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Communication and cultural interaction in health promotion strategies to migrant populations in Italy: the cross-cultural phone counselling experience

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Abstract

Introduction. In the last 10 years migration processes have progressively increased worldwide and in Italy about 5 millions of residing migrants are estimated.
To meet health needs of these new residents, effective relational and communication tools, which allow a reciprocal intercultural interaction within health care structures, are therefore necessary.

Aim. This article faces the main features of the relational-communication processes associated with health promotion and care in the migrant population in Italy to the aim of identifying the key and critical points within the interaction between different cultures, focusing on the role of specific professional figures, including cultural mediators and health educators.

Results. Within the activity of HIV phone counselling operated by Psyco-socio-behavioural, Communication and Training Operating Unit of National Institute of Health in Italy, an intercultural approach was successfully experienced in a project targeted to migrants (2007-2008). Specifically, the presence of cultural mediators answering in the languages of main migrants' groups allowed the increase of calls from migrant people and of the information provided.

Key words
- intercultural communication
- immigration
- health
- phone counselling

INTRODUCTION

In the last 10 years migration processes have progressively increased involving heterogeneous populations from several world areas and different migration routes. Over 1 billion migrants are estimated today throughout the world, 214 million of whom from international areas. Migration flows comprise a wide range of populations, such as workers, refugees, students, undocumented migrants and others, with different health determinants, needs and levels of vulnerability [1]. In whole Europe over 33.3 millions of migrants are estimated [2], and in this process Italy is the fifth County with a number of almost 5 millions [2].

In the last years this process of migration has progressively undergone different features and entered deeply inside the Italian society [2-4], thus requiring new social politics and health organization to fit the needs of people from different culture and background [4].

To this aim, it is necessary to explore and set up new communication-relational procedures which, enabling the reciprocal understanding between health operators and migrant people, better answer to health needs of these "new citizens" [5]. Social and anthropological research, including health topics, have suggested to focus on multicultural relational models which allow to build an intercultural approach, a dynamic process in which different cultures actively interact on the territory. The leitmotif of the present document is the individuation of an intercultural approach as the basis to adequately face:

- the constitutive elements of the interaction between health operator and foreign person in order to ease health promotion and care;
- the criticism within the communication process and the tools required for an effective professional relationship;

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- the definition of the processes of mediation between different languages and cultures which enable an effective relationship with people who need health protection.

These considerations led researchers of research psico-socio-behavioural, communication, training unit of the National Institute of Health in Italy to experience an intercultural phone counselling intervention within the institutional activity of primary and secondary prevention regarding HIV/AIDS/STIs.

INTERCULTURAL COMMUNICATION

Intercultural communication becomes necessary in a territory in which people from different cultures face a reciprocal relationship. In this scenario language barriers but also other individual dynamic variables play a role in the determination of the modalities of interaction with resident foreigner persons. To this aim, health operators require adequate tools and competences for an effective interaction beyond language and cultural distances. The relationship with a different "Other" may in fact result difficult for the own static ethno-centric vision that needs to evolve in the dynamic "know to understand". Indeed, the anthropologic concept of ethnic identity may be dynamically permeated by properly applied communication processes.

Intercultural communication is a recent branch of communication disciplines, developed in the second half of 20th century as a tool to enable relationship of industrialized countries with developing ones on the basis of a reciprocal cultural knowledge.

In a first phase, defined as first level, intercultural communication aims to an instrumental analysis of the communication difficulties between person from different cultures. In a second phase, defined as second level, it faces deeper elements, focusing on interactive dialogic processes and on the reciprocal adaptive changes.

Thus, any communication between person and health operator bears its own specificity within communication processes [7] and requires the improvement of communicative and relational competence for an effective transmission of messages related to health prevention and care to achieve an excellent quality in the processes of diagnosis and follow up [8]. The gathering of health-related subcultures, which reside within any basic culture, is essential to the communication process in a field where logistic and communicative gaps may be critical for the health needs of the person. In particular, beyond cultural distances, the peculiar characteristics of the diseases, including diagnostic approaches and treatment options, the health structures organization and health operators competence markedly affect the outcome of these reciprocal interactions.

In this dynamic process a complementary re-modulation of roles, functions and identities, through both verbal and non-verbal communication, could allow the health operator to penetrate into the personal and cultural dimension of the person demanding for health assistance [9].

The communication circularity of the professional relationship between health operator and the person-migrant can be so outlined (*Figure 1*) the emitter sends the message to the receiver; the message is referred in a context in which it has its unique specific meaning and it can be verbalized or non-verbalized to be effectively receipted. In this model the two parts are involved in the relationship through dynamic changes of communication competences within their own identity and culture boundaries. The communication productions by both induce reciprocal bi-directional influences which actively interact in a dynamic equilibrium subjected to continuous transformations [8]. Thus, intercultural communication is an interactive fluid in which cultural competences of both the native and foreigner persons actively play [6].

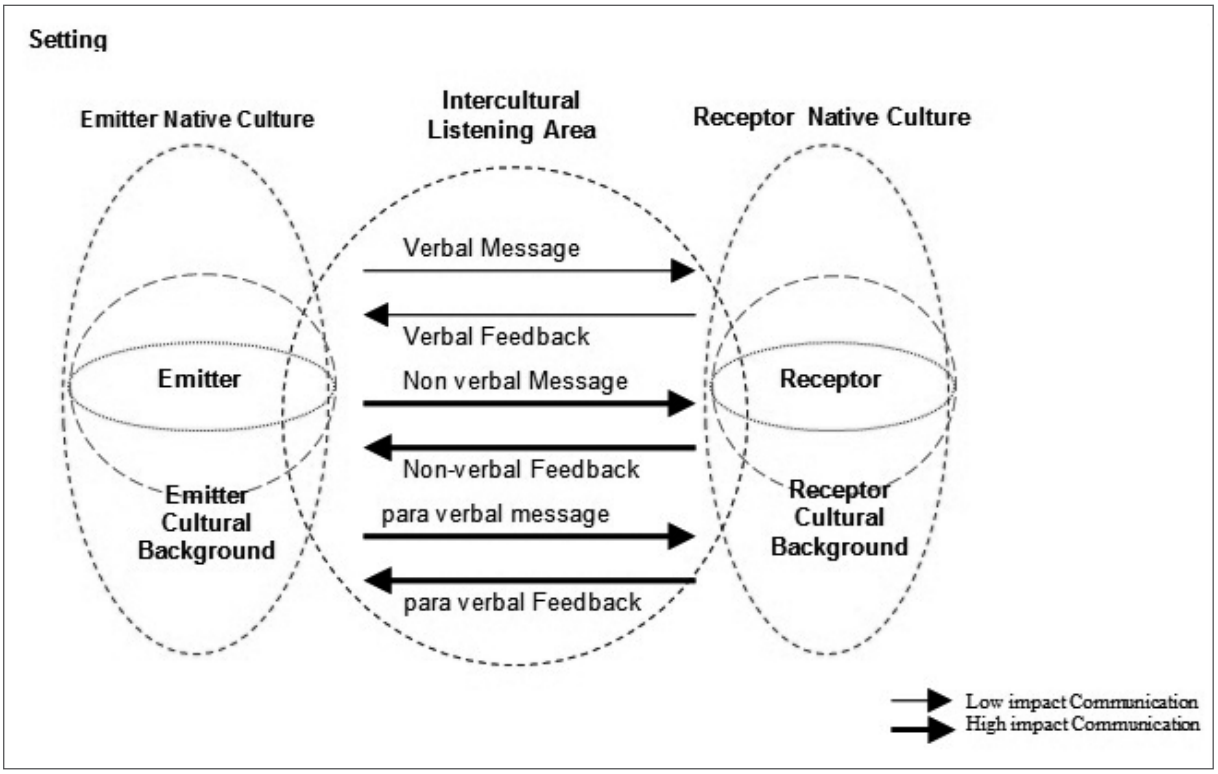
Verbal and non-verbal communication codes are deeply affected by own and contacted cultures. This may determine prejudices and discrimination behaviors, including ethnocentrism, by which the other is evaluated and managed based on own reference codes and self-judgment [10].

THE ROLE OF LINGUISTIC AND CULTURAL MEDIATION IN HEALTH COMMUNICATION

The increasing interaction with persons from different world areas and cultural background requires a deeper consideration of the role of linguistic and cultural mediation in the communication within health care context. In the period following the II World War, the concept of cultural mediation has progressively spread in Europe and North America for strategic diplomatic interventions also related to migration events. In Italy the need of cultural mediation arose in the '90s, due to the growth and differentiation of migrant people in the territory.

Communication in health care is complicated by the different meanings and views within different cultures, where they dynamically undergo changes in relation to the "new environment". This determines the complex action of the cultural mediator which should support the action of health operator by the information and translation of the different views and concepts which reside in the relative cultural background. In some European Countries, as the United Kingdom, the professional figure of "community health educator", generally identified within people from different cultures, helps the cultural mediator by the promotion of health topics into marginal social realities including second and third-generation migrants [11]. This approach could allow, also in Italy, the setting of effective health care interventions targeted to migrants of different ethnic and cultural communities. The exploiting of persons from migrant communities in healthcare mediation and education can usefully help their acknowledgement and access to the health programs. However, individual differences should be adequately minded to avoid a reductionist view [11]. The creation of a network involving cultural mediators, health educators and operators (environment mediation) could therefore provide adequate resources to the health needs of foreigner and migrant persons by the identification and valorization of the specific intervention tools for any different cultural reality [12].

Figure 1
Intercultural relationship area in the communication process.
The diagram shows the communication flows in intercultural communication processes, adequately set for interactions with migrants. In particular, is underlined the cross-cultural interaction area where the message from the emitter, in all specific facets (verbal, non-verbal, para-verbal), can be adequately received by the receptor, thus creating an effective relationship. In this cross-cultural area, an active dynamical exchange occurs allowing the successful delivery of the informative message regarding health topics



THE ACCESS OF MIGRANTS TO PHONE COUNSELLING SERVICE ON HIV/AIDS/STIs BY THE NATIONAL INSTITUTE OF HEALTH IN ITALY/ ITALIAN MINISTRY OF HEALTH

The Italian phone counselling service on HIV/AIDS and sexually transmitted infections (TV AIDS/STIs) instituted in 1987 by the AIDS National Committee, is an anonymous and free service, which has been providing for almost twenty-five years phone counselling intervention, aimed to give scientifically corrected information on HIV and STIs.

Between November 1995 and December 2011 the TVA-IST recorded 3707 accesses from migrant persons. The geographic provenience of migrant persons was prevalently Africa (27.6%), followed by America (24.7%), non-EU Europe (22.9%), EU Europe (15.5%), Asia (8.7%) and Oceania (0.1%). The calls came mainly from Northern Italian Regions (49.3%) and Central Italian Regions (40.3%), followed by Southern Regions (7.9%) and Islands (1.6%).

Migrants who accessed the Service were prevalently males (63.6%) and mostly in the age range of 20-39 years (2983 out of 3707 callers). The distribution of calls for year (1995-2011), shown in *Figure 2*, evidences a significant increase in 2007 and 2008, years in which an intercultural counselling service was activated at TVA-IST through the involvement of cultural-linguistic mediators within the project "Trans-cultural phone counselling. Intervention for the prevention of HIV infection in non-Italian population living in Italy" funded by the Italian Ministry of Health. The overall aim of the project was to provide scientific, updated and customized information not only in Italian language but also in seven other languages (English, French, Spanish, Chinese, Arabic, Russian and Romanian) selected from those spoken by the ethnic groups living on Italian territory and formerly used in the 8th informative educational campaign sponsored by the Ministry of Health. This project has been performed through the full partnership of researchers of the TVA-IST cultural-linguistic professionals as well as other consultants responsible for issues concerning both HIV/AIDS and communication in cross-cultural context.

As detailed in a previously published report, the methodology of this specific project was developed through three main stages [13]:
- recruiting and training on counselling process methodology;
- creation and organization of Phone Cross-cultural Helpline about HIV/AIDS, training on data entry system, training about helplines worldwide;
- dissemination of results, project evaluation and identifying of indicators to develop a cross-cultural model of phone counselling.

The cultural mediators were recruited based on the prevalent ethnic and cultural minorities residing in Italy.

In particular, according to the Statistical Dossier on Migrants 2007 [14] and specific individuation by experts within Italian Ministry of Health and Italian National Focal Point "Infectious Diseases and Migrants", seven languages, mainly used by migrants living in Italy and come from Eastern Europe, Northern and West Africa, South America and Asia, were selected: Romanian, Russian, English, Spanish, French, Arab and Chinese. Thus, operators with adequate background of health topics within these specific cultures/languages were selected as potential mediators of messages and counselling processes targeted to migrants. These operators underwent a specific training activity on communication and counselling approach related to health topics including infectious diseases and HIV/AIDS held at National Institute of Health in Italy by personnel of *Telefono Verde AIDS (TVA-IST)* Unit. This training included a 5 days course about information on HIV/AIDS (epidemiology, transmission ways, testing and care approaches), approaches to health in different world cultures, and specific methodologies of phone counselling. These operators underwent a training-on the job period of 30 days under the supervision of professional operators of TVA-IST Unit. Trained operators started their phone counselling activity with this weekly schedule: English and French on Mondays, Romanian on Tuesdays, Spanish on Wednesdays, Arab and Chinese on Thursdays and Russian on Fridays for a period of about two years (2007-8).

The counselling intervention applied with migrants follows the scheme below:

- to greet;
- to listen actively;
- to focus on the real problem;
- to point out conjunctly a goal;
- to propose and share possible solutions/decisions;
- to summarize;
- to verify the comprehension of the messages;
- to conclude (to say adequately goodbye).

Within the calls, essential data as the country of origin, the age, the gender, the Italian province of residence, risky behaviors and the questions and topics raised were recorded in a specific data entry system specifically built up for phone counselling interventions by TVA-IST.

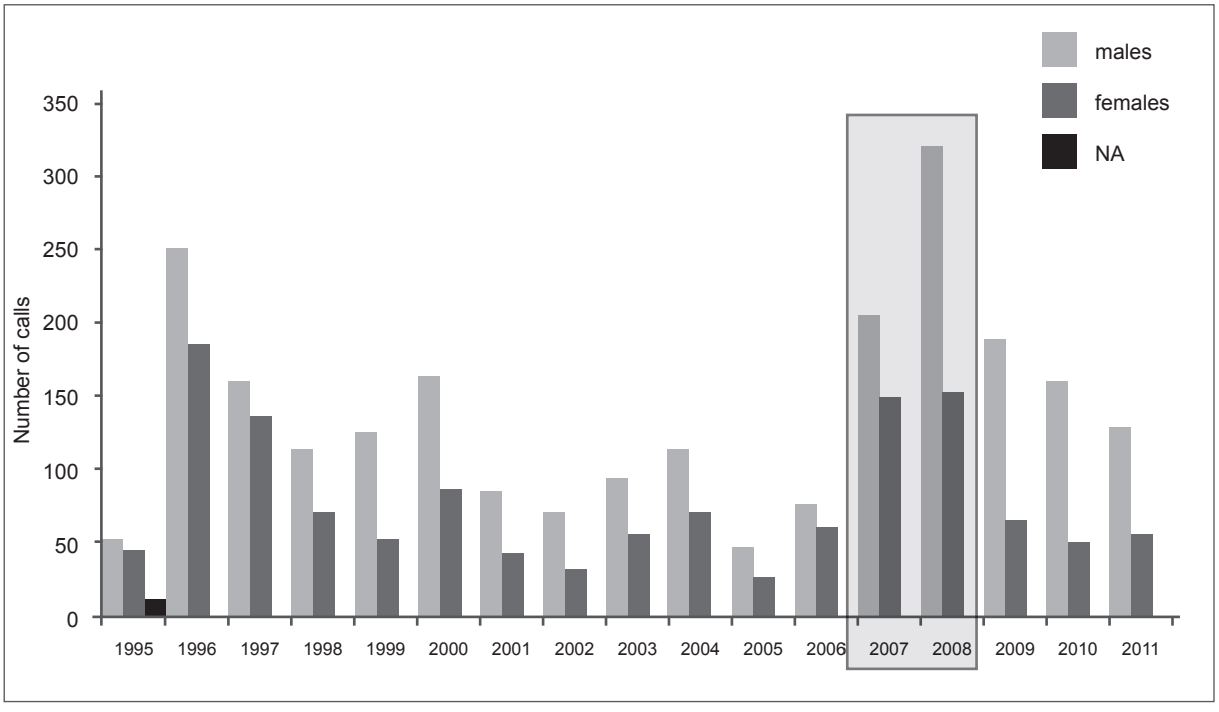
Specifically, in this two years project 828 calls were received from migrants coming from Europe (29.0%), Africa (24.0%), non Europe (21.7%), America (15.0%) and Asia (10.3%) and the main languages used were Arab (23.5%) and Romanian (23.2%). Calls from men were prevalent (63.5%), particularly by users speaking in Arab (88.7%) while women were prevalent only within French- and Russian-speaking users. The main question topics by Migrant users were regard to HIV testing (30.2%) and HIV transmission (29.7%), and 17.3% did not report risky behaviors for HIV infection [13].

In this context, the use of an intercultural approach, based on a professional équipe including both TVA-IST researchers and adequately trained cultural and linguistic mediators, facilitated the interaction with migrants, allowing an easily understandable and effective counselling intervention. Of note, in the years following the end of the project, a lower number

Figure 2

Distribution for year of calls from migrants persons.

Calls from migrants at TVA-IST in the period 1995-2011 have been stratified for single years, separately for males and females. The two years period in which the contribution of cultural mediators was experienced is evidenced with gray shadow



of calls from migrant people was recorded (*Figure 2*). Thus, the presence of cultural and linguistic mediators may significantly favor the access of migrants persons to the Helpline Service. This also suggests that public health communication approaches should focus on the information needs within the cultural background of targeted migrants.

CONCLUSIONS

The health operator should focus his professional interaction on the individual person by an active listening and understanding of the health needs related and expressed by verbal and non-verbal tools. In the intercultural context an effective integration involving the migrant person, health operator, cultural mediator and community health educator can overcome the difficulties associated with cultural differences, as prejudices and ethnocentric views, allowing health promotion and care actions based on reciprocal interaction and exchanges. This process means, according to Bennet's view [15], neither a culture prevarication nor a simple compromise but rather a positive use of cultural differences for a common benefit. Moreover, the right intercultural approach can favor the motivations of the foreigner or migrant person where a treatment is prescribed or further follow up is required.

In Italy this intercultural approach, involving both culture mediators and educators, can be exploited in the managing of public health strategies targeted to migrant communities. The creation of this model of network can also determine, in health operators, educators and mediators, the growth of professional competence and the awareness of the health needs related to people of different cultural backgrounds. This can enrich the potential effectiveness of health structures and operators, optimizing economical and managerial resources for health promotion and care of the community, including migrants and other marginal social realities in the territory.

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Conflict of interest statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

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