Addressing migration and health inequity in Europe

Capacity building in migration and health in higher education: lessons from five European countries

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Summary

Capacity building in migration and health in higher education is key to better, sustainable, and equitable health care provision. However, developments so far have been patchy, non-structural, and often unsustainable. While training programs have been evaluated and competency standards developed, perspectives from individual teachers are hardly accessible. We present expert perspectives from five European countries to illustrate good examples in higher education and identify gaps to further the advancement of capacity building in migration and health. Based on these perspectives, we have identified thematic areas at four levels: conceptual evolution, policy and implementation, organization at the academic level and teaching materials and pedagogies. Finally, we propose creating spaces to share concrete educational practices and experiences for adaptation and replication. We summarize key recommendations for the advancement of capacity building in migration and health.

Keywords: Capacity building; Migrants; Perspectives; Higher education

Equitable health care for migrants across Europe has not been achieved.[1] To improve the health of migrants and society as a whole,[2–5] much remains to be done. In this effort, we need capacity building in higher education and strengthening competence of the health workforce to achieve diversity responsiveness.[6,7] Capacity building is a broad term defined by WHO as the development and strengthening of human and institutional resources.[8] While addressing all realms of capacity building is beyond the scope of this article, we focus on both increasing competences as well as developing training tailored for specific issues that are not currently being addressed.

One of the necessary capacity building pillars is introducing migration and health in higher education. However, improvements in the field are slow and patchy.[9] Chiarenza finds that training programs often (i) have low levels of participant involvement, (ii) underrepresent patients in training development and delivery, (iii) need to move from cultural competence to intersectionality and person-centeredness, (iv) do not systematically focus on outcomes in training design, implementation, and evaluation, and (v) are poorly linked to key organizational and policy support mechanisms. Changes are dependent on individuals being specially interested in the field, but these are transient, and not often sustainable. Consequently, there are major differences between and within European countries. Since curricula developments for higher education in migration and health are not easily available, good examples of capacity building in higher education relevant for learning, sharing and as inspiration to other countries remain largely unexploited.

We draw in this paper from our experiences both in training professionals and teaching migrant health in higher education. We document and illustrate how health worker training has developed over time through

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Key recommendations for capacity building in migration and health

- Create spaces within and across countries to share concrete teaching experiences that can be adapted and replicated to other contexts.
- Promote diversity-sensitive communication skills programs for trainers and teachers.
- Integrate training on migration and health within the broader framework of social determinants of health.
- Develop participatory and intersectional approaches that also focus on improving attitudes and skills rather than merely passing on (cultural or epidemiological) knowledge.
- Capacity building should be both top-down (leadership) as well as bottom-up (involving teachers and students).
- Advocate that government guidelines for curricula development reflect and include diversity sensitive approaches in content and implementation.
- Medical and continuous education accreditations should include new standards about diversity sensitive healthcare, to further ensure that all medical schools deliver competent practicing doctors.
- Prioritize student assessments and course evaluations instead of seeing them as optional.
- Promote mandatory diversity-related competences in both undergraduate and specialized training.
- Co-create and maintain dialogue with key stakeholders, different members of the health care team and, in particular, migrants.

the personal views of six experts with longstanding experience in the field as both researchers and educators in five European countries: Poland, Spain, Germany, Norway, and the Netherlands. Despite differences in migrant populations and policies, these countries have similar objectives and goals in higher education in health care. The experts were invited to map the progress in migration and health in higher education, and present good examples of advancing capacity building as well as identify critical gaps. The country case studies were then read by all authors to identify common themes.

Country case studies: expert perspectives

Poland

Elżbieta Czapka is a sociologist with 16 years of research experience in migrant health and personal experience as a migrant in Norway. She explains that at most of Poland's medical universities, there are no specific courses for medical students related to multiculturalism, migration, and health. The Polish medical publishing house published in 2010 a textbook for students discussing multiculturalism in medicine.[10] However, in most medical training programs, topics related to culture and health are only covered for a few hours in disciplines such as history of medicine, sociology, clinical psychology and psychiatry.[11] The Medical University of Bialystok is an exception to the rule and teaches multiculturalism through study visits where students can learn more about Orthodox, and Jewish religions and the Tatar minority. There are otherwise very few examples of initiatives aimed at increasing students' cultural competence. One example is the course "Interculturalism in a doctor's office" conducted at the Medical University of Warsaw by the International Association of Medical Students. Czapka notices that interest in migrant health is wider among non-health professionals like sociology students, and most schools offer a variety of courses on multiculturalism for nursing and midwifery students.

Spain

Luis Andres Gimeno-Feliu is a specialist in Primary and Community Health who works as a GP. He has conducted research on migration and health for 15 years. He explains that, despite universal healthcare access, there is no systematic training policy for health professionals to deal with diversity, and social, occupational or cultural circumstances. At the beginning of the 2000s, the possibility of creating specific centres to attend to the migrant population was considered, but rejected. Gimeno-Feliu regrets that universal healthcare has become care that focuses on treating everyone the same without seeking to treat different needs differently.

The Spanish Society of Family and Community Medicine (semFYC), though not a part of the university yet responsible for continued higher education, has worked to spread the bio-psycho-social model for health care professionals for several years. Within the semFYC, Gimeno-Feliu is one of the founders of the "Group on Inequities in Health - International Health",[12] which aims to train physician's competencies regarding migration and other social determinants of health with an intersectional approach. Approximately 2000 health care professionals every year improve attitudes and knowledge through workshops, seminars, and escape–room activities. However, this is still a small proportion of healthcare professionals. In 2022, the Spanish government approved a new regulation obliging all specialties to receive training on equity and social determinants. Therefore, a priority objective is to make this training compulsory.

The Andalusian School of Public Health[13] has been a pioneer in cultural diversity training for all health professionals in both Primary and Specialized Care with a focus on training trainers, in and outside of Spain.

Norway

Esperanza Diaz is professor at the University of Bergen (UiB) and has researched migration and health for over 15 years. She moved to Norway 25 years ago and has collaborated with health authorities and civil society to implement research findings in education. She explains that in Norway, very few non-compulsory hours specific to migrant health are offered to health care students. Including the subject in the written evaluation of students has helped increase attendance.

UiB organizes an elective, interdisciplinary two-weeks course on "Migration and Health" for

candidates at different academic levels. Students can learn from one another's perspective and experiences, while the faculty maximizes possibilities for capacity building.

Although interpreter services are free of charge, patients are often not asked if they need an interpreter.[14] A few years ago, following interpreters' wish for better team work among professionals to improve patient care,[15] UiB collaborated with the Interpreters' Unit to develop and pilot a student course. However, advocacy from teachers to the head of the Faculty of Medicine was necessary before implementation in teaching in 2021. Reducing course cost was achieved by collaborating with interpreter students, who were in turn exposed to clinical situations.

Norway developed a strategy for equity in healthcare for 2013–2017,[16] in which Bernadette Kumar, the director of the previous National Research Centre for Migration and Health (NAKMI), was key. But after 2017 the government meant that the awareness on migrant health was already on its way to be achieved without further specific strategies. NAKMI has now disappeared as independent organisation.

One recent national effort starting in 2020 to respond to increasing population diversity and ensure equitable health care provision is the Inter-ministerial National Curriculum Regulation for Norwegian Health and Welfare Education (RETHOS). The RETHOS guidelines prescribe, among others, knowledge on cross-cultural competence to be embedded in medical curricula to ensure that students are trained to understand culture's influences on health, mitigate language barriers, understand discrimination's impact on health and provide equitable healthcare to all of society. However, curricula at medical universities only recently began to include some of these themes.

Germany

Already with the onset of work migration in the 1950s, migrants with a legal residence status became members of the German statutory health insurance. However, when migrants needed a doctor, they frequently became victims of prejudice and culturalization. "Morbus Bosporus" is one of the disparaging terms that doctors used to describe expressions of pain in their patients from Turkey when they failed to come up with a "proper" biomedical diagnosis. Health workers conceived migrant patients as not fitting into the German health care system – rather than the system needing reforms to accommodate *all* patients. Furthermore, German society often constructed migrants as being in poor health, when many were, in fact, quite healthy and enterprising at the time of migration.[17]

Oliver Razum, a medical doctor and epidemiologist with almost 30 years of experience in migrant health research, argues that barriers to accessing healthcare persisted, as did the tendencies of staff members to blame what they called "cultural differences". At one point, there was a debate over whether to set up specialized health facilities for migrants to solve this issue. The idea of a two-tiered health system was quickly abandoned, but culture remained an issue. The concept of culturally sensitive health facilities took hold, trying to increase the staff's competency to care for patients from "foreign" cultures. However, this disregarded the heterogeneity of Germans themselves, and that they would also benefit from staff realizing that *all* patients may have different needs. At the same time, it remained unclear who should be responsible for establishing translation services, both structurally and financially.

In training and higher education "culture" is now being replaced by the concept of diversity. Training is no longer about "foreign" cultures, but acknowledging differences and related health needs. Ideally, everyone will benefit, whether migrant or not.[18]

The Robert Koch Institute, Germany's national institute of public health, published the first health information report covering the health of migrants only in 2008.[19] Migrants, the report and subsequent research showed, experience poorer health outcomes not necessarily because of migration, but because of their socioeconomic disadvantage in Germany. This evidence now informs health workforce training.

The Netherlands

The general Dutch medical framework in 2020 stated that graduated medical students should be able to communicate in a culturally-sensitive and non-judgmental way and consider contextual factors of the patient, including health literacy, language, cultural, or spiritual background.[20] However, medical students still perceive a lack of diversity and awareness in education.[21]

Jeanine Suurmond is Associate Professor at the Amsterdam University Medical Centre and teaches about diversity responsive healthcare. Students learn about differences in disease prevalence in diverse migrant groups and how to communicate across language barriers.[22] However, much is yet to be improved in the curriculum, as the underrepresentation of dark skin tones in teaching materials, which may lead to misdiagnosis in darker-skinned patients. Digital resources (https://www.blackandbrownskin.co.uk) with images in a broad spectrum of skin colors, are available, but not yet recognized as important competencies of future doctors.

Suurmond argues that part of the problem may also be the lack of daily contact between medical students and persons with different migrant backgrounds. Suurmond invited a migrant as a simulation patient in an elective communication class and noticed that it was hard for students to be empathetic and truly listen to a patient with cultural and religious beliefs about illness that were not in line with students' biomedical knowledge. But the students were eager to learn.

In the European project 'Culturally Competent in Medical Education', a competency framework for medical teachers was developed, along with corresponding tools and teaching materials. Still, medical teachers find it difficult to include sensitive topics in their teaching, like discrimination, racism, privilege, or experiences of micro- and macroaggressions and structural inequities, in a safe and respectful way. These topics should be included in training for all students,[23–25] and Teach the Teacher training.

The medical school at the University of Amsterdam is now investing in infrastructure to support all medical teachers to obtain competencies to create an inclusive learning environment. Suurmond, for example, is a faculty diversity officer involved in processes to make the curriculum more diverse and inclusive. To truly change the curriculum, Suurmond wants to start with community-based learning for all students as part of their regular training to build trust and mutual respect between the school and Amsterdam's diverse population.

Discussion

We present contextualized capacity building initiatives and perspectives contributing to improving equitable health care provision. The case studies include relevant lessons learned in higher education on migration and health, which are built upon progress in the field at the country level. Although some common themes recur, the solutions differ from country to country, thus reiterating the need to adapt and tailor teaching to address the social and political context of migration. We chose an experienced-based approach to generate knowledge because it highlights the personal perspectives that are often lost.

Though a number of conceptual frameworks on migration and health exist,[26,27] we did not find any framework for capacity building in migration and health related to higher education. Inspired by Cooke's framework to evaluate capacity building in healthcare targeting the supra-organisational, organisation, team, and individual levels,[28] we present four levels of our themes: conceptual evolution, policy and implementation, organization at the academic level, and teaching materials and pedagogies. Acknowledging that this framework is developed for research in general practice, we believe it is also relevant for capacity building in higher education in the field of migrant health. The framework was introduced after the experts described the cases.

Conceptual evolution

Cultural competence[29] was one of the first terms used in migration and health, but the debate has led to nuanced terminology, with the advent of terms like diversity management, critical consciousness, cultural awareness and cultural humility.[30] This need "to move away from 'cultural competence' towards an approach that integrates the person's "life-world", socioeconomic circumstances, and social and physical environment" has been expressed by a recent EU report.[9] Most country cases describe journeys illustrating the shift from cultural competence to diversity responsiveness, tracing the progression from segregated care and focus on selected specific diseases to a more diversity-friendly, intersectional approach.

Diversity responsiveness in health provision[6] is recognized as a necessary system response to increasingly heterogeneous societies. Diversity responsiveness is complex and recognizes intersectionality and intragroup diversity, and it does not rely exclusively on cultural knowledge to respond to the so-called "culturally unique needs". Discrimination, racism and bias in access to healthcare are key themes in the evolution of inclusive, diversity-sensitive health care education.[31] These topics are clearly touched upon in several expert, but to a large extent have not been addressed in teaching or training so far despite the evidence that racism and discrimination adversely affect health.[32]

Policy level development and implementation

Representation of migrant groups in health care services and research, as both users and decision makers, is critical for appropriate and sustainable improvements within capacity building.[33] Migrants are invisible in most available health datasets,[34] and underrepresented at the leadership level in health care services[35] Furthermore, the migrant perspective is seldom included in the development of capacity building, as explained in the Netherlands.[4,36,37]

We present some good examples of high-level policy development, such as the strategy for equity in health care or the government guidelines for curricula development in Norway, Spain and the Netherlands. While we applaud these examples, they are either short-lived or do not sufficiently guide towards a diversity-sensitive approach. Regional health academic institutions and health professional associations (often primary care and nursing) are also initiators of capacity building, but do not seem to be included in the development or evaluation of national policies, despite their crucial role for the appropriateness, continuity, and sustainability of these policies. This highlights the need for systematic implementation and evaluation strategies.

Organisation at the academic level

An important way to build capacity is through advancing teaching and training for educators[38] as seen in the cases of Train the Trainers in Spain and the Netherlands. We present some examples of advocacy from teachers for implementation in Norway and courses organized by student associations in Poland. While the discussion on mandatory courses is ongoing, examples of co-creation including users (students, interpreters, migrants) and activities (visits) presented in Norway and the Netherlands pave the way for participatory approaches

based on systematic interaction. Evaluation of courses and assessment of students' needs should be prioritized to make progress as suggested in Norway.

Training and courses must take into consideration the undergraduate, post-graduate and PhD-levels as well as the professions. Interdisciplinarity, both in terms of teachers and students enriches content, increases mutual respect, and enables cooperation. Good examples of this are presented in Spain and Norway. Capacity building bridges policy, practice and research at different levels.[9]

Teaching material and pedagogics

There is a need to update textbooks, digital resources and course content by including diversity among simulation patients, practicing with interpreter-students and ensuring that illustrations include patients other than the host population, without feeding common stereotypes. The Netherlands is pioneer in this regard. Innovative and low-cost initiative like study visits and escape rooms, are presented as inspirational cases, and could improve understanding and attitudes.

The concept of intersectionality[39] comes up in the expert perspectives for example in Spain, where migration is taught as one of a complex array of interacting social determinants. This view is also linked to a diversity friendly response in health care provision, as proposed in Germany, but adds complexity to teaching the field. Integration of migration and health training within the social determinants' framework can facilitate a holistic and bio-psycho-social approach. Systematic Train the Trainer programs to enhance the necessary pedagogical skills as in the Netherlands should be spread across countries.

To move ahead from Chiarenza's description of training programs,[9] good examples can guide us toward the development of new trainings. As a step in the right direction, we propose creating within- and across-country spaces to share concrete educational practices and experiences for adaptation and replication. The Key Recommendations box summarizes the main recommendations that have emerged from our case studies.

Contributors

ED and BK conceptualized the paper. All authors contributed with the national case studies, agreed to the key recommendations, and approved the paper.

Declaration of interests

The authors declare no conflict of interest.

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