Training programme

Diversity-sensitive competences towards older persons with a migrant background and their families / informal carers

DI.S.C.O.P.M.B.

DIVERSITY SENSITIVE CARE OF OLDER PEOPLE WITH MIGRANT BACKGROUND AND THEIR FAMILIES

Co-funded by the European Union

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INTRODUCTION

" I feel insecure in how to provide qualitative care to older persons with a migrant background."

Student

"Professionals do not understand what matters to me."

Older person with a migrant background

"It's too hard to gain access to services."

Informal carer of older person with a migrant background

These concerns, voiced from various perspectives, prompted the development of the European DI.S.C.O.P.M.B. project (2022-2025) and this training package. In our increasingly "super-diverse" society, persons have vastly different backgrounds, experiences and needs, even within groups.

The proportion of older persons with a migrant background is expected to grow in the coming decades. This group often encounters limited access to professional health and social care services. National minorities are not included in the project, but similar issues arise in working with these populations. To ensure high-quality, accessible care for all, it is essential that health and social care professionals offer services that are diversity sensitive.

The care system must take demographic changes into account. According to the ImmiDem study (Canevelli et al., 2020), two key trends, population ageing and migration, are significantly shaping European societies. These growing phenomena are increasingly important to the European Union, as they have a substantial impact on the welfare systems of its member countries (Canevelli et al., 2020). Both older persons and persons with a migrant background are often subject to stereotypes due to their specific needs. Although these groups have typically been considered separately, they are closely linked. As migrant population ages, their health needs shift, with a greater prevalence of age-related conditions. As a result, older persons with migrant background will form a more significant part of the overall older population, making their presence and needs more important to consider in discussions about aging and related services in Europe.
Diversity-sensitivity promotes the idea that health and social care professionals

"should be aware of different forms of cultural diversity – be it related to gender, ethnicity, age, socioeconomic status, religion, sexual orientation or other social markers; that difference should be integrated into the delivery of effective and equitable health care for patients; and that, regardless of its source, diversity can itself be a positive social contribution" (WHO, 2020, p. 9).

The training programme targets students of Higher Education and health and social care professionals. It supports the acquisition of competences to provide diversity-sensitive care. In the "making of" the training, the project team integrated several sources of knowledge: scientific literature, experiential knowledge within the organisation, storytelling-interviews and best practices. As diversity-sensitive competences are broad, the team chose to focus on a selection of basic concepts and interactive exercises to develop knowledge, attitudes and skills.

In a recent review, Lauwers et al. (2024) summarise the main components of diversity-sensitive care from the perspective of care recipients. Diversity-sensitive care builds on person-centred care and requires more complex and targeted competences that are specifically relevant to diversity-sensitive care. They conclude that health and social care professionals should adopt the following competences: knowledge (i.e., cultural, religious and spiritual knowledge), attitudes (i.e., demonstration of respect, concern, self-awareness, community partnership, allyship) and skills (i.e., communication, individualised care, shared decision making, adjustment of care to personal needs, providing culturally tailored information) (Lauwers et al., 2024).

The training is composed of four chapters, that are linked to these components.

1 **Person-centred care in a context of diversity (knowledge and skills)**

Access barriers to professional health and social care services (knowledge and skills) **2**

3 **Stereotypes and prejudices (attitudes)**

Diversity-sensitive communication (skills) **4**

1. Person-centred care in a context of diversity (knowledge and skills)
The chapter provides trainees with insights into the concepts of person-centred care, culture and cultural diversity, and super-diversity.

2. Access barriers to professional health and social care services (knowledge and skills)
Through the chapter, trainees gain a better understanding of barriers to access professional health and social care services experienced by older persons with a migrant background and their families/informal carers, and how to overcome these.

3. Stereotypes and prejudices (attitudes)
Trainees learn about stereotypes and prejudices in the care setting and how to be aware of them and develop respect and self-awareness.

4. Diversity-sensitive communication (skills)
The chapter provides trainees strategies in communicating with older persons with a migrant background and their families / informal carers and give insight into the TOPOI model to facilitate inclusive communication.

Each chapter is composed of reading materials and different learning activities. PowerPoint presentations of the reading materials for each chapter can be accessed here. Learning activities are diverse, e.g., reflection exercises, storytelling, role play, etc.

They are linked to specific learning content and include learning objectives related to knowledge, attitudes and skills regarding diversity-sensitive care towards older adults with a migration background and their families / informal carers. The training programme can be tailored according to trainees' needs and learning objectives. Facilitators and trainees can choose to follow the complete training programme or specific chapters, or even select specific training materials within the chapters.

The training programme was tested and evaluated in the partner countries, involving a total of 276 participants, including students and professionals in the health care and social work sectors. Feedback was used to reorganise the content, incorporate additional activities, and enhance theoretical sections. Knowing that diversity is a broad and complex theme, we hope that both trainees and facilitators will find inspiration and practical information to strengthen their diversity-sensitive competences.

DI.S.C.O.P.M.B. project team

CHAPTER 1: PERSON-CENTRED CARE IN A CONTEXT OF DIVERSITY

1. What is person-centred care

The concept of person-centred care offers a powerful framework for addressing diversity in health and social care, as it respects and acknowledges persons as unique beings with their own values, experiences and needs. Person-centred care and diversity-sensitive care are intrinsically linked because both require health and social care professionals to possess not only knowledge but also attitudes and skills that respect individual differences and promote inclusive care (Lauwers et al., 2024).

At its core, person-centred care recognises the whole person, addressing not just physical issues but also spiritual, psychological, social and existential aspects. This holistic approach validates the individual's experience of illness and seeks to improve well-being from their own perspective, incorporating their unique values, beliefs, and preferences (Claeys et al., 2021). By doing so, person-centred care moves beyond the traditional disease-centric model, emphasising that persons are not defined by their medical conditions but as people living with conditions. This shift helps preserve the person's identity, countering the tendency to reduce them to a label or diagnosis (Swedish Nurses' Association, 2019).

In contrast to the traditional medical models that focus mainly on treatment, person-centred care highlights collaboration between the care recipient and the care providers (both informal and formal) and promotes shared decision making (Coulter & Oldham, 2016). Indeed, person-centred care extends beyond the individual to their social context, including families / informal carers[1]. It recognises the care recipient as well as their families / informal carers as equal partners in the care process, thus valuing their voices as much as the care professionals. This shift allows for personal agency, as care recipients are encouraged to take an active role in their own health management, which helps to promote their capabilities and potential for self-care rather than viewing them as passive care receivers.

Moreover, person-centred care requires care professionals to develop skills beyond clinical expertise. It calls for a deep ethical understanding and the ability to adapt care practices to meet diverse health beliefs, values and preferences.

This ensures that care is delivered in a diversity-sensitive manner, where individual differences are respected and health and social care professionals acknowledge diverse thresholds for symptom recognition, expectations of care and patient preferences regarding treatments (Currie & Currie, 2024).

[1] Care is often provided by informal carers combined with support from health and social care professionals arranged in so-called ‘care triads’; a care network consisting of the care recipient, informal carers and care professionals (Hengelaar et al., 2018; van Muijden et al., 2024).

LEARNING ACTIVITY: stories of person-centred diversity-sensitive care

Objectives	Trainees can analyse notions of diversity-sensitive care interventions towards older persons with a migrant background and their families / informal carers.
Methods	Storytelling-interviews; critical thinking; group discussion
Time allocated	Approximately 1 hour of self-study.
Resources needed	· Story of Patrizio, older person here · Story of Giovanna, healthcare professional here
References	/
Instructions	The teaching method consists of practical content that includes watching the storytelling-interview from the older persons' and care professionals' view and engaging in reflection. Trainees watch the storytelling-interviews (see links in resources needed) and engage in a group discussion (2-4 people) by responding to the following reflection questions: • ***What are main concerns and barriers expressed in the video's about how to ensure that personalised and diversity-sensitive care is provided to older persons with a migrant background?*** • ***What do Patrizio and Giovanni consider to be key success factors in providing person-centred care? What are they positive about?*** Trainees document the reflections on a single A4 page (Arial 11, interline 1.5) and submit their answers to the facilitator after group discussion.

2. Culture and cultural diversity

In his essay *A Scientific Theory of Culture and Other Essays*, Malinowski (1944), a key figure in modern ethnography, defines culture as an "integral whole" made up of material, social and spiritual components that help persons cope with their environment and challenges. He argues that culture encompasses tools, beliefs, customs, and social institutions, and that each culture evolves through both internal development and external influences. This perspective forms the basis of cultural relativism, which suggests that every culture should be understood within its own symbolic and social context. Cultural relativism acknowledges the diversity of human societies and opposes the idea that any one culture is superior to another (Dietz, 2007). Malinowski's ideas highlight how culture provides a framework for understanding how societies organise themselves and develop systems to address their specific historical and social circumstances.

Culture is that set of knowledge, beliefs, traditions and customs created, acquired and transmitted by persons as members of a society. Culture is not static; it continuously evolves and responds to external and internal pressures, shaping the way persons live and interact with one another (Helman, 2007).

Our culture influences the patterns in which we assume roles and responsibilities within the family, with friends and in the workplace. In the context of care, understanding the cultural background of persons is crucial for providing inclusive, diversity-sensitive care. This requires both a deep understanding of specific cultures as well as a broader awareness of the diversity present in society (McFarland Wehbe & Alamah, 2019).

Cultural diversity goes beyond just accepting differences; it requires recognising and respecting them as essential to human coexistence. No culture is inherently superior to another (Dietz, 2007). The UNESCO Convention on the Protection and Promotion of the Diversity of Cultural Expressions emphasises that cultural diversity is a

"common heritage of humanity"

that must be protected and promoted for the benefit of present and future generations.

Cultural pluralism, which involves fostering intercultural dialogue and exchange, is key to promoting respect, solidarity and peace among people (Dietz, 2007).

Within the workplace of health and social care, cultural diversity plays a vital role as care professionals' own cultural backgrounds, the care recipients' and families' / informal carers' cultural identities, and the institutional culture of the work environment all intersect. These overlapping cultural influences shape interactions and the delivery of care. To ensure that care is diversity-sensitive, care professionals must be aware of cultural rights and the importance of respect for cultural diversity in their ethical codes of conduct (Gilman, 2005). However, many European professional codes, such as those for nurses and general practitioners, do not explicitly address cultural diversity, focusing instead on human dignity in broader terms (CEOM, 2010). There is a growing need for deontological rules that explicitly prohibit cultural discrimination and ensure respect for cultural, religious and customary differences in the care context.

LEARNING ACTIVITY: the iceberg of culture

Objective(s)	·Trainees can identify and categorise cultural aspects using the iceberg model, distinguishing between visible and non-visible elements of culture. ·Trainees are aware of personal cultural associations, enhancing understanding of one's own cultural background. ·Trainees can apply the iceberg model to recognise and organise cultural traits. Trainees understand visible and hidden dimensions of culture and diversity in general
Methods	Individual work; group discussion The activity can be performed face-to-face or online using as a support a Jamboard (or similar).
Time allocated	30 minutes
Resources needed	Pen, markers, post it and flipchart with a drawing of an iceberg. If the session will be implemented online a meeting platform is needed (e.g., Zoom) and an online software for group working (e.g., Jamboard, Ideaboarz or Mural).
References	BICAS – Building intercultural competencies for ambulance services (2016)
Instructions	The facilitator will give a brief explanation of the iceberg model: ·Culture can be visualised by the model of an iceberg. ·What do you see when you look at an iceberg? ·As is well known, only a small part of the iceberg is visible on the surface. The remaining part is underwater and cannot be seen at first glance. One must imagine the iceberg model as a way to show visible and non-visible aspects of culture.

LEARNING ACTIVITY: the iceberg of culture

Instructions	The facilitator should then give trainees 10 minutes to think about aspects or components they associate with the word culture. Trainees should then write the words that came to mind on post it notes (there is no limit to the number of words) and should then stick the post it notes by deciding whether to attach them to the visible or invisible part of the iceberg[2]. At the end, the results will be read and discussed with the group, trying to highlight how stopping at the surface does not allow one to see so much more that can emerge upon closer observation and analysis. Following guiding questions can be used to start the discussion: • ***When you meet persons with different cultural background, do you focus more on the visible aspects or on the hidden ones?*** • ***What can prevent you from grasping the hidden aspects of someone's culture? What instead allows you to grasp them?*** • ***How can you relate the iceberg to other aspects of diversity (not related to culture)?*** • ***How could it be useful in your work to recognise the deeper, invisible aspects of culture and of diversity in general?***

[2] Some aspects that might emerge or that you can suggest for the visible part are language, gender, age, clothing style, ethnicity, eating habits, symbols, rituals. Some aspects that might emerge or that you can suggest for the invisible part are norms, values, attitudes, understanding of roles and authorities, emotions, socialisation and education, social behaviour, own- and foreign perception, religion.

3. Living in a super-diverse society

European societies are becoming increasingly diverse due to a combination of global changes, including migration driven by employment, education, family ties and crises such as climate change, pandemics, financial instability, and conflicts. Historically, Europe has always been diverse, though this has only recently been more widely acknowledged.

In response to these changes, the concept of super-diversity emerged, introduced by Vertovec (2007, 2022), to challenge the overemphasis on culture and ethnicity as the primary categories in addressing diversity. Super-diversity highlights the complexity of modern migration and social differentiation, considering a multitude of factors that go beyond ethnic and cultural identities.

Super-diversity focuses on the speed, spread, and scale of changes happening in societies (Vertovec, 2007). It critiques traditional multiculturalism, which tends to view the world as divided into fixed, homogenous groups.

In contrast, super-diversity recognises that people simultaneously belong to multiple social groups and that these identities are dynamic, changing over time and across contexts (Martikainen et al., 2023).

Migration, as just one event in a person's life, intersects with other factors such as legal status, education, social hierarchies, and individual life experiences. By emphasising the intersectionality of identities (see also chapter 2), super-diversity encourages a more nuanced understanding of persons. Rather than categorising people solely based on ethnicity or culture, it asks us to consider the many overlapping social realities that shape a person's life (Vertovec, 2022). For example, an older migrant's experience is influenced by more than just their cultural background; it is shaped by their migration status, socioeconomic conditions and personal history. This view rejects static, one-dimensional interpretations of identity.
Super-diversity challenges systems, particularly in professional health and social care services, to adapt to the complex needs of diverse populations.

Traditional models of integration, which often expect (older) persons with a migrant background to conform to the dominant norms of their host countries, are seen as insufficient. Instead, super-diversity calls for a more flexible and inclusive approach, recognising the varied and evolving identities of persons and communities (Vertovec, 2007).

This framework promotes more personalised and context-sensitive support, whether in policymaking, professional care services or everyday interactions.
Super-diversity expands the lens through which diversity is viewed, moving beyond ethnicity to consider the full spectrum of social, economic and political factors that define persons. It presents both challenges and opportunities for societies, demanding more responsive and inclusive systems that acknowledge the complexity of human identity and experience.

4. Cultural competence in a super-diverse society

Cultural competence in health and social care has significantly evolved from making generalised assumptions based on individual's backgrounds to embracing a more inclusive, person-centred care approach. This shift emphasises empathy and a genuine interest in understanding care recipients' unique needs, values and preferences. By integrating quality health and social care with an understanding of individual diversity, person-centred care can effectively address the specific needs of each patient, rather than treating them as representatives of a cultural stereotype (McFarland Wehbe & Alamah, 2019).

Focusing on the individual and their social context, rather than relying on preconceived ideas or stereotypes, enable health and social care professionals to better understand the unique experiences and uncertainties that each care recipient may face. Cultural competence becomes essential in this context, equipping care professionals with the necessary awareness, knowledge, skills and sensitivity to provide effective care to persons from diverse backgrounds. This competence involves a multicultural knowledge base that care professionals can apply to deliver diversity-sensitive and appropriate care (McFarland Wehbe & Alamah, 2019).

Adjusting professional health and social care services to meet the needs of older persons with a migrant background and their families / informal carers is crucial. Rather than expecting them to adapt to a one-size-fits-all system, the care system should adapt its services to align with their understanding and values. This not only ensures better communication and care delivery but also leads to improved health outcomes. As care recipients are better informed and their values respected, professional health and social care interventions are more likely to succeed, which in turn can lead to economic benefits by reducing the need for repeated or ineffective treatments.

LEARNING ACTIVITY:

person-centred, diversity-sensitive care interventions towards older persons with a migrant background and their families / informal carers

Objective(s)	·Trainees can identify barriers in the provision of diversity-sensitive care to older persons with a migrant background and their families / informal cares. Trainees can derive aspects for effective diversity-sensitive care interventions towards older persons with a migrant background and their families / informal carers.
Methods	Self-study: critical thinking; group discussion
Time allocated	3 hours
Resources needed	Internet and access to journals databases
References	Sagbakken, M., Ingebretsen, R., & Spilker, R.S. (2020). How to adapt caring services to migration-driven diversity? A qualitative study exploring challenges and possible adjustments in the care of people living with dementia. PLoS One, 15(12), e0243803. https://doi.org/10.1371/journal.pone.0243803

LEARNING ACTIVITY:

person-centred, diversity-sensitive care interventions towards older persons with a migrant background and their families / informal carers

Instructions	Trainees read the publication of Sagbakken et al. (2020) and engage reflection in group discussion (2-4 people) by responding to the next reflection questions: • ***What challenges in the provision of diversity-sensitive care do you identify? Which challenges are cited in the study by the care recipients, which by the informal carers and which by the care professionals? What similarities and discrepancies between the different care actors do you identify?*** • ***In what way could these challenges be overcome in order to provide diversity-sensitive care to older persons with a migrant background and their families / informal carers?*** Trainees document their reflections on a single A4 page (Arial 11, interline 1.5) and submit their answers to the facilitator.

CHAPTER 2: ACCESS BARRIERS TO PROFESSIONAL HEALTH AND SOCIAL CARE SERVICES

1. Migration flows

The patterns of migration have diversified significantly, leading to a growing understanding that European nations are heterogeneous. Historical narratives that once portrayed Europe as largely homogeneous are being re-evaluated to reflect the deep-rooted diversity that has existed for centuries. This diversity was shaped by centuries of human migration, as people moved across borders to escape poverty, political repression, and to pursue new economic opportunities, engage in trade, and explore the world. It is important to have basic knowledge about diversity in migration flows as it has implications for the experiences and barriers that older people with migrant background encounter.

Migration has always been a fundamental aspect of human existence. Over time, persons and communities have been driven to relocate due to a wide range of factors, including war, environmental changes, economic hardship, and cultural exchange. As a result, European societies, like many others globally, have become a tapestry of intersecting ethnicities, languages, and cultural traditions. Migration patterns today reflect a broad range of experiences and backgrounds, challenging traditional notions of identity and encouraging societies to embrace their inherent plurality. Van Mol and de Valk (2016) distinguish three historical periods of migration, starting after the Second World War.

Period 1 (1950s – 1974): guest worker schemes and decolonization

In the period after the Second World War, North-western Europe was economically booming. The local, native population in this region became increasingly educated and faced growing possibilities for social mobility. They were often no longer willing to take up unhealth and poorly paid jobs (e.g., in agriculture, cleaning, construction, mining). As a result, North-western Europe started to recruit in peripheral countries. The recruited foreign workers were expected to return home after completing work and, therefore, were granted few rights and little or no access to welfare support. Most migrants in North-western Europe originated from Algeria, Greece, Italy, Morocco, Portugal, Spain, Tunisia, Turkey, and Yugoslavia. The main destination countries were Belgium, France, Germany, Luxembourg, the Netherlands, Sweden, and Switzerland. International migration was generally viewed positively because of its economic benefits, from the perspective of both the sending and the receiving countries.

At the same time, the process of decolonization gave rise to considerable migration flows towards Europe's (former) colonial powers. A significant number of people from the colonies came to Belgium, France, the Netherlands, the UK, and Portugal. Many of these (return) migrants were juridically considered citizens. Although European migrants returning from the colonies were often quickly able to integrate themselves, this was less the case for those of non-European origin who were economically and socially deprived and also often discriminated.

Period 2 (1974-1980s): the oil crisis and migration control

The oil crisis of 1973-1974 had considerable impact on the economic landscape of Europe and sharply reduced the need for labour. North-western European countries invoked a migration stop. However, policies aiming to control and reduce migration transformed rather than stopped migration.

Migrants from non-European countries who had come under labour recruitment schemes increasingly settled permanently, as returning to their home country for long periods entailed a significant risk of losing their residence permit. Many migrants started to bring their families to Europe (family reunification of migrant workers was considered a fundamental right, anchored in art. 19 of the European Social Charter of 1961). The composition of the residing migrant population also changed during this period. Whereas in the first period, European migrants were most numerous, the share of non-European migrant populations, especially the number of Turks and North Africans, significantly grew during this period. After the migration stop, countries increasingly controlled entries of foreigners, and migration became an important topic in national political and public debates. Increasing unemployment levels due to economic recession fuelled hostility, racism, and xenophobia towards migrants. However, awareness also grew that immigrant populations were here to stay. As a result, the need for adequate integration policies became apparent and started to develop. In this same phase, numbers of asylum applications started to rise in Europe.

The restrictions on the entrance of foreigners into North-western Europe also had another effect: migration flows increasingly diverted towards Southern Europe (e.g., Greece, Italy, Portugal, Spain). As these countries had long been emigration countries, they did not dispose of well-developed immigration legislation and entrance control systems. Furthermore, these countries were experiencing economic growth and falling birth rates, resulting in labour shortages. Southern Europe became not only an attractive destination for non-European migrants, but the favourable economic conditions also resulted in return migration among those who have moved to Northern Europe.

Period 3 (1990s- current): recent trends in migration towards and within Europe

This period is characterised by significant changes and further diversification of patterns of migration. Eastern Europe underwent new flows of asylum seekers due to several events (e.g., conflicts in Afghanistan and Iraq, the Arab Spring). The intra-EU movements were considerably eased while entrance into the EU became progressively restricted due to the unification of the European market, which imposed strict border controls and visa regulations. Migrants' countries or origin as well as their migration motives became increasingly diversified (Van Mol & de Valk, 2016).

Past years have been characterised by refugees, asylum seekers, and economic migrants leaving their country of origin due to wars and civil wars, human rights violations, environment and climate changes, and economic hardship. In 2015 and 2016, Europe experienced an unprecedented influx of refugees and migrants (European Union, 2017).

Namely, more than 1 million people arrived in the European Union, most of them fleeing from war and terror in Syria and other countries. On 24 February 2022, Russia launched a military aggression against Ukraine. As of January 2023, 4 million Ukrainian refugees were benefiting from temporary protection in the European Union (European Council, 2023).

Following the escalation of the Israeli-Palestinian conflict in October 2023, Palestinians applied for asylum in record numbers in 2023. 11,561 Palestinians requested protection in EU territory, mainly in Greece and Belgium (EUAA, 2024).

LEARNING ACTIVITY: diversity in migrant backgrounds

Objective(s)	Trainees know the demographic profile of the population in their country / regional differences.
Methods	Self-study; desk research
Time allocated	2 hours
Resources needed	Internet connection; world map
References	Databases and websites of national / regional governments; statistical bureaus. Students need to be told where to get the data and given resources.
Instructions	Trainees are asked to collect data about the demographic profile of the population in their country / region. Using reliable sources, trainees gather information on following aspects and discuss their results: • ***What is the age pyramid and gender distribution of your country / region?*** • ***What is the number of persons with a migrant background within the different age groups?*** • ***Diversity of backgrounds / countries of origin: to which countries are persons with a migrant background related? What are the numbers for each group?*** • ***Which countries of origin can you identify for the older population? Mark these on a world map.*** • ***Which countries of origins are highly represented among persons with a migrant background in your country / region? Mark these on a world map.*** • ***How can you relate the numbers for your country / region to the different period(s) of migration in Europe?*** • ***What groups cannot easily be identified from national / regional databases?*** Trainees discuss their findings in max. three pages (Arial 11, interline 1.5) and submit their answers to the facilitator.

2. Intersectionality

In chapter 1 we mentioned the concept of super-diversity, which refers to the increased heterogeneity within the population due to the various countries of origin, motifs for migration, legal statuses, etc (Ciobanu, 2023). The concept intersectionality is partly related but different, as it aims to understand sources of inequality as they emerge at the intersection of several factors, with main ones being gender, class and ethnicity (Ciobanu, 2023). Intersectionality, a concept that was introduced by Kimberlé Crenshaw, emphasises that various norms overlap and interact, leading to inequalities in different contexts. It suggests that multiple factors, such as age, gender and migrant background, influence how persons are treated in health and social care as well as in other areas of life. This perspective highlights that inequality results not only from individual characteristics but also from the interplay of these factors within specific contexts (Dilworth-Anderson et al., 2020).

Understanding intersectionality allows us to recognise how various factors combine to create inequalities, revealing the complexity of power dynamics and opportunities available to different groups. Health and social care professionals who only consider one factor, such as gender, risk overlooking other crucial elements (Dahlborg & Tengelin, 2022).

Moreover, intersectionality is not merely about accumulating factors; rather, it involves understanding how these factors can exacerbate inequalities when they converge. For example, if care access is limited for women, this barrier may be intensified for a foreign-born woman with disabilities. The significance of each factor varies depending on the context and their interactions. A simplistic additive approach can obscure the complexity of these issues (Dahlborg & Tengelin, 2022).

In discussions of intersectionality, it is essential not to focus solely on the “vulnerable side” of experiences, such as those of foreign-born, older women, but also to consider the “privileged side,” like middle-aged white men, who often hold more power. Recognising these dynamics is crucial for a comprehensive understanding of intersectionality and norms (Dahlborg & Tengelin, 2022).

Ahmad et al. (2022) emphasise the importance of using an intersectional approach to explore care relationships. Their study reveals how various social categories, particularly migration history and social class, impact care-sharing practices between older persons with a migrant background and their families / informal carers. These intersecting factors can either facilitate or obstruct educational opportunities, thereby influencing the dynamics of care-sharing and the effectiveness of communication between caregivers and care recipients. In their study, they found that persons who grew up in a lower or working-class family and migrated later on in life from an environment where educational opportunities were limited, were less likely to be equipped with management skills to organize and share care-tasks. In contrast, persons who grew up in a middle-class family, migrated at a young age, and grew up in an environment with educational opportunities, were more likely to share the care, both with family and formal care. In addition, migration history and social class did influence perceptions of “good care” and therefore one's willingness to share the care with formal services.

LEARNING ACTIVITY: the wheel of privilege

Objective(s)	·Trainees understand intersectionality, power relations, privilege and marginalisation in society.
Methods	Self-study; group discussion
Time allocated	30 minutes
Resources needed	The wheel of privilege is printed for all trainees.
References	The wheel of privilege is applied from research of Gayle Rubin (1989) and Kimberlé Creshaw (1989). ·Gayle, R. (1989). Reflexionando sobre el sexo: Notas para una teoría radical de la sexualidad. In C. Vance (Ed.), Placer y peligro: Explorando la sexualidad femenina. Revolución. ·Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. https://scholarship.law.columbia.edu/faculty_scholarship/3007 The theory is adapted into a wheel of privilege by the CCR Canadian Council for Refugees (https://ccrweb.ca/en/anti-oppression), and further developed by S. Duckworth (https://www.researchgate.net/figure/Wheel-of-Power-Privilege-and-Marginalization-by-Sylvia-Duckworth-Used-by-permission_fig1_364109273).

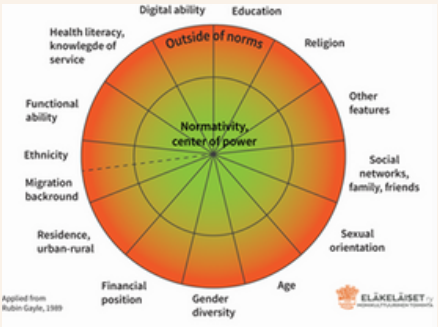
LEARNING ACTIVITY: the wheel of privilege

Instructions	In this exercise, trainees get acquainted with the wheel of privilege. They work independently, after which the exercise is collectively discussed with the whole group. For the reflection discussion, the facilitator can use following questions: • ***How did it feel to do the exercise and what thoughts arose from the exercise?*** • ***What do you think the exercise brings out about intersectionality and people's different social positions in society?*** • ***In what way would the result of the exercise you did change if you think you are in a different context, e.g. in a different country?*** The facilitator will give instructions to the trainees. Before giving out the handout, the facilitator will explain to the trainees that the wheel of privilege does not try to explain every aspect of human life and the identities people carry. It is not a universal model. It is a starting point of understanding intersectionality, power relations, privilege and marginalization in society. The wheel of privilege is used as a pedagogical tool for understanding interconnected inequalities. At first the trainees will get themselves familiarised with the wheel of privilege. After that they are instructed to think about themselves and their own identities in the context of the current society and country they live in. Second, they will draw with a pencil a small cross or a dot to every sector of the wheel, in a place where they think they are situated in the society. When finished the dots will form a figure which is either smaller or larger within the wheel itself. The closer to the centre of the wheel of privilege (ag. the smaller the figure is) the more privileged the person is in the society they are living in. The further from the centre of the wheel (ag. the bigger the figure is in size), the less privileged the situation of the person in question is. The group will then with the help of the facilitator conduct a discussion and reflect on the exercise and what it brings forward about intersectionality and privilege, power relations and marginalization in society. Trainees don't need to present their own work to others if they don't want to. The discussion will be done in more general level. The group can then look at two examples of figures done for older migrant women (see picture 2).

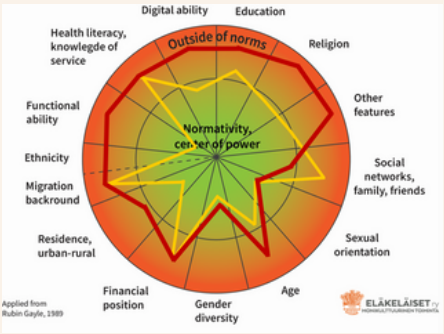
LEARNING ACTIVITY: the wheel of privilege

Instructions

Picture 1. The wheel of privilege



Picture 2. The wheel of privilege as an example with two figures of older migrant women.



3. Access of professional health and social care services by older persons with a migrant background and their families / informal carers

Populations with a migrant background tend to use professional health and social care services less frequently than native populations, despite having similar levels of engagement with primary healthcare services (Sarria-Santamera et al., 2016). One reason for this is that persons with a migrant background often have a better understanding of medical care compared to other professional health and social care services. In the case of older persons with a migrant background, many assume they can rely on the traditional family safety net for caregiving, relying on informal carers such as family members (Ahaddour et al., 2016; Ahmad et al., 2022). However, when care needs become more intensive, informal carers may experience significant pressure, leading to a situation where they may not be able to meet all caregiving responsibilities.

As the population of older persons with a migrant background grows, it is expected that demand for institutional care services will rise. Currently, a key issue in the lower use of professional health and social care services by this group may be the mismatch between the supply and demand for access to care. Many health and social care professionals assume that older persons with a migrant background are familiar with the available services, which often is not the case. This misalignment has led to limited tailored services that meet the specific cultural and personal needs of those persons.

A significant shift in care provision is required, particularly given the increasing multiculturalism in society, which is changing care needs. Care must go beyond standardised models and be diversity-sensitive to the specific needs of persons. When care provision is too general and does not account for the unique profiles and needs of older persons with a migrant background, they risk creating dissatisfaction and inadequate care. This can result from mutual misunderstandings between care professionals and care recipients, which can only be avoided with effective communication and cultural understanding. Barriers to accessing professional health and social care services for older persons with a migrant background can foster stereotypes and prejudices that negatively impact the relationship between care professionals and care recipients. To improve these interactions, it is crucial that both current and future care professionals are aware of the cultural, social, and communicative barriers that may arise when caring for older persons with a migrant background. Addressing these barriers is key to fostering better relationships and providing person-centred, diversity-sensitive care.

4. Experienced barriers to access professional health and social care services

Health literacy

Older persons with a migrant background and their families / informal carers sometimes lack knowledge about certain physical and mental health conditions, such as dementia, often viewing it as a normal part of ageing rather than a medical condition requiring treatment (Ahaddour et al., 2016; Duran-Kiraç et al., 2022). This perception can lead to delays in seeking professional care services and appropriate care interventions. The lack of awareness may also hinder early diagnosis and treatment, which is crucial for managing health conditions like dementia.

In many migrant communities, there is a tendency to underestimate or misunderstand the symptoms of age-related conditions, partly due to cultural factors or limited access to health education (Ahaddour et al., 2016; Duran-Kiraç et al., 2022).

This knowledge gap can lead to informal caregiving being the primary source of support, while professional care services remain underused, exacerbating both the health condition and the pressure on informal carers.

Language and communication barriers

Language barriers are indeed a significant challenge for older persons with a migrant background and their families / informal carers when interacting with health and social care professionals. The study by Priebe et al. (2011) highlights that language problems are among the most frequently reported barriers, leading to a communication gap that complicates the exchange of vital health information, including the expression of symptoms, diagnoses, and prescribed treatments. This communication gap can negatively impact not only the relationship between care professionals and care recipients but also complicates administrative procedures and access to professional care services. According to the study, language barriers often cause frustration and limit the effectiveness of communication, which can decrease openness and trust between the two parties.

In addition to language barriers, older persons with a migrant background may face additional communication challenges due to age-related factors such as sensory or cognitive impairments. These impairments can make it difficult for them to follow conversations, particularly if the speech is dense with information or delivered in an inappropriate tone. Physical issues, such as hearing loss, may also hinder effective communication.

Moreover, psychological factors, including emotional changes like depression, anxiety, or embarrassment, can further complicate communication. Self-perception plays a role as well; older persons may fear being judged or discriminated against, while they may perceive health and social care professionals as too formal or distant. These factors create communication barriers that can exacerbate misunderstandings between the care recipient and the care professional. Furthermore, stereotypes about older persons, such as assumptions that they are “deaf,” “closed off,” or “suspicious,” can influence interactions and reduce the quality of care.

Overcoming these challenges requires health and social care professionals to be sensitive to both the physical and psychological needs of older persons, adapting their communication style accordingly.

Low level of education

Education determines not only health condition, but also access to professional health and social care services. The provision of information and administrative procedures including filling out forms are hindered by a high literacy rate among older persons with a migrant background (Ahhadour et al., 2016).

Financial barriers

The poor financial situation and low socio-economic position of many older persons with a migrant background and their families / informal carers is a key barrier in the accessibility and use of professional health and social care services (Ahhadour et al., 2016; Jacobsen et al., 2023). A low socio-economic position seems to explain poorer health as persons with insufficient income save on health care. Also, the high costs of specific professional health and social care services are not affordable for persons with a low socio-economic position.

Lack of knowledge about professional health and social care services

Older persons with a migrant background and their families / informal carers often lack awareness of available professional health and social care services due to unfamiliarity with the care structures in their host country (Ahaddour et al., 2016; Duran-Kiraç et al., 2022). This unfamiliarity stems from the fact that in their culture or home country, they may not have a comparable concept of professional health and social care services.

As a result, these persons may view professional care negatively. Additionally, insufficient knowledge and lack of information regarding available resources, such as translated informational materials and language- and diversity-sensitive tools, further contribute to this gap in use and awareness of professional health and social care services.

Cultural and religious barriers

Professional health and social care services often lack sufficient knowledge about the cultural and religious beliefs and practices of older persons with a migrant background and their families / informal carers (Ahaddour et al., 2016). This can lead to neglecting important factors such as the care recipient's attitudes towards health, illness and treatment options. In traditional collective societies, relying on professional care is sometimes seen as a failure of children to fulfill their caregiving responsibilities, which can result in a loss of face within the community.

Cultural differences also raise concerns about engagement with physical examinations and non-pharmacological therapies, particularly in areas involving bodily treatments. Practical issues may also arise, such as missing appointments, showing up late or seeking informal advice outside the care system. This can create frustration for care professionals, who are often constrained by time and resources, and it may lead to mutual misunderstandings and stereotypes. These cultural differences can act as barriers, fostering perceptions of distance and even incompatibility between care professionals and care recipients. This gap can feel unbridgeable, as it is often perceived as a symbolic and cultural divide (Priebe et al., 2011; Martin, 2015).

Different conceptions of illness and treatment

Medical anthropology emphasizes that persons' perceptions and approaches to illness and health are deeply shaped by their personal experiences and socio-cultural environments. For example, in a case reported by a Danish healthcare professional, a Somali woman believed that the pain in her back was caused by air moving inside her body. She requested that the professional care provider perforate her shoulder to release the air. The professional care provider faced difficulty explaining that her back pain was related to muscle issues, not air, and ultimately had to use an anatomy book to help the patient understand. Although the woman took the prescribed pills and felt relief, her initial reluctance underscored the vast differences in cultural perceptions of the body and illness.

These differing understandings of the human body and treatment options can significantly influence the care recipient's level of trust toward the care professional, as well as their adherence to prescribed therapies. Miscommunication or differences in interpretation can lead care professionals to perceive care recipients as untrusting, arrogant or ignorant, which in turn may foster a judgmental attitude. This can result in care professionals either giving up on or becoming confrontational with the care recipient (Priebe et al., 2011).

Return and care dilemmas

Older persons with a migrant background often experience a profound sense of disorientation and alienation as they navigate the complexities of aging in a foreign country.

Many wish to grow old in their home country, driven by nostalgia and a desire to remain connected to their cultural roots. However, practical and emotional factors, such as the presence of grandchildren, social networks, and financial security, may compel them to stay in their new country (Ahhadour et al., 2016).

Additionally, there is a significant shift in the traditional expectations of familial care. For instance, older Muslims often rely on their children for support as it is considered a religious duty grounded in the Quran. While children may acknowledge this obligation, they frequently find themselves unable to meet these expectations due to changing societal norms. The influence of globalisation and individualisation has transformed the traditional extended family structure into a more westernized nuclear family model. This shift can create feelings of disappointment and insecurity for older persons with a migrant background who are accustomed to a different caregiving dynamic rooted in collective family responsibilities.

Trust and expectations

In the care professional-care recipient relationship, mistrust can emerge, leading to the omission of critical information and reluctance to engage with care professionals. This mistrust may extend to interpreters or mediators involved in the care process. Such hostility can create discomfort for all parties and may stem from negative experiences with professional health and social care services.

Priebe et al. (2011) note that older persons with a migrant background often express mistrust towards care professionals and interpreters from countries where they have previously encountered political or religious conflicts. In some instances, these care recipients explicitly request to be seen by different staff members or withhold information based on these concerns.

Health and social care professionals also recognise this challenge. A healthcare worker from the Netherlands observes that many older persons with a migrant background face discrimination and rejection within the healthcare system, describing experiences where they were treated unkindly or made to feel inferior due to language barriers. These negative encounters contribute to a pervasive distrust that influences the care professional-care recipient relationship.

Building trust in professional health and social care is particularly crucial for older persons with a migrant background and their families / informal carers. The lack of diversity sensitivity from health and social care professionals can exacerbate feelings of mistrust. Stereotypical thinking among care professionals can hinder the continuity of care and contribute to misunderstandings. This lack of trust can lead persons to feel offended and defensive, sometimes resulting in negative attitudes that further entrench perceptions of older persons with a migrant background and their families / informal cares as closed-off or arrogant. These attitudes often overlook the deeper issues driving their behaviour.

LEARNING ACTIVITY: stories of older persons with a migrant background

Objective(s)	·Trainees are aware of the perceived access barriers to professional health and social care services experienced by older persons with a migrant background and their families / informal carers. ·Trainees can reflect on their role as professional in how to lower the barriers and support older persons with a migrant background and their families / informal carers.
Methods	Storytelling-interview; discussions
Time allocated	40 minutes
Resources needed	Kurdish stories (video): Internet connection; world map
References	/
Instructions	Trainees watch the video and discuss the stories in small groups or one big group. It is important to encourage discussion to improve critical thinking about the subjects of those videos. Trainees can discuss the information from the videos with the support of the following questions: • ***What were the main points or concerns expressed in the video?*** • ***Do you have experience related to the issues highlighted in the video? Did the video raise any new perspectives to look at these experiences?*** • ***What kind of solutions can be offered to overcome the barriers discussed in the video? Focus on the barriers of language and social isolation.***

LEARNING ACTIVITY: empathy map access to professional health and social care services

Objective	Trainees can immerse themselves in the lived experiences of older persons with a migrant background regarding receiving informal care and professional health and social care services.
Methods	Empathy map; storytelling-interviews; critical thinking, reflection; group discussion
Time allocated	1 hour
Resources needed	Empathy map template or mural template (see https://online.visual-paradigm.com/diagrams/templates/empathy-map/empathy-mapping-template/)
References	/
Instructions	An empathy map helps describe the aspects of a user's experience, needs and pain points, to understand their experience and mindset. It is a simple visual that captures knowledge about a user's behaviours and attitudes. For more information, please look at following video: https://www.youtube.com/watch?v=skGUy2iq_dw Trainees watch the YouTube video on empathy maps. Afterwards, they make an empathy map about themselves: how do you feel when you are sick / unwell and are in need of care? Fill in the template. ***·What do you say?*** ***·What do you think?*** ***·What do you do?*** ***·What can other people see you doing?*** ***·What do you feel?***

LEARNING ACTIVITY: empathy map access to professional health and social care services

Instructions	Trainees will then with the help of the facilitator conduct a group discussion and reflect on the questions. After this exercise, trainees select a case based on their experience in working with persons with migrant background (during an internship, or as a care professional). Fill in the template a second time. ·***What does the person say about his needs, and professional and/or informal care received?*** ·***What does the person think about his needs, and professional and/or informal care received?*** ·***What does the person do about his care needs, and professional and/or informal care received?*** ·***What does the person feel about his care needs, and professional and/or informal care received?*** Can you see common / different experiences between you and the case that was discussed, based on the empathy maps? Trainees will with the help of the facilitator once again conduct a group discussion and reflect on the questions.

CHAPTER 3: STEREOTYPES AND PREJUDICES

1. Stereotypes: what they are and what they are for?

Recognising and addressing stereotypes is crucial not only for promoting equality and respect among different social groups but also for fostering deeper understanding and empathetic communication between persons. Stereotypes serve various cognitive and social functions, including simplifying information processing in uncertain situations. However, while they can facilitate quick judgments, they may also foster prejudice and discrimination, contributing to exclusion and social injustice. The self-defence function of stereotypes is particularly important to consider. By devaluing out-group members, persons from high-status groups may temporarily bolster their self-esteem. However, this dynamic creates an environment of inter-group competition that can exacerbate conflicts and divisions. Stereotypes act as 'glue' within a social group, creating a sense of belonging through shared beliefs and norms. This can both foster social cohesion and feed forms of exclusion towards those who do not share those values.

The definition of Hamilton and Troiler (1986) regarding stereotypes emphasises their role as cognitive structure:

> *stereotypes simplify and categorise reality, creating distorted images that, although they may contain elements of truth, fail to reflect the complexity of persons within a group.*

Their categorising function is useful for processing information quickly but can be problematic because it leads to generalisations and prejudices. Stereotypes, regardless of whether they are categorically positive or negative, limit the ability to see and recognise individuality and diversity within a group. The automatic activation of stereotypes can occur unconsciously, influencing perceptions and behaviours even in the absence of overt prejudice. This unconscious bias can reinforce social inequalities and perpetuate discriminatory attitudes in subtle and insidious ways. Despite stereotypes appearing to represent collective characteristics, they often focus on averageness and generalisation, leading to inaccurate representations that overlook the distinct experiences and qualities of each person.

The justification of social inequalities through stereotypes is a critical aspect. Stereotypes can mask and legitimise existing power structures, preventing persons from critically reflecting on their own status and the inequalities around them. Therefore, it is essential to challenge and dismantle stereotypes to promote greater equity and social justice, fostering an environment where diversity and individuality are recognized and valued.

LEARNING ACTIVITY: lemons are all the same

Objective	·Trainees recognise diversity within groups, understanding that initial appearances can mask significant differences. ·Trainees are open-minded and inclusive and can move beyond surface-level judgments in intercultural interactions.
Methods	Group exercise The activity can be performed only face-to-face.
Time allocated	30 minutes
Resources needed	At least one lemon for each participant, white sheets Other fruits could be chosen (e.g., nuts, oranges, apples, etc.)
References	BICAS – Building intercultural competencies for ambulance services (2016)
Instructions	The facilitator places the lemons in a row on a table. Each trainee should choose one of the lemons and look at it for one minute (they can also touch it and take notes of what observed). Each trainee should remember the characteristic of the lemon. Now all the lemons are mixed again (e.g., in a bowl) and each trainee must take the lemon they chose earlier. Then, the facilitator asks the trainees following questions: ***·Did they choose the right lemon?*** ***·How did they recognise it?*** ***·What specific characteristics?*** ***·Was it easy or difficult to recognise them? Why?***

LEARNING ACTIVITY: lemons are all the same

Instructions	At the end of the exercise, a reflection takes place on the fact that all lemons look the same. But if you look closer, they are all different and have specific characteristics. A general association does not represent the appearance or detailed characteristic of the fruit. In our daily lives we categorise human beings and situations. We use generalisations and stereotypical thinking. We still cannot assume that this says something about an individual in the group. It is important to reflect our own categories and use them only as a first orientation. Keep an open mind for individual details. Even though people might belong to one cultural area, they have their own identity and different affiliations that shape their attitudes and opinions.

2. How do stereotypes arise?

The psychological and social processes that lead to the formation and maintenance of stereotypes are strongly influenced by different cognitive, affective and social mechanisms. Below, we summarise the key points discussed.

Cognitive Bias

Stereotypes and prejudices are influenced by cognitive biases, which act as filters of information, selecting only data relevant to one's goals and ignoring other elements.

Social categorisation

Humans tend to categorise persons according to shared characteristics, such as gender, ethnicity, or social class, leading to a simplified view of others as members of a group rather than as persons.

Intragroup assimilation principle

Similarities between people within a group are overestimated, while differences between different groups (outgroups) are underestimated.

Attribution errors

Fundamental attribution error and illusory correlation can distort the way we perceive the behaviour of persons belonging to different groups, often leading to erroneous conclusions about personality traits based on a few observed behaviours. For example, a Muslim user recounts how the doctor assumed that her hijab was made for passive religious conformity imposed by the user's parents and that she was therefore backward, silly and unintelligent (Martin, 2015).

- ***Affective mechanisms***

  Negative emotions and anxiety towards external groups can intensify with the lack of direct contact, causing these emotions to be associated with the group and reinforcing stereotypes.

- ***Social learning***

  Stereotypes may also result from social learning, where beliefs about social groups are transmitted culturally through families, friends, school and the media, rather than from direct experience.

Stereotype construction is a complex and multidimensional phenomenon, influenced by multiple psychological and social factors. To counter stereotypes, it is crucial to promote positive and meaningful interactions between different groups, as well as to encourage active and conscious criticism of social and cultural representations.

3. Prejudices

Etymologically, the term prejudice derives from the Latin praeiudicium, which combines prae (meaning “pre”) and iudicium (meaning “judgment”). This suggests that prejudice involves forming an evaluation or judgment before acquiring all necessary information for a well-informed decision.

In social psychology, prejudice is commonly understood as a generally negative attitude directed towards a group or persons perceived as belonging to that group. This attitude is often based on stereotypes rather than individual characteristics.

Prejudice can manifest at various levels of awareness and is influenced by social norms and cultural values. Crandall and Eshleman's justification-suppression model posits that persons experience both prejudicial thoughts and societal pressures that inhibit their expression. This creates a complex interplay between personal biases and societal expectations.

The distinction between "old-style prejudice" and "modern prejudice" is particularly significant. Old-style prejudice is characterized by explicit, overt attitudes and discriminatory behaviour, whereas modern prejudice is often more subtle and nuanced.

It frequently involves inner conflicts, leading to what is termed aversive racism. In this form of prejudice, persons may unconsciously hold discriminatory views while outwardly espousing beliefs in equality and justice, resulting in inconsistent behaviours.To effectively understand and address the dynamics of prejudice, one must consider multiple factors, including cultural influences, psychological mechanisms, and social interactions. The challenge lies in promoting awareness and understanding to mitigate prejudice in all its forms, fostering more equitable and just societal interactions.

4. Stereotypes and prejudices: commonalities and differences

Prejudices and stereotypes emerge from the process of social categorisation, which allows persons to distinguish between the ingroup (the group to which one belongs) and the outgroup (other social groups).

While stereotypes and prejudices are often considered synonymous, they have distinct characteristics that warrant differentiation (Marx & Ko, 2019).

Stereotypes are cognitive representations that simplify and categorize perceptions of groups, serving as the basis for general beliefs about their characteristics. They can be seen as the preliminary stage of prejudice.
On the other hand, prejudice is a broader attitude comprising three components:

- **Cognitive Component**
  this includes stereotypes, which represent beliefs about an outgroup
- **Affective Component**
  this encompasses the emotions elicited by the outgroup, such as fear, anxiety or anger
- **Behavioural Component**
  this refers to the intentions or actions taken towards the outgroup, which can manifest as discrimination.

Discrimination is the behavioural expression of prejudice, representing negative actions directed at persons based on their group membership. However, prejudice does not always lead to discrimination, as there can be instances where persons consciously choose to override their prejudiced beliefs.

Example illustration:

Stereotype: "North Africans are noisy."
Prejudice: "If I could, I would never rent a house to a North African person." This reflects a cognitive belief about North Africans (noisiness) along with an emotional response of anxiety about the situation (affective component).
Discrimination: "Do not rent to North Africans," which is the actual behaviour enacted based on the prejudice.

CASE STUDY IN AN EDUCATIONAL CONTEXT

Consider a group of students from diverse ethnic backgrounds working on a project. One student from a minority ethnic group may encounter stereotypes suggesting that persons from their background are less capable or intelligent. These stereotypes form the cognitive component of prejudice. However, the presence of these stereotypes does not automatically result in discriminatory behaviour. As the group collaborates, the other students may initially feel influenced by their biases but could later develop empathy for their minority classmate. This shift signifies the affective component, leading to a positive attitude towards inclusivity.

In this scenario, despite the initial activation of negative stereotypes, the group's collective intention to foster an inclusive environment can mitigate discriminatory behaviour. This illustrates the distinction between stereotypical beliefs and actual actions, highlighting how awareness, empathy, and social dynamics can play critical roles in overcoming prejudice. Overall, this example underscores that while stereotypes can influence perceptions and thoughts, they do not dictate behaviour. Intentional efforts to engage positively can create a more inclusive and equitable atmosphere, demonstrating the capacity for persons to rise above initial biases.

Prejudice and Discrimination: Crash Course Psychology

In this video, the concept of stereotyping, prejudice and discrimination is explored in depth and several suggestions are made to become more aware of one's own stereotypes.

LEARNING ACTIVITY: working with labels

Objective	Trainees are aware of stereotypes.
Methods	Group discussion The activity can be performed face-to-face or online using as a support a Jamboard (or similar)
Time allocated	1 hour
Resources needed	Post-its / pens If the session will be implemented online a meeting platform is needed (e.g., Zoom) and an online software for group working (e.g., Ideaboarz or Mural).
References	/
Instructions	·The facilitator invites trainees to think about a stereotype or discrimination situation associated with a stereotype and the emotions it aroused – the stereotype and associated discrimination situation may not relate to the participant but refer to more general situations known to the trainees. ·The facilitator invites trainees to write down on two different post it notes the stereotype / associated discrimination situation and the emotions this arouses. If done online, trainees can write digital post its, on Jamboard for example or similar. ·Trainees are divided into pairs and the post its are exchanged. The facilitator promotes a discussion in pairs, supported by the following questions: are you aware of the stereotype the other person has written? Have you had experiences that support this stereotype or, vice versa, that deconstruct it? If done online, the discussion activity is done as a group, or sub-rooms can be created for each couple.

LEARNING ACTIVITY: working with labels

Instructions	The facilitator invites trainees to stick all the post its with the stereotypes / situations of discrimination on the left of the wall and the associated feelings on the right side - if done online, the facilitator sorts the post its effectively to promote a group discussion. Trainees are led by the facilitator in a discussion on the variety and diversity of stereotypes, supported by the following questions: • ***Are you aware of all these stereotypes? Have you ever thought about them?*** • ***What do you think is the impact of these stereotypes?*** • ***In your opinion, have these stereotypes ever influenced you in your daily life and if so, how?*** • ***Why do these stereotypes/situations of discrimination make you feel this way?*** • ***Choose three stereotypes and reflect as a group on their impact and the counterevidence you have experienced: what are the commonalities and differences between these three stereotypes?***

5. Older persons with a migrant background: stereotypes and prejudices in the care setting

Being an older person and a migrant at the same time can expose the individual to the double risk of marginalisation and social exclusion, as well as to conditions of disability, existential loneliness and poverty in the broadest sense of the term. The combination of age and migration thus plays as an invisible influencing factor that can more easily expose older persons with a migrant background to stereotypes and prejudices in societal contexts and in care settings, which in fact preclude the possibility of access to quality services.

For example, a person discriminated against based on their ethnicity may also be discriminated against on the basis of gender, sexual orientation, age, disability, etc.

Such multiple discrimination creates, in fact, a cumulative disadvantage which in the case of older persons with a migrant background translates into economic hardship, lower quality of health, limited social security and health care rights, limited access to services, inadequate policies (Dolberg et al., 2018).

Ethnic inequalities in health and social care are a significant issue, with studies, like Nazroo (2006), showing that these inequalities tend to worsen with age, largely due to socio-economic factors. Furthermore, Nazroo (2006) emphasises the importance of understanding structural racism to properly analyse ethnic inequalities in health and social care. Discrimination against older persons with a migrant background is fuelled by stereotypes and prejudices that

present them as deviant or inferior, as shown by Chaouni et al. (2021). For example, the preference for female care professionals by older women with a migrant background is often incorrectly attributed to ethnic rather than cultural reasons, while similar preferences in native older women go unnoticed.

Discrimination in health and social care is particularly evident for religious and ethnic minorities, such as Muslims, as demonstrated by Martin (2015). Muslims frequently report ignorance, exclusion, and offensive behaviour from health and social care professionals, particularly around religious practices like prayer. These experiences highlight a broader lack of sensitivity among health and social care professionals.

These studies encourage a rethinking of the approach towards different ethnicities in the health and social care sectors, suggesting the need for staff training and awareness-raising to address stereotypes and prejudices, and to ensure equitable care that respects different cultures. The understanding and inclusion of cultural differences could contribute to improved care experiences for older persons with a migrant background, as well as for other ethnic minorities.

The experiences of discrimination extend to hospital settings, where older persons with a migrant background reported delays in care due to religious practices, limited dietary options like halal food, awkward reactions to prayer and assumptions about their English-speaking abilities. These examples reflect social categorisation, where “we” (staff and native users) and “them” (older users with a migrant background) create unequal treatment and exclusion.

Ageism [3], particularly when combined with migrant status, adds another layer of disadvantage, leading to devaluation and marginalisation. Ageism in health and social care manifests in both negative and seemingly benign behaviours, negatively impacting communication between health and social care professionals and older persons.

Studies, like the study of Caris-Verhallen et al. (1999), show that ageist attitudes among health and social care professionals result in shorter, superficial interactions and task-oriented communication styles, which undermine the active involvement of older care recipients in decision-making. The literature presents a complex picture of care professions' attitudes: some studies show a clear negativity towards older persons, while others offer more neutral or even positive assessments.

However, it is worrying to note that ageism also manifests itself in clinical practices and treatment choices, leading to unequal treatment between different age groups (Wyman et al., 2018). Ambady (2002) for example indicates that physicians tend to exclude older people from the decision-making process regarding their care, favouring younger patients instead.

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[3] Ageism is a specific form of discrimination affecting older people, aggravated in the case of migrants, who may face a multiplicity of social and economic disadvantages (WHO, 2021).

The concept of “elderspeak,” a patronising way of talking to older persons, further exacerbates this issue, contributing to a childlike treatment of older persons (Shaw & Gordon, 2021). The effect of this discriminatory attitude negatively affects several aspects of older people's lives, including cognitive, behavioural and health processes, and this happens even in the absence of their awareness (Wyman et al., 2018).

Both older persons and care professionals highlight numerous barriers to older people's participation in shared decision-making (Belcher et al., 2006; Wetzels et al., 2004). These factors make clear the complexity of the situation, which requires significant efforts to train care professionals and to provide support to older persons and their families / informal carers. Recognising and addressing ageism is essential to improve the quality of care and to promote greater inclusion of older people in their care.

6. What are the effects of stereotypes?

The topic of stereotypes and their effects is highly relevant in social psychology, particularly in understanding how they shape intergroup dynamics and personal identity. Steele and Aronson’s research on stereotype threat demonstrates that simply being aware of negative stereotypes can harm an individual’s performance. This creates a cycle where performance anxiety reinforces the very stereotypes that caused the anxiety in the first place.

Theory suggests that when people from stigmatised groups are aware of the negative stereotypes associated with their group, they tend to feel threatened and behave in ways that confirm these stereotypes, even in areas not directly related to the content of social identity. This phenomenon can have significant consequences on their self-perception and psychological well-being.

For example, stereotypes about older persons not only influence others' expectations of them but also affect older persons' self-confidence and sense of efficacy (National Research Council Committee on Aging Frontiers in Social Psychology, Personality, and Adult Developmental Psychology; Carstensen & Hartel, 2006).

These beliefs can lead older persons to underestimate their abilities, which can directly harm their quality of life. This illustrates how stereotypes, once internalised, can perpetuate marginalization and discrimination on both a societal and personal level.

The issue of discrimination against older persons with a migrant background in the context of health care is extremely relevant and deserves in-depth attention. Stereotypes surrounding both older age and belonging to minority social groups create significant barriers to access to adequate and appropriate care. Ignorance and lack of awareness of these dynamics can lead not only to a poor assessment of symptoms but also to a generalised rejection of care by older persons themselves.

A crucial first step in addressing these issues is the dissemination of critical awareness about stereotypes and their negative consequences. This implies education and training for medical and social personnel to recognise and overcome their prejudices. Working on intercultural training and promoting positive role models can provide care professionals with good opportunities to develop greater empathy and understanding. In addition, it is essential to create a hospital and social environment that is welcoming and inclusive and able to meet the specific needs of older persons with a migrant background.

This could include implementing diversity-sensitive care programmes, effective translation of health information and encouraging open dialogue between care recipients and care professionals.

Promoting the communication and active participation of older persons with a migrant background in decision-making processes concerning their health and wellbeing can also help to improve their experience and reduce the perception of marginalisation.

When older persons feel listened to and involved, the likelihood that they will accept and follow recommended care increases.

Bias in healthcare

This video on YouTube shows how there are implicit biases in the provision of care and as much as the goal of health experts is to provide appropriate and equitable care, sometimes cultural influences can undermine quality care.

CHAPTER 4: DIVERSITY-SENSITIVE COMMUNICATION

1. Inclusive communication

Inclusive communication encourages to focus on the encounter between unique persons, connected with others, at an intersection of identities (see chapter 1 and 2). It goes beyond a culturalistic approach where the focus is on specific cultures and cultural characteristics (Hoffman, 2024). Being aware of and committed to overcome communication barriers is the first step to help older persons with migrant background and their families to feel comfortable with practitioners and in the care pathway. These communication barriers are not only represented by verbal language, but also by non-verbal and para-verbal communication, and by the way we interpret conflicts and misunderstandings.

Inclusive communication is based on the principles of recognised equality and recognised diversity (Hoffman, 2024). Recognised equality refers to the idea that communication between people, regardless of their background, is always the communication between human beings. Recognised diversity means that we are unique persons connected with others, with multiple identities, own life stories, and embedded in diverse socio-cultural contexts. Communication therefore is an interplay between persons with their unique personality, physical and mental conditions, biography, cultural habits, etc. AND the specific situational context in which the communication, the interaction takes place.

Hoffman explains with an example how the context determines how to approach people inclusively: depending on the context, people are first and foremost e.g., employees, clients, learners, parents, citizens, etc. (recognised equality), each with their own specific personal characteristics, competences, motives, needs, emotions and values (recognised diversity).

Hofmann (2024 p. 24) explains:

> An employer was asked by an employee if he could get Friday off to go to the mosque.
> The employer responded by saying, "That's not possible. Here in the Netherlands, we go to church on Sundays!" From an inclusive approach, the employer should see the man as an employee (recognised equality) - and not a Muslim - who has a particular wish (recognised diversity), as any employee can have.
> For example, other employees might want to enjoy a long weekend and also take the Friday off.

Let's give another example. With advancing age, certain problems may appear or become more acute. Among these, a common problem is related to deficits in the auditory system. The risk in this respect could be to fall into the stereotype that all older people have hearing problems and to address them in an inappropriate tone or by using 'elder speak'. Kemper et al. (1998) describe elder speak as a simplified speech register with exaggerated pitch and intonation, simplified grammar, limited vocabulary and slow rate of delivery. It is used by younger persons in communication with older adults in a variety of community and health care settings and based on stereotypes of older adults as less competent communicators (Williams, 2011).

The features align with a communication style typically used when speaking to (dependent) children. Hence, elderspeak is also referred to as secondary baby talk. The result is unsatisfactory communication for both the speaker and the receiver. From an inclusive point of view, every client should be treated in a way that they are able to understand the information given to them and feel welcome (recognised equality). Some will need some aid to understand auditory information or written information, others prefer to be talked to in a formal way, or called by their first name, etc.

To communicate in an inclusive way, care professionals need to be aware of verbal, non-verbal and para-verbal aspects and the context in which the interaction takes place. Care professionals should not stop at the surface, at stereotypical images of the care recipient: ask questions, ask for explanations, make sure the user is put in a position to understand and express himself/herself effectively.


Boxes & All that we share TV 2 | All That We Share - YouTube

Look at this video. What does it say about differences and communalities?


Family caregiving in a super-diverse context

Go through this Reusable Learning Object (RLO) to learn more about informal care and how to include informal carers in the care process, while acknowledging super-diversity.

2. Cultures don't meet, people do: the TOPOI model

The TOPOI model created by Edwin Hoffman, is used to analyse communication. It is a helpful analytical framework to detect and analyse possible misunderstandings and conflicts during and after the conversation. It is based on the assumptions that communication is universal, and the emphasis is on interaction, not culture.
According to the model, there are 5 areas in communication where differences may occur.

- ***Tongue: each person's verbal and non-verbal language***
  E.g., communication styles, politeness, feedback, connotations, interaction rules, body language, eye-contact, socially accepted behaviour, clothing, ...
- ***Order: each person's view and logic***
  E.g., different views of life/the world/..., different ways of reasoning (holistic, analytical, deductive, inductive, ...)
- ***Persons: the identities, roles of persons involved and the relation between them***
  E.g., images, faces, masculinity/femininity, gender-equality, trust building, ...)
- ***Organisation: the organisational and societal context of the interaction***
  E.g., legislation, political context, socio-economical context, procedures, functions, leadership styles, ...
- ***Intentions: motives, emotions, needs, values, spirituality of the persons involved***

The model raises sensitivity of the influence of each area and the differences that can occur. It helps to zoom in on the concrete interpersonal interaction, reflect on the possible differences and misunderstandings, formulate hypotheses and address them.

LEARNING ACTIVITY: TOPOI model

Objective	Trainees can apply the TOPOI model to analyse communication and domains of misunderstanding.
Methods	The activity can be performed individual or in group. When in group, it can be face-to-face or online using as a support a Jamboard (or similar)
Time allocated	2 hours
Resources needed	If the session will be implemented online a meeting platform is needed (e.g., Zoom) and an online software for group working (e.g., Ideaboarz or Mural).
References	https://www.digi-pass.eu/ST-Culture-How-to Hoffman, E. (2024). Inclusive communication and the TOPOI-model. Beyond intercultural communication and competence: 'Cultures don't meet, people do.' doi: 10.13140/RG.2.2.32123.32802/1 https://www.researchgate.net/publication/379815719_ Inclusive_communication_Edwin_Hoffm
Instructions	Step 1. Trainees familiarize with the TOPOI model and the questions to analyse communication using the above-mentioned sources (individual).

LEARNING ACTIVITY: TOPOI model

Instructions	Step 2. Trainees read this case Fatima is a woman of 88 years old with Moroccan roots. At the age of 42, she immigrated to Belgium with her husband and her children. Her husband passed away 3 years ago and Fatima stays behind in their house, with her daughter Zeynep living close to her. She was able to manage well for a long time with help from her daughter, but now she needs more help and supervision. After a few very difficult months at home, her daughter Zeynep arranged access to a local residential care facility. After some time Zeynep asks for a meeting with the head nurse. She is worried about her mother's care and the fact that her mother seems not happy. Her mother told her she does not like the food and he is not invited to the activities. During the conversation the nurse refers a situation where Zeynep did not participate at a group activity because she wanted to stay in her room to pray (as she does several times a day). Some staff members are bothered by this because they feel that they should not wait for Fatima and some do not even invite her to participate in an activity anymore. "Why can Fatima not settle with the time frame like the others"? A discussion arises between Zeynep and the nurse. Step 3. Trainees analyse the case based on the TOPOI framework. • ***Where can you see differences and communalities in the 5 TOPOI areas between Fatima, Zeynep and the nurse?*** • ***What domains can lead to miscommunication?*** • ***What can you do as a nurse to overcome miscommunication?***

To overcome communication barriers, general attitudes and communication skills are important. Think about: respect, openness, curiosity, critical self-reflection, flexibility, active listening, 'reading the air'/'reading between the lines' (Hoffman, 2024). Unlabeling people and avoiding ‘otherness’ are essential. This was already stressed in the chapter on stereotypes.

Here we can add that it is important to be attentive to roles and identities during a conversation.
For instance: a daughter can- even just in her position of informal carer- have different roles. She is an expert on care for her mother (having cared for years at home), but also a person in need of support herself, a co-caregiver of the professionals, a daughter who is close to her mother… Even in the same conversation, there can be shifts in these roles or identities that people relate to (Hoffman, 2024).

When faced with a lack of trust or an attitude of mistrust, it may be helpful to offer more time and listening to the person, helping him/her to break down barriers. Underlying negative attitudes due to a lack of trust may be misunderstandings or patients' feelings that they do not feel taken seriously. Certainly, in this case patience and understanding can be a good strategy. The good news is, as Hoffman (2024, p. 24) states, that mistakes can be made:

“Be true to who you are, unconcerned, authentic”.

3. Overcoming language barriers

The language barrier is one of the main obstacles that can create mutual misinterpretation between the practitioner and the care recipient. There are 3 main strategies for health and social care professionals to overcome language barriers (Van Landschoot et al., 2021): to adjust your language as a professional, to use support tools, or to engage third parties.

Adjust language	• Use simple 'national language' • Choose a 'contact language' (that both have some level of understanding of) • Use language of the conversation partner
Support communication with tools	• (Multilingual) visual aids • Multilingual documents • Multilingual digital aids (apps and translation computers)
Engage third parties	• Intercultural mediator • Social interpreter (on-site interpreter, webcam interpreter or telephone interpreter) • Language assistance • Colleague • Informal interpreter

All strategies have pro's and con's or issues to be aware of.

For instance, a family member, not being a professional and not being completely neutral, might limit himself/herself to an interpretation of the patient's report, omitting some parts or giving his/her own point of view (Priebe et al., 2011).

Translation devices, on the other hand can contain translation errors and generate misunderstandings between the parties. There are many tools on the market, and you have to make a selection based on topic, goals and type (e.g., do you want visual support or not) (Van Landschoot et al., 2021).

Working with family as interpreters

Look at these 2 video's. What do they tell about working with families / informal carers as interpreters? What are points of attention? How can you make sure that concerns of the family / informal carer is taken into account?

Video 1: Go through this Reusable Learning Object (RLO) to learn more about informal care and how to include informal carers in the care process, while acknowledging super-diversity.

Video 2: Go through this Reusable Learning Object (RLO) to learn more about informal care and how to include informal carers in the care process, while acknowledging super-diversity.

Ladha et al. (2018) also highlight some effective tips working with interpreters:

- Familiarise with the interpreter services in the area.
- Speak with the interpreter before each appointment to clarify expectations.
- Use the interpreter to arrange the next appointment and confirm transportation arrangements.
- Arrange for triangular seating, so everyone present can see nonverbal cues.
- Introduce everyone who is present.
- Ask who is the most appropriate person to address your questions to.
- Look at family members as you speak and try to speak directly with them.
- Debrief with interpreter afterward to ensure communications were fully translated.

LEARNING ACTIVITY: stories of health and social care professionals

Objective(s)	·Trainees develop critical thinking skills to enhance the ability to analyse and evaluate communication challenges, particularly in the context of language barriers. ·Trainees cultivate creative communication strategies to effectively express thoughts and ideas, even when language limitations are present. ·Trainees improve self-expression skills by exploring various methods of conveying messages clearly and effectively in cross-cultural interactions. ·Trainees enhance awareness of personal communication styles and behaviours when interacting with others from diverse linguistic backgrounds. ·Trainees foster understanding of others' behaviours and communication styles, developing empathy and adaptability in cross-cultural exchanges.
Methods	Storytelling-interviews; critical thinking; group discussions
Time allocated	40 minutes
Resources needed	Storytelling-interview here
References	/
Instructions	Trainees watch the video and discuss about it in small groups or in one big group. It is important to encourage discussion to improve critical thinking about the subjects of the video.

LEARNING ACTIVITY: stories of health and social care professionals

Instructions	Trainees can discuss the information from the video with the support of following questions: • ***What kind of factors should professionals (e.g., health care professionals or some other representative of an organisation) consider when dealing with them?*** • ***How can you improve your way of communicating when dealing with a representative of an organisation?*** • ***What factors contribute to understanding when dealing with those representatives?*** • ***What factors hinder understanding when dealing with those representatives?*** • ***Can you explain your personal experiences that demonstrate the issues presented in the video?*** • ***What was the main point or the most important thing that was raised from the video?*** • ***Does the information affect your behaviour in the future?*** • ***Did you get any information from the video that is beneficial to you in the future?*** • ***How reliable do you consider the information and events in the video?***

LEARNING ACTIVITY: soundscape storytelling

Objective(s)	·Trainees use non-verbal communication to communicate effectively without relying on language. ·Trainees enhance creativity in communication by exploring alternative forms of expression such as sounds, gestures, and body language. ·Trainees develop storytelling abilities using non-verbal elements like sounds and gestures to convey messages and emotions. Trainees are flexible and adaptable in communication by fostering an understanding of how to convey meaning without spoken language.
Methods	Drama exercise
Time allocated	30-40 minutes
Resources needed	Optional: large piece of paper with the “words” written on it (ANA, NA GRRRR, PHUT, BOOM!) Optional: music to play in the background for the performances
References	/
Instructions	The facilitator divides the trainees into small groups of 3-4 persons. Assign each group a simple scenario or story involving older persons with a migrant background and their families / informal carers, such as a doctor visit or a social interaction at a community centre. The facilitator instructs the groups to create a soundscape using their voices and body movements to portray the scenario without using any spoken language. Give the groups a few minutes to practice and refine their soundscape. The soundscapes can be different kind of voices such as “hmm”, “ana”, “na”, “grrr”, “phut”, “boom!”, sound of laughter, etc. The soundscape should convey the setting, actions and emotions of the scenario / story.

LEARNING ACTIVITY: soundscape storytelling

Instructions

After practicing and refining their soundscape, each group performs it for the rest of the trainees. After each performance, the facilitator facilitates a brief discussion about the emotions and messages conveyed through non-verbal communication. This allows participants to share their interpretations and reflections. The facilitator encourages trainees to reflect on the importance of non-verbal cues in overcoming language barriers.

Trainees can discuss with the support of following questions:

- ***What was your personal experience - how did you feel communicating without words?***
- ***Were there any challenges that you noticed? What kind of challenges?***
- ***Were there factors that helped understanding? How about factors that hindered understanding?***
- ***What methods do you think there would be available to facilitate the communication and mutual understanding?***
- ***Did this exercise affect your understanding about nonverbal communication?***

Remember to adapt and modify these exercises based on the language proficiency and cultural context of the trainees. Consider providing debriefing sessions after each exercise to encourage reflection and sharing of experiences.

Scenario Examples
Remember, soundscape storytelling relies on non-verbal sounds and gestures to convey the essence of the scenario. These voice elements should be used sparingly and effectively to enhance the atmosphere and emotions experienced in each situation.

LEARNING ACTIVITY: soundscape storytelling

Instructions	**Scenario 1: Doctors Visit** Soundscape Voices: Doctor's voice: Speaking in a calm and very low voice tone, asking questions and providing medical instructions. Caregiver's voice: Expressing concern, explaining the patient's symptoms and medical history to the doctor. Patient's voice: Uttering fragmented words or phrases, demonstrating confusion and difficulty in expressing themselves. Background chatter: Representing the sounds of a busy clinic, including voices of other patients and medical staff. Medical equipment sounds: Incorporate sounds like a stethoscope, blood pressure cuff, or other medical tools being used. **Scenario 2: Community Centre Gathering** Soundscape Voices: Event facilitator's voice: Welcoming participants, providing instructions, and encouraging interaction. Caregiver's voice: Supporting and encouraging the older migrant to participate, offering gentle guidance. Older migrant's voice: Uttering sounds of confusion or attempts to communicate. Conversations: Background voices representing conversations among other attendees in different languages. Group activities: Sounds of group activities like laughter, clapping, or musical instruments to indicate engagement and enjoyment

4. Cultural knowledge

While we focus in this module on inclusive communication, it is important to also mention cultural knowledge. Inherent in cultural differences can be different perceptions of illness, diagnosis and treatment. Miscommunication can be shortened through increased knowledge and openness towards cultures as long as culture is not seen as a determinant. Cultural knowledge can be increased through exchange, both with patients and relatives and with other professionals. It may also be useful to participate in training that encourages the adoption of a specific and culturally adapted approach by health, social and school professionals, cultural mediators, and asylum seeker reception centre workers. In this regard, it is essential to work alongside and optimise collaboration with cultural mediators, also to get to know and understand cultural habits that may hinder treatment.

In “Cross-cultural communication: Tools for working with families and children” (2018) the LEARN model (Listen, Explain, Acknowledge, Recommend, Negotiate) is presented as a useful tool to support cross-cultural communication, mutual understanding and users’ care. The authors describe it as follows (Ladha et al., 2018):

- ***Listen:***

  assess each patient’s understanding of their health condition, its causes and potential treatments. Elicit expectations for the encounter and bring an attitude of curiosity and humility to promote trust and understanding.

Explain:

convey your own perceptions of the health condition, keeping in mind that patients may understand health or illness differently, based on culture or ethnic background.

Acknowledge:

be respectful when discussing the differences between their views and your own. Point out areas of agreement as well as difference and try to determine whether disparate belief systems may lead to a therapeutic dilemma.

Recommend:

develop and propose a treatment plan to the patient and their family.

Negotiate:

reach an agreement on the treatment plan in partnership with the patient and family, incorporating culturally relevant approaches that fit with the patient's perceptions of health and healing.

Knowledge and training are also crucial in this regard. In fact, it is useful to improve the intercultural competence of social and health workers through the integration and deepening of issues related to:

- Intercultural medicine
- Communication on health issues with patients from other cultures
- Health systems in the world
- Teaching programmes of various health professions
- Health peculiarities of the immigrant population (prevalence of major diseases)

LEARNING ACTIVITY: multilingual improvisation

Objective(s)	·Trainees enhance adaptability and responsiveness in communication within multilingual contexts. ·Trainees foster creative communication techniques to overcome language barriers and improve understanding. ·Trainees develop active listening skills to better comprehend others. ·Trainees strengthen non-verbal communication skills. Trainees develop improvisation skills to think quickly and adjust communication style in real-time interactions.
Methods	Drama exercise
Time allocated	30-40 minutes
Resources needed	Scenarios or prompts written on cards or printed out for each pair Optional: props or simple costumes to enhance the improvisation
References	/
Instructions	The facilitator pairs up trainees and assign each pair a specific language that neither of them is fluent in. Provide each pair with a scenario or a simple prompt involving an interaction between a care professional and an older person with a migrant background. The facilitator instructs the pairs to engage in an improvisation exercise where they must communicate and act out the scenario using their limited knowledge of the assigned language, non-verbal cues and gestures. After a designated time, the facilitator has each pair present their improvisation to the rest of the trainees. The facilitator facilitates a group discussion about the challenges faced, strategies used, and the importance of adaptability and creativity in overcoming language barriers.

LEARNING ACTIVITY: multilingual improvisation

Instructions

Examples of the questions to help facilitate the group discussion:

- ***What was your personal experience - how did you feel communicating without words?***
- ***Were there any challenges that you noticed? What kind of challenges?***
- ***Were there factors that helped understanding? How about factors that hindered understanding?***
- ***What methods do you think there would be available to facilitate the communication and mutual understanding?***
- ***How did this exercise affect your understanding about communication and nonverbal communication?***

Remember to adapt and modify these exercises based on the language proficiency and cultural context of the participants. Consider providing debriefing sessions after each exercise to encourage reflection and sharing of experiences.

Example Scenarios
In both scenarios, the emphasis is on effective communication, empathy and finding alternative ways to overcome language barriers. These scenarios provide opportunities for students and care professionals to develop their skills in cross-cultural communication, adaptability and providing person-centred care to older persons with a migrant background and their families / informal caregivers.

Scenario 1: Nurse and Older Migrant
Description: An older migrant with limited proficiency in the local language is admitted to a hospital for medical treatment. The scenario involves an interaction between the older migrant and a nurse who needs to provide care and gather relevant medical information.

Scenario: The nurse enters the hospital room and introduces herself but realizes the older migrant doesn't understand the language. The nurse needs to find alternative ways to communicate and provide care effectively.

LEARNING ACTIVITY: multilingual improvisation

Instructions	**Objectives**: ·The nurse must assess the patients' symptoms and medical history ·The older migrant needs to convey their health concerns and understand the nurse's instructions. Possible Actions: ·The nurse can utilize translation tools or seek assistance from an interpreter if available. ·The nurse can use visual aids, gestures and simple words to explain medical procedures and gather information. ·The older migrant can respond using gestures, facial expressions or pointing to specific body parts to indicate pain or discomfort. ·Both parties can display patience, empathy and active listening to bridge the language gap and ensure effective communication. **Scenario 2: Social Worker and Caregiver Meeting** Description: A social worker arranges a meeting with a caregiver who takes care of an older migrant with MB. The purpose of the meeting is to assess the caregivers needs, provide support and ensure the well-being of the older migrant. Scenario: The social worker arrives at the caregivers home and realizes that the caregiver speaks more limited language proficiency of the language than it was expected. As this was found out just now and the meeting is happening, it's difficult to get someone to come translate. The social worker needs to establish a report, gather relevant information and provide appropriate guidance. Objectives: ·The social worker must understand the caregivers challenges, concerns and needs. ·The caregiver needs to express their experiences, seek advice and receive support. Possible Actions: ·The social worker can use visual aids, diagrams or translated materials to convey information effectively. ·The caregiver can utilize gestures, facial expressions or pictures to communicate their experiences and challenges. ·The social worker can engage in active listening, paraphrasing and demonstrating empathy to create a supportive environment. Both parties can explore alternative communication methods, such as using a trusted interpreter or utilizing technology for translation if available.

LEARNING ACTIVITY: hearing exercise

Objective(s)	·Trainees recognise the importance of active listening in situations where effective communication is critical. ·Trainees develop awareness of various listening techniques, including verbal and non-verbal communication cues. ·Trainees understand the role of non-verbal communication in listening and its impact on overall communication effectiveness. ·Trainees can observe and interpret non-verbal signals to improve understanding during conversations. Trainees improve their skill of being heard by fostering an awareness of how to communicate in ways that ensure others listen effectively.
Methods	Group work; group discussion
Time allocated	20 minutes
Resources needed	/
References	/
Instructions	The group is divided in pairs. Trainees will take turns listening to and talking about the instructions given by the facilitator. There will be in total 3 rounds, after which the exercise will be reflected in group discussion. In the beginning the pair will decide which one of them is #1 and which is #2. The facilitator will give the pairs 30 seconds or 1 minute time to talk in each round and ring a bell when the time is up. In the first round, person #1 is the only one talking. They can talk about their morning: “This morning I woke up at nine and had porridge for breakfast. Then I …”. Person #2 is instructed to listen, but they can make no gestures or sounds at all. They only need to listen with a neutral expression on their face.

LEARNING ACTIVITY: hearing exercise

Instructions	The group is divided in pairs. Trainees will take turns listening to and talking about the instructions given by the facilitator. There will be in total 3 rounds, after which the exercise will be reflected in group discussion. In the beginning the pair will decide which one of them is #1 and which is #2. The facilitator will give the pairs 30 seconds or 1 minute time to talk in each round and ring a bell when the time is up. In the first round, person #1 is the only one talking. They can talk about their morning: "This morning I woke up at nine and had porridge for breakfast. Then I ...". Person #2 is instructed to listen, but they can make no gestures or sounds at all. They only need to listen with a neutral expression on their face. In the second round, person #2 is the one talking. They will also start to talk about their morning, the similar way as before. Person #1 is instructed to listen. They can now make gesture (e.g., nod) and make reassuring sounds if they wish to, but they are not allowed to say any words. In the third round, person #1 is the one talking. This time they will talk about their favourite or dream vacation. Person #2 is instructed to listen, but they are now able to respond and join the dialog as they wish (e.g., make notions or comment) and use any gesture and make sounds as they wish. After the last round, the exercise will be reflected upon together with the whole group, by using following reflection questions: • ***What factors should professionals (e.g., healthcare professional) consider when interacting with a care recipient with a migrant background?*** • ***What can facilitate the care relationship between a care professional and a care recipient with a migrant background?*** • ***What can hinder the care relationship between a care professional and a care recipient with a migrant background?***

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