II. Migration

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Improving the quality of care for a culturally diverse population: Understanding immigrant women's hospital experiences

Abstract

The European Union has seen a marked rise in immigration over the last decade. The study aims to describe the nature of health problems for which immigrant women most often seek medical help and explore their health system/healthcare professional experiences and their perception of the level of integration of culture in the care delivered. A mixed methods research design was used. The quantitative part included 52 immigrant women hospitalised in a single Slovenian hospital for female diseases and obstetrics between March and September 2018. The data were collected using a semi-structured questionnaire. The qualitative part was based on a descriptive-interpretative approach which encompassed a purposive sample of five immigrant women with experience of the Slovenian healthcare system. The data were gathered in 2018 with a semi-structured, one-to-one interview. Immigrant women most often sought help in a healthcare institution due to gynaecological problems, fever/infectious diseases and injuries. One of the greatest problems affecting the quality of medical treatment in everyday clinical practice perceived by the immigrant women was the language barrier and gender issues, especially concerning the provider. The integration of cultural concepts into healthcare should occur on systemic and operative levels.

1. Introduction

Migration is increasing around the world. People move to high-income countries for a variety of reasons. Individuals usually emigrate to improve their socio-economic status (labour migration), for study reasons or to seek family reunification, although a significant share of them are also forced to migrate due to war, human rights violations or persecution.[1] In the last decade, the European Union (EU) has con-

[1] Trine Filges, Edith Montgomery, Marianne Kastrup, Anne-Marie K. Jørgensen: The

fronted a significant rise in immigration from outside the continent, leading to a growing ethnically diverse population in many EU member states. Data for 2015 indicate that approximately 54 million immigrants are living in the EU, making up almost 10.4 % of the total population.[2] While it is generally believed that the majority of immigrants are male, data for 2018 show that women account for around 46.0 % of international migrants in EU-27 member states,[3] showing that the migration of women is an important element of international migration.

There is a general consensus that migrant women are a particularly vulnerable group that should be guaranteed early access to the healthcare system.[4] However, unequal access to health services between migrant women and the host population are reported around the globe.[5] The literature[6] shows that migrant women face delayed access to screening (e. g. mammograms and cervical cancer screening), treatment and care (regular check-ups to help prevent, detect and treat diseases like heart disease, cancer and diabetes), have limited access to family planning (contraception and pregnancy termination)

Impact of Detention on the Health of Asylum Seekers: A Systematic Review. In: Campbell Systematic Reviews 11 (2015), pp. 1–104; Nicole C. Schmidt, Vanessa Fargnoli, Manuella Epiney, Oliver Irion: Barriers to Reproductive Health Care for Migrant Women in Geneva: A Qualitative Study. In: BMC Reproductive Health 15 (2018), https://doi.org/10.1186/s12978-018-0478-7.

[2] Vivian Graetz, Brend Rechel, Wim Groot, Marie Norredam, Milena Pavlova: Utilization of health care services by migrants in Europe-a systematic literature review. In: British Medical Bulletin 121 (2017), pp. 5–18.

[3] Eurostat: Migration and Migrant Population Statistics (2020). https://ec.europa.eu/eurostat/statistics-explained/pdfscache/1275.pdf (accessed 5. 9. 2020).

[4] Ines Keygnaert, Aurore Guieua, Gorik Oomsab, Nicole Vettenburgc, Marleen Temmermana, Kristien Roelensa: Sexual and Reproductive Health of Migrants: Does the EU Care? In: Health Policy 114 (2014), pp. 215–225; Zelalem B. Mengesha, Janette Perz, Tinashe Dune, Jane Ussheret: Refugee and Migrant Women's Engagement with Sexual and Reproductive Health Care in Australia: A Socio-Ecological Analysis of Health Care Professional Perspectives. In: PLoS One 12 (2017), https://doi.org/10.1371/journal.pone.0181421.

[5] Céline Ledoux, Eva Pilot, Esperanza Diaz, Thomas Krafft: Migrants' Access to Healthcare Services within the European Union: A Content Analysis of Policy Documents in Ireland, Portugal and Spain. In: Globalization and Health 14 (2018), https://doi.org/10.1186/s12992-018-0373-6; Schmidt, Fargnoli, Epiney, Irion: Barriers to Reproductive (Note 1).

[6] Filges, Montgomery, Kastrup, Jørgensen: The Impact of Detention (Note 1); Keygnaert, Guieua, Oomsab, Vettenburgc, Temmermana, Roelensa: Sexual and Reproductive Health (Note 4).

and are at greater risk of sexually transmitted infections. The reasons for these health inequalities between migrant women and the host population are multifactorial and hence quite complex. The main reasons for such inequalities are identified as language barriers and general communication problems between healthcare professionals and patients, lower health literacy, the low multicultural competence of healthcare providers, negative attitudes and low trust between healthcare professionals and patients, higher socio-economic stressors among migrant women/minority groups, difficulties in providing care for undocumented migrants, and issues arising during hospitalisation.[7]

Research on migrant women's experiences continues to show that healthcare providers lack awareness of such women's existence while the expectations between women and healthcare professionals are often uneven due to differences in culture.[8] Recognising the factors that might contribute to inequalities in the way migrant women are treated may help healthcare professionals in their efforts to make sure that women receive culturally appropriate care.[9] Culturally competent care is defined as a patient-centred approach that respects the diversity in the patient population and the cultural factors able to influence health and healthcare, such as language, beliefs, values, attitudes and behaviour.[10] Health systems that do not address cultural

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[7] Anna Bonmatí-Tomás, Maria del Carmen Malagón-Aguilera, Cristina Bosch-Farré, Sandra Gelabert-Vilella, Dolors Juvinyà-Canal, Maria del Mar Garcia Gil: Reducing Health Inequities Affecting Immigrant Women: A Qualitative Study of Their Available Assets. In: Globalization and Health 12 (2016), https://doi.org/10.1186/s12992-018-0373-6; Paola O. Ikhilor, Gabriele Hasenberg, Elisabeth Kurth, Fana Asefaw, Jessica Pehlke-Milde, Eva Cignacco: Communication Barriers in Maternity Care of Allophone Migrants: Experiences of Women, Healthcare Professionals, and Intercultural Interpreters. In: Journal of Advanced Nursing 75 (2019), pp. 2200–2210; Sandra Peláez, Kristin N. Hendricks, Lisa A. Merry, Anita J. Gagnon: Challenges Newly-Arrived Migrant Women in Montreal Face When Needing Maternity Care: Health Care Professionals' Perspectives. In: BMC Globalization and Health 13 (2017), https://doi.org/10.1186/s12992-016-0229-x; Schmidt, Fargnoli, Epiney, Irion: Barriers to Reproductive (Note 1).

[8] Ikhilor, Kurth, Asefaw, Pehlke-Milde, Cignacco: Communication Barriers in Maternity (Note 7).

[9] Mirko Prosen, Sabina Ličen, Urška Bogataj, Doroteja Rebec, Igor Karnjuš: Migrant Women's Perspectives on Reproductive Health Issues and Their Healthcare Encounters. In: Sabina Ličen, Igor Karnjuš, Mirko Prosen (Eds.): Women, Migrations and Health: Ensuring Transcultural Healthcare. Koper 2019, pp. 117–137.

[10] Jacqueline McKesey, Timothy G. Berger, Henry W. Lim, Amy J. McMichael, Abel

diversity within healthcare institutions find it hard to provide culturally appropriate and congruent care.

The study aims to describe the nature of the health problems for which immigrant women most often seek medical help while exploring their health system and healthcare professional experiences together with their view on the level of integration of culture into the care delivered.

2. Methods

A mixed methods research design was used. This research approach requires a purposeful mixing of methods in data collection, data analysis and interpretation of the evidence. Mixed methods research exploits the potential strengths of both qualitative and quantitative methods and allows researchers to explore the different perspectives and relationships that exist between the complicated layers of the multiple research questions. This approach is often used in healthcare these days due to the internationally growing complexity of healthcare delivery.[11]

The quantitative part is based on a survey comprising a convenience sample of 52 migrant women hospitalised in one Slovenian hospital for female diseases and obstetrics between March and September 2018. Only adult migrant women over the age of 18 were included in the survey, and participation in the study was voluntary. Data were collected by means of a semi-structured questionnaire developed by the University of Trieste in collaboration with Burlo Garofolo Paediatric Institute. The Italian version of the questionnaire was translated into Slovenian and adapted to the Slovenian cultural context by a panel of experts in the field of health and sociology, and coordinated with the existing health system in the Republic of Slovenia. In addition to the socio-demographic part, the questionnaire contained 69 items concerning the social integration of migrant women in the host country and their sexual and reproductive health. Relevant is-

Torres, Amit G. Pandya: Cultural Competence for the 21st Century Dermatologist Practicing in the United States. In: Journal of the American Academy of Dermatology 77 (2017), pp. 1159–1169.

[11] Allison Shorten, Joanna Smith: Mixed Methods Research: Expanding the Evidence Base. In: Evidence-Based Nursing 20 (2017), pp. 74–75.

sues were analysed only for the purposes of this paper. The participants' confidentiality and anonymity were guaranteed and maintained during the completion and return of the questionnaire. All participants were informed about the objectives, guidelines and study methods. The quantitative data were analysed using univariate descriptive statistics. The data were processed and analysed using SPSS version 23 (SPSS Inc., Chicago, IL, USA). For topics where open questions were used, the respective word units were ranked and presented according to the frequency of their occurrence.

The qualitative part was based on a descriptive-interpretative approach which included a purposive sample of five immigrant women with experience with the Slovenian healthcare system. Qualitative descriptive designs tend to be methodologically eclectic and based on the general premises of constructivist inquiry.[12] Interpretativeness in this approach requires integrity of purpose from an actual goal in practice and therefore seeks to generate new insights able to help shape applications of qualitative evidence to practice.[13] The data were gathered in spring 2018 with a semi-structured, one-to-one interview. The interviews lasted 30 minutes on average and were conducted at the women's homes on invitation. All women were informed about the study's purposes and signed an informed consent. The qualitative data were analysed using the method of content analysis.[14]

The study was performed as part of the European Union funded project Interreg V-A Italy-Slovenia 2014–2020 »Cross border network for migrant women: social integration, sexual and reproductive health – INTEGRA« and focused on various aspects of migrant women's lives. Within this project, the data collected was analysed from different perspectives and the findings in this book chapter are presenting one of this perspective. The funding source had no role in the: study design; collection, analysis and interpretation of data; writing of the manuscript; and decision to submit the manuscript for publication. The study was approved by the National Medical Ethics Committee (26. 10. 2017; No. 0120–544/2017/7).

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[12] Geri Lobiondo-Wood, Judith Haber: Nursing research: Methods and critical appraisal for evidence-based practice. 9th Edition. St. Louis, Missouri 2018.

[13] Janet Houser: The nursing research: reading, using, and creating evidence. 4th Edition. Burlington, Massachusetts 2018.

[14] Denise F. Polit, Cheryl Tatano Beck: Essentials of Nursing Research: Appraising Evidence for Nursing Practice. 9th Edition. Philadelphia 2017.

3. Findings

3.1 Quantitative study findings

The convenience sample included 52 migrant women. The participants' average age was 32.46 years (SD=8.06). Most participants (n=32; 61.5 %) had immigrated to Slovenia between 2014 and 2018. The average duration of their stay in Slovenia was 4.16 years (SD=7.25). Most of the migrant women included in the study come from the former republics of Yugoslavia (n=36; 69.2 %) or Russia (n=11; 21.2 %) and are members of the Orthodox Church (n=26; 50 %) or Islam (n=19; 36.5 %). With regard to their current employment status in Slovenia, 28 respondents (53.8 %) said they were unemployed or running a household and being at home; 24 (46.1 %) said they had a job. The majority of migrant women (n=44; 84.6 %) had completed at least upper secondary education or more. The main reason for moving to Slovenia was the desire to join a family member already living in Slovenia (n=29; 55.8 %). A similar proportion indicated marriage (n=10; 19.2 %) or work (n=11; 21.2 %). Participants were also asked whether they spoke the Slovenian language. More than 50 % do not speak Slovenian or speak it only a little.

The respondents named cardiovascular diseases such as arterial hypertension, acute myocardial infarction, angina pectoris, etc. (n=33) and diabetes (n=15) as the most common family diseases. Other family diseases cited by migrant women were diseases of the thyroid gland (n=7), liver disease (n=6), stroke (n=4) and cancer (n=4). Since having arrived in Slovenia, the health status of the majority of respondents (n=38) had not changed, although seven participants stated their health status had improved and four that the number of diseases had decreased. They most frequently sought help in a health facility for gynaecological problems (n=20), fever/infectious diseases (n=12) and injuries (n=10). Fifteen respondents (28.8 %) had experienced one or more abortions in the past. The latter mostly come from less developed republics of former Yugoslavia such as Kosovo (n=3), Bosnia and Herzegovina (n=3) and North Macedonia (n=4), as well as from Russia (n=3).

The participants were asked whether they had encountered any difficulties in society by virtue of belonging to a different ethnic group. Eleven respondents (21.1 %) answered this open question in the affirmative, with most mentioning communication problems due

to their poor language skills (n=6) and, as a result, difficulties in integrating into everyday social life (e.g. socialising with neighbours). However, three respondents reported problems with finding work and two stressed they had encountered disrespectful behaviour in administrative offices.

Most respondents (n=51) stated they had not been subjected to any form of discrimination or violence in a healthcare institution; only one indicated she encountered less tolerance towards those who did not speak Slovenian properly. The biggest obstacle when in contact with a healthcare provider was the »language barrier« (n=32), but they also noted the »time constraints when dealing with foreigners« and »lack of knowledge of other cultures«. A large share of respondents (n=39.75 %) believed that interpreters/translators would be a possible solution for bridging communication problems in clinical settings. Another suggestion for improving communication between healthcare professionals/institutions and patients from other countries is to provide more healthcare professionals who either speak other languages or even come from other countries/cultures, as well as leaflets, brochures and instructions for foreign patients in different languages.

3.2 *Qualitative study findings*

The purposive sample included five women. The average age of the respondents was 34.6 years. Their education level was relatively low: three had completed elementary school, one vocational and one secondary school. Three women were nationals from North Macedonia, one migrated from Bosnia and Herzegovina, and one from Kosovo. Two of the respondents migrated to Slovenia because of marriage and three to re-join their husband who was a working migrant in Slovenia. Three women had two children and two women three. Their average age upon their first child was 18.6 years. All of the respondents included in the qualitative study had lived in Slovenia for over 10 years; three in the rural and two in urban parts. All of the women declared themselves to be Muslim.

The results of the content analysis, which was focused on »social diversity«, »access to healthcare« and »minority groups«, yielded two themes: (1) ensuring respectful care; and (2) culture affects access to healthcare.

The first theme of »respectful care« represents the respondents' perception that they had received appropriate care and were satisfied with the understanding shown by most of the healthcare professionals they had encountered. Besides pointing out the qualities of the health system in Slovenia compared to their home country, other aspects were also put in the forefront:

> »I'm very satisfied with the system here. When you get your turn, you receive care that you need. You always get your answers and things are explained to you.«

> »The health system is ›free‹ and this means a greater chance of health for you.«

One respondent who takes care of her two children, now both adults with intellectual disabilities, described her experience with the health system upon arriving in Slovenia. She described the understanding displayed by healthcare professionals, also informing her of her rights and access to health and social security possibilities for her family and herself.

> »There was that doctor, I cannot remember her name. She informed me so much about the things (diapers, wheelchair, hospital bed) I need for my two children and how to get them. This really improved my children's quality of life. […] When you arrive and you are new here, you do not know how to get things or access the health system. I'm perfectly aware that my children would have a different quality of life in Macedonia than here (Slovenia).«

She also described the role of the community nurse upon arriving in Slovenia, who not only assisted with accessing the health system or »bringing the health system to them«, but also helped them become more included in the community.

> »At the beginning, the children had nothing. They were at home. But then the community nurse came to us because she found out that we have two children with intellectual disabilities and asked me if I would accept her help. I answered that I would do so gladly. She suggested that it wouldn't be good that the children are at home all the time and that they need to be included in different development programmes in specialised institutions. And so both of them did. This helped them both a lot. She draws, reads, uses a mobile.«

The second theme »culture affects access to healthcare« is even more revealing. It emphasises the need for healthcare professionals to de-

velop cultural competences and to empower them with cultural knowledge and skills, and for developing strategies to tackle cultural issues that limit access to healthcare due to patriarchy and gender issues. All of the women described how the gender of a healthcare professional is an important factor for accessing the health system, especially when the reasons involve gynaecology or obstetrics.

> »The gender of a practitioner is important. If you really need to see a doctor, you go to a male doctor if there is no other choice.«

> »Gender is an important factor. When I first arrived, I had a male doctor and I was so embarrassed, because of the exam. Afterwards, I found a female doctor, because in our culture a male doctor cannot touch you. I feel better with this doctor.«

One woman described an »offensive« experience, even though her own perception of it was different:

> »I had an older doctor. He was around 70 years. […] Two years ago, I had the feeling that something wasn't right here (showing her breasts) and I didn't want to go to the doctors. It was hard but finally I went. He mentioned to me that he sees that I'm embarrassed but that he is just doing his work. Then he said to take my shirt off. Then also my undershirt. At the end, he said he has to undress me like an onion (laughs). […] After this experience, my son changed the doctor and chose a female doctor.«

On that note, access to healthcare seems to be affected even before a woman enters the healthcare arena. Culturally-rooted gender issues and strong patriarchy, even if at first glance they do not seem very present, still shape women's access to healthcare. Each of the respondents confessed that they turn to a husband or another family member (most often mother-in-law) before going to see a doctor: »First I turn to a family member, then I go to the doctor.«

This was noticeable in another interview topic where one woman stated:

> »Concerning men as the authority in the family […] it is a bit strict. Well, not that strict, but it is polite to notify your husband before taking on a survey or doing an interview. A woman has to ask her husband, but it is her choice whether to participate or not.«

It may be concluded that the same principal applies when health issues emerge and women need medical assistance. In this context, the husband's presence during the examination is described in two cases

that, despite being ethically questionable and causing a great dilemma for healthcare professionals in delivering care, is also a matter to be considered in terms of health system access. Refusing a husband might mean negative health outcomes for the woman or unwilling exclusion from the health system, e. g. cancer screening.

4. Discussion

The study shows the respondent migrant women had not often experienced any form of discrimination or violence in the health system. Moreover, they found the care provided to be adequate, pointing out the high quality of the healthcare system in Slovenia. The main difficulty they encountered in the clinical environment when in contact with healthcare staff was the language barrier. Therefore, introducing interpreters/translators could be a possible way to overcome the communication problems. However, the content analysis also revealed the need for healthcare professionals to develop additional cultural knowledge and skills.

In the 1990s, Slovenia was confronted with a major wave of migration due to the war in the Balkan region. At that time, refugees mainly from Bosnia and Herzegovina and Kosovo applied for asylum. Although up until recently Slovenia was mostly not the final destination for those coming to Europe from other continents for various reasons, the situation has changed somewhat in the last few years. In fact over the past decade, Slovenia, like other EU member states, has been under pressure due to the migration flows resulting from the conflicts in the Middle East and Africa.[15] This growing cultural diversity means that not only society but also the healthcare system is facing increasing challenges. The migrant population often has different habits, traditions and healthcare needs and therefore requires a different approach to medical treatment. Some studies suggest that migrants face various problems in the healthcare system in Slovenia, among which language barriers and healthcare professionals' lacking intercultural skills are the biggest problems.[16]

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[15] Blaž Lenarčič, Mateja Sedmak: Reproductive Health of Migrant Women in Slovenia: State of the Art. In: Sabina Ličen, Igor Karnjuš, Mirko Prosen (Eds.): Women, Migrations and Health: Ensuring Transcultural Healthcare. Koper 2019, pp. 35–57.

[16] Uršula Čebron Lipovec: »Ko nujno postane nenujno« Raziskovanje zdravstvenih

Language barriers make it difficult for women to find adequate care and understand health information.[17] Successful communication between migrants and healthcare professionals is essential and significantly impacts outcomes and health service delivery. Schmidt et al.[18] found that language barriers increase migrant women's insecurity and fear of using healthcare services and thus limit their access to healthcare facilities. This can delay or even prevent a visit to a specialist and lead to numerous misunderstandings or even traumatic experiences in the medical environment. Healthcare facilities in Slovenia are still reacting slowly to the presence of an ever more diverse population. In fact, the Slovenian health system does not have effective systemic solutions in place to overcome the language barrier in the clinical environment.[19] From a linguistic point of view, the Slovenian healthcare system may be characterised for its pronounced monolingualism. Indeed, interpreters/translators are not systematically regulated in the healthcare system in Slovenia. Moreover, brochures, instructions or various forms, e. g. informed consent, referrals to specialist medical examinations, in different languages other than Slovenian are rarely found. When migrant women do not speak Slovenian, their husband, relative or friend from the ethnic community is often involved in resolving the communication barriers with the health worker.[20] Although these ad hoc interpreters are often the sole solution available in the current situation, they might interpret inaccurately, omit or add information and thus contribute to many errors and misunderstandings in the clinical environment or fail to respect the confidentiality of data.[21] Policymakers are not the only

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vidikov migracije v Sloveniji [»When Urgent Becomes Non-Urgent«: Researching Health Aspects of Migration in Slovenia]. In: Glasnik Slovenskega etnološkega društva 57 (2017), pp. 54–64; Zorana Medarič, Mateja Sedmak: When Language and Culture Interfere: Sexual and Reproductive Health of Migrant Women in the Coastal Region of Slovenia. In: Ličen, Karnjuš, Prosen (Eds.):Women, Migrations and Health (Note 5), pp. 155–171.

17 Ikhilor, Kurth, Asefaw, Pehlke-Milde, Cignacco: Communication Barriers in Maternity (Note 7).

18 Schmidt, Fargnoli, Epiney, Irion: Barriers to Reproductive (Note 1).

19 Uršula Čebron Lipovec, Lea Bombač, Nike Kocijančič Pokorn, Miha Lučovnik: Monoligual Health? Linguistic Barriers in Slovene Healthcare Experienced by Migrant/Refugee Women. In: Ličen, Karnjuš, Prosen (Eds.): Women, Migrations and Health (Note 5), pp. 139–153.

20 Medarič, Sedmak: When Language and Culture Interfere (Note 6).

21 Phyllis Butow, Elizabeth Lobb, Michael Jefford, David Goldstein, Maurice Eisen-

ones who should address the language barrier. At the operational level, health institutions should also more carefully address the problem by reviewing current practices and translating some health promotion/health education materials into different languages according to the actual demographic structure of migrants in the country. In this context, few projects have been carried out in Slovenia to translate some health materials into various languages, e.g. Albanian, Arabic, Russian, Turkish etc., and these are mainly disseminated through websites.[22]

Almost all study participants reported that they did not feel discriminated against by healthcare professionals; they also emphasised that they found the health system in Slovenia to be good. However, the results of the qualitative part of the study reveal a need to develop strategies to address the cultural problems that are hindering migrant women's access to health services as a result of patriarchy and gender issues. Culturally defined gender roles in conjunction with patriarchal values can have an impact on a woman's health.[23] Healthcare professionals must strive to provide culturally appropriate or congruent care, for which cross-cultural competencies are essential. The concept of intercultural competences underlines the importance of taking into account the linguistic, cultural and religious specificities of migrants who are treated in the health system.[24] Yet, recent studies show that many women still have negative experiences in the clinical setting due to the inadequate cultural competence of healthcare providers.[25] Indeed, some prejudices and stereotypes still exist in the

bruch, Afaf Girgis, Madeleine King, Ming Sze, Lynley Aldridge, Penelope Schofield: A bridge between cultures: interpreters' perspectives of consultations with migrant oncology patients. In: Supportive Care in Cancer 20 (2012), pp. 235–244.

[22] Čebron Lipovec, Bombač, Kocijančič Pokorn, Lučovnik: Monoligual Health (Note 9).

[23] Christine Metusela, Jane Ussher, Janette Perz, Alexandra Hawkey, Marina Morrow, Renu Narchal, Jane Estoesta, Melissa Monteiro: In My Culture, We Don't Know Anything About That: Sexual and Reproductive Health of Migrant and Refugee Women. In: International Journal of Behavioral Medicine 24 (2017), pp. 836–845.

[24] Medarič, Sedmak: When Language and Culture Interfere (Note 6).

[25] Medarič, Sedmak: When Language and Culture Interfere (Note 6); Jana Sami, Katharina C. Quack Lötscher, Isabelle Eperon, L. Gonik, B. Martinez de Tejada, M. Epiney, Nicole C. Schmidt: Giving Birth in Switzerland: A Qualitative Study Exploring Migrant Women's Experiences during Pregnancy and Childbirth in Geneva and Zurich Using Focus Groups. In: BMC Reproductive Health 16 (2019), https://doi.org/10.1186/s12978-019-0771-0.

healthcare environment. In the past, no specific training was given in either formal studies or professional careers to prepare healthcare professionals for work in a culturally and ethnically diverse healthcare environment.[26] In the light of the demographic change and growing cultural diversity seen in the EU, healthcare professionals are becoming ever more aware of the need to acquire the necessary knowledge and skills in cultural competence because culturally competent care ensures patient satisfaction and thus leads to better health outcomes for a culturally diverse population.[27] In Slovenia, certain recent project-based initiatives have tried to fill this gap, e. g. by organising training courses on the cultural competence of healthcare professionals.[28] Educational institutions that train healthcare professionals are also becoming increasingly cognisant of the need to include transcultural content in their formal curricula at all levels of study.[29]

Several limitations of this study should be considered. In the quantitative part, we used a relatively small convenience sample. In addition, the quantitative and qualitative parts only included migrant women treated in a single regional maternity hospital in Slovenia. Caution should therefore be exercised when generalising the results of the study. Moreover, in qualitative research both the data and the conceptualised results are vulnerable to subjectivity. However, the mixed methods approach allows for more in-depth analysis with the possibility of combining the evidence in different ways, as dictated by the purpose of the study and the subject matter.[30] Most of the migrant women included in our study had a stable socio-economic background. Future studies should include newly arrived women with irregular status and different backgrounds, e. g. refugees, given that

[26] Čebron Lipovec, Bombač, Kocijančič Pokorn, Lučovnik: Monoligual Health (Note 9).

[27] Ruth W. Gallagher, Joshua R. Polanin: A Meta-Analysis of Educational Interventions Designed to Enhance Cultural Competence in Professional Nurses and Nursing Students. In: Nurse Education Today 35 (2015), pp. 333–340.

[28] Čebron Lipovec, Bombač, Kocijančič Pokorn, Lučovnik: Monoligual Health (Note 9).

[29] Mirko Prosen: Developing Cross-Cultural Competences. In: Obzornik Zdravstvene Nege 52 (2018), pp. 76–80.

[30] Rashmita S. Mistry, Elizabeth S. White, Kirby A. Chow, Katherine M. Griffin, Lindsey Nenadal: A Mixed Methods Approach to Equity and Justice Research: Insights from Research on Children's Reasoning About Economic Inequality. In: Advances in Child Developmeđnt and Behavior 50 (2016), pp. 209–236.

experiences in this group with the healthcare system and healthcare professionals may vary.

5. Conclusion

Healthcare professionals have an important role to play in recognising the health inequalities and different needs of migrant women arising from their cultural and religious background. However, healthcare professionals also have an obligation to prevent and fight health inequalities, and to strive to ensure access to high-quality, safe, integrated, effective and women-centred healthcare. In the study, migrant women emphasised that language barriers and gender issues, particularly in relation to the healthcare provider, largely influence the quality of their medical treatment in everyday clinical practice. This finding underlines the need to adopt a socio-ecological approach at all levels of healthcare in order to improve the quality of care provided and avoid exclusion. Furthemore, given the relatively rapid changes in society, it is crucial that both the systemic and the operational levels of healthcare be adapted to the currently expressed needs of patients entering the health system. It is clear that the problem of health inequalities needs to be addressed in the context of health policy, which must be more responsive to the needs of migrants in general or other minority groups who have access to the health system. In addition, the lack of appropriate guidelines for clinicians and solutions to address the problems that typically cause health inequalities is evident.

In the future, we need to focus on improving research to better understand the phenomena of social integration and social equity within the health system, making health and social services more gender-sensitive, raising self-awareness and finding other ways to stimulate the development of cultural competences. The latter gives healthcare professionals a sense of self-empowerment, provides patients with a sense of equality and healthcare organisations a confirmation of the level of quality of care provided. Ultimately, they are also a reflection of social values and societal attitude towards those who must not remain invisible.