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Claeys, Ann; Berdai-Chaouni, Saloua; Tricas-Sauras, Sandra; Donder, Liesbeth De

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Barriers And Facilitators In Providing Care For Patients With A Migration Background

Ann CLAEYS[1,3], Saloua BERDAI-CHAOUNI[1,3], Sandra TRICAS-SAURAS[1,2], Liesbeth DE DONDER[3]

[1]Erasmushogeschool Brussel – Nursing | Department of Health care and Landscape Architecture- Laarbeeklaan 121, 1090 Brussels, Belgium.
[2]Université Libre de Bruxelles (ULB) | Social Approaches to Health Research Centre, School of Public Health, Route de Lennik, 808, 1070 Brussels, Belgium.
[3]Vrije Universiteit Brussel (VUB) | Department of Educational Sciences, Pleinlaan 2, 1050 Brussels, Belgium.

Authors note

Ann CLAEYS: https://orcid.org/0000-0001-8335-9227
Saloua BERDAI-CHAOUNI: https://orcid.org/0000-0002-0455-0144
Sandra TRICAS-SAURAS: https://orcid.org/0000-0003-2226-6689
Liesbeth DE DONDER: https://orcid.org/0000-0003-4999-5902

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Correspondence concerning this article should be addressed to Ann Claeys, Erasmushogeschool Brussel – Nursing, Laarbeeklaan 121, 1090 Brussels, Belgium. Email: ann.claeys@ehb.be

Abstract

Aims and objectives

The aim of this study is to identify the barriers and facilitators experienced by healthcare professionals while caring for patients with a migration background.

Background

People with a migration background often face several structural inequalities and barriers in terms of accessibility to, and affordability of, healthcare. In order to provide quality care for patients with a migration background, it is important to understand which barriers healthcare

professionals experience that prevent them from providing care and which factors can facilitate this.

Design and methods

Qualitative research following the COREQ criteria. A total of six focus groups (n = 37) and twelve individual interviews were conducted with a multi-disciplinary sample: doctors, nurses, social workers, and occupational therapists. Nursing and medical students were also included. Thematic content analysis was used.

Results

Key findings suggest that the main barrier is that healthcare professionals regard people with a migration background as 'the other'. Healthcare professionals do not feel secure or competent to provide care for these 'others'. According to the healthcare professionals, the hospital structures – and, particularly, the managerial instances – appear to be only slightly supportive. Structural barriers at the level of the healthcare system, such as limited implementation of care coordination and austerity measures (time pressure or economic restrictions), were also perceived as barriers. Facilitators can be the healthcare professionals' attitude or the flexibility of the management.

Conclusions

Healthcare professionals experience barriers in caring for people with a migration background. Othering plays a key role in building or maintaining several barriers. A multilevel approach is necessary to tackle these barriers and enable facilitators.

Relevance to clinical practice

Raising awareness about 'othering' in the educational programs of students and healthcare professionals is essential. Also, deploying support mechanisms and valuing the competences of multicultural and multilingual healthcare professionals can help facilitate quality care for patients with a migrant background.

Patient or Public Contribution

Patients, informal and formal caregivers participated in the study at several stages (e.g.: by involving them during the research design phase or providing feedback and input at specific moments across the study). In addition, community participants played a key role also during the research design and data analysis phases as well as by facilitating patients' recruitment.

What does this paper contribute to the wider global clinical community?

- This paper provides insight into the barriers and facilitators that play a role for healthcare professionals in providing care to people with a migrant background.
- This paper provides tools for clinical practice in pursuing care for patients with a migration background.

- This paper addresses the theme of the worldwide challenge for care for people with a migration background.

Keywords: Patient with migration background, healthcare professionals, healthcare providers, management, healthcare organisation, barriers, facilitators

Introduction

In order to 'leave-no-one-behind', irrespective of their migration status, the Sustainable Development Goals urge for more evidence-informed health responses that engage with migration (Wickramage et al., 2018). As a fact, people with migration background often face several structural disadvantages, inequalities and barriers in terms of accessibility to, and affordability of, healthcare (Berdai Chaouni, 2021; Scheppers et al., 2006). Racial and ethnic minorities of migrant background face unfavourable social determinants of health – such as lower education, lower housing quality, and living in disadvantaged areas – which also decrease accessibility to care (Nair & Adetayo, 2019). In addition, it is known that healthcare professionals find it challenging to provide care to people with a migrant background (Claeys et al., 2020; Markey et al., 2018). These challenges are reinforced by the lack of organizational support that exists in delivering care for ethnic-diverse patients (Claeys et al., 2020; Narayanasamy, 2003). Finally, migrants and ethnic minority groups seem to make poorer use of healthcare services (Nielsen & Krasnik, 2010; Uiters et al., 2006). This is important to note, because adequate use of healthcare services is an important precondition for health in general (Wickramage et al., 2018).

If the ultimate purpose is to provide accessible and high-quality healthcare for people with a migration background, it is important to understand which barriers healthcare professionals experience that prevent them from providing this quality care, or which facilitators enable this. Taking this purpose into consideration, the aim of this study is to identify the potential barriers and facilitators that healthcare professionals experience in providing care to patients with a migration background.

Background

Healthcare providers struggle with the implementation of care for patients with a migration background (Claeys et al., 2020; Markey et al., 2018). A study by Taylor and Alfred (2010) showed that healthcare professionals perceived caring for ethnoculturally diverse clients as both challenging and frustrating. The literature identifies barriers and facilitators to providing quality care for people with a migration background on 3 different levels within the healthcare system: the individual and interpersonal level, the level of management and the organisation, and the level of the healthcare system.

A number of barriers can be identified both at the individual level of the healthcare professionals' (such as uncertainty regarding their own competences) and at the interpersonal care relationship with the patient (for instance, discriminatory perception towards 'others'). A

barrier that can be identified is the healthcare provider's limited linguistic proficiency in a given foreign language (Scheppers et al., 2006). Professionals seem to have certain objections concerning the role of translators to overcome language barriers (Claeys et al., 2020; Suurmond et al., 2016). Communication is more than mere language, and professionals maintain that a patient's lower educational level (Scheppers et al., 2006) and lower social status (Smith et al., 2000) can lead to ineffective communication between the patient and the healthcare provider (Suurmond et al., 2016). Moreover, professionals seem to hold stereotypical attitudes towards patients with a migration background (Claeys et al., 2020), yet are unaware that this can influence the trust relationship between the patient and the professional and can equally influence the care process (Berdai Chaouni et al., 2020; Carlsson & Pijpers, 2020). Conversely, the literature also describes several factors – such as cultural awareness (Grandpierre et al., 2018), well-developed social skills, and self-awareness – that facilitate the caregiver in providing quality care to persons with a migrant background (Berg et al., 2019). In addition, it is also important that the professional be able to provide respectful person-centred care (Jones et al., 2017) and understand and can deal with the expectations of the patient (Harrison et al., 2020). Finally, research also shows that bicultural professionals can facilitate the alignment of health programs with culturally and linguistically diverse communities (Cyril et al., 2017).

On a second level, there are barriers at the level of the management of the care organization. Healthcare professionals do not work alone often, but in a team or a care organization with a specific vision, policy, management and culture. This also plays a role in the barriers that professionals experience. Dell'Aversana and Bruno (2021) point out that resistance and hesitation in the organization are the main barriers in providing care for patients with a migration background. On the other hand, cultural awareness in the management and policy level of the organization can ensure that care provision to people with a migrant background is facilitated. This can involve the use of culturally appropriate assessment and intervention materials and support for professionals to provide tailored care that meets the needs of minority patients (Grandpierre et al., 2018). Awareness of inequalities in services and a patient-oriented care culture can also be facilitators. These factors can facilitate quality care if managers are aware of the barriers that exist in caring for people with a migrant background and if they see opportunities to improve this (Dell'aversana & Bruno, 2021).

Third, when considering barriers and facilitators on a wider scale, obstacles and enablers can equally be found at the structural healthcare system level. For example, time restrictions and austerity measures increase the workload for care providers (Scheppers et al., 2006). Staff shortage limits the possibilities for professionals to provide person-centred care (Barrett et al., 1998). Consultations and treatments that are carried out in an abrupt and quick manner can lead to miscommunication and distrust (Smith et al., 2000). Referral between different care services, or between primary care and more specialized care, can be experienced as barriers to providing good care to persons with a migrant background. General practitioners can facilitate referrals and make it easier for patients to go from primary care to more specialized care. Efforts and interventions to make healthcare more accessible to certain minority groups must consider economic, geographic and social factors (Jones et al., 2017).

Taking this information into account, it is necessary to better understand which multilevel factors in daily practice play a role in facilitating or hindering quality care provision for persons with a migration background: on the individual and interpersonal level of the healthcare professional, the level of management and organisation, and the healthcare system level. In response, the following research question is highlighted in this study: Which facilitators and barriers do healthcare professionals experience in providing care for patients with a migration background?

Method

This study is part of the larger Diverse Elderly Care research project, which examines culturally sensitive dementia care for migrants in Brussels, from the perspectives of patients, family carers and healthcare professionals. In particular, this paper explores in depth the barriers and facilitators in providing care to patients with a migration background, but from the perspective of the healthcare professional.

Study design and procedure

A series of focus group (FG) interviews and individual interviews were conducted with healthcare professionals and students. The aim of the FG interviews was to explore the different barriers and facilitators in providing care for patients with a migration background. The use of individual interviews allowed us to study the barriers and facilitators in more depth. All interviews were analysed using a Thematic Content Analysis as described by Burnard (2008). A descriptive qualitative approach was deemed most suitable for exploring the professionals' views on barriers and facilitators for culturally sensitive care (Beck & Polit, 2014; Bernard & Bernard, 2000). We followed the EQUATOR COnsolidated criteria for REporting Qualitative research (COREQ) checklist guidance to report the method of our study and this checklist was added as a supplementary file (Supplementary File 1) (Tong et al., 2007). Ethics approval was granted by the Ethics Committee of the University Hospital of Brussels (CE 2016-105).

A total of six FG interviews (n=37) and 10 'individual' interviews (n=12; 2 interviews were held with two respondents for practical reasons) were conducted with healthcare professionals. Having experience in care (as a job or from an internship) in a diverse city (e.g., Brussels) was the inclusion criteria for all participants. Respondents were selected by using consecutive sampling for the FGs and purposive sampling for the individual interviews. The (interview) participants were recruited from a network of professionals in Brussels and were invited by e-mail and telephone by the first or second author. Their contact details were collected through the professional network of the first and second author and respondents indicated their willingness to participate in the study. All confidential process was respected, and special care was taken into ensuring data protection and GDPR. The FGs participants were invited face-to-face during a seminar or during class. Data collection took place between November 2017 and January 2019. All interviews were scheduled at a time that was convenient for the participants, and the interviews were audio taped after obtaining verbal informed consent at the beginning of each interview. The FG interviews took place in a meeting room at a

university college or at a hospital in Brussels. The individual interviews took place at the individual offices or meeting rooms of the healthcare provider and were conducted in Dutch or French. Both interviewers spoke the two languages. Table 1 and Table 2 provide an overview of general demographic information of the participants. There were four all-female FGs and two groups with male and female participants. In the individual interviews, there was also a feminine majority with nine female participants compared to 3 males. The participants of the FG sessions were relatively young, with an average age per group between 19 (students) and 36 (nurses).

Table 1: Overview of demographic information of the participants in the FG sessions.

Table 2: Overview of demographic information of the participants in the individual interviews (INT).

Data saturation was reached by the 7th interview because of the richness of the data, meaning that additional data did not lead to new emerging themes as it tended to reinforce the previous findings (Saunders et al., 2018). The interview guide, based on the literature review, was used to structure the interviews. The interview started with an ice-breaker question: "Could you please clarify what is good (quality of) care according to you?". Thereafter, participants were asked to share their opinions regarding the following topics:

1) How do you define and perceive culturally sensitive care (in theory and in practice)?
2) How do you (try to) provide culturally sensitive care in practice?
3) What are facilitators for, and barriers to, providing care for patients with a migration background?
4) What is the role of the patient and the healthcare organisation in culturally sensitive care?

The answers to questions 1 and 2 were covered in a previously published paper (Claeys et al., 2020). The answers to questions 3 will be addressed in the current paper. In order to not influence the perception of the participants regarding the topic, no *a priori* definition or description of culturally sensitive care was provided. After each session, a debriefing report was made by the main author, including observational notes and comments about the process.

Analysis

All interviews were audiotaped, and an official transcription office transcribed them verbatim and field notes were made during the interviews. Thematic content analysis was used to analyse data, following the stage-by-stage process of Burnard's model (Bengtsson, 2016; Burnard et al., 2008). The central aim of this thematic content analysis is to classify data into more relevant and manageable parts or themes, which makes this methodological framework suitable for exploring barriers and facilitators on different levels of the healthcare system (Weber, 1990). Data was coded by the main author, using the qualitative data analysis software MAXQDA©. The coding tree was built following the main themes used by the interview guide. After initial coding, the authors discussed data coding. A second round of analysis led to a classification of barriers and facilitators on 3 different levels concerning the care system:

namely, the level of the healthcare professional, the level of the management, and the level of the healthcare organization. These findings were again discussed by the research team. A third round of analysis led to the findings presented below.

Research team and reflexivity

The first and second authors conducted the FGs and interviews. Both researchers have experience in the field of qualitative research methods, organisation of healthcare and management, and culturally sensitive care. All authors have experience in qualitative research methods and thematic content analysis, and all are lecturers in a healthcare or research program. The two researchers who collected the data reflected comprehensively on their position and their role leading to potential biases during the research process. At the beginning of each interview or focus group session, the researchers introduced themselves. The participants were informed of the purpose of the study, the course of the study, the logic of the session, and the ethical and privacy terms. Participants were reassured that anonymity and confidentiality was guaranteed, as no names were traceable in the transcriptions since numbers were used as substitutes. With the informed consent, the participants also received the contact details of the researchers.

Results

This section presents the barriers and facilitators that participants experienced in providing care for patients with a migration background, as mapped by the data analysis: barriers and facilitators experienced a) at the healthcare professionals' level, b) on the level of the management of the care organisation, and c) at the level of the healthcare system. These results underline the barriers and facilitators as perceived by the healthcare professional, even when factors are defined at the management or healthcare system level. The study participants were asked about their care for patients with a migration background, but in most cases, the respondents talked about patients with a non-western background, and, more specifically, about Muslim patients. Therefore, the results below should be considered from that perspective.

Main findings show that healthcare professionals see people with a migration background as 'the other'. This othering shapes and externalises the barriers that healthcare professionals experience in providing care. Healthcare professionals do not feel secure or competent to provide care for these 'others'. According to the healthcare professionals, the hospital structures – and, particularly, the managerial instances – appear to be only slightly supportive. Structural barriers at the level of the healthcare system, such as limited implementation of care coordination and austerity measures (time pressure or economic restrictions), were also perceived as barriers.

a. Barriers and facilitators experienced at the healthcare professionals' level

Participants reported barriers experienced by themselves or by their colleagues: uncertainty about their own competences in providing care for patients with a migration background, discriminatory perceptions, and discriminatory behaviours. The facilitating factors mainly concern the critical self-awareness and attitude of the healthcare professional.

Uncertainty regarding their own competences in providing care for patients with a migration background

The student participants indicated that it felt difficult to deal with situations or conflicts in which they were confronted with issues related to ethno-cultural differences or that involved racism. They reported they had insufficient skills for interacting with patients with diverse backgrounds and felt insecure about handling these situations. Also, student participants reported that, during their programs, cultural issues were discussed in a very stereotypical way, by zooming in on certain characteristics of a certain population group (e.g., 'the' Muslim patient, 'the' Jewish patient, 'the' Chinese patient). The student participants indicated that the ethnic-cultural diversity in the classroom was not actively taught as an added value during the lessons, for instance to provide examples or providing a broader vision when exploring specific topics. According to them, this could have been the starting point to exchange personal experiences which could lead to more openness towards each other. In addition, the student participants felt too few tools were given to deal with situations in practice, as the next quote illustrates:

> *"We did learn something about culturally sensitive care, but not enough to be able to work very well with that." (Nursing student, FG)*

Also, the students (participants) emphasized that sometimes during their internships, they felt vulnerable which limited their ability to appropriately react when they felt a difficult situation arose. This would be linked to their role as a student and the fact that subsequently their evaluation depended on the professionals that may have been confronted due to an incorrect management.

In addition, students indicated that they also felt insecure and uncertain regarding their own competences when considering caring for patients with a non-western background. This feeling of insecurity obstructed a natural approach to their care. They also underlined that they had little knowledge to deal with 'other cultures' and they had received too little education or guidance during their programs on how to work with patients with a migration background. The quote below illustrates this.

> *"I recently had someone [with a migration background] who was diagnosed with high blood pressure, and he asked me "what is blood pressure?" Then you are sitting there and … [participant sighs] okay, how do you explain that? Usually, people experience this intuitively. They have heard something from someone else, but now you have to explain it in a different way." (Medical student, FG)*

Moreover, experienced participants felt insecure when interacting with patients who do not speak or understand the dominant language, or who have a different communication style than the healthcare professional. Although the participants saw a solution to overcome this barrier in working with interpreters, the participants indicated that they perceived working with external interpreters as difficult and cumbersome. Working with (official and informal) interpreters is often not done because of the following reasons: (1) limited trust from the healthcare professional to work with interpreters, (2) practical feasibility (i.e., scheduling a meeting with the interpreter together with the patient; administration and/or payment of the

interpreter), and (3) the position and role of the healthcare professional, where the healthcare professional must be prepared to let something be out of their hands. The next quotes illustrate this hesitation:

> *"What if the interpreter mistranslates it?" (Nurse, FG)*

> *"[working with a professional interpreter] is a hassle … often you can't do that … how to time on a test when there is also a need to be translated? … What if the patient doesn't show up?" (Doctor, interview)*

Discriminatory perception of healthcare professionals towards 'others'

The practice of thinking in terms of 'us and them' and othering – i.e., micro-racism by defining *the other* in an inferior way (Dervin, 2016; Fleras, 2016) – was present throughout the whole discourse of the interviews and focus groups, and was especially noticed in opinions and statements such as 'we' and 'they', 'they are different', 'that is also the case with *normal* people, not just with them', 'ordinary people', 'they have to adapt', and so on. Participants spoke of people with a migration background, even if they were second or third generation, in terms of 'a guest', a temporary situation, or they made the comparison with a situation where one is on a holiday trip in a foreign country. Also, other terminology like 'integration', 'to westernize', 'knowing *the* language', etc. shows that participants position themselves within a superior framework and perceive the migrant patients in a more inferior framework. This type of comments was mainly present among professionals that had no migration background themselves. In general, healthcare professionals with a migration background used a more nuanced discourse, and the perceived otherness was directed towards patients with migration roots in another region (for example, Central Africa or Eastern Europe).

Some participants – students and experienced workers – stated that it was sometimes good to have some prejudices. These participants saw this as a preparation for certain situations and used the prejudices to handle their uncertainty, as the next quote shows:

> *"I don't think it is bad to have a little prejudice. In our society, prejudices are seen as something very negative, and you should not judge anyone. But I think that, very often, these prejudices are correct. When you have someone from a certain culture, maybe there will be some of those people who don't mind you extending your hand to them, but you have 95 out of 100 who do. And they may find that a really big problem." (Medical student, FG)*

These prejudices led to thinking in stereotypes towards patients with a migration background, as the following quote illustrates:

> *"Usually, these women are at home and then, during the day, they are busy with their parents and in the evening, they go and get the children from school – they really live among each other. These social contacts are there [within their own community] ... Those families take care of each other. Like I say, usually the women are at home, mostly unemployed."* (Social worker, interview)

Moreover, participants saw patients with a migration background in the stereotypical image where the family takes care of the patient. Participants therefore concluded that certain care solutions (e.g., care provision in a long-term care facility) would not be accepted because of cultural norms – and so they hesitated to propose care solutions, based on the preconception that they would not be accepted anyway.

Discriminatory behaviour of healthcare professionals towards 'others'

In addition to the discriminatory perceptions, student participants described discriminatory and racist behaviour by fellow caregivers or by internship counsellors towards patients and colleagues with a migration background, as the following quotes also illustrate:

> *"At my last internship, I was on my way to the waiting room to fetch a patient. A nurse grabbed me by the arm [and said] 'You shouldn't put too much time in that black one.' ... And afterwards I was typing my report and then she came back to me [and said] 'It was a typical black one again for sure?' Just because it was someone with a black skin colour, that doesn't mean that they don't deserve the care I'd give to someone else. So, I was pretty worked up about that. Or another colleague who said: 'We're not going to give the Wi-Fi password to strangers [= patients with a migration background].'" (Medical student, FG)*

> *"There was a man, but the nurse could not communicate with him. ... But I knew he was Muslim and so I said, 'That's meat, he can't eat that.' The nurse said, 'yes, but he doesn't know that.' And she said to me, 'yes, give it.' And I said, 'No, I am not giving him that. Is there some bread I can give him?' And then the nurse got mad at me because I just had to give the meat to him. I just don't agree with that. I knew he was Muslim, and he was repeating 'no meat' ". (Nursing student, FG)*

There was a strong focus on Islam and on Muslim patients: next to the illustrated islamophobia, the care was adapted to what is believed to be desirable for 'the Muslim'. The religion, and religion-bound wishes, preferences and needs were not discussed with the patient. These were assumed on the basis of the name or the appearance of the patient and were filled in very generally, based on general stereotypical ideas about 'the Muslim', as the following quote illustrates:

> *"A woman who had requested vegetarian meals and who had a Moroccan-sounding name, she [the nurse] had changed the meal preference to 'halal'." (Nursing student, FG)*

Facilitators at the level of the healthcare professional

An aspect often cited as a facilitator was the healthcare professional's attitude: an openness to the patient's background, respect for self-esteem, with attention to the needs of the patient with a migration background, openness and willingness of the individual care provider to see what options there are to meet the patient's needs, to deal with this in a creative way and to think outside the box. Healthcare professionals' skills in asking questions and engaging in an open conversation can also facilitate quality care for patients with a migration background, with self-awareness of their own frame of reference and critical awareness of (societal and own)

stereotypes and prejudices. The participants indicated that one needs to be aware that there are intracultural differences, that education level, literacy, social network, etc. also influence a person, and that not everything can be reduced to the cultural difference.

'*It is about treating people the way you yourself want to be treated.'* (Nurse, FG)

Finally, the "multilingualism" of the healthcare professional can also be a facilitator in the care for patients with a migration background, although at times could be challenging. The participants indicated that it is a common practice to call upon a multi-lingual colleague when translation for a patient or a relative is required. Therefor the availability of a multilingual colleague is seen as an asset or a facilitator. For the multi-lingual colleagues however, this is an extra challenge or task on top of the already heavy workload.

> *"But they [professionals] never use them [official interpreters]. For example, I had a patient who spoke Arabic and they just asked me 'can you translate?' But I was doing something else. I shouldn't, I am not a translator and even though I can speak Arabic… One just has to call an interpreter, but yes… that takes too much time." (Nursing student, focus group)*

Moreover, multi-lingual participants reported that, if they spoke a language other than Dutch or French with a patient on their own initiative or if they suggested this, they sometimes received negative comments from non-multi-lingual healthcare professionals or they were ignored.

b. Barriers and facilitators experienced on the level of the management of the care organisation

The most common barriers they experienced were lack of leadership and guidance and lack of organisational policy towards situations in which patient and healthcare professional – from different ethnic-cultural backgrounds – interact with each other. Facilitators at the management level were mainly structural conditions that allowed the healthcare professional to be more flexible towards the needs of the patients.

Lack of leadership and guidance towards culturally sensitive care

The answers of the respondents indicated that, in both employment situations (working in their own practice or working as an employee), they experienced a lot of individual responsibility in deciding how far they could go to meet the needs of the patient in certain situations. The study participants reported that they perceived a lack of support from their employer to deal with certain situations in which they felt insecure about care provision related to a patient with a particular migration background. At the same time, respondents stated that they perceived little flexibility in care organisations for the healthcare professional to meet the needs of the patient. Professionals who, for example, deviated from visiting hours or who met the language or nutritional wishes of the patient with a migration background, were sometimes held accountable for these actions. As one participant said in an interview, they allowed relatives to enter the hospital unit during a night shift, to be with a dying patient with a migration

background. Afterwards, they were reprimanded for this, by both the supervisor and some colleagues.

> *"I thought 'Let those people say goodbye' and then [afterwards] I was reprimanded. I was like, 'If you, as a large institution that cares for people, reprimand employees for such a reason…, well I thought that was bad." (Nurse, interview)*

In addition, participants emphasized that often the manager or supervisor of the team plays an important role and has an exemplary function in the way in which the team provides care for people with a migration background. As a participant said in a focus group, an in-service training on culturally sensitive care was given, and the supervisor allowed some team members to skip the training because they were not interested in the theme. The participant experienced this as a strong signal to the other team members about the importance that was attached to this theme by their supervisor or by the management and the organizational policy.

Lack of organisational policy towards culturally sensitive care

Several participants confirmed that their healthcare organisations were not prepared to consider the individual cultural or religious needs of the patient. Participants asked themselves:

> *"Why do our care organisations not offer meals buffet-style, so that everyone could choose for themselves? Why is there no neutral place for prayer? Why is it so difficult to let patients speak their mother tongue?" (Doctor, interview)*

The participants linked the need for an organisational policy on culturally sensitive care to the diversity of the patient population, and they felt it was necessary and urgent for the management to work on this theme actively within the organisation. They felt this also had an influence on the extent of expertise regarding this theme in the organization.

Participants indicated that the organisational policy, the vision and the working culture of the care organization played a role in how the individual healthcare professional approaches patients with a migration background. Some participants stated that, in an ideal situation, all aspects in the organizational structure should become culturally sensitive – e.g., the cleaning services, the professionals, and the infrastructure, amongst others. This would make it easier and more supportive for the individual healthcare professional to provide culturally sensitive care.

Facilitators on the level of the management of the care organisation

Facilitators at the management level were experienced mainly in the structural decisions that allowed individual healthcare professionals to be flexible and creative in order to meet the needs of the patient. In the quote below, the healthcare professional is given the time to go to the residential care facility himself, whether or not accompanied by the family and the patient, in order to make the best possible choice for a further care solution.

> *"At that time, we try to look for a caring home where there are people of the same nationality as the patient... For example, I think of a lady who was Turkish and finally I*

went to visit a caring home where I saw there was more Turkish staff." (Social worker, interview)

Moreover, the management can facilitate or structurally support consultation meetings with the patient, the family and the healthcare professional. These meetings benefit the provision of care and the care organisation.

c. Barriers and facilitators experienced at the level of the healthcare system

Finally, there were barriers reported that are the result of structural measures or policies in healthcare, and that influence how individual care provision is provided and perceived. These barriers were difficult implementation of integrated and tailored care under pressure due to austerity and bureaucracy measures. The facilitators mentioned here also related to the division of available time in care.

Difficult implementation of an integrated care approach

Participants indicated that there were no guidelines for cooperation between organisations and individual healthcare professionals in healthcare, and by extension this would also impact social services and welfare care. The lack of guidance may lead to a problematic cooperation between professionals and local healthcare services. Participants indicated that the cooperation at a local level is flawed for the primary care services (e.g., homecare nurse, general practitioner) and for the connection to the second-line care services (e.g., hospitals). The hospital's initiatives to contact other professionals outside the hospital appeared to vary, and is mainly at the initiative of the individual healthcare professional, as the next quote illustrates:

"But in general [there is] not much [contact with the GP], because in general they come with a referral letter from the GP, and then I think to myself: '[the letter] will include everything that he has to say [about the patient]' … [If the GP wants to reach us] then it is not always easy to contact us. And vice versa too. And so, we both just stay in our own cocoon." (Doctor in hospital, interview)

Participants also described situations the caring process was dependant on individual efforts of specific individuals, for instance by being better connected or able to seek specific support. By the same token, participants claimed to be aware that this fragmented care and service offer complicated the care provision, and that this constituted a barrier for people who had less knowledge of the healthcare system, such as some people with a migration background or people in precarious situations.

Tailored care under pressure due to austerity and bureaucracy measures

Participants perceived that tailored care – and even the quality of care – was under pressure because of specific barriers in terms of the time required for administrative purposes. Also, other issues such as staff shortages, or bureaucratic issues would jeopardise correct care. Participants perceived that there was high time pressure on healthcare professionals, also reinforced by the standard-time-setting system, which prohibited them from spending extra time on additional needs of patients or the family or on additional practical tasks like translating.

"We currently have an average of 20 [clients] to care for during one afternoon. So, you can't take the time to listen to their story." (Social worker, interview)

Within this limited time frame, professionals in this study seemed to focus on daily essential perfunctory tasks, rather than focusing on the person-centred needs of patients. This resulted in too much time pressure with too little staffing. As a result, there was little flexibility for dealing with patient needs that differ from the norm – for example, patients with a migration background or people in poverty, as the next quotes show:

"You certainly don't have to start questioning the needs [of patients with a migration background] in advance, because that's going to make it difficult for everyone, and then there's even more time pressure." (Student nurse, focus group)

"The problem is, if you start questioning what [the needs are] in advance, then everyone is going to start making a fuss about care. ... Yes, better to respond at the moment than to start questioning the whole hospital. [Otherwise] the staff is going to be even more overworked." (Student nurse, focus group)

Furthermore, although care students indicated that they have slightly more time to invest in the patient relationship than professionals in the field, they also perceived that the provided care was not always experienced as human, or it lacked human dignity, due to too much work and too little staffing.

Specifically for the organisation of home care in Belgium, the system of remuneration per task was called into question. This system ensured that nurses who performed a lot of actions/tasks also earned a lot. The question remained: what is the number of visits per day that one can provide good quality of care? Participants indicated that, as a result of this system, some nurses who consciously chose to care for fewer patients per day and take more time in order to provide sufficient quality care earned less and, therefore, bore the financial consequences for wanting to provide quality of care.

In addition, in home nurses' organisations, home visits are ended against a timetable, which meant that the nurse either had to work very quickly or that they were still working outside their paid working hours. There were also very few regulations in this field, which contributed to abuse of vulnerable patients and competition between professionals.

"I know of a home nurse who goes to wash people with ear plugs and music on, because 'they don't understand me anyway'." (Nurse, interview)

Participants indicated that the way in which care was currently organised did not allow room to provide tailored person-centred care.

Facilitators at the level of organisation of healthcare

It is interesting to point out that the time factor is named as a barrier by one participant and as a facilitator by another participant, as the next quote shows:

"We organise a meeting where we invite the family and the doctors and other disciplines (within the team) … The whole family is present … in general, this is very well received. … It comforts them … So, it takes time, but it also facilitates in a large way." (Social worker, interview)

Although the content of these types of interprofessional meeting were valued by the health care professionals, several healthcare professionals could not invest the necessary time to these meetings, because of their patient- and workload. Although many participants experienced the restricted time as a barrier, there were also participants who found ways to deal with this. For example, some GPs work according to the system in which the patient pays a lump sum per year instead of paying per consultation. This gave the GPs the opportunity to take more time with their patients. There were also some homecare nurses who suggested that they take more time per patient. In both examples, this way of working does have financial consequences for the healthcare provider. Certain nurses choose to spend more time per patient, and therefore earn less due to a limited patient portfolio than other colleagues who may decide to deliver a more hurried type of care.

Discussion

The aim of this study was to describe the barriers and facilitators that healthcare professionals experience when providing care to persons with a migration background. Overall, the results show that healthcare professionals think primarily in terms of barriers when it comes to taking care of patients with a migration background. Facilitators are also discussed, but they are mentioned less often and less specifically. This is in line with the results of previous research, which shows that professionals find culturally sensitive care difficult and challenging (Claeys et al., 2020; Markey et al., 2018).

The barriers and facilitators experienced at the level of the healthcare professional show, first of all, that they feel insecure about their own competencies. These findings are also consistent with other research (Markey et al., 2018; McClimens et al., 2014; Tortumluoglu et al., 2006). To overcome these feelings of insecurity, our participants search for more knowledge. However, research has shown that more knowledge about cultural diversity does not ultimately lead to having more cultural competencies, and education programs about cultural diversity or culturally sensitive care are perceived as stereotypical (Berdai-Chaouni et al., 2020; Seeleman et al., 2009). Additionally, following a course in an ethno-diverse class setting, or following lessons by a teacher with a migration background, does not necessarily lead to a culturally sensitive attitude among the students (Seeleman et al., 2014). Although respondents also struggle with language, they undertake only limited action to overcome this barrier (Kynoe et al., 2020; Vissenberg et al., 2018). Instead of using official interpreters, our results show the often-used practice of calling upon a multi-lingual colleague healthcare provider to come over and translate. However, the perspective of the multi-lingual colleague, the impact of this request on how this colleague is positioned, and workload are not taken into consideration. This practice raises some questions about how multilingualism is acknowledged and rewarded by fellow colleagues and the employer, or about the ambiguous attitude towards one's own language skills and the language skills of others. Language and cultural factors seem to form a tandem whereby they can reinforce each other (Hughson et al., 2018). Language and

cultural factors can also reinforce the disposition of healthcare professionals to be even more task-oriented than they already are. This allows them to minimize the relational opportunities for a meaningful and respectful communication (Small et al., 2015; Taylor & Alfred, 2010). Small et al. (2015) also suggest that the healthcare professional's non- or under-accommodating language behaviour is linked to 2 communication predicaments: lack of understanding and devaluing the other. So here too, becoming aware of the mechanisms of 'othering' plays a role in overcoming this barrier.

Secondly, thinking in terms of 'us and them' has a major influence on how we see 'the other' and how we treat them (Arnaut et al., 2015). There is a rather negative attitude towards everything that is perceived as 'the other'. This othering was highly present in the narratives in our study, and definitely illustrates the point of view with superior and inferior cultures. These ideas of racial superiority are also described in other research (Markey et al., 2012; Torres, 2006) and can be reinforced by the already present relationship of reliance between the healthcare professional and the patient. The concept of racial superiority even seems to overrule the relationship of reliance between a healthcare professional and a patient, as professionals with a migration background experience hostility from patients without a migration background, because of ethno-cultural differences (Martin-Matthews et al., 2010). In addition, during the exchanges with professionals, it becomes clear that there is a certain prevailing view among fellow professionals that culturally sensitive care is not important, which affects the individual actions of the healthcare professional, despite his/her own competencies. It is a natural reflex to see the world through one's own frame of reference, but it is important to become conscious of this point of view in order to outgrow it. That way, one becomes more conscious of the stereotypes and prejudices that were unconsciously developed at an early age (DiAngelo, 2011; Markey et al., 2012). Furthermore, in suggesting care solutions for patients, a markedly predominant biomedical framework is still present for the healthcare professional. The care solution proposed by the healthcare professional does not always correspond with the choice or the personal preferences or financial possibilities of the patient or their caregiver, which is then perceived as refusal of care, sometimes because of cultural reasons (Fatahi & Krupic, 2016; Nielsen et al., 2019). Although these factors seem universal and not only occur in patients with migration backgrounds (Piacentini et al., 2019; Rosenow, 2005), these barriers are framed as cultural barriers that are especially problematic in patients with a migration background or as barriers that are linked to a migration history (Ryan & Scullion, 2000). Our results support the concept of the *migrants' othering* , a problem very present in Western societies (Fadil, 2019), in which the situation of 'the other' is always more problematic, more challenging, with lower health skills, with more refusal of care, than for persons that are not seen as 'the other'.

Third, the results also show that discriminatory and racist behaviour in healthcare reinforces feelings of insecurity and is a very explicit and discriminatory expression of the idea of othering. In the absence of tools to deal with this, and in the absence of a communication channel for this, racist behaviour or expressions are tolerated or ignored. Denial of racist practices is a common problem, but it is particularly problematic in nursing (Markey et al., 2012), as our study also clearly illustrated.

Both the results and previous research confirm that the attitude of the healthcare professional can be a facilitator in the provision of care for patients with a migrant background. Critical self-reflection and critical self-awareness are especially important, along with an openness and attitude that demonstrate a willingness to learn (Grandpierre et al., 2018). In addition, it appears that a healthcare professional's bi-cultural background can also help remove barriers when it comes to reaching certain target groups, although this should always be seen in combination with other competencies necessary for a care provider. A healthcare professional's multilingualism can also be a facilitator (Cyril et al., 2017).

Barriers on the level of the care organisation and its management point out that there is a lack of leadership and guidance towards culturally sensitive care and a lack of organisational policy towards culturally sensitive care when patient and healthcare professional – from different ethnic-cultural backgrounds – interact with each other. Although research has proven that the role of the care organisation and the management is very important to support the healthcare professionals in daily care practice and to strengthen structural changes (Aspinall et al., 2021; McClimens et al., 2014), our study shows that there is little support from the employer or the manager, and the responsibility to find flexible solutions or to think out of the box lies with the individual healthcare provider. Markey (2012) claims the whiteness of the care institutions goes unnoticed as the prevailing framework, which plays an important role in the deceleration of structural changes. The managers can play a facilitating role by (for example) offering a safe environment for the healthcare provider to learn and discuss situations in which they feel insecure, but also by enhancing workplace diversity and community outreach (Ogbolu et al., 2018). As already mentioned, there is the notion that the topic of culturally-sensitive care is not important, and that the cultural competence of healthcare professionals is still too little regarded as a strategic goal for the care organisation (Weech-Maldonado et al., 2018). The results also indicate that the need for a policy for a diverse patient population is experienced mostly at management level, when an increasing number of patients with a migration background make use of the organisation's healthcare offer.

At the management level, our findings emphasize that there is a need for structural support towards professionals in providing tailored patient care. This requires that the organization has awareness of inequalities in our society and that the organization has a clear vision and has a policy for person-centred care. However, this first requires a growing awareness within the policy and management of the healthcare organization (Grandpierre et al., 2018).

Finally, barriers on the level of the healthcare system were identified, such as difficult implementation of integrated care and tailored care under pressure due to austerity measures. An essential aspect of integrated care is that it must bring together fragmented key elements of the care system (Goodwin, 2016). The WHO and the UN see integrated care as an action area in the decade of healthy ageing (2021-2030) and this confirms the importance that is attached at an international policy level to an adequate integration of care and services in the professional field. For several years now, actions have been supported at various policy levels to promote integration of care services, providing more efficient collaboration and seamless care (Antunes & Moreira, 2011; UN, 2020). Nevertheless, the results show that it is precisely the lack of

integration of care that appears to be a barrier for healthcare professionals in providing good care to people with a migration background. Despite good initiatives, many healthcare professionals often continue to work only in their own domain and within their own discipline, and the bridge to other care or services is not, or not sufficiently, established. Patients need access to acceptable and accessible care and welfare, but the patient must also be able to trust that those care and welfare services can correctly and supportively refer to other services that are needed to fully meet the patient's needs (Fret et al., 2019; UN, 2020).

Furthermore, austerity measures, such as economic restrictions, shortage of staff, and limited time are major limiting factors to the delivery of culturally and linguistically appropriate care services that suit the needs of every patient (Hughson et al., 2018; Ogbolu et al., 2018). Time and work pressure in daily care provision is high and, in these circumstances, the demand for person-centred care cannot be seen as a realistic policy requirement. The structural barriers, such as difficult cooperation and austerity measures, can be seen as an additional barrier in the provision of care to persons with a migrant background, but these structural barriers also reinforce the other perceived barriers (Bagnasco et al., 2018).

Within the healthcare system, it is in certain situations possible for individual healthcare professionals to spend more time on the individual needs of the patient. However, this choice has negative financial consequences for the healthcare provider. Moreover, this remains an individual choice, and there is no structural policy on this matter from the healthcare organization. The individual choice to spend more time in providing quality of care does not fit into the healthcare system, which is based on rewarding care provision within a limited time frame.

As in any research, certain limitations can be identified in this study. Firstly, it could be stated that the participants of this study had rather similar opinions and experiences in relation to the research question. Second, a selection bias may have occurred, as all participants participated voluntarily in this study. As a consequence, this can cause an over-representation of participants with an interest in this topic of ethnic diversity in care and an under-representation of participants not interested in the topic. Finally, the sample of participants included a combination of students and professionals, which may lead to under-representation of certain healthcare professionals regarding the topic.

Conclusion

Healthcare professionals experience a number of barriers while providing care for patients with a migration background. However, only a limited number of facilitators were acknowledged. As indicated above, 'othering' appears to play a crucial role in the identification of several of these barriers, and in building or maintaining several barriers. In addition, other factors also play a role, such as awareness, skills and attitudes. We can conclude that a multilevel and a multifactor approach is necessary to tackle the barriers identified regarding providing quality care to patients with a migration background. A multilevel approach should address the barriers at the level of the healthcare provider, the management, and the healthcare system. At the same time, efforts should be made to focus on multiple factors, such as awareness

of othering, recognition and appreciation of the competencies of the care providers and tackling discrimination and racism in care.

Relevance to clinical practice

Taking into account the above identified barriers, 'othering' plays an important role in the construction and maintenance of those. We suggest that a multilevel approach is necessary to tackle the very present 'othering' within care provision. Other barriers at healthcare provider, managerial, and healthcare system levels should be tackled too.

A formal acknowledgement of the essential competencies for healthcare professionals in looking after patients with a migration background, and enhancing a multi-lingual healthcare environment, seem essential in this context (Hughson et al., 2018; Martin-Matthews et al., 2010).

Finally, mandatory training on cultural diversity should be integrated in all healthcare professionals' curricula, with no delay (HyeRin Roh & Nirta, 2018). Moreover, mandatory training and continuous support of all healthcare professionals on cultural competences seems essential.

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The authors declare that there is no conflict of interest.

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Appendix

Table 1: Overview of demographic information of the participants in the FG sessions.

	Number of participants	**Profile of the participants**	**Sex**	**Mean age**
FG1	7	Intercultural mediators	female	34y
FG2	5	Multidisciplinary geriatric team	female	32y
FG3	7	Nurses	female	36y
FG4	6	Nursing students	female	19y
FG5	8	Nursing students	mixed	20y
FG6	4	Medical students	mixed	21y

Table 2: Overview of demographic information of the participants in the individual interviews (INT).

	Profile of the participant	**Sex**	**Age range**
INT1	2 social workers in a hospital	Female	30-35
INT2	Social worker in a healthcare organisation	Female	40-45
INT3	Geriatrician in a hospital	Female	35-40
INT4	Neurologist in a hospital	Male	40-45
INT5	Neurologist in a hospital	Male	40-45
INT6	General practitioner	Male	30-35
INT7	Carer in a long-term care facility	Female	40-45
INT8	Social worker in a care organisation	Female	50-55
INT9	2 home-care nurses	Female	40-45
INT10	Occupational therapist in a long-term care facility	Female	35-40