Implementation of intercultural mediation at the primary level in preventive healthcare in Slovenia

VPELJEVANJE MEDKULTURNE MEDIACIJE V PREVENTIVNE PROGRAME NA PRIMARNEM NIVOJU ZDRAVSTVA V SLOVENIJI

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Abstract

This paper describes the implementation of intercultural mediation in Slovene preventive healthcare. We argue that the implementation of intercultural mediation was the result of multiple activities that took place within three intertwined contexts: *the research context, the local community context and the national context*.

Regarding the research context, the qualitative research conducted in the *Together For Health* project strived to detect particular needs as expressed by the local community. Among other findings many healthcare workers emphasized linguistic and cultural barriers that arise with foreign-speaking patients and the absence of professional intercultural mediators or interpreters in healthcare institutions. An important result of the research process – especially the interviews and discussions with the Albanian-speaking community – was the identification of a locally active intercultural mediator, Vera Haliti. Once communicated to the local stakeholders, ethnographic research enabled a strong local recognition of the issue and a pilot implementation of intercultural mediation in preventive programmes organized by the Health Promotion Centre in Celje.

With respect to the local community context, the above-mentioned process could not have been possible without the intercultural mediator for the Albanian-speaking community in Celje, whose active engagement was decisive for both local stakeholders' cooperation regarding the Albanian-speaking community and the national decision-makers.

The national context is outlined by the National Institute of Public Health support for intercultural mediation implementation as part of negotiation with the Health Insurance Institute of Slovenia, which provided a first step towards systemic funding for intercultural mediation in three localities of the aforementioned project.

Keywords intercultural mediation, preventive healthcare, primary level of healthcare, ethnographic research, qualitative methodology

Kaj je znanega?

Medkulturna mediacija je mednarodno uveljavljen način premoščanja jezikovnih in kulturnih ovir tujejezičnih oseb do zdravstvenih in drugih obravnav. V Sloveniji je bilo do sedaj objavljenih nekaj raziskav o jezikovnih in kulturnih ovirah tujejezičnih pacientov ter evalvacija pilotnega vpeljevanja medkulturne mediacije na primarni ravni zdravstvenega varstva.

Kaj je novega?

Prispevek daje vpogled v proces vpeljevanja medkulturne mediacije v preventivne programe na primarnem nivoju zdravstvenega varstva v Sloveniji.

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Izvleček

Članek opisuje vpeljevanje medkulturne mediacije v preventivno zdravstveno varstvo v Sloveniji. Avtorji besedila utemeljujejo, da je ta proces rezultat mnogoterih aktivnosti, ki so se izvajale na treh ravneh: *na ravni kvalitativne raziskave, na ravni lokalne skupnosti in na nacionalni ravni*.

V projektu *Skupaj za zdravje* je bila izvedena kvalitativna raziskava z namenom preučiti potrebe lokalnega prebivalstva pri dostopu do zdravstvenega sistema. Med drugim se je izkazalo, da se veliko zdravstvenih delavcev sooča z jezikovnimi in kulturnimi ovirami pri obravnavi tujejezičnih oseb na eni, na drugi strani pa z odsotnostjo strokovnih medkulturnih mediatorjev ali tolmačev v zdravstvenih ustanovah. Pomemben rezultat raziskave – še posebno po intervjujih, opravljenih z albansko govorečo skupnostjo – je bila identifikacija v Celju delujoče in lokalno prepoznane medkulturne mediatorke Vere Haliti. Sporočanje rezultatov raziskave deležnikom v širših pilotnih timih je pokazalo pomen te teme za lokalno

skupnost, kar je spodbudilo proces vpeljevanja medkulturne mediacije v preventivne programe v Centru za krepitev zdravja Celje.
Na ravni lokalne skupnosti bi bil proces vpeljevanja medkulturne mediacije nemogoč brez medkulturne mediatorke za albansko govorečo skupnost v Celju, Vere Haliti. Njeno aktivno sodelovanje je imelo odločilno vlogo pri sodelovanju deležnikov na lokalni in nacionalni ravni.
Nacionalni inštitut za javno zdravje je na nacionalni ravni zagovarjal medkulturno mediacijo kot dobro prakso, na podlagi česar je Zavod za zdravstveno zavarovanje Slovenije naredil prve korake k sistemskemu financiranju medkulturne mediacije v preventivnih programih na primarnem nivoju zdravstvenega varstva v treh pilotnih okoljih zgoraj omenjenega projekta.
Ključne besede medkulturna mediacija, preventiva, primarni nivo zdravstvenega varstva, etnografska raziskava, kvalitativna metodologija

1 INTRODUCTION

Since 2015, the National Institute of Public Health in Slovenia (hereinafter NIJZ) and other stakeholders have been developing intercultural mediation (hereinafter IM)[1] in Slovene preventive healthcare at the primary level. The aim of this process has been to broaden access to healthcare for non-Slovene speaking communities in Slovenia.

In addition to the officially recognized Italian, Hungarian and Roma minorities, there are other ethnic groups that reside in Slovenia but do not have the status of recognized ethnic minorities (2). The most numerous of these are from the former Yugoslavia, thus many Serbs, Croats, Bosnians, Macedonians, Montenegrins and Albanians[2] live in different parts of Slovene territory (4, 5, 6). If members of those ethnic groups that speak languages similar to Slovene (e.g. Serbian, Croatian, Bosnian, Macedonian) do not encounter noticeable linguistic barriers in healthcare facilities, the same is not true for many Albanian-speaking users of the Slovene healthcare system who migrated from Kosovo, Macedonia or Albania (4, 7, 8, 9, 10) as well as for migrant communities from the Middle East, Asia and Africa.

This article describes the implementation of IM in Slovene preventive healthcare. We argue that the implementation of IM was the result of multiple activities that took place within three intertwined contexts. *The research context* refers to a qualitative ethnographic study, which strived to detect particular needs regarding access to healthcare as expressed by the local community. Among other findings many healthcare workers emphasized linguistic and cultural barriers that arise with foreign-speaking patients and the absence of professional intercultural mediators or interpreters in healthcare institutions. These communication barriers were frequently present with Albanian-speaking patients. *The local community context* refers to dynamics in an Albanian-speaking community in the Municipality of Celje, including the pivotal role of the intercultural mediator Vera Haliti. *The national context* represents the negotiation process between state institutions and non-governmental actors (including particular individuals with a migrant background).

2 (ADDRESSING) LANGUAGE AND OTHER OBSTACLES IN THE CONTEXT OF SLOVENE HEALTHCARE

Some studies have already proven the existence of language and cultural barriers to healthcare for non-Slovene speaking users in Slovenia. A nation-wide survey [3] among 564 healthcare workers on communication between healthcare workers in the Slovene healthcare system and non-Slovene speaking or limited Slovene proficiency patients showed that language diversity poses a great challenge to healthcare personnel in ensuring quality healthcare (7). The results of this survey have revealed that 94% of healthcare workers have contacts with foreign-speaking patients, and that the most challenging encounters are those with Albanian-speaking patients

[1] The term “intercultural mediator” refers to a person who is working in healthcare institutions to overcome language and culture barriers and to increase responsiveness to the needs of ethnic minority users (1).

[2] The official statistics demonstrate that the majority of foreign-born residents in Slovenia are from the territory of former Yugoslavia: for example, at the end of 2017 there were 150,787 inhabitants with residence permits (both temporary and permanent) in Slovenia, of which 124,432 were citizens of what are called third countries (among them 66,705 citizens of Bosnia and Herzegovina, 17,987 of Kosovo, 15,193 of Serbia and 12,926 of Macedonia) and 26,355 were citizens of the European Economic Area (among them 11,387 citizens of Croatia, 4,670 of Bulgaria and 3,094 of Italy). (3)

[3] This online survey was issued in the autumn of 2016 and was designed to explore how often healthcare providers encounter patients who do not understand Slovene, which languages pose the greatest challanges in communication with non-Slovene speaking patients and what strategies are used to overcome communication problems. The survey was a part of the project "Designing a Multilingual Aid for Better Communication of Migrants with Healthcare Personnel" /2016-2018) that was coordinated by the Faculty of Arts (Department of Ethnology and Cultural Anthropology and Department of Translation) with the collaboration of the Faculty of Medicine and the Faculty of Health Sciences at the University of Ljubljana, the National Institute of Public Health and the Medical Chamber of Slovenia.

as well as with patients who speak Arabic, Chinese, Russian, Roma, Bulgarian and other languages (ibid).

The survey also showed that besides language obstacles, encounters in healthcare may result in various cultural misunderstandings and administrative or other barriers for non-Slovene speaking users. Other previous research in Slovenia revealed that Albanian-speaking users experience communication difficulties within the healthcare system, resulting in lower quality healthcare services and unequal treatment (2, 4). In resolving language and other barriers, users and healthcare workers are left to their own inventiveness since no systematic solutions exist.

The problem of unaddressed language barriers in access to healthcare was also exposed in the Country Report for Slovenia: "Even though the Patient Rights Act (ZpacP) includes the patient's right to understand the procedure, to be informed and not to be discriminated against, in practice there is a great lack of systematic solutions (national or regional policy) regarding the availability of interpretation services." (11).

In the NIJZ project *Together For Health*[4], qualitative ethnographic research was conducted in 8 Slovene cities. Although it showed some findings that are similar to the above-mentioned, we will expand on it since it is itself a part of the process of implementation of IM in Slovene preventive healthcare. The research included in-depth interviews with 121 individuals (healthcare workers, employees of public health institutions as well as different professionals from the non-governmental sector and users of healthcare services). It aimed to address barriers in access to healthcare services for different vulnerable populations and detect existing practices aimed at surmounting these barriers (2). In the municipality of Celje the research revealed numerous barriers that the Albanian-speaking population, especially women, faces when accessing health and other public services.[5]

Before presenting the main research findings it is important to stress two aspects related to Albanian-speaking communities in Slovenia. First, it is important to understand that we cannot speak about the numerousness of the Albanian speaking community in Slovenia in general, since this data cannot be gathered based on official residence permit or citizenship statistics. Members of the Albanian speaking community are either citizens of Slovenia and/or persons born in Slovenia, either individuals who immigrated to Slovenia from different states (Kosovo, Macedonia, Albania etc.) in the period of ex-Yugoslavia or later. In both cases the Slovene authorities do not gather data on national/ethnic affiliation. Second, connected with this is the question of access to healthcare, more precisely access to the national health insurance scheme. Most Slovene citizens and migrants living in Slovenia acquire their health insurance based on employment, that is, either as employees and their dependent family members or as retirees. At the same time the local communities provide financial resources for socially disadvantaged individuals, but only if they are citizens or persons with permanent residence permits. In addition, persons with refugee status have the right to compulsory health insurance, while other non-citizens have conditional or limited access to healthcare. Since the Albanian-speaking communities have a long and heterogeneous history in the territory of Slovenia their members are found in various legal statuses (citizens, permanent residents, temporary residents as labour migrants or family members, asylum seekers, refugees) and thus have differentiated access to health insurance.

The results of research confirmed that the most common obstacles for Albanian-speaking women are language, cultural and administrative barriers. This results in a range of different consequences, commonly being:

- users avoiding visits to healthcare institutions;
- healthcare professionals avoiding receiving users from the Albanian-speaking community;
- health problems and complications arising from lack of understanding;
- healthcare professionals not being able to perform their work on such levels of quality as they would otherwise. (12)

The main barrier being language, anthropologists at the pilot site identified the existing practices whereby the Albanian-speaking community in Celje alleviated or at least in part tried to establish communication.[6]

[4] The *Together For Health* (pilot) project (2013–2016) focused on developing new approaches in preventive healthcare, improving the availability of preventive care for all population groups, capacity building and intersectional cooperation with special emphasis on approaches for reducing inequalities in health. It was a pilot project where first upgraded Health Promotion Centres (hereinafter HPCs) were established, including the HPC in Celje which will receive more attention in the article. The project is being upscaled to 25 HPCs within the project *Upgrade and Development of Preventive Programmes and their Implementation in Primary Health Care and Local Communities*, in short: *Health Promotion for All* (2017–2020). Qualitative research and intercultural mediation were integrated into both projects.

[5] The research was done by cultural anthropologists and included 6 unstructured interviews (four with healthcare professionals and two with unofficial translators/intercultural mediators) who frequently work with the target population.

[6] As mentioned above, in addressing language barriers patients and healthcare professionals were mostly left to their own inventiveness. In their attempts to address communication obstacles healthcare professionals rely on ad hoc interpreters (untrained persons who are called upon to interpret, such as children and other family members or self-declared bilingual members of the Albanian-speaking

3 ADDRESSING VULNERABILITY OF MIGRANTS AT THE PRIMARY LEVEL OF HEALTHCARE AND WITHIN LOCAL COMMUNITIES

At the primary level of healthcare in Slovenia, upgraded Health promotion centres (HPCs) were established in 2002 and have been upgraded to provide integrated lifestyle interventions against key risk factors for non-communicable diseases. A special focus of HPCs is on vulnerable populations[7] to assure equity in delivery of preventive healthcare services for all. NIJZ supports the implementation of HPCs at the national level (13). Since NIJZ has collaborated with health institutions at the primary level, most of the activities for reducing health inequalities were embedded at this level.

In the *Together For Health* project, processes of upgrading preventive programmes in HPCs were accompanied by strengthening HPCs' dialogue and cooperation with other local stakeholders (Municipalities, Social Work Centres, Health Insurance Institute of Slovenia [8] regional branches, regional employment offices, NGOs in the field of homelessness and mental health, other humanitarian organisations etc.) which were identified as relevant for improving health in local communities. Local stakeholders' meetings were organised in all three pilot sites. Researchers conducting qualitative ethnographic research were present in local stakeholders' meetings in the municipality of Celje. They presented the research findings with a special emphasis on language and cultural barriers in healthcare which Albanian-speaking women in Celje face. We claim that the presentations of qualitative research findings represent a step in the relationship-building effort among local stakeholders, since it documented and analysed local issues which had been noted by stakeholders but had never been so openly discussed before.

In the local stakeholders' meetings, qualitative researchers proposed IM as a viable service to address the above-stated issues. After the presentation, several stakeholders (Community Healthcare Centre, Social Work Centre, Municipality etc.) expressed interest in the topic and confirmed the analysed need to overcome the communication problems (however it may commonly occur, no major opposition was expressed). It seems that the discussion about viable possibilities to overcome language barriers to healthcare united the stakeholders in their interest in overcoming the issue. Additionally, researchers presented a good practice of social inclusion of the Albanian-speaking community (through the Folk High School programme of Slovene as a second language). This was followed by proposals of different stakeholders for joint actions in order to increase access to various public (healthcare, social etc.) services through the introduction of an intercultural mediator. Vera Haliti, intercultural mediator for the Albanian-speaking community, took part in the local stakeholders' meetings as well. She was found to have been a reference individual in overcoming language and cultural barriers in a local community in the municipality of Celje. In the meeting, she presented her work in the community.

To address some of the above-stated barriers to healthcare, an interdisciplinary team of experts decided to pilot the implementation of IM for Albanian-speaking women in a healthcare setting. Implementation was carried out between September and December 2015 at the Health promotion centre in the Celje Community Health Centre and in the family medicine Health Station at Vojnik (also a part of the Celje Community Health Centre). The key role was played by Vera Haliti.

As one can observe, healthcare was an entry point for an appropriate response to challenges posed by language and cultural barriers – firstly inside healthcare services (IM was implemented in existing healthcare preventive programmes) as well as in the local community (with the existing healthcare preventive programmes entering other stakeholders' programmes).

The story of Vera Haliti, intercultural mediator

Mrs Vera Haliti is a native Albanian-speaking person who has been certified for the work of court interpreter and who has been working for more than ten years as an intercultural mediator for various Slovene institutions (including Celje Health Centre, Polytechnic University of Celje, Asylum Centre in Ljubljana) (14). She describes her first years in the role of an intercultural mediator with the following words:

> *I began working as an intercultural mediator before this term was even known in Slovenia. In the beginning I reacted intuitively, I just responded to people's needs: Albanian-*

community as well as bilingual staff members who volunteer to interpret) or on non-verbal methods of communication (for example they write and draw). In order to be able to do examinations, healthcare professionals also adjust their schedules to meet users when someone who can interpret is present. (12)

[7] Participants in the qualitative research found the following categories as vulnerable: migrants, homeless, elderly people, users of illegal drugs, unemployed, people with mental health issues, the Roma, self-employed, precarious workers, people with various disabilities (2). It is important to note that these categories are always fluid and intertwined. It is therefore preferable to focus on concrete obstacles in access to healthcare since these can be common for different categories.

[8] The HIIS is a public institute that provides compulsory health insurance. Its principal task is to provide effective collection and distribution of public funds in order to ensure the insured individuals' rights arising from the said funds.

> *speaking people perceived me as somebody who is willing to solve the problem and with whom they can collaborate. From the beginning I had an insight into a lot of problematic situations, a lot of complex problems. Many other court interpreters did not want to deal with social and health issues to such an extent. These issues seemed too complex for them; therefore, they preferred to interpret at courts. However, I was always too emphatic to let these people down and leave them to themselves. (15)*

Today Vera Haliti is active in various training programs for Albanian-speaking women in Slovenia and in the training for healthcare workers in the field of cultural competences (a programme provided by NIJZ). She is a prominent and respected figure in the Albanian-speaking community in Celje, who also has a remarkable media presence and has often spoken about IM, emphasizing the need to overcome linguistic and cultural problems encountered by the members of migrant communities. As she emphasizes, her appearance at different seminars and other public events are crucial since they enable her to reach professionals of different backgrounds (social, health and education sectors) in order to make them sensitive to the issues of language and cultural barriers. Therefore, Mrs. Haliti can be understood as an important "champion" in the field of IM in Slovenia. Currently she collaborates with NIJZ to provide mentorship and training to new IMs.

4 ANCHORING OF IM VIA NEGOTIATION WITH STATE ACTORS

Despite a limited period and a small number of participants, the results of the evaluation[9] carried out during the pilot implementation show that Albanian-speaking women perceived the presence of the intercultural mediator as extremely important and expressed satisfaction with the mediator's work (4). Moreover, the pilot implementation of IM confirmed that health professionals obtained more reliable data and that patients were able to better understand health professionals as well as express themselves more easily and directly (ibid).

Based on this evidence, the Ministry of Health and NIJZ supported the implementation of IM and presented arguments to the Health Insurance Institute of Slovenia. The HIIS was a key player in providing the first step towards systemic funding of IM in the three pilot HPCs. By the end of the project *Together for Health*, the Health Insurance Institute of Slovenia decided to systemically finance the programme of three new upgraded Health Promotion Centres through a so-called "general agreement" scheme which regulates the HIIS's financing of Community Health Centres (in which HPC are embedded). In practice this means that the costs of intercultural mediation in the three HPCs can now be covered from finances for material costs. Since intercultural mediation is not yet a separate service for which systemic funding is assured, we call the above-described funding mechanism "the first step" for systemic funding of IM.

Coming back to the negotiation process, the Ministry of Health gave support to the project, but NIJZ provided the main arguments for the implementation of IM. Several reasons which contributed to the first step towards systemic funding can be highlighted.

First, the ethnographic research and evaluation of IM provided data that enabled NIJZ and the Ministry of Health to present a strong case for the first step towards systemic implementation and funding of IM after the conclusion of the project *Together For Health*. Second, NIJZ published *Standards for equity in health care for migrants and other vulnerable groups – Self-assessment tool* [10] for pilot implementation, which included as an appendix the "Declaration of the importance of implementation of intercultural mediation in Slovene health institutions". The Declaration was written by the interdisciplinary team of experts led by NIJZ and was signed by several important Slovene NGOs in the field of migration and health, and stated that: 1) IM reduces inequalities in healthcare delivery; 2) it increases the quality of healthcare services; 3) it increases patient participation in healthcare programmes; 4) it reduces the costs of healthcare delivery (16). The third decisive factor was a charismatic presentation made by Vera Haliti at the national stakeholders' meetings (17) in which she presented her experiences in delivering the IM service to the Albanian-speaking population in the municipality of Celje.

Although IM in HPC Celje addressed the language and cultural barriers of only the Albanian-speaking community, the current research in 25 HPCs suggests

[9] The focus of the evaluation was on the needed adjustments of preventive healthcare workshops and examinations and on the dynamics in the work process between the intercultural mediator, healthcare professionals and users of services (4).

[10] The Standards and Self-Assessment Tool were originally developed and published by The *Task Force on Migrant-Friendly and Culturally Competent Health Care, The International Network of Health Promoting Hospitals and Health Services*. As the project *Together for Health* introduced several activities in addressing vulnerabilities and inequalities in health, the document was recognized as potentially useful to evaluate access to healthcare services at collaborating Community Health Centres. It was therefore translated into Slovene with the addition of the Declaration, which was prepared by NIJZ with the purpose of calling attention to the importance of implementation of IM. As such it represents a first document of its kind.

that there are similar needs across Slovenia. The need of IM is thus not restricted to the Albanian-speaking community, but to migrants/refugees with diverse ethnic/language backgrounds in all regions. Recently, IM went through its initial implementation phase in several other HPCs in Slovenia. In some communities, where the needs for IM services are expressed by various stakeholders, considerable efforts are being made to organise stakeholders' meetings (from healthcare, social care, non-governmental and other sectors) within which needs as well as viable options to properly respond to them are discussed.

Currently, NIJZ organizes regular meetings for intercultural mediators. At these meetings, at least two different groups of intercultural mediators are present. First one refers to mediators working in the *Health Promotion for All* project. The second group includes other (mainly informal) mediators who are not a part of the current NIJZ project but consider these meetings useful for their everyday practice. The meetings are designed both to deliver various professional topics to support mediators in their work (training includes interpreting skills, anthropological reflection on culture and health etc.) and to offer a context of mutual support and sharing experience for intercultural mediators. Until now there has not been any opportunity to develop a formal training module for intercultural mediators. However, as the project is in its implementation phase, much effort is still being invested in maintaining research and support activities in the field with intercultural mediators and HPCs, planning advocacy activities (such as organizing formal mediator training, ensuring legal background and funding) for the future.

4 CONCLUSION

Important lessons can be learned by observing the process of implementation of IM in preventive healthcare in Slovenia. On the one hand, qualitative research was crucial for detecting local needs in accessing healthcare for the population with a migrant background as well as identifying existing practices which addressed those needs. It is important to note that prior to qualitative research, local stakeholders had no opportunity to express their experiences and needs regarding the Albanian-speaking community and their restricted access to healthcare. It was also important that research results were continuously communicated to local stakeholders since this gave voice to the vulnerable population. In this way qualitative research was an action-oriented empowering practice, as it helped to voice some already identified barriers and negotiate possible solutions to at least some of the problems the Albanian-speaking community faces when interacting with the Slovene healthcare system. On the other hand, from the political standpoint, the role of the intercultural mediator for the Albanian-speaking community in Celje, Vera Haliti, was crucial to successful implementation of IM. Her active engagement was decisive for both local stakeholders' cooperation when addressing the needs of the Albanian-speaking community and for the national decision-makers who ultimately provided a first step towards systemic support. In relation to the support of IM implementation, NIJZ's role must be underlined, since it was a central institution which coordinated various activities related to the establishment of IM. In addition, NIJZ was a key advocate of IM during the negotiation process with the Health Insurance Institute of Slovenia, which provided the first step towards systemic funding after the conclusion of the pilot project. The combination of meaningful qualitative data, the professionalism and charisma of Vera Haliti, the "first" intercultural mediator, and legitimacy of the NIJZ which coordinated the project, made the negotiation process at the national level with HIIS uncomplicated. Institutional anchoring indeed was crucial here as it enables sustainability and further development of IM. The process is now being upscaled in the project *Health Promotion for All*, in which more intercultural mediators for different migrant populations are being contracted within HPCs around Slovenia. However, there is still a long process before IM is systemically implemented and funded.

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