

HEALTH EVIDENCE NETWORK SYNTHESIS REPORT 64

What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?

Hans Verrept



The Health Evidence Network

The Health Evidence Network (HEN) is an information service for public health decision-makers in the WHO European Region, in action since 2003 and initiated and coordinated by the WHO Regional Office for Europe under the umbrella of the WHO European Health Information Initiative (a multipartner network coordinating all health information activities in the WHO European Region).

HEN supports public health decision-makers to use the best available evidence in their own decision-making and aims to ensure links between evidence, health policies and improvements in public health. The HEN synthesis report series provides summaries of what is known about the policy issue, the gaps in the evidence and the areas of debate. Based on the synthesized evidence, HEN proposes policy considerations, not recommendations, for policy-makers to formulate their own recommendations and policies within their national context.

The Migration and Health programme

The Migration and Health programme, formerly known as Public Health Aspects of Migrants in Europe (PHAME), was established in 2011 to support Member States of the WHO European Region to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020. The programme provides support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect the health of the host community.

Evidence for health and well-being in context

The Evidence for health and well-being in context project was initiated by the WHO Regional Office for Europe in response to Member States' demand for more locally relevant health information. As part of this project, a specific initiative examines the cultural contexts of health and well-being. Awareness of cultural contexts has always been central to the work of WHO, and the importance of cultural contexts is increasingly being recognized, whether in investigating the attitudes that determine the success or failure of immunization programmes as part of the European Vaccine Action Plan or in understanding community resilience and well-being in the face of poor health and economic hardship. The initiative aims to take a more systematic approach to investigating how culture affects the perceptions of, access to and experiences of health and well-being in order to help to improve health interventions and health policy-making. Supported by an expert group, the project works horizontally within WHO Regional Office for Europe and provides technical assistance to various programmatic areas by drawing on scholarship from the humanities and social sciences to promote a more nuanced, contextual understanding of a variety of public health challenges.

Health Evidence Network synthesis report 64

What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?

Hans Verrept

Abstract

Intercultural mediators are employed to resolve linguistic and cultural barriers in a variety of health-care contexts. This report examines the main roles performed by intercultural mediators in health care across the WHO European Region and analyses evidence on their effectiveness in improving accessibility and quality of care for refugees and migrants, and the factors that enable them to have a positive impact. The beneficial impact of intercultural mediators is hindered by a lack of professionalization, insufficient training and the non-systematic and inconsistent implementation of intercultural mediation programmes. Developing training programmes and accreditation systems, further research into the effectiveness of intercultural mediators in health care, and the development of strategies that guarantee access to intercultural mediators in health care wherever and whenever needed will enormously improve the quality of health care for refugees and migrants.

Keywords

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

Address requests about publications of the WHO Regional Office for Europe to:

Publications

WHO Regional Office for Europe

UN City, Marmorvej 51

DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (<http://www.euro.who.int/pubrequest>).

ISSN 2227-4316

ISBN 978 92 890 5435 5

© World Health Organization 2019

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Verrept H. What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? Copenhagen: WHO Regional Office for Europe; 2019 (Health Evidence Network (HEN) synthesis report 64).

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

The named authors alone are responsible for the views expressed in this publication.

Printed in Luxembourg

CONTENTS

▶ Abbreviations.....	iv
▶ Contributors.....	v
▶ Summary.....	vii
▶ 1. Introduction.....	1
▶ 1.1 Background.....	1
▶ 1.2 Methodology.....	4
▶ 2. Results.....	6
▶ 2.1 Roles of intercultural mediators in health care.....	6
▶ 2.2 Training, accreditation and deployment.....	13
▶ 2.3 Contributions and effectiveness of intercultural mediators in health care.....	18
▶ 2.4 Factors facilitating the performance of intercultural mediators.....	26
▶ 3. Discussion.....	28
▶ 3.1 Strengths and limitations of the review.....	28
▶ 3.2 Development of intercultural mediation as a fully integrated health profession.....	28
▶ 3.3 Further research.....	29
▶ 3.4 Policy considerations.....	30
▶ 4. Conclusions.....	31
▶ References.....	32
▶ Annex 1. Search strategy.....	43
▶ Annex 2. Main differences between interpreters and intercultural mediators in health care.....	48

ABBREVIATIONS

HEN	Health Evidence Network
MIPEX	Migrant Integration Policy Index
NGO	nongovernmental organization
TIME	Train Intercultural Mediators for a Multicultural Europe (project)

CONTRIBUTORS

Author

Hans Verrept

Head of Intercultural Mediation and Policy Support Unit, Federal Public Service Health, Food Chain Safety and Environment, Brussels, Belgium

Acknowledgements

Support in preparation of this report was given by Theda Borde, Antonio Chiarenza, Kristof Eelen, Joseph Kaufert, Tona Lizana, Akrivi Panagiotopoulou, Roumyana Petrova-Benedict, Robert Putsch, Adil Qureshi and Jean Rukara.

Peer reviewers

David Katan

Professor, University of Salento, Lecce, Italy and Research Fellow, University of South Africa, Pretoria, South Africa

Adeline Degratet

Referent for Intercultural Mediators, Médecins Sans Frontières, Operational Centre of Brussels, Belgium

Editorial team, WHO Regional Office for Europe

Division of Information, Evidence, Research and Innovation

Nils Fietje

Research Officer, Evidence for Health and Well-being in Context

Shanmugapriya Umachandran

Consultant, Evidence for Health and Well-being in Context

Division of Policy and Governance for Health and Well-being

Santino Severoni

Acting Director, Division of Health System and Public Health, and Coordinator, Migration and Health programme

Soorej J Puthoopparambil

Senior lecturer in Global Health, International Maternal and Child Health (IMCH),
Department of Women's and Children's Health, Uppsala University, Sweden and
External Consultant, Migration and Health programme

Elisabeth Waagensen

Consultant, Migration and Health programme

Health Evidence Network (HEN) editorial team

Kristina Mauer-Stender, Acting Director

Tanja Kuchenmüller, Editor in Chief

Ryoko Takahashi, Series Editor

Tyrone Reden Sy, Technical Officer

Krista Kruja, Consultant

Ashley Craig, Technical Editor

The HEN Secretariat is part of the Division of Information, Evidence, Research and Innovation at the WHO Regional Office for Europe. HEN synthesis reports are commissioned works that are subjected to international peer review, and the contents are the responsibility of the authors. They do not necessarily reflect the official policies of the Regional Office.

SUMMARY

The issue

Since the late 2000s, the number and proportion of refugees and migrants in the WHO European Region have substantially increased. A long-standing focus of WHO is protection of the rights of refugees and migrants, including their right to health. Despite this, refugees and migrants continue to encounter cultural and linguistic barriers in accessing high-quality health care in the Region, leading to health inequalities. A recent initiative to address these barriers, the WHO Regional Office for Europe's Cultural Contexts of Health and Well-being project, includes migration as one of its four key focus areas. Since the 1990s, intercultural mediators have been increasingly introduced to improve the accessibility and quality of health care for refugees and migrants. However, little is known about the roles performed by intercultural mediators in different countries and their effectiveness in resolving the existing barriers to health care.

The synthesis question

What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?

Types of evidence

This report used a rapid review to synthesize evidence from the academic and grey literature published between August 2018 and January 2019 in Dutch, English, French, German, Russian and Spanish. A total of 82 documents were included, with 71 reporting on work from 20 Member States of the WHO European Region and 11 from Canada and the United States of America. Of these, 58 studies described the various roles of intercultural mediators in health care, 28 assessed their effectiveness and 46 reported the factors that enable them to make a positive impact.

Results

Three main categories of evidence were identified in the review.

Roles of intercultural mediators in health care

The review found that intercultural mediators perform six main roles for refugees/migrants and the health-care system:

- interpreting;
- bridging sociocultural gaps (culture brokerage);

- preventing conflict and supporting resolution;
- supporting integration into health systems, supporting empowerment (by providing information on the available health and social services and on health-care entitlements) and providing advocacy (against institutional racism or discrimination);
- building trust and facilitating the therapeutic relationship; and
- providing psychosocial support (including acting as liaison inside and outside medical settings), health education and promotion, and co-therapy (in mental health-care settings).

A general concern was that intercultural mediators are often required to undertake these tasks after limited training and in the absence of professional standards and ethical codes.

Training and certification

Intercultural mediators working in the WHO European Region were often found to lack sufficient training and formal certification because most Member States lacked an accreditation process. In many countries, intercultural mediation is a precarious, temporary occupation with an uncertain income. The evidence showed that this is mainly due to the non-systematic and short-term implementation of intercultural mediation programmes aimed at providing equitable care to refugees and migrants.

Contributions and effectiveness of intercultural mediators

The review did not identify evidence on the effect of intercultural mediation on the health status of refugee and migrant patients. However, the literature indicated that intercultural mediation between health-care providers and refugee/migrant patients can:

- facilitate communication;
- improve the therapeutic relationship by enhancing intercultural understanding;
- increase patient participation in health promotion and education programmes;
- reduce the perceived level of discrimination; and
- contribute to adapting health services to the cultural characteristics and needs of refugees and migrants.

Intercultural mediators were described as being indispensable to high-quality, comprehensive health-care provision. Intercultural mediators' insufficient

training, dominance in a three-way dialogue and overemphasis on cultural differences of patients to reinforce their role as experts on the patients' cultures were identified as critical issues, which can disempower patients and reinforce the power imbalance and cultural stereotypes in the therapeutic relationship.

The analysis revealed that intercultural mediators are effective in bridging linguistic and cultural gaps. Full professionalization and strategies that guarantee access to intercultural mediators in health care for both refugee and migrant patients and health-care providers were found to be lacking.

Policy considerations

Based on the review findings, the following policy considerations to improve the equity of health services for refugees and migrants can be considered by Member States:

- establish clear and coherent definitions of the roles and responsibilities of intercultural mediators working in the health sector;
- establish professional guidelines, standards and quality assurance processes to support the recognition and full professionalization of intercultural mediation in health care;
- develop standardized training and accreditation processes to facilitate the systematic deployment of intercultural mediators;
- provide ongoing training, supervision and psychological support for intercultural mediators to build capacity and enhance the quality and consistency of their service;
- provide training for health-care professionals in the use of intercultural mediation; and
- develop and implement formal national strategies to maximize the contributions and effectiveness of intercultural mediators in the health sector and encourage managers and health-care providers to develop a comprehensive and systematic approach to the management and integration of intercultural mediators.



1. INTRODUCTION

1.1 Background

1.1.1 Health care provision for refugees and migrants in the WHO European Region

Since the late 2000s, the number and proportion of refugees and migrants in the WHO European Region have substantially increased (1). International migrants, including refugees, now make up almost 10% (90.7 million) of the population in the 53 Member States of the Region.

A long-standing focus of WHO is protection of the rights of refugees and migrants, including their right to health (2–4). World Health Assembly resolution WHA61.17 (2008) called upon Member States to promote migrant-sensitive health policies and promote equitable access to health promotion, disease prevention and care for migrants (5). In 2010, a global consultation, *Health of Migrants; the Way Forward*, was convened to create an action framework to assist in moving this resolution forward (6). One of four identified key action domains was the creation of migrant-sensitive health systems that are “financially sustainable, culturally sensitive and linguistically appropriate and delivered by a workforce aware of health issues associated with migration”. In response to international frameworks and strategies and efforts to achieve the vision of the 2030 Agenda for Sustainable Development towards leaving no one behind in the WHO European Region (incorporating the Sustainable Development Goals), the health of refugees and migrants emerged as an important theme for all Member States in the Region (1,7).

The 2016 *Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region* (resolution EUR/RC66/R6) emphasized the need to address communication barriers in order to strengthen health systems and promote the health of refugees and migrants (8). A WHO framework of priorities and guiding principles to promote the health of refugees and migrants adopted at the Seventieth World Health Assembly in 2017 (resolution WHA70.15) (9) collected evidence, information, best practices, experiences and lessons learned on addressing the health needs of refugees and migrants. Subsequently, the Global Action Plan on promoting the health of refugees and migrants was adopted at the Seventy-second World Health Assembly in May 2019). The Global Action Plan commits Member States to reducing communication barriers and training health-care providers on

culturally sensitive service delivery, including the use of intercultural mediators and interpreters (10).

Other WHO reports and guidance documents emphasize the importance of intercultural mediation in refugee and migrant health, for example in health-care provision for children (11). Refugee and migrant health is also a key component of universal health coverage, as stated in the Thirteenth General Programme of Work, 2019–2023 (12):

the health and social systems of some countries are greatly strained by the presence of large numbers of people on the move including refugees and migrants. Through its equity and human right lens, WHO sees the health of refugees and migrants as a critical element of universal health coverage and will help countries to address this challenge.

The importance of cultural considerations in health, well-being and health care has been demonstrated by increasing evidence that the provision of medical care is limited if it does not match the priorities and perceived needs of those it seeks to serve (13). The 2014 Lancet Commission on Culture and Health argued that “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide” (14). Migration is one of four key focus areas of the WHO Regional Office for Europe’s Cultural Contexts of Health and Well-being project. Its activities related to culture, migration and health include a toolkit to examine ways to promote migrant participation at different stages of policy and practice (13).

1.1.2 Intercultural mediation in health-care settings

Studies have shown that refugees and migrants in the WHO European Region receive a lower quality of care compared with the host population (15). The barriers to accessing health-care services include financial and legal barriers, linguistic and cultural barriers, discrimination from health-care providers, a lack of cultural competence in health-care providers and a lack of knowledge and understanding of the health-care system and of their rights among refugees and migrants (1,15). There is compelling international evidence on the negative impacts of unresolved linguistic and cultural barriers on health and health care for refugees and migrants. These include poor provider–patient communication, delayed patient presentation for care, an increased risk of misdiagnosis, poorer management of (chronic) disease, low participation in health promotion and prevention activities, and poorer health outcomes for refugees and migrants. The culturally influenced beliefs, concepts,



types of behaviour, traditions and religious convictions of both refugees/migrants and health-care providers have a profound impact on their respective expectations and affect their interactions. Inadequate management of these cultural differences may reduce the willingness of refugees and migrants to rely on health-care services that they feel are culturally unacceptable, irrelevant or of poor quality, thereby reducing both accessibility and quality of care (13,15–18).

Intercultural mediators are intermediaries who improve communication and understanding between participants by reducing the interference of linguistic and sociocultural differences (19,20). Examples of informal intercultural mediation include friends and family assisting refugee and migrant patients or clinicians from refugee and migrant communities performing this service in their new environment. However, this report focuses on the formal engagement of intercultural mediators by health-care services, in which they attend consultations to help to remove the linguistic and sociocultural barriers for refugees and migrants in accessing health-care services (21). Important aspects of their work are to prevent and reduce conflicts between patients and providers and reduce the power imbalance in the provider–patient relationship through empowering patients. Intercultural mediators assist health-care providers at the individual and organizational levels to adapting their services to the needs of refugees and migrants. Intercultural mediators also advocate for individual patients or patient groups, particularly where discriminatory practices limit the accessibility or quality of care (20,22–24). However, intercultural mediation programmes vary widely in their goals, priorities and the roles of intercultural mediators: some focus on linguistic differences, whereas others focus on developing cultural competence or empowering the patient. A complicating issue is the lack of clarity between the roles of interpreters and intercultural mediators in health care (23,25–30).

1.1.3 Objectives of this report

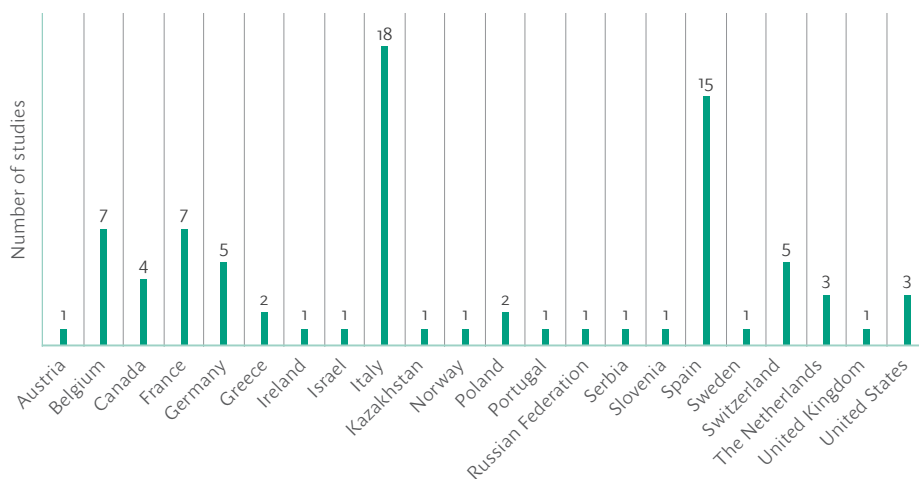
Little is known about the roles performed by intercultural mediators in the WHO European Region, the effectiveness of their work and the factors that enable them to have a positive impact. This report synthesizes the best available evidence to address the question: “What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?” It complements Health Evidence Network (HEN) synthesis report 62 (29), which examined the policies addressing communication barriers for refugees and migrants in health-care settings across the Region, and relates to HEN synthesis report 57 (31), which examined health literacy.

1.2 Methodology

Literature searches of peer-reviewed and grey literature was carried out from August to November 2018 in English and from December 2018 to January 2019 in Russian to identify publications on the use of intercultural mediators in health care in the WHO European Region. Studies published from January 2008 to September 2018 in Dutch, English, French, German, Russian and Spanish were included. An expert enquiry led to the identification of 11 documents from outside the Region that were included in the final analysis for their relevance as key documents providing a comprehensive overview of the definition and the roles of intercultural mediators. Annex 1 outlines the databases and websites searched and the search strategy.

A total of 82 documents on intercultural mediation in health care in 22 countries were included in the synthesis (15,19–30,32–100). Of these, 71 documents covering 20 Member States of the WHO European Region were obtained from the literature searches. The literature from the United States and Canada obtained from an expert enquiry was also analysed specifically to describe the roles and definitions of intercultural mediators and how these differ from those of medical interpreters (24,36,37,46,63,64,77,85,90,93,94). Fig. 1 shows the geographical distribution of

Fig. 1. Countries discussed in studies included in the review





studies included in this review. Note that several documents analysed intercultural mediation programmes in more than one country. Furthermore, Fig. 1 does not include documents that were not limited to one geographical region (15,19, 20–22,24–26,29,35,36,39,40,44–46,54,63,64,77,78,84,99). In total, 58 studies described the various roles of intercultural mediators in health care, 28 assessed their effectiveness and 46 reported the factors that enable them to make a positive impact.

2. RESULTS

According to the Migrant Integration Policy Index (MIPEX),¹ intercultural mediators are currently employed in health care in 17 Member States of the WHO European Region with the aim of reducing cultural and linguistic barriers and increasing the accessibility and quality of health care for refugees and migrants (101). However, no review of their roles or evaluation studies of their effectiveness in these roles have so far been published. To address this issue, this report synthesizes evidence from a wide range of academic disciplines, reflecting the approach of WHO's Cultural Contexts of Health and Well-being project (13). This section describes the evidence identified on the roles and responsibilities of intercultural mediators, as well as key findings on their contributions and effectiveness in providing health-care services for refugees and migrants in the Region.

2.1 Roles of intercultural mediators in health care

The literature search identified evidence on the roles performed by intercultural mediators in health-care interventions; for reasons of clarity, they are described separately. In practice, however, the different roles may overlap. In particular, the role of building trust and facilitating the therapeutic relationship is highly cross-cutting (45, 46, 51–53, 56). Sections 2.1.1–2.1.5 describe roles shared by most, if not all, intercultural mediators working with refugees and migrants in health care in the WHO European Region, whereas section 2.1.6 describes roles that are performed by only some intercultural mediators.

Box 1 contains four vignettes that illustrate the various cross-cutting roles of intercultural mediators in health-care scenarios.

2.1.1 Linguistic facilitation

The main task of many intercultural mediators is to facilitate linguistic exchange, which nearly always includes (linguistic) interpreting and transmitting messages in one-to-one meetings between health-care providers and patients who do not share a common language. In this role, intercultural mediators may act as interpreters only (21, 28, 32, 33, 34, 38, 41, 45) or may also translate written messages (32, 55, 62, 97).

¹ The Migrant Integration Policy Index measures policies to integrate migrants in all European Union Member States and in Australia, Canada, Iceland, Japan, South Korea, New Zealand, Norway, Switzerland, Turkey and the United States in a number of different domains, including health care.



Box 1. Four vignettes illustrating the roles of intercultural mediators in health care

Vignette 1. Introduction of intercultural mediators in Celje, Slovenia

A study described the introduction of an intercultural mediator to improve the accessibility and quality of care for Albanian-speaking women in Celje, Slovenia, and increase the responsiveness of the newly designed preventive programmes to the needs of these women (32). As members of the target group had not previously been responsive to such programmes, the main role of the intercultural mediator was to raise awareness among potential participants and motivate them to respond to invitations (issued via Facebook and/or telephone) to attend the workshops. No information was provided on which medium gave the better response. Other tasks of the intercultural mediator included simultaneous translation of the workshop and cooperation in adapting the workshops to the specific needs of the target population. The latter task included informing health professionals about the specific socioeconomic/cultural contexts and lifestyle of this community. This case study illustrates the intercultural mediator's roles in linguistic facilitation, bridging sociocultural gaps and integrating the community into health care and social services.

Vignette 2. The work of an intercultural mediator in a hospital consultation, Belgium

A detailed description was given of the roles adopted by an intercultural mediator during an intervention with an Italian patient at a Belgian hospital (28). After interpreting for the health-care provider and the patient, the intercultural mediator checked whether the patient knew how to get to the outpatient clinic to which he had been referred. She explained the way to the centre but, noticing the patient's confusion, decided to accompany him. During the walk, she asked him whether he had health insurance and about the nature of his medical problem. He replied that he has a dermatological problem affecting the genital area and wanted to know whether the dermatologist would speak Italian. She told him that she did not know but would accompany him to interpret, if necessary. This case study illustrates the role of the intercultural mediator in linguistic facilitation, integration and provision of psychosocial support, both formally in the consultation and informally afterwards.

Vignette 3. Intercultural mediation for west African refugees in Calabria, Italy

A study described the work of intercultural mediators with west African refugees in Calabria (Italy) (52). Thiam, an intercultural mediator of Wolof origin, made two trips per day to the tent camps to take patients to the medical

Box 1. (Contd)

centre. He estimated that more than 80% of the refugees had never been to a doctor before. Taking blood samples is often an issue because some refugees were afraid of becoming sick or of dying from loss of blood. In such cases, he began by asking patients to explain their concerns. He then explained to the patient that a doctor is a person “who learns all his life to help people and that they understand that if they take your blood nothing will happen to you”.

At the clinic, Thiam met people in his office before their consultation with a medical provider. His first aim was to understand the patient's reason for attending the clinic. Often people staying in tent camps will come just to talk in an attempt to ease their mental suffering. He quoted a patient: “I just come to ask for help because I need to talk to someone. Talk to me. You are my brother. I have big desperation and I want someone to help me”.

This vignette illustrates the role of the intercultural mediator in linguistic facilitation, bridging sociocultural gaps, integration, building trust and providing psychosocial support.

Vignette 4. Moroccan *jinn*s and treatment of an epileptic child

In a case study of an intercultural mediator sharing a Moroccan explanatory model with a medical doctor treating an epileptic child, the child's mother said the cause of her son's epileptic seizures was a *jinn* (23). The intercultural mediator told the health-care provider that a *jinn* is a spirit and that many Moroccans believe that *jinn*s can cause different health problems. She felt that it was important to refer to this common explanatory model because the simple translation would not enable full comprehension of the message. She added that these patients may consult traditional Moroccan healers, which may lead to the patient not adhering to the treatment. This vignette illustrates the roles of the intercultural mediator in linguistic facilitation and bridging sociocultural gaps.

2.1.2 Bridging sociocultural gaps

More than any other, the role of bridging sociocultural gaps is central to the work of intercultural mediators. Intercultural mediators perform this function by explaining and contextualizing messages and situations for both participants; they may also explain the sociocultural values and norms underlying their language, behaviour or practices (51,93,94). In the context of mental health, intercultural mediators may also comment on how a patient's behaviour might be understood in their



community of origin and whether it would be considered usual or acceptable (47). The different aspects of the role of the intercultural mediator can be described as cultural clarification and culture brokerage.²

The bridging of sociocultural gaps may be performed during three-way dialogues between the health-care provider, patient and intercultural mediator; in one-to-one meetings between the mediator and the health-care provider or patient; or in group sessions with health-care providers and users. In these contexts, intercultural mediators may inform the health-care providers of the specific needs and socioeconomic and cultural contexts of the users (50). They may also be involved in planning, designing, implementing and evaluating interventions tailored to the needs of refugees and migrants (26,38,53,54). An example would be translating and adapting health education materials to the cultural characteristics and needs of the target population (32,55,62,97).

2.1.3 Preventing conflict and supporting resolution

A common role of intercultural mediators is to anticipate, prevent, negotiate and resolve divergent viewpoints or conflicts between health-care providers and patients (46–48,51,53). These issues may relate to divergent views of health and healing, and highlight the possibility that cultural values related to topics such as informed consent, truth-telling and end-of-life decision-making may be incommensurable (93,94). Conflict resolution often involves culture brokerage. In this context, the intercultural mediator has been described as an intermediary who helps to construct shared meanings in the search for conflict resolution (51).

2.1.4 Supporting integration and empowerment and providing advocacy

Intercultural mediators function as agents of integration by providing information to refugees and migrants on the existing social and health services and their rights and entitlements to these services (57); they help refugees and migrants to interact with these public services (35,46,47). In this context, the roles of intercultural mediators include both empowerment and advocacy (22). In the empowerment role, mediators help refugees and migrants to make the best use of the information at their disposal and to use the most effective strategies to resolve their own problems, thereby achieving the greatest possible level of independence. In the advocacy role,

² The distinction between cultural clarification and culture brokerage is not completely clear. However, cultural clarification seems to encompass mediating spoken messages between health-care providers and patients, whereas culture brokerage may also take account of cultural characteristics (e.g. in development of a therapeutic strategy) (46).

mediators speak on behalf of refugees and migrants who are experiencing forms of institutional racism and discrimination and have difficulties in defending their rights.

2.1.5 Building trust and facilitating the therapeutic relationship

Many studies describe a crucial aspect of the work of intercultural mediators as building trust and facilitating the therapeutic relationship: in this context, they are also described as relational mediators (45,46,51–53,56). This role may include assisting both patients and health-care providers to make the most of the health-care encounter, for example through encouraging the patient to ask questions and prepare for the consultation and suggesting communication or other strategies to the health-care provider to facilitate the interaction (23).

2.1.6 Providing psychosocial support, health education/counselling and co-therapy

Psychosocial support

Many studies described the roles adopted by intercultural mediators in terms traditionally associated with the activities of social workers, counsellors, psychologists and health educators/promoters (28,32,37,38,44–47, 49–53,55,56,58–60,69,70,97). Several described the different types of psychosocial support frequently provided by intercultural mediators (28,38,46,47,49,53,58–60), including general psychosocial support (49), acting as liaison inside and outside medical settings (including accompanying patients to different administrative/therapeutic meetings (28,46)) and administrative and practical help (38,53). Specific examples include telephone counselling on HIV (58), communication of death and the possibility of organ donation (59), interventions to detect social problems and gender violence (60) and arranging/carrying out home visits for hard-to-reach patients (47).

Health education/counselling

Studies describing the involvement of intercultural mediators in health education and health promotion initiatives/interventions (32,47,52,55,56,58,60,69,97) highlight the different strategies used: group sessions led by an intercultural mediator (32,47,56), one-to-one meetings (52,55,58,60,69) and adaptation of health education material (55,97).

Co-therapy

The involvement of intercultural mediators and their contributions to different types of mental health consultation were described as following



an ethnopsychiatric or intercultural psychiatric approach (44–47,51,70). For example, in the Centre George Devereux (Paris, France), ethnoclinical mediators, who share the same background as their patients, act as co-therapists and participate in group therapy. In the Centro Frantz Fanon (Turin, Italy), intercultural mediators are encouraged to engage freely with patients to elicit their life histories (46). One study described the intercultural mediator's role in mental health care as that of “a very junior co-therapist”; it is openly recognized and incorporated therapeutically (45). In this context, the mediator may, for example, provide feedback on the patient's interpersonal style or participate in role play with a patient. However, the study emphasized that the intercultural mediator does not play the role of co-diagnostician and that it is “the clinician who directs the session with the mediator taking on a supporting role, always following the direction of the former”.

2.1.7 Intercultural mediation versus interpretation

A large number of studies contrasted the roles of intercultural mediators and medical interpreters in clinical settings (see Annex 2 for more information on the differences between these roles). The analysis revealed that a number of authors were concerned about a lack of consensus on the role of intercultural mediators in health care and about their sometimes poorly defined job description (21,34,61).³ Their tasks have sometimes been described as “an unrealistic array” (50) and as “an interdisciplinary minefield” (49).

Other authors have argued, however, that the roles traditionally associated with intercultural mediators are necessary if we want to improve the accessibility and quality of care for refugees and migrants. As a result, in the literature on medical interpreting, there is a move away from the interpreter-as-conduit role to a more involved role: there is a change from viewing the interpreter as a mere word-translation machine (also called the conduit model) to an intercultural mediator. This change permits all participants to interact on an equal basis and favours objectivity over impartiality (35). Some studies have indeed defined the roles of interpreters in terms that clearly refer to roles traditionally associated with intercultural mediators, such as culture brokerage, advocacy, communication facilitation and providing help (22,26,28,35–39,102).

³ Our analysis of the characteristics of the roles taken up by the intercultural mediators shows, however, that the criticism concerning the lack of consensus on the roles of intercultural mediators is, at least partially, unjustified.

It has been pointed out that, without a proper understanding of the complexity of health-care interpreters' practices, their codes of ethics do not necessarily improve the quality of care, facilitate provider-patient communication or honour the values of health-care contexts (e.g. patient empowerment and autonomy) (63). By enforcing the interpreter-as-conduit model, interpreters inevitably maintain the imbalance of the provider-patient relationship and reinforce the low health literacy of language-discordant patients (i.e. patients that do not speak the language of the care provider). It is also advocated that interpreters should be allowed to adopt an active interfering role in medical encounters. In that way, interpreters as communicative experts in bilingual cross-cultural care may be able to anticipate the patients' communicative needs, convey the providers' therapeutic goals and facilitate provider-patient interactions in a way that enhances the other speakers' abilities to seek, process and utilize health information to make appropriate health decisions (63,64). It is clear that this approach is very close, if not identical, to the one adopted by many intercultural mediators. Empirical research into the roles that interpreters are actually performing seems to confirm an overlap of the roles of intercultural mediators and interpreters in health care (15,24,29,41-44,92).

There is a clear lack of empirical grounding for discussions on the roles of medical interpreters and intercultural mediators. As a consequence, task descriptions, ethical codes and professional standards may be inconsistent with the reality of the workplace (26,63,64). For example, one study found that only 34 of the 1121 references cited in articles published on the concepts of interpretation and the roles of interpreters in health care contained empirical evidence to support their recommendations (40). Until now, there has been insufficient research focus on the pathways and strategies that allow intercultural mediators and interpreters to improve the quality of care (63).

This rapid review identified a number of differences between the two professions (26,54). However, these may be more prominent in official task descriptions and codes of conduct than in the workplace (78). The main difference is that the activities of intercultural mediators often do not involve the simultaneous presence of health-care providers and patients, for example providing information to patients on the health-care system or informing health-care providers on how to adapt their services to the needs of refugees and migrants. In contrast, these types of activity are rarely performed by interpreters. Annex 2 describes the differences in the roles of interpreters and intercultural mediators in health care in more detail.



2.2 Training, accreditation and deployment

2.2.1 Training

Many studies presented little or no information on the educational background (e.g. degrees held in other domains such as nursing or social work) or specific training of those involved in intercultural mediation programmes (28,32,53,62,71,73–75). Others gave a brief indication of the mediators' training (46,50,56,58,60,70,72,96). When information on the training of the mediators was given, it often related to the specific discipline that the mediators were prepared to work in, for example organ donation (59), mental health (46), HIV counselling (58,66), sexual and reproductive health, and gender-related violence (60).

A few studies mentioned the professional background of the mediator, ranging from lay person to bilingual/bicultural clinician, anthropologist, social worker and psychologist (46,47,58,60,67,70). Originally (the early 1990s for most western European countries), sharing ethnicity with the target group and knowledge of the group's language was deemed sufficient to be recruited as a mediator (47). As a result, intercultural mediators currently comprise an extremely diverse group with, undoubtedly, a range of differing training needs.

Limited evidence was found on the training available for intercultural mediators. The review found a lack of standardized training programmes to prepare mediators for their numerous and complex tasks (21,26,33,38,46,47,50,76). The fact that some intercultural mediators have limited, or no, training in interpreting is another area of concern because for many interpretation is a frequent, or even the main, task (21,48). To what extent and how intercultural mediators are evaluated and accredited also remains unclear. In addition, the dearth of professional guidelines, standards and quality assurance strategies and the limited involvement of academic institutions in the professionalization of the intercultural mediator are serious concerns (26,38,46).

Training has often been, and still is, provided by local nongovernmental organizations (NGOs) without the involvement of academic institutions (49,50). The absence of empirical grounding (e.g. evaluation studies into the effectiveness of different approaches) has been consistently identified as a barrier to constructing a curriculum to ensure the professionalization of intercultural mediation in health care (26,38,46,50,76,77).

Training programmes currently offered in the WHO European Region vary enormously, from very informal, two-day workshops (26,38) to two-year programmes

and postgraduate studies (26). They may or may not lead to a recognized degree, and the degrees or certificates obtained may be recognized only in one region of a country, for example those of some regional programmes in Italy and Spain (78).

Across the Region, vocational training programmes and training courses related to the implementation of intercultural mediation projects are most common. In Italy, several universities also offer training programmes in intercultural mediation at both the graduate and postgraduate levels. Access requirements for training programmes vary from completion of lower secondary education to a university degree (for access to a postgraduate programme). Furthermore, the content of training courses varies among countries depending on the organizing entity or the project specifications. However, the more extensive training programmes aimed specifically at intercultural mediation in health care tend to be similar across countries. They typically include courses on the professional identity and tasks of the intercultural mediator; (cross-cultural) communication skills; (medical) anthropology; the history and context of migration; the organization of health and social services; basic medical terminology; interpreting; and ethics. Theoretical courses are nearly always combined with on-the-job training and supervision sessions (78). (Case studies 1 and 2 give detailed examples of training programmes.)

Case study 1. Training programme of the Catalan Department of Health and a hospital psychiatry department, Barcelona

The immigration plan of “la Caixa” social and cultural outreach projects aimed to train all intercultural mediators in Spain (72,76). Part of the plan was to develop a training programme in Catalonia, with certification by the Health Studies Institute of the Catalan Department of Health. Based on four years of experience of the SURT women’s foundation (an association that supports the economic, social and cultural rights of women (103)) and the Psychiatry Department of Vall d’Hebron University Hospital, the programme provided 200 hours of theoretical training and 1200 hours of practical training to 50 currently employed intercultural mediators and 30 novices. Modules included medical anthropology, western biomedicine, community health, linguistic interpretation, cultural competence, professional identity and ethics. An important part of the training was role-play sessions on mediation. Small group supervision sessions using the interpersonal process recall approach provided a supportive environment for students to apply theoretical concepts in a practical context. The sessions focused on role confusion, the management of complicated situations and self-reflection. High-quality training materials were specifically developed for the course.



Case study 2. The Training Intercultural Mediators for a Multicultural Europe project

From 2014 until 2016, the Training Intercultural Mediators for a Multicultural Europe (TIME) project (involving experts from Austria, Belgium, Germany, Greece, Italy, Poland and Portugal) explored the practices of training and employing intercultural mediators throughout the European Union (78). It promoted the exchange of good practices in intercultural mediation by proposing model training programmes for both intercultural mediators and their trainers. The TIME project analysed existing structures in the partner countries and proposed recommendations for the validation of training for intercultural mediators. Based on its research, the TIME project defined the desired professional profile of intercultural mediators and their trainers and subsequently designed comprehensive training programmes for mediators and their trainers, integrating best practices from all over Europe. The training programme is aligned with national and European qualification frameworks and the European credit system for vocational education and training. The validation, certification and accreditation procedures in partner countries were explored and the report provided tailored recommendations for each country.

The experiences of the different countries showed the importance of intercultural mediators having a sufficiently high level of general education. Higher secondary education was generally considered to be the lowest acceptable level for entry to the profession. However, mediators with a bachelor's or master's degree were more easily accepted as professionals by health-care providers. The consensus was that intercultural mediators should undergo specific training, ideally leading to a bachelor's or master's degree in intercultural mediation (European qualification framework level 6 or 7).

The TIME training course is modular and intended for both initial training and upskilling. Each module of the curriculum covers a certain number of the specified learning outcomes; the modules can be combined flexibly to accommodate different initial competence profiles. The course includes both general and specialized modules (e.g. for intercultural mediators working in health care) and is available on the project website (<http://mediation-time.eu>). The website provides an overview of the subjects covered by the training course, along with teaching methods and training material (in seven languages).

2.2.2 Certification and deployment

In general, very little information was found on existing certification and accreditation procedures. Certification criteria and procedures for intercultural mediators have been developed in at least four countries of the WHO European Region (Germany, Italy, Spain and Switzerland). However, the possibility cannot be excluded that such procedures exist in other countries but that no information was found owing to language bias in the literature search. The Germany Ministry of Health is not involved in accreditation and there was no indication that the ministries of health of Italy, Spain and Switzerland are involved in accreditation. Certification procedures in the four countries are not specifically oriented towards one field (e.g. health care, education) (78).

In Germany, SprInt Certification (Sprach- und Integrationsmittler) can be obtained after the successful completion of an 18-month programme and is recognized nationwide (104,105). In the Valencia Region of Spain, the Department of Solidarity and Citizenship regulates both the accreditation and the official registry of intercultural mediators. In Switzerland, the confederate professional certificate for intercultural interpreters and mediators, which is issued by the State Secretariat for Education, Research and Innovation after a successful examination, is also recognized nationwide (106). However, this does not mean that the profession is protected by law and that only certified intercultural mediators can be employed (78). Nevertheless, several European countries have passed specific legislation concerning or defining the profession of intercultural mediator, including Germany (Zertifizierte Mediatoren Ausbildungs Verordnung (82)), Italy (Testo Unico sull'Immigrazione [Consolidated Law on Immigration] (83)),⁴ Portugal (Joint Decree No. 1165/2000 of the Presidency of the Council of Ministers (78)) and Spain (Royal Decree No. 638/2000⁵ (78)).

Intercultural mediators tend to be employed by NGOs (often within the context of a project of uncertain duration), host institutions (e.g. hospitals, primary care centres) and placement agencies. Their employment status varies considerably, from being volunteer to freelance to salaried employee. A study by the TIME project partnership in 11 countries (Austria, Belgium, France, Germany, Greece, Italy, the Netherlands, Poland, Portugal, Spain and Switzerland) revealed that for most trained intercultural mediators employment is “short term and cannot be

4 In addition, every Italian region has defined the profession of intercultural mediator and has a specific training standard. As a result, certification is only valid in the region in which it was issued.

5 Royal Decree No. 1368/2007 launched the National Catalogue of Professional Qualifications (107), which established six professional qualifications (including community mediation) within the category of community and sociocultural services, indicating that intercultural mediation is a related occupation.



considered a professional occupation” (78). Intercultural mediators usually also receive low fees for their services. These combined factors mean that, for most, being an intercultural mediator is not a full-time job but rather a marginal employment that must be combined with another job (22,79–81). (See Case studies 3 and 4 for examples of the professionalization of intercultural mediators.)

Case study 3. Intercultural mediation programme in Belgian health care

Since 1999, the Belgian Government has funded intercultural mediators who are employed by hospitals to carry out on-site and video remote interventions in health care (23). The funding is incorporated into national hospital and the health insurance budgets. A total of 100 intercultural mediators now operate as salaried employees. A professional profile, standards for performing the different tasks of the mediator (interpreting, facilitating and advocacy) and a deontological code have been developed by the Federal Public Service for Health in close collaboration with both the intercultural mediators and the health-care providers (the professional profile, standards and ethical code are described in the Guide for Intercultural Mediation in Health Care (23,27)). This document also defines the actions that hospitals should develop and the conditions they should create to allow the work of the intercultural mediator to be effective.

Case study 4. Intercultural mediation in health care in the Emilia-Romagna Region, Italy

In the Emilia-Romagna Region of Italy, intercultural mediator is a recognized professional qualification in health care and social assistance. A defined set of skills and knowledge can be developed through a training course lasting 300–500 hours combined with an internship (constituting 20–45% of the total training). Access to the training course is based on an evaluation of the student’s knowledge and skills in the area of social or health services, acquired through either vocational training or professional experience.

Emilia-Romagna provides cultural and linguistic mediation services in the following areas: women’s health, children’s health, specialist health-care services, mental health, public health, prisons, centres for the health of foreign families, and health services specifically for undocumented migrants and organized by the volunteer-based NGO Caritas Internationalis (87).

According to MIPEX, intercultural mediators are currently present to some degree in the health-care systems of 17 European countries. However, none of these countries has deployed intercultural mediation in health care in a systematic way across all regions and health-care sectors in the country (101).

Finally, no study provided a systematic assessment of the number of intercultural mediators that might be needed to provide care for refugees and migrants or discussed the cost and cost-effectiveness of employing intercultural mediators.

2.3 Contributions and effectiveness of intercultural mediators in health care

Little empirical evidence was found on the effectiveness of intercultural mediators in improving the accessibility of care for refugees and migrants nor on the highly relevant aspects of care quality such as adherence to treatment, respect for patient rights, patient safety and treatment outcomes. Moreover, the heterogeneity of intercultural mediation programmes limits the generalizability of the existing evidence. In addition, the review found no empirical evidence on the contributions of intercultural mediators to the health status of refugee and migrant patients.

The available evidence examined the effectiveness of intercultural mediators in improving the quality of communication and building the relationship between health-care professionals and users, with some evidence on reducing perceived discrimination, identifying social problems and gender violence, improving access and increasing culture competence of health-care providers/institutions (28,32,46,50,53,56,58,60,62,70–75,96).

2.3.1 Quality of communication: effect on the patient-provider relationship

The studies included in this synthesis review have focused on how the presence and intervention of the intercultural mediator affected the quality of communication and the relationship between health-care professionals and patients. The most commonly used indicator of the effect of intercultural mediators on the quality of care was the perception of change in the quality of communication between health professionals and patients as a result of mediation.

Qualitative evaluation of a Belgian intercultural mediation programme employed in-depth interviews with health-care providers, patients and intercultural mediators; participant observation; and analysis of a survey of interventions carried out by the intercultural mediators (56). All parties confirmed that intercultural mediation



contributed to an increased quality of care, in particular in facilitating the exchange of correct, detailed information between health-care providers and patients. Health professionals stated that the programme should be continued to become a regular service. The study found that patients were less inhibited about telling their stories when an intercultural mediator was present, rather than an informal interpreter such as a child or spouse.

Qualitative evaluation of a recently introduced video remote intercultural mediation service in Belgium showed that health-care providers and patients alike considered it an acceptable and valid alternative to on-site intercultural mediation (Case study 5) (71). The service improved the quality of communication and contributed to bridging cultural gaps (although to a lesser extent than on-site intercultural mediation). Health-care providers recounted instances in which mediators had provided information on the meaning of certain concepts or terms used by patients. However, all parties (including the intercultural mediators themselves) generally preferred the intercultural mediator to be physically present.

Case study 5. Video remote intercultural mediation in Belgium

Since 2016, health-care providers working in hospitals, primary care centres and medical services at refugee centres have been able to access the services of trained intercultural mediators remotely (71). Using a specific app, the health-care provider can book (and in many cases use the services of) a suitable intercultural mediator within seconds. About 160 health-care organizations currently have access to a network of intercultural mediators. It provides intercultural mediation in over 20 languages. For the languages in most demand (Arabic (Maghreb and Middle Eastern), Bulgarian, Russian and Turkish), one or two intercultural mediators are on call during office hours, but for Dari, Farsi and Romanian intercultural mediators are only on call in the mornings. Mediators working in other languages always have to be booked in advance. The programme enables services to be provided at a large number of health-care organizations for many different migrant groups in a more efficient way than using on-site mediators. However, the uptake of mediation services by health-care providers has been slow and it is difficult for intercultural mediators to perform much-needed roles beyond linguistic interpreting and cultural clarification.

A qualitative study of the views of health-care providers, managers and interpreters/mediators on the roles of interpreters/mediators working in a Barcelona hospital indicated that health service staff considered that intercultural mediators brought

added value over interpreting because they also successfully interpret the cultural code (62). Mediators were further described as the link between the health system and the migrant patient and as “facilitating and helping towards understanding”.

In a quantitative study of how different health-care professionals in Italy coped with the difficulties of working with refugee and migrant patients (57 health-care providers), all staff members of a paediatric haematology and oncology department indicated that intercultural mediators were the most useful type of support (jointly with the availability of translated health education material) (75). Intercultural mediators were effective for both overcoming the language barriers and understanding different cultural attitudes.

A case study of an Indian patient in an Italian neurology department described in minute detail how, during the translation process, “ample room is left for the mediator’s creative contribution and sensitivity”. The intercultural mediator adapted and created a new message, taking into account the culture of the receiver of the message (73). The intercultural mediator contributed to the patient’s increased participation and involvement in the mediated dialogue by giving emotional reassurance, encouraging the patient’s self-expression and promoting doctor–patient contact. These factors promoted intercultural dialogue and mutual understanding.

Evaluation of an intercultural mediation programme in Catalonia, Spain, found that the programme responded to the needs and demands of both health professionals and the migrant population, and subsequently improved communication between these groups (72). Similarly, the first evaluation of intercultural mediation in health care in Greece concluded that the project was effective in increasing accessibility and quality of care and contributed to reducing health disparities (53). Hospital managers (both participants and those not included in the programme) agreed unanimously to continue the intercultural mediation programme.

One study examined two recorded interventions of intercultural mediators (one at a Belgian hospital emergency department and another at an Italian migrant health centre) (28). The study analysed the roles performed by mediators during and outside the three-way dialogue intervention and their effects on the relationship between the patient and the different health-care providers (28). In both cases, mediators interpreted, accompanied patients, helped patients to navigate the health-care system, conferred with health-care providers and provided after-care support, which involved advocacy. The mediators made it possible for patients to communicate with the different health-care providers and created the conditions needed to give them the same access and opportunities as indigenous patients.



Advocacy by the mediators enabled patients to receive the care they were entitled to in a timely manner.

An analysis and description of the effects of 55 recorded interventions of intercultural mediators noted how interpreting a patient's turn of phrase, including the interpretation of implicit content (primarily emotions), improved the emotional rapport between the patient and doctor (74).

2.3.2 Access to health services

Another quantitative study examined the satisfaction level of Albanian migrants in Slovenia and their evaluation of health education sessions; migrants considered the presence of the intercultural mediator to be extremely important and helpful (32). The study found that intercultural mediation was an efficient tool for overcoming the linguistic obstacles faced by the Albanian-speaking community in accessing the Slovene health-care system and might ultimately increase the quality of health care and reduce inequalities in access.

Quantitative data on HIV telephone counselling showed that call answering by specifically trained intercultural mediators in the languages of the main migrant groups substantially increased the number of calls from migrants (58). The study further found that use of an intercultural approach (based on a professional team of researchers and trained cultural/linguistic mediators) facilitated the interaction with migrants and improved the effectiveness of the counselling intervention (see Case study 6 for further information).

Case study 6. Telephone counselling for HIV/AIDS in Italy

An Italian telephone counselling service for HIV/AIDS and sexually transmitted infections (Telefono verde Aids e infezioni sessualmente trasmissibili (TVA/IST), operated by the Psycho-Socio-Behavioural Research, Communication and Training Operating Unit, Italian National Institute of Health) trained a group of linguistic and intercultural mediators to provide information and counselling to migrants by telephone (58). Specific training on communication and counselling related to health topics (including infectious diseases and HIV/AIDS), delivered by TVA/IST personnel, included a five-day course on HIV/AIDS (epidemiology, transmission paths, testing and care approaches), approaches to health and health problems in different global cultures and specific methodologies for telephone counselling. Mediators also received

Case study 6. (Contd)

30 days of on-the-job training under the supervision of professional operators at the TVA/IST unit. Mediators were selected from migrant groups that speak the languages mainly used by migrants living in Italy (Arabic, Chinese, English, French, Romanian, Russian and Spanish) and came from north and west Africa, eastern Europe, South America and Asia.

The project led to a significant increase in telephone calls from migrants over the 2007–2008 period when the intercultural counselling service was active. The presence of cultural and linguistic mediators was considered to significantly favour the access of migrants to the helpline service. Notably, fewer calls from migrants were recorded in the years following the end of the project.

2.3.3 Perceived discrimination

A study found that the interventions of trained intercultural mediators in a Spanish hospital serving a high number of refugees and migrants reduced the perceived level of discrimination in migrant patients from other cultures (96). These mediators had received 100 hours of training in interpreting and two and a half months of practical training. No further details of the training were given.

2.3.4 Identification of social problems and gender-related violence

A quantitative study on care for migrant women carried out in Madrid, Spain, found that intercultural mediators identified social problems more often than other professionals, and detected more than double the number of cases of gender violence (60). The migrant women had been referred to the mediator by health professionals and social workers at a centre for sexual and reproductive health because of social problems, relational problems, gender violence and requests for contraception. The mediators had received special training in these domains and met the migrant women (from the Maghreb and Latin America) in one-to-one meetings, in which they mainly provided information on sexual and reproductive health issues and referred the women to appropriate specialized services.

2.3.5 Critical issues observed in the interventions of intercultural mediators

Several studies described critical issues that influence the quality of care for refugees and migrants or limit the impact of the mediators' interventions (46,50,56,62,70).



An analysis of 92 mediated three-way dialogue (triadic) interventions with five mediators working with sub-Saharan migrants in a gynaecology/family planning clinic and primary care centre in Italy found that the migrant patients rarely participated as actively as the other participants, with mediators becoming the main interlocutors by assuming conversational dominance and/or proxy roles (50). This two-way, instead of three-way, dialogue left little conversational space for patients, who were largely limited to yes/no responses.

Another study noted a lack of transparency in the interventions of mediators, along with a tendency to make decision on behalf of the patients and a lack of interpreting skills (62). The mediators used summarizing (with the positive intention of simplifying the information and not overwhelming the patient) but did not give patients all of the information being shared in the interaction.

A study of intercultural mediation in mental health-care services in France found that a focus on cultural differences by intercultural mediation programmes was perceived as threatening by some patients. The patients were afraid that the presence of an intercultural mediator during the consultation would cause them to lose their individuality and be reduced to a cultural stereotype (70). Another study found that culture brokers tended to overemphasize the role of culture in the patient's point of view as a way of reinforcing their own role as the expert on the patient's culture (46). Combined with the tendency of health professionals to too quickly and wrongly attribute health problems (and problems experienced in delivering health care) to the culture of the migrant patients (56), this may lead to undue, harmful and ineffective attention to culture.

A main goal of intercultural mediation is to empower the patient and mitigate the effects of the power imbalance between the health-care provider and patient. Nevertheless, the power dynamics in institutional settings and feelings of social vulnerability may lead intercultural mediators to align themselves with the institution rather than the patient, even when health practitioners encourage the latter course (46).

2.3.6 Perceived added values and risks

Several studies provided insight from experts on the perceived added benefit of intercultural mediators in health care (55,59,65,66). Although the studies did not aim to assess the effectiveness of intercultural mediators and their primary focus was not to study intercultural mediators, they nevertheless included observations of how intercultural mediators contribute to health care.

Some of the studies described the contributions of intercultural mediators in bridging sociocultural gaps and building trust. For example, mediators who facilitated group awareness, psychoeducation and individual therapy sessions for refugees and migrants who had experienced violence along the western Balkan route were reported to have contributed to enhancing dialogue, trust and intercultural understanding (65). They were also described as generating confidence in families and understanding the emotions, feelings and traditions of refugees and migrants, mainly during interviews with families of organ donors born outside Spain (59).

The contributions of intercultural mediators to increasing the uptake of health-care services were documented in several studies. Mediators working in socioculturally adapted services for the prevention and early diagnosis of HIV in Spain were described as contributing to a higher HIV detection rate compared with similar programmes in different settings (66). The mediators had a background in psychology, social work or social education and had received specific training in HIV.

Cultural mediators also contributed to the design and distribution of multilingual, culturally relevant health education materials in a programme to prevent travel-related illnesses for those in Spain who were intending to visit friends and relatives in their countries of origin (Case study 7) (55).

Several studies highlighted the positive influence of intercultural mediators on inclusion and the provision of high-quality care for refugees and migrants (22,46,48,68,76). Intercultural mediators were recognized as contributing to a positive social dynamic that prevents exclusion and promotes respect for cultural diversity (22). They also facilitated the integration of refugees and migrants into society, increased the culture sensitivity of their institutions and showed initiative in providing refugees and migrants with access to extra information (e.g. about bureaucratic procedures in hospitals) (48). Intercultural mediators were acknowledged to facilitate effective communication and exchange between health-care providers and refugees and migrants (46,68,76).

A qualitative study based on in-depth interviews with seven nurses and six intercultural mediators⁶ assessed the perceptions of palliative care professionals regarding the management of migrant patients in Huelva, Spain, and aimed to identify whether there was a need to incorporate intercultural mediators. The study

6 The intercultural mediators were involved in the study only as informants (they did not appear to be working in the palliative care unit).



Case study 7. New citizens, new patients: development of a culturally adapted health education campaign in Ramon y Cajal Hospital, Madrid

This campaign was particularly aimed at informing people of sub-Saharan African or Latin American origin (i.e. migrants) who intended visiting friends and relatives of the risks associated with travelling to their countries of origin (e.g. severe malaria) (55). Intercultural mediators who had received specific training on this topic were involved in the adaptation of culturally tailored illustrated leaflets and posters that were then tested by the mediators and a team of health staff. This measure was adopted to ensure that the materials were fully comprehensible and would not be offensive. The most important contribution made by the intercultural mediators related to the colours used to represent risk in the maps (warm colours, such as red or yellow). Mediators also helped in designing drawings by explaining which images would be mostly understood, regardless of the education level of readers.

Leaflets were distributed by intercultural mediators before the Christmas and summer holidays in various locations. At the same time, the mediators also gave the information verbally but without any specific medical advice. Finally, intercultural mediators contributed to the development of a multilingual website aimed at improving the accessibility of health promotion information to visiting friends and relatives (<http://www.saludentreculturas.es>). No formal evaluation of the impact of the intervention was performed.

found that the health-care providers adopted “an ethnocentric stance... without being aware of their own cultural convictions restricting their care”, and concluded that intercultural mediators were crucial to provide culturally competent care at the end of life because they can shed light on areas of potential conflict caused by a lack of knowledge about the patient’s culture (67).

A study in the Piedmont Region of Italy described how linguistic and cultural barriers led to misunderstandings between health staff and migrant families regarding organ donation (98). A specific training course was developed for intercultural mediators already qualified in health care with the aim of decreasing misunderstandings and improving communication in this area. The study argued that health professionals should support the relationship between the intercultural mediators and the family to bring families and staff closer together, not only to smooth any linguistic and cultural difficulties but also to enable health staff to learn the social habits and conventions, religious beliefs and culture of migrants.

2.4 Factors facilitating the performance of intercultural mediators

Little evidence was available on the conditions needed to enable intercultural mediators to effectively perform their tasks. However, a number of contributory factors were identified.

Professionalization

Clear definitions of the nature and the limits of the profession, including regulation of the professional practices (a code of ethics and standards) were considered essential factors in the effectiveness of intercultural mediators in health care (19,45,78). Absence of these factors can lead to uncertainty in the mediator, a lack of recognition of the mediator's function by health-care providers and unclear expectations of mediator's role in the health service (22,46,87). It is, therefore, essential that clinicians are adequately informed on the roles and tasks of intercultural mediators, and are trained to collaborate with them and to accept their advice (46,71,87).

Training and support

Strong linguistic skills combined with training in interpreting were considered essential for mediators because their tasks frequently involve interpreting (either officially or unofficially) (21,48–50). Mediators must also understand the organization of health and social services, the roles of the different health-care providers and basic medical terminology (78,95). After completing basic training, mediators should receive regular training for capacity-building and supervision sessions to discuss problems they encounter in their work (22,38,45,46,56,69). An important dimension of the supervision sessions is providing support because mediators may lack psychological support when dealing with challenging cases and are at risk of secondary traumatization and developing burn-out (45,46,56,90,91). Where necessary, intercultural mediators should also have access to individual supervision and psychological support (23,45). Supervision sessions are generally considered the most useful aspect of training: the most common issues are imposing boundaries, clarifying their role in the three-way dialogue relationship and managing emotions.

Biculturalism

Intercultural mediators have to be able to navigate between different sociocultural world views and cope with tensions raised by conflicts of interest and loyalty (84). To achieve this, intercultural mediators may be bicultural (84) or share the

A decorative header image showing the silhouettes of several people standing in front of a large window, looking out. The scene is backlit, creating a warm, yellowish glow. The silhouettes are dark against the bright light from the window.

same cultural background and a similar migration history as the patients they support (49,85,86,88). However, an ethnic or cultural match between the mediator and migrant patient is not always considered a prerequisite for successful intercultural mediation (46). One study warned against making the assumption that having a common origin and migration history is sufficient to be an effective culture broker; instead, having theoretical insight into the culture and sharing knowledge/experiences of their role can help intercultural mediators to avoid bias towards their own biographical experience (89).

Recognition of status

The low status of intercultural mediators in Belgian hospitals reportedly made it difficult for them to defend patients' rights or intervene to protect patients' well-being or dignity (e.g. because of discrimination) (56). Consequently, mediators found it difficult to advocate effectively for the patients.

Incorporation into the health service strategy

To provide effective intercultural mediation, health-care services need to develop a comprehensive strategy that facilitates a reliance on intercultural mediators, encourages health-care providers to call them in when necessary and provides the necessary logistics. This requires the organization to have a coordinated approach, ideally as part of a well-developed equity strategy, as well as a point of contact for mediators to report problems that occur (23,90).

3. DISCUSSION

3.1 Strengths and limitations of the review

This is the first synthesis of evidence on the roles and effectiveness of intercultural mediators in improving accessibility and quality of care for refugees and migrants in the WHO European Region. It combines insight and evidence from diverse disciplines, including medicine (different fields), anthropology, psychology, interpretation and linguistics.

This rapid review was based on an extensive review of both peer-reviewed and grey literature. Searches were carried out in English and Russian, the two most widely spoken languages across the Region. The analysis was limited to documents published in Dutch, English, French, German, Russian and Spanish. This linguistic bias undoubtedly led to the exclusion of relevant literature from other countries, particularly those without a long history of intercultural mediation. This review includes documents reporting on 20 Member States in the WHO European Region, although intercultural mediation in health care may currently not be available in all of these. For example, the database of mediators for 12 post-Soviet countries (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) lists a limited number of mediators, and health care is not explicitly mentioned as one of the domains in which they are active (99,100). Most publications were from Belgium, France, Italy and Spain, where intercultural mediation is well established.

Studies in which intermediaries were described as (inter)cultural mediators (and equivalent terms such as intercultural interpreter and mediator and culture broker) were included in the review. However, studies in which intermediaries were not described in these terms were excluded, even though their work (official or unofficial) may closely resemble the work of intercultural mediators, for example interpreters working in health care, link workers and patient navigators (mainly active in the United States), as discussed in HEN synthesis report 62 (29).

3.2 Development of intercultural mediation as a fully integrated health profession

The review found consensus on the main roles of intercultural mediators in bridging cultures to improve communication and understanding between health-



care providers and patients who do not share the same sociocultural background. This nearly always included linguistic interpreting, and often included assisting in adapting services to the needs of refugees and migrants. However, there was lack of clarity on the scope of the work. Although this gives intercultural mediators the freedom to tailor their help to the patient's needs, it can also lead to a lack of clarity on the role of intercultural mediators: for refugees and migrants, in not knowing what help mediators can provide; for mediators, in not knowing where their professional boundaries lie and what is expected of them; and for health-care managers and clinicians, in not knowing what to expect of mediators. Intercultural mediators currently employed in health-care settings would benefit from psychological support, continuing education programmes and accreditation systems.

The review identified a need for professionalization, with coherent definitions, professional standards and an ethical code to clarify the roles and responsibilities of intercultural mediators. This would increase the awareness of how and where mediators can support health/social-care providers and patients and would help policy-makers to determine the best ways to incorporate mediators into health systems. The review found that training courses for intercultural mediators vary in duration, educational outcome and quality across different programmes and contexts. Standardization of training at the national and regional levels would contribute to the development of a clear professional identity for intercultural mediators and support their rational deployment by health service providers and policy-makers.

Both refugee and migrant patients and health-care providers would benefit from guaranteed access to standardized health-care services facilitated by intercultural mediators in health care whenever and wherever needed. National and institutional policies could be developed to provide a comprehensive, systemic approach to managing diversity and patient equity in health-care organizations, including the use of intercultural mediators in defined roles. The design and implementation of these policies could involve input from intercultural mediators and refugees and migrants. In addition, the contribution of intercultural mediators to equitable health care could be recognized, for example by considering their use in the accreditation process for health-care institutions.

3.3 Further research

This review identified a lack of evidence on the benefits of using intercultural mediators in terms of measured improvements in accessibility and health outcomes

and the cost-effectiveness of using intercultural mediators. Further interdisciplinary research and the creation of international networks are needed to support evidenced-informed practice and the exchange of best practices.

3.4 Policy considerations

Based on the review findings, the following policy considerations to improve the equity of health services for refugees and migrants can be considered by Member States:

- establish clear and coherent definitions of the roles and responsibilities of intercultural mediators working in the health sector;
- establish professional guidelines, standards and quality assurance processes to support the recognition and full professionalization of intercultural mediation in health care;
- develop standardized training and accreditation processes to facilitate the systematic deployment of intercultural mediators;
- provide ongoing training, supervision and psychological support for intercultural mediators to build capacity and enhance the quality and consistency of their service;
- provide training for health-care professionals in the use of intercultural mediation; and
- develop and implement formal national strategies to maximize the contributions and effectiveness of intercultural mediators in the health sector and encourage managers and health-care providers to develop a comprehensive and systematic approach to the management and integration of intercultural mediators.



4. CONCLUSIONS

Intercultural mediators bridge sociocultural and linguistic gaps; prevent and resolve conflicts; facilitate the therapeutic relationship and the integration and empowerment of patients; and provide advocacy. Some are also involved in social work, counselling, health education and promotion, and they may act as co-therapists in mental health care. Intercultural mediators are a diverse group: they differ in the roles they perform, their professional backgrounds and the content and duration of their training.

This review found that intercultural mediators contribute to reducing the interference of sociocultural and linguistic differences in health care and improve the accessibility and quality of care, mainly through improving communication and creating trust and understanding in the relationship between health-care provider and patient. With sufficient training, they should be able to achieve their full potential to empower patients and increase the cultural competence of the health-care provider. However, recognition of intercultural mediation as a profession is hampered by a lack of training, certification and accreditation procedures, and the non-systematic and inconsistent implementation of intercultural mediation programmes. Moreover, health-care providers have insufficient training in working with intercultural mediators.

Interdisciplinary research and the creation of international networks are needed to support evidenced-based practice and the exchange of best practices. Finally, the wider implementation of intercultural mediators in health care should be promoted, along with strategies that encourage managers and health-care providers to develop a comprehensive and systemic approach to the management of diversity.

REFERENCES

1. Report on the health of refugees and migrants in the WHO European Region: no public health without refugee health. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0004/392773/ermh-eng.pdf?ua=1, accessed 23 July 2019).
2. Human rights and health. In: Fact sheets [website]. Geneva: World Health Organization; 2017 (<https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>, accessed 8 June 2019).
3. International covenant on economic, social and cultural rights. New York: United Nations; 1966 (https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsq_no=IV-3&chapter=4&clang=_en, accessed 27 June 2019).
4. General comment no. 20: non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International covenant on economic, social and cultural rights). New York: United Nations Economic and Social Council; 2009 (E/C.12/GC/20; <https://www.refworld.org/docid/4a60961f2.html>, accessed 14 July 2019).
5. Resolution WHA61.17. Health of migrants. In: Sixty-first World Health Assembly, Geneva, 16–24 May 2008. Geneva: World Health Organization; 2008 (http://apps.who.int/iris/bitstream/handle/10665/23533/A61_R17-en.pdf;jsessionid=CC5E570EABCC5AD0E653539039737FF0?sequence=1, accessed 27 June 2019).
6. Health of migrants: the way forward. Report of a global consultation, Madrid, 3–5 March 2010. Geneva: World Health Organization; 2010 (https://www.who.int/migrants/publications/mh-way-forward_consultation-report.pdf, accessed 8 June 2019).
7. Transforming our world: the 2030 Agenda for sustainable development. Resolution adopted by the General Assembly on 25 September 2015. New York: United Nations; 2015 (A/RES/70/1; http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E, accessed 8 June 2019).
8. Strategy and action plan for refugee and migrant health in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (Regional Committee for Europe 66th session; EUR/RC66/8 + EUR/RC66/Conf.Doc./4; http://www.euro.who.int/__data/assets/pdf_file/0004/314725/66wdo8e_MigrantHealthStrategyActionPlan_160424.pdf?ua=1, accessed 8 June 2019).

9. Promoting the health of refugees and migrants: framework of priorities and guiding principles to promote the health of refugees and migrants. Geneva: World Health Organization; 2017 (http://www.who.int/migrants/about/framework_refugees-migrants.pdf, accessed 8 June 2019).
10. Promoting the health of the refugees and migrants: draft global action plan 2019–2023. New York: United Nations; 2019 (Report by the Director-General to the Seventy-second World Health Assembly; http://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_25Rev1-en.pdf, accessed 24 July 2019).
11. Health of refugee and migrant children. Copenhagen: WHO Regional Office for Europe; 2018 (Technical guidance on refugee and migrant health; <https://reliefweb.int/sites/reliefweb.int/files/resources/tc-health-children-eng.pdf>, accessed 14 June 2019).
12. Thirteenth general programme of work 2019–2023. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>, accessed 27 June 2019).
13. Napier AD, Depledge M, Knipper M, Lovell R, Ponarin E, Sanabria E et al. Culture matters: using a cultural contexts of health approach to enhance policy-making. Copenhagen: WHO Regional Office for Europe; 2017 (Policy brief no. 1; http://www.euro.who.int/__data/assets/pdf_file/0009/334269/14780_World-Health-Organisation_Context-of-Health_TEXT-AW-WEB.pdf?ua=1, accessed 8 June 2019).
14. Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H et al. Culture and health. *Lancet*. 2014;384:1607–39. doi: 10.1016/S0140-6736(14)61603-2.
15. Verrept H. Notes on the employment of intercultural mediators and interpreters in health care. In: Ingleby D, Chiarenza A, Devillé W, Kotsioni I, editors. *Inequalities in health care for migrants and ethnic minorities* (vol. 2). Antwerp: Garant Publishers; 2012:115–43.
16. Bowen S, Roy J, Edwards J. From “multicultural health” to “knowledge translation”: rethinking strategies to promote language access within a risk management framework. *JoSTrans*. 2010;14:145–65.
17. Pavlish CL, Noor S, Brandt J. Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Soc Sci Med*. 2010;71(2):353–61. doi: 10.1016/j.socscimed.2010.04.010.
18. Saadi A, Bond BE, Percac-Lima S. Bosnian, Iraqi and Somali refugee women speak: a comparative qualitative study of refugee health beliefs on preventive health and breast cancer screening. *Womens Health Issues*. 2015;25(5):501–8. doi: 10.1016/j.whi.2015.06.005.

19. Flor Pérez P, Antonin Martin M. Proposal for a code of ethics for intercultural mediators in health care. *Ramon Llull J Appl Ethics*. 2014;5:179–203.
20. Chiarenza A. Equity standards in health care 2014. Reggio Emilia: Task Force on Migrant Friendly and Culturally Competent Health Care; 2014. doi: 10.13140/RG.2.2.27349.93928.
21. Pöchhacker F. Interpreting as mediation. In: Valero-Garcés C, Martin A, editors. *Crossing borders in community interpreting: definitions and dilemmas*. Amsterdam: John Benjamins Publishing; 2008:9–26.
22. Catarci M. Intercultural mediators as relational facilitators in a plural society. In: Portera A, Grant C, editors. *Intercultural education and competences: challenges and answers for the global world*. Newcastle upon Tyne: Cambridge Scholars Publishing; 2017:65–82.
23. Verrept H, Coune I. Guide for intercultural mediation in health care. Brussels: FPS Health, Safety of the Food Chain and Environment; 2016 (https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/2017_11_14_guide_english_o.pdf, accessed 6 June 2019).
24. de V. Souza IET. Intercultural mediation in health care: from the professional medical interpreters' perspective [e-book]. Bloomington (IN): Xlibris; 2016.
25. Resource package for ensuring access to health care of refugees, asylum seekers and other migrants in the European Union (EU) countries. Granada: Andalusian School of Public Health; 2016 (717275 SH-Capac: https://www.sh-capac.org/pluginfile.php/2274/mod_resource/content/1/SH-CAPAC_ResourcePackage.pdf, accessed 6 June 2019).
26. Martin M, Phelan M. Interpreters and cultural mediators: different but complementary roles. *Translocations*. 2010;6(1).
27. Verrept H, Coune I. Desarrollo de una guía para la mediación intercultural en la atención sanitaria en Bélgica [Development of a guide for intercultural mediation in health care in Belgium]. In: Mendoza R, Gualda E, Spinatsch M, editors. *La mediación intercultural en la atención sanitaria a inmigrantes y minorías étnicas. Modelos, estudios, programas y práctica profesional: una visión internacional* [Intercultural mediation in health care for immigrants and ethnic minorities. Models, studies, programmes and professional practice: an international vision]. Madrid: Ediciones Díaz de Santos; 2019:5–29 (in Spanish).
28. Niemants N. L' "entre-deux-rencontres": activités de médiation autour des entretiens. *Dragoman*. 2017;5(7):142–63.

- 
29. McGarry O, Hannigan A, Manuela De Almeida M, Severoni S, Puthooppambal SJ, MacFarlane A. What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European Region? Copenhagen: WHO Regional Office for Europe; 2018 (Health Evidence Network (HEN) synthesis report 62; http://www.euro.who.int/__data/assets/pdf_file/0006/380229/who-hen-62.pdf?ua=1, accessed 6 June 2019).
30. Gustafsson K, Norström E, Fioretos I. The interpreter: a cultural broker? In: Schäffner C, Kredens K, Fowler Y, editors. *Interpreting in a changing landscape*. Amsterdam: John Benjamins Publishing; 2013:187–202.
31. Rowlands G, Russell S, O'Donnell A, Kaner E, Trezona A, Rademakers J et al. What is the evidence on existing policies and linked activities and their effectiveness for improving health literacy at national, regional and organizational levels in the WHO European Region? Copenhagen: WHO Regional Office for Europe; 2018 (Health Evidence Network (HEN) synthesis report 57; http://www.euro.who.int/__data/assets/pdf_file/0006/373614/Health-evidence-network-synthesis-WHO-HEN-Report-57.pdf?ua=1, accessed 14 June 2019).
32. Čebren U, Pistotnik S, Jazbinšek S, Farkaš-Lainščak J. Case study: evaluation of the implementation of intercultural mediation in preventive health-care programmes in Slovenia. *Public Health Panorama*. 2017;3(1):114–19.
33. Archibald J, Garzone G. Conceptualising linguistic and cultural mediation [editorial]. *LCM J*. 2014;1(1–2). doi: 10.7358/lcm-2014-0102-arch.
34. Rudvin M, Tomassini E. Migration, ideology and the interpreter–mediator: the role of the language mediator in education and medical settings in Italy. In: Valero-Garcés C, Martin A, editors. *Crossing borders in community interpreting: definitions and dilemmas*. Amsterdam: John Benjamins Publishing; 2008:245–66.
35. Santamaria Ciordia L. A conceptual and contemporary approach to the evolution of impartiality in community interpreting. *JoSTrans*. 2017;28:1–20.
36. Hsieh E. Bilingual health communication: medical interpreters' construction of a mediator role. In: Goldsmith D, Brashers D, editors. *Communicating to manage health and illness*. New York: Routledge; 2009:135–60.
37. Mirza M, Harrison EA, Chang H-C, Salo CD, Birman D. Making sense of three-way conversations: a qualitative study of cross-cultural counseling with refugee men. *Int J Intercult Relations*. 2017;56:52–64. doi: <https://doi.org/10.1016/j.ijintrel.2016.12.002>.

38. Lietz R. Kriterien zur Umsetzung von Integrationslotsenprojekten [PhD thesis]. Jena: Friedrich Schiller University Jena; 2015.
39. Katan D. Translation at the cross-roads: time for the transcultural turn? *Perspectives*. 2016;24(3):365–81. doi: <https://doi.org/10.1080/0907676X.2015.1016049>.
40. Sleptsova M, Hofer G, Naser M, Langewitz W. The role of the health care interpreter in a clinical setting: a narrative review. *J Community Health Nurs*. 2014;31(3):167–84. doi: 10.1080/07370016.2014.926682.
41. Uluköylü S. Manchmal streite ich auch. Sprach- und Kulturmittlung für türkische Migrantinnen im Gesundheitsbereich. In: Grbić N, Pöllabauer SS, editors. Ich habe mich ganz peinlich gefühlt. Forschung zum Kommundolmetschen in Österreich: Problemstellungen, Perspektiven und Potenziale. Graz: Department of Translation Studies, University of Graz; 2006:181–228.
42. Van de Geuchte S, Van Vaerenbergh L. Sprach- und Kulturmittlung im Gesundheitsbereich. Die Situation in den Niederlanden und Flandern. *Transkom*. 2013;6(2):420–40.
43. Vargas-Urpi M. Public service interpreting for Chinese immigrants in Catalonia: a study based on interpreters', coordinators' and users' view. *LAIC*. 2014;14(4):475–99.
44. Béal A, Chambon N. Le recours à l'interprète en santé mentale: enjeux et problèmes. *Rhizome*. 2015;1(55):9–19.
45. Qureshi A, Warra-Revollo H, Collazos F, el Harrak J, Visiers C, del Mar Ramos M et al. Intercultural mediation: reconstructing Hermes: the messenger gets a voice. In: Bhugra D, Gupta S, editors. *Migration and mental health*. Cambridge: Cambridge University Press; 2010:245–60.
46. Miklavcic A, LeBlanc MN. Culture brokers, clinically applied ethnography, and cultural mediation. In: Kirmayer L, Guzder J, Rousseau C, editors. *Cultural consultation*. New York: Springer; 2014:115–37 (International and cultural psychology series).
47. Sargent C, Larchanché S. The construction of “cultural difference” and its therapeutic significance in immigrant mental health services in France. *Cult Med Psychiatry*. 2009;33(1):2–20.
48. Rudvin M, Spinzi C. Negotiating the terminological borders of “language mediation” in English and Italian: a discussion on the repercussions of terminology on the practice, self-perception and role of language mediators in Italy. *LCM J*. 2014;1(1–2):57–79. doi: 10.7358/lcm-2014-0102-spin.

- 
49. Abetti N. Mediation in the Mediterranean: Italy as a crucible for immigration and intercultural mediation [thesis]. Brattleboro (VT): SIT Graduate Institute; 2018 (MA TESOL Collection 734; https://digitalcollections.sit.edu/ipp_collection/734, accessed 6 June 2019).
 50. Amato A, Garwood C. Cultural mediators in Italy: a new breed of linguists [online journal]. inTRAlinea. 2011;13 (<http://www.intraline.org/archive/article/1673>, accessed 6 June 2019).
 51. Boss-Pietro O, De Roten Y, Elghezouani A, Madera A, Despland J-N. Differences in therapeutic alliance when working with an interpreter: a preliminary study. *Schweizer Arch Neurol Psychiatr*. 2010;161(1):14–16.
 52. Sperber A. Mediators help migrants access health services in Italy. *Lancet*. 2018;391(10129):1468–9. doi: 10.1016/S0140-6736(18)30892-4.
 53. Ioannidi-Kapolou E, Vassilikou K. Intercultural mediation in Greek hospitals. First assessment. In: Fouskas T, Tseurenis V, editors. *Contemporary immigration in Greece: a sourcebook*. Athens: EPLO Publications; 2014:297–305.
 54. Chiarenza A. Towards the development of health systems sensitive to social and cultural diversity: the perspective of healthcare organizations. In: *Health and migration in the EU*. Lisbon: Ministry of Health of the Republic of Portugal; 2008:167–76.
 55. Navarro M, Navaza B, Guionnet A, López-Vélez R. A multidisciplinary approach to engage VFR migrants in Madrid, Spain. *Trav Med Infect Dis*. 2012;10(3):152–6. doi: <https://doi.org/10.1016/j.tmaid.2012.03.001>.
 56. Verrept H. Intercultural mediation: an answer to health care disparities? In: Valero-Garcés C, Martin A, editors. *Crossing borders in community interpreting: definitions and dilemmas*. Amsterdam: John Benjamins Publishing; 2008:187–201.
 57. Sani S. The profession and the roles of the intercultural mediator in Italy. *Proc Soc Behav Sci*. 2015;191:2546–8. doi: <https://doi.org/10.1016/j.sbspro.2015.04.286>.
 58. Taglieri FM, Colucci A, Barbina D, Fanales-Belasio E, Luzi AM. Communication and cultural interaction in health promotion strategies to migrant populations in Italy: the cross-cultural phone counselling experience. *Ann Ist Super Sanita*. 2013;49(2):138–42. doi: 10.4415/ANN_13_02_05.
 59. Frutos M, Mansilla JJ, Ruiz P, Guerrero F, Lebrón M, Ortuño R et al. Increased organ donations from people born outside Spain. *Transplant Proc*. 2008;40(9):2872–3. doi: 10.1016/j.transproceed.2008.08.095.

60. Alcaraz Quevedo M, Paredes-Carbonell J, Sancho Mestre C, López-Sánchez P, Luis García Moreno J, Vivas Consuelo D. Atención a mujeres inmigrantes en un programa de mediación intercultural en salud [Health care for immigrant women in an intercultural mediation programme]. *Rev Esp Salud Publica*. 2014;88(2):301–10. doi: 10.4321/S1135-57272014000200012 (in Spanish).
61. Rhazzali K. The end of life from an intercultural perspective. Mediators and religious assistants in the health service. *Ital J Soc Educ*. 2014, 6(2), 224–55. doi: 10.14658/pupj-ijse-2014-2-10.
62. Riba-Arumí M. The fuzzy boundary between the roles of interpreter and mediator in the public services in Catalonia: analysis of interviews and interpreter-mediated interactions in the health and educational context. *Across Lang Cult*. 2017;18(2):195–218. doi: <https://doi.org/10.1556/084.2017.18.2.2>.
63. Hsieh E. Bilingual health communication: working with interpreters in cross-cultural care. New York: Routledge; 2016.
64. Angelelli C. Medical interpreting and cross-cultural communication. New York: Cambridge University Press; 2004.
65. Arsenijević J, Schillberg E, Ponthieu A, Malvisi L, Ahmed WAE, Argenziano S et al. A crisis of protection and safe passage: violence experienced by migrants/refugees travelling along the western Balkan corridor to northern Europe. *Confl Health*. 2017;11:6. doi: 10.1186/s13031-017-0107-z.
66. Esteban-Vasallo M, Domínguez-Berjón M, García-Riolobos C, Morán-Arribas M, Rico-Bermejo J, Collado-González S et al. Factors associated to a reactive result of rapid-HIV test in socio-culturally adapted services in primary care in Spain. *AIDS Behav*. 2015;19:2370–9. doi: 10.1007/s10461-015-1162-3.
67. García-Navarro E, Martins Teixeira da Costa E. Intercultural mediation at the end of life. Different perceptions of the same process. *Proc Soc Behav Sci*. 2017;237(2017):649–53. doi: <https://doi.org/10.1016/j.sbspro.2017.02.036>.
68. Radjack R, Titia Rizzi A, Harf A, Moro MR. Actualité en psychiatrie transculturelle en France. *Ann Med Psychol (Paris)*. 2017;175(6):561–6. doi: <https://doi.org/10.1016/j.amp.2017.05.004>.
69. Levin-Zamir D, Keret S, Yaakovson O, Lev B, Kay C, Verber G et al. Refuah Shlema: a cross-cultural programme for promoting communication and health among Ethiopian immigrants in the primary health care setting in Israel – evidence and lessons learned from over a decade of implementation. *Glob Health Promot*. 2011;18(1):51–4. doi: 10.1177/1757975910393172.

70. Coyer G. Médiation interculturelle: une mutuelle interprétation. *Evol Psychiatr.* 2014;79(1):142–55. doi: <https://doi.org/10.1016/j.evopsy.2012.08.001>.
71. Verrept H, Coune C, Van de Velde J, Baatout S. Evaluatie van de projecten interculturele bemiddeling op afstand (via videoconferentie) in de gezondheidszorg [Evaluation of the projects for intercultural remote mediation (via videoconferencing) in health care]. Brussels: Federal Public Service Health; 2018 (in Dutch).
72. Lizana T. Developing a migrant health policy for Catalonia. In: Ingleby D, Chiarenza A, Devillé W, Kotsioni I, editors. *Inequalities in health care for migrants and ethnic minorities* (Vol. 2). Antwerp: Garant; 2012:82–97.
73. Pignataro C. Interlinguistic and intercultural mediation in health care settings. *The Interpreters' Newsletter.* 2012;17:71–82.
74. Farini F. Interpreting and intercultural mediation in Italian health care settings. *J Intercult Commun.* 2013;33 (<https://immi.se/intercultural/nr33/farini.html>, accessed 6 June 2019).
75. Caprino, D, Massimo L. “Lost in translation”: the experience in trans-cultural work in an Italian department of pediatric hematology and oncology. In: Jaworski JA, editor. *Advances in sociology research* (Vol. 15). New York: Nova Science; 2014:183–90.
76. Qureshi A, Collazos F, Revollo HW, Ramos M, Delgadillo C, El Harrak J et al. The Catalan healthcare intercultural mediation training project of “la Caixa” social and cultural outreach projects. *Eur Psychiatry.* 2009; 24 (suppl 1): S962. doi: [https://doi.org/10.1016/S0924-9338\(09\)71195-2](https://doi.org/10.1016/S0924-9338(09)71195-2).
77. Angelelli C. The role of the interpreter in the health care setting: a plea for dialogue between research and practice. In: Valero-Garcés C, Martin A, editors. *Crossing borders in community interpreting: definitions and dilemmas*. Amsterdam: John Benjamins Publishing; 2008:147–63.
78. Research report on intercultural mediation for immigrants in Europe. Pyrgos Ilias: Olympic Training and Consulting for the TIME Project Partnership; 2015, 2016 (http://www.mediation-time.eu/images/TIME_OI_Research_Report_v.2016.pdf, accessed 6 June 2019).
79. Calderón-Grossenbacher R. Interkulturelles Übersetzen und Vermitteln im Sozial- und Bildungsbereich: Aktuelle Praxis und Entwicklungspotenzial. Bericht zuhanden Bundesamt für Migration, Arbeit, Integration & Bürgerrecht, Sektion Integration. Bern: RC Consulta; 2010 (<http://www.rc-consulta.ch/pdf/ber-interkultur-uebersetzen-d.pdf>, accessed 6 June 2019).

80. KEK-CDC Consultants. Bedarf an Ausbildungsplätzen für interkulturelle Übersetzerinnen: Vorschlag für die Beitragszustellung in der Periode 2011–2013. Im Auftrag des Bundesamtes für Gesundheit, Programm Migration und Gesundheit 2010 (<http://docplayer.org/9623739-Bedarf-an-ausbildungsplaetzen-fuer-interkulturelle-uebersetzer-innen-vorschlag-fuer-die-beitragszuteilung-in-der-periode-2011-2013.html>, accessed 14 June 2019).
81. Llevot Calvet N, Garreta Bochaca J. La mediación intercultural en las asociaciones de inmi-grantes de origen africano. *Rev Int Sociol.* 2013;71(1):167–88. doi: <https://doi.org/10.3989/ris.2012.09.07>.
82. Verordnung über die Aus- und Fortbildung von zertifizierten Mediatoren (Zertifizierte-Mediatoren-Ausbildungsverordnung - ZMediatAusbV). Berlin: Federal Ministry of Justice for Consumer Protection; 2016 (<https://www.gesetze-im-internet.de/zmediatausbv/BJNR199400016.html>, accessed 14 June 2019).
83. Legislative Decree No. 286 of 1998. Testo unico sull'immigrazione [Consolidated law on immigration]. Rome: Government of Italy; 1998 (<https://www.refworld.org/pdfid/58c2aa5e4.pdf>, accessed 14 June 2019).
84. Katan D. Translating cultures: an introduction for translators, interpreters and mediators. Manchester: St Jerome Publishing; 2004.
85. Morisette K. L'interprétariat. Espace de médiation interculturelle dans le contexte franco-phone Québécois. *Ethnologies.* 2005;27(1):307–27. doi: <https://doi.org/10.7202/014031ar>.
86. Grassineau D, Papa K, Ducourneau A, Duboz P, Boëtsch G, Chiaroni J. Improving minority blood donation: anthropologic approach in a migrant community. *Transfusion.* 2007;47:402–9. doi: 10.1111/j.1537-2995.2007.01130.x.
87. Genova A. policy to tackle health inequalities in accessing health services for migrant women in Italy: a regional comparative analysis in Marche and Emilia Romagna. *Soc Diritto.* 2014;1:121–41. doi: 10.3280/SD2014-001006.
88. De Freitas C, García-Ramírez M, Aambø A, Buttigieg SC. Transforming health policies through migrant user involvement: lessons learnt from three European countries. *Psychosoc Intervent.* 2014;23:105–13. doi: <https://doi.org/10.1016/j.psi.2014.07.007>.
89. Plivard I. La pratique de la médiation interculturelle au regard des populations migrantes... et issues de l'immigration. *Connexions.* 2010;93(1):23–38. doi: <https://doi.org/10.3917/cnx.093.0023>.

90. Jackson-Carroll L, Graham E, Carey-Jackson J. Beyond medical interpretation: the role of interpreter cultural mediators (ICMs) in building bridges between ethnic communities and health institutions. Seattle (WA): Harborview Medical Center; 1998.
91. Tribe R, Lane P. Working with interpreters across language and culture in mental health. *J Ment Health*. 2009;18(3):233–41. doi: 10.1080/09638230701879102.
92. Bischoff A, Dahinden J. Dolmetschen, vermitteln und schlichten in vielsprachigen Basel. *J Intercult Commun*. 2008;16(2):1–20.
93. Kaufert JM, Koolage WW. Role conflict among “culture brokers”: the experience of native Canadian medical interpreters. *Soc Sci Med*. 1984;18(3):283–6. doi: [https://doi.org/10.1016/0277-9536\(84\)90092-3](https://doi.org/10.1016/0277-9536(84)90092-3).
94. Kaufert J, Putsch R. Communication through interpreters in health care: ethical dilemmas arising from differences in class, culture, language, and power. *J Clin Ethics*. 1997;8(1):71–87.
95. Sukhareva E, Chernikova N. [Problems of medical discourse translation in the context of social translation.] *Bulletin Voronezh State University. Series: Linguistics and Intercultural Communication*. 2014;4:115–20 (in Russian; <http://www.vestnik.vsu.ru/pdf/lingvo/2014/04/2014-04-24.pdf>, accessed 16 July 2019).
96. Guionnet A, Estévez L, Navaza B, Navarro M, Martínez LC, López-Vélez R. Intercultural mediation as solution to linguistic and cultural conflicts between health personnel and migrant patients and a way to social integration. *Trop Med Int Health*. 2009;14(suppl 2):67–8.
97. Lazaro Gutiérrez R. Health care videos addressed to the migrant population: from intercultural mediation to transcreation. *Rev Leng Fines Específicos*. 2017;23(1):140–62. doi: <http://dx.doi.org/10.20420/rlfe.2017.161>.
98. Potenza R, Guermani A, Grosso M, Fossarello L, Fontaneto C, Casciola A et al. Organ and tissue donation in migrants: advanced course for cross-cultural mediators. *Transplant Proc*. 2013;45:2584–6. doi: <http://doi.org/10.1016/j.transproceed.2013.07.029>.
99. Mediation Europe–Asia [website]. Minsk: UPU “Center for Mediation and Negotiations”; 2019 (in Russian; <https://mediation-eurasia.pro>, accessed 6 June 2019).
100. Registry of mediators in health care in Kazakhstan. Almaty: National Medical Association; 2019 (in Kazakh; <http://www.nma.org.kz/mediation/reestr-mediatorov-v-oblasti-zdravookhraneniya>, accessed 6 June 2019).

101. Summary report on the MIPEX health strand and country reports. Brussels: International Organization for Migration; 2016 (IOM Migration Research Series no. 52; https://publications.iom.int/system/files/mrs_52.pdf, accessed 6 June 2019).
102. California standards for health care interpreters: ethical principles, protocols, and guidance on roles and intervention. Sacramento (CA): California Health Care Interpreters Association; 2002 (http://www.chiaonline.org/resources/Pictures/CHIA_standards_manual_%20March%202017.pdf, accessed 6 June 2019).
103. SURT [website]. Barcelona; SURT; 2019 (in Spanish; <http://www.surt.org>, accessed 8 July 2019).
104. SprInt Wuppertal bildet aus. In: Qualifizierung [website]. Wuppertal: SprInt Servicestelle; 2019 (<http://www.sprachundintegrationsmittler.org/index.php/sprach-und-integrationsmittler/qualifizierung>, accessed 16 June 2019).
105. Qualifizierung zum/zur Sprach-und Integrationsmittler/in [website]. Erfurt: Institute for Vocational Training and Social Management Nonprofit; 2018 (<https://www.ibs-thueringen.de/projekte/sprintpool-thueringen/qualifizierung/>, accessed 16 June 2019).
106. Interkulturelles Dolmetschen und Vermitteln in der Schweiz. Bern: Interpret; 2019 (www.inter-pret.ch, accessed 16 June 2019).
107. National catalogue of professional qualifications. Madrid National Institute of Qualifications; 2007 (in Spanish; https://www.oei.es/historico/etp/catalogo_nacional_cualificaciones_espana.pdf, accessed 8 July 2019).



ANNEX 1. SEARCH STRATEGY

Databases and websites

Searches were performed in August and September 2018 in English and in December 2018 and January 2019 in Russian and included peer-reviewed literature identified through academic databases (English: Cochrane Library, Embase, Google Scholar, Pubmed and Scopus; Russian: Bielefeld Academic Search Engine, Cyberleninka, East View, eLibrary, Nauka-rastudent, Scholar.ru and Scientific Archive of the Russian Federation) and grey literature identified through websites of the Council of Europe, the International Organization for Migration and the WHO Regional Office for Europe. The references of key documents were reviewed to identify further relevant documents. In addition, experts involved in the ADAPT network (1) (a former COST action¹) and the Erasmus+ TIME project (2)² and members of the Migrant Friendly and Culturally Competent Healthcare Task Force³ (operating within the framework of the WHO International Network of Health Promoting Hospitals and Health Services (4)) were contacted to identify other relevant documents.

Study selection

Studies published between January 2008 and November 2018 and based in Member States of the WHO European Region were eligible for review if they:

- focused on one (or more) of the following topics:
 - the concept of intercultural mediation in health care;
 - training programmes for intercultural mediators in health care;
 - accreditation and deployment of intercultural mediators in health care;
 - effects of intercultural mediators on the accessibility and quality of care; and

1 The ADAPT network (2011–2015) included 130 members from 30 countries, chosen for their knowledge of the research on migrant and ethnic minority health in their country, with the aim of obtaining an overview of the situation in COST (European Cooperation in Science and Technology) countries (mainly those in the European Union and European Free Trade Association). It was the largest and most representative scientific network in this domain.

2 The ERASMUS+ TIME project involved experts in intercultural mediation from seven European Union countries. They developed the most comprehensive training programme for intercultural mediators to date.

3 A group of experts on equity in health care. The Task Force developed the *Standards for Equity in Health Care for Migrants and other Vulnerable Groups* (3), which have been used in 16 countries.

- the conditions that determine the effectiveness of intercultural mediation in health care; and
- were published in Dutch, English, French, German, Russian or Spanish.

Studies were excluded if they:

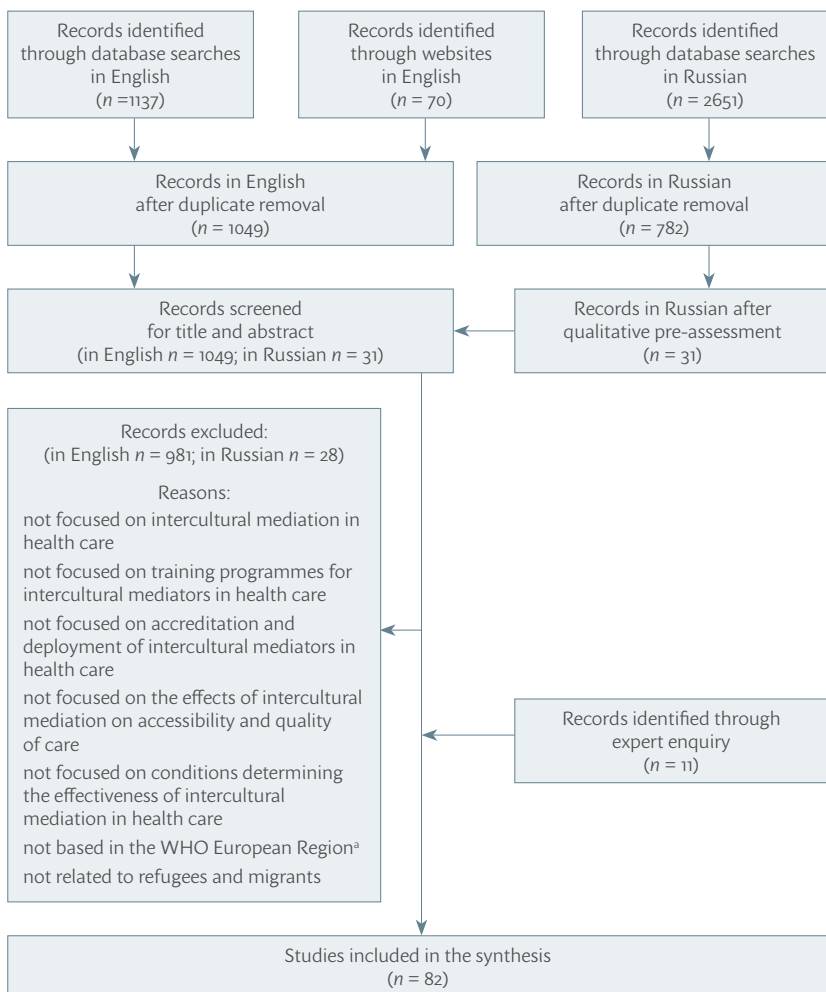
- did not contain the search terms “intercultural mediator” or “cultural mediator” (or their equivalents in Dutch, French, German, Russian or Spanish) in the title or the abstract (for documents without an abstract, the whole text was scanned for the presence of relevant information on intercultural mediators in health care); or
- did not concern refugees and migrants.

The literature searches identified 3858 records in the peer-reviewed and grey literature (1137 from database searches in English, 2651 from database searches in Russian and 70 from website searches in English). For searches in English, after removal of duplicates 1049 titles and abstracts were screened (if no abstract was available, then the introduction and conclusions were read) and 68 records were selected. For searches in Russian, manual qualitative pre-assessment after removal of duplicates identified 31 potentially relevant documents; of these three were included in the synthesis. A further 11 documents were identified from the expert enquiry. Despite the fact that they were published outside the WHO European Region, these were included in the final analysis for their relevance as key documents providing a comprehensive overview of the roles of intercultural mediators. In total, 82 documents were selected for inclusion in the synthesis (Fig. A1.1).

Search terms

The following search terms were used for searches in English in Cochrane Library, Embase, Pubmed and the WHO Regional Office for Europe website: “cultural mediator”, “intercultural mediator”, “cultural mediation” and “intercultural mediation”. For the searches in Google Scholar, Scopus and the websites of the Council of Europe and the International Organization for Migration these search terms were combined with “health care”. An additional search was conducted in Google Scholar to identify documents providing information on the training, accreditation and deployment of intercultural mediators in health care using the search terms “intercultural mediator”, “cultural mediator” in combination with “training” AND “health care”; “accreditation” AND “health care”; and “deployment” AND “health care”. For the searches in Google Scholar, results were limited to documents published in Dutch, English, French, German and Spanish.

Fig. A1.1. Selection of studies



^a Apart from 11 documents retained for their overview information.

The following search terms were used for the searches in Russian in the Bielefeld Academic Search Engine, Cyberleninka, East View, eLibrary, Nauka-rastudent, Scholar.ru and the Scientific Archive of the Russian Federation:

("Межкультурная медиация" ИЛИ "Межкультурная коммуникация" ИЛИ "Межкультурное посредничество" ИЛИ "Межкультурное общение" ИЛИ "Межкультурный диалог" ИЛИ "Межкультурный подход" ИЛИ "Межкультурная компетентность" ИЛИ "Межкультурный посредник" ИЛИ "Межкультурный медиатор" ИЛИ "Культурный посредник" ИЛИ "Культурный медиатор" ИЛИ "Медицинский переводчик" ИЛИ "кросс-культурная медиация" ИЛИ "кросс-культурная коммуникация" ИЛИ "кросс-культурное посредничество" ИЛИ "кросс-культурное общение" ИЛИ "кросс-культурный диалог" ИЛИ "кросс-культурный подход" ИЛИ "кросс-культурная компетентность" ИЛИ "кросс-культурный посредник" ИЛИ "кросс-культурный медиатор" ИЛИ "кросскультурная медиация" ИЛИ "кросскультурная коммуникация" ИЛИ "кросскультурное посредничество" ИЛИ "кросскультурное общение" ИЛИ "кросскультурный диалог" ИЛИ "кросскультурный подход" ИЛИ "кросскультурная компетентность" ИЛИ "кросскультурный посредник" ИЛИ "кросскультурный медиатор");

("Здравоохранение" ИЛИ "больница" ИЛИ "заболевание" ИЛИ "посещение медицинского учреждения" ИЛИ "проблема со здоровьем" ИЛИ "доступ к здравоохранению" ИЛИ "врач" ИЛИ "пациент" ИЛИ "медицинский персонал" ИЛИ "медицинская страховка" ИЛИ "государственная больница"); ("миграция" ИЛИ "мигрант" ИЛИ "мигранты" ИЛИ "беженец" ИЛИ "беженцы" ИЛИ "трудовые мигранты" ИЛИ "языковой барьер")

The number of results for the databases and website were as follows:

Bibliographic databases:

In English:

Google Scholar [1020]

Scopus [56]

Pubmed [32]

Embase [29]

Cochrane Library [0]

In Russian:

Scientific Archive of the Russian Federation [1175]

eLibrary [667]



Cyberleninka [663]
Bielefeld Academic Search Engine [132]
Scholar.ru [12]
Nauka-rastudent [2]
East View [0]

Websites of regional and global organizations:

Council of Europe [43]
International Organization for Migration [7]
WHO Regional Office for Europe [20]

References

1. IS1103: adapting European health systems to diversity (ADAPT). In: COST: European Cooperation in Science and Technology [website]. Brussels: COST Association; 2019 (<https://www.cost.eu/actions/IS1103/#tabs|Name:overview>, accessed 18 June 2019).
2. Good practice example on Erasmus+ project results platform. In: TIME: train intercultural mediators for a multicultural Europe [website]. Mediation-Time; 2015 (<http://mediation-time.eu/>, accessed 18 June 2019).
3. International Network of Health Promoting Hospitals and Health Services. Standards for equity in health care for migrants and other vulnerable groups: self-assessment tool for pilot implementation.; Copenhagen: WHO Regional Office for Europe; 2014 (http://steso.fi/data/documents/Equity_Standards_SAT_kasikirja.pdf, accessed 18 June 2019).
4. Research project: TF MED – Task force migration, equity and diversity. Seville: Center of Community Research and Action at the University of Seville; 2019 (<https://cespyd.es/en/research/tf-med-task-force-migration-equity-diversity/>, accessed 18 June 2019).

ANNEX 2. MAIN DIFFERENCES BETWEEN INTERPRETERS AND INTERCULTURAL MEDIATORS IN HEALTH CARE

The main differences between the roles of interpreters and intercultural mediators in health care as found in the synthesis are shown in Table A2.1.

Table A2.1. The main differences in the roles of interpreters and intercultural mediators in health care

Role	Interpreter	Intercultural mediator
Resolving language barriers	Focuses on resolving language barriers through mediating spoken messages between people speaking different languages without adding, omitting or distorting meaning or editorializing (23,28,33,34,35,63,64)	Resolves language barriers through mediating spoken and written messages (i.e. may also translate) (21,23,28,32–34,38,55,56,58,93) Focuses on ensuring the comprehension/understanding of messages exchanged between care provider and patient and facilitating the care provider–patient relationship (22,23,28,32,45,46,52,53,56,93)
Resolving (socio) cultural barriers	Culture brokerage, if accepted by professional standards/organization; mostly limited to the use of cultural knowledge to interpret accurately (64,102)	Strong focus on the possible interference and management of (socio)cultural differences in health care through culture brokerage (19,21,23,26,33,34,38, 45–47,51,52,54–56,93,94) In the case of written messages, may be involved in transcreation of the message, taking into account the (cultural) characteristics of the target population to make the message understandable, acceptable and effective (32,55,62,97)



Role	Interpreter	Intercultural mediator
Setting/ types of assignment	Strong (often exclusive) focus on the encounter between the health-care provider and user No (or limited) one-to-one meetings with the health-care provider and patient (28)	Frequent one-to-one meetings with the health-care provider and patient as a strategy to resolve the interference of sociocultural differences (23,52,54,56,58,60) Provides information to groups of patients and health-care providers to resolve the interference of sociocultural differences (19,32,50,52,54,56)
Neutrality vs advocacy	Focus on impartiality, neutrality (35,94,102)	Default position is impartial/neutral but with an additional focus on inequity/inequality; explicit mission is patient empowerment and advocacy (20,22,23,56,93,94)
Improving cultural competence	No involvement in the process of improving cultural competence (of the health-care provider/organization)	Assists individual care providers and the organization to provide culturally competent care; focus on accessibility and quality of care (20,23,26,38,45,54,56,58,60,93)
Managing conflict	Not involved in the processes of conflict prevention and resolution	Often explicitly involved in conflict prevention and resolution (15,47,48,51,53)

Note: references are numbered according to the main reference list.

World Health Organization

Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00

Fax: +45 45 33 70 01

Email: eurocontact@who.int

Website: www.euro.who.int

