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Diversity and equality of opportunity

Fundamentals for effective action
in the microcosm of the health care institution

Peter Saladin, Editor

Published by the Swiss Federal Office of Public Health (FOPH)
in collaboration with H+ Swiss Hospital Association

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International migration is one of the defining attributes of recent decades. It has had a marked effect on the social and economic development of numerous countries. Efforts are under way at both the national and international level to meet the challenges migration poses for the people and countries concerned. Migration influences practically every area of life to a greater or lesser extent. Health care is among the areas most notably affected. Situated at the heart of Europe, Switzerland has for centuries been a crossroads for migrants from all points of the compass. The multiplicity of cultures and languages in Switzerland is an essential feature of its society. Today, roughly a quarter of the Swiss population is of migrant origin, principally as a result of immigration related to employment. Switzerland's migrant population is very diverse, not only in origin, religion and language, but also in terms of its skills, lifestyle and social status. Like most modern societies, Switzerland has experienced considerable changes in its cultural and social values as a result.

Not all areas of society pay sufficient heed to this diversity. Critical self-examination shows that the Swiss health care system, for example, is not adequately equipped to provide appropriate health care to the country's migrant population, as demonstrated by the fact that some migrants are exposed to heightened health risks and are disadvantaged relative to other population groups.

This manual aims to provide the administrators of Swiss health care institutions – hospitals, clinics and long-term-care facilities – with practical support in addressing the societal issues surrounding diversity and migration. The backgrounds to diversity and migration are examined, as are the opportunities which the acquisition of cross-cultural competence can open up. The organisational challenges posed by potential conflicts between diversity and equality of opportunity are highlighted. The manual also makes a number of practical recommendations on how effectively to address these issues in the context of a health care institution. Appropriate diversity management can help an institution to utilise its employee resources effectively, thus bringing about more satisfactory outcomes for patients and health care workers alike.

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English translation of the original publication in German entitled: *Diversität und Chancengleichheit. Grundlagen für erfolgreiches Handeln im Mikrokosmos der Gesundheitsinstitutionen*

Peter Saladin (editor), with contributions from Renate Bühlmann, Janine Dahinden, Rahel Gall Azmat, Gerhard Ebner and Joachim Wohnhas

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The German, French and Italian versions of this book were published in 2006 with an accompanying DVD entitled *Verstehen kann heilen. Globale Migration – lokale Lösungen im Gesundheitswesen / Quand comprendre peut guérir. Migration globale – solutions locales au sein de la santé publique / Quando capire è guarire. Migrazione globale – soluzioni locali nel settore sanitario*. The English version of this book does not include this DVD.

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Diversité et égalité des chances
Les fondements d'une action efficace dans le microcosme des institutions de santé

Diversità e pari opportunità
Basi per un'azione efficace nel microcosmo delle istituzioni sanitarie

This manual was written for a Swiss audience and therefore focuses principally on conditions prevailing in Switzerland. Given the worldwide significance of the issues covered, this English translation was published in order to make experience gained in Switzerland accessible to as wide an audience as possible. This English text is a translation of the German version published in 2006. Unless otherwise stated, the information contained in this English version is that which was current at that time.

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Acknowledgements

In-depth analysis of the subjects of diversity, migration and equal opportunity provides new insights into Switzerland's health care system and institutions. Do they really provide everyone in this country with the excellent care which we so often assume? If we take an unbiased look into the mirror, the outstanding features we see are contrasted with some less flattering attributes, and it is these which are often experienced by those not familiar with local practices, those who are foreigners, migrants or members of a minority, when they need the support of our health care system.

This book aims to improve this situation, in the interests of all concerned. It was written as part of the "Migrant-Friendly Hospitals – a hospital network for the migrant population MFH" project. The MFH project was initiated by the Federal Office of Public Health FOPH as part of the Confederation's migration and public health 2002–2007 strategy. The MFH project was carried out by H+ Swiss Hospital Association.

I would like to take this opportunity to thank all those who, with their knowledge, their experience and their personal commitment, have contributed to making this publication a reality.


Particular mention should be made of the main writing team and the other authors (see the list of contributing authors starting on page 116).

Special thanks are also due to the officials of the Federal Office of Public Health FOPH, particularly P. Aemmer, R. Gall Azmat and Th. Spang, who guided and helped this project throughout. I would also like to thank the staff at H+ Swiss Hospital Association for their support, particularly M. Zweiacker, who provided us with valuable assistance in administrative matters.

Major contributions were also made by the representatives of the hospitals, clinics and long-term-care institutions and the other professionals who worked on the MFH project, providing the advisory board, the core group and especially the working groups with a wealth of practical ideas. My heartfelt thanks go to them all. Those chairing the working groups provided informed leadership to the often controversial discussions, devoting particular care to the formulation of the final recommendations. The working groups were chaired by G. Ebner (Medical procedures), Ch. Aeschlimann / W. Brunner (Strategy), R. Simon / M. Wietlisbach (Language, communication, information) and H. Rennhard-Hollenweger (Empowering hospital staff). Their contributions deserve particular recognition.

Contacts with the EU's MFH project enabled us to exchange valuable experience with representatives of health care and medical research institutions outside Switzerland. In this connection, I would particularly like to thank the Ludwig Boltzmann Institute for the Sociology of Health and Medicine in Vienna for granting us access to the EU project's work and for their kind permission to reproduce their quality questionnaire (see page 102).

P. Saladin



Chairman H+
Project leader

Foreword

The significance of migration has increased considerably in this current age of globalisation. Whether they are seeking better living conditions or are driven by poverty, war, persecution or natural catastrophe, more and more people are leaving their homes and trying to start a new life abroad. To a large extent, the success of their endeavours depends on the state of their physical and mental health. Healthy people find it easier to make their way in an unfamiliar environment. The challenges posed by integration, conversely, often have an adverse effect on people's health.

In Switzerland, scientific studies have shown that various aspects of the health of members of the migrant population are worse than that of the native population. Migrants are exposed to greater health risks and find it harder to access the services of our health care system. The fact that migrants constitute a good fifth of Switzerland's population makes this all the more worrying. Migrants contribute to our prosperity, they help to finance our health care system and they need to access its services when their health requires this. A major proportion of those employed in health care are either migrants themselves or the children of migrants. Their diverse languages, values and cultures are part of everyday working life in the health care sector. Without the help that migrants provide, our health care institutions could not fulfil their mission.

What skills are needed for the effective provision of health care services to the migrant population? And how can the quality of health care services be maintained at a satisfactory level while at the same time meeting multifaceted medical needs? It is questions such as these that this manual addresses. It is based on experience gained during the "Migrant-Friendly Hospitals – a network of hospitals for the migrant population" project and provides practical advice to the health care sector on how better to address migrants' needs. The attainment of an organisational culture which facilitates the access to appropriate medical care afforded to people of both sexes, the most diverse origins and all social classes is a worthwhile goal in itself.

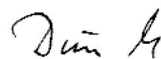
Current circumstances are not particularly conducive to achieving this objective. Hospitals and other health care institutions are under pressure to cut costs at a time when the demands placed on the quality and range of services they provide are growing. Nevertheless, effective provision of medical services to migrants not only has the potential to boost the quality and efficiency of an organisation, it also reduces the cost of providing medical care over the medium term. That is why we urge you to review the strategies outlined in this manual and to make the attainment of equal opportunity in health care one of your top priorities.

Prof. Dr. Thomas Zeltner



Director
Federal Office of Public Health FOPH

Dr. Markus Dürr



Minister of Health and Social Affairs of the
Canton of Lucerne,
Chairman of the Swiss Conference of the
Cantonal Ministers of Public Health

Brief summary for the reader in a hurry

This manual aims to support Swiss health care institutions¹ – hospitals, clinics and long-term-care facilities – in their efforts to respond credibly and effectively to the manifest societal phenomena of diversity and migration. It is intended primarily for the levels of management responsible for setting organisational policy. Effective action depends on their ability to deal decisively and intelligently with the questions posed by diversity and migration. When planning and implementing policy in this area, they need to weigh up carefully the opportunities and risks involved. Consistent focus on the well-being of those seeking help is paramount.

The introductory section of this manual (see pages 15 to 19) covers both the Swiss Confederation's strategy on migration and public health matters and the Migrant-Friendly Hospitals project. Key terms are defined on pages 91 to 95. The chapter on migration and cross-cultural competence (see pages 23 to 32) deals with sociological and ethnological questions as well as research findings in the areas of diversity, migration and public health. The importance of communication in an environment characterised by foreign languages is examined with reference to examples from clinical practice. The remarks on the organisational challenges posed by diversity and migration (see pages 35 to 39) deal with the management of diversity, the quality of services, the principles of efficacy, appropriateness and efficiency as well as funding issues.

The main part of the manual (see pages 43 to 77) formulates recommendations for management. These recommendations aim to assist management in reviewing organisational policy critically in the light of diversity and migration. They also provide practical advice on implementing appropriate measures.

As used in this manual, the term diversity is a value-neutral description of personal and social differences which are an innate feature of modern societies and which have their origin *inter alia* in a person's background, gender, language, skills, age, lifestyle and social status. Migration, in the context of this manual, signifies the movement of a person or group of persons across administrative, political or geographical borders with a view to settling temporarily or permanently in a place other than their place of origin. It is this migration which results in social diversity. Diversity management attempts to deal with these differences in a positive and self-critical manner, enabling an organisation, its clients and its employees to operate effectively. Diversity management is based on the principles of human dignity and equal opportunity, which are of particular importance to the day-to-day work of health care institutions. Cross-cultural competence at all levels of an organisation means "the ability to perceive and understand individual lives in a particular situation and in differing contexts, so as to develop courses of action which are appropriate" (see page 26).

The recommendations are classified into the following fields of activity: strategy, data capture, quality, staff policies, medical care procedures, interpretation and translation, ongoing employee education and central services. Background information on individual areas sheds light on specific aspects of the recommendations.

The **actions recommended** here can be summarised as follows:

→ The core attributes of an organisation, such as its task, mission, strategy, portfolio of services offered and its resource planning, should be expressly directed towards the attainment of an organisational policy which takes due account of diversity and migration issues. Appropriate organisational development projects will both promote the self-critical assessment of current practices and assist in defining new action-oriented initiatives.

Brief summary for the reader in a hurry

| Peter Saladin

Introduction

Migration and cross-cultural competence

Challenges to the organisation

Recommendations

Basic structure of the organisation

¹ Hereinafter, these terms will sometimes be referred to collectively as "health care institutions", "public health institutions", "the public health system", "institutions" or "organisations" when the text does not explicitly refer to a hospital, a specialised clinic (for rehabilitation or psychiatric care, for example) or a long-term-care institution.

- Personal commitment and determined action from management are the prerequisites for success here.
- Specific data → Health care institutions make up a multifaceted microcosm, which can be gauged with the help of specific data provided by each individual institution about its own organisation and the services it provides, the dimensions involved and the effect these have on its performance. This data serves to integrate, not to discriminate. Data protection procedures should be observed.
- Structure, procedure and outcome quality → All measures taken to improve the quality of an institution's structure, processes and outcomes should always also take explicit account of considerations specific to diversity and migration. Indeed, the extent to which it takes diversity and migration issues into account is the true litmus test for the effectiveness of patient- and client-oriented service delivery. By acknowledging differences in patients' and clients' basic situations, an institution can put in place efficient structures and processes which produce tailor-made results.
- Employee skills → The wide range of skills with which employees' backgrounds, language, religious affiliation and social status have endowed them should be recognised, utilised and encouraged. These skills can help to foster cross-cultural competence within the organisation. The guiding principles of an organisation's human resources policy, its human resources services, its appointment and promotion criteria and its information and communication practices should all reflect this situation.
- Medical care procedures → Medical care procedures should be based on a person-centred approach which respects patients' autonomy and freedom to make their own decisions. This approach should determine institutional processes relating to regular admissions, emergency admissions, diagnoses, treatment and discharge. Mutual understanding is crucial when information is being exchanged between people speaking different languages or between people with differing understandings of the same language. This is particularly true in all matters relating to informed consent. Institutions should draw up written procedures regulating assistance provided by those with specific language skills. These procedures should be known throughout the organisation. A conscious effort should be made to utilise and promote the individual resources of patients and long-term-care residents² and their entourage.
- Cross-language communication → In order to overcome language barriers, each institution should define and regulate the use of the various possible approaches for enabling communication between people with differing language skills. Depending on the specific needs of a situation and under defined circumstances, the institution may have recourse to external interpreters (if necessary by telephone), multilingual employees may serve as ad hoc interpreters, pictorial or reference works (such as pictograms or dictionaries) may be used, assistance may be requested from patients' families or entourage or written translations may be made. It is management's task to determine what linguistic aids are used and how, and to ensure that the prerequisites for their effective deployment are met. Appropriate human and financial resources should be mobilised so access to the linguistic aids deployed is as open and free of discrimination as possible.
- Ongoing employee training → Health care employees should receive ongoing and systematic training, so that quality of treatment can be maintained in a continuously evolving environment. Such training should foster employees' self-assurance when dealing with people of diverse origins,

² The term "patient" refers to a person who is "sick" or "seeking medical help" at a hospital or clinic. The term "long-term-care resident" refers to a person living in a long-term-care institution.

language, religion and social class. This, in turn helps to minimise stress and incorrect conduct, avoid unnecessary costs and raise efficiency. Form and content of the training provided must be adapted to the institution's needs. These recommendations include an appropriate programme framework.

→ Each institution's central services – such as admission and discharge administration, telephone services, enquiries, information and documentation, patient-related services (such as visiting rules), accommodation and catering, religious affairs and social services – should all have the necessary knowledge and skills to address the diverse needs of individuals and groups. Central services

→ Health care institutions should avail themselves of the closely knit network of national and international services available (see pages 81 to 88). This network not only provides support and assistance, but also offers a forum for the exchange of insights and experiences. A broad range of scientific literature is also at hand, providing in-depth analysis of various specific subjects (see pages 111 to 113). The 2005 "Amsterdam Declaration – Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe" sets the standards for future development in this area (see pages 96 to 101). Network

This manual provides a starting point for health care institutions to conduct an in-depth review of the issues of diversity, migration and equal opportunity, with the objective of providing optimal service to all population groups. Insights and experience gained in medical practice will pave the way for further developments here. Target audience

Introduction

Rationale for this manual

This manual is addressed to the managers of hospitals, clinics and long-term-care facilities.¹ It aims to support these managers in their efforts to make their institutions respond credibly and effectively to the manifest societal phenomena of diversity and migration.

Three challenges are becoming noticeably more significant:

- The expectations placed by patients and long-term-care residents² on the inpatient and outpatient care they receive and on their stays in health care institutions are becoming increasingly diverse. This diversity of expectations is the result of differences in background, culture, language, values and societal or individual attributes, and of different behaviour with regard to health issues and illness. This diversity is brought about not only by people who have emigrated to this country in recent years or decades. Migration within Switzerland's borders – from North to South, from West to East and from rural to urban environments – has also helped to bring about situations in which "otherness" becomes an issue at all levels of a health care institution.
- Practical experience and scientific study have shown that the state of health of members of migrant populations and minorities is often worse than that of people of local origin. This state of affairs has many causes: differences in the availability of material resources, social imbalances and unequal access to health care institutions. The health care sector should pay particular heed to the core values of the Swiss Federal Constitution, especially Articles 2, 7 and 8, which call for equal opportunity to the extent possible, human dignity and equality before the law.
- A significant proportion of those working in hospitals, clinics and long-term-care institutions – be they doctors, nurses, or members of the many other health care professions – come from outside Switzerland. Without their work, Switzerland's public health system could not fulfil its tasks.

Migration is one of the factors to which diversity is due. It is not its sole cause. Rather, diversity is the result of complex societal, economic and political developments which lead to a variety of needs, expectations and modes of behaviour.

Forward-looking, well-managed institutions will thus pose – and develop effective strategic and operational responses to – questions which include, but are not limited to, the following:

- Is management aware of the significance, scope and effects of diversity and migration on the institution it runs?
- How can the quality of medical care and administrative services be assured, given the diverse needs of patients, long-term-care residents and employees?
- How can the professional and social competence of employees best be developed, so that they can give of their best when confronted by this diverse environment?
- How can the institution as a whole make use of the specific experience and skills which its employees already possess in issues relating to diversity and migration?
- Does the institution set proper store by treating the people entrusted to it with respect and to ensuring equal opportunities for all?
- How can the institution promote patients' and long-term-care residents' satisfaction with the care it provides? How can employee job satisfaction be furthered? How can the satisfaction of patients, long-term-care residents and employees be measured?

Rationale for this manual

| Peter Saladin

Challenges

Key questions

¹ Hereinafter, these terms will sometimes be referred to collectively as "health care institutions", "public health institutions", "the public health system", "institutions" or "organisations" when the text does not explicitly refer to a hospital, a specialised clinic (for rehabilitation or psychiatric care, for example) or a long-term-care institution.

² The term "patient" refers to a person who is "sick" or "seeking medical help" at a hospital or clinic. The term "long-term-care resident" refers to a person living in a long-term-care institution.

Management responsibility

This manual thus explicitly addresses institutions' managements, for it is they who are ultimately responsible for their organisation's performance and development. The manual draws both on the experience gained at institutions in and outside Switzerland, as well as on a substantial body of scientific and practical literature. The book deals with the issues involved in a systematic manner, and aims to facilitate a critical appraisal of an institution's current directives in the light of the needs of rational diversity management. Consistent focus on the requirements of every individual demands that management systematically consider diversity and migration issues, so as to provide care which is attuned to the patients' and long-term-care residents' needs. The authors are of course aware that diversity and migration constantly give rise to new events and situations. National and international circumstances alter the social, economic, societal and political characteristics of diversity and migration and vice versa. The recommendations contained in this manual are based on the factual circumstances known at the time of its original publication in German, French and Italian in 2006. It is management's task to use these to formulate a coherent set of policies which are adapted to an institution's specific needs.

The terms used in discussing diversity and migration are defined on pages 91 to 95.

The health care institution – a multifaceted microcosm

Hospitals, clinics and institutions for long-term-care often see themselves as a world apart, a city within a city, possessed of their own culture and governed by their own laws. Personal, social and societal realities are reflected in them, and these realities often clash. They are places where a person's health – even life – is in danger. They demonstrate, very starkly, what a diversified and mobile society really means.

In 2004, foreigners constituted 21.8% of Switzerland's resident population.¹ The proportion of the population with a migrant background is in fact much larger than that statistic would suggest. Migrants live in Switzerland for personal, occupational, economic or political reasons, either permanently or temporarily. They make a significant contribution to the prosperity of the country. They help to keep the Swiss public health system going and they avail themselves of it when the need arises.

Economic, societal and political factors make mobility and migration constant features of a country's development. Millions of holidaymakers, business people and visitors travel inside or through Switzerland. All could conceivably need to avail themselves of our health care system. The same applies to Swiss people abroad.

In 2003², 36 473 people living outside Switzerland received stationary or semi-stationary treatment in Swiss hospitals, which equates to some 2.7% of the 1.3 million patients treated that year. Assuming that persons with migrant backgrounds use the public health system roughly as often as the Swiss, some 22% of this 1.3 million total can be added to 2.7% just mentioned. Thus, about a quarter of the patients treated in public and private hospitals in Switzerland are either foreigners living in Switzerland or non-Swiss residents. There are, however, large differences between individual institutions, depending on the services they provide and their geographical location.

The inner world of health care institutions is a microcosm, too. Foreigners and Swiss nationals of migrant origin form a large part of hospital staff of all occupational categories. In some large health care institutions, they account for up to 80% of all staff. The proportion of foreign employees working in inpatient care was 28% in 2001 (the most recent year for which figures are available), compared to 24.4% of all people employed in the country as a whole.³ These employees come from many different countries. Their different cultures, languages, training, values and modes of behaviour form an integral part of day-to-day hospital life. Often, they have skills which could be used to improve the quality of hospital care but which remain unutilised. Health care institutions employ these people to do a specific job, but do those institutions pay heed to their essential human personalities? Is the culture of the organisation equipped to use what distinguishes these people from others to help the institution develop? Can they defend themselves if they are subjected to discrimination? Are the necessary bridges being built to promote and encourage integration? Questions of this kind illustrate that health care institutions need to adopt active, forward-looking policies which incorporate cross-cultural competence if they are to treat all patients, all long-term-care residents and all employees with respect.

The health care institution – a multifaceted microcosm

| Peter Saladin

Proportion of population represented by foreign nationals

1 Federal Statistical Office FSO (2005) Ausländerinnen und Ausländer in der Schweiz. Neuchâtel

2 Federal Statistical Office FSO (2005) Medizinische Statistik 2003. Neuchâtel

3 Federal Statistical Office FSO (2003) Beschäftigte im Gesundheitswesen. Ergebnisse der Betriebszählung 2001, Beschäftigtenstatistik (BESTA). Neuchâtel

The Confederation's strategy for 2002–2007: migration and public health

The Confederation's strategy for 2002–2007: migration and public health

| Petra Aemmer

Certain parts of Switzerland's public health system are inadequately prepared to provide care for the country's migrant population, as is evidenced both by research and practical experience. Part of the migrant population is exposed to major health risks and migrants are disadvantaged compared to other population groups. "Health for all" is an objective and an expectation whose attainment will require specific action to be taken.

The Confederation's "Migration and Public Health" strategic orientation for 2002–2006 was the result of broad-based expert analysis and extensive consultation. This strategy, inspired by the World Health Organisation's "Health for all in the 21st century" target, was formulated by the Federal Office of Public Health FOPH in collaboration with the Federal Office for Migration (FOM) and the Federal Commission for Foreigners (FCF). It was approved by the Federal Council in July 2002. In May 2005, the Federal Council extended its duration by one year to the end of 2007. The longer-term objective is to create a public health system which takes due account of the changes to society and health care clientele which have arisen as a result of migration.

In order to improve access to health care and to provide services specific to migrants' needs, the following five areas of intervention have been determined (in order of priority):

1. Education (basic education, advanced and continuing training)
2. Public information, prevention and health promotion
3. Health care provision
4. Therapy for traumatised asylum seekers
5. Research (basic research, evaluation and monitoring)

Implementation is being carried out in close collaboration with the relevant federal agencies, and with cantons, towns, aid organisations, non-governmental organisations NGO and research institutions, among others. Additional information regarding the strategy can be found on www.bag.admin.ch.

This manual is devoted to the 3rd area of intervention listed above: health care provision. The primary objective here is to diminish the often higher barriers to access to regular health care in hospitals, clinics and long-term-care institutions which migrants encounter in comparison with the native Swiss population. The quality of health care delivery should also be maintained in situations where particular attention needs to be paid to the differing attributes of patients. This was also the objective of an agreement signed between the FOPH and H+ Swiss Hospital Association at the end of 2003 which mandates H+ to implement the Migrant-Friendly Hospitals – a hospital network for the migrant population MFH project (see page 19) which is described in more detail hereafter. This Swiss project is partly based on a similar project, which was carried out in one hospital in each of 12 EU nations and has since been completed (www.mfh-eu.net).

Five areas of intervention

Health care provision

The MFH project

www.bag.admin.ch

www.mfh-eu.net

The MFH project: Migrant-Friendly Hospitals – a hospital network for the migrant population

The project, which runs from 1.12.2003 until 30.11.2007, has the following objectives:

- To create a network of health care institutions with particular skills in the care of members of migrant population groups.
- To transfer knowledge and skills through the exchange of information and experience by the doctors, nurses and administrative staff directly participating in the project.
- To formulate recommendations and best practice standards for cross-cultural competence, to publish these and make them available to a broader audience.
- To promote and support specific measures to be implemented by health care institutions.

The project has a pool of resources available to it, from which start-up financing for innovative projects by health care institutions can be granted.

P. Saladin was nominated project leader for the implementation of the project. A core group, to which all health care institutions have access, serves both as a forum for the exchange of ideas and experience and to promulgate recommendations to health care institutions. Most of these recommendations were developed by working groups, and these are reproduced in this manual. An advisory board, comprising specialists from the fields of migration and health care, advises and supports the project.

By 30 June 2006 the funding pool had provided 15 projects and studies with partial financing amounting to CHF 605 879.

At the time of writing, no decisions had been reached regarding the network's long-term official future after the conclusion of the project. The objective is to ensure that independent organisational developments and common initiatives by the health care institutions will enable the processes which the project has initiated to be sustained in the future.¹

More detailed information about the MFH project can be found on www.hplus.ch.

The MFH project: Migrant-Friendly Hospitals – a hospital network for the migrant population

| Peter Saladin

Exchanging experience

Financing

Sustainability

¹ Since 2007, the MFH network has been part of the Swiss Network of Health Promoting Hospitals.

See www.healthhospitals.ch

www.hplus.ch

Migration and cross-cultural competence

Migration and diversity

Migration, in the context of this manual, signifies the movement of a person or group of persons across administrative, political or geographical borders with a view to settling temporarily or permanently in a place other than their place of origin.¹ The idea that people naturally remain in one place and that migration is exceptional holds good only at a very superficial level. People have been on the move since time immemorial and are constantly seeking new or better living conditions. Be it in ancient times, in the age of the Vikings, as a result of colonisation or the mass European emigration to North America in the 18th and 19th centuries, people have always migrated. Nevertheless, the scale of migration throughout the world has seen a steady increase since the end of the Second World War and migration is now part of life in every region of the planet. Scarcely anywhere is untouched by this phenomenon, be it as a source of migration, a migration destination or a transit country. Stephen Castles², a contemporary sociologist studying migration, when describing the global dimension of migration during the 20th century, speaks of an “Age of Migration”. This expression has since become an established metaphor for the omnipresence of migration. Estimates show that, at the beginning of the 21st century, 3% of the world’s population, or some 200 million people, were international migrants. Put another way, 1 person in 35 is a migrant, and the migrant population as a whole is as large as that of Brazil, the fifth most populous country in the world.³

Until the beginning of the last century, Switzerland was a country with net emigration. As industrialisation progressed, demand for workers grew, and this demand was increasingly met by foreigners from the second half of the 19th century onwards. The quota of foreigners in Switzerland’s total population declined during the First World War, but by the end of the Second World War, Switzerland’s economy was again short of workers and they were again recruited abroad, a practice which continued well into the 1980’s. Swiss immigration policy was largely determined by economic needs and was always at least partially governed by the requirements of the labour market.⁴ From the 1980’s onwards, Switzerland’s admission policies for migrants have become increasingly restrictive. One consequence of this has been that the proportion of foreigners arriving in Switzerland as asylum seekers rose continuously. Asylum seekers have sought entry on humanitarian – not economic – grounds. Although the number of asylum seekers has risen, it remains lower than that of migrants coming to Switzerland to take up employment. In 2004, foreigners accounted for 21.8% of Switzerland’s resident population. Only a tiny proportion of these foreigners – 3.4% of the total foreign population or 55 100 people – are asylum seekers.⁵

Historically, a large proportion of Switzerland’s migrant population has come from Europe, and this remains the case today. The migrant population has nevertheless become increasingly diversified in recent years. The proportion of migrants from non-European countries has risen continuously, reaching 14.6% of the foreign population, or 238 000 people, in 2004.⁶ Switzerland’s migrant population, that is to say all those born outside Switzerland – irrespective of their current nationality – and their children (the so-called 2nd generation), undoubtedly constitute a very heterogeneous group in terms of origin, age, family circumstances and socio-occupational attributes. People of migrant origin can be found today in all social groups and all occupations. The circumstances in which they live are as varied as those which

Migration and Diversity

| Janine Dahinden

1 International Organization for Migration IOM (2003) Facts and Figures on International Migration. Migration Policy Issues 2

2 Castles S and Miller M J (1993) The age of migration – international population movements in the modern world. Houndmills [etc.]: MacMillan

3 The Global Commission on International Migration (2005) Migration in an Interconnected World – New Directions for Action. Report of the Global Commission on International Migration. www.gcim.org

4 Piguet E (2005) L’immigration en Suisse depuis 1948. Une analyse des flux migratoires vers la Suisse. Seismo, Zurich and

Wicker HR (2003) Einleitung: Migration, Migrationspolitik und Migrationsforschung
In: Wicker HR, Fibbi R and Haug W (ed.) Migration und die Schweiz. Seismo, Zurich, 12–62

5, 6 Federal Statistical Office FSO (2005) Ausländerinnen und Ausländer in der Schweiz. Neuchâtel

Switzerland: from migration source to migration destination

Increasing diversity among the migrant population

| | |
|---|---|
| Diversity and plurality: elements of a modern society | <p>led to their migration. The migrant population is thus by no means homogeneous, but a colourful and diversified mosaic of people.</p> <p>Immigration is, however, not the only factor making for the very pluralistic society Switzerland has today. Linguistic and cultural diversity have been established in this country for a long time, as reflected by the various linguistic groups within Switzerland. Nevertheless, Switzerland has been subject to pronounced cultural and social change in recent years. A similar trend can be observed in most modern societies. It is most noticeably evidenced by a pluralisation of lifestyles, modes of living, languages and values. Sociologists see this diversification as the result of a host of different factors. It has undoubtedly been driven by the democratisation of the education system, the introduction of social security systems in the context of the welfare state and the propagation of the market economy.</p> |
| Migration and equal opportunity | <p>Diversity, which is at least partially the result of migration, has, however, also had another effect. A person's origin now plays an increasingly important part in determining their opportunities for access to a society's resources such as education, apprenticeships and employment, as well as the services of the health care system. This can have adverse consequences for the migrant population.</p> <p>Some migrant groups are over-represented in the lowest socio-economic classes. They also suffer discrimination in employment prospects when competing against comparably qualified Swiss candidates.⁷</p> <p>This state of affairs also manifests itself in the fact that part of the migrant population suffer health deficiencies and that there are barriers to their access to appropriate health care. Migration can thus be an obstacle to equal opportunity even in a democratic society. Besides such established factors as class or gender, nationality and ethnicity are now increasingly at the root of social inequality.</p> |
| Diversity and health care institutions | <p>What does this diversity mean for health care institutions? Patients and long-term-care residents reflect this diversity. In their daily work in wards, policlinics, and in outpatient services, too, doctors and nurses are increasingly coming into contact with migrants whose social practices, values and behaviour they experience as alien and they find unsettling. If difficulties in linguistic or cultural communication also occur, medical staff may not become aware of important aspects of the realities of the patients' daily lives and the symptoms of illness they experience, which could be crucial in ensuring that they receive appropriate treatment. It is the medical institutions' task to adapt their services so that they take account of this diversity, so that all patients and long-term-care residents have equality of access to, and participation in, medical care, as the World Health Organisation requires.</p> |
| Two approaches | <p>A dual-track strategy needs to be adopted to attain these objectives:</p> <ul style="list-style-type: none"> → The first part of the strategy involves pursuing a policy which takes account of differences generally. Such a policy sees migration not only as a process, but also as both a (contributory) cause and a consequence of a pluralistic society. Public health and migration thus become part of the overall mainstreaming of diversity now being called for in various sections of society. Such mainstreaming requires a holistic view to be taken of individual and group-specific diversity, whose causes include gender, social class, cultural affinity and experience of migration. Migration is thus but one element among many which needs to be included in such a view. The ultimate goal of managing diversity in this way is to achieve equality of opportunity in a context of diversity. → The second part of the strategy involves deploying migration-specific services within an |

⁷ Fibbi R, Kaya B and Piguet E (2003) Le passeport ou le diplôme? SFM. Neuchâtel

institution in order to make that institution more open to all. Many of these migration-specific services are indispensable, those facilitating effective communication being but one example. Migration-specific services in the health care context should give migrants equal access to health care.

For health care institutions, adopting a comprehensive approach to diversity means examining when a particular measure should be implemented as part of a general policy of institutional openness and when a migration-specific approach needs to be adopted.

Cross-cultural competence

Cross-cultural competence

| Dagmar Domenig

Cross-cultural competence describes the ability to grasp individual life environments in special situations and a variety of contexts, to understand these environments and to act in a manner which is appropriate to them. Professionals endowed with cross-cultural competence perceive migrants as individuals with surroundings of their own, rather than as people from alien cultures. Seeing migrants primarily in a cultural context is a practice born of the assumption that they have become socialised in a specific, clearly delimited culture, with defined norms and values, and that they will therefore behave according to that culture.

Such rigid cultural concepts are no longer valid in an increasingly globalised world with a high degree of mobility. They are no longer applicable because they no longer reflect the reality of migrant life. Acquiring cross-cultural competence also requires one to seek and recognise common features as well as differences. It requires a willingness to be open to and understand others, so as to prevent discrimination and exclusion. Cross-cultural competence centres around better understanding between professionals and members of the migrant population. In essence it involves the ability of the professional to interact with clients in a migration context. To acquire cross-cultural competence, professionals must first learn to reflect effectively on their own living environment and their own experience of life. Once they have acquired this ability, they can build on, and more effectively contextualise and comprehend, the living environment and life experiences of migrants. The constant exercise of cross-cultural competence requires professionals to be ready to contemplate the most multifaceted of issues and to be prepared not only to question their own modes of behaviour and familiar ways of viewing the world, but also to have these questioned by others.^{1, 2}

Culturally competent professionals act to ensure that migrants can exercise their rights to equal opportunity in health care despite the barriers posed by language and other migrant-specific issues.

Culturally competent medical treatment requires a basic respect for human dignity, for the right to equal opportunity and for the prohibition of discrimination. Article 2 of the Swiss Federal Constitution states that it "shall ensure equal opportunities for all citizens to the extent possible".

Article 7 of the Swiss Federal Constitution guarantees the respect and protection of human dignity, while Article 8 states that nobody shall suffer discrimination, particularly on grounds of origin, race, sex, age, language, social position, lifestyle and religious, philosophical or political conviction, or because of a corporal or mental disability.³

Remarks based on a person's culture may harbour racist attitudes, which result in the human dignity of migrants being wounded and in their being discriminated against on the basis of their origin, lifestyle or personal convictions. Racism occurs only in circumstances where perceived differences draw adverse comment and these perceived differences result in someone being excluded or disadvantaged.⁴

A culturally competent institution also recognises the cross-cultural competence of its employees of migrant origin and the critical importance of such competence in the treatment of migrants and thus, by extension, for the organisation as a whole. Such institutions are at pains to ensure that their employees of migrant origin are not in any way disadvantaged vis-à-vis their Swiss colleagues, be it on appointment, during working hours, in vocational training or with regard to promotion.

1 Domenig D (2001a) Einführung in die transkulturelle Pflege. In: Domenig D (ed.) Professionelle transkulturelle Pflege. Handbuch für Lehre und Praxis in Pflege und Geburtshilfe. Hans Huber, Bern, 139–158

2 Domenig D (2001b) Migration, Drogen, transkulturelle Kompetenz. Hans Huber, Bern

3 Bundesverfassung, 18. 12. 1998 (AS 1999 2556)

4 Memmi A (1992) Rassismus. Europäische Verlagsanstalt, Hamburg, 151 p.

Breaking down barriers

Implementing cross-cultural competence is a multifaceted, multidisciplinary task which needs to be addressed at all levels and in all areas of a health care institution. While it is certainly true that offering specific training or seeking the services of interpreters can contribute to a change in the conduct of specific professionals, health care institutions will be able to achieve only isolated improvements in the way they treat migrants unless they are prepared to undertake the necessary structural initiatives, some of which will require profound changes in the way an institution is managed and those working in it relate to each other. Comprehensively integrating the cultural perspective into all aspects of health care provision does, however, provide an opportunity that the barriers to access which migrants are confronted with will be reduced in an effective manner, so that they, too, receive treatment which is adapted to their life history, living environment and current situation.

Cross-cultural competence
as a cross-disciplinary task



Communication: foreign languages in hospitals

| Alexander Bischoff

Communication: foreign languages in hospitals

In a hospital, one of the consequences of diversity is a multiplicity of languages. Language barriers form between people when they have no language in common. In fact, what are commonly termed language barriers are really language gaps. There is nothing actively separating those trying to communicate; rather, there is a gap or chasm between them, which makes it impossible for them to communicate with each other.

While language barriers are receiving increasing attention in day-to-day clinical practice, the fact that they can have direct clinical consequences is still widely overlooked. The following three examples of clinical consequences arising from language barriers serve to illustrate this point. The quotations which follow are drawn from the clinical histories of patients speaking foreign languages, who were treated in a policlinic.¹ They have been arranged in order of their frequency of occurrence in patient treatment. Each example is followed by references to similar cases in the international literature, most being drawn from the Anglo-Saxon literature.²

Obstacles to medical examination

1. "Olfactory capability cannot be tested if language skills are not adequate." "The question could have been answered by taking urine samples during the day and at night. It was, however, not possible to communicate this to the patient for linguistic reasons."

Study findings: Patients speaking foreign languages tended to speak less often (compared to those who spoke English) about their state of health, and what they did say during consultations tended to be ignored more frequently. Preliminary patient questioning was carried out less frequently with patients speaking foreign languages, with the result that speaking a foreign language became one of the factors preventing systematic cancer screening among women. When symptoms occurred, however, diagnostic examinations were carried out more frequently on patients speaking foreign languages, presumably in an effort to compensate for the effects of inadequate understanding.

Impeded adherence to therapy prescriptions

2. "Given the language difficulties encountered and the fact that her accommodation arrangements were subject to frequent change, the patient probably took the medicines incorrectly for a relatively long period of time."

Study findings: Patients speaking foreign languages were less disciplined in monitoring their own blood sugar levels. In another clinical setting, foreign language speakers proved to be generally less disciplined in adhering to therapy prescriptions.

Obstacles to appropriate treatment

3. "Misunderstood: Insulin every second day, rather than blood sugar every second day!" Study findings: Patients speaking foreign languages tended to be asked to attend follow-up consultations less frequently and also returned to their referring institution less often. Complications arising from medicine intake were also observed more frequently among patients speaking foreign languages.

Overcoming language barriers

These adverse and – as the examples above show – sometimes dangerous effects of language barriers are not something which hospitals have to accept fatalistically. There are two main approaches which the migrant-friendly health care institution can adopt to tackle them. Either employees working at the institution are trained so that they can communicate with patients in the patients' own language or interpret for them, or the institution avails itself of the services of appropriately trained interpreters. Finding specialised medical staff who speak a patient's language or enabling such staff to learn that language is certainly a worthwhile strategy. There is evidence in the literature that patients prefer to be treated by a doctor who speaks their language rather than communicating via an interpreter. Efforts are

1 Bischoff A, Kurth E, Schneider M, Hoffmann S, Heuss L-TI (2005) "A-Care" Gesundheitsversorgung und -kosten von Asylsuchenden in Basel. Forschungsbericht zuhanden des Bundesamtes für Migration. Institut für Pflegewissenschaft, Universität Basel and Universitätsspital Basel

2 Bibliographical references can be obtained from the author.

The following reviews do, however, refer to most of the articles cited.

Flores G (2005) The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev* 62(3): 255–299, and

Jacobs E, Chen AH et al (2006) The need for more research on language barriers in health care: a proposed research agenda. *Milbank Q* 84(1): 111–133

under way in Switzerland to acknowledge and develop the potential of medical staff with migrant backgrounds and their language skills. Some institutions take the ability to speak several languages into account at the appointment stage. The question as to which particular situations and areas would benefit from the deployment of multilingual hospital staff as ad hoc interpreters is examined in detail on pages 65 to 67. That section also includes a list of the key criteria to apply in deciding when to seek the assistance of multilingual hospital staff and when to seek that of interpreters. One recommendation is that an organisational structure be established to organise the interpreting work of multilingual staff in an efficient manner. Training is also recommended to prepare multilingual staff for their work as interpreters.

Ad hoc interpreters

The Confederation's strategy sees the establishment of interpreting services staffed by qualified interpreters as the main priority. Services of this kind already exist in larger towns and cities in Switzerland. Certification and standards of professional practice for such interpreters have now reached the stage where there is a certain *unité de doctrine* regarding the skills they require and their professional role.

Qualified interpreters

These developments are the result of efforts undertaken by various state and non-state institutions, such as the Federal Office of Public Health, the Federal Commission for Foreigners, the Federal Office for Professional Education and Technology (which is concerned with the formal recognition of a new profession) and INTERPRET, an organisation founded in 1999. INTERPRET is playing a pivotal role in the professionalisation of cross-cultural interpretation and communication, particularly in the public service sector. Analysis of treatment and care outcomes in cases where communication took place through interpreters has been carried out only in the last few years and the volume of data examined has so far been modest. The first study to demonstrate that interpreting services improve the quality of care was carried out in Chicago.³ This study showed that patients accompanied by interpreters attended follow-up consultations more regularly, had more medicines prescribed to them and showed greater interest in preventative measures such as cancer screening and inoculations.

Effects of interpreter involvement

Other studies have examined patient satisfaction. This was shown to be consistently greater when interpreters facilitated communication between medical staff and patients speaking different languages. A study of medical interventions in Geneva found that communication with patients speaking foreign languages improved as doctors became more adept at working with interpreters. Patients speaking foreign languages reported the quality of both communication and care as having improved after the introduction of so-called "triadology" training, which was devoted to getting the most out of consultations supported by interpreters.⁴ Green⁵ observes similar results.

Professional interpreters are not always readily available to attend in person or to do so at short notice. In such cases, interpreting by telephone is an alternative to the gold standard of face-to-face interpreting on the spot (see page 67).

Interpreting by telephone

Interpreting saves time and money when the communication it enables means that fewer medical services are needed and treatment can be brought to a successful conclusion more rapidly, thus benefiting both patient and medical staff. One doctor, who was treating a patient whose language he did not speak and who, thanks to the help of an interpreter, was able to calm and then resolve an escalating medical situation, noted the following (this example comes from the "A-Care" study mentioned above): "Increasing discrepancies between the medical care administered and that being continually requested by the patient

3 Jacobs E A et al. (2001) The impact of interpreter services on delivery of health care to limited English proficient patients. *J Gen Intern Medicine* 16: 468–474

4 Bischoff A et al. (2003) Improving communication between physicians and patients who speak a foreign language. *British Journal of General Practice* 53: 541–546

5 Green A (2005) Interpreter services, language concordance and health care quality. *J Gen Intern Medicine* 20 (11): 1050–1056

resulted in a temporary disagreement, which the interpreter was able to resolve. I was then able to complete the case.”

Research into migration and public health

In Switzerland, little research was carried out in the field of migration and public health until about fifteen years ago. The situation has changed fundamentally since then, however. Migrant health issues have been examined from various perspectives, in a number of disciplines and by a variety of methods. While research was initially mainly conducted from a medical and epidemiological standpoint, with quantitative methods dominating, a sociological perspective has become established in the last few years.

Research in this area conducted from a medical and epidemiological standpoint studies the causes and population distribution of health-related conditions and events among the migrant population. It thus concerns itself with the incidence and prevalence of particular health phenomena, such as infectious diseases (tuberculosis, etc.), as well HIV or heart and circulatory disorders. Research carried out with a sociological perspective, on the other hand, deals primarily with issues of equality of opportunity, differing perceptions of health and sickness or the search for solutions to the problems of providing care to the migrant population.

The fact that there is still no clear assessment of the relationship between migration and health is a reflection of the extremely complex range of issues involved. Causal, one-way explanation will always remain inadequate in this area. The migrant population is too diverse and the number of variables affecting people's health is too great. There is a broad consensus in the discipline that nationality alone says little about health patterns. The status of a person's right of domicile in Switzerland, the length of time they have lived here, their situation before leaving their country of origin, their social class, their experience of adapting to a new social and cultural environment, their gender, occupation, experience of discrimination, as well as their family structures are all factors which are both affected by, and affect, their state of health. Regula Weiss's¹ standard work "Macht Migration krank?" was the first to provide a differentiated overview of these issues in Switzerland. Her book reviews the situation of migrants from sociological, psychiatric and somatic perspectives. Her thesis is that it is not migration itself which makes people ill, but rather the structural environment and personal availability of resources both before and after migration.

Switzerland's first comprehensive survey to be conducted among various migrant groups was recently completed with a project on health monitoring for Switzerland's migrant population carried out on behalf of the Federal Office of Public Health. The results promise to be interesting, especially since they will be directly comparable to the data on the overall population of Switzerland from a recent health questionnaire.

The extent to which migrants have access to adequate medical treatment and care is another subject that has attracted much research interest. Use of health care services among the migrant population differs in some regards from that of the native Swiss population. Economic, linguistic and administrative hurdles make it harder for migrants to obtain equal access to medical services.

Current research in this area is very varied, both in the issues it analyses and the population groups on which it focuses. Subjects currently being covered range from the ageing migrant population and its prevalent specific health issues to the sexual and reproductive health of migrants, to the effects on health of violence and trauma experienced in the context of migration. Health in the workplace is another topic to which increasing attention is now being paid.

Research into migration and public health

| Janine Dahinden

Research into causes

Health monitoring

Current research

¹ Weiss R (2003) Macht Migration krank? Eine transdisziplinäre Analyse der Gesundheit von Migrantinnen und Migranten. Seismo, Zurich

Research also needs to take its cue from diversity mainstreaming. This has three implications:

1. A key task is to identify those circumstances where factors specific to migration or origin are relevant health indicators and to distinguish them from circumstances in which other variables, such as gender or social class, are of greater significance.
2. A valid criticism of public health research carried out to date is that it is only gradually being influenced by considerations related to diversity mainstreaming. Migration as a topic in its own right or as an explanatory variable is gaining ground in individual areas of research only slowly. In other words, the pluralisation of society is so far only marginally reflected in the content of research being carried out.
3. A comparative perspective would be particularly useful at present, with research questions being more frequently reviewed on the basis of comparisons between countries.

Challenges posed to the organisation by diversity and migration

Challenges posed to the organisation by diversity and migration

Managing diversity

Managing a health care institution is a complex task. The institution is the focal point of innumerable expectations, be it from patients, long-term-care residents, the various employee groups, the federal and cantonal regulators or those bearing the institution's costs, i.e. health insurers and the public purse. All these expectations are brought to bear on the health care institution and they are sometimes contradictory. This is particularly evident in the conflict between economic pressure on funding on the one hand and ever-increasing demands on the quality and range of services provided on the other. These conflicting demands can lead to some daunting situations, often made all the more acute by the constraints placed on certain institutions' freedom of action by overarching political mechanisms.

In such an environment diversity and migration create both additional tensions and new opportunities and risks. How are these tensions perceived by management and employees? What needs to be done in order to establish cross-cultural competence in all areas of the organisation? Given that resources are in any case scarce, can measures to promote cross-cultural competence even be funded? Are patients and long-term-care residents from different cultural backgrounds even welcome?

Diversity management addresses an institution's ability to respect the diversity of the patients entrusted to it when providing them with medical care, in a manner beneficial to all concerned, including the institution itself. For an institution to adopt such an approach, it needs to have an organisational culture which places due emphasis on openness and the willingness to learn from each other. The individual's strengths and weaknesses form the basis for positive development. Non-discriminatory conduct should be an overarching goal.¹

All those entering a health care institution see themselves as a special case in their own right – and this view is entirely justified. Everyone brings their own individual circumstances and needs with them. The same applies to health care employees.

It is management's task to structure the organisation in such a way that these individual attributes are recognised and respected, and that this is done in a manner from which both the individual concerned and the organisation can derive the greatest benefit. The unfamiliar should not be perceived as a nuisance or a disturbance, but rather should become a factor in determining the successful outcome of the care and treatment administered, even if this appears at first sight to upset existing routines or to require additional initial effort. Taking account of differences is a major prerequisite for making procedures efficient. The skill lies in balancing the contradictory needs which arise from diversity with the standardisation of procedures, so that any action taken is as effective as possible.

The organisation must, of course, also determine where specific individual needs cannot be catered for, whether alternatives can be pursued in such cases and what those alternatives would be. Implementation of a comprehensive diversity policy then becomes the key to developing a client-focused, efficient and competitive organisation.

Knowledge and experience of processes of organisational development exists which will enable such situations to be mastered, and a variety of strategic and operational management tools have been developed to assist their implementation.² The purely technical and professional aspects of management are not sufficient to enable institutions which are deal-

Managing diversity

| Peter Saladin

Opportunities and risks

Diversity and standardisation

Focusing on people

¹ The Amsterdam Declaration. Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe (2004), reproduced on page 96

² Grossmann R (2005) Umsetzung einer MFH-Strategie. Überlegungen zu Kooperation und Steuerung in der Organisation: Erkenntnisse der Organisationsentwicklung für den Umgang mit Migrantinnen und Migranten und kulturellen Unterschieden in der Organisation Spital. Vortrag, Bern, 22. August 2005. www.hplus.ch

ing with critical human situations – birth, illness and death – to perform their task effectively. Such organisations also need to base their policies and practices on a reliable ethical foundation. The phrase “Everything centres around people” – or words to that effect – can be found in every mission statement. Radically observing that preception in practice is what is key to developing and implementing an organisational policy which appropriately addresses the issues of diversity and migration. Two principles deserve particular mention here: human dignity and equality of opportunity.

Human dignity

This is widely recognised as an inalienable human right, and health care institutions need to exercise particular care in ensuring that it is respected. The individuals in an institution's care are often in a particularly precarious situation and almost entirely dependent on health care staff. Human dignity must be respected at all times, irrespective of individual patients' origins, language, gender, religion, social and economic status and state of health.

Equal opportunity

The circumstances prompting people to seek treatment in a health care institution are numerous and diverse, and depend on their assessment of greater or smaller risks and opportunities. Giving birth, suffering a major accident, illness, whether curable or not, and old age are but some examples. As a rule, the circumstances applying prior to admission are beyond the institution's control. The principle of equal opportunity requires the institution to create a framework within which everyone, irrespective of their origin, language, gender, religion, social or economic status or their current state of health, is admitted, treated and cared for in a manner both befitting their situation and in keeping with current medical standards.

Key aspects of organisational management

These two principles of human dignity and equal opportunity are central points of reference for all professional work carried out in a health care institution. Implementing them within an organisation's day-to-day routine requires a conscious effort to structure its medical, care-related, administrative and technical procedures and structures effectively and appropriately. It is not simply a question of finding some naive ethical label to stick onto an organisation's existing policy; nor are these principles something secondary, which ought perhaps to be pursued at some stage when circumstances permit it. They are, instead, crucial aspects of the way an organisation is managed.

Adopting this view requires one to reflect critically on one's own actions. Only by “questioning one's own values and attitudes can one recognise one's own prejudices and ethnocentric assumptions, so that one can address those that are perceived as foreign with as little prejudice as possible. Only when one becomes aware of how relative one's own values and modes of behaviour are, only when one has grasped the unendingly different ways in which societies can operate and individuals can view the world, only then can one aspire to cross-cultural competence, because it is only then that one can situate not only the behaviour of others, but also one's own behaviour within a broader sociocultural context.”³

3 Domenig D (2001b) Migration, Drogen, transkulturelle Kompetenz. Hans Huber, Bern, 39

Quality – at odds with effectiveness, appropriateness and efficiency?

Readers are assumed to be familiar with the provisions of the Swiss federal law on Health Insurance (specifically Articles 32 and 58 thereof)¹, the federal law on Accident Insurance (specifically Articles 48 and 54 thereof)², the federal law on Military Insurance (specifically Article 25 thereof)³, and the federal law on Invalidity Insurance (specifically Articles 26^{bis} thereof)⁴. The literature discusses these subjects in detail.

Without anticipating the recommendations made later in this manual or repeating the general principles relevant to the criteria of effectiveness, appropriateness and efficiency, two questions need to be examined at this point:

- Do migration and diversity require any particular measures to be taken with regard to quality policy or with regard to the criteria of effectiveness, appropriateness and efficiency?
- If so, what particular aspects should such measures take into account?

Medical, care-related, infrastructural and administrative quality standards are based on national and international standards and legal requirements as well as internal guidelines and directives. These directives generally aim to dictate some element of standardisation, with the inherent risk that they will tend to generalise, even if a more individual approach would be more appropriate. Taking account of needs arising from diversity and migration means making a long-term investment in services at a personal level and thus in the qualities of individuals. This approach requires specific needs to be recognised and paid due heed in the development of an organisation and its quality management. Experience has shown that this cannot be assumed to occur automatically. Quality can thus not be achieved through unconsidered application of purely standard procedures. Its attainment requires diversity to be taken properly into account (see page 47).

Similar considerations also apply with regard to the criteria of effectiveness, appropriateness and efficiency. Superficially, it might appear that taking the needs arising from diversity and migration into account would result in greater effort, thus undermining the efficiency of an institution. In fact, the opposite is the case. Not taking proper account of special situations generally leads to an increase in overall effort, organisational disruptions as well as misdirected, inadequate or excessive provision of services. The same applies to effectiveness and appropriateness. Attempting to make one size fit all inevitably prevents one from addressing diversity in an appropriate manner.

This then leads to the second question posed above. What particular aspects need to be taken into account? The foregoing remarks have made it clear what basic concerns must motivate a health care institution which is diversity oriented and migrant-friendly. For these concerns to find their expression in day-to-day practice requires a conscious management effort, attuned to the various tasks, organisational structures and processes which are peculiar to each health care institution. The recommendations set out from page 43 onwards provide some practical pointers to how this can be achieved.

Quality – at odds with effectiveness, appropriateness and efficiency?

| Peter Saladin

Quality standards

Meeting criteria of effectiveness, appropriateness and efficiency by respecting diversity

1 SR 832.10 (AS 1995 1328).
Federal law of 18 March 1994
on Health Insurance

2 SR 832.20 (AS 1982 1676).
Federal law of 20 March 1981
on Accident Insurance

3 SR 833.1 (AS 1993 3043).
Federal law of 19 June 1992
on Military Insurance

4 SR 831.20 (AS 1959 857).
Federal law of 19 June 1959
on Invalidity Insurance

Questions relating to funding

| Peter Saladin

Federal Law on Public Health
reimbursement tariffs

No costs for migrant-specific services
assumed

Questions relating to funding

Readers are assumed to be familiar with the funding arrangements at federal and cantonal level for hospitals, clinics and long-term health care institutions in Switzerland. This section examines specific funding issues related to diversity and migration.

The Federal Office of Public Health's view of the legal framework is that everyone resident in Switzerland is required, under the terms of the federal law on Health Insurance, to have basic health insurance cover. Anyone who becomes ill and is not covered by a recognised health insurer will be referred by the relevant cantonal authorities to such an insurer.

This ensures that a health care institution which provides recognised medical services as defined in the federal law on Health Insurance will be paid for providing them. Putting these principles into practice often presents major administrative and financial difficulties, which can vary significantly from canton to canton. Overcoming these obstacles requires clear rules, drafted with a measure of understanding for individual circumstances, in order for the principles of equal opportunity and non-discrimination to be respected properly. Three questions are particularly relevant in this regard:

1. If, under certain circumstances, it becomes necessary to devote a comparatively large amount of time to the treatment and care of migrants (as might occur if difficulties in mutual understanding and communication arose, for example) will the institution concerned be additionally compensated for this additional effort?

In Switzerland, reimbursement of treatment costs by health insurers occurs on the basis of either a fixed tariff of uniform, predetermined completion times per item of medical care, or of a fixed tariff of predetermined reimbursable amounts per treatment in money terms. In both cases, reimbursements are the same for all patients. As far as can be determined, neither tariff arrangement allows for the reimbursement of any extra expenditure of time or effort which is required in order to overcome communication difficulties between patient and medical staff. The quality of the attention paid to migrants therefore effectively depends on the willingness of health care employees to perform extra work for which their institution will not be paid. This clearly constitutes a risk which needs to be addressed when fixed tariffs are re-negotiated or restructured (e.g. in the context of the Swiss schedule of diagnosis related groups, or Swiss DRG for short).

2. Should care and treatment which is migrant specific be recorded separately, even if payment for it has not yet been ruled on?

H+ Swiss Hospital Association recommends that individual institutions configure their systems for recording service delivery in such a way that such additional efforts can be reported. This provides a basis for substantiating the relevant arguments during future discussions with authorities and the bodies ultimately bearing treatment costs. Rekole®, the system which H+ Swiss Hospital Association requires for recording service delivery in acute treatment cases, provides the necessary functionality for recording service delivery in this manner.

3. Can costs for interpreting services be charged to health insurers as part of treatment costs under the federal law on Health Insurance?

Neither the federal nor the cantonal legislation contains any rules governing whether and under what circumstances interpreting services may be used and whether the costs so incurred will be borne. This is all the more surprising given that the duty to inform the patient is – either explicitly or implicitly – a fundamental patient right which is not in dispute. This right

requires that the patient be informed about the treatment to be performed, and this information must be supplied to the patient before any medical intervention, any medical diagnosis or any psychotherapy.

1 Unpublished Federal Court ruling K 138/01, dated 31. 12. 2002

A Federal Court ruling has explicitly stated that, based on Article 25 of the federal law on Health Insurance, there is no obligation to meet the cost of interpreters' fees.¹

2 Ayer A and Gilbert M (2005) Die Rechte des migrierten Patienten: Welche Rechtsgrundlagen bestehen für die Arztkonsultation in Gegenwart eines Dolmetschers? Study commissioned by the Federal Office of Public Health, Bern

Legislation and court rulings at both national and cantonal level leave many questions unanswered with regard to the respect for human dignity, equal opportunity and non-discrimination for migrants. Future legislative work in this area will need to pay due heed to these questions.² One particular need is for the current legislation to be adapted to recognise interpreting services as chargeable costs.

Despite this unsatisfactory situation, it is the task of every health care institution – within its available scope for management manoeuvre – to seek to apply solutions which are compatible with the principles laid out in this manual. Possible solutions which have proved useful in this regard include special budget items dedicated to this purpose, financing by patient donations or financial contributions from charitable institutions. It is encouraging to note that many institutions have been able to use approaches like these to find novel solutions.

Novel solutions

Recommendations

The section which follows contains recommendations on how a health care institution can shape its structures, procedures and outcomes in the light of the needs arising from diversity and migration. The recommendations have been ordered by subject area. They describe objectives, make suggestions for their implementation and point to measures which can be taken to evaluate progress towards achieving the goals set out.

For the benefit of those readers who may have passed over the observations on matters of fundamental principle earlier in this manual, the following central issues may be briefly stated.

The first step towards cross-cultural competence must be a critical review of one's own behaviour patterns, attitudes and language. The measures recommended in this section should be viewed as development processes which require each of us to learn from others and which need to be developed and realised with others. The purpose is not – and never can be – to exclude, discriminate against or stigmatise others vis-à-vis oneself. The social interactions of the kind described here will take time and, it goes without saying, must be something which all parties involved want and are prepared to support. Developing a patient-oriented organisational policy also requires human and financial resources. Making these available is management's task. Ultimately, the adoption of diversity-oriented policies should benefit the institution itself, its patients, long-term-care residents and employees.

The recommendations made here are based on a wide range of insights and experience, gained not only in many health care institutions, but also in private and public organisations outside the health care sector, both in Switzerland and in other countries. The research and project work which the MFH network has helped to fund (see page 19) has served to analyse specific issues in greater detail, thus enabling practical and concrete recommendations to be made on how to implement an organisational policy which is both diversity-oriented and migrant-friendly.

The recommendations illustrate what constitutes good practice. They do not aim to cover every course of action which needs to be taken. It thus remains the task of each institution to decide itself how best to implement these recommendations and, if necessary, to take other, additional specific measures in line with its particular mandate. Implementation should over time lead to the formulation of best practice prescriptions. The available literature is substantial (see pages 111 to 113). Particular mention should be made of the work carried out during the EU project¹ mentioned earlier. There are also ever more numerous practical aids available (see pages 114 to 115). Finally, readers are reminded of the terminological definitions set out on pages 91 to 94.

Recommendations

| Peter Saladin

¹ www.mfh-eu.net

Organisational strategy

| Peter Saladin

Organisational strategy

For an organisation to put into practice the insights and principles set out here, targeted action will need to be taken at all levels of management. If the highest echelons in an institution both perceive and acknowledge these recommendations as worthwhile, if they champion them credibly and take appropriate action to further their implementation, then employees will also take them seriously and can set in motion the necessary processes of change.

One key initial step is to avoid adopting problem-focused attitudes. The people who will be affected by the changes recommended here are not a problem group, needing help in overcoming its own difficulties. Such an approach can only stigmatise. The whole purpose of a successful diversity policy is to avoid pigeonholing people into specific categories. Rather, diversity policy is based on the premise that a joint effort from everyone in an organisation is needed if that organisation is to achieve the greatest possible improvement in quality and efficiency.

Organisational strategy checklist

| | | |
|--|---|-------------------------------------|
| Institutional management | <input type="checkbox"/> Management's convictions regarding diversity and migration issues are well known and these convictions are being acted on | Objective |
| | <input type="checkbox"/> Review examples from other institutions, and also from industry | Implementation suggestions |
| | <input type="checkbox"/> Carry out workshops and training initiatives with specialist facilitators | |
| | <input type="checkbox"/> Make relevant literature available | |
| | <input type="checkbox"/> Ensure diversity policy includes a definition of what patient orientation means in practice | Evaluation of measures taken |
| <input type="checkbox"/> Management decision to initiate organisational development (OD) project | | |
| Organisational development processes | <input type="checkbox"/> An OD project has been launched, taking equitable account of people's skills, attitudes and values | Objective |
| | <input type="checkbox"/> Rules of play, procedures, structures and cooperative relationships have been developed jointly | Implementation suggestions |
| | <input type="checkbox"/> Mandate a group of people to carry out preparatory work | |
| | <input type="checkbox"/> Carefully define project procedures | |
| | <input type="checkbox"/> Collect data on the reality of diversity and migration within the institution and in its immediate surroundings | |
| | <input type="checkbox"/> Take account of existing initiatives | |
| | <input type="checkbox"/> Assess needs, individual potentials and resources | |
| | <input type="checkbox"/> Involve migrant employees in the project | |
| | <input type="checkbox"/> Get external specialists (from university institutes, specialised NGO's) involved, so as to ensure authentic outside input and views | |
| | <input type="checkbox"/> OD-focused quality management | |

| | | |
|-------------------------------------|--|--|
| Objective | <ul style="list-style-type: none"> ■ Key principles of diversity policy (equal opportunity, respect for human dignity, taking proper account of the individual circumstances and needs of patients, long-term-care residents and employees) are promulgated in the mandate, mission statement and strategic principles of the organisation (see also "The Amsterdam Declaration. Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe", page 96) | Fundamental strategic principles |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Principles of diversity policy to be formally adopted by top supervisory and executive committees | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Organisational strategy audit | |
| Objective | <ul style="list-style-type: none"> ■ Diversity-oriented and migrant-specific services in the areas of medical care and treatment, therapy and infrastructure (such as consultations in migrants' languages) have been reviewed and are in place to the extent necessary | Diversified range of services |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Place particular emphasis on the range of services offered in gynaecological, paediatric and psychiatric clinics and emergency services ■ Question migrant communities on their needs ■ Ensure principles of equal opportunity and non-discrimination are adhered to | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Financial audit | |
| Objective | <ul style="list-style-type: none"> ■ The organisation's structures take due account of diversity and migration issues | The structure of the organisation |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Create new organisational units responsible for implementing measures addressing diversity and migration issues, or assign this responsibility to existing units ■ Define tasks, authority and resources | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Institutional audit | |
| Objective | <ul style="list-style-type: none"> ■ Formally adopted principles are applied throughout the organisation | Implementation |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Define specific diversity- and migration-related objectives and tasks within the annual plan ■ Involve migrant employees ■ Get external specialists (from university institutes, specialised NGO's) involved ■ Join with partner institutions and specialised organisations to establish a permanent network to review migration issues ■ Ensure that a portion of the organisation's regular publications (annual report, employee newsletter, material published to mark the day of the sick, anniversary publications) is devoted to reporting on this subject ■ Establish control and sanction mechanisms | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Questionnaires for patients (see page 49) | |

Collecting information relevant to diversity policy

| Peter Saladin

Collecting information relevant to diversity policy

In order to address diversity and migration issues effectively, it is essential to have relevant data and information. Such information makes it possible to structure the services offered by an institution to fit the various needs and existing resources. What information needs to be collected to this end, by whom, for whom, how and when? How should the information be used within the institution? In dealing with this information, it is important to distinguish between personal data, data of a medical, care- or therapy-related nature, and administrative data.

Knowledge of the cross-cultural competence and resources of employees can also be useful to line management and human resources managers. Care must always be taken to avoid emphasising the differences between people or making value judgments. Rather, details of people's individual competences, freely volunteered by those concerned, should make it possible to further, strengthen and efficiently utilise employee resources (see page 52).

It goes without saying that the relevant data protection legislation at federal and cantonal level must be observed.

Checklist for collecting information relevant to diversity policy

| | | |
|--|---|------------------------------|
| Sociodemographic data on patients and long-term-care residents | <ul style="list-style-type: none"> ■ Data and information necessary for the realisation and monitoring of a diversity-oriented and migration-friendly organisational policy has been obtained ■ Directives governing the collection, use, storage and destruction of this data have been adopted ■ Those responsible for the various disciplines involved have been appropriately trained | Objective |
| | <ul style="list-style-type: none"> ■ Management to determine data rules ■ In addition to the standard data required for medical and administrative statistics the following should (ideally) also be recorded on admission: place of birth, nationality at birth, present nationality, religious affiliation, languages spoken, residence status ■ Collect additional data and information, as relevant to the institution's field of activity (e.g. type of employment) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality audit on diversity-oriented and migrant-friendly organisational policy and on data protection ■ Assess appropriateness of data collected | Evaluation of measures taken |
| Information on employees' personal knowledge and resources | <ul style="list-style-type: none"> ■ Information on the use made of employees' potential and measures to develop it has been collected | Objective |
| | <ul style="list-style-type: none"> ■ Management to define rules ■ On appointment, collect from employees information (on a voluntary basis) on the special knowledge and resources they have which are relevant to diversity and migration issues, such as language skills, particular skills or knowledge from their prior working lives, knowledge of other modes of living and religions, social networks | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality audit on personnel policies | Evaluation of measures taken |

Quality

Systematic quality management is not only mandated by current legislation on compulsory health insurance (see federal law on Health Insurance, Article 58, and the ordinance on Health Insurance, Article 77); it is also one of the standards to which every health care institution adheres. The requirements of an institution's diversity and migration policy must form an integral part of its quality management. Respect for diversity is the litmus test of an institution's focus on its patients and clients. A health care institution can fulfil its mission only if it succeeds in providing tailor-made services of a defined quality to all people entrusted to its care, and it must do so irrespective of a person's origin, religion, social class and status or differences in their circumstances prior to admission. If these principles, and the standards resulting from them, become embedded in the day-to-day routine of clinical and care- and therapy-related procedures, they will generate added value for the institution, its patients, its long-term-care residents and its employees, benefiting them all. Additional information and practical aids can be found in the quality questionnaire from the EU project on migrant-friendly hospitals (see page 102) and the additional information on canvassing patients' views (see page 49).

Quality

| Peter Saladin

Quality checklist

| | | |
|-------------------------------------|--|---|
| Objective | <ul style="list-style-type: none"> ■ The basic principles relating to diversity and migration form an integral part of the fundamental documentation on quality management | Fundamentals of quality management documentation |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Raise awareness among staff responsible for quality issues ■ Initiate project for review of quality management | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ External audit | |
| Objective | <ul style="list-style-type: none"> ■ The specific needs arising from diversity and migration are paid due heed in the institution's management and organisational structures at all levels | Quality of structures |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Designate managers responsible for issues specific to diversity and migration ■ Establish an interdisciplinary commission to review cross-cultural issues ■ Define tasks and authorities ■ Involve all fields of activity ■ Ensure migrant employees are represented ■ Review organisational manuals, project handbooks, guidelines and standards, adapting them as necessary | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Organisational audit | |
| Objective | <ul style="list-style-type: none"> ■ Issues relating to diversity and migration are appropriately reflected in medical, care- and therapy-related processes, as well as in processes relating to catering, accommodation and administrative matters | Process quality |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Pay due attention to criteria of effectiveness, appropriateness and efficiency ■ Mobilise personnel and financial resources and inform staff accordingly | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Process analyses | |

| | | |
|---|--|-------------------------------------|
| Outcome quality | <input type="checkbox"/> Defined aspects, relevant to the migrant population, are recorded in outcome measurements | Objective |
| | <input type="checkbox"/> Incorporate migration-specific criteria into current outcome measurement | Implementation suggestions |
| | <input type="checkbox"/> Identify aspects of current medical coding needing review | |
| | <input type="checkbox"/> Incorporate migration-specific data into patients' (electronic) dossiers | |
| <input type="checkbox"/> Organise meetings to exchange experience, both among doctors and among nursing staff | Evaluation of measures taken | |
| <input type="checkbox"/> Record results in manuals and standards | | |
| <input type="checkbox"/> Quality management | | |
| Patient interviews (see page 49) | <input type="checkbox"/> Interviews with migrants on the quality of admission, treatment and care have been standardised | Objective |
| | <input type="checkbox"/> Review current interview methods for patients and long-term-care residents in the light of migration issues | Implementation suggestions |
| | <input type="checkbox"/> Quality management | Evaluation of measures taken |
| Grievance review and ombudsman services | <input type="checkbox"/> Migrants' access to grievance review procedures and ombudsman services is assured | Objective |
| | <input type="checkbox"/> Review current procedures in the light of circumstances specific to migrants (e.g. limited knowledge of local language, doubts about usefulness of making complaints) | Implementation suggestions |
| | <input type="checkbox"/> Inform migrants of their rights to avail themselves of these services | |
| | <input type="checkbox"/> Define appropriate sanctions | |
| <input type="checkbox"/> Quality management | Evaluation of measures taken | |

Background information

Measuring hospital patient satisfaction¹ among the migrant population

Summary of the findings of a research report prepared for the MFH network²

| Denise Efionayi

| Ursula Stotzer

| Philippe Wanner

In Switzerland, generally, the migrant population accounts for a large proportion of hospital patients. In some hospital units (emergency services and maternity wards) it has above-average representation. No reliable data for Switzerland as a whole are available, however.³ International migration has made for a plurality of lifestyles in society, and this plurality needs to be borne in mind when assessing the quality of medical care. Patient satisfaction is a key indicator of the quality of such care.

In the international literature, statements made by migrants about their degree of satisfaction with the medical care they have received are contradictory. This is largely because the instruments used for measuring patient satisfaction have not always been appropriate and have given rise to a number of methodological problems. This is exacerbated by the fact that too little attention has been devoted hitherto to developing techniques specifically aimed at measuring patient satisfaction among migrants.

No scientific research has been conducted into this question in Switzerland, even though it is crucial to achieving good quality management and is receiving plenty of attention in hospitals. To close this gap and point to courses of action which hospitals in Switzerland can take in this area, a study was recently carried out, comprising three main parts:

- A review of the international literature, mostly Anglo-Saxon.
- Discussions with health care professionals responsible for quality issues in hospitals, particularly in the field of migration and public health, and with polling firms.
- Discussions in focus groups made up of migrants of different origins.

This complementary approach made it possible to compare international experience with that gained in Switzerland and with the views expressed by migrants, thus enabling recommendations to be made which took account of the situation in Swiss hospitals.

Because the situation of minorities or migrant groups differs considerably from country to country, it is difficult to derive best practice for Switzerland from the input described above. Nevertheless, review of the literature currently available does allow some interesting conclusions to be drawn, with regard to both the degree of patient satisfaction among migrants and to the interviewing methods used.

Measuring the degree of satisfaction felt by migrant patients is harder than with the local native population, because the results can be influenced by external factors which are not directly related to the quality of the treatment received. One such factor is the local language, which will be spoken by the doctors and nurses, but not necessarily the migrants. Sociocultural considerations also affect a person's perception of health issues, such as expectations regarding health care services or discrimination against foreigners. These factors can create a social distance, which has an adverse effect on the way the quality of medical care is perceived and on confidence in the public health system.

Other structural factors also exert an influence, such as age, socio-economic class and general state of health.

The questionnaires used in quantitative evaluations lack reliable and uniform variables for recording the responses from members of migrant populations. Such variables would be useful in helping to identify groups confronted with particular difficulties.

Questionnaire return quotas are often lower among minorities, and this can distort results or have the effect that a survey does not have enough participants to allow its results to be compared with those from other groups. Enquiries by telephone or reminders, both common in the United States, would make it possible to achieve more meaningful results. Differences in response style, i.e. in the way patients behave when responding to questions, make it difficult to evaluate results obtained from studies where patients were asked to respond in their own words. Using a combination of

¹ This is a term in common use.

We would propose adopting other, more neutral terms, which are less evocative of an overall assessment by the patient, such as patient survey or patient reaction.

² The research report can be viewed and downloaded on: www.hplus.ch

It is also available as a publication from the Swiss forum for migration and population studies SFM: Efionayi D, Stotzer U, Wanner Ph (2006) Messung der Zufriedenheit von Spitalpatientinnen und -patienten mit Migrationshintergrund. Neuchâtel

³ The census conducted in Switzerland in 2000 in fact shows that nearly 40% of the people who were resident in Switzerland and accommodated in public hospitals on the census date were not Swiss nationals. However, these figures cover only those people whose place of residence was inferred from the location of the hospital. It is thus a rough estimate, which cannot simply be generalised.

Results from the literature

grading scales (for result indicators) and factually based answers (for process evaluation) could help to alleviate this problem.

Qualitative methods, comprising one-to-one interviews or focus groups, are seldom used to survey patient opinion. Principally because of their cost, such methods do not make it possible to collect large quantities of data. They are therefore generally recommended for identifying opportunities to improve methodology or to perform more in-depth analysis of specific subjects on which quantitative questionnaires cannot provide adequate information. Qualitative methods do, however, have a major advantage when it comes to reaching groups of people not captured in classic, quantitative surveys.

The situation in Switzerland: results and recommendations

In Switzerland, hospitals regularly conduct surveys. These are either organised by the hospitals themselves or are entrusted to specialised third parties. Quality measurement is usually carried out using a variety of standardised tools. These are not always suitable, however, for reaching patients of migrant origin and examining their responses. The study found that no hospital in Switzerland had yet taken any further measures to improve the effectiveness of its patient satisfaction surveys conducted among migrants. There are inadequacies both in the method of conducting the surveys and in the questionnaires themselves.

Weaknesses noted in survey procedures and recommendations to address them

First, questionnaires are always sent to the patients by post after their discharge. This is a problem insofar as certain groups of particularly mobile foreigners might not be reached, such as those with precarious residence status. This could lead to survey results being distorted. Conversely, the most integrated migrants tend to be over-represented in patient satisfaction surveys. Interviews have also shown that written survey questionnaires are not suitable for some migrants. These questionnaires are not effective when sent to people whose understanding of the local language is poor or non-existent, and they are especially ineffective when sent to people whose residence status is precarious and who tend to be wary of official questionnaires. These people do not understand why their opinion is being sought and believe that it will not be heeded in any case. They thus see little point in replying. This attitude is further explained by the fact that very little is communicated about the use to which the results obtained will be put.

Finally, language itself appears to be a factor excluding migrants from surveys. In principle, all patients who were discharged from hospital during the period covered by a given survey should receive a questionnaire. In some hospitals, however, questionnaires are not sent at all to those patients whose hospital patient records indicate that they do not speak the language in which the questionnaire is written.

These difficulties will be overcome only if patients are better informed about the purpose, process and usefulness of these surveys. Greater use should also be made of alternative approaches which would permit one-on-one dialogue, such as surveys conducted by telephone. Additional focus group surveys should also be carried out, and the possibility of face-to-face interviews conducted on a one-on-one basis could usefully be considered.

Weaknesses noted in the instruments used and recommendations to address them

The effectiveness of these surveys is also limited by the weakness of the measurement tools used. There are a number of inadequacies in this area, notably in the collection of sociodemographic data about migration profiles of interviewees and in the fact that the questionnaires used are limited to those available in existing language versions.

The measurement tools used in Switzerland do not capture any sociodemographic variables which would enable patients with migrant backgrounds to be identified, so that data specific to this group could be collated and analysed. This point is also criticised in the literature. It would be useful, in particular, to collect data about nationality at birth (or about current nationality), about place of birth and possibly also about residence status.

Although the questionnaires used in Switzerland are sometimes available in several languages – generally French and German, sometimes also Italian and English – use of versions in different languages also poses problems such as availability, quality and comparability. In any case it would be desirable to identify which of these languages the patients understand best, so that the appropriate version could be supplied to them.

For those migrants who do not speak any of Switzerland's national languages, versions in the most widely spoken languages could, after appropriate testing, be introduced (e.g. English, Albanian, Spanish, Portuguese, Serbo-Croat and Turkish). This should be feasible provided the hospitals agreed on a limited number of questionnaires and gave up the practice of using questionnaires they had prepared themselves.

Apart from the language in which questionnaires are written, which can obviously constitute a major hurdle for people whose knowledge of the language concerned is limited or non-existent, the level of language used must also be considered. The level of language used in questionnaires does not always match that of all patients, be they members of minority groups or not. This affects people with deficient reading and writing skills, those with poor education and patients whose powers of comprehension are undermined by their state of health. The situation becomes all the more delicate if a patient is confronted with several of these difficulties.

Interestingly, many of the difficulties listed above are most common among migrants. To a greater or lesser extent, however, these difficulties can be encountered by all patients, particularly those coming from disadvantaged sections of society, who have little education or whose employment situation is precarious. The more general point arising here is that if more patient-oriented questionnaires were used, which made it possible to record the situation of patients from migrant backgrounds more accurately, it would no longer be necessary to conduct regular interviews specifically aimed at migrants.

This does not mean that no thought should be given to how better to identify the situation of migrants and their needs and/or that no action should be taken to achieve such understanding. Interviews assisted by interpreters appear worthwhile, as do steps to improve cross-cultural competence in hospitals and to develop qualitative survey techniques which would make it easier to reach specific migrant groups.

The results of this study argue in favour of including members of the migrant population in general patient surveys in an integrated approach. This does not rule out the possibility of accompanying these surveys with migrant-specific initiatives, such as complementary questionnaires, or additional modules within existing questionnaires tailored to migrant needs.

An approach adapted to the needs of migrants would also provide an excellent opportunity for a quality system to measure its general sensitivity to the differing needs and attributes of target groups. This would not simply be an extra burden, since taking such an approach would make it easier to direct patient surveys towards mainstreaming, thus covering the concerns of all patients. This should make it possible to raise patient interest in the surveys and to increase the numbers of patients answering and returning the forms, particularly those who are normally excluded from current satisfaction surveys because these tend to be directed towards middle and upper social strata.

The approach recommended here should thus contribute to setting greater store by the satisfaction of all patients and therefore, by extension, that of the medical staff caring for them. Analysis of the various forces at work suggests that current institutional reservations towards change need to be overcome. This insight should enable hospitals to take the necessary steps voluntarily, rather than in response to outside pressure, to start developing and using appropriate quality assurance mechanisms in a spirit of constructive cooperation.

Cross-cultural competence – accepted, practised and promoted by all staff

Cross-cultural competence – accepted, practised and promoted by all staff

| Peter Saladin

It is an institution's employees who carry out all the services it offers and who maintain its organisational culture. Employees with migrant backgrounds are part of this culture, whether they wish to be so or not, whether consciously or unconsciously. The fact that the staff in most health care institutions is extremely heterogeneous in terms of origin, language, religious affiliation and social status, provides those organisations with an opportunity to raise the profile of cross-cultural competence and to make it more effective in practice. Recognising, utilising and furthering the multifaceted skills of its employees is a major step forward in an organisation's development. Are employees with migration backgrounds even perceived as such? Are they perceived as a nuisance, a problem group which needs to be integrated? Or do they represent an opportunity for the institution? Are they represented on the institution's various official bodies? Can they use their skills and strengths to participate in the development of a diversity-oriented and migrant-friendly organisational culture? What is the institution doing to break down the barriers preventing them from taking part more fully in its development?

Continuing staff training on matters related to diversity, migration and public health is examined on page 70.

Checklist

for acceptance, practice and promotion of cross-cultural competence by all staff

| | | |
|---|---|------------------------------|
| Personnel policy | <input type="checkbox"/> Respect for equal opportunity and non-discrimination is ensured | Objective |
| | <input type="checkbox"/> Employees' human, social and specialist skills in cross-cultural matters are being utilised optimally | Implementation suggestions |
| | <input type="checkbox"/> Personnel managers to review current principles of personnel policy | |
| | <input type="checkbox"/> Establish the attainment of equal opportunity and non-discrimination (with regard to remuneration, career planning, ongoing vocational training, etc.) as personnel policy objectives | |
| | <input type="checkbox"/> Determine sanctions to be applied in the event of directives being breached | |
| | <input type="checkbox"/> Record employees' strengths and skills in cross-cultural matters, and their willingness to apply them, in personnel files (see page 46) | |
| | <input type="checkbox"/> Ensure that employees with particular skills and experience in diversity and migration issues are represented in personnel policy-making bodies (e.g. personnel committees, institutional committees, organisational committees and project organisations) | |
| | <input type="checkbox"/> Conduct introduction courses for new employees with migrant backgrounds | |
| | <input type="checkbox"/> Personnel audit | Evaluation of measures taken |
| <input type="checkbox"/> Annual assessment interviews with employees | | |
| <input type="checkbox"/> Interviews and reports for leaving employees | | |
| Personnel services | <input type="checkbox"/> Personnel department employees with special duties in the area of diversity and migration issues have been designated and appropriately trained | Objective |
| | <input type="checkbox"/> Employ staff with migrant backgrounds in personnel services | Implementation suggestions |
| | <input type="checkbox"/> Inform all new employees of the available contact persons and specialised units concerned with diversity and migration issues | |
| | <input type="checkbox"/> Personnel audit | Evaluation of measures taken |

| | | |
|-------------------------------------|---|--|
| Objective | <ul style="list-style-type: none"> ■ Guidelines governing the appointment of employees with migrant backgrounds have been defined in the various units | Appointment of employees with migrant backgrounds |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Advertisements for vacant positions to be couched in terms which do not rule out potential candidates with migrant backgrounds (e.g. stating that the local language should be the candidates' main language, rather than their mother tongue) ■ Institutions to ensure that their diversity and migration-related guidelines are clearly explained during introduction programmes for new employees ■ Create and foster a network of employees with migrant backgrounds who can participate in cross-cultural communication ■ Record employees' migration-related data on appointment | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Personnel audit ■ Employee interviews ■ Interviews and reports for leaving employees | |
| Objective | <ul style="list-style-type: none"> ■ Guidelines for translating directives, announcements and other documents relevant to personnel matters have been defined ■ Understanding of key information by all employees has been ensured ■ Aids available for translation and assisting mutual comprehension are generally known | Written translation of personnel directives |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Define guidelines for involving employees with migrant backgrounds ■ Organise collaboration with interpreting and translation services ■ Take alternative measures to ensure effective mutual understanding and communication when translations cannot be made | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Evaluation of the individual measures taken | |
| Objective | <ul style="list-style-type: none"> ■ Services to enable employees to acquire language competence in fields specific to their job have been created | Language knowledge specific to the job |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Offer special language courses (daytime or evening courses) ■ Provide managers with the means to train their team members in the use of language specific to their particular field during their daily work (on-the-job learning) | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Employee interviews ■ Periodical review by hierarchical superiors | |
| Objective | <ul style="list-style-type: none"> ■ Tensions between employees arising from ethnic or linguistic differences, as well as those due to racist incidents, are addressed appropriately and effectively | Dealing with tensions |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Ensure employees are aware of the mediation, supervision and care functions at the various levels of the institution (administration, nursing staff, medical staff, supplies, etc.) | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Periodical review by supervisory management | |
| Objective | <ul style="list-style-type: none"> ■ The resources of self-help groups, charities, religious associations and cantonal and municipal integration staff are being appropriately used | External networks |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Designate staff responsible for establishing and maintaining contacts with these organisations ■ Facilitate regular meetings ■ Carry out or support health promotion programmes for employees | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Targeted interviewing of those participating in the network | |

| | | |
|------------------------------------|---|-------------------------------------|
| Migration-specific projects | <ul style="list-style-type: none"> ■ Internal and external sources of finance have been established for migration-specific projects initiated by employees | Objective |
| | <ul style="list-style-type: none"> ■ Ensure input into "suggestions box" on migration-specific projects is taken into account ■ Make sure internal publications regularly draw attention to the relevant internal and external points of contact (such as cantonal and municipal integration units and the Federal Commission for Foreigners) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Evaluation of the individual project | Evaluation of measures taken |
| Cross-cultural events | <ul style="list-style-type: none"> ■ Appropriate events for the promotion of mutual understanding take place regularly | Objective |
| | <ul style="list-style-type: none"> ■ Discover other countries' modes of living and reflect on one's own values and prejudices (e.g. through language courses, social and educational events, cultural initiatives such as films or theatre, religious services, culinary events) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Evaluation of the individual measures taken | Evaluation of measures taken |
| Internal communication | <ul style="list-style-type: none"> ■ The institution's concept of diversity and its commitment to respecting its practical implications have been communicated | Objective |
| | <ul style="list-style-type: none"> ■ The opportunities and risks of the diversity policy are subjected to critical analysis | Objective |
| | <ul style="list-style-type: none"> ■ Address issue of diversity regularly in internal and external communications | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Plan regular sections on the subject of diversity in publications ■ Give a voice to employees with migrant backgrounds | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Evaluation in the context of overall communication policy | Evaluation of measures taken |

Medical care procedures

Taking individual needs and individual circumstances (especially those related to diversity) into account is an integral part of quality control today. Both the literature and clinical experience have shown that some special considerations need to be applied in the treatment of the migrant population.

Clearly, the quality of diagnosis, therapy, compliance and post-intervention care must be maintained at all times, and this applies just as much to the migrant population as to everyone else. Language comprehension is central to this process. Attention must also be paid to particular attributes of how illness initially occurs and manifests itself among migrants, how illness is understood and how the support of the health care system is sought. The significance of these factors should not be overestimated, however. Often too much attention is paid to cultural factors (such as concepts of sickness and health, gender roles and values generally), while too little account is taken of social differences (income, employment status, social network).

To facilitate clear presentation, the following section divides medical care procedures into the classic stages of patient care (regular admission, emergency admission, diagnosis, treatment and discharge).

Medical care procedures

| Gerhard Ebner

Regular admission

What happens on admission already has a determining effect on a patient's subsequent treatment and post-intervention care. Consequently, it is at this stage that basic cultural and migration-specific information should be collected, language difficulties identified and procedures to overcome hurdles initiated. The key objective here is to gain information, to document it appropriately and to start determining the course of action to come. At the stage of regular patient admission, effective steps can be taken to avoid the wasteful use of resources which can result from extreme pain and general uncertainty due to difficulties in communication.

Particular attention should be paid to *sans papiers* patients on admission. In its ruling of 23.12.2003, the Federal Social Insurance Office determined that people with *sans papiers* status, who are resident in Switzerland as defined in Article 24 of the Swiss Civil Code, are subject to the health insurance requirements of the federal law on Health Insurance. This means that health insurers are required to provide health insurance to *sans papiers* just as they are required to do for anyone else obliged by law to take out such insurance. The insurers are also required to maintain the confidentiality of such arrangements vis-à-vis third parties. It is self-evident that both a health care institution's mandate and medical ethics require that *sans papiers* be admitted and treated just like all other people resident in Switzerland. Both the health care institution and its staff are required to maintain complete confidentiality regarding *sans papiers* vis-à-vis third parties, such as the Swiss alien police authorities (*Fremdenpolizei / police des étrangers*).

Regular admission

Regular admission checklist

| | | |
|---|---|-------------------------------------|
| Providing and receiving information | <ul style="list-style-type: none"> ■ Patients are informed about the health care system in general, about their rights and obligations and about the special features and services of the hospital in question ■ Basic information about the residence status and situation of the patient, their special requirements (religious or other) and the legal implications have been obtained and documented ■ Procedures for handling data and medical staff's access to it have been determined | Objective |
| | <ul style="list-style-type: none"> ■ Make information available in the languages most commonly spoken by migrants (regarding patient rights, hospital rules, provision of nutrition, scope for religious activity and other services, such as the Health Guide Switzerland, www.migesplus.ch) ■ Make available resources for recording fundamental information about patients' values and expectations (with regard to treatment, nutrition, religious support, etc.) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Audits on standards and how they have been implemented in practice ■ Interviews with patients and employees | Evaluation of measures taken |
| | | |
| Interpreting (see pages 63 to 69) | <ul style="list-style-type: none"> ■ Modalities for communication between people speaking different languages (interpreting and translation) have been defined | Objective |
| | <ul style="list-style-type: none"> ■ Facilitate access to interpreters and internal language resources ■ Define precise procedures ■ Involve patient's entourage ■ Ensure thought is given to the role of interpreters | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Audits ■ Interviews with patients and employees | Evaluation of measures taken |
| | | |
| Triage | <ul style="list-style-type: none"> ■ Appropriate triage procedures are in place (to determine whether case concerns justice department, somatic care, psychiatry or basic medical treatment) | Objective |
| | <ul style="list-style-type: none"> ■ Organise migration-specific consultations ■ Systematically involve patient's general practitioner ■ Inform patients about health care system ■ Define appropriate standards | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Standards ■ Audits ■ Interviews with both referring units and units carrying out subsequent treatment as part of overall quality management | Evaluation of measures taken |
| | | |
| Continuity of care, case management | <ul style="list-style-type: none"> ■ Carers and staff responsible for processes are defined and continuity of care is assured (including deputies) ■ Patients are aware of who is responsible for what ■ Existing hurdles in the institution have been identified and measures to overcome them have been defined | Objective |
| | <ul style="list-style-type: none"> ■ Set out clear standards, with separate standards for outpatients and inpatients, if necessary ■ Provide patient with contact details of carers in writing | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Internal quality management | Evaluation of measures taken |
| | | |

| | | |
|-------------------------------------|--|--------------------------------|
| Objective | <ul style="list-style-type: none"> Key data on patients' linguistic, migration and culture-specific attributes have been documented | Documentation |
| Implementation suggestions | <ul style="list-style-type: none"> Update clinical information systems Provide everyone with standardised forms | |
| Evaluation of measures taken | <ul style="list-style-type: none"> Internal quality management | |
| Objective | <ul style="list-style-type: none"> The patient's entourage (particularly family) has, with the patient's consent, been involved as soon as possible (generally at the time of admission) Cross-language comprehension is assured | Involving the entourage |
| Implementation suggestions | <ul style="list-style-type: none"> Formalise standards and prepare checklists as part of overall quality control Ensure ongoing staff training is available | |
| Evaluation of measures taken | <ul style="list-style-type: none"> Audits Interviews with patients and employees | |

Some general points on informed consent

Informed consent is crucial not only to compliance with the law but ultimately also to the successful outcome of therapy. Particular care must be taken to ensure that patients properly understand any forms or declarations of consent which they are asked to sign. For these documents to be legally binding, patients must understand what they are signing. The institution must ensure that any legally binding forms are translated into the relevant languages.

Some general points on informed consent

Emergency admission

The following recommendations on emergency admissions complement those already made regarding regular admission. For members of the migrant population, emergency units are often the sole, or the simplest, means they have of obtaining rapid medical attention. Interpreters are, however, generally not available in an emergency. The scope for standardising procedures is also necessarily limited. Generally, any information needed can be provided only from the resources available (employees speaking foreign languages, family members and tools such as dictionaries). The availability of interpreting services by telephone should be explored, so that use can be made of these services in the future. If the patient is then referred for hospital care, the documentation prepared in the emergency unit should be sent to the relevant medical staff.

Emergency admission

Emergency admission checklist

| | | |
|--|--|-----------------------------------|
| No interpreter available at short notice | <input type="checkbox"/> Rudimentary understanding, sufficient to cope with emergency situations, is assured | Objective |
| | <input type="checkbox"/> Appropriate tools are available | |
| | <input type="checkbox"/> Action to take in the event of mutual understanding being impossible has been defined | |
| | <input type="checkbox"/> Ensure dictionaries and pictograms are available | Implementation suggestions |
| | <input type="checkbox"/> Recruit employees with knowledge of foreign languages and train them appropriately | |
| | <input type="checkbox"/> Use telephone-based interpreting services | |
| <input type="checkbox"/> List of resources and tools available | Evaluation of measures taken | |
| <input type="checkbox"/> Audits | | |

Diagnosis

Diagnosis

Properly documented case history, preliminary steps towards informed consent and knowledge of the issues specific to diversity and migration play a large part in facilitating effective medical treatment.

Diagnosis checklist

| | | |
|--|---|-------------------------------------|
| Migration-specific case history | <input type="checkbox"/> Key data on the patient's origin, migration history and current life situation are available | Objective |
| | <input type="checkbox"/> Make forms available | Implementation suggestions |
| | <input type="checkbox"/> Define standards and establish checklists for them | |
| | <input type="checkbox"/> Ensure ongoing staff training | |
| | <input type="checkbox"/> Facilitate coaching | |
| | <input type="checkbox"/> Audits | Evaluation of measures taken |
| | <input type="checkbox"/> Internal quality management | |
| <input type="checkbox"/> Controlling | | |

Informed consent
(see page 57)

| | | |
|--|---|-------------------------------------|
| | <input type="checkbox"/> The patient has been informed about his/her illness, its causes and its consequences | Objective |
| | <input type="checkbox"/> The patient has been supplied with the necessary information to enable him/her to give informed consent to diagnosis and treatment (and the patient is thus in a position to give meaningful informed consent) | |
| | <input type="checkbox"/> Cross-language comprehension is ensured | |
| | <input type="checkbox"/> Refer to www.migesplus.ch | Implementation suggestions |
| | <input type="checkbox"/> Audits | Evaluation of measures taken |
| | <input type="checkbox"/> Interviews with patients and employees | |

Treatment

Limited scope for mutual understanding and effective communication and differences in the way illness and treatment are perceived can give rise to problems regarding informed consent. Patients today are considered, in principle, to be capable of managing their own affairs. After being provided with comprehensive information, they are then assumed to be able to decide for themselves on the subsequent course of treatment. The choices they make can be constrained not only by linguistic barriers to communication but also by unreasonable expectations of what medical staff can achieve, which can lead to problems if patients expect unrealistically rapid results.

Treatment

Treatment checklist

| | | |
|------------------------------|---|---|
| Objective | <ul style="list-style-type: none"> ■ A rational indication is ensured (even if there are language barriers, differing approaches to illness or acute suffering) ■ Up-to-date information material is available to medical and nursing staff ■ Medical and nursing staff are aware of the patient's perception of his/her condition and expectations with regard to treatment | Indications |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Arrange interdisciplinary colloquia (for example to review treatment of extreme pain) ■ Raise awareness of differing concepts of illness and medical treatment in various cultures ■ Facilitate coaching and supervision | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Outcome measurement ■ Audits ■ Interviews with employees ■ Interviews with supervisors | |
| Objective | <ul style="list-style-type: none"> ■ Rules defining recourse to services of qualified interpreters have been defined ■ Obstacles to involving interpreters have been reduced to a minimum ■ No decisions on treatment are made unless cross-language comprehension between medical staff and patient is assured (except in emergencies) | Involving interpreters and informing patients about key milestones in their treatment |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Ensure that the involvement of external interpreters and internal ad hoc interpreting staff can be easily organised ■ Determine precise procedures for the use of interpreting services (both external and internal) ■ Involve patient's family or carers in informed consent process ■ Make sure role of any person performing interpreting tasks is properly thought out ■ Define general standards and formulate recommendations accordingly | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Audits ■ Interviews with patients and employees | |
| Objective | <ul style="list-style-type: none"> ■ The quality of treatment given is equivalent to that received by the local native population | Ensuring treatment is rational |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Ensure cross-language comprehension is consistently achieved ■ Promote basic knowledge of cross-cultural communication (through coaching, supervision, ongoing training) within the institution | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Audits ■ Interviews with patients and employees ■ Outcome reviews ■ Grievance review procedures | |

| | | |
|-------------------------------|--|-------------------------------------|
| Empowering the patient | <ul style="list-style-type: none"> ■ The patient's resources, as well as those available from their entourage and culture, are systematically put to use ■ The patient's concept of illness and traditional methods of healing are taken into consideration | Objective |
| | <ul style="list-style-type: none"> ■ Establish rules governing the involvement of traditional healers ■ Acquire knowledge of the traditional healing methods requested by the patient ■ Set standards ■ Ensure staff are generally made aware of, and have opportunities for ongoing training in, diversity issues | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Audits of standards applied ■ Interviews with patients and employees | Evaluation of measures taken |
| | | |

Discharge

Discharge

Discharge is the moment to establish the framework for ensuring that necessary ongoing treatment is continued. Informed consent covering the entire treatment, involvement of the patient's entourage and of the medical staff who will provide post-hospital care are the essential elements here.

Discharge checklist

| | | |
|---|---|-------------------------------------|
| Information and organisation, ongoing treatment and triage | <ul style="list-style-type: none"> ■ On discharge or on transfer to another institution, the patients – and, if necessary, their entourage – have been informed of, and have understood, the follow-up and ongoing treatment which will occur ■ Any necessary ongoing treatment has been organised ■ Principal carers have been identified ■ These carers have been contacted ■ If ongoing treatment is necessary, interpreters attend and facilitate the discharge discussion ■ Patient has been referred for any necessary ongoing treatment to medical staff speaking patient's principal language (if possible) | Objective |
| | <ul style="list-style-type: none"> ■ Define clear standards for procedures and those responsible for them ■ Make information material available ■ Provide patient with a passport for access to emergency services, recording essential information concerning what needs to be done in cases of medical emergency ■ Provide patient with a copy of discharge report (for presentation to patient's doctor) or send this to patient ■ Provide patient with a list of general practitioners in the area | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Audits ■ Interviews with services or persons providing ongoing care | Evaluation of measures taken |
| | | |

Background information

Provision of health care to *sans papiers*: an example from the *Unité mobile de soins communautaires* at the University policlinic in Geneva

| Hans Wolff

Migrants without residence permits

It is estimated that some 90% of the 80 000 to 100 000 *sans papiers*¹ believed to be living in Switzerland do not have health insurance. This situation prevails despite a directive issued to all health insurers in Switzerland by the Federal Social Insurance Office (FSIO) and the Federal Office of Public Health (FOPH) in 2002. This directive states that all *sans papiers* who wish to contract health insurance cover must be granted such cover and that their personal details must be protected from transmission to the alien police authorities. The main obstacle, however, is the cost of paying the premiums. The pay earned by *sans papiers* is low – in Geneva it is estimated to be about CHF 1200 per month on average – while health insurance premiums are high – in Geneva they amount to more than CHF 400 per month. This is the main reason why a large number of *sans papiers* have no health insurance.²

To alleviate the distress in which this marginalised social group lives, and to improve their access to medical care, the University policlinic in Geneva created the *Unité mobile de soins communautaires* in 1996, referred to hereafter simply as *unité mobile*.

89% of the *unité mobile*'s patients are *sans papiers*. In Geneva, 60% of the patients are women and 63% originate from Latin America. On average they stay two years in Switzerland and are aged between 20 and 40. Their educational background is generally very good, with an estimated 60% having completed secondary education and some 30% holding university degrees.

Sans papiers attending consultations predominantly need medical care specific to women. These patients are generally also suffering from considerable psychological distress, often as a result of the constant fear of police searches, separation from their families and their own children and arduous working conditions.

The *unité mobile*'s main objective is to provide the socially disadvantaged and those without health insurance with access to medical care. Its other objectives are:

- To ensure people living in poverty have access to medical care.
- To integrate the activities of the *unité mobile* and its patients into the existing health care system. Emphasis has been placed from the beginning on acting as a link to existing health care services, so as to keep stigmatisation of *unité mobile* patients to a minimum and to benefit from resources already available.
- To coordinate the charitable network with partner organisations within the Geneva platform to combat poverty.
- To conduct research into the health needs of specific target groups and to find solutions for them.

Objectives

Access to health care services is provided and regulated by a gate-keeping model, the first stage of which is staffed by nurses. Access here is open to all and free of charge. The nursing staff then decide whether medical attention is required. This gate-keeping function prevents some 70 to 80% of consultations from going on to the next stage. Only 20 or 30% of the patients are then referred to the policlinic's general practitioners. These doctors in turn act as gate keepers for the university hospital's specialist physicians.

The *unité mobile* also acts as a gate-keeper for the Geneva University Hospitals. Patients who are referred by the *unité mobile* are provided with all medically necessary treatment (as set out in the catalogue of medical services under the federal law on Health Insurance). All treatment provided by the *unité mobile* is based on this catalogue, and its quality is thus the same as that of the treatment provided to everyone else who has basic compulsory health insurance cover. A large part of the *unité mobile*'s work comprises preventative measures, thus helping to obviate both acute situations and serious pathological conditions, whose treatment often results in considerable costs.

How it works

1 Longchamp C, Aebersold M, Rousselot B et Ratelband-Pally S (2005) Sans Papiers en Suisse: c'est le marché de l'emploi qui est déterminant, non pas la politique d'asile. Final report commissioned by the Federal Office for Migration. GFS Bern

2 Syndicat interprofessionnel de travailleuses et travailleurs SIT (2003) Pour mettre au jour l'économie de l'ombre. Geneva

Poor birth control practice is a significant problem area among the *sans papiers*. A survey recently conducted among pregnant *sans papiers* women found that 83% of all full-term pregnancies were unwanted. 70% of the women questioned used no form of contraception.³ The number of abortions is thought to be very high. Efficient and appropriate prevention programmes should thus be put in place as a matter of urgency.

Costs

The Geneva University Hospitals bear the *unité mobile*'s personnel and treatment costs. Consequently, all the treatment ensured by the *unité mobile* must be carried out in the various sections of those institutions. This makes it possible to fund all diagnostic and medical treatment services carried out, from medical examinations to laboratory tests and radiography to surgery. *Sans papiers* patients are asked to contribute to these costs, their contribution being based on the type of treatment and their personal financial circumstances. Roughly 10% of these costs are met by the patients themselves.

Other models of low-threshold access to health care in Switzerland

The Geneva University Hospitals coordinate and finance the *unité mobile* model described above and the access to medical care it provides for *sans papiers* patients. The approaches taken in German-speaking Switzerland are generally based on private initiatives. Outpatient treatment is provided by a network of committed doctors. *Sans papiers* patients are referred to them by various so-called contact points. These doctors often work without emolument, or charge very low fees. If expensive diagnosis or treatment is necessary, patients often have no choice but to take out health insurance cover, even if their finances do not permit them to pay more than a few months' worth of premiums. Exceptions in this regard can be found in the canton of Basel-Stadt and the canton of Vaud. In these two cantons, *sans papiers* who wish to take out health insurance cover receive a subsidy of between 50 and 70% of the monthly premiums. In fact, the FSIO/FOPH directive mentioned above also states that *sans papiers* are entitled to premium rebates under current legislation. Application of this entitlement has proved to be difficult and time-consuming in practice.

There are also mixed-form models, Lausanne being a case in point. There, the principal contact point for *sans papiers* patients (called Point d'Eau) is privately financed, while Lausanne's policlinic PMU is publicly funded.

Generally, *sans papiers* find it difficult to obtain access to most public hospitals in Switzerland. The exceptions are Lausanne, Geneva and Basel, all of which appear to guarantee such access.

To improve this situation, a networked approach needs to be taken by the various health care professions. In particular, it would be advantageous for the public hospitals to work together with the cantonal health authorities and undertake the following steps:

- Establish the status quo: listing the existing medical facilities offered as well as the key partners involved (associations, NGO's, *sans papiers* organisations, contact points, doctors, nurses, midwives, hospitals, health authorities and others).
- Establish a health care network.
- Organise financing.
- Initiate and promote projects which provide the *sans papiers* population with access to health care.
- Evaluation.

3 Wolff H und Stalder H (2005) Medizin für Menschen in Armut! – *Unité mobile de soins communautaires* in Genf. Soziale Medizin 1: 36–39.
Wolff H, Stalder H, Epiney M, Walder A, Irion O, Morabia A (2005) Health care and illegality: a survey of undocumented pregnant immigrants in Geneva. Soc Sci Med 60: 2149–2154

Interpreting and translation

Experience gained both in Switzerland and other countries shows that the main ways in which health care institutions can facilitate communication between people speaking different languages are:

- having external interpreters physically present, face-to-face with the patient and medical staff, or involving either cross-cultural interpreters or cross-cultural communicators (these terms are defined in the section beginning on page 91)
- involving external interpreters by telephone
- involving multilingual employees as ad hoc interpreters
- using linguistic aids (such as pictograms and multilingual dictionaries)
- involving family members or carers
- using translated documents

It is essential to develop an overall concept governing the use, availability and funding of the various types of cross-language communication. The recommendations which follow merely address the key elements. Readers are also referred to the background information on pages 65 to 69.

Interpreting and translation

| Peter Saladin

Interpreting and translation checklist

| | | |
|-------------------------------------|--|---|
| Objective | <ul style="list-style-type: none"> ■ Availability of external interpreters for foreseeable sessions is assured | Involvement of external interpreters in face-to-face situations |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Analyse the need for interpreting services (type and extent of possible involvement, languages, internal and external resources) ■ Set out rules governing the use of interpreting services and how they are organised ■ Cooperate with external specialist organisations (such as INTERPRET, mutual assistance organisations, cross-cultural translation associations, see pages 83 to 86) ■ Tap synergies with other institutions and authorities (such as cantonal and municipal integration officers) ■ Organise employee training with interpreters ■ Establish a budget for interpreting services and secure funding for it | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients ■ Working with specialist organisations to review the quality of interpreting services | |
| Objective | <ul style="list-style-type: none"> ■ Round-the-clock availability of external interpreters is assured for all languages ■ The institution supports cantonal and national telephone interpreting initiatives | Involving interpreters by telephone (see background information on page 67) |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Analyse the need for telephone interpreting services ■ Assess the technical feasibility and infrastructure required ■ Set out rules for the use of telephone interpreting services and how they are organised ■ Tap synergies with other cantonal and national authorities ■ Cooperate with external specialist organisations ■ Train employees in working with telephone interpreters | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients | |

| | | |
|---|---|------------------------------|
| Involving multilingual employees as ad hoc interpreters (see background information on page 65) | <ul style="list-style-type: none"> ■ Availability of employees to work as ad hoc interpreters is assured | Objective |
| | <ul style="list-style-type: none"> ■ Analyse needs ■ Define specific criteria to distinguish involvement of ad hoc, in-house interpreters from that of qualified external interpreters ■ Create and maintain a database of relevant employee language skills ■ Determine criteria for including employees in the language skill database ■ Determine organisational rules and employee remuneration ■ Organise training for ad hoc interpreters and those running discussions with patients | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients ■ Employee assessment | Evaluation of measures taken |
| Linguistic and pictorial aids (dictionaries and pictograms) (see background information on page 68) | <ul style="list-style-type: none"> ■ Aids to facilitate cross-language communication are available and the institution promotes their use | Objective |
| | <ul style="list-style-type: none"> ■ Analyse the need for pictorial and linguistic aids, as well as audio-visual media, particularly in the nursing care context ■ Review suitability of material currently available ■ Set out rules for the use of such material and how it is organised ■ Tap synergies with other institutions ■ Cooperate with external specialist organisations ■ Organise training for employees in the use of linguistic and pictorial aids | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients ■ Assess the comprehensibility and effectiveness of the linguistic and pictorial aids used, both prior to and after use | Evaluation of measures taken |
| Involvement of family members and carers | <ul style="list-style-type: none"> ■ As a rule, recourse to the help of family members and carers, particularly children, is avoided | Objective |
| | <ul style="list-style-type: none"> ■ Set out simple rules ■ Assess the risks (barriers to impartiality, risk of incorrect information being given, urge to protect the family) ■ Limit the involvement of family members and carers to participation in general discussions with medical staff, and only then if this is expressly requested by the patient (see page 68) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients | Evaluation of measures taken |
| Use of translated documents | <ul style="list-style-type: none"> ■ All information important to patients and their entourage is available in the languages most commonly spoken among the migrant population | Objective |
| | <ul style="list-style-type: none"> ■ Set out rules governing the translation of documents ■ Work with professional translation services (see pages 83 to 86) | Implementation suggestions |
| | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients | Evaluation of measures taken |

Background information

Interpreting in hospital: maintaining lists of employees with foreign language skills, training them and targeting their resources

Summary of a research report commissioned by the MFH network¹

Alexander Bischoff
Regine Steinauer
Elisabeth Kurth

Communication between patients and health care staff is a major factor in determining the course of an illness. The literature reviewed shows that the risk of incorrect diagnosis or treatment increases if communication between the patient and the medical staff looking after them is hindered because they do not speak a common language. This can result in lower levels of patient satisfaction and compliance.

Various approaches can be taken to overcome language barriers in the health care sector. Institutions are recruiting increasing numbers of doctors and nursing staff who speak several languages. Switzerland has also seen an increase in the involvement of external interpreters, especially in recent years; however, experience has shown that only limited use is made of the services available, because their existence is insufficiently publicised. Financial considerations and uncertainty about how to involve professional interpreters are other explanatory factors. In day-to-day practice, members of a patient's entourage, or various staff members who happen to be available, are often asked to serve as ad hoc interpreters. As the literature demonstrates, this can often lead to significant problems.

Numerous studies exist which show that the best results, both in terms of translation accuracy and cross-cultural communication, are achieved when patients are able to talk with and through interpreters. The main disadvantage which health care personnel see in this approach is that interpreters' availability is often limited and sessions involving them have to be planned well in advance. Medical staff are also sometimes sceptical of interpreters' ability to understand specialised medical terminology and to translate terms accurately. Some health care professionals also regard conducting patient consultations with an interpreter present as somewhat cumbersome. Conversely, involving internal employees who speak several languages as ad hoc interpreters presents a number of obvious advantages. They can be available at much shorter notice and they also understand medical terminology. Surveys in psychiatric clinics, in particular, show that ad hoc interpreters' knowledge of various pathologies is very much appreciated. The disadvantages cited include possible conflicts regarding the interpreter's role, and conflicts which can arise when members of a team are asked to step in for one of their number who has been called away to interpret.

In addition to reviewing the literature, this study also conducted surveys of its own at the university psychiatric clinics in Basel (UPK) and the university psychiatric policlinics in Basel (PUP). In both institutions, lists are maintained of medical staff speaking several languages who are willing to act as interpreters. Once they have been trained, they are listed as ad hoc interpreters in the internal language skills database. The 18 employees thus recruited speak 11 different languages between them and generally also have prior experience of working as ad hoc interpreters.

This study did not assess their language skills. Part of the study did, however, involve the formulation of "guidelines on the creation of an internal language skills database for a hospital". These guidelines present the procedures involved from an organisational management perspective and emphasise the importance of including the language skills database in an overall concept of cross-cultural medical care.

One of the study's objectives was to develop criteria for deciding when to involve external interpreters and when to involve ad hoc internal interpreters.

These questions were discussed in focus groups as well as being researched in the literature. This process enabled nine relevant criteria to be identified. For ease of interpretation they are presented in the decision diagram below. The basic conclusion was that, for complex consultations which could be planned in advance and which could be expected to deal with emotional or cultural issues, external interpreters were more appropriate. Conversely, for one-off urgent discussions of short duration, on simple, non-abstract subjects, ad hoc interpreters would be the better choice.

¹ The research report can be viewed on www.hplus.ch

Decision criteria

| | | |
|---|---------------------------------------|--------------------------------|
| Urgency | high | low |
| Predictability | poor | good |
| Duration | short | long |
| Complexity | low, non-abstract | high, abstract |
| Implications/consequences for patient | low | high |
| Availability of interpreting resources | good, short-term | good, medium-term |
| Emotional content | low | high |
| Cultural and religious aspects | few | many |
| Follow-up consultation | not envisaged | envisaged |
| | → internal ad-hoc interpreters | → external interpreters |

The effectiveness of tripartite conversations where medical staff and patient do not have a common language does not only depend on the efforts of the interpreter, however. The person leading the discussion can also make a significant contribution to improving the quality of translation. One of this study's main recommendations to medical staff working with interpreters was that they should provide interpreters with details of the background to, and objectives of, the consultation and should speak in short, easily understood sentences.

Based on this study, the following practical recommendations can be made:

- Working with certified interpreters, preferably those with INTERPRET certificates, is a worthwhile objective.
- Whenever possible, involvement of members of a patient's entourage or of untrained hospital employees as ad hoc interpreters should be avoided. Children should be involved only in situations of absolute emergency and only then if the patient expressly requests this.
- Employees should be involved as ad hoc interpreters only if they have had training to prepare them for this kind of work and if the institution has appropriate structures in place.
- Employees may be asked to act as ad hoc interpreters only if they are willing to perform the task.
- Simply setting up an internal database of employees' language skills will not, in and of itself, help to eliminate language barriers. Such a database is useful only if the employees listed in it have been carefully recruited and trained, the list is kept up to date, and is regularly reviewed and evaluated.
- Ideally, the internal language skills database should list several male and female ad hoc interpreters for the most commonly spoken languages. This is the only way of realising its chief potential benefit, namely that of being able to call on interpreting resources at short notice. For smaller institutions with few employees speaking foreign languages the introduction and maintenance of such an internal database has little to recommend it.
- The institution should formulate an internal interpreting concept, governing not only how professional interpreters are to be involved in consultations but also how multilingual employees should serve as ad hoc interpreters. This concept should also specify which patient information sheets should be available in the most commonly spoken languages.
- The language skills of employees also interested in serving as ad hoc interpreters should be reviewed when they are appointed.

Background information

Hospital interpreting by telephone

Summary of a research report commissioned by the MFH network¹

Alexander Bischoff

Florian Grossmann

Language barriers are a challenge to all those involved in the health care sector. A number of strategies for providing access to medical care to all patients speaking a foreign language are under review. The main approach is undoubtedly setting up communication units with professional interpreters. Alongside this, an institution may involve its multilingual employees and interpreters working by telephone.

This research project examines whether telephone-based interpreting is an effective means of overcoming language barriers. It is based on field reports, expert opinions, surveys, clinical studies and the international literature. It shows that telephone-based interpreting is predominantly viewed as an effective form of interpreting. The results can be summarised as follows:

- Various clinical studies have found a high degree of satisfaction among both patients and doctors and an improvement in the quality of communication between them. Patients' acceptance of telephone-based interpreting is comparable to that of interpreters who are physically present (also called face-to-face interpreting).
- A survey found that emergency medical staff in England would support the creation of a national telephone-based interpreting service. Interpreting by telephone is particularly useful when less common languages are involved. Speed of availability was mentioned as being particularly important.
- A survey of doctors in Switzerland found that telephone-based interpreting was not regarded as a priority.

This study reviewed a number of strategy papers, including those of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care drawn up by the US Department of Health and Human Services (see page 107). These papers conclude that, in situations where interpreting services are needed at once or rare languages are involved, telephone-based interpreting can complement face-to-face interpreting or the involvement of multilingual staff. These strategy papers explicitly advise against involving a patient's family members or friends as interpreters.

Six further case studies were conducted on existing telephone-based interpreting services² and, here, expert opinions were sought. The results clearly endorse the use of telephone-based interpreting services.

The prerequisites for effective use of telephone-based interpreting services can be summarised as follows:

- The telephone-based interpreting service should be offered to all patients who do not have a sufficient command of the local language.
- Telephone-based interpreting services should be organised on a nationwide basis. It should be available around the clock. All health care institutions should have access to a telephone-based interpreting service, with smaller institutions likely to draw the greatest benefit. Use of the service by medical staff should be as simple as possible and should be governed by an agreement between the institution and the service provider. All staff working with patients should have access to these facilities. The service should be established in collaboration with INTERPRET and be staffed by interpreters and communicators certified by INTERPRET.
- Hospitals should promulgate guidelines to facilitate decisions by doctors and nurses as to when interpreters should be involved in consultations and what methods should be used. Staff using these services should be trained in working with interpreters face to face and over the telephone.
- The necessary technical prerequisites (such as "hands-free" telephones) must be met. Telephone-based interpreting services place considerable demands on the communications technology used by the provider and require tailor-made software.
- It must be possible to assess the quality of the telephone-based interpreting services being provided. Necessary measures include interpreter certification, by INTERPRET for example, as well as ongoing quality assurance, conducted on the basis of evaluations of recorded conversations, for example.

¹ The research report can be viewed on www.hplus.ch

² Inter Service Migrants ISM, Paris, Academisch Medisch Centrum AMC, Amsterdam, Kantonsspital Baden KSB, Baden, Kolding Sygehus Dänemark, Harbourview Medical Center HMC, Seattle, and Pacific Interpreters USA, Boston Medical Center BMC, Boston

→ Telephone-based interpreting services can be used to complement face-to-face interpreting.

The current state of knowledge suggests that creating a national telephone-based interpreting network in Switzerland would be a major step towards ensuring equitable access to medical care for all. Combined with other initiatives (such as units for facilitating communication, regional face-to-face interpreting services, identifying multilingual health care employees and training them as ad hoc interpreters), a telephone-based interpreting service could contribute decisively to overcoming the language barriers faced by patients not speaking the local language.

Background information

Madeleine Wick Marcoli

Scope for using pictograms to assist communication with migrant patients in Swiss hospitals

Summary of a research report commissioned by the MFH network¹

The purpose of this study was to provide Swiss hospitals with guidelines and recommendations on the use of pictograms for cross-cultural communication, particularly in the fields of medical and nursing care. Existing pictogram collections were examined and the opportunities and risks of using these as aids to cross-cultural communication were assessed. The study comprised two principal steps: a survey conducted among medical professionals and research in the literature and the Internet. A total of 41 experts from health care institutions (mostly hospitals) were interviewed, working in administration and research both in Switzerland and in other countries. Substantial amounts of applicable literature in various specialised fields were also collected from databases, libraries and by using Internet search engines, and this was evaluated in the light of the questions the study set out to examine.

A pictogram can be defined as “a picture created by a person as a means of rapid and unambiguous communication, independent of words or language, showing or pointing to a particular thing”.² To meet the requirement of being comprehensible independently of the written word, of language and of sociocultural origin, pictograms are sometimes subjected to strict international norms. The uniformity required of norm-based pictograms is often not adhered to in practice, however. A multiplicity of different pictograms exist alongside each other, and they are in fact very much dependent on the geographical or sociocultural context in which they were designed.

In Swiss hospitals, pictogram collections today are used sporadically rather than systematically, as a means of facilitating cross-cultural understanding between hospital staff and migrant patients. The study's research shows that the same situation applies in other countries as well, despite the fact that nursing staff see an urgent need for pictograms and other visual forms of communication. If external communication resources are used in a hospital, then these are generally in the form of written material whose text is accompanied by pictures to make it easier to understand and read. Hospitals also avail themselves of the services of cross-cultural interpreters to support this process. Audio-visual material, audio tapes and other tools are also used.

Assessing the scope for using pictograms and the opportunities and risks involved essentially means evaluating how effective and how easy to understand they are. This last point depends on many different factors. Comprehensibility does not solely depend on the formal characteristics of the drawings. Both the context in which the pictograms are used and the characteristics of those to whom they are being shown are just as important. For pictograms to work effectively, what the symbols mean both to the person showing them and the person to whom they are being shown must be known. This requires certain conventions, or at least some prior discussion, or one global set of associations for the pictures. In summary, use of pictograms can be said to comprise the following opportunities and risks:

¹ The research report can be viewed on www.hplus.ch.

² Abdullah R, Hübner R (2005) Piktogramme und Icons. Pflicht oder Kür? Hermann Schmidt, Mainz

- Opportunities**
- Rapid and simple communication
 - Communication independent of word, language or culture
 - Information can be transmitted compactly and requires little space
 - Cognitive information is presented differently than in written language
 - Symbolic and indicative aspects can help to introduce a subject of conversation
 - Easier to use than written information
 - Can help to increase acceptance of written material
 - Can help to make complex and abstract texts easier to understand and remember, and can help less literate groups to understand written material
- Risks**
- Universal intelligibility is not guaranteed in practice
 - Pictograms need to be carefully tested in the situation for which they are intended with target groups
 - The meaning of pictograms – especially those which are abstract – often has to be learned
 - Picture-based aids always introduce an element of uncertainty, as they cannot be guaranteed to be understood; therefore, understanding often has to be checked through additional explanations or by presenting additional written text
 - Patient may refuse to accept introduction of new, language-independent aids into a conversation
 - In practice, introducing innovative communication tools means that health care staff have to be trained in their use, which results in expenditure of human and financial resources

Institutions need to review their communication policies in the light of the sociocultural diversity of the migrant population and the substantial number of people with limited literacy. Messages and pictures about health matters need to be adapted to the information needs of the target audience. In selecting the information strategy to use, an institution must take account of ethnicity, age, gender and degree of literacy.

Health care staff must be appropriately trained before using external resources in cross-cultural communication.

It is certainly worthwhile to consider using pictograms as language-independent forms of communication in practical everyday situations in cross-cultural care and in wards generally; however, when complex medical matters which require decisions or which have potential legal implications are being discussed, interpreters should be involved. The possible use of pictograms to complement written material and make it easier to understand and remember is a relevant consideration not only when communicating with migrant patients but, given the worryingly inadequate level of adult literacy in Switzerland generally, when communicating with native Swiss patients as well.

Nurses, in particular, cite the need for pictograms as a means of facilitating communication with members of the migrant population, a need which could most efficiently be reviewed in the context of a nationwide pilot study. A limited number of relevant everyday situations (such as patient nutrition and meals) should be selected and reviewed from the nurses' standpoint, with simple visual aids which are easy to use being prepared. It is recommended that other types of pictorial material (such as drawings and photographs) should be considered in addition to pictograms.

A nationwide project should also be initiated to create dictionaries for the Swiss health care system, containing words and whole sentences from the various relevant areas translated into different languages. The hospital dictionary prepared for the St. Gallen-Rorschach health authority should be evaluated and the project should also review the experience already gained in Switzerland and elsewhere in compiling and using dictionaries for hospitals.

In-depth research needs to be carried out into various areas, such as the interplay between literacy and public health in Switzerland, the implications of low literacy levels for the transfer of public health information and the scope and limitations of innovative information instruments (including those which can generate pictures).

Recommendations for health care institutions

Recommendations for the Migrant-Friendly Hospitals (MFH) project and for H+ Swiss Hospital Association

Recommendations for the Confederation

Ongoing training for employees

| Joachim Wohnhas

Ongoing training for employees

Training in cross-cultural competence aims to achieve three objectives:

- To ensure that the quality of treatment afforded to the migrant population lives up to the principles of equality of opportunity and non-discrimination.
- To promote a sense of security among health care employees treating migrant patients, thus reducing stress and errors in professional conduct.
- To avoid unnecessary costs and thereby increase efficiency.

Diversity, migration and public health are multidisciplinary issues which cover many areas of activity. They affect behaviour, perception and knowledge, as well as skills and techniques.

All training must obviously be adapted to the needs of the institution and those being trained. Alongside systematic, ongoing training, it may be useful to use specific events within or outside the institution as the starting point for training initiatives.

To remove any doubt, let it be said that diversity, migration and public health are subjects which should be covered in the basic vocational education of all health care professionals.

This requirement should be reflected in the educational and training policies at both federal and cantonal level. The revision of a number of health care curricula provides a good opportunity for integrating these subjects into teaching.

Checklist for ongoing training for employees

| | | |
|-------------------------------------|---|--|
| Objective | <ul style="list-style-type: none"> ■ Ongoing training on aspects of diversity, migration, discrimination and public health are integral to the mission statement and strategy of the organisation ■ Management has provided those responsible for training with a clear mandate | Fundamental structure of the organisation |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Review current fundamental organisational structure ■ Set out overarching goals | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Strategic audit | |
| Objective | <ul style="list-style-type: none"> ■ Longer-term planning for ongoing training with overall and discipline-specific objectives and strategies has been completed ■ Directives are in place identifying which ongoing training modules are compulsory, which are voluntary and for whom ■ General objectives for ongoing training are: to focus on diversity, migration and public health issues when developing existing professional expertise; to provide staff with specific knowledge in these areas; to learn appropriate methods and techniques; to include cross-cultural competence and interdisciplinary cooperation as elements of expected professional conduct ■ Appropriate objectives for ongoing training have been defined: following particular events in a department; as a reaction to external factors or political developments; in the context of a new mission statement or a new organisational policy being introduced | Planning ongoing training |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Regularly assess needs, especially those of employees concerned ■ Involve people with migrant backgrounds ■ Adapt training to the needs of those receiving it: independent training (impulsion training); include diversity, migration and public health subjects in regular internal training, both discipline-specific and interdisciplinary; associate training with specific subjects (e.g. birth, rehabilitation) ■ Arrange cooperation with other health care institutions ■ Offer practice-based workshops and case reviews (intra- or interdisciplinary) | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Interviews with patients ■ Have employees assess needs ■ Evaluation of each training module | |
| Objective | <ul style="list-style-type: none"> ■ Trainers have specific qualifications relevant to the stated objectives | Trainers |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Work together with university institutes, specialist organisations and external specialists ■ Make available lists of arguments relevant to frequently asked questions on the subjects of equal opportunity, non-discrimination and racism | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Evaluation of each training module | |
| Objective | <ul style="list-style-type: none"> ■ Funding for ongoing training has been organised and secured | Financial resources |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Make budgeted expenditure and third-party funding available | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Financial controlling | |
| Objective | <ul style="list-style-type: none"> ■ Programme for ongoing training on diversity, migration and public health is available | Framework programme |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Adapt the example described (see page 72) to the needs of the institution | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Evaluation of the individual training activities | |

Background information

Joachim Wohnhas

Example of a framework programme for interdisciplinary training on diversity, migration and health issues in obstetrics, nursing, medicine and management services

The framework programme described below is the result of experiences exchanged between training specialists and was developed on a common, interdisciplinary basis. It consists of six subject blocks whose form and content should be adapted to the needs of each institution.

Acting professionally

| | | |
|--|--|-------------------|
| Equal opportunity, public health and barriers to access | <ul style="list-style-type: none"> <input type="checkbox"/> Ensure equitable access to health care services and take part in current developments | Objectives |
| | <ul style="list-style-type: none"> <input type="checkbox"/> Ability to provide equal opportunity of access to health care services, to understand the interplay between diversity, migration and public health issues, to express opinions on topical subjects in this area based on fact and to participate in implementing appropriate measures in one's own professional practice | Skills |
| | <ul style="list-style-type: none"> <input type="checkbox"/> Human dignity, equality of opportunity, culturalism, stereotyping, discrimination and racism <input type="checkbox"/> Influence of media and politics <input type="checkbox"/> Migration-specific barriers to access to health care <input type="checkbox"/> Migration-specific information about the Swiss health care system <input type="checkbox"/> Special health care services for migrants <input type="checkbox"/> Effects of migrants' living conditions on health <input type="checkbox"/> Migration, pain and invalidity <input type="checkbox"/> The epidemiology of migration (HIV/Aids, addiction, etc.) <input type="checkbox"/> Migration and public health (action taken at federal and cantonal level) <input type="checkbox"/> Migration-specific preventative work <input type="checkbox"/> Cross-cultural organisational development and diversity management <input type="checkbox"/> Interdisciplinary and interprofessional aspects of cross-cultural issues | Content |

Communication

| | | |
|---|---|-------------------|
| Interpreting and medical ethnology | <ul style="list-style-type: none"> <input type="checkbox"/> Establish a basis for communication and communicate objectively and appropriately with migrants | Objectives |
| | <ul style="list-style-type: none"> <input type="checkbox"/> Ability to establish an adequate basis for communication and to communicate objectively and adequately in different contexts <input type="checkbox"/> Ability to negotiate the health care provision process and to incorporate appropriate methods of explaining causes of illness, its treatment and its course to patients | Skills |
| | <ul style="list-style-type: none"> <input type="checkbox"/> Migration-specific forms of communication (pictures, pictograms, videos, brochures in languages spoken by migrants) <input type="checkbox"/> Professional interpreting <input type="checkbox"/> Non-verbal communication <input type="checkbox"/> Building a relationship from the moment of initial contact <input type="checkbox"/> Case histories based on migrants' specific circumstances <input type="checkbox"/> Concept for explaining medical matters to patients and illness versus disease concept (as in Kleinman) <input type="checkbox"/> Concepts of harmony and balance (Galen's and other medical systems) <input type="checkbox"/> Perceptions of the body and the soul <input type="checkbox"/> Magic, possession and other social or supernatural causal concepts <input type="checkbox"/> Somatic versus psychological explanations <input type="checkbox"/> Ethno-psychiatry | Content |

Integration

| | | |
|-------------------|--|--|
| Objectives | <ul style="list-style-type: none"> ■ The institution's staff assess the legal, social and economic problems faced by migrants by reference to, and in comparison with, their own sociocultural backgrounds | Asylum, migration, concept of culture |
| Skills | <ul style="list-style-type: none"> ■ Ability to recognise and evaluate legal, social and economic problems specific to migrant communities, to recognise and reflect on one's own sociocultural background and its effect on one's interactions with others and one's actions, and to act accordingly | |
| Content | <ul style="list-style-type: none"> ■ Concepts of integration ■ Legislation on aliens and asylum ■ Migrants' living conditions ■ Uncertain residence status and its effect on modes of living ■ <i>Sans papiers</i> and illegal immigration ■ Children and adolescents in migration ■ Changes in the concept of culture and ethnology ■ Culturalism and stereotyping ■ Concept of cross-cultural competence ■ That which is foreign and that which is other (ethno-psychoanalytic approaches) | |

Sociocentric systems

| | | |
|-------------------|---|---|
| Objectives | <ul style="list-style-type: none"> ■ The institution involves migrant resources in its work and works together with their systems and institutions | Working together with sociocentric systems, mutual assistance associations and other resources and establishing networks |
| Skills | <ul style="list-style-type: none"> ■ Ability to understand how sociocentric systems operate and to work together with them using available resources ■ Ability to recognise one's own limitations as well as external constraints, to seek appropriate support where needed and to work together with existing networks and external resources | |
| Content | <ul style="list-style-type: none"> ■ Sociocentric systems versus systems focused on the individual ■ Understanding roles in sociocentric systems ■ Migrant families ■ Migrant children and the space they inhabit between different worlds ■ Relationships between men and women in migrant families and how they evolve as a result of migration ■ Familiarity versus professional remoteness or professionalism ■ The role of empowerment and focus on resources in professional conduct ■ Violence in migrant families ■ Cooperation with migrant networks, specialist agencies and other services ■ Involvement of mediators as "bridge builders" | |

Trauma

| | | |
|---|--|-------------------|
| Trauma in adults and adolescents | <ul style="list-style-type: none"> ■ Recognise trauma when it occurs in patients with migrant backgrounds and react appropriately to it | Objectives |
| | <ul style="list-style-type: none"> ■ Ability to recognise trauma, to care for traumatised people and if necessary to seek professional help | Skills |
| | <ul style="list-style-type: none"> ■ Definition of trauma ■ Sequential trauma ■ Post-traumatic stress syndrome ■ Post-traumatic counselling and therapy ■ Secondary trauma ■ Traumatised families ■ Children's and adolescents' experience of war | Content |

Gender

| | | |
|---|--|-------------------|
| Gender-specific aspects to health in the migrant context | <ul style="list-style-type: none"> ■ Know the gender-specific needs of men and women in the migrant population and address these in a gender-specific manner | Objectives |
| | <ul style="list-style-type: none"> ■ Ability to recognise gender-specific aspects of the lives of migrants, to take account of these at all times and to address these in the appropriate health care disciplines specific to men and women | Skills |
| | <ul style="list-style-type: none"> ■ Changes in role perception due to migration ■ Motivations for migration specific to men and women ■ Gender, migration and health ■ Gender-specific work environments and the health risks attending them ■ Pregnancy, birth, obstetrics ■ Birth control and abortion ■ Women and domestic employment ■ Women and prostitution ■ Female slavery ■ Female genital mutilation ■ Male circumcision | Content |

Central services

The very first contact with a health care institution which most people have – be they patients, long-term-care residents, family members, visitors, suppliers or people dealing with the institution for whatever other reason – is not in fact in a medical or paramedical context. Rather, it will be in front of the information board at the main entrance, at the enquiries desk, in the admissions unit, in the cafeteria, while looking for a patient’s ward or while reading information material. What impression does the institution want to make at these various contact points? How does it want to come across to people who are seeking guidance, information or communication, often when their own personal situation is difficult and burdensome? How these contact points and services are set up plays an important part in determining whether equality of opportunity in access to health care is in fact achieved. As used here, the designation “central services” means all those areas of an institution which provide non-medical and non-paramedical services to patients, long-term-care residents and, to a limited extent, to employees. Such services include social services, religious support, administration, accommodation and catering services, infrastructure, IT and telephone services. The following section singles out some specific activities, because experience has shown that they play an important part in the communication process. The list is not intended to be exhaustive.

Central services

| Peter Saladin

Central services checklist

| | | |
|------------------------------|--|-------------------------|
| Objective | <ul style="list-style-type: none"> ■ Admission and discharge interviews are structured to ensure that patients and long-term-care residents understand the information which needs to be imparted, that they know their rights and obligations and that any questions they may have are answered ■ Employees inform persons being admitted about the availability of information material in other languages and about the other information services available ■ Employees are specially trained for their contact with migrants | Admission and discharge |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Define processes in writing and assess how easy they are to understand (with people concerned) ■ Recruit multilingual staff ■ Ensure availability of interpreting services (over the telephone) ■ Have key documents available in the most commonly spoken languages ■ Have available an up-to-date list of all information material in other languages and of information services ■ Provide special training to central services personnel, if necessary in cooperation with external service providers | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Quality management ■ Interviews with patients and long-term-care residents ■ Grievance review procedures ■ Special evaluation interviews with patients and long-term-care residents from migrant backgrounds after their admission and discharge interviews ■ Regular reviews conducted jointly with external specialist organisations ■ Interviews with employees | |

| | | |
|--|---|-------------------------------------|
| Telephone services | <ul style="list-style-type: none"> ❑ Information provided by telephone service staff is comprehensible to persons speaking foreign languages | Objective |
| | <ul style="list-style-type: none"> ❑ Recruit staff with appropriate language skills ❑ Set out recruiting policy guidelines ❑ Organise compulsory ongoing training | Implementation suggestions |
| | <ul style="list-style-type: none"> ❑ Interviews with patients and long-term-care residents ❑ Interviews with employees ❑ Grievance review procedures ❑ Targeted quality control initiatives | Evaluation of measures taken |
| | | |
| Enquiry and information services within the institution | <ul style="list-style-type: none"> ❑ Patients and long-term-care residents are provided with information about internal and external advice services (such as advice to mothers and fathers, advice on diabetes, incontinence and stoma-related issues and, especially, about the availability of pre- and post-intervention care and general practitioner services) | Objective |
| | <ul style="list-style-type: none"> ❑ Make information about advice centres and other services available in information brochures, at enquiry desks and through electronic media | Implementation suggestions |
| | <ul style="list-style-type: none"> ❑ Interviews with patients and long-term-care residents ❑ Interviews with employees | Evaluation of measures taken |
| | | |
| Directions, signs and the display of information | <ul style="list-style-type: none"> ❑ Directions, signs and information for migrant populations are set up throughout the institution's premises | Objective |
| | <ul style="list-style-type: none"> ❑ Design information boards, signposts and patient thoroughfares so that people not speaking the local language or who are unfamiliar with the premises or locality can find their way | Implementation suggestions |
| | <ul style="list-style-type: none"> ❑ Review by suitably qualified experts | Evaluation of measures taken |
| Visiting rules | <ul style="list-style-type: none"> ❑ The rules governing visitors take as much account as possible of differences in modes of living due to cultural, religious and personal factors | Objective |
| | <ul style="list-style-type: none"> ❑ Review current rules ❑ Include visiting rules in guides to getting around the hospital | Implementation suggestions |
| | <ul style="list-style-type: none"> ❑ Interviews with patients and long-term-care residents (see pages 49 to 51) | Evaluation of measures taken |
| | | |
| Accommodation and catering services | <ul style="list-style-type: none"> ❑ Catering and other accommodation-related services take as much account as possible of differences in modes of living due to cultural, religious and personal factors | Objective |
| | <ul style="list-style-type: none"> ❑ Set out directives for accommodation and catering services in writing ❑ Make sure they can be understood by all (for example by translating ordering instructions and menu plans) ❑ Provide initial and ongoing staff training in addressing diversified accommodation and catering needs | Implementation suggestions |
| | <ul style="list-style-type: none"> ❑ Interviews with patients and long-term-care residents ❑ Internal quality management ❑ Grievance review procedures | Evaluation of measures taken |
| | | |
| | | |
| | | |

| | | |
|-------------------------------------|--|---------------------------|
| Objective | <ul style="list-style-type: none"> ■ The needs of different religions and denominations are taken into account (especially for birth, dying and death itself) ■ Arrange silent contemplation room in a manner enabling members of all religious faiths to feel comfortable and secure in it | Religious services |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Ensure religious support organisation is attuned to the needs of migrants ■ Formulate written guidelines for religious services ■ Make a room for silent contemplation available ■ Designate contact persons for the various religious faiths ■ Refer to available religious services in information documents | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Interviews with patients, long-term-care residents and employees ■ Internal quality management ■ Grievance review procedures | |
| Objective | <ul style="list-style-type: none"> ■ Specific and adequate counselling services provided by social workers are available | Social services |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Ensure institution's social services are in contact with all relevant external bodies and that case management is at hand ■ Recruit personnel from migrant backgrounds | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Interviews with patients and long-term-care residents ■ Internal quality management ■ Grievance review procedures | |
| Objective | <ul style="list-style-type: none"> ■ Documents important in ensuring equal opportunity access to the institution's services are available in the languages most commonly spoken among the migrant population ■ A dictionary of hospital terms with information on various cultures and religions is available (for example on the Intranet) | Documentation |
| Implementation suggestions | <ul style="list-style-type: none"> ■ Establish guidelines for selecting which documents must be translated ■ Establish contacts with specialist organisations and other health care institutions with a view to adapting material already available (such as the St. Gallen cantonal hospital's hospital dictionary, Spitalwörterbuch®, which can be ordered on www.pflegedienst-kssg.ch) ■ Maintain contacts with university institutes and specialist organisations ■ Consult the www.migesplus.ch website | |
| Evaluation of measures taken | <ul style="list-style-type: none"> ■ Internal quality management | |

The network –
addresses of specialist organisations
and advisory services

The network – addresses of specialist organisations and advisory services¹

Federal authorities

The list below shows the addresses of the federal offices and advisory services dealing with the various aspects of migration and public health. Readers are also referred to www.admin.ch and the websites of the various bodies concerned.

Federal Office for Migration FOM

Quellenweg 6, 3003 Bern
Tel. +41 31 325 11 11 | Fax +41 31 325 93 79
info@bfm.admin.ch | www.bfm.admin.ch

Federal Office of Public Health FOPH Equal Opportunity and Public Health Section

P.O. Box, 3003 Bern
Tel. +41 31 322 21 11 | Fax +41 31 322 95 07
info@bag.admin.ch | www.bag.admin.ch
www.migesplus.ch

Federal Office for Professional Education and Technology OPET

Effingerstrasse 27, 3003 Bern
Tel. +41 31 322 21 29 | Fax +41 31 324 96 15
info@bbt.admin.ch | www.bbt.admin.ch

Federal Social Insurance Office FSIO

Effingerstrasse 20, 3003 Bern
Tel. +41 31 322 90 11 | Fax +41 31 322 78 80
www.bsv.admin.ch

Federal Statistical Office FSO Demography and Migration Section

Espace de l'Europe 10, 2010 Neuchâtel
Tel. +41 32 713 67 11
info@bfs.admin.ch | www.bfs.admin.ch

State Secretariat for Economic Affairs seco

Effingerstrasse 1, 3003 Bern
Tel. +41 31 322 56 56 | Fax +41 31 322 56 00
www.seco.admin.ch

Federal Commission for Foreigners FCF

Quellenweg 9, 3003 Bern
Tel. +41 31 325 91 16 | Fax +41 31 325 80 21
eka-cfe@bfm.admin.ch | www.eka-cfe.ch

¹ The organisations listed on pages 81 to 87 are all based in Switzerland. Those which have official names in English appear with their official English title in the middle column of pages 81 to 87 (and no designation in other languages). For those which have no official English designation, the German or French name appears in the middle column, while the outer column provides an English translation of that name (see pages 83 to 86). The English translations appearing in the outer column serve solely to assist comprehension by English-speaking readers. They have not been supplied or authorised by the organisations concerned.

Federal Commission against Racism

Inselgasse 1, 3003 Bern

Tel. +41 31 324 12 93 | Fax +41 31 322 44 37

www.edi.admin.ch/ekr/

Federal Coordinating Committee for Family Affairs

Effingerstrasse 20, 3003 Bern

Tel. +41 31 322 90 11 | Fax +41 31 322 78 80

www.bsv.admin.ch/organisa/kommiss/ekff/d/

Federal Service for Combating Racism FSCR

General Secretariat EDI, Inselgasse 1, 3003 Bern

Tel. +41 31 324 10 33 | Fax +41 31 322 44 37

www.edi.admin.ch/ara

Cantonal and municipal authorities

The responsibilities of cantons and municipalities with regard to migration and public health issues are organised in a variety of different ways. It is therefore advisable to contact the relevant official cantonal or municipal organisations directly. Particular attention is drawn to the following organisations :

Swiss Conference of the Cantonal Ministers of Public Health

Amthausgasse 22, P.O. Box 684, CH-3000 Bern 7

Tel. +41 31 356 20 20 | Fax +41 31 356 20 30

office@gdk-cds.ch | www.gdk-cds.ch

Swiss Conference of Cantonal Ministers of Education

Zähringerstrasse 25, P.O. Box 5975, 3001 Bern

Tel. +41 31 309 51 11 | Fax +41 31 309 51 50

edk@edk.ch | www.edk.ch

Swiss Conference of Cantonal Ministers of Social Affairs

Central Secretariat, Eigerplatz 5, P.O. Box 459, 3000 Bern 14

Tel. +41 31 371 04 29 | Fax +41 31 371 17 44

office@sodk-cdas-cdos.ch

www.sodk-cdas-cdos.ch

Conference of Cantonal Directors for Justice and Police CCJPD

General Secretariat, Kramgasse 14, 3000 Bern 8

Tel. +41 31 318 15 05 | Fax +41 31 318 15 06

info@kkjpd.ch | www.kkjpd.ch

Schweizerische Konferenz der kommunalen, regionalen und kantonalen Integrationsdelegierten

Koordinationsstelle für Integration
Regierungsgebäude, 9001 St.Gallen | Tel. +41 71 229 33 02

Swiss Conference of municipal, regional and cantonal delegates for integration matters | Integration coordination unit

National non-governmental organisations (NGO's)

The list below provides the addresses of a number of non-governmental organisations with particular concerns in the area of migration and public health. The list is not intended to be exhaustive. Readers are also referred to the www.zewo.ch website.

Pro Senectute Switzerland

Lavaterstrasse 60, P.O. Box, 8027 Zurich
Tel. +41 44 283 89 89
www.alter-migration.ch

Forum für die Integration der Migrantinnen und Migranten FIMM

Speichergasse 39, P.O. Box 6117, 3011 Bern
Tel. +41 31 328 98 98 | Fax +41 31 328 98 81
info@fimm.ch | www.fimm.ch

Forum for migrant integration

IAMANEH Schweiz International Association for Maternal and Neonatal Health

Aeschengraben 16, 4051 Basel
Tel. +41 61 205 60 80 | Fax +41 61 271 79 00
info@iamaneh.ch | www.iamaneh.ch

International Organization for Migration IOM Bern

Koordinationsbüro Bern | Thunstrasse 11, P.O. Box 216, 3000 Bern 6
Tel. +41 31 350 82 11 | Fax +41 31 350 82 15
bern@iom.int | www.iom.int/switzerland

Caritas Switzerland

Löwenstrasse 3, P.O. Box, 6002 Lucerne
Tel. +41 41 419 22 22 | Fax +41 41 419 24 24
info@caritas.ch | www.caritas.ch

Radix Gesundheitsförderung

Stampfenbachstrasse 161, 8006 Zurich
Tel. +41 44 360 41 00 | Fax +41 44 360 41 14
info-zh@radix.ch | www.radix.ch

Radix health promotion

Swiss Labour Assistance SLA

Quellenstrasse 31, P.O. Box 2228, 8031 Zurich
Tel. +41 44 444 19 19 | Fax +41 44 444 19 00
info@sah.ch | www.sah.ch

Swiss Refugee Council

Weyermannsstrasse 10, P.O. Box 8154, 3001 Bern
Tel. +41 31 370 75 75 | Fax +41 31 370 75 00
info@osar.ch | www.osar.ch

Swiss Red Cross SRC

Rainmattstrasse 10, 3001 Bern
Tel. +41 31 387 71 11 | Fax +41 31 387 71 22
www.redcross.ch

INTERPRET

Swiss Association for Community Interpreting and Cultural Mediation
Monbijoustrasse 61, 3007 Bern
Tel. +41 31 351 38 28 | Fax +41 31 351 38 27
coordination@inter-pret.ch | www.inter-pret.ch

Society of Minorities in Switzerland

Lessingstrasse 5, P.O. Box, 8027 Zurich
Tel. +41 43 344 49 66 | www.gms-minderheiten.ch

Swiss network of health promotion hospitals and health services – a network of WHO

Weidweg 14, 5034 Suhr
Tel. +41 62 836 20 30
contact@healthhospitals.ch | www.healthhospitals.ch

Foundation against racism and anti-Semitism

P.O. Box, 8027 Zurich
Tel. +41 43 344 49 66
hastu@datacomm.ch | www.gra.ch

Foundation for education to tolerance

Hardstrasse 219, 8005 Zurich
Tel. +41 44 277 71 21 | Fax +41 44 277 71 12
info@set-toleranz.ch | www.set-toleranz.ch

Contact Netz

Monbijoustrasse 70, P.O. Box, 3000 Bern 23
Tel. +41 31 378 22 22 | Fax +41 31 378 22 25
info@contactmail.ch | www.contactnetz.ch

Health Promotion Switzerland

Dufourstrasse 30, P.O. Box 311, 3000 Bern 6
Tel. +41 31 350 04 04 | Fax +41 31 368 17 00
www.promotionsante.ch

Solidarité sans frontières

Neuengasse 8, 3011 Bern
Tel. +41 31 311 07 70 | Fax +41 31 311 07 75
sekretariat@sosf.ch | www.sosf.ch

H+ Swiss Hospital Association

Head Office | Lorrainestrasse 4A, 3013 Bern
Tel. +41 31 335 11 11 | Fax +41 31 335 11 70
geschaeftsstelle@hplus.ch | www.hplus.ch

Aktive Vermittlungsstellen Interkultureller Übersetzung

www.eka-cfe.ch/d/Doku/vermittlungstellen.pdf
<http://inter-pret.ch/contenus/shtml/acteurs-centresplacement-dt.shtml>

Coordination centres
for cross-cultural translation

Regional non-governmental organisations and other specialist organisations

Outpatient clinic for victims of torture and war

Werkstrasse 16, 3084 Wabern
Tel. +41 31 960 77 77 | Fax +41 31 960 77 88
ambulatorium.miges@redcross.ch | www.redcross.ch/org/national/mig/ambu/index-de.php

Outpatient clinic for victims of torture and war

Zurich University Hospital, Psychiatric policlinic | Culmannstrasse 8, 8091 Zurich
Tel. +41 44 255 52 80 | Fax +41 44 255 44 08
www.psychiatrie.usz.ch/german/PatientenUndBesucher/Spezialangebote/FolterKrieg/

Appartenances

Rue des Terreaux 10, Case postale 52, 1000 Lausanne 9
Tel. +41 21 341 12 50 | Fax +41 21 341 12 52
association@appartenances.ch | www.appartenances.ch

Dolmetschdienst Zentralschweiz

Morgartenstrasse 19, 6002 Lucerne
Tel. +41 41 227 31 41 | Fax +41 41 210 00 22
dolmetschdienst@caritas-luzern.ch | www.dolmetschdienst.ch

Interpreting services
for Central Switzerland

List of legal advice centers for asylum seekers

www.osar.ch/2005/00/00/rbsadr-extern-idra

Médecins sans Frontières MSF

Rue de Lausanne 78, P.O. Box 116, 1211 Geneva
Tel. +41 22 849 84 84 | Fax +41 22 849 84 88
office-gva@geneva.msf.org | www.msf.ch

Meditrina
Outpatient walk-in centre

Meditrina
Medizinische Anlaufstelle
Anwandstrasse 7, 8004 Zurich
Tel. +41 44 291 92 33

Medios
Cross-cultural translation
and communication facilitation

Medios
Interkulturelles Übersetzen und Vermitteln
Seestrasse 43, 8002 Zurich
Tel. +41 43 960 26 50 | Fax +41 43 960 25 54
info@medios.ch

NCBI TeleLingua
Alte Landstrasse 89, 8800 Thalwil
Tel. +41 44 721 10 50 | Natel +41 78 770 21 78
info@telelingua.ch

Research

The list below shows the addresses of Swiss research institutions whose fields of activity include issues relating to migration and public health. The list is not intended to be exhaustive.

Department of community medicine
Policlinique de médecine, *Unité mobile de soins communautaires* UMSCO
Rue Hugo-de-Senger 4, 1205 Geneva
Tel. +41 22 382 53 11

Institute of social anthropology of the University of Bern
Länggassstrasse 49a, 3000 Bern
Tel. +41 31 631 89 95 | Fax +41 31 631 42 12
information@anthro.unibe.ch | www.ethno.unibe.ch

Ethnological seminar of the University of Basel
Münsterplatz 19, 4051 Basel
Tel. +41 61 267 27 38
ethnologie@unibas.ch | www.unibas-ethno.ch

Swiss forum for migration and population studies SFM
Rue St-Honoré 2, 2000 Neuchâtel
Tel. +41 32 718 39 20 | Fax +41 32 718 39 21
secretariat.sfm@unine.ch | www.migration-population.ch

Institute of nursing science of the University of Basel
Bernoullistrasse 28, 4056 Basel
Tel. +41 61 267 30 40
nursing@unibas.ch

Institute of social and preventative medicine of the University of Zurich

Hirschengraben 84, 8001 Zurich
Tel. +41 44 634 46 11 | Fax +41 44 634 49 86
gutzwill@ifspm.unizh.ch

Institute of social and preventative medicine of the University of Bern

Finkenhübelweg 11, 3012 Bern
Tel. +41 31 631 35 11 | Fax +41 31 631 35 20
info@ispm.unibe.ch

Institute of social and preventative medicine of the University of Bern

Department of health research
Niesenweg 6, 3012 Bern
Tel. +41 31 631 35 12 | Fax +41 31 631 34 30

Institute of social and preventative medicine of the University of Basel

Steinengraben 49, 4051 Basel
Tel. +41 61 267 60 66 | Fax +41 61 267 67 90
SDISPM@bs.ch | www.ispm-unibasel.ch

Institute of social and preventative medicine

Bugnon 17, 1005 Lausanne
Tel. +41 21 314 72 72 | Fax +41 21 314 73 73
iumsp@chuv.ch

Institute of social and preventative medicine

Centre médical universitaire
Chemin de la Tour-de-Champel 17, 1211 Geneva 4
Tel. +41 22 379 59 16 | Fax +41 22 379 59 12
biblio@imsp.unige.ch | www.imsp.ch

University of Lausanne medical policlinic

Rue du Bugnon 44, 1011 Lausanne
Tel. +41 21 314 60 60 | Fax +41 21 314 48 88
pmu@hospvd.ch | www.polimed.ch

International contacts

Many international organisations are concerned with the issues of migration or public health. The list below provides the addresses of a selection of these, without intending to be exhaustive.

World Health Organisation WHO

Avenue Appia 20, 1211 Geneva 27
Tel. +41 22 791 21 11 | Fax +41 22 791 31 11
info@who.int | www.who.int

WHO Regional Office for Europe

8, Scherfigsvej, DK-2100 Copenhagen O
Tel. +45 39 171 717 | Fax +45 39 171 818
postmaster@euro.who.int

Ludwig Boltzmann Institute for the Sociology of Health and Medicine

WHO Collaborating Centre for Hospitals and Health Promotion

Rooseveltplatz 2 / 4, A-1090 Vienna
hm.soc-gruwi@univie.ac.at | www.mfh-eu.net

Task Force on Migrant-Friendly and Culturally Competent Hospitals TF MFCCH

Coordinated by HPH Regional Network of Emilia Romagna, Antonio Chiarenza,
Via Amendola 2, IT-42100 Reggio Emilia
Antonio.chiarenza@ausel.re.it

International Hospital Federation IHF

Immeuble JB SAY, 13, Chemin du Levant, F-01210 Ferney Voltaire
Tel. +33 (0)450 42 6000 | Fax +33 (0)450 42 6001
info@ihf-fih.org | www.hospitalmanagement.net

International Organization for Migration IOM

17, Route des Morillons, 1211 Geneva 19
Tel. +41 22 717 91 11 | Fax +41 22 798 61 50
info@iom.int, www.iom.int

Definition of terms often used in the areas of migration and public health

The following list defines, in alphabetical order, a number of key terms used in the areas of migration and public health. It does not claim to be complete. Readers should also refer to the relevant legislation and literature.

Asylum seekers are persons who have made an application for asylum in Switzerland and whose application is being processed. They are granted an N permit. While their asylum application is being processed, they are entitled to remain in Switzerland. Under certain circumstances they can be allowed to undertake paid employment.

Federal Office for Migration

The task of the **cross-cultural communicator** is to provide information both to migrants and to public employees – in terms suitable to the person they are addressing – about specific cultural matters, differing rules governing political and social life, and different modes of acceptable behaviour. In so doing, they build bridges between migrants and educational or advisory institutions, and thus reduce the scope for misunderstanding between doctors ↔ and patients, lawyers ↔ and their clients, or teachers ↔ and parents. See also the remarks about cross-cultural interpreters below.

www.inter-pret.ch

Cross-cultural competence is the ability to perceive and understand individual lives in a particular situation and in differing contexts, so as to develop courses of action which are appropriate to a given situation.

Domenig D, see p. 26

Cross-cultural interpreters are linguists specialised in sequential interpreting between two other people. Their role is to enable people of different linguistic backgrounds to communicate verbally with each other. Their interpreting work takes account of the social and cultural backgrounds of those engaging in conversation.

www.inter-pret.ch

Note: In practice, the terms interpreter, cross-cultural interpreter (often also cross-cultural translator) and cross-cultural communicator are not used synonymously. In this manual the widespread designation “interpreter” is used to describe all who facilitate verbal communication by translating verbally. This choice of term is not intended to state any preference as to which of the various methods of cross-language communication an institution should prefer either generally or in a specific individual case. As used in this manual, the term “ad hoc interpreter” refers to a multilingual employee of a health care institution who helps to facilitate verbal communication between patients and staff speaking different languages on a case-by-case basis. The term “translator” is always used here to designate someone who translates from one language to another in writing.

Culturalism refers to the practice of over-emphasising the purely ethnic elements of a given culture and can manifest itself in statements where the word race has simply been replaced with the word culture. Culturalistic attitudes are characterised by:

- Ethnic formulations, which regard a person’s culture as resulting solely from their origins.
- Homogeneity: All members of an ethnic group are regarded as necessarily having the same culture.
- Reducibility: Seeing an individual’s characteristics as being limited to the cultural attributes of a particular group.

Definition of terms often used in the areas of migration and public health

| Peter Saladin

Asylum seekers

Cross-cultural communicators

Cross-cultural competence

Cross-cultural interpreters

Culturalism

→ **Rigidity**: Expressed in the belief that cultures cannot be changed, or can change only over long periods of time (i.e. over generations).

Culturalistic forms of argument can be found both in right-wing extremism and in truncated, multiculturalistic attitudes. Such a view of what constitutes a culture is at odds with the heterogeneity of societies as witnessed by clearly evident differences between old and young, town and country, rich and poor or religious affiliation.

www.wikipedia.org

Culture

Culture describes the dispositions which individuals acquire throughout their lives and which enable them to create concepts understandable to others and to act purposefully. Culture is thus an open, dynamic process requiring ongoing analysis. It is not a static affair.

Wicker HR (1996) Von der komplexen Kultur zur kulturellen Komplexität. In: Wicker HR et al. (ed.) Das Fremde in der Gesellschaft: Migration, Ethnizität und Staat. Seismo, Zurich, 373–392

Wicker HR (1996)

Diversity

In the context of this manual, **diversity** refers to those personal and societal differences which arise, inter alia, as a result of a person's origin, gender, language, skills, age, mode of living and social status and have an effect on the individual's development within a society. Management of diversity aims to engender a positive approach to these differences in order to generate action which is positive for an organisation, its clientele and its employees.

P. Saladin

Equal opportunity

Equal opportunity in health care means that everybody has the same opportunity to attain the highest state of health possible. Societal conditions – i.e. the political, socio-economic, ecological and legal framework – should be so structured as to allow each individual to reach his or her full health potential.

Kolip P (2005) Wie erreiche ich meine Ziele? Gesundheitliche Chancengleichheit durch massgeschneiderte Projekte fördern. In: Focus: das Magazin von Gesundheitsförderung Schweiz (25): 14–16

Kolip P (2005)

Foreigners

In Switzerland, there is no legal definition (i.e. a definition in the text of a given law) of the term **foreigner**. In practice, every person whose only nationality or nationalities are those of a country other than Switzerland is defined as a foreigner. Foreigners are distinct from those who were born outside Switzerland and who have since acquired Swiss citizenship. Persons who, in addition to being foreign nationals, also hold Swiss citizenship (dual nationals) are included among the Swiss population in all statistics. Conversely, stateless people and persons whose nationality has not been determined are regarded as foreigners.

Federal Statistical Office

Gender

The term gender describes the **gender** roles of men and women which society, culture and history have defined. In contrast to biological gender or sex, these are learned and thus constantly evolving.

Scott J W (1986) Gender as a useful category of Historical analysis, cited in: Kimmich D et al. (ed.) Texte zur Literaturtheorie der Gegenwart. Reclam, Stuttgart

Scott J W (1986)

Informed consent

Informed consent means a patient's agreement, after they have been fully informed of what is envisaged, to permit an examination or treatment to be carried out on them, or to participate in a clinical test.

www.wikipedia.org

| | | |
|---|--|-----------------------|
| Federal Office for Migration | <p>Integration means equal opportunity of access to societal and economic resources being granted to Swiss citizens and foreign residents. In Switzerland, integration encompasses all initiatives serving to promote mutual understanding between Switzerland's Swiss and foreign populations. Key elements here are living together on the basis of common fundamental values and modes of behaviour, informing foreigners about Switzerland's institutions, laws and living conditions and the creation of conditions conducive to equal opportunities, and participation in the life of society. Integration is a two-way process which requires willingness on the part of foreigners to integrate and openness on the part of the Swiss population.</p> | Integration |
| www.inter-pret.ch | <p>Interpreters are persons who have perfect mastery of their own mother tongue and one or more foreign languages. They possess the necessary interpreting skills to convey a spoken version in the target language of a message originally made in the source language. See also the reference to cross-cultural translators above.</p> | Interpreters |
| www.mediation-svm.ch | <p>Mediators most commonly work in post-conflict situations. They are independent of particular interests and equally behave to either party to a conflict. They support the parties to a conflict by helping them to resolve their differences, fairly, through negotiation and in mutual respect. While mediators help conflicting parties to reach agreement, they themselves have no power of decision.</p> | Mediators |
| P. Saladin | <p>The terms migrant population and population of migrant origin, in the context of this manual, mean all persons not born in Switzerland and their children (2nd generation migrants), irrespective of their nationality.</p> | Migrant population |
| International Organization for Migration IOM (2003) | <p>Migration signifies the movement of a person or group of persons across administrative, political or geographical borders with a view to settling temporarily or permanently in a place other than their place of origin.</p> <p>International Organization for Migration IOM (2003) Facts and Figures on International Migration. Migration Policy Issues 2</p> | Migration |
| www.bfm.admin.ch/index | <p>Provisional admission is granted to people who have been subject to deportation orders from Switzerland, but whose deportation cannot be carried out because it is inadmissible under international law, inadmissible on humanitarian grounds or not technically feasible. Provisional admission is thus a substitute for deportation. It can also be granted in cases of acute personal distress, provided no legal ruling on an asylum seeker's application for asylum has been reached within four years of such an application being first made.</p> | Provisional admission |
| Federal Service for Combating Racism FSCR | <p>Racial discrimination refers to any practice which denies rights to people, treats them unjustly or intolerantly, humiliates or offends them, or endangers life and limb, on the basis of their physiognomy, ethnic origins, cultural attributes (such as language or name) or religious affiliation. In its effect on victims and perpetrators alike it is similar to discrimination on the basis of gender, sexual orientation, age or invalidity. Racial discrimination can, but need not, be based on ideological beliefs (racism in the classic sense).</p> | Racial discrimination |

| | | |
|---|--|--|
| Racism | <p>Racism strictly means an ideology which assigns people to groups it sees as ordained by Nature, on the basis of their physiognomy, their cultural attributes, or their ethnic, national or religious affiliation – thus defining “races” as having distinct physical characteristics – and places each such race in a clearly defined hierarchy. People are thus not viewed as individuals, but are viewed, and treated, as belonging to pseudo-related groups with largely unalterable characteristics. Classic racism is based on false assumptions. It has served in the past and still serves today to justify colonialism, slavery, Nazi crimes against humanity, and the apartheid regime.</p> <p>Since the 1960’s (which saw decolonisation and the movement to emancipate black people in the United States), the term racism has been widely used to describe racial discrimination of a direct, indirect, institutional or structural nature. When dealing with the practical aspects of these matters, it is, however, worthwhile to distinguish between racial discrimination on the one hand and racism as an ideology on the other.</p> | Federal Service for Combating Racism FSCR |
| Recognised refugees | <p>Refugee status is recognised for any person who has suffered persecution, or has legitimate reason to fear that they will suffer such persecution in the future, as a result of their political convictions, their membership of a particular ethnic, national or social group, their religion or their nationality. A decisive criterion is that such persecution originates in the country from which the person has come. Those granted refugee status are issued with an annual residence permit (B permit).</p> | Federal Office for Migration |
| Refugees | <p>Refugees are persons who, either in their country of origin or the country in which they last lived, have suffered persecution, or have legitimate reason to fear that they will suffer such persecution in the future, as a result of their political conviction, their membership of a particular ethnic, national or social group, their religion or their nationality. Persecution in this context refers to jeopardy to life, limb or liberty, as well as circumstances which exert intolerable psychological pressure on an individual. Reasons for flight specific to women must be taken into account.</p> | Asylum Act of 26 June 1998, Art. 3, SR 142.31 |
| Resident permit categories for foreigners | <p>An overview of the various types of residence permit categories and explanations relating to them can be found under www.bfm.admin.ch ▶ Topics ▶ Residence ▶ Aufenthaltskategorien im Ausländerbereich / Catégories de séjour dans les domaines des étrangers.</p> | www.bfm.admin.ch |
| Sans papiers | <p>In Switzerland, there is no legal definition (i.e. a definition in the text of a given law) of the term sans papiers. In practice, the term sans papiers refers to people who have remained in Switzerland for more than one month without a regular residence permit and who have no firm intention of leaving the country.</p> <p>Forschung für Politik, Kommunikation und Gesellschaft gfs. Bern (2005) Sans Papiers in der Schweiz: Arbeitsmarkt, nicht Asylpolitik ist entscheidend. Concluding report commissioned by the Federal Office for Migration, Bern</p> | gfs. Bern (2005) |
| Translators | <p>Translators are linguistic specialists who translate texts written in one or several source languages into one or several target languages, the latter generally being their mother tongue. They have a perfect command of their mother tongue and of one or several foreign languages.</p> | www.inter-pret.ch |



The Amsterdam Declaration – Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe

Migration, diversity, health and hospitals

Migration, ethno-cultural diversity, health and health care are closely interlinked in many ways. Due to worldwide migration, globalisation and also European enlargement, European communities are becoming more and more diverse on the local level as well.

The health status of migrants and ethnic minority groups is often worse than that of the average population. These groups are more vulnerable, due to their lower socio-economic position, and sometimes because of traumatic migration experiences and lack of adequate social support. Thus, it seems only rational that human rights activists argue that access to health care services must be seen as a basic right for everyone and that they are supported therein by international conventions (e.g., the International Convention on the Elimination of All Forms of Racial Discrimination and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families). Even beyond this human rights aspect, increasing diversity is an important quality assurance and development issue for health systems and services.¹ Minority groups are at risk of not receiving the same level of health care in diagnosis, treatment and preventive services that the average population receives. Health care services are not responsive enough to the specific needs of minorities. There are many challenges facing both service users and providers. Examples include not only language barriers² and cultural diversity, but also scarcities in hospital resources and low levels of minority purchasing power and entitlements. All this poses new challenges for quality assurance and improvement in health services – especially for hospitals which play a particularly important role in serving this segment of the population.³

Lower levels of health literacy among migrants is also relevant, especially as concerns the appropriate use of health care systems. Migrants in Europe often lack information about available hospital and ambulatory care services or about general health matters in the specific context of European societies. This is one of the reasons migrants often give for not using health services effectively and for not taking action themselves to prevent illness.⁴

The current situation is thus one which poses challenges to hospitals and their staff, a staff which is itself at the same time becoming more diverse, thereby presenting an opportunity, a resource and an additional challenge for hospital organisations.

To work on these challenges, a group of hospitals from 12 European countries came together as Pilot Hospitals to participate in the Migrant-Friendly Hospital project (for details see below). National and regional networks of the WHO Network of Health Promoting Hospitals (HPH) played an important role in bringing the partners from Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain, Sweden, and the UK together. They represent a wide range of hospital types, from large metropolitan University teaching hospitals to small-town community hospitals, with public and with private, non-profit ownership. Some of the partners had already had a long-standing record in serving diverse communities before the project, some of these communities being rather well-established and homogeneous, others being very diverse and comprised of a large number of undocumented migrants. Some partners serve their communities in the context of a rather well integrated health care system, others have had to cope with rather fragmented structures.

The text of the Declaration can be viewed in various languages on www.mfh-eu.net

1 World Health Organization (WHO): Report International Migration, Health and Human Rights, Iss. No. 4, 2003

2 Bischoff, A.: Caring for migrant and minority patients in European hospitals. A review of effective interventions, 2003, Swiss forum for migration and population studies. A study commissioned by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine, Vienna, "MFH – Migrant-Friendly Hospitals"; WHO 2003

3 Bischoff, 2003

4 WHO 2003, p. 28

The project received financial support from the European Commission and the Austrian government. European and international organisations joined the initiative as supporting partners (see list at the end of this document). Project partners agreed on basic principles to be at the core of a Migrant-Friendly Hospital mission statement: valuing diversity by accepting people with diverse backgrounds as principally equal members of society; identifying the needs of people with diverse backgrounds and monitoring and developing services with regard to these needs; and finally, compensating for disadvantages arising from diverse backgrounds.

Based on a needs assessment, the project was able – despite the diversity of health care systems and local situations in European hospitals – to identify many common problems for migrants / ethnic minorities and staff.

For selected issues, knowledge-based solutions were successfully implemented and evaluated in the areas of interpreting, cultural competence training for hospital staff, and empowerment in mother and child care.

The Pilot Hospitals also aimed at generally improving their diversity management by developing their organisational structures and cultures to become migrant-friendly and culturally competent organisations. For the partners, becoming a (more) “migrant-friendly” organisation proved feasible but not trivial: many stakeholders must contribute to these change processes. Project results and tools are available at www.mfh-eu.net.

In order to guarantee the sustainability of the initiative, a “Task Force on Migrant-Friendly Hospitals” was set up in the framework of the Health Promoting Hospital Network of WHO Europe. This task force will serve as one focus for further initiatives, organise workshops, maintain the MFH website and conduct other activities.

Recommendations

Based on the experiences of the MFH project partners, international discussions and the scientific literature, the following crucial points for the successful development of services and organisational cultures can be identified:

1. Developing a migrant-friendly hospital is an investment in more individualised and more person-oriented services for all patients and clients as well as their families.
2. Increased awareness will be needed of migrant population experiences and existing health disparities and inequities, including those that are gender-related, leading to changes in communication, organisational routines and resource allocations.
3. Focusing on ethno-cultural diversity implies the risk of stereotyping – but migrant status, ethnic descent, cultural background and religious affiliation are just a few of the many dimensions of the complexity of human beings.
4. Developing partnerships with local community organisations and advocacy groups who are knowledgeable about migrant and minority ethnic group issues is an important step that can facilitate the development of a more culturally and linguistically appropriate service delivery system.

Like any other form of organisational development, the success of becoming a “migrant-friendly” hospital willing and able to serve its diverse communities in an equitable way will depend on the complementary contributions of a number of different stakeholders.

Hospital owners / Management / Quality Management

Hospital owners, management and quality management should put the quality of services for migrants and ethnic minorities on the agenda of hospital organisations:

5. It will be important to define aims and objectives (mission, vision and value statement, policies and procedures)
6. Adequate resources (working time, financial resources, qualification) must be provided if changes are to be realised.
7. An organisational development process should be initiated, supported and monitored by leadership, management and quality management.
8. As an important step, the needs and assets of stakeholders – users (patients, relatives, community) and providers (staff) – should be monitored.
9. Outcomes as well as the structures and processes that influence outcomes should be monitored.
10. Concerns, complaints and grievances related to service delivery should be tracked and appropriately addressed.
11. Investment in capacity building with regard to staff's cultural and linguistic competence is needed (selection, training, evaluation).

Staff / Health professions

Hospital staff and the professions and professional organisations of which they are part should acknowledge that the issues are relevant and they should be prepared to invest in achieving competency.

12. An important step will be to find consensus on criteria for migrant-friendliness / cultural competence / diversity competence adapted to their specific situation and to integrate them into professional standards and enforce that they are realised in everyday practice. The principles applied in the MFH project can serve as starting point for this development.
13. Professionals and other staff will have to build capacities concerning cross-cultural and communicative and diversity-related competencies.
14. Clinical practice, preventive services and health promotion action should be appropriately tailored for use with diverse populations. Preventive services and health promotion that rely strongly on communicative interventions are especially dependent on the cultural and linguistic competencies of professionals if they are to be effective.
15. Taking the literacy and health literacy of users systematically into account at all levels of services will be an important prerequisite. This implies monitoring, the development of adequate orientation systems/information material as well as patient education programmes.
16. Potentially traumatic migration experiences mean that heightened awareness of mental health issues is important in hospital care for migrants.

Users (actual and potential patients, relatives) / representatives of community groups

Patient organisations and community groups can make most important contributions to the process by putting diversity and health and health care on their respective agendas.

17. Patient organisations should incorporate the diversity of their clientele into their strategies and policies and should act as advocates for these diverse patient populations.
18. Migrant / minority community representatives can contribute not only by advocating but also by mediating. They should act as advocates for adequate access to and quality of services, and they should also become agents for the development of greater health literacy within their communities.
19. By investing in improvements in their health literacy, all members of migrant / minority communities can contribute to their own better health and better use of health services.

Health policy and administration

Health policymakers and administration are responsible for quality standards in health care and have the final responsibility for the health of the population in their geographical areas of authority. In most countries, they are also responsible for financing health care services and are thus also interested in the effectiveness and efficiency of these services.

20. Health policy should provide a framework to make migrant-friendly quality development relevant and feasible for each hospital (legal, financial, and organisational regulations).
21. A framework for health-oriented community development for migrants and ethnic minorities has the potential to be most helpful in developing these groups' health literacy.
22. Policy and administration have an important role to play in facilitating knowledge development – for example in initiating and funding research, reviews, standards development and dissemination (networking, education, exchange of experience).

Health sciences

Scientific knowledge and expertise can be very helpful in the process. By moving diversity issues in health and health care higher up on their agendas, by including them in their theory-building and the development of systematic evidence, health science disciplines can make important contributions.

23. Ethnic and migrant background information should be included as a relevant category in epidemiological, socio-behavioural, clinical, health service and health system research.
24. Scientific experts should be prepared to assist other stakeholders in planning, monitoring and evaluating their efforts by providing reviews, assessment tools, designs and tools for evaluation.
25. Scientifically based efforts can contribute to combating racism, prejudice, discrimination and exclusion by providing information on the negative consequences of these processes.
26. Participatory, multi-method research and evaluation efforts should be carried out in partnership and consultation with communities.

All European hospitals are invited to implement the Amsterdam Declaration, become migrant-friendly and culturally competent organisations and develop individualised, personal services from which all patients will benefit. Investments in increased responsiveness to the needs of populations at risk will be an important step towards overall quality assurance and development.

Further contact / Opportunities to communicate and collaborate

- Task force in the Health Promoting Hospitals Network of WHO Europa, co-ordinated by HPH Regional Network of Emilia-Romagna, Antonio Chiarenza, Via Amendola, 2, 42100 Reggio Emilia, Italy. E-mail: Antonio.chiarenza@ausl.re.it
- Website: www.mfh-eu.net
- Pharos (Evelien van Asperen, www.pharos.nl, e-mail: e.asperen@pharos.nl)
- Bradford Teaching Hospitals NHS Foundation Trust, Dilshad Khan, BRI, Duckworth Lane Bradford BD9 6RJ, United Kingdom, e-mail: dilshad.khan@bradfordhospitals.nhs.uk
- International Union for Health Promotion and Education (IUHPE), John Kenneth Davies (IUHPE Europe), Falmer, BN1 9PH Brighton, United Kingdom, e-mail: J.K.Davies@bton.ac.uk, caroline.hall@brighton.ac.uk

Who developed the Amsterdam Declaration?

The MFH Project Group in the framework of the European Commission project “MFH – Migrant-Friendly Hospitals, a European initiative to promote health and health literacy for migrants and ethnic minorities”.

Financially supported by European Commission, DG Health and Consumer Protection, Public Health Program; co-financed by the Federal Ministry for Education, Science and Culture, Republic of Austria, Vienna, and the local Pilot Hospitals.

European Pilot Hospitals: Kaiser-Franz-Josef-Spital, Vienna, AT, Immanuel-Krankenhaus GmbH, Rheumaklinik Berlin-Wannsee, Berlin, GER, Kolding Hospital, Kolding, DK, Hospital “Spiliopoulou Agia Eleni”, Athens, EL, Hospital Punta de Europa, Algeciras-Cádiz, ES, Turku University Hospital, Turku, FI, Hôpital Avicenne, Paris, FR, James Connolly Memorial Hospital, Dublin, IR, Presidio Ospedaliero della Provincia di Reggio Emilia, Reggio Emilia, IT, Academic Medical Center, Amsterdam, NL, Uppsala University Hospital, Psychiatric Centre, Uppsala, SV, Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK⁵

Project co-ordinator: Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM) at the University of Vienna, Faculty of the Social Sciences, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care⁶ Project website: <http://www.mfh-eu.net>

Supported by:

A Group of international Experts⁷, European Commission, DG Health and Consumer Protection; Austrian Federal Ministry for Education, Science and Culture

European, international and scientific Organisations acting as supporting partners: International Alliance of Patients’ Organizations (IAPO), International Labour Organisation (ILO), International Organisation for Migration (IOM), International Union of Health Promotion and Education (IUHPE), Migrants Rights International, Standing committee of the hospitals of the EU (HOPE), United for Intercultural Action, WHO Centre for Integrated Health Care, Barcelona, National and Regional Networks of the WHO Network for Health Promoting Hospitals (HPH) in the member states of the European Union, PaceMaker in Global Health, Pharos, Andalusian School of Public Health (EASP)

The original text of the Declaration concludes with the flags and logos of the various participants.

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6 Project director: Juergen M. Pelikan, Core team: Gabriele Bocek, Karl Krajic, Sonja Novak-Zezula, Ursula Trummer, Martha Wirtenberger

7 Alexander Bischoff (Basel), Sandro Cattacin (Neuchâtel/Geneva), Julia Puebla Fortier (Geneva), Ilona Kickbusch (Bern), Robert Like (New Brunswick), Lourdes Sanchez (Boston). Thanks as well to other experts that contributed to the project by support and advice like Anita J. Arnold (Doylestown, Pa.), Shani Dowd (Boston), Susan Auger, Ines Garcia Sanchez, Caroline Hall, Evelien van Asperen and many others.



Quality questionnaire used in the EU Migrant-Friendly Hospitals pilot project

The quality questionnaire reproduced on the following pages was developed by the working group Cross-cultural competence in public health for the Austrian Ministry of Public Health, Family and Youth (bmfjg) in Vienna and subsequently edited by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM), a joint body of the Ludwig Boltzmann Society and the University of Vienna. It is a shortened and revised version of the Migrant-Friendly Quality Questionnaire (MFQQ), developed by the European Migrant-Friendly Hospitals project in cooperation with 12 EU partner hospitals for the European Commission, DG Public Health and Consumer Protection (Sanco), Public Health Programme. The original version is available on the MFH homepage www.mfh-eu.net.

www.mfh-eu.net

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.

“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 ethnic 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 health care for diverse populations, i.e., face validity is ensured.

SF_MFQQ

Migrant-Friendliness Quality Questionnaire

Short Form

Part A: MF Characteristics of Services

Please give estimated degree of implementation of the named MF criteria in quartiles:

0% not at all | 1st quartile: up to 25% (e.g. in some units, erratically) | 2nd quartile: up to 50% (in several units) | 3rd quartile: up to 75% (widespread, rather reliable) | 4th quartile: up to 100% (full coverage, good quality, reliable, fast ...)

General resources to facilitate communication and information

| • Interpreting services available at the hospital | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Interpreting service implemented at hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Telephone interpreting service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Co-operation with external interpreting service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Utilisation of language competencies of staff members | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cultural mediation services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other (please specify, e.g. informal or proxy interpreters): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| • Information material | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
| 7. Patient information translated in the local community languages | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Patient information prepared in the appropriate form (culturally specific, pictographs, audiotapes) (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| 9. Visual orientation systems at the hospital (signposts, pictographs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |

| Accessibility, pre-entry and entry into hospital | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 11. Hospital information for prospective patients translated into the local community languages | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Hospital information for prospective patients prepared in the appropriate form (culturally specific, pictographs) (please specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| 13. Hospital information for prospective patients available in places in the community (e.g. community centres, pharmacies, mosques, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |

SF_MFQQ

Migrant Friendliness Quality Questionnaire

Short Form

| Ursula Karl-Trummer

| Beate Schulze

| Karl Krajcic

| Sonja Novak-Zezula

| Peter Nowak

| Jürgen M. Pelikan

Ludwig Boltzmann Institute for the

Sociology of Health and Medicine

LBISHM, Vienna, 2007

Whilst in hospital

| | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Hotel services | | | | | |
| 15. Provision of adequate food | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Provision for patients to practice their religion within the hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Arrangements/facilities for family visits (more than 2 visitors per patient) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |
| • Medical / nursing treatment | | | | | |
| 19. Provisions for patients to be treated by a doctor and nurse of same gender (if they choose) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Provision for ensuring that patients are able to consent to treatment in a language they understand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Transcultural mental health service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |

Discharge

| | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 23. Provision of information regarding treatment and post-discharge care translated into the local community languages | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Provision of information regarding treatment and post-discharge care in appropriate form (culturally specific, pictographs) (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |
| 25. Provision of culturally adequate recommendations and health information at discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |

MF patient education / health promotion / empowerment

| | 0% | up to 25% | up to 50% | up to 75% | up to 100% |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 27. Provision of culturally sensitive patient education programmes (please specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |
| 28. Provision of culturally sensitive health promotion services (please specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | | | | |

Part B: MF Support System**General quality system in hospital**

| | yes | no |
|--|--------------------------|--------------------------|
| 29. Does your hospital use a comprehensive quality system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. If yes, please specify model, e.g. EFQM, ISO, TQM ... | | |
| 31. Are MF criteria integrated in this quality system? | <input type="checkbox"/> | <input type="checkbox"/> |

Written MF policy

| | yes | no |
|---|--------------------------|--------------------------|
| 32. Migrant-friendliness as an explicit aim + value in the mission statement | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Formulated MF strategic policy document, specifying MF core strategies and policies to reach them | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. (Annual) MF action plan | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. MF written process regulations (organisation manuals, guidelines, standards, pathways ...) | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Policies for the training and development of staff with a migrant background | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Policies how to handle discrimination | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Other (please specify): | <input type="checkbox"/> | <input type="checkbox"/> |

MF budget

| | yes | no |
|--|--------------------------|--------------------------|
| 39. Does your hospital have an explicit MF budget? | <input type="checkbox"/> | <input type="checkbox"/> |
| If possible, please specify the amount: euros per year | | <input type="text"/> |

MF management structure

| | yes | no |
|------------------------------------|--------------------------|--------------------------|
| 40. MF project officer or manager | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Multiprofessional MF committee | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Network of MF contact persons | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Type and size of network: | | |

Marketing of MF

| • Internal marketing of MF (at the hospital) | | yes | no |
|--|--|--------------------------|--------------------------|
| 44. MFH internal newsletter | | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. MFH annual presentations | | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. List of MFH contact persons at the hospital available to all staff members | | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Other (please specify): | | | |
| • External marketing of MF (to the public) | | yes | no |
| 48. MFH external newsletters | | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. MFH open house | | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. MFH flyers or brochures available at doctors' offices or migrant community centres | | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Other (please specify): | | <input type="checkbox"/> | <input type="checkbox"/> |

National standards on culturally and linguistically appropriate services (CLAS) in health care in the United States¹

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

1. Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic

¹ Excerpt from the Federal Register, December 22, 2000 Vol. 65, 247: 80865–80879

The full text of the standards, including explanatory notes and a comprehensive project report, can be viewed on the Internet on www.med.umich.edu/multi-cultural/ccp/CLASpage.htm

The CLAS standards were commissioned by the U.S. Department of Health and Human Services, Office of Minority Health and developed by Resources for Cross-Cultural Health Care

competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcome-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

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Tools¹

- I am going to hospital!
- **Federal Office of Public Health FOPH**
Information on health matters for health care, social work and education professionals
(in German, French and Italian)
www.migesplus.ch
- **Health guide Switzerland**
Second, revised edition now available
Can be ordered on: www.migesplus.ch/publikationen-de.php?thema=26&pub=6
- Your rights at the doctor's and in hospital
- **Ich gehe ins Spital!**
Published by: Schweizerischer Verein für die Rechte von Kindern und Jugendlichen im Gesundheitswesen
Can be ordered on: www.migesplus.ch
- Information on motherhood
- **Ihre Rechte bei der Ärztin, beim Arzt und im Spital**
Published by: Volkswirtschafts- und Sanitätsdirektion Kanton Basel-Landschaft
Can be ordered on: www.migesplus.ch
- In other words – interpreting services during medical treatment, consultation and care
- **Info Mutterschaft**
Published by: Travail.Suisse
Can be ordered on: www.migesplus.ch
- Female patients who have suffered genital mutilation: Swiss recommendations for doctors, midwives and nurses
- **Mit anderen Worten – Dolmetschen in Behandlung, Beratung und Pflege**
Published by: INTERPRET. Swiss Association for Community Interpreting and Cultural Mediation
Can be ordered on: www.inter-pret.ch
- Pregnancy and motherhood
- **Patientinnen mit genitaler Beschneidung: Schweizerische Empfehlungen für Ärztinnen und Ärzte, Hebammen und Pflegefachkräfte**
Published by: Schweizerische Gesellschaft für Gynäkologie und Geburtshilfe
Can be ordered on: www.terre-des-femmes.ch
- Maintaining independence in later life – an advisory booklet
- **Schwangerschaft, Muttersein**
Published by: Schweizerischer Hebammenverband
Can be ordered on: www.migesplus.ch
- **Selbstständig bleiben im Alter – ein Ratgeber**
Published by: Swiss Red Cross SRC. Nationales Sekretariat der Kantonalverbände
Can be ordered on: www.migesplus.ch

¹ Of the publications listed in this "Tools" section, only one "Health guide Switzerland" was available in English at the time of writing (the text describing the FOPH items at the top of the list is purely descriptive, it is not the title of a single specific publication). For all the other publications listed under "Tools" on pages 114 and 115 the middle column contains the German name of the publication concerned. Many of these publications are also available in French and/or Italian. The outer column provides an English translation of the German title appearing in the middle column. This translation is provided solely to assist comprehension by English-speaking readers, it does not mean that an English version under the English title is available.

→ **Spitalwörterbuch**

Published by: Kantonsspital St.Gallen, Departement Pflege
Can be ordered on: www.pflegedienst-kssg.ch

Hospital dictionary

→ **Video "Trialog", Dolmetschen im Gesundheitswesen** (with handbook)

Published by: INTERPRET. Swiss Association for Community Interpreting and Cultural Mediation
Can be ordered on: www.inter-pret.ch

"Trialog" video. Interpreting in health care (with handbook)

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Peter Saladin (editor), with contributions from
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