



MULTI CULTURAL **CARE**

**Educating students through
innovative learning methods
to intervene in complex
multicultural contexts**



E-BOOK

MULTICULTURALCARE PROJECT - MulticulturalCare: Educating students through innovative learning methods to intervene in multicultural complex contexts (ref^a. 2020-1-PT01-KA203-078530)

Consortium

Nursing School of Coimbra
University of Castilla-La Mancha
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Funded by the Erasmus+ Programme, the MulticulturalCare Project, reference 2020-1-PT01-KA203-078530, aims at educating nursing students through innovative learning methods to intervene in multicultural contexts

Although focused on educating nursing students, the Project also intends to reach the health community, organizations, mentors, and teachers.

Its primary goal is to promote the education in cultural skills of European health professionals, as a key strategy to address health inequalities and contribute to achieving the health-related United Nations (UN) Millennium Development Goals.

Presentation video



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1. INTRODUCTION

Ana Paula Monteiro, Beatriz Xavier, María Idoia Ugarte Gurrutxaga, Rocío A. Baquero, Brígida Molina-Gallego & Gonzalo Melgar de Corral.

Migration and displacement are social, political, and public health issues for the countries of the World Health Organization (WHO) European Region and beyond. The Region hosts nearly 36% of the international migrant population, with more than 13% of its total population consisting of international migrants, a 9% increase from 1990 (WHO, Regional Committee for Europe, 2022).

Europe is facing more than ever the impact of the mobility of people which has been fuelled by the circulation of EU citizens and the arrival of migrants from different regions of the world. Since the start of the millennium, over 20,000 human beings have passed away trying to cross the Mediterranean Sea through Europe (United Nations-UN, 2021). European healthcare services face the challenge of providing more and better-quality care to a multicultural population.

Advocating for the inclusion of migrants and refugees into national health systems at affordable costs and sufficient quality is a priority to the UN (2021). This strategy is aligned with the [Global Compact on Refugees](#) and the [2030 Agenda for Sustainable Development](#).

Responding to the needs and vulnerabilities of refugees and migrants requires culturally sensitive and effective care that recognizes and responds to all their needs across the life course, including non-communicable and communicable diseases and trauma from injuries and violence. There is a global need for good-quality, robust and resilient health services that are culturally and linguistically sensitive and that can respond to the needs of refugees and migrants. Health services should be provided with an adaptable, well-trained and culturally competent workforce (WHO, 2020, p.5).

Nowadays the climate and biodiversity crisis has emerged as a genuine civilizational threat. According to [UNHCR \(2020\)](#), climate change is the defining crisis of our time and disaster displacement one of its most devastating consequences. Refugees, internally displaced people and the stateless are on the frontlines of the climate emergency. As we face serious risks to the future of humanity and our planet, we must urgently reinvent education to help address these common challenges.

A new social contract for education needs to allow us to think differently about learning and the relationships between students, teachers, knowledge, and the world. This contract for education

must unite us around collective endeavors and provide the knowledge and innovation needed to shape sustainable and peaceful futures for all anchored in social, economic, and environmental justice (UNESCO, 2021).

Multicultural competencies of health professionals, particularly nurses, need to be developed to meet these challenges. European higher education institutions that train health professionals should integrate into their curricula courses and learning methods on minorities, migrants, and asylum seekers, future-proofing their care delivery to migrants and appointing them as ambassadors for quality care delivery in clinical settings.

The MultiCulturalCare Project - *Educating students through innovative learning methods to intervene in complex multicultural contexts* (Project reference: 2020-1-PT01-KA203-078530), is part of the Strategic Partnerships for Higher Education. This project started on 02 of December 2020 till 01 of May 2023. The Project's detailed information is available online and also on the [MultiCulturalCare Project website](#).

The Project's partners are [ESCOLA SUPERIOR DE ENFERMAGEM DE COIMBRA \(ESEnfC\)](#) as Coordinator, Coimbra, Portugal; [UC LEUVEN-LIMBURG \(UCLL\)](#), Diepenbeek, Belgium, and [UNIVERSIDAD DE CASTILLA - LA MANCHA \(UCLLL\)](#), Toledo, Spain.

The MulticulturalCare project's main objective is to promote education in cultural skills of health professionals in Europe, as an important strategy to address health inequalities, contributing to the achievement of the health-related Millennium Development Goals (UN).

This project intends to build, develop and apply the MulticulturalCare Nursing Education Model as a pedagogical standard for developing nursing students' cultural competencies and training their multicultural health skills. It also aims at improving the participants' cooperation and networking skills, and nursing students' entrepreneurial skills. This will enable them to design innovative solutions and humanitarian interventions targeting the health of migrants, refugees, and asylum seekers, and to develop collaborative networks between European higher education institutions, healthcare institutions, and non-governmental institutions, increasing the capacity of higher education nursing institutions to operate transnationally, by sharing ideas, practices, and methods of nursing training in multicultural competencies.

In order to achieve the goals of the Project, three intellectual outputs were designed, each of them serving its own purpose.

The first Intellectual Output (IO1) is the MulticulturalCare Model for Nursing Education. It is a general model containing the organizational, educational, and professional elements for developing students' competencies in the multicultural area. In addition to providing the best

practice guidelines, the MulticulturalCare Model aims to stimulate nursing students to think critically about the realities around them.

The second Intellectual Output (IO2) is the MulticulturalCare e-book, a digital handbook with innovative pedagogical strategies and simulation scenarios, designed so that teachers and nursing students get the most benefit of the MulticulturalCare Model.

The third Intellectual Output (IO3) consists of a tool for students self-assessment of MulticulturalCare pedagogical strategies effectiveness.

This e-book, the IO2, contains the process of development of the MulticulturalCare Model for Nursing Education, its principles, and the theoretical framework, models, theories, standards and terminologies of Nursing Sciences and other disciplines (Anthropology, Sociology, Psychology and Education Sciences) that support the Model .

It includes the description of the MulticulturalCare Education Model Diagram; the rationale and definition of the nursing students' multicultural core competencies, including the dimensions and indicators of each core competence (the Core individual multicultural competencies and the Social Cultural competencies) and the corresponding expected learning results and indicators.

The e-book also integrates the final results of the third Intellectual Output (IO3), a pedagogical proposal for implementing the MulticulturalCare Education Model, the educational methods, a Guide for developing training activities in MulticulturalCare competencies and examples of innovative pedagogical practices, the results of agile pilots, interactive simulation scenarios and training resources. Finally, supporting materials are presented.

This e-book is to be used by anyone interested in the area, with a special focus on trainers of nursing professionals and graduate nursing students. We hope that it will be a contribution to more inclusive healthcare for migrants, refugees and asylum-seekers.

It intends to be a resourceful tool in the complex task of expanding knowledge and raising awareness of the importance of culture in health and in nursing care, improving multicultural competencies in healthcare delivery.

1.1. Aim and scope of the e-book

The present e-book aims to be a theoretical and methodological nursing education tool for nursing teachers, tutors, and students who wish to learn about and/or improve their competencies in cultural care.

It includes the MulticulturalCare Project's most relevant results and further information needed to develop nursing students' core competencies and skills in multicultural care.

This e-book has an initial chapter with the conceptual framework of the MulticulturalCare Education Model, including a comprehensive approach to it and practical instructions on how to use it in nursing education.

It also includes the Key Principles of the MulticulturalCare Education Model, a description of its construction process and an explanation of the contents of its diagram, the pedagogical proposals for implementing the MulticulturalCare Education Model, the guide for developing the suggested training activities, with detailed implementation and organization procedures and instructions, and some support materials (examples of simulations scenarios).

The MULTICULTURALCARE e-book also references the best practice guidelines focusing on healthcare interventions for migrants, refugees, and asylum seekers.

1.2. How to navigate the e-book.

As previously stated, the purpose of this e-book is:

- to provide a theoretical and methodological tool that teachers can use to facilitate the incorporation of cultural competence in nursing care.

In order to achieve this, the e-book collects the most relevant results of the project and the information needed to develop the basic competences and skills required for culturally competent care by nursing students. ▼

▲ *Depending on your interests, the e-book can be consulted in different ways. That is why it seems interesting to us to make this reading guide, pointing out the usefulness it can have according to the different interest profiles of each reader.*

In particular, the **SECOND CHAPTER** (2. KEY PRINCIPLES OF THE MULTICULTURALCARE EDUCATION MODEL → [GO](#)) includes:

- **The conceptual assumptions** (2.1. Fundamental Principles and Concepts of MulticulturalCare Nursing Education → [GO](#)). ▼

- **Theories, models and terminology from other disciplines**, which are necessary to build the multicultural competency model in nursing education (2.2. Theoretical framework: models, theories, standards, and terminologies from other disciplines. → [GO](#)). ▼
- **Models of multicultural competence in nursing and health care**. This is a synthetic but well-documented overview of the theoretical models related to cultural competence that have been developed in nursing over time (2.3. Models of multicultural competencies in nursing and healthcare → [GO](#)). ▼

▲ *If you are interested in the theoretical foundations of nursing cultural competence these three subchapters will appeal to you. For example: university teaching staff teaching content related to nursing cultural competence; students training in cultural competence; people developing theoretical or research work on nursing cultural competence, culturally competent health care, theoretical studies on health care in multicultural contexts, etc.*

- **The process of building the Model** included in this document. (2.4. Building the MulticulturalCare Education Model. → [GO](#)). As a whole, this chapter reveals the methodology of model building, which is not only based on theoretical reflection, but is also built from the bottom up, relying on:
 - The **study of training experiences** in multicultural competencies that have been implemented over the last few years (2.4.3 Reviewing MulticulturalCare principles and theoretical framework → [GO](#)). ▼

▲ *If you are interested in learning about the cultural competence training that has been carried out over the last decades, this sub-chapter will be of interest to you. For example, it will be useful if you want to replicate training experiences from the bibliography.*

- The **voice of experienced practitioners** working in today's multicultural contexts. ▼
- The **voice of migrants** in the European context. ▼

▲ If you are interested in implementing or planning a training process in cultural competence in nursing, whether in undergraduate or postgraduate education, theoretical or practical, or continuing education, this complete chapter 3 includes all the theoretical elements necessary to carry it out (it would be easily implemented with the practical elements that are incorporated in chapter 4).

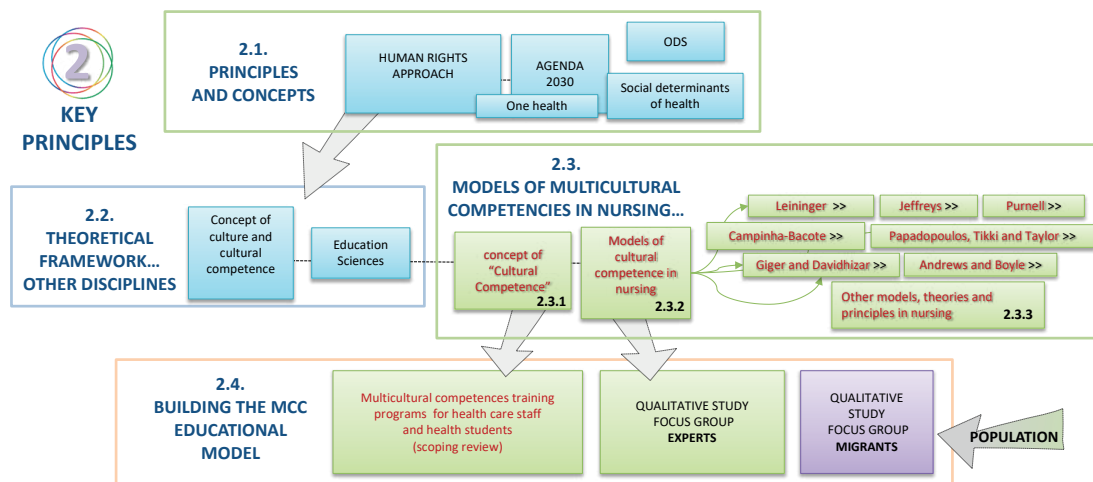


Figure 1. Reading guide for chapter 2.

The **THIRD CHAPTER** is the **Model itself** (3. “MULTICULTURALCARE EDUCATION MODEL”) and contains:

- The evolution of the model throughout the project up to its final diagram (3.1 Development of the MulticulturalCare Model for Nursing Education → [GO](#)). ▼
- **Detailed description of the model** (3.2. Description of the MulticulturalCare Education Model Diagram (Figure and components)→ [GO](#)), including:
 - **Principles and values** of the model (3.2.1. PRINCIPLES AND VALUES → [GO](#)). ▼

▲ If you are interested in the care needs identified by patients, clients and experienced professionals, these two sub-chapters may reveal some key insights. For example, you will find it useful if you are trying to implement equitable health care as a health care professional in a multicultural context.

- The **pedagogical approach** that establishes the model in order to put it into practice in nursing education (3.2.2. PEDAGOGICAL APPROACHES → [GO](#) and 3.2.3 MULTICULTURAL EDUCATIONAL METHODS → [GO](#)). ▼
- And the model's **core competencies**, described, documented and referenced (3.3. Multicultural Core Competencies → [GO](#)). This chapter includes a table of the competences of the model, including their dimensions, the expected learning outcomes, and some indicators for each of them → [GO](#). ▼ ▼

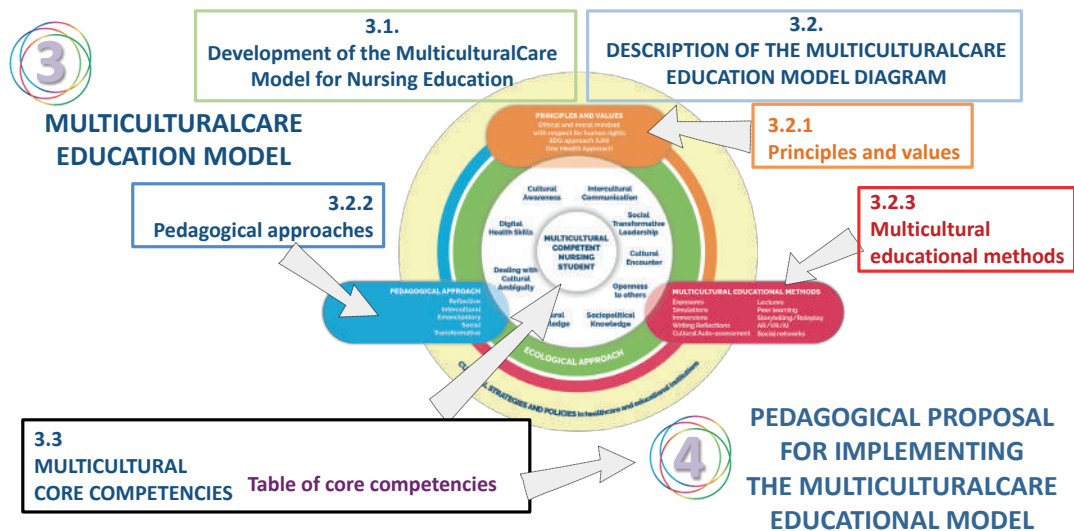


Figure 2. Reading guide for chapter 3.

The **FOURTH CHAPTER** is intended as a **proposal for the application of the model** in nursing education (4. PEDAGOGICAL PROPOSAL FOR IMPLEMENTING THE MULTICULTURALCARE EDUCATION MODEL → [GO](#)) and as such contains:

- The **pedagogical framework** necessary to implement the training model in a coherent way (4.1 Theoretical and pedagogical framework → [GO](#)) including popular education (4.1.1), dialogical learning (4.1.2) and critical thinking (4.1.3). ▼

▲ *If you are interested in implementing or planning a training process in cultural competence in nursing, whether in undergraduate, postgraduate or continuing education, you should start from a pedagogical framework congruent with the competences you intend to achieve in your students.*

- And the **guide for the development of teaching activities** to facilitate the work of teachers who intend to plan training activities in multicultural competences (4.2. Guide for developing training activities in MulticulturalCare competencies. → [GO](#)) following the model. This is embodied in:
 - A proposed table (template) to facilitate the programming of activities (4.2.1. Proposal of Template → [GO](#)). ▼
 - A series of experiences of application of the model: Agile Pilots (4.2.2 → [GO](#))

In the **FIFTH CHAPTER** are presented the simulation scenarios (5. → [GO](#)). ▼

▲ *If you are interested in implementing or planning a training process in cultural competence in nursing, whether in undergraduate, postgraduate or continuing education, this complete chapter includes all the practical elements necessary to carry it out (the theoretical elements described in chapter 3 should be taken into account).*

Finally, the **CONCLUSIONS** of the e-book are included, as well as bibliographical references and other resources ([GO](#)).

▲ *If you are interested in the main contributions of the e-book and the project as a whole, you should read the **CONCLUSIONS***



2. KEY PRINCIPLES OF THE MULTICULTURALCARE NURSING EDUCATION MODEL

Ana Paula Camarneiro, Beatriz Xavier, Aliete Cunha-Oliveira, Ana Paula Monteiro, Gonzalo Melgar de Corral & Maria Idoia Ugarte-Gurrutxaga.

Training nurses to provide care in an increasingly multicultural and global society requires a comprehensive approach highlighting cultural competence education. However, the available indicators and studies demonstrate that nursing training in multicultural skills is sparse and inconsistent (Handtke, Schilgen & Mösko, 2019). It is also not explicitly integrated into nursing curricula in many European countries (Anton-Solanas et al., 2021). Moreover, the lack of uniformity in educating healthcare professionals about cultural competence and the inconsistencies in defining cultural competence (Nardi et al., 2012, p.3) are additional factors when examining standards for culturally competent healthcare.

The literature review reveals the importance of defining a shared European and international higher education curriculum on specific topics related to general, transversal, and specific competencies in multicultural health. The combination of different educational skills and the training of expert teachers should be considered critical in higher nursing education (Gradellini et al., 2021).

In 2008, the American Association of Colleges of Nursing (AACN) defined the Cultural Competencies for Graduate Nursing Education and outlined six core competencies for training culturally competent nurses at the graduate level. The goal is to eliminate health disparities through education, clinical practice, research, scholarship, and policy-making. Hence, a **culturally competent nurse** must:

- prioritize social and cultural factors that affect health when designing and delivering care across multiple contexts;
- use people and populations' social and empirical cultural knowledge to guide practice and research;
- assume leadership in developing, implementing, and evaluating culturally competent nursing and other healthcare services;
- transform systems to address social justice and health disparities;
- provide leadership to educators and members of the healthcare or research team in learning, applying, and evaluating continuous cultural competence development;
- and conduct culturally competent scholarship to be applied in practice.

2.1. Fundamental Principles and Concepts of MulticulturalCare Nursing Education

The macro aspects of Nursing Education Multicultural Competencies Models include the traditional nursing meta-paradigms (Person, Groups, Families, and Communities; Environment; Health, and Nursing) and the key concepts of Globalisation, Migration, and Global Health and Society, which provide a holistic and global perspective.

The MulticulturalCare Nursing Education Model is based these principles:

2.1.1. Human Rights-Based Approach (HRBA)

The Human Rights-Based Approach (HRBA) is a core Nursing Multicultural Care Education principle. The equal and inalienable rights of all human beings provide the foundation for freedom, justice, and peace in the world, according to the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948. The HRBA is a conceptual framework for the human development process. It is based on international human rights standards and directed at promoting and protecting human rights, including the right to health. Moreover, the HRBA seeks to analyse inequalities at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress and often result in groups of people being left behind (United Nations Sustainable Development Group, n.d.).

The HRBA focuses on the most marginalized, excluded, or discriminated against, which often requires analysing gender norms, different forms of discrimination, and power imbalances to ensure that interventions reach the most neglected populations (United Nations Sustainable Development Group, n.d.).

Nursing science, in general, and as it relates to current social justice and human rights tenets, has been advanced and strengthened locally and globally over the last 40 years. Scholarships and the call for sociocultural action in nursing practice have concentrated attention on the following:

- the nursing manifesto as emancipatory praxis;
- peace and power for community building, empowerment, and transformational leadership;
- the critical theoretical interpretation and cultural healthcare rights as a model of cultural competence and advocacy;
- and the communitarian/transcultural ethical caring and critical caring theory for health equity advocacy (Ray & Turkel, 2014).

2.1.2. Sustainable Development Goals (SDG) principles and components

Another fundamental principle of Nursing MulticulturalCare Education is the UN 2030 Agenda for Sustainable Development, which places people at the centre of all actions, particularly those most marginalized and disempowered, to achieve more equitable and inclusive societies.

In a globalized world characterized by the population's increasing mobility, the Sustainable Development Goals (SDGs) principles and components must be considered a background framework in multicultural healthcare.

The SDGs consider current health and development challenges as more complex, integrated and interlinked (World Health Organization, 2020).

Multi-sector partnership and coordinated efforts are needed to ensure that migrants' health is addressed throughout the migration cycle, as are efforts to develop migration-sensitive health systems that respond to the population's increasingly diverse health profiles and needs.

The need exists globally for good-quality, robust, and resilient health services that are culturally and linguistically sensitive and can respond to refugees' and migrants' needs. Responding to the needs and vulnerabilities of refugees and migrants demands culturally sensitive and effective care that recognizes and responds to their specific needs across the life course, including non-communicable and communicable diseases and trauma from injuries and violence (WHO, 2021a; WHO 2021b).

2.1.3. The Social Determinants of Health Approach

The Social Determinants of Health Approach provide a model for understanding the social and structural factors that influence health at different levels according to their causal proximity to a health problem and upstream and distal (socioeconomic and environmental) or downstream and proximal (individual) factors. Structural and social factors are responsible for a significant share of health inequalities (Dahlgren & Whitehead, 1991.)

For disadvantaged populations, these factors relate to higher risks, reduced access to services leading to poor outcomes in many diseases, and worse economic and social outcomes related to poor health and treatment costs. In addition, the health-related targets of the SDGs, including universal health coverage, cannot be fulfilled without ensuring that all migrants can exercise their rights (Pant et al., 2019).

A systematic review conducted by Egli-Gany et al. (2021) identified six themes that operate at four different levels in an adapted version of the Dahlgren and Whitehead - Social Determinants

of Health Model, namely:

- economic crisis and hostile discourses on migration;
- limited legal entitlements, rights, and administrative barriers;
- inadequate resources and financial constraints;
- poor living and working conditions;
- cultural and linguistic barriers;
- and stigma and discrimination based on migration status, gender, sex, and ethnic group.

A comprehensive approach is needed to consider the migrant's health across disciplines and contexts framed by political, social, economic, cultural, biological, and medical factors.

The migration process can expose migrants to health risks, such as psychosocial stressors and abuses, nutritional deficiencies, lifestyle changes, exposure to infectious diseases, limited access to prevention and quality healthcare, and/or interrupted care.

Migrants in 'irregular situations,' low skilled or low educated, and in other vulnerable or disadvantaged situations are more likely to suffer from a compromised health status. Other barriers to health services include discrimination and stigmatization, administrative hurdles, and restrictive norms generating fear of deportation or the loss of employment for those affected by medical conditions. When health services are available to migrants, these may not be culturally, linguistically, and socially-sensitive to their needs, leading to delayed or undiagnosed conditions or ineffective treatment (International Organization for Migration, 2022).

For instance, migrant populations are overrepresented among people diagnosed with HIV in the European Union and the European Economic Area. Understanding the timing of the HIV acquisition - premigration or postmigration - is crucial for developing public health interventions and producing reliable estimates of HIV incidence and the number of people living with undiagnosed HIV infection (Pantazis et al., 2021).

2.1.4. One Health Approach

In 2008, the World Health Organization (WHO), the World Organization for Animal Health (WOAH, former OIE), and the Food and Agriculture Organization (FAO) launched an initiative called "*One World, One Health*." "One Health" (OH) was the suggested concept to demonstrate the inseparability of human, animal, and environmental health (Mackenzie & Jeggo, 2019). Recognizing the complex and multidisciplinary issues raised by rethinking health in the human-animal-ecosystem interface, which requires greater coordination and collaboration between national and international sectors and agencies, the WHO highlights specific areas where an OH approach is particularly relevant.

These are food safety, zoonosis control, and addressing antibiotic resistance (World Health Organization, 2021c). The OH grounds the current theoretical and research approaches to health, advocating a transdisciplinary, interprofessional, and ecological vision.

The OH concept has also been defined as a movement advocating closer bonds between human medicine, veterinary medicine, and environmental and ecological health. It invites the professions to develop cooperative and investigative actions that support the assessment, treatment, and prevention of interspecies transmission diseases (Pan American Health Organization & World Health Organization, 2021).

A humanistic approach to the OH concept focuses on promoting human health, considering that it is related to the health of animals and the environment; that is, human food, animal food, human and animal health, and environmental contamination are closely linked and interdependent. This movement, originating from the concern and focus on Human Health and its interrelation with Animal and Environmental Health, has progressively acquired another dimension. More recently, with the profound conceptual change introduced by animal rights movements and post-humanist currents, the OH concept has been affirmed as a global strategy for expanding interdisciplinary collaborations and connections in all aspects of Healthcare for Humans, Animals, and the Environment. It considers that promoting human and animal health should go hand in hand to “ensure that all humans and animals benefit from sustainable and equal medical progress and not at the expense of animal life and welfare.” In December 2021, the FAO, WOA, United Nations Environment Programme (UNEP), and WHO welcomed the following new operational definition of the OH concept from their advisory panel, the One Health High-Level Expert Panel (OHHLEP):

“One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals, and ecosystems. It recognizes [that] the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems) are closely linked and interdependent. The approach mobilizes multiple sectors, disciplines, and communities at varying levels of society to work together. The aim is to foster well-being and tackle threats to health and ecosystems while addressing the collective need for clean water, energy, and air, safe and nutritious food, taking action on climate change, and contributing to sustainable development.” (United Nations Environment Programme, 2021, p.1).

Although the OH approach is relatively recent in transdisciplinary academic discussions and research, it relates to classical nursing paradigms based on holistic approaches to understanding health phenomena and care practices. Nursing has always considered a humanistic vision of care central to a systemic and ecological conception of the human being in developing its theoretical and meta-theoretical premises. The current model of OH incorporates some dimensions known to theoretical nursing models, such as the concept of teamwork and the need for an interdisciplinary and interprofessional approach to solving complex health-related problems. Also, the theories

of Person-Centred Care and the integration of the Social Determinants of Health Model can be considered the most recent efforts to include biopsychosocial ecological approaches in healthcare and nursing care (Rabinowitz et al., 2017).

Nursing theorists have recently proposed a theoretical framework to incorporate environmental issues and climate change into nursing interventions and professional clinical practices, such as the Ecological Planetary Health Model. This Model considers that nursing can play a central role in applying mitigation, resilience, and adaptation strategies to climate change and its impact on human health. Climate change knowledge is vital in basic and advanced nursing education to empower nurses to respond to adverse health events, develop climate change management policies, and perform advocacy roles (Demorest et al., 2019, International Council of Nurses, 2019).

The complex interaction between living things, including humans, animals, and pathogens, sharing the same environment should be considered as a single dynamic system where the health of each component is inextricably interconnected and dependent on the others, following a holistic view of the ecological system. This approach can be applied at the community, national, regional, and global levels and depends on shared and effective policy strategies, communication, collaboration, and coordination to develop equitable and holistic solutions on a global scale (Calistri et al., 2013).

2.2. Theoretical framework: models, theories, standards, and terminologies from other disciplines.

Models, theories, standards, and terminologies, developed by nurses to guide culturally competent care are anchored and complemented by frameworks and tools from diverse disciplines, such as Anthropology, Sociology, Psychology, Health Sciences, Education Sciences, International Law, and Migration studies.

These theoretical approaches are seminal in building the MulticulturalCare Competence Models for Nursing Education.

2.2.1. Contributions of Anthropology, Sociology, and Psychology in constructing the concepts of Culture and Cultural Competence

Contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups. Instead, culture involves a flexible, ongoing process of transmitting and using the knowledge that depends on the dynamics both within communities and the interface between ethnocultural communities and institutions of the larger society, like

the healthcare system, as well as global networks (Kirmayer, 2012; Moodod, 2007; Phillips, 2009). As a result, cultures are often hybrid, mixed, and constantly changing (Burke, 2009).

As pointed out by Davis (2020), despite the turn towards more plural definitions, there has persisted an essentialist discourse on the concept of culture that considers that people have a fixed “culture.” These essentialist discourses often find expression in references to a group of people, a nation, or an ethnic or language group, implying that peoples are homogeneous entities and obscuring or denying diversity within a cultural group. According to this author, this perspective goes back to the nineteenth-century concept of culture, particularly to the work of E. B. Tylor, considered one of anthropology’s founders:

“Culture or Civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.” (Tylor, 1889).

Today, a shift toward a more fluid and processual notion of culture, not linked to certainty, homogeneity, and fixity, is needed (Davis, 2020, p.17).

Social Construction of illness (Conrad & Barker, 2010)

The social construction of health is an important research topic within medical sociology. Conrad and Kristin Barker’s framework in the *Social Construction of Illness* (2010) presents three overarching constructionist findings: first, some illnesses are mainly rooted in cultural meaning; second, all illnesses are socially constructed at the experiential level; and third, medical knowledge about illness and disease is not necessarily “given by nature but is constructed and developed by claims-makers and interested parties.” Social constructionism contrasts with the deterministic medical approaches to disease and illness and can contribute to expanding policy deliberations and decisions.

Kleinman’s Explanatory Model of Illness (Kleinman, 1978; Kleinman et al., 1978)

Kleinman developed the Explanatory Model in response to an unmet, inherent, and unavoidable need of the current healthcare system. Patients complained of “dissatisfaction, inequity of access to care, and spiralling costs,” which Kleinman considered the traditional medical approach was unable to solve (Kleinman et al., 1978). Kleinman explains his distinction between illness and disease, clarifying that “illness” is a flexible concept across cultures and individuals, while “disease” has a concrete definition and diagnosis (Kleinman et al., 1978). Therefore, each patient feels, describes, and understands the experience of a specific disease differently.

Kleinman's explanatory model includes the patient's beliefs about their illness, the personal and social meaning they attach to their disorder, their expectations about what will happen to them and what the provider will do, and their therapeutic goals. It uses questions to decipher the patient's understanding and expectations about their illnesses.

By understanding the patient's needs and expectations, health professionals can meet these needs by altering the treatment plan according to the patient's behaviour patterns and belief system. This model emphasizes the perspective of symptom experience in person-centred care. Considering a perspective that starts from each person's symptom experience is crucial to complement the biomedical approach. This requires healthcare professionals to be skilled in listening to patient narratives and acquiring knowledge about how symptom experiences can be individually expressed and interpreted. Listening to symptom experiences provides insights into the personal meaning of illness and information about physical and social restrictions caused by symptom distress. This way, caring about symptoms will improve the prerequisites for establishing person-centred care planning

The Explanatory Model has three potential limitations: translation, interviewer bias, and patronizing. For interviews to be conducted effectively, the patient and the health professional must understand each other, which can depend on the interpreter's availability and skill level. An interpreter can experience difficulties correctly translating the cultural meanings assigned by the patient, and confusion can arise. Another limitation occurs when physicians focus on aligning the patient's view with their own instead of combining the different views when prescribing a treatment to the patient (Hodsdon, n.d.).

Social Presence Theory (John Short, Ederyn Williams & Bruce Christie, 1976)

Social Presence Theory (SPT) was initially defined by Short et al. (1976) as "*the degree of salience of the other person in the interaction and the consequent salience of the interpersonal relationships.*" A more modern definition of the Social Presence Theory was refined by Gunawardena (1995) to state "*the degree to which a person is perceived as a 'real person' in mediated communication.*" According to Short et al. (1976), Social Presence as a construct was primarily composed of two main concepts: intimacy (Argyle & Dean, 1965) and immediacy (Wiener & Mehrabian, 1968). Intimacy in a communication medium is influenced by several factors, such as physical distance, eye contact, smiling, and personal topics of conversation. Wiener and Mehrabian (1968) conceptualized "immediacy" as a measure of the psychological distance communicators put between themselves and the object of their communication.

The Intercultural communication

Communication is a dynamic, complex, and ongoing process through which people send and receive messages to understand and be understood. In this process, ideas, knowledge, purposes, feelings, emotions, etc., are transmitted and shared through several means (Ruiz & Medina, 2000).

It's a *sine qua non* condition for social life. It is also a defining act of life that, taken for granted, seems to have little value (Nunes, 2010). However, since it is impossible not to communicate (Watzlawick et al., 1967), health professionals must be aware of the impact that their behaviours have on others (Nunes, 2010) and themselves, considering that to communicate is, from the Latin, to "put in common." Intercultural communication puts in common the culture and the underlying dynamics of people all around the globe.

The concept of intercultural communication has evolved since the 1990s. Traditionally, it has been defined as all communication between people with different languages and/or cultural backgrounds, with cultural groups considered the main predictors of misunderstandings in multicultural settings (Alsina, 1999; Thije, 2020). Later, Thije restricted intercultural communication to the differences between each language and/or culture relevant to processing inter-verbal communication results (2020).

According to the same author, a current view of the scientific and societal relations spectrum presents a more complex perspective of Intercultural Communication. It proposes an analysis considering five different theories and methodological approaches, focusing on the within and the in-between of these approaches, as well as articulating the concept of Intercultural Communication with the concept of Intercultural Mediation, their interrelationships, and interfaces (Thije, 2020).

The current concept of Intercultural Communication requires at least two interlocutors, in which none of the roles is overvalued as "the subject and the other." The emphasis is put on the interaction. Moreover, the different interlocutors' cultural contexts must be considered to understand each one's social representations of themselves and the other(s) and the context, in space and time, where the interaction takes place (Ogay, 2000).

Intercultural Communication implies being aware of how cultural differences influence communication and results. Professionals and individuals with a particular cultural identity need to know how to communicate and interact in the environment and context in which they find themselves to mutually promote a good intervention by the professional (Bracons, 2020).

Thije (2020) proposes five approaches to intercultural communication: (1) interactive; (2) contrastive; (3) cultural representations; (4) multilingualism and linguistic diversity; and (5) transfer. These approaches systematize the fundamental principles of intercultural communication.

- The first approach, **INTERACTIVE**, analyses face-to-face intercultural interaction and the need for intercultural mediation, connoted with "metapragmatic awareness" (Thije, 2020, p. 49), which leads to the concept of the cultural mediator. This mediator is an independent third person and has the function of helping the parties involved to find solutions to conflicts. In many cases, the cultural mediator is the interpreter called

upon to facilitate mutual understanding. Therefore, there is a relationship between the intercultural mediator, the interpreter, and the different approaches to communication. When needed, interpreters participate in official conferences and institutional settings such as healthcare, business, and transnational government interactions. To mark their translation, in the strategies of interactive interpretation, they use a speech introducing the “she/he said” and summarising or commenting as long as it is clear. In these cases, they are often intercultural mediators. In these circumstances, the work of interpreters deserves special attention, as well as their training, currently at a higher level because interpreting the interaction reveals cognitive and interactive structures that remain invisible in other types of multilingual interactions (Thije, 2020). In an interaction, it is necessary to bear in mind the cognitive and emotional aspects, and it is essential to have a minimum of knowledge of the other, culturally different (Alsina, 1999).

- A second approach, **CONTRASTIVE**, focuses on the contrasts between cultures and linguistic systems. These “require a reliable *tertium comparationis*” to develop proper equivalences across languages and cultures. (Thije, 2020, p. 49). In this case, the Intercultural Mediators are the ones who use these formal and functional equivalences to express sensitive issues or carry out complex actions in other languages. Umberto Eco (2003) stated, “To translate is an intercultural mediation act aiming at saying “almost the same thing.”
- The third approach refers to **CULTURAL REPRESENTATIONS**. These appear in the different forms of communication and consider the self’s and the other’s individual and collective images. Representations of the self and its counterparts include an idea of others’ knowledge, value systems, attitudes, cultural backgrounds, and perspectives. (Hall, 1997). Cultural representations continue through the uninterrupted manifestation of identity, with an essential and immutable core of similarities, which persist across space and time, claim authenticity and authority to speak on behalf of the group, and demand to represent the group as a whole (Thije, 2020). According to the author, alternatives to cultural representations are the ambiguity of representation, the creative ways of dealing with cultural differences, and the variety of perspectives and/or identities/images.
- The fourth approach presented is **MULTILINGUALISM AND LINGUISTIC DIVERSITY**. Intercultural Mediators have the theoretical models and analytical tools “to dismantle the traditional language ideology of one nation, one culture, one language.” In this situation, “the native speaker transforms via the intercultural speaker into the intercultural mediator.” It is interesting to introduce the notion of “contextualization cues.” It was created to analyse intercultural misunderstandings. It is an essential principle to underline in dealing with linguistic and cultural diversity in general interaction. Indeed, misunderstandings can arise in cultural encounters if people do not recognize the cultural knowledge indicated by certain expressions, spoken actions, intonation, code-switches, or gestures (Thije, 2020). According to Bastos (2014), the success of the interaction does not seem to depend on the participants’ language competence. They assume that communication in a global context must be done using a *lingua franca*, usually English.

Thus, the linguistic and communicative dimension of intercultural communication skills does not establish any relationship with the mastery/use of languages.

- Finally, **TRANSFER APPROACHES** refer to the transmission of knowledge, attitudes, skills, reflectivity, and motivation to acquire multicultural competence (Thije, 2020). However, in Ogay's perspective (2000), an intercultural encounter can occur without the interlocutors being aware that they are participating in the process of negotiation of cultural identities. This will depend on the competence of intercultural communication. Furthermore, intercultural communication is often based on asymmetry and inequalities, although the organizational and institutional context must be considered in this analysis.

Arasaratnam's et. al (2010) Integrated Model of Intercultural Communication Competence, cited by Bastos (2014), proposes the following three dimensions associated with intercultural communication skills:

- Affective dimension, underlying the variables "global attitude" and "motivation" (acceptance and respect for difference, as well as interest and enjoying learning more about the other's culture);
- Praxeological dimension visible in the variables "experience," "involvement in interaction," and "empathy" (empathy, cultural pluralism, and ability to integrate others' ways of behaving and thinking into the self's way of being a person);
- Cognitive dimension, implicit in the variables "experience" and "involvement in the interaction" (recognition of similarities and differences between the different cultures at stake and the self-concept based on a dynamic perspective).

Thus, the skills that contribute to developing intercultural communication competence in the cultural communicator as described above are:

- a) cultural empathy;
- b) involvement in the interaction (namely, the ability to listen and the cognitive and praxeological involvement in the interaction);
- c) global attitude (which is intended to be ethnorelative);
- d) experience (intercultural experiences);
- e) motivation (the willingness to participate in intercultural encounters). As independent variables, empathy and motivation also promote intercultural communication skills.

According to Ogay's model (2000), the intercultural communicator reveals cultural competence when completing the following distinct phases: (1) to recognize the similarities and differences between the different cultures at stake; (2) to accept and respect differences; (3) to want to learn more about the other's culture; (4) to demonstrate empathy; (5) to demonstrate cultural pluralism;

(6) to integrate the other's ways of behaving and thinking into their ways of behaving and thinking; and (7) to see themselves in a dynamic perspective, constantly under construction.

Therefore, intercultural communication includes the interpersonal dimension, the interaction between groups, and the intercultural dimension. It is not the cultures that interact with each other but the representations of these cultures, transforming the intercultural encounter into an interpersonal encounter in which each party carries its cultural identity and individual identity. Furthermore, the interpersonal encounter is also intercultural or intergroup since the same social identities are never the same, influencing the communication process between individuals (Thije, 2020). Intercultural Communication Skills must be developed, particularly by health professionals, to deal with cultural diversity.

Dealing with Cultural Ambiguity

Cultural ambiguity "includes all instances in which people produce or encounter multiple meanings, whether in the medium of language or other communicative acts (Bauer, 2021)."

According to Bauer (2021), linguistic ambiguity occurs if one statement can be associated with two or more propositions. Nevertheless, some situations containing multiple meanings occur entirely without language, as is shown by the example of Benedict XVI's "prayer" in the Blue Mosque. Cultural ambiguity is not exclusive to such public scenes. It permeates our everyday lives, although not always with the same degree of complexity. Language, gestures, and signs are not unambiguous, and actions can be interpreted by those who observe them. Norms must be explained, and sometimes contradictory values must be reconciled or tolerated in their coexistence.

In short, any cultural activity is hardly conceivable without moments of cultural performance that do not require a kind of disambiguation. Cultural ambiguity is part of the human condition. But not all cultures are tolerant of this ambiguity (Bauer, 2021).

"Tolerance of ambiguity must not be taken for tolerance in an ethical-social sense. Tolerance, defined as 'the general ability to accept any form of being different or acting different regarding opinions, background, sexuality, morals, religions, etc., always proposes a clear and unequivocal differentiation between one's own norms and the other's norms. Tolerance in this sense is one of several ways of reacting to an unequivocal situation, that is, a confrontation with interpretations, values, and norms that are different from one's own interpretations, values, and norms.'" (Bauer, 2021).

As healthcare becomes increasingly complex, nurses must successfully deal with more significant clinical ambiguity. Although ambiguity is discussed in nursing, minimal concept refinement exists to capture the contextual intricacies from a nursing lens. Nurses' perception of an ambiguous

clinical event, in combination with their level of tolerance of ambiguity, can impact their response to what constitutes ambiguity within the nursing practice (McMahon & Dluhy, 2017).

2.2.2. Contribution of models and theories from Education Sciences

Transformative Learning Theory (Mezirow, 1990)

Mezirow's Transformative Learning Theory theoretically underpins the teaching model. Mezirow proposed "perspective transformation" as the process through which one becomes critically aware of how and why one's assumptions influence one's perspectives and how to develop a more inclusive perspective by changing these habitual constructs. Transformation can occur through critical reflection, including critically reflecting on one's assumptions to change the taken-for-granted frame of reference and about the others' assumptions that lead to successful communication. Fostering emancipated, autonomous, and responsible thinkers is the ideal outcome of transformative learning.

Experiential Learning (David A. Kolb, 1984)

David A. Kolb's Experiential Learning Theory (ELT) Model, published in 1984, was inspired by Kurt Lewin's work (gestalt psychology). According to this perspective, learning is the process of creating knowledge through transforming experience. Knowledge results from understanding and transforming the experience using Active Experimentation and Reflective Observation (Kolb, 1984).

Critical Pedagogy (Paulo Freire, 1968)

The dialogical pedagogical process proposed by Paulo Freire includes cooperation, unification, and organization. Freire describes that "dialogue with the oppressed is a commitment to freedom," which involves altering reality using critical-reflexive communication. In this perspective of critical pedagogy, according to Paulo Freire (1968), the teacher doesn't teach but learns through dialogue with students, while students learn while teaching. In critical pedagogy, students' actions aren't limited to receiving, sorting, and storing the information provided by teachers. On the contrary, students have a real opportunity to recognize reality and to act on that recognition, transforming reality.

Reflective Pedagogy

Reflective pedagogy has long been considered critical to facilitating meaningful learning through Experiential Learning based curricula in Nursing Education.

Over the last several decades, particular focus has been given to how students are taught to reflect within life-long and experiential learning contexts. Many educators have identified critical

thinking, engaged dialogue, and reflective practice as essential to furthering substantive learning in experiential settings. *Reflection* is a central element of experiential education, solidifying the connection between a student's experiences and the meaning/learning they derive from that experience (Denton, 2011). It is defined as "an evidence-based, integrative, analytical, capacity-building process that serves to generate, deepen, critique, and document learning" (Schön, 1983). Additionally, reflective pedagogy allows students to develop critical thinking skills that will assist them throughout their academic and professional life. Eyer et al. (1996) identified and developed structured reflection as critical to meaningful academic learning. Daudelin (1996) defined reflection as central to "...the process of stepping back, carefully and persistently from an experience to ponder on its meaning and explain it to the oneself, through the development of inferences," highlighting that engaging in such processes lays the foundation for future decision-making and behaviours" (p. 39).

Green Pedagogy

Green Pedagogy is a framework for planning learning experiences from a sustainable perspective that can be applied at several educational levels and pointed in different academic and vocational directions.

A responsible and green pedagogy considers the negative environmental impacts generated by its proposed educational activities consumption (including water, energy, materials, pollution levels, and waste management). It promotes environmentally responsible behaviours and the sustainable use of resources in its pedagogical practices. It also includes enhancing students' knowledge about using green technology (e.g., e-learning and digital technologies are already considered green technologies due to their contribution to cleaning the environment).

2.3. Models of multicultural competencies in nursing and healthcare

2.3.1. Defining the concept of "Cultural Competence"

Considering the mentioned above, what does "cultural" mean in cultural competence? Davis (2020) answers this question, pointing out that

"If we examine the relationship between "cultural" and "competence" it becomes evident that the concept of culture here must be understood as dynamic and expressive: as process. (...) Extending this further, we might infer that to be culturally competent means that one has legitimacy in doing,

being in, expressing, understanding and/or interpreting culture – both one’s own culture and that of others. This idea of “having competence” or “being competent” in one’s own culture and different cultures also requires a view of culture as adaptive, creative, performative and expressive, as the above has shown” (Davis, 2020, p.22).

Healthcare professionals’ multicultural competence is a recognized approach to improving healthcare provision to ethnic minority groups to reduce racial/ethnic health disparities in health (Truong et al., 2014).

Lack of cultural competence among care providers limits the potential to provide high-quality care for the growing number of people with diverse backgrounds (de Almeida Vieira Monteiro & Fernandes, 2016).

Cultural competence is a complex, multidimensional concept explored within many disciplines and is particularly important for healthcare providers. It has been defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professions to work effectively in cross-cultural situations (Nardi et al., 2012).

A review of culturally competent healthcare systems identified five interventions to improve cultural competence: (1) gear programs to recruit and retain diverse staff members, (2) cultural competence training for healthcare providers, (3) use of interpreter services to ensure individuals from different backgrounds can effectively communicate, (4) culturally appropriate health education materials to inform staff of different cultural backgrounds, and (5) provision of culturally specific healthcare settings (Nair & Adetayo, 2019).

Thus, cultural competence is a broad and complex construct that enables healthcare professionals to acquire “the *attitudes, knowledge, and skills necessary for providing quality care to diverse populations*” (Jean Gilbert & California Endowment, 2003) while considering their cultural background, and including patients’ health and illness beliefs, religious influences, their primary language, values, and other cultural factors that influence their health. Another factor that can become challenging when examining standards for culturally competent healthcare is the lack of uniformity in educating health providers about cultural competence and the inconsistencies in how cultural competence is defined (Nardi et al., 2012, p.3).

In Nursing, cultural competence is defined as a process, meaning that the healthcare provider must continually strive to effectively work within each patient’s cultural context (Campinha-Bacote, 2002). Culturally competent healthcare is the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs

of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death (Leininger, 2002). Purnell & Paulanka (2003) defined cultural competence in health as the self-cultural awareness, knowledge, and understanding of the patient's culture, the acceptance of and respect for cultural differences, the openness to cultural encounters, and the adaptation of care to be compatible with the patient's culture.

Several models have been proposed to describe cultural competence in healthcare. However, in Nursing studies and educational models, the concept of Cultural Competence lacks a definition. Shen (2014) reviewed cultural competence models and assessment instruments developed and published by nurse researchers since 1982 and found *14 definitions for Cultural Competence in Nursing*.

Some of them include theoretical approaches and specific dimensions of multicultural competencies. Specific cultural care competence models developed by nurses are available to guide cultural understanding and culturally competent nursing care.

The concept of cultural competence in nursing originates in the theories of intercultural nursing, specifically within the Leininger model, in the 1970s (Leininger, 1994; Leininger & McFarland, 2006).

From its roots in early models, the Nursing Cultural Competence concept expanded in the late 1980s through the 1990s beyond culture *per se* and embraced issues such as prejudice, stereotyping, and the social determinants of health. The scope of cultural competence also expanded beyond the interpersonal domain of cross-cultural care to include health systems and communities (Saha et al., 2008). The populations to whom multicultural care was applied expanded from immigrants to all minority groups, particularly those most affected by racial disparities in healthcare quality (Saha et al., 2008).

2.3.2. Models of “Cultural Competence in Nursing”

The Models of Cultural Competence in Nursing serving as the foundational theoretical framework for the Multicultural Care Model are listed below:

Leininger's Cultural Care Diversity and Universality Theory/Model

Madeleine Leininger conceived seminal ground-breaking works on transcultural nursing, such as the ethno-nursing research method, and her theory on culture care diversity and universality (Leininger, 1970, 1978, 1991, 1995; Leininger & McFarland, 2002, 2006; McFarland & Wehbe-Alamah, 2018). Leininger (1988) first coined the term cultural competence in the 1960s as part of her theory of cultural care diversity.

The theorist holds that cultural care provides the broadest and most essential means to study, explain, and predict nursing knowledge and concomitant nursing care practice. The theory's goal is to provide culturally congruent nursing care practices. Leininger claims that one can explain and predict health or well-being if one fully discovers care meanings, patterns, and processes. The Sunrise Model presents the assumptions, definitions, and theoretical explanations related to cultural care, representing the major components of Leininger's theory (1988).

The holistic Sunrise Model presents seven main domains that influence the care and health status of individuals, families, groups, and sociocultural institutions, namely:

- lifestyle patterns;
- specific cultural values and norms;
- cultural taboos and myths;
- worldview and ethnocentric perspectives;
- general attributes that patients perceive as different or similar to other cultures;
- caring behaviours, health and life care rituals, and rites of passage to maintain health,
- and folk and professional health-illness systems used.

Campinha-Bacote Model of Cultural Competence

The Campinha-Bacote cultural competence model characterizes *the process of achieving cultural competence* as a dynamic process. This model's main assumptions are: (1) cultural competence is a process of becoming; (2) it consists of five main elements/competencies: cultural awareness, cultural knowledge, cultural skills, cultural encounter, and cultural desire; (3) within the groups there is more variation than across them; (4) healthcare providers' cultural competence is strongly related to services providing culturally responsive care for ethnically diverse people (Campinha-Bacote, 2002; 2007; 2008). Campinha-Bacote's IAPCC-R and IAPCC-SV have been extensively used in nursing education and practice to measure the cultural competence of healthcare practitioners and students, respectively.

Giger and Davidhizar's Transcultural Assessment Model

Giger and Davidhizar's Transcultural Assessment Model (TAM) was developed in 1988, responding to the need for undergraduate nursing students to assess and provide care to culturally diverse patients. The model includes six cultural phenomena: communication, time, space, social organization, environmental control, and biological variation (Giger & Davidhizar, 2002; Dowd et al., 1998; Giger & Davidhizar, 2002, 2004, 2008). Each cultural phenomenon occurs across cultures, relates to each other, overlaps, and varies in utility and application (Dowd et al., 1998; Giger & Davidhizar, 2008).

Cultural Competence and Confidence (CCC) Model: Transcultural Self-Efficacy (Jeffreys, 2010)

Jeffreys' Cultural Competence and Confidence (CCC) Model interrelates concepts that explain and describe the phenomenon of acquiring cultural competence while incorporating the transcultural self-efficacy (confidence) construct as a critical influencing factor (Jeffreys, 2016). Within the CCC model, *cultural competence* is defined as a multidimensional learning process that integrates transcultural skills in all three dimensions (cognitive, practical, and affective) and includes transcultural self-efficacy (TSE) as a fundamental component. TSE is the perceived confidence in learning or performing transcultural skills needed for culturally congruent care. Culturally congruent care actions involve using culturally based knowledge in sensitive, responsive, and responsible ways.

According to Jeffreys (2016), *optimal* cultural competence goes beyond competence (a minimum expectation) toward the pinnacle or peak performance goal, embraces the diversity of diversity, fosters multicultural harmony, facilitates cultural safety, promotes the delivery of the highest level of culturally congruent patient care for individuals, families, and communities, and requires ongoing active learning.

This model was primarily used for teaching and research in cultural competence.

The Purnell Model of Transcultural Healthcare

Developed in 1991, the Purnell Model for Cultural Competence (PMCC) conceptualizes the development of cultural competence along an upward curve of learning and practice. The model is characterized by an increasing level of competence achievement, with practitioners moving through four levels: a) from a stage of unconscious incompetence to b) conscious incompetence, followed by c) conscious competence, and finally, d) unconscious competence (Purnell, 2000, 2013).

The PMCC is depicted as a circle with an outside rim representing global society, a second rim representing the community, a third rim representing family, and a fourth rim representing the individual (person). The circle's interior is organized into 12 wedge-shaped sections constituting the Model's organizing framework. The 12 constructs are as follows:

- Overview/heritage (including concepts concerning the country of residence, origin, and reasons for immigration, among others);
- Communication (incorporating concepts related to verbal and nonverbal elements, such as the native language, body language, eye contact, and acceptable greetings, among others);
- Organization and family roles (describing gender roles, family roles, and priorities, roles of children and aged people within the family, among others);

- Workforce issues (including concepts such as autonomy, assimilation, and ethnic communication styles from the country of origin, among others);
- Biocultural ecology (regarding variations in biological aspects, among others);
- High-risk behaviours (concerning the abuse of tobacco, alcohol, or drugs, high-calorie diets, and insufficient physical activity, among others);
- Nutrition (including concepts such as the adequate amount of food to satisfy hunger, food choices, and how food affects well-being, among others);
- Pregnancy and childbearing (regarding information about fertility, birth control methods, views toward pregnancy, and pregnancy-related taboos, among others);
- Death practices (describing bereavement behaviours, perceptions of death, and death rituals, among others);
- Spirituality (concerning religious practices and the meaning of prayers, among others);
- Healthcare practices (including concepts such as attitudes towards illness, different medical beliefs, and practices, among others);
- Healthcare practitioners (considering concepts related to the status, use, and perceptions of traditional, magico-religious, and Western biomedical healthcare providers) (Purnell, 2000, p. 43).

The 12 constructs (cultural domains and their concepts) can be used together, or their concepts can be selectively used when applying the model. The PMCC is one of the most widely used models of nursing curricula (Lipson & Desantis, 2007).

Papadopoulos, Tilki, and Taylor (PTT) Model of transcultural nursing and cultural competence

The Papadopoulos, Tilki, and Taylor (PTT) Model for developing cultural competence in nursing students considers cultural awareness, knowledge, and sensitivity (the third stage) as core cultural competencies in nursing. Culturally sensitive care cannot be achieved unless patients are considered true partners. Health professionals who act otherwise are using their power oppressively. Equal partnerships involve trust, acceptance, respect, facilitation, and negotiation. The fourth stage (cultural competence) requires synthesizing and applying previously gained competencies: cultural awareness, knowledge, and sensitivity.

A further focus is given to practical skills such as assessment of needs, clinical diagnosis, and other caring skills. A crucial component of the fourth stage of development is the ability to recognize and challenge racism and other forms of discrimination and oppressive practice. The PTT model combines multiculturalism and anti-racist perspectives and facilitates the development of a broader understanding of inequalities and human and citizenship rights while promoting the development of the skills needed to bring about change at the patient/user level (Papadopoulos, 2006).

The Andrews/Boyle Transcultural Interprofessional Practice (TIP) Model (2019)

The Andrews/Boyle Transcultural Interprofessional Practice (TIP) model aims to provide a patient- or user-centred systematic, logical, orderly, scientific process for delivering safe, culturally congruent and competent, affordable, accessible, evidence-based, and quality care for people from diverse backgrounds across the lifespan (Andrews & Boyle, 2019).

The TIP model includes as key components:

- the context from which people's health-related values, attitudes, beliefs, and practices emerge;
- the interprofessional healthcare team (whose *raison d'être* is the patient or user, placed at the team's core);
- the patient's family, and significant others, including legally appointed guardian(s) or person(s) (family or not) named in the patient's medical directive, credentialed health professionals, cultural, folk, indigenous, or traditional healers, religious or spiritual healers, and other sentient beings the patient or user considers as significant to their health, well-being, or healing (for example, service or companion animals or pets as culturally appropriate and requested by the patient or client);
- effective communication;
- and a five-step systematic, scientific problem-solving process-assessment, mutual goal setting, planning, implementing, and evaluating the effectiveness of therapeutic interventions and care.

The TIP model can be used wherever nurses practice, teach, learn, lead, consult, and conduct research.

2.3.3. Other models, theories, and principles in nursing

Other nursing theoretical models and approaches shaped the conceptual framework of Nursing Cultural Care. The literature review presents:

The Patient-centred Care Model

The Patient-centred Care model of nursing focuses on a personalized approach to healthcare aimed at caring for patients that remain in control of their environment, care process, and daily lives, as well as developing patients' abilities and contributing to their well-being (Nolte, 2017). This model seeks to increase care quality by considering the quality of life-related dimensions, providing respectful and responsive care to patients' individual preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Nursing Ethical Competence Model (Gallagher, 2006)

Healthcare professionals that incorporate cultural competence and ethical decision-making in their practice will be empowered to provide the best services to their users/ patients in multicultural contexts and ensure optimum outcomes (Louw, 2016).

Cultural competence in ethical decision-making in multicultural settings with migrants, refugees, and asylum seekers constitutes the core of culturally sensitive nursing care.

Socio-Political Knowledge in Nursing

Kagan et al. (2010) identified in their analysis of a Nursing Manifesto forms of nurses becoming more aware of the meaning of the values of social justice by turning to the meaning of emancipation in nursing research, practice, education, and leadership.

2.4. Building the MulticulturalCare Education Model.

The MulticulturalCare Model is the first and main intellectual product of the project MULTICULTURALCARE – Educating students through innovative learning methods to intervene in complex multicultural contexts (ref. 2020-1-PT01-KA203-078530). It is a theoretically guided educational model designed to teach multicultural awareness, knowledge, skills, and other core competencies that nurses and other health professionals must learn before working in clinical or community multicultural settings.

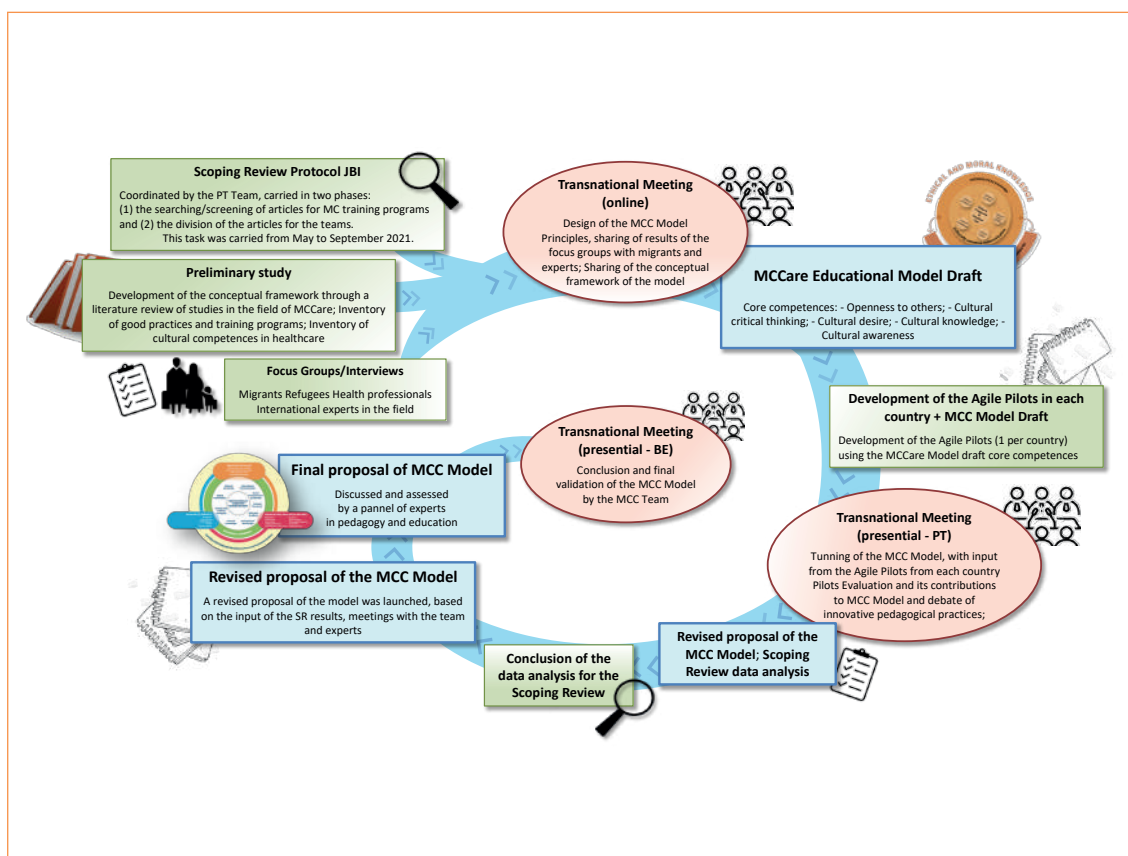


Figure 3. MulticulturalCare Model Flowchart.

Building an educational model of cultural competence for the European context must not be exclusively based on the references of the theoretical framework and the project team's training experience in multicultural competencies. First, two questions must be answered:

How should culturally competent healthcare be defined?

How should cultural competence be trained?

The answer to the first question requires the theoretical frameworks of the Nursing discipline and other disciplines and the description of the process as contextualization. It is based on the following:

- The opinions of **patients or users**, particularly those requiring a multicultural approach to healthcare in the partner countries of the MULTICULTURALCARE Project, at the present time and circumstances, that is, migrants in these countries. Qualitative research was conducted to gather this information using Focus Groups and Interviews with migrants to provide insight into their healthcare experiences.

- The opinions of **experts** with first-hand knowledge of healthcare problems in multicultural European environments complement the migrants' perspectives. The group experts focused on analysing the Health System (Socio-health-educational system) structure regarding intercultural competence.

In addition to being grounded on the theoretical frameworks of the Nursing discipline and other disciplines, the answer to the second question is based on a systematic review conducted on **multicultural competence training programs**.

The research process for building the MulticulturalCare model is represented below:

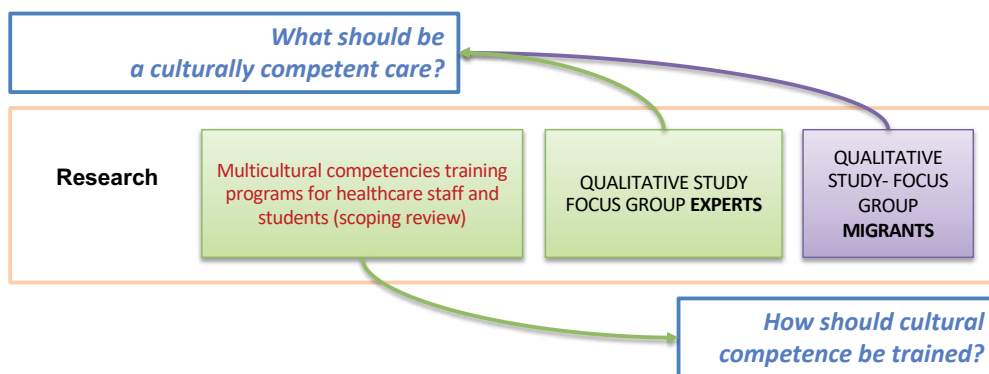


Figure 4. MulticulturalCare Model research process.

2.4.1. Reviewing MulticulturalCare principles and theoretical framework

A **preliminary literature review** was conducted to develop a conceptual framework of the Model's fundamental principles, which was discussed and shared with all the MulticulturalCare team partners. These principles are included in this e-book as **general principles** in chapter 2.1, a **theoretical framework** from other disciplines in chapter 2.2, and a **nursing-specific theoretical framework** in chapter 2.3.

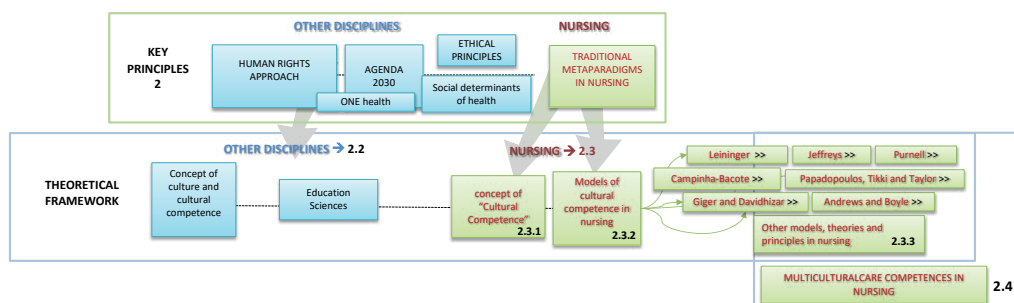


Figure 5. Outline of the theoretical principles and framework of multicultural care.

2.4.2. Incorporating migrants' and experts' perspectives

To build the **MulticulturalCare Education MODEL DRAFT**, the project partners included the perspectives, needs, and 'voices' of migrants and health professionals as the model's final stakeholders.

Three focus groups (FGs) and six interviews were conducted in community and academic settings, involving migrants, refugees, health professionals, and international experts. All partners developed, discussed, and validated the script for these interviews and focus groups.

These studies' main goal was to identify the **key domains** to be included in a Multicultural Care Competence Training Model for European nurses. Their specific objectives were as follows:

- to gather information on **migrants' experiences** in European health services;
- to collect data on the **interpersonal communication process** between migrants, refugees, and asylum seekers, and nurses in healthcare settings;
- to obtain information on the **multicultural competencies profile** required for nurses.

All partners and an independent Ethics Committee approved the study's ethical guidelines, the participant selection criteria and methods, and the data collection/data analysis technical guidelines (UICISA: E, Nursing School of Coimbra, Portugal).

Each partner cooperated in the FGs/interviews, data collection/analysis, final reporting, and evaluation of results. After each decentralized FG/interview, each team sent progress reports for monitoring. During February and March 2021, all project partners discussed the final results.

The focus group study with experts specifically aimed to identify the key domains to include in the MulticulturalCare Competencies Training Model for European Nurses from the international experts' perspectives.

Based on experts' perspectives on migrants' experiences in European healthcare services, the communication process and relationship between migrants and nurses, and nurses' multicultural competencies profile, these domains constitute one of the bases for building the MulticulturalCare Model. After contacting participants, a final FG of five participants (two from Belgium, one from Spain, one from Portugal, and one from the USA) was formed with researchers, academics, and healthcare professionals considered experts in Transcultural Health, Migration, and Migrants' Human Rights and Healthcare, and with more than five years of professional experience on these areas. A group consisting of three men and two women with English proficiency was selected from the total sample. All participants provided their informed consent. The FG took place online, via ZOOM (Colibri), due to the pandemic contingencies, on 5 February 2021. It was conducted by two interviewers, one from the Escola Superior de Enfermagem de Coimbra (ESENFC, Coimbra,

Portugal) and the other from the UC Leuven-Limburg (UCLL, Belgium). A third member timed and assisted in the logistics of the FG. The FG sessions had a duration of 90 minutes.

After the session or interview, the research team converted the audio or audio-visual recording into an audio file and transcribed the content. The data coding process followed an inductive research approach, in which the descriptive concepts and categories emerged during the multiple readings of the FG or interview transcripts. The 12 N-VIVO computer software analysis identified the main dimensions of the discourse and distinguished the most relevant aspects of each topic, organizing the collected data around categories and subcategories.

RESULTS - The voice of migrants: Culturally competent care from the point of view of migrants.

The results reveal the several **BARRIERS** immigrants face in European health systems (figure 6):

- The deficit of **access** to the health system;
- The **barriers** to care, specifically in terms of **communication**;
- The frequent **discriminatory relationship** established within professional care;
- The **low level of structural cultural competence**, mainly due to the lack of translation and intercultural mediation resources, the low flexibility of care systems, and the biomedical orientation;
- The **low level of professional cultural competence** in health services, which migrants perceive as a lack of interest and/or openness towards cultural differences.

Migrants describe these **BARRIERS** as having profound **CONSEQUENCES**, such as:

- Health inequity;
- Significant loss of care quality;
- Health **vulnerability**.

Different actors address these barriers and their consequences, using different **STRATEGIES**, some adequate, others partially effective but many inadequate, as they further complicate care and reduce its quality:

- As part of their strategies, **these populations** sometimes resort to support networks and NGOs, seek information on resources and rights, or practice a certain cultural pragmatism and adapt to the system. However, they also adopt non-adapted strategies such as postponing care, limiting it to emergencies, using informal translators, or using private health services.

- Professionals commonly resort to **strategies** such as intercultural mediation, organizing care times, adapting technical language, or respecting patients' beliefs and values. Nonetheless, sometimes professionals opt for strategies that hinder care, such as reducing information during care delivery, limiting care to the technical and biomedical approaches, and requiring the immigrant to know the host country's language and adapt to the care system, among others.

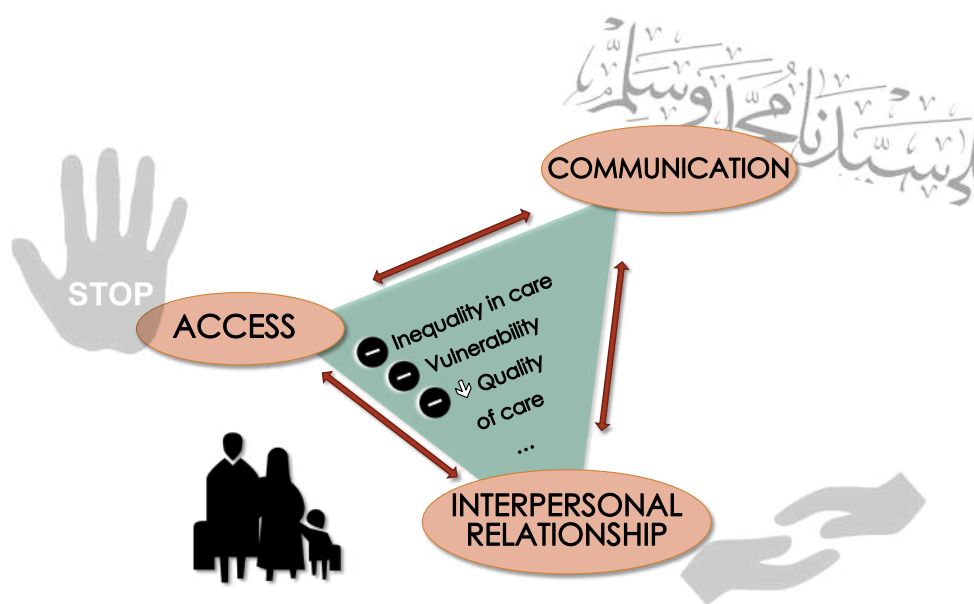


Figure 6. Culturally competent care from the point of view of migrants.

RESULTS - The voice of experts: culturally competent attention from the point of view of experts.

To understand the specialists' perceptions of migrants' experiences in European healthcare services, a group of experts was invited to share their opinions about possible barriers and facilitators in healthcare access. The data analysed show that experts identified four levels of **barriers to migrants' access** to healthcare related to:

- 1) the migrants,
- 2) the healthcare professionals,
- 3) the host country's healthcare system, and
- 4) the host country's social-political policies (Fig 7).

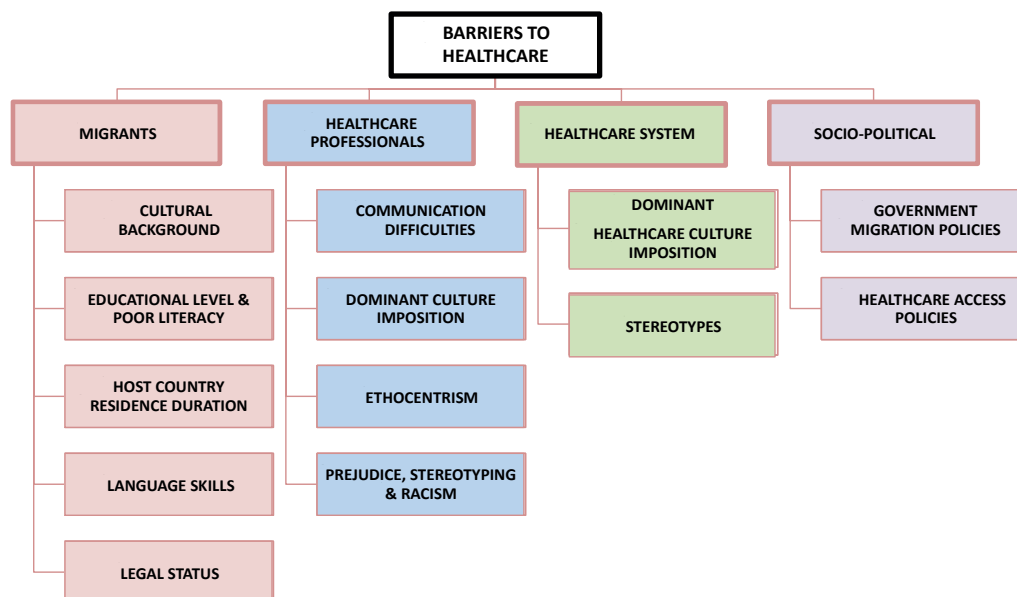


Figure 7. Barriers to the access of migrants to Healthcare in Host Countries.

They also identified the following three levels of **facilitators/resources to overcoming barriers to migrants'/minority cultural groups' access to healthcare** in host countries associated with:

- 1) the healthcare professionals,
- 2) the host country's healthcare system, and
- 3) the host country's social-political policies (Fig 8).

The experts' opinions about the interpersonal communication process and the relationship between migrants and nurses (objective 2) were correlated with "barriers" and "overcoming barriers" to access adequate healthcare.

Access to healthcare was considered from the migrant's entrance into the healthcare system and facilities until leaving after receiving care.

The characteristics of the **interpersonal communication process and relationship between migrants and nurses** can be a facilitator or a barrier to providing nursing care. Therefore, this category was integrated into the "barriers related to health professionals" and the ways of "overcoming the barriers through effective communication/ health professionals."

According to the experts, the nurses' multicultural competencies profile also relates to the specific resources to overcoming the barriers to access to healthcare, so it was included in that subcategory.

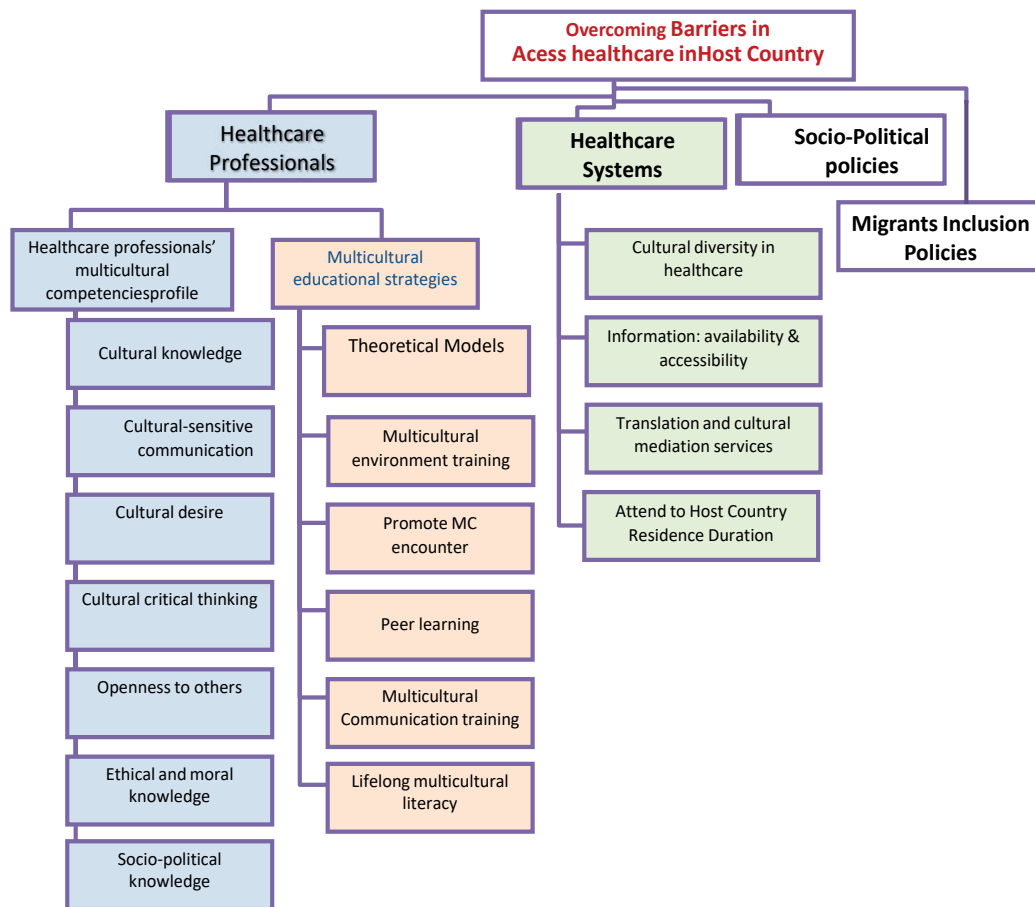


Figure 8. Overcoming barriers to migrants' access to healthcare in host countries.

2.4.3. Studying the experiences of training in multicultural competencies.

A search and review of studies of other educational models and experiences of teaching multicultural competencies was carried out as a third step. Thus, all partners conducted a scoping review of 250 scientific articles and collected and analysed data according to the JBI Protocol Guidelines.

The *Joanna Briggs Institute (JBI)* Scoping Review Protocol (SRP) was coordinated by the Portuguese Team, accepted, and published. The first phase consisted of searching/selecting studies to include, followed by a first screening of the articles listed according to the SRP criteria. In the second phase, all partners equally shared, distributed, and analysed the final list of articles. The analysis (blind review) of each article's contents was performed by two members of each team (a third member acted as the referee in case of disagreement).

The research focused **specifically** on the following **research questions**:

RESEARCH QUESTIONS
Who are the healthcare staff and students attending multicultural competencies training programs?
Who are the agents conducting the training programs in multicultural competencies for healthcare staff and students?
In what settings are the training programs in multicultural competencies for healthcare staff and students implemented?
What are the multicultural competence domains in the multicultural care competencies training programs available for healthcare staff and students?
What training strategies are used for training healthcare staff and students in multicultural competencies (e.g., length, frequency, content, delivery methods)?
What models, theories, or principles are used to conceptualize the training programs in multicultural care competencies available for training healthcare staff and students?
What facilitators and/or barriers have been reported relating to the programs' success and/or failure?

Figure 9. Scoping Review research questions.

Final data were presented in charts, graphs, and narratives to describe the literature according to the defined research questions, detailing the characteristics of the training programs.

2.4.4. Key aspects of culturally competent care

The Project's research was conducted with the immigrant population and experts and used scoping reviews to search for articles with intercultural competencies (IC) in health sciences. It identified several **key aspects (needs)** that the immigrant population and the experts recognize as necessary to offer culturally competent healthcare, as well as the experiences of intercultural training in health sciences.

These are summarized in five key healthcare aspects that guide the competencies of the MulticulturalCare model:

It was possible to identify within **INDIVIDUAL CULTURAL COMPETENCE** (concerning more personalized healthcare) three fundamental aspects/needs:

- **COMMUNICATION**
- **RELATIONSHIP**
- **INTEREST AND OPENNESS TO CULTURAL DIFFERENCE**

The **SOCIAL CULTURAL COMPETENCE** (community and social-related healthcare) considers two essential aspects/needs:

- The **INSTITUTIONAL COMPONENT** of care - an essential aspect/need often disregarded as cultural competence. It contemplates the need for institutional change when the institutions (particularly healthcare institutions and others related to health) do not respond to the care needs of other cultures.
- The **SOCIAL/COMMUNITY COMPONENT** of care - another critical aspect/need associated with recognizing the need for social change and the participation of culturally diverse groups in healthcare.

These five key aspects of culturally competent care guide and organize the cultural competencies identified throughout the process (Figure 10).

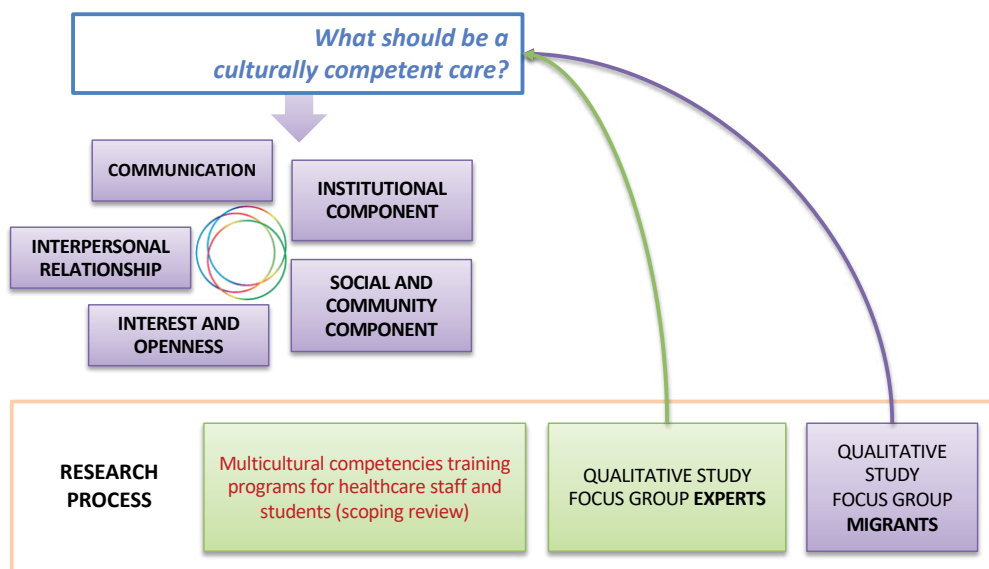


Figure 10. Key aspects of culturally competent care.

The Project also identified nine **MULTICULTURAL COMPETENCIES**, subdivided according to three **types of dimensions**:

- **CONCEPTUAL/KNOWLEDGE**
- **ATTITUDINAL**
- **SKILLS/ABILITY**

This way of understanding competencies is useful when focusing on the teaching or training process and the type of competencies for which learners are trained in each training process.



3.

“MULTICULTURALCARE MODEL”

Maria Idoia Ugarte-Gurrutxaga, Brígida Molina-Gallego, Rocío Baquero, Flore Geukens, Ana Paula Camarneiro & Ana Paula Monteiro.

3.1. Development of the MulticulturalCare Model for Nursing Education

The MulticulturalCare Model for Nursing Education is the first and main Intellectual Output of the MulticulturalCare Project. This theoretically guided educational Model aims to provide nurses and other health professionals with multicultural awareness, knowledge, skills, and core competencies before working in clinical or community settings.

The first draft version of the MulticulturalCare Model was created with the input of numerous sources. A **preliminary literature review** was carried out, and a conceptual framework was developed, discussed, and shared between all partners to define the principles of the MulticulturalCare Model, map the available MulticulturalCare training programs, and define nursing students' core competencies.

The Project partners agreed that the perspectives, needs, and “voices” of migrants, stakeholders, and the final users of these outputs should be included. All the partners conducted Focus Groups (FGs) and Interviews in community and academic settings involving migrants, refugees, health professionals, and international experts in the field.

The MultiCulturalCare team developed a script for data collection to explore the current realities of care delivery in multicultural contexts. All partners and an independent Ethics Committee approved the study's ethical principles, sampling criteria and methods, and technical data collection/analysis guidelines. Each partner cooperated in the FGs/interviews, data collection/analysis, final reports, and the evaluation of the results.

The FGs and in-depth interviews with migrants (a primary source of input for the MulticulturalCare Model) discussed language, structural elements of healthcare systems, information elements, and cultural sensitivities. Each partner institution focused on a specific target audience of asylum-seekers or migrants. Male migrants already living for several years in Belgium were the focus of the Belgian partner. The Spanish partner focused on Moroccan female migrants living in Spain for five years, while the Portuguese partner focused on migrants of various origins and genders living in Portugal for at least one year.

In addition, **FGs with experts in the field** were held to obtain information on the experts' perceptions of migrants' experiences in European healthcare services, the interpersonal communication process between migrants, refugees, asylum-seekers, and nurses in healthcare settings, and nurses' multicultural competencies and skills.

Furthermore, the Portuguese partner institution coordinated a formal Joanna Briggs Institute (JBI) Scoping Review Protocol (SRP). The first step was to search and select studies to be included. The Portuguese team performed the initial screening for the data extraction articles listed according to Protocol criteria until 30 May 2021. The second step was to equally share and analyse the final article list among all partners. Two members of each team performed the analysis (blind review) of each article's contents. A third reviewer solved any arising issues in case of disagreement. The (JBI) SRP Protocol was accepted and published.

The first draft of the MulticulturalCare Education Model (Figure 11) was developed by the Escola de Enfermagem de Coimbra, with the contributions of the FG data analysis and reports and the preliminary literature review.

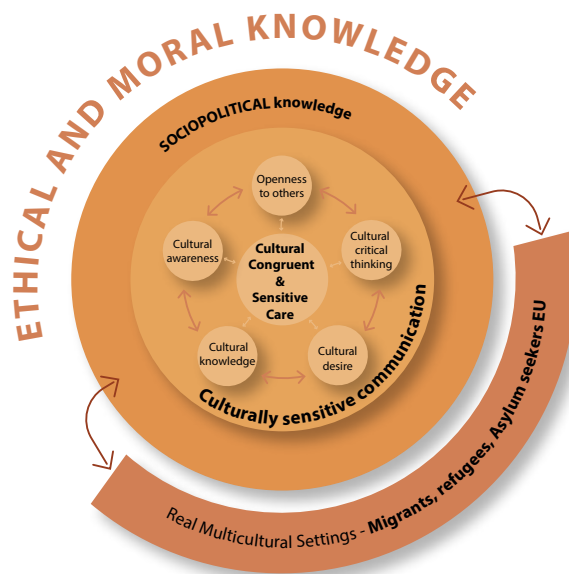


Figure 11. MCCare Education Model Draft (December 2021).

This MulticulturalCare Model draft was used to identify Key MulticulturalCare competencies in nursing students and to conduct three Pilots with Innovative Pedagogical Approaches in each partner institution.

In the third phase, all partners conducted a (JBI) **Scoping Review** of 250 scientific articles each, collected and analysed data according to published Protocol Guidelines.

Each partner focused on specific research questions:

- Who are the healthcare staff and students attending the training programs in multicultural competencies training programs? (Spanish Team)
- Who are the agents conducting the training programs in multicultural competencies for healthcare staff and students? (Spanish Team)
- In what settings are the training programs in multicultural competencies for healthcare staff and students implemented? (Spanish Team)
- What are the multicultural competence domains in the multicultural care competencies training programs available for healthcare staff and students? (Belgian Team)
- What training strategies are used for training healthcare staff and students in multicultural competencies (e.g., length, frequency, content, delivery methods)? (Belgian team)
- What models, theories, or principles are used to conceptualize the training programs in multicultural care competencies available for training healthcare staff and students? (Portuguese Team)
- What facilitators and/or barriers have been reported relating to the programs' success and/or failure? (Portuguese Team)

Final data were presented in charts, graphs, and narratives to describe the literature according to the defined research questions, detailing the characteristics of the training programs.

The data from qualitative studies (FGs and Interviews), the outcomes of the pilots' experiences, and the final results of the Scoping Review contributed to building the MulticulturalCare Model's final version.

Health and educational experts were also asked to provide input to validate the Model's final version.

All the Project partners participated in online meetings to discuss the Model and the input from the FGs, in-depth interviews, and JBI Scoping Review results. During the most recent Transnational Partner Meeting in May 2022 (in Belgium), the Model was finalized (as presented below).

MULTICULTURALCARE EDUCATIONAL MODEL



3.2. Description of the MulticulturalCare Education Model Diagram (Figure and components)

The MulticulturalCare MODEL is a Multicultural Nursing Education Model defined as a generic model containing the organizational, educational, and professional elements for developing nursing students' competencies in this area. The MulticulturalCare Model is an original model structured through qualitative studies (FGs/Interviews), documental research, literature review (initial conceptual framework and a formal JBI Scoping Review), group work, and peer validation (MulticulturalCare Team) in three Transnational Meetings, Agile Pilots and a final Expert Panel.

The MulticulturalCare Model for Nursing education was designed following a bottom-up approach, focused on the specific needs and perceptions of migrants, refugees, and asylum seekers and Migration and Multicultural Healthcare experts. This educational Model follows an intersectoral strategy that addresses cultural competence in nursing students.

According to a multilevel and ecological approach, the MulticulturalCare Education Model (Figure 12) is represented using a Bronfenbrenner diagram. The systemic Model is shown with multiple levels interacting in different degrees of complexity.

Nursing students are presented at the model's center. The model's first level (Circle) presents **the nine MulticulturalCare Core Competencies** required for undergraduate nursing students to provide culturally competent care.

The **nine multicultural competencies** are as follows:

1. **OPENNESS TO OTHERS:** the ability to interact with individuals of different cultural backgrounds with an open mind and without prejudice; the willingness to understand, accept, and respect the perspective of others (Jenks, 2011; Zoucha, 2000).
2. **CULTURAL AWARENESS:** the awareness of one's cultural heritage and values, as well as the attitudes and beliefs towards or about other ethnic or cultural groups (Arredondo et al., 1995; De Almeida Monteiro & Fernandes, 2016).
3. **CULTURAL KNOWLEDGE:** the process of seeking and obtaining a solid education on diverse cultural and ethnic groups.
4. **CULTURAL ENCOUNTER:** the process that encourages nurse students to engage directly in cross-cultural interactions with patients from culturally diverse backgrounds. These encounters are necessary to become culturally competent (Campinha-Bacote, 2010).
5. **INTERCULTURAL COMMUNICATION:** the ability to communicate effectively and clearly with/among professionals and patients with different cultural backgrounds and/or language abilities.
6. **DEALING WITH CULTURAL AMBIGUITY:** the ability to deal with culturally ambiguous and uncertain nursing care situations.
7. **DIGITAL HEALTH SKILLS:** "the skills to seek, find, understand, assess, and apply information from digital sources to manage and address multicultural health problems" (Dunn & Hazzard, 2019).
8. **SOCIO-POLITICAL KNOWLEDGE:** the knowledge that multiculturally competent nurses should have about the political, social, and economic reality in which they operate (White, 1995).
9. **SOCIAL TRANSFORMATIVE LEADERSHIP:** the ability to stimulate change in clinical practice and health policies and organizations and empower others to stimulate such change as well (Del Barrio-Linares, 2014).

The Model's green circle represents **the ecological approach from which a multiculturally competent nurse should act**. A multiculturally competent nurse should be aware of the growing issue of climate change and how it affects human migration and health. Moreover, the actions of a multiculturally competent nurse should always be as sustainable as possible and have as low as possible carbon footprint.

The MULTICULTURALCARE EDUCATION MODEL is based on **three fundamental aspects**:

- PRINCIPLES AND VALUES
- PEDAGOGICAL APPROACHES
- MULTICULTURAL EDUCATIONAL METHODS

3.2.1. Principles and values

the Model's orange box shows the guiding principles and the core values of the formal education of multiculturally competent nurses.

The Ethical mindset approach is a guiding principle in Nursing Education. Healthcare professionals who incorporate cultural competence and ethical decision-making will be empowered to provide the best care services to their patients in multicultural contexts and ensure optimum outcomes (Louw, 2016). Cultural competence in ethical decision-making in multicultural settings with migrants, refugees, and asylum seekers is at the core of culturally sensitive nursing care.

The Human Rights-Based Approach (HRBA) is another guiding principle of the Nursing MulticulturalCare Education Model. According to the Universal Declaration of Human Rights, adopted by the United Nations (UN) General Assembly in 1948, recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world. The HRBA is a conceptual framework for the human development process that is normatively based on international human rights standards and operationally aimed at promoting and protecting human rights, including the right to health. Within this approach, the focus is on the most excluded and discriminated groups in today's society. A multiculturally competent nurse should use this approach to ensure that all individuals, including those marginalized, have access to quality healthcare.

The UN Sustainable Development Goals (SDGs) also guide the Nursing MulticulturalCare Education Model.

In a globalized world with increasing population mobility, the principles and components of the SDGs should be considered as a background framework in multicultural healthcare that puts people at the center of all actions, particularly those most marginalized and disempowered, for achieving more equitable and inclusive societies.

As today's health problems become increasingly complex and intertwined (WHO, 2021), multiculturally competent nurses should work towards ensuring more equity and inclusion in society.

Finally, a multiculturally competent nurse should adopt the One Health approach. This approach emphasizes the interconnection between human, animal, and environmental health (Mackenzie & Jeggo, 2019) from a transdisciplinary, interprofessional, and ecological perspective. This approach is particularly relevant for food safety, zoonosis control, and antimicrobial resistance (WHO, 2021).

3.2.2. Pedagogical approaches

The Model's blue box presents the pedagogical approaches to be adopted when training nursing students to become multiculturally competent nurses, namely:

- **Reflective:** Educators should encourage students to develop critical thinking skills by reflecting on and evaluating their actions. Educators should also adopt this reflective attitude.
- **Intercultural:** Nursing education should reflect the cultural diversity of today's society.
- **Emancipatory:** Educators should encourage nursing students to become agents of change in healthcare settings and advocate for the rights of the most disadvantaged. Nursing education institutions should also display an emancipatory attitude.
- **Social:** Educators should promote social interactions between nursing students and patients from different cultural backgrounds. Students should have the opportunity to get to know the person behind the patient.
- **Transformative:** Educators should encourage students to be more aware of their own beliefs and attitudes toward cultural diversity and more open to other beliefs and attitudes through transformative learning experiences.

3.2.3. Multicultural educational methods

The Model's red box includes several multicultural educational methods, which can be applied in educational settings to train multiculturally competent nursing students and enhance their cultural competencies. These methods include exposures, simulations, immersions, reflection papers, cultural self-assessment, lectures, peer learning, storytelling, role-playing, Augmented Reality (AR), Virtual Reality (VR), Artificial Intelligence (AI), and social media. VR, AR, and AI technologies enable users to interact with and control virtually-displayed components within virtual and physical environments. These rich, immersive technologies will continue to evolve as powerful and essential tools in multicultural nursing education.

This Project's e-book includes several simulation scenarios that can be used in educational settings. In addition to patients from different cultural backgrounds, some scenarios also involve

linguistic difficulties. These simulation scenarios allow students to experience some of the potential challenges of multicultural care and reflect on their actions.

Finally, the Model's yellow circle represents the cultural strategies, healthcare policies, and educational settings in which the educational Model for multiculturally competent nursing students can be implemented. These aspects cannot be ignored as they influence students' options for becoming multiculturally competent nurses.

3.3. Multicultural Core Competencies

The MulticulturalCare Project's research (through Qualitative Research with immigrant populations and experts and the Scoping Review) aimed to collect the core aspects of culturally competent healthcare and the experiences of intercultural training in health sciences that both the immigrant populations and experts identify as necessary to deliver culturally competent healthcare.

The Bronfenbrenner diagram was used to graphically present the MulticulturalCare Model in a multilevel and ecological approach. It is a systemic model with several levels interacting with different degrees of complexity.

Nursing Students are at the Model's centre, and the **nine** essential MulticulturalCare **Core Competencies in Nursing** are presented in the first level (circle). Some of these are considered "*classic cultural competencies*" and are mentioned in different Cultural competence Models in Nursing. Others are original, such as the competencies "Dealing with Cultural Ambiguity" or "Digital Health Skills."

Bearing in mind that this is a Higher Education Model, a *competence-based education approach* was adopted, and experiential learning was considered an underpinning concept. Competence-based learning is described as learner-focused and frequently learner-directed, thus accounting for nursing students' positioning at the Model's centre.

In this Educational Model, competence is defined as:

"(...) the ability of a nursing student/nurse to demonstrate the attitudes, knowledge, skills, and judgement required to perform activities within the defined scope of practice at an acceptable level of proficiency."

Within this perspective, a set of Core Competencies are defined, and the best pedagogical strategies and teaching methodologies for their development are recommended.

Pedagogical decisions/ strategies must be guided toward developing these specific competencies. Also, these Core Competencies constitute an essential guiding framework for the suggested curricular contents and the corresponding learning methodologies.

According to the MulticulturalCare Model, the nine Core Competencies are essential for undergraduate nursing students to deliver culturally competent care.

The nine **CORE COMPETENCIES** can be organized according to their **INDIVIDUAL or SOCIAL** type, the two primary competencies for working in culturally diverse contexts.

3.3.1. Core individual multicultural competencies

These are competencies aimed at individual culturally competent attention (such as communication and/or openness to cultural differences). The seven core individual competencies are as follows:

1.- OPENNESS TO OTHERS

Rationale and definition

Openness to others as a nursing cultural competence is defined as the ability to interact with individuals of different cultural backgrounds with an open mind and without prejudice; the willingness to understand, accept and respect the perspective of others (Jenks, 2011; Zoucha, 2000).

2.- CULTURAL AWARENESS

Rationale and definition

Cultural awareness competence is defined as the awareness of one's cultural heritage and values, as well as the adverse emotional reactions, preconceived notions, biases, and stereotypes about other ethnic groups (de Almeida Vieira Monteiro & Fernandes, 2016, Arredondo et al., 1996; Sue et al., 1992). Cultural awareness competence refers to nurses' awareness of their worldview and cultural biases that can affect the quality of healthcare delivery. Considering that all students, nurses, and other health professionals belong to one or more cultural groups before entering professional education, they bring their patterns of learned values, beliefs, and behaviours into the academic and professional settings (Jeffreys, 2012, p. 579). These cultural values are the "powerful directive forces that give order and meaning to people's thinking, decisions, and actions" (Leininger, 1995). Students, nurses, and other health professionals also hold numerous beliefs (ideas, convictions, philosophical opinions, or tenets) that are accepted as accurate without requiring evidence or proof. Cultural values and beliefs unconsciously and consciously

guide thinking, decisions, and actions that ultimately affect the process of nursing care. Cultural awareness is the recognition or in-depth exploration of one's attitudes, cultural background, and assumptions regarding the similarities or differences in others while acknowledging racism, bias, and stereotyping (Mareno & Hart, 2014; Campinha-Bacote, 2002).

Some examples of CULTURAL AWARENESS LEARNING OBJECTIVES

To be aware of one's culture and cultural identity and relate them to personal values, health beliefs, and practices and to perform one's cultural self-assessment.

To critically examine the concepts of ethnocentrism and stereotyping

To recognise and challenge discrimination and racism both at the nursing practice and healthcare policy level

To identify one's cultural prejudices, myths, stereotypes, and misinformation about immigrants, refugees, and asylum seekers in Europe

To be aware of nurses' potential biases and the unavoidable impact of stereotyping on nursing care.

To describe potential ways to address bias in the clinical and community setting.

Note - According to the International Organization for Migration (2020), the COVID-19 pandemic prompted widespread solidarity and support from states, civil society, and individuals transcending socioeconomic status and backgrounds. However, it also created generalized fears and worries that have fed off an existing culture of distrust and discrimination against migrants.

3.- CULTURAL ENCOUNTER

Rationale and definition

The cultural encounter is the process that encourages nurses to directly engage in cross-cultural interactions with patients from culturally diverse backgrounds to modify existing beliefs about a cultural group and prevent possible stereotyping. Cultural encounters are the key construct of cultural competence that provides the energy source and foundation for one's journey toward cultural competence (Campinha-Bacote, 2010).

4.- CULTURAL KNOWLEDGE

Rationale and definition

Cultural knowledge is the process of seeking and obtaining a sound education about culturally diverse groups. In acquiring this knowledge, healthcare professionals must focus on integrating three specific issues: health-related beliefs, practices, and cultural values; disease incidence and prevalence (Lavizzo-Mourey, 1996). A culturally competent health professional actively attempts to know and understand the worldview of culturally diverse populations – their values, assumptions,

practices, communication styles, group norms, biases, and personal experiences. Students and trainers should acquire specific knowledge of their patients' cultures and life experiences, including community issues concerning specific ethnic minority groups. They should develop knowledge about specific cultural issues in assessment, clinical intervention, and the institutional barriers in health services (Arredondo et al., 1996; Sue et al., 1992). Knowledge of cultural differences refers to specific facts about a given cultural group. "Knowledge" is different from "Awareness" in that someone may *know* a piece of information about a culture but not be *aware* of when and how that information comes into play in real life. In other words, "Knowledge" is what one can bring to a cross-cultural encounter, while "Awareness" frequently emerges during the encounter. Cultural knowledge alone can be risky since one can never know all there is to know about another culture, let alone every culture. Moreover, the knowledge acquired can never be applied to every member of a culture.

For nursing students to obtain this knowledge base, their multicultural education must focus on integrating specific issues:

Some examples of CULTURAL KNOWLEDGE LEARNING OBJECTIVES

To consider anthropological, sociological, psychological, and biological determinants of health to understand health and welfare inequalities in the EU.

To understand how persons of diverse cultures and belief systems perceive health and illness and respond to various symptoms, communicable and non-communicable diseases (a), and treatments.

To describe the problems immigrants, refugees, and asylum seekers face and identify the psychosocial and cultural issues that primarily affect people's health behaviours and well-being in multicultural transitions.

To know the health-related beliefs and cultural values of culturally specific groups of migrants, asylum seekers, and refugees in the EU.

To use a wide range of data and resources to acquire knowledge about communities and recognise similarities and differences between culture-specific health beliefs and behaviours.

To locate the national and European legislation related to immigration, human rights, and discrimination and establish links between them and structural inequalities

To understand refugees' specific healthcare needs and the guidelines and special treatment programs for traumatised refugees and asylum-seekers.

- (a) Example: Infectious diseases and injuries acquired before or during travel in the migratory process are treated early on, but new diseases, such as non-communicable and occupational diseases resulting from lifestyle shifts in the new location, increase over time, as well as mental health problems that emerge and resurface at intervals as a result of traumatic events before or during migration and as longer-term stressors such as fear of deportation, separation from family, loneliness, isolation and social exclusion accumulate. Before departure, migrants' health status usually reflects the characteristic health patterns of their countries. Low- and middle-income countries typically involve relatively high levels of communicable diseases and maternal, perinatal, and nutritional conditions compared with non-communicable diseases and injuries, the cause groups being those used in the global burden of disease studies (Ingleby, 2012; Matlin et al., 2018). However, local factors can significantly alter the disease distribution. In the longer term, migrants' health reflects the changes in lifestyle, diet, and environment in the host country, for example leading to increases in cardiovascular disorders (Domnich et al., 2012).

A substantial proportion of migrants living in Europe acquire HIV after migration, according to a recent study supported by the European Centre for Disease Prevention and Control (ECDC). Studies show migrants are at increased risk of various health conditions after migration due to social inequalities, structural factors, and limited access to health services, including HIV prevention, testing, and care. Migrants accounted for approximately 12% of people living in the European Union and 44% of new HIV diagnoses in 2019. As the evidence accumulates, it becomes clearer that migrants are at an increased risk of many postmigration diseases, including sexually transmitted infections. Migrants are typically a young and healthy population. However, limited access to HIV and sexually transmitted infections prevention and testing, social inequalities, and structural factors may lead to individual behaviours, which increase their vulnerability and may explain the higher HIV prevalence compared with native populations (Pantazis et al., 2021).

5.- INTERCULTURAL COMMUNICATION

Rationale and definition

This cultural competence in nursing is the ability to communicate effectively and clearly with/ among professionals and patients with different cultural backgrounds and/or language abilities.

Cultural Awareness and cultural Knowledge are abstracted from the actual clinical context and insufficient for developing an effective therapeutic interaction and caring intervention. Technical competence or skills are essential in applying these standards in the clinical context. These essential skills include **intercultural communication proficiency**, the capacity to develop a therapeutic relationship with a culturally different patient, and the ability to adapt diagnosis and treatment in response to cultural differences between healthcare providers/nurses and the patients/users /families (Schouler-Ocak et al., 2015).

Effective communication between healthcare professionals and patients from different cultural origins and with differing language capacities includes

- Cross-cultural communication skills, both verbal and nonverbal,
- Skills in identifying and integrating specific cultural issues in both diagnostic and treatment formulation,
- Skills in applying emic approaches in assessment and treatment,
- Skills in advocating for a specific patient or patient population,
- Reflective skills in monitoring one's performance and effectiveness within specific cultural contexts. (Arredondo et al., 1996; Pedersen & American Counseling Association, 1994; Sue et al., 1982; Sue et al., 1992)

As mentioned earlier in this e-book (2.2.1), according to the Model of Arasaratnam et al. (2010), the capacities to develop intercultural communication skills are: cultural empathy, involvement in interaction, a global attitude of cultural relativism, intercultural experiences and motivation.

6.- DEALING WITH CULTURAL AMBIGUITY

Rationale and definition

This competence is the ability to deal with culturally ambiguous and uncertain nursing care situations.

7.- DIGITAL HEALTH SKILLS

Rationale and definition

The increased use of digital health technologies requires digital multicultural health literacy. Dunn and Hazzard (2019) define it as the ability to seek, find, understand, appraise, and apply information from digital sources to manage and cope with multicultural health issues.

Current nursing care is mediated through hyper-technological processes (Monteiro & Curado, 2016). Nurses are faced with the new challenges posed by the digitization of healthcare, including the concept of digital care as a nursing intervention (cyber nursing) and the integration into “holistic care” of the concepts of techno-self and virtual identities (Salzmann-Erikson & Eriksson, 2015, p.37). Nursing care through digital platforms is a sociotechnical system that expresses a particular way of understanding disease and care, narrowed down to the domain of information networks and systems of response (expected to be quick and effective) to standardised symptoms (Monteiro & Curado, 2016, p. 145). These are not mere neutral computer applications but also cultural narratives. Moreover, digital health technologies can facilitate or hinder access to healthcare, as not all patients have the skills to use and exploit digital health technologies effectively. Nurses must seek to promote Digital Literacy on Health in vulnerable populations and cultural minority groups, migrants, and refugees to improve successful integration and health outcomes.

3.3.2. Social-cultural competencies

These competencies have a more collective, institutional and social nature. Without them, competencies would be limited to individual professional performance, leaving behind aspects regarding communities, societies, and changes in the health system. In multicultural societies, it is vital to have professionals who adopt the social change approach, favouring health system changes and contributing to the social evolution of an intercultural society. The following are described as social-cultural competencies:

8.- SOCIO-POLITICAL KNOWLEDGE/SKILLS

Rationale and definition

The Socio-political Knowledge competence allows nurses/nursing students to understand the political, social, and economic reality in which nursing care is anchored. The Community Health Nurses Association of Canada (2008, p.7) considers Emancipatory Knowing significant because *“it places nursing within the broader social, political and economic context where nursing and healthcare happen and equips the nurse to question the status quo and structures of domination in society that affect the health of individuals and communities.”*

Chim and Kramer (2011) consider Emancipatory Knowledge in Nursing as a specific way of understanding the world and social reality and actively intervening. Moreover, they perceive nursing as a potentially powerful force that can act in favour of those deprived of organizational and institutional power. In addition to Socio-political Knowledge (conceptual knowledge), to develop nursing skills linked to social responsibility (attitudinal, conceptual, and ability), it is vital to train skills that develop *“cultural strategies and cultural policies”* with institutions. These should also contribute to the awareness raising and training of citizens and professionals from academic and social areas (among others) coexisting in culturally diverse contexts.

This strategy aims to transform societies so that all individuals have their right to healthcare recognized. Healthcare that responds to individuals' *“needs”* (associated with the concept of *acceptability* in quality care delivery) and in which they have a voice and vote (patients with acting capacity and participatory skills).

This approach aligns with the ethics of care. Hence, in addition to *“caring,”* it is essential to *“transform”* the institutional and community factors that originate culturally motivated inequities. Taking on this responsibility is the way to *“becoming”* culturally competent.

9.- SOCIAL TRANSFORMATIVE LEADERSHIP

Rationale and definition

Transformational leadership is observed when *“leaders and followers make each other (...) advance to a higher level of moral and motivation”* (Burns, 1978). In literature, transformative social leadership has been described as stimulating change in clinical practice, health policies and organizations, and empowering others to stimulate such change (del Barrio-Linares, 2014). Transformative leadership requires individuals to critically examine the world in which they live and work to change it. The central premise of transformative leadership is to *“transform and empower”* (Burns, 1978; Shields, 2010).

3.3.3. Table of core competencies

TABLE 1 – NURSING STUDENTS’ CORE COMPETENCIES

1st CORE COMPETENCE – OPENNESS TO OTHERS		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Empathy towards people from other cultures; Genuine interest in knowing “the other”; Curiosity about cultural diversity; Commitment and positive attitude towards diversity; Respect for different cultural ways of understanding health and disease;	Understands the concept of cultural sensibility in healthcare; Knows collective alternative health projects in the socio-cultural context; Understands collective alternative health projects in the socio-cultural context;	Adapts alternative cultural projects in nursing assessment and interventions in healthcare; Integrates other ways of understanding health and disease in nursing care assessment, diagnostic, and implementation; Uses cultural empathy techniques in nursing assessment;
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Shows interest in knowing “the other” and her/his culture 2. Shows interest and curiosity to know and deeply understand other cultures 3. Respects different beliefs and values. 4. Understands personal interactive behaviour according to social and multicultural context without prejudices 5. Genuinely wants to learn how to understand cultural differences. 		
INDICATORS		
- Demonstrates empathy, curiosity, and willingness to learn and encounter persons and patients from other cultures.		

2nd CORE COMPETENCE – CULTURAL AWARENESS Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
<p>Critical reflective approach</p> <p>Cultural humility</p> <p>Willingness to learn and reflect on her/his biases and misperceptions</p>	<p>Understands her/his concepts of ethnocentrism, racism, xenophobia, stereotype, stigma, racism, discrimination, oppression, and privilege.</p> <p>Is self-aware of her/his attitudes/ prejudices towards different cultures and how to overcome them.</p>	<p>Critically examines the concepts of ethnocentrism and stereotype and their impact on nursing care;</p> <p>Recognises and challenges discrimination and racism in nursing practice and at a personal level;</p> <p>Assesses the institutional determinants of bias, unequal treatment, discrimination, prejudice, and unethical behaviour contributing to health disparities;</p> <p>Identifies her/his cultural prejudices and myths about immigrants, refugees, asylum seekers, and cultural minority groups.</p> <p>Uses strategies for overcoming racist evaluations in nursing assessment.</p> <p>Critically examines the impact of personal ethical values on the nursing care process.</p> <p>Explores the origin and ethnicity of the person/ patient without prejudices or bias.</p> <p>Performs her/his cultural self-assessment.</p>
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Critically examines the concepts of ethnocentrism and stereotyping 2. Recognizes the influence of her/his culture on the way she/he behaves 3. Recognizes the influence of her/his prejudices in caring for people from other cultures 4. Recognises and challenges discrimination and racism at the levels of nursing practice and healthcare policy 5. Identifies her/his cultural prejudices, myths, stereotypes, and misinformation about immigrants, refugees, and asylum seekers in Europe. 6. Recognizes that nursing culture influences the understanding of health, disease, death, and care. 7. Is aware of nurses' potential biases and the unavoidable impact of stereotyping in nursing care. 8. Describes potential ways to address bias in the clinical and community settings. 		
INDICATORS		
<ul style="list-style-type: none"> - Understands how her/his cultural background influences nursing work with Culturally and Linguistically Diverse (CALD) healthcare patients/users¹ - Examines and describes her/his cultural identities, including assumptions, values, beliefs, stereotypes, and biases, and recognizes how these affect nursing care - Is aware of how cultural beliefs (including her/his "isms," such as racism, sexism, ethnocentrism, homophobia, ageism, and xenophobia) influence her/his attitudes, beliefs, and behaviours, with impact on nursing care 		

¹ CALD is an acronym meaning "Culturally and Linguistically Diverse", which includes migrant populations (coming from different countries across the world), populations that speak languages other than the host country's language, or people that represent different cultural backgrounds and minority religious beliefs.

- Understands the connection between cultural identity and health
- Recognizes that nursing culture influences the understanding of health, disease, death, and care
- Understands the relationship between cultural practices and health
- Is aware of how a CALD patient’s culture impacts health
- Is aware of how cultural barriers may impact therapy and the therapeutic relationship between nurses and patients/users
- Is aware of how CALD patients’ assumptions about therapy/counselling may affect their treatment
- Is aware of how working with traumatised patients/users may affect nurses and health professionals
- Is aware of the cultural bias inherent in several health evaluation tools and instruments
- Understands the stressors families experience because of post-migration and adaptation

3rd CORE COMPETENCE – CULTURAL ENCOUNTER Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
<p>Flexibility towards using other health belief systems</p> <p>Valorisation of diverse perspectives and cultural concepts of health and wellbeing</p> <p>Respect for the beliefs and values of people in different multicultural contexts.</p> <p>Respect for the patient, family, community, and multi- or interdisciplinary team, regardless of their differences</p>	<p>Knows the historical and contextual cultural backgrounds;</p> <p>Understands the concept of culture;</p> <p>Knows the importance of culture in health choices and health behaviours.</p>	<p>Prioritizes the social and cultural factors that affect health when designing and delivering nursing care across multiple contexts;</p> <p>Uses culturally sensitive understanding techniques in nursing assessment;</p> <p>Performs active listening in nursing care to understand the patient/user’s beliefs and values in different multicultural contexts;</p> <p>Educates, facilitates, and supports health and well-being from an intercultural perspective.</p>
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Identifies alternative and/or integrative models of care 2. Considers the opinions of patients/users and professionals when making decisions as a team 3. Promotes the participation of individuals and groups in issues related to their health-disease process 4. Considers social and cultural aspects in nursing prescriptions 5. Provides appropriate and congruent nursing care to patients based on cultural factors 6. Employs diversity factors to improve healthcare resources 7. Can educate, facilitate, and support health and well-being from an intercultural perspective 		
INDICATORS		
<ul style="list-style-type: none"> - Has the ability to interact with people belonging to different cultures effectively - Provides appropriate and congruent nursing care to CALD patients 		

4th CORE COMPETENCE – CULTURAL KNOWLEDGE
Type of Competence - INDIVIDUAL CULTURAL COMPETENCE

DIMENSIONS OF THE COMPETENCE

ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Interest in obtaining reliable information on migrants, refugees, and diverse minority cultural groups.	Identifies the psycho-social and cultural issues that deeply affect people's health behaviours and well-being in multicultural societies.	Provides adequate person-centred care to culturally diverse patients, considering the patients' cultural factors and their concept of health/disease. Uses a wide range of data and resources to acquire knowledge of cultural minority communities.
Curiosity to understand different health systems, beliefs, and values	Knows about patients' value systems, beliefs, and practices relevant to health and illness and how they affect nursing care and practice Distinguishes between diverse care practices in different cultures (between themselves, each other, and the professional care they expect).	In nursing assessment and nursing care delivery: - Prioritizes the social and cultural factors that affect nursing and healthcare across multiple contexts - Considers the patient's customs and beliefs about different situations in the life cycle - Enquires about traditional treatments Considers the person-patient's origin and ethnic origin in nursing assessment and care. Includes (if possible) therapeutic alternative approaches in care delivery to culturally diverse patients. Applies specific nursing care to at least two different communities/cultures in the area where she/he lives.
	Knows Theoretical foundations of Nursing Multicultural Care	Characterizes the Key-concepts of at least two theoretical Cultural Nursing Models
	Is familiar with conceptual theories on migratory phenomena	Describes two migration process theories Identifies the main components influencing and explaining changes in migration flows. Uses relevant data sources on international, global, and European migratory flows and the health conditions of migrants, refugees, and asylum-seekers
	Knows the different health systems and policies in Europe and their implications for healthcare accessibility among migrants, refugees, and asylum-seekers	Critically appraises different health systems and policies in Europe and their implications for healthcare accessibility among migrants, refugees, and asylum-seekers.
	Critically analyses the approach of the hegemonic biomedical model in multicultural nursing care	Integrates diverse ways of understanding health and disease into assessing, diagnosing, and implementing nursing care . Recognises that the biomedical model ignores the psycho-socio-cultural dimension in health/disease/expected care

	Accurately defines the concepts of culture, ethnocentrism, racism, stereotyping, cultural relativism, acculturation, cultural shock, cultural pain	Integrates the concepts of culture, ethnocentrism, acculturation, cultural shock, and cultural pain into nursing assessment and nursing interventions
	Identifies diverse cultural practices and customs related to significant life events (childbirth and death)	Considers individual customs and beliefs about life cycle situations during nursing assessment and care interventions Allows patients' cultural practices and customs related to significant life events (childbirth and death) Designs health education plans for culturally diverse patients.
	Recognizes different concepts and forms of gender-based violence. Identifies culturally bound gender-based violence in patients and families Understands people's interactive gender-based behaviours in their social and multicultural context	Focuses on specific women's health issues, such as Female Genital Mutilation/Cutting (FGM/C), Gender-Based Violence, and Reproductive Health. Assesses culturally bound gender-based violence in patients and families Implements culturally sensitive care interventions in victims of gender-based violence. Integrates culturally bound gender roles into nursing interventions
	Understands people's interactive behaviours based on their social and multicultural context	Includes preferences and cultural prohibitions about food and diet patterns in nursing assessment Respects the dietary patterns of patients' cultures in nursing prescriptions and interventions
	Understands the patient's religion and how important it is in her/his daily life.	Integrates the patient's religion, values, and beliefs into nursing care
		Collaborates with patients and families to identify mutually agreed-upon goals and care outcomes
	Knows the importance of space and the concept of "personal space" as an important cultural phenomenon for patient assessment, from which culturally sensitive care can be designed. Knows that each culture has defined what appropriate or inappropriate physical boundaries are.	Considers the importance of personal space in nursing assessment . Maintains an appropriate physical distance in conversations and interactions during nursing interventions without trespassing the limits according to the patient's culture. Identifies at least three specificities of culturally bound ways of physical contact in diverse cultures. Considers the importance of physical boundaries in nursing assessment and care delivery. Considers cultural prohibitions regarding touching certain body parts when providing nursing care.

	Knows the importance of “time” as an important cultural phenomenon for patient assessment, from which culturally sensitive care can be designed.	Integrates the concept of personal time orientation into multicultural nursing assessment and nursing care.
	<p>Describes the most frequent health problems of newly arrived refugees and migrants, like accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy- and delivery-related complications, diabetes, hypertension, and sexual infections and diseases (World Health Organisation, 2021).</p> <p>Knows cultural practices that can negatively impact health.</p>	Migrant and refugee nursing care includes comprehensive physical assessment, mental health assessment, immunisation history, catch-up, family planning, oral health, nutrition, torture and trauma sequelae, infectious, parasitic, and vaccine-preventable diseases, and chronic disease recognition and management.
	Knows about the risk factors for mental health problems in vulnerable populations, such as refugees and asylum-seekers, and the mental and emotional response of individuals to adverse circumstances	<p>Directly asks about trauma and mental health concerns in refugee patients’ healthcare.</p> <p>Identifies, during nursing assessment of migrants and refugees, symptoms classically associated with mental health problems such as insomnia, changes in appetite and eating behaviours, nightmares, muscle tension, headaches, and/or diffuse body pain with no known aetiology.</p>
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Knows about the different theoretical models of Transcultural Nursing 2. Characterizes the key-concepts of at least two theoretical Cultural Nursing Models 3. Explores the origin and ethnicity of the person-patient to understand her/his culturally specific patterns 4. Explores health beliefs and practices of cultural minorities/ Explores customs and cultural beliefs related to the life cycle 5. Explores culture-related preferences, prohibitions, eating habits, patterns, and taboos 6. Explores person-patient social support in association with cultural community ties 7. Identifies common health problems of migrant patients and CALD healthcare users in their specific social context 8. Plans, provides, and evaluates nursing care focused on the family and caregivers considering cultural diversity 9. Plans, develops, and evaluates culturally congruent programs and activities in the community (health education, prevention, and promotion) 10. Applies strategies of community participation, promotion of healthy lifestyles, and self-care in culturally minority groups 11. Knows about alternative and/or integrative healthcare models 12. Understands gender roles according to different cultural backgrounds 13. Relates violence to gender roles 14. Asks about religion and its importance in the patient’s life. 15. Explores and respects the form of eye contact (intense, fleeting, or avoided as a sign of respect). 16. Respects patients’ personal space according to their culture (physical boundaries). 17. Respects patients’ type of physical contact according to their culture (physical boundaries) 18. Explores and respects physical contact according to patients’ culture (appropriate physical contact, inappropriate or prohibited physical contact). 19. Explores and respects time orientation according to patients’ culture (objective or subjective time; punctuality and sufficient attention time) 		

INDICATORS

- Identifies common health problems of CALD patients in their social context
- Considers the determinants of health to understand the health and welfare inequalities in the EU
- Describes the problems that immigrants, refugees, and asylum seekers face and identifies the psycho-social and cultural issues fundamentally affecting the health behaviours and well-being of people in multicultural transitions
- Knows health-related beliefs and cultural values of culturally specific groups of migrants, asylum seekers, and refugees in the EU
- Uses a wide range of data and resources to acquire knowledge about communities and recognises similarities and differences between culture-specific health beliefs and behaviours
- Demonstrates specific knowledge about traditional and non-traditional providers and patient groups
- Knows the importance of time/ space / physical contact and the concept of “personal space” as critical cultural phenomena for patient assessment, from which culturally sensitive care can be designed and implemented
- Understands her/his country’s multicultural policies
- Knows about the settlement and support services provided to CALD patients
- Knows about the Government and European policies regarding cultural diversity and service provision
- Knows frameworks for developing culturally responsive services
- Knows her/his country’s Immigration Program
- Is familiar with the advantages and disadvantages of each health service model for CALD patients
- Is familiar with potential clinical-community linkages for CALD patients
- Knows how to implement culturally responsive services to produce change
- Understands the significant barriers to health services experienced by CALD patients
- Knows refugees’ specific healthcare needs and the guidelines and special treatment programs aimed at traumatised refugees and asylum-seekers
- Focus on specific women’s health issues such as Female Genital Mutilation/Cutting (FGM/C), Gender-Based Violence, and Reproductive Health in the migrant population.

5th CORE COMPETENCE – INTERCULTURAL COMMUNICATION
Type of Competence - INDIVIDUAL CULTURAL COMPETENCE

DIMENSIONS OF THE COMPETENCE

ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Respect for other forms or styles of communication	Recognizes linguistic diversity in healthcare Understands the causes of communication difficulties or lack of language skills	Ensures optimal cross-cultural communication in clinical and/or community settings for patients with limited proficiency in the host country's language, low health literacy, and/or nonverbal styles of communication
Flexibility towards the use of other languages or forms of communication in healthcare Respect for patients' right to receive information about their health processes despite communication difficulties	Knows strategies for effective communication with culturally diverse persons, families, and social groups, allowing them to express their concerns and interests	Interviews culturally diverse patients and provides health assessment; Interacts face-to-face with culturally diverse patients/ users in healthcare settings
Acceptance of people's right to express themselves in other languages if they are unaware of or have difficulty employing the host country's language		Provides cultural congruent nursing care to patients with limited language proficiency and low health literacy Ensures the patient's right to receive information about health processes despite communication difficulties Respects confidentiality despite language or communication difficulties
Empathy towards people from other cultures		Uses techniques of cultural empathy in nursing assessment interventions
	Knows specific techniques and principles of using translators and cultural mediators	Works with translators, cultural mediators, and interpreters in patient care situations
	Understands the meaning of silence in different cultures Identifies forms of nonverbal communication in interactions with patients from different cultures	Uses silence and other forms of non-verbal communication to support interactions with patients in culturally diverse settings
	Identifies the stereotypes and prejudices related to communication difficulties in healthcare	Avoids stereotyping in contexts of patients' communication difficulties
		Respects the different communicative styles during nursing assessment and nursing interventions Communicates effectively to promote health outcomes in patients, families, and communities

EXPECTED LEARNING RESULTS
<ol style="list-style-type: none"> 1. Respects confidentiality despite language or communication difficulties. 2. Tries to guarantee the patient's right to receive information about health processes despite communication difficulties 3. Considers people have the right to express themselves in other languages if they are unaware of or have difficulty using the host country's language. 4. Respects culturally diverse forms or styles of communication 5. Considers the causes of communication difficulties or lack of knowledge of the language 6. Does not use stereotypes to assess communication difficulties 7. Explores the characteristics of the person-patient's nonverbal communication style 8. Explores the style, pauses, and speed of conversation according to the culture. Interprets and respects silences. 9. Interprets and respects the style of the conversation (direct, indirect, or "using stories").
INDICATORS
<ul style="list-style-type: none"> - Uses interview techniques that respect the role of diverse languages and meanings in the patient's culture - Has the ability to decentre herself/himself from her/his culture of reference and access the "other's" narrative/subjective experience - Conducts culturally effective communication in nursing assessments and culturally congruent nursing intervention plans - Works with translators, cultural mediators, and interpreters in patient care situations - Understands the speech of people with strong accents - Provides clear messages to people who may be struggling with the host country's language - Develops culturally appropriate intercultural communication response styles to meet the needs of CALD patients and their families - Can build therapeutic rapport with CALD patients - Negotiates with a CALD patient a shared understanding of each other's beliefs regarding how illness is perceived, what causes it, and how it should be treated.

6TH CORE COMPETENCE – DEALING WITH CULTURAL AMBIGUITY Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Cross-Cultural tolerance	<p>Understands people’s interactive complex behaviours based on their social and multicultural context</p> <p>Understands the cultural contexts of nursing care, who the stakeholders are, and what deliverables are expected</p>	<p>Adapts quickly to changing circumstances in multicultural settings without compromising quality patient care</p> <p>Establishes clear intercultural communication with well-defined concepts</p> <p>Takes adequate action without having every detail of the situation in complex multicultural care settings</p>
Embraces change with a growth mindset	Identifies the uncertainty points of nursing care with multicultural patients	Identifies complex health/disease/ social and healthcare needs or problems arising from cultural differences (gender, age, ethnicity)
		Lists a few of the most probable decisions that need to be made and how they affect the next steps of care
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Is aware of potential misunderstandings related to the interaction between different cultures 2. Understands interactive behaviour according to the social and multicultural context 3. Uses a conceptual framework for health, its evolution, and complexity 4. Has an attitude of dialogue and flexibility in cultural conflict 5. Identifies specific needs or potential problems arising from cultural differences (gender, age, ethnicity), linguistic difficulties, or social inequities. 		
INDICATORS		
<ul style="list-style-type: none"> - Describes areas of conflict and congruity between her/his personal and professional values and those of culturally diverse patients - Adapts quickly to changing circumstances in multicultural settings without compromising quality patient care - Manages health-related cultural conflicts - Communicates clearly and precisely with the other team members to explain the difficulties found in developing activities 		

7TH CORE COMPETENCE – DIGITAL HEALTH SKILLS Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Acceptance of digital tools in all aspects of students' academic experiences	Displays high levels of digital multicultural health literacy	Uses digital devices, communication applications, and networks to access and manage information on multicultural issues
	Shows proficiency in using health information systems	Applies information from digital sources to manage and cope with multicultural health issues Creates and shares digital content on multicultural health issues Integrates socio-cultural data into new and existing health technologies and informatics to plan, implement, and evaluate culturally competent care
Commitment to developing and using digital technologies to improve the health of vulnerable populations		Suggests the use of digital health technologies in healthcare adapted to different languages and cultural patterns Provides digital health literacy to vulnerable populations and cultural minority groups, migrants, and refugees to improve successful integration and health outcomes Contributes to the design of innovative, culturally competent digital care systems to achieve safe and quality care outcomes
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Recognizes meaningful information to identify relevant data on multicultural nursing care 2. Shows proficiency in using health information systems 3. Supports citizens and patients from cultural minority groups to find reliable health information 4. Employs digital health communication strategies and skills 5. Provides digital health literacy to vulnerable populations and cultural minority groups, migrants, and refugees to improve successful integration and health outcomes. 		
INDICATORS		
<ul style="list-style-type: none"> - Recognizes meaningful information to identify relevant data on multicultural nursing care - Evaluates the reliability of the various information or advice sources and selects the most reliable sources from the range available. - Understands how data is structured within health record systems – complying with legal and professional requirements when using and sharing information - Uses data analysis and protection programs, mobile applications, cloud storage, and the internet, as well as reads, understands, and forwards health information using a smart device. - Identifies information needed to improve clinical decision-making in multicultural settings - Supports citizens and patients from cultural minority groups to find reliable health information - Uses information and communication technologies and digital processes to deliver safe nursing care to culturally diverse populations in several settings - Works with culturally diverse patients and citizens to co-design and co-develop digitally enabled ways of working - shaping digital innovation - Contributes to the design of innovative, culturally competent digital care systems to achieve safe and quality care outcomes 		

8TH CORE COMPETENCE – SOCIOPOLITICAL KNOWLEDGE
Type of Competence - SOCIAL-CULTURAL COMPETENCE

DIMENSIONS OF THE COMPETENCE

ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
<p>Commitment to and positive attitude toward diversity/ cultural diversity</p> <p>Acceptance of “the other” as an equal member of society</p> <p>Commitment to cultural Health risk assessments (HRA) in the healthcare system</p> <p>Commitment to the non-discrimination of vulnerable populations and promotion of equity in healthcare</p> <p>Dialogue and flexibility in cultural conflicts</p> <p>Awareness-raising of the nurse’s role in political issues related to community health</p>	<p>Recognises the historical and contemporary implications of public policies and discrimination affecting health, healthcare systems, and use of healthcare services by migrants, refugees, and other vulnerable cultural groups</p> <p>Knows the national and European legislation and politics related to migrants, refugees, asylum-seekers, human rights, and discrimination</p> <p>Identifies principles and legislation on human rights, particularly of minorities, migrants, and refugees;</p> <p>Identifies structural factors contributing to adverse health outcomes for migrants and refugees in host countries</p> <p>Recognises the importance of health advocacy for minorities</p>	<p>Uses the HRA approach in nursing assessment and care for minorities, migrants, and refugees;</p> <p>Assumes social co-responsibility in defending the right to health, healthcare access policies, and government migration policies</p> <p>Promotes the right to accessible and equitable healthcare for conflict-affected and -displaced populations</p> <p>Respects and complies with the nursing code of ethics, general legislation, and health legislation in all its interventions</p> <p>Promotes health coverage and provides access to safe and affordable medication and vaccines to migrants, refugees, and minority groups</p> <p>Identifies at least two political advocacy strategies for the right to healthcare of migrants, refugees, and minorities</p> <p>Advocates at local, regional, and national levels for improving refugees’ and asylum seekers’ health regardless of their country of origin, religion, age, or other parameters that may impede their ability to seek and receive healthcare</p> <p>Reports individual and institutional discrimination practices, unequal treatment practices, breaches of patients’ human and civil rights, or violations of respect for patient autonomy to the proper authorities</p> <p>Is involved in the legislative process and public policymaking by taking and supporting public positions on migrants’ and refugees’ rights in healthcare</p> <p>Participates in community projects involving culturally diverse community members</p>

EXPECTED LEARNING RESULTS
<ol style="list-style-type: none"> 1. Knows the migratory phenomenon 2. Criticizes the approach of the hegemonic biomedical model in healthcare 3. Has a solid commitment to social justice and human rights 4. Knows about the associative movements in the context where she/he works 5. Knows who are the respondents of policymaking and how to communicate with them 6. Has the political skills needed to advocate for individuals and communities 7. Provides victims of violence with support and tools 8. Is aware of her/his professional role in political issues related to community health 9. Is aware of the importance of advocacy on issues related to the health of ethnic minorities 10. Advocates for the health rights of culturally diverse individuals and communities.
INDICATORS
<ul style="list-style-type: none"> - Locates the national and European legislation related to immigration, human rights, and discrimination in healthcare - Identifies at least two political advocacy strategies for the right to healthcare of migrants, refugees, asylum-seekers, and minorities - Advocates for social justice, including a commitment to the health of migrants and cultural minority populations, as well as the elimination of health disparities - Is involved in the legislative process and public policymaking by taking and supporting public positions on migrants' and refugees' rights to healthcare - Has participated in social policies for extended periods (at least one year) - Respects and complies with the nursing code of ethics, general legislation, and health legislation in all her/his interventions in multicultural nursing care.

9th CORE COMPETENCE – SOCIAL TRANSFORMATIVE LEADERSHIP Type of Competence - SOCIAL-CULTURAL COMPETENCE		
DIMENSIONS OF THE COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIORAL SKILLS, PRAXIS DIMENSION
Motivation to contribute to social transformation	<p>Knowledge of health and social policies.</p> <p>Knowledge of the health system and its portfolio of services.</p> <p>Knowledge of the socio-health resources in the context.</p> <p>Forms of participation in health.</p>	<p>Leads interprofessional teams towards minimising and preventing health disparities and achieving culturally competent programmes and culturally competent healthcare delivery</p> <p>Focus on personal and social transformation that contributes to better leadership, management, and interpersonal relationships</p> <p>Mobilises multicultural healthcare motivations towards an organizational vision by empowering staff, challenging them beyond the status quo, and recognizing their individual needs and inspirations.</p>
EXPECTED LEARNING RESULTS		
<ol style="list-style-type: none"> 1. Shows respect for the patient, family, community, and the multi- or interdisciplinary team, regardless of their differences 2. Identifies health strategies for comprehensive and multidisciplinary care 3. Shows ability to lead interdisciplinary and inter-sectoral teams 4. Shows coordination and negotiation skills 5. Assesses the roles and skills of all members of the healthcare and social care teams 6. Applies the principles of moral and ethical reasoning in conflict analysis and decision-making 7. Engages with members of the healthcare and social care teams in taking action to meet patients' needs 8. Reviews and evaluates care with members of care teams 9. Systematizes the corresponding records with the evidence of the process carried out 10. Contributes to building networks based on a democratic spirit 11. Has the ability to collaborate and manage teams 		
INDICATORS		
<ul style="list-style-type: none"> - Identifies the specific needs and capacities of individuals and groups - Adjusts the messages to fit each unique cultural situation - Manages health-related cultural conflicts - Shows leadership and decision-making skills, communication skills, collaboration, and consensus 		



4.

PEDAGOGICAL PROPOSAL FOR IMPLEMENTING THE MULTICULTURALCARE EDUCATION MODEL

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4.1. Theoretical and pedagogical framework

One of the elements included in the Model presented, essential for its implementation in the classroom, is the pedagogical approach on which it is based. Using participatory and experiential methodologies will help to acquire competencies in a meaningful way by examining reality and emotions. Specifically, it is recommended to become familiar with the principles of Popular Education, Dialogic Learning, and Critical Thinking, as these methodologies are closely related to each other, as described in the summaries presented below:

4.1.1. Popular education

Popular Education is a philosophical and pedagogical approach that understands education as a process that transforms reality. Using critical reflection, students depart from their experience to learn about and analyse the factors and structures that determine their lives, aimed at developing the strategies and skills necessary for transforming their realities. With this approach, people cease to be passive subjects, who only receive and store information, to become active and participatory subjects in their process of appropriating and transforming reality. This way, they contribute to building a more egalitarian society and become capable of critically understanding their world and acting to transform it.

Popular Education was widely developed in the work of Paulo Freire (1921-1997). Throughout his work, Freire stresses that the importance of education implies a profound consideration of the act of educating and its conception as a process that includes elements that differentiate it from banking education, conceived as the mere instruction and repetition of knowledge and behaviours. As Freire defined it, *“Teaching is not transferring knowledge, but creating the possibilities for its production or construction.”*

Like any pedagogical system, Popular Education is made up of four primary dimensions:

- a) **The epistemological dimension** refers to how one learns and unlearns to re-elaborate knowledge. For Freire, to educate is critically knowing reality and one’s practice. Knowing

the world is a collective, practical process involving different forms of knowledge, such as consciousness, feeling, desire, will, and body. All educational practices must recognize what learners and educators know about the subject and generate collective and dialogical experiences to build new knowledge. Freire says, "No one knows everything, no one ignores everything." Therefore, the process is continuously fed back to the extent that progress is made in the transformation process since each change implies a new reality to reflect upon and re-conceptualize to return to it and modify it. The world "is not given" but "giving itself" in continuous change and movement, about which it is possible to constantly problematize by exercising a pedagogy of questioning for which exact and immobile answers are not expected (Freire, 1970, 1997). This dimension is also closely related to critical thinking, which will be developed independently.

- b) **The pedagogical dimension** focuses on didactic and methodological aspects, using innovative participatory techniques to facilitate the experiential problematization of reality and maintain the student's interest and learning from emotion. Neuroscience has proved that without emotion, there is no curiosity, attention, or memory. These elements are vital for meaningful learning (Mora, 2013).
- c) From the perspective of Popular Education, the educator plays the role of facilitator during the development of participatory techniques so that the group and its participants formulate the necessary questions and build their answers, what Freire called "praxis" or "learning by doing." This methodology allows working on training for action and transformation based on the realities of each context and/or situation. This way, the practice serves as an evaluation criterion of truth. However, the use of participatory techniques is not in itself Popular Education, nor is the objective of its use simply group dynamization. The techniques used are merely instruments that allow for specific objectives according to the participants with whom work is carried out. A single technique is generally not enough to work on a topic, requiring others that allow an orderly and systematic process of deepening the scope to reach all target audiences. Therefore, each technique must be carefully selected and coherent within a design oriented to fulfil a pedagogical objective and serve for the learners to carry out their transforming process (Vargas et al. 1995).
- d) **The ethical dimension** refers to respect for human beings and their rights as an essential basis for building a more egalitarian and just society. From this approach, people are the centre of the educational process, and their most effective tool is the word, which generates dialogue with other people and their environment. Dialogue provides other points of view and the certainty that the world is flexible and adjustable according to one's senses and utopias. Freire states, "it is through shared conversation, where I speak and listen to those who speak and listen to me, [that] I recognize myself as a subject in permanent construction." As already mentioned, far from the conditioning of banking education, Popular Education sees people as subjects, protagonists of their process of transformation and change, and not objects of an educational system.

- e) From the perspective of Popular Education, educators do not teach but learn while they are in dialogue with learners, and learners also learn while they teach. Learners and educators become subjects through such action, reflection, and dialogue. The importance of this ethical dimension is included in other pedagogical currents involving different actors in the training process, such as dialogical learning. This concept is particularly relevant to the pedagogical model proposed, which is why it has a separate section dedicated to it.
- f) **The political-pedagogical dimension** refers to how each person is and relates to the world around them and how they can learn from it to rethink and transform it. For Freire, all educational practice is political, just as political practice is educational because it involves values, projects, and utopias that reproduce, legitimise, question, or transform the prevailing power relations in society. Education alone does not change the world, but without it, it is impossible to do so. Education is never neutral. It is in favour of domination or emancipation, which is why Freire proposes a pedagogy of hope that he summarises in one of his last books, published in 1992. His main message is the need to vindicate the importance of educational activity as an indispensable element in searching for social justice and the enjoyment of human rights, as stated by Vélchez Quesada in his last essay (2021).

4.1.2. Dialogic learning

As mentioned above, dialogic learning is based on interactions between people and uses dialogue as a learning tool in environments involving several actors, such as in health interventions. According to this perspective, people learn through the various interactions in the formal, non-formal, and professional or educational environments that constitute part of their training curriculum. As Aubert et al. (2008) put it, “through interactions and dialogue, participants share the lifeworld from which understanding is possible.”

Dialogic learning incorporates seven basic principles (Aubert et al., 2008; Duque et al., 2009):

- 1) **Egalitarian dialogue**, in which contributions are valued according to the validity of the arguments provided and not according to established power relations or social hierarchies.
- 2) **Cultural intelligence**, which recognises people’s capacity for culture-related action and reflection. It includes academic, practical, and communicative intelligence, employing the agreements that can be established through language.
- 3) **Transformation of the social environment** through education, which changes people and their context.
- 4) **Instrumental dimension**, which considers all knowledge essential for today’s society to avoid social exclusion.

- 5) **Creation of a vital meaning** to our existence, which guides the learning process to fulfil dreams and projects.
- 6) **Solidarity**, which is a critical element of any democratic educational practice that integrates all people to overcome school and social vulnerability in the educational sphere.
- 7) **Equality of differences**, which assumes that diversity, far from being an obstacle to learning, is an opportunity to add elements and ways of understanding life. This principle emphasises that true equality will only exist when all people have the same right to be and to live differently and be treated with the same respect and dignity.

4.1.3. Critical thinking

Critical thinking is people's processes and strategies to analyse and solve problems by evaluating existing information to make appropriate decisions and learn new concepts (Robert Sternberg, 1986). Among the most influential theorists who have set out to define critical thinking is Robert H. Ennis (1985), who summarises critical thinking as rational and reflective thinking concerned with deciding what to believe or do.

From the approach proposed by critical thinking, learning is not conceived as a collection of unquestionable knowledge but as a process of constructing one's own opinion and the arguments that support it. Therefore, to educate by fostering critical thinking is to educate for the transformation of one's life and environment (Bezanilla-Albisua et al., 2018).

Critically rethinking reality requires deepening and problematizing the context to propose hypotheses appropriate to that reality. As López Aymes (2012) points out, this process involves different steps, namely: *"to focus on the question; to analyse arguments; to formulate clarifying questions and give an answer; to judge the credibility of a source; to observe and judge reports derived from observation; to deduce and judge deductions; to induce and judge inductions; to make value judgements; to define terms and judge definitions; to identify assumptions; to decide what action to take and interact with others; to integrate dispositions and other skills to make and defend a decision; to proceed in an orderly manner according to each situation; to be sensitive to the feelings, level of knowledge and degree of sophistication of others; to employ appropriate rhetorical strategies in discussion and presentation, both oral and written."*

Competence-based learning must be based on critical thinking to be truly meaningful and not merely vicarious and a multiplier of learned behaviours and attitudes. It is about doubting the information, dogmas, and absolute axioms surrounding us to build new justified arguments about reality and not blindly accept constructed opinions. It is about elaborating one's point of view based on the verification and contrast of data. Critical thinking is closely related to other skills,

such as creativity, logic, or intuition, allowing us to develop new strategies and ways of seeing and perceiving things. Good critical thinking skills allow people to avoid conformism and advance as human beings, assuming there is no single way of seeing the world.

Other authors, such as Badia and Gisbert (2013), relate critical thinking to Bloom's Taxonomy since not all cognitive actions have the same complexity. Thus, critical thinking allows us to go beyond the basic levels of remembering and understanding to reach consecutively higher levels such as applying, analysing, evaluating, and creating.

Stimulating critical thinking via educational spaces allows students to become aware of the social, political, ethical, and personal context from which they depart or in which they may be immersed. This way, they can experience reality from other perspectives and generate and defend transformative actions individually and for society (Lipman, 1987; Bezanilla-Albisua et al., 2018). Therefore, critical thinking is essential for innovation, improvement, creativity, and personal and professional engagement.

4.2. Guide for developing training activities in MulticulturalCare competencies.

4.2.1. Proposal of Template: Putting the model into practice

In order to facilitate the teaching work of teachers who wish to implement the Multiculturalcare model in their lessons, we propose the use of a simple template to create training activities based rigorously on the model. The basis on which to design activities contextualised to the specific needs of each subject will be established by means of a hierarchical selection of the components of the model (see section 3.2). The use of this innovative tool for the incorporation of the model in the classroom will allow the creation of collections of activities focused on different aspects of the Multiculturalcare model in such a way that it is also a suitable tool for the systematisation of the educational process. In the following pages, we will describe the content of the worksheet and the procedure for filling it in.

Each template summarises a training activity, and is made up of both the rationale for the activities based on the competences and learning outcomes to be worked on, and a specific design in order to work on these competences and obtain the expected learning outcomes. At the end of the template there is a proposal for assessment that will make it possible to ascertain whether the students have acquired the selected competences and have adequately achieved the planned learning outcomes, and some complementary resources or materials that can enrich the proposal with subsequent modifications. Table lists and describes all the sections of the template.

Template for the creation of teaching activities in the framework of the Multiculturalcare model.

TITLE:	<i>It should be concrete and describe the proposed activity in a simple way.</i>
SPECIFIC OBJECTIVE:	<i>The specific objective to be covered by the planned activity.</i>
CULTURAL COMPETENCES:	<i>Cultural competence to be worked on with the planned activity.</i>
DIMENSIONS:	<i>These will be the dimensions included according to the cultural competence chosen in the previous section.</i>
EXPECTED LEARNING OUTCOMES:	<i>Learning outcomes associated with the cultural competences selected in the previous section.</i>
EXECUTION OF THE ACTIVITY:	<i>Exhaustive design of the activity to be carried out.</i>
MATERIALS:	<i>List of all the elements needed to develop the activity and facilitate its implementation in the classroom. There can be stationery materials, audiovisual materials, elements to characterise the stage space and characters, own materials, etc.</i>
EVALUATION:	<i>Assessment method that will make it possible to ascertain the degree of acquisition of competences and expected learning outcomes.</i>
RESOURCES:	<i>This section can include complementary information that can facilitate small modifications to the original design of the activity, allowing to diversify it without changing its basis.</i>

Procedure for filling in the template

As previously described, the usefulness of this tool is to facilitate the creation of activities based rigorously on the Multiculturalcare model. In order to do so, it is essential to follow a simple procedure for its completion in cascade, divided into five moments composed of different steps which are described below:

Moment 1.- Basis of the activity

Step 1.- Firstly, we will select the competences we want to work on in depth from Table 1 (section 3.3.3). It is recommended to choose as few competences as possible in order to be able to focus the activity and facilitate the achievement of the specific objective. And also select some dimensions of these competences. Then, we will transfer this information to section **3.- Cultural competences**, of the template and to section **4.- Dimensions**.

Step 2.- Then, we will select, from the learning outcomes tables, the learning outcomes associated with the chosen competences. We will select those that we want the students to achieve and the indicators that can be used for their assessment. All this will be included in the section **5.- Learning outcomes**.

Moment 2.- Design of the activity

Step 3.- Once the elements to be worked on have been selected, we will begin the search for options that will allow us to combine the information and work on it together. To do this, we will first formulate a specific objective, which will be reflected in section **2.- Specific objective**. It is very useful to start from our own or known experiences that can help us to put ourselves in context and formulate specific work objectives. It is important to point out that all the activities proposed within the framework of the Multiculturalcare model will always have as a general objective to train culturally competent nurses, the central point of our educational model.

Step 4.- Having set out the specific objective, in section **6.- Execution of the activity**, we will describe the activity designed to achieve it, always in a simple way so that any teacher who wants to use it can replicate it in their classes without difficulty. For this purpose, it is advisable to make an exhaustive and structured description of the different moments that comprise it and to describe what is included in each of them, their duration, as well as the resources necessary to carry them out.

Step 5.- We will carefully analyse the materials that we will need for the development of the activity, and we will list them in order to facilitate their preparation in advance, including this information in this section as well.

Moment 3.- Evaluation design

Step 6.- It is essential to add to the design of the activity an appropriate method of evaluation that allows us to know the degree of acquisition of the competences worked on and the achievement of the learning outcomes. We will use the selected indicators for this purpose. We recommend competency-based assessment methods and the use of rubrics. The description of the assessment system will be included in section **8.- Evaluation**.

Moment 4.- Choice of different complementary resources

These supplementary materials, which are relevant to the subject matter of the activity, can be used as inspiration to make changes to the activity without changing its rationale. This information will be very useful for those teachers who want to use the training activity but need to adapt it to their particular contexts. This information will be collected in section **9.- Resources**.

Moment 5.- Title

To complete the template, fill in section 1.- Title, choosing one that describes the proposed activity, which serves to classify and identify it within the range of activities on offer.

After carefully carrying out this procedure of filling in the template in the proposed order of the sections, we will generate a final template in the form of a report which will summarise all the information in an orderly manner and facilitate its classification and filing, according to the format indicated in the Table of this section. As mentioned above, this tool will facilitate the creation of collections of possible activities to be used whenever you want to work with students from the perspective of the Multiculturalcare Model in a rigorous way. Moreover, such an archive is an important tool for the systematisation of the Multiculturalcare model in teaching work.

4.2.2. Agile Pilots: Examples of innovative pedagogical practices.

Using the MulticulturalCare Model Draft, each team built an Agile Pilot (AP) focused on the MulticulturalCare core dimensions. The partners, using innovative pedagogical approaches, carried out the AP. The entire process, materials, and results were shared on a platform, including the description of the most critical parameters of each AP, the theoretical framework, the activities carried out, the practical guide, and the evaluation tools used. For planning the AP, the European Credit Transfer and Accumulation System (ECTS) was used as a standard criterion of implementation and evaluation.

The partners discussed the main results and achievements and developed the preliminary version of the simulation scenarios. These scenarios were agreed upon on 22 June and included in this e-book as examples of the Model's application.

In the following pages you can find some examples of Agile pilots developed by the Project partners. They have been collected in the format of Template for the creation of teaching activities in the framework of the Multiculturalcare model (4.2.2).

PILOT University College Leuven-Limburg

<p>TITLE: EXPOSURE AS A MEANS TO LET THE STUDENT GROW INTO A SKILLED COMPANION IN MULTICULTURAL CONTEXTS</p>
<p>SPECIFIC OBJECTIVE:</p> <ul style="list-style-type: none"> - To become students in nursing whose central focus is on the care receiver and his/her context - To become a skilled companion and a proponent of the interest of the care receiver - Increase the receptivity of the students to dare to 'immerse' themselves - Personal growth through the exchange of experiences in a safe context (reflection) - Bringing together insights about multiculturalism and 'presence in care' through a creative working method (exposure and reflection) - Generating personal learning goals regarding to multiculturalism and diversity
<p>CULTURAL COMPETENCES:</p> <ol style="list-style-type: none"> 1. Core individual multicultural competencies <ul style="list-style-type: none"> - Openness to others - Cultural awareness - Cultural encounter - Cultural knowledge - Intercultural communication - Dealing with cultural ambiguity 2. Social-cultural competencies <ul style="list-style-type: none"> - Social transformative leadership

DIMENSION:		
1ST CORE COMPETENCE - OPENNESS TO OTHERS		
Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
<p>Empathy towards people from other cultures.</p> <p>Genuine interest in getting to know the "other".</p> <p>Curiosity for cultural diversity.</p> <p>Commitment and positive attitude towards diversity.</p> <p>Respect for diverse cultural understandings of health and disease.</p>	<p>Understands the concept of cultural sensitivity in healthcare.</p> <p>Knows about collective alternative health projects in the socio-cultural context.</p> <p>Understands alternative collective health projects in a socio-cultural context.</p>	<p>Adapts alternative cultural projects in nursing assessment and nursing health care interventions.</p> <p>Integrates other understandings of health and illness in the assessment, diagnosis and implementation of nursing care.</p> <p>Uses cultural empathy techniques in nursing assessment.</p>

2 ND CORE COMPETENCE - CULTURAL AWARENESS Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
<p>Uses a critical reflective approach.</p> <p>Cultural humility.</p> <p>Willingness to learn and reflect on one's own prejudices and misperceptions.</p>	<p>Understands one's own concepts of ethnocentrism, racism, xenophobia, stereotyping, stigma, discrimination, oppression and privilege.</p> <p>Is aware of one's attitudes/prejudices towards different cultures and how to overcome them.</p>	<p>Critically examines the concepts of ethnocentrism and stereotyping and their impact on nursing care.</p> <p>Recognises and challenges discrimination and racism in nursing practice and at the personal level.</p> <p>Assesses the institutional determinants of bias, unequal treatment, discrimination, prejudice and unethical behaviour that contribute to health disparities.</p> <p>Identifies cultural prejudices and myths about migrants, refugees, asylum seekers and cultural minority groups.</p> <p>Uses strategies to overcome racist judgements in nursing assessment.</p> <p>Critically examines the impact of personal ethical values on the nursing care process.</p> <p>Explores the origin and ethnicity of the person/patient, without prejudice or bias.</p> <p>Conducts one's own cultural self-assessment.</p>
3 RD CORE COMPETENCE - CULTURAL ENCOUNTER Type of competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
<p>Flexibility towards the use of other health belief systems.</p> <p>Positively values diverse cultural perspectives and concepts of health and well-being.</p> <p>Respects the beliefs and values of people in different multicultural contexts.</p> <p>Respects the patient, the family, the community and the multi- or interdisciplinary team, regardless of their differences.</p>	<p>Knows the historical and contextual cultural background.</p> <p>Understands the concept of culture.</p> <p>Knows the importance of culture in health choices and behaviours.</p>	<p>Prioritises social and cultural factors affecting health when designing and delivering nursing care in multiple contexts.</p> <p>Uses culturally sensitive comprehension techniques in nursing assessment.</p> <p>Performs active listening in nursing care to understand the beliefs and values of the patient in different multicultural contexts.</p> <p>Educates, facilitates and supports health and well-being from an intercultural perspective.</p>

4 th CORE COMPETENCE - CULTURAL KNOWLEDGE Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONES DE LA COMPETENCIA		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
Interest in obtaining solid information on migrants, refugees and various cultural minority groups.	Identifies psychosocial and cultural issues that deeply affect the health behaviours and well-being of people in multicultural societies.	Provides appropriate person-centred care to culturally diverse patients, taking into account the individual's cultural factors and concept of health/illness.
Curiosity to understand different health systems, beliefs and values.	<p>Knows the value systems, beliefs and practices relevant to patients' health and illness and how they affect nursing care and practice.</p> <p>Deeply defines the concepts of culture, racism, stereotypes.</p> <p>Understands the interactive behaviours of people based on their social and multicultural context.</p> <p>Understands the patient's religion and how important it is in his/her daily life.</p> <p>Distinguishes between different care practices in different cultures (of themselves, of each other, and the professional care they expect).</p>	<p>Considers the origin and ethnicity of the person-patient in nursing assessment and nursing care.</p> <p>Applies specific nursing care to at least 2 different communities/cultures in the area where he/she live.</p> <p>Characterises the key concepts of at least two theoretical models of cultural nursing.</p>
5 th CORE COMPETENCE - INTERCULTURAL COMMUNICATION Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
Respect for other forms or styles of communication.	<p>Recognises linguistic diversity in healthcare.</p> <p>Understands the causes of communication difficulties or lack of language skills.</p>	Ensures optimal intercultural communication in clinical and/or community settings for patients with limited fluency in the dominant language, low health literacy and/or non-verbal communication styles.
<p>Flexibility towards the use of other languages or forms of communication in healthcare.</p> <p>Respect for the patient's right to receive information about his/her health processes despite communication difficulties.</p>	Knows strategies for communicating effectively with culturally diverse individuals, families and social groups, enabling them to express their concerns and interests.	Performs face-to-face interaction in healthcare settings with culturally diverse patients.

Acceptance of the individual's right to express him/herself in other languages if he/she does not know or has difficulty using the official language.		Provides culturally congruent nursing care to patients with limited language fluency and low health literacy. Respects confidentiality despite language or communication difficulties.
Empathy towards people from other cultures.		Uses cultural empathy techniques in nursing assessment interventions.
	Knows techniques and principles specific to the use of translators and cultural mediators.	Works with translators and cultural mediators and interpreters in real-life patient care situations.
	Understands the meaning of silence in different cultures. Identifies forms of non-verbal language in interactions with users from different cultures.	Uses silence and other forms of non-verbal communication to support interactions with patients in culturally diverse settings.
	Identify stereotypes and prejudices related to communication difficulties in healthcare	Avoids stereotypes in the context of the patient's communication difficulties.
		Respects different communication styles during nursing assessment and nursing interventions. Communicates effectively to promote health outcomes in patients, families and communities.

6th CORE COMPETENCE - DEALING WITH CULTURAL AMBIGUITY
Type of Competence - INDIVIDUAL CULTURAL COMPETENCE

DIMENSIONS OF COMPETENCE

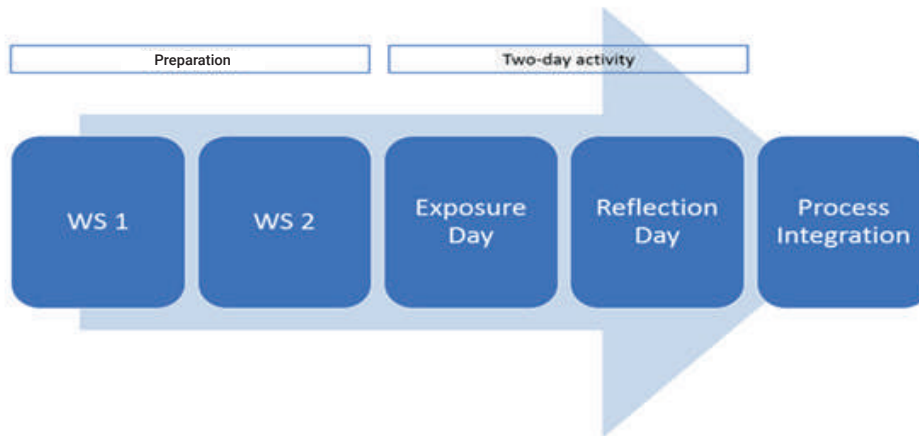
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
Intercultural tolerance.	Understands the complex interaction behaviours of people according to their social and multicultural context. Understands the cultural contexts of nursing care.	Adapts quickly to changing circumstances in multicultural environments without compromising the quality of patient care.
Embracing change with a growth mindset	Identifies points of uncertainty in nursing care with multicultural patients.	

9th CORE COMPETENCE - TRANSFORMATIONAL SOCIAL LEADERSHIP Type of Competence - INDIVIDUAL CULTURAL COMPETENCE		
DIMENSIONS OF COMPETENCE		
ATTITUDES	KNOWLEDGE	BEHAVIOURAL SKILLS; PRAXIS DIMENSION
Motivation to contribute to social transformation.	Knowledge of health and social policies. Knowledge of the health system and its portfolio of services. Knowledge of the socio-health resources in the context. Forms of participation in health.	Focus on personal and social transformation that contributes to better leadership, management and interpersonal relationships.

EXPECTED LEARNING OUTCOMES:

- Shows interest in knowing “the other” and their culture
- Shows interest and curiosity to know and deeply understand other cultures
- Respects different beliefs and values
- Understands personal interactive behaviour according to social and multicultural context without prejudices
- Genuine wants to learn how to understand cultural differences
- Recognizes the influence of her/his culture on the way she/he behaves
- Recognizes the influence of their own prejudices in caring for people from other cultures
- Identify one’s own cultural prejudices, myths, stereotypes and misinformation about immigrants, refugees and asylum seekers in Europe
- Is aware of nurse’s own potential biases and unavoidable stereotyping impact in nursing care
- Describes potential ways to address bias in the clinical and community settings
- Takes into consideration the opinions of patients/clients and professionals when decisions are made as a team
- Provides appropriate and congruent nursing care to patients, based on cultural factors
- Inquires about religion and the importance in the patient life’s
- Explores and respects physical contact according to her/his culture
- Explores and respects time orientation according to the client’s culture
- Describes the problems that immigrants, refugees and asylum seekers face and to identify the psycho-social and cultural issues fundamentally affecting the health behaviours and well-being of people in multicultural transitions
- Respects confidentiality despite language or communication difficulties
- She/he considers it a right for people to express themselves in other languages if they are unaware of or have difficulty employing the official language
- Respects culturally diverse forms or styles of communication
- Interprets and respects silences
- Interprets and respects the style of the conversation (direct, indirect or “bij stories”)
- Uses translator systems and cultural mediators in intercultural communication
- Has the ability to the decentring themselves from their own culture of reference and access the “other” narrative/subjective experience
- Understands the speech of people with strong accents
- Provides clear messages to people who may be struggling with dominant language
- Is aware of potential misunderstanding related to interaction between different cultures
- Shows coordination and negotiation skills

EXECUTION OF THE ACTIVITY:



Preparation

Content workshop 1:

- Context and goals
- Kolb as an experiential learning tool
- How to deal with emotions: RULER method
- Dignity-enhancing care and presence
- Discussion in duo about subcultures with whom it is difficult to make contact with, needs of growth concerning that issue, competence that can be used regarding personal growth
- Reflection about 'the danger of a single story', <https://youtu.be/D9lhs241zeg>
- class discussion about multiculturalism and diversity based on the theoretical ethical concepts closeness, hope, waiting, silence, not-knowing and the small goodness
- Explanation assignment: documentary 'For Sama' or 'Beautiful boy' by Felix Groeningen as exposure => reflection by using 2 self-chosen theoretical concepts workshop 1

Content workshop 2:

- Diversity framework
- Culture sensitivity and active pluralism
- Superdiversity – increase of diversity in diversity – normalising diversity
- Cultural competence: knowledge – skills – Encounters, attitude, desire – awareness
- Intercultural communication: TOPOI-model
- Language tips – types of conduct

1 or 2-day exposure

Students are immersed in a context that is new to them where they make contact with people in a vulnerable situation, confrontation with diversity and multiculturalism from a broad perspective

Contexts:

- Streetnursing
- Asylum center: students are welcomed as asylum seekers by asylum seekers and live in the center as asylum seekers for 1,5 day. 0,5 day students meet the asylumseeker as person
- Day center for people that are homeless
- Day center for people with psychiatric vulnerability and other complex needs

Reflection day

Exchange of experiences through videobooth, reflection leading to ethical concept attendance approach

Process integration

Describe personal goals

MATERIALS:

- Group of 10-12 students
- Classroom with furniture and audiovisual material (laptop, beamer, wifi)
- 1 lecturer
- Powerpoint presentation (attached)
- Whiteboard and whiteboard markers
- External context exposure

EVALUATION:

- Reflection assignment
- involvement, courage and daring during the exposure
- Videobooth and reflection based on the following questions:

With which feelings do you look back to today?

What were the moments of enlightenment in the reciprocal contacts?

When did you have the feeling that you connect with the other as a human? What supported this? How would you describe this feeling?

In which manner did the other and you yourself recognize your own abilities?

Did you recognize any vulnerabilities with the other or with yourself? Can you describe these and how this made you feel?

What did you learn, as a human, from today? What will you carry along with you?

What did you learn, as a professional, from today? What will you carry along with you?

What made the biggest impression on you?

What did you like to see differently? Where are there things you wanted to do differently?

Did something happen that gave you mixed feelings?

Did the exposure broaden your view on diversity? Can you describe this?

During reflection the lecturer motivates the students to link their experiences to ethical and multicultural concepts

Resources: the method can be applied in all contexts where vulnerability and diversity are applicable, e.g. shelters, accommodation for unaccompanied minors,...

PILOT Universidad de Castilla-La Mancha

TITLE:

CULTURAL COMPETENCE IN NURSING CARE: INTERCULTURAL COMMUNICATION.

SPECIFIC OBJECTIVE:

The aim of role playing is to enable learners to identify the core competences that distinguish culturally competent care from non-culturally competent care.

CULTURAL COMPETENCES, DIMENSIONS AND LEARNING OUTCOMES**1- OPENESS TO OTHERS****DIMENSIONS****ATTITUDES:**

Empathy towards people from other cultures; Genuine interest in knowing "the other"; Respect for diverse cultural ways of understanding health and disease.

KNOWLEDGE:

Understands the concept of cultural sensitivity in health care.

BEHAVIORAL SKILLS; PRAXIS DIMENSION:

Integrates other ways of understanding health and disease in nursing care assessment, diagnostic, and implementation; Uses cultural empathy techniques in nursing assessment.

SOME EXPECTED LEARNING RESULTS

Shows interest in knowing "the other" and their culture; Respects different beliefs and values; Demonstrates empathy, curiosity and willingness to learn and encounter persons and clients from other cultures; Understands personal interactive behaviour according to the social and multicultural context without prejudices.

2- INTERCULTURAL COMMUNICATION

DIMENSIONS

ATTITUDES:

Respect for other forms or styles of communication; Respect for the patient's right to receive information about their health processes despite communication difficulties; Empathy towards people from other cultures.

KNOWLEDGE:

Recognizes linguistic diversity in healthcare; Knows strategies of effective communication with persons, families and culturally diverse social groups, allowing them to express their concerns and interests; Knows specific techniques and principles of using translators and cultural mediators; Understands the meaning of silence in different cultures; Identifies forms of non-verbal language in interactions with clients from different cultures.

BEHAVIORAL SKILLS; PRAXIS DIMENSION:

Performs face-to-face interaction in health care settings with culturally diverse clients; Uses techniques of cultural empathy in nursing assessment interventions; Respects confidentiality despite language or communication difficulties; Provides culturally congruent nursing care to patients with limited language proficiency and low health literacy; Works with translators, cultural mediators and interpreters in actual patient care situations; Ensures the client's right to receive information about health processes despite communication difficulties; Avoids stereotyping in the context of patient's communication difficulties; Respects the different communicative styles during nursing assessment and nursing interventions; Communicates effectively to promote health outcomes in client's, families and communities.

SOME EXPECTED LEARNING RESULTS

- Respects confidentiality despite language or communication difficulties; She/he tries to guarantee the right of the user to receive information about health processes despite communication difficulties; She/he considers it a right for people to express themselves in other languages if they are unaware of or have difficulty employing the official language; Respects culturally diverse forms or styles of communication; Takes into account the causes of communication difficulties or lack of knowledge of the language; Explores the characteristics of the nonverbal communication style of the person-patient; Explore the style, pauses, and speed of conversation according culture Interprets and respects silences; Interprets and respects the style of the conversation (direct, indirect or "by stories"); Works with translators, cultural mediators, and interpreters in actual patient care situations.

3. CULTURAL ENCOUNTER

DIMENSIONS

ATTITUDES:

Values positively diverse perspectives and cultural concepts of health and wellbeing; Respects the beliefs and values of people in different multicultural contexts; Respects for the patient, family, community, and the multi or interdisciplinary team, regardless of their differences.

KNOWLEDGE:

Understands the concept of culture; Knows the importance of culture in health choices and health behaviours.

BEHAVIORAL SKILLS; PRAXIS DIMENSION:

Performs active listening in nursing care, to understand client's beliefs and values in different multicultural contexts; Educates, facilitates, and supports health and well-being from an intercultural perspective.

SOME EXPECTED LEARNING RESULTS

Takes into consideration the opinions of patients/clients and professionals when decisions are made as a team; Considers social and cultural aspects in nursing prescriptions; Provides appropriate and congruent nursing care to patients, based on cultural factors; Is able to educate, facilitate and support health and well-being from an intercultural perspective.

DEVELOPMENT OF THE ACTIVITY:**Part I: Theoretical-practical session:**

Audiovisual material will be used in the classroom, combining the theoretical presentation of the contents with experiences of good practice in intercultural health care.

Student participation will be encouraged through a participatory dynamic of questions and reflections shared in the classroom, guided and monitored by the teaching team.

Part II: Role playing:

A structured role-playing dynamic will be used, giving students the different roles and explaining the profile and discourse of each of them during the role-play. Before starting the role play, the participating students will be asked to sign an informed consent form.

The scene will be a paediatric nursing consultation in a Health Centre (Primary Care) in the city of Toledo, attended by a mother and grandmother, immigrants from Mauritania, with a child for a check-up as part of the Child Health Programme, a programme included in the Primary Care Services Portfolio. The focus will be on umbilical cord care and feeding. The Role Playing script will be developed on the basis of the competences we want to work on with the students.

The role-play will be articulated in two situations: Situation 1 and Situation 2 (30 min. in total), where two different ways of approaching nursing care will be represented in a care encounter where there are differences in values, beliefs and expectations about child care between the nurse and the mother and grandmother of the child.



Situation 1. Healthcare encounter in a primary care paediatric practice. Nurse without cultural competence in health. 14th May 2021.



Situation 2. Healthcare encounter in a primary care paediatric practice. Nurse with cultural competence in health. 13th May 2021.

During the Role Playing, each student will have to play the role of the script assigned to him/her (mother or grandmother). After the performance of each of the two situations, the rest of the students, with participant observation profile, will collect their opinions on the selected competences in the document Intercultural Communication and Cultural Critical Thinking Competences Form with a checklist (10 min. after each of the two situations. 20 min. in total) and which will serve as a tool to evaluate the recognition of cultural competences by the participating students.

Part III: Reflection in plenary

Finally, there will be a space for reflection and sharing with all the students (50 min.) guided by the teaching team, based on several open questions. The feelings of the actresses will be explored by asking them questions about their experience and asking them to stay in the role when answering (mother, grandmother, nurse, intercultural mediator and nursing coordinator). Afterwards, they will take off their role and the discussion and reflection will be resumed with the actresses already incorporated with the rest of the students.



Image reflection and debate. 13th May 2021.

The activity will end with a brief closure where the teaching team, based on the most relevant contributions of the students, will put into context the theoretical and methodological elements of the activity.

MATERIALS:

It will be used:

- Presentation for the class
- Role playing script.
- Two checklists (Intercultural Communicative Competences and Critical Thinking Form), one for situation 1 and one for situation 2.
- Material for the scenography and characterization of the actors.

EVALUATION:

For the assessment, the Measurement Scale of Cultural Competence in Health Care Workers (EMCC-14), validated by Pedrero et al. (2020), will be used. The scale includes 14 items that are grouped into three dimensions consistent with the theoretical model: sensitivity to one's own prejudices, cultural knowledge and skills to work in culturally diverse environments. The scale will be administered before starting the pilot experience (before the theory) and after the end of the role-playing. The answers of the Checklist (Intercultural Communication and Critical Thinking Competences Form) will also be analysed.

RESOURCES:

Videos for theoretical introduction:

- The migratory movements: <https://www.youtube.com/watch?v=fknilBqJI5g>
- #PersonasQueSeMueven
- Pilar Baraza. Migrant women without rights face even more serious problems. <https://www.youtube.com/watch?v=c2BI5h11k38>
- Manifestations of diversity: https://www.youtube.com/watch?v=10TcXyEhr_o
- Health and immigration: Pilar Baraza. Our centres are intercultural meeting points and people don't always like that. <https://www.youtube.com/watch?v=QYhXNG7UxhY>
- Blanca de Gispert. Lack of training for social and health professionals. https://www.youtube.com/watch?v=E_TUkudHfp0&list=PLRqkJ0JZzCun7bArMcXPHbLbIKbdSR1Re&index=4&t=10s

Escola Superior de Enfermagem de Coimbra - PILOTS

Pilot 1

<p>TITLE: “CULTURAL AWARENESS WORKSHOP”</p>
<p>SPECIFIC OBJECTIVE: The aim of these activity is to improve the nursing students’ awareness of one’s own worldview and cultural biases that can affect the quality of nursing care delivering.</p>
<p>CULTURAL COMPETENCES: Core Individual competences: CULTURAL AWARENESS / OPENNESS TO OTHERS</p>
<p>DIMENSIONS:</p> <p>ATTITUDES: Critical reflective approach; Willingness to learn and reflect on her/his biases and misperceptions;</p> <p>KNOWLEDGE: Understands her/his concepts of ethnocentrism, racism, xenophobia, stereotype, stigma, racism, discrimination, oppression, and privilege; Is self-aware of her/his attitudes/prejudices towards different cultures and how to overcome them;</p> <p>BEHAVIORAL SKILLS, PRAXIS DIMENSION: Critically examines the concepts of ethnocentrism and stereotype and their impact on nursing care; Recognises and challenges discrimination and racism in nursing practice and at a personal level; Identifies her/his cultural prejudices and myths about immigrants, refugees, asylum seekers, and cultural minority groups; Performs her/his cultural self-assessment.</p>
<p>EXPECTED LEARNING OUTCOMES: Students are expected increase self-cultural awareness, through self-examination exercises and in-depth exploration of one’s own cultural identity and background. This process also involves the recognition of their own biases, prejudices, racism, stereotypes, and assumptions about individuals who are different.</p> <ul style="list-style-type: none"> • Genuine wants to learn how to understand cultural differences • Recognizes the influence of her/his culture on the way she/he behaves • Recognizes the influence of their own prejudices in caring for people from other cultures • Identify one’s own cultural prejudices, myths, stereotypes and misinformation about immigrants, refugees and asylum seekers in Europe • Is aware of nurse’s own potential biases and unavoidable stereotyping impact in nursing care • Describes potential ways to address bias in the clinical and community settings
<p>EXECUTION OF THE ACTIVITY:</p> <p>A - CLASSROOM ACTIVITY</p> <p>1. Lecture: Theoretical framework on cultural competence in nursing (short movie and PowerPoint presentation).</p> <ul style="list-style-type: none"> • Concept of Cultural Awareness Competence • Concept of stereotype/discrimination/ Racism • Openness to others. <p>2.Exercise - Privilege walk (outdoor activity) Privilege Walk (adapted from https://bit.ly/3o98cPH) followed by group work and debriefing on how students felt;</p> <p>3. Group Discussion - Group work: 4 groups of 5 students - analysis of concepts in small groups (can be done outdoors)</p> <p>4. Debriefing- Analysis and synthesis of concepts in a large group</p>

B- INDOOR ACTIVITY

1- Exercise: Who am I? Who are you? Who are we?

<https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:4096a682-93a8-40f0-a64d-1ce8746abe4a>, (<https://adobe.ly/30ffn0L>), in which students write their personal story; then, they are split in 5 groups of 5 students and share their stories, debating what are the similarities and differences among the members of the group;

2. Group work:

- What similarities between the elements of the group?
- What sets them apart?

3. **Debriefing:** reflect on the impact of diversity on society and in healthcare settings; prejudice/stereotype

4. **Theoretical framework** on cultural awareness in nursing (short movie and PowerPoint presentation).



MATERIALS:

In door activity:

- Big classroom with chairs [one for each participant], five tables, one whiteboard, and two markers of different colours]. Computer/ 2 PowerPoint Presentations /Net Connection/ Short movie.
- Writing materials for each group (notepad and pens/markers), POST-IT NOTES;

Outdoor activity:

- Ample space (outdoor)/Sound Projection Equipment
- Writing materials for each group (notepad and pens/markers)

Participants should bring:

- Comfortable clothing, suitable for physical activity
- Comfortable flat shoes (e.g., trainers)
- Notepad or notebook
- Pencil, eraser

25 to 30 participants

1 Nursing Teacher for each exercise

EVALUATION:

Short Debriefing - group discussion of the students after each exercise.

Group sharing – Final Debriefing.

Guiding questions:

Consider what was taught in today's session:

- What?... Think about a topic that has been relevant to you
- So what?... What is the impact of this topic on your learning and clinical practice?
- And now?... How to put this knowledge or skill into practice?

Mentimeter – www.menti.com - cloud

Write a word that characterizes what they learned today.

Final Short Questionnaire: [Cross-Cultural Nursing Questionnaire \(google.com\)](https://www.google.com)

RESOURCES:

Duration 1 day – for classroom training

Suggested reading list documents /bibliography

Pilot 2**TITLE:**

"BODY AND VOICE WORKSHOP" - training intercultural communication

SPECIFIC OBJECTIVE:

The aim of these activity is to help participants to develop their skills both in sending and interpreting nonverbal communication messages in multicultural communication.

CULTURAL COMPETENCES:

Core Individual competences:

INTERCULTURAL COMMUNICATION.

DIMENSIONS:

Respect for other forms or styles of communication/ Understands the causes of communication difficulties; Flexibility towards the use of other languages or forms of communication in healthcare; Acceptance of people's right to express themselves in other languages if they are unaware of or have difficulty employing the host country's language;

Identifies forms of nonverbal communication in interactions with patients from different cultures; Uses silence and other forms of non-verbal communication to support interactions with patients in culturally diverse settings

EXPECTED LEARNING OUTCOMES:

Considers the causes of communication difficulties; Does not use stereotypes to assess communication difficulties; Explores the characteristics of the person-patient's nonverbal communication style ; Explores the style, pauses, and speed of conversation according to the culture; Interprets and respects silences; Interprets and respects the style of the conversation (direct, indirect, or "using stories; Has the ability to decentre herself/himself from her/his culture of reference and access the "other's" narrative/subjective experience.

EXECUTION OF THE ACTIVITY:

We start from some provocative questions to experience the act of communication as the conscious use of the imagination through the contact with some of the essential assumptions of the actors' art and the theater's understanding of action as a structuring language of bodily discourse and using this strategies to experiential learning in nursing students.

Main Contents

1. Prolegomenon of the communicational act

- Here and Now: Requirements for efficient face-to-face communication
- An elementary structure of the communicational experience: from Objective Guidance to discursive strategies
- About the quality of the communicational experience
- Cultural, social, and personal inhibitors [Prejudice, Standardization, and Shift of Focus]

2. The body in dialogue

- Nature and Culture
- Action as the structuring language of physical discourse [body and voice].
- The body [mine and the Other's] as a producer and source of signs
- The latency of the bodily sign
- The external manifestations of interiority

3. The professional of the contact areas as an *Observer in Situ*

- The instruments of Active Observation
- External stimuli and internal stimuli
- Self-awareness
- Object, Focus, and Focal Point



MATERIALS:

Big classroom only with chairs [one for each participant], five tables, one whiteboard, and two markers of different colours]. Even though the materials are designed to be trainer-led, they allow for plenty of interaction between teachers and learners. As a result, participants can learn actively.

Participants should bring:

- Comfortable clothing, suitable for physical activity
- Comfortable flat shoes (e.g., trainers)
- Notepad or notebook
- Pencil, eraser

25 to 30 participants

Nursing Teachers / 2 professional actors

EVALUATION:

Short Debriefing - group discussion of the students after each exercise.

RESOURCES:

Duration 1 day – for classroom training
Suggested reading list documents / bibliography



5.

INTERACTIVE SIMULATION SCENARIOS: EXAMPLES OF INNOVATIVE PEDAGOGICAL PRACTICES

Flore Geukens, Ellen Westhof, Paulien Kriekemans, Sylvianne Vroonen & Kristel Liesenborghs

A.- SCENARIO MCC 1 "ANGELO"

Simulation Multi Cultural Care UC-Limburg

1.- Scenario and briefing students

Background

Mr. Angelo is 62 years old, married and has 3 children. He is a retired miner. His partner has always been a stay-at-home mom and only speaks Italian. He went to school until the age of 12, but speaks English well. He only has difficulties when people are speaking too quickly or using difficult words.

Mr. Angelo will be admitted to the hospital in Belgium on Tuesday. The reason for admission is a planned TURB (transurethral resection of the bladder). He had blood in his urine for a long time, he had to urinate often and he also had pain while urinating. During a cystoscopy bladder polyps were identified and the doctor decided to perform a TURB. During this TURB, the bladder polyps are removed and the tissue is sent to the lab for anatomical pathological examination.

Scenario

Mr. Angelo asked to be in a single room. The nurse who did the admission asked if he wanted to sign a form for this, because then extra costs will be charged. He was a bit shocked by this and wonder what this means exactly.



The head nurse has asked you to explain to Mr. Angelo what the papers are for that he still has to sign for the single room.

2.- Briefing simulant

It is important that you play someone who is low-skilled and low-literate. You have difficulties understanding information given to you. You don't understand difficult words at all. You are also unable to look up information on the internet or through folders and brochures that you have previously received because you cannot read or understand what you are reading properly. Processing too much information at once is not possible.

You don't understand the difference in price between a single room and a double room and you certainly do not understand that doctors may charge more for a single room. You do not have insurance for a single room so you are not going to sign the paper at the end.

Moreover you are also worried about the tissue that is sent to the lab for anatomical pathological examination.

3.- End of scenario

When does the scenario end?

The scenario ends when Mr. Angelo knows what the paper is for and understands why the tissue is being examined.

Life savers?

4.- Simulator setup

Bloodpressure: 13/8

Heart rate: 65/min

Breathing: 6/min

5.- Materials needed for the simulation

NaCl 0,9%

6.- Principles from the MCC model included in this scenario

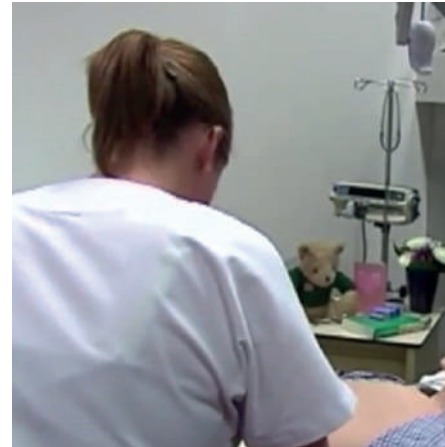
Human Rights-Based Approach (HRBA)

The Social Determinants of Health Approach

Ethical and moral mindset

B.- SCENARIO MCC 2 "ELIZABETH"

Simulation Multi Cultural Care UC-Limburg



1.- Scenario and briefing students

Background

Elizabeth is 72 years old widow, mother of 5 children and of Congolese descent. Since 1980 she has lived in Brussels with three of her children. The two eldest still live in Congo. Her three children who live in Brussels are married and live separately. She has always been a very strong, independent woman. Recently she felt a lump in her breast. Her family doctor send her to ultrasound and there they diagnosed breast cancer. Last week, her entire breast was surgically removed.

Scenario

Today, one week after operation, they start radiation therapy. You are the nurse that is responsible for the take in of the new patients and do the simulation of the radiotherapy. You see Elizabeth with her daughter, Marie-Ange. When you ask them to follow you to the room for the explanation and the simulation of the radiotherapy, Marie-Ange grabs you by the arm.

2.- Briefing simulants: patient in bed (doll) and daughter next to the bed (real person)

Marie-Ange is concerned about the radiation therapy they are going to give her mother. The operation was already drastic enough. Plus, natural ingredients will heal her mother. She brings out ampules based on grasses. Her mother has been healthy all her life, thanks to these natural supplements. That radiation therapy is dangerous. She doesn't understand what this is for. She also wants to be in the radiation room with her mother. Besides Marie-Ange is pregnant and Elizabeth wants to be with her daughter and support her.

Moreover, her mother has to leave the hospital as soon as possible to return to her own environment.

3.- End of scenario

When does the scenario end?

When the nurse has been able to convince the daughter to start the radiation therapy.

Life savers?

4.- Simulator setup

Bloodpressure: 12/8

Heart rate: 70/min

Breathing: 8/min

5.- Materials needed for the simulation

High fidelity simulators

6.- Principles from the MCC model included in this scenario

Human Rights-Based Approach (HRBA)

The Social Determinants of Health Approach

Ethical and moral mindset

C.- SCENARIO MCC 3 "NATALYA"

Simulation Multi Cultural Care UC-Limburg

1.- Scenario and briefing students

Background

Natalya is a 24 year old woman from Ukraine. She is a talented ballet dancer and her Belgian trainer offered her and her 17 year old sister Daria to live with his family in Belgium. Due to the war in her country, they felt unsafe and decided to take the offer. They are in Belgium since 4 weeks now. Natalya speaks a little bit of English and a few words of Dutch. Daria only speaks Ukraine.

Scenario

Since her arrival in Belgium Natalya trained many hours a day. Doing the thing she loves most is healing her broken spirit of leaving her country and her Ukrainian family. Yesterday she fell badly during an air spin. An echo of her knee showed a full rupture of her meniscus. Today she is already in the day hospital for a surgery of her meniscus. Her trainer had to go to a conference in the Netherlands so he couldn't accompany her to the hospital. Her sister Daria is with her.

Natalya is back from surgery 4 hours now and the surgeon tells you to inform her about the after care and send her home. She had a painkiller 1 hour ago and her IV line has been removed after the administration of the painkiller.

2. Briefing simulants

Natalya has pain in her belly due to urine retention of the anesthesia (but the nurse has to find out, so don't tell). She complains about pain. Due to the language problem she doesn't refer to a specific area of the pain. So the nurses need to ask a lot of questions before they know the area of pain. When they tell Natalya that she has too much urine in her bladder and that they have to catharize her, she doesn't know what that means. Natalya is very scared of what is going to happen. She will ask a lot of questions and she does not want anybody to touch her before she knows the answers.

Natalya is very scared that she cannot dance anymore and that she and Daria will be sent home. Daria is telling the whole time that she doesn't want to go back home, that she is really scared.

3.- End of scenario

When does the scenario end?

When the students figured out that she did not urinate yet and do a catheterization of the urine. They need to explain what they will do and how.

They also need to pay attention to the fear of the girls for having to go home again.

Life savers?

If students don't know what the problem is then Natalya tells the nurse "no pipi".

If the students know immediately what to do, then Natalya asks about her career as a ballet dancer and that she is afraid she cannot dance anymore that she and her sister need to go back home.

4.- Simulator setup

Simulation doll and sister (real sim patient).

Blood pressure 11/6

Hart rate 45bmp

Breathing 8/m

5.-Materials needed for the simulation

Catheterization material

Blather scan

6.-Principles from the MCC model included in this scenario

Human Rights-Based Approach (HRBA)

The Social Determinants of Health Approach

Ethical and moral mindset

D.- SCENARIO MCC 4 "ADO"

Simulation Multi Cultural Care UC-Limburg

1.- Scenario and briefing students

Background

Ado is an 42 year old African male from Ghana. Due to the economic crisis in his country he fled 2 years ago to Belgium with his wife and 4 children. They are still in an administrative procedure to get asylum in Belgium. Hence, he cannot work legally in Belgium. Because the family needs money to survive, he works illegally in construction. He speaks English.

Scenario

3 weeks ago Ado fell of the roof when fixing it. An ambulance was called by his wife. Ado was brought to a nearby hospital. He had several surgeries on his back and neck. He broke his neck and damaged some nerves in his spine. He is not able to move and the surgeon told them that there is little to no chance at recovery. He is advised to go in rehabilitation therapy. His wife doesn't leave his side. You need to do the morning care of Ado. His wife wants to take good care of him and already washed him and you need to take parameters.

2.-Briefing simulants

What really happened: Ado worked illegal in a construction area. He had to do a dangerous job on the roof of a flat building without any safety material. Due to very bad weather conditions he fell of the roof. The boss of the company he works for was really afraid to call an ambulance as Ado did not have a contract and he was scared that they would call the police. He decided to move Ado to his car and bring him home. Ado was in a lot of pain. When they arrive at the home of Ado, his wife realized that he was in a very bad condition and called an ambulance for him. The boss was really angry and told them to shut up about the accident. If they would tell anybody then he would call the police and tell that he works illegally in Belgium and that they will be deported back to Ghana.

Ado and his wife are really afraid now that somebody finds out he was working illegally. His wife wants to tell the nurses what really happened, but Ado doesn't want that as he is afraid that they will send the family back home. They are also scared that they cannot pay the hospital bills and they have no idea how to pay for the rehabilitation. Ado also doesn't understand yet that he might not recover again.

3.- End of scenario

When does the scenario end?

When the students figured out what really happened with Ado

Life savers?

Ado asked his wife not to tell "ssst do not tell".

Boss calls to "give" them money if they do not tell.

4.- Simulator setup

Simulation doll and wife (real sim patient).

Blood pressure 10/6

Hart rate 98bmp

Breathing 17/m

5.- Materials needed for the simulation

Cell phone wife

6.- Principles from the MCC model included in this scenario

Human Rights-Based Approach (HRBA)

The Social Determinants of Health Approach

Ethical and moral mindset



SUPPORT MATERIALS

Aliete Cunha-Oliveira, Ana Paula Monteiro, Brígida Molina-Gallego, María Idoia Ugarte Gurrutxaga, Ellen Westhof & Ana Paula Camarneiro

The use of audiovisual materials can be helpful in educational settings. Thus, some examples of audiovisual materials used in teaching multicultural competencies are presented below:

- Chimamanda Ngozi Adichie: “The danger of a single story” | TED:
 - o TED talk by Chimamanda Adichie, in which the writer addresses the narrow way people tend to think about other people or cultures and shows the relevance of understanding that there is more than one side to every story and that people do not correspond to popular stereotypes.
 - o Core competency(ies): Cultural awareness, Openness to others
 - o <https://www.youtube.com/watch?v=D9lhs241zeg>
- Film “Beautiful Boy”:
 - o The film by Felix Van Groeningen is based on a book about a father and his drug-addicted son. It shows the relationship between a young drug addict and his environment, the importance of the environment for people’s well-being, and the value of maintaining an open-minded attitude.
 - o Core competency(ies): Openness to others
 - o English trailer: https://www.youtube.com/watch?v=sgRq-J_MunA
- Documentary “For Sama”:
 - o This documentary shows the story of Waad Al-Kateab, a female journalist in the Syrian war. The story is about how she falls in love, gets married, and starts a family while the conflict in the region becomes increasingly problematic. She and her husband must decide whether to flee the region or stay and help the war victims. “For Sama” reveals the harsh daily reality of an armed conflict.
 - o Key competency(s): Cultural awareness
 - o https://en.wikipedia.org/wiki/For_Sama

- Trailer: <https://www.youtube.com/watch?v=vsvBqtg2RM0>
- Trailer: <https://www.youtube.com/watch?v=vsvBqtg2RM0>
- Zanzu:
 - An online tool to talk about sexual health in 14 languages, with audio recordings for those who cannot read
 - www.zanzu.be
- Health: a different word in every language, but with the exact meaning - WHO Regional Office for Europe
 - <https://www.youtube.com/watch?v=j7st19Oo29M>
- Video “The DNA journey”:
 - The notions of “race” or “immigrant” are being increasingly questioned, and the travel agency Momondo published a viral video online to prove it.
 - The video “The DNA Journey” features people of different races and nationalities volunteering for an experiment. Although convinced of their identity, they agree to undergo a DNA test to find out where their roots lie.
 - <https://www.youtube.com/watch?v=fknilBqJI5g>
- VIDEOTECA #PersonasQueSeMueven (#PeopleThatMove) (Spanish)
 - This campaign aims to reveal the reality of migrants and refugees and bring visibility to the adversities they must overcome during the migration process.
 - <http://personasquesemueven.org/videoteca-es/>
- Short film “HYAB” (Spanish with English subtitles):
 - Xavi Sala’s short film depicts a scene in Fatima’s life, a Spanish girl of Muslim origin who clashes with her teacher because she refuses to remove her Islamic veil.
 - <https://www.youtube.com/watch?v=HFaVukU3saw>
- Micro-learning: What is Critical Thinking and how to develop it?
 - A video explaining what Critical Thinking is and how to develop it.
 - <https://www.youtube.com/watch?v=92u6ibginyk>
- Award-winning CG animated short film “Migrants”:
 - Award-winning CG animated short film that tells the story of two polar bears (mother and cub) pushed into exile due to global warming. The two polar bears will encounter brown bears along their journey, with whom they will try to coexist.

- <https://www.youtube.com/watch?v=ugPji8kMK8Q&t=3s>
- Mental health: BCIHub
 - Mental health, treatment, access to health care, and help-seeking are closely linked to behavioral and cultural factors. Understanding these factors is crucial to promoting mental health knowledge and preventing, caring for, and treating mental disorders.
 - <https://bci-hub.org/focus-areas/mental-health>



7. CONCLUSIONS

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In a world of increasing human mobility, voluntary or forced, many health outcomes are shaped by transnational interactions between care providers and care recipients who find themselves in locations where nationalities and ethnic groups do not coincide.

Health systems must be resilient and adapt to changing environments, facing significant challenges with limited resources. The World Health Organization (WHO, 2019) has emphasized the importance of socially including migrants, refugees, and asylum seekers. It has also reinforced the need to develop the competencies of health professionals in multicultural settings. Developing these competencies should be a central component of professional education, training, certification, and continuous education, thus strengthening the role of academia in generating this knowledge and translating it into practice.

Across the EU, nurses represent the most significant health workforce group. Their scope of clinical intervention, social mission, and privileged contact with patients are key characteristics that confirm their vital role in care delivery to minorities and vulnerable groups. Many challenges faced in healthcare delivery to migrants, refugees, and asylum seekers are relatively new or not yet included within the existing tools and strategies (WHO, 2018). Furthermore, the presence of curricula or programs for training nurses in multicultural contexts is reduced compared to the need for socially including migrants and refugees in the EU.

To meet the challenges posed by this context, the MCCare Project has achieved its primary objective, that is, to contribute to the education of cultural competencies to European nurses and health professionals as an essential strategy to address health inequalities by considering the achievement of the health-related United Nations Millennium Development Goals and producing the IOs previously defined and now disseminated in this e-book.

The Project has been under development since 3 December 2020 and will end in May 2023. It has been a long, complex process with several interconnected and mutually supporting phases.

As presented in this document, the first IO was the design of a theoretical MulticulturalCare Nursing Education Model for Nursing Education. This Model is anchored in the knowledge and

previous research conducted by the Project's multidisciplinary team, as well as the systematic literature reviews combined with the findings emerging from the analysis of interviews and focus groups conducted with experts and migrants residing in the three European countries involved in the study.

The MulticulturalCare Nursing Education Model, comprised of innovative pedagogical practices for nursing students, focuses on developing competencies:

- to intervene in multicultural contexts, attending to the health of migrants and refugees;
- to educate nursing students and related key figures, such as teachers, healthcare professionals, and mentors, on implementing the MulticulturalCare Nursing Education Model;
- to promote the implementation of the MulticulturalCare Nursing Education Model in undergraduate nursing education;
- to foster entrepreneurial skills in nursing students, enabling them to conceptualize innovative solutions that tackle humanitarian challenges and implement health-related interventions for refugees and asylum seekers.

The Project's second IO, the e-book presented here, was built to promote and disseminate innovative pedagogical strategies and simulation scenarios for acquiring multicultural competencies in Nursing in the digital age. To prepare it, the MulticulturalCare Nursing Education Model for Nursing Education was used as a starting point in a progressive creation process through teaching-learning experiences, Agile-Pilots, and building and testing simulated scenarios. Also, the core competencies and their variables were operationalized, and didactic methodologies for acquiring multicultural competencies were proposed. The several Transnational meetings and Learning and Teachers Training (LTTs) incorporated the innovative pedagogical experiences contained in the e-book and were used to consolidate it.

This e-book is a dynamic, open, and accessible tool, made available online for teachers and nursing students from different European universities to develop skills for working with migrants, refugees, and asylum seekers while encouraging critical thinking and decision-making.

These IOs have been replicated and validated in the different European countries involved in the Project through multiplier events in a dynamic process of gradually developing, validating, and updating the e-book toward creating the MCCare Transnational Community.

The e-book contributes to developing collaborative networks between higher educational institutions, health institutions, and non-governmental institutions, which support the expansion and implementation of the MulticulturalCare Nursing Education Model and innovative solutions designed by nursing students. It also fosters the conditions for the Project's continuity,

disseminating the MulticulturalCare Nursing Education Model by involving students, teachers, healthcare professionals, and communities from other countries.

Finally, this e-book focuses on training nurses to work in a global world with ethical, scientific, and technical quality and, more specifically, find solutions to emerging multicultural health problems. In the medium- and long term, the e-book is expected to contribute to developing nursing programs for the 21st century.



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9.

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