Assessing the need for and access to migrant-sensitive rehabilitative healthcare: An analysis of current Swiss and German practices

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Assessing the need for and access to migrant-sensitive rehabilitative healthcare: An analysis of current Swiss and German practices
Lauren Cuppy
December 10th, 2021
Abstract

In recent years, the noticeable increase in migration has placed scrutiny on the migrant-sensitive services provided in healthcare settings globally. Migrants, in general, experience different health issues and worse health outcomes than non-migrants. In response to this, healthcare systems around the world have begun implementing migrant-sensitive healthcare (MSHC) systems; yet, although nearly a third of the world’s population experiences some health condition that would benefit from rehabilitation, the implementation of MSHC rehabilitation services have been critically understudied. This paper seeks to investigate the geographic and MSHC accessibility of rehabilitation in Geneva, Switzerland to fill the current gap of literature and identify areas to improve accessibility to these services for migrants. Preliminary results revealed that there are several areas within the canton of Geneva where a migrant would struggle to reach MSHC or general rehabilitation services on either public transportation or via walking. An analysis of the websites of both hospitals and private facilities in Geneva also revealed a general lack of MSHC offerings. The current trend towards integrating MSHC systems globally is crucial to begin providing equitable healthcare to migrants, but the results of this paper reveal that there is still much more work to be done and new concepts to consider in this process to truly eliminate the healthcare disparity for migrants.
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Introduction

In response to the growing number of migrants across the world, a greater scrutiny has been made towards disparities in migrant health and the healthcare systems that are exacerbating them (World Health Assembly, 2017). Migrant-sensitive health care (MSHC) is a form of healthcare that aims to provide equitable and culturally competent care to migrants by implementing services that target specific barriers to healthcare accessibility, such as language barriers, cultural insensitivity and misunderstanding, and financial instability (Fortier, 2010).

One of the greatest disease groups plaguing migrants today is musculoskeletal disorders (MSD) and, subsequently, access to rehabilitation services (Cieza, 2020). More than a third of the world’s population suffers from a health condition that would benefit in some way from rehabilitation, yet it continues to be viewed as an elite form of healthcare reserved for the upper class. Efforts have been made to make rehabilitation services more accessible both for the general population and for migrants specifically, but there is still a significant number of facilities that do not offer or advertise migrant-sensitive rehabilitation services (Grandpierre et al., 2018).

Switzerland and Germany both have significant migrant populations and the literature in both countries cites disparities in migrant health and efforts to develop MSHC to address them (Brzoska, 2018; FSO, 2017). While researchers in Germany have published a significant amount of literature on the utilization of healthcare (specifically rehabilitation) by migrants and the availability of migrant-sensitive rehabilitation services (Brzoska & Razum, 2018; Langbrandtner et al., 2018; Schröder et al., 2018), the same cannot said in Switzerland. This paper seeks to first analyze the methodologies and results of the German literature on migrant-sensitive rehabilitation accessibility and utilization to then analyze the availability of migrant-sensitive
rehabilitation services in Switzerland in order to better understand the disparities in physical health conditions among migrants that exist there.

**Methodology**

In order to assess a topic as specific as migrant-sensitive rehabilitation services in Switzerland and Germany, it was necessary to start with a broad conceptual approach to the literature and gradually specifying more in each section. This meant first reviewing literature broadly on the health needs of migrants, then the implementation of MSHC, and then the necessity of MSHC in rehabilitation services. Armed with this literature review, it eased the process of analyzing and comparing the services provided by Germany and Switzerland.

The comparative analysis included both qualitative and quantitative approaches. Because there is more published literature on migrant-sensitive rehabilitation services in Germany, the analysis was primarily a meta-analysis of the methods and results of these studies to gauge the trends on the accessibility and utilization of MSHC in rehabilitation. Conversely, there is less published research on MSHC in rehabilitation in Switzerland, so it was necessary to consider the inputs of the governing body and authorities, MSHC providers, general providers, and humanitarian organizations individually to get a comprehensive understanding of the services provided.

The analysis of Swiss practices included several prongs. First, a section on the migrant landscape of Switzerland was necessary as background. Then, a comprehensive analysis of the Swiss healthcare and insurance systems as published by the Federal Office of Public Health was necessary to begin considering accessibility. Following that, a qualitative analysis of the migrant-friendly hospital initiative and the services provided through it, specifically by the HUG group in Geneva, was conducted to understand the presence of MSHC in the country and in Geneva. In
order to quantitatively gauge geographic accessibility to migrant-sensitive rehabilitation services in Geneva, I utilized QGIS to create isochrone maps reflecting the areas that could access HUG facilities offering rehabilitation services within one hour by public transport and by walking. Creating isochrone maps allows for a better visualization of the level of accessibility.

A similar method was used to analyze general rehabilitation services in the canton of Geneva. Rehabilitation facilities were compiled through a search of local.ch, the official online phonebook of Switzerland. Isochrone maps were also created using the same parameters in order to visualize geographic accessibility to rehabilitation services. In order to qualitatively analyze MSHC in these facilities, I conducted an investigation of the facilities with websites for their practices utilizing the methodology used by Langbrandtner et al. (2018).

The final analysis was a qualitative examination of the services offered to migrants by l’Association pour la Promotion des Droits Humains (APDH) and the Swiss Red Cross (SRC). Though the methodologies utilized for the analysis of Germany and Switzerland are very different based on the availability of literature and data, the results of the meta-analysis of German literature were used to inform on the results of the Swiss analysis in order to answer how migrant-sensitive rehabilitation services are accessed and utilized in Switzerland.

**Literature Review**

**The health needs of migrants**

Today’s world is an increasingly globalized space. Global markets and increased mobility have spurred a growth of international migration. In 2015, it was estimated that 244 million people, or 3.5% of the world’s population, were considered to be an international migrant, a 44% increase since 2000 (World Health Assembly, 2017). Migration can be accompanied by several positive benefits—health, education, growth of human and social capital—but only so long as
migrants have access to the same knowledge, resources, and rights as non-migrants. Reliable housing and employment are necessary to succeed in a new country. Yet, 2000 immigrants surveyed in Malta reported “exposure to cold, lack of space and overcrowding, lack of activity, poor diet and high levels of stress” in their home environment (Lebano et al., 2020, p. 5). Other stressors such as poor employment and discrimination also hinder the migrant process and inhibit integration.

Unfortunately, equity is also lacking in many countries’ healthcare systems, leading to disparities in healthcare utilization and health outcomes as a result. Factors such as “high costs, language and cultural differences, discrimination, administrative hurdles, the inability to affiliate with local health insurance schemes, and lack of information about health entitlements” exist as barriers to migrants, preventing them from accessing the same quality of healthcare and fulfilling their own right to health (World Health Assembly, 2017, p. 4). Similarly, migrants tend to overuse emergency services and underuse primary care, which inherently compounds with the language barrier and lack of knowledge of health resources to create disparities in continuity of care and leading to worse outcomes in certain chronic disease (Lebano et al., 2020).

This multifactorial burden of migrating to a new country inevitably leads to worse health outcomes. Lebano et al. (2020) reports that migrants are more susceptible to “communicable diseases, occupational diseases, poor mental health, injuries, diabetes mellitus, and maternal and child health problems” (p. 3). In combination with poor access to healthcare resources, migrants’ health tends to deteriorate during their time living in a foreign country. In order to address these inequities, healthcare systems need a greater focus on making their care and knowledge more accessible for all people, despite their country of origin.
MSHC

All of the above-mentioned barriers, as well as an overall lack of appropriate cultural competence training for healthcare staff and the presentation of health conditions by migrants that are not commonly seen in the new country, such as those caused by the “effects of displacement, trauma, torture, or sexual abuse,” outlines the necessity of migrant-sensitive systems (Fortier, 2010, p. 3). MSHC aims to “incorporate the needs of migrants into all aspects of health services financing, policy, planning, implementation, and evaluation” (p. 3). These systems are not just “migrant”-sensitive, they are built to ideally be culture-, diversity-, and disparity-sensitive as well. There is no one way to do this, but the Global Consultation for Migrant Health suggests developing language services, culturally informed care delivery, culturally tailored health promotion, disease promotion, and disease support programs, institutional and community-based cultural support staff, migrant-friendly primary healthcare, overall capacity of the health system, and research and data collection to build a strong, sensitive foundation. Villa and Raviglione (2019) summarize it succinctly by asserting that:

A proper migrant-sensitive system should provide free of charge services, with availability of interpretation and language-appropriate written materials. To reduce discrimination, health care workers must be trained to be culturally sensitive and well-informed, thus knowing how to raise a topic according to the beneficiary. Efforts should be made to overcome possible societal stigma originating from the home country culture, especially when handling mental health disorders, as well as lack of trust in providers. In addition, adapting services for adverse living and working conditions through regular working hours and reasonable service locations can increase adherence and outcomes of treatment. The model of care should also account for the nature of risk factors and health
determinants, together with the co- or multi-morbidities connected with social disadvantages. Engaging people and local communities in the strengthening of health services may prove crucial. (p. 47)

Implementations of the MSHC concept have been slow to develop throughout the world. In 2002, 12 hospitals from varying European countries sought out to establish “migrant-friendly hospitals” with the principle four focuses: international communication, responsiveness to the socio-cultural backgrounds of migrant and minority patients, empowerment of migrant and minority patients and communities, and monitoring the health of migrants and minorities and the healthcare they receive (Bischoff et al., 2009). Though the project has since ended, a Task Force for Migrant-Friendly and Culturally Competent Healthcare was formed within the larger WHO Health Promoting Hospitals and Health Services.

On a policy level, Mladovsky et al. (2012) conducted an exploratory study of various European migrant health policies. According to their timeline, in 2004, “ten of the 25 EU member states provided only emergency care to asylum seekers” and, in 2010, “only five of the now 27 EU member states…gave undocumented migrants access to virtually the same range of services as nationals of that country” (p. 2). The results of their study revealed that, as of 2009, only 11 of the 25 European countries had “established national policies that are aimed at improving migrant health and go beyond statutory or legal entitlements” (p. 4). The policies varied greatly in their primary health focus and coverage. England, Spain, and the Netherlands looked to improve mental health care, while Italy looked more to reproductive healthcare and communicable disease and Germany focused on the health of women and girls. The policy aims provided were generally more broad strategic directions listing a number of tasks: improved training, interpreter provision, data collection, and improved health education. While these
strategies are necessary, Mladovsky et al. (2012) also highlight that little information is provided on the implementation of these policies both in initial and follow-up reports. Similarly, although the policy is published at a national level, implementation is performed at the discretion of regional leadership, leading to uneven application and results.

**The need for MSHC in rehabilitation**

Cieza (2020) estimates that there were 2.41 billion people in 2019 with a condition that would benefit from rehabilitation, a set of interventions aimed at lessening physical, mental, or cognitive limitations caused by disease, injury, or trauma (p. 6). Although a variety of disease areas would benefit from rehabilitation, the most prevalent is MSD (1.71 billion people) and, more specifically, low back pain (568 million people). MSD impact migrant and refugee populations more heavily, as they are more likely to engage in hazardous occupations, are not privy to many preventive instructions due to language barriers, and many times fear reporting their conditions in case of “employee reprisal, income loss, or even deportation” (Senthanar, 2018, p. 460).

Senthanar (2018)’s study focused specifically on the preventative measures taken in Canada to avoid MSD in refugees and found that a great disparity arises in the linguistic availability of occupational safety and hazards education. The Institute of Work and Health in Canada provides many resources to migrants explaining employment standards, occupational health and safety, and worker’s compensation, but the resources are primarily in French or English. Furthermore, resources on MSD prevention are made available to employers and workers, but do not address migrant participation and cultural competency in the workplace. Although some improvements are being made in the sense of cultural competence toolkits for
employers, the majority of MSD education still focuses on prevention, and the study does not touch on the availability of rehabilitation for migrants in Canada.

Going beyond the common MSD that affect both non-migrants and migrants alike, there are also migrant-specific health issues that require a degree of cultural competence to understand and treat. Migrants, and refugees specifically, are often fleeing conflict-ridden homes and many times experience some sort of trauma or torture before arriving in their new country (Fortier, 2010). Practitioners need training on handling these situations and the health situations that arise from them. For example, in a 2015 study by the International Organization of Physical Therapists, 21% of the surveyed physical therapists reported that they had treated women or girls for the effects of female genital mutilation (FGM), but there is very little literature on if physiotherapy is effective for the symptoms related to FGM (Brook, 2018).

While the concept of MSHC is beginning to become more mainstream in policy and humanitarian missions, the idea of MSHC in rehabilitation specifically is still a relatively new field. Accessibility to migrant-sensitive rehabilitation is not an easy feat to accomplish, as the users fall into two highly marginalized groups: migrant and disabled, yet the need for such care is great and requires a greater focus in literature. Grandpierre et al. (2018) outlines several challenges to achieving cultural competence in rehabilitation, listing the influence of a patient’s culture on their values and beliefs regarding health and care, the fact that rehabilitation interventions are built to cater to a large, broad audience, and the incorrect interpretations of patients’ competence and symptoms leading to misdiagnosis and ineffective treatments.

According to the Grandpierre et al. (2018) study, a migrant-sensitive approach includes inquiring about a patient’s culture and allocating more time to visits with migrant patients to foster more connection and trust, employing a more diverse workforce and fostering a culturally-
competent workplace with more training and education, utilizing interpreter services, and providing a more comprehensive understanding of the purpose and process of the rehabilitation to the patient and their family. Cieza (2020) also suggested the integration of rehabilitation into primary healthcare to alleviate some of the socioeconomic disparities in rehabilitation utilization, which could also be useful for migrants to reduce the number of practitioners visited and could also be extended to community-based rehabilitation, where members of the migrant community are directly involved in the development and implementation of rehabilitation interventions. Approaching rehabilitation this way would be beneficial in fostering trust between patient and practitioner and eliminate the language barrier (Nualnetr, 2009).

Analysis

**Accessibility, Utilization, and Outcomes of Rehabilitation for Migrants in Germany**

More than 20% of Germany’s population if of immigrant origin, and approximately half, 7.6 million people, are non-German nationals (Brzoska, 2018, p. 2). In Germany, the majority of the immigrant population originated in Turkey, former Yugoslavia, and SE (Portugal, Italy, Spain, and Greece), and thus are the most represented groups in the literature regarding migrants and rehabilitation in Germany.

In general, it has been shown that migrants utilize less preventative healthcare, such as screening, vaccinations, and rehabilitation, and also experience worse health outcomes in comparison to native Germans (Brzoska, 2018). Migrants are more likely to develop certain chronic diseases, such as Type II Diabetes and mental illness, and experience higher rates of occupational diseases and accidents, as well as disability. These outcomes are not necessarily linked directly with their country of origin. Rather, migrants in general have less favorable living conditions and socioeconomic statuses and tend to work in more physically and psychologically
stressful environments, oftentimes in a manual manufacturing setting. That said, having a migrant origin creates several barriers in accessing healthcare in Germany. 

Even if the rehabilitation system is physically accessible, there are several migrant-specific characteristics of a system that prevents migrants from utilizing their resources. In Germany, these characteristics center around the lack of health literacy and knowledge of the healthcare system in migrant populations, facilities being non-sensitive to religion, culture, and gender, persisting discrimination, and miscommunication driven by a reduced German language proficiency (Schröder et al., 2020, p. 9). Such barriers have generated the statistic that migrants are 40% less likely to utilize medical rehabilitation in general (p. 9). More specifically, among employees in the German workforce, Schröder et al. (2020) found no significant differences in utilization of in-patient services among German-born employees and 1st and 2nd generation migrant employees but did find that 1st generation migrants are 58% less likely to utilize out-patient services than German-born employees, even when considering sociodemographic and other explanatory co-variates (Schröder et al., 2020, p. 8).

In order to reduce these disparities, German institutions thought to implement migrant-sensitive aspects to the rehabilitation prospects. Langbrandtner et al. (2018) outlines these changes as: migrant-sensitive orientation via systemic organization, migrant-sensitive accommodations supplies and meals, multilingual services, and appreciation (p. 55-56). However, the same study investigated the websites of 44 rehabilitation facilities to assess their migrant-sensitive services and found that only 9.1% included cultural sensitivity in their missions, none mention professional interpreters, 13.6% offered a website translation, but was mainly limited to English and only on some pages, 4.5% employed diversity officers, 6 facilities provided a website search function, and none state any sort of quality management for migrant-
sensitive services (Langbrandtner et al., 2018, p. 58-59). Other migrant-sensitive services exist in a parallel structure to normal services, creating facilities focused on only treating people of a certain origin. While these facilities do take into account the needs of a group besides German nationals, this system leads to exclusion and hinders the integration process. These staggering statistics indicate that there still needs to be a systemic shift to integrate successful changes and correlates with the finding that there has been no change in the disparities of rehabilitation outcomes from 2006 to 2014 (Brzoska, 2018).

Brzoska (2018) studied rehabilitation outcomes in Germany and found that nationals from SE, former Yugoslavia, and Turkey had a 17%, 50%, and 43% higher chance respectively than German nationals of completing rehabilitation without improvement (p. 6). Brzoska and Razum (2015) echo this finding with their own that 54.2% of German nationals, 28.1% of Turkish nationals, 34.5% of former Yugoslavian nationals, and 38.0% of SE nationals had an improvement in their state of health and everyday life as a result of rehabilitation (p. 556). The same study also found that rehabilitants from Turkey had a higher probability of being only moderately or slightly satisfied with their rehabilitation, with the most pronounced differences being in the “treatment” and “health education” categories (12% and 10% higher respectively than for German nationals (Brzoska & Razum, 2015, p. 556-557).

The general consensus for the German literature is that there are persisting disparities in both utilization and outcomes of rehabilitation services for migrants and there must be diverse healthcare offers promoting cultural openness and competence as well as accessibility to understandable, needs-based information to allow migrants the same rights and opportunity to make informed decisions about their health and reap the same benefits of the rehabilitation process.
Analysis of Swiss Practices

Swiss Migrant Landscape and Health

According to a report from the 2017 Swiss Health Survey by the Office Fédéral de la Statistique (FSO), 37.2% of the Swiss population over the age of 15 is a migrant, with 81% of this population being a 1st generation migrant, meaning they were born abroad. Migrants in Switzerland have a lower state of mental and physical health than the native Swiss population (FSO, 2020, p. 1). 1st generation migrants from South-West Europe are 8% more likely to present with significant physical disorders and 7% more likely to present with osteoarthritis than for native Swiss and 1st generation migrants from East and South-East Europe are 5% more likely to present with significant physical disorders and 6% more likely to present with risk factors for cardiovascular disease than the native Swiss population (p. 2). The report also found that while there was not evidence of a systemic difference in access to care (82% of the migrant population had seen a doctor in the past 12 months), migrants were significantly less likely to utilize specialty care and dentistry, but more likely to opt for primary care and emergency services (p. 4).

Migrant Access to Healthcare

In Switzerland, migrants are entitled to the same health benefits as native Swiss people and are expected to comply with the national law requiring all residents have a form of basic health insurance (Navarro & Liewald, 2017). Residents are required to purchase at least a basic health insurance plan from one of the 53 health insurance companies in Switzerland. Under these plans, policyholders pay an annual premium to their insurer and an annual deductible (CHF 300 minimum) in exchange for coverage of the rest of their medical treatment (Health Insurance Costs). After filling the deductible, policyholders are still required to pay 10% of their medical
bills up to CHF 700, as well as a flat rate CHF 15 per day in the event of a hospital stay. Maternity services and certain preventive care are excluded from these costs, meaning there is no deductible or hospital cost contribution. This insurance coverage ensures policyholders’ right to inpatient treatment, emergency treatment, medications, pregnancy and childbirth treatment, rehabilitation, illness abroad, and alternative treatment. Residents have the option to add supplemental insurance to cover other health needs, such as optometry and dentistry.

The average annual premium in 2018 was CHF 5584 (average cantonal premiums ranged from CHF 4248 to CHF 7102) for the basic insurance coverage model (Tikkanen et al., 2020). There are premium-saving models for those who cannot afford or wish not to pay the premium cost. Under these models, policyholders are responsible for a larger out-of-pocket deductible for their medical treatment in exchange for a lower premium for the same coverage (Health Insurance Costs). Other options include restricting your medical consultations to primary care or telemedical practitioners and only seeking specialty care with a referral from these practitioners. For those with financial constraints, each canton offers premium reductions based on income level and financial situation.

This health insurance model applies to all residents of Switzerland, including migrants and, specifically, asylum seekers, refugees, and sans-papiers (Bilger et al., 2011). For those with N, F, and S permits, cantonal authorities automatically provide health insurance (Navarro & Liewald, 2017). Hospitals are obligated to provide emergency care to all people, including sans-papiers, and health insurance companies are obligated to accept all people to their basic health insurance plan, regardless of their immigration status. Sans-papiers are also protected in the sense that hospitals, insurance companies, social services, and cantonal authorities do not have the right to report personal data on sans-papiers to the Immigration Department.
According to Badia El Koutit, the founder of APDH, the process for migrants to access rehabilitation services in Switzerland is to first visit a general practitioner, for the case of insured migrants, or to visit a community clinic, for the case of migrants without legal status, and obtain a prescription in order to access the specialty care (Badia El Koutit, personal communication, November 29th, 2021).

**Migrant-Friendly Hospitals**

The path to building a migrant-friendly healthcare system in Switzerland began in 2005 and 2006 as part of the Federal Office of Public Health (FOPH) Migration and Public Health Strategy. In 2009, a group of eight hospitals and hospital networks received federal funding as part of this project to become cultural competence centers and evaluate the needs for an action program to building a migrant-friendly system. In 2010, the initial steps of this action program were taken through the funding of five hospital groups: Basel University Hospital (USB), Solothurner Spitäler AG and Aarau Cantonal Hospital (UNIDO), the Swiss Pediatric Hospital Alliance (AllKidS), Vaud University Hospitals (CHUV), and Geneva University Hospitals (HUG). Each hospital or group submitted their own funding proposals to become a “center of excellence” in the needs of treatment of migrants, with actions in several categories, such as: cultural competence, communication, mental health, diversity management, interpreting, patient empowerment, and training and research, and worked to implement their plans over a three-year period (Activities of the Swiss Hospitals for Equity, 2018).

**HUG**

The HUG group in Geneva interacts with the largest population of migrants, with 40% of Geneva residents and 50% of HUG patients being of a foreign nationality, 25% of Geneva residents speaking a language other than French as their primary language, and 8% of HUG
patients speaking no French at all (Hudelson et al., 2014, p. 2). Even before receiving the FOPH funding, HUG was implementing migrant-friendly initiatives such as primary care clinics specifically for asylum seekers, uninsured patients, and migrant children, psychiatric consultation for migrant children and victims of war and torture, and a community interpreter service ran by the Geneva Red Cross. The “Health for All Network” (now called Healthcare Network for Everyone) was established at the HUG with the FOPH action program funding and several new migrant-friendly initiatives were implemented over the next three years. A reference-nurse post was established at the hospital for migrant care issues, language data was included in electronic patient files, a national telephone interpreting service was promoted in four emergency services, new staff were given an orientation on the interpreting and migrant-friendly services available, brochures were created and disseminated for staff on when and how to use the migrant-friendly services, and public events were organized to bring attention to the Health for All Network. A representative of HUG revealed that all migrant patients now have access to several cross-cutting resources, such as interpreter services, social workers, cultural consultations, chaplains, dietary choice, and “healing spaces” that can be used for prayer and meditation. These are resources that can be accessed from any department or facility within HUG, but there are also several clinical units throughout the canton that specialize specifically in treating migrants (Anonymous, personal communication, December 2\textsuperscript{nd}, 2021).

The efforts of the Health for All Network are almost exclusively aimed at the staff at HUG and improving their competence in using hospital services. However, Hudelson et al. (2014) conducted surveys with the HUG staff, revealing that by the end of the three-year period, less than half of the responding staff had even heard of the HUG Health for All Network. They did report improvements in communicating across language barriers but had not improved the
staff’s comfort level in taking social/cultural backgrounds and identifying sources of cultural misunderstanding. One potential reason for this is a lack of cultural competence training for staff at the HUG. According to the HUG representative, there are courses in the undergraduate medical training in Switzerland that address topics on cultural competence and the challenges of treating vulnerable populations, so the topics are not addressed again with staff after they have completed medical training (Anonymous, personal communication, December 2nd, 2021).

Integrating a new training curriculum for the staff in which the MSHC services provided by the hospital can be included and described in the context of addressing cultural competence could improve these statistics. There is clearly still work to be done on the side of the staff; however, there is an even greater need to include migrants in the implementation of migrant-friendly initiatives.

An analysis of the HUG website (https://www.hug.ch/en) revealed very little information about the migrant-friendly services provided at the hospital, besides the fact that they exist, or on how to access them. The website is only provided in English and French, automatically hindering any patient who does not speak one of those two languages from inquiring about services at the hospital. The website does have a search function, enabling some mobility on the website if the user knows what services they are looking for in French and English. The Healthcare Network for Everyone mission statement does inform migrants about the HUG’s dedication to providing quality care to migrants, but there are no details on the multilingual or culturally sensitive services provided by the hospital. The only migrant-friendly service mentioned at all in the Pediatric Migrant Health Consultation to assess and monitor the health of migrant children who are patients at the HUG Children’s Hospital.
In terms of geographic accessibility, there are 38 locations associated with the HUG hospital group, shown below in yellow. Of these locations, the HUG website specifically mentions 7 that provide rehabilitative services, shown in red. The map’s blue shading reflects the percentage of the population in each of Geneva’s 44 communes that was born outside of Switzerland, attained from the FSO data titled “Permanent and non-permanent resident population by institutional units, place of birth, sex and marital status” (FSO Section Demography and Migration, 2021).
31 of the HUG locations, 5 being of those providing rehabilitation services, are located within the Genève commune, encompassing the city center. The concentration of facilities in this area is to be expected, as this is the most populated area of the canton with 205,610 of the 509,098 total residents. 59.14% of the population, or 121,604 people, living in the canton were born abroad. This number is reflective of 46.78% of the total migrant population in the canton of Geneva. There are seven other communes in the canton of Geneva where migrants compose more than 49% of the population (Pregny-Chambtsy, Le Grand Saconnex, Vernier, Meyrin, Versoix, Cologny, and Genthod), yet there are no HUG facility locations in any of these communes.

At least one HUG rehabilitation facility is within an hour’s journey on public transport from all areas in only 11 communes, leaving 33 communes with at least some geographic area that is more than one hour’s travel time to the closest HUG rehabilitation center. The results are even more shocking for walking time. There are 16 communes with no geographical area that is

Figure 3. An isochrone map reflecting accessibility by public transport to HUG facility locations that provide rehabilitation services. Areas shaded in red could access at least one facility within one hour if departing at 12:00 PM on Monday, November 23rd.

Figure 4. An isochrone map reflecting accessibility by walking to HUG facility locations that provide rehabilitation services. Areas shaded in red could access at least one facility within one hour if departing at 12:00 PM on Monday, November 23rd.
within one hour’s walking distance from any of the rehabilitation services and only 10 that are completely within the hour range. One of these 7 facilities is the Community Care Mobile Clinic Consultation (CAMSCO), a HUG clinic targeted towards vulnerable population groups, such as homeless persons, those without health insurance, and sans papiers. Madame El Koutit states that for those without legal status to receive a prescription for specialty rehabilitation care in Geneva, they must first visit the CAMSCO (Badia El Koutit, personal communication, November 29th, 2021). The location and timetables for CAMSCO is shown below, with a darker isochrone input shown for clarity.

![Figure 5. An isochrone map reflecting accessibility by public transport to the CAMSCO facility. Areas shaded in red could access at least one facility within one hour if departing at 12:00 PM on Monday, November 23rd.](image1)

![Figure 6. An isochrone map reflecting accessibility by walking to the CAMSCO facility. Areas shaded in red could access at least one facility within one hour if departing at 12:00 PM on Monday, November 23rd.](image2)

CAMSCO is located in the Geneva city center, thus the migrant population living in the Genève commune have the greatest accessibility, however some populations living in the adjoining communes could reasonably access the clinic by walking and the clinic alone has a similar accessibility compared to all of the HUG rehabilitation facilities in terms of public transport, being available to the majority of the canton, excluding the communities living closer to the outskirts of the canton. Despite these findings, the HUG representative claims that there is
no difference for geographic access between migrants and non-migrants and that migrants do not live in remote areas of the canton (Anonymous, personal communication, December 2nd, 2021). However, the statistics provided by the Swiss Confederation in the “Permanent and non-permanent resident population by year” data table revealed that there are between 129 and 121,604 migrants in every commune in Geneva. While there are definite differences in the number of migrants in each canton, those living in the more rural or less populated areas of the canton cannot be disregarded. This could imply, though, that the disparity in geographic accessibility in the canton is not between migrants and non-migrants, but rather between rural and urban residents. Nevertheless, this disparity would still burden migrants more heavily, especially those of lower SES or who are disabled, who may not have access to a vehicle or the understanding, funds, and physical ability to access public transportation.

**General Rehabilitation Facilities**

It is also possible that migrants will seek out their own rehabilitation services outside of the HUG network. Utilizing local.ch, the official phonebook website for Switzerland, I used the simple search term “Rehabilitation” to locate potential services migrants could seek out. This search returned 49 results. After filtering for repeats and relevance, I was left with 36 site locations, seen below. Similar to the HUG group, the majority of these sites are located within the Genève commune (20 out of 36), but there is more commune diversity overall.
Figure 7. A map reflecting the proportion of each commune’s population was born in a country other than Switzerland and the locations of rehabilitation facilities in the canton of Geneva, as provided by local.ch.

There are rehabilitation centers in 10 of the 44 communes in the canton of Geneva, including 3 communes in which migrants compose more than 50% of the population. The majority of the facilities are concentrated in and around the Genève commune, similar to the HUG locations, with a few facilities venturing towards the southern communes of the canton. The communes on the western, eastern, and northern sides of the canton have no rehabilitation facilities according to the local.ch results. The arrangement of these facilities further confirms the theory that there is an inequity not necessarily to the migrant population, but rather between to the canton’s rural residents. Populations living in the communes on the edge of the canton are significantly further from the concentration of facilities in the city center, leaving them to rely on vehicles or public transport to access those facilities.
The accessibility of general rehabilitation services from public transport is relatively similar to that of the services offered by HUG; however, the density of red shading on the map in many areas implies that patients have more options to choose from in their vicinity. The walkability to these services is also relatively similar to that of HUG facilities, except that the communes on the eastern side have noticeably less access while those on the western side have more opportunity for a reasonable walking distance than with solely HUG locations. This analysis does not take into account the migrant-sensitive services offered by these facilities.

Utilizing the methodology developed by Langbrandtner et al. (2018) to analyze the integration of migrant-sensitive services into rehabilitation center websites, I analyzed the available websites provided for these 36 locations. Of the search results provided by local.ch, there were 21 functioning websites associated one of the facilities which were analyzed for multilingual services provided, culturally sensitive mission statements, and the inclusion of other migrant-sensitive services offered.
Only six (28.6%) of the websites were offered in a language other than French; however, in all cases, the other available language was English. Four (19.0%) of the websites also included the languages spoken by some or all of the practitioners and staff. Both Ms. Clancy and Madame El Koutit echoed this outcome in their interviews, stating that while interpreters are common in hospitals, they are rare in private practices (Meg Clancy, personal communication, November 29th, 2021; Badia El Koutit, personal communication, November 29th, 2021). Yet, according to Ms. Clancy, communication is one of the most critical parts of rehabilitation, as “a huge component of physiotherapy is patient education—for example, explaining the benefit, reasoning, and techniques being used for their treatment—so, without the ability to easily communicate with your patient, this becomes very difficult.”

In terms of mission statements, there were four (19.0%) results that could loosely be associated cultural sensitivity, although only one (4.8%) mentions culture outright. Specific key words utilized in these statements that stood out were respect, adaptability, and mindfulness. The only migrant-sensitive services noted in the website investigations were the offer for telemedicine or home treatment in four (19.0%) facilities, compliance to special dietary restrictions in two (9.5%), physiotherapy catered specifically to women in one (4.8%), and self-assessment tools provided by one (4.8%). Migrants were never mentioned outright in any of the websites, so it is difficult to say if these services were created with migrants or cultural sensitivity in mind at all. These results do demonstrate, however, that even if rehabilitation services are accessible geographically, it is unlikely that these services would accommodate the cultural and linguistic needs of a migrant patient. It is possible that there are more migrant-sensitive services provided beyond what is listed on the website. However, as Langbrandtner et al. (2018) states in their study, more than one in two people in Germany, including migrants, use
the internet to access health information and services, and this finding could reasonably be true in Switzerland as well. While the provision of migrant-sensitive services is incredibly important in private facilities as much as in hospitals, it is equally as important to advertise these services openly on the internet so that migrants can be informed of the type of care they can and will receive.

The role of humanitarian organizations

**APDH**

APDH ([https://www.apdh.ch/](https://www.apdh.ch/)) is an “international, non-profit, religiously neutral, non-governmental organization (NGO)” operating in the canton of Geneva. They provide training and seminars on human rights in Switzerland to various groups, including vulnerable migrant populations, imprisoned persons, and human rights students. Their primary target are Arabic-speaking migrants in Geneva from the Middle East and North Africa. There are a variety of activities conducted by APDH aimed at improving the lives of migrants, such as: intercultural communication through hotline and individual interview consultations, their Citizenship program which empower migrants by educating them about their personal, family, and social well-being through thematic round tables, the Migration and Culture program which serves to integrate migrants to Swiss culture through round tables at Geneva cultural venues, research and publications on migration and integration issues, trainings on human rights, interculturality, and migration to a variety of audiences, and advocacy for intercultural issues at the local, regional, national, and international levels.

The APDH addresses the health of migrants primarily through their Citizenship program round tables. Their thematic round tables address a variety of topics, put forth at the request of the audience, but several have been directed towards helping migrants better understand health,
mental health, the Swiss healthcare system, and psychiatry. For example, during the COVID-19 round table, facilitators answered the audience’s questions about how the vaccine worked in the body and the side effects of the vaccine using easy terminology and speaking in their native tongue to ensure that the audience fully understood the benefits and risks of the vaccine. This sort of programming which is organized specifically with the needs of the migrant is incredibly important, as many migrants just need a mediator in their new country to ease the process of integrating to new systems and cultures.

**SRC and migesplus**

The SRC ([https://www.redcross.ch/en](https://www.redcross.ch/en)) is a humanitarian aid organization comprised of 24 cantonal associations, 4 rescue organizations, 2 institutions, and the SRC Head Office. Their seven Fundamental Principles—“Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity, and Universality”—guide them towards assisting vulnerable and underprivileged populations Switzerland. Although they work in a variety of capacities, one of their projects aimed at assisting migrants in Switzerland is migesplus.ch, a website that provides health information brochures, guides, films, and educational materials in up to 56 languages. The materials utilize simple language for the educationally disadvantaged and disabled as well. By covering a wide array of topics, migesplus inadvertently addresses the topic of migrant-sensitive rehabilitation by providing health information on the process of the Swiss healthcare system, back pain and rheumatism, FGM, their health promotion and prevention program “Move” encouraging movement and exercise, and the process for accessing intercultural interpreters.

Beyond migesplus, SRC also works to combat the inequalities in the Swiss healthcare system. This has been seen most recently with their efforts to reduce inequities in COVID-19 testing and vaccination by bringing attention to the existing disparities, advocating for those with
unstable residence or legal status in accessing testing and vaccinations, and working to bring as many vaccines to the countryside as the cities.

Conclusion

As the world witnesses ongoing conflicts, climate disasters, and poverty, the issue of migration will remain at the forefront of critical agendas. While migration and human mobility in general continues to grow, so must the investment into migrant-sensitive systems, specifically health systems. This paper has demonstrated that the health needs of migrants are vastly different from those living in their native countries, yet there is still a large gap in the literature considering the extent of these differences and the proper steps to address them. The need for widespread implementation of MSHC systems throughout the world is critical to address these differences and begin to offer equitable services to all people, regardless of race, religion, migration status, or SES.

While many developed countries have begun some sort of implementation of MSHC systems, a disparity still remains among rehabilitation services, despite the fact that MSD and other conditions warranting rehabilitation treatment remain one of the most prominent health concerns for migrants. The literature collected on the status of migrant health and rehabilitation in Germany demonstrated that migrants tend to utilize rehabilitation less than non-migrants, reap less benefits from rehabilitation, and experience worse health outcomes. One reason for this is the lack of MSHC in rehabilitation.

While the same studies have not yet been conducted for Switzerland, a geographic analysis of the migrant-sensitive and general rehabilitation offerings echoed its result: the current migrant-sensitive rehabilitation offerings are not enough. A greater effort must be made to make rehabilitation accessible to all people, even those living in remote areas. There are limitations to
this study. Only the rehabilitation centers within the canton of Geneva are considered, although there may be closer facilities in the neighboring canton of Vaud or in France that could reasonably be accessed before those in the canton of Geneva. Furthermore, the migrant-sensitive services investigated and included in this study were only those gleaned from website analyses. As the HUG representative revealed, there are many services at the HUG that were not advertised on their website, and it is possible that this is true for private facilities as well. That said, the internet is a powerful tool used by billions, and making tools and services accessible on the internet is just as important as it being available physically. Even so, future studies should consider all of the services offered by practices, not just the ones advertised on their websites. It would also be beneficial to extend the study parameters to consider the whole of Switzerland, rather than just the canton of Geneva. This approach would eliminate any limitations caused by not considering neighboring cantons and identifying areas of the country where accessibility to care is a larger issue for migrants.

While the work done by the HUG, APDH, and SRC have been crucial to bringing migrants the rights and abilities they currently have, the work is still far from over. Migrant-sensitive systems must exist in private healthcare settings as well as hospital settings, so that migrants are not limited in their service offerings, and the literature must begin to address the gaps currently existing in the Swiss healthcare system for there to be any progress towards erasing them.
Abbreviation List

AllKidS – Swiss Pediatric Hospital Alliance
APDH – Association pour la Promotion des Droits Humains
CHUV – Vaud University Hospitals
EU – European Union
FGM – Female Genital Mutilation
FOPH – Federal Office of Public Health
FSO – Federal Statistical Office
HUG – Geneva University Hospitals
MSD – Musculoskeletal Disorder
MSHC – Migrant-Sensitive Healthcare
SE – Southern Europe
SES – Socioeconomic Status
SRC – Swiss Red Cross
UNIDO – Solothurner Spitäler AG and Aarau Cantonal Hospital
USB – Basel University Hospital
WHO – World Health Organization
Bibliography

PRIMARY

Badia El Koutit, personal communication, November 29th, 2021

Meg Clancy, personal communication, November 29th, 2021

Anonymous (HUG), personal communication, December 2nd, 2021

SECONDARY


FSO Section Demography and Migration. (2021, June). Population and Households Statistics STATPOP Definition of the permanent resident population.


from https://www.commonwealthfund.org/international-health-policy-center/countries/switzerland.


## Appendix

### Appendix 1. Resident Population in Geneva by Institutional Unit

<table>
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<th>Identifying Code</th>
<th>Name</th>
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## Appendix 2. General Rehabilitation Facility Website Analysis Results

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<tr>
<th>Name</th>
<th>Website</th>
<th>Language/Translations</th>
<th>Mission Statement include migrants/culture Y/N</th>
<th>MSHC Services Offered</th>
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<td>Physionomade</td>
<td><a href="https://www.physionomade.ch/contact">https://www.physionomade.ch/contact</a></td>
<td>French only</td>
<td>&quot;We all share the same humanistic values and we adapt to the needs of patients in their daily lives&quot;</td>
<td>Comes to home or nursing home</td>
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<td>Institut Genevois de la Main et du Membre Supérieur</td>
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<td>Alpha-Reha Sàrl</td>
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<td>Physio-Centre de Vernier</td>
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<td>French only</td>
<td>&quot;From the start, and with the recent and enriching experience that I had just acquired, I wanted to remain faithful to a line of conduct when I arrived in Vernier: &quot; Respect the Patient &quot;.&quot;</td>
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<td>Activ Santé Physiothérapie</td>
<td><a href="https://www.activsante.ch/">https://www.activsante.ch/</a></td>
<td>French only</td>
<td>N/A</td>
<td>Home treatments, physiotherapy dedicated specifically to women, some staff includes languages spoken</td>
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<td>Clinique du Grand Salève</td>
<td><a href="https://www.grand-saleve.ch/">https://www.grand-saleve.ch/</a></td>
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<td>N/A</td>
<td>Meals are catered to special dietary requirements</td>
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<td>Elia Coppens</td>
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<td>Plaut Michael</td>
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<td>Clinique Bois-Bougy Sàrl</td>
<td><a href="https://www.bois-bougy.ch/">https://www.bois-bougy.ch/</a></td>
<td>French only</td>
<td>Beyond the technical aspect of care, a permanent reflection on our values is constantly carried out by the teams: the well-being of the patient and the respect of his rights are at the center of our concerns, our therapeutic approach is based on the partnership between the patient and the caregivers, we attach great importance to the welcome and comfort of families and loved ones, we respect each other's beliefs and culture, our teams are aware of and respect patients' rights</td>
<td>Compliance to specific diets</td>
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<td>Office Med Centre Médical Georges-Favon</td>
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<td>Languages spoken by practitioners, self-assessment tools</td>
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<td><a href="https://www.clinique-maisonneuve.ch/">https://www.clinique-maisonneuve.ch/</a></td>
<td>French only</td>
<td>N/A</td>
<td>None listed</td>
</tr>
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<td>Delessert Yves</td>
<td><a href="http://www.yvesdelessert.com/index.php?id=2&amp;L=1">http://www.yvesdelessert.com/index.php?id=2&amp;L=1</a></td>
<td>French and English</td>
<td>N/A</td>
<td>None listed</td>
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<tr>
<td>Hôpital de La Tour</td>
<td><a href="https://www.latour.ch/en">https://www.latour.ch/en</a></td>
<td>French and English</td>
<td>&quot;In addition to providing expertise, our mission commits us to caring for each and every one of our patients while being mindful of the quality of life that they cherish and deserve, and offering them the same care that we would want for ourselves and our loved ones.&quot;</td>
<td>None listed</td>
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