Health Service Research

Guidelines and training initiatives that support communication in cross-cultural primary-care settings: appraising their implementability using Normalization Process Theory

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Abstract

Background. Guidelines and training initiatives (G/TIs) available to support communication in cross-cultural primary health care consultations are not routinely used. We need to understand more about levers and barriers to their implementation and identify G/TIs likely to be successfully implemented in practice.

Objective. To report a mapping process used to identify G/TIs and to prospectively appraise their implementability, using Normalization Process Theory (NPT).

Methods. RESTORE is a 4-year EU FP-7 project. We used purposeful and network sampling to identify experts in statutory and non-statutory agencies across Austria, England, Greece, Ireland, Scotland and the Netherlands who recommended G/TI data from the grey literature. In addition, a peer review of literature was conducted in each country. Resulting data were collated using a standardized Protocol Mapping Document. G/TIs were identified for inclusion by (i) initial elimination of incomplete G/TI material; (ii) application of filtering criteria; and (iii) application of NPT.

Results. 20 G/TIs met selection criteria: 8 guidelines and 12 training initiatives. Most G/TIs were identified in the Netherlands (n = 7), followed by Ireland (n = 6) and England (n = 5). Fewer were identified in Scotland (n = 2), and none in Greece or Austria. The majority (n = 13) were generated without the inclusion of migrant service users. All 20 were prospectively appraised for potential implementability by applying NPT.

Conclusions. NPT is useful as a means of prospectively testing G/TIs for implementability. Results indicate a need to initiate meaningful engagement of migrants in the development of G/
Each of these has subcomponents that are divided into a set of 16 collective action (enactment) and reflexive monitoring (appraisal). Time and space, and the inter-relationships between different kinds of health care contexts (response to multiple failures to implement innovations in complex the application of Normalization Process Theory (NPT). Prospectively appraising their potential implementability through communication in primary care settings in six European countries. This paper focuses on improving communication between migrants and primary care providers.

Introduction

Responding to the health needs of migrants is difficult and a universal issue in European primary health care where there is still important progress to be made. This problem is further marked by differences between countries in their (primary) health care systems, and their migrant health care policies (1). In addition, there are significant differences between countries in relation to migrant groups, in terms of cultural diversity, religious affiliation, ethnicity and country of origin (1–3). Notwithstanding these differences, primary health care is directed at the care of individuals in most countries (4), including the most vulnerable communities (5). This is why improvement of health care of migrants should be approached through primary health care. This paper focuses on improving communication between migrants and primary care providers.

Communication in primary health care

Communication skills are a core competency for GPs (6), and vital in achieving optimal health outcomes (7). The fundamental importance of communication in general practice consultations is amplified in cross-cultural consultations involving migrants where additional language and cultural difficulties exist. In such situations, it is often a challenge for patient and doctor to surmount language and cultural barriers sufficiently to develop the necessary trusting relationship, and ensure clinical effectiveness (8,9), particularly when informal rather than professional trained interpreters are used (10,11). For that reason, international organizations have called for primary health care to be provided in a culturally appropriate way (12,13).

Evidence-based guidelines and training initiatives (G/TIs) are available for students, educators and practitioners in European settings and have been reviewed and evaluated in a recent EU project, http://www.mem-tp.org. Despite the availability of these resources, they are not routinely used in day-to-day practice (1,14). Therefore, to address this translational gap, it is necessary to understand more about levers and barriers to their implementation and, ideally, to identify G/TIs that are likely to be successfully implemented in practice.

The EU RESTORE project (REsearch into implementation STRategies to support patients of different ORigins and language background in a variety of European primary care settings) in migrant health was developed to investigate and support the implementation of G/TIs to improve cross-cultural communication in primary health care delivery throughout Europe. This paper reports on a first step in RESTORE: identifying G/TIs designed to support communication in primary care settings in six European countries and prospectively appraising their potential implementability through the application of Normalization Process Theory (NPT).

Normalization Process Theory (NPT) was developed as a response to multiple failures to implement innovations in complex health care contexts (15). It is not a rigid conceptual framework but is designed to emphasize the realities of implementation work in real time and space, and the inter-relationships between different kinds of implementation work. There are four components in NPT (Table 1): coherence (sense-making), cognitive participation (engagement), collective action (enactment) and reflexive monitoring (appraisal). Each of these has subcomponents that are divided into a set of 16 sensitizing questions that have been successfully used by researchers as sensitizing concepts in implementation research (15,16). Our use of NPT to prospectively appraise G/TIs is a unique use of NPT and represents a significant contribution to the literature on communication in cross-cultural consultations.

Methods

Study context

This study is part of a 4-year EU FP-7 project, RESTORE. We were interested in working closely, meaningfully and in a democratic way with key stakeholders (migrant patients, GPs, practice staff, community interpreters, migrant representatives and policy planners) in five of the six participating countries (Austria, England, Greece, Ireland and the Netherlands). Scotland’s brief was to focus on policy-related implications of the research. The choice of these countries was directly related to the academic teams who developed and submitted the original FP-7 proposal and intentionally contains countries with diverse primary health care systems, ranging from those regarded as weak (Greece and Ireland) to strong (UK and the Netherlands) (17,18). Following pilot work in Ireland, a mapping process was carried out to identify G/TIs in all participating countries following the steps outlined below.

Identification of pertinent G/TIs

We utilized purposeful network and snowball sampling to identify agencies and individuals who we expected would be able to assist us in identifying potentially useful G/TIs in the ‘grey literature’. Those contacted included academic, policy planner, migrant service user and community interpreter colleagues. This initially involved accessing networks already known to research teams in each country, rippling outwards from these to wider networks of linked colleagues and agencies, with the initial network in each country growing to become a larger and more inclusive network. This trawl of grey literature was our primary means of identifying examples of G/TIs to include in a comprehensive portfolio.

We also conducted a literature search of peer-reviewed articles in each country to identify examples of any language-specific G/TIs that had been developed. We used a variety of databases and resources including ‘Web of Science’, within Web of Knowledge, SCOPUS plus EMBASE and Cochrane. Each country also accessed a number of databases specific to their own settings (see RESTORE website for complete databases included, www.fp7restore.eu).

The focus of our search was on primary care and followed the comprehensive definition in the Alma-Ata Declaration (19) and the core competencies of primary care as described in The European Definition of General Practice. Although we did not actively pursue examples from secondary health care, we decided not to exclude secondary health care examples if suggested to us by our networks of colleagues—acknowledging that, in some of our settings, secondary health care refers to specialist services that may be either community or hospital-based. This meant that we allowed examples from secondary care to be included on a case-by-case basis if country teams and partner leads judged them to be of sufficient value for this primary care research project.
Table 1. NPT constructs, subconstructs and 16 sensitizing questions applied to 20 G/TIs

<table>
<thead>
<tr>
<th>NPT constructs</th>
<th>Cognitive Participation: can stakeholders get others involved in implementing the intervention?</th>
<th>Collective Action: what needs to be done to make the intervention work in practice?</th>
<th>Reflexive Monitoring: Can the intervention be monitored and evaluated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subconstructs: 16 sensitizing questions</td>
<td>Enrolment: do the stakeholders believe they are the correct people to drive forward the implementation? Are they prepared to invest time and energy in it?</td>
<td>Interactional workability: does the intervention make it easier or harder to complete routine tasks?</td>
<td>Systematization: will stakeholders be able to judge the effectiveness of the intervention?</td>
</tr>
<tr>
<td>Differentiation: do stakeholders see this as a new way working?</td>
<td>Initiation: are they willing and able to engage others in the implementation?</td>
<td>Skill-set workability: do those implementing the intervention have the correct skills and training for the job?</td>
<td>Individual appraisal: how will individuals judge the effectiveness of the intervention?</td>
</tr>
<tr>
<td>Individual specification: do individuals understand what tasks the intervention requires of them? Can they make sense of the work it might create for them in their daily routine?</td>
<td>Activation: can stakeholders identify what tasks and activities are required to sustain the intervention?</td>
<td>Relational integration: do those involved in the implementation have confidence in the new way of working?</td>
<td>Communal appraisal: how will stakeholders collectively judge the effectiveness of the intervention?</td>
</tr>
<tr>
<td>Internalization: do all the stakeholders grasp the potential benefits and value of the intervention?</td>
<td>Legitimation: do they believe it is appropriate for them to be involved in the intervention? Do they ‘buy into’ it?</td>
<td>Contextual integration: do local and national resources and policies support the implementation?</td>
<td>Reconfiguration: will stakeholders be able to modify the intervention based on evaluation and experience?</td>
</tr>
</tbody>
</table>

Screening of identified G/TIs

A ‘Protocol Document’ was used in each setting to help researchers in each country review their identified G/TIs in a consistent and rigorous manner. When G/TIs that lacked sufficient material were eliminated, a set of filtering criteria were then applied to the comprehensive portfolio (Table 2) in order to guide the selection of G/TIs in all countries. Seven (equally weighted) criteria were deemed to be essential in sharpening the focus for what to include when searching the grey literature and were strictly applied, that is, we only included G/TIs that comprehensively met all seven criteria. An eighth criterion was identified by RESTORE colleagues as a highly desirable one that was congruent with our project aim to involve all key stakeholders, ‘was the item generated in a participatory manner in terms of having migrant input’.

To see how implementable they were, each team appraised the included G/TIs using NPT. This ensured that the assessment process was conducted in a consistent manner across countries and that decisions were informed by knowledge related to factors that promote or impede implementation processes and thus support the normalization of the implemented G or TI in each country.

We first piloted the use of NPT on a set of five G/TIs and from this developed a standardized set of instructions for teams to appraise the remaining G/TIs. The instructions were to use the 4 NPT constructs and set of 16 NPT-based sensitizing questions to appraise the G/TIs using teams’ knowledge of their local setting and contexts. All teams were asked to give a score in an excel sheet on a five-point ‘Likert Scale’ for each. They were asked to record their decision-making processes about the scores using qualitative notes and, then, to make a judgement on the overall implementability of each G/TI.

Results

Across the consortium, 325 agencies were accessed through local networks in each country. These were statutory and non-statutory organizations who suggested relevant country-specific examples of G/TIs. A wide range of organization types were accessed: medical, academic, primary care, university departments, policy and health services, health care planning organizations, professional bodies, interpreting organizations, migrant support agencies, advocacy and representative organizations, equality organizations, nurse training organizations, cultural mediation and cultural competency contacts. We identified 230 examples of G/TIs from a large variety of sources and from different countries (Table 3). The results of the peer reviewed literature searches in each country yielded only one additional G/TI (included in the 230) in the Netherlands (‘Practical Assignment—Cultural Interview’: a training initiative designed to teach GP trainees how to carry out a cross-cultural interview with migrant patients).

As Table 4 shows, 97 examples of G/TI-related material were not sufficiently detailed in description to be of further use and were eliminated (n = 97). These eliminated ‘components’ of G/TI material were in the form of articles, books, information packs and applications for smart phones. After applying our filtering criteria, the remaining 133 G/TIs (guidelines, n = 69 and training initiatives, n = 64) was reduced to a set of 20 relevant examples. These consisted of 8 guidelines and 12 training initiatives. Half of the guidelines (n = 4) originated in

Table 2. Inclusion/exclusion criteria applied to remaining G/TIs after elimination of incomplete material

<table>
<thead>
<tr>
<th>Number</th>
<th>Inclusion/exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the focus on primary health care?</td>
</tr>
<tr>
<td>2</td>
<td>Is the focus on migrants?</td>
</tr>
<tr>
<td>3</td>
<td>Is the focus on migrants who experience language and cultural barriers?</td>
</tr>
<tr>
<td>4</td>
<td>Does the item (G/TI) aim to enhance communication in cross-cultural consultations?</td>
</tr>
<tr>
<td>5</td>
<td>Was the item generated as a guide or support for professional health-care workers?</td>
</tr>
<tr>
<td>6</td>
<td>Is the item practically shareable with stakeholders in the field?</td>
</tr>
<tr>
<td>7</td>
<td>Does the item match your health focus?</td>
</tr>
<tr>
<td>8</td>
<td>Was the item generated in a participatory manner in terms of having migrant input?</td>
</tr>
</tbody>
</table>

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Ireland, while half of the training initiatives \( (n = 6) \) originated in the Netherlands. The greatest number of suitable G/TIs were identified in the Netherlands \( (n = 7) \), followed by Ireland \( (n = 6) \) and England \( (n = 5) \). Fewer were identified in Scotland \( (n = 2) \), and no relevant examples were identified in Greece \( (n = 0) \) or Austria \( (n = 0) \). We also note that none of the resources identified in this European six-country mapping process has the status of being an official professional standard guideline or training initiative.

All of the included 20 G/TIs addressed the well-known difficulties in cross-cultural communication, offering advice and/or training programmes to GPs and other health care providers. Only one of the G/TIs focused on ‘why migrants should communicate with health services through an interpreter’, while another directly involved migrants along with other key stakeholders to design a more inclusive guideline. Please see Supplementary Appendix in Supplementary Documentation for a more detailed description, comparison and summaries of the 20 G/TIs and in addition please see this website for links to the original sources (http://www.fp7restore.eu/index.php/en/about-restore/relevantgtis).

We also analysed how the 20 G/TIs related to the filtering criteria. It was notable that only 7 of the 20 matched criterion number 8. This points to the fact that the large majority \( (n = 13) \) of the 20 G/TIs were generated without the inclusion of migrant service users/patients, meaning that their important perspectives were missing from these G/TIs. Following the NPT appraisal, differences between country settings were apparent. Seven G/TIs were not selected by any country as all teams considered them unlikely to have implementation potential in their specific contexts. The reason for low NPT scores (leading to elimination of G/TIs) was that in some cases, the G/TIs did not ‘make sense’ in the local context (low coherence), for example, cultural mediation was not fully understood or familiar in the Greek or English settings. Sometimes stakeholders also excluded G/TIs because they did not believe they could drive the implementation forwards sufficiently or encourage others to do so (low Cognitive Participation). For example, the English team chose not to select some G/TIs because they were judged to be too lengthy and this would act to discourage implementation by some stakeholders. In other cases, there was a lack of essential resources to support the implementation work (low Collective Action). For example, as there are no longer state funds to pay interpreters in the Netherlands the Dutch team eliminated all G/TIs that involved the use of interpreters. The diversity of findings across settings suggests that, as expected, issues of context and cultural specificity might be influencing the appraisal process.

**Discussion**

**Summary**

In this paper, we have described a mapping process that accessed a large number of G/TIs that focused on primary healthcare for migrants. An important aspect of this study was the way NPT was then used to prospectively appraise G/TIs and therefore identify ones that had the likelihood of successful implementation.

**Methodological critique**

The study identified 20 pertinent G/TIs originating from four of the six participating countries. We acknowledge that there is a limited number of countries included in this study. There is, by definition, a trade-off between number of research groups involved and the depth of interaction, and, on balance, we consider the choice for in-depth interaction the correct one. We acknowledge the abundance of other G/TIs related to our own topic in EU countries who have not participated in the RESTORE project (20).

No relevant G/TIs were found in Austria and Greece, despite the central role of primary health care for migrants’ health in these countries. Our search strategy was directed at the most likely sources where G/TIs for primary health care professionals were published and disseminated, and national teams led this search. Therefore, it is in our view highly unlikely that methodological bias can be the reason for this result. Primary health care in Austria and Greece is therefore encouraged to develop more resources for the care of migrants.

An important aspect of this study was the way NPT was used to prospectively appraise G/TIs and therefore maximize the likelihood of successfully implementing G/TIs designed to enhance communication between GPs and migrant service users. It was important to pilot the use of NPT in this way. We acknowledge that research teams found it difficult to answer some of the 16 sensitising questions without knowing which stakeholders or sites were going to be involved with the implementation work.

**Key findings**

We highlight the usefulness of the NPT constructs as they encouraged stakeholders to focus on issues related to the work that needed to be completed for implementation and the need to actively engage other important actors; the constructs thus worked as an effective mechanism of elimination in all countries.

There were marked differences between the six participating countries that have very different and unique histories of migration and primary health care development (21). Given this, it was unsurprising that the Netherlands and England, with long histories of primary health care and in-migration, identified several resources. What was more surprising was that Ireland, whose migration history had been one of net emigration until relatively recently (22), yielded the second highest number of G/TIs after the Netherlands.

The inclusion of stakeholders and service users in intervention development has been demonstrated to enhance the suitability of interventions in addressing health issues. Drawing on the existing knowledge of stakeholders, such as service users and community

**Table 3. Comprehensive portfolio: distribution of 230 G/TIs by country, type and number**

<table>
<thead>
<tr>
<th>Country</th>
<th>Guideline</th>
<th>Training initiative</th>
<th>Information pack</th>
<th>Articles</th>
<th>Report</th>
<th>Book</th>
<th>Computer application</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>The Netherlands</td>
<td>24</td>
<td>47</td>
<td>5</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>15</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td>18</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Subtotal by type</td>
<td>69</td>
<td>64</td>
<td>13</td>
<td>34</td>
<td>35</td>
<td>6</td>
<td>1</td>
<td>8</td>
<td>230</td>
</tr>
<tr>
<td>Total Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
groups, ensures the suitability of intervention design and the validity of guidelines for implementation in specific contexts as well as increasing the likelihood of ‘buy in’ (23–27). The mapping process showed the limited role migrants have in the development of G/TIs. Of the seven G/TIs that did involve migrants in their generation, we can be sure that only three of these are explicit about the strong involvement of migrants while the remaining four merely mention in passing that migrants contributed. This leaves the question open as to whether these four engaged in a genuinely meaningful way with migrants, or in a ‘lighter’, more consultative manner.

The lack of migrant engagement in the development of G/TIs reflects a situation where primary health care remains in a mode of doing ‘for’ migrants rather than ‘with’ them, and might well be an important factor as to why G/TIs remain relatively underutilized and underimplemented.

Conclusions and recommendations

It proved very useful to prospectively apply the NPT theoretical framework to the identified G/TIs. Reporting our experiences here may be useful for other researchers considering using NPT as a predictive tool for implementation of G/TIs in primary care settings.

The mapping process allowed us to clearly establish that, in their generation, very few G/TIs in the study involved meaningful engagement with hard-to-reach migrants. The literature is clear that this is not a helpful approach, and we suggest that researchers involved in the development of such interventions involve migrants and their communities early in the design stage, throughout the ongoing development and testing of the implementation, to final evaluation and dissemination. If migrants are involved as suggested above, their involvement will constitute a ‘co-design’ and ‘co-evaluation’ process that meaningfully links resource development in primary health care with hard-to-reach communities.

Given that none of the resources identified in this European six-country mapping process has the status of being an official professional standard guideline or training initiative, we suggest that attention be given to the generation of European professional standards for the development of G/TIs in this field, similar to the CLAS (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care) standards in the USA http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.
Such a standard would offer a set of clear guidelines on key 'non-negotiable' elements to be adhered to in the generation of such resources in all European settings, including the recommendation that the involvement of migrant service users/patients would be required in the generation of guidelines designed to enhance communication between health care providers and migrants who experience language and cultural barriers.

Declaration

Funding: none.

Ethical approval: no ethical approval was required for this component of the RESTORE project as this was a mapping activity based on identifying publically available resources. The RESTORE project did receive all ethical approvals for those components of the project that required them from the relevant national/regional/local approval boards in each of the participating countries.

Conflict of interest: none.

Supplementary material

Supplementary material is available at Family Practice online.

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References