EduOnMed

Training for refugee and migrant professionals in matters related to medicine

2021-1-EL01-KA210-ADU-000035031

EduOnMed
TRAINING FOR REFUGEE AND MIGRANT PROFESSIONALS IN MATTERS RELATED TO MEDICINE

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EduOnMed Project

This curriculum has been developed in the framework of the EduOnMed project- KA210-ADU - Small-scale partnerships in adult education- and is based on Healthy Diversity Training Programme in the framework of the "Healthy Diversity" project.

The main objective of EduOnMed project is to bridge intercultural, intergenerational and social divides by fostering social inclusion and intercultural understanding as well as by improving the competencies of migration professionals in relation to health and medicine matters. Linked to this, the project focuses also on the physical and mental health of refugees and migrants as the skills that the participants will acquire will be used to improve the refugees and migrant's wellbeing and will help their integration.

In order to develop this curriculum, the EduOnMed partnership carried out local roundtables with professionals from health and social care sector, in Greece, Italy and Spain. The programme has been adapted according to the feedback of participants and a special focus has been done to the Covid pandemic and how it changed the perception or interaction between patient and health professional.

Problem statement – why this intercultural training is needed

Healthcare provision has become increasingly diverse, from the range of patients accessing services to the considerations that need to be met by practitioners. Diversity manifests on a daily basis: in diverse habits and forms of communication (shaking hands, eating habits, contraception, fasting, expression of feelings, concepts of the body). It proves relevant for many core questions health care staff have to pose themselves when treating patients:

- *Does my patient understand the illness?*
- *Can I confidently distinguish cultural / personal or clinical motives behind the patient's behaviour?*
- *Am I aware of cultural taboos that can affect his/her reception of the treatment proposed?*
- *Does my institution allow me to adapt to the patient's cultural / religious prescriptions?*
- *How can I deal with linguistic barriers?*
- *Which information do I have to give the patient for him/her to feel safe?*

When not addressed properly by trained professionals, challenges arising from the work with heterogeneous patients can result in the refusal of treatment, under-treatment or maltreatment, and the potential for discrimination.

For a long time, health care education in Europe has focused primarily on conveying medical knowledge to students and training specialized skills and methods deemed necessary for performing the job as a surgeon, a nurse, a paramedic, etc. What has been lacking within this approach is an emphasis on social and communicative skills needed for encountering patients as well as for working together with colleagues in teams. Furthermore, health care education in Europe rests heavily on a biomedical model of health, in which disease is indicated by bodily malfunctions and is to be diagnosed according to scientific methods of measuring and assessing the body's inner workings. Within this approach, patient backgrounds, their individual characteristics, but also their

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belonging to certain social groups, have not been on the forefront of practitioners' minds.
Even though medical concepts have begun to change over the last decades, putting more emphasis on individualised medicine and patient-centred approaches, health care students across Europe are still rarely confronted with a comprehensive training of intercultural competences needed for diversity-oriented health care work. Professionals already working in the health care sector are often lacking time and institutional impetus to further develop their intercultural competences.
As a result, staff members tend to lack intercultural competencies; awareness of intercultural competence has not been raised to its full extent, especially in rural areas. The Healthy Diversity curriculum offers 7 training modules to health professionals aiming to further develop their intercultural skills, which offer flexibility and can be chosen and adapted according to the healthcare system, existing knowledge of the participants and their busy schedules.

Current context of healthcare for refugees and migrants in Greece, Italy and Spain

Situation in Greece

Since 2014, more than 1,250,000 refugees and migrants have arrived in Greece. The restrictions that had been imposed in the wake of the coronavirus pandemic have led to a reduction in migration flows to the EU. However, the number of arrivals started to increase again in 2021 and 2022, partly due to Russia's aggressive invasion in Ukraine. A quantitative research published by the Greek Ministry of Migration, indicates that the flow of arrivals had increased by 56% in January 2022, corresponding to those of January 2021.

Migrant and refugee populations are a particularly vulnerable social group, and often face an increased risk of social exclusion. Equal access to health care and effective medical access for refugees and migrants is a key factor for their integration and the prevention of inequalities. Alongside, 37% of the refugees and migrants admitted to our country last year are children which are exposed to persistent protection risks due to inadequate security and conditions. Similarly, people who have applied for asylum and are awaiting confirmation of their recognition as asylum seekers have access to health care only in emergency situations. Meanwhile, many refugees do not have access to covid vaccinations due to administrative, policy or documentation reasons, while lack of information may also create difficulties with regards to accessing covid vaccination.

In Greece, migrants who are legally residing in the country have the same rights as Greek citizens in terms of access to healthcare. However, a large percentage of the migrant population expresses that health services do not meet all their needs, with the main reasons being long waiting times in hospitals, difficulty in communicating with health professionals, costs of care and medicines, the complexity of the system and lack of knowledge of available health services. These are compounded by cultural differences and socio-economic status, which make it difficult to access appropriate information and medical services. Still, among health professionals there still exists a lack of awareness regarding the complex needs of migrants, also with regards to medication. Such way, the large influx of migrant populations in Greece has highlighted the need for preparedness, to meet the immediate and long-term medical needs of people. In this context, the adequate education and awareness-raising of health professionalsis are essential to combat discrimination in health care in order to uphold every person's fundamental right for access in healthcare.

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Situation in Italy

For what concerns arrivals at the sea border, Italy continues to play a role in indirect push-backs by providing the Libyan authorities with the means and technologies to improve sea tracing.

In 2021, 67,477 persons had disembarked in Italy, almost doubling the number of arrivals of 2020 (34,154) and an even more relevant increase when compared to 2019 (11,471) and 2018 (23,370). However it is considerably lower than the arrivals of 2017 (119,369). The main nationality of people disembarked remained to be the Tunisians, who were 15,671 in total. Over 31,500 came from Libya, more than 20,000 from Tunisia, 13,000 from Turkey and 1,500 from Algeria. At least 32,425 persons, in 2021, were returned to Libya (already over 3 thousand as of March 19, 2022).

Problems continued to be reported in accessing the procedure, both at the borders, due to reported pushback practices and to the use of quarantine ships as de facto administrative detention facilities/hotspots in main cities. This situation has been mainly caused by non-uniform practices in different areas of the country and to the long waiting time that lodging an application entails.

In 2021, 56,388 asylum requests were registered in Italy, compared to 21,200 in 2020. The number of children seeking asylum also increased to 10,053, compared to 4,687 of 2020.7 The main countries of origin of the applicants were Pakistan, Bangladesh, Tunisia, Afghanistan and Nigeria. There were 52,987 first instance decisions (compared to 40,800 in 2020). An increase in the recognition of protection statuses was noticed; 44% (compared to 28% in 2020) of these decisions led to a protection status (32% international protection, and 12% special/ protection status).

In general, the approach to migrant health is understood as access to services at the time when an illness or emergency appears. Short attention has been given to the need of providing prevention programs that facilitate the possibility of undergoing vaccinations or follow-up screenings.

In addition to bureaucratic barriers, the migrant population often encounters language and cultural barriers. The difficulty in understanding the Italian language limits the ability of the migrant population to express their needs and requirements, and prevents them from understanding what services are available to them.

The operators' lack of knowledge about the customs, beliefs and approaches to medicine proper to the patients' backgrounds prevents them from deeply understanding who is being treated and their reasons, why they refuse a diagnosis or follow recommended treatment.
This is especially the case from a gender perspective, so that depending on the countries of origin it may happen, for example, that a woman may prefer not to be seen by a male doctor.

In general, it's necessary to have cultural mediators that can deal with resolving the language gap but also of mediating in cultural terms in order to be able to dialogue with the patient, taking into consideration the beliefs and traditions that guide the migrant in the course of treatment is of fundamental importance.

In order to facilitate access to services, it is important that health and social workers are also trained

to better manage the needs and requirements of migrant users. Operators should be trained to welcome and manage helping relationships as a necessary prerequisite for efficient service delivery, giving the capacity to understand the person and establish a fruitful relationship with them in order to provide personalized and quality care pathways. Trainings should also be aimed at delving into the methods of traditional country-of-origin medicine and also elements of ethnopsychiatry, as well as gender medicine, in order to understand that culture, gender and socioeconomic status are determinant variables to be considered in the care relationship with the patient.

Situation in Spain

Resident population in Spain increased by 34,110 persons during 2021 and stood at 47,432,805 inhabitants on 1 January 2022. The number of foreigners increased by 49,612 persons during 2021, reaching 5,417,883 on 1 January 2022. Among the main foreign nationalities, the largest increases corresponded to the Italian population (19,093 more than the previous year), Colombian (18,203) and Venezuelan (11,481).

This phenomenon of immigrant population reception makes it necessary to address a series of new issues that affect all public sectors, especially the health sector. Health care in Spain for foreigners is regulated by the Organic Law on the Rights and Freedoms of Foreigners in Spain and their Social Integration, which establishes that “foreigners have the right to health care under the terms set out in current legislation on health care”. Thus, the main aim of the latest royal decree-law launched by the government is to restore universal public health care, free of charge, so that anyone living in Spain, whether a national or a foreigner, can go to a hospital in the event of a health problem.

Full health care in Spain for foreigners means that anyone, regardless of their situation, whether they have a residence permit or not, can be treated in a public health center. However, there are a number of measures for accessing the health system. Among these measures is the need to prove residence in Spain for more than 90 days. This prevents foreigners who have their own medical coverage in their country of origin from accessing the public health system. However, undocumented immigrants also have access to health care, although they need a report from the social services certifying that they do not have the minimum resources. With regard to the purchase of prescription drugs, this group must pay the same amount as Spaniards with an income of less than 18,000 euros, i.e. 40% of the total.

In any case, it should be noted that the immigrant population suffers from difficulties in accessing the health system for different reasons: because they are unaware of the administrative procedures required for access; because they are unaware that some health services exist; because they lack the necessary economic resources to access others; because of incompatible working hours due to long working hours; or because they have difficulties in communicating with health system staff, either due to language problems or cultural issues (Chauvin, Parizot & Simonnot, 2009).

For this reason, we need a provision that offers efficient and quality care to the whole population, including migrants. The health system needs a reorientation of care through a model that responds to the experiences, expectations and health needs of a very diverse society (Karl-Trummer,

Novak-Zezula & Metzler, 2010).

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Aims and target groups

The **target group** of this curriculum are staff members in the health and social care sector, who want to take part in an interactive diversity training. These professionals come from different professional groups, such as nursing, psychology, medicine, administration, interpreting, social work, etc. Patients and relatives are not the target groups.

The **main aim** of this curriculum is to make diversity part of their professional identity. This is done in seven modules, administering a training of 3 half-days. This face-to-face curriculum is complemented by an open online course.

The **structure** of the curriculum is the following. The full duration of the curriculum is 12 hours in total, which can be split into 3 training days.

Module Title

Check-in Introduction and learning objectives
MODULE 1 Introduction to healthy diversity
MODULE 2 Diversity in encountering patients
MODULE 3 Practical intercultural communication and negotiation skills
MODULE 4 Working in intercultural teams
MODULE 5 Diversity management skills
Check-out Final feedback and goodbye

Course Aims And Objectives

• To provide the necessary background knowledge on the Healthy Diversity themes (Diversity knowledge box) in order to increase learners' awareness about socio-cultural diversity and its relevance for medical and social care practice.
• To offer real examples of both good practices and stories that would confirm the need for improved capacities as to intercultural communication and diversity management in the healthcare sector (state of the art and Diversity resource box for institutions).
• To provide learners with creative tools that they can incorporate into their daily life to enhance their capacity to work in multicultural settings, with greater consciousness and avoiding stereotyp-

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ing (Diversity toolbox).
• To promote a greater understanding of internal, contextual and cultural factors affecting individual behaviours and social interactions, while enhancing intersectional thinking between different health and social care settings.

Didactic methods

The didactic approach is based on learner-centred, interactive methods, combining a variety of training methods to facilitate diverse processes of learning and to cater to heterogeneous learning needs.
The training operates with didactical methods of face-to-face training: working groups & small groups, problem & solution focused sessions, critical incident case studies, printed material & hand-outs, group dynamic exercises, brainstorming processes and presentations. It includes icebreaking and trust-building exercises to create a good working atmosphere. The training will also employ a digital game which plays an important role in the acceleration of the learning process.

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2 Diversity Knowledge Box[1]

"Every culture is a formulation of what is true, beautiful and just, and of how to get there"
Carmel Camilleri, Professor of cultural psychology

Up to the present there is no single consensual definition of "culture". Already in 1952, Kroeber and Kluckhohn compiled a list of 164 definitions in their work "Culture: A Critical Review of Concepts and Definitions".
One of the reasons for the many definitions is that there are many different angles from which it is possible to tackle the notion of culture. Some of these perspectives are described below.

Manifestations of culture

"Culture ... is that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by an individual as a member of society." Edward Tylor, 1871

"Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, that encompasses, in addition to art and literature, also life-styles, ways of living together, value systems, traditions and beliefs" UNESCO, 2001.

Despite the examples above, we cannot have an exhaustive list of all the manifestations of cultures, and it is important to remember some elements which are likely to be forgotten or underestimated when talking about culture, such as:
- Activities such as washing the dishes, using toilets and traffic jams are also part of culture
- Religion is part of culture
- The way we use our body is cultural
- Science is part of culture, even natural sciences, their equations, axioms are cultural products.

People and cultures

Cultures are created, developed and transferred by groups of people. In a strict sense there is no "personal" or "individual culture", and the identity of each individual is composed of different features . At the same time, the type of social groups that can generate and maintain culture is very wide: we talk about national cultures, regional, urban or rural culture, gender culture, youth culture, musical subcultures, and even cultures related to the community of people with disabilities.

Acquisition of culture(s)

Get acquainted with the methodology of Margalit Cohen-Emerique, which helps better understand the mechanisms of intercultural encounters. Before you read the introduction, put a few questions to yourself and jot down your answers:

- What do you understand by "culture"?
- What was your strongest culture shock you can remember?
- What do you think was the reason for that culture shock?

1 Based on Margalit Cohen-Emerique 1999. Le choc culturel, méthode de formation et outil de recherche. In: Demorgon,J., Lipiansky,E.,M. (eds) Guide de l'interculturel en formation. Paris, Retz. Pp 301-315. 2015. Pour une approche interculturelle en travail social. 2ème éditionRennes, PRESSES EHESP

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Individuals learn the culture they are born into through enculturation, the process by which people learn the requirements of their surrounding culture and acquire values and behaviours appropriate or necessary in that culture by engaging themselves in interaction and all kinds of cultural practices with others, first of all parents (caretakers) and then schools, peers, etc.
Once an individual acquires a culture, its values, beliefs, s/he also learns to look at other cultures through the filter of this culture. This phenomenon is also referred to as ethnocentrism.
Furthermore, once acquired, such values, beliefs and practices become precious and someone may think they need to be defended. This explains the power of cultural identification and the difficulty to really adopt a relativist approach, especially when it comes to ethics.

Characteristics of culture

No culture is homogeneous, static and totally closed; they are in permanent evolution and change, also partly thanks to exchange with other cultures. This process of cultural and psychological change that results following meeting between cultures is known as acculturation.

Origins of culture

The "terror management theory" proposes that culture is a response of humans to the existential fear triggered by the awareness of our certain and unavoidable death. Other researchers, such as Tomasello, attribute the birth of culture to the capacity of "cumulative learning" seemingly unique to human beings, which is based on the recognition of others as intentional beings and allows us not to reinvent the wheel each time but to learn from each other.

Identification Of Values And Emotions In Critical Incident Analysis Concept Of Culture Shock

Culture shock – as an individual experience, and not in the sense often employed by ethnologists as "shock of civilisations" or mentalities - can have a negative tone as a reaction of disorientation, frustration, rejection, indignation or anxiety. It can trigger a negative representation of oneself and feeling of lack of approval that can give rise to uneasiness and anger. On a positive tone, culture shock can be experienced as a reaction of fascination, enthusiasm, and amazement.
Culture shock happens in situations set in a specific space and time, they are both emotional and intellectual experiences. Anyone can experience culture shock, who find themselves out of their usual socio-cultural context, and engage in interaction with a person or object from a different culture.

The Source Of The Shock

Culture shocks usually form around "sensitive zones" = cultural domains particularly important in one's cultural (i.e. national, ethnic, age, gender, professional etc..) reference frame. It is important to stress that these sensitive zones are different according to one's nationality, ethnicity, religion, age, professional culture, political culture etc..
The list below is proposed on behalf of Cohen Emerique's work and our own exploratory project (Intercultool 2009).
For each sensitive zone we propose the value dimensions along which cultures can differ (several dimensions identified by researchers such as Hofstede, Trompenaars, Kluckhohn).

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Domains or "sensitive zones"	Value dimensions
Rules of social organisation: gender roles, the role of community, family	- Basic unit: individual or community? = individualism VS collectivism or interdependence - Equality VS acceptance of inequality - Gender equality – hierarchical gender relations, fixed gender roles, gender differences emphasised or diminished
Embodiedness: role of physical contact, experience of body, hygiene, smells, climate	- Ritual erasure of the body (e.g. taboo of nose blowing, body sounds, smells etc) – expectations / acceptance of body manifestations - Preference of physical contact – avoidance of physical contact - Eye contact a value and sign of respect – eye contact sign of disrespect and prohibition of eye contact with people higher in hierarchy - Preference of shorter / bigger physical distance in interactions (always in accordance with the relationship of interaction partners) - acceptance of physical punishment or prohibition of physical punishment based on physical integrity - physical integrity VS use of the body to participate / show belonging to social groups, religions etc.
Conceptions and uses of space	Context rich communication = use of the arrangement of the space, of the position in space to communicate VS context-poor communication: not much relevance of special arrangement in the communication, rather it is the verbal message that has priority - Approach to the environment focusing on domination / instrumentalisation VS harmony
Conceptions and uses of time	- Linear vs nonlinear - Monochronic (one task in one moment) vs Polychronic (several tasks in the same time simultaneously) - Future / past / present orientation
Way of life, working style	- Problem solving approaches: focus on relation or the task - Democratic vs hierarchic problem solving - Explicit vs implicit rules of conduct - Rules applicable to everyone the same way VS importance of adapting rules according to the situation (universalist vs. particularist)

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Domains or "sensitive zones"	Value dimensions
Thinking, learning style, conceptions of the world	- Tolerance of uncertainty vs. avoidance of uncertainty - Materialist / scientific approach VS transcendental – magico-realistic Approach
Interaction codes and patterns	Direct vs indirect communication - Context rich vs context poor communication - Formal vs informal communication
Intergroup relations, different demographic and religious composition of the societies	- Groups must be well separated (ex. Cast system) VS differences between groups must be minimised - Particular cultural patterns / heritage must be valued and guarded (=multiculturalism, particularism) VS differences must be diminished and similarities emphasised (= universalism)

Reactions Accompanying Culture Shock Experiences [2]

Emotions are indicators that "something is happening", they reveal a strong reaction to a conflict, to some tension, to the difference between an expected and a received scenario. Some emotions often brought up during the decentration with pictures exercise:

Mostly negative, variations of:
- Fear, terror
- Pity, sorry
- Anger, frustration, revolt
- Disgust
- Pain
- Miscomprehension, confusion, embarrassment, puzzled, surprised

Sometimes positive:
- Joy, beauty
- Admiration, amazement
- Empathy
- Happiness

Beyond emotional reactions, behaviour reactions also occur, the most common:
- Avoidance, running away, retreat
- Aggression, violence
- Nausea, headache, "bad feeling"

2 Based on Margalit Cohen-Emerique 1999. Le choc culturel, méthode de formation et outil de recherche. In: Demorgon,J., Lipiansky,E.,M. (eds) Guide de l'interculturel en formation. Paris, Retz. Pp 301-315. 2015. Pour une approche interculturelle en travail social. 2ème éditionRennes, PRESSES EHESP

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3 Diversity Resource Box For Institutions

"Differences make a Difference". This slogan from a diversity management programme reflects that diversity basically means differences or dissimilarity. So, when diversity is expected to make a difference, we automatically associate diversity with a positive and beneficial change. However, diversity must be contextualised, anchored, managed and followed up regularly to be effective. Diversity must have a clear goal and be implemented through conscious choices of strategy and methods in order to make a positive and sustainable difference.

The concept of ***diversity management*** represents this anchorage and the conscious implementation process. Thus, diversity management is essentially an organisational term, which in itself points to organisational goals, strategies, practices and skills.

This applies in particular to institutions and organisations with core functions within welfare services to citizens characterized by cultural diversity and diverse needs. These include institutions being responsible for providing service on equal terms for all citizens regardless of origins, socio-economic and socio-cultural affiliations. This is a core characteristic of the healthcare sector, and therefore diversity management and intercultural skills have a strong and significant importance for the building of organisational structures and for the professional upgrading within this sector.

For Additional Resources, please, see the resource box section.

What are the implications of diversity management in organisations?

The diversity strategy ***challenges the values and basic assumptions in the organisational culture****. Entering the diversity management strategy, many institutions and workplaces have to build a whole new attitude towards differences, diversity and otherness. Diversity is not a question of merely tolerating differences and otherness – and* ***adapting differences and otherness to the prevailing culture*** *and existing behavioral norms. On the contrary, diversity management is a question of expanding the organizational, mental and behavioral frameworks, thus to transform differences into resources that strengthens the overall competence of the organization.." (Margit Helle Thomsen, mhtconsult)*

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4 Diversity Toolbox For Health Professionals

4.1 Introduction To Healthy Diversity

The aim of this session is to offer a guide to participants into the conceptual universe of Healthy Diversity. We will establish a common vocabulary which will facilitate working with the participant group during the full training. More particularly participants will form a common understanding of concepts like culture, cultural identity, frame of reference, critical incidents and sensitive zones. Furthermore the session will also highlight how culture may influence medical practices and how basic notions related to health and illness that seem to be universal are in fact highly relative and culture-sensitive. Participants will be led to think about how to acknowledge differences without rigidifying them.

Authors: Diana Szántó
Time frame: 3.5 hours
Sample session

Ethical problems related to healthcare in intercultural settings	
1) Learning objectives	This session aims at focusing on the problems of moral decision making during the doctor-patient encounter when the parties have different cultural identities. We would like to put emphasis on the very nature of biomedical ethics and formulate the critiques of it on the basis of cultural diversity. Participants will be aware of the core values on which biomedical ethical principles rely and will be able to identify the difficulties when moral dilemmas have to be solved in a multicultural environment. Language barriers represent one of the most well-known obstacles in these situations, but the nature of these barriers are often superficially or barely understood. During this session, participants will learn how to gain a more thoroughly elaborated understanding of the impact of language on moral thinking. Additionally, partakers are encouraged to take a critical perspective on the universalistic approach to the moral universe that characterizes biomedical ethics.
2) How to run this session	After giving a brief theoretical overview of the problem with the help of some thought experiments, major problems should be highlighted actively involving the participants into the discussion. Then the session is continued using mentimeter or kahoot – live survey systems, in which real-time answers of participants can be mapped and immediately discussed in class.

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3) Methods/ style of delivery	Blended learning approach with some frontal teaching and live simulations using live surveys. The trainer advises the participants to enter www.menti.com and to enter the password projected on the screen to the actual survey. Participants answer the posed questions on the website live. Which obstacles can you imagine in a doctor-patient relationship? Think of 5 answers and submit them live with the help of your smart devices (phones, tablets). Your answers will be seen immediately on the projected screen in the form of a word-cloud. (Examples: communication problems, misunderstandings, time constraint, language, hierarchy, taboos, gender, different expectations, lack of motivation...) The trainer discusses the results with the group trying to contextualize and adapt the answers into an intercultural encounter: what if the doctor (service provider) and the patient have a different cultural identity. Trying to get an answer from the participants to the question: Do people of differing ethnicities and cultures view medicine and bioethics differently? And if they do, should they? The presentation part of the session gives a brief insight into the 4 bioethical principles, which are widely used today in solving ethical dilemmas in medicine: respect of autonomy, not harming anyone, beneficence, and justice (Beauchamps, Childress 2012). Tensions between these principles are discussed, for example when a doctor is confronted with the wish of a patient for euthanasia. In this case, the doctor is drawn between beneficence – wanting the best treatment for the patient (healing, saving their life) – and respect of autonomy – letting the patient make his/her decisions on their own (in this case to end their life). Furthermore, examples are given about situations where the different moral views of the parties (doctor/patient) create enormous difficulties in applying these principles. (E.g. when the patient's autonomy is not valued by herself as much as the doctor would assume, or when the privacy of the visit is understood differently, or about truth-telling, especially in relation to pious fraud). One big group of problems stem from language barriers, but this kind is often overlooked and simplified to the obstacles of understanding foreign languages. Helping to understand the very nature of the problem, the trainer chooses amongst some well discussed moral questions as exemplification. Live surveys still can be used to assess the answer of the participants to a moral dilemma prior to the discussion.

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	E.g. The famous Trolley dilemma (1967) is introduced in a new context by Costa et al (2014). In this example groups of people with different mother tongue were asked about two versions of the dilemma: in one group the questions were explained and posed in their native language, while in the control group in a foreign language. Results suggest that utilitarian decisions were made more likely in foreign languages – so the language in which a moral question is to be discussed has an impact on our choice. In other words: the same problem may imply different solutions in native and in a foreign language. This situation happens quite often in hospital wards today due to the increasing diversification of our societies. Other nicely discussed examples can be chosen (e.g. Harris 2003, Geipel 2015).
4) Didactic recommendations / information for the facilitator	Ethical debates can easily be endless and often useless, so the facilitator should be focused on the given issues and should not allow participants to include their personal histories that much. However, including a personal touch always makes it more accessible and understandable. So the challenge here is to find the proper balance between these two important elements.
5) Resources / equipment	PC, beamer Power point Wifi for the participants Live survey system
6) Issues to consider	It would be nice to prepare and include practices from the countries of the participants. Case studies can also be nicely used here, but may exceed the frame of this session. This session needs to be adapted to the specific audience and their training needs and be made more specific or more basic according to the audience's previous knowledge of the subject.
7) Duration	*45 minutes*
8) Glossary	*bioethical principles, moral thinking, informed consent, language barriers, cultural dimensions*

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4.2 Diversity In Encountering Patients

Module 2 focuses on how to better understand patients/relatives from different cultural backgrounds. But how to behave once we have this understanding? Is it the health professional's role to adapt to the other entirely? How to know until when adaptation is required from the health professional? Or how to get from the understanding of one's own and the other's reference frame to the negotiation of mutually acceptable solutions for the problem?

Authors: Clara Malkassian, Vera Varhegyi
Time frame: 6 hours
Sample session

Culture in the room	
1) Learning objectives	To tackle the notion of culture with a relatively prepared group (participants who are familiar with some basic concepts) To discuss the notion of culture and to become aware of how culture surrounds us in any moment To point to the connection of the more visible aspects of culture with underlying values
2) How to run this session	Participants are split into small groups, after the exchange in the small groups has taken place, participants are led back into the plenary and asked to present their discussions. The facilitator moderates and tries to make sure that all groups add to aspects brought up by one group.
3) Methods /style of delivery	Participants are asked to write down three signs of culture in the room on a piece of paper. The trainer assigns one of three fruits to each participants (i.e. banana, cherry, orange). Participants are asked to find the other members of their groups and share the signs of culture that they found in the room. Afterwards, they are asked to discuss in the small groups which values stand behind the manifestations of culture. Model of understanding culture: **The metaphor of the iceberg** For the signs that participants have identified in the room, they are asked to find underlying values. Just like with an iceberg culture produces some very visible manifestations of culture, which are built upon values, ideas, concepts that are hidden beneath ("under the water"). What we can see is in a way a "tip of the iceberg", that is the easily perceptible outer layers of culture.

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	However these outer layers are not free-floating, nor are they coincidental: they are the manifestations or consequences of deeper values that organise and orient our life. The groups are asked to uncover these hidden values the visible manifestations are based on. At this point ask participants to go back to the elements they have noted before and try to identify which values correspond to them. Some examples: The arrangement of the room: spatial arrangement reflects a representation of knowledge sharing and hierarchy. Frontal arrangements (participants seated in rows all facing the facilitator) imply an idea that it is the facilitator that possesses the relevant knowledge and transfers it to students, whereas circular arrangements reflect an idea of distributed knowledge and a belief in the value added of the participation of all. If we are all sitting in chairs around the table, this reflects a representation of learning as a cognitive, disembodied activity, where only brains / heads need to be involved (as opposed to a more embodied conception of learning where moving, bodily activities are included). The big clock on the wall can reflect the value of linear time perception where "time is money" and the duration of activities is carefully calculated, time frames are kept precisely. This would be in contrast with a more polychromic approach where time is less linear, more flexible. The way we are dressed tells about our values of gender (women may need to be beautiful, wearing make-up, jewellery, veil, etc. and men expected to not to wear all these things) conception of "decency" (what is it that we need to cover…) and of course aesthetics, etc. Are there images on the wall of kings / political leaders / religious figures? If so you can address them too. Are there instructions related to safety? These are connected to both the value of physical integrity and to a preference of reduced uncertainty. How we talk: probably taking turns? Waiting for one to finish before we start? Values related to politeness and respect govern our communication, while values and preferences related to verbal or non-verbal communication, expression of emotions, etc. give the more or less subtle differences in how we communicate.

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	WIFI-code written on a flipchart: Values associated with it: connection with the outside world, connectedness, constant availability, communication, technology in society (dependence) In the final round, after participants have identified elements of culture and values connected to them, they come back into the big group. Each group presents one sign of culture and the values they have identified corresponding to it. The facilitator asks if any other group identified the same sign and if there could be further values connected to it. Examples: It is important to also think about the bodies in the room, how the individuals represent culture. A handout on emotions and values is handed out, in order for participants to check important elements of emotions and values to think about when analysing manifestations of culture.
4) Didactic recommendations / information for the facilitator	The facilitator should have thought through the aspects of culture in order for him/her to be able to address the values that may be connected to these. To close the activity give a short recap of the main message of the activity: culture surrounds us, is within us at all moment of our life. Visible elements of culture are connected to values which give meaning to these visible manifestations. We react to what we see based on our own system of cultural references in which we integrate cultural perceptions, values, and preferences of different social groups we've been in contact with. At the end of the chat ask participants whether there is a small change in how they now see the space surrounding them.
5) Resources / equipment	Flipchart, pens Paper for the participants to note 3 signs of culture Handout "Emotions and values"
6) Issues to consider	At first the decoding of cultural elements may be difficult but after the first few examples it becomes easier. Participants may need some help to understand what counts as "value". A metaphor that can be useful is the compass: values usually indicate what is considered as true, worthy in a given culture – in a way it orients our thoughts and behaviours.
7) Duration	*30 minutes*
8) Glossary	*visible elements of culture*

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4.3 Practical Intercultural Communication And Negotiation Skills

This module provides an understanding of intercultural communication, the principal elements and challenges of negotiation, a conceptual approach toward rational thinking and trains the learner in professionally using the most suitable tools and techniques to establish productive and cross cultural relationships and agreements. The module emphasises continuing personal professional development and specialisation to allow health practitioners to bring a high level of expertise and insight when dealing with diverse patients.

Authors: Claire Edwards, Junaid Hussain, Maggie O'Rourke, Suki Rai, Priya Tek-Kalsi
Time frame: 4 hours
Sample session

Intercultural Communication and Culture as an Iceberg	
1) Learning objectives	Introduction to intercultural communication Be aware of and understand cultural differences in communication Identify cultural variations in communication styles and possible barriers Identify resource requirements to overcome barriers
2) How to run this session	The facilitator will need to be familiar with theories behind intercultural communication This part of the session will comprise of: Brainstorming exercise PowerPoint slides Small group activity / discussions
3) Methods / style of delivery	**Activity introducing non-verbal communication** For this activity, participants move around in the room and do small exercises together with other participants: Participants are asked to walk around in the room and choose two people, without telling them, and while walking around position themselves in the same distance to each of the people they have chosen. Since the people chosen may keep moving, participants may have to readjust in order to keep an equidistance. After some time, stop the activity and see whether participants know who they were chosen by. Participants are asked to walk around and make eye contact with someone who will be their partner.

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	One of them will be the subject and the other one will be the mirror. The mirror reflects everything the subject does. Instruct participants that they shall try to move in a way that outsiders do not know who is the subject and who is the mirror. Blind car: in pairs, one standing in front of the other. The first person has their eyes closed. The person standing behind is the driver who will drive the car with the following movements: tapping on the head to move forward, tapping on the right shoulder to move right, tapping on the left shoulder to move left. Tapping on the back to move backwards. **Definitions of intercultural communication** are presented to the group and related to the exercises previously done. Which elements does communication entail? How does verbal, non-verbal and para-verbal communication differ from each other? How may cultural differences inform the different forms of communication? This section continues with the description outlined in module 1 of culture, using the iceberg analogy, focusing on aspects of communication. How are communication styles and methods connected with either the overt (iceberg tip) or the underlying, invisible dimension (underneath the water) of the iceberg? Participants are split into groups and asked to find examples of communication styles and locate them on the iceberg, i.e. high degree of physical contact at the top of the iceberg and the corresponding underlying value of a preference for proximity and expressing closeness. After working in small groups, participants will share the examples they found with the plenary. It is the facilitator's job to really dig deep and try to arrive at underlying values and to divide overt expressions from covert value systems. The group will then be asked to compare similarities between **methods of expression/ communication** of their differing **cultural identities.** The facilitator needs to make sure that a broad concept of cultural identity – i.e. differences in medical special fields – is taken into account. In plenary participants will discuss **how cultural differences can impact on the communication styles / preferences** identified above. At the end, a PowerPoint slide will be displayed detailing different levels of communication.
4) Didactic recommendations / information for the facilitator	This session refers back to the iceberg concept introduced in module 2 and the core concepts of culture and cultural identity discussed in module 1. Thus, the facilitator needs to make sure to build on the previous discussions and take them up in order to now reflect on communication.

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5) Resources / equipment	Powerpoint Flip chart paper Flip chart pens Blue tac
6) Issues to consider	That duplication from module 1 is avoided. The emphasis should remain on intercultural communication and the individual techniques that participants use.
7) Duration	*45 minutes*
8) Glossary	*intercultural communication, negotiation theories, intercultural negotiation*

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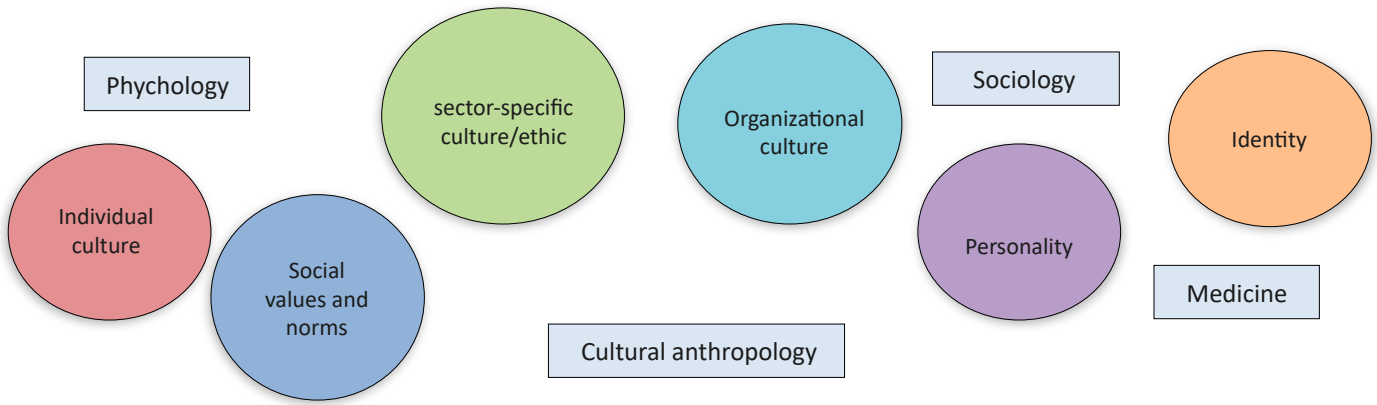
4.4 Working In Intercultural Teams

The overall aim of the module is to enhance the ability to build a sustainable and trusting, well-functioning workplace characterised by good group dynamics. The sessions, in fact, will encourage participants to further reflect on their personal/professional identity and values, focusing on stereotypes and possible prejudices they might hold, and developing a greater understanding of how personality affects team-work. The importance of having trusting and well-functioning group dynamics is especially important in intercultural teams, where misunderstandings linked to the different cultural backgrounds are more likely to occur compared to more culturally homogeneous settings. However, if good group dynamics and tools to solve intercultural conflicts are in place, the working process and outcomes will be efficient, rewarding and will indeed benefit from the intra-group diversity.



Authors: Alessandra Cannizzo, Noemi De Luca
Time frame: 3 hours
Sample session

Values at work	
1) Learning objectives	To enhance learners' understanding of additional intertwined elements affecting intercultural teams (i.e. social values and norms, organisational culture, sector-specific ethics and expectations, personality) To identify one's own work-related values and attitudes using the Values at Work Checklist To reflect on cultural stereotypes in relation to work behaviour

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2) How to run this session	As introduction, participants are guided to reveal the keywords of this module (words in the diagram above) through a revised version of the evergreen guessing game “the hangman” (15 min). The word to guess is represented by a row of dashes (one per each letter) drawn on a large piece of paper. One after another, participants guess / suggest a letter and if it occurs, the facilitator writes it down in all its correct positions. In the original version of the game, if the suggested letter does not occur, the facilitator would rather draw one element of a hanged man stick figure as a tally mark (other images could be used, e.g. a tree with falling fruits). At any time players can attempt to guess the whole word. If the word is correct, the game is over and the guessers win. On the other hand, if they make enough incorrect guesses to allow the facilitator to complete the “hangman”, the game is also over, this time with the guessers losing. In order to make this introductory activity faster, players could be asked to simultaneously guess all the words, therefore drawing on the poster various circles containing the rows of dashes for the different words. Although questions and examples from participants are always welcome, no discussion is meant in this introductory phase, as the additional definitions are contained in the handout and learners will reflect on them afterward. Individually, **participants read each statement of the “values at work checklist” and indicate how strongly they tend to exhibit the described attitudes in their professional life (0= never, 5= always)**, reflecting at the same time on the reasons: Is it linked to the personality? To social expectations? To the organisational culture of the workplace? Is there any difference regarding the attitude towards such values when **comparing personal and professional life?** 20 min ***Direct:*** I prefer people to go directly to the point and not to spend time beating around the bush. (1–5) ***Indirect:*** I think it is important to avoid conflict even if it means only hinting at difficult issues. (1–5) ***Being frank:*** It is important to be frank, open and honest at all times, even at the risk of causing others to lose face and experience shame. (1–5) ***Saving face:*** It is important that nothing I do causes others to lose face, even if this means that I have to find other ways of transmitting important information. (1–5)

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	Theory: I prefer to learn by receiving and absorbing information from an expert source. (1–5) ***Practice:*** I prefer to learn by exploring, practicing and experimenting with new ideas. (1–5) ***Deal:*** When I have a job to do, I prefer to focus on the task: walking straight into the situation, sorting things out and moving on. (1–5) ***Relationship:*** When I have a job to do, I prefer to focus on the people: spending time getting to know those I will work with. (1–5) ***Prompt:*** I prefer people to stick strictly to measureable and structured deadlines. Being on time is the key to efficiency. (1–5) ***Flexible:*** I prefer people to take a flexible approach to timekeeping. Being flexible about deadlines is the key to efficiency. (1–5) In pairs, participants discuss their reflections with the partner, focusing on potential differences linked to **the type of relation considered (colleague-colleague or colleague-patient).** 20 min Debriefing in plenary. 30 min Why are these differences important? (i.e. diversity of skills and preferences in teams) To what extent are they related to the specific organisational culture participants work in? (i.e. communication rules in teams) How might these differences become apparent in the working environment? (i.e. how detailed people write e-mails) How might people from another country or culture perceive your approach? What challenges do these differences present? In what ways might you adapt your behaviour to manage and overcome these differences?
3) Methods / style of delivery	This module is based on participatory and learner-centred methods where all participants are actively involved. In particular, for this activity the methods used are: Warm-up introductory game (15 min) individual self-reflection (20 min) peer-to-peer learning / brainstorming (20 min) group discussion (30 min)

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4) Didactic recommendations / information for the facilitator	During the debriefing participants could also share about experiences with other assessment tools and what they have learned from them.
5) Resources / equipment	The "Values at Work" checklist from www.culturewise.net/wp-content/uploads/2013/05/Cultural-awareness-training-exercise-pack.pdf Paper and pencils Flipchart and pens
6) Issues to consider	-
7) Duration	*90 minutes*
8) Glossary	*intercultural teams, identity, stereotypes, organisational culture , social culture, sector-specific ethics, individual culture, personality, medicine, psychology, social psychology, anthropology, cultural anthropology, sociology*

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4.5 Diversity Management Skills

Authors: Margit Helle Thomsen and Henning Schultz
Time frame: 2 hours
Sample session

Session 5.1 ***Diversity management and intercultural competence – state-of-the-art in my healthcare organisation***	
1) Learning objectives	That participants' awareness of the state-of-the-art of diversity management and the approach to intercultural communication and understanding in their own healthcare organisation is enhanced. This may also include the lack of diversity management and intercultural practices in the organisation. The state-of-the-art analysis is carried out by using a specific process- and profile tool which helps the participants to draw a diversity profile of their healthcare organisation, in terms of the organisational culture and values, the recruitment policy and practices, etc. Moreover, the process- and profile tool also provides the participants with an insight into strategic perspectives of diversity management and how to start the implementation process. That participants exchange analyses, profiles and reflections as well as practical experience in terms of institutional / organisational strategies and procedures for diversity management and intercultural competence in their healthcare work places.
2) How to run this session	In order to meet these objectives, **session 5.1** will alternate between: **5.1.1.:** An introduction to the process- and profile tool "From small attempts to concrete steps", thus to make the participants ready for an individual analysis of the diversity management state-of-the-art in their healthcare organisations. **5.1.2:** Group work including group presentations on the state-of-the art analyses and profiles in terms of diversity management in the participants' own healthcare institutions / work places group reflections on key questions related to challenges, potentials and barriers to the implementation of diversity management and intercultural competence in healthcare organisations **5.1.3:** Group presentations of key results from the group work on key questions

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3) Methods / style of delivery	**5.1.1:** timeframe 25 minutes **Methodology:** The facilitator briefly introduces the objectives of the section, underlining the inductive approach to the diversity management module, where we are starting with the state-of-the-art analysis in specific healthcare organisations. From this experience, we will move to a general theoretical-practical understanding of the concept of diversity management and intercultural competence from the structural / institutional perspective. The facilitator provides a thorough step-by-step introduction to the process- and profile tool "From small attempts to concrete steps", which is an easily accessible and suitable tool for making a profile analysis and creating awareness of state-of-the-art in the participants' own healthcare organisations. The process- and profile tool was originally developed by mhtconsult for municipal service providers, including municipal healthcare services. Later, it was adapted to the private sector and also to foreign municipal frameworks. Thus, the tool was previously tested in healthcare services as well as in other services in both public and private sectors. The participants conduct their individual profile analyses for their own healthcare organisation. If some participants are working in the same organisation, they still make an individual profile analysis, thus getting the opportunity to compare experiences during the subsequent group work. **5.1.2:** timeframe 30 minutes **Methodology:** The participants are divided into groups, approx. 3–4 people in each group. Participants from the same organisation may form a group together. However, they may also spread to different groups. The group work is based on the following procedures: The participants in the group briefly present their individual profile analysis of their own organisation. The other participants are allowed to ask clarifying – but not analytical – questions. After the individual presentations, the participants point to key elements and awareness points from their analyses: Which diversity profiles are present in the group – ranging from high to low in terms of organisational diversity management and structured intercultural procedure and practices?

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	What would be the most important challenges and barriers in the present healthcare organisations in terms of diversity management? Would it be lack of leadership, lack of engagement, lack of competences and tools, etc.? What could be a first step towards diversity management in healthcare organisations, and who is responsible? Name three good reasons for establishing strategies for diversity management in the healthcare sector, including participants' own organisations. The groups write key words on these issues on large paper sheets.
4) Didactic recommendations / information for the facilitator	It is important to communicate the basic didactic idea of the inductive approach, where some theoretical / deductive questions and reflections will only be addressed in the subsequent module. So, the participants must understand the basic order of introductions, where their own experience is the starting point, whereas the conceptualisation will be the last and summarising point.
5) Resources / equipment	Learning materials for the introduction of the process- and profile tool Copies for each participant of the tool materials and instruction exercise Large paper sheets and speed markers for the group work
6) Issues to consider	As the definition of diversity has already been a subject in the first module, it is important to stress from the beginning of module 5.1 that we are now taking a step further and explicitly elaborating on organisational practice and the very concept of diversity **management**.
7) Duration	*90 minutes*
8) Glossary	*diversity management; affirmative action; diverse recruitment; cloning culture; complementary culture; corporate culture; working organisation and division of labour; decision-making procedures*

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5 Course competencies - recap

Linked to the course aims and objectives, the competence framework is composed of three macro areas: *knowledge, skills and attitude*, which respectively refer to the cognitive, psychomotor and affective domains of learning. Each area includes five competencies that are linked to the various activities and resources.

Cognitive Domain

KNOWLEDGE of the internal, contextual and cultural factors affecting individual behaviors and social interactions

- Understand the concepts and the practical application of the Critical Incidents Methodology.
- Know at least two good practices in relation to intercultural communication and diversity management in the healthcare sector as they are assessed through the project assessment tool.
- Have an overview of the collected critical incidents, in relation to the different sensitive zones.
- Develop an in depth knowledge of at least two critical incidents.
- Develop familiarity with the basic concepts of medical anthropology and read at least two literature reviews.

Practical Domain

SKILLS that learners can incorporate into their daily life to enhance the capacity to work in multicultural settings

- Analyse experiences of cultural shock through the Cohen-Emerique analysis grid.
- Improve IT skills thanks to the different tasks carried out during the course.
- Assess a healthcare practice using the Healthy Diversity assessment tool.
- Have familiarity with at least two practical training activities for professionals in the health and social sector.
- Have the ability to clearly convey the basics of the Healthy Diversity approach on diversity in the healthcare sector.

Affective Domain

ATTITUDE, that is the awareness about the relevance of socio-cultural diversity for medical and social practice

- Have a greater sense of self-awareness about own cultural lens.
- Reflect on the cultural aspects of interactions and disagreement, developing negotiation strategies accordingly.
- Mature higher levels of consciousness during interactions, with clear attempts to avoid stereotyping and sexism.
- Improve intersectional thinking between different health and social care settings.
- Develop an international understanding of diversity in the healthcare sector thanks to the interactions with colleagues and other professionals from other countries.

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6 Resource

- **Good Practice Catalogue** and Collection of European good practices on diversity management and intercultural communication capacities. Practices are presented through a short descriptive template.
- **Good Practice Assessment Tool** to provide a comprehensive monitoring, evaluation and impact analysis of efforts on diversity management and intercultural communication in healthcare institutions.
- Video 1 - Migrant woman and vaccination
- Video 2 - Roma family in crowded hospital room
- Video 3 - Hospital as home

7 Literature sources

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- Unhcr operation guidance on refugee protection and solutions in urban areas

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Annex I Healthy Diversity Glossary

GLOSSARY

A

Anthropology

Literally “the science of humanity” that studies human beings in aspects ranging from the biology and evolutionary history to the features of society and culture.

(Encyclopaedia Britannica, www.britannica.com)

B

Bioethics

Bioethics interrogate the ethical and philosophical bearings associated with biomedicine, i.e. what does this mean for the conceptualisation of death, where does life begin, what types of procedures are acceptable from an ethical standpoint, etc.

Biomedicine

Biomedicine denotes a concept of medicine, dominant in the Western hemisphere, in which knowledge of health and disease is gained through natural sciences and scientific methods. Biological processes are deemed most important for understanding and treating bodily conditions conceived as diseases. Biomedicine is linked to specific assumptions about what constitutes health / a healthy body and which factors are considered relevant for diagnosis and cure. While physical and biochemical processes are given priority, social context and individual experiences are largely neglected.

C

Critical incident

A critical incident is a first-hand experience with one or more other people, located in a concrete time and space that causes a heavy emotional reaction (that can be negative or positive) in the narrator. The experience is both cognitive and emotional, and may also involve physical reactions (see also culture shock).

The method of critical incidents developed by French social psychologist Margalit Cohen-Emerique proposes an ingenious strategy to uncover the set of cultural norms, values, behaviours that people bring into an encounter with others, and which filter the way they interpret and respond to others. It helps to become aware of the illusion of our own cultural neutrality, and invites us to explore the cultural reference frames in a more objective way, and opening up a margin for negotiation where prejudice has a lesser role to play.

(Cohen-Emerique 2015: 65)

Cultural anthropology

A major division of anthropology that deals with the study of culture in all of its aspects and that uses the methods, concepts, and data of archaeology, ethnography and ethnology, folklore, and linguistics in its descriptions and analyses of the diverse people in the world. (Medical anthropology

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emerged as a special field of research and training after World War II, when senior American anthropologists worked as consultants on oversea health care projects).

(Encyclopaedia Britannica, www.britannica.com)

Cultural identity

Our personal identity includes our group affiliations, and the sum of our social roles and statuses, but what we make out of this material is a unique composition. We position ourselves differently in different situations. (Healthy Diversity project).

Cultural values and norms

Communities and societies are based on shared cultural values and norms that regulate actions and behaviours, but that also generate meaning. A metaphor that can be useful for thinking about values is the compass: values usually indicate what is considered as true and worthy in a given culture – in a way it orients our thoughts and behaviours. Norms on the other hand are concrete regulations of how to act or how not to act in a certain situation.

Culturalisation

Culturalisation refers to a process by which a situation is interpreted through the lens of cultural difference and the actions of a person are primarily attributed to their cultural background – even in moments where other factors (personal, situational, etc.) are at play. Thereby the impact of cultural difference is overemphasised, running the risk of reifying, essentialising culture and reinforcing differences.

Culture

“Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of a society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (UNESCO 2001)

“Each culture is an answer to the question of what is beautiful, true and just – and how to get there” (Camilleri, C. Les conditions de l’interculturel 1990).

Culture shock

“Culture shock is an interaction with a person or object from a different culture, set in a specific space and time, which provokes negative or positive cognitive and affective reactions, a sensation of loss of reference points, a negative representation of oneself and feeling of lack of approval that can give rise to uneasiness and anger”.

Culture shock – as an individual experience, and not in the sense often employed by ethnologists as “shock of civilisations” or mentalities – can have a negative tone as a reaction of disorientation, frustration, rejection, indignation or anxiety. It can trigger a negative representation of oneself and

feeling of lack of approval that can give rise to uneasiness and anger.
On a positive tone culture shock can be experienced as a reaction of fascination, enthusiasm, and amazement.

Culture shocks happen in situations set in a specific space and time, they are both emotional and intellectual experiences. Anyone can experience culture shock, who find themselves out of their usual socio-cultural context, and engage in interaction with a person or object from a different culture.

(Cohen-Emerique, 2015: 65)

Annex II Culture shock analysis grid for screenshot

ANALYSIS GRID FOR CULTURE SHOCK
MARGALIT COHEN-EMERIQUE

Describing the SITUATION
Please give a short account (10-15 sentences) of a critical incident you experienced. Write from your own point of view. Include where and when the incident took place, how you felt, what you did. (Do not analyze the incident, that will be a next step..)

1. Identities of the actors in the situation
Who are the actors involved in this cross-cultural situation, what are their identities (age, sex, origin, profession, etc.), what kind of connection are there between them and with their social groups?

2. Context of the situation
What is the concrete situation/context in which this scene takes place (physical context, social, psychological, etc.)?

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3. Emotional reaction
The shock reaction: experienced feelings and if the shock raised any particular reaction (feelings, behaviour etc).

4. Representations, values, norms, ideas, prejudice: The frame of references of the person who experienced the shock.

5. What image emerges from the analysis of point 4 for the other group? (neutral slightly negative, very negative, “stigmatized”, positive, very positive, real, unreal, etc.)

6. Representations, values, norms, prejudice: The frame of references of the person or group that is causing the shock / that caused the shock in the narrator.

7. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

Other remarks:

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Annex III What happens when our individual values contrast with the ones of our workplace or the society we live in? Reflect on that through the "values at work checklist"

VALUES AT WORK CHECKLIST

Read each statement and indicate how strongly you tend to exhibit the described attitude in your professional life (0=never, 5=always), reflecting at the same time on the reasons: Is it linked to your personality? To social expectations? To the organisational culture in your workplace? Do you notice any difference regarding your attitude towards such values when **comparing** your **personal and professional life?**

Statement	Self assessment
Direct: I prefer people to go directly to the point and not to spend time beating around the bush.	
Indirect: I think it is important to avoid conflict even if it means only hinting at difficult issues.	
Being frank: It is important to be frank, open and honest at all times, even at the risk of causing others to lose face and experience shame.	
Saving face: It is important that nothing I do causes others to lose face, even if this means that I have to find other ways of transmitting important information.	
Theory: I prefer to learn by receiving and absorbing information from an expert source.	
Practice: I prefer to learn by exploring, practicing and experimenting with new ideas.	
Deal: When I have a job to do, I prefer to focus on the task: walking straight into the situation, sorting things out and moving on.	
Relationship: When I have a job to do, I prefer to focus on the people: spending time getting to know those I will work with.	
Prompt: I prefer people to stick strictly to measureable and structured deadlines. Being on time is the key to efficiency.	
Flexible: I prefer people to take a flexible approach to timekeeping. Being flexible about deadlines is the key to efficiency.	

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Annex IV Stabbing pain? A burning heart? Cultural variations in the experience of pain (AT)

Written by Agnes Raschauer

Text reference: Kohnen, Norbert (2009): Feeling and coping with pain in different cultures. In: Ruth Kutalek / Armin Prinz, eds. Essays in Medical Anthropology. The Austrian Ethnomedical Society after Thirty Years, p.321-328. LIT Verlag GmbH: Vienna.

Introduction

Generally, the experience of pain is either thought of as something purely individual or connected to biological processes that affect all human beings in a certain way. Thus, some people seem to have a high threshold for pain, while some people seem to have a lower one and might be considered oversensitive to pain. However, how humans experience pain and make sense of it, is not only subject to their individual tolerance level or simply given on the basis of biochemical reactions. Rather, experience of pain hinges on social ways of making sense of the world, which affect how bodily sensations are interpreted. In his paper, Norbert Kohnen delineates **cultural variations** in the concepts that underlie **the experience of pain**. Reviewing anthropological research, he gives a vast number of examples of how pain is experienced and processed in a culturally specific way.
Being unaware of variations in how pain might be felt and expressed in different cultures can have negative effects for a medical practice, for example when a doctor thinks that a patient is not in pain when actually what happens is that the patient's experience does not fit with the doctor's preconceived ideas about how pain is felt.

Anthropologies demonstrating cultural variations in the experience of pain

Kohnen explains that while there are few cultural variations in the *"sensation threshold* […] the lowest stimulus that results in tingling or warmth" (p. 321), the ***pain threshold*** is found to be highly variable. A very illustrative example is by Hardy et al. (1952), who reports that heat levels considered painful are experienced quite differently by people living in the Mediterranean and people living in Northern Europe. Heat levels the former define as "warm" are considered painful by the latter[3]. The author further refers on the ground-breaking work of Mark Zborowski (1951, 1969)[4], who established that not only experience and expression of pain are highly variable and subject to culturally specific interpretations of the world, but also how communities deal with suffering members. He carried out anthropological research (interviewing, handing out surveys and doing observations on-site) in a veteran's hospital ward, focusing on four patient groups: Irish Americans, Italian Americans, Jewish Americans and Old Americans. Zborowski concluded that while Irish American patients hardly talked about their pain and withdrew in isolation, Italian Americans tended to be quite outspoken about their suffering and in need of social contact. He also reported different approaches to pain in terms of how much weight a patient put on the fact that he was in pain and how much he trusted his own experiences.

3 Hardy, James Daniel, Harold George Wolff and Helen Goodell (1952): Pain sensations and Reactions. Baltimore: Williams & Wilkins.

4 Zborowski, Mark (1952): Cultural components in responses to pain. *Journal of Social Issues* 8: p. 16-30. Zborowski, Mark (1969): People in pain. San Francisco: Jossey-Bass.

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"Cultural coping strategies"

Within anthropology the ways of handling pain that cultural communities develop are called **"cultural coping strategies"** (p. 323). These strategies build upon knowledge and traditions that have been passed down from previous generations and have long informed social practices of dealing with disease, pain and healing. They entail culturally accepted scenarios showing individuals how to act in the advent of pain and how to make sense of it. The ***"control beliefs"*** a cultural group holds on to be especially relevant for developing specific coping strategies. While the British, the Irish or people from Northern Europe are characterised as individual-oriented, with a tendency for an internal control belief, the Italian or the Turkish society are described as family-oriented with a tendency for an external control belief. This means that the former tend to focus on the individual when dealing with pain, keeping feelings inside and opting for social retreat. The latter, on the other hand, prefer the company of family members when suffering and also devise communal strategies for handling pain.

Kohnen describes five distinct coping strategies and attributes each to an "ethnic and religious group" that it is characteristic for, while stressing that "all named strategies will be found proportionately within every culture" (p. 323). Among others, Kohnen names ***fatal strategies of coping with pain*** which entail attributing the ending of pain to a higher entity. As a consequence, the suffering individual has little obligation to act, i.e. to seek a doctor and to do "the right thing" in order to alleviate suffering. Sometimes magical practices are carried out which may have an impact on how the pain is experienced. ***Religious treatment of pain***, customary e.g. among Christians or Buddhists, on the other hand conceptualises pain as a trial an individual has to endure in order to demonstrate his/her faith. A third concept is a ***rational treatment of pain*** in which pain is examined, attributed to a specific body part, monitored and subjected to professional medical treatment. An emotional approach towards pain seems out of place.

Conclusion: Attention toward cultural variations in experiencing pain needed in medical practice

Kohnen argues that treating pain as a universal, single phenomenon is detrimental to quality care. Patients might express their experience of pain in various ways: by retreating, by rationalising, by crying and demonstrating emotional distress. No one expression of pain is more valid or more indicative of a true suffering than the other. Holding on to the idea that the experience of pain and even the pain itself, as communicated by the patients, has to manifest a certain way, leads to misunderstandings, frustration and maybe even maltreatment of the patients' conditions. "Every patient is an informant, but not every informant is a good one. Whether or not a patient is a good informant really depends on the examining doctor and how well they understand their patient and how well they are able to broaden the horizons and experiences of the informant.".

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Annex V Women and mothers: Meaning of their vulnerability in migration flows (IT)

Written by Alessandra Cannizzo
Text reference: "Donne e madri nella migrazione" (Women and mothers in migration) by Viapiana, S., Antrocom Online Journal of Anthropology, 2011; 7:1+, pp. 83-91.

Abstract
In recent years, the role of women in migration flows has also become crucial in terms of structural changes in the migrant communities. The new setting leads them to rethink their traditional values and norms when confronted with the different concepts, ideas and organisational structures of the host country, in terms of an understanding of the body and organisation of the social and health systems, etc. Migrant women are particularly affected by such re-signification and negotiation processes, especially as far as motherhood, marital relationships and bodily rituals (e.g. infibulation) are concerned.

Introduction
The paper by anthropologist Stefania Viapiana presents an interesting analysis offering practical examples on how some corporal practices and lifestyles vary according to the country and culture of the origin of the people. Firstly, the author introduces the concept of "double transit", understood as the challenging situation experienced by the migrant woman who finds the values and norms of the host country different from hers, but also has to deal with the values of her culture of origin. Secondly, the author analyses the new challenge for migrant women fighting for autonomy from the authority of the husband in the new social context. References to eminent experts are offered in the text in an attempt to clarify some aspects of gender identity and to shed light on the meaning of practices of "female genital modifications", taking up some cases for reflection. In the case of gender identity, some facts presented by the experts underline how in certain cultures the superiority of the man is perceived as a natural and biological matter, an idea which is greatly shared and actively contributed to by women themselves. The topic of female genital modifications is analysed through several examples indicating such practices as rituals that are preserved by women as part of the local tradition. Finally, a set of studies is presented, which highlights how some traditional practices become challenging for those women who are living as migrants in contact with Western populations.

Double transit of migrant women and aspects of ethno-psychiatry
The author offers an overview of research, including recent anthropological contributions, focusing on individual identity crisis experienced by migrants, and on the risk of overlooking gender identity issues in such contexts.
A study by Levinson and Beneduce (2004) has shown that societies with lower incidences of violence against women are those where there is an efficient division of power between genders. Based on these results, the author states that conflicts arising after migration events are the outcome of changes experienced by the couple, which is modified by new life conditions. Therefore, the original idea proposed by Viapiana is that the migrant woman is fighting a new enemy that is the authority of her husband for the conquest of her autonomy in the new social context.

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Detailing the novelties introduced by the new setting where the migrant woman is living, the text further clarifies that the cultural identity of the woman becomes even more difficult with no support from family or from the parental group. Part of these difficulties is the fact that she is not able to resort to some of the rituals of the origin country, a circumstance that often causes psychological disorders. Many examples are related to childbirth, for instance as to the protection of the baby from demons (e.g. djinn in the Maghreb region) or special food and hygiene habits for both the baby and the future/new mother. According to Ba, it is possible to define such ceremonies as real "transition rituals" (Ba, 1994, pp. 59-72) aimed at appeasing the fears and anxieties of the woman who has just given birth and decreeing the arrival of the baby in the group.
Viapiana offers her point of view on a "double transit" phenomenon, occurring when migrant women are "confronted by the novelty of the values and norms of the host country, whilst also being painfully removed from the values and practices of their culture of origin" (Viapiana, 2011, p.86, translated).

Gender identity and gender conflicts

In the second part of the publication the author expands on the theories of gender identity and gender conflicts elaborated by a range of experts and researchers, with the aim of providing a theoretical background to the explanation of cultural practices involving the body of migrant women in Western society. The anthropological theories and studies presented offer an overview of the social and cultural construction of the identity of the woman as inferior to men, symbolically and practically. The unequal relationship between men and women is also represented in the different concepts and practices around the body of the woman and her characteristics perceived as inherent "natural" handicaps, such as fragility, less weight, less stature, pregnancy and breastfeeding (Nahoum-Grappe, 1996; Héritier, 2002). In these regards, Héritier argues that the concept of otherness started from something seen as interrupting the world's harmony, maybe a transgression (she recalls the notion of lost paradise). For instance, Western African mythology holds that women and men used to live in separate and independent groups and were able to reproduce autonomously. Afterwards, the discovery by men of women's bodies as a source of pleasure and not related to reproduction, offended the creator divinity, which therefore forced men and women to live together. This tradition is not an isolated case as many cultures worldwide have myths where women give birth without any male contribution and are rather fecundated by natural elements (wind, sea) or by parthenogenesis.
Moisseeff (1997) proposes another interesting example by stressing how the relationship between settlers and colonised populations, and in general between dominators and dominated people, has an impact and relevance especially in the spheres of sexuality, body, reproduction and gender roles. The author links the conflicts related to gender to the resistance that the developing economies oppose to the increasing cultural hegemony of more economically developed countries.

Infibulation, abscission, identity: the marks on the body

This section of the paper examines the reality of the corporal practices exercised on women's bodies, supported by some examples from different cultural traditions. Systems of signs, mythic and ritual customs focusing on the body of the woman and her sexuality are widely present in several societies. Viapiana stresses the prevalence of such processes controlling the reproductive sphere

of the woman, and carrying a wide range of meanings and purposes, for instance purification, marking the passage from childhood to womanhood, or reinstating harmony and social order in contrast with the disorderly female body.

Female genital modifications are practices that could be found since before the emergence of the major world religions (Islamic, Jewish and Christian) and are a persisting ritual for the maintenance of power relations among dominant and subordinate cultures. Different rituals related to such modifications exist in different societies (Ethiopia, Saudi Arabia, Somalia, Egypt and Sudan), where infibulation prevails in order to control the sexuality and virginity of women. Sometimes, it also has the meaning of purification or is intended as the removal of a remotely-masculine body part (the clitoris) to force the female child into the "correct" sexual category (e.g. the Dogon tribe in Mali, studied by Griaule in the 1930s). Through such examples and studies, Viapiana underlines how the integrity of the body, can be listed among one of the most challenging values when it comes to the encounter of different cultures. Different rationales exist for marking the body (e.g. the regulation of power dynamics, as stated by Augé, 2002), which convey different meanings and certainly influence the psyche of the "marked" woman. The experience of infibulation is hardly revealed by migrant women; however, as the author stresses, they refer to it as a fundamental experience in their life, necessary to comply with aesthetic standards of beauty of the female body in their culture of origin (Fusaschi, 2003).

Viapiana emphasises the deeply conflicting values of Western and other societies surrounding female genital modifications, a conflict that migrant women from infibulation-practising countries are bound to experience in the host country.

Van der Kwaak, (1992, pp. 777-787) remarks that for instance in Somalia chastity and the control of female sexuality are deeply linked to the definition of female identity itself. In this context, infibulation has an initiation value that is expressed by both the ritual and the language used, in fact, before the surgery a girl is called gabar ("small girl"), whereas after she becomes qabar dhoocil ("infibulated girl") and therefore "a marriageable girl" for whom the future husband will have to pay "the bride's price". In addition to that, the fact that girl's hair gets shaved makes even more explicit the initiation meaning of the ritual.

Conclusion

The current immigration system introduces some challenges in the everyday life of those who flee their countries, as well as in the life of the population in the receiving countries. Undoubtedly, women are the most vulnerable in these processes, first and foremost because they are mothers and because of the different meanings attached to their bodies. As supported by Viapiana through several references to a number of studies, migrant women are called to face a "double transit", as they must confront both the values and norms of the host country, while having to deal with the values of their culture of origin.

On the one hand, the author offers in the text a critical understanding of different practices surrounding the female body in cultures other than the Western. On the other hand, she shows a great distance between the values of the migrant communities and those of the host countries (although with some commonalities, such as the binary conception of female and male), underlining an even greater difficulty for migrant women to negotiate between dominant values in their culture of origin and of those in the receiving society. To conclude the author provides food for thought

allowing the clarification of the role of women in societies affected by migration. Given the variety of examples and the diversity of the authors cited, the text is an accessible introduction to the challenging aspects of cultural diversity related to health.

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Co-funded by
the European Union