	☐	☐
46.	Written process regulations in place for follow-up care for migrant patients (integrated system with primary care services)	☐	☐	☐	☐	☐
47.	Other (please specify):	☐	☐	☐	☐	☐

	MF patient education / health promotion / empowerment	0%	up to 25%	up to 50%	up to 75%	up to 100%
48.	Written process regulations to check general literacy of migrant patients	☐	☐	☐	☐	☐
49.	Provision of adequate info material for illiterate migrants (please specify):	☐	☐	☐	☐	☐
50.	Provision of culturally sensitive patient education programmes (please specify:)	☐	☐	☐	☐	☐
51.	Provision of culturally sensitive education programmes for families and carers (please specify:)	☐	☐	☐	☐	☐
52.	Provision of culturally sensitive health promotion services (please specify:)	☐	☐	☐	☐	☐
53.	Availability of a culturally and linguistically sensitive complaints system, e.g. ombuds-people, complaint forms, complaints box, etc. (please specify:)	☐	☐	☐	☐	☐

Part B: MF Support System

	General quality system in hospital		
		yes	no
54.	Does your hospital use a comprehensive quality system?	☐	☐
	If yes, please specify model, e.g. EFQM, ISO, TQM...		
55.	Are MF criteria integrated in this quality system?	☐	☐
	If yes, in which way? Please specify:		

	Does your hospital have a written MF policy ?		
		yes	no
56.	Migrant-friendliness as an explicit aim + value in the mission statement	☐	☐
	If yes, please quote the relevant passage in your mission statement (English translation):		
		yes	no
57.	Formulated MF strategic policy document, specifying MF core strategies and policies to reach them	☐	☐
58.	(Annual) MF action plan	☐	☐
59.	MF written process regulations (organisation manuals, guidelines, standards, pathways...)	☐	☐
60.	Reference to migrant-friendliness in general process regulations If yes, please specify:	☐	☐
61.	Hiring policies aimed at actively recruiting staff with a migrant background	☐	☐
62.	Policies for the training and development of staff with a migrant background	☐	☐
63.	Policies how to handle discrimination	☐	☐
64.	White book on health assistance for migrants in the region or country	☐	☐
65.	Other (please specify):	☐	☐

	MF budget			
			yes	no
66.	Does your hospital have an explicit MF budget? If possible, please specify the amount: Euro _____ per year		☐	☐
	Source of funds		yes	no
67.		regular hospital budget	☐	☐
68.		external public funds	☐	☐
69.		private sponsoring	☐	☐
70.		Other (Please specify):	☐	☐

	Is a specific MF management structure in place?		
		yes	no
71.	Multiprofessional MF steering committee	☐	☐
72.	Including migrant representatives	☐	☐
73.	Including representative(s) of top hospital management	☐	☐
74.	Including representative(s) of primary care	☐	☐
75.	Including representative(s) of local politics	☐	☐
76.	Including representative(s) of hospital staff	☐	☐
77.	Including representatives of other relevant groups: (Please specify)	☐	☐

	Is a specific MF management structure in place? (ct.)		
		yes	no
78.	Multiprofessional committee on access restrictions and health problems of migrants and ethnic minorities	☐	☐
79.	MF project officer or manager	☐	☐
80.	Network of MF contact persons on sub-unit level	☐	☐
81.	Type or size of network **(please give number of contact persons)**	Please specify:	

	Involvement of migrant representatives in organisational change		
		yes	no
82.	Members of top hospital management	☐	☐
83.	Members in health circles, project groups, etc.	☐	☐
84.	Members of staff	☐	☐
85.	Other (please specify):	☐	☐

	Marketing of MF		
	internal marketing of MF (at the hospital)		
		yes	no
86.	MFH communication policy and/or plan	☐	☐
87.	MFH logo	☐	☐
88.	MFH internal newsletter	☐	☐
89.	MFH annual presentations	☐	☐
90.	MFH intranet	☐	☐
91.	List of MFH contact persons at the hospital available to all staff members	☐	☐
92.	MFH office	☐	☐
93.	Others (Please specify):	☐	☐
	External marketing of MF (to the public)		
		yes	no
94.	MFH communication policy and/or plan	☐	☐
95.	Public relations manager with MFH responsibilities	☐	☐
96.	MFH logo	☐	☐
97.	MFH external newsletters	☐	☐
98.	MFH press releases	☐	☐
99.	MFH open house	☐	☐
100.	MFH flyers or brochures available at doctors' offices or migrant community centres	☐	☐
101.	MFH public website	☐	☐
102.	Available in the most commonly used migrant languages	☐	☐
103.	Other (please specify):	☐	☐

	MF training and education for staff		
		yes	no
104.	Staff training for MF	☐	☐
	Focus of staff training		
105.	Communication (language + interaction skills)	☐	☐
106.	Cultural competence	☐	☐
107.	Specific health problems prevalent among migrants and ethnic minorities	☐	☐
108.	"Migration medicine"	☐	☐
109.	Refugee trauma	☐	☐
110.	Transcultural psychiatry	☐	☐
111.	Managing diversity	☐	☐
112.	Working with interpreters	☐	☐
113.	Other (please specify:)	☐	☐
114.	Staff exchange programmes with other countries (please specify:)	☐	☐
115.	Inclusion of MF in curricula for education (medical students, nursing students, etc.)	☐	☐

	Monitoring of migrant clientele		
		yes	no
116.	Patient profiling data analysed and used for service planning	☐	☐
117.	Patient profiling (ethnic monitoring) takes place within the hospital for all patients	☐	☐
118.	systems have been developed for collecting patient data	☐	☐
119.	staff has been trained in collecting ethnic data in a way sensitive to the patients' emotions and interests	☐	☐
120.	strategies have been developed for raising public awareness regarding data collection, both internal and external	☐	☐
	Characteristics monitored:		
121.	Country of origin	☐	☐
122.	Ethnic background	☐	☐
123.	Legal status	☐	☐
124.	Language skills	☐	☐
125.	Social networks at host country	☐	☐
126.	(Former) occupation	☐	☐
127.	Educational level	☐	☐
128.	Other data (please specify):	☐	☐

	Monitoring of migrant-specific service outcomes		
	Which service outcomes are regularly monitored for migrant patients at your hospital?		
		yes	no
129.	Clinical outcomes (Please specify outcomes and indicators:)	☐	☐
130.	Health literacy	☐	☐
131.	If yes: please specify type of monitoring (e.g. questionnaire [name if possible], in initial medical/nursing interview...)	☐	☐
132.	If yes: please specify content (health literacy concerning available services, access to services, medication, acute illness, health-related behaviour.....)	☐	☐

	Monitoring of migrant-specific service outcomes (ct.)		
		yes	no
	Health behaviour		
133.	Compliance	☐	☐
134.	Compliance with medication	☐	☐
135.	Compliance with a treatment plan	☐	☐
136.	Compliance with an appointment schedule	☐	☐
137.	Other indicators of health behaviour : (please specify)	☐	☐
138.	Quality of life of migrants (Please specify: if questionnaires like the SF 36 are used, please name) ☐ Self-reported ☐ By proxies (= as seen by others)	☐	☐
139.	Service satisfaction	☐	☐
140.	of migrant patients	☐	☐
141.	of migrant carers (families, friends, etc.)	☐	☐
142.	Job satisfaction	☐	☐
143.	of staff with a migrant background	☐	☐
144.	of staff interacting with migrant patients	☐	☐
145.	Other service outcomes (please specify):	☐	☐
146.	Are outcome data for migrants compared with outcome data of other patient groups? (If yes, please specify:) ☐ For all assessed outcomes ☐ For selected assessed outcomes, namely:	☐	☐

	Method/approach used for monitoring migrant data		
		yes	no
147.	Admission monitoring service	☐	☐
148.	Electronic patient records	☐	☐
149.	Common health documents or data management system for migrants at hospital and primary care services	☐	☐
150.	Other approaches (please specify):	☐	☐

	Monitoring of MF impact on organisational quality		
		yes	no
151.	Surveys (e.g. inclusion of MF indicators in regular patient satisfaction surveys)	☐	☐
152.	Balanced Score Card	☐	☐
153.	Electronic patient records	☐	☐
154.	Other (please specify):	☐	☐

	Reporting system on MF activities and impact		
		yes	no
155.	Annual Report	☐	☐
156.	Public presentation of Annual Report	☐	☐
157.	Other (please specify):	☐	☐

	Partnerships and partner alliances		
		yes	no
158.	MFH partnership strategy and protocols for co-operation with partners	☐	☐
159.	Co-operation with migrant-specific extramural services (please specify:)	☐	☐
160.	Co-operation with health professionals at primary care level (e.g. in assessing migrant-specific outcomes or degree of MF in hospital treatment)	☐	☐
161.	Co-operation with social workers in the community (e.g. in assessing migrant-specific outcomes or degree of MF in hospital treatment)	☐	☐
162.	Co-operation with migrant associations or migrant representatives in the community	☐	☐
163.	Co-operation with local politicians (esp. health and social policy)	☐	☐
164.	Co-operation with education and training institutions (e.g. nursing/medical schools)	☐	☐
165.	International human/material resources exchange programmes	☐	☐
166.	MF as an explicit aim in national or regional health policy	☐	☐
167.	Other (please specify):	☐	☐

	General Comments	

Thank you very much for your co-operation!

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Websites

www.omhrc.gov/clas (CLAS - Culturally and Linguistically Appropriate Services, Recommendations for national (US) standards by the Office of Minority Health, US Department of Health and Human Services)

www.diversityrx.org/CCCONF/02/CultureandQuality (Improving Quality of Care for Diverse Populations)

[i] „written process regulations" means concrete instructions as to how to handle a situation on the operational level. These may be termed differently in different countries, e.g. in the UK they are referred to as "policies and procedures".

APPENDIX 6 DATA SOURCE

PUBLICATIONS	YEARS											
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Health Care Management Review						x						
Journal of Transcultural Nursing	x			xxx					x			
Nursing Standard					x							
Journal of Advanced Nursing						x			x			
Health and Social Care in the Community						x						
Urologic Nursing									x			
Journal of Community Health											x	
Diversity in Health and Social Care							x					
Scandinavian Journal of Caring Sciences											x	
Journal of Pediatric Orthopaedics					x							
Journal for Nurses in Staff Development							x					
International Journal of Environmental Research and Public Health												x
Journal of Clinical Nursing		x										
Home Health Care Management & Practice				x								
International Nursing Review										x		
Health Research and Educational Trust									x			
TOTAL	= 21 scientific articles											