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

Evaluation Report

MEM-TP Pilot Training

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Migrants & Ethnic Minorities Training Packages

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CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES

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EMILIA-ROMAGNA
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Evaluation Report
MEM-TP Pilot Training Spain

1. Introduction

The aim of the MEM-TP project is to improve access and quality of health services for migrants and ethnic minorities in the European Union by reviewing, developing, testing and evaluating training in migrant and ethnic minority health for front-line health professionals, and disseminating the project results.

The European Commission (EC) awarded the project in late December 2013 to a consortium of institutions under a service contract. The consortium consists of the Andalusian School of Public Health (EASP) as the lead partner, and the University of Copenhagen (Faculty of Health and Medical Sciences), Azienda Unita Sanitaria Locale Reggio Emilia in Italy and University of Amsterdam (Academisch Medisch Centrum) as members. The International Organization of Migration (IOM), European Public Health Alliance (EPHA), Jagiellonian University in Poland, National Institute of Public Health of Romania, and Trnava University in Slovakia collaborate with the project as subcontractors.

The project consists of the following phases:

- From April to September 2014, a review of the situation of migrants and ethnic minorities in the EU and a review of the existing training materials was conducted, documented in two reports.
- From August to December 2014, training materials were developed taking into account the findings of the two reports, and reviewed by CHAFEA and the consortium partners.
- From January 28-30, 2015, a training of trainers' workshop took place at the Andalusian School of Public Health, Granada, Spain, with trainers of the six countries that participate in the pilot training (Denmark, Italy, Poland, Rumania, Slovakia and Spain).
- Following the workshop, between April and May 2015, the trained trainers adapted the training package to their local context, translated the contents and run pilot training programmes in their own countries. All pilot trainings were evaluated by trainees and trainers.

This report summarises the results of the evaluation of the Pilot Training in Spain contributed by the trainees and trainers.

2. Objectives

The evaluation process was conducted with the following objectives:

- To assess the training materials.
- To evaluate the development of the pilot training.
- To evaluate the opportunities for knowledge transference.
- To evaluate the professional profile and training needs of the participants before or after the training.
- To assess the quality and satisfaction of the trainees regarding the teaching activities.

3. Assessment Methodology

The assessment methodology conducted in each of the pilot trainings included three levels:

- Assessment of the training materials by means of the participants and coordinators of the pilot trainings, including an evaluation of the training materials, activities, development of the pilot training and opportunities for knowledge transference. This assessment level is specific for the piloting process, conducted with the objective of piloting and evaluating the quality and appropriateness of the training materials and include the proposals for improvement in the final version of the training packages (English version and country versions).

- Evaluation of the professional and demographic profile / training needs by means of the training participants. This assessment level has been implemented with the objective of piloting the assessment tools, to be applied in future uses of the training package, as well as to evaluate the appropriateness of the training contents in relation to the profile and knowledge level of the participants.

- Assessment of the quality of teaching and satisfaction by means of the training participants. This assessment level contributes information regarding the perceived quality of teaching in the training sessions.

The participants of the pilot trainings had a double role:

1. As participants of the piloting process, with the task of assessing the training materials.
2. As trainees, following the evaluation process of professional profile, training needs, quality of teaching and satisfaction to be applied in future uses of the training packages.

In detail, the following assessment tools were used:

- Assessment of training materials
    - Training materials questionnaire (participants) (Annex I)
    - Template for a qualitative evaluation of the pilot training, training materials and transference (trainers) (Annex II)
    - Qualitative feedback in the website forum (participants)

- Evaluation of professional and demographic profile / training needs.
    - Pre-Test: Professional and demographic profile / training needs questionnaire (participants) (Annex III)

  - Post-Test: Training needs questionnaire (participants) (Annex IV)

- Assessment of quality of teaching and satisfaction
  - Quality of teaching and satisfaction questionnaire (participants) (Annex V)

The assessment tools directed to the participants were prepared as online surveys in the local language, sent to the trainees by means of a personal e-mail and access and analyzed by the EASP team.

The qualitative evaluation of the training materials and transference was prepared as a Word template (in English), sent to the trainers by e-mail and analyzed by the EASP team.

4. Results of the Assessment Process

In the following chapter, the results of the assessment process will be presented, including the assessment of the training materials (quantitative and qualitative assessment), the evaluation of the professional profile and training needs, as well as the assessment of the quality of teaching and satisfaction (questionnaires: see Annex I-V).

4.1. Assessment of training materials

The assessment of the training materials includes the results of the quantitative training materials questionnaire, as well as the results of the qualitative assessment tool.

4.1.1. Training materials questionnaire

In this chapter, the results of the training materials questionnaire (Annex I) will be presented. The following table shows the number of responses, 120 in total, per country.

Country	Number of responses
Denmark	17
Spain	29
Italy	21
Poland	21
Romania	20
Slovakia	12
Total	**120**

Table 1. Responses per country

Relatively, the Module 4 has been the module with minor valuation of the different aspects as presented in the following table.

	Module 1	Module 2	Module 3	Module 4
Clarity, understanding and legibility	4,34	4,31	4,31	4,22
Adequacy of length	4,14	4,12	4,09	4,05
Accuracy	4,28	4,21	4,27	4,16
Credibility	4,32	4,30	4,21	4,28
Consistency between the contents and the objectives	4,22	4,16	4,22	4,21
Quality of design	4,17	4,19	4,17	4,10
Adequacy of images	4,25	4,23	4,21	4,16
Consistency between the activity(ies) and the objectives	4,24	4,16	4,22	4,18

M1 M2 M3 M4

Table 2. Evaluation of the training modules

In general, for the five components the most valuated training material's aspect is *Clarity, understanding and legibility*, except in Module 4, where this aspect is *Credibility.* On the contrary, the aspect with less valuation is *Adequacy of the length*. These results will be presented in the following points as a comparative table per country for the different aspects in each module.

4.1.1.1. Module 1

Sensitivity and awareness of cultural and other forms of diversity.

	Avarage						
	Denmark	Spain	Italy	Poland	Romania	Slovakia	Total
Clarity, understanding and legibility	4,12	4,00	4,24	4,71	4,90	4,08	**4,34**
Adequacy of length	4,00	3,31	4,19	4,76	4,85	4,00	**4,14**
Accuracy	4,12	3,93	4,10	4,75	4,80	4,00	**4,28**
Credibility	4,06	4,00	4,19	4,75	4,84	4,08	**4,32**
Consistency between the contents and the objectives	3,94	3,93	3,90	4,70	4,90	3,92	**4,22**
Quality of design	3,76	3,62	4,00	4,75	4,90	4,17	**4,17**
Adequacy of images	3,88	3,90	4,05	4,80	4,85	4,00	**4,25**
Consistency between the activity(ies) and the objectives	3,94	4,10	3,95	4,75	4,80	3,67	**4,24**

Table 3. Evaluation – Module 1

4.1.1.2. Module 2

Knowledge about migrants, ethnic minorities and their health.

	Avarage						
	Denmark	Spain	Italy	Poland	Romania	Slovakia	Total
Clarity, understanding and legibility	4,19	4,14	3,95	4,60	4,80	4,20	**4,31**
Adequacy of length	4,00	3,59	3,67	4,65	4,80	4,36	**4,12**
Accuracy	4,06	4,00	3,67	4,71	4,85	3,91	**4,21**
Credibility	4,19	4,10	3,76	4,79	4,90	4,09	**4,30**
Consistency between the contents and the objectives	3,88	4,00	4,24	4,71	4,90	4,08	**4,16**
Quality of design	3,88	3,90	3,76	4,70	4,85	4,09	**4,19**
Adequacy of images	3,93	3,97	3,81	4,74	4,90	4,00	**4,23**
Consistency between the activity(ies) and the objectives	3,75	4,07	3,70	4,70	4,80	3,73	**4,16**

Table 4. Evaluation – Module 2

4.1.1.3. Module 3

Professional skills.

	Avarage						
	Denmark	Spain	Italy	Poland	Romania	Slovakia	Total
Clarity, understanding and legibility	4,13	4,24	3,76	4,60	4,89	4,25	**4,31**
Adequacy of length	3,94	3,66	3,52	4,75	4,84	4,08	**4,09**
Accuracy	4,00	4,24	3,70	4,67	4,84	4,08	**4,27**
Credibility	3,94	4,21	3,50	4,70	4,84	3,92	**4,21**
Consistency between the contents and the objectives	4,00	4,24	3,57	4,62	4,84	3,92	**4,22**
Quality of design	4,13	3,90	3,67	4,65	4,79	4,00	**4,17**
Adequacy of images	3,93	4,00	3,76	4,70	4,79	4,08	**4,21**
Consistency between the activity(ies) and the objectives	3,81	4,28	3,50	4,80	4,79	3,92	**4,22**

Table 5. Evaluation – Module 3

4.1.1.4. Module 4

Knowledge application.

	Avarage						
	Denmark	Spain	Italy	Poland	Romania	Slovakia	Total
Clarity, understanding and legibility	4,13	4,03	4,05	4,42	4,80	3,83	**4,22**
Adequacy of length	3,73	3,52	3,86	4,68	4,85	3,75	**4,05**
Accuracy	3,87	4,07	3,67	4,63	4,85	3,75	**4,16**
Credibility	4,00	4,10	3,95	4,60	4,85	4,08	**4,28**
Consistency between the contents and the objectives	3,87	4,07	3,76	4,68	4,85	3,92	**4,21**
Quality of design	3,73	3,79	3,90	4,58	4,80	3,75	**4,10**
Adequacy of images	3,86	3,83	3,86	4,74	4,89	3,75	**4,16**
Consistency between the activity(ies) and the objectives	3,87	4,10	3,80	4,68	4,90	3,42	**4,18**

Table 6. Evaluation – Module 4

4.1.1.5. Trainees manual

	Avarage						
	Denmark	Spain	Italy	Poland	Romania	Slovakia	Total
Trainees Manual	3,60	3,72	3,42	4,57	4,80	4,00	**4,03**
Clarity, understanding and legibility	3,69	3,76	3,63	4,55	4,80	3,83	**4,05**
Adequacy of length	3,50	3,61	3,47	4,75	4,60	3,75	**3,96**

Table 7. Evaluation – Trainees manual

4.1.2. Qualitative assessment of the pilot training, training materials and transference

In the following chapter, the results of the qualitative assessment of the pilot training, training materials and transference in the six participating countries will be presented (template: see Annex II), including a summary, as well as the complete answers contributed by the collaborating institutions in the six countries.

4.1.2.1. Preparation of the piloting

4.1.2.1.1. Contact with authorities

Which authorities did you contact? How would you assess the contact process with the authorities? Did you experience any obstacles or difficulties?

Summary

Country	Contact with authorities
Denmark	• All hospitals in the capital region and the region of Zealand • All municipalities in the capital region and the region of Zealand
Italy	• Health Departments of the 21 regions and autonomous provinces of Italy • Each regional health department contacted its local health authorities which identified the participating health professionals
Poland	• Ministry of Health, Department of Science and Higher Education • The chamber of physicians and the chamber of nurses and midwifes (there are national and local professional chambers in Poland for both types of professions) • Professional organisations which do not have the status of “chamber” • Hospitals

	• Medical Centre for Continuing Education
Romania	• National authorities (MoH) and District Public Health Directorates (DPHD) from 6 districts (Botosani, Neamt, Giurgiu, Calarasi, Gorj, Dolj). • National Institute of Public Health (NIPH)
Slovakia	• Slovak medical chamber • Slovak chamber of nurses • Ministry of Health of the Slovak Republic • Slovak Medical University in Bratislava • Slovak Public Health Association • Faculty hospital in Trnava • Regional Hospitals in Piešťany, Skalica, Senica • 4 main university hospitals in Bratislava • Healthy City Trnava office (Committee for health and social issues) • Public Health Authority of the Slovak Republic • 36 Regional Public Health Authorities
Spain	• Andalusia o Aquilino Alonso Miranda, Vice-Minister of Health, Regional Ministry for Equality, Health and Social Policies, Andalusia o José Miguel Aranda Lara, Director of the Public Health Care System, Andalusia o Juan Tomás García Martínez, General Director of Health Care and Health Outcomes, Andalusia • Aragón o Ángel Sanz Barea, Director of the Public Health System, Aragón o Mª José Lafuente, Director of Primary Health Care, Calatayud • Basque Country o Miren Dorronsoro Iraeta, General Director of Public Health, Regional Health Ministry, Basque Country o Juan Luis Uría Serrano, Medical Inspector of the Public Health System, ONG Osalde, Basque Country o Michol González Torres, Director of the Health Care District Bilbao / Hospital Basurto • Castilla-La Mancha o Luis Carretero Alcántara, Director of SESCAM, Public Health System, Castilla La- Mancha o Pedro Tárraga López, Coordinator of the Integrated Primary Health Care Subdirection, Albacete • Ceuta o Justo Ostale Blanco, Director of the Health Care District Ceuta (INGESA) o Antonio Miguel Carrión Sánchez, Director of Health Care, Health Care District (INGESA), Ceuta • Madrid o Manuel Martínez Vidal, General Director of Health Promotion, Regional Health Ministry, Madrid o Susana Granado de la Orden, Subdirector for Health Promotion and Health Prevention, Madrid • Melilla

	○ Dr. Pedro Villaroel Gil, Director of the Health Care District Melilla ○ Antonia Vázquez de la Villa, Director of Health Care, Health Care District (INGESA), Melilla ○ • Murcia ○ Francisco José García Ruiz, General Director of Public Health and Drug Dependence, Regional Ministry for Health and Social Affairs, Murcia ○ Director of the Health Care Area II, Cartagena • Valencia ○ Manuel Yarza, General Director of Health Care, Health Care Agency, Valencia ○ José David Zafrilla, Director of the Health Department, Elche, Vinalopó and Torrevieja

Table 8. Contact with authorities

Detailed answers

Denmark

We send out an invitation letter with descriptions of the course contents and practical matters to the following:

- All hospitals in the Capital Region and the Region of Zealand
- All municipalities in the Capital region and the Region of Zealand

We did not encounter any problems in this procedure, though we did not evaluate it formally. But due to the heterogeneous background of the participants we assume that the invitation letter was distributed to relevant health professionals.

Italy

National authorities, such as the Ministry of Health and the National commission for medical training (AGENAS), were not the ideal bodies to contact to select participants for this training. The reason for this lies in the current decentralization the Health Sector in Italy. National health authorities are tasked with designing strategies and national policies. However, the regional adaptation and implementation of those policies is under the authority of Regional health governments.

We recruited 32 participants from 6 different regions. Travel and accommodation costs for the trainees were covered by the Local Health Unit of Reggio Emilia (MEM-TP partner for Italy).

We did not experience specific obstacles or difficulties with this recruitment process.

Poland

Main organisations organising continuing education for health professionals we contacted:

1. For the organisational support: Medical Center for Continuing Education, an institution offering the technical support like possibility of easy registration of participants, giving educational points for them and also having big experience in organising training for medical professionals.

2. The chamber of physicians and the chamber of nurses and midwifes (there are national and local professional chambers in Poland for both types of professions). For emergency professionals we contacted several professional organisations which do not have the status of “chamber”.
3. Hospitals.
4. Ministry of Health, Department of Science and Higher Education.

Difficulties:
Generally the main problem is that Poland is too big country to offer only 30 places for participants if the training is so interesting for them. Even if we only invite 1 person from each local chamber for this piloting event, that would give us about 60 participants. After some days, when we had already full list of participants, we still have other institutions (ex. Hospitals) wishing to send us their representatives for the training.

The lack of official chamber of emergency professionals (as existing for other medical professionals) is another problem in Poland – we had to contact several parallel organisations (associations), but this is a specific problem of these health professionals in our country.

Romania
We have contacted the national authorities (MoH) and District Public Health Directorates (DPHD) from 6 districts of Romania (Botosani, Neamt, Giurgiu, Calarasi, Gorj, Dolj). We selected these 6 districts as all of them are pilot districts in a project financed with Norwegian Grants, aiming to build the community team (community nurse and Roma health mediator) to work in a community health centre, destined to Roma population, but further enlarged to cover the vulnerable population in the community.

So, there were no big obstacles, the community health coordinators from the district level were contacted and they mobilised family doctors, community nurses and representatives of the DPHDs.

The only difficulty was to mobilise family doctors because they had to leave their practice for 3 days. Nevertheless, we have had family doctors from all districts as well.

There were also involved in the training participants from the National Institute of Public Health (NIPH) who are going to further develop and use a training curricula for the people working at community care level (family doctors, community nurses, Roma health mediator). The curriculum will be used by the Training Centre for Community Health Care located at the NIPH.

Slovakia
We sent invitation letter and information about piloting to:
Slovak medical chamber
Slovak chamber of nurses
Ministry of health of the Slovak Republic
Slovak Medical University in Bratislava

Slovak Public Health Association
Faculty hospital in Trnava
Regional Hospitals in Piešťany, Skalica, Senica
4 main university hospitals in Bratislava
Healthy City Trnava office (Committee for health and social issues)
Public Health Authority of the Slovak Republic
36 Regional Public Health Authorities
17 GPs working at health centre in Trnava

The training received accreditation by the Slovak medical chamber and by the Slovak chamber of nurses. We have received national wide credits for health professionals from the accreditation committee within the Continual Medical Education for medical doctors, nurses and public health professionals.
http://www.saccme.sk/podujatie/treningove-aktivity-pre-zdravotnickych-pracovnikov-na-zlepsenie-pristupu-k-zdravotnickym-sluzbam-pre-migrantov-a-etnicke-mensiny-vratane-romov.html

Obstacles and difficulties:
The interest from the side of the professionals to attend the meeting was limited mainly due to the relatively long duration. The majority of the professionals that were approached found it difficult to free themselves from their duties for such a long time. Also, the topic was not compelling enough to prioritize it over other activities.

Spain
Contacted authorities:

- Andalusia
    - Aquilino Alonso Miranda, Vice-Minister of Health, Regional Ministry for Equality, Health and Social Policies, Andalusia
    - José Miguel Aranda Lara, Director of the Public Health Care System, Andalusia
    - Juan Tomás García Martínez, General Director of Health Care and Health Outcomes, Andalusia
- Aragón
    - Ángel Sanz Barea, Director of the Public Health System, Aragón
    - Mª José Lafuente, Director of Primary Health Care, Calatayud
- Basque Country
    - Miren Dorronsoro Iraeta, General Director of Public Health, Regional Health Ministry, Basque Country
    - Juan Luis Uría Serrano, Medical Inspector of the Public Health System, ONG Osalde, Basque Country
    - Michol González Torres, Director of the Health Care District Bilbao / Hospital Basurto
- Castilla-La Mancha
    - Luis Carretero Alcántara, Director of SESCAM, Public Health System, Castilla La-Mancha
    - Pedro Tárraga López, Coordinator of the Integrated Primary Health Care Subdirection, Albacete
- Ceuta

  - Justo Ostale Blanco, Director of the Health Care District Ceuta (INGESA)
  - Antonio Miguel Carrión Sánchez, Director of Health Care, Health Care District (INGESA), Ceuta
- Madrid
  - Manuel Martínez Vidal, General Director of Health Promotion, Regional Health Ministry, Madrid
  - Susana Granado de la Orden, Subdirector for Health Promotion and Health Prevention, Madrid
- Melilla
  - Dr. Pedro Villaroel Gil, Director of the Health Care District Melilla
  - Antonia Vázquez de la Villa, Director of Health Care, Health Care District (INGESA), Melilla
  -
- Murcia
  - Francicsco José García Ruiz, General Director of Public Health and Drug Dependence, Regional Ministry for Health and Social Affairs, Murcia
  - Director of the Health Care Area II, Cartagena
- Valencia
  - Manuel Yarza, General Director of Health Care, Health Care Agency, Valencia

José David Zafrilla, Director of the Health Department, Elche, Vinalopó and Torrevieja

Contact process:

January 2015:

- Autonomous Communities (ACs) were prioritized based on size of migration in the region and initial budget estimate of travel costs of participants (explained in specific document).
- Some ACs were excluded due to cost of participation (Galicia, Asturias and Cantabria) or low concentration of migrants in the region (Extremadura, Rioja and Castilla - Leon).
- Officials of the Regional Ministries of Health were contacted to explore their interest in participating and take the responsibility of selecting the participants from their Regional Health Service (SRS).

February 2015:

- Preliminary information was sent to those responsible for the selected SRSs indicating the required participant profile. All were sent the same informational letter, which explored the possibility of participants being released from work to attend the training.
- Personalized phone calls by senior staff of the Department of International Health at the EASP to clarify the desired profile of participants and the number of available candidates.

March 2015:

- Preparation of a preliminary list of potential participants who met the selection criteria. Final invitation and agreement with SRS officials on the number of participant slots available for each SRS (see annex 2)

April 2015:

- Personal invitation to the selected professionals. Management of their travel and lodging.

Obstacles:

- Existence of 17 regional services and 2 autonomous cities, which made the selection of participants complex and laborious.
- Severe restrictions on all SRSs for authorizing two days' absence from work for training (the pilot scheduled to run until Saturday noon to minimize the impact of absence from work).
- Financial constraints; professionals from the farthest ACs (Northern Spain) could not be included due to the cost of travel.

4.1.2.1.2. Participants

How many health professionals participated in the training? What are their professional profiles?
How would you assess the contact process with the participants? Did you experience any obstacles or difficulties?

Summary

Country	Number of participants and professional profile
Denmark	38 participants • Nurses • Physiotherapists • Medical doctors • 1 midwife • 1 dietician • 1 social worker, working in a community psychiatry service • 1 master in Public Health, working with health promotion strategies in a municipality
Italy	32 participants from 6 different Italian regions: Emilia-Romagna, Liguria, Trentino, Abruzzo, Umbria, Basilicata and Sicilia. • 12 nurses • 10 medical doctors • 4 psychologists • 2 obstetricists • 1 social worker • 1 health promotor • 1 sociologists • 1 administrative staff member
Poland	31 professionals invited, 28 participants, professional groups working in hospitals, outpatient clinics, emergency centers, sanatoriums: • Emergency professionals • Midwifes • Nurses • Physicians
Romania	• Family doctors • Representatives of DPHDs, coordinators at district level of the community care program • Community nurses

	• Public health experts • Psychologists • Juridical expert
Slovakia	• Public health professionals: 5 • Nurses: 21 • Medical doctors: 11 • Other health professionals: 4 • Ministry of health representing: 1
Spain	Total: 30 Professionals from eight Autonomous Communities (Andalusia, Aragon, Castilla - La Mancha, Madrid, Valencia, Murcia, Ceuta and Melilla) *Professional distribution:* • 17 Doctors: o 11 specialists in Family Medicine (1 of whom temporarily heads the Hospital in Melilla) o 4 pediatricians from health centers o 1 from a medical emergency hospital o 1 psychiatrist from a community mental health center • 12 Nurses o 7 from primary care centers. Four of them engaged exclusively in clinical work. o 1 Deputy Director of Basic Zone, 1 Clinical Director and 1 head of patient's service, all of whom combine clinical work with management tasks either part-time or temporarily. o 1 nurse working in a hospital emergency department o 4 midwives working on call in primary care and / or emergency hospital. • 1 social worker (responsible for Service Patient in Health Center).

Table 9. Number of participants and professional profile

Detailed answers

Denmark

38 participated.

Their professional backgrounds: Most of the participants were nurses, physiotherapists and medical doctors. Additionally, there were one midwife, one dietician, one social worker working in a community psychiatry service and one master in public health who worked with health promotion strategies in a municipality.

All applicants with relevant backgrounds were accepted for the course.

Exceptions were those who beforehand wrote that they were not able to attend all the training days, and those who applied later than deadline for application.

We received several applications after deadline, which were dismissed due to a more than complete course, which indicates a general interest in the subject.

Italy

All 32 identified participants participated in the training travelling to Bologna from six different Italian regions: Emilia-Romagna, Liguria, Trentino, Abruzzo, Umbria, Basilicata and Sicilia.

There were 12 nurses; 10 medical doctors, 4 psychologists, 2 obstetrics, 1 social worker, 1 health promoter, 1 sociologist and 1 administrative staff member. The complete list of participants attached to this report. We think that having been able to put together a multi-professional audience, including health managers and social/administrative staff, was a definite asset of the training.

The contact process with participants was fluid and we did not experience obstacles or difficulties.

Poland

On the final list we had 31 names, finally 28 participated, from 3 professional groups (in alphabetical order): Emergency professionals, midwife, nurses, physicians.

Some of them work for hospitals, some others for outpatient clinics, emergency centers, sanatoriums also.

This combination of different professions and profiles was very enriching our programme. We found (with a kind of surprise sometimes) that their cooperation (ex. during activities) was excellent.

The first contact with them (by emails about the details of the training, accommodation etc.) was of course very official. When the real training started, the “real” contact was very good (in our opinion).

Difficulties:

Some participants informed us very late that they would not come. We had the reserve list but it was impossible to attract participants from the reserve list when informing them just one day before the beginning. That's why we loosed these places – the new invited participants just could not organise their arrival (even if they tried to manage it).

Romania

As described above, we covered a wide range of actors:

- Family doctors
- Representatives of DPHDs, coordinators at district level of the community care program
- Community nurses
- Public health experts
- Psychologists
- Juridical experts

All the persons outside Bucarest were contacted by the district coordinators, guided by the trainers from the NIPH.

Contact was easy, all of them responded with enthusiasm. Even the family doctors responded positively at our invitation.

Slovakia
Public health professionals: 5
Nurses: 21
Medical doctors: 11
Other health professionals: 4
Ministry of health representing: 1

Main obstacles and difficulties we have observed with motivation for attendance.

Spain
Total: 30 Professionals from EIGHT Autonomous Communities (Andalusia, Aragon, Castilla - La Mancha, Madrid, Valencia, Murcia, Ceuta and Melilla)

Professional distribution:

- 17 Doctors:
  - 11 specialists in Family Medicine (1 of whom temporarily heads the Hospital in Melilla)
  - 4 pediatricians from health centers
  - 1 from a medical emergency hospital
  - 1 psychiatrist from a community mental health center

- 12 Nurses
  - 7 from primary care centers. Four of them engaged exclusively in clinical work.
  - 1 Deputy Director of Basic Zone, 1 Clinical Director and 1 head of patient's service, all of whom combine clinical work with management tasks either part-time or temporarily.
  - 1 nurse working in a hospital emergency department
  - 4 midwives working on call in primary care and / or emergency hospital.

- 1 social worker (responsible for Service Patient in Health Center). The health centre was particularly interested in including this category of staff.

Obstacles:

- The final selection of participants was outside the control of the organisers of the Pilot Training
- In the case of Andalusia, the distribution of the larger number of training slots between the provinces required the coordination of the process by the Director General of Health Care of the Andalusian Health Service. The EASP contacted each province to guide them in selecting participants who fit the required profile.

Contact with individual participants previously on notice for its Regional Services, it was easy and pleasant.

4.1.2.1.3. Adaptation of the materials

How did you adapt the training materials? Which contents and/or activities have you added to the core contents? How would you assess the adaptation process? Did you experience any obstacles or difficulties in the process?

Summary

Adaptation of the materials
• The team of trainers selected by every leader institution adapted and translated the core contents. • Many contents were reorganised and activities changed to better fit the audience and invite their participation. • Country-specific contents, statistical data and resources were added, according to the context-specific priorities. • Contents from Modules 1 and 3 remained mainly unaltered, although activities were adapted to include practical cases in local context. • Module 2, Additional Module 2 and Module 4 were adapted in most cases to include country-specific data (migrant and ethnic minorities demography, disease patterns, health determinants, access to health services, local programmes and community projects). • Content from Additional Module 1 was inserted when relevant to the local context. • In some countries, the order of the modules was modified. • Most of the materials were translated. • Activities were selected according to the country-specific priorities. • The coordinators highlight that adaptation was time-consuming, at the same time as highlighting its relevance.

Table 10. Adaptation of the materials

Detailed answers

Denmark

Module 1 was adapted in such a way that most of the core theoretical content was covered but it was reorganized and the presentation methods altered slightly to better reflect the audience and invite their participation.

Module 2 was extensively adapted to include disease patterns, determinants for health and access to health services specifically for the ethnic minority and migrant population in Denmark.

Module 3 was adapted aiming at including more practical cases in a Danish context. Moreover, some of the concepts were regarded as being too basic for some of the Danish health professionals. Such as 'empathy', and active/reflexive listening, which were well known to e.g. all Danish nurses. Consequently, these concepts were only touched upon very briefly. Nevertheless, we did go through an activity with active listening, but the participants seemed to find it way too basic.

Module 4 was adapted to a Danish context and some of the units were shortened a lot down. This, because some of the concepts were also a little too basic, but primarily in order to leave space for more practical cases from a Danish context, and in order to leave time for activities.

We added the additional module regarding vulnerable migrants, and focused on human trafficking. Here we showed a 30 min. film, produced by the Danish centre against human trafficking.

Most of the materials were translated into Danish.

In general, adaptation of the materials was time consuming. We found that the material could not only be translated, but also needed adaptations in order to better reflect a Danish migration context as well as the culture and traditions related to this kind of teaching in Denmark and the competences of the participants. Therefore, we could not rely on translations from a student assistant but needed to do the translations/adaptations ourselves.

Italy

We selected the Italian trainer team on the basis of the skills and knowledge required to adapt and conduct the modules. The team was multi-disciplinary. We assigned the adaptation of each module a different trainer.

The training team conducted a number of meetings (face to face and via skype) ahead of the pilot training in order to agree on the training flow, timetable, sequentially of modules and to ensure the content of the entire training was coherent in the terms and concepts proposed. Specific attention was also devoted in allocation of time to each module and to reducing overlaps between modules.

Time allocation was mostly kept unvaried with the exception of a slight shortening to the time allotted to Module 2 and a slight increase to time dedicated to module 3. The choice was dictated on one side by the subject-matter expertise of the target audience that covered some aspects under module 2. For this reason the additional material under this module was synthesized in this adaptation. On the other the training team agreed that in order to address the quantity of concepts included in module 3 more time should be allocated.

The sequentially of modules was also slightly altered. In particular module 2 was switched after module 1 and 3 and before module 4. The main reasons were to avoid breaking module 1 and 3 that were very complementary and to link the discussion of health determinants and

barriers, present in module 2, with the discussion on the strategies to overcome barriers present in module 4.

The adaptation process overall worked well and did not present any problem. The only obstacle identified by the training team was the short time available to address such a great variety of contents. Across all modules it was necessary to synthesize, select and/or reduce the number of slides and activities to address this constraint.

The specific adaptations made to each module are presented in the following paragraphs:

Module 1

Adaptation of Module 1 consisted in: (1) reduction of the number of slides (for the purpose of presentation); (2) exclusive use of mandatory activities; (3) substitution of some terms in order to give consistency to the material presented in other modules; (4) switch to module 3 of the issue of intercultural dialogue; 5) switch to module 2 of the methodology of the activity proposed on the barriers to intersectionality; 6) simplification of the slides on prejudice and on the normative framework, deemed necessary in order to ground the issues in terms as practical as possible for the trainees.

During the presentation, in order to give a practical idea of the clinical relevance of the core content it was necessary to give concrete examples to the trainees. It may be suggested to reframe some part of the content in order to show the clinical relevance of cultural processes.

Module 2

The module 2 and all additional modules were integrated and conducted the afternoon of day 2 (from 2:15 pm to 6:00 pm including a 15’’ coffee break).

The module started with a description of the populations of migrants and ethnic minorities in Europe and in Italy. The original material included Module 2 Unit 1 and all additional modules 1. Local adaptation consisted in the revision and synthesis of the original materials and in the inclusion, where available, of official data on the demographics of migrants by status in Italy, on the demographics of Roma Sinti populations in Italy and on relevant data trends. Specific attention was given to the issue of migration surges from the central Mediterranean migration route that is a very current and important issue in Italy where many of the participants were actively engaged.

Following this, health determinants and health issues among migrants and ethnic minorities were addressed. The original material for this section included Module 2 Unit 1 and all additional module 2. Adaptation to the local context consisted in the revision and synthesis of the original materials and in the integration of Italian data on socio-economic inequalities among migrants and ethnic minorities and of epidemiological data on all addressed health conditions among migrant populations in Italy (disaggregated health data on ethnic minorities was not available).

The concepts were introduced with a brainstorming exercise among participants. Due to lack of time it was not possible to show the translated Module 2 Unit 1 and all additional brainstorming exercise among participants.

Following this, the focus was on access barriers to health services. Participants were divided into 6 groups of 5-6 people each. Each group was asked to identify max 5 barriers to accessing healthcare they know migrants/ethnic minorities experience in their working context. Each barrier was written on a separate post it. Then the participants split for coffee break. During the break the facilitators set up a wall poster and classified the identified barriers according to the categories presented in module 2 unit 1. When the participants reconvened, they prioritized barrier categories. Each participant had 5 stickers and s of 5-6 people each. Each group was asked to identify max 5 barriers to accessing healthcare. This activity substituted the vision of the video "*percorsi salutari*".

After this, the discussion verged on barriers to accessing health care. Original material for this section was module 2 unit 2. Local adaptation included the drawing of diagrams of barrier categories and the inclusion of an analysis of the current legal framework entitling migrants' access to health care in Italy. Finally the main barriers identified by participants were discussed in relation to the Italian context and the following module 4, concerning strategies to overcome these barriers was introduced.

Module 3

Adaptation of Module 3 and Module 4 (slides 6-18) consisted in: (1) simplification of the content of all slides (for purpose of presentation); (2) exclusive use of the mandatory activities (as they were very numerous); (3) substitution of the content of some of these activities; (4) substitution of the content of a few slides.

Additional or substituted contents:

Module 3, Unit 1

- Activity 1: adaptation of the second version of the activity (using the original version provided by the Italian team).
- Activity 4 (presented as activity 3 in the pilot): substitution of the proposed activity with an alternative activity on real-life transcribed interactions between midwives and migrant patients (methodology: group analysis, presentation by the groups and general discussion).
-

Module 3, Unit 2

- Activity 2 (presented as activity 1 in the pilot): substitution of the proposed activity with an activity on a real-life transcribed nurse-patient interaction (methodology: group analysis, presentation by the groups and general discussion).
- Additional slide on the concept of communication (following the activity)
- Activity 7 and activity 8 (presented as activity 4 in the pilot): adaptation of activity 7 on negotiation, including conflict management in it.

Additional materials in Module 3 (unit 2):

- Inclusion of the sequence of slides concerning interpreting and mediation, after the slide on facilitation of communication (from module 4, unit 2).
- Adaptation of these slides to the Italian specific case of linguistic and cultural mediation: inclusion of additional content on the relationship between interpreting (or language mediation) and intercultural mediation, with examples from transcriptions of real-life transcribed interactions.

Module 4

Adaptation of Module 4 consisted in: (1) simplification of the content of some slides; (2) exclusive use of the mandatory activities; (3) substitution of the content of a few slides; (4) inclusion of additional contents; (5) introduction of changes in the chronological order of units: 1, 2, 4, 3, 6, 5.

Unit 1: In order to improve the understanding of the changes needed at system level some topics have been added:

- A focus on changes concerning both the migration process and welfare policies.
- A focus on how these changes have determined a new definition of diversity and responsive policy measures.
- A focus on the ecology of the health system and how the concept of persons centred care should be implemented at the whole system level.
- Finally among the various related frameworks to People-Centred Health Care Oriented towards Diversity the frame work of Equity was added.

Unit 2: A number of examples of programmes and projects developed at local level were introduced to show the operationalization of the EU strategies presented in the unit (e.g.: anti-discrimination plans; cultural mediation services; projects to foster participation, information and health literacy strategies, etc.)

Unit 3: It was switched after Unit 4 and before Unit 6. The HIV example was replaced in the local adaptation with a project developed in the region of Emilia Romagna. It focused on inequalities of access to screening and on health promotion strategies oriented towards migrant population.

Unit 4: This unit focused on the issue of Equity, as a criteria for measuring health care quality and responsiveness. Particular focus was on the *"Standards for equity in health care"* developed by the *Task Force on Migrant-Friendly Hospitals*.

Unit 5: Community Projects for Health Prevention and Reduction of Health Disparities was replaced in the local adaptation by examples based on projects conducted in the Emilia Romagna region. Through a community approach, these projects introduced figures of mediation among individuals, communities, health and social services (e.g. "Agenti di salute; Community Health Educators) in health community centres; psychiatric and social services; prevention and health promotion services and prisons.

Therefore videos were not shown. Participants were encouraged to view them by accessing the course materials.

Some theoretical contents were integrated in order to promote a critical reflection on the issues of ‘involvement’, ‘participation’ and ‘power relations’. Activity 4 closed the whole training pilot and worked very well.

Unit 6: No changes were made to this unit, however it was moved after Unit 3 and before Unit 5.

Poland

The adaptation was focused on searching the statistical, demographical and epidemiological data on MEM groups in Poland, their health status etc., also the legal status, legal acts, human rights regulations in Poland. So this was mostly module 2, units 1 and 2, with all additional module. Additionally, in module 3 and 4, we used examples from Poland (ex. For the part about community participation). We included some Polish video as an example of health mediation for female patient from Asia giving birth in Polish hospital, as well as some discussions on Polish cases like 1) lack of health mediation/interpretation in relation to patient rights in Poland, 2) examples of good practices related to MEM situation.

In the final version, we will include also a video found by our participants.

The other type of adaptation was starting the introduction to the training using the quite exotic language (Turkish, just 2 minutes welcome) – just to give to the participants the impression how difficult is the situation of someone participating in something he/she does not understand at all. We think that this type of “activity” is not obligatory but we found it contributing to the content.

Difficulties: the adaptation process required many changes in presentations during translation due to the fact, that sometimes on the presentation were not included the most important things from guidelines. Some errors in English language make the translation process difficult (even for professional translator we asked for the translations) – sometimes they reported that they should probably understand Spanish to have better understanding of some sentences.

Video searching: there is very few materials in Polish we could use (or participants could find).

Romania

We had to adapt especially the first part, to focus mainly on the Roma people. We have invited as trainer and training material developer a Roma sociologist, with PhD in Roma history. She gave 2 extremely interesting presentations on Roma tribes (based on occupation) with their traditions and habits, and other one on stereotypes related to Roma people.

There were also 2 nice exercises proposed for these 2 introductory sessions.

The rest of the training materials, especially those including statistics about Roma health and socio-economic determinants of health, were adapted with data from studies done in Romania.

The final exercise was a summary one, each district was assigned with a problem (e.g. mother health, child health, NCDs, TB etc.). They had to address 2-3 determinants of health related to that problem, the most frequent disease/problems encountered, the main actors involved in addressing the problem and the proposed plan aiming to improve the problems.

Adaptation was a bit time-consuming, but very successful for the participants.

Slovakia

We used all core contents (program as it was sent to us) translated to national language and we did exercise and discussions focused on local examples from participant´s daily experience.

We have mostly focused on discussions among participants, providing examples of good practices and we did not use role playing often, because they were more time consuming. The learning experience was better when the participants shared their views from their practice and could discuss them with their colleagues.

Spain

- The team of trainers selected by the Leader Institution adapted and translated the core contents.
- Many contents were reorganized and activities were altered in some aspects to better reflect every audience and invite their participation.
- Contents from Modules 1 and 3 remained mainly unaltered, although activities were adapted to include practical cases in local context.
- Module 2, Additional Module 2 and Module 4 were mostly adapted to include country-specific data (migrant and ethnic minorities demography, disease patterns, health determinants, access to health services, local programmes and community projects)
- Content from Additional Module 1 was inserted in others when relevant to the local context.

4.1.2.2. Piloting process

4.1.2.2.1. Organization of the training sessions

How would you assess the organization of the training sessions in regard to time distribution, venue, and organizational aspects? Did you experience any obstacles or difficulties?

Summary:

Country	Organisation of training sessions	Dates
Denmark	3 whole days (7+7+6 hours)	March 12, March 26 and April 9,

		2015
Italy	3 consecutive days according to the proposed agenda in April 2015	April 27 – 29, 2015
Poland	3 consecutive days according to the proposed agenda in April 2015	April 24 – 26, 2015
Romania	3 consecutive days according to the proposed agenda in May 2015	May 25 – 27, 2015
Slovakia	3 consecutive days according to the proposed agenda in May 2015	May 18 – 20, 2015
Spain	3 consecutive days according to the proposed agenda in May 2015	May 7 – 9, 2015

Table 11. Piloting process

Detailed answers:

Denmark

In Denmark, the training pilot was conducted in March – April (according to the original project timetable). As the completion of the report and the elaboration of course materials were delayed, we were left with little time to prepare the pilot. Thus, we had approx. one week after receiving the material, to translate it and adapt it. This was probably the main obstacle with regards to planning.

We chose to organize the course as three whole days (7+7+6 hours). This, because we thought it would be easier for the participants to reserve three whole days than four half days.

We chose a classroom venue with tables set up in such a way that students were facing each other, thus facilitating discussion and group work. The same venue was used for each course day to encourage a sense of continuity. Students seemed pleased with the facilities and expressed satisfaction regarding the food and beverages served throughout the three days.

Italy

The venue for training was a Hotel near the railway station in Bologna. This location was chosen in order to facilitate access and provide for accommodation for participants arriving from various parts of Italy.

The choice of the venue proved to be successful. The organisation and the time distribution among the modules worked well. No difficulties or obstacles for these aspects.

The only real issue we found, was not related to the organisation of the pilot, but to the mentioned relationship between time, contents and activities of the modules (see below for problems about time).

Poland

Our team assessed the organisation of the training very well. Actually, time distribution was a challenge – even if we made a choice of subjects (as suggested in some units) and a choice of activities, it was difficult to have time for all we choose. Anyway, we did it, but with a feeling that almost each of the subjects was worth of deeper analysis and discussions with our participants. Another thing was that such course could be divided into 4 days as well. Of course for professional who do not wish to loos too many working days such concentration of work into 3 days is very good.

Physicians, nurses and midwife participating in the training received educational points. Emergency professionals did not because there was no any official examination (there is a separate regulations on this issue in Poland). All participants received two types of certifications:

- The certification of participating in the MEM-TP project
- The diploma issued by the Medical Center for Continuing Medicine.

Romania

Training sessions were well planned in time, all of them were adequately covered, giving space enough for discussions and experience sharing.

However, maybe a shorter program (fewer topics) would be better covered in time, giving more space for more practical exercises and experience sharing. We believe that this curriculum can be used for several short training courses.

Venue was the training centre room of the NIPH, properly equipped for training sessions.

Only obstacle was the short time left for preparing the public procurement for the event organisation (travel and accommodation of participants), but we eventually succeeded.

Slovakia

The time distribution was in accordance with the suggested programme. We had no problems with securing an appropriate venue and; we have booked a classroom that allowed for both, plenary sessions and group work; the classrooms were equipped with presentation and learning tools (beamer, flipcharts etc.) and access to computers with internet access was provided during the whole meeting.

There were no obstacles and difficulties with the organizational part; as a university we have the staff, premises and experience to organize similar events.

Spain

Organization of the training sessions in Spain took place in May 2015 in three consecutive days according to the proposed agenda.

4.1.2.2.2. Methodology of the training sessions

How would you assess the training sessions in regard to length, time distribution between presentations and activities, and appropriateness of the methodologies? Did you experience any obstacles or difficulties? Which aspects would you change?

Summary

Methodology of the training sessions
• Due to the extension and complexity of the training materials, a selection of the most relevant contents was carried out, according to context-specific priorities. • The coordinators suggest the distribution of the contents in several training courses. • Length of the training sessions was adapted to the local context (breaks, lunch time…) • Time distribution between activities and presentations was affected by the focus on the topics that a country's trainees were less familiar with. Due to the extension of the training materials, a selection of the most relevant contents was conducted, according to context-specific priorities. • Activities and practical experience sharing were very well appreciated, occasionally taking a bit longer than planned in the agenda.

Table 12. Methodology of the training sessions

Detailed answers

Denmark

Length of the training sessions was adapted to a Danish context. We removed some content and added other. In general, we had a break every 45 min.

Time distribution between activities and presentations was OK. We did not include all the activities, nor all the slides in every presentation as there simply wasn't enough time, and as some of the activities or slides did not seem necessary (to avoid repetition). In general, there were 1-2 activities per 45 min.

Also, as mentioned above, the overall level of knowledge and understanding of some of the topics among the group of students was quite high, and therefore some of the material had to be skimmed in order to move on to topics that were less familiar.

A major benefit of adapting training materials before and during delivery lies in the fact that the learning needs of the audience can be met, once the trainer develops a better sense of the overall level of the students.

Italy

Time was insufficient for the quality and quantity of contents that had to be delivered. The obstacle is the disproportion between quantity and quality of contents on the one hand and time on the other. This risks an information overload that could reduce the impact of training.

Since the trainees are health professionals, it takes time to discuss concepts that are new and delicate such as those introduced particularly in modules 1 and 3.

It was not possible to discuss the topics in any depth and to show all videos. Notwithstanding, time was allocated for explanations in order to clarify some important points.

It may be suggested that the modules require more time than provided according to the manual in order to fully exploit all the training materials and to allow enough time for further explanations/ to answer the participants' questions.

Two possible changes may be suggested:
1. Allow more time for the training. Our suggestion is to re-balance the relationship between presentations and activities in terms of 60% - 40%, in order to have enough time to go in depth on crucial core elements;
2. Select more restrictively the training's core contents keeping the same allotted time.

Poland

Too little time for such a large material!

Time distribution between presentations and activities is very good: more or less 50%-50%. Tis allows people to be really involved in the subjects, is more attractive than only presentations. Also different kinds of activities are very good practice.

Romania

Time distribution between the presentations and exercises/discussions was ok, but a bit too many topics to be covered in a short time (3 days).

Also, the daily program was a bit long and tiring.

Exercises and practical experience sharing was very well appreciated, consequently taking a bit longer than planned in the agenda.

We would propose several short trainings (2-3 days) for the curriculum proposed.

Slovakia

The content was very interesting and important and generated a lot of interesting discussions. However, some parts were rather academic and not quite suitable for the audience (professionals used to practice rather than academic debates and discussions). We feel that the time distribution and the length of the training sessions were appropriate. Some activities (especially discussion or brainstorming sessions) were popular with the participants and perhaps more time could be allocated to them. As we said, three days of training in a row poses a problem and prevents some professionals from attending. If the workshop was to be divided in shorter sessions distributed throughout the year (perhaps as part of the continuous education of professionals) it could yield higher interest.

No further specific obstacles or difficulties in this respect.

Spain

- Length of the training sessions was adapted to the local context (breaks, lunch time…).
- Time distribution between activities and presentations was affected by the focus on the topics that were less familiar for the trainees.
- Activities and practical experience sharing was very well appreciated, occasionally taking a bit longer than planned in the agenda.
- Participants and trainers considered too many topics to be covered in a short time (3 days).

4.1.2.2.3. Training materials

How would you assess the training materials in regard to relevance and adequacy of the contents, length, clarity and understanding, consistency with the objectives, and design? Did you experience any obstacles or difficulties? Which aspects would you change?

Summary

Training materials
• Content was found relevant and generated a lot of interesting discussions. However, some parts were not suitable in all national contexts. This depended on the trainees' previous knowledge. • Many original slides were found to include too much content. It took time to reduce the number and simplify them. • The orientation of the training contents was considered as being too theoretical. The inclusion of more practical aspects and Good Practices examples was proposed, as well as the limitation of the contents to a selection of relevant topics. • Training teams had to adapt training materials during piloting to meet the learning needs of the audience, following the trainer having developed a better sense of the overall level of the participants. • Some contents were oriented to health services management; participants asked for tools to help them take back to their organisation the knowledge and tools acquired in the

training, and to integrate these into the aims/vision and daily practices of the organisation.

Table 13. Training materials

Detailed answers

Denmark

Same as previous answer.

Additionally, students expressed an interest in the topic of how to bring about organisational change with regard to diversity sensitivity. They asked for tools on how to take back to their organisations the knowledge and tools acquired in the training, and integrate these into the organisation's aims/vision and daily practices

Perhaps a module on the topic of how to bring about organisational change coupled with more hard-core evidence on patient safety and financial arguments for improving diversity sensitivity and cultural competence at the organisational level would be relevant.

Italy

All the materials provided are relevant and consistent with the objectives. However, as mentioned, their quantity is a serious obstacle given the allotted time. It took some work to reduce slides and activities in order to make the pilot feasible while ensuring that all topics were addressed coherently and with adequate clarity.

There were also some problems in the design of the original slides, as they include too much content. There were too many slides and several were too densely written. This we found could compromise timing and content clarity.

It took some work to reduce the number of slides and simplify them (e.g. through diagrams/bullet points etc.). Sometimes we were also obliged to distribute the contents of one slide in more slides, to better describe and explain them. In addition, as part of the local adaptation, data on Italy and nationally relevant concepts needed to be integrated (e.g. Module 2, Module 3, Module 4).

Poland

The training materials “touch” many different areas and problems, but very cursorily and briefly. To achieve good effects of training it would be useful to limit a number of subjects, but to do it much deeper. Sometimes the materials were not clear and after recourse to the source it turned out, that this subject could be understand in a little different way.

The other question is the recruitment of trainers. Of course they should be familiar with health area but finally we had to invite trainers directly from sociology for example. Without this – yes, 3 trainers who participated in the ToT could do it but not being sociologists – well, we found that it looks better if we invite a sociologist and also if the participants have specific

questions it will be much better for the total look of the training if they receive a proper answer from a real sociologist.

So maybe for the future it would be good to specify the specialties who should be in the team not generally “related with health/public health” but to suggest to choose sociologist/psychologist/political scientist (we repeat: of course our public health team could do this but we found it better if we invite specialists).

Romania

Training materials were fine (especially the Readings) after the adaptation. A memory stick with all adapted presentations were distributed to the participants, together with all printed materials translated in Romanian language, as they were designed by EASP.

Slovakia

Materials were very important in content, but much more suitable for academic sphere.

We felt, that our participants were lost sometimes in theories and facts. They would need more practical issues – examples of good practices, how to deal with diversity in health care. Many issues are given by the system itself and our participants don’t have the possibilities to change the situation (financing of the health care system, need of interpreters, or mediation in health care in Slovakia due to small number of migrants).

This course could be also oriented on health care services management.

Health professionals – they need more facts about concrete cultural signs at individual level
Health care management – they are target group for system changes.

Spain

- Content was found relevant and generated a lot of interesting discussions. However, pending on the audience’s previous knowledge, some parts were not suitable in all national context.
- Many original slides include too much content and it took time to reduce the number and simplify them.
- Training team had to adapt training materials during delivery to meet the learning needs of the audience, once the trainer develops a better sense of the overall level of the participants.
- Some contents were oriented on health care services management and participants asked for tools on how to take back to their organisations the knowledge and tools acquired in the training, and integrate these into the organisation's aims/vision and daily practices.

4.1.2.2.4. Training activities

How would you assess the training activities in regard to appropriateness of the methodologies, length, clarity and understanding, and consistency with the objectives? Did you experience any obstacles or difficulties? Which aspects would you change?

Summary

Training activities
• Depending on the national context, the standardised skills activities did not fit the learning needs of all health professionals, as these differed according to type of role and years of experience. • The adaptation of the local context to the local context is considered relevant. • The methodology allowed participants to be very active and share perspectives and experiences. • Activities based on real-life materials (such as participants' narratives about their experiences or discussion of real-life transcribed interactions) made it possible to deal with the full complexity of situations which the trainees may face.

Table 14. Training activities

Detailed answers

Denmark

Some of the activities tended to focus too much on stereotypes.

In a Danish context, the skills activities were a little too basic. While learning communication skills is a life-long process, perhaps a more advanced level of training activities in this area would be more appropriate. The learning needs of health professionals differ according to type of role and years of experience. Adapting to local and professional contexts is therefore key to the successful uptake of the training. Maybe it is an impossible task to design a standardized training program that encompasses the needs of health professionals throughout EU, but a more flexible approach could be developed?

Italy

The participative approach adopted for the training proved to be a successful methodology, ensuring involvement and active participation from all trainees.

The activities worked well but they were too many. Priority was given to the mandatory activities. For lack of time it was not possible to show all videos.

During the presentations, in order to give a practical idea of the clinical relevance of the core contents we found it necessary to provide concrete examples to the trainees.

Some activities have been changed starting from the principle that working with real-life materials is better than using abstract examples (e.g. Module 3). Activities based on real-life materials (such as participants' narratives about their experiences, or discussion of real-life transcribed interactions) allow to deal with the full complexity of situations in which the trainees can be involved. The use of abstract activities and examples can create, rather than

reduce stereotyped interpretations of situations and cases. The appropriateness of activities depends on their relation to the trainees' professional trainees' professional "lifeworld".

As reported above, the vision of the video T-Share "percorsi salutari" (Module 2) was substituted in the local adaptation with an interactive identification and prioritization exercise on access barriers to health services whose methodology was "borrowed" from an activity originally proposed in module 1.

No particular difficulty or obstacles were observed neither in adapting the activities, nor in conducting those that were maintained unchanged.

Poland
As we said, it is good that MEM-TP proposes different kinds of activities.

Some texts in activities are unclear – like the text about psychiatric problems in US during 30 years. Participants had problem with activity related to intersectionality – the results of the activity were numerous but it was not exactly what they had to do (but generally there were not very familiar to "intersectionality").

Romania
Activities were the most appreciated by participants, as almost all of them are practicians and were ready to learn practical experiences from others.

Slovakia
Training activities in regard to appropriateness of methodologies was very well designed, our participants were very active and they discussed a lot.

Different health professions were inspiriting each other with their own perspectives and experiences.

There were no special obstacles and difficulties within the clarity.

Spain
- The methodology allowed participants to be very active and share perspectives and experiences.
- Activities based on real-life materials (such as participants' narratives about their experiences, or discussion of real-life transcribed interactions) allow to deal with the full complexity of situations in which the trainees can be involved.

4.1.2.2.5. Evaluation methodology

How would you assess the evaluation methodology? Did you experience any obstacles or difficulties? Which aspects would you change?

Summary

Evaluation methodology
• The evaluation plan is considered appropriate, but faced several challenges in execution. • There were some doubts regarding the focus of the assessment (on the original contents or the adaptation), as well the function of the pre-test / post-test methodology. • The assessment tools were not used adequately by all six countries due to different circumstances (online format, *lime survey* platform, availability of accurate participant data, lack of information to participants, number and length of questionnaires). • Centralised management of the four online evaluation questionnaires generated additional difficulties due to the use of six languages and the number of participants involved.

Table 15. Evaluation methodology

Detailed answers

Denmark

Due to various reasons, the online evaluations forms were not made available to students until one + weeks after the training was concluded. Ideally, the evaluations could have been conducted the same day or shortly after.

We are still awaiting the completed evaluations of a number of students and we will encourage once more the non-respondents to improve the response rate.

Italy

The evaluation methodology for the administration of pre-test and post-test, and for the evaluation of materials is fine. However, we identified two issues.

The first concerns the **evaluation of presentations and trainers**. As the training was mainly designed and prepared by the Granada team, it is not clear to what extent the evaluation can also assess the local trainers' presentation and methodology.

We think that it should be more clearly stated that trainers should be evaluated for their "performance"/local adaptation and not for the content of it.

We feel there might be a lack of clarity on whether the participants assess the MEM TP training or its adaptation.

We are also uncertain whether in principle the trainers should be assessed in this way, given the constraints posed to adaptation of materials prepared by others. This is an issue to consider, as for the trainees it is not so easy to separate the two aspects of the training process.

The second problem concerns the meaning of the pre-test, which was presented as concerning the trainees' "needs". Conversely, we understand this pre-test has the function of testing the adequacy of the contents of the pilot, rather than the general needs of the trainees. This

interpretation seems confirmed by the “last minute” administration of the pre-test, which was obviously not useful for any possible modification of the pilot, following the trainees’ needs. Testing trainees’ needs would mean fixing a starting point for the construction of a training.

Poland

It was practically impossible to organise online pre-questionnaire. We would need to have a room with 31 computers – or to invite participants with their own laptops (but in this case that would be a risk that instead of paying attention to presentations/activities they would be in the social networks...). If it is organised by sending emails t participants prior to the training – maybe this would be a good idea, of course we cannot be sure that they would like to open the link and do this “homework”.

Having some feedback from some participants – they were glad to have emails/evaluation instructions in Polish.

Romania

Evaluation was a bit too lengthy and a bit confusing with the use of the electronic platform.

A shorter evaluation form would be much more appreciated.

Slovakia

The evaluation methodology was very well prepared.

What is a big problem is the feedback response from our respondents, due the fact that all questionnaires were anonymous, we don’t have really too much power to stimulate and control them if they answered the questionnaires (Personal links).

We would like to recommend to add to the evaluation a qualitative part, for example informal interview, talks with participants during the sessions etc.

Spain

- The evaluation plan is considered appropriated but faces several challenges when developing it.
- The assessment tools were not all used adequately because of the number and length of questionnaires. The pre-test was not available before the training and participants filled in it just before the course started. Not all participants filled in all questionnaires.
- Centralised management of the four online questionnaires used to evaluate has generated additional difficulties to follow up the filling in.

4.1.2.3. Findings, lessons learnt and recommendations

4.1.2.3.1. Most important findings and lessons learnt

Which are the most important findings and lessons learnt from the training?

Summary

Most important findings and lessons learnt
• Health professionals in the EU countries can have very different educational profiles and experiences. Adapting to local and professional contexts is key to the successful uptake of the training. It may be possible to design a training program with a more flexible approach to encompass the needs of health professionals throughout EU. Such a design should leave room for extensive adaptations in the local training material and set-up of the courses.
• The heterogeneity of the trainees adds diversity and brings different perspectives into the classroom. It also makes it more difficult to target the needs of participants as regards their professional backgrounds.
• Three consecutive days of training poses a problem for the health services involved and prevents some professionals from attending.
• A broader coverage to ensure that health professionals with little knowledge on / interest in the topic are also trained requires a management decision on the relevant levels of health services to facilitate their participation.
• It may be useful to design two different levels of the training package, one for "ab initio" trainees and the other for "more expert trainees".
• Training time was insufficient for the quality and quantity of content that had to be delivered. The risk of an information overload can reduce the impact of training. Modules require more time than provided to fully exploit all the training materials and to allow enough time for further explanation and answering the participants' questions. There should be always enough time for participant discussions and sharing experiences.
• There is a need to involve not only health professionals, but also managers and decision makers.
• The successful involvement of the trainees shows both the trainees' interest in learning and the quality of the training materials, methodology and presentations. The pilot was very useful to test the trainees' interests, to provide rich information for them, and to enhance collective work and discussions.
• The multidisciplinary composition of the training teams had a positive effect on the individual trainers and on the trainees. It opened up views to different perspectives and understandings on health and healthcare for migrants and ethnic minorities.
• A new module would be relevant on bringing about organisational change, coupled with more hard evidence on patient safety and financial arguments for improving diversity sensitivity and cultural competence at the organisational level.
• Evaluation tools should be simplified and include an additional qualitative part.

Table 16. Most important findings and lessons learnt

Detailed answers:

Denmark

It is a difficult task to design a teaching programme which meet the needs of health professionals (HP) in different countries of the EU.

HPs have very different educational profiles and experiences in the EU. Moreover, one can discuss whether training should be aimed at one particular group (e.g. nurses), or if it is beneficial with this mix of professional backgrounds. On the one hand the heterogeneity adds diversity and brings different perspectives into the classroom. On the other hand, it is more

difficult to target the needs of participants when they are this heterogeneous as regards professional backgrounds.

Another challenge lies in how to target and encourage the participation of HPs who have little to no exposure to or interest in the field of migrant health and diversity sensitivity. In our experience, those who attended the training were HP with an interest in and dedication to improving health services encounters with migrants. As such, the training is a bit like "preaching to the choir." A broader coverage probably requires a management decision on the relevant levels of health services and probably local settings in order to facilitate participation.

Italy

The pilot went very well as far as we are concerned, and the trainees' enthusiasm confirms our impression.

However few suggestions can be made:

1) **Time was not proportioned to the quantity and quality of contents** that were provided. Trainees might have liked to focus a bit longer on certain topics but the schedule was too tight. We think that too much content does not help the learning process and that in future editions the training materials should be further selected (as we did in the local adaptation). The participants did not have sufficient time to reflect on the different modules during the training. This lack of immediate reflection cannot be fully compensated by homework. It may be suggested to provide a more proportioned relation between time and contents, reducing the contents, or increasing time for training and for more accurate group and personal reflection.

2) The **provided materials sometimes proved to be redundant and the fluidity of contents' presentation not always ensured**. The Italian team decided to change the order of modules (i.e.: MOD.1; 3; 2; 4) and in some cases the order of units within modules (e.g.: MOD.4 Unit. 1,2,4,3,6,5), in order to reduce repetitions within and between modules and to provide a better sequence of contents. It may be suggested that local adaptations can be used as an opportunity to create variety in the training rather than trying to standardise it.

3) One important result is the **successful involvement of the trainees**, which shows both the trainees' interest in learning and the quality of training materials, methodology and presentations. The pilot was very useful to test the trainees' interests, to provide rich information for them, and to enhance collective work and discussions.

4) Another positive result was to have a **multi-professional audience coming from various regional health services and with different professional profiles** This proved to be an important and effective aspect during the pilot, as in many occasions participants were clearly interested in finding out what colleagues elsewhere were doing in relationship to the topics discussed. This opportunity to exchange, share and network across different regions is of particular relevance in Italy given the mentioned

decentralization of the Public Health System. We think this aspect could be further strengthened and considered among the main aims of the training programme.

5) Finally, we considered an added value to the pilot as a whole **the multi disciplinary composition of the training team** (anthropologists; sociologists; public health experts; medical doctors). We established an effective team of complementary experts from different disciplines and with different interests. This type of inter-disciplinary integration had a positive effect on the individual trainers, opening up views to different perspectives and understandings on health and healthcare for migrants.

Poland

There should be always enough time intended for discussions – for health professionals who have many problems with migrants and minorities in their work the discussion and sharing the experiences are sometimes much more important than theory.

Romania

It is rather difficult to use the same curricula for migrants (even for different migrants) and for Roma population (even for different types of tribes). They should be properly adapted for each population group.

It should be decided id this curricula is designed for a Master type course or for continuous education, because they differ in approach.

An inventory of exercises and experiences from each country would be of great value for the future trainings.

Slovakia

1. Three days workshop is too long for health professionals under the conditions of our country.
2. The topic is very important, and becoming more and more necessary also in Slovakia (so far we still are not one of the ultimate target countries for migrants).
3. Less theoretical presentations, more practical activities, especially discussions and sharing of experience and views.
4. Recommendation: use problem based learning as a method (although it requires some training on the side of the trainers as well).
5. It is a good idea to have different health professionals in one room, because they are learning from each other and they can understand different perspectives – (they have professional continual education separately from each other).

Spain

- Adapting to local and professional contexts is key to the successful uptake of the training. It may be suitable to design a training program with a more flexible approach to encompass the needs of health professionals in every local context. Therefore,

there must be room for extensive adaptations in the local training material and set-up of the courses.

- The heterogeneity of the trainees adds diversity and brings different perspectives into the classroom. But it also makes more difficult to target the needs of participants as regards professional backgrounds.
- Three days of training in a row poses a problem for the services involved and prevents some professionals from attending.
- A broader coverage, to guarantee those HP with little interest on this field are trained, probably requires a management decision on the relevant levels of health services and probably local settings in order to facilitate participation.
- Time was insufficient for the quality and quantity of contents that had to be delivered. This risks an information overload that could reduce the impact of training. Modules require more time than provided to allow enough time for participants' discussions and sharing experiences.
- There is a need to involve not only HP, but also managers and decision makers.
- The successful involvement of the trainees shows both the trainees' interest in learning and the quality of training materials, methodology and presentations. The pilot was very useful to test the trainees' interests, to provide rich information for them, and to enhance collective work and discussions.
- The multidisciplinary composition of the training teams had a positive effect on the individual trainers and on the trainees, opening up views to different perspectives and understandings on health and healthcare for migrants and ethnic minorities.
- Evaluation tools should be simplified and include an additional qualitative part.

4.1.2.3.2. Recommendations

Which are your recommendations for the review of the training package and future trainings?

Summary

Recommendations
• To adapt the training contents to the local context and specific needs of the health professionals. • To find a balance regarding the heterogeneity / homogeneity of trainees, according to the country-specific priorities. • To organize a time schedule that fits with the working commitments of the attending professionals. • To promote the participation of health professionals with a low level of previous knowledge on / interest in the topic. • To design two different levels of the training package, one for "ab initio" trainees and the other for "more expert trainees". • To select the contents, in order to avoid an information overload and give time for participant discussions and sharing experiences. • To involve not only health professionals, but also managers and decision makers. • To build up training teams with multidisciplinary composition. • To include a new module on organisational change, coupled with evidence on patient safety and financial arguments for improving diversity sensitivity and cultural competence on an organisational level.

• To simplify the evaluation tools, including a qualitative part.

Table 17. Recommendations

Detailed answers

Denmark

The needs and educational backgrounds of health professionals in different EU countries are very different. Therefore, there must be room for extensive adaptations in the local training material and set-up of the courses.

An additional module on initiating organisational change would also be relevant according to feedback from the students who attended the Denmark pilot.

Italy

Optimization of activities and content in relation to time (see above).

- The time proved to be not sufficient to tackle all contents in a fruitful way. One suggestion for improvement could be to expand the number of days from three to four (6 hours per day) and to present one module per day in two different weeks (2 modules in the 1st week and 2 modules in the 2nd week).
- A second suggestion is to create two differentiated level of the training package, one for “ab initio” trainees and the other for “more expert trainees”.

Poland

Less subjects, but more deeply.

Trying to invite participants from different professions – as the goal is to improve the whole system.

Including something extra: during the Saturday dinner we organised the show of... flamenco. We found it will be interesting because of Granada and another cultures participation in the project. In the end of this show the dancers proposed to participants the very short lesson of basic flamenco step/figures, no more than half an hour. And it was a very good idea – not only because of physical activity but it was good for creating the real group. And for fun!

Romania

Several trainings based on this curriculum.

Less conceptual, more practical if used for professional development.

Slovakia

There is a big need for this kind of training packages in Slovakia, despite low number of migrants in Slovakia.

Slovakia is a country full of stereotypes, and less sensitive to diversity.

There is a big need to start discussions with professional bodies in Slovakia how to incorporate health of migrant topic to the pre-gradual and post-gradual medical or other health education.

There is a need to involve not only health professionals, but also other as for example managers and decision makers.

Spain

- Adaptation of the learning materials to the local and professional contexts is proposed, encompassing the needs of health professionals.
- Thee need for an adequate balance regarding the heterogeneity / homogeneity of the professional profiles is highlighted.
- The coordinators propose an adaptation of the schedule to the time availability of the health professionals.
- The relevance of promoting participation of HP with a low level of previous knowledge / interest in the topic is stressed.
- The need for an adequate selection of the materials is mentioned, avoiding an information overload and facilitating time for discussion and experience sharing.
- The involvement of managers and decision makers, not only health professionals, is proposed.
- The importance of a multidisciplinary composition of the training teams is highlighted, in order to open up different views on health care for migrants and ethnic minorities.
- The coordinators propose a simplification of evaluation tools, including an additional qualitative part.

4.2. Evaluation of the professional profile an training needs

The participants from Italy, Poland, Romania, Slovakia and Spain completed the questionnaires available in Annex III-V. For the evaluation, the results of the core contents in each module were explored, as an example of the pre-/post-training needs.

4.2.1. Pre-Test: Professional and demographic profile / training needs questionnaire

Professional profiles (basic training and current occupation) of the participants in the Pre-Test questionnaire (Annex III) are shown in the following table:

Basic Training	Current Occupation	Denmark	Italy	Poland	Romania	Slovakia	Spain	Subtotal	Total
Dietician	Dietician	1						**1**	**1**
Engineer	Analyst				1			**1**	**1**
Jurist	Jurist				2			**2**	**2**
Medical Assistant	Economist				1			**1**	
	Inspector				3			**3**	
	Medical Practitioner				8			**8**	
	Medical Assistant				2			**2**	**14**
Medical Doctor	Dentist			1				**1**	
	Emergencies						1	**1**	
	Epidemiologist				2			**2**	
	Gynaecology and Obstetrics			5				**5**	
	Hygiene and Public Health		1					**1**	
	Infectious diseases		1					**1**	
	Inspector				1			**1**	
	Medical Practitioner			2	8	1	11	**22**	
	Neonatology			1				**1**	
	Pediatric					1	3	**4**	
	Psychiatry		1	2			1	**4**	
	Public Health	1				1		**2**	
	Surgery			2				**2**	
	Medical Doctor	11	6	4	1	3	2	**27**	**74**
Nursing	Emergencies						1	**1**	
	First Aid		2					**2**	
	Gynaecology and Obstetrics		1	1			2	**4**	
	Infectious diseases			1				**1**	
	Midwifery	1		3			2	**6**	
	Neonatology		1					**1**	
	Pediatric						1	**1**	
	Pneumology		1					**1**	
	Nurse	15	7	2		12	5	**41**	**58**
Physiotherapists	Physiotherapist	8						**8**	**8**
Psychologist	Psychologist		3		2			**5**	**5**
Social Work	Psychiatry	1						**1**	
	Social worker		1				1	**2**	**3**
N/A	-					2		**2**	**2**
Total		**38**	**25**	**24**	**31**	**20**	**30**		**168**

Table 18. Professional profiles

The participants indicated the following distribution per gender:

Gender	
Woman	49
Man	22
N/A	59

Table 19. Distribution per gender

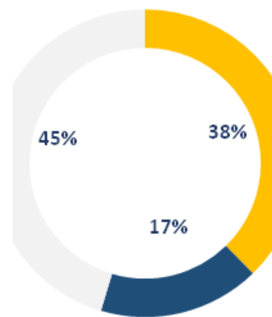


Figure 1. Distribution per gender

The evaluation of the pre-test training needs are summarized in the following table:

		Average					
		Spain	Italy	Poland	Romania	Slovakia	Total
MODULE 1 SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY	Cultural and other important types of diversity (cultural diversity refers to the plurality of cultural identities, population groups and societies).	3,79	4,04	4,08	4,10	3,47	3,93
	Intersectionality (intersectionality refers to the way migration status, ethnicity, class, gender, sexual orientation, ability status or other aspects interact, shaping the social situation and lived experience of the person).	3,83	4,32	4,13	4,19	3,24	3,99
	Construction of discrimination and stigma	3,74	4,00	4,39	4,13	3,00	3,91
	Improving the minorities knowledge about their health rights and fighting discrimination and stigma	4,04	4,44	4,25	4,52	3,53	4,21
	Influence of cultural backgrounds on health professionals' and patients' perceptions and behaviours	4,10	4,36	4,63	4,37	4,00	4,30
	Addressing one's own identity and prejudices;	3,93	4,40	4,42	4,20	3,65	4,14
	Identifying aspects related to the positive contribution of interculturality and diversity sensitivity.	3,90	4,44	4,21	4,35	3,12	4,07
	Developing strategies for health promotion and health education based on cultural diversity and interculturality.	4,28	4,76	4,33	4,67	3,29	4,34
MODULE 2 KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH	Social context of migrants and ethnic minorities	3,48	4,25	3,79	4,06	3,06	3,78
	Social determinants of health	3,72	4,67	4,26	4,32	3,71	4,15
	Needs and frequent types of health problems of migrants and ethnic minorities.	3,69	4,67	4,54	4,39	3,71	4,22
	Morbidity and mortality patterns	3,41	4,42	4,08	4,06	3,18	3,86
	Patterns of health services usage	3,62	4,46	4,29	4,26	3,94	4,11
	Barriers of access to health care	3,69	4,08	4,29	4,13	3,65	3,98
MODULE 3 PROFESSIONAL SKILLS	Key elements in communicating with migrants or ethnic minority patients	3,96	4,46	4,71	4,52	3,50	4,28
	Communication and intrapersonal skills (Empathy, Active/Reflective listening)	4,07	4,71	4,83	4,59	3,67	4,43
	Barriers and facilitators to communication	3,96	4,58	4,63	4,14	3,50	4,20
	Negotiation/collaboration	3,89	4,50	4,71	4,21	3,56	4,21
	Conflict management	3,93	4,38	4,71	4,24	3,31	4,17
	Breaking bad news	3,89	4,13	4,54	3,93	3,00	3,96
MODULE 4 KNOWLEDGE APPLICATION	People-centered approaches in health care for migrants and ethnic minorities	3,79	4,32	4,46	4,16	3,35	4,06
	Health care oriented towards cultural and ethnic diversity	3,86	4,44	4,50	4,26	3,35	4,13
	Health prevention and promotion oriented towards cultural and ethnic diversity	3,82	4,24	4,30	4,45	3,41	4,10
	Reduction of health inequalities	4,07	4,44	4,21	4,35	3,35	4,14
	Access to and quality of health care for migrants and ethnic minorities	4,00	4,40	4,46	4,47	3,65	4,23
	Community-based approaches and promotion of the users' and communities' participation and involvement	4,00	4,24	4,04	4,16	3,18	3,98
	Intersectoral action for health (intersectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector).	3,61	4,12	4,04	4,16	3,24	3,88
I understand:	The concepts of "culture", "ethnic groups and minorities", "migrants" and their background.	3,62	3,96	3,92	4,03	3,75	3,86
	The concept of "intersectionality" and "intersectoral action"	3,29	3,22	3,33	3,90	2,75	3,37
	The concepts of "stereotypes and generalisations", "prejudices" and "discrimination".	3,62	4,32	4,13	4,19	3,44	3,97
	The concepts "multiculturalism", "interculturalism", "cultural competence", "intercultural competence" and "diversity sensitivity",	3,59	3,91	3,83	3,90	3,13	3,72
	Basic demographic characteristics of the current migrant population and ethnic minorities.	3,45	3,91	3,38	3,81	3,00	3,55
	Major trends and health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health.	3,62	4,00	3,29	4,39	3,00	3,74
	Social determinants of health of migrants and ethnic minorities.	3,59	4,17	3,33	4,16	2,80	3,70
	Main patterns of use of health care services by migrant population and ethnic minorities according to the literature.	3,52	3,87	3,22	3,77	2,88	3,51
	Barriers of access to health care.	3,52	3,83	3,54	4,35	2,75	3,69
	Key elements in communicating with migrants or ethnic minority patients.	3,62	3,74	3,46	4,29	2,88	3,68
	Techniques related to intrapersonal outcomes aiming to improving health professional-patient interaction in culturally diverse contexts.	3,76	3,83	3,25	4,06	2,56	3,59
	Strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities.	3,59	3,74	3,33	3,87	2,56	3,50
	Best Practices related to health prevention and promotion oriented towards cultural and ethnic diversity from multidisciplinary perspectives.	3,66	3,70	3,50	4,33	2,75	3,68
	Relevant aspects of quality oriented towards cultural and ethnic diversity, assessment methodologies and strategies.	3,52	3,65	3,33	3,83	2,44	3,44
	Concepts and relevant aspects related to community-based approaches.	3,71	3,61	3,38	4,03	2,63	3,56
	Strategies for developing intersectoral actions.	3,30	3,50	3,00	3,90	2,25	3,28
When I work, I'm able:	To identify barriers and strategies for taking into account intersectionality in the health care practice.	3,21	3,33	3,42	4,10	2,63	3,42
	To think over strategies against discrimination in health care oriented towards cultural and ethnic diversity.	3,24	3,46	3,38	3,61	2,75	3,34
	To understand the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.	3,48	3,71	3,92	3,90	3,19	3,68
	To introduce the concepts of "health promotion", "Health education" and relate them with cultural diversity and interculturality.	3,62	3,50	3,83	4,35	2,75	3,71
	To identify aspects related to the positive contribution of interculturality and sensitivity to diversity	3,68	3,67	3,88	3,90	2,53	3,63
	To apply the acquired knowledge about health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health to clinical practice.	3,39	3,58	4,00	4,35	2,88	3,72
	To identify barriers of access to health care and strategies to overcome those barriers	3,25	3,29	3,67	4,00	2,81	3,47
	To identify the role of stereotypes in communication with migrants and ethnic minorities.	3,37	3,30	3,79	3,83	3,00	3,51
	To identify communication and intrapersonal skills (empathy, active/reflective listening).	3,64	3,67	4,04	4,19	3,38	3,83
	To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction	3,39	3,26	4,08	4,16	3,00	3,65
	To practice the negotiation and collaboration skills	3,57	3,33	3,78	4,16	3,31	3,68
	To think over the behaviors involved in conflict management	3,61	3,42	3,92	3,94	2,88	3,62
	To apply a model of "people-centered health care" in the field of health care oriented towards cultural and ethnic diversity.	3,71	3,65	4,00	4,03	2,87	3,73
	To reflect on the opportunities and limitations for applying organizational change related to cultural and ethnic diversity in the own institutional context.	3,46	3,50	3,30	3,90	2,40	3,42
	To develop health promotion and health prevention actions oriented towards cultural and ethnic diversity.	3,64	3,17	3,57	4,39	2,73	3,61
	To apply quality assessment methods.	3,25	2,92	3,13	4,10	2,44	3,27
	To develop participatory approaches in the field of health care oriented towards cultural and ethnic diversity.	3,21	2,96	3,26	4,00	2,47	3,28
	To identify relevant stakeholders for intersectoral action related to the health of migrants and ethnic minorities in the own context, as well as opportunities, barriers, resources and strategies.	3,32	3,25	3,30	4,13	2,56	3,41

Table 20. Pre-Test questionnaire results

4.2.2. Post-Test: Training needs questionnaire

After the pilot training, the participants indicated the following evaluation of training needs:

		Average					
		Spain	Italy	Poland	Romania	Slovakia	Total
MODULE 1 SENSITIVITY AND AWARENESS OF CULTURAL AND OTHER FORMS OF DIVERSITY	Cultural and other important types of diversity (cultural diversity refers to the plurality of cultural identities, population groups and societies).	4,42	4,56	4,75	4,82	3,79	4,44
	Intersectionality (intersectionality refers to the way migration status, ethnicity, class, gender, sexual orientation, ability status or other aspects interact, shaping the social situation and lived experience of the person).	4,46	4,59	4,80	4,94	3,38	4,43
	Construction of discrimination and stigma	4,39	4,13	4,80	4,82	3,54	4,31
	Improving the minorities knowledge about their health rights and fighting discrimination and stigma	4,36	4,59	4,60	4,76	3,93	4,44
	Influence of cultural backgrounds on health professionals' and patients' perceptions and behaviours	4,40	4,47	5,00	4,82	4,43	4,55
	Addressing one's own identity and prejudices;	4,60	4,24	4,60	4,81	4,00	4,45
	Identifying aspects related to the positive contribution of interculturality and diversity sensitivity.	4,40	4,65	4,60	4,76	3,64	4,41
	Developing strategies for health promotion and health education based on cultural diversity and interculturality.	4,28	4,53	5,00	4,88	4,00	4,46
MODULE 2 KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH	Social context of migrants and ethnic minorities	4,42	4,53	4,60	4,71	3,64	4,38
	Social determinants of health	4,36	4,59	4,60	4,82	4,00	4,46
	Needs and frequent types of health problems of migrants and ethnic minorities.	4,16	4,35	4,80	4,82	4,07	4,37
	Morbidity and mortality patterns	4,32	4,06	4,80	4,76	3,57	4,26
	Patterns of health services usage	4,04	4,18	4,80	4,82	3,93	4,27
	Barriers of access to health care	4,20	4,06	5,00	4,76	3,93	4,29
MODULE 3 PROFESSIONAL SKILLS	Key elements in communicating with migrants or ethnic minority patients	4,48	4,12	4,80	4,65	3,86	4,35
	Communication and intrapersonal skills (Empathy, Active/Reflective listening)	4,52	4,29	4,80	4,71	4,36	4,50
	Barriers and facilitators to communication	4,52	4,18	4,80	4,82	4,07	4,45
	Negotiation/collaboration	4,48	4,18	4,80	4,82	4,07	4,44
	Conflict management	4,52	4,00	4,80	4,82	4,07	4,41
	Breaking bad news	4,16	3,82	4,80	4,71	3,79	4,18
MODULE 4 KNOWLEDGE APPLICATION	People-centered approaches in health care for migrants and ethnic minorities	4,28	4,06	4,80	4,82	4,00	4,34
	Health care oriented towards cultural and ethnic diversity	4,28	4,06	4,60	4,94	3,79	4,31
	Health prevention and promotion oriented towards cultural and ethnic diversity	4,40	4,18	4,80	4,94	3,79	4,38
	Reduction of health inequalities	4,36	4,24	4,80	4,88	3,86	4,38
	Access to and quality of health care for migrants and ethnic minorities	4,16	4,24	4,80	4,88	3,86	4,31
	Community-based approaches and promotion of the users' and communities' participation and involvement	4,32	4,18	4,60	4,75	3,57	4,26
	Intersectoral action for health (intersectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector).	4,30	4,12	4,60	4,88	3,71	4,29
I understand:	The concepts of "culture", "ethnic groups and minorities", "migrants" and their background.	4,44	4,35	4,60	4,76	4,27	4,47
	The concept of "intersectionality" and "intersectoral action"	4,48	4,24	4,60	4,71	3,87	4,37
	The concepts of "stereotypes and generalisations", "prejudices" and "discrimination".	4,64	4,06	4,60	4,82	4,27	4,48
	The concepts "multiculturalism", "interculturalism", "cultural competence", "intercultural competence" and "diversity sensitivity",	4,54	4,29	4,60	4,82	4,00	4,45
	Basic demographic characteristics of the current migrant population and ethnic minorities.	4,12	4,18	4,40	4,82	3,93	4,27
	Major trends and health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health.	4,36	4,35	4,60	4,82	4,00	4,41
	Social determinants of health of migrants and ethnic minorities.	4,56	4,29	4,60	4,71	3,87	4,41
	Main patterns of use of health care services by migrant population and ethnic minorities according to the literature.	4,32	4,06	4,60	4,53	3,80	4,23
	Barriers of access to health care.	4,40	4,35	4,60	4,88	3,80	4,39
	Key elements in communicating with migrants or ethnic minority patients.	4,52	4,35	4,80	4,76	4,00	4,46
	Techniques related to intrapersonal outcomes aiming to improving health professional-patient interaction in culturally diverse contexts.	4,52	4,29	4,60	4,71	3,73	4,37
	Strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities.	4,32	4,24	4,60	4,65	3,47	4,23
	Best Practices related to health prevention and promotion oriented towards cultural and ethnic diversity from multidisciplinary perspectives.	4,40	3,94	4,60	4,88	3,87	4,32
	Relevant aspects of quality oriented towards cultural and ethnic diversity, assessment methodologies and strategies.	4,43	4,06	4,60	4,71	3,43	4,24
	Concepts and relevant aspects related to community-based approaches.	4,20	4,00	4,60	4,88	3,53	4,20
	Strategies for developing intersectoral actions.	4,29	4,12	4,80	4,88	3,33	4,22
When I work, I'm able:	To identify barriers and strategies for taking into account intersectionality in the health care practice.	4,04	4,06	4,80	4,71	3,60	4,15
	To think over strategies against discrimination in health care oriented towards cultural and ethnic diversity.	4,04	3,94	4,60	4,71	3,67	4,13
	To understand the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.	4,32	4,06	5,00	4,76	4,20	4,38
	To introduce the concepts of "health promotion", "Health education" and relate them with cultural diversity and interculturality.	4,29	4,12	4,80	4,82	3,53	4,26
	To identify aspects related to the positive contribution of interculturality and sensitivity to diversity	4,16	4,12	5,00	4,59	3,53	4,18
	To apply the acquired knowledge about health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health to clinical practice.	4,12	4,06	5,00	4,94	3,93	4,30
	To identify barriers of access to health care and strategies to overcome those barriers	3,88	4,12	4,80	4,82	4,00	4,22
	To identify the role of stereotypes in communication with migrants and ethnic minorities.	4,08	4,00	5,00	4,65	3,80	4,19
	To identify communication and intrapersonal skills (empathy, active/reflective listening).	4,36	4,44	5,00	4,65	3,93	4,40
	To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction	4,12	4,13	4,80	4,76	3,60	4,21
	To practice the negotiation and collaboration skills	4,24	4,06	5,00	4,65	3,73	4,24
	To think over the behaviors involved in conflict management	4,20	4,13	4,80	4,53	3,53	4,17
	To apply a model of "people-centered health care" in the field of health care oriented towards cultural and ethnic diversity.	4,44	4,53	4,80	4,82	3,73	4,43
	To reflect on the opportunities and limitations for applying organizational change related to cultural and ethnic diversity in the own institutional context.	4,12	4,06	4,80	4,71	3,33	4,13
	To develop health promotion and health prevention actions oriented towards cultural and ethnic diversity.	4,16	4,12	4,80	4,76	3,53	4,20
	To apply quality assessment methods.	3,80	3,76	4,40	4,82	2,93	3,89
	To develop particip[illegible] diversity.	[illegible]	[illegible]	4,80	4,71	2,93	4,00
	To identify relevant [illegible] minorities in the o[illegible]	[illegible]	[illegible]	4,60	4,82	3,20	3,97

Tabla 21: Post-Test questionnaire results

Pre-/Post-Test: Comparative evaluation

In the following comparative evaluation, the results of training needs previous and after the training, related to the selected core contents were compared.

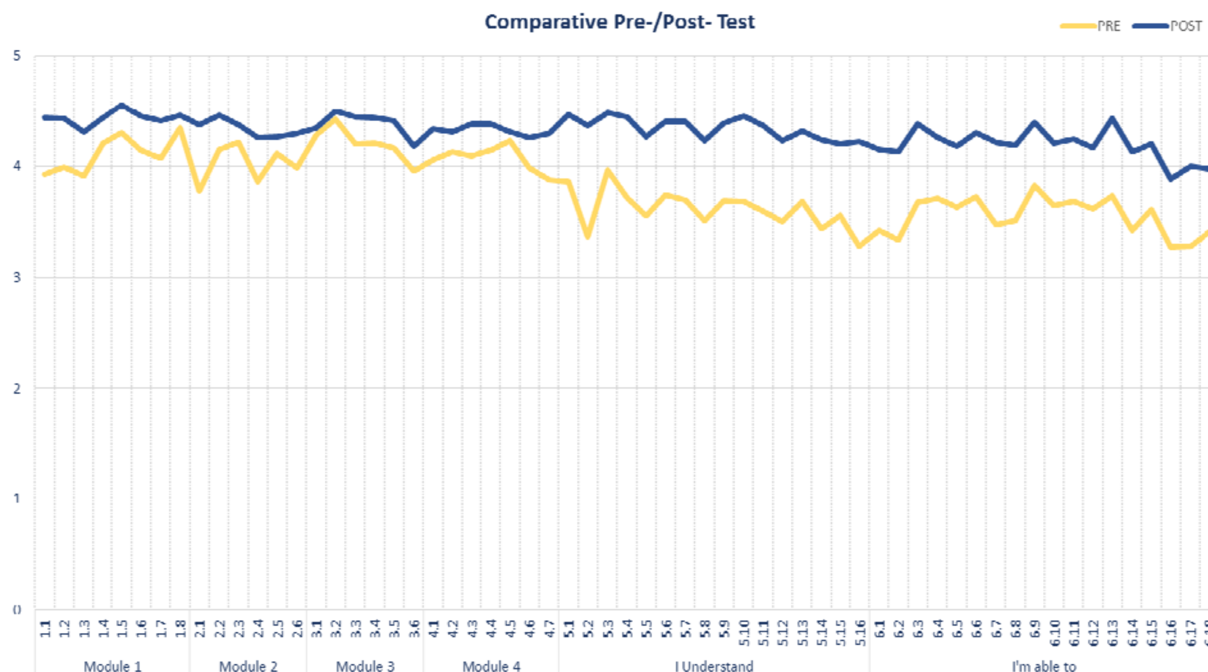


Figure 2. Pre-/Post-Test : Comparative evaluation

In the following figures, the comparative evaluation per country can be consulted.

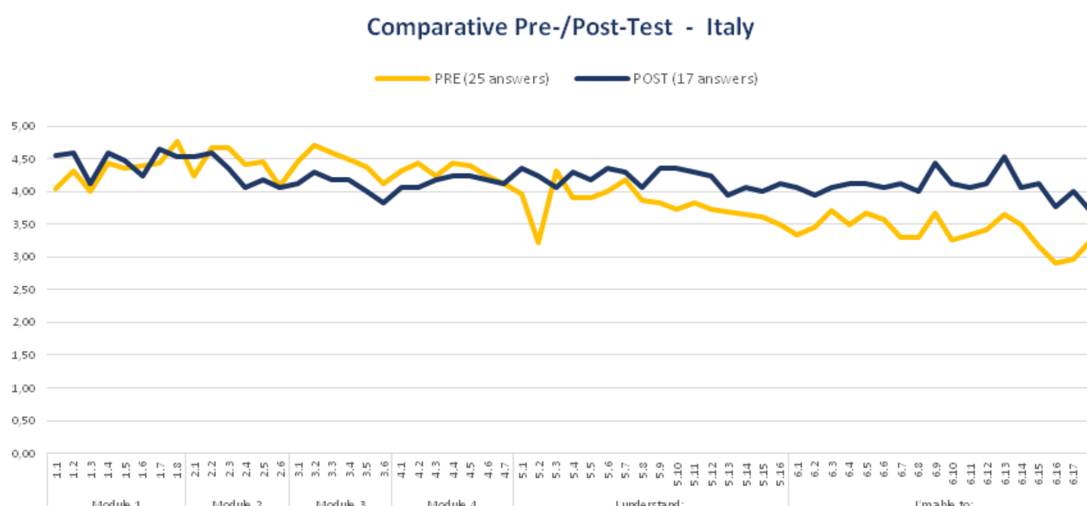


Figure 3. Pre-/Post-Test : Comparative evaluation – Italy

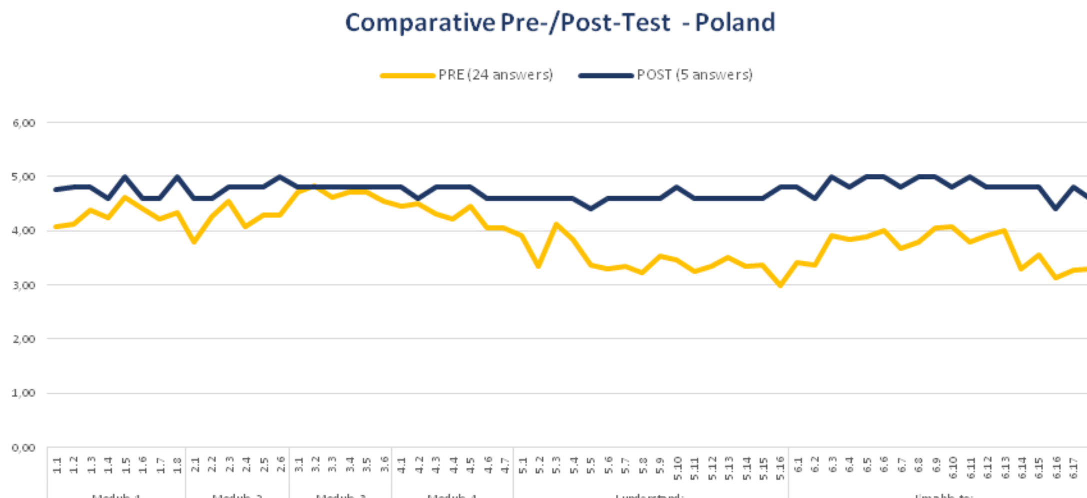


Figure 4. Pre-/Post-Test : Comparative evaluation – Poland

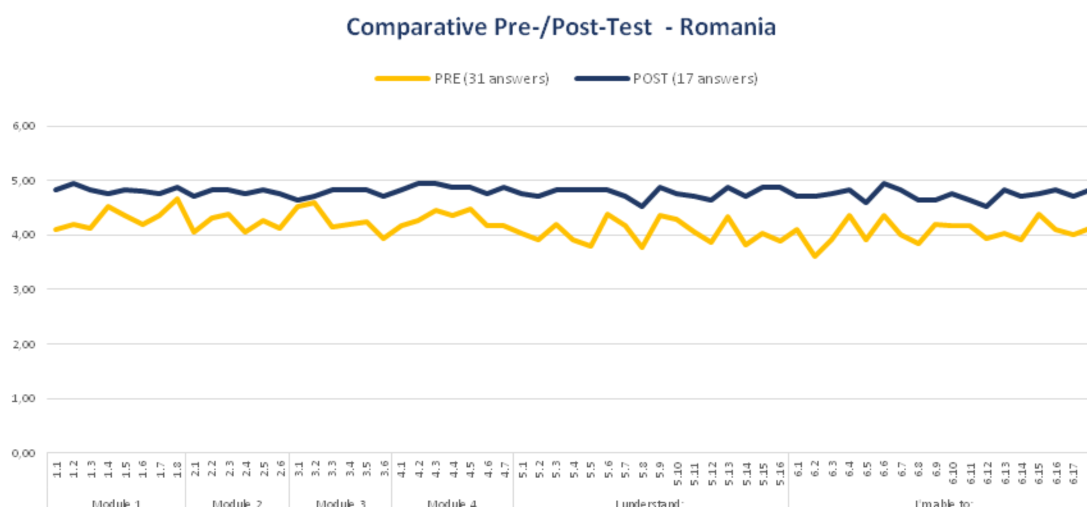


Figure 5. Pre-/Post-Test : Comparative evaluation – Romania

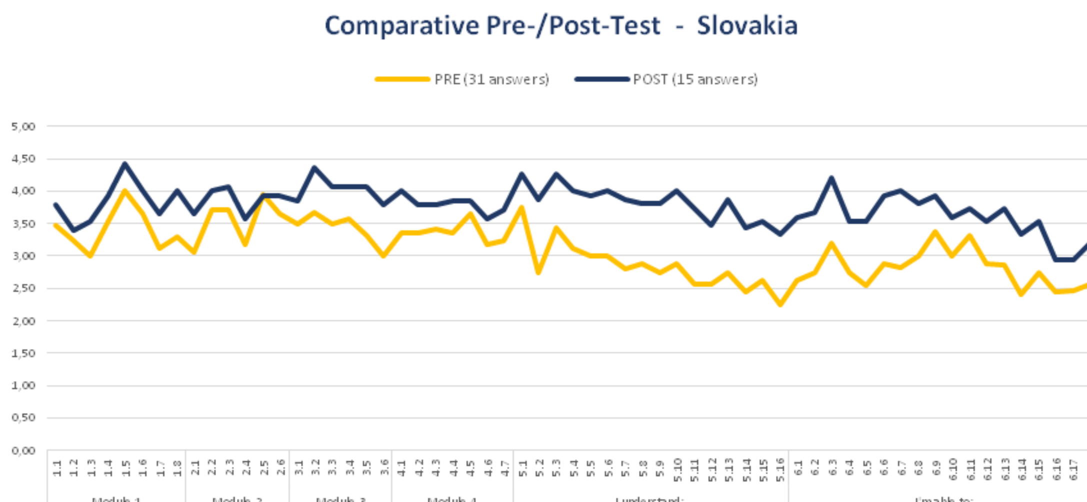


Figure 6. Pre-/Post-Test : Comparative evaluation – Slovakia

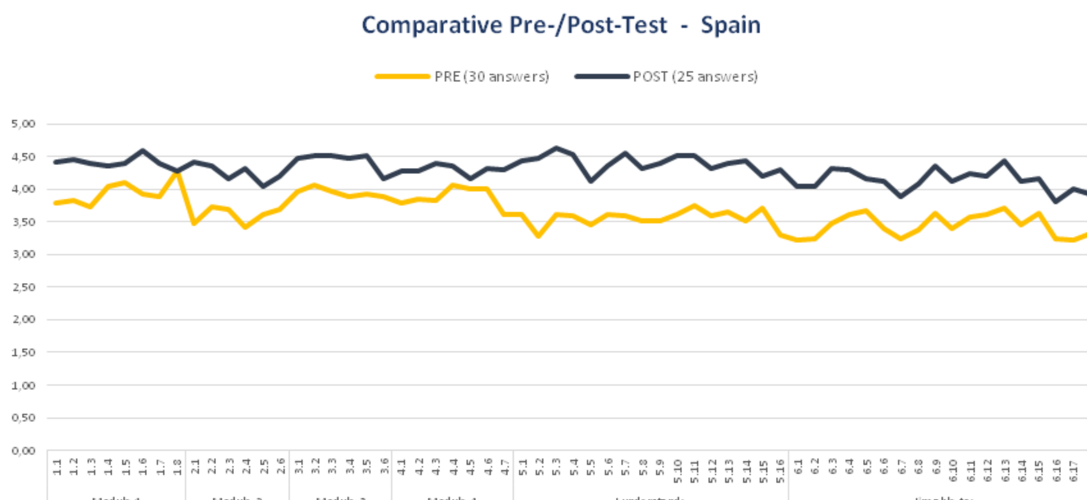


Figure 7. Pre-/Post-Test : Comparative evaluation - Spain

4.3 Evaluation of the quality of teaching and satisfaction

The *Quality of teaching and satisfaction questionnaire* (Annex V) has been answered by the participants from Romania, Slovakia and Spain. The following chart shows a comparative of the results in each country.

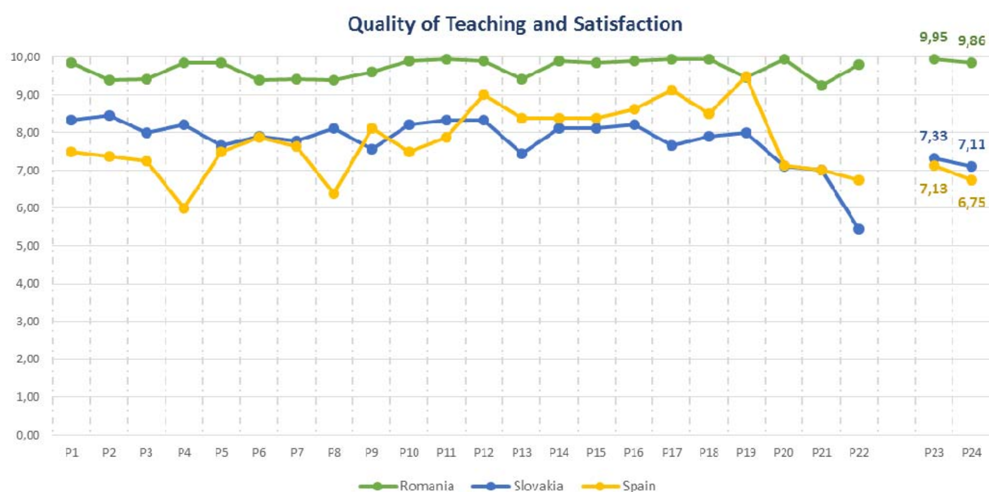


Figure 8. Quality of teaching and satisfaction

		Romania	Slovakia	Spain
OBJECTIVES	P1. Clarity of the objectives outlined in the course schedule	9,86	8,33	7,50
	P2. Level of attainment of the proposed learning objectives	9,38	8,44	7,38
THEMATIC CONTENT	P3. Suitability of the content developed for achieving the course objectives	9,43	8,00	7,25
	P4. Adequacy of the structure and organization of the course content	9,86	8,22	6,00
LEARNING-TEACHING METHODOLOGY	P5. Suitability of the methodology for fulfilling the course objectives	9,86	7,67	7,50
	P6. How useful did you find the practical cases used in the course?	9,38	7,89	7,88
	P7. Quality of the teaching resources used on the course	9,43	7,78	7,63
	P8. Quality of support provided by the EASP Online Platform	9,38	8,11	6,38
BIBLIOGRAPHY	P9. Relevance of the course bibliography	9,62	7,56	8,13
ORGANIZATION OF TEACHING	P10. Quality of the course coordination (Adequacy in terms of program design, organization of the teaching staff, and	9,90	8,22	7,50
COURSE ADMINISTRATION	P11. Efficiency of the course administration (Course logistics, attention given to the participants, etc.)	9,95	8,33	7,88
TEACHING TEAM	P12. Level of expertise of the teaching staff in relation to the course content	9,90	8,33	9,00
	P13. Quality of theoretical presentations given by the teaching staff	9,43	7,44	8,38
	P14. Quality of the methodological skills of the teaching staff	9,90	8,11	8,38
	P15. Adaptability of the teaching staff to the needs of the group	9,86	8,11	8,38
	P16. Suitability of individual guidance given by the teacher	9,90	8,22	8,63
	P17. Encouragement given by the teaching staff in terms of student participation in the teaching activities	9,95	7,67	9,13
	P18. The extent to which the teacher has displayed different points of view with regard to the given topics	9,95	7,89	8,50
	P19. Quality of the treatment given to students on the part of the teaching staff	9,48	8,00	9,50
	P20. Noteworthy aspects of the teaching team: Write: Name of the teacher / outstanding aspects (positive or negativ	9,95	7,11	7,13
LEARNING LEVEL	P21. How do you rate the level of learning that you have achieved throughout this course?	9,24	7,00	7,00
USEFULNESS OF THE COURSE	P22. Usefulness of the course for your professional activities	9,81	5,44	6,75
GENERAL SATISFACTION	P23. In general, how satisfied are you with this course?	**9,95**	**7,33**	**7,13**
	P24.To what extent has this course met your expectations?	**9,86**	**7,11**	**6,75**

Table 22. Quality of teaching and satisfaction

Furthermore, the *Quality of teaching and satisfaction questionnaire* contained the following open-ended questions.

> ***K. ADDITIONAL INFORMATION***
> *P25. Could you indicate what other topics might be of interest to you if you were to do another course with EASP in the future?*
> ***L. COMMENTS OR SUGGESTIONS***
> *P26. Please highlight any comments you wish to make about this course in the space below (positive or negative)*

The answers contributed by the participants in Romania, Slovakia and Spain refer to Question P26. The answers included to the following aspects:

- Positive evaluation:
  - Training course in general.
  - Provided knowledge.
  - Focus on people-centered health care, diversity, intersectionality and social determinants of health.
  - Activities and videos.
  - Course organization.
  - Availability of materials in the virtual campus.
  - Diversity of participants.

- Critiques:
  - Consideration of the contents as too extensive and dense.

  - Excessive theoretical focus.

- Proposals:
  - Increase of hours, reduction of contents or provision of part of the contents in virtual format.
  - Provision of more practical examples and tools, as well as audiovisual materials.
  - Inclusion of communication skills as transversal content, instead of limiting this aspect to a particular module.
  - Inclusion of cultural aspects of social determinants of health regarding ethnic communities.
  - Dissemination of the materials by means of the Andalusian School of Public Health or MEM-TP project.

5. Annexes

5.1. Annex I: Training materials questionnaire

EVALUATING THE QUALITY OF MATERIALS USED (ONLINE QUESTIONNAIRE 1)

Please, assess the presentations and activities, where 1 is very low and 5 is very high

Please, assess the trainees' manual, where 1 is very low and 5 is very high

	Name module 1	Name module 2	Name module 3	Name module 4
Presentation	Name units 1-2	Name units 1-2	Name units 1-2	Name units 1-6
Clarity, understanding and legibility	Scale 1-5			
Adequacy of length	Scale 1-5			
Accuracy	Scale 1-5			
Credibility	Scale 1-5			
Consistency between the contents and the objectives	Scale 1-5			
Quality of design	Scale 1-5			
Adequacy of images	Scale 1-5			
Activities				
Consistency between the activity(ies) and the objectives	Scale 1-5			

Trainees' Manual	**Scale 1-5**
Clarity, understanding and legibility	Scale 1-5
Adequacy of length	Scale 1-5

5.2. Annex II: Qualitative assessment of the pilot training, training materials and transference

Evaluation of the MEM-TP Piloting

Country:
Contact:

Please complete the following template, describing the piloting experience in your country.

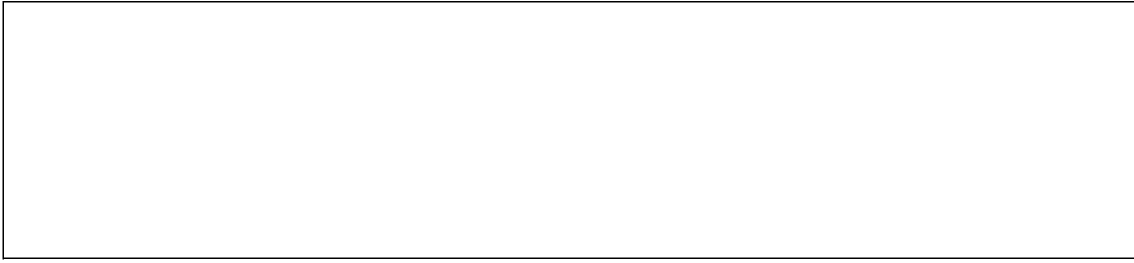
Preparation of the Piloting
Which authorities did you contact? **How would you assess the contact process with the authorities?** **Did you experience any obstacles or difficulties?**
7
How many health professionals participated in the training? **What are their professional profiles?**

How would you assess the contact process with the participants? Did you experience any obstacles or difficulties?
How did you adapt the training materials? Which contents and/or activities have you added to the core contents? How would you assess the adaptation process? Did you experience any obstacles or difficulties in the process?
Piloting Process
How would you assess the organization of the training sessions in regard to time distribution, venue, and organizational aspects?

Did you experience any obstacles or difficulties?
How would you assess the training sessions in regard to length, time distribution between presentations and activities, and appropriateness of the methodologies? **Did you experience any obstacles or difficulties? Which aspects would you change?**
How would you assess the training materials in regard to relevance and adequacy of the contents, length, clarity and understanding, consistency with the objectives, and design? **Did you experience any obstacles or difficulties? Which aspects would you change?**

How would you assess the training activities in regard to appropriateness of the methodologies, length, clarity and understanding, and consistency with the objectives? Did you experience any obstacles or difficulties? Which aspects would you change?
How would you assess the evaluation methodology? Did you experience any obstacles or difficulties? Which aspects would you change?

Findings, Lessons Learnt and Recommendations
Which are the most important findings and lessons learnt from the training?
Which are your recommendations for the review of the training package and future trainings?



5.3. Annex III: Pre-Test Professional and demographic profile / training needs questionnaire

PRIOR PROFESSIONAL AND DEMOGRAPHIC PROFILE / TRAINING NEEDS (ONLINE QUESTIONNAIRE 1)

PROFESSIONAL AND DEMOGRAPHIC PROFILE

1. Basic Training Received (Educational qualifications – certificates, degrees, diplomas, etc):
2. Current occupation (*position currently occupied and tasks you are responsible for completing):*
3. Workplace location (primary care center, level):
4. Year in which basic training certificates, degrees or diplomas were obtained:
5. Nationality:
6. Gender:

QUESTIONNAIRE ON THE PROGRAM'S NEEDS

This is an anonymous and confidential questionnaire. Your opinions will contribute to improving the quality of training this Program provides, and we thank you in advance for your collaboration.

Following is a list of the training program's core contents. We would like to know how useful they are to you in carrying out your work:

Please rate on a scale of 0 to 5, with 0 indicating not at all useful and 5 very useful

- **Not at all useful: absolutely unnecessary for carrying out tasks related to my position**
- **Very useful: Essential for carrying out tasks related to my position.**

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

- Cultural and other important types of diversity (cultural diversity refers to the plurality of cultural identities, population groups and societies).
- Intersectionality (intersectionality refers to the way migration status, ethnicity, class, gender, sexual orientation, ability status or other aspects interact, shaping the social situation and lived experience of the person).
- Construction of discrimination and stigma
- Improving the minorities knowledge about their health rights and fighting discrimination and stigma
- Influence of cultural backgrounds on health professionals' and patients' perceptions and behaviours

- Addressing one’s own identity and prejudices;
- Identifying aspects related to the positive contribution of interculturality and diversity sensitivity.
- Developing strategies for health promotion and health education based on cultural diversity and interculturality.

MODULE 2: KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH

- Social context of migrants and ethnic minorities
- Social determinants of health
- Needs and frequent types of health problems of migrants and ethnic minorities.
- Morbidity and mortality patterns
- Patterns of health services usage
- Barriers of access to health care

MODULE 3: PROFESSIONAL SKILLS

- Key elements in communicating with migrants or ethnic minority patients
- Communication and intrapersonal skills (Empathy, Active/Reflective listening)
- Barriers and facilitators to communication
- Negotiation/collaboration
- Conflict management
- Breaking bad news

MODULE 4: KNOWLEDGE APPLICATION

- People-centered approaches in health care for migrants and ethnic minorities
- Health care oriented towards cultural and ethnic diversity
- Health prevention and promotion oriented towards cultural and ethnic diversity
- Reduction of health inequalities
- Access to and quality of health care for migrants and ethnic minorities
- Community-based approaches and promotion of the users' and communities’ participation and involvement
- Intersectoral action for health (intersectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector).

Please express the degree to which you would agree with the following statements regarding the Program’s objectives

Please rate on a scale of 0 to 5, with 0 indicating “absolutely disagree” and 5 “totally agree”

1. I understand:

- The concepts of “culture”, “ethnic groups and minorities”, “migrants” and their background.
- The concept of “intersectionality” and “intersectoral action”
- The concepts of “stereotypes and generalisations”, “prejudices” and “discrimination”.
- The concepts “multiculturalism”, “interculturalism”, “cultural competence”, “intercultural competence” and “diversity sensitivity”,
- Basic demographic characteristics of the current migrant population and ethnic minorities.
- Major trends and health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health.
- Social determinants of health of migrants and ethnic minorities.
- Main patterns of use of health care services by migrant population and ethnic minorities according to the literature.
- Barriers of access to health care.
- Key elements in communicating with migrants or ethnic minority patients.
- Techniques related to intrapersonal outcomes aiming to improving health professional-patient interaction in culturally diverse contexts.
- Strategies for planning and implementing actions related to one’s own workplace and daily professional practice with migrants and ethnic minorities.
- Best Practices related to health prevention and promotion oriented towards cultural and ethnic diversity from multidisciplinary perspectives.
- Relevant aspects of quality oriented towards cultural and ethnic diversity, assessment methodologies and strategies.
- Concepts and relevant aspects related to community-based approaches.
- Strategies for developing intersectoral actions.

2. When I work I have the capacity:

- To identify barriers and strategies for taking into account intersectionality in the health care practice.
- To think over strategies against discrimination in health care oriented towards cultural and ethnic diversity.
- To understand the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.
- To introduce the concepts of “health promotion”, “Health education” and relate them with cultural diversity and interculturality.
- To identify aspects related to the positive contribution of interculturality and sensitivity to diversity
- To apply the acquired knowledge about health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health to clinical practice.
- To identify barriers of access to health care and strategies to overcome those barriers
- To identify the role of stereotypes in communication with migrants and ethnic minorities.
- To identify communication and intrapersonal skills (empathy, active/reflective listening).

- To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction
- To practice the negotiation and collaboration skills
- To think over the behaviors involved in conflict management
- To apply a model of "people-centered health care" in the field of health care oriented towards cultural and ethnic diversity.
- To reflect on the opportunities and limitations for applying organizational change related to cultural and ethnic diversity in the own institutional context.
- To develop health promotion and health prevention actions oriented towards cultural and ethnic diversity.
- To apply quality assessment methods.
- To develop participatory approaches in the field of health care oriented towards cultural and ethnic diversity.
- To identify relevant stakeholders for intersectoral action related to the health of migrants and ethnic minorities in the own context, as well as opportunities, barriers, resources and strategies.

Thank you for completing this questionnaire.

5.4. Annex IV: Post-Test Training needs questionnaire

POST TRAINING NEEDS (ONLINE QUESTIONNAIRE 1)

QUESTIONNAIRE ON THE PROGRAM'S NEEDS

This is an anonymous and confidential questionnaire. Your opinions will contribute to improving the quality of training this Program provides, and we thank you in advance for your collaboration.

Following is a list of the training program's core contents. We would like to know how useful they are to you in carrying out your work:

Please rate on a scale of 0 to 5, with 0 indicating not at all useful and 5 very useful

- **Not at all useful: absolutely unnecessary for carrying out tasks related to my position**
- **Very useful: Essential for carrying out tasks related to my position.**

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

- Cultural and other important types of diversity (cultural diversity refers to the plurality of cultural identities, population groups and societies).
- Intersectionality (intersectionality refers to the way migration status, ethnicity, class, gender, sexual orientation, ability status or other aspects interact, shaping the social situation and lived experience of the person).
- Construction of discrimination and stigma
- Improving the minorities knowledge about their health rights and fighting discrimination and stigma
- Influence of cultural backgrounds on health professionals' and patients' perceptions and behaviours
- Addressing one's own identity and prejudices;
- Identifying aspects related to the positive contribution of interculturality and diversity sensitivity.
- Developing strategies for health promotion and health education based on cultural diversity and interculturality.

MODULE 2: KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH

- Social context of migrants and ethnic minorities
- Social determinants of health
- Needs and frequent types of health problems of migrants and ethnic minorities.
- Morbidity and mortality patterns
- Patterns of health services usage
- Barriers of access to health care

MODULE 3: PROFESSIONAL SKILLS

- Key elements in communicating with migrants or ethnic minority patients
- Communication and intrapersonal skills (Empathy, Active/Reflective listening)
- Barriers and facilitators to communication
- Negotiation/collaboration
- Conflict management
- Breaking bad news

MODULE 4: KNOWLEDGE APPLICATION

- People-centered approaches in health care for migrants and ethnic minorities
- Health care oriented towards cultural and ethnic diversity
- Health prevention and promotion oriented towards cultural and ethnic diversity
- Reduction of health inequalities
- Access to and quality of health care for migrants and ethnic minorities
- Community-based approaches and promotion of the users' and communities' participation and involvement
- Intersectoral action for health (intersectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector).

Please express the degree to which you would agree with the following statements regarding the Program's objectives

Please rate on a scale of 0 to 5, with 0 indicating "absolutely disagree" and 5 "totally agree"

3. **I understand:**

- The concepts of "culture", "ethnic groups and minorities", "migrants" and their background.
- The concept of "intersectionality" and "intersectoral action"
- The concepts of "stereotypes and generalisations", "prejudices" and "discrimination".
- The concepts "multiculturalism", "interculturalism", "cultural competence", "intercultural competence" and "diversity sensitivity",
- Basic demographic characteristics of the current migrant population and ethnic minorities.
- Major trends and health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health.
- Social determinants of health of migrants and ethnic minorities.

- Main patterns of use of health care services by migrant population and ethnic minorities according to the literature.
- Barriers of access to health care.
- Key elements in communicating with migrants or ethnic minority patients.
- Techniques related to intrapersonal outcomes aiming to improving health professional-patient interaction in culturally diverse contexts.
- Strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities.
- Best Practices related to health prevention and promotion oriented towards cultural and ethnic diversity from multidisciplinary perspectives.
- Relevant aspects of quality oriented towards cultural and ethnic diversity, assessment methodologies and strategies.
- Concepts and relevant aspects related to community-based approaches.
- Strategies for developing intersectoral actions.

4. When I work I have the capacity:

- To identify barriers and strategies for taking into account intersectionality in the health care practice.
- To think over strategies against discrimination in health care oriented towards cultural and ethnic diversity.
- To understand the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.
- To introduce the concepts of "health promotion", "Health education" and relate them with cultural diversity and interculturality.
- To identify aspects related to the positive contribution of interculturality and sensitivity to diversity
- To apply the acquired knowledge about health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health to clinical practice.
- To identify barriers of access to health care and strategies to overcome those barriers
- To identify the role of stereotypes in communication with migrants and ethnic minorities.
- To identify communication and intrapersonal skills (empathy, active/reflective listening).
- To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction
- To practice the negotiation and collaboration skills
- To think over the behaviors involved in conflict management
- To apply a model of "people-centered health care" in the field of health care oriented towards cultural and ethnic diversity.
- To reflect on the opportunities and limitations for applying organizational change related to cultural and ethnic diversity in the own institutional context.
- To develop health promotion and health prevention actions oriented towards cultural and ethnic diversity.
- To apply quality assessment methods.
- To develop participatory approaches in the field of health care oriented towards cultural and ethnic diversity.

- To identify relevant stakeholders for intersectoral action related to the health of migrants and ethnic minorities in the own context, as well as opportunities, barriers, resources and strategies.

Thank you for completing this questionnaire.

5.5. Annex V: Quality of teaching and satisfaction questionnaire

SATISFACTION AND QUALITY REGARDING THE TEACHING (EASP QUESTIONNAIRE)

TEACHING QUALITY FEEDBACK QUESTIONNAIRE (FACE-TO-FACE COURSE)

Course Information

Title:

Coordinators:

Secretary:

Indicate on a scale from 0 to 10, where 0 represents the most negative valuation possible (poor quality, totally dissatisfied, etc.), and 10 is the highest possible score (excellent quality, total satisfaction, etc.). If you are unable to give a response, please use DK (don´t know)

A. OBJECTIVES

P1. Clarity of the objectives outlined in the course schedule

P2. Level of attainment of the proposed learning objectives

B. THEMATIC CONTENT

P3. Suitability of the content developed for achieving the course objectives

P4. Adequacy of the structure and organization of the course content

C. LEARNING-TEACHING METHODOLOGY

P5. Suitability of the methodology for fulfilling the course objectives

P6. How useful did you find the practical cases used in the course?

P7. Quality of the teaching resources used on the course

P8. Quality of support provided by the EASP Online Platform

D. BIBLIOGRAPHY

P9. Relevance of the course bibliography

E. ORGANIZATION OF TEACHING

P10. Quality of the course coordination (Adequacy in terms of program design, organization of the teaching staff, and methodology)

F. COURSE ADMINISTRATION

P11. Efficiency of the course administration (Course logistics, attention given to the participants, etc.)

G. TEACHING TEAM

P12. Level of expertise of the teaching staff in relation to the course content

P13. Quality of theoretical presentations given by the teaching staff

P14. Quality of the methodological skills of the teaching staff

P15. Adaptability of the teaching staff to the needs of the group

P16. Suitability of individual guidance given by the teacher

P17. Encouragement given by the teaching staff in terms of student participation in the teaching activities

P18. The extent to which the teacher has displayed different points of view with regard to the given topics

P19. Quality of the treatment given to students on the part of the teaching staff

P20. Noteworthy aspects of the teaching team: Write: Name of the teacher / outstanding aspects (positive or negative)

H. LEARNING LEVEL

P21. How do you rate the level of learning that you have achieved throughout this course?

I. USEFULNESS OF THE COURSE

P22. Usefulness of the course for your professional activities

J. GENERAL SATISFACTION

P23. In general, how satisfied are you with this course?

P24.To what extent has this course met your expectations?

K. ADDITIONAL INFORMATION

P25. Could you indicate what other topics might be of interest to you if you were to do another course with EASP in the future?

L. COMMENTS OR SUGGESTIONS

P26. Please highlight any comments you wish to make about this course in the space below (positive or negative)

Thank you for completing this questionnaire.