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

MODULE 1.

Sensitivity and Awareness of Cultural and Other Forms of Diversity

Unit 1. Diversity

Guidelines

Prepared by:
Ainhoa Ruiz and Amets Suess
Andalusian School of Public Health

Migrants & Ethnic Minorities Training Packages

Funded by the European Union in the framework of the EU Health Programme (2008-2013) in the frame of a service contract with the Consumer, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate from the European Commission. The content of this report represents the views of the Andalusian School of Public Health (EASP) and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body in the European Union. The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

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

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

Cultural and other important types of diversity

PREPARED BY:
Ainhoa Ruiz Azarola,
Andalusian School of Public Health, 2015

Cultural and other important types of diversity

Slide 1: Module title page.

Slide 2: Outline of the session

Slide 3: Title page.

Cultural diversity is expressed in the co-existence and exchange of culturally different practices and in the provision and consumption of culturally different services and products[1].

[1] Council of Europe. Committee of Ministers. Declaration on cultural diversity. *(Adopted by the Committee of Ministers on 7 December 2000 at the 733rd meeting of the Ministers' Deputies)*.

Diversity was traditionally viewed through the narrow lens of 'cultural differences,' health workers are now urged to take account of all aspects of a person's social context and position in society.

Experts have suggested that cultural competence has to be redefined in order to improve the capacity of care providers to meet the diverse needs of their diverse users. They propose the development of an improved 'sensitivity to diversity', encompassing gender, age, religion, disability, sexuality and socioeconomic position[2, 3].

Cultural diversity is sensitive to, and adapts own behaviour to accommodate the differences found in diverse work environments. It treats all individuals and groups fairly and with respect, irrespective of cultural background, gender, religious belief, age, sexual orientation, marital status, physical disability or political conviction.

What we mean by culture?

Slide 4: ***Activity 1: Brainstorming***

We can give a classical definition of culture and discuss the way it relates with professionals daily practice.

Traditional definition*: Culture can be defined as the values, beliefs, norms and practices of certain groups, acquired and shared, that acts as a model to guide thinking, decisions and actions*[4]*.*

Slide 5: Culture has been defined for many years and by many authors as a static and a complex whole[5]. This definition has evolved to something that is co-produced, an intersubjective process of giving meaning to reality and shaping one's own experience of it.

> *Important changes have taken place over the last 30 or 40 years in the way 'culture' has been understood. During much of this period,* ***'cultural differences'*** *(conceptualised in a certain way) have been considered to be the main barrier standing between*

https://wcd.coe.int/ViewDoc.jsp?id=389843 (retrieved: January 12, 2015).

[2] Chiarenza, A. (2012). Developments in the concept of 'cultural competence.' In: Ingleby, D. et al (eds.). *Inequalities in health care for migrants and ethnic minorities*, Vol. 2. COST Series on Health and Diversity. Antwerp: Garant Publishers.

[3] Renschler, I., Cattacin, S. (2007). Comprehensive 'difference sensitivity' in health systems. In. Bjorngren-Cuadra, C, Cattacin, S. (eds). *Migration and Health: difference sensitivity from an organizational perspective*. Malmo: IMER: 37-41 (http://hdl.handle.net/2043/4289, accessed 28/7/14).

[4] Leininger, M. (Ed.). (1985). Qualitative research methods in nursing. New York: Grune & Stratton.

5 Cattacin, Sandro, Antonio Chiarenza and Dagmar Domenig (2013). "Equity Standards for Health Care Organisations: a Theoretical Framework." Diversity and Equality in Health and Care 10(4): 249-258. http://www.academia.edu/5536743/Cattacin_Sandro_Antonio_Chiarenza_and_Dagmar_Domenig_2013_._Equity_Standards_for_Health_Care_Organisations_a_Theoretical_Framework._Diversity_and_Equality_in_Health_and_Care_10_4_249-258

migrant and ethnic minority patients and health service providers.[6] *In this conceptualisation, 'culture' is a relatively fixed and homogeneous set of characteristics that migrants bring with them, like baggage, from their country of origin. Language, religious beliefs, diet, hygiene practices and gender roles are typical items in this 'cultural baggage'. Unawareness of these cultural characteristics was seen as hampering the delivery of appropriate care. Knowledge of different cultures was proposed as the way to tackle this barrier, and textbooks on different cultures became the main training tools for health professionals.*

This view of the role of culture in health services for migrants and ethnic minorities has increasingly come under fire since the 1990's.

At the same time, given the increase in the number and diversity of sending countries, becoming a culturally competent health provider has become increasingly difficult for those who try to follow the traditional text-book approach. A different approach has come to the fore, which proposes that little of use can be learned about a patient's culture from books. Instead, ***the first task is seen as understanding one's own culture: in this way one can become better able to accept and understand that of others****. As in* ***'patient-centred care'****, the way to overcome cultural barriers is to take the time to get to know the patient better.*[7] *The appropriate attitude for health professionals is therefore one* ***of 'cultural humility'***[8] *- "a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves"* [9]

It is important to note that abandoning a static, stereotypical view of migrant and ethnic minority 'cultures' does not mean abandoning the concept of culture altogether in favour of a purely individual-centred approach. Migrants and ethnic minorities are likely to appreciate a health worker who knows and respects their traditions and shows an informed interest in their country of origin. In addition, although a huge variety of cultural and ethnic groups can be found across Europe, large migrant communities often gravitate to specific locations, making it possible for service providers to focus on the needs of particular groups without necessarily pigeon-holing them according to rigid stereotypes[10].

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

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

[8] This theme is also developed in unit 2 of module 1.

[9] Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125.

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

Slide 6 and 7: Race and racism

The concept of ethnicity has superseded the concept of 'race.' The term **'race'** has now been largely discredited as a residual concept from the nineteenth century, when it was used to define recognisable categories within the human species in order to rank people according to physical and ideological criteria. The acceptance of 'race' as a credible concept has been used as a justification for racism.

The UNESCO and UN declarations on racism are the most widely acknowledged definitions of racism and give a clear statement that racism is without scientific foundation and is contrary to internationally accepted human rights.

The UNESCO Declaration (1978) states:
'Any theory involving the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or eliminate others who would be inferior; or which places a value judgement on racial differentiation, has no scientific foundation and is contrary to the moral and ethical principles of humanity.'

The UN International Convention on the Elimination of all Forms of Racial Discrimination (1969) states: *'Any distinction, exclusion, restriction or preference, based on race, colour, descent, national or ethnic origin, which has the purpose of modifying or impairing the recognition, the enjoyment or exercise on an equal footing of human rights and fundamental freedom in the political, economic, social, cultural, or any other field of public life constitutes racial discrimination.'*

Lisbon Treaty[11] defines the role of the EU in combat discrimination (2007). The article 10 defines and implements its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.

It is now most widely accepted that human beings are one species. Species is a biological term given to any group of animals or plants than can procreate and produce descendants. Within this species (Homo Sapiens) there is a diversity of physical features: skin colour, facial features, bone structures, hair, height and so on.

Ethnic groups and ethnicity

Following the idea that culture is a dynamic process, we can also talk about ethnicity as one possible way of defining social groups (internally and / or externally).

Ethnic group has been defined as a group of people sharing a collective identity based on a sense of common history and ancestry. Within this definition ethnic groups possess their own

[11] Treaty of the European Union: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012E/TXT&from=en

culture, customs, norms, beliefs and traditions. Other relevant characteristics shared in common could be language, geographical origin, literature, or religion. An ethnic group can be a majority or a minority group within a larger community.

It is impossible to make a definitive list of the ethnic minorities that exist in Europe because of the lack of shared understanding in this field. Moreover, studies on health have only been carried out on a few minorities (most of them 'indigenous') – although in the UK and the Netherlands the variable 'ethnicity' is commonly used in health research. In this presentation, special attention is shown to the Roma for three reasons. Firstly, the group is much larger than any other ethnic minority in Europe (10-12 million). Secondly, Roma experience an extreme degree of social disadvantage and discrimination. Thirdly, data on other European minorities are sparse, whereas there is a growing body of research on the inequalities in health experienced by Roma in Europe.

It is safe to say, however, that many ethnic minorities in Europe – however they are defined – experience some of the same socioeconomic disadvantages and prejudices as the Roma, leading to inequalities in health and barriers to quality health care. The Sami in Northern Norway, Sweden and Finland provide an example of this. Health professionals should be trained to understand the particular socioeconomic conditions, health risks and barriers to health care experienced by the ethnic minorities present in the countries where they practice.

Slide 8:

Ethnic minorities

The term 'ethnic minority' covers a range of disparate groups: there are also widely differing views about what ethnicity is, which ethnic groups exist and who should be regarded as a member of them. For these reasons alone, ethnicity is a topic on which useful statistics are much harder to get hold of[12]*. An additional problem is that in many countries, the collection of data on ethnic minorities is a highly controversial issue.*

***Regarding the nature of ethnicity**, there are two contrasting approaches in the social sciences*[13]*.*

- ***The classic ('primordial') approach** maintains that people can be ascribed to an ethnic group on the basis of objective characteristics such as their place of origin, genetic heritage, language, culture or religion.*
- ***'Instrumental' definitions,** by contrast, regard ethnicity as a social construction and/or an individual choice, the boundaries of which are negotiated in a pragmatic way. In some countries there exist officially recognised ethnic minorities, to which legal definitions (usually based on the 'primordial' approach) apply.*

Different types of 'ethnic group' can be distinguished.

[12] Bhopal, R. (2014). *Migration, ethnicity, race, and health in multicultural societies*. Oxford: Oxford University Press.
[13] Scott, J.G.M. (1990). A resynthesis of the primordial and circumstantial approaches to ethnic group solidarity: towards an explanatory modal. *Ethnic and Racial Studies,* (13)2, 147-71.

- ***Indigenous peoples*** *are groups, which may have lived in a country as long as or even longer than, the majority (or dominant) ethnic group, e.g. the Sami in the north of Norway.*
- ***National minorities*** *can be created by migration or by changes in national borders – as happened on a large scale, for example, during and after the First and Second World Wars, the break-up of the Soviet Union and the Balkan Wars. Examples of national minorities include the Hungarians in Romania or the Russians in the Baltic States. Their members have a common national origin and may maintain the customs and language of this nation, even though they may acquire the citizenship of the country they live in*[14].

* It is also important to consider the population groups represented from descendants from migrants, which have migrated mainly by economic reasons or recent conflicts and are not yet integrated, like the Turkish, Maghrebians, Russians, Syrians, Libyans, Afghans, etc

Ethnicity is not always associated with nationhood, however, but can also be rooted in language, religion, culture and other shared behaviours. Indeed, members of an ethnic group can be scattered across many different countries.

There is no agreed distinction between 'national minorities' and other ethnic minorities formed by migration. In this field, 'objective' definitions have gradually given way to 'instrumental' ones: ethnicity is increasingly considered to be a question of the group one identifies with, so that what counts is the group that a person *says* that he or she belongs to. This is how ethnicity is treated in the US or UK census, i.e. through 'self-ascription'[15].

Slide 9: Migrants

The terms 'migrant' and 'ethnic minority' are complex, and definitions often vary from country to country. Regarding migrants, this presentation adopts the definition used by the UN, World Bank, OECD and EU, which defines an (international) migrant as a **'foreign-born' resident** (i.e. a person born outside the country in which he or she lives). Migrants may be classified in terms of the grounds on which they receive a residence permit, for example labour migrants, students, migrants arriving for family reunification or family formation or asylum seekers. Most irregular (or 'undocumented') migrants have at some time held a valid permit.

Migration history and background

Migration is not simply the movement from one place to another. Migration is a complex and multifaceted phenomenon that includes economic, political, psychological, social, and cultural

[14] Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a, p. 13. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).
[15] Bhopal (2013), *op.cit.*

factors. Although migration has always been related to humans as a natural fact, we are going to describe it historically in order to contextualise it.

In Europe, there are four distinct phases from the Second World War regarding migration movements:

- **From 1945 to 1970**. The first migration wave towards industrialised countries, whose education systems had incomplete assimilation programs.
- **Since the economic crisis of 1973**. Several countries promulgated restricting actions towards the arrival of immigrants, whilst other countries started or intensified family reunion actions.
- **During the 1980s.** The presence of migrants increased significantly in Europe with Turkish people in Germany and Maghrebi (Moroccan, Tunisian and Algerian) people in France. The linguistic and cultural difficulties increased, including those associated with religion.
- **Currently**. During the last decade, the situation of immigrants has deteriorated due to the economic recession. Restrictive politics towards immigration in Europe have been toughened. There is a risk of falling into a situation of desintegration or segregation within schools, although educationally the rights to the identity of ethnic and cultural minorities are recognised, along with the right to a differential education.

Europe experiences three main immigration flows.

- **From East to West.** From the middle of the last century until now, there has been a significant migrant movement that has created a parallel trend of an agricultural and industrial workforce. This workforce has moved from the poor eastern countries to the rich capitalist centres and northern Europe. Until the end of the 1960´s, the profile of immigrants in Europe corresponded to that of a young man, of working age and with low or no qualifications and a rural background. He moved within a workforce to other countries in Europe to be able to maintain his family, which stayed in the country of origin. Since 1975, this worker profile, however, was progressively replaced by four new immigration profiles: the family (women and children), the refugee or an individual demanding asylum due to war conflicts, ethnic or religion prosecution (e.g. the recent war in the Balkans), the clandestine or 'illegal' individual without documents, and the new middle class worker. The appearance of these new four categories could be explained not only in terms of economic changes in the countries of origin, but also because of the evolution of the law in the recipient countries. A gradual settlement of immigrants from Asian countries (China, Cambodia, etc.) has also been detected.

- **From South to North.** A large percentage of the African population are between 18 and 25 years of age due to the still high birth rate. Therefore, they have the highest migratory potential. The migrant movements are increasing at an alarming rate from countries that not only include Maghreb (Morocco, Tunisia, Alger), but also the sub-Saharan countries (Senegal, Sudan, Equatorial Guinea, etc.). It is not uncommon to see a massive arrival of immigrants to Europe through Spain, due to the geographical proximity to the African continent. The immigrants cross the Gibraltar strait and arrive on illegal boats or as stowaways to the Andalucian coasts and to the Canary islands.

- **From South American countries to Europe:** The main driving forces behind the emigration of these people are poverty, economic and social scarcity, and the extinction of the middle class in the countries of origin. The origin countries are varied and include Argentina, Peru, the Dominican Republic, Colombia, Ecuador, and Chile.

After the 14th century, the migration of the Romani people to Europe has primarily taken place in the past century and a half. The abolition of slavery of Roma in Romania[11], and the subsequent destitution of the freed slaves and their descendents at the end of the 19th century and the early part of the 20th century caused many Roma to flee southeastern Europe for the western and northern points in search of a better life, and at times, simply in search of food .

The last recent migration in Europe flows coming to Europe from East and Southern borders due to the Mid-East and North African conflicts.

What does the migration process involve?

There are several reasons why people move from one country to another: political, moral, religious, but, above all, economic. In this point, the decision-making process is complex and difficult, because it implies making choices, giving up, and hoping. The decision-making process also generates ambiguous feelings, stress, anxiety, feelings of guilt, sadness, fear of failure and of the unknown, etc. The migration process thus involves a migrating grief that should be taken into account.

The arrival also involves confusion and feelings of fear, as well as emotional ambiguity: joy and sadness. The new situation generates conflicts between rules and/or absence of rules that usually expresses itself as an identity crisis. Upon arrival, the caring and managing roles that some public and private institutions play in the recipient society are of fundamental importance, and at this stage, instrumental in determining the future process.

The “Intra-cultural Social Support Network” by a group of immigrants from the same country and culture of origin is also essential for reception, support, and counselling.

Recommended readings:

Cattacin, Sandro, Antonio Chiarenza and Dagmar Domenig (2013). "Equity Standards for Health Care Organisations: a Theoretical Framework." Diversity and Equality in Health and Care 10(4): 249-258.
http://www.academia.edu/5536743/Cattacin_Sandro_Antonio_Chiarenza_and_Dagmar_Domenig_2013_._Equity_Standards_for_Health_Care_Organisations_a_Theoretical_Framework._Diversity_and_Equality_in_Health_and_Care_10_4_249-258

Chiarenza, A. (2012). Developments in the concept of 'cultural competence.' In: Ingleby, D. et al (eds.). *Inequalities in health care for migrants and ethnic minorities*, Vol. 2. COST Series on Health and Diversity. Antwerp: Garant Publishers.

Council of Europe. Committee of Ministers. Declaration on cultural diversity. *(Adopted by the Committee of Ministers on 7 December 2000 at the 733rd meeting of the Ministers' Deputies).* https://wcd.coe.int/ViewDoc.jsp?id=389843 (retrieved: January 12, 2015).

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125.

Complementary readings:

Bhopal, R. (2014). *Migration, ethnicity, race, and health in multicultural societies*. Oxford: Oxford University Press.

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

Leininger, M. (Ed.). (1985). Qualitative research methods in nursing. New York: Grune & Stratton.

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

Renschler, I., Cattacin, S. (2007). Comprehensive 'difference sensitivity' in health systems. In. Bjorngren-Cuadra, C, Cattacin, S. (eds). *Migration and Health: difference sensitivity from an organizational perspective*. Malmo: IMER: 37-41 (http://hdl.handle.net/2043/4289, accessed 28/7/14).

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

Scott, J.G.M. (1990). A resynthesis of the primordial and circumstantial approaches to ethnic group solidarity: towards an explanatory modal. *Ethnic and Racial Studies,* (13)2, 147-71.

Treaty of the European Union: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012E/TXT&from=en