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# Confronting Cultural Challenges for Migrant Healthcare in Switzerland

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*SIT Study Abroad*

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Cultural Challenges for Migrant Healthcare in Switzerland

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Spring 2015

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### **Abstract**

Switzerland is home to many migrants, and migration exacerbates health risks. In addition to physical health problems, migrants are more likely than Swiss nationals to face mental health challenges and cultural barriers, which complicate their experiences seeking healthcare. Similarly, clinicians encounter numerous challenges related to the special circumstances of migrant patients. As a response to the specific health needs of migrants, hospital networks and migrant support organizations promote the migrant health situation. However, these services are not ubiquitous in Switzerland, partly due to the partial freedoms of each canton to create its own health policy. This paper explores the barriers to access to quality healthcare services for migrants in Switzerland and assesses the Swiss health system's responses to confront these barriers. Some ways that the Swiss health system confronts the health problems faced by migrants are through the facilitation of communication by community interpreters, cross-cultural competency training for clinicians and promotion of health literacy. Transcultural psychiatry and group therapy methods are employed to address the additional mental health challenges for migrants. A specific focus on vulnerable migrant populations including asylum seekers and undocumented immigrants in the canton of Vaud highlights the challenges faced at by migrant groups a local level.

### **Preface**

I became inspired to begin this project following a field visit to the International Organization for Migration (IOM), where I began to learn about the health issues associated with migration are confronted globally. An IOM employee explained the dangerous situation of migrants arriving by boat in desperate conditions from East Africa

to Yemen, where IOM workers would meet them and offer humanitarian services. While I had previously learned about migration and health through my college coursework, this presentation struck me and piqued my interest in migrant health.

Around the same time, I began to inform myself about migration in Switzerland. I began to wonder about the health status and concerns of migrants in Switzerland and found that there was a wealth of available information on migrant health. For a local case study course assignment, I decided to investigate potential barriers to healthcare access for migrants in Switzerland, and I learned that many resources exist to help migrants in general, and I began to expand my network, leading to my work on this project focusing more cultural concerns.

As a pre-med student majoring in Anthropology, I used to think that I wanted to combine my interests in medicine and culture by working as an international humanitarian doctor. However, working on my Independent Study Project has revealed to me other ways I might be able to someday work with patient populations who face varied challenges and who come from diverse backgrounds.

### **Acknowledgements**

Although known as the *Independent* Study Project, this paper could not have been completed without the support of others who have helped me gather information and organize my work. My academic director Dr. Alexandre Lambert, academic advisor Dr. Heikki Mattila and academic coordinator Françoise Flourens have been indispensable sources of guidance and help. I would like to recognize my senior honors thesis advisor Dr. John Bowen for helping me formulate my research goals and for his willingness to help me further develop this project into a senior thesis next year. In addition, I would

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## **Introduction**

Around one fifth of the Swiss population is made up of immigrants, and migration poses additional health risks (Health Policy Directorate, page 1). Addressing health problems among migrants, particularly those in vulnerable situations, can be challenging from both a psychosocial perspective. Upon arrival and throughout their stays in Switzerland, migrants have many adjustments to make and obstacles to tackle, regardless of their place of origin. Barriers such as financial challenges and cultural perceptions about seeking healthcare services prevent some from seeking treatment. Once care is

sought out, other factors related to the quality of care challenge its effectiveness. Perceptions of illness and understanding of treatment methods differ cross-culturally. This issue is especially pronounced in the situation of mental healthcare. Defining one's mental state as normal or abnormal and further determining the degree of abnormality is guided by cultural norms and expectations (Kleinman, 1988, p. 49).

Among immigrants in Switzerland, some are more vulnerable to mental health challenges than others are. Refugees and asylum seekers who have experienced traumatic experiences and who risk persecution, violence and even death upon their return live in situation that make them disproportionately prone to mental illness. Given their potentially uneasy situation dealing with authorities, they may be less likely to trust health professionals and mental health practitioners.

In this study, I will address the health challenges faced by vulnerable migrant populations including asylum seekers, illegal immigrants and refugees. These challenges will be discussed in the context of available services, networks and programs related to migrant health, including those that provide cultural mediation and cultural translation. The efficacy of these systems and networks will then be explored.

### **Background**

As the Swiss healthcare system has seen a new influx of vulnerable immigrant populations in recent years, there has been a need to improve the cultural competency training of providers as a response to the increased amount of non-Swiss patients whose cultural backgrounds can present challenges to clinicians (Casillas et al., 2014, p. 2).

Migrants experience cultural barriers to healthcare that include language, different

concepts of health and disease, racism and xenophobia, which must be addressed (Maggi & Cattacin, 2003, p. 13).

The field of cultural competence has evolved to address sociocultural health disparities by training healthcare providers to use patient-centered approaches that benefit the patient's experience with the healthcare system. However, the definition of cultural competence is not fully agreed upon, which makes it difficult to implement (Paez, Allen, Carson, & Cooper, 2008, p. 1205). One definition of cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1987, p. iv). While this definition is useful, it does not adequately describe the behaviors, attitudes and policies that must be put in practice, and there are varied approaches to respond to the need for cultural competency.

The term "cultural sensitivity" has been offered as an alternative to the term "cultural competence" to describe the desired training outcome for practitioners, which requires self-reflection and humility to create partnerships with diverse patients and communities. Via this model, cultural sensitivity is not discretely measurable and learnable in the same way as other aspects of medical education such as scientific competences. Rather, it is a lifelong process of self-critique and development. This viewpoint presents a challenge to medical education researchers and program developers who aim to quantitatively evaluate outcomes of medical training. Further, it has been argued that cultural competency training can be potentially harmful if cultural stereotypes are called upon to interpret a patient's perspective, which may well not align with the patient's reality (Tervalon & Murray-García, 1998, pp. 118-119).

### **Research Questions**

In the context of the migrant health situation in Switzerland, I sought to analyze how individuals and systems try to resolve the cultural challenges associated with the health of vulnerable migrant population. My research questions are:

- What are cultural and other barriers that prevent access to quality healthcare services for migrants in Switzerland?
- How does the Swiss health system address these problems for vulnerable migrant populations such as asylum seekers, refugees and undocumented immigrants?
- What kinds of services exist to address the mental health challenges associated with migration, and are they successful in addressing the complexities of cross-cultural mental health care?

In addressing these questions, I have formulated others, whose responses will be presented as a part of my analysis and discussion below.

### **Methods**

Both primary and secondary sources were used to complete this study. Primary sources were obtained through both formal and informal interviews with those who work in migrant healthcare and psychiatric care, as well as with professors whose research relates to the topic of migrant health and with members of organizations that help migrants in Switzerland. Interviewees were found through online searches and through personal contacts and were recruited via email or phone conversations. Formal interviews were conducted in French and were conducted at the workplaces of the interviewees. These interviews were semi-structured, using a pre-made list of questions as well as spontaneous follow-up questions, which allowed for the freedom to move toward topics

considered relevant by the interviewee. The informal interview was conducted in an isolated corner of a café, and was more discussion-based, leaving the interviewee freer to spontaneously share her impressions.

All interviews were recorded with permission from the interviewee, and key parts of the interviews were later translated from French to English and transcribed into a work journal. Interview questions varied based on the role and expertise of the interviewee and focused on cultural considerations of healthcare for Switzerland's most vulnerable migrants.

This approach was taken in order to gain a variety of perspectives on the subject of migrant health and to be able to learn the opinions and experiences of those working in with migrants. While talking to migrants themselves and learning about their experiences first-hand would have enriched the study, there was limited time for this project, and such an endeavor was not feasible given the scope of this work. Other sources used included articles from academic journals, reports from international organizations that handle migration issues and websites of migrant support organizations.

Ethical considerations were addressed by asking interviewees if our conversations could be recorded and if their names could be included in the final research report. Further considerations would have been taken if migrant populations participated as interviewees, but including such participant groups was outside the scope of this study.

Limitations of this study are related to its short-term timescale. As there was only one month available to work on this project, there was limited time to conduct extensive interviews and to gain many perspectives and opinions. Further study is required to create a more comprehensive overview of cultural concerns related to migrant health.

## Analysis

### Historical Context: Migrant Health in Switzerland

In 1996, compulsory health insurance became obligatory under a law known as the *Loi fédérale sur l'assurance-maladie* (LAMal) or the federal law on health insurance, made basic health insurance obligatory for everyone, even those without a provisory permit, within three months of taking up residence or from time of birth in Switzerland (*Loi fédérale sur l'assurance-maladie* (LAMal), 1996). Those who are unable to pay for their own health insurance receive assistance from the state to gain access to the health system for free. In light of this financial burden, Vaud cantonal authorities realized that the average cost of care for asylum seekers and for illegal immigrants was much higher than for the general population, and realized that reform was needed (R. Ilario, Personal communication, April 23, 2015).

At the time, the ongoing Kosovo War led approximately many migrants to seek asylum in Switzerland and Vaud canton was assigned to take in 10,000 of them. As members of this migrant population generally did not have the money to pay for their compulsory health insurance required by LAMal, the Office of Migration in Bern provided funding of 18,000,000 CHF to Vaud to tackle the health challenges of this new immigrant population (R. Ilario, Personal communication, April 23, 2015). In an effort to reform the health system, the canton of Vaud created a “double gatekeeping” scheme. The first “gate” was a system of well-trained and well-supported nurses that receive all asylum seekers. If a patient’s condition is too complicated to be cared for by nurses, the patient was referred to a primary care doctor, who acted as the second “gate.” If

necessary, the primary care physician could then refer the patient to a specialist (R. Ilario, Personal communication, April 23, 2015).

To properly implement this new system, doctors, nurses, psychologists, psychiatrists and social workers came together to create a common training scheme to reinforce specific measures that providers should take when caring for specific patient groups, including migrants. Evaluation has proven this system has been successful at controlling costs and acted “to create a culture of networking, notably via training”<sup>1</sup> (R. Ilario, Personal communication, April 23, 2015).

Around the same time, a rather new organization called *Appartenances*, whose name translates to “belongings” in English, was working in the area of migrant health in Vaud. *Appartenances* was created in 1992, the year of the Bosnian War. At that time, hundreds of Bosnian women who had suffered violence and rape, many of whom were single mothers, arrived in Switzerland. To address the mental health challenges of this migrant population, *Appartenances* introduced a community health program that was modeled after a program implemented in Nicaragua at the time of the War of Sandinista. In this model, group therapy techniques were used to help women relive tensions, share information and bring order to their lives. Such an initiative was especially crucial, since individual psychiatric services with one-on-one consultations were completely overwhelmed, particularly because of the difficulties of communicating with migrant patients (R. Ilario, Personal communication, April 23, 2015). From 1994 to 1999, over

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<sup>1</sup> This quotation was translated from French to English. Original quotation: “créer une culture de formation, nottament via la formation”

200 “health promoters”<sup>2</sup> were trained in communities in the French-speaking part of Switzerland and in Bern, Solothurn and Ticino, as part of a project to improve the quality of life of migrant populations (*Association Appartenances*, 2015). As trained health workers, community members became actors to help promote the mental health of migrants who arrived later on, which has been effective way to address the mental health challenges faced by migrant women (R. Ilario, Personal communication, April 23, 2015).

### **Clinical Challenges**

**Health risks.** In situations of forced migration, the conditions of pre-migration, during migration and post-migration exacerbate health risks. In a country of origin before migration, in a warzone, for example, people’s priorities may be safety, as opposed to health. Then, migrants often face traumatism and obstacles during the migration process that further deteriorate their health. During the post-migratory phase, migrants’ priorities may be related to integration and finding work, rather than taking care of their health.

Immigrants, particularly those in situations of forced migration, have an elevated risk for infectious diseases. Tuberculosis, in particular, presents a challenge for patients and clinicians, as do HIV/AIDS and malaria. Chagas syndrome is common in patients from Latin America (P. Bodenmann, Personal communication, April 28, 2015). The epidemiological transition, that is the change from infectious diseases to noncommunicable diseases (NCDs), is evident within migrant populations, as well. Among NCDs, increased risk factors for cardiovascular diseases relate to the increasing prevalence of obesity in developing countries, which contribute to the sending of forced

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<sup>2</sup> “Health promoters” was translated from the term originally in French “promoteurs et promotrices de santé.”

migrants to Switzerland (Amuna & Zotor, 2008). NCDs related to obesity include hypertension, diabetes and hypercholesterolemia. Comorbidity between infections and NCDs create a double burden for patients and for practitioners. It is important to note that migrants are also equally prone to the same illnesses as all other patients and that their illnesses may not have to do with their migrant status (P. Bodenmann, Personal communication, April 28, 2015).

**Mental health challenges.** The often-traumatic experience of migration exacerbates mental health risks and can lead to mood disorders, depression, anxiety, post-traumatic stress disorder (PTSD), psychosis or other mental health problems. Migrants who come from foreign countries and cultures experience require special attention from clinicians. This need is highlighted by the statistic that around 40% of psychiatric patients at the CHUV are migrants (F. Faucherre, Personal communication, April 27, 2015). Challenges for psychiatric care of migrant patients relate to the experience of the patient and the perspective of the practitioner.

In some cases, there may be a question of whether a patient's symptoms are considered psychologically normal or abnormal, a distinction which heavily relies on culture. This problem is particularly prominent in cases of psychosis. For example, patients who claim to see things that are not really there or who speak of spirits may seem to be psychotic from a Western perspective, but these types of perspectives may be considered normal in other cultures (F. Faucherre, Personal communication, April 27, 2015).

Another issue regarding mental health services for migrants is that migrants may be unfamiliar with psychiatric services and may be wary of approaching mental health

practitioners. Their idea of psychiatry may be that it is for crazy people, or they may be worried about their friends' and family members' negative opinions of them for seeking mental healthcare (F. Faucherre, Personal communication, April 27, 2015).

A particular mental health challenge for asylum seekers relates to their legal status. While applying for asylum, the fear of being sent back to their dangerous origin country can have extremely detrimental effects on mental health (D. Mamin, personal communication, March 30, 2015). Sometimes mental health practitioners who are not familiar with laws regarding asylum think that they cannot treat asylum seekers, which is not true; asylum seekers have the same rights as all other patients. When asylum seekers are denied a permit, they are placed to live in shelters in the form of underground bunkers. Life in these underground bunkers is unpleasant and has deleterious effects on mental health. If asylum seekers living in these bunkers are very sick, nurses may send them to the Psy/Migrants Unit at the CHUV, where they can receive a note confirming that they must be placed outside of these bunkers for mental health reasons (F. Faucherre, Personal communication, April 27, 2015).

The challenges associated with mental health for migrants is further complicated when considering their children. Dr. Florence Faucherre of the Psy/Migrants Unit at the CHUV explained that when migrant adults experience stressful situations, including mental illness, their children's mental health suffers as well, as they lack proper parental support (Personal communication, April 27, 2015).

### **Cultural challenges.**

*Patient perspective.* Culture can pose a challenge when treating patients from different backgrounds. When people migrate, they arrive with their culture and begin the

process of acculturation, as a migrant adapts to the culture of the destination country. The acculturation process can be very rich, as migrants may share their original culture with those in their new country of residence, and they learn from the culture of their new country. According to Dr. Patrick Bodenmann, head of the PMU's *Centre de populations vulnérables* (CPV), or Center for vulnerable populations, the richness of this exchange can be threatened if it occurs in an unbalanced way, and can lead to the migrant losing his or her sense of identity or ability to adapt to the new country (P. Bodenmann, Personal communication, April 28, 2015).

Another potential cultural challenge is the lack of common understanding of a diagnosis. One example illustrated by Dr. Bodenmann is tuberculosis. Based on his or her cultural perception, a patient from a developing country may have the impression that tuberculosis kills and that it is an untreatable disease of prostitutes and the homeless. On the other hand, someone in a wealthy, developed country like may be more likely to see tuberculosis as treatable sickness that is usually healed with medicine and that is not just a disease of prostitutes and the homeless (P. Bodenmann, Personal communication, April 28, 2015). This lack of common understanding may make a patient less likely to seek or accept care.

Another issue may be that forced migrants may not trust authorities, including healthcare professionals because of their vulnerable status. Some reasons for this problem may be that in their country of origin, healthcare professionals were associated with the government or that they suffered a bad experience that led to their mistrust of doctors. Another possibility is that a migrant patient in a vulnerable may expect to be discriminated against (P. Bodenmann, Personal communication, April 28, 2015).

*Healthcare provider perspective.* One of the most difficult aspects of treating patients from migrant backgrounds is the communication challenge. This can be a challenge because of the lack of a common language or because of the lack of common understanding, even if the patient and the physician speak the same language. The lack of understanding may relate to a lack of patient health literacy (P. Bodenmann, Personal communication, April 28, 2015).

Another essential aspect of providing healthcare to migrant populations is the need to pay attention to social determinants of health. If a doctor does not pay attention to the patient's life as a whole, he or she will not be able to provide quality care adapted to the patient's situation. According to Dr. Bodenmann, work needs to be done to improve physicians' focus on this concern, as medical students do not tend to readily accept it as important (P. Bodenmann, Personal communication, April 28, 2015).

In addition to the rather obvious cultural differences that must be addressed regarding the cultural differences of doctor and patient coming from different countries in backgrounds, there is another cultural challenge to address. Physicians and other healthcare providers have a double culture, which includes their culture as a member of society and their culture in their professional domain (P. Bodenmann, Personal communication, April 28, 2015). This extra level of cultural difference adds one more implicit boundary between the patient and physician, creating an extra obstacle for the physician who tries to relate to his or her patient. The physician must keep track of the perceptions, fears, beliefs and expectations of a migrant patient, which can be difficult to do in the context of these cultural differences (P. Bodenmann, Personal communication, April 28, 2015).

### **Confronting the Challenges**

**Hospitals and healthcare networks.** Switzerland's efforts to address the challenges associated with migrant health have been exemplified by the Federal Office of Public Health's (FOPH) Migrant Friendly Hospitals (MFH) network, which intended to meet the objective "to invest in those measures that are to be implemented in hospitals and which contribute to the realisation of a health care system that is more adapted and more accessible to the migrant population" (*MFH Pilot Project: Guidelines and Regulations*, 2010). This program was currently implemented starting in 2005 in five hospitals in Switzerland: University Hospital Basel, Smolothurner Spitaler AG & Kantonsspital Aarau, Children's Hospital Zurich with University Children's Hospital Basel & Children's Hospital of Eastern Switzerland St. Gallen, University Hospital Centre of Vaud (CHUV) and University Hospitals of Geneva (HUG) (M+G, 2014).

Despite the common goals of the program, MFH was relatively decentralized, as each hospital in the network received funding from the FOPH and then organizes its own programs itself (R. Ilario, Personal communication, April 23, 2015). Nevertheless, a network that facilitates communication between different hospitals is key as a means to share ideas and practices surrounding migrant care. At the HUG, MFH initiatives have led to improvements in migrant health services, but there is still work to be done, especially in improving providers' comfort levels in carrying out culturally sensitive tasks like taking social/cultural histories of patients, identifying and addressing potential sources of cultural misunderstanding, and negotiating treatments plan that take into consideration the patient's cultural beliefs (Hudelson, Dao, Perneger, & Durieux-Paillard, 2014, p. 4).

In 2014, MFH was renamed “Swiss Hospitals for Equity” (SHE) to highlight the goal of ensuring quality care for all patients (Federal Office of Public Health, 2014). In replacing the word “friendly” with “equity,” the program’s focus on empathy and professionalism becomes more evident. In addition, the name change recognizes that migrants are just one of many minority groups, including the LGBT community, the disabled and others, who require special cultural competences from practitioners (P. Bodenmann, Personal communication, April 28, 2015).

The CHUV in Lausanne presents a good example of the implementation of the ideals put forth by the MFH and SHE systems. At the CHUV, there are several units that specialize in migrant care. The PMU’s CPV supports high-risk patients, including migrant groups such as undocumented immigrants, asylum seekers, those whose asylum requests have been rejected, and guarantees care adapted to their specific needs (“Centre Des Populations Vulnérables (CPV),” 2015).

The Psychiatry Department of the CHUV has a specialized unit known as Psy&Migrants whose goal is “to improve the quality and accessibility of psychiatric care for people coming from migration, while keeping in mind linguistic, culture and social particularities that result from migration”<sup>3</sup> (Département de Psychiatrie CHUV, n.d.). This relatively new unit of the Psychiatry Department was born in 2010 out of a need to better address migrant patient populations and carries out several other functions in addition to clinical services. The Psy&Migrants Unit also organizes professional training and conducts research. In addition, it acts as a resource as part of a network of other units

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<sup>3</sup> This quotation was translated from French to English. Original quotation: “[Elle a pour objectif] d’améliorer la qualité et l’accessibilité des soins psychiatriques pour les personnes issues de la migration, en tenant compte des particularités linguistiques, culturelles et sociales qui en découlent.

in the Psychiatry Department. The Psy&Migrants hotline is available for those in need of advice on how to handle the specific situations of migrant patients. This hotline is well used, and Psy&Migrants receives multiple calls per week, and most calls are related to legal and administrative questions. For example, another psychiatrist or psychologist may call to ask about laws on asylum, when it is appropriate to write a letter to help a patient stay in Switzerland, how to help a patient with a permit or problems related to money (F. Faucherre, Personal communication, April 27, 2015).

**Community interpreters.** Community interpreters orally translate from one language to another while taking into account social and cultural origin of those participating in the conversation, thereby creating a “trialogue” as opposed to a dialogue between migrant patients and healthcare practitioners (Association suisse pour l’interprétariat communautaire et la médiation interculturelle, 2014). In Vaud, *Appartenances* trains and employs cultural interpreters to translate language and to carry out cultural mediation to help migrants access available services including healthcare. In some cases when deemed necessary, psychiatrists or doctors will call in a community interpreter. This is especially helpful in psychiatric cases when there is a question of whether certain behaviors or mental states are normal or abnormal for a given culture and where direct language translation is insufficient to understand a patient’s world (F. Faucherre, Personal communication, April 27, 2015). At the PMU, funding presents an obstacle for this service, as interpretation for a given consultation costs even more than the consultation itself (P. Bodenmann, Personal communication, April 28, 2015).

**Mental healthcare strategies.**

*Transcultural psychiatry.* To respond to the specific needs of migrant patients from different cultures and backgrounds, the Psy&Migrants unit and other psychiatric teams use a method known as transcultural psychiatry. Using this method, psychiatrists work in the most open way possible when talking to patients. They ask questions without judgment to try to learn about the patient's experience and understanding of his or her problem. The psychiatrist will ask questions about what people think of the patient's condition in their own country and whether the patient has already tried any other treatments such as herbal remedies or whether he or she seen any traditional healers. Then, the psychiatrist will explain the therapies and tools he or she has to offer to treat the patient's condition (F. Faucherre, Personal communication, April 27, 2015).

According to Dr. Faucherre, this technique is helpful because it is good for patients to talk about their problem and its treatment. For example, if a patient gives meaning to his or her mental health condition by saying that someone has bewitched him or her, he or she may feel a sense of relief in being able to talk about the issue (Personal communication, April 27, 2015).

*Group therapy.* Another strategy used in mental healthcare that has been successful among migrant groups is group therapy. Group therapy helps to establish a community and allows participants to share and discuss their experiences. When *Appartenances* was established, women who initially participated in group therapy became group therapy leaders, allowing them to become actors in helping alleviate their peers' stress. This system was successful in helping both the participants and the leaders

in the group to find meaning in therapy sessions (R. Ilario, Personal communication, April 23, 2015).

At the Psy&Migrants clinic, therapy groups with targeted themes create environments where migrants facing similar situations can discuss their experiences. One of these groups is for asylum seekers who are mothers with young children. This group is very open, and the mother comes with her child. Several languages are spoken, and several interpreters facilitate translation. There is a similar group for migrant parents who have children with developmental problems. The Psy&Migrants team would like to create a group for people whose asylum applications have been refused and whom are therefore forced to live in underground bunkers. However, this group has not yet been formed (F. Faucherre, Personal communication, April 27, 2015).

**Cultural competency training.** To improve the ways practitioners approach patients from different backgrounds, the health system must train health workers to work with cultural differences. Cultural competency training is included as a part of medical training for medicals students and residents and should be continued throughout the medical career. In the case of community interpreters, the health team needs to be trained to work in a situation with three people instead of two. In other words, doctors need to be taught to work with a patient and a community interpreter instead of just a patient (P. Bodenmann, Personal communication, April 28, 2015).

Cultural competency training modules for practitioners are created through collaboration between those who have practical experience and theoretical knowledge in migrant health. Content of these training sessions is developed based on research that includes consulting doctors themselves as well as anthropological studies that reveal

patients' perspectives (R. Ilario, Personal communication, April 23, 2015). A scientific committee of doctors, professors and nurses together organize and hold training seminars several times per year concerning migration and health.

Through this training, practitioners are taught, for example, how to treat allophonic patients and patients with low health literacy. Training also addresses social determinants of health and explains why it is important using data from the World Health Organization (WHO) that links poor social determinants of health with low health status. With the knowledge and understanding of social determinants of health, practitioners are better able to explore the contributing factors to patients' health when interviewing patients. Training also includes the explanation of certain transcultural specificities such as religiosity, nutrition and diet. However, it is important to avoid stereotyping certain groups' behaviors and mapping them onto individual patients (P. Bodenmann, Personal communication, April 28, 2015). Finally, training includes an explanation of Kleinman's explanatory model of illness and why it is important for physicians to take into account patients' understanding of their health and body (Kleinman, 1978, p. 88).

***Cross cultural competency and mental health.*** Cross-cultural competency is becoming a more important part of training for mental health practitioners, as well. At first, members of the Psy&Migrants team held workshops focused on awareness of the needs of migrant patients were held, but only those interested in the topic attended the events. To reach more people, the team began to run workshops in the form of one-hour-long presentations at the regular meetings of the different units with the Psychiatry Department. During these training sessions, the Psy&Migrants team would choose a particular theme such as working with an interpreter or handling the specific conditions

of asylum seekers. They would then present the topic to all of the units. While these sessions do not occur very often—only once per year or once every two years—they are very efficient and practical because all members of the department receives the same training and they become more attentive to the specific needs of migrants (F. Faucherre, Personal communication, April 27, 2015).

Twelve hours of transcultural psychiatry have also been integrated into post-graduate training for psychologists and psychiatrists. This training includes subject matter such as how to talk about how to care for patients who have experienced traumatic experiences such as conflict and violence, and how to manage the precarious situations of migrants. Similar training exists for nurses and social workers. According to Dr. Faucherre, medical students have only one seminar in cultural competency, which she believes is not enough (Personal communication, April 27, 2015).

**Health literacy.** Health literacy poses a challenge not just for migrants, but for the population in general, according to Dr. Bodenmann, who estimated that 30-40% of the general population has health literacy difficulties. He explained that he and other physicians have the impression that patients do not understand a large portion of what they say. In his opinion, it is the responsibility of doctors and of the health system to improve health literacy among patients. This goal plays a role in teaching physicians. Some ways that physicians are trained to address health literacy issues are to use drawings to help explain conditions to patients and to screen for health literacy deficiencies by asking questions. There are also educational structures in place to help illiterate patients learn to read and to help them learn math skills.

According Dr. Faucherre, some of the patients in the Psy&Migrants clinic cannot read or do not have adequate health literacy rates to understand the instructions in medication packages. To address this issue, she explains medications to her patients and makes sure to ask them if they agree to take these medications and whether they understand. This helps patients adhere to treatment regimens and helps them better understand their condition from a medical perspective (Personal communication, April 27, 2015).

**Migrant organizations.** Numerous organizations that aid migrants exist in Switzerland, some of which have specific targets associated with health. Those that do not have explicit goals surrounding health tend to implicitly address social determinants of health by helping migrants find work or housing, for example. The few that I shall discuss are representative examples that I found during my research, and I do not intend to put forth a comprehensive overview of migrant support organizations, as such a task is outside the scope of this project.

As noted above, *Appartenances* is a key organization that supports migrants, as outlined by their mission statement: “The mission of the association Appartenances (*Belongings* in English) is to promote the wellbeing and autonomy of migrants, and facilitate their reciprocal integration into local society, based on relations of equality” (Association Appartenances, 2015). *Appartenances* offers specialized psychotherapeutic consultation service for migrants, social spaces for migrant groups, community-interpreting services, and in-service training for issues linked to migration, interculturality and organized violence (Association Appartenances, 2015).

Another organization, *le Collectif de soutien aux sans-papiers*<sup>4</sup> operates through local chapters throughout Switzerland and supports undocumented immigrants. One of Vaud's regional chapters, *le Collectif de soutien aux Sans-papiers de la Côte*, located in Gland, advocates for undocumented immigrants by spreading positive information to the public. It is important to do so because *Le Collectif* often acts as an interface between the government and undocumented immigrants. According to Philippe Sauvin, a committee member *le Collectif*, the space to work with the government is not very wide, as many government decisions are made directly through the population's votes. However, *le Collectif* plays a vital role in supporting undocumented immigrants. Through contacts with *le Collectif*, undocumented immigrants can reach the services and supports they need to take care of their health. Having *le Collectif* as an interface between undocumented immigrants and the government is important, as undocumented immigrants may not be able to advocate for themselves.

An organization that works specifically with asylum seekers is the Asylum-Migration Coordination of the Riviera (CAMIR).<sup>5</sup> The CAMIR holds walk-in hours every Monday evening to help asylum seekers fill out their application to request asylum. In addition, the organization offers supports to asylum seekers based on their needs (D. Mamin, Personal contact, March 30, 2015). Unfortunately, this organization is understaffed and is unable to help all those who could benefit from its services. However, for those it is able to help, its services help asylum seekers manage some of the stressors

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<sup>4</sup> English translation: The Collective for Support for Undocumented Immigrants

<sup>5</sup> The name of the organization was translated to English from the original French "La coordination asile-migration de la Riviera."

in their lives, which is a positive for mental health and can leave people with more agency to take care of their physical health.

Other organizations in Geneva and Vaud that support migrants include *le Centre de Contact Suisses – Immigrés*<sup>6</sup>, *l’Observatoire romand du droit d’asile et des étrangers*<sup>7</sup>, and *la Fraternité*<sup>8</sup> in Lausanne. This list is still not comprehensive, but gives an idea of the various supports that exist. Evidently, there are numerous resources available for migrants in Vaud and Geneva.

**Federal and regional politics.** In Switzerland, each canton has a great deal of freedom to determine its own politics. At the same time, there is some federal power over migrant health. The FOPH is responsible for galvanizing national public health efforts and for guaranteeing the quality of work in public health in the cantons. At a national level, the FOPH has legitimized the training of interpreters, pushed institutions and created networks for European collaboration. Each canton is responsible for applying the efforts promoted by the FOPH.

Geneva and Vaud have public health goals and clinical goals that coincide (R. Ilario, Personal communication, April 23, 2015). According to Dr. Bodenmann, political leaders in Vaud understand that the health challenges associated with migration are important, and substantial funds are available to promote migrant health services (Personal communication, April 28, 2015). However, in the German-speaking part of Switzerland, services for migrants are less available. Zurich does not provide healthcare to undocumented immigrants to the same extent as Vaud and Geneva, and

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<sup>6</sup> English translation: The Center of Swiss Contact – Immigrants

<sup>7</sup> English translation: The Francophone Swiss Observatory of rights of asylum and foreigners

<sup>8</sup> English translation: The Fraternity

nongovernmental organizations sometimes step in to provide health support to migrants there (R. Ilario, Personal communication, April 23, 2015). The Valais is also notorious for its lack of support for migrants and specifically for asylum seekers (D. Mamin, Personal communication, March 30, 2015).

In some cases, the politics of health and the politics of migration coincide, like in Vaud canton, but in other cases they clash. Special services such as the Psy&Migrants clinic might have less of a burden if the asylum seeking process were less arduous and if they were not placed in bunkers, whose living conditions are detrimental to mental health. According to Danielle Mamin, who works for the CAMIR, once people fill out their application to be granted asylum, they may wait up to 12 years and then find out that their request has been rejected (Personal communication, March 30, 2015). The stress associated with such a situation is detrimental to one's mental health and is directly related to administrative issues.

**Philosophy and attitude.** To enact programs to adapt to the particular health needs and considerations of migrants, health institutions must address health disparities, particularly those related to migration, as a part of their mission. Forced migration is linked to health inequities, and institutional backing is required to supply funding and support for programs aimed to counter such inequities. While migrants may require different types of care, they deserve the same quality of care as other patients. The provision of such care requires special services, which can only be made available consistently if supported by institutional measures (P. Bodenmann, Personal communication, April 28, 2015).

In addition, there needs to be a combination of top-down and bottom-up collaboration. Bottom-up organization involves using clinical insights and observations from practitioners themselves and from social science research reports that reveal the issues related to what happens in the field. At the same time, there must be a top-down organizational body that enacts policies, compiles data and allots funding to create an efficient, functional system (P. Bodenmann, Personal communication, April 28, 2015). According to Dr. Bodenmann, the CHUV is lucky to have a strong combination of both and to be well funded.

### **Access to Care**

**Insurance.** Swiss law requires that those residing in Switzerland have health insurance, and insurance companies are not allowed to refuse health insurance even to undocumented immigrants. If insurance companies do refuse to grant insurance, there is a cantonal service will force them to do so (S. Neffah, Personal communication). Nevertheless, due to their situations, migrants may not have the means to take care of their health, and they may not have health insurance for any of several reasons (P. Sauvin, Personal communication).

Even though health is considered a right in Switzerland, health insurance is very expensive, costing up to 500 CHF per month (S. Durieux, Personal communication). Immigrants with low or no income sometimes invent strategies to gain insurance coverage while saving money. For example, several people may share one health insurance plan under a single name. This strategy works if health services are not used often and may prevent people from seeking care. Avoiding care at early stages of illness can lead to complications later on that would not have arisen had patients been treated

early on (S. Cattacin, Personal communication). Immigrants with small children must have health insurance for their children, and many parents buy health insurance for their children but not for themselves (P. Sauvin, Personal communication).

The HUG offers free access for "*sans-papiers*" or undocumented immigrants, including for ambulatory care, through a system of nurse gatekeeping (S. Durieux, Personal communication). The PMU in Lausanne accepts all patients, even undocumented immigrants, whether or not they have insurance, and payment is determined after (P. Bodenmann, Personal communication, April 28, 2015). This example of cantonal differences highlights one issue regarding access to care in Switzerland. Since each canton has the freedom to create its own policies, there is no single standard between cantons for the care of migrant patients.

**Navigating the healthcare system.** Migrants in Switzerland may experience difficulties accessing healthcare if they lack proper information about how to find a doctor, for example, or because the healthcare system is complicated (P. Bodenmann, Personal communication, April 28, 2015). When migrants arrive in Switzerland, they receive a paper with information on how to access services including healthcare. However, many do not read it, as it is part of a stack of other paperwork they receive upon arrival, and they have many concerns to handle as they arrive in a new country. The most common way for migrants to inform themselves about healthcare services is to ask peers (S. Cattacin, Personal communication, March 30, 2015). However, if a migrant arrives without a strong social support network, this strategy cannot be used to navigate the healthcare system.

According to Dr. Faucherre, it is easy for migrant patients to go to the hospital for emergency care, but it is harder for them to reach specific services for psychotherapy, as there is not yet equity for migrant mental health services (Personal communication, April 27, 2015). Once patients enter the health system, nurses and doctors can refer them to specialists, if needed.

**Quality and adherence.** Even if a migrant does access healthcare services, the care may not be of high quality for reasons including the cultural barriers discussed above. Despite best efforts made by some to improve the quality of care for migrants and to establish guidelines for treating migrant patients throughout healthcare networks, treatments are sometimes inappropriate, as evidenced by the following anecdote, which highlights the health and social challenges faced by one asylum seeker from Togo.

In August 2014, an asylum seeker from Togo, who had finally landed a job at a medico-social establishment after completing his education and an internship, lost his stay permit and was told he had to leave Switzerland by September 30. He began working on September 1, and continued until he became ill three days before he was supposed to leave. Nightmares about when he had been tortured and fears of returning to Togo led him to the emergency room in Lausanne, and he was then sent to a psychiatric care center in Prangins, as there were no more psychiatric beds in Lausanne. He was well taken care of for three weeks and then left with extensive medication. Danielle Mamin of the CAMIR, who called him each day after he was discharged, recalls his poor condition post-discharge, and she discussed his case with a psychiatrist at *Appartenances* who agreed to treat him. The psychiatrist concluded that the asylum seeker had been given the

wrong medications by the previous doctor and proceeded to treat him properly (D. Mamin, Personal communication, April 22, 2015).

This example underlines some of the mental health challenges faced by forced migrants and presents a case of maltreatment by medical professionals. While the cause of the maltreatment may or may not have to do with the status of the patient as an asylum seeker, it exemplifies one type of problem a migrant may face when seeking care. Danielle Mamin offered a as possible reason for this situation that is expensive to keep patients in mental hospitals, which leads some doctors to lean toward medicating patients and sending them off, rather than truly treating the root of the problem (Personal communication, April 22, 2015).

When proper treatment is provided, an undocumented immigrant, for example, whose priority is finding work, may not adhere to his or her prescribed medication regimen. He or she may not buy medications that are too expensive or may share it with family and friends (P. Bodenmann, Personal communication, April 28, 2015). Opening a dialogue with patients and discussing treatment options is a helpful way to encourage adherence. Explaining how medications work and asking the about patient his or her thoughts and understanding of the treatment makes the patient more likely to follow treatment plans. The need to provide such explanations is especially crucial for non-Swiss patients whose first language may differ from that of the clinician (F. Faucherre, Personal communication, April 27, 2015).

### **Discussion & Conclusions**

Migrant healthcare poses vast challenges, only some of which have been addressed in this paper, due to the limited scope of this project. Vaud canton seems to be

making a faithful effort to address the problems associated with migrant healthcare. However, much of the progress in community interpretation has been made by *Appartenances*, a private organization. It is uncertain whether or not the cantonal government or hospitals would have introduced such a service without private initiative. The founding and success of *Appartenances* highlights the potential and the need for private individuals to take action to improve the conditions of migrants.

Switzerland seems to be heading in the right direction in favor of migrant healthcare, as there are establishments in place such as the SHE network, which help to connect different hospitals in their efforts to improve care for migrants. However, this program is currently only in place in eight hospitals in the entire country and the efforts associated with it are not ubiquitous. Several interviewees noted the striking differences between different cantons' levels of friendliness toward migrants. These differences are typical of the decentralized Swiss system in which each canton is relatively free to manage its own affairs. However, when it comes to health, which is considered a right by the WHO, quality treatment should be available to all patients, including migrants, everywhere throughout Switzerland.

Work remains to be done to increase the willingness and enthusiasm of medical students and practitioners to address the specific clinical needs of migrant patients. As Dr. Bodenmann explained, medical students are not often enthusiastic to learn about cultural competency (Personal communication, April 28, 2015), and as Dr. Faucherre noted, cultural competence does not make up a big part of medical education (Personal communication, April 27, 2015). Finding out why some medical students and clinicians

lack interest in cultural competency could help to inform improvements in cultural competency training to make it more appealing to healthcare practitioners.

In Switzerland, cultural competency training is among the main strategies used to improve the capacity of clinicians to appropriately treat migrant patients. However, some argue that cultural competency should not be taught to medical students and medical practitioners in the same way that scientific medical concepts are taught, as cultural competency is not measurable and not well defined. In addition, the idea of cultural competency leads to the risk of stereotyping patients based on their perceived culture. Kleinman and Benson suggest as an alternative that clinicians perform mini ethnographies to address the cultural differences between patient and clinician. In other words, the clinician should ask questions to try to understand the illness experiences and worlds of their patients (2006, p. 1674). The suggestion offered by Kleinman and Benson, however, appears almost identical to the skills termed “cross-cultural competency” explained by Dr. Bodenmann. At some point, the debate over the use of cross-cultural competency training seems to become a question of terminology rather than of practice.

As highlighted by Dr. Bodenmann, social determinants of health are a key factor in the creation of health inequities (Personal communication, April 28, 2015). It is not the healthcare provider who is responsible for promoting social determinants of health, although he or she can take them into account during a consultation. It is difficult to determine a specific group or professional who is responsible for fostering social determinants of health for migrants, as social determinants of health cover many aspects

of the lives of migrants. However, any programs in favor of migrants' wellbeing could potentially correspond to better health outcomes.

One potential challenge to migrant support programs, specifically those related to health, is the associated financial burden. A common argument that I have heard from various Swiss nationals is that immigrants living in Switzerland have not paid Swiss taxes and should not benefit from Swiss services. In the context of healthcare, denying quality services to migrants due to high costs is counterproductive, as minor health problems left unaddressed can develop into more complicated conditions, which tend to be more costly. Fortunately, the Swiss healthcare system provides care to migrants and to vulnerable populations. However, as discussed with regard to social determinants of health, clinical care is not the sole answer to a population's health needs. Given the system of direct voting on laws in Switzerland, public attitudes toward services for migrants can be linked to migrant health status.

### **Further Study**

The information uncovered in this project has led me to develop further research questions including the following:

- Is the transcultural competency model the correct way to go? How can this model be improved to better address the needs of patients and the skills of clinicians?
- Do migrant patients in Switzerland feel like their needs are being addressed with care and fairness?
- Do the special services tailored to migrant needs make them feel singled out or stigmatized?

The responses to these questions are difficult to answer and require ethnographic study and evaluation. These types of studies are already being done to some extent, but the situation is constantly changing, as different waves of migration occur. In addition, multiple perspectives and study types are useful in researching such a vast topic to inform future migrant health policy and to improve clinical training for healthcare practitioners.

The specific migrant health services discussed in this study were all located in the canton of Vaud. A comparative study between cantons or between countries could be helpful in identifying and analyzing the successes and the areas in need of improvement regarding healthcare for migrants.

Over the next few months, I plan to continue my research on migrant health in Switzerland in an ethnographic study of vulnerable migrant populations in Vaud to learn their perspectives and experiences with the Swiss healthcare system.

### **List of Abbreviations**

CAMIR: Asylum-Migration Coordination of the Riviera (*Coordination asile-migration de la Riviera*)

CHUV: University Hospital Centre of Vaud (*Centre hospitalier universitaire vaudois*)

CPV: Center for Vulnerable Populations (*Centre des populations vulnérables*)

FOPH: Federal Office of Public Health

HUG: Geneva University Hospitals (*Hôpitaux Universitaires de Genève*)

IOM: International Organization for Migration

LAMal: Federal law on health insurance (*Loi fédérale sur l'assurance-maladie*)

MFH: Migrant Friendly Hospitals

NCD: Noncommunicable disease

PMU: University Medical Center Outpatient Clinic (*Policlinique médicale universitaire*)

PTSD: Post-traumatic stress disorder

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