

HEALTH EVIDENCE NETWORK SYNTHESIS REPORT 62

What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European Region?

Themed issues on migration and health, IX

Orla McGarry | Ailish Hannigan | Maria Manuela De Almeida | Santino Severoni
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Health Evidence Network synthesis report 62

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Abstract

The provision of effective health care to linguistically and culturally diverse migrant populations has been identified as a crucial public health issue. This scoping review examines strategies which have been implemented and evaluated to address communication barriers experienced by refugees and migrants in health care settings across the WHO European Region. Four main types of strategy were identified: cultural mediation, interpretation, translation of health information, and guidance and training for health care providers. These have been used to support access to health care, management of specific diseases and promotion of health across a wide variety of health care settings. Intersectoral collaboration was seen as important in the development and implementation of strategies. Policy considerations include the development of national policies and the promotion of intersectoral dialogue to augment the knowledge base and resolve the common issues identified, such as provision of training and confusion regarding the roles of mediators/interpreters, that affect strategy implementation and evaluation.

Keywords

COMMUNICATION BARRIERS, CULTURAL COMPETENCY, LINGUISTICS, TRANSIENTS AND MIGRANTS, REFUGEES, DELIVERY OF HEALTH CARE, EUROPE

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ABBREVIATIONS

GP	general practitioner
IOM	International Organization for Migration
NGO	nongovernmental organization

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SUMMARY

The issue

The provision of effective health care to linguistically and culturally diverse migrant populations has been identified as a crucial public health issue in contemporary society. Persistent evidence across countries, and over time, indicates that communication barriers can severely hamper access to, and use of, health care services by refugees and migrants, leading to health inequalities. However, the development of national policies on migrant health in general, and on communication barriers in particular, varies significantly across countries. Many European countries have no clear policy guidance in this area and there are notable differences in the focus and scope of existing policies.

The development of pragmatic and ad hoc responses to the challenge of overcoming communication barriers, such as the use of friends and family members as interpreters and the use of online translational tools in consultations, can cause clinical, social and ethical problems. More formalized responses (i.e. deliberate as opposed to ad hoc) and initiatives by statutory and non-statutory agencies to address communication barriers have proven efficacy in reducing inequities between ethnically diverse groups in North America. Little is known, however, about the policies and formalized responses that have been implemented and evaluated in the WHO European Region.

The synthesis question

The review will systematically examine the evidence available for policy and formalized responses to address the question: "What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European Region?"

Types of evidence

Evidence was obtained by a scoping review of both peer-review and grey literature published in English and Russian between 2008 and 2018. A total of 49 studies from 14 Member States of the WHO European Region on policies and formalized responses that had been implemented and evaluated to address communication barriers for refugees and migrants in health care settings in these Member States were considered for the review.

Results

Four main strategies were identified in the Region: (i) cultural mediation, (ii) interpretation, (iii) translation of health information, and (iv) guidance and training for health care providers.

Most studies reported on external, process evaluations. Analysis of the included studies highlighted characteristics such as the goals and roles involved. These strategies are usually implemented as a result of intersectoral collaboration between two or three agencies, such as the statutory health care service, nongovernmental organizations (NGOs) involved in migrant health, and academic institutions. The identified strategies are usually implemented in one or more regional sites, with only one example of a nationally implemented strategy. There was limited evidence about the resources required for implementation.

The two most commonly discussed strategies in the literature were cultural mediation and interpretation. Further analysis of their implementation found different perspectives on whether these are two distinct roles or a dual role for interpretation/mediation and coordination of communications. This role confusion, as well as problems in the nature and quality of training for cultural mediators and interpreters, can prevent refugees and migrants from fully participating in consultations and reduce the motivation of health care providers to use these formal strategies to support communication with refugees and migrants. Other implementation challenges were found, including a lack of training among health care providers to work with cultural mediators and interpreters and a lack of availability of trained and accredited cultural mediators and interpreters in health care settings. The studies examining translation focused on translation and cultural adaptation of written materials on specific disorders or on issues such as communicating with clinicians and availability of health services. Intersectoral collaborations have been used to address all these issues. An incident reporting system has proved useful when using interpreters in health care settings and it could support the implementation of the reporting system and other formal strategies in day-to-day practice.

Findings on the effectiveness of implemented strategies on health outcomes, knowledge, health behaviour and access to and utilization of health care were encouraging. These findings provide a strong imperative to develop policy considerations to improve the implementation of formal strategies to address communication barriers experienced by refugees and migrants in health care settings.

Policy considerations

The main policy and practice considerations based on the findings of this review in the WHO European Region are to:

- encourage collaboration between statutory health care organizations, non-statutory organizations such as NGOs with an interest in migrant health, and academic institutions to develop and implement strategies to address communication barriers for refugees and migrants in health care settings;
- establish intersectoral dialogues on cultural mediation and interpretation among academic, policy, health care and professional organizations and NGOs concerned with refugee and migrant health to:
 - clarify the terminology used to describe the role(s) of mediating and interpreting, and
 - develop and implement consistent systems across countries for training, accreditation and professionalization;
- provide training for health care staff in working effectively with cultural mediators and interpreters in cross-cultural consultations with refugees and migrants;
- ensure the use of professionals who have been trained and accredited for mediating and interpreting roles in health care settings;
- establish incident reporting systems in health care settings where strategies to address communication barriers are being implemented to provide a system-level mechanism for reporting, monitoring and responding to problems and barriers to implementation;
- involve migrants in developing and implementing strategies to address communication barriers;
- encourage development of a combination of strategies such as specific clinics and support services within a centre to support both health care professionals and refugees and migrants in provision of effective health care; and
- develop a national policy that emphasizes the importance of formal strategies to effectively address communication barriers experienced by refugees and migrants in health care settings.



1. INTRODUCTION

1.1 Background

1.1.1 Migration in the WHO European Region

Communication is at the heart of good health care and encompasses linguistic and cultural aspects: the cultural nuances and meaning behind words must be fully understood by health care providers and patients for information exchange about presenting symptoms and the patient's social world in order to deliver comprehensive, equitable health care (1,2). The provision of effective health care to linguistically and culturally diverse migrant populations is a crucial public health issue in contemporary society (3–5). As defined by the International Organization for Migration (IOM), the term **migrant** includes any person who moves across an international border away from their habitual place of residence, regardless of legal status. Migration may last from several months to a lifetime and may be caused by a variety of factors, from forced migration of refugees and asylum seekers to migration for family reunification or for educational or economic reasons (6–8). Globalization and technological developments have resulted in the movement of ever more diverse groups (in terms of cultural, geographical and socioeconomic background) across international borders (8).

The increased diversity among migrants is reflected across the WHO European Region. Migration into the Region accounted for nearly 70% of population growth between 2005 and 2010 (9). Currently, migrants residing in the Region account for almost 10% of the total population. The proportion of migrants living in the Member States of the WHO European Region varies from 1.1% in Bosnia and Herzegovina to more than 50% in Monaco (10).

1.1.2 Health care provision for migrants

The challenges associated with addressing diversity and promoting health in resident refugee and migrant populations vary for each Member State depending on the proportion, type and country of origin. While the health problems are generally similar in refugees and migrants and the resident populations in the Region, there can also be differences. For example, the dangerous journeys undertaken by some refugees and asylum seekers can affect their health and resilience and can worsen the health of those with chronic diseases (11). In addition, the experience of migration and loss of existing social and familial networks can culminate in social isolation,

loneliness and stress. Navigation of unfamiliar, and often complex, health systems on arrival in the destination country can further exacerbate stress and anxiety (12).

World Health Assembly resolution WHA 61.17 called upon the Member States to promote equitable access to health promotion, disease prevention and health care for migrants (13). Equitable access (and more specifically on universal health coverage) was regarded as essential for effective public health responses in 2008, well before the current large increase in migration flow into the Region (14). The 2010 Global Consultation on Migrant Health was convened in response to this resolution and outlined an operational framework in which one component was migrant-sensitive health systems in which health services are delivered to migrants in a culturally and linguistically appropriate way by a workforce that has the capacity to address the health issues associated with migration (15). This was confirmed as a priority in the WHO framework of priorities and guiding principles to promote the health of refugees and migrants adopted at the Seventieth World Health Assembly in 2017 (16). The Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region emphasizes the need to (i) address communication barriers in order to strengthen health systems and (ii) promote the health of refugees and migrants (17). This emphasis is also a policy imperative for the Council of Europe (18).

Communication is at the heart of good health care and encompasses linguistic and cultural aspects. The cultural nuances and meaning behind words must be fully understood by health care providers and patients for information exchange about presenting symptoms and the patient's social world in order to deliver comprehensive, equitable health care. While the provision of effective health care to linguistically and culturally diverse migrant populations has been identified as a crucial public health issue in contemporary society, the development of national policies on migrant health in general, and policies about communication barriers in particular, varies significantly across countries. Many European countries have no clear policy guidance on migrant health and there are notable differences in the focus and scope of the policies that exist (19). A study of policy implementation in Portugal, Spain and the United Kingdom reported that, where policies do exist, they are not always evaluated (20). Against this backdrop, consistent evidence across countries and over time indicates that communication barriers can severely hamper access to, and use of, health care services by refugees and migrants, leading to the following (1):

- limited knowledge about what health care services are available to them and what their health care entitlements are;
- discomfort about approaching health care services because of language differences;



- incomplete information exchange about symptoms during consultations, which affects clinical decision-making and can result in clinical errors; and
- limited understanding of verbal or written information provided by health care providers, which can result in noncompliance with treatment or lack of opportunities for health promotion and disease prevention.

These outcomes lead to health inequities, either directly (e.g. language barriers cause stress and stress causes ill health) or indirectly (e.g. difficulties in making appointments can mean that health care services are not accessed and utilized, with subsequent negative health effects) (21).

The literature clearly shows that family members and friends (including children) and bilingual health care staff (such as hospital cleaners and administrative staff) try to support communication between migrants and their health care providers on an ad hoc basis (22,23). Online translation tools may also be used during consultations. These ad hoc responses have been extensively examined by academics (23–25) and, while they are pragmatic and can be useful, they are replete with clinical, social and ethical problems. They, therefore, cannot be promoted as best practice. As an example, Box 1 describes specific problems with the use of family members and friends as ad hoc interpreters.

Box 1. Problems with the use of ad hoc interpreters in health care settings

Several studies have highlighted problems with using ad hoc interpreters to support communication between refugees and migrants and their health care providers (23,26,27). For example, family members and friends are not trained as interpreters and are unlikely to have the appropriate medical vocabulary, leading to inaccurate and incomplete transmission of information. Using children as interpreters has additional problems, including:

- the authority of parents may be compromised by reliance on their child for interpreting;
- the parent and/or child may experience emotional trauma, fear, embarrassment or shame; and
- the child may miss school to accompany a family member to a health care consultation.

Moreover, online translational tools cannot provide accurate or comprehensive details of symptoms to both parties and cannot cope with psychosocial/mental health issues or the complexity of cultural interpretations of health and illness.

There are also examples of more formalized responses, that is, deliberate (as opposed to ad hoc) initiatives by statutory and/or non-statutory agencies to address communication barriers. These responses include translating health information; hiring interpreters, cultural mediators or bilingual health care providers; and training health care staff in cultural competency/diversity. Such responses have proved effective in reducing inequities among ethnically diverse groups in North America (28). The use of trained interpreters rather than untrained family members or friends, for example, significantly reduces errors with potential clinical consequences (26,29,30), thus raising the standard of care to equal that of patients without communication barriers (31). There are also complex debates in the literature about interpreting versus mediating roles (2,25,32,33). For example, are these distinct roles? Cultural mediators, whose focus is usually to act as a bridge between community members and health care services, sometimes interpret. Similarly, interpreters may become involved in mediation-type activities during health care consultations, such as addressing conflicts that arise or taking an advocacy role. Furthermore, the terminology used to describe these roles and the availability and extent of training, accreditation and professionalization vary across countries.

1.1.3 Objectives of this report

Little is known, however, about what policies and formalized responses to address the identified communication barriers for refugees and migrants in health care settings have been implemented and evaluated in the WHO European Region. This review systematically examines the evidence base for policy and formalized responses to address the question: "What strategies have been implemented and evaluated to address communication barriers experienced by refugees and migrants in health care settings?"

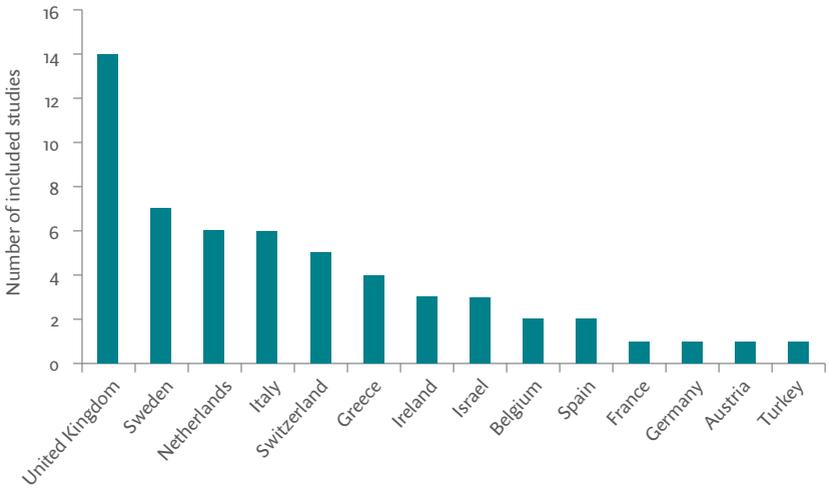
1.2 Methodology

A literature search of peer-reviewed and grey literature was carried out in April and May 2018 to identify empirical research on policies and formalized responses which had been implemented and evaluated to address communication barriers for refugees and migrants in health care settings in the WHO European Region. Studies published from January 2008 to April 2018, in either English or Russian, were included. Annex 1 outlines the databases and websites searched and the scoping review methodology (34).



The search of peer-reviewed literature returned 902 articles, of which 120 were eligible for full-text screening and 46 were eligible for inclusion (see Annex 1). The search of grey literature returned 2933 documents of which 155 were eligible for full-text screening and three were eligible for inclusion. A total of 49 studies were included for synthesis (35–83), originating from 14 of the 53 Member States of the WHO European Region (Fig. 1).

Fig. 1. Distribution of studies across the WHO European Region.



2. RESULTS

The results are presented in three sections. The first discusses what strategies have been implemented and how they have been evaluated. It describes the key characteristics of each strategy: what it entails (e.g. in terms of its goals and the roles and responsibilities of actors) and what health care settings it is used in and for what purposes. The second draws on process evaluations, describing the characteristics of implementation with reference to the actors involved, whether the strategies are part of new or existing services, and the resource implications. It also provides further analysis of implementation issues for the two most commonly discussed strategies: cultural mediation and interpretation. The third section draws on outcome evaluations, examining the effectiveness of the strategies on improving health knowledge, health behaviour and health care utilization.

2.1 Types of strategy

In the 49 studies in this review that have been implemented and evaluated to address communication barriers experienced by refugees and migrants in health care settings in the Region, four main strategies could be identified: cultural mediation, interpretation, translation and cultural adaptation of health information and materials, and guidance and training for health staff. A variety of other strategies included a migrant-friendly hospital initiative, employment of bilingual staff, two culturally adapted treatment programmes that did not use cultural mediators, and establishment of a database of language needs. Five studies provided examples of combined strategies (35–39).

Most of the included studies ($n = 44$, 90%) had a defined or explicit aim to evaluate the strategy used; the others provided data on evaluation in their discussion of the primary focus of the study. In most studies ($n = 40$, 82%), the evaluation was external (i.e. led by researchers from external organizations rather than the health care providers implementing the strategy). A variety of methods were used to evaluate the strategies, including qualitative methods ($n = 24$, 49%), quantitative methods ($n = 13$, 27%) and mixed methods ($n = 12$, 24%). Most evaluations were concerned with the experiences of refugees and migrants accessing or utilizing health care (i.e. process evaluations; $n = 33$, 67%); 12 studies (24%) were outcome evaluations (i.e. evaluating the effectiveness of the strategy to improve health knowledge, health behaviour or access to services), and four studies (8%) evaluated both the process and the outcomes.



2.1.1 Cultural mediation

Cultural mediation studies addressed the linguistic and cultural aspects of communication through a bridging role to connect migrants with the health care system. Multiple terms were used to describe this role across studies, such as cultural mediator (40,41,43,44), bilingual worker or advocate (37,45,46), link worker (43,44), community health worker (40,47) and lay advisor or educator (48,49). All descriptions of the role emphasized that cultural mediators share the same language and culture as the migrant community being served. Generally, the role of the cultural mediator was to encourage and enhance the use of services by, for example, explaining to migrants what the service provided and fostering their trust in the service and its staff. Cultural mediation, therefore, has three main components: language interpretation, a responsibility to mediate cultural differences or facilitate intercultural communication and knowledge about a given health topic or service of interest. Depending on the study focus, cultural mediators conducted their duties in community or health care settings and engaged in formal or informal meetings and interactions (Case study 1).

Case study 1. Effective use of community representatives to increase foreign-born women's participation in a Swedish cervical cancer screening programme

A qualitative analysis of the role of community representatives (i.e. doulas) in a local community collaboration to increase the participation of foreign-born women in a cervical cancer screening programme in Sweden found it beneficial to engage representatives who shared the cultural background and mother tongue of the target group (40).

Doulas support new parents during pregnancy and childbirth. They usually live in the same area and have the same cultural background as those they support. Their role is to interpret language as well as culture. For this initiative, doulas worked closely with midwives and advised on the cultural adaptation of the cervical screening service. Before the intervention they received formal training on the skills needed to promote the screening programme to the target community, on the Papanicolaou test (Pap smear) and on the screening service. In follow-up training sessions with midwives, the doulas were able to discuss questions that had arisen from their meetings with the public and obtain answers for those they had been unable to answer themselves. In meetings with the target community at local events and through relevant community associations, they presented information on a new mobile unit for Pap smears.

Case study 1. (contd)

Informal meetings with business owners (e.g. of local fruit stores, computer shops, kebab shops and hair salons), identified based on the local knowledge of the doulas, were arranged to promote the service and discuss the service directly with women. As the doulas were living in the community, they were always available to answer the women's questions. The analysis showed that verbal communication was considered more effective than translated written materials because the latter can be difficult to understand and cannot address any fears associated with the test. After one year of collaboration with doulas, the number of Pap smears in the target community increased by 42%.

The focus of the bridging role in studies examining cultural mediation was quite varied. In some studies, the strategy aimed to enhance access for migrants to all services in local health units or hospitals (42,45). More commonly, however, cultural mediation services were put in place to improve access to health care for specific conditions such as diabetes (43,44,46), mental health (48–50), tuberculosis (47), chronic disease management (51), cancer (37), HIV (53) and general practitioner (GP) care for psychosomatic symptoms (52). Two studies provided examples of cultural mediation to improve access for migrant women to health care: these focused on gynaecology and family planning (54) and cervical screening services (40). Examples were found of cultural mediation to promote migrant health by promoting the participation of migrant mothers in a physical exercise programme (55), enhancing health literacy (56), providing health education information on travel health (57) and providing a telephone health promotion counselling service (41). Some studies focused on the use of cultural mediators in community-based settings designed to provide services for migrants, for example in a health care support centre for foreign families (58), in delivering peer education interventions for recently settled migrants (59) and in the use of cultural mediators to support humanitarian aid workers and teachers in refugee reception centres (38,39).

2.1.2 Interpretation

The identified studies used the term interpreter to describe those actors supporting the linguistic aspects of communication through translating spoken information from one language to another.



Studies on interpreting described face-to-face health care consultations in hospitals (60,61), primary health care (62–65), a rest home (66) or the health system in general (67). Other studies were condition specific and reported on the use of interpreters in dementia evaluation (70), and cancer (37,68), mental health (69) and diabetes (71) care services. Two studies described the use of interpreters working with humanitarian aid workers and teachers in a reception centre for refugees (38,39). Another study was on the use of interpreters in a health information session with asylum seekers about their rights to health care (35).

2.1.3 Translation

Studies on translation had a focus on written materials and their cultural adaptation. Two studies focused on translating information about migrants' rights to health care (35,75).

Two focused on clinical settings: translation of a leaflet designed to improve doctor–patient communication (76) and translation of written materials on osteomalacia for south Asian patients by the United Kingdom Arthritis Research Campaign (77). One study focused on written materials for migrants in a refugee reception centre in Greece about the asylum-seeking process, including available health care services (78).

2.1.4 Guidance and training for health care staff

The guidance and training strategy aims to provide direct support for skill development for health care providers, including guidelines for health care professionals to work with interpreters (42) and training in cultural competence for primary care staff (42), cultural awareness and sensitivity (56) and cross-cultural mental health (72). In another two examples, support was provided through cultural consultancy services that aimed to provide direct support for clinicians who experience intercultural difficulties (i.e. by developing the clinicians' skills to elicit relevant social and cultural information from patients during consultations), as well as modelling good practice in ethnographic interviewing to develop clinicians' knowledge of cultural anthropological perspectives in psychiatry (73) and in a general hospital setting (74).

2.1.5 Other strategies

The Migrant Friendly Hospitals initiative (Case study 2), incorporating a combination of strategies, emphasized the importance of facilitating access to professional

interpreter services and cultural consultancy services, routine collection of patient language data, training health workers in cross-cultural communication, and adapting information to migrants' health literacy levels. In another strategy, bilingual pharmacists were deliberately employed in a community pharmacy setting (79). Two studies from the Netherlands reported culturally adapted treatment programmes for Turkish migrants, both delivered via the Internet (80,81): one focused on providing easily accessible web-based treatment to address the high prevalence of depressive disorders among Turkish migrants (80), and the other was a culturally tailored web-based intervention promoting screening for hepatitis B virus infection in this community (81). Finally, there was a strategy to consolidate available datasets to map language needs and resources in major transit and entry points in Europe, which has significance for the humanitarian workers, including health care providers, working in these settings (39).

Case study 2. The Migrant Friendly Hospitals initiative

As part of a national strategy on migration and public health, the Swiss Federal Office of Public Health has promoted the development of migrant-friendly hospitals (36). The Geneva University Hospitals is one of five hospital groups funded under this initiative.

For over 15 years, the Geneva University Hospitals has been developing migrant-friendly services, including several specific primary care clinics for asylum seekers, uninsured patients and migrant children; a paediatric ethnopsychiatry consultation service; a consultation service for victims of war and torture; a community interpreter service; and a cultural consultation service to aid clinicians who encounter cultural barriers with their patients. However, there was no systematic and widespread provision of information to staff about these services and how to use them.

A working group set up with representation from the main clinical departments at the hospital identified and implemented activities to improve staff knowledge on and use of the existing migrant-friendly resources. The activities included creating a new nurse position to provide information to staff on migrant care issues; developing and disseminating brochures; providing a presentation to all new staff on the available resources; promoting a national telephone interpreting service as part of the emergency services at the hospital; including patient language data in electronic patient files; and organizing public dissemination events.



A staff survey assessing the Migrant Friendly Hospitals initiative (36) suggested that the institution-wide information campaign contributed to increased awareness and use of migrant-friendly resources by clinical staff. The importance of the commitment and financing from the hospital, along with interdepartmental participation in all activities, were highlighted as contributing to a migrant-friendly institutional culture (36).

2.2 Characteristics of implementation

2.2.1 Analysis of all strategies identified

Several different actors and agencies were involved in strategy implementation: statutory health care organizations, non-statutory organizations such as NGOs with an interest in migrant health, and academic institutions. Many strategies were implemented in multiple settings at the subnational level through interagency collaborations.

Regarding their location, 18 studies (37%) described strategies implemented at a single site, 27 studies (55%) related to more than one site and one strategy (2%) was implemented at a national level.

Half of the studies provided evidence on existing strategies for a particular setting, while the rest examined strategies being introduced/piloted ($n = 24$, 49%). While cultural mediation was described as a pilot/new strategy, interpretation was often described as an existing strategy.

Limited evidence was found on the resources required for strategy implementation. One three-year Swiss study reported that using professional interpreters in a hospital setting added to health care costs at first but appeared to be cost-effective in the longer term. The authors posited that the use of professional interpreters can prevent the escalation of costs. This was because an effective solution for patients with language barriers could be achieved after fewer consultations with the use of a professional interpreter service than without (60). (See Case study 3.)

Case study 3. Saving costs using professional interpreters

A Swiss cross-sectional survey collected data on the hospital health care costs for 795 asylum seekers, including consultations, diagnostic examinations, medical interventions, stays in the clinic, medication and the use of professional interpreter services (60). Analysis of data from a three-year period found that

Case study 3. (contd)

higher health care costs were incurred when there was a language barrier between asylum seekers and health professionals. Most of the higher costs were attributable to the use of professional interpreting services.

Importantly, however, asylum seekers facing language barriers who used professional interpreter services attended health care services less frequently than others who instead relied on ad hoc informal interpreters. This shows that provision of an interpreter enables an effective solution to be reached after fewer visits through achieving a clearer understanding of the patient's condition. This suggests that any initial higher cost can become a long-term investment in health care for asylum seekers with language barriers.

2.2.2 Further analysis of cultural mediation and interpretation

Given that most studies identified in this review were related to cultural mediating and interpreting, data on their implementation was analysed further. The analysis showed that the terms **cultural mediator** and **interpreter** are sometimes used interchangeably within studies (58,82). There were also different perspectives on whether these represent two distinct roles or a single dual interpretation/mediation role. Box 2 provides illustrative examples on this issue from two studies. The broader literature includes arguments to both support and challenge these conceptualizations and perspectives (25,33), but it was beyond the scope of this review to discuss them further.

Box 2. Differing perspectives on the roles of mediators and interpreters

The following quotations provide examples of the different perspectives on the roles of mediators and interpreters.

Typically, interpreters verbally translate spoken information from one language to another and **nothing more**. Cultural mediators facilitate mutual understanding between groups by interpreting as well as providing advice to both parties regarding cultural behaviours. Both roles are commonly called on by service providers working with refugees and migrants in Europe [emphasis added] (39).

Sociolinguistic studies on dialogue interpretation suggest that the interpreters in healthcare settings **play a double role**: they interpret and coordinate communication: for this reason, interpreting is considered a form of intercultural mediation [emphasis added] (58).



Linked to this difference in perspective, there is a lack of congruence between the training provided for cultural mediation and interpretation and actual practice on the ground. For example, the role of a cultural mediator requires skills in mediating and interpreting, and knowledge about the specific health topic on which the role is focused. Only six studies reported that cultural mediators had received training in mediation skills (38,39,52,56,57,82) and only 10 reported training in the project topic area (40,41,43,48,49, 51,53,56,59,83). No study explicitly mentioned that those working as mediators had received training for the interpreting component of their role. One study explained that confusion about the cultural mediator role led to debates about whether cultural mediators needed training in interpreting and, if so, how central that should be to their overall training (54). It also explained how role confusion and training gaps can lead to poor practice, such as cultural mediators dominating consultations and constraining refugees' and migrants' voices and participation in those consultations. This study mentions the importance of university involvement in cultural mediation and some examples of intersectoral initiatives to consult with all relevant stakeholders to progress the field and develop guidelines for practice.

Only nine studies explicitly reported that interpreters had received some training (37,45,61,63–65,67–69). There was a lack of detail about the nature or quality of the training, although some studies explained that professional interpreters may only have limited training from the company employing them rather than being trained and accredited by external bodies (65,70). The evidence indicated that interpreters may engage in mediation or coordination of communications for which they are not trained (58), and that health providers have concerns about involving such interpreters in consultations in that they might misreport the patient's meaning or omit details that the patient wishes to share (64,71). One study in England found that patients in interpreted consultations were less likely to talk about their own ideas about diabetes and less likely to talk about clinical topics related to diabetes compared with native English speakers (71). There were also fewer questions from patients in interpreted consultations. These findings highlight again that role confusion and training gaps can constrain refugees' and migrants' voices and their participation in interpreted consultations.

Health care providers have also reported concerns about a lack of professionalism among interpreters, citing, for example, those interpreters who provide telephone interpreting services in noisy public places (62) or show a lack of commitment to patient confidentiality (64). These concerns can reduce the motivation of health care providers to use professional interpreters, leading to their use of informal,

ad hoc interpreters (62). Based on these findings, several authors emphasized the need to address role confusion and to stabilize the training, accreditation and professionalism process of cultural mediation and interpreters (38,39,45,54,69).

The review found other explanations for a low uptake of available interpreting services (compiled from several studies (37–39,42,61,62,64,65,71)), including:

- lack of awareness among health care providers of the risks associated with ad hoc interpreter use;
- lack of training among health care providers in working effectively and confidently with interpreters;
- challenges of incorporating the use of professional interpreters into busy clinical settings where established routines have normalized the use of ad hoc interpreters;
- practical issues such as difficulties in accessing the interpreter agency and the time required to organize an interpreted consultation, which may be longer than a standard consultation (although this is not always the case); and
- lack of availability of professional interpreters with proficiency in the required language or dialect at the time required and problems matching patient and interpreter by sex and ethnicity.

A Swedish study provided an example of a system-level mechanism that was helpful for recording and systematically analysing challenges to implementation: the use of incident reports by health care professionals in a primary health care centre (62). The primary purpose of incident reports is to enhance patient safety by learning lessons from all adverse events. Incident reports are then used to formulate and disseminate recommendations for system changes. This study found that the use of incident reports as a standard mechanism for patient safety brought problems that occurred when using interpreters to the attention of the primary health care centre manager. The study recommended better cooperation between interpreter agencies and primary health care centres in examining such incidents, seeking solutions and supporting the implementation of policies promoting the use of professional interpreters.



2.3 Effectiveness in reducing communication barriers

Several studies on the effectiveness of strategies in reducing communication barriers provided outcome data for interventions on cultural mediation (35,40,41,43,52,53,56,59,83), interpretation (35,60), translation (35,78), guidance and training (42) and other strategies (80,81). There were positive impacts on health providers' behaviours and attitudes (see Case studies 2 and 4). This analysis of effectiveness focused on outcomes related to health knowledge, health behaviour and access and utilization of health care for refugees and migrants. Both subjective (based on self-reports) and objective (based on the use of standardized questionnaires or quantitative measures) evidence was reported. In relation to health knowledge, one study measured comprehension by refugees and migrants of professionally translated information materials about the asylum process for newly arrived refugees in Greece (78). The analysis found objective evidence that different modes of presentation (text only, infographic, or text and visual) influenced levels of health knowledge. The study concluded that the most effective way of increasing levels of health knowledge is through combining formats. The evidence also emphasized that levels of comprehension could be improved by cultural adaptation of the translated materials to make the content more appropriate to the target population. Therefore, involving migrants in the development of translated materials was recommended.

Case study 4. Involvement of migrants and primary care stakeholders in a participatory project to implement guidelines and training initiatives

RESTORE was a participatory implementation study funded by the European Union involving migrants, primary health care clinicians and practice administrative staff, community interpreters and health service planners (42). The project aimed to promote cooperation among these groups to select, adapt and implement guidelines and training initiatives to improve communication between migrants and their primary care providers.

Guidance and training, with different foci, were delivered to primary care providers in five countries: new migrant communities in Austria; culturally sensitive primary health care practices in England (United Kingdom); communication in cross-cultural general practice consultations in Greece; working with professional interpreters in Ireland; and communicating with migrants with lower education and less command of the Dutch language in the Netherlands. In keeping with the participatory research design, migrants

Case study 4. (contd)

co-designed and participated in training in some settings to ensure that their perspective was included in all stages of the implementation process.

All stakeholders reported benefits of the implemented guidance and training in daily practice. Primary care clinicians and administrators reported having a more tolerant attitude towards migrants, more effective communication with migrants and a better focus on migrants' needs. Consultations using professional, trained interpreters were rated much more favourably by health care providers and migrants compared with consultations with family members and friends as informal, untrained interpreters. Migrants were more likely to trust the GP's diagnosis and GPs reported a clearer understanding of migrants' symptoms and consequent adjustments to treatments. Further use of participatory research to involve migrants in the adaptation of health care services was recommended.

Three Swedish studies reported subjective evidence (based on the self-reported perceptions of migrants) for improved health knowledge resulting from the use of (i) an interpreter and translated materials with Arabic- and Somali-speaking asylum seekers about their right to health care (35); (ii) international health advisors in a peer-education intervention aimed at providing health information for recently settled migrants (59); and (iii) trained civic and health communicators to provide education about sexual and reproductive health rights (83).

Some evidence was based on objective measures for changes to health behaviour. A study in the United Kingdom reported a reduction in the prevalence of risk factors for cardiovascular disease in patients of south Asian origin with type 2 diabetes (i.e. improved compliance with medication and improved diet and lifestyle) resulting from a comprehensive care package which included link workers (43). In addition, improvements in self-care practices were reported following the use of intercultural mediators to improve health literacy among Ethiopian immigrants in Israel (56).

Other evidence was based on objective measures of improved access to, and use of, health care. Better follow-up and treatment for migrants with HIV with the use of community-based mentors was reported in Israel (53). The inclusion of cultural mediators within a transcultural psychiatry team decreased the drop-out rate of migrants attending mental health services in Italy (50). The work of community



health workers (community doulas) improved access to, and use of, cervical screening services among foreign-born women in a Swedish cervical cancer screening programme (40). Greater uptake of an Italian health promotion phone counselling service by migrants was achieved after the introduction of cultural mediators (41). The use of intercultural mediators, combined with in-service cultural sensitivity training for clinical staff and health education community activities to reduce health disparities, promoted health literacy and self-care practices among Ethiopian immigrants in Israel (56). Similarly, a participatory project involved migrants and primary care stakeholders in designing and implementing guidelines and training initiatives to improve communication in cross-cultural consultations. The project had positive outcomes such as increased empathy among staff towards migrants and more flexible practices around appointment making (42). (See Case study 4.)

Three studies did not report positive outcomes for strategies aiming to reduce communication barriers (59,81,83). All three studies claimed that the unsatisfactory findings related to methodological limitations (including problems with recruitment and sampling) and two linked them to the broader policy and political context. A study which failed to identify a positive impact of a web-based culturally adapted treatment programme for migrants with hepatitis B reported unanticipated political sensitivity towards culturally specific health promotion activities in the target population over the study period (81). The political climate severely restricted the public promotion of the programme and may have discouraged migrants from participating. A second study on a cultural mediation strategy to promote health among recently settled migrants in Sweden did not report an impact on health status (59). The authors considered methodological limitations in their study design and a change in Swedish establishment policy in 2008 meant that efforts to provide health information for recently settled migrants were downplayed in favour of providing civic information. As a result, reorganization of the planning of resettlement activities and of the actors responsible for these limited the implementation of this health promotion programme.

3. DISCUSSION

3.1 Strengths and limitations of the review

This scoping review was based on an extensive review of both peer-reviewed and grey literature. Searches were carried out in English and Russian because these represent the two most widely spoken languages across the WHO European Region. Although literature in other languages in the 53 Member States of the WHO European Region will exist, it is not included. Furthermore, many relevant studies from Australia, New Zealand and North America were not eligible for inclusion.

The review identified four main strategies to overcome these communication barriers: cultural mediation, interpretation, translation, and guidance and training for health care providers. Other strategies reported in the wider international literature, such as web-based interpretation (84,85), were not included because they did not meet all inclusion criteria (see Annex 1).

More studies were on the topics of cultural mediation and interpretation than on translation, guidance and training for health care providers and other initiatives such as the Migrant Friendly Hospitals initiative (36) and the culturally adapted treatment programmes (80,81). However, this finding does not necessarily reflect how common any of these strategies are in practice or their effectiveness but could instead reflect a publication bias. Publication may be biased towards studies on novel initiatives with positive outcomes, such as cultural mediation. Cultural mediating and interpreting strategies were the most common and were thus analysed in the most detail.

3.2 Strategies in use to address communication barriers

The review identified a growing literature in English over the 2008–2018 period from 14 different countries in the WHO European Region on strategies that have been implemented and evaluated. Four main strategies were in use to improve access to health care, support management of specific communicable and noncommunicable diseases and promote health across a wide variety of health care settings: (i) cultural mediation, (ii) interpretation, (iii) translation of health information, and (iv) guidance and training for health care providers.



Implementation of these strategies often relied on intersectoral collaborations between those working in statutory health care, community NGOs and academic settings. Such collaborations can lead to strategies operating in a single setting or across a region. Most evaluations reported positive changes in health knowledge, health behaviour and access and utilization of health care for refugees and migrants. This finding highlights the importance of intersectoral collaboration and development by regional and local authorities to develop and implement formal strategies to address communication barriers for refugees and migrants in health care settings across the Region.

The analysis identified specific differences in the strategies of cultural mediation and interpretation. The former usually has equal emphasis on both the linguistic and cultural aspects of communication as part of a bridging role, while the latter has a primary emphasis on the linguistic aspects of communication. In keeping with previous research, this review identified differing perspectives on the specific roles of interpreters and mediators and contributes to the literature by providing further insight into the operationalization of these roles. Cultural mediators often operate in formal and informal encounters in both community and health care settings, particularly through providing a bridging role (see Case study 1). In contrast, the duties of interpreters are more often confined to formal interactions in either health care or community setting (usually not both). A more detailed synthesis of the operationalization of these roles would be valuable.

The analysis also revealed an important, interrelated issue: there is a lack of clear and consistent reporting in published studies about what training cultural mediators and interpreters may have received. This issue has previously been highlighted in the field (2). It is essential to improve the reporting of training in published studies to build a robust evidence base about strategies and their effectiveness. The available data in this review clearly identify gaps in the training provided to cultural mediators. No study reported that cultural mediators had received training in all of the three main components of their role: mediating skills, interpreting skills and knowledge about a given health topic or service of interest. Similar gaps in the training provided to interpreters were also reported; moreover, in this case, training may be provided by a commercial interpreting agency rather than a higher education facility (61). As mentioned above, it is also unclear whether interpreters are currently, or should be, trained in mediation or coordination of communications.

Evidence suggests that such skill deficits resulting from role confusion, and training issues may constrain or compromise the participation of refugee and migrants in health care consultations with interpreters and cultural mediators (54,71). Furthermore,

some health care providers have reported concerns about the professionalism of cultural mediators and interpreters, which can reduce their motivation to use these formal strategies (62,64). Addressing the issue of role confusion and improving the supply of trained and accredited cultural mediators and interpreters in health care settings are essential to overcome the communication challenges experienced by refugee and migrants in health care settings. Several studies included in the review call for these actions and one emphasized the value of intersectoral dialogue among stakeholders to develop professional guidelines and training (54). These findings are consistent with previous reports in the wider literature (28,32). Therefore, strengthening collaborations between academia, the health sector and NGOs working with migrants is important to advance dialogues on these challenges and to inform training and accreditation opportunities.

The review found that even when strategies (i.e. interpreters, guidance and training for health care staff) are available for use in health care settings they may not be used by health care providers, because of a lack of either knowledge about the problems associated with informal strategies or the skills to operationalize a strategy (37,42). In addition, organizational problems between health care and interpreter agencies may prevent the right kind of interpreter being available at the right time to facilitate busy clinicians (62). The Swedish example of how an incident reporting mechanism to record adverse events occurring in practice revealed problems with interpreters in a primary health care centre provides a good example of a system-level response to monitor strategy implementation in day-to-day practice (62).

3.3 Further research

This scoping review provides a comprehensive overview of strategies that have been implemented and evaluated to address communication barriers for refugees and migrants in health care settings across the WHO European Region along with their characteristics, facilitators and barriers to implementation, and effectiveness. Other issues beyond the scope of this review but warranting further investigation include:

- a comprehensive international literature review of implemented and evaluated strategies, drawing, in particular, on publications from Australia, New Zealand and North America;
- a systematic review of the roles of cultural mediation and interpretation to advance debates about their precise scope, and implications for training, accreditation and professionalization;

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- an analysis of the resources required to establish and maintain the implementation of strategies; and
 - more outcome evaluations of strategies that have been implemented.

3.4 Policy considerations

The main policy and practice considerations based on the findings of this review in the WHO European Region are to:

- encourage collaboration between statutory health care organizations, non-statutory organizations such as NGOs with an interest in migrant health, and academic institutions to develop and implement strategies to address communication barriers for refugees and migrants in health care settings;
- establish intersectoral dialogues on cultural mediation and interpretation among academic, policy, health care and professional organizations and NGOs concerned with refugee and migrant health to:
 - clarify the terminology used to describe the role(s) of mediating and interpreting, and
 - develop and implement consistent systems across countries for training, accreditation and professionalization;
- provide training for health care staff in working effectively with cultural mediators and interpreters in cross-cultural consultations with refugees and migrants;
- ensure the use of professionals who have been trained and accredited for mediating and interpreting roles in health care settings;
- establish incident reporting systems in health care settings where strategies to address communication barriers are being implemented to provide a system-level mechanism for reporting, monitoring and responding to problems and barriers to implementation;
- involve migrants in developing and implementing strategies to address communication barriers; and
- develop a national policy that emphasizes the importance of formal strategies to effectively address communication barriers experienced by refugees and migrants in health care settings.

4. CONCLUSIONS

The review considered evidence published in English and Russian in the WHO European Region. It identified four main formal strategies that have been implemented and evaluated to address communication barriers experienced by refugees and migrants in health care settings: cultural mediation, interpretation, translation of health information, and guidance and training for health care providers. Other valuable strategies also in use include the Migrant Friendly Hospitals initiative and culturally adapted treatment programmes. The strategies are usually implemented through collaboration between two or three agencies such as the statutory health care service, NGOs involved in migrant health, and academic institutions. An in-depth analysis of the most commonly reported strategies, cultural mediation and interpretation, revealed complex interrelated issues that impact their implementation and effectiveness. Most evaluations reported positive changes in health knowledge, health behaviour and access and utilization of health care.

The importance of promoting intersectoral collaboration to develop and implement formal strategies in health care settings and to clarify the roles and training requirements for cultural mediators and interpreters was emphasized. Other useful actions include providing training for health care providers in working effectively with cultural mediators and interpreters and improving the supply of trained cultural mediators and interpreters in clinical settings. Finally, the use of incident reporting systems could be promoted in health care settings in the WHO European Region as an effective mechanism for recording problems with strategy implementation and for identifying solutions.



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ANNEX 1. SEARCH STRATEGY

Databases and websites

Searches were performed in April and May 2018 for empirical research on formal strategies designed, implemented and evaluated to address communication barriers affecting the delivery of, or access to, health care for refugees and migrants in Member States of the WHO European Region. Nine databases were searched for peer-reviewed literature: Academic Search Complete, Cochrane Library, EconLit, Embase, the International Bibliography of the Social Sciences, Medline, Scopus, Social Sciences Full Text and Web of Science. In tandem, a search of Elibrary, a Russian language database, was carried out by a Russian-speaking member of the review team. Studies published in either English or Russian were included in a scoping review. Russian was chosen as well as English since almost 300 million people in 16 of 53 countries of the WHO European Region speak Russian as either their native language or on a regular basis, and publications originating from these countries are often published only in Russian (1).

The search plan for grey literature was based on published protocols (2) and involved three complementary sources: (i) grey literature databases, (ii) Google, and (iii) targeted websites of relevant health organizations and agencies identified by the research team. Six websites were searched using a shortened search strategy based on the terms developed for use across the academic databases: Council of Europe, Google Scholar, IOM, the Migrant Integration Policy Index, the SOPHIE project (Evaluating the Impact of Structural Policies on Health Inequalities and their Social Determinants, and Fostering Change) and the United Nations High Commissioner for Refugees.

Study selection

Studies written in English or Russian and based in a health care setting in one of the Member States of the WHO European Region were eligible for review if they:

- focused on:
 - the interaction between health care staff (providers, administrators) and migrant service users,
 - access to health care, or
 - experiences of utilizing health care services;

- described a formal strategy implemented to overcome communication barriers; and
- provided an evaluative account of strategy implementation.

Studies included in systematic reviews that met the inclusion criteria were also eligible for review.

In addition, studies were excluded if they:

- were not based on original research;
- full text was not available;
- focused on the interaction between health care providers only or migrant service users only; or
- did not include evaluative data of strategy/policy implemented to overcome communication barriers.

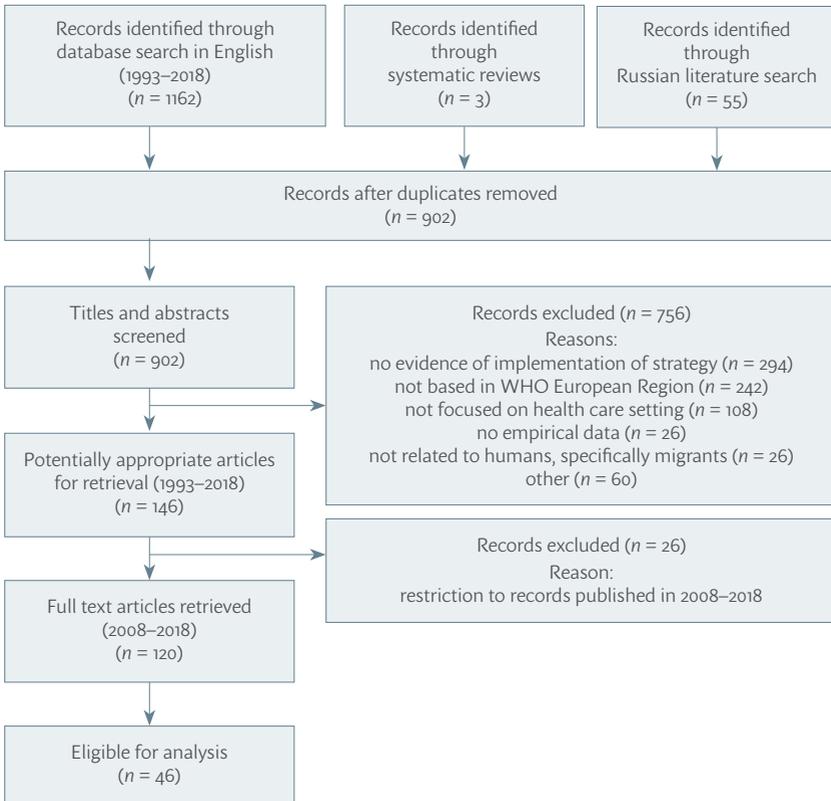
Two reviewers independently assessed the English language peer-reviewed literature, with disagreements resolved by consensus among all authors. Russian language peer-reviewed literature was assessed by a Russian-speaking colleague. Grey literature was assessed by a member of the review team, with queries on the inclusion of studies in the Russian language or grey literature resolved in consultation with another member of the review team.

The selection strategy included the following steps:

1. removal of duplicates of studies retrieved from different databases
2. screening titles and abstracts to determine eligibility
3. full-text analysis to ensure that selected studies met the eligibility criteria.

Of the 902 titles and abstracts screened from the peer-reviewed literature after removal of duplicates, 146 were eligible for full-text screening. This number was reduced to 120 by restricting the selection to those published from 2008 to April 2018 for reasons of practicality and to reflect the most recent developments in the literature. A total of 46 peer-reviewed studies were included in the synthesis (Fig. A1.1)

Fig. A1.1. PRISMA flowchart for peer-reviewed literature.



Of the 2933 titles and abstracts screened from the grey literature, 155 were eligible for full-text screening and of these only three were eligible for inclusion in the review. The main reasons for exclusion of grey literature at full-text screening were:

- no evidence of implementation of a strategy ($n = 43$, 28%)
- not based in the WHO European Region ($n = 36$, 23%)
- not based in a health care setting ($n = 22$, 14%).

Data was extracted from all 49 studies on the author, year of publication and country in which the strategy was implemented; study design; participants; definition of migrant population; health care setting; type of strategy; whether the strategy was being routinely used in practice or was a pilot/new strategy; the statutory and non-statutory agencies involved in implementing the strategy; number and type of implementation sites; and design and focus of the strategy evaluation. A more in-depth analysis broadly followed the principles of content analysis (3).

Types of study included

Most of the included studies had a qualitative design ($n = 32$, 65%), 11 (22%) had a quantitative design and six (12%) has a mixed methods design. The studies were carried out in a variety of settings, including primary care and the community ($n = 22$, 45%), mental health services ($n = 8$, 16%), secondary care ($n = 5$, 10%), health screening/health promotion/health information ($n = 5$, 10%), all health care settings in a given location (e.g. city; $n = 4$, 8%) and cancer care ($n = 2$, 4%). Three studies (6%) were carried out at migrant/refugee camps at entry or transit points to Europe.

Data was collected from staff in 25 (51%) studies, including health and social care providers and humanitarian aid workers. As in a Health Evidence Network synthesis report on the definition of migrant (4), a wide variety of terms was used to describe the population of interest. Five studies (10%) included a source for their definition, most commonly the United Nations High Commissioner for Refugees' definition of a refugee. The remaining 44 studies used project-specific working definitions of the population, related to country of birth or parental country of birth (e.g. foreign born, migrant, immigrant, at least one parent born in a country other than the country of residence); language spoken (e.g. non-English speaker, unable to communicate in Swedish, Somali speaker or Arabic speaker); ethnic or cultural background (e.g. ethnic minority, diverse ethnic community); and legal status (e.g. with a residence permit or "illegal work immigrants"). In eight studies (16%), the population of interest was asylum seekers or refugees.



Search terms

The following search terms were used across all English language databases with minor adaptations:

((Population: ABS (asylum* OR refugee* OR migrant* OR migrat* OR emigrant* OR emigrat* OR immigrant* OR nomad* OR foreigner* OR displaced OR stateless OR state-less OR noncitizen* OR non-citizen* OR outsider* OR newcomer* OR "newly arrived" OR "new arrival*" OR "recent entrant*" OR "non national" OR non-national OR ethnic*)) AND (Subject: ABS (health*)) AND (Strategy: ABS ((strategy OR intervention OR initiative OR approach OR program* OR Training OR Plan OR Resources OR Policy))) AND (communicat* OR interpret* OR translat* OR mediat*) AND (Focus: KEY (language OR cultur* OR cross-cultural OR transcultural)) AND (Countries)/regions of studies: ALL (albania* OR andorra* OR armenia* OR austria* OR azerbaijan* OR belarus* OR belgium* OR belge OR belgian* OR bosnia* OR bulgaria* OR croatia* OR cyprus OR czech OR denmark OR danish OR estoni* OR finland OR finn* OR france OR french OR georgia* OR german* OR greek OR greece OR hungar* OR iceland* OR ireland OR irish OR israel* OR italy OR italian* OR kazak* OR kyrgyz* OR latvia* OR lithuania* OR luxembourg* OR malta OR maltese OR monac* OR montenegri* OR netherlands OR dutch OR holland OR norw* OR poland OR polish OR portug* OR moldova* OR romania* OR russia* OR "san marino" OR serb* OR slovak* OR sloven* OR spain OR spanish OR sweden OR swedish OR switzerland OR swiss OR tajik* OR macedoni* OR turkey OR turkish OR turkmenistan* OR ukraine* OR britain OR british OR uk OR "united kingdom" OR uzbek*))

The following Russian translation of the search terms was used in Elibrary.

((Население: АБС (убежище* ИЛИ беженец* ИЛИ мигрант* ИЛИ миграц* ИЛИ эмигрант* ИЛИ эмиграц* ИЛИ иммигрант* ИЛИ иммиграц* ИЛИ кочевник* ИЛИ переселенец ИЛИ иностранец* ИЛИ перемещённое лицо* ИЛИ не имеющий гражданства* ИЛИ апатрид* ИЛИ не гражданин* ИЛИ не граждан* ИЛИ посторонний* ИЛИ недавно поселившийся* ИЛИ вновь прибывший* ИЛИ недавно прибывший* ИЛИ не имеющий национальности* ИЛИ этнический*)) И (Предмет: АБС (Здоровье*)) И (Стратегия: АБС ((стратегия ИЛИ вмешательство ИЛИ ИнИциатИва ИЛИ подход ИЛИ програм* ИЛИ обучение ИЛИ план ИЛИ ресурсы ИЛИ полИтИка) И (общение* ИЛИ устный перевод* ИЛИ письменный перевод* ИЛИ посредн*)) И (Фокус: КЛЮЧ (язык ИЛИ культур* ИЛИ межкультурный ИЛИ транс культурный)) И (Страны/регионы Исследования: ВСЕ (албания* ИЛИ андорра* ИЛИ армения* ИЛИ австрия* ИЛИ азербайджан* ИЛИ беларусь* ИЛИ бельгия* ИЛИ босния* ИЛИ болгария*

ИЛИ хорватИя* ИЛИ кИпр ИЛИ чехИя ИЛИ данИя ИЛИ датскИй ИЛИ эстонИя
ИЛИ эстон* ИЛИ фИнляндИя ИЛИ фИн* ИЛИ францИя ИЛИ французскИй ИЛИ
грузИя* ИЛИ германИя ИЛИ немец* ИЛИ греческИй ИЛИ грецИя ИЛИ венгрИя*
ИЛИ ИсландИя* ИЛИ ИрландИя ИЛИ ИрландскИй ИЛИ ИзраИль* ИЛИ ИталИя
ИЛИ ИтальянскИй* ИЛИ казах* ИЛИ кИргИз* ИЛИ латвИя* ИЛИ лИтва* ИЛИ
люксембург* ИЛИ мальта ИЛИ мальтИйскИй ИЛИ монак* ИЛИ монтенегр* ИЛИ
недерланды ИЛИ голландскИй ИЛИ голландИя ИЛИ норв* ИЛИ польша ИЛИ
польскИй ИЛИ португал* ИЛИ молдова* ИЛИ румынИя* ИЛИ россиЯ* ИЛИ сан
марИно* ИЛИ серб* ИЛИ словак* ИЛИ словен* ИЛИ ИспанИя ИЛИ ИспанскИй
ИЛИ швецИя ИЛИ шведскИй ИЛИ швейцарИя ИЛИ швейцарскИй)))

However, as this Elibrary strategy returned no results, two further searches were run using an abbreviated search strategy.

Search 1 (17 results): Иммигрант общенИе Здоровье стратегИя ИнициатИва язык межкультурный перевод

Search 2 (38 results): Иммигрант* общенИе* Здоровье стратегИя

Abbreviated versions of the search strategy were used in the grey literature search. The following representative search strategy (for OpenGrey) was adapted for each search engine/website:

"migrant health" OR "communication barriers" OR "language barriers" OR "migrant AND communication barriers" OR "migrant AND language barriers"

Number of results for databases

Academic Search Complete: 80

EconLit: 3

Elibrary (Russian): 55

Embase: 198

Cochrane Library: 20

International Bibliography of the Social Sciences: 48

Medline: 127

Scopus: 397

Social Science Full Text: 29

Web of Science: 262

Total: 1219



Number of results for websites

Council of Europe: 2000

Google: 92

Google Scholar: 92

IOM: 349

Migrant Integration Policy Index: 33

Open Grey: 200

SOPHIE: 1

United Nations High Commissioner for Refugees: 166

Total: 2933

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