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Improving education and training for health and social care staff to provide person-centred, diversity-sensitive care

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Strategies to support person-centred, diversity-sensitive care

In Europe, persons with migration backgrounds face various barriers to accessing healthcare (Lebano et al. 2020). These barriers include legal restrictions, financial barriers, language barriers, lack of knowledge in navigating health systems and discrimination. A variety of strategies have been proposed by researchers (Diaz et al. 2024), older migrants (Lauwers et al. 2024) and their informal caregivers (Shreshta et al. 2023) to improve access to health and social care services for older migrants. These include the development and implementation of services tailored to the specific needs of older migrants, and education and training for health and social care staff in diversity sensitivity (Kadi et al. 2025). The field of migration and health has made notable progress in recent years, but further advancements are needed, for instance in policy development (Diaz et al. 2024). Researchers have called for increasing the cultural competence of nurses (Gradellini et al. 2021) and other health and social care staff, as well as educating those who train professionals in this field (Gradellinie et al. 2023). Beyond the competences of nurses and other health professionals, the health sector also needs to improve intercultural competence at the national, organisational and professional levels (WHO 2020).

This Policy Brief discusses recommendations for supporting person-centred, diversity-sensitive care through education and training for health and social care staff[1].

1 The results presented here are based on work carried out in the DI.S.C.O.P.M.B. (Diversity-sensitive care of older people with migration background and their informal carers) project, funded through the Erasmus+ programme of the European Union. The DI.S.C.O.P.M.B. project focuses on promoting person-centred, diversity-sensitive care. It developed a training program for face-to-face education and an open online educational resource (massive open online course available in six languages) to be used across health and care professions, in face-to-face teaching and self-study. The training program and the educational resource were developed based on scientific literature, the skills and prior expertise of project partners, and with the input from older persons with migration backgrounds and their families, as well as health and care staff. We are grateful for comments received from Elif Naz Kayran and Mirjam Pot. We also thank Daria Jaric for editing and Anna Obernberger for the layout.

These recommendations on the content and formats of education and training to support diversity sensitivity were jointly developed based on five workshops held in Austria, Sweden, Italy, Finland, and Belgium, which gathered older persons with migration backgrounds and professionals from health and social care services (see Box 1 on D.I.S.C.O.P.M.P.B. methodology).

Box 1: D.I.S.C.O.P.M.B. Methodology

The principles presented in this Policy Brief are based on workshops with older persons with migration backgrounds and individuals providing care for them.

- **Overall workshop topic**: views and experiences regarding person-centred, diversity-sensitive care
- **Number of workshops**: 5 (one each in Austria, Sweden, Italy, Finland and Belgium)
- **Number of workshop participants**: 31
- **Workshop participant composition**: only older people receiving care, only health and care professionals, joint workshop
- **Countries of origin of workshop participants receiving care**: Iran, Bosnia-Herzegovina, Tunisia, China, Iraq
- **Fields of work of health and care professionals**: psychiatry, midwifery, emergency care, radiology, care management, multicultural memory work, associations for health and social care, cultural work, cultural mediation, social work for older persons, support for carers, occupational therapy, psychology and speech therapy.
- **Workshop methods**: photo elicitation; discussion on challenges and best practices in access and provision of person-centred, diversity-sensitive care for older persons with migration backgrounds and their families; discussion of views and experiences on the current state of the art regarding training and education in person-centred, diversity-sensitive care; discussion of suggestions for improving training and education.
- **Workshop documentation**: workshop reports
- **Writing-up of principles**: Policy Brief authors based on the workshop reports

The concept of person-centred, diversity-sensitive care

The barriers to health and social care for older migrants are manifold. They can include, for instance, affordability of services, lack of education, lack of familiarity with the health system or lack of cultural and religious knowledge among staff (Ahhadour et al., 2016). Informal carers of older migrants report culturally insensitive practices by professional carers (Claeys et al. 2025). The provision of person-centred care for older migrants needs to take their particular needs into account, and this requires specific skills by health and care staff. This section discusses the concept of diversity-sensitive care and its origins to provide a foundation for the following recommendations on strengthening education and training for diversity sensitivity.

Cultural competence includes cultural awareness, cultural knowledge, cultural skills, cultural encounter and cultural desire

The origins of person-centred, diversity-sensitive care lie in the concept of transcultural care, as it was developed by Madeleine Leininger in the United States (Prosen 2015; Lauwers et al. 2024). Leininger developed the theory of transcultural nursing since the 1950s and first wrote about it in the early 1990s (Gonzalo, 2024). With the concept of transcultural care, Leininger aimed to improve the delivery of health care by highlighting the need for culturally congruent care, which is congruent with the culture of the person in need of sought to enhance the delivery of healthcare by emphasising the importance of culturally congruent care, which is tailored to the culture of the person in need of care. Courses which provided training in transcultural care have been offered in the United States since the 1970s. While the concept of transcultural care was disseminated internationally at the time, its inclusion in nursing curricula in European countries took much longer (Prosen 2015).

The concept of transcultural care was further developed in nursing education through a focus on cultural competence (Gradellini et al. 2021). Campinha-Bacote's concept of cultural competence, which includes cultural awareness, cultural knowledge, cultural skills, cultural encounter and cultural desire, has become a key reference for teaching cultural competence and addressing the need for transcultural care through education and training. In this context, cultural diversity refers to diversity related to age, gender, ethnicity, socioeconomic status, and other social markers (WHO 2020).

Currently, a shift can be observed from the concept of transcultural care to the concept of person-centred, diversity-sensitive care (Díaz et al., 2024). Compared to the focus on cultural competence, this approach moves away from the terminology of overcoming barriers between cultures. It pays more attention to intergroup diversity and reflects an increasing awareness of how different social categories (e.g., ethnicity, gender, class) interact, a phenomenon studied

under the term intersectionality (Díaz et al., 2024). The term diversity sensitivity is used to describe health and care professionals who (1) are aware of different cultures, (2) include this awareness in the delivery of care, and (3) view diversity itself as a potentially positive contribution to society (WHO 2020).

More recent conceptual developments aim to capture the systemic aspects of discrimination better than a focus on cultural competence alone can convey (Lauwers et al., 2024). With a similar aim, patient perspectives also point to the importance of including cultural safety in a diversity-sensitive approach. Cultural safety encompasses concepts such as allyship, sensitivity, self-awareness and cultural humility.

What should be included in education and training for person-centred and diversity-sensitive care?

Education and training for person-centred, diversity-sensitive care should include knowledge about different cultures and skills to apply a diversity-sensitive approach.

Fostering an empathetic approach of listening without judgement.

The **knowledge** acquired in the training should include the history of cultures different to those in the host country, history of the countries of origin of the care receivers, and the current situation of these countries, and cultural and religious knowledge such as treatment and care preferences linked to specific cultures and religions (e.g. same-gender care, pain management in end of life care). It should also cover anthropology and cultural differences more generally. Education and training courses should transfer knowledge on migration, such as migratory routes, the reasons behind migration, and the current working conditions of migrants. Health and social care staff should learn about concepts of ageing and disease by region and about nursing practice and theory in different countries.

Regarding **skills** needed to apply a diversity-sensitive approach, it is recommended that education and training opportunities foster an **empathetic approach** of listening without judgment, which creates a space where older persons with migration backgrounds and their families feel that they can express themselves. Training should involve sessions that include **dialogue about reflections** on the students' own experiences in health and social care, on the situation of older migrants, and on how care can be developed to be person-centred and diversity-sensitive. Education should raise **awareness on the impact of power inequalities** within the health and care system. Health and care staff who are trained to analyse power inequalities are better able to reduce them or address their negative consequences. While awareness of power inequalities is important in the health and social care

system in general, it is especially relevant in the context of care for particularly vulnerable groups such as older migrants. Training for diversity-sensitive health and social care should enable staff to **analyse the current situation of the person in need of care** and to examine what led to this situation. Analysing the current situation involves identifying potential barriers in health and social care. This can also require knowledge of healthcare in the country of origin. Both can be of use in the process of providing person-centred, diversity-sensitive care.

Language barriers in health and care can negatively impact, for instance, patient safety (Chauhan et al. 2020) and practitioners should learn **to work with interpreters and to use translation tools**. While working with professional interpreters is very much recommended, it might be necessary sometimes to involve bilingual staff, or, in emergency situations, relatives of older migrants with care needs. Access to professional translators is easier where this is legally required and dedicated financial resources are available. Translation tools can be developed for health and social care, built by health and social care staff for individual patients (e.g. cards with pictures and words in the native language of the person receiving care) or adapted from other fields (e.g. online translation tools developed for general use).

Which formats should be used in training for person-centred and diversity-sensitive care?

Recommendations from the workshops for implementing education and training include formal learning opportunities and specific methods.

Formal education and training can include face-to-face teaching in groups (e.g. small group teaching, seminars, lectures) and independent study. Furthermore, it can also be complemented by online training. Improvements in training on diversity sensitivity should, however, not be restricted to a new and additional course. Rather, modules on person-centred, diversity-sensitive care for older people with a migration background and their families / informal carers should also be included in existing core education across health and care professions. Moreover, it is recommended that diversity should be **mainstreamed** across education, including disciplines beyond health and care, and there should be efforts to develop a common understanding of diversity across different disciplines.

Combining theoretical input, reflection and roleplaying exercises.

Education and training opportunities should be updated through an **interdisciplinary approach** which promotes collaboration among the various professions involved in care provision, such as nurses, doctors, therapists, care managers, and nurse assistants. Training should include **'reflection days'** following a defined period after a training course, with the same participants who participated in the training

to provide an opportunity for exchange among participants and to facilitate feedback on the course. This should be conceptualised as a 'knowledge transfer activity' and defined as working time paid for by the employer.

Specific **methods** of teaching and learning that combine **theoretical input**, **reflection and roleplaying exercises** need to be promoted. Training should involve active learning methods and foster interaction among students, including seminars where students read up on a topic and then meet to discuss reflection questions and client cases in small groups. Reflection should also be supported through supervision. The emphasis on interaction among students and reflection is particularly important since person-centred, diversity-sensitive care aims to change a status quo where migrants are facing various barriers in accessing care and because it entails skills linked to specific values (see reference to diversity as a value in the previous section). Analysing gaps in care and learning about individual values are facilitated through interaction and reflection. Face-to-face education can be complemented by online training to reach as many individuals as possible. Online training should include diverse activities beyond reading online text, such as listening to podcasts to guide individual reflection.

Key Takeaways

Diverse societies experiencing demographic change need to provide high-quality person-centred, diversity-sensitive care. To achieve this, it is essential to raise awareness among students and professionals through education and further skills training, enabling them to provide high-quality care to all, including older migrants and their families.

The policy brief offers recommendations on content and formats for teaching diversity sensitivity across various disciplines.

- Diversity sensitivity should be part of core education across health and care, and simultaneously taught in specialised courses for different professions.
- Person-centred, diversity-sensitive care includes specific skills (e.g. listening, analysis, reflection) and certain forms of knowledge (e.g. about different cultures). The topic of intersectionality should be included in teaching diversity-sensitive care, enabling health and social care professionals to consider an individual's cultural background, personal characteristics, and social position.
- Competences in person-centred, diversity-sensitive health and social care can be fostered through formal learning activities, including face-to-face courses with theoretical input, reflection, and role-playing exercises, as well as online training and resources.

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DI.S.C.O.P.M.B.
DIVERSITY SENSITIVE CARE OF OLDER PEOPLE WITH MIGRANT BACKGROUND AND THEIR FAMILIES

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