



NUI Galway  
OĒ Gaillimh



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



Centre for Participatory Strategies  
Galway, Ireland

# Guideline *for* Communication in Cross-Cultural General Practice Consultations

Developed using a Participatory Research Approach

This project is funded by the Health Research Board and the HSE National Social Inclusion Unit  
through a Health Research Board Partnership Award 2009-2011



# Foreword

This research is a direct and practical response to the ongoing and distressful reality in Ireland that, on a daily basis, many service users from migrant communities and their general practitioners (GPs) face significant communication challenges in their consultations together because of language and cultural differences.

The HSE National Intercultural Health Strategy 2007-2012, developed by the HSE National Social Inclusion Unit, acknowledges the need for supports for cross-cultural communication in healthcare settings including general practice. The Strategy recommends a multi-stakeholder approach to explore the issue further, and specifically to clarify what kind of supports work best, for whom, and in what circumstances.

To progress this recommendation, and to inform best practice, the HSE National Social Inclusion Unit has worked in partnership with the Discipline of General Practice, NUI Galway and the Centre for Participatory Strategies, Galway. Funded by the Health Research Board Partnership Award, we have conducted research for this Guideline that has created opportunities for:

- Migrants to have a genuine 'voice' in determining what is best practice for supporting communication in cross-cultural general practice consultations in the Republic of Ireland.
- A dialogue between migrants and other key stakeholder groups about their shared and differential perspectives about best practice so that the content of the Guideline has relevance and resonance across stakeholder groups, which may act as a lever to its implementation.

The development of this Guideline is the result of an innovative, extensive and rigorous research process using Participatory Learning and Action (PLA) research methods which, we believe, renders it faithful to a diverse range of voices in our society, and we are pleased to recommend it to you.

We are committed to widespread dissemination of the Guideline. It has already been presented to representatives of migrant communities, academics, and practising GPs and interpreters, and further dissemination events with these and other audiences are planned. We are committed to investigating and supporting the implementation of this Guideline in general practice settings in order that best practice becomes routine and 'the norm' for service users from migrant communities and their GPs. A recent EU FP7 funding award has provided us with resources for a four-year project (2011-2015) to work with international colleagues on the implementation of guidelines like this (see [www.fp7restore.eu](http://www.fp7restore.eu)). For effective implementation, inter-disciplinary and inter-agency dialogue and working are required and we welcome initiatives from all sectors that will support the implementation of this specific Guideline.

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## DEVELOPMENT OF A GUIDELINE FOR COMMUNICATION IN CROSS-CULTURAL GENERAL PRACTICE CONSULTATIONS

Our overall aim was to generate ideals for best practice – we acknowledge that the current economic climate will radically affect implementation of these ideals in practice

In 2009, the Discipline of General Practice at NUI Galway, in collaboration with the Centre for Participatory Strategies, Galway and the HSE National Social Inclusion Unit, began a participatory research project to involve migrants and other key stakeholders in the development of a Guideline for communication in cross-cultural general practice consultations. This project was funded by the Health Research Board and the HSE National Social Inclusion Unit through a Health Research Board (HRB) Partnership Award

The development of the Guideline is a direct and practical response to the reality that service users with limited English and their GPs face significant challenges on a daily basis in their consultations together because they do not have a shared language or cultural background. This frequently results in misunderstandings and communication breakdowns, which are distressing and unsatisfactory for all involved. The National Intercultural Health Strategy 2007-2012 recognises these challenges and recommends research to clarify what supports and models of service provision are required in the Irish context.

For strategies that are acceptable for best practice, go to pages 6.

For strategies that are unacceptable and to be avoided, go to pages 10.

The Guideline research was conducted in the Discipline of General Practice, NUI Galway and was led by Dr. Anne MacFarlane, Lecturer in Primary Care, with Mary O'Reilly-de Brún as the project's Senior Researcher. Together they worked with the Steering Group that included representatives from migrant communities in the Galway region and a range of relevant organisations and agencies - the Centre for Participatory Strategies, Galway, the HSE Social Inclusion Division, and representatives of the interpreting profession in Ireland.

One of the key innovative elements of this project was that it was based on a university-community partnership: seven representatives of migrant communities in the Galway region trained as peer researchers and formed a research team with the NUI Galway researchers. The **Service User Peer Researchers (SUPeRs)** were Khalid Ahmed, Jean Samuel Bonsenge Bokanga, Maria Manuela De Almeida Silva, Aga Mierzejewska, Lovina Nnadi, Florence Ogbonor and Katya Okonkwo.

Mary O'Reilly-de Brún, in her capacity as Co-founder of the Centre for Participatory Strategies, with Co-founder Tomas de Brún, provided the Participatory Learning and Action (PLA) training to the SUPeRs. This training enabled the SUPeRs to invite participants from their wider communities to 'have a voice' throughout the research process, to engage in research confidently and comfortably in their own languages and culture groups, ensuring that their perspectives were included in the development of the Guideline.

# 2

## AIM

The aim of this project was to inform implementation of the National Intercultural Health Strategy 2007-2012 by involving service users and other key stakeholders in the development of a guideline for enhancing communication in cross-cultural general practice consultations.

### Specific objectives were to:

- Map the range of strategies currently used 'on the ground' to manage language and culture gaps.
- Invite stakeholders to envision potential ideal strategies that might go 'beyond the map'.
- Determine how acceptable strategies are across stakeholder groups.
- Identify strategies appropriate for inclusion in the Guideline.

### The key stakeholder groups were:

- Service users from the migrant community.
- GPs and practice staff.
- Professional, trained interpreters.
- HSE social inclusion planners.

Our aim was to generate a menu of options of acceptable strategies that stakeholders could consider using to support communication in cross-cultural consultations, depending on the specific needs and circumstances of their consultations.

As the diagram indicates, the project was designed to enable knowledge (data) to be generated in research encounters with stakeholder groups working separately, but also working together. Some stakeholders were able to meet face to face 'at the stakeholder table' to share insights from their perspectives, and to discuss their experiences and views. Some stakeholders learned about each others' experiences and views through the university researchers who acted as 'brokers' – bringing PLA charts, diagrams, maps and data displays to stakeholder groups to facilitate learning across the groups about communication in cross-cultural general practice consultations.

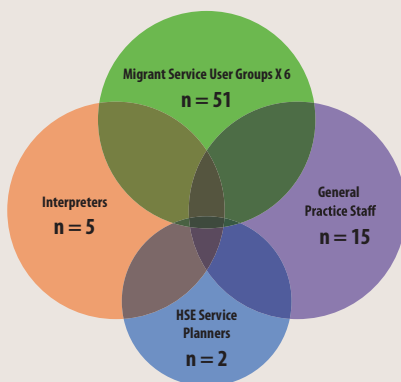


Figure 1. Overview of Stakeholder Groups involved in the Development of this Guideline

# 3

## METHODOLOGY

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In order to ensure that members of migrant communities and other key stakeholder groups would be included in the development of the Guideline, we used a participatory research approach – Participatory Learning and Action (PLA). This is about doing research *with*, not *on*, people and is best described as a growing family of approaches and methods that enable service users to share, enhance and analyse their knowledge of life and conditions in order to plan collaboratively for positive action.

PLA places high value on building relationships of trust and a key feature of PLA is the recognition that **building trust** is a necessary condition for creating ‘**safe spaces**’ that enable stakeholders, particularly those from marginalised communities, to be involved in research or development projects and to speak confidently from their perspectives. PLA includes a wide range of data generation tools and techniques, including many **visual techniques** that make PLA accessible to literate and mixed-literacy-ability groups. For these reasons, PLA was a very appropriate methodology for this project, which involved a mixed-literacy-ability group of people living in Ireland as refugees, people seeking protection<sup>1</sup>, migrant workers and undocumented migrants.

This large PLA project involved several iterative cycles of data generation and analysis across stakeholder groups. Figure 1 above shows the number of participants involved (51 migrant community service user participants and 22 service provider participants). It is important to highlight that many stakeholders participated more than once in the process, making the overall number of data generation encounters considerably higher than the actual numbers showing.

Each participating group was ‘information rich’ in its own terms, bringing relevant expertise and experience to the stakeholder table, which is central to a PLA process.

Our project had a series of inter-related activities that took place in three phases over a two-year period:

### Phase I: Sharing insights from the academic literature

We shared relevant findings from national and international academic literature about communication in cross-cultural general practice consultations with our key stakeholder groups – the SUPeRs (representing migrant communities), interpreters, general practice staff (GPs and practice managers), and social inclusion service planners from the Health Service Executive.

### Phase II: Fieldwork with stakeholder groups

Peer researchers (the SUPeRs) engaged in fieldwork with migrant participants from Polish, Russian, Portuguese, Urdu, Nigerian and French-Lingala-speaking Congolese communities in the Galway region. Using a consistent PLA approach and techniques, university researchers engaged in similar fieldwork with general practice staff

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1. We use this term instead of ‘asylum seeker’ to emphasise the fact that it is, in fact, protection that people are seeking.

in the Galway region, and interpreters and social inclusion service planners from the Health Service Executive based in Dublin. Our focus was on strategies for supporting communication in cross-cultural general practice consultations. We used PLA techniques to:

- *Map* clear details of all strategies currently in use ‘on the ground’.
- *Explore* and analyse strategies in terms of
  - *Usefulness*
  - *Problems*.
- Generate additional *Ideal Scenarios* that are not currently in use ‘on the ground’ to create a ‘vision’ for best practice.
- *Rank* all of these strategies in terms of overall acceptability

### Phase III: Co-analysis and dialogue

We used a PLA democratic dialogic process throughout the co-analysis phase to determine the strategies for inclusion in the Guideline. Representatives from all stakeholder groups worked alongside university and peer researchers using an *Options Assessment* process to examine charts, diagrams, data displays and visual material. In this way, they discussed and co-analysed the knowledge generated during the fieldwork phase. This extensive dialogue within and across stakeholder groups is typical of PLA, because the aim is to reach democratic (majority) agreement; in rare cases consensus may even emerge following careful co-analysis. Our dialogue allowed us to clarify which strategies were

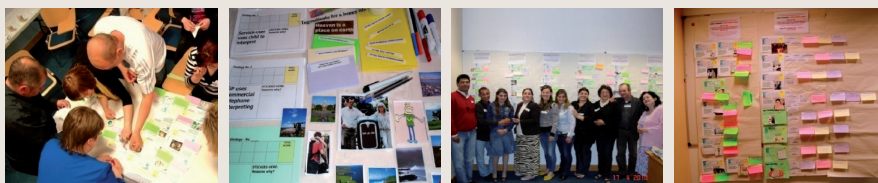
We had several experiences of ‘insight’ (or ‘aha!’ moments) during the dialogue where stakeholders’ views were enhanced and also altered as a result of hearing about other stakeholders’ experiences or perspectives.

- **Acceptable** for recommendation as best practice in the Guideline.
- **Unacceptable** as best practice and should be discontinued in the future.

The outcome was very positive. Stakeholders arrived at a consensus view on the vast majority of strategies for recommendation as best practice (or not) in this Guideline, and achieved a democratic majority on the inclusion or otherwise of the remaining strategies.

The result is a ‘menu of options’ that all key stakeholders believe will support cross-cultural communication. We acknowledge that each specific communication encounter is, in itself, unique – it is context-specific and complex. Therefore each strategy described below, and what it offers, needs to be considered in light of the specific needs of any individual consultation.

Remember - it is not a simple case of ‘one size fits all’ or ‘one strategy works for all consultations’.



Flexible Brainstorming Chart, participants engaging in Direct Ranking technique, and completion of Ideal Scenario chart  
SUPERS PLA Research Sessions, NUI Galway, April 17th 2010

# 4

## FINDINGS

**‘Ideal’ strategies with high acceptability** included as best practice in this Guideline pertain to the use of formal, trained professionals:

- Interpreters for telephone and face-to-face interpreting.
- Bilingual GPs who are completely fluent in the language of the service user with whom they are consulting.

**Strategies with low acceptability** across stakeholder groups that **do not constitute best practice** and are not included in this Guideline relate to the use of:

- Family members and friends as informal interpreters.
- Other informal strategies, e.g. the use of dictionaries or technological and visual aids.

Details of these strategies are set out in the following pages. All strategies were generated by stakeholders during fieldwork processes, and each element of each strategy can be traced back to specific research encounters with one or more stakeholder groups.



PLA ‘flexible’ research materials, Direct Ranking Chart, and section of Ideal Scenario Chart produced by research participants SUPERS PLA Research Sessions, NUI Galway, April 17th 2010



## Additional findings about communication in cross-cultural general practice consultations

Agreed by democratic majority

Migrant service users said that it would be ideal for them if they could **become fluent in English** so that they could communicate directly with their GPs themselves.

All stakeholders agreed that this may be an important aspiration but acknowledged that in reality, and for many reasons, it is not easy for all migrants to achieve this. For instance there is poor availability of accessible English language classes for migrants in Ireland.

Stakeholders agreed that it is important to have **appropriate support for language and culture so that cultural diversity can be understood and respected.**

Proper attention to intercultural issues using trained, qualified professionals would help discussions and diagnoses in general practice consultations and provide service users with security and peace of mind that their cultural and religious beliefs were being looked after.

Stakeholders had many questions about what kind of model is best to address intercultural issues - internationally, there are different models in practice. Further research for the Irish context is required.

Migrants emphasised the **positive power of being listened to attentively by their GPs** – this makes for a very positive communication event.

## 4.1 ACCEPTABLE STRATEGIES

### 4.1.1 Use of a professional interpreter for face-to-face or telephone interpreting.

**This is a crucial strategy for addressing and supporting language differences between service users and GPs.**

Agreed by consensus.

#### 4.1.1.1 Under the Following Conditions

- The interpreter must be a formal, trained, qualified, accredited professional who is ethically responsible and abides by a recognised relevant Code of Ethics.
- The interpreter must be adequately monitored for professional conduct and best practice.
- The interpreter must have all the necessary skills to co-ordinate the interaction (whether face to face or by telephone) during the consultation.
- Ideally, the interpreter would also have training in medical interpreting/vocabulary. Related to this is the need for the GP to brief the interpreter adequately in advance of the consultation to enable the interpreter to prepare practical terminology.
- Interpreters approach every consultation as a potentially serious medical condition as the nature of the medical condition cannot necessarily be established a priori; therefore interpreters should be used for all consultations in which there is a language difference between GP and service user.

#### 4.1.1.2 Rationale and Benefits

##### **Stakeholders emphasised that professional interpreting of this kind can:**

- Provide peace of mind, satisfaction, reassurance and a sense of security and control for service users.
- Reduce stress and create a calmer consultation; the service user feels listened to, heard, understood; everyone concerned feels happy leaving the consultation.
- Relieve the service user's family of the burden of providing informal interpreting and avoid the potential for trauma that might occur if a child is used to interpret. Professional interpreters are unlikely to be as adversely affected (traumatised) by consultations. It might be possible and useful for an adult family member to be present as well as the professional interpreter, in order to provide support and comfort to the service user.
- Ensure the competent, effective, accurate, confidential, ethical, neutral and sensitive transmission of messages between service user and provider.
- Enable clear communication and provide opportunities for clarification of problems/ concerns.
- Promote GPs' confidence in relation to treatment (medicine and dosage).
- Promote greater trust between interpreter and GP (when GPs have opportunities to work with one interpreter regularly).
- Save time and money.
- Reduce stress and pressure for nursing, administrative and other practice staff as they are not expected to struggle to accommodate and meet service users' needs in situations where language is a major barrier and the service user may be distressed.
- Allow the interpreter to say 'I've done a good job' (because they facilitated the communication between GP and service user).

##### **Comparing face-to-face and telephone professional interpreting:**

- The physical presence of a face-to-face professional interpreter, and the use of body language and facial expressions, add to the positive quality of the communication. Telephone interpreting cannot cover human elements of the interaction that come via body language but it is useful in situations where an on-site interpreter cannot be accessed, and where service users might fear that interpreters could align themselves in a power bloc with GPs – this is less likely to occur during telephone interpreting.
- The use of face-to-face interpreting is considered more personal than telephone interpreting.
- Telephone interpreting should not be used for breaking bad news to a service user or in consultations with deaf service users.

- Telephone interpreting requires a good quality telephone connection and private surroundings.
- Telephone interpreting works best for shorter consultations.
- Telephone interpreting makes efficient use of interpreters' time because they don't have to travel widely from GP surgery to GP surgery and can provide fast access to interpreting for GP and service user.

### 4.1.1.3 Implementation

#### **Stakeholders noted that the delivery of this strategy would require:**

- Reform of the current interpreting service in Ireland so that it becomes as well developed as in other countries, for instance the UK and USA, and operates as an interpreting service that is convenient and quick to access and use.
- A service that is funded by the government/HSE and centrally organised so it is not in the control of private companies.
- The development of a business approach by the HSE to identify a cost-effective service. This business case should include attention to the risks associated with *not* providing an effective interpreting service.
- A service that service users do not have to pay for and that provides country-wide face-to-face professional interpreting that people can access even if they relocate to different parts of Ireland.
- A HSE-administered register of professionally trained interpreters that doctors and service users can work from to identify and choose interpreters.
- A multi-lingual call centre that service users can call 24:7 (a model like general practice out-of-hours co-operatives) and, using their own language, arrange without stress for a professional trained interpreter to accompany them to the GP practice. This implementation suggestion should complement (not replace) the responsibility on general practice staff to ensure that an interpreter is arranged for all consultations between GPs and service users with limited English. It is recognised that there may be challenges to implementing this idea in the current economic climate.
- Consideration of the development of video-conference interpreting as a potentially viable mechanism for efficiently delivering the most important benefits of face-to-face interpreting and telephone interpreting combined, given the time constraints usually involved (culture of ten-minute consultations).
- Strong encouragement from the government for GPs to use professional interpreting services - until the right to an interpreter is legislated for in the Republic of Ireland.
- Training for GPs and other health professionals about the use of interpreters.

## 4.1.2 Bilingual GP uses service user's language.

While having service users from one language group all accessing a GP who speaks their language might impact somewhat negatively on integration into Irish society, stakeholders considered that overall there were significant benefits to be gained from consulting with a bilingual GP because there is no language barrier and it may, on occasion, assist cultural understanding between GP and service user.

Agreed by consensus.

### 4.1.2.1 Under the Following Conditions

- The bilingual GP needs to be fluent in the service user's language and the language of the host country.

### 4.1.2.2 Rationale and Benefits

**Stakeholders emphasised that this strategy can:**

- Improve the quality of the medical consultation as it builds trust and reassurance; service users can confidently explain their condition and are likely to feel fully understood and appropriately medically treated and cared for by the GP.
- Reduce the stress that might otherwise be associated with visiting the GP and put the service user at ease because s/he is able to speak freely in his/her own language.
- Promote a sense of empowerment and confidence for the service user.
- Ensure that service users are dealt with more quickly at the surgery.
- Benefit the GP because there are no communication problems.
- Ensure appropriate prescription and medical treatment by the GP, bringing the service user to a state of good health.
- Allow the GP to take account of the particular difficulties and challenging life circumstances of refugees and asylum seekers, and be sensitive to their vulnerability.
- Allow the GP to address certain cultural concepts/practices that service users may have about their health and facilitate beneficial health education.
- Create an atmosphere of welcome and comfort for GP and service user.
- Ensure the retention of intimacy between GP and service user as there is no third party, such as an interpreter, involved; this can also eliminate feelings of shame and/or embarrassment.
- Save time and money for the general practice as there is no need to hire interpreters and because bilingual GPs may also assist with filling out forms.
- Promote diversity and broadening of treatment within the Irish health system, thus promoting its credibility.

### 4.1.2.3 Implementation

**Stakeholders noted that the delivery of this strategy would require:**

- Government/HSE to support and fund the employment of bilingual GPs in the health system and engage in recruitment drives to support the creation of new, additional jobs for these GPs. This must be seen in the context of a wider strategy and policy that perceives the need for the national health service to reflect the profile of our ethnically diverse population. This would indicate commitment [on the part of health services] to the genuine integration of migrant community service users in the health service.
- Promotion, mentoring and support for bilingual GPs who take up employment in the HSE.

## 4.2

### STRATEGIES THAT ARE NOT CONSIDERED BEST PRACTICE AND SHOULD NOT BE USED IN GENERAL PRACTICE CONSULTATIONS

Agreed by consensus

The remaining strategies were not considered as best practice by stakeholders in this research. We know that these strategies are very commonly used and we thought it would be useful to share stakeholder perspectives on why they should be avoided.

Unacceptable strategies may continue to be utilised because, currently, the acceptable strategies are not fully available for use by all – there is important work to be done to implement the recommendations of this Guideline.

#### 4.2.1

**The most common strategy used by service users and GPs in cross-cultural medical consultations is the use of family members or friends as interpreters. This may have certain benefits:**

- Pragmatic ‘handy’ way of managing the language gap between GP and service user.
- Can provide a measure of enhanced understanding between GP and service user.
- Service users sometimes like to have someone known to them in the consultation for comfort and advocacy.

However, there are **serious problems** with these strategies and stakeholders, including service users themselves and service user representatives, agreed that these do not constitute ‘best practice’ and should not be used in general practice consultations.

### **Service user uses child as face-to-face interpreter: *Problems***

- A child is not a professional interpreter and is unlikely to have a medical vocabulary.
- A child may have limited English; important information could be missed.
- A child may not be available (during school hours) or may be missing out on schooling.
- The authority of parents may be compromised by a reliance on their child to interpret.
- A child may be traumatised, embarrassed, frightened or confused – does not have sufficient ‘emotional distance’.
- There may be fear or shame on the part of the parent and/or child – both may be embarrassed.
- How can a child tell a mother, the doctor says, ‘you have a tumour’?

### **Service user uses adult family member or friend as face-to-face interpreter: *Problems***

- Family and friends are not trained and accredited interpreters.
- The accuracy of the interpreting may be badly compromised because of limited medical vocabulary.
- The family member or friend does not have the necessary [emotional] ‘distance’.
- The family member or friend may be embarrassed and not tell the full truth.
- Some family members, when interpreting, may try to ‘soften the blow’ and not tell the service user all they should know.
- A friend may not want to ‘lose face’ and may make something up.
- The communication is not confidential to the patient. There is a danger of breach of confidentiality to other family members and/or issues of asymmetrical gendered power relations, which compromise the safety of the patient.
- Service users are unaware that some GPs will book a formal trained interpreter if asked; if they did know, they would prefer the professional interpreter [to a family member or friend] because of issues of confidentiality and trust.

## Service user arranges to have own ‘informal’ interpreter on mobile phone: *Problems*

- Service users call a friend for interpreting in the surgery, then again at the pharmacy, then later at home about how to take the medicine – this may strain the relationship between them.
- Accuracy of interpreting – things may be misheard and mis-communicated via a mobile phone.
- ‘Informal’ interpreters may not always be available when needed.
- The service user may feel under obligation to the informal interpreter and the relationship can become strained.

### 4.2.2

Other strategies that are commonly used by service users and GPs in cross-cultural medical consultations are shown below, and while they may provide a small measure of enhanced understanding on occasions, there are **serious problems** with these strategies because they cannot represent ‘best practice’. In relation to the seriousness and complexity of cross-cultural consultations, these strategies cannot ‘stand alone’, and in particular cannot replace the use of a professional trained interpreter or a bilingual GP who speaks the language of the service user. Stakeholders agreed that the following strategies are therefore **unacceptable for inclusion in this Guideline for best practice**.

## GP uses body language and gestures: *Problems*

- Body language is an everyday communication tool the GP may use to signal friendliness/comfort to a service user, but is unreliable as a diagnostic support.
- Different cultural backgrounds can lead to misunderstanding of body language (e.g. eyes lowered – does it mean respect or avoidance?).
- Not a precise form of communication – very difficult to explain how to take medication using body language/gesture.
- Stressful for all involved.
- Frustrating for GP who wants service user to get the best help possible.

## **Bilingual practice staff (receptionist/nurse/manager) use service user's language: *Problems***

- Bilingual practice staff members are not trained interpreters.
- Bringing a bilingual practice staff member into the consultation to interpret raises ethical issues – could compromise the confidentiality between GP and service user.
- The presence of a practice receptionist/manager during a physical examination could create discomfort for the service user.

## **Computer programmes that offer translation of words and phrases: *Problems***

- When desperate, when people are under stress, it may be helpful, but a computer programme is a tool, not an ideal for best practice.
- Could distract attention away from the fact that a formal trained interpreter is needed.
- Cold, interruptive of the intimacy of the consultation, can be intimidating.
- Difficult for such programmes to transmit knowledge in a culturally sensitive manner.

## **Bilingual or multi-lingual materials (phrase books, dictionaries, written notes, posters): *Problems***

- Perhaps useful as a basic explanatory tool or as a complementary tool alongside the use of a professional interpreter, but not best practice.
- Could distract attention away from the fact that a formal trained interpreter is needed.
- Bilingual or multi-lingual materials cannot cope with psychological/mental health/social health issues.
- Bilingual or multi-lingual materials are not three-dimensional so have limited use.
- Service user's language may not be included in the material being used.



# ACKNOWLEDGEMENTS

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**We are very grateful for the participation of all stakeholders who engaged in this research:**

- Service User Peer Researchers – SUPeRs
- Members of the migrant communities in Galway
- GPs, practice staff and GP trainees in the Galway research sites
- Service planners and interpreters in the Dublin research sites.

**We are particularly grateful to stakeholders who took part in the extensive cycle of data generation encounters and data analysis meetings – thank you for your sustained interest and excellent contributions.**

**We sincerely thank members of our Project Steering Group for their support and advice throughout the project:**

- |                       |                         |
|-----------------------|-------------------------|
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| • Mr. Tomas de Brún   | • Ms. Ekaterina Okonkwo |
| • Ms. Diane Nurse     | • Ms. Mary Phelan.      |



Feb 26th 2011

Almost one year after engaging in initial PLA research, migrant stakeholders returned to NUI Galway, and, facilitated by ‘SUPERS’ peer researchers and University-based researchers, engaged in assessment and co-analysis of the draft content of the Guideline.



National Intercultural Health Strategy  
2007 – 2012

