

Intercultural Mediation in MSF



GU MSF GUIDELINES

INTERCULTURAL MEDIATION IN MSF

MEDICAL DEPT - OCB / 10.2024

Intercultural Mediation in MSF

" A set of activities aimed at reducing the negative consequences of language barriers, sociocultural differences, and tensions between ethnic groups in healthcare settings "

Verrept H., FPS Public Health, Belgium





Intercultural Mediation in MSF

- *The intercultural mediator (ICM) acts as an **intermediary** between two parties who initially could not communicate*
- *Mediation aims to reduce the **negative consequences** of language barriers and sociocultural differences*
- *It fosters communication, **trust** and mutual understanding between patients and healthcare providers*
- *ICMs are essential for **person-centred**, high-quality care, in line with Equity, Diversity and Inclusion (EDI) principles*



Intercultural Mediation

Intercultural mediation carried out since the early 1990s are mainly referred to three general principles:

- ***Equal opportunities***

Mediation contributes to achieving equal opportunities for the migrant population in access to services.

- ***Active participation***

By offering space for listening, attention to communication, mediation promotes the active participation of the subjects involved.

- ***Intercultural***

Mediation adopts the intercultural perspective as a privileged way for the knowledge and mutual valorization of cultural models, values, traditions, social systems and to remove prejudices, stereotypes and discrimination between people.

Intercultural Mediators need pay attention to some fundamental aspects

The founding values of the reference culture: family, social relations, hierarchy, status, conception of time, health perception, mental health perception, etc..;

Non-verbal communication: some cultures reserve greater importance for certain gestures than others;

Verbal communication: the choice of words, the logical construction of sentences, etc .;

Paraverbal communication: tone of voice, timbre, rhythm, pauses, etc.



Intercultural mediation







Building on Castiglioni's (1997) three levels, the literature commonly identifies three components of intercultural mediation::

- ***Practical – directive component***

  >> to orientate, to inform

- ***Linguistic - communicative component***

  >> Facilitating communication and clarifying meanings between patients and health staff

- ***Psycho-social component***

  >>to improve the service provided to individuals receiving care



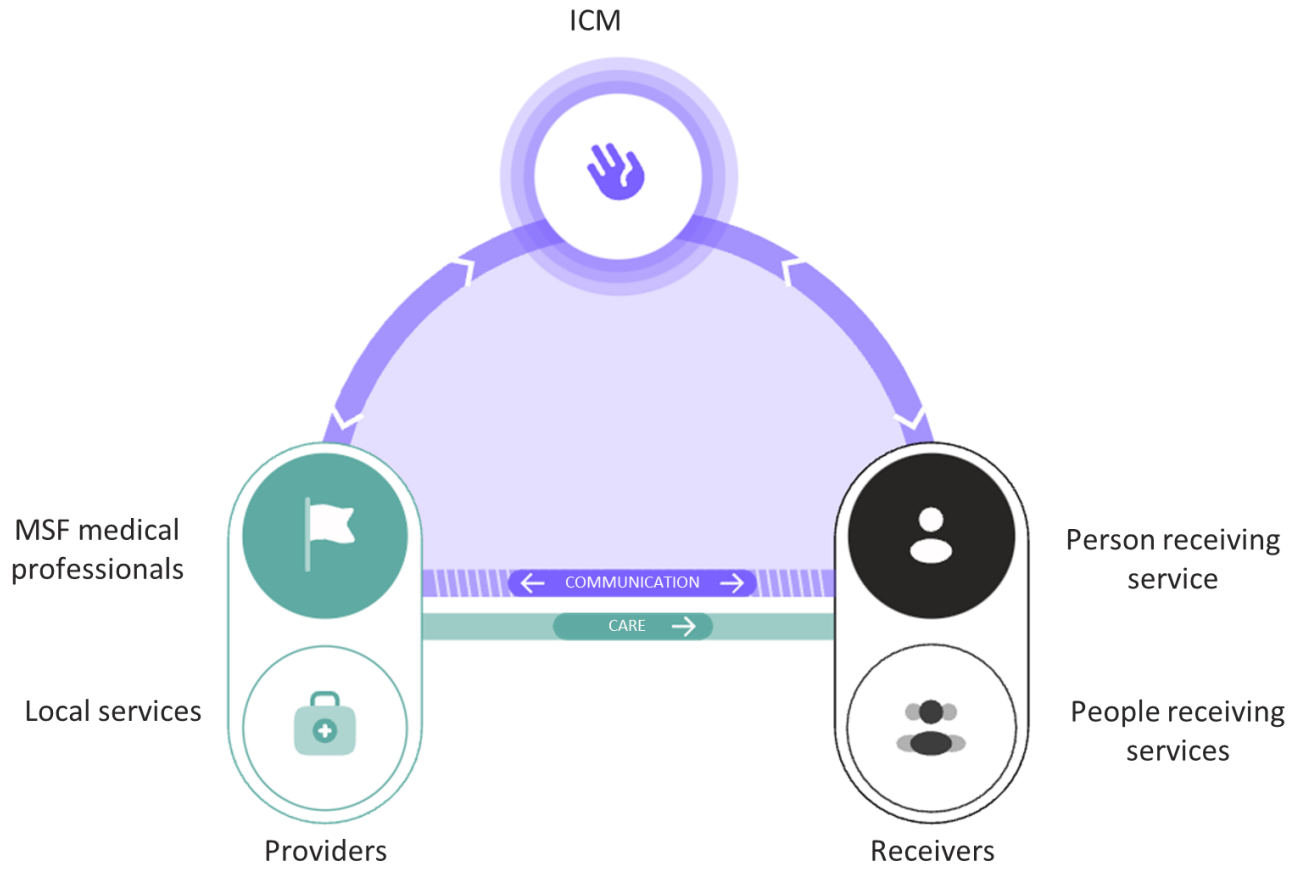
Linguistic-communicative

ICM is bridging the linguistic and cultural gap between care provider and receiver compensating for the incomprehension in communication that obstructs proper care provision.

Roles and responsibilities

- Interpreting in a culturally sensitive way and providing cultural insights to the parties
- Linguistic and meta-linguistic interpretation
- Triangular communication or triadic consultation (“trialog”)
- Cultural brokerage

Among the three main ICM functions, **this is the most central, present in all the projects**. It however **needs some reinforcement in distinguishing ICM’s work from medical interpreter role** through specific trainings to clinicians and other people working with ICMs.



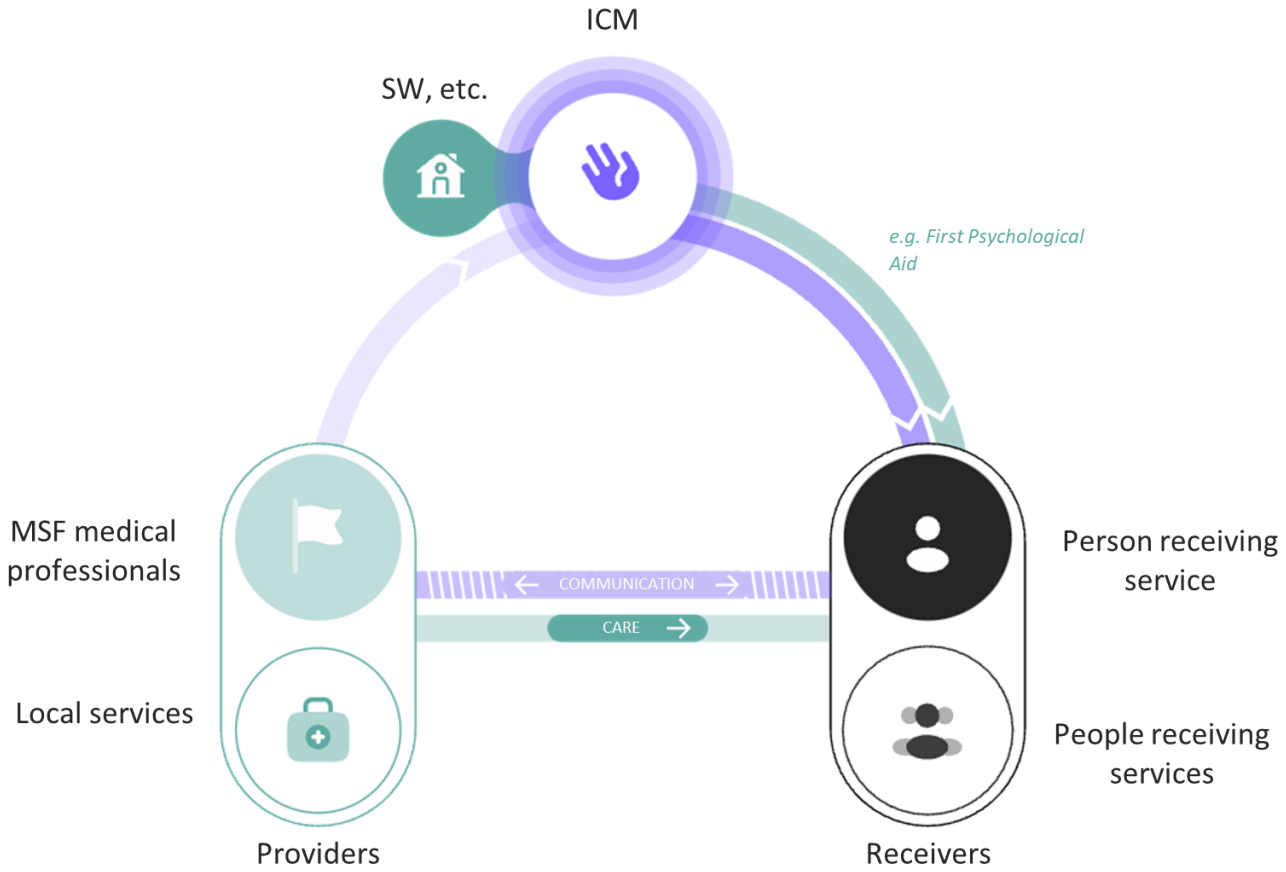
Practical-directive

ICM is working autonomously with guidance and support of other MSF care team members in order to provide non-medical services and information to the receivers.

Roles and responsibilities:

- Autonomously provide some services
- Psychological first aid
- Providing general and health promotion information to favour empowerment and autonomy of the people receiving services
- Accompanying the people receiving services for referrals to external services

This **function needs to be supported through additional training** to ICMs about local contexts, health services and laws**. It is important to distinguish roles of ICM and Health Promoter and Social Worker** which can require support of ICMs in their work, based on the project set up.



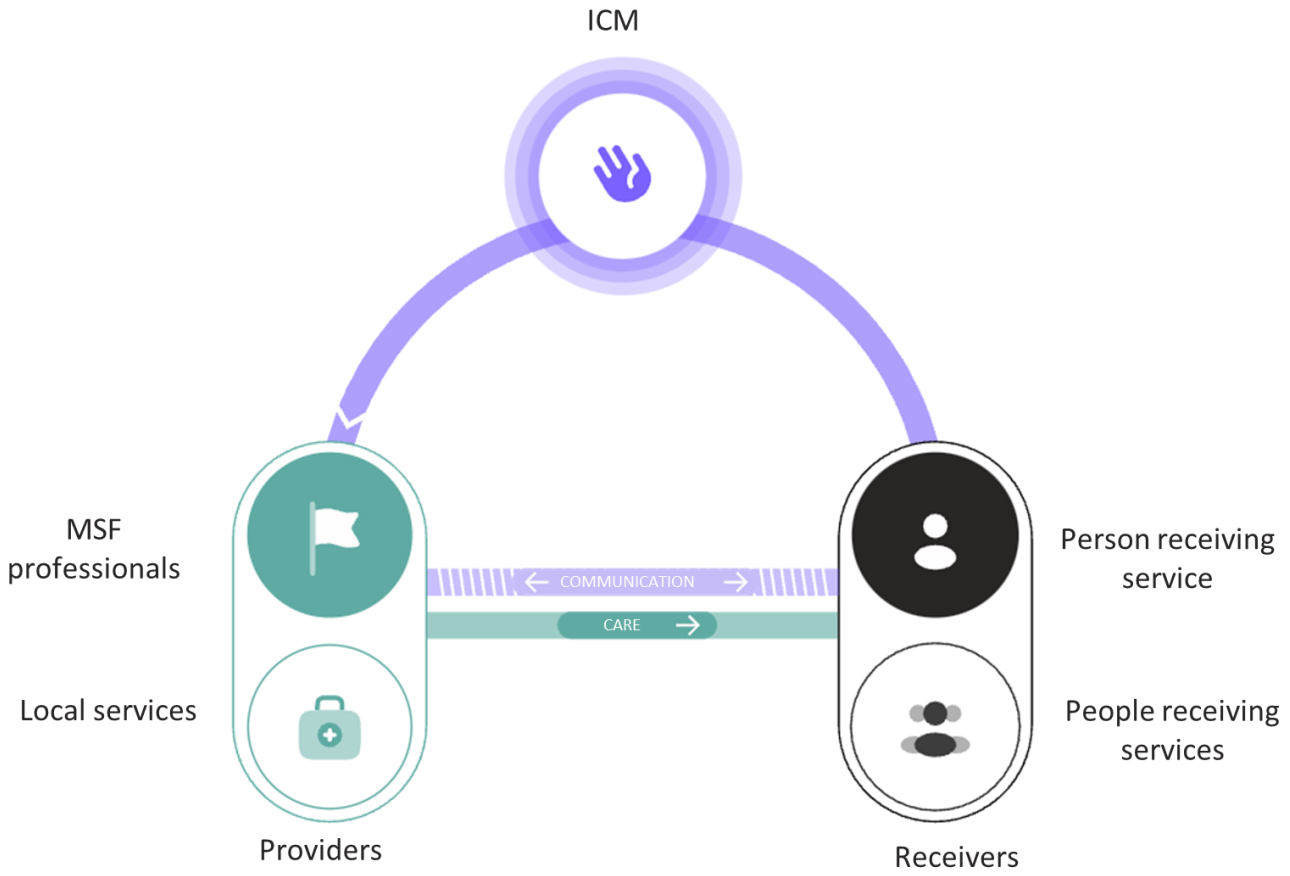
Service improvement

ICM is contributing to making the services (directly for MSF, indirectly for external ones) more culturally adapted to the characteristics and needs of the people receiving them

Roles and responsibilities

- Formal consultations but also briefings, debriefings, case management meetings, and other interactions
- Raising the cultural awareness of the care providers
- Data and information collection
- Involvement in needs assessment

This function **needs to be strengthened through more consistent involvement of ICMs in case discussions** and structured moments for them to present their view of the cultural context and perception of different health-related aspects like mental health, etc.



WORKING WITH AN INTERCULTURAL MEDIATOR





Teamwork: The Intercultural Mediator (ICM) is fully part of the professional multi-disciplinary team

Not interpreters: They have also a position of mediators, as the ones able to inform the clinicians about cultural habits, meaning of expression, subtle differences, cultural references + nonverbal communication

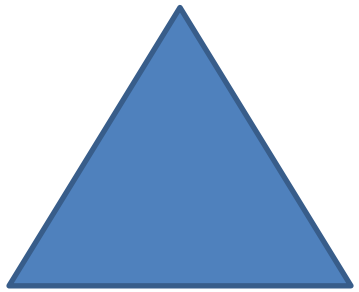
Briefing/debriefing: of both ICM and clinician, optimal collaboration

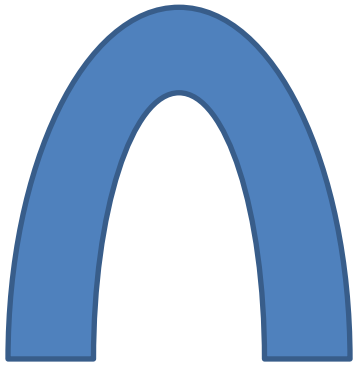
Trust: triangular. Patient trusts ICM, and ICM and clinician must develop a mutual trustful working relationship. This way, a therapeutic triangle can be achieved in the best interest of the patient.



Key points of a bilingual consultation

- **A. Before the consultation, in order to optimize mediation > quality** **:** preparation, content of the session, briefing for 5 minutes the ICM on the session, trustful working relationship, clarification of roles if necessary, take care of the cultural aspects and confidentiality, allow enough time.
- *Seating arrangements:* horse-shoe or triangle or circle formation





B. BEGINNING THE CONSULTATIONS

- Introductions – give some time to the ICM to introduce themselves or introduce them.

- Patient agreement for the ICM, explain the role of the ICM (This can help to avoid the patient asking irrelevant questions/favours/personal questions). Informing the patient with simple statements about the ICM's role, that they interpret everything that is said, and are bound by a code of ethics. This should be routinely explained to patients.

- Look at the patient and not at the ICM, speak directly to the patient, show respect in a cultural appropriate way.

C. During the consultation

- Keep it simple, use clear and unambiguous language.
- Ask the ICM to distinguish clearly between his own remarks and those of the patient.
- Check understanding.
- Guide the conversation.
- Avoid bringing up subjects that would make the patient or the ICM uncomfortable without prior explanation during briefing.
- Encourage, observe, recognise and accept emotions (in the triangle

D. After the consultation

- Debrief (Exchange, sum up, support each other)
- Do not overlook good experiences, provide constructive feedback,
- Provide emotional debriefing (allow the ICM time to discuss any aspect of the meeting s/he may have found confusing or distressing or traumatic),
- Discuss any safety issues,

Avoid jargon: be clear and simple

- It is best to avoid: professional jargon, ambiguous remarks, abstractions, idiomatic expressions, conditional forms such as “If”, “perhaps”, “maybe”, “could”…
- Suggestions: ask questions that are short and keep your commentary brief, pause frequently; break statements down into short sections, if long explanations are necessary; keep in mind that certain expressions may not exist in a given language.
- Avoid sarcasm and jokes. They are difficult to be translated.
- Make sure that the ICM knows the medical terms used during the consultation.
- Make a list of technical terms that come often in consultations.
- Make use of documents with illustrations.

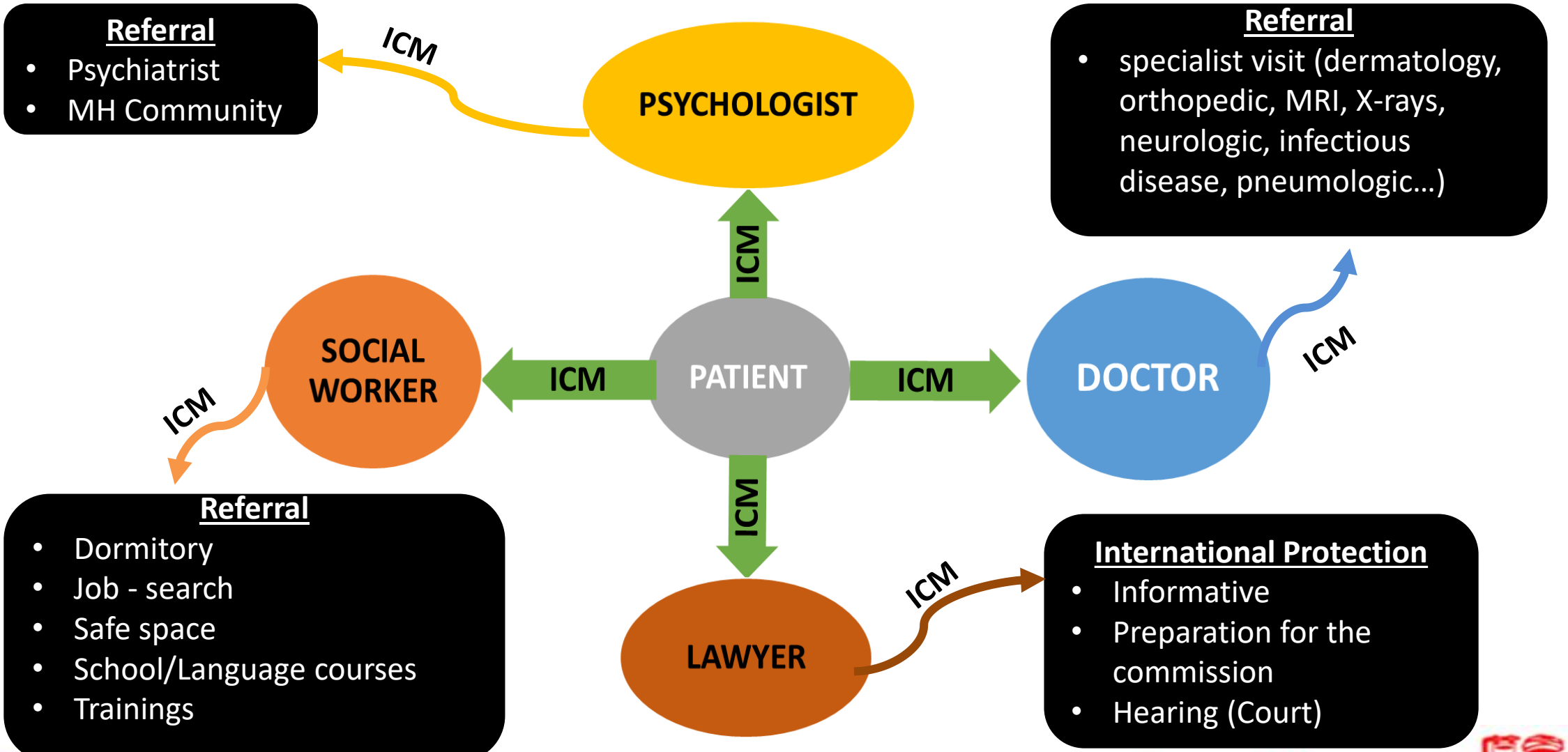
Health professionals: do not forget that the ICM…

- Can often be torn between you and the patient.
- Sometimes patient /family members tell ICMs something and then ask them not to pass this on to health staff member (you may need to explain the ICM's role again in such cases).
- Has her/his own feelings and expectations.
- Needs time to establish a relationship with you and to develop cooperation with the two of you (therapeutic alliance).
- Is not responsible for the behaviour or the complaints of the patient.
- Does not have the responsibility to direct the consultation or keep it under

Careful…

- Body language/nonverbal communication can be understood (avoid to express frustration, disdain, doubt…) even if patient does not speak the same language as you.
- Avoid making comments about the patient, the patient's file or anything not related to the consultation in your language, because: patients sometimes understand even if they don't speak, and you put the ICM in a very difficult position since his/her role requires them to interpret everything that is said, at all times.

Model of care



Ethical Imperatives in Intercultural Mediation

- ***The user's agreement to the intervention of the ICM;***
- ***confidentiality and obligation of professional secrecy;***
- ***accuracy and completeness;***
- ***professionalism and respect of boundaries;***
- ***impartiality and neutrality.***

The rules of the ICM

- **Explain the non-decision-making role of the mediator;**
- **The request to postpone the consultation if one of the two parties expresses such pressure as to cause confusion on the meaning of the presence of the mediator;**

The rights of the ICM

- **Refuse to violate the laws of the state, or organization for which it carries out its activity;**

- **Refusing to participate in cases of discrimination, racism, offense to the customs, culture, beliefs and values of one of the three parties (beneficiary, consultant, ICM).**

Wellbeing of the intercultural mediator

The Staff Health Unit considers ICMs particularly exposed, as they stand in first line with the people receiving services. Being regularly confronted with the situation of survivors of traumatic events has an impact on staff wellbeing.

What prolonged exposure can produce

Burnout. Emotional, physical and mental exhaustion caused by excessive and prolonged stress.

Compassion fatigue. Exhaustion after working over time with many traumatised individuals, with strong empathic involvement.

Vicarious traumatisation. Cognitive changes in identity, worldview, beliefs and sense of safety, from long-term work with traumatised individuals.

What the project puts in place

- Brief the ICM on these risks and ask their view on prevention and self-care
- Allow the ICM to decline a session that is emotionally too heavy, with the supervisor following up
- Limit the number of consultations involving traumatic accounts, set per project
- Include the ICM in team meetings and multidisciplinary case discussions
- Supervision and psychological support from a practitioner external to the team
- Self-care and stress management as a training module

Negative emotional reactions after hearing traumatic accounts are expected and common. They are not to be pathologised, nor equated with the experience of the person who lived the trauma: resilience is built on as well.

Thank you!!

Q&A

