Bachelor Thesis

Strengthening the Psychosocial Health Literacy of People with Migrant Backgrounds: A Literature Review

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Date: 24.03. 2020 Precious Chiebonam Nnebedum eh.

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List of Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AMA	American Medical Association
GuKG	Gesundheits- und Krankenpflegegesetz
IOM	International Organisation for Migration
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WHO	World Health Organisation

Abstract

Background: Individuals with migrant backgrounds make up over 270 million of the world's population. Migrants often have poorer psychosocial health literacy and need more mental health care than the average population of their host country. Despite this realization, they are confronted with multi-faceted barriers in accessing psychosocial support. The aim of this review is to explore ways in which the psychosocial health literacy of people with migrant background can be improved.

Method: A literature review using the databases PUBMED and CINAHL was conducted. A hand search on Google Scholar and reference lists was performed as well. A strategy with a combination of keywords and MeSH terms was used to search for qualitative and quantitative literature. Studies published in both English and German languages were searched for in these databases. The PICO and PICo Framework aided the inclusion eligibility process. Selected studies were assessed for quality using the Mixed Methods Appraisal Tool by Hong et al. (2018).

Results: Nine articles were included. Findings suggested that people with migrant histories have various perceptions of psychosocial needs, some contrary to western psychiatric and medical concepts. Barriers to gaining access to psychosocial care were categorized into three groups: individual, social and system level barriers. Participants inclined to seek help from less professional means and certified counselling was sought rather for administrative reasons.

Conclusion: Based on this literature review, it is evident that a number of factors stand in the way of people with migrant backgrounds and their acquisition of psychosocial health care. Thus, making it more difficult for health care professionals to implement practises that would aid the promotion of the psychosocial health literacy of these individuals. Furthermore, it is recommended that healthcare institutions tackle these barriers which are situated on different levels if they want to gain improvements related to psychosocial health situations of migrants.

Key Words: Health Literacy, Psychosocial, Migrants

Zusammenfassung

Hintergrund: Menschen mit Migrationshintergrund machen über 270 Millionen der Weltbevölkerung aus. MigrantInnen haben oft eine schlechtere psychosoziale Gesundheitskompetenz, benötigen jedoch mehr psychosoziale Versorgung als die Durchschnittsbevölkerung ihres Gastlandes. Trotz dieser Erkenntnis sind sie mit vielfältigen Hindernissen beim Zugang zu psychosozialer Unterstützung konfrontiert. Ziel dieses Literaturreviews ist es, Möglichkeiten zu untersuchen, wie die psychosoziale Gesundheitskompetenz von Menschen mit Migrationshintergrund verbessert werden kann.

Methode: Eine Literaturrecherche in den Datenbanken PUBMED und CINAHL wurde durchgeführt. Eine Handrecherche in Google Scholar und Referenzlisten wurde ebenfalls ausgeführt. Eine Strategie mit einer Kombination aus Schlüsselwörtern und MeSH-Begriffen wurde angewendet, um nach qualitativer und quantitativer Literatur zu suchen. In diesen Datenbanken wurde nach Studien gesucht, die sowohl in englischer als auch in deutscher Sprache veröffentlicht wurden. Das PICOS- und das PICo-Framework unterstützten den Auswahlprozess. Ausgewählte Studien wurden von der Autorin mit dem Mixed Methods Appraisal Tool von Hong et al. (2018) geprüft.

Ergebnisse: Neun Artikel wurden inkludiert. Die Ergebnisse weisen auf, dass Menschen mit Migrationsgeschichte unterschiedliche Vorstellungen von psychosozialen Bedürfnissen haben, die zum Teil konträr zu westlichen psychiatrischen und medizinischen Konzepten sind. Hindernisse für den Zugang zu psychosozialer Versorgung wurden in drei Gruppen eingeteilt: Hindernisse auf individueller, sozialer und Systemebene. Die TeilnehmerInnen neigten dazu, um Hilfe von weniger professionellen Mitteln zu suchen. Zertifizierte Beratung hingegen, wurde eher aus administrativen Gründen gesucht.

Schlussfolgerung: Aus dieser Literaturrecherche geht hervor, dass Menschen mit Migrationshintergrund und deren Erwerb psychosozialer Gesundheitsversorgung eine Reihe von Faktoren im Wege stehen. Dies erschwert es den Angehörigen der Gesundheitsberufe, Praktiken umzusetzen, die zur Förderung der psychosozialen Gesundheitskompetenz dieser Personen beitragen. Darüber hinaus wird den

Gesundheitseinrichtungen empfohlen, diese Hindernisse, die auf verschiedenen Ebenen angesiedelt sind, zu beseitigen, wenn sie Verbesserungen in Bezug auf die psychosoziale Gesundheitssituation von MigrantInnen erzielen möchten.

Schlüsselwörter: Gesundheitskompetenz, Psychosozial, MigrantInnen

1. Introduction

It is estimated that the global number of international migrants reached about 272 million as of 2019 with an increase of 51 million in contrast to the year 2010 (UN, 2019). During the “European migrant crisis”, otherwise known as “refugee crisis” dating from the start of 2015, Europe experienced a notable incline in migration with numbers as high as 1 841 305 (IOM, 2019a).

In the year 2015 alone, a total immigration of 4.7 million into the European Union (EU) was registered, encompassing both people immigrating into Europe from another EU Member State and those coming from countries not included in the EU (Eurostat, 2019). Europe has experienced the largest wave of international migration over the past few years with a total number of 82 million in 2019, Northern America following close behind with 59 million (UN, 2019). Germany remains the highest immigrant host with 12 165 083 immigrants in 2017 compared to 1 543 848 in 2015, followed by Spain with 342 114 individuals in 2015 and 532 132 individuals in 2017 and France with 364 221 people in 2015 and 369 964 immigrants in 2017. Austria experienced an increase in migration in 2015 as well, with numbers as high as 166 323 persons, however a slight decrease to 111 801 subjects was observed in 2017 (Eurostat, 2019).

1.1 Migrant

Although there is no universal and official definition of the term “migrant”, some organisations have attempted to describe a migrant as:

- *“any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant ties to this country” (UNESCO, 2017).*
- *“a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national” (OHCHR, 1990).*

The above-mentioned definitions do not explicitly include refugees, displaced or people impelled and forced to leave their place of residence, therefore the

International Organization of Migration (IOM) proposed the definition below as an inclusive approach:

"Any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is" (IOM, 2019b).

According to the international definition, a "person with migratory background" is described as someone whose parents were born in a country that differs from their current residence, regardless of their nationality (UN, 2006). An average of two million people with migration background reside in Austria, which equates to about 23.3% of Austria's population. This population can be clustered into two groups:

a) "first-generation immigrant": this term can be brought into connection with people who were born in one country and relocated to another.
b) "second-generation immigrant": this term pertains to persons who were born in their current country of residence, however, have foreign-born parents.

As of 2018, an estimated number of 1493 people belong to the group of "first-generation immigrant" in Austria, while about 530 000 are "second-generation immigrants" (Statistik Austria, 2019).

1.2 Health and Migration

In 1948, the World Health Organization (WHO) defined "health" as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition has not been altered since. WHO also stated that it is a fundamental right of every human being to enjoy the highest attainable standard of health regardless of the individual's race, religion, political belief, economic or social condition (WHO, 1948).

On the 23rd of February 2017, a conference of the Ministers and Government Representatives was held at the meeting of the 2nd Global Consultation on Migrant Health in Colombo, Sri Lanka with the reinforcement of the International Organization for Migration (IOM) and World Health Organization (WHO). This

consultation was held as a wake-up call to the issue of migrants' health, with the main focus placed on providing essential principles that would aid its improvement.

At this meeting, it was established that despite the rapid increase in migration, the health prospect of migrants is an area in global health that still needs research. Governments are yet to include the health needs of this population into national health plans, policies and strategies. The few governments who have, placed only little emphasis on the characteristics of health education and programmes which would act as an efficient response to social, psychological, emotional, economic, and environmental challenges of health and well-being amongst subjects migrating to a foreign country (Thomas et al., 2019). When migration is brought in connection with health, it can be observed as a coin phenomenon and an inevitable determinant of health (Castañeda et al., 2015). Migration has potential to better the health of migrants by enabling them escape oppression, mistreatment, victimization and violence, hence, improving their social and economic status by means of better access to education, higher and more stable income and overall serenity (Jass & Massey, 2004). The rear side of the coin reveals that when migrants set out on their journeys, they are initially fit, agile and mostly young, however, the hardships pertaining to health risks, psychosocial stress factors, limited or no access to health services, poor nutrition and difficult living and working circumstances of the journey results in a majority of these migrants feeling vulnerable, being traumatized and generally unwell upon arrival to their destination country (IOM, 2017).

The consultation report underlines several guiding principles as to what steps should be taken in the future, some of which concern the acknowledgement that in order to enhance migrants' health situation, there has to be accessible and non-discriminatory coverage of health care at an affordable price, so combating financial disadvantages for migrants. There is further accentuation on the relevance of conversation and cooperation regarding migrants' health policies in all member states, especially in developing countries, with a strong emphasis on the delivery of health services to migrants in vulnerable situations (IOM, 2017).

Migrants are often met with discrimination and social exclusion in their destination country, which can further exacerbate their health. Some available services may be culturally and linguistically insensitive, difficult to access or even unknown to

migrants and in turn lead to either ineffective or completely absent treatment (IOM, 2017).

In this case, it is essential to ensure effective health literacy of migrants in order for them to not only understand interventions that respond to some of the fundamental causes of poor health but to also apply them functionally, hereby contributing to the improvement of health within these communities (Castañeda et al., 2015). The theory of health and illness, “The Salutogenetic Model” by Aaron Antonovsky, serves as a substantial example. This model is based on a continuum on which health and disease are on both extremes. However, it places factors that create health rather than illness or disease in focus (Antonovsky, 1979). If migration were placed as a factor on this continuum, it would be easier for migrants to enhance their health and well-being if more awareness of resources was raised and their perception of their world is of a manageable, controllable and meaningful kind (Riedel et al., 2011).

1.3 Literacy

The fundamentality of literacy in a global society is anchored in the United Nations General Assembly’s Sustainable Development Goal number 4: “*Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all”*. Target 4.6 indicates by 2030, it should be ensured that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy (UN, 2015).

The United Nations Educational, Scientific and Cultural Organization (UNESCO) defines literacy as:

“the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts. Literacy involves a continuum of learning in enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and wider society” (UNESCO, 2004).

The European Literacy Policy Network provides a broader definition of literacy, taking functional and multiple literacy into consideration:

"Literacy refers to the ability to read and write at a level whereby individuals can effectively understand and use written communication in all media (print or electronic), including digital literacy" (UIS, 2018).

In October 2019, the global youth literacy rate was registered to have inclined from 83% to 91% in twenty years while the number of illiterate youths decreased from 170 million to 115 million. Young women amount to 59% of the total illiterate population of youths (UNICEF, 2019).

Although several other subcategories of literacy include computer, vernacular, digital, visual, school, media, health, emotional, cultural and moral (Kapur, 2019), this bachelor thesis focuses on the subclass "health literacy" given that it is of utmost essence that an individual is capable of taking responsibility of not only their own health, but also that of their family and community equally. More so if said individual is a migrant, as members of this population face very different health-related challenges compared to natives of the host country in question (Sørensen et al., 2012).

1.4 Health Literacy

The term "Health Literacy" has acquired greater meaning since first defined in the 1970s. While various works of literature have provided definitions of this term, the ones stated by the American Medical Association (AMA), the Institute of Medicine (IoM) and particularly the World Health Organization (WHO), have shown to be the most established in literature:

"Health Literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (WHO, 2009).

The main correspondence being the focus on an individual's skill to obtain, process and understand health information and services necessary to make appropriate health decisions (Sørensen et al., 2012). The systematic review published by

Sørensen et. al. (2012) gathered seventeen definitions from literature. The authors observed that health literacy encompasses more than just the individual but also their skills in correlation with the demands of health systems, after which they successfully established a more inclusive definition of this term as such:

> *"Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course" (Sørensen et al., 2012).*

Sørensen et. al. (2012) defines health literacy as a strong point for strengthening the understanding of the role of an individual in aspects of healthcare, disease prevention and health promotion. The authors elucidate that key factors of health literacy can largely be summarized into two dimensions *(1) the core qualities of health literacy*, which generally refers to the basic and advanced skills of an individual to function and socially participate in everyday situations, while actively deriving, critically analysing and implying won information in order to exercise control over situations and their lives in general. *(2) scopes and areas of application*, which implies to the different contexts in which health literacy can be applied, be it as a patient in a healthcare institute or as a citizen in a political arena.

Sørensen et. al. (2012) devised an integrated conceptual model of health literacy which depicts main dimensions of existing conceptual models, proximal and distal factors that influence the health literacy of individuals, as well as elements connecting health literacy and health outcomes (Figure 1) (Sørensen et al., 2012).

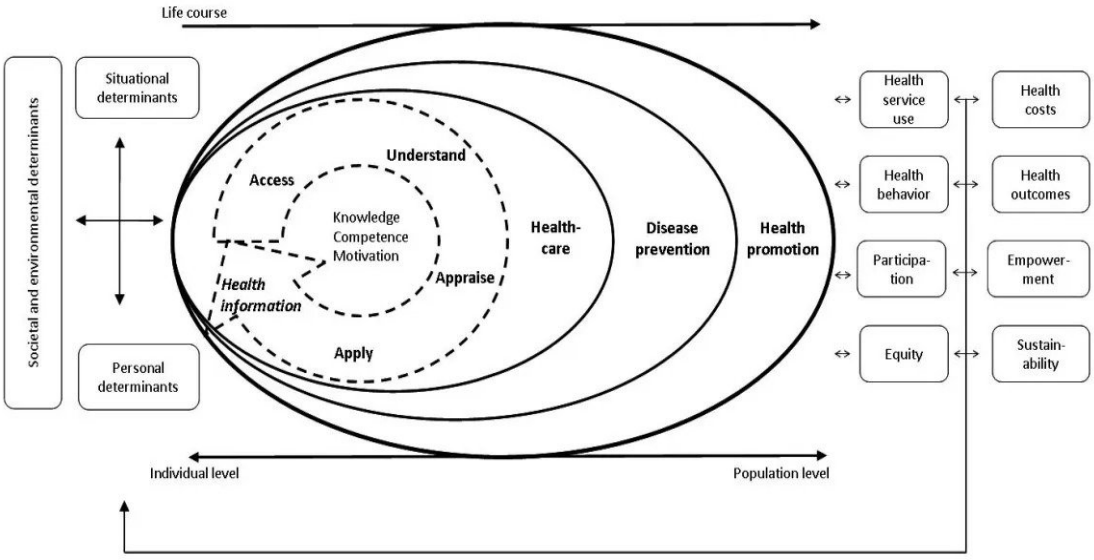

Figure 1: Integrated Model of Health Literacy (Sørensen et. al., 2012)

Emphasis is placed on the core of this process which enables an individual to access, understand, appraise and apply health information. Further on, factors which affect health literacy are categorized into three groups: *(1) proximal* or personal influences, some of which are age, race, gender, education, socioeconomic status, occupation, employment, literacy or income, *(2) distal* or societal/environmental determinants such as language, culture, demographic situation or societal systems and *(3) situational determinants* which include family influences, media use, social support and environment (Sørensen et al., 2012).

Surveys conducted in the past in Canada, United States of America and Australia show that not only is the literacy of minorities and immigrants considerably low, but the health literacy is at a crucial point (Corbeil, 2006; Kutner et al., 2006; Australian Bureau of Statistics, 2006).

Although an estimated 24% of Austria's population consist of people with migrant background, there is hardly any data published about the health literacy of this group. The Ludwig Boltzmann Institute for Health Promotion Research (LBI HPR) released the results of a study on the health literacy of migrants from former Yugoslavia and Turkey residing in Austria, in which stated that migrants do not necessarily have lower health literacy in comparison to natives of their host country,

however, they possess distinctive characteristics generally associated with risk of limited or low health literacy such as financial instability, inequalities in education, being majorly represented in lower formal educational levels and weaker self-assessment of health, compared to the average population (Ganahl et al., 2016).

Migrants face different and at times more complicated health challenges in contrast to the average population and are on account of that, at higher health risks. As a result of this, it is essential that these risks both apparent e.g. tendency to chronic diseases such as diabetes, as well as inapparent risks like psychosomatic and psychosocial health conditions are identified and individually tackled (Ganahl et al., 2016).

1.4.1 Psychosocial Health Literacy

The *Oxford English Dictionary* provides a definition of the term "psychosocial" as such:

"pertaining to the influence of social factors on an individual's mind or behaviour, and to the interrelation of behavioural and social factors" (OED, 2019).

Another definition suggests that psychosocial health encompasses the mental, social, emotional and spiritual areas of health (Howell et al., 2012). Mental health can be described as the "thinking" proportion of psychosocial health. This involves the ability to not only interpret, reason and remember from a subjective perspective, but also to organize and process information, while thinking rationally and connecting this information with meaning in order to make plausible decisions based off this. Social health relates to one's interactions with other individuals and their environment, effectively adapting to each component. It covers the ability of a person to form healthy relationships and successfully coexist within them, as well as detect a suitable social space, acting in an appropriate and responsible manner. The "feeling" aspect of psychosocial health can be categorized under emotional health (Study.com, 2014). The *American Psychology Association* (APA) defines emotion as a complex pattern of reaction, which involves elements of experience, physiology and behaviour. The quality of the emotion shown is dependent on the specific significance of the event to the individual. Therefore, the emotional health

can be understood as the ability to manage emotions, react in a stable demeanour even in upsetting situations and recover from disappointments. The individual understanding of hope, meaning, belonging and purpose of life can be summarized under spiritual health (Howell et al., 2012).

Failure to consider deterioration of these aspects of health, can lead to suffering and influence the general health of persons concerned (Howell et al., 2012).

1.4.2 Psychosocial Health and Mental Health

In the framework of support services, there is a fine line between the definitions of psychosocial health and mental health. Psychosocial health is often described as a cultural expression of mental, physical, social, moral or spiritual well-being. Psychosocial disorder is, therefore, an absence of this well-being and a state of distress in the given context. Treatment here aims to revitalize the connection between the individual in question and his or her environment, culture, interpersonal relationships and community (de Jong, 2011). Mental health on the other hand, pertains to the psychological well-being of a person. With the objective of minimizing psychological distress, mental health treatments aim to enhance psychological well-being, which in turn aids the daily functioning of an individual and establishes effective coping mechanisms (ICRC, 2017).

The noteworthy relationship between psychosocial distress and poor mental health makes it clinically difficult to distinguish and diagnose. Cultural agitation, social isolation and discrimination, political and environmental conflicts, gender violence, traumatic migration and poverty are particularly associated with mental disorders such as depression, post-traumatic stress disorder (PTSD) and anxiety (Jacob, 2013). Psychosocial support is of utmost importance in preserving sound physical and mental health during trying times. According to a report by the International Committee of the Red cross, a union of mental and psychosocial healthcare is essential in the effective support of individuals in psychological distress (ICRC, 2017). Based on this knowledge, the terms “psychosocial health” and “mental health” will be used correspondingly in this review.

1.5 Problem Statement

Previous researchers have continued to link limited individual health literacy to consumers of health services experiencing difficulties with not only recalling and understanding health information provided to them by various health professionals, but also essentially having difficulties putting this information into practice where needed (Johnson, 2015; Jordan et al., 2010; McCarthy et al., 2012). Jordan et. al (2010) illuminates that lack of proficient health literacy leaves health consumers with less knowledge of their health situation, interventions that can be utilized, as well as the necessary skills required to become acquainted with healthcare systems.

Alongside groups of the elderly, communities of persons with either lower socio-economic status and/or educational level, people with migrant history very often count to the population mostly affected with limited health literacy (Horn et al., 2015; Smith et al., 2012). A possible reason could be the demanding pathway to healthcare sector on account of language barriers, insufficient information and possible racism or cultural variations in the interpretation of health and disease. It goes without saying that migrants are confronted with additional psychosocial stress and burden that may involve separation of family members during the migration process or upon arrival in the host country, unclear laws and policies of their destination country and traumas experienced during the course of migration which often serve as disadvantages to those involved (Razum et al., 2008). Not much research has been conducted concerning the psychosocial health literacy, its determinants and what consequences its absence brings for migrants and minority groups in particular. Furthermore, there is close to no collected data on this topic to compare with in Austria (Ganahl et al., 2016).

According to the Austrian Federal Act on Health and Nursing Professions, *Gesundheits- und Krankenpflegegesetz* (GuKG), it is established in the law that core competences of nursing staff are amongst others, advice provision on healthcare and nursing, as well as the organization and implementation of training courses, promoting health literacy, health promotion, disease prevention and psychosocial care in health and nursing (GuKG, 1997; Advokat Unternehmensberatung, 2020). In absence of understanding information on prevention and self-management of health situations, individuals are more likely to miss out on medical appointments

and disregard check-ups. In worse cases, hospitals and clinics will as a result of this, experience overflowing emergency room visits for conditions that could be easily dealt with at home. Further, hospitals and clinics may witness a so-called “revolving door effect”, which is a medical phenomenon, whereby, inadequate treatment or insufficient care at home leads to the re-admission of a patient shortly after hospital discharge. Nurses are in most instances, the first and last point of contact for consumers at health institutes and so are with no doubt in an advantageous position to promote and improve health care consumer’s comprehension of health information. In light of this, nurses are inevitably tasked with ensuring the education of their patients in a linguistically, culturally adequate manner (Toronto & Weatherford, 2016).

1.6 Research Aim and Question

Upon consideration of the above-mentioned points, the following objective was formulated for this thesis: explore ways in which the psychosocial health literacy of people with migrant background can be improved.

Subsequently, the following research question was derived:

"How can the psychosocial health literacy of people with migrant background be improved?"

2. Method

A literature review was conducted to derive answers to the research question. A written literature review summarizes evidence on a research problem and the gaps that this evidence fails to fill. It primarily focuses on the study findings (Polit & Beck, 2017).

Pre-conditions of this review were that a research question and a search for relevant material following the conception of an appropriate search strategy are provided.

After carrying out a thorough literature research in various databases, a title-, and abstract screening were performed in that order to identify adequate studies which aided in answering the research question. Upon completion, the selection of studies underwent a final screening of the full texts according to inclusion and exclusion criteria set by the author using the PICO/PICo Framework. A critical appraisal of their weaknesses or limitations and strengths was then performed on these studies to assess their quality employing the Mixed Methods Appraisal Tool (MMAT).

2.1 Literature Research

Within the timeframe of October until November 2019, a literature search was conducted in the medical databases Public Medical Literature Online (PUBMED) and Cumulative Index to Nursing and Allied Health Literature (CINAHL). A combination of MeSH (Medical Subject Heading Terms), and keywords were used in connection with the Boolean operators “OR” and “AND”. MeSH is a controlled vocabulary used in MEDLINE (PUBMED) to categorize articles in fitting topic fields. These headings simplify search processes and deliver a more precise result count as they sort out data that use different terms but share the same major idea. In CINAHL, MeSH terms are indicated by Subject Headings.

For the search strategy in PUBMED, the following keywords and synonyms were used: health literacy, health promotion, health education, health knowledge, health proficiency, psychosocial, social, well-being, emotional, mental. The MeSH term “emigrants and immigrants” was also applied.

In CINAHL, the following Subject Headings were implemented: health literacy, emigration and immigration, while the keywords: psychosocial, social, emotional, psychological, mental, well-being were used.

In both databases, the filter “title/abstract” was used to ensure that specific words were stated in either the title or the abstract of the article in order to be included in the search result. Further limitations were set to only suggest articles not older than ten years and written in English. For PUBMED, German was also included as a limit (Table 1). A hand search of reference lists and the first ten pages on Google Scholar was also carried out with the keywords: psychosocial, health literacy and migrants. The limitations here were set to suggest articles published within the last ten years, however two studies were included which were published in the years 2000 and 2008, as their findings were very much relevant to the objective of the literature review.

Although “nursing or nurses” were initially part of the keywords in the conceptual phase, they were not included in the search strategy, as they notably reduced the number of results when they were added.

Table 1: Search Strategies

Database	Search Terms	Limitations	Results
PUBMED	((“health literacy"[Title/Abstract] OR "health promotion"[Title/Abstract] OR "health education"[Title/Abstract] OR "health knowledge"[Title/Abstract] OR "health proficiency"[Title/Abstract])) AND (emigrants and immigrants[MeSH Terms])) AND (psychosocial[Title/Abstract] OR social[Title/Abstract] OR "well being"[Title/Abstract] OR emotional[Title/Abstract] OR mental[Title/Abstract])	10 years, English, German language	137

Database	Search Terms	Limitations	Results
CINAHL	(MM "Health Literacy") AND MH ("Emigration and Immigration") OR MM ("Emigration and Immigration") AND TI (psychosocial or social or emotional or psychological or mental or wellbeing or well-being)	10 years, English language	208
Google Scholar	Psychosocial health literacy of migrants	10 years	

2.2 Inclusion and Exclusion Criteria

Studies that addressed the topic of health literacy with migrants or people with migrant background as the population were included in the literature review. Another major focus was placed on studies which elaborated on the psychosocial situation of migrants and how this affected their acquisition, apprehension and implementation of health literacy. To assure the conduction of an effective search and inclusion of only articles which provide evident answers to the research question, both the PICO framework for quantitative research and a modified version PICo for qualitative research were applied to provide structure to the research (Tables 2 and 3). PICO which stands for *population, intervention, comparison or control and outcome* is a format used to transform clinical questions into searchable keywords which will render evidence-based answers (Richardson et al., 1995). This format however, has to be adapted if it is to be used for qualitative research as the factors “intervention” and “control” are not common in a qualitative approach (Methley et al., 2014). Therefore, a modified method, the PICo framework: *population, phenomena of interest and context,* has to be employed (Lockwood et al., 2015).

Table 2: Quantitative Study Inclusion Criteria using PICO Framework

Population	Migrants, people with migrant background, any socioeconomic group, health professionals involved in migrant care, any age, any sex
Intervention	All studies that investigated health literacy and most especially, the psychosocial aspects of it within the given population
Control	Comparison of effect of high/low psychosocial health literacy, and effect of availability of educational programmes on (psychosocial) health literacy
Outcome	Higher psychosocial health literacy, no or reduced mental instability and fragility, improved self-care, reduced hospitalisation

Table 3: Qualitative Study Inclusion Criteria using PICo Framework

Population	Migrants, people with migrant background, any socioeconomic group, health professionals involved in migrant care, any age, any sex
Phenomena of Interest	All studies that investigated health literacy and most especially, the psychosocial aspects of it within the given population
Context	Involvement of the nursing profession, interdisciplinary and multidisciplinary collaboration in ensuring health literacy of migrants

Upon conclusion of the literature search, a selection of 460 articles from the databases PUBMED and CINAHL, as well as results from the hand search were transferred into the reference management software EndNote x9. There, existing duplicates were removed, and a title and abstract screening of 402 studies commenced. The title screening took place first with the set criteria that studies would only then be included if their title contained at least two of the given keywords

and a MeSH term. Subsequently, an abstract screening was performed based on the inclusion criteria of PICO/PICo Framework where only 37 studies remained.

After a full-text screening where the residual articles were assessed based on the relevance and proficiency of their results toward answering the specified research question, nine studies were left. This final amount of studies was critically appraised and included in the literature. The study selection procedure is described in detail in the PRISMA flow diagram below (Figure 2).

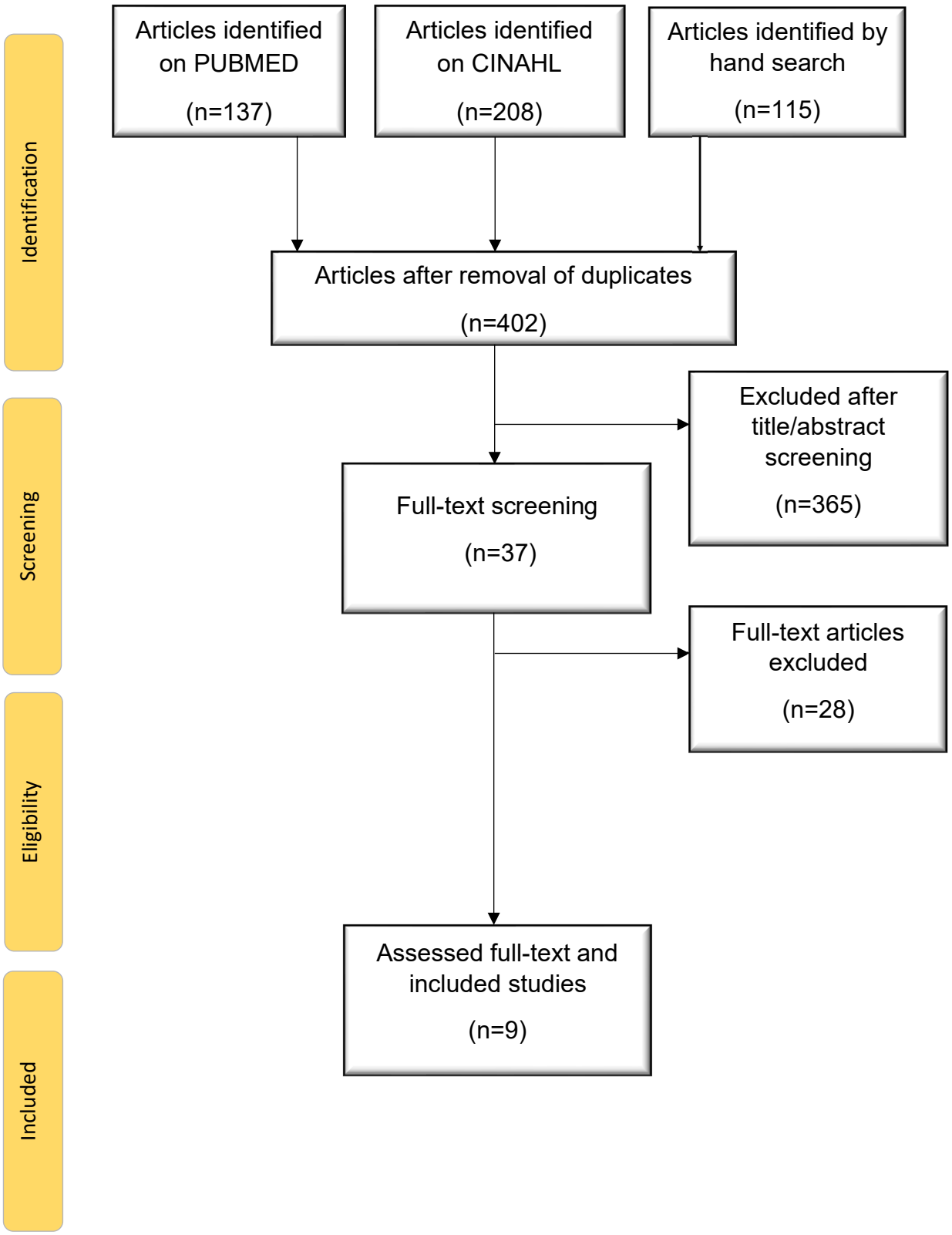

Figure 2: PRISMA FLOW CHART for Study Selection

Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement

2.3 Quality Criteria

A critical appraisal of literature is essential in deciding whether the evidence or results of a study is adequate, recommendable and applicable into clinical practice (Polit & Beck, 2017). The studies were assessed by the author of this review using the Mixed Methods Appraisal Tool by Hong et al. (2018). This critical appraisal tool can be used to assess the quality of qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies (Hong et al., 2018).

This tool is divided into two parts, part I shows a checklist and part II consists of an explanation of the criteria that must be met in order to be able to categorize a study into a design. Prior to the main appraisal, there are two screening questions asked, whose answers determine whether this tool is appropriate for the literature to be appraised: *"S1. Are there clear research questions?"* and *"S2. Do the collected data allow to address the research question?"* If the answer to one or both screening questions is *"No"* or *"Can't tell"*, it is suggested that this tool is not applicable. To begin with the appraisal, a befitting design must be determined, there are five questions asked in each category of study design. These questions can be answered with "Yes", "No" or "Can't tell", if needed, a comment can be added following every answer. As there are no numeric scores to be awarded, it is advised to perform a detailed and sensitive analysis of each point to get a sound assessment of the study (Hong et al., 2018).

The characteristics of the studies can be deduced from Table 4. The detailed and complete assessment of every study can be found as an attachment arranged in the order of inclusion in this literature review.

3. Results

This part of the review gives insight into the characteristics and common denominators in findings of the nine selected studies. Only studies which thematized either the psychosocial or mental health literacy of a migrant population were included. A further criterion which was necessary to successfully answer the research question was that the studies had to elucidate on the provision and utilization of either psychosocial or mental healthcare services by said population in their respective host country.

3.1. Characteristics of the studies

Of the nine studies selected, more than half were qualitative studies. Two among these were descriptive and another was an explorative study, while the rest utilized semi-structured group and individual interviews, as well as expert- and user interviews to gather information from their participants. The quantitative studies included a broad variety of data collection methods ranging from a self-report questionnaire to secondary data analysis of record extracted from mental health information systems, as well as a cross-sectional survey and a semi-structured interview exerting a vignette methodology with a questionnaire in the Likert-scale format. The sample population not only consisted of people with migrant background hailing from various countries in the world, but also involved immigrant service providers and nursing students, with the sample size stretching from as little as 16 participants in a descriptive study to as many as 8990 in the secondary data analysis. The age range of the participants also varied, with age groups starting already at 6 to 18 years in one study, while the majority maintained an average of 18 to 75-year-olds. One study did not provide the age of its participants and another study included subjects aged 60 years and above with no limit to the upper value.

The findings of this review are grouped into three main themes: (i) perception of psychosocial needs, (ii) barriers regarding gaining access to psychosocial services, (iii) gaining appropriate help. The design and characteristics of the studies and their respective populations are detailed in Table 4.

Table 4: Characteristics of included Studies

Author/Year	Country	Country of origin	Sample characteristics	Design/Method
Al Obaidi & Atallah, 2009	Egypt	Iraq	*n* = 204, age ranges 6-18 years and 18-75 years, 97 females and 107 males, 60% university or postgraduate-qualified, 29% completed secondary school and 2% had difficulties reading and writing	Qualitative explorative
Schoenmakers et al., 2017	The Netherlands	Turkey, Morocco, Surinam, The Netherlands	*n* = 58 in 8 groups and 11 individuals, mean age for group interviews = 50 years and above, mean age for individual interviews = 60 years and above, 28 females and 26 males took part in the group interviews, 4 are unaccounted for, 8 females and 3 males took part in the individual interviews	Qualitative with semi-structured group and individual interviews

Author/Year	Country	Country of origin	Sample characteristics	Design/Method
Horn et al., 2015	Germany	Turkey and Russia	*n* = 48 (30 experts and 18 users), age ranges varied between 35-65 years for experts and 18-50 years for potential users or 64-75 years for real users	Qualitative expert- and user interviews
May et al., 2014	Australia	Iraq, Sudan, Australia	*n* = 97, aged 18 and above, 42 females and 55 males, 42.3% had obtained tertiary education, 46.4% had secondary education, 8.2% had attained primary education and 3.1% had no education	Non-randomized Quantitative using Vignettes with Likert-scale
Knipscheer et al., 2000	The Netherlands	Ghana	*n* = 81, aged between 13 and 48 years, 26 females and 55 males, 18.5% had university educational level, 56.8% had acquired senior secondary level and 11.1% had attained primary educational level	Quantitative descriptive using self-report questionnaires

Author/Year	Country	Country of origin	Sample characteristics	Design/Method
Salami et al., 2019	Canada	N/A	*n* = 53 immigrant service providers, 47 females and 6 males, 49 participants had migrant background themselves	Qualitative descriptive study with individual and focus group interviews
Toronto et al., 2016	United States of America	N/A	*n* = 16 nursing students, aged between 25 and 54 years, 14 female and 2 male participants, Caucasian majority, 7 had reported exposure to health literacy content prior to research	Qualitative descriptive
Rucci et al., 2014	Italy	72 countries, majorities being Italy, Morocco, Romania, Albania, Moldova, Ukraine	*n* = 8990 patients, 8602 Italians (between 54 and 65 years of age) and 388 immigrants (between 39 and 50 years), 5245 females and 3745 males, 40.2% of Italians and 43.2% of immigrants obtained higher education	Quantitative secondary data analysis from records extracted from mental health information system

Author/Year	Country	Country of origin	Sample characteristics	Design/Method
Toselli & Gualdi-Russo, 2008	Italy	Senegal, Morocco, Pakistan, Tunisia, Kosovo, Roma	*n* = 396, 83 female and 313 male participants, mean age range 27-45 years, 254 acquired primary school educational level, about 96 had further attained a high school degree and 23 obtained a university degree. Altogether 197 participants had no school degree	Quantitative descriptive study with cross-sectional survey

3.2. Perception of Psychosocial Needs

The notion of psychosocial and mental health needs is experienced in different forms by people with migrant backgrounds. While a population of a particular country may perceive mental health disorders as a taboo, a crisis of faith, personal weakness, the invasion of the body by evil spirits, and a result of westernization (Schoenmakers et al., 2017; Salami et al., 2019), another may regard it as daily stress, compromised interpersonal interactions and psychological discomfort that reveals itself through the means of disturbance in sleep, anxiety, depression and irritability (Toselli & Gualdi-Russo, 2008). Beliefs of the Sudanese population in the study of May et al. (2014) about the mental health literacy of refugees in Australia, elucidated that the influence of *external higher power* is a core reason for the manifestation of depression. These beliefs were notwithstanding, regarded furthest from the western psychiatric concept. May et al. (2014) went on to clarify that the majority of both migrant and non-migrant communities in Australia are convinced that social and adverse life experiences are key causes of psychosocial issues such as depression and posttraumatic stress. This finding was significant for posttraumatic stress ($p = 0.037$), but not for depression (0.287). In the study by Knipscheer et al. (2000) about the general health, acculturative stress and use of mental health care by the Ghanaian immigrant communities, the participants specified that psychosocial problems significantly involved financial instability, societal issues ($p = 0.034$), unemployment ($p = 0.0006$), legal matters ($p = 0.023$) and housing problems. Schoenmaker et al. (2017) and Salami et al. (2019) revealed in their studies, that migrant populations did talk about feelings of depression and loneliness, however, due to the significant lack of not only their mental health literacy, but also essentially that of their social network, they very often failed to recognize these as symptoms of impaired mental health.

3.3. Barriers Regarding Gaining Access to Psychosocial Services

Refugees and migrants tended to shy away from seeking professional mental health care services on account of different factors which frequently went hand in hand. To

provide a better understanding, these factors can be grouped into subcategories of barriers pertaining to *individual, social* and *system level barriers*.

3.3.1 Individual Barriers

Hurdles directly connected with the personal competency of a subject to attain, understand and implement psychosocial health information into their daily lives can be referred to as individual barriers. The most prominent and reoccurring of these were by far the cultural and linguistic differences perceived by migrant communities. The language deficiency experienced, was a grave impediment to seeking appropriate help. Migrants who were not proficient in the language of their host country were most likely confronted with issues of expressing themselves and conveying their general well-being, further leading to misdiagnosis and misinterpretation of professional advice or even inappropriate treatment (Horn et al., 2015; May et al., 2014; Toronto & Weatherford, 2016; Schoenmakers et al., 2017). Additionally, people with migrant background tended towards the belief that it was their personal responsibility to manage their stressors and deal with them without interference of an outside factor. Furthermore, they often inclined to be distrustful of strangers, with the explanation that the confidentiality of their personal data could not be assured (Salami et al., 2019; Horn et al., 2015). Toronto and Weatherford (2016) explained that patients who displayed an avoidant behaviour toward interaction with health care professionals often had limited resources of comprehending health information and would most likely disregard the health recommendations given to them by professionals. Migrants who were not aware of the available consulting services in their countries of origin also remained oblivious to the offers in their host countries, causing yet another personal barrier between themselves and mental health care services (Horn et al., 2015).

3.3.2 Social Barriers

The most listed barriers pertaining to the social life of people with migrant background and the likelihood that they would seek psychosocial help were the cases of stigma and fear of discrimination. Psychosocial and mental needs were

often stigmatized within the social networks and communities of this population (Rucci et al., 2014; Schoenmakers et al., 2017; Knipscheer et al., 2000). Knipscheer et al. (2000) illuminated that the Ghanaian population in the Netherlands would rather utilize the means of traditional healers and spiritualist churches for mental healing on account of this and Salami et al. (2019) suggested that health care providers employ other terms when reaching out to immigrant clients as mental health topics were often perceived as taboo topics. Other forms of social restraints included fear of losing their social status or being socially excluded from and discriminated against by their respective communities, worries concerning deportation or loss of child custody and lack of support from the government of the host country (Salami et al., 2019; Toselli & Gualdi-Russo, 2008; Knipscheer et al., 2000; Al Obaidi & Atallah, 2009). Another noteworthy hurdle faced by immigrant populations was the financial aspect of seeking psychosocial counselling service providers. Immigrants worried not only about the cost of said providers not being covered by their health insurance, but also that transportation costs and contingent childcare services accumulated and acted as an additional burden to them (Salami et al., 2019; Al Obaidi & Atallah, 2009).

3.3.3 System Level Barriers

Salami et al. (2019), Toronto and Weatherford (2016), Horn et al. (2015) and Rucci et al. (2014) all gave accounts of the barrier level seen to be higher than the immigrants themselves and relating directly to healthcare institutions and counselling centres. The most frequent of such being the complexity of the referral system of health institutions, also that necessary procedures and information needed to gain access to psychosocial help– such as opening hours or enrolling procedures– were unclear and confusing. Deficiency in various forms were identified in the above-mentioned studies, namely the use of medical terminology in reports and conversations with patients who, without a medical background, found it almost impossible to comprehend. Furthermore, a lack of certified interpreters and foreign language proficiency on the part of the healthcare organisations, as well as the absence of linguistic variety in both verbal and written, educational material were described (Toronto & Weatherford, 2016; Salami et al., 2019). The elderly

population is confronted with an especially demanding challenge, as several information obtainment and registration processes were situated on the internet and the use of a computer and browsing skills were required. In this case, these individuals either relied on their younger relatives and acquaintances to undertake this assignment or they deemed the task too complicated to continue, thus forfeiting the psychosocial care they could have acquired (Schoenmakers et al., 2017).

3.4. Gaining Appropriate Help

A majority of the studies elucidated that their sample of people with migrant backgrounds generally tended to employ other less professional and complementary methods such as healing from traditional leaders, spiritual guidance, self-help and family support over professional psychosocial and mental health care providers (Knipscheer et al., 2000; Salami et al., 2019). Despite this fact, a number of these migrants still frequented counselling centres and approached mentioned care providers, however they often had a propensity towards seeking help for reasons not tailored to the services offered. Such individuals for instance, expected help with administrative problems or medication for their health issues or symptoms and were disappointed when they were asked to talk about their feelings or were provided with informative brochures on preventive measures (Knipscheer et al., 2000; Salami et al., 2019; Horn et al., 2015). Knipscheer et al. (2000) reported that the migrants who eventually sought help, did so from general practitioners and social workers, professional psychological care centres as outpatients and self-help groups, clergies, medical specialists and labour offices. Amongst these individuals, a quarter of them experienced difficulties accessing said services as they felt misinterpreted or treated without concern. Of the immigrants who successfully gained access to appropriate psychosocial help, a majority significantly preferred and received group therapy method over individual therapy ($p < 0.001$) (Rucci et al., 2014).

Toronto and Weatherford (2016) and Horn et al. (2015) proposed a need to display empathy, kindness, patience and persistence on the part of mental health care providers and nurses in particular, towards their migrant clients. A healthy patient-nurse relationship not only accelerated the trust building process but also encouraged a more frequent return of these clients to the mental healthcare

institutions and counselling centres. Furthermore, Schoenmakers et al. (2017) suggested health care services be more outreaching, instead of waiting for clients to come to them, as older migrant populations found it especially difficult– for reasons stated above– to ask for help and express their psychosocial issues.

4. Discussion

This literature review aimed to analyse the psychosocial health literacy of people with migrant backgrounds and examine ways of strengthening the psychosocial health literacy of this population. The findings of the included studies are categorized into three groups that explain migrants' perception of psychosocial needs, the barriers they face when attempting to talk about or seek help regarding psychosocial issues and the possibilities of them gaining appropriate help. All studies established that individuals with migrant histories tendentially have poor mental and psychosocial health literacy, showing discrepancies as to the meaning and causes of psychosocial stress. Though participants of the studies hailed from a variety of countries and resided in different host countries, similar individual, social and system level barriers to seeking psychosocial help were registered amongst them all. Most immigrants admitted they would rather keep their problems to themselves or only discuss them within family circles than seek counselling from an unfamiliar source. A majority of those who sought the advice of a psychosocial health care professional, did so for more administrative issues such as filling out forms or needing assistance with translation and drafting of letters and documents.

A systematic review reported that migrants– refugees and asylum seekers in particular– undergo various displacement stressors of psychological and social nature before and during migration. These stressors include major losses and potentially traumatic occurrences such as torture and war exposure. Besides these, they are similarly exposed to post-displacement stressors as well, including relocation and integration, linguistic barriers, discrimination and perceived stigma. As a result, these individuals have shown to be confronted with substantially higher prospects of psychosocial distress and equally higher chances of acquiring mental health conditions such as post-traumatic stress disorder (PTSD), anxiety and depression (Turrini et al., 2019). Considering this fact, it is understandable that

migrants of any kind are in crucial need for psychosocial counselling. More than half of the studies included in the review however, dwelled on the fact that several hinderances stand between migrant populations and their employment of psychosocial services in their host countries. A recurrent barrier being the cultural differences between migrants in their roles as patients, consumers or clients and health care providers in various settings. Ganahl et al. (2016) showed that individuals with migrant backgrounds have a different perception of health and illness compared to the general population of their country of residence. Therefore, misunderstandings occur during interactions between migrant health consumers and health professionals as these varying perceptions of knowledge, experiences and expectations regarding treatment and counselling clash with each other. Furthermore, this notion is placed in direct association with a phenomenon known as “Doctor Hopping”, where a patient or client changes doctors ever so often on grounds of misunderstandings. Patients either feel they are being treated in an unfriendly and discriminative manner or that the process of conceptualizing a reliable diagnosis takes longer than in the cases of non-migrants, thus further encouraging distrust toward health professions and in turn increasing the chances of non-compliance. Additionally, misdiagnosis of the conditions of these patients results in overmedication to the level of habituation of the body toward the medication, which most frequently occurs with anti-depressants.

It is estimated that people with lower individual health literacy tendentially experience conflicting health outcomes (Dewalt et al., 2004). The Australian Commission on Safety and Quality in Health Care (ACSQHC) released a paper in 2014 outlining the importance of both the individual health literacy and the health literacy environment, which pertains to the facilities, processes, policies and interactions that essentially constitute every health system and influences the manner in which consumers access and utilize information and services provided (ACSQHC, 2014). As previously established, adequate communication plays a fundamental role in administering safe and quality care, most especially in the case of migrants who many a time are not proficient in the language of their destination country. According to ACSQHC (2014), deficient communication is amongst others, one of the most referenced causes of adverse health outcomes. Toronto and Weatherford (2016) summarized several useful points that can be employed in

tackling system level barriers experienced within the interpersonal communication between health care consumers and health professionals in regard to the strengthening of health literacy. These recommendations are provided in the following Box 1:

Box 1: Recommendations for Interpersonal Communication Between Health Care Consumers and Health Professionals to Strengthen Health Literacy (Toronto and Weatherford, 2016)

- Speak slowly, using plain and everyday language when communicating health information and instructions.
- Provide concrete, simplified instructions.
- Express compassion, patience and care so consumers are open to guidance.
- Assume consumers have difficulty understanding health information in order to assure all health literacy levels can thrive, nonetheless.
- Administer trainings two or three concepts at a time using culturally sensitive language.
- Provide patient folders with a summary of useful information and instructions.
- Use visual tools such as pictures, models, symbols and pictographs alongside text.
- Provide material in a language understood by the consumer.
- Employ Teach-Back, Show-Me and Ask-tell-ask methods when teaching new skills to correct inaccurate information and evaluate where gaps need to be filled.
- Provide shame-free environment and opportunities that allow consumers to ask and respond to questions and confirm their acquired knowledge.
- Repeat taught concepts in different contexts.
- Request verbal confirmation from consumer, using open-ended rather than close-ended questions than can be easily answered with “yes” or “no” to evaluate understanding.

In the social context, the term “hard to reach population” comprises of several characteristics namely, a lower socio-economic status, poorer educational level, belonging to an ethnic minority background and migration and socio-cultural factors. A combination of some of these characteristics can often be found in the population of people with migrant background, which incites the theory that immigrants belong to the society commonly tagged as “hard to reach”. This theory is very often used as a justification for the exclusion of migrants from research and integration in disease prevention and health promotion initiatives (Borde, 2009).

An immigrant background can serve as a potential obstacle in obtaining access to counselling and treatment services in the healthcare system (Anzenberger et al., 2015). However, it should not serve as an excuse. A network of connections and contacts with an established interface can facilitate access to this group of people. Empirically, a target group prone to isolation within its community will most likely only accept and utilize offers or services provided by institutions recommended by persons within their community, who they can truly trust (Anzenberger & Gaiswinkler, 2016). In the light of this, it is essential to consider following points in the delivery of psychosocial healthcare services:

- Networking in the health sector evolves mainly around interdisciplinary work, which in turn requires resources such as time, professional staff and budget in both planning and implementation stages.
- Are there already existing and useful networks which can be adopted to save resources?
- Is there need for further networks to implement specific interventions or to grant entry into communities?
- Who are the key actors of the communities and what do they offer?
- Are these offers sufficient and do they guarantee continuity?

After taking these points into consideration, the next step would be to contact the identified actors and assess their own level of health literacy in order to ensure that they not only understand what role they play in the network cascade, but also can effectively pass on the information provided in order to create a clear path for health professionals into the isolated communities where help can be offered.

Important starting points for counselling services for instance, are integration and migration offices, health care centres, youth local centres, youth welfare offices and religious organisations (Anzenberger & Gaiswinkler, 2016).

Salami et al. (2019) suggested strategies that when implemented, could improve the delivery of mental health services to migrant populations. A key aspect with the most weight was the community-based model. In order to be effective enough, this model has to be flexible and adaptable in addressing the complex needs of this population, thus going beyond just mental health issues and reaching as far as tackling economical, linguistic, social and integrational barriers experienced by people with migrant histories while adjusting to their new country of residence. By doing this, the services offered take on a prevention approach rather than a crisis management approach. A further point that needs attention is the demand for well-trained immigrant service providers who feel well-equipped to counsel migrants and refugees on matters of psychological and social needs. It is of essence that they are aware of their core responsibilities pertaining to the identification of individuals in need of these services and referral to the appropriate health sectors if required.

Additionally, there is an urgent call for interpreters and “cultural brokers”, who provide educational and cultural meaning of mental stress and explain the role of health professionals and treatment to members of cultural groups. This way, discrepancies in expectations around objectives of therapy sessions and counselling can be eliminated. Admittedly, the use of cultural brokers who share the same language as the clients or patients can also cause tension when for instance, social or religious differences are present between these brokers and the clients or patients, as this might jeopardize the confidentiality of the information shared at the therapy sessions. Despite this fact, it can be said that the implementation of cultural brokers can do more good than harm if they are taught to uphold an objective and non-prejudiced attitude toward their job (Salami et al., 2019).

Studies have indicated that people with migrant backgrounds respond better to group therapies than individual sessions (Rucci et al., 2014; Knipscheer et al., 2000). This could be a promising method to adapt in counselling centres, as this notion shows the importance of community in the lifestyle of migrants. Providing group members who share similar experiences and face comparable challenges

can with no doubt help clients open up more and seek advice from each other as well as from professionals.

Strengths and Limitations

A noteworthy strength of this thesis is the inclusion of both qualitative and quantitative study designs with a vast variety of data collection methods. By doing this, information could be gathered from diverse points of view, which aided with the objective of the thesis being reached and the research question being answered. Moreover, the PICO/PICo Framework was used respectively for the inclusion criteria. This way, a more purposeful and sensitive research could be conducted, making sure to include only studies that were relevant to the research aim in the final screening process. Furthermore, title- and a subsequent abstract screening were performed separately to ensure the inclusion of only suitable articles tailored to the requirements of the thesis.

However, a limitation of the thesis could be the conduction of research on only two databases: CINAHL and PUBMED. Although a hand search on Google Scholar was performed additionally, only few literatures could be found. A further limitation of the review is also the search of only English and German literature, possibly leaving out relevant research. Furthermore, a limitation on these databases assured that only literature published within the last 10 years were suggested, notwithstanding, two studies were included which were older than the 10-year span and were published in the years 2000 and 2008. In addition to this, a possible bias of the thesis is including studies with results dating back to six and even ten years, where it could be argued that nursing research and practice may have evolved since the collection of data, rendering their results outdated or even irrelevant. Systematic reviews were excluded from the literature search at the outset, and the focus was placed on studies that dealt with the psychosocial and mental health literacy of migrants in particular. Only one study elaborated on general health literacy of people with migrant backgrounds, which may lead to a bias, as other studies could have possibly investigated this topic in a different manner.

Implications for Practice and Research

As only limited research has been carried out on the psychosocial health literacy of people with migrant backgrounds so far, and close to none conducted in Austria, there is only a very restricted amount of studies that could be used in comparison to support or contradict the findings of this review. There is, therefore, an urgent need to carry out further research with implementable results as individuals with migrant backgrounds make up a large percentage of health care consumers. Furthermore, a mixed-methods study design with a combination of an interventional study such as randomized controlled trial or quasi-experimental study and a qualitative approach employing a case study or descriptive method would be advantageous for future research as these can, when properly performed, elaborate on the benefits and disadvantages of proposed interventions pertaining to the improvement of health literacy. Moreover, it would be of interest to gain insight into the personal and detailed evaluations of migrants before and after their utilization of mental health care services. Further research should also embed the nursing profession into the process as there is only few literature involving nurses although it has been disclosed that nurses are in most instances patient's first point of contact in stationary and ambulatory settings. Besides that, it is often the nursing profession that is tasked with the education of patients, clarification of health information and advocacy on their behalf (Johnson, 2015). More research is also required to elucidate on ways nurses can be empowered to be more transculturally sensitive to the psychosocial needs of their patients. Although there were literatures that described the concept of transcultural nursing, there were hardly any on the psychosocial aspects of health literacy.

It is recommended that health personnel are trained to assess the health literacy of patients with migrant backgrounds correctly in the future. This group of the population has shown to require different health-related needs compared to the rest of the population and should be counselled accordingly. Studies reveal that the use of trained interpreters in health facilities and institutions increase the chances of positive health outcomes in patients and clients. Additionally, the appropriate delivery of health information is essential to the improvement of health literacy. Health institutions are advised to provide verbal and written health-related materials

in simple, everyday language to assure that consumers understand the information being shared.

In Austria, written educational materials should be provided in various languages aside from the German language, as patients with a low proficiency of the language would experience difficulty comprehending information in German. These materials can be in form of a pamphlet, flyer, poster, folder or visual clips and animations.

Follow-ups are also a necessity when dealing with patients who have insufficient knowledge of the health system. Health professionals can either send out letters reminding patients and clients of their follow-up appointments, especially if these are to take place in a different institution. In cases of psychosocial counselling, follow-up phone calls can be made to determine the well-being of health consumers and to confirm that key messages and instructions are understood and are being upheld.

5. Conclusion

The findings of this literature review show that migrant health is an important topic which unfortunately is not thematized enough in globally held discussions concerning health care processes. Although a number of studies have investigated the health literacy of people with migrant backgrounds, hardly any research has been conducted to explore the psychosocial aspect of this topic and even fewer have been carried out and published in German-speaking Europe. This matter shows great potential for future research. In order to strengthen the psychosocial health literacy of people with migrant histories, barriers in the way of said population and duly required health care services should primarily be put into consideration. Doing this provides a solution to a substantial percentage of the problem at hand.

Given that nurses are in most cases perceived to be the primary point of contact for patients and health care consumers in general, it is essential that while caring for individuals with migrant backgrounds, they display openness and compassion while exercising patience with these individuals if they want to have a positive impact on the psychosocial health literacy of this population.

Furthermore, the provision of trained translators as well as multi-lingual health information in simple and plain language is recommendable as migrants often hail from various cultural and linguistic backgrounds.

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7. Appendix

7.1. Mixed Methods Appraisal Tool by Hong et al. (2018)

The studies were critically assessed using the Mixed Methods Appraisal Tool (MMAT), Version 2008 by Hong et al. (2018).

Notes on the appraisal tool for each paper:
Each question is grouped under one of the following categories of study design: Qualitative, Quantitative randomized controlled trials, Quantitative non-randomized, Quantitative descriptive or Mixed methods.
Following screening questions for all types of study designs are asked to determine whether the appraisal tool is appropriate for the study:

S1. Are there clear research questions?

S2. Do the collected data allow to address the research questions?

If either of these questions are answered with “No” or “Can’t Tell”, the appraisal tool is most probably not suitable to assess the study in question.
Each question can be answered with “Yes”, “No” or “Can’t tell”. There is also a possibility of adding a comment as a response.

1. Qualitative:
   1.1. Is the qualitative approach appropriate to answer the research question?
   1.2. Are the qualitative data collection methods adequate to address the research question?
   1.3. Are the findings adequately derived from the data?
   1.4. Is the interpretation of results sufficiently substantiated by data?
   1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

2. Quantitative randomized controlled trials:
   2.1. Is randomization appropriately performed?
   2.2. Are the groups comparable at baseline?
   2.3. Are there complete outcome data?
   2.4. Are outcome assessors blinded to the intervention provided?
   2.5 Did the participants adhere to the assigned intervention?

3. Quantitative non-randomized:
    3.1. Are the participants representative of the target population?
    3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?
    3.3. Are there complete outcome data?
    3.4. Are the confounders accounted for in the design and analysis?
    3.5. During the study period, is the intervention administered (or exposure occurred) as intended?

4. Quantitative descriptive
    4.1. Is the sampling strategy relevant to address the research question?
    4.2. Is the sample representative of the target population?
    4.3. Are the measurements appropriate?
    4.4. Is the risk of nonresponse bias low?
    4.5. Is the statistical analysis appropriate to answer the research question?

5. Mixed methods
    5.1. Is there an adequate rationale for using a mixed methods design to address the research question?
    5.2. Are the different components of the study effectively integrated to answer the research question?
    5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?
    5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?
    5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

7.2. Hong et al. (2018) critical appraisal

Al Obaidi, A. K. S. & Atallah, S. F. 2009. Iraqi refugees in Egypt: an exploration of their mental health and psychosocial status. *Intervention,* 7**,** 145-151.

- *Quantitative descriptive study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*No, but there is a clearly stated aim*
S2. Do the collected data allow to address the research questions?	*Yes, they did, even though only sparsely*
Is the sampling strategy relevant to address the research question?	*The authors employed a convenient sampling method, which was probably the easiest way to gather the desired data to address the research topic*
Is the sample representative of the target population?	*No, there was no POWER calculation to prove this. The authors state that it was difficult to obtain a larger participant number, rendering the sample size non-representative*
Are the measurements appropriate?	*Although the checklist used was designed by the author and discussed by peer experts, it is stated that it was not tested for reliability and validity, therefore the results are to be interpreted with caution*
Is the risk of nonresponse bias low?	*Can't Tell, there is little to no information on the response rate*
Is the statistical analysis appropriate to answer the research question?	*Can't Tell, there is little to no information on the analysis of data*

Schoenmakers, D., Lamkaddem, M. & Suurmond, J. 2017. The Role of the Social Network in Access to Psychosocial Services for Migrant Elderly—A Qualitative Study. International Journal of Environmental Research and Public Health, 14, 1215.

- *Qualitative study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*No, but there is a clear aim*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the qualitative approach appropriate to answer the research question?	*Yes*
Are the qualitative data collection methods adequate to address the research question?	*Yes, the interviews served their purposes well*
Are the findings adequately derived from the data?	*Yes*
Is the interpretation of results sufficiently substantiated by data?	*Yes – the results and discussion were derived from the data collected*
Is there coherence between qualitative data sources, collection, analysis and interpretation?	*Yes*

Horn, A., Vogt, D., Messer, M. & Schaeffer, D. 2015. Health Literacy von Menschen mit Migrationshintergrund in der Patientenberatung stärken. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz,* 58**,** 577-583.

- *Qualitative study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*No, but there is an aim*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the qualitative approach appropriate to answer the research question?	*Yes, as it was necessary to conduct interviews with the participants in order to collect their experiences*

Are the qualitative data collection methods adequate to address the research question?	*Yes, the interviews served their purposes well*
Are the findings adequately derived from the data?	*Yes*
Is the interpretation of results sufficiently substantiated by data?	*Yes – the results and discussion were derived from the data collected*
Is there coherence between qualitative data sources, collection, analysis and interpretation?	*Yes*

May, S., Rapee, R. M., Coello, M., Momartin, S. & Aroche, J. 2014. Mental health literacy among refugee communities: differences between the Australian lay public and the Iraqi and Sudanese refugee communities. *Social Psychiatry and Psychiatric Epidemiology,* 49**,** 757-769.

- *Non-randomized quantitative study*

Methodological quality criteria	**Response - Comment**
S1. Are there clear research questions?	*No, but the purpose is stated*
S2. Do the collected data allow to address the research questions?	*Yes*
Are the participants representative of the target population?	*No. On the one hand, there was no POWER calculation to prove this; on the other hand, the authors explain that due to the sample being non-random, small and of convenient nature, the results may not be generalizable*
Are measurements appropriate regarding both the outcome and intervention (or exposure)?	*Yes*
Are there complete outcome data?	*One participant did not complete a vignette, and this was treated as missing data – otherwise, yes*
Are the confounders accounted for in the design and analysis?	*The non-randomization of the sample selection, the difficulty experienced with the use of the measurement tool by a group in the sample and the*

	cultural differences that could not fully be put into consideration, were stated by the authors to be cofounding influences
During the study period, is the intervention administered (or exposure occurred) as intended?	*Yes*

Knipscheer, J., Jong, E., Kleber, R. & Lamptey, E. 2000. Ghanaian migrants in The Netherlands: General health, acculturative stress and utilization of mental health care. *Journal of Community Psychology,* 28.

- *Quantitative descriptive study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*Yes*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the sampling strategy relevant to address the research question?	*Yes, a snow-ball sampling method was employed, according to the authors, this was a recommendable method to employ when dealing with a relatively unknown population*
Is the sample representative of the target population?	*No, there was no POWER calculation to prove this. The authors state that it was a challenge obtaining a representative and adequate sample of participants*
Are the measurements appropriate?	*Yes – the author states that the instrument used was the most adequate at that time*
Is the risk of nonresponse bias low?	*Although the risk of non-response was initially expected to be high, the response rate was good with 71.88%*
Is the statistical analysis appropriate to answer the research question?	*Yes*

Salami, B., Salma, J. & Hegadoren, K. 2019. Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, 28, 152-161.

- *Qualitative descriptive study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*No, but there is an aim*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the qualitative approach appropriate to answer the research question?	*Yes, as it was necessary to conduct interviews with the participants in order to collect their perspectives*
Are the qualitative data collection methods adequate to address the research question?	*Yes, the interviews served their purposes well*
Are the findings adequately derived from the data?	*Yes*
Is the interpretation of results sufficiently substantiated by data?	*Yes – the results and discussion were derived from the data collected*
Is there coherence between qualitative data sources, collection, analysis and interpretation?	*Yes*

Toronto, C. E. & Weatherford, B. 2016. Registered nurses' experiences with individuals with low health literacy: A qualitative descriptive study. *Journal for nurses in professional development,* 32**,** 8-14.

- *Qualitative descriptive study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*Yes*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the qualitative approach appropriate to answer the research question?	*Yes, open-end questions were asked in order to obtain undiluted experiences from the participants*
Are the qualitative data collection methods adequate to address the research question?	*Yes*

Are the findings adequately derived from the data?	*Yes*
Is the interpretation of results sufficiently substantiated by data?	*Yes – the results and discussion were derived from the data collected*
Is there coherence between qualitative data sources, collection, analysis and interpretation?	*Yes*

Rucci, P., Piazza, A., Perrone, E., Tarricone, I., Maisto, R., Donegani, I., Spigonardo, V., Berardi, D., Mariapia, F. & Fioritti, A. 2014. Disparities in mental health care provision to immigrants with severe mental illness in Italy. *Epidemiology and psychiatric sciences,* 24**,** 1-11.

- *Quantitative secondary data analysis (Quantitative descriptive study)*

Methodological quality criteria	**Response - Comment**
S1. Are there clear research questions?	*No, but there is a clear aim*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the sampling strategy relevant to address the research question?	*Can't Tell, the sample strategy was not described in detail, only the data collection process*
Is the sample representative of the target population?	*Can't Tell, was not stated in the study*
Are the measurements appropriate?	*Yes*
Is the risk of nonresponse bias low?	*Can't Tell – there was nothing to respond to*
Is the statistical analysis appropriate to answer the research question?	*Yes*

Toselli, S. & Gualdi-Russo, E. 2008. Psychosocial indicators and distress in immigrants living in Italian reception centres. *Stress and Health,* 24**,** 327-334.

- *Quantitative descriptive study*

Methodological quality criteria	Response - Comment
S1. Are there clear research questions?	*No, but there are clear aims*
S2. Do the collected data allow to address the research questions?	*Yes*
Is the sampling strategy relevant to address the research question?	*Yes, there were many participants and surveys were translated into other languages and cultural mediators were offered as assistance to illiterate participants and to those who did not understand any of the languages the survey was translated into*
Is the sample representative of the target population?	*Can't Tell – there was no POWER calculation to prove this nor further information on the recruitment process*
Are the measurements appropriate?	*Yes*
Is the risk of nonresponse bias low?	*Yes, the lowest response rate from a group was 88.1%*
Is the statistical analysis appropriate to answer the research question?	*Yes*