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MAPPING THE NORMATIVE LANDSCAPE OF MEDIATED INTERCULTURAL COMMUNICATION IN HEALTHCARE

*International and national regulatory and
policy frameworks*

Within the research project

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Preface

The purpose of this report is to examine the extent to which mediated intercultural communication in healthcare, in its various forms and figures, is reflected in regulatory and policy documents at the International, European, Spanish and Catalan levels. Throughout the report, mediated intercultural communication is understood in a broad sense, encompassing both professional and non-professional forms of mediated intercultural communication (both human and technology-assisted), as well as healthcare interpreting and related practices aimed at facilitating communication and understanding between healthcare providers and users with limited proficiency in the local languages. The documents analysed include not only legally binding instruments, such as international covenants and domestic laws, but also recommendations, guidelines, standards, policy papers and other normative texts that shape healthcare practices and public policies.

This report has been prepared within the framework of the research project *CIMAS – Comunicación Intercultural Mediada en el Ámbito Sanitario*, conducted by the MIRAS group at the Universitat Autònoma de Barcelona and funded by the Spanish Ministry of Science, Innovation and Universities. The overall aim of the project is to study mediated intercultural communication in healthcare settings in Catalonia from the perspective of all the actors involved. More specifically, the present report contributes to the second macro-objective of the project, which focuses on evaluating public policies concerning intercultural communication in healthcare. Among its specific objectives, this macro-objective includes the analysis of existing regulatory texts and the preparation of a report describing the state of mediated intercultural communication policies at the international, European, national and regional levels. In this sense, the present document aims to provide a comprehensive overview of the normative frameworks that shape intercultural communication practices in healthcare and to identify strengths, limitations and areas in need of further development.

The initial intention behind this work was to analyse the legal status of mediated intercultural communication within the Catalan public healthcare system. However, it soon became evident that such an analysis could not be carried out in isolation from the broader Spanish legal framework, since many Catalan provisions derive from or interact with state legislation. Further examination revealed that a considerable number of Spanish regulations are themselves influenced by Council of Europe and European Union instruments, which, in turn, are often inspired by international human rights principles and standards. Consequently, what

began as a regional legal study gradually evolved into a broader and more ambitious undertaking aimed at tracing the normative foundations of mediated intercultural communication across different levels of governance. This multilevel approach not only allows for a better understanding of the origins and interconnections of existing regulations but also highlights the progressive development of legal and policy frameworks concerning language access and intercultural communication in healthcare.

Accordingly, the report is organised into four main sections corresponding to the four geographical and institutional levels under consideration: international, Council of Europe and European Union, Spanish and Catalan. Each section contains a series of tables designed to facilitate comparison and provide a systematic overview of the documents examined. The tables include information on the title of each document, its scope, the issuing institution, its legal status and period of validity, relevant excerpts or provisions related to intercultural communication and healthcare, analytical comments concerning their significance and implications, and references to other related documents or academic texts. In order to make it easier to search through and analyse this report, the most relevant concepts and themes are highlighted through the use of keywords in bold. These keywords make it possible to identify recurring issues and to detect similarities and differences across normative levels and document types.

The decision to publish this report in English reflects the intention to make its findings accessible to a broader readership. Since the issues addressed transcend the Catalan and Spanish contexts and are increasingly relevant in multilingual and multicultural healthcare systems worldwide, English provides an appropriate vehicle for reaching researchers, policymakers, healthcare professionals and practitioners from different countries and disciplines. Furthermore, the use of English seeks to encourage international dialogue and facilitate the dissemination and transfer of knowledge generated within the CIMAS project beyond its immediate geographical context. In this regard, the report aspires not only to serve as a descriptive inventory of legal and policy documents, but also to contribute to ongoing debates concerning equitable access to healthcare, language rights and the role of mediated intercultural communication in ensuring quality healthcare for increasingly diverse populations¹.

¹ Where official translations were not available, the relevant texts were translated using automated translation tools and/or artificial intelligence. In all cases, however, the resulting translations were subject to a thorough review process to ensure accuracy, consistency, and fidelity to the original content.

1. INTERNATIONAL NORMS

1.1. United Nations

Name	The Universal Declaration of Human Rights
Scope	International
Issuing body	General Assembly of the United Nations
Validity / Publication	In force since 1948. Adopted and proclaimed by General Assembly resolution 217 A (III) of December 10, 1948.
Text	Article 2 of the Declaration states that: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty. Article 21.2 also states that “Everyone has the right of equal access to public service in his country.” Finally, Article 25 states that: 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
Comments	The UN General Assembly adopted the Universal Declaration of Human Rights (UDHR) by consensus in 1948. It is a normative text of international scope, and all UN members are strongly committed to its implementation. Even though it is non-binding, many of its principles and rights enjoy such undisputed recognition as to be considered part of customary international law. In Article 25, it promotes the right to health and well-being, including medical care, as well as giving special status to the protection of mothers and children in this context. In Article 2, it suggests that the entitlement to the rights in this Declaration should apply without distinctions based on language, among others. In Article 21.2, it also promotes “equal access to public service”. Taken together, these articles could be said to provide the general foundations for the right to health, regardless of language, and access to public service, such as medical care provided by states, as a modern human right. However, there is no explicit reference to the need for interpreters or intercultural mediators in order to be able to successfully guarantee these rights in certain cases.

Related references:

ISO 21998:2020(en) Interpreting services — Healthcare interpreting: Requirements and recommendations, <https://www.iso.org/obp/ui/es/#iso:std:iso:21998:ed-1:v1:en:ref:6>

Arya, A. N., Hyman, I., Holland, T., Beukeboom, C., Tong, C. E., Talavlikar, R., & Eagan, G. (2024). Medical interpreting services for refugees in Canada: Current state of practice and considerations in promoting this essential human right for all. *International Journal of Environmental Research and Public Health*, 21(5), 588.

Name	International Covenant on Economic, Social and Cultural Rights
Scope	International
Issuing body	General Assembly of the United Nations
Validity / Publication	In force since 1976. Adopted and opened for signature, ratification or accession by General Assembly resolution 2200 A (XXI) of 16 December 1966.
Text	
Article 2.2 of the Covenant states that: The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language , religion, political or other opinion, national or social origin, property, birth or other status. Article 12 also states that: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health . 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness .	
Comments	
The International Covenant on Economic, Social and Cultural Rights (CESCR) developed many of the rights that were enshrined in the UDHR and made them legally binding on state parties. In Article 12, it promotes the right to physical and mental health, giving special mention to child and maternal health, while also referring to several underlying determinants of health. It places the onus on states to produce the conditions in which it is possible for people who are sick to be able to access medical care. Similar to the UDHR, Article 2.2 indicates that the	

rights in this Covenant should be guaranteed on a non-discriminatory basis, including language aspects. While there are explicit references to the role of states in creating the conditions in which the right to medical care can be fulfilled, there is no mention of the need for interpreters or intercultural mediators.

The subsequent “CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), adopted on 11 August 2000, indicates that the right to health includes “the right to a **system of health protection** which provides **equality of opportunity** for people to enjoy the highest attainable level of health” (para 8). In terms of acceptability, it suggests that “health facilities, goods and services” must be “**culturally appropriate**, i.e. respectful of the culture of individuals, minorities, peoples and communities” (para 12[c]). In addition, it establishes the specific legal obligation not to deny or limit equal access to health for “minorities, asylum-seekers and illegal immigrants” (para 35). Finally, it refers to the core obligation to “ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups” (para 43[a]).

Despite the abovementioned provisions on equal access and non-discrimination, these have not tended to have a strong influence on states’ translation policies (Mowbray 2017), where existing.

Related references:

Monzó-Nebot, E., & Mellinger, C. D. (2022). Language policies for social justice—Translation, interpreting, and access. *Just. Journal of Language Rights & Minorities, Revista de Drets Lingüístics i Minories*, 1(1–2), 15-35.

Mowbray, J. (2017). Translation as marginalisation? International law, translation and the status of linguistic minorities. In *Translation and public policy* (pp. 32-57). Routledge.

Report of the UN Independent Expert on Minority Issues 2012, par. 68

UN Special Rapporteur on Minority Issues 2017, 25–26.

Name	Convention on the Rights of the Child
Scope	International
Issuing body	General Assembly of the United Nations
Validity / Publication	In force since 2 September 1990. Adopted by the UN General Assembly 20 November 1989.
Text	
Article 3 of the Convention states that:	
1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. [...] 3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.	

Article 24 also states that: 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries. Article 32 also states that: 1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development. Finally, Article 36 states that: States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.
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Comments
For all countries that have ratified or acceded to this Convention, it is legally binding under international law. While a state that has signed but not ratified or acceded to the treaty is not obligated to adhere to its provisions, it is required to refrain from actions that undermine its purpose. As of 13 January 2025, 196 states are parties to the treaty, including all United Nations member states (except the United States). This convention seeks to protect the rights of children, considered to be rights-holders in need of special care and assistance. In Article 3, it states that public or private institutions carrying out actions involving children must privilege the best interests of the latter. In Article 24, it establishes the child's right to health and medical assistance, including maternal health. Most importantly, Article 32 protects children from economic exploitation or hazardous forms of work that will interrupt their education or be detrimental to their health or development. Moreover, Article 36 ensures that states parties safeguard children from types of exploitation

that have a negative effect on their welfare. Under this convention, it could be argued that the use of children as language brokers by public institutions (such as public health systems) does not treat the child's best interests as paramount. Also, child language brokering could be considered a form of exploitation that impinges children's health, development, education, and welfare.

Related references:

Bundesverband der Dolmetscher und Übersetzer (BDÜ). (2021). Position paper: Children as interpreters.

https://bdue.de/fileadmin/files/PDF/Positionspapiere/BDUe_PP_Kinderdolmetschen_Child_Language_Brokering_2021_EN.pdf?utm_source=chatgpt.com

McQuillan, J., & Tse, L. (1995). Child language brokering in linguistic minority communities: Effects on cultural interaction, cognition, and literacy. *Language and Education*, 9(3), 195-215.

Name	<u>Convention on the Elimination of All Forms of Discrimination against Women</u>
Scope	International
Issuing body	UN
Validity / Publication	In force since 3 September 1981. Adopted and opened for signature and ratification or accession by General Assembly resolution 34/180 of 18 December 1979.
Text	
Article 12 of the Convention states that:	
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. 2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.	
Comments	
This Convention came into force once it had been ratified by twenty countries. Its implementation is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW), to which states parties submit a national report at least every four years on the measures they have introduced to enforce its provisions. It promotes women's rights and fundamental freedoms and seeks to eliminate discrimination against women and obstacles to equality between men and women. Article 12 seeks to remove discrimination against women in health care, as well as to promote women's access to health care services in general and in relation to reproductive health. While there is no explicit reference to some women's need for interpreting or intercultural mediation in order to ensure that access to health care is effective or appropriate services are provided, several articles in this Convention, including Article 12, were the basis of some of the claims brought by <i>Szijarto v. Hungary</i>, which was adjudicated by CEDAW. In this case, a caesarean section was performed on a Roma Hungarian woman after she had a miscarriage.	

On the operating table, she signed an informed consent requesting sterilisation (the Latin term was used) without having understood the meaning of this word or having been given complete information on the procedure and its effects. Under Article 12, she successfully claimed that having been unable to exercise informed consent, her right to appropriate health care services had been violated. According to Dalton-Oatons (2017), this case is an example of a medical issue being argued as a gender issue.

Related references

Dalton-Oates, B. (2017). Medical translation: the neglected human right. *International Journal of Human Rights in Healthcare*, 10(4), 228-238.

Name	Convention on the Rights of Persons with Disabilities
Scope	International
Issuing body	United Nations General Assembly
Validity / Publication	In force since 3 May 2008. Adopted on 13 December 2006 and opened for signature on 30 March 2007.
Text	
Article 9 - Accessibility of the Convention states that: 1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia: [...] (b) Information, communications and other services, including electronic services and emergency services. 2. States Parties shall also take appropriate measures to: (a) Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public; [...] (e) Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public; Article 25 - Health also states that: States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:	

- (a) Provide persons with disabilities with the **same range, quality and standard of free or affordable health care and programmes** as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
[...]
- (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of **free and informed consent** by, inter alia, raising awareness of the **human rights, dignity, autonomy and needs** of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
[...]

Comments

As of January 2026, this Convention has 164 signatories and 193 parties, including 191 states and the European Union, which ratified it on 23 December 2010. Implementation is overseen by the Committee on the Rights of Persons with Disabilities.

Its signatories are obligated to promote, protect and guarantee human rights for individuals with disabilities, ensuring they experience full equality under the law. It promotes rights in relation to accessibility and individual autonomy, among others. It also seeks to protect persons with disabilities from various forms of discrimination. According to Venada de Sousa (2022), the provisions in this Convention form the basis for a legislative framework that States must implement to ensure that sign language obtains legal status and is recognised and used.

Article 9.1 promotes equal access to information, facilities and services that are available to the public. Furthermore, Article 9.2(e) makes an explicit reference to the need to provide professional sign language interpreters to ensure access to public buildings and facilities. This is a milestone as it is the first Convention to mention sign language (Stone 2013).

In relation to health, the paragraphs in Article 25 promote access to health and health services in conditions of equality, requiring health professionals to provide the same quality of care to persons with disabilities, as well as free and informed consent.

This Convention clearly establishes the right to sign language interpreters on the grounds of accessibility. In addition, sign language interpreters are often essential for ensuring the effective exercise of the rights to health, healthcare services, free and informed consent, and access to information and facilities, as well as for preventing discrimination on linguistic grounds. However, as found in Haualand (2009), States often do not provide enough funding, training and available services. This may mean that, while there is a willingness to support such rights on paper, the necessary resources are not provided.

Related references

ISO 21998:2020(en) Interpreting services — Healthcare interpreting: Requirements and recommendations - <https://www.iso.org/obp/ui/es/#iso:std:iso:21998:ed-1:v1:en:ref:6>

Haualand, H. (2009). Sign language interpreting: A human rights issue. *International Journal of Interpreter Education*, 1(1), 7.

Stone, C. (2013). The UNCRPD and “professional” sign language interpreter provision. In *Interpreting in a Changing Landscape: Selected papers from Critical Link 6* (pp. 83-100). John Benjamins Publishing Company.

De Sousa, F. V. (2022). Essential framework of the legal status of sign language: recognition and officiality. *Revista de Llengua i Dret*, 177-193.

1.2. World Health Organization

Name	WHO Strategic Communications Framework for Effective Communications
Scope	International
Issuing body	World Health Organisation
Validity / Publication	2017
Text	
The framework recommends the following measures to promote communication in healthcare: To ensure target audiences understand WHO information, advice and guidance, communicators should create messages in multiple languages and provide translation support (p. 39). People are more likely to understand messages presented to them in their local languages (p. 39). Use regional and country offices to create and adapt content to meet specific preferences of their communities and partners (p. 39). Encourage creating original messages in non-English languages rather than translating English messages (p. 39).	
Commentary	
The intercultural communication recommendations in the World Health Organization's communication framework emphasize a core principle that runs through most effective public health messaging: communication is not culturally neutral. In practice, this means that health information must be adapted to different cultural contexts, languages, belief systems, and social norms rather than assuming a single "universal" audience. The framework aligns with the idea that trust and comprehension are built when messages are co-created or at least shaped with input from the communities they are intended for. This includes using culturally appropriate language, engaging trusted local intermediaries, and avoiding technical or institutional phrasing that may not translate meaningfully across settings. A key strength of this approach is that it moves beyond simple translation toward genuine cultural adaptation, recognizing that misunderstandings in health communication often stem not from lack of information but from mismatched frames of reference. It also implicitly acknowledges power dynamics in global health messaging, encouraging communicators to adopt a more dialogical and less top-down stance. At the same time, one challenge is operational: implementing intercultural communication at scale requires resources, local expertise, and time—factors that are often constrained in emergency or fast-moving public	

health situations. Still, the framework's emphasis on cultural humility and audience-centered design provides a practical foundation for improving equity and effectiveness in health communication across diverse populations.

Related references:

Tan, N. & Cho, H. (2019). *Cultural Appropriateness in Health Communication: A Review and a Revised Framework*. *Journal of Health Communication*, 24(5), 492–502.

Name	<u>Declaration on the Promotion of Patients' Rights in Europe</u>
Scope	Europe
Issuing body	WHO Regional Office for Europe (WHO/EURO)
Validity / Publication	Declaration published in April 1994
Text	Article 2. Information of the declaration states that: 2.2. Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment. 2.4. Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.
Commentary	This Declaration was endorsed by the European Consultation on the Rights of Patients, which was held in Amsterdam on 28-30 March 1994 under the auspices of the WHO Regional Office for Europe (WHO/EURO) and hosted by the Government of the Netherlands. The purpose was to create a coherent and comprehensive set of principles and guidelines based on existing rights frameworks that could be useful for policy discussions in Member States. It is the result of a large study conducted on patients' rights in Europe, and it aims to constitute a common European framework. It promotes the rights and responsibilities of patients within the context of the healthcare reform process that was being carried out in most countries. Its main policy objectives are respect for persons and equity in health, and it focuses more on individual rights than social rights. In Article 2.2., this Declaration establishes patients' rights to information. In addition, in Article 2.4., it is stipulated that information must be communicated in such a way that patients are able to understand it. In this sense, there is an explicit reference to the need to provide interpreting in the event that a patient does not speak the common language. However, in the sections dealing with consent, confidentiality and privacy, and care and treatment, there is no mention of the existence or impact of language barriers. Even so, this Declaration makes a clear link between the right to information, appropriate communication and healthcare interpreting.

Related references:

Leenen, H. J. (1994). The rights of patients in Europe. *Eur. J. Health L.*, 1, 5.

European Commission et al. 2016. *Patient's Rights in the European Union. Mapping Exercise. Final Report*. 244 pp. European Commission.

Name	Strategy and action plan for refugee and migrant health in the WHO European Region
Scope	Europe
Issuing body	WHO, Regional Committee for Europe
Validity / Publication	2016-2022
Text	In point 21 of the Guiding principles, this strategy states that: Access to responsive, people-centred health systems is essential to ensure available health care for all refugees, asylum seekers and migrants throughout the migration journey. This implies overcoming formal and informal barriers to health care, such as language, administrative hurdles, lack of information about health entitlements, and meeting the needs of all people, without discrimination, including on cultural or religious grounds [...]. In addition, “Strategic area 5: strengthening health systems and their resilience”, this strategy states that: 43. Health systems should aim to offer culturally sensitive health care, overcoming barriers such as language, access to interpreters, administrative hurdles, and lack of support for patient fees or for information about health entitlements. Systems should ensure support to refugees and migrants in navigating through the system, and should respond to the needs of all persons, without discrimination, and with dignity and respect. [...]. 47. Training on health equity and human rights-based approaches is a key element for health professionals and relevant non-health actors. Patient-sensitive health systems may benefit from fostering active and effective community participation and empowerment of refugees and migrants. The promotion of health literacy is a vital part of responding to migrants’ health needs. Health systems should be sensitive to migrants’ own languages, although in the longer term it is important that migrants learn the language of the country in which they are living. If permitted by national labour legislation, integrating migrants as health workers may be possible. In the “Actions by Member States” section of this strategic area, meeting the above objectives implies that states would: (g) ensure that necessary health and social services are delivered, within available resources, to refugees and migrants in a gender-sensitive, culturally and linguistically appropriate way without stigma, through advocacy and the provision of cultural mediators and by enforcing, when necessary, laws and regulations that prohibit discrimination. Furthermore, in point 67 of “Strategic area 9: improving health information and communication”, this strategy states that:

Communication efforts should offer health promotion and health communication to migrants, to provide them with key messages and advice on health-seeking behaviours. These efforts should also **provide information to refugees, asylum seekers and migrants on the health system in the host country** and the avenues by which they can seek advice and support. Such communication should dissipate fears and false perceptions among refugees, asylum seekers and migrants, **in an appropriate language, taking into account sociocultural and religious determinants**; and should be adapted for the host population as well.

Commentary

This is a strategy for collaborative action on refugee and migrant health to ensure a coherent regional response and thus avoid uncoordinated single-country solutions. In the context of migration as a global phenomenon and its political, social and economic challenges, as well as the influx of refugees, asylum seekers and migrants in Europe, a response based on solidarity and mutual assistance was deemed necessary.

This strategy promotes the rights of refugees, asylum seekers and migrants, as well as the right to health. It is based on the principles of universality, solidarity and equal access. It also takes into consideration the social determinants of health and the possible risk of worse health conditions for migrants.

In point 21, there is an explicit reference to the need to ensure access to health systems and to overcome barriers to health care, one of which is language.

In point 43 of the “Strategic area 5: strengthening health systems and their resilience”, in the context of the goal to provide culturally sensitive healthcare, there is a further reference to language as a barrier and, in this case, access to interpreters. It is also stated that refugees and migrants should receive assistance navigating healthcare systems. In point 47, it is noted that sensitivity should be shown towards migrants’ own languages, while giving importance to learning the local language in the long term. Furthermore, there is a mention of integrating migrants as health workers. Point (g) of “Actions of Member States” in this area refers to ensuring that health services are offered in a culturally and linguistically appropriate way, including an explicit reference to the provision of cultural mediators.

Finally, in point 67, it is stated that health promotion and health communication for refugees, asylum seekers and migrants should be in an appropriate language and consider sociocultural and religious determinants.

In sum, this strategy and action plan clearly recognises language and lack of access to interpreters as barriers to health care, health promotion and health communication for migrant populations. It strikes a balance between sensitivity to migrants’ own languages and the importance of learning the language of the host country. To provide culturally and linguistically appropriate care, it recommends the use of cultural mediators, as well as the possibility of employing migrants as health workers.

Name	WHO global action plan on promoting the health of refugees and migrants, 2019-2030
Scope	International

Issuing body	World Health Organization
Validity / Publication	From 2019 until 2023. In May 2023, extended to 2030.
Text	
Under “Health consequences and challenges”, this global action plan states: 14. Barriers to accessing health care services differ from country to country; they may include language and cultural differences, high costs, discrimination, administrative hurdles, inability to affiliate with local health financing schemes, adverse living conditions, occupation or blockade of territories and lack of information about health entitlements. All these conditions make seeking care difficult. Additionally, these experiences can precipitate negative mental health outcomes. In addition, in “Priority 2: Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures”, one of the objectives is to: 31. To improve the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among refugee and migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems, in accordance with Member States’ national contexts, priorities and legal frameworks. Furthermore, in “Priority 3: Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms”, it states that: 32.b. Supporting the development and implementation of evidence-based public health approaches and the building of health care capacity for service provision, affordable and non-discriminatory access and reduced communication barriers, and training health care providers in culturally-sensitive service delivery and provisions for persons with disabilities [...] 32.d. Supporting the development of recommendations and tools for the governance, management and delivery of health care services that address epidemiological factors, cultural and linguistic barriers, and legal, administrative and financial impediments to access, with the involvement of refugee and migrant health workers.	
Commentary	
This global action plan was instigated at the Seventieth World Health Assembly when the Director-General was asked to develop a global strategy to promote refugee and migrant health. This led to the WHO global action plan on promoting the health of refugees and migrants, 2019-2023, whose time frame was extended to 2030 at the Seventy-sixth World Health Assembly.	

This text serves as a resource for Member States to adopt an inclusive approach to the health and well-being of refugees and migrants, as well as to contribute to achieving the 2030 Agenda for Sustainable Development. It seeks to coordinate international efforts and to link health care to humanitarian programmes.

As with the initial “WHO global action plan on promoting the health of refugees and migrants, 2019-2023”, there is no direct mention of the role of interpreters and intercultural mediators in refugee and migrant health. However, this subsequent version of the action plan contains several more references to language and cultural barriers. The text explicitly acknowledges language and cultural differences as one of the barriers to accessing health services, along with the lack of information available to refugees and migrants regarding their health entitlements. It also clearly states that to achieve the goal of improving the quality, acceptability, availability and accessibility of health care services, one of the necessary measures is to overcome linguistic and cultural barriers. Moreover, depending on the context of Member States, it also recommends the improvement of the coverage, access and quality of primary healthcare. There are further references to reducing communication barriers, training in cultural sensitivity for healthcare professionals, provisions for people with disabilities, and employing refugee and migrant health workers.

Based on this action plan, it can only be assumed that to achieve its goals of overcoming language and cultural barriers and improving access to information and healthcare for refugees and migrants, some form of interpreting and mediation are required.

Related references:

World Health Organization. 2023. *Promoting the Health of Refugees and Migrants* <https://iris.who.int/bitstream/handle/10665/366326/9789240067110-eng.pdf?sequence=1>

WHO. 2022. *World Report on the Health of Refugees and Migrants*. <https://www.who.int/publications/i/item/9789240054462>

WHO. 2019. *Health and Migration Programme*. <https://www.who.int/teams/health-and-migration-programme/overview>

WHO. 2017. *Promoting the Health of Refugees and Migrants*. https://iris.who.int/bitstream/handle/10665/275698/A70_R15-en.pdf?sequence=5

Name	<u>Refugee and migrant health: Global Competency Standards for health workers</u>
Scope	International
Issuing body	World Health Organization
Validity / Publication	Since 2021
Text	
The competencies in these Standard are aimed at promoting the necessary behaviours among the health care workforce to provide high-quality care to refugees and migrants. According to “Competency standard 3: engages safe and appropriate aids to meet language and communication needs of refugees and migrants”:	

- 3.1. Recognizes the person's right to timely, gender- and age-appropriate information, **including assistance with communication.**
- 3.2. **Mitigates language and communication barriers by engaging trained individuals including interpreters and cultural mediators**, as appropriate, to facilitate communication between the person and health workers, wherever necessary.
- 3.3. Uses **language and communication aids that are language and culturally appropriate**, sensitive and age- and gender-responsive.
- 3.4. **Adapts practice to work effectively with interpreters and cultural mediators, as appropriate, in person or remotely, including by telephone or video link.**

In addition, according to "Competency standard 4: supports refugees and migrants to understand information about their health care":

- 4.1. Ensures that the person **understands information about their health care in view of the language, communication and health literacy barriers** to understanding.
- 4.2. Communicates in plain language, avoiding the use of medical jargon.

Furthermore, according to "Competency standard 5: engages in collaborative practice to promote the health of refugees and migrants":

- 5.2. Undertakes **effective handover of care to other health workers through verbal and/or written communication, including information about relevant individual, cultural and language considerations and needs** as well as migration- and displacement-related factors.
- 5.3. Utilizes the **skills, including language and communication capabilities, of health workers from refugee and migrant backgrounds** in supporting people with experiences of migration and displacement.

Commentary

This document seeks to provide consistent standards of practice, competencies and behaviours for the healthcare workforce when it comes to interactions with refugee and migrant beneficiaries. It considers refugees and migrants as vulnerable communities at risk of a lack of access to essential health services.

It promotes the right to health and the highest attainable standard of health for refugees and migrants, along with access to people-centred, high-quality health services. It is committed to universal health coverage and equipping health workers with sensitivity towards migrant needs, languages and specific health problems.

These Standards explicitly recognise the language and communication needs of refugees and migrants, including the link between the right to information and the potential need for assistance with communication. They directly mention the use of interpreters and cultural mediators to lessen language and communication barriers. In addition, they refer to the adaptation of practices in order to work effectively with interpreters and cultural mediators, including over the phone or through a video link. They also allude to making sure that migrants and refugees understand information regarding their health care, which means that health care workers must be aware of language, communication and health literacy barriers. There is a reference to the provision of information regarding cultural and language considerations when referring individuals to other health workers. Finally, using the language and communication skills of refugee and migrant workers in health care is also mentioned.

In the explanatory notes, there is a comprehensive summary of language and communication issues. Regarding **culturally sensitive care**, they recommend taking individuals' preferences

into consideration regarding the **gender** of their clinician and language and communication aids. In terms of specific areas of risk, barriers with respect to language, culture, financial means, and health literacy are seen to potentially impede upon the **safe use of medicine**.

There are also two dedicated sections on the use of interpreters and cultural mediators. If the need for an interpreter is established, it is up to the healthcare worker to set this course in motion or to assess the risks of proceeding without one. The individual's particular preferences regarding an interpreter (ethnicity, religion, gender, dialect, etc.) should also be acknowledged, and the available options explained. It is also noted that **telephone interpreting** may be preferred by individuals for reasons of confidentiality or in the case of consultations on sensitive topics. A series of risks associated with using **family members** as interpreters are listed. In addition, healthcare workers are said to have the **responsibility not to engage minors** for these purposes. Some issues in relation to **language-competent health workers** are also explained. There is discussion of the special importance of providing interpreting services to **deaf migrants and refugees**.

Moreover, the distinct role of **cultural mediators** is explained in some detail. The use of flashcards and translation apps are mentioned as communication aids. However, while Google Translate is said to be effective where there is no other option, it should not become a default option, and **artificial intelligence** is deemed ineffective for translating nuanced and complex information. The use of **plain language** is recommended, especially when interpreters or cultural mediators are present as they may be less familiar with medical terminology.

Related references:

Dalton-Oates, B. (2017). Medical translation: the neglected human right. *International Journal of Human Rights in Healthcare*, 10(4), 228-238.

Name	Rabat Declaration Adopted to Improve Refugee and Migrant Health
Scope	International
Issuing body	Kingdom of Morocco, World Health Organization (WHO), IOM, UN Migration Agency, UNHCR and UN Refugee Agency
Validity / Publication	Since 13 th June 2023
Text	
The declaration states that:	
1/b. Working towards supporting public health and social protection considerations are included in national policies related to refugees and migrants in line with national priorities, and that implementation of regional and national health strategies, programmes, plans and services include measures to reach refugees and migrants, addressing their health needs , that respect human rights, needbased, human-centered, transparent, equitable, non-discriminatory, nonstigmatizing, culturally sensitive, gender-sensitive, child-sensitive and disability responsive, with the aim of leaving no one behind;	
1/c. Addressing the root causes that negatively influence the health of refugees and migrants , especially key determinants that lie outside the health domain including but not limited to socio-economic, working, cultural, environmental, structural conditions and human rights considerations;	

1/d. **Promoting advocacy and awareness raising concerning refugees and migrants' health,** and promoting host communities, refugees and migrants' health as part of a "One Health" approach;

5/a. **Provide technical support to Member States and countries,** as appropriate, when and where requested, in improving health systems to better respond to the health needs of refugees and migrants and hosting communities.

Commentary

No direct mention is made regarding communication or language barriers in any part of the document.

Related references:

Kokori, Emmanuel; Olatunji, Gbolahan. 2023. "Transforming refugee health: exploring the implications and potential of the new Rabat Declaration". *International Journal of Surgery: Global Health* 6(4):e0227.

https://journals.lww.com/ijsggh/fulltext/2023/07010/Transforming_refugee_health_exploring_the.64.aspx

2. EUROPEAN NORMS (COUNCIL OF EUROPE)

2.1. Binding texts

Name	<u>Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 005) a.k.a. European Convention on Human Rights</u>
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 4/11/1950. Entry into force: 3/9/1953 (10 ratifications).
Text	
Article 6.3.e) of the ECHR states: That everyone charged with a criminal offence has the right "to have the free assistance of an interpreter if he cannot understand or speak the language used in court".	
Commentary	
The ECHR protects the right of the accused in a criminal proceeding to be assisted by an interpreter if he or she does not understand the language of the court and includes an explicit reference to (court) interpreters. The ECHR contains no parallel provision for people who cannot understand or speak the language used in healthcare or medical settings. To ensure that the Parties uphold their obligations under this convention, the European Court of Human Rights in Strasbourg was set up. As the Convention does not include healthcare among the fundamental rights and freedoms, the non-provision of healthcare interpreting is not a legal argument in court cases. For example, in the following cases language was a significant factor but the non-provision of interpreting was not relevant: <i>Vo v. France</i> (no. 53924/00) 8.7.2004; <i>R.K. and A.K. v. United Kingdom</i>. (no. 38000/05) 30.09.2008; <i>Jasinskis v. Latvia</i> (no. 45744/08) 21.12.2010. Related references: Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". <i>International Journal of Human Rights in Healthcare</i>. Vol. 10 No. 4, pp. 228-238. https://doi.org/10.1108/IJHRH-01-2017-0004 González Núñez, Gabriel. 2012. <i>Translation and Healthcare in Europe: An Overview of Europe's Legal Framework</i>. CETRA Paper. KU Leuven, Belgium. McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". <i>Ethnicities</i>. Vol. 17 No. 5, pp. 603–626. Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". <i>European Journal of Health Law</i>. Vol. 19 No. 4, pp. 333-353.	

Name	European Convention on Social and Medical Assistance (ETS No. 014)
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 11/12/1953. Entry into force: 1/7/1954 (2 ratifications). Spain signed the Convention on 9/2/1981 and ratified it on 21/11/1983. Entry into force on 1/12/1983
Text	
Article 1 states: Each of the Contracting Parties undertakes to ensure that nationals of the other Contracting Parties who are lawfully present in any part of its territory to which this Convention applies, and who are without sufficient resources, shall be entitled equally with its own nationals and on the same conditions to social and medical assistance (hereinafter referred to as "assistance") provided by the legislation in force from time to time in that part of its territory.	
Commentary	
This treaty protects the right to social and medical assistance for nationals of the contracting parties (i.e. Council of Europe members). It does not extend this protection to non-European immigrants. It contains no reference to interpreters, intercultural mediators or other equivalent figures in healthcare. No monitoring body oversees this Convention.	

Name	European Social Charter (ETS No. 035)
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 18/10/1961. Entry into force: 1/7/1954 (2 ratifications). Spain signed the Charter on 27/4/1978 and ratified it on 6/5/1980. Entry into force on 5/6/1980. Spain ratified the Revised European Social Charter on 17/05/2021
Text	
Article 13 states: <i>The right to social and medical assistance.</i> With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake: 1. To ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition; 2. To ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights; 3. To provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;	

4. To apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to **nationals of other Contracting Parties** lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

Commentary

The ESC protects the right to social and medical assistance. The contracting parties must apply its provisions "on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories" and so it excludes nationals of non-Contracting Parties. Neither the ESC nor the European Convention on Social and Medical Assistance mentioned in article 13 contains a reference to a linguistic intermediary figure. Such a role has emerged in the monitoring of this treaty, but only in relation to legal proceedings not social and medical assistance.

The European Committee of Social Rights (former Committee of Independent Experts) examines the reports submitted by the parties and decides whether the countries concerned are fulfilling their obligations under the Charter. According to article 19.7, the contracting parties undertake to provide migrant workers lawfully within their territories "treatment not less favourable than that of their own nationals in respect of legal proceedings". In its conclusions, the Committee ruled that "whenever the interests of justice so require, a migrant worker must have the free assistance of an interpreter if they cannot properly understand or speak the national language used in the proceedings and have any necessary documents translated" (Conclusions 2011, Statement of Interpretation on Article 19§7).

Related references:

Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". *International Journal of Human Rights in Healthcare*. Vol. 10 No. 4, pp. 228-238. <https://doi.org/10.1108/IJHRH-01-2017-0004>

González Núñez, Gabriel. 2012. *Translation and Healthcare in Europe: An Overview of Europe's Legal Framework*. CETRA Paper. KU Leuven, Belgium.

McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". *Ethnicities*. Vol. 17 No. 5, pp. 603–626.

Name	European Convention on the Legal Status of Migrant Workers (ETS No. 093)
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 24/11/1977. Entry into force: 1/5/1983 (5 ratifications). Spain signed the Convention on 24/11/1977 and ratified it on 6/5/1980. Entry into force on 1/5/1983
Text	Article 19 states: <i>Social and Medical Assistance</i> Each Contracting Party undertakes to grant within its territory, to migrant workers and members of their families who are lawfully present in its territory, social and medical assistance on the same basis as nationals in accordance with the obligations it has assumed by virtue of other international agreements and in particular of the European Convention on Social and Medical Assistance of 1953.

Commentary
This treaty protects the right of migrant workers to social and medical assistance. Neither this treaty nor the European Convention on Social and Medical Assistance of 1953 mentioned in article 19 contain a reference to a linguistic intermediary figure. Paragraph 79 of the Explanatory Report to this Convention makes it clear that "article 19 imposes no obligation on States other than the obligations assumed under international instruments". Related references: Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". <i>International Journal of Human Rights in Healthcare</i>. Vol. 10 No. 4, pp. 228-238. https://doi.org/10.1108/IJHRH-01-2017-0004 González Núñez, Gabriel. 2012. <i>Translation and Healthcare in Europe: An Overview of Europe's Legal Framework</i>. CETRA Paper. KU Leuven, Belgium. McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". <i>Ethnicities</i>. Vol. 17 No. 5, pp. 603–626. Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". <i>European Journal of Health Law</i>. Vol. 19 No. 4, pp. 333-353.

Name	<u>Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164) a.k.a. Oviedo Convention</u>
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 4/4/1997. Entry into force: 1/12/1999 (5 ratifications). Spain signed the Convention on 4/4/1997 and ratified it on 1/9/1999. Entry into Validity on 1/1/2000
Text	The convention states: Article 3 – <i>Equitable access to health care</i> Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality. Article 5 – <i>General rule</i>. An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.
Commentary	

This treaty protects human rights and dignity regarding biomedicine. Although every person has the right to give free and informed consent to any medical intervention, the treaty does not address the issue of how language barriers are to be overcome when the person concerned does not speak or understand the language in which the information is provided.

The Steering Committee on Bioethics (CDBI), or any other committee designated by the Committee of Ministers or the Parties, may request the European Court of Human Rights to give advisory opinions on legal questions concerning the interpretation of the Convention. For Phelan (2012: 9), "there is no specific mention of interpreters in the Convention but for its provisions to be implemented, interpreters are required for people who do not speak the language".

Related references:

Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". *International Journal of Human Rights in Healthcare*. Vol. 10 No. 4, pp. 228-238. <https://doi.org/10.1108/IJHRH-01-2017-0004>

González Núñez, Gabriel. 2012. *Translation and Healthcare in Europe: An Overview of Europe's Legal Framework*. CETRA Paper. KU Leuven, Belgium.

McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". *Ethnicities*. Vol. 17 No. 5, pp. 603–626.

Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". *European Journal of Health Law*. Vol. 19 No. 4, pp. 333-353.

Name	European Charter for Regional or Minority Languages (ETS No. 148)
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 5/11/1992. Entry into force: 01/03/1998 (5 ratifications). Spain signed the Charter on 5/11/1992 and ratified it on 9/4/2011. Entry into force on 1/8/2001
Text	
The Charter states:	
Article 1 – <i>Definitions</i> For the purposes of this Charter: a "regional or minority languages" means languages that are: i) traditionally used within a given territory of a State by nationals of that State who form a group numerically smaller than the rest of the State's population; and ii) different from the official language(s) of that State; it does not include either dialects of the official language(s) of the State or the languages of migrants;	
Article 13 – <i>Economic and social life</i> [...] 2 With regard to economic and social activities, the Parties undertake, in so far as the public authorities are competent, within the territory in which the regional or minority languages are used, and as far as this is reasonably possible: [...] to ensure that social care facilities such as hospitals, retirement homes and hostels offer the possibility of receiving and treating in their own language persons using a regional or minority language who are in need of care on grounds of ill-health, old age or for other reasons.	

Commentary
This treaty protects regional or minority languages traditionally used in the countries of the Contracting Parties. The Charter contains various references to interpreters, but none of these is related to healthcare settings. As it stands, the Charter cannot be used to claim a right to interpretation for languages other than regional or minority languages, in healthcare or in any other context. Enforcement of the Charter is under the control of a Committee of Experts which periodically examines reports presented by the Parties. In some of its evaluation reports, the healthcare interpreter is mentioned (for instance, 7th ER on Finland, adopted 7 March 2024, para. 90: "the Act on Organising Healthcare and Social Welfare Services ensures that interpretation in Sami must be provided only if a [Sami-speaking] health or social service professional is not available. The use of an interpreter to help a Finnish speaking health or social sector professional can lead to unpleasant situations, when sensitive and personal matters are discussed. In order to avoid such situations, Sami patients prefer to waive their right to use Sami"). Related references: Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". <i>International Journal of Human Rights in Healthcare</i>. Vol. 10 No. 4, pp. 228-238. https://doi.org/10.1108/IJHRH-01-2017-0004 González Núñez, Gabriel. 2012. <i>Translation and Healthcare in Europe: An Overview of Europe's Legal Framework</i>. CETRA Paper. KU Leuven, Belgium. McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". <i>Ethnicities</i>. Vol. 17 No. 5, pp. 603–626. Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". <i>European Journal of Health Law</i>. Vol. 19 No. 4, pp. 333-353.

Name	Framework Convention for the Protection of National Minorities (ETS No. 157)
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Opening of the treaty: 1/2/1995. Entry into force: 1/2/1998 (12 ratifications). Spain signed the Framework Convention on 1/2/1995 and ratified it on 1/9/1995. Entry into force: 1/2/1998
Text	
Article 15 states:	
The Parties shall create the conditions necessary for the effective participation of persons belonging to national minorities in cultural, social and economic life and in public affairs, in particular those affecting them.	
Commentary	

This treaty applies to (autochthonous) "national minorities" (which are not defined either in the text or in the explanatory report) and not to immigrants. It contains no reference to a linguistic intermediary figure in healthcare.

Enforcement of the Framework Convention is under the control of an Advisory Committee which periodically examines reports presented by the Parties. In its Thematic Commentary on the language rights of persons belonging to national minorities (2012), the Advisory Committee mentions medical interpretation in connection with article 15 (participation in cultural, social, and economic life). According to the Committee, "medical and administrative staff employed in health services and care of the elderly in areas inhabited in substantial numbers by persons belonging to national minorities should be able to provide services in minority languages". Additionally, "the employment of health mediators or assistants belonging to national minorities (or at least interpreters speaking the minority language) can contribute to improved communication".

Related references:

Advisory Committee on The Framework Convention for the Protection of National Minorities (2012). *Thematic Commentary No. 3. The Language Rights of Persons Belonging to National Minorities under the Framework Convention*. ACFC/44DOC(2012)001 rev

Dalton-Oates, Bradley. 2017. "Medical translation: the neglected human right". *International Journal of Human Rights in Healthcare*. Vol. 10 No. 4, pp. 228-238. <https://doi.org/10.1108/IJHRH-01-2017-0004>

González Núñez, Gabriel. 2012. *Translation and Healthcare in Europe: An Overview of Europe's Legal Framework*. CETRA Paper. KU Leuven, Belgium.

McDermott, Philip. 2017. "Language rights and the Council of Europe: A failed response to a multilingual continent?". *Ethnicities*. Vol. 17 No. 5, pp. 603–626.

Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". *European Journal of Health Law*. Vol. 19 No. 4, pp. 333-353.

2.2. Non-binding texts

Name	Recommendation (1997)5 on the protection of medical data
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Adopted by the Committee of Ministers on 13 February 1997 at the 584th meeting of the Ministers' Deputies
Text	
The document states:	
8. <i>Rights of the data subject. Rights of access and of rectification</i> 1. Every person shall be enabled to have access to his/her medical data, either directly or through a health-care professional or, if permitted by domestic law, a person appointed by him/her. The information must be accessible in understandable form.	

Commentary
This non-binding Recommendation is meant to protect the right to privacy during the collection and processing of medical data. Although every person is entitled to have access to his or her medical data “in understandable form”, the Recommendation does not address the issue of how language barriers are to be overcome when the person concerned does not understand the language in which the medical data is provided. Phelan's (2012) observations on the Oviedo Convention can be applied to this Recommendation as well. For its provision on "understandable" information to be implemented, translation or interpreting seems to be required for people who do not speak the local official language(s).

Name	Recommendation (2006)18 on health services in a multicultural society
Scope	Europe
Issuing body	Council of Europe
Validity / Publication	Adopted by the Committee of Ministers on 8 November 2006 at the 979th meeting of the Ministers' Deputies
Text	
The document states: Article 2: <i>Access to health care</i> 1. Equitable access to health care services of appropriate quality should be promoted and monitored. In order to achieve the objective of equal access to health care, member states should develop strategies for eliminating practical barriers for multicultural populations to access health care, including linguistic and cultural hurdles. Article 3. <i>Improving quality of communication – Language barriers</i> 1. Removing barriers to communication is one of the most urgent, evident and straightforward areas in which interventions are needed; a general policy that facilitates the learning of the language of the host country for ethnic minority members and immigrants should also be developed. 2. Professional interpreters should be made available and used on a regular basis for ethnic minority patients who need them, whenever appropriate. 3. Linguistic diversity should be taken into account, including appropriate legal measures. 4. Health care professionals should be made aware that linguistic barriers have negative effects on the quality of health care. They should be trained to work together with interpreters in an effective way. 5. Training programmes are needed for interpreters working within the field of health care. Besides basic interpreting skills, these should include medical terminology, courses on the structure of the health care system, ethical interpreting practice, culture competence and culture brokerage. Interpreters working in mental health care settings ought to be specially trained to perform their tasks in the context of psychotherapeutic or psychiatric interventions. Public health authorities should be encouraged to monitor the quality of medical interpreter services for ethnic minorities.	
Commentary	
This non-binding Recommendation is meant to guarantee equitable access to healthcare in a multicultural society, i.e. a society in which various “ethnic” groups coexist, including immigrants. To overcome cultural and language barriers, the Recommendation contains an explicit reference to professional interpreters, training of healthcare professionals to work	

with interpreters, ad hoc training programs for interpreters, and the need for public health authorities to monitor the quality of the interpreting services provided.

Related references:

González Núñez, Gabriel. 2012. *Translation and Healthcare in Europe: An Overview of Europe's Legal Framework*. CETRA Paper. KU Leuven, Belgium.

Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". *European Journal of Health Law*. Vol. 19 No. 4, pp. 333-353.

3. EUROPEAN NORMS (EUROPEAN UNION)

Name	<u>European Charter of Fundamental Rights</u>
Scope	European Union
Issuing body	European Parliament, the Council and the Commission
Validity / Publication	The European Charter of Fundamental Rights was drafted in 2000 and became legally binding on the EU with the entry into force of the Treaty of Lisbon, in December 2009. Since then, the Charter has the same legal standing as "the Treaties" (the Treaty of the European Union and the Treaty on the Functioning of the European Union)
Text	
The charter states: Article 3 – <i>Right to the integrity of the person</i> [...] 2. In the fields of medicine and biology, the following must be respected in particular: a) the free and informed consent of the person concerned, according to the procedures laid down by law. Article 21 – <i>Non-discrimination</i> Any discrimination based on any ground, such as race, sex, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited. Article 35 – <i>Health care</i> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.	
Commentary	
This Charter protects fundamental rights across European Union Member States. This includes the right to free and informed consent in the fields of biology and medicine (see the Oviedo Convention above), the prohibition of discrimination (including on the basis of language), and the right to preventive healthcare and to health protection. The Charter contains no reference to a linguistic intermediary figure as a means to overcome language barriers and ensure the enjoyment of the rights protected therein, not even in the case of the judiciary (articles 47-50). Regarding article 3, Phelan (2012: 12) considers that respecting informed consent implies "the use of interpreters and the translation of informed consent forms where people do not speak the language of the country in which they find themselves". Regarding article 35, Phelan (2012: 13) considers that this "high level of human health protection" could include the provision of interpreters to persons who need them to access healthcare. The Fundamental Rights Agency (FRA) was established in 2007 to collect evidence about fundamental rights in the EU, to advise the EU institutions on how to improve the situation, and to inform people about their rights (Council Regulation (EC) No 168/2007). Although the FRA is not a monitoring body, it keeps a "Charterpedia" database that includes a large spectrum of information on the Charter, including case law by national courts that refers to the Charter.	

Related references:

Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". *European Journal of Health Law*. Vol. 19 No. 4, pp. 333-353.

Name	Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare
Scope	European Union
Issuing body	European Parliament and Council
Validity / Publication	
Text	
The Directive states: Article 4 <i>Responsibilities of the Member State of treatment</i> [...] 2. The Member State of treatment shall ensure that: (a) patients receive from the national contact point referred to in Article 6, upon request, relevant information on the standards and guidelines referred to in paragraph 1(b) of this Article, including provisions on supervision and assessment of healthcare providers, information on which healthcare providers are subject to these standards and guidelines and information on the accessibility of hospitals for persons with disabilities; (b) healthcare providers provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability. To the extent that healthcare providers already provide patients resident in the Member State of treatment with relevant information on these subjects, this Directive does not oblige healthcare providers to provide more extensive information to patients from other Member States. [...] (e) the fundamental right to privacy with respect to the processing of personal data is protected in conformity with national measures implementing Union provisions on the protection of personal data, in particular Directives 95/46/EC and 2002/58/EC; (f) in order to ensure continuity of care, patients who have received treatment are entitled to a written or electronic medical record of such treatment, and access to at least a copy of this record in conformity with and subject to national measures implementing Union provisions on the protection of personal data, in particular Directives 95/46/EC and 2002/58/EC. [...] 5. This Directive shall not affect laws and regulations in Member States on the use of languages. Member States may choose to deliver information in other languages than those which are official languages in the Member State concerned.	
Commentary	

This Directive aims to establish rules for facilitating access to safe and high-quality cross-border healthcare in the European Union. It applies to individual patients who decide to seek healthcare in a Member State other than the Member State of affiliation. Although the Directive refers to the information which is to be provided to such patients to make an informed choice and their entitlement to a written or electronic medical record of the treatment they have received, it does not foresee any linguistic obligations on the part of Member States and does not hint at any linguistic intermediary figure in relation to the process of providing information or delivering records. The possibility of delivering information in other languages than the official one(s) is left to the discretion of each Member State.

A draft version of this Directive included a paragraph on equity and non-discrimination as responsibilities pertaining to the authorities of the Member State providing treatment. However, it was not included in the final version. According to Phelan (2012: 16), “the omission of the non-discrimination clause means that interpreters will not necessarily be provided in the country of treatment. Travel and accommodation costs do not have to be reimbursed. It is likely that only patients who are well off and fluent in a second language will be able to avail of the rights under this directive”.

Related references:

Phelan, Mary. 2012. "Medical Interpreting and the Law in the European Union". *European Journal of Health Law*. Vol. 19 No. 4, pp. 333-353.

4. SPANISH NORMS

Name	Spanish Constitution (Constitución Española)
Scope	España
Issuing body	Cortes Generales
Validity / Publication	29 th of December 1978
Text	
Article 43 states: 1. The right to protection of health is recognized. 2. It is the responsibility of public authorities to organize and safeguard public health through preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all in this regard.	
Commentary	
Paragraph 1 of Article 43 provides for the right of all citizens to health protection. In this context, this right must be understood as being effectively realized through a series of measures, such as the right to understandable health information. Therefore, linguistic comprehension in the healthcare setting is essential to fulfilling the constitutional right to protect the health of all people. Related references: González-Trevijano (2021). <i>El derecho a la salud, una perspectiva de derecho comparado</i>. Unidad Biblioteca de Derecho Comparado. http://www.europarl.europa.eu/thinktank	

Name	Act 41/2002, of 14 November, on Patient Autonomy and on Rights and Obligations regarding Clinical Information and Documentation (Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica).
Scope	España
Issuing body	Cortes Generales
Validity / Publication	16 th of May 2003
Text	
This Act states: Article 2 2.2 Any action in the field of healthcare generally requires the prior consent of patients or users. Consent, which must be obtained after the patient receives adequate information, shall be given in writing in the cases provided for by law. Article 4 1. Information, which as a general rule will be provided verbally with a record kept in the medical history, shall include, at a minimum, the purpose and nature of each intervention, its risks, and its consequences. 2. Clinical information shall be communicated to the patient in a comprehensible manner and in a way that is appropriate to their needs and shall help them make decisions in accordance with their own free will.	

Article 5

Right to clinical information. When the patient, in the opinion of the attending physician, lacks the **capacity to understand the information** due to their physical or mental condition, the information will be made available to the people connected to them by family or de facto relationships.

Article 8. Informed consent.

1. Any medical procedure requires the **free and voluntary consent of the patient**, once they have received the information provided for in Article 4 and have evaluated the options relevant to their case.

2. **Consent shall be verbal** as a general rule. However, **it must be given in writing in the following cases**: surgical intervention, invasive diagnostic and therapeutic procedures, and, in general, the application of procedures that pose risks or disadvantages with a foreseeable negative impact on the patient's health.

Article 10.2

The **attending physician must weigh in each case** that the more uncertain the outcome of an intervention, the more necessary the patient's prior written consent becomes.

Commentary

This Act aims to promote the patient's right to be informed in a way that is understandable, but it does not address how this process unfolds if the patient does not understand one of the official languages, nor does it explicitly refer to interpreters, intercultural mediators or equivalent figures. Hence, while the Act requires that information be conveyed in a way that is understandable, it does not specify how to ensure understanding if the patient does not understand one of the official languages. This leads us to interpret that it is the duty of the healthcare administration to provide the adequate means to ensure understanding, such as interpreters or the translation of documentation into other languages.

Related references:

González-Trevijano (2021). *El derecho a la salud, una perspectiva de derecho comparado*. Unidad Biblioteca de Derecho Comparado. <http://www.europarl.europa.eu/thinktank>

Parejo G., María José (2018). *Consentimiento informado y autonomía de paciente: Su aplicación en el ocaso de la vida en la España y Europa del siglo XXI*. Instituto de Investigación Jurídica de la Universidad Nacional Autónoma de México.

Name	Act 14/1986, of 25 April, on Health (General Health Act) (Ley 14/1986, de 25 de abril, General de Sanidad)
Scope	España
Issuing body	Cortes Generales
Validity / Publication	25 th of April 1986
Text	
This Act states:	
Article 1.	

1. The purpose of this Law is to provide general regulation of all actions that enable the realization of the **right to health protection** recognized in Article 43 and related provisions of the Constitution.
2. All Spanish **nationals and foreign citizens who have established residence in the national territory** are entitled to the right to health protection and health care.
3. **The Autonomous Communities may enact implementing and supplementary regulations** for this Act in the exercise of the powers conferred upon them by their respective Statutes of Autonomy.

Article 9.

Public authorities must **inform users** of public health care services, or services linked to the public health care system, **of their rights and duties**.

Article 10.

Everyone has the following rights with respect to the various public health administrations:

1. **To respect for their person, human dignity, and privacy**, without being discriminated against on the basis of racial or ethnic origin, gender, sexual orientation, disability, or any other personal or social circumstance.
2. **To inform about the health services** they can access and the requirements for using them. This information must be provided in appropriate formats, following the guidelines set by the principle of design for all, so that it is accessible and understandable to people with disabilities.

Article 12.

Public authorities shall direct their health spending policies toward **correcting health inequalities and ensuring equal access** to public health services throughout Spanish territory, in accordance with the provisions of Articles 9.2 and 158.1 of the Constitution.

Article 16.

The rules governing the use of health services shall be the same for everyone, regardless of the circumstances under which they access such services.

Article 46.

The fundamental characteristics of the National Health System are:

- a) The extension of its services to the **entire population**.
- b) An appropriate **organizational structure to provide comprehensive health care**, encompassing both health promotion and disease prevention as well as treatment and rehabilitation.
- e) The provision of comprehensive health care, **ensuring high levels of quality** that are duly evaluated and monitored.

Article 56.

2.a) In the field of primary health care, through teamwork approaches, care shall be **provided to individuals, families, and communities**; programs shall be developed to carry out functions of health promotion, prevention, treatment, and rehabilitation, utilizing both basic resources and primary care support teams.

Commentary

The General Health Act, particularly Article 10, aims to protect the rights of users of the healthcare system. At no point does it refer to a specific type of language intermediary. However, we note that Paragraph 5 (which has been repealed) clearly refers to language

rights: “The right of the patient—and their family members or close relatives—to receive, in terms they can understand, complete and ongoing information, both verbal and written, regarding their condition, including diagnosis, prognosis, and treatment options.” This means that healthcare professionals must ensure that the patient understands the information provided to them, whether in writing or verbally, regarding their health condition. If the patient is not fluent in one of the official languages, appropriate measures must be taken to ensure that the patient understands the information. The Act does not explicitly refer to this, but it arguably follows from the duty to ensure that the information is understood. We believe that Section 5, although repealed, falls within the framework of the rights to information and understandable communication, which require healthcare professionals to ensure that patients understand the information communicated to them.

According to Abril (2006: 130), “although the laws cited [the Constitution, the General Health Act, and the Immigration Act] make no explicit reference to the right to an interpreter when accessing public healthcare services, there are provisions in current legislation that, in the case of foreign nationals, are difficult to comply with without the assistance of an interpreter.” According to Abril (2006: 131, our translation), Article 10 of this Act implies the need for communication between the healthcare system and users, which can hardly be carried out satisfactorily if users are not fluent in the official language(s).

Related references:

Abril Martí, María Isabel (2006). La interpretación en los Servicios Públicos: Caracterización como género, contextualización y modelos de formación. Hacia unas bases para el diseño curricular. Tesis doctoral. Granada: Universidad de Granada.
<http://hera.ugr.es/tesisugr/16235320.pdf>

González-Trevijano, Pedro (2021). *El derecho a la salud, una perspectiva de derecho comparado*. Unidad Biblioteca de Derecho Comparado.
<http://www.europarl.europa.eu/thinktank>

Name	Act 16/2003, of 28 May, on Cohesion and Quality of the National Health System (Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud)
Scope	España
Issuing body	Spanish Parliament
Validity / Publication	30 th of May 2003
Text	
This Act states:	
Article 1. The purpose of this law is to establish the legal framework for coordination and cooperation among public health authorities, in the exercise of their respective powers, in order to ensure equity, quality, and social participation in the National Health System, as well as the system’s active collaboration in reducing health inequalities. Article 3. Persons Entitled to the Right to Health Protection and Health Care. 1. All persons of Spanish nationality and foreign nationals who are permanently resident in Spanish territory are entitled to the right to health protection and health care.	

Article 3-ter: Health Protection and Health Care for Foreign Nationals Who Are in Spain but Do Not Have Legal Residence in Spanish Territory.

1. **Foreign nationals who are not registered or authorized as residents in Spain are entitled to health protection and health care** under the same conditions as Spanish nationals, as established in Article 3.1

Article 7. List of Benefits Provided by the National Health System.

2. Individuals receiving these benefits shall **have the right to health and care-related information and documentation** in accordance with Law 41/2002, of November 14, the basic law regulating patient autonomy and rights and obligations regarding clinical information and documentation.

Article 28 of the Law establishes that the autonomous communities must **guarantee the quality of health care services** through independent audits. In addition, health care institutions shall promote the humanization of care and the improvement of administrative accessibility.

Within the Interterritorial Council of the National Health System, decisions will be made regarding the designation of referral services, the necessary number of such services, and their strategic location within the National Health System, using a comprehensive planning approach to address those conditions that require a concentration of diagnostic and therapeutic resources in order to ensure the quality, safety, and efficiency of care.

Commentary

This Law seeks to ensure that all Spanish nationals and residents have access to quality healthcare, regardless of their place of residence.

. In this context, the Act recognizes the right to receive understandable information, but does not explicitly address how this is achieved in cases where the patient does not understand one of the official languages. Nevertheless, we can infer that the right to understandable information in healthcare must be guaranteed through standard information mechanisms. Therefore, there is a need for interpreters and/or translations of informative documents into the languages of patients who do not understand one of the official languages.

Related references:

Montalvo-Jääskeläinen, F., Moreno-Alemán, J. y Santamaría-Pastor, M. (2005). Incidencia de la Ley de autonomía del paciente en la gestión del riesgo sanitario. Nuevas perspectivas legales de la información y la historia. *Revista de Calidad Asistencial*, 20 (2), 100-109.

[10.1016/S1134-282X\(08\)74729-8](https://doi.org/10.1016/S1134-282X(08)74729-8)

Name	<u>Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social</u> (Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social)
Scope	España
Issuing body	Cortes Generales
Validity / Publication	1 st of February 2000
Text	
This Constitutional Law states:	

Article 3. Rights of Foreign Nationals and Interpretation of the Provisions. 1. Foreign nationals shall enjoy in Spain the rights and freedoms recognized in Title I of the Constitution, under the terms established in international treaties, in this Act, and in the laws regulating the exercise of each of those rights. As a general interpretive principle, it shall be understood that foreign nationals exercise the rights recognized to them by this Act on an equal footing with Spanish citizens. Article 6. Public Participation. 2. Resident foreign nationals who are registered in a municipality have all the rights established in this regard by the legislation governing local government, and may be heard on matters affecting them in accordance with the applicable regulations. Article 12. Right to Health Care. Foreign nationals have the right to health care under the terms set forth in current health care legislation. Article 62 bis. Rights of Detained Foreign Nationals. A foreign national has the right to: “d) Receive adequate medical and health care and be assisted by the center’s social services.” h) To be assisted by an interpreter if they do not understand or speak Spanish, free of charge if they lack the financial means. Article 64. b) The provision of emergency health care and basic treatment for illnesses.
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Commentary
The “Immigration Law” is designed to regulate the rights of foreign nationals in Spain, and it also includes guidelines regarding social integration. While it is true that the Law does not explicitly address healthcare, it does include important sections on healthcare for foreign nationals, as well as on their right to receive understandable information in this context. The Law stipulates that foreign nationals must be informed of their rights and obligations, particularly in administrative matters. Although it generally refers to administrative and legislative procedures, the Law also covers access to information in the public healthcare system. However, it does not specify how the foreign patient’s understanding of such information should be ensured if they do not speak one of the official languages. Related references: Vázquez, María Luis; Terraza-Núñez, Rebeca; S-Hernández, Silvia; Vargas, Ingrid; Bosh, Lola; González, Andrea; Pequeño, Sandra; Raquel, Cantos; Ignacio Martínez, Juan; Andrés López, Luis (2013). Are migrants health policies aimed at improving access to quality healthcare? An analysis of Spanish policies. <i>Health Policy</i>, 113 (3) 236-246. https://doi.org/10.1016/j.healthpol.2013.06.007 Soriano-Miras, Rosa M. (2011). Análisis sociológico de la Ley 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. Sus reformas (8/2000, 11/2003, 14/2003, 2/2009) y su implicación social, <i>Papers</i>, 96 (3), 683-705. https://doi.org/10.5565/rev/papers/v96n3.141

Name	<u>Ley 27/2007, de 23 de octubre, por la que se reconocen las lenguas de signos españolas y se regulan los medios de apoyo a la comunicación oral de las personas sordas, con discapacidad auditiva y sordociegas</u> (Ley 27/2007, de 23 de octubre, por la que se reconocen las lenguas de signos
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	españolas y se regulan los medios de apoyo a la comunicación oral de las personas sordas, con discapacidad auditiva y sordociegas)
Scope	España
Issuing body	Spanish Parliament
Validity / Publication	25 th of October 2007
Text	
This Act states: Article 10c The competent public authorities shall promote the provision of sign language interpretation services in Spanish Sign Language and/or in the sign languages of the autonomous communities, if any, upon prior request, for users who need them at healthcare centers that serve people who are deaf, hard of hearing, or deafblind. They shall also adopt the necessary measures to ensure that health-related information and prevention campaigns are accessible to people who are deaf, hard of hearing, or deafblind in Spanish sign language.	
Commentary	
Article 10c of this Act recognizes the sign languages of Spain and regulates oral communication support for people who are deaf, hard of hearing, and deafblind. It is the only legal text that explicitly and clearly refers to the right to interpreting for people who are hard of hearing and deafblind in healthcare settings. Public administrations must ensure the provision of sign language interpreting services in state and regional healthcare facilities. Furthermore, the same text reflects the need to take appropriate measures to ensure that information and prevention campaigns are universally accessible to the aforementioned individuals with disabilities, in official or co-official sign languages. However, despite guaranteeing the right to interpreting, the Act itself includes a condition that negatively affects the provision of interpreting services, which are only offered “if requested in advance.” This stipulation can create communication barriers if users are unaware of this right or are unable to make the relevant request in advance. For this reason, the autonomous communities differ in their interpretation of the scope of this clause. Furthermore, this Act—included since 2023 in the General Provisions of the Ministry of Social Rights and the 2030 Agenda—echoes Article 43 of the Constitution and Ley 14/1986, de 25 de abril, General de Sanidad (General Health Act), which establish the right to health and its protection. With this, we aim to draw attention to the existence of a disparity in the existing laws—and particularly the rights they entail—with respect to certain individuals. While we applaud the legal recognition of the specific communication needs of people with hearing impairments and those who are deaf-blind, in our view, this Law should serve as precedent for the need to legally enshrine the right to an interpreter in the case of other groups who also have difficulties accessing healthcare services due to language barriers. Related references: Belda Pérez-Pedrero, E. y Sierra Fernández, F. J. (2022). <i>Informe de valoración jurídica de la Ley 27/2007 tras 15 años</i>. Centro de Normalización Lingüística de la Lengua de Signos Española (CNLSE). Informe Valoración jurídica Ley 27/2007	

Castaño Calle, R. (2010). *El reconocimiento de las lenguas de signos españolas como instrumento de comunicación para la comunidad de personas sordas*. *Hekademos: Revista Educativa Digital*, 5, 23–44.

https://www.hekademos.com/hekademos/media/articulos/05/02_Las_lenguas_de_signo_e_sp.pdf

5. CATALAN NORMS

5.1. Binding texts

Name	Act No. 7, of 18th April 1983, on Language Normalization in Catalonia (Llei 7/1983, de 18 d'abril, de normalització lingüística a Catalunya)
Scope	Catalonia
Issuing body	Catalan Parliament
Validity / Publication	Since 23 April 1983 until 9 January 1998
Text	
Article 2 of the Act states that:	
(1) Catalan is the native language of Catalonia. All citizens have the right to know it and to express themselves in it, both orally and in writing, in public and private interactions, whether official or unofficial. This right specifically includes the ability to: address the administration, public bodies, and both public and private companies in Catalan, either orally or in writing; express themselves in Catalan in any meeting; conduct professional, labor, political, and union activities in Catalan; and receive education in Catalan. (2) Expressions of thought or will, as well as oral or written acts, whether public or private, cannot lead to any form of discrimination in Catalonia if they are expressed wholly or partially in the Catalan language. These expressions must have the same legal effects as if they were expressed in Spanish and, therefore, in terms of their validity, cannot be subject to any difficulties, delays, translation requirements, or any other demands. (3) Under no circumstances may anyone be discriminated against based on the official language they use.	
Commentary	
This Act protects the right of any citizen of Catalonia to express themselves in Catalan, both orally and in writing, in their daily life and in official or unofficial public events. There is no explicit reference in the text to a language intermediary figure, nor can this figure be implicitly inferred. The communication needs of those citizens who do not speak or understand any of the official languages of Catalonia (Catalan, Spanish and Aranese) are not taken into account. Although this Act does not contain any specific provisions on healthcare, Article 2 covers healthcare in that it refers to 'daily life'. This Act is no longer in effect. It was replaced by Act No. 1, of January 7, 1998, on language policy. Related references: Bastardas i Boada, A. (1984). Integració dels immigrants i legislació lingüística a Catalunya. <i>Revista de llengua i dret</i>, nº 4, 59-72.	

Name	Act No. 1, of 7th January 1998, on linguistic policy (Llei 1/1998, de 7 de gener, de política lingüística)
Scope	Catalonia
Issuing body	Catalan Parliament

Validity / Publication	Since 10 January 1998 (in force)
Text	
Article 4 of this Act states: (1) In accordance with Article 3 of the Statute of Autonomy, and within the framework of an active policy by the Generalitat to create conditions that enable full equality in linguistic rights and duties, everyone in Catalonia has the right to: a) Know both official languages. b) Express themselves in either of the two official languages, orally and in writing, in public and private interactions. c) Be attended to in either of the two official languages under the terms established by this Law. d) Freely use either of the two official languages in all areas. e) Not be discriminated against based on the official language they use. (2) Everyone has the right to appeal to the courts and tribunals to obtain judicial protection of their right to use their language. (3) Everyone has the right to address the Administration of the Generalitat and the Ombudsman (Síndic de Greuges), requesting that, within their competencies, they take action to specifically guarantee their linguistic rights.	
Commentary	
As in the previous text, this Act protects the right of any citizen in Catalonia to express themselves in Catalan, both verbally and in writing, in their everyday lives and in public acts, as well as public and private interactions. No explicit reference is made to linguistic figures, but many references to written translation can be found, though always in relation to Catalan and Spanish. The communication needs of those who do not speak or understand either of these two official languages of Catalonia is, as in the previous case, not considered. Although there is no specific provisions on healthcare in this Act, it is indirectly referred to in Article 4, which provides for everyone's right attended to in either of the two official languages and to freely use either of the two official languages in all areas. Related references: Pradilla Cardona, M. À. (2022). <i>Catalan Sociolinguistics: State of the Art and Future Challenges</i>. John Benjamins Publishing Company. https://doi.org/10.1075/ivitra.32	

Name	Organic Act 6/2006, of 19th July, on the Reform of the Statute of Autonomy of Catalonia (Organic Act 6/2006, of 19 th July, on the Reform of the Statute of Autonomy of Catalonia)
Scope	Catalonia
Issuing body	Spanish Parliament
Validity / Publication	Since 9 August 2006 (in force)
Text	
Article 33, on Linguistic rights in dealings with Public Administration bodies and State institutions, states: 1. Citizens have the right to linguistic choice. In their relations with institutions,	

organizations and Public Administration bodies in Catalonia, each individual has **the right to use the official language of his or her choice**. This right binds **public institutions**, organizations and administration bodies, including the electoral administration in Catalonia, and, in general, any private bodies depending on them when exercising public functions.

Commentary

This Constitutional Law protects the right for any citizen in Catalonia to choose either Catalan or Spanish as their language of communication in their dealings with the public administration. There is no explicit reference to any linguistic figure and the communication need of those who do not speak or understand any of the official languages of Catalonia is not considered. The Statute makes no mention of other languages other than the official ones, together with a third language (that is, English) that public authorities must ensure students have sufficient knowledge of by the end of compulsory education (article 44.2), and Catalan Sign Language, the use of which shall be guaranteed in conditions of equality (article 50.6).

Related references:

Aragall, X., & Aubarell, G. (2015). *El desenvolupament de l'estatut en matèria d'immigració i les dinàmiques de gestió de les migracions en l'àmbit euromediterrani*. 30, 83-94.

Name	Act No. 17, of 3rd June 2010, on Catalan Sign Language (Llei 17/2010, del 3 de juny, de la llengua de signes catalana)
Scope	Catalonia
Issuing body	Catalan Parliament
Validity / Publication	Since 10 July 2010 (in force)

Text

Article 3 states:

Sign language interpreter and guide-interpreter: Professionals who interpret and translate information expressed in Catalan Sign Language into spoken and written languages, and vice versa. In the case of deafblind individuals, this also refers to the various communication support systems and methods they use, which provide them with contextual information about their surroundings and act as a guide in mobility situations.

Article 4:

The use of sign language in public services. Deaf and deafblind sign language users are guaranteed **the right to use Catalan Sign Language within the scope of Catalan public administrations**, in accordance with the regulations referenced in the first additional provision.

Commentary

This Act protects the right for deaf and deafblind sign language users to use this language to communicate in any context involving the Catalan public administration. In this case, there is an explicit reference to sign language interpreters and guide-interpreters, but only to define their role, and without stating any official use for them. Languages other than Catalan Sign Language are not considered.

Related references:

Pere Mas, Jordi (2021). Approach to the Status and Management of Languages in the Catalan Public Health Care System. *Linguistic Minorities and Society*, 15-16, 167-197.

Name	Decree 209/2023, of 28 November, approving the Accessibility Code of Catalonia (Decree 209/2023, of 28 November, approving the Accessibility Code of Catalonia)
Scope	Catalonia
Issuing body	Catalan Parliament
Validity / Publication	Since the 1 st of March 2024 (in force)
Text	
The decree states:	
Article 119.5: Public services must adopt measures to guarantee communication and allow participation and access to regular information for people with sensory, intellectual and/or physical disabilities through the simultaneous use of various communication channels that meet the criteria indicated in section B of Annex 5a, and the adoption of technologies that improve accessibility. This aspect is especially relevant in areas such as justice and includes requesting information, processing complaints and participating in hearings. Article 120.4: Personal assistants, communication mediators, sign language interpreters, transcribers or any other professional who is providing a personal support service to a person with a disability in the development of activities of daily living, must be able to accompany the person with a disability to personal care services, both medical and legal or others, whenever the person requests it.	
Commentary	
This Decree regulates accessibility in all kinds of public services for people with sensory, intellectual and/or physical disabilities. It guarantees the right to communication, participation and access to public services (healthcare included) , making explicit reference to communication mediators and sign language interpreters. It is worth observing that the provision of various communication channels is only for people with disabilities. Similarly, the Decree's concept of accessibility does not include other groups of people that might experience communication barriers. Research on the communication barriers experienced by people with disabilities and migrants or refugees has shown that there are several similarities and shared needs. See, for example, the reference below. Related references: Jiménez-Andrés, María (2022). <i>Communication and language management in third sector organisations supporting refugees</i>. PhD Dissertation. Universitat Autònoma de Barcelona. https://www.tesisenred.net/handle/10803/675844#page=1	

Name	Health Regulation Law 15/1990 (Llei 15/1990, de 9 de juliol, d'ordenació sanitària de Catalunya)
Scope	Catalonia

Issuing body	Catalan Parliament
Validity / Publication	Since 9 July 1990 (in force)
Text	
This Act states: Title 1: General Provision Article 2: c) Universalization of individual or collective health services for all citizens residing in Catalonia d) Community participation in the formulation of health policy and the control of its execution. e) Rationalization, effectiveness, simplification and efficiency of health organization. f) Equity and overcoming territorial or social inequalities in the provision of health services.	
Commentary	
This Act aims at regulating the healthcare system in Catalonia, while preserving all the rights and principles to health protection provided in Article 43 of the Spanish Constitution. No direct reference to communication barriers or linguistic intermediary figures is made in this text, though, in the first section of the Act, guiding principles such as the universalization of healthcare services, community participation or overcoming social inequalities are mentioned. The text discusses the General Health Act, which aims to make effective the constitutional right to health protection by establishing the foundations of a healthcare system. This system, known as the Sistema Nacional de Salud (National Health System), is composed of the health services of the autonomous communities, including all healthcare centres, services, and establishments, local corporations, and other intracommunity territorial administrations, all of which are under the responsibility of the relevant autonomous community. Specifically, the Act focuses on the organization of the public healthcare system in Catalonia, based on principles such as universal access, service integration, simplification, rationalization, efficiency, health conception, decentralization, healthcare sectorization, and community participation. To achieve this, the Act establishes a public entity, the Servei Català de la Salut (Catalan Health Service), which includes all public and publicly covered healthcare centres, services, and establishments in Catalonia. This entity is responsible not only for managing and administering the public healthcare system, but also for health planning, programming, and evaluation, including public health and socio-health aspects. It also handles the distribution of financial resources according to the guidelines of the Pla de Salut de Catalunya (Catalonia Health Plan) and the general criteria set by the Department of Health and Social Security. This structure aims to improve organization and overcome deficiencies, like the disconnection between health planning and service management, by assigning these tasks to a single entity. The Catalan Health Service, as a public body of the Generalitat of Catalunya, is attached to the Department of Health and Social Security. This Department is in charge of the direction, supervision, control, inspection, and evaluation of the Catalan Health Service's activities. Related references:	

Tresserras, Ricard *et al.* (2000). Health targets and priorities in Catalonia, Spain. *European Journal of Public Health*, Volume 10, Issue suppl. 4, 51-56, https://doi.org/10.1093/eurpub/10.suppl_4.51

Name	<u>Law 21/2000, of December 29, on information rights concerning the health and autonomy of the patient, and clinical documentation.</u> (Llei 21/2000, de 29 de desembre, sobre els drets d'informació concernent la salut i l'autonomia del pacient, i la documentació clínica)
Scope	Catalonia
Issuing body	Catalan Parliament
Validity / Publication	Since 29 December 2000 (in force)
Text	
This Act states: b. Chapter II, Article 2, discusses the right to healthcare information: i. Patients have the right to obtain all information about their health in any healthcare intervention, but the patient's wish not to be informed must be respected. ii. Information should be part of all healthcare actions, truthful, understandable, and tailored to the patient's needs and requirements to assist in making autonomous decisions. iii. The doctor responsible for the patient must ensure this right to information is upheld. Healthcare professionals who provide care or apply specific techniques or procedures also bear responsibility in the information process. c. Chapter IV, Article 6, on informed consent: i. Any health intervention requires the affected person's specific and free consent after being informed, as established by Article 2. ii. Such consent should be in writing for surgeries, invasive diagnostic procedures, and generally when procedures involve significant and foreseeable risks or inconveniences that could affect the patient's health.	
Commentary	
This Act focuses on patient rights concerning their access to all kinds of information related to their health. It explicitly emphasizes the need to recognize various and extensive patient rights, including the right to information and informed consent, as well as the privacy of health-related information. However, no reference to communication barriers or intermediary linguistic figures is made in the Act, which raises the question about how these rights can be exercised when patients cannot communicate in any of the official languages in Catalonia. Related references: Damau-Bueno., Albert <i>et al</i> (2021). Frequency of health-care service use and severity of illness in undocumented migrants in Catalonia, Spain: a population-based, cross-sectional study. <i>The Lancet. Planetary Health</i>, Volume 5, Issue 5, e286-e296. https://doi.org/10.1016/S2542-5196(21)00036-X Porthé, Victoria <i>et al.</i> (2016). Changes in access to health care for immigrants in Catalonia during the economic crisis: Opinions of health professionals and immigrant users. <i>Health Policy</i>, Volume 120, Issue 11, November 2016, Pages 1293-1303. https://doi.org/10.1016/j.healthpol.2016.09.005	

Vázquez, María-Luís et al. (2016). Was access to health care easy for immigrants in Spain? The perspectives of health personnel in Catalonia and Andalusia. *Health Policy*, Volume 120, Issue 4, April 2016, 396-405. <https://doi.org/10.1016/j.healthpol.2016.01.011>

Name	Law 10/2010, of May 7, on the reception of immigrants and returnees to Catalonia (Llei 10/2010, del 7 de maig, d'acollida de les persones immigrades i de les retornades a Catalunya)
Scope	Catalunya
Issuing body	Generalitat de Catalunya
Validity / Publication	14/05/2010, amended on 19/07/2017 (in force)
Text	
This Act states:	
Article 1, Object and purpose:	
1. The object of this law is to create and regulate the first reception service for immigrants and returnees in Catalonia , which is part of migration policies, and to create the Migration Agency of Catalonia.	
2. The purposes of this law are to promote autonomy and equal opportunities for immigrants and returnees in Catalonia , and also to remove the obstacles that prevent this due, mainly, to the lack of basic language skills and ignorance of society and the legal system, with the aim of making the principle of equality effective and achieving greater social cohesion.	
Article 9, Basic language skills:	
1. The person with the right to access the first reception service, throughout the process of integration into Catalan society, must achieve basic language skills in Catalan and Spanish .	
2. The first reception service must offer the training and means necessary to acquire basic skills in the Catalan language to those with the right to access the service who do not know it, whenever possible through the Consortium for Language Normalisation.	
3. The minimum reference level that must be achieved with regard to the language skills referred to in the Common European Framework of Reference for Languages, established by the Council of Europe, must be established by regulation.	
4. Catalan, as the language of Catalonia, is the common language for the management of reception and integration policies . It is also the language of training and information, a basic instrument for full integration into the country. To this end, the language learning offered by the first reception services begins with the acquisition of basic skills in the Catalan language.	
5. The first reception service, once the training in the Catalan language has been completed, must offer training to acquire basic skills in the Spanish language to people who request or require it [Not in force].	
Commentary	
This Act aims at creating and regulating the first reception services for immigrants and returnees in Catalonia and at promoting autonomy and equal opportunities for them. The text foresees policies for migration planning, including citizenship and immigration plans in Catalonia, and the creation of <i>programes d'acollida especialitzada</i> (specialized integration plans). It explicitly mentions that the Act does not intend to refer to rights in relation to various areas (such as education, health, language teaching, work, etc.), as these are covered in the relevant sectoral laws. Despite the explicit references made to language and communication	

barriers, The Act establishes learning Catalan as the primary priority, followed by learning Spanish. No mention is made to any intermediary figure such as the intercultural mediator, interpreter or translator.

Related references:

Casademont Falguera, Xavier and Sera Serra, Macià (2021). Immigrant Integration Policies in Catalonia (1993-2017): Political Frames. *Migraciones*, vol. 52, 221-247. <https://10.14422/mig.i52.y2021.008>

Flors Mas, Avel·lí (2021). Immigration and Languages in Catalonia: From Policies to Results. *Journal of Iberian and Latin American Research* 27(2):368-385. <http://dx.doi.org/10.1080/13260219.2021.1994712>

5.2. Non-binding texts

Name	Immigration Master Plan in the Health Sector (see also here) (Pla Director d'Immigració en Salut)
Scope	Catalonia
Issuing body	Healthcare Department, Generalitat de Catalunya
Validity / Publication	Since 2006 until 2007
Text	This Plan states the following basic principles: • The right of all individuals to health and quality healthcare, as recognized in the Universal Declaration of Human Rights. • The right of citizens to participate. • The duty of citizens to care for their own health and that of others. • The right and duty of healthcare professionals to have access to the tools and training needed to perform their jobs as well as possible. • The duty of the system to adapt to changes, such as population shifts. Core Values: • Humanization and comprehensiveness in healthcare, openness to diverse communities, equity in access and services, intercultural bioethics, continuous research and innovation, and social commitment. • Equality, cohesion, and coexistence, thereby enabling progressive integration of newcomers with minimal social cost and the fewest possible problems. • Tolerance and respect, cross-cutting actions, and interdisciplinarity. • A commitment to fighting against racism and xenophobia, ignorance and intolerance, while avoiding paternalism and voluntarism as solutions to inequalities, and aiming for normalization. The text also outlines strategies to adapt mediation models to regional needs in Catalonia, focusing on healthcare settings. The key points include:

- **Evaluation of existing mediation models:** assess current mediation models in Catalonia based on the government-approved mediation policy framework. This involves identifying needs and functions (such as translation, accompaniment, community mediation, health worker in prevention initiatives, etc.) and evaluating their effectiveness.
- **Recommendations for hospitals:** to minimize existing risks in hospitals, several strategies are recommended:
- **Hiring foreign professionals:** Encourage the recruitment of healthcare professionals of foreign origin to better serve diverse patient populations.
- **Staff reinforcement:** Bolster care services with staff from the same communities as the patients.
- **Joint welcoming actions:** Promote collaborative initiatives with local immigration plan actors for welcoming and integrating patients.
- **Community interpreter pool:** Create a pool of community interpreters for emergencies and other special services (like maternal and child healthcare).
- **Speakerphones for communication:** Acquire speakerphones to facilitate communication with remote interpreting services like "Sanitat Respon" (telephone interpreting service provided by the Catalan Department of Health).
- **Networking with professionals:** Foster contact with other professionals, both national and foreign, to initiate joint actions for collaboration and/or support.

The plan provides a more detailed explanation of how mediation plans should be developed, as well as core ideas around the concept of “mediation”.

Commentary

To date, this Plan is one of the most ambitious political measures concerning healthcare and immigration in Catalonia. It is also one of the only Catalan political initiatives that aims at defining and consolidating the figure of the intercultural mediator as an intermediary between *nouvinguts* (newcomers and migrants) and healthcare providers. Despite its importance for intercultural mediation in healthcare in Catalonia, the plan was never completely implemented and was not reapproved after 2007 due to political changes in the Catalan Government.

One of the main objectives of the plan was to improve immigrant population's access to healthcare services. The aim was to adapt services in three main areas: reception plans, mediation, and professional training. The mediation plan, which was part of broader policies on reception, equality, and accommodation, included the use of professional mediators in healthcare. These mediators were not for resolving conflicts but rather for overcoming difficulties related to accessibility and communication in a broader context, including cultural, social, or linguistic differences. The mediation plan aimed to reduce the disadvantages faced by newly arrived immigrants in accessing healthcare services, adapt the healthcare system to new realities, and provide information about cultural, social, or linguistic differences. The plan established criteria for offering flexible mediation services in various forms within the healthcare system. It defined the roles, profiles, and competencies of mediators, promoting collaboration with other departments and entities for training.

This model focused on actions to improve the effectiveness of services that facilitate intercultural communication in collaboration with other key social actors to enhance access to the healthcare system. It included a registry for monitoring and evaluating mediation

activities. This initial approach should adapt to the specific needs of each territorial health unit, with regional tables identifying needs. Based on the number of mediators for the immigrant population in Girona, the plan roughly estimated the number of mediators needed per population range and nationality in each region. This estimation would then be analysed and adjusted according to each territory's needs.

Related references:

Vázquez Navarrete, M. Luisa; Terraza Núñez, Rebeca; Vargas Lorenzo, Ingrid; Lizana Alcazo, Tona (2009). Necesidades de los profesionales de salud en la atención a la población inmigrante. *Gac Sanit.* 23(5):396–402.

Name	Citizenship and immigration plan (Pla de Ciutadania i Immigració)
Scope	Catalonia
Issuing body	Secretariat for Immigration, Department of Welfare and Family (Generalitat de Catalunya)
Validity / Publication	2005 – 2008
Text	The document outlines strategies and objectives for improving integration of immigrants in Catalonia and includes specific mention of access to healthcare, professional training in healthcare, mediation, equality policies, and legal changes to establish a more just and realistic model of citizenship. Regarding healthcare policies, the key points are: 1. Improvement of access to healthcare. The government aims to enhance the quality of healthcare services by strengthening deficient areas and promoting the role of professional mediators in healthcare. Priority actions include developing healthcare reception protocols, improving records and information, defining specific professional roles (welcome agents, mediators, translators), providing tailored training to professionals to serve people from diverse cultural backgrounds, ensuring sufficient resources where workloads are impacted, and solving situations related to universal healthcare access. 2. Professional training. Training for professionals is crucial for improving knowledge and handling new situations, ensuring equal access to public services. The plan promotes training programs across various sectors, enhancing the task of professionals and focusing on intercultural mediation professionals who currently lack training and support. Priority actions involve training public service professionals in diversity care and promoting a coherent model of diversity professionals. “The training of diversity professionals will be an area of focus, in coordination with universities and training centres. These professionals, generally known as intercultural mediation professionals (mediators) suffer from a training deficit and, above all, work without sufficiently broad professional and institutional support. The Plan will promote the creation of a model of diversity professionals, their appropriate training and the coordination between this training and the institutional framework. Priority areas of action: • Train public service professionals who work with diverse populations. • Promote a unique and coherent model for diversity professionals”.

3. Equality policies. The document mentions the need to facilitate equal access to services and resources, improving and adapting them as necessary.

Commentary

This Plan encapsulates efforts to improve healthcare access for immigrants, professional training for culturally responsive care, and broader policies and legal changes aimed at fostering a welcoming, equitable society. Linguistic intermediary figures to cope with communication barriers are directly mentioned: welcome agents, mediators and translators (i.e. interpreters). Their specific roles should be defined, and they should receive the appropriate training (in coordination universities and training centres). Despite the importance and innovative character of this plan, the measures related to intercultural communication were never fully applied in Catalonia.

Related references:

Vázquez Navarrete, M. Luisa *et al.* (2009). Necesidades de los profesionales de salud en la atención a la población inmigrante. *Gaceta Sanitaria*, 23(5), 396–402. DOI: [10.1016/j.gaceta.2008.10.008](https://doi.org/10.1016/j.gaceta.2008.10.008)

Name	A pact to live together. National Pact for Immigration (Pacte Nacional per a la Immigració: un pacte per viure junts i juntes)
Scope	Catalonia
Issuing body	Secretariat for Immigration, Department of Social Action and Citizenship (Generalitat de Catalunya)
Validity / Publication	19 December 2008 – (in force)
Text	
Challenge 2 focuses on scaling public services to ensure access for everyone, with a specific emphasis on healthcare. It starts with a diagnosis and then outlines proposals, and strategies.	
Diagnosis: - There is a significant overlap in the challenges faced by various basic public services, particularly due to the increase in users and the linguistic and cultural diversity brought by the immigrant population. These persistent issues negatively affect service provision and its social effectiveness. - In healthcare, adaptations to provide quality service to newcomers have been pioneering compared to other public services. The universalization of healthcare services, along with an approach that avoids parallel structures and normalizes care, is highlighted as key.	
Proposals and strategies related to healthcare: Language assistance: Implement high-quality, timely language assistance for public service professionals, utilizing human and technological resources efficiently. This is intended to be temporary, as learning the common language is seen as a means of social mobility and a civic duty. Health mediation: Undertake health mediation actions to serve the immigrant population. Healthcare accessibility: Ensure the entire population has access to healthcare services.	

- Follow **uniform criteria and procedures** for healthcare card access, ensuring necessary care is provided (e.g. to pregnant women, in emergencies, and for healthcare card access for minors without a registered address).
 - **Evaluate compliance with these measures.**
 - Utilize **support materials** developed by the Department of Health to ensure useful support and convey consistent messages about service access and use.
4. **Language services: Maintain and improve the availability of language services**, like those currently offered by “061 Sanitat Respon” to overcome communication barriers.
 5. **Temporary needs in communication and mediation:** Address specific resource needs for temporary communication and mediation.
 - Establish a community health strategy with primary care and public health interventions in specific communities: promote training and accreditation projects for professional figures who can provide external, temporary support to the system and professionals, initiating coordinated community health efforts and working with immigrant communities.

Commentary

This Plan, still in force, attempts to ensure access to public services for all citizens in Catalonia. Concerning healthcare, the plan does not explicitly mention any intermediary communication figure, but it does refer to (1) high-quality, timely language assistance for public service professionals; (2) health mediation actions to serve the immigrant populations; (3) the use of support materials to convey consistent messages about service access and use; (4) maintaining and improving the availability of language services, like those currently offered by “061 Sanitat Respon” to overcome communication barriers; (5) establishing a community health strategy with primary care and public health interventions in specific communities and; (6) promoting training and accreditation projects for professional figures that facilitate communication between public service professionals and newcomers.

Related references:

Sànchez, Jordi (2008). 15 consideracions sobre la immigració estrangera a Catalunya en perspectiva comparada. *IDEES. Revista de temes contemporanis*, 2008, núm. 31, p. 249-54, <https://raco.cat/index.php/idees/article/view/290436>.

Zapata-Barrero, R. (2010). La governabilitat de la immigració a Catalunya: D'on venim, on som i on hem d'anar. *EINES per a l'esquerra nacional*, nº 11, p.75-86.

Name	Citizenship and immigration plan (Pla de Ciutadania i Immigració)
Scope	Catalonia
Issuing body	Secretariat for Immigration, Department of Social Action and Citizenship (Generalitat de Catalunya)
Validity / Publication	2009-2012
Text	
The Plan contains 3 axes, 17 programs, 131 projects and 235 actions.	
Three axes:	
1. Management of migratory flows and access to the labour market	
2. Adaptation of public services to a diverse society	
3. Integration into a common public culture	

There are some mentions of linguistic and cultural communication: • Within axis 2, challenge 1, program 6, strategic objective 6.1. (Create a universal and homogeneous reception service throughout the territory), project 6.1.2.: 6.1.2. Implementation of 4 basic welcome points, one of which is a translation and interpretation service • Within axis 2, program 7, strategic objective 7.2. (Guarantee access to health services for the entire population), projects 7.2.1.: 7.2.1. Access to public healthcare a. Reinforce language assistance for healthcare professionals b. Reinforce the “Sanitat Respon” service	
Comments	
The 2009-2012 Citizen and Immigration Plan attempts to develop, advance and coordinate immigration policies in Catalonia, promoting Catalonia as an inclusive, intercultural and participatory nation. It also attempts to implement and develop the measures established in the Pacte Nacional per a la Immigració (National Immigration Pact). There are several mentions of linguistic intermediary figures in the document. The first one is concerning the creation of four welcome points for immigrants, one of which is a translation and interpretation service. The budgetary cost related to this action is €55.191 and its responsible body is the SIM (Servei d’Informació Mediadora), managed by town halls, county councils and other local institutions. The document also mentions specific budget provisions for projects related access to public healthcare, including reinforcing language assistance for healthcare staff (€1.649.350) and reinforcing the telephone interpreting service “Sanitat Repon” (€78.156). The body responsible for these two actions is the Department of Health. Budgetary costs are specified only for the actions included in the plan for the 2009 financial year. No data is available on the final implementation of these actions. Related references: Ferrero-Turrión, R. <i>et al.</i> (2009). Immigration and the Construction of Public Philosophy(ies) of Integration in Spain. In <i>Illiberal Liberal States</i> (1st ed., pp. 337–356). Taylor & Francis. https://doi.org/10.4324/9781315587813-22	

Name	Citizenship and migration plan: horizon 2016 (Pla de Ciutadania i Immigració: Horitzó 2016)
Scope	Catalonia
Issuing body	Directorate General for Immigration (Interdepartmental Commission on Immigration), Department of Social Welfare and Family (Generalitat of Catalonia).
Validity / Publication	Since 2014 until 2016
Text	

The plan is based on the three axes referred to in the National Plan for Migration:

Axis 1. **Management of migratory flows and access** to the labour market

Axis 2. **Adaptation of public services to a diverse society**

Axis 3. **Integration into a common public culture**

Axis 2, program 15 for access to public services and attention to users:

- **CatSalut Respon 061**
- **Strengthening language assistance** to healthcare professionals

Comments

The migration policy of the Generalitat is organized around four-year plans. The first was approved by the Government in 1993. This plan is the fifth of its kind. Their purpose is to specify the axes and mechanisms for making its migration policy fully operational. The 2013-2016 Citizen and Immigration Plan (Pla de Ciutadania i Immigració 2013-2016) attempts to implement and develop the measures established in the Pacte Nacional per a la Inmigració (National Immigration Pact), but in a new scenario marked by the economic and political crisis in Catalonia. The plan no longer mentions the translation and interpreting service included in the previous plan with a budget of €55.191 and drastically reduces the budget for reinforcing healthcare language assistance for healthcare professionals to €236.374 (in the previous plan: €1.649.350). It also reduces the budget for the telephone interpreting service Sanitat Repon to €22.590 (in the previous plan: €78.156. No data is available on the final implementation of these actions.

Related references:

Branchadell, A. (2015). Language education for adult migrants in Catalonia: Nation-state ambitions without nation-state resources. In: J. Simpson & A. Whiteside (eds.) *Adult Language Education and Migration* (1st ed., pp. 82–93). Routledge. <https://doi.org/10.4324/9781315718361-6>

Name	Charter of rights and duties of citizens in relation to health and health care (Carta de drets i deures de la ciutadania en relació amb la salut i l'atenció sanitària)
Scope	Catalonia
Issuing body	Catalan Government [Executive Council of the Generalitat of Catalonia in the Session of August 25, 2015]
Validity / Publication	Since 2015 (This Chart is an update of that approved in 2001).
Text	
The charter is structured around ten guiding principles, each one of which contains a certain number of rights and duties (62 rights and 28 duties): 1. Equity and non-discrimination of individuals 2. Protection and promotion of health and disease prevention 3. Access to the healthcare system 4. Privacy and confidentiality 5. Autonomy and decision-making	

6. Healthcare information, clinical documentation and information and communication technology

7. Quality and security of the system

8. Genetic constitution

9. Research and experimentation

10. Participation

The Charter states the following:

6.1.1. Right to ownership of health information

The person has **the right to know all the information** obtained regarding their health in terms understandable to them and given their personal circumstances regarding their health and the healthcare process that provides them with sufficient elements of judgment to make the necessary decisions for their health and healthcare.

7.1.1. Right to receive quality healthcare

The person has **the right to receive quality care** in all its dimensions (efficient, effective, **accessible, person-centered**, equitable and safe) based on the available scientific evidence and that responds to their uniqueness and values.

7.1.3. Right to have their clinical safety guaranteed

The person has **the right to be treated with the minimum possible risk**, within the framework of quality healthcare, guaranteeing their clinical safety in order to reduce the probability and effects of adverse events of any nature that may occur during the provision of this care.

Commentary

This non-binding charter establishes the rights and duties of all Catalan citizens in relation to health and healthcare. No mention is made of any kind of communication issues or a linguistic intermediary figure, though many of its rights, when applied to users who do not speak Spanish or Catalan, cannot be understood without considering language and cultural barriers.

Related references:

Generalitat de Catalunya (2010). *The Healthcare System in Catalonia: Evolution and Strategic Orientation from the Perspective of the Catalan Health Service*.
<https://catsalut.gencat.cat/web/.content/minisite/catsalut/publicacions/docs/sistema-atencio-salut-catalunya-angles.pdf>

Name	Citizenship and migration plan (Pla de Ciutadania i immigració)
Scope	Catalonia
Issuing body	Department of Labor, Social Affairs and Families (Generalitat de Catalunya)
Validity / Publication	2017-2020
Text	
This plan states:	
Line 2.4. Accessibility of public services for immigrants, refugees and returnees	
2.4.1. Accessibility to public services and social benefits	

Objective: These are ongoing actions by the different departments of the Generalitat to facilitate accessibility to public services through **intercultural mediation, translation and interpretation**, and information on the existence of specialized services.

Description:

1. **Increase the offer of interpretation services** for people without linguistic competence (061 CatSalut Respon and others).
2. **Accreditation of the training carried out by interpreters** working in public services.
3. **Training, accreditation and availability of the service of intercultural mediators and translators**
4. **Reception in health services through intercultural mediators** and CatSalut Respon
5. Access to public health services for all people, regardless of their administrative situation.

Commentary

As with the previous citizenship and migration plan, this text includes 433 actions, grouped into 44 programs that are organized into 4 axes: interaction, inclusion, democratic quality and state tools. In the second axis (inclusion), in Section 2.4.1. (Access to public services and social benefits), there is an explicit mention of intercultural mediation, translation and interpreting. Specifically, in relation to the need to (a) increase the availability of interpreting services (061 CatSalut Respon and others); (b) accredit the training undertaken by interpreters; (c) provide training and accreditation to intercultural mediators and translators, as well as extending the service provision; (d) receive health services through intercultural mediators and CatSalut Respon; and (e) access to public health services for all people, regardless of their administrative situation. No data is available on the actual application of these measures.

Related references:

Sánchez-Martí, Angelina et al. (2022). Towards a Common Public Culture? Boundaries to Belonging in Catalonia. Social Inclusion, Volume 10, Issue 2, 132–142
<https://doi.org/10.17645/si.v10i2.4943>

Name	Catalonia Healthcare Plan 2021-2025 (Pla de Salut de Catalunya 2021-2025)
Scope	Catalonia
Issuing body	Department of Healthcare, Generalitat de Catalunya
Validity / Publication	Since 2021 until 2025
Text	
This plan states:	
Objectives and indicators:	
1. Equal opportunities in healthcare throughout life 1.2.6 Improve emotional, sexual and reproductive health at all ages, especially in adolescents and young people.	
Main actions: Create the Sexual and Reproductive Health Plan with the aim of achieving a global approach and guaranteeing the effective exercise of these rights for the entire population with a gender perspective and aligned with the framework of the National Strategy for Sexual and Reproductive Rights.	
1.2.7 Promote skills that improve the emotional well-being of individuals and groups	

Main actions: Launch the Emotional Well-being and Community Health Program in primary and **community health care** teams and in the rest of professional teams with **community intervention**, prioritizing its deployment in areas with the highest rate of deprivation and greater socioeconomic need.

2. Integration of health care

3.7.26 Deploy community health with local involvement and territorial equity

Main actions: Establish local multidisciplinary community health boards, with the co-leadership of **primary and community health care**, together with public health, local entities and community resources.

3.8.30 Strengthen **community guidance on mental health** and addictions.

Commentary

This Plan establishes the measures that should be implemented in a five-year period (2021-2025) in the Catalan healthcare system. Although the text claims to adopt a person-centred approach and has as a first objective to provide equal opportunities in healthcare, no specific references are made to the migrant population or communication barriers. There is also no mention of the 061-interpreting service or the intercultural mediation services funded in previous plans, which nonetheless have continued to be offered in Catalonia until now.

Related references:

Lizana, Tona et AL (2014). Strategies on migration and health in Catalonia. *The 22nd International Conference on Health Promoting Hospitals & Health Services. International HPH Network; WHO Collaborating Centre for Health Promotion in Hospitals and Health Services; Generalitat de Catalunya – Agència de Salut Pública de Catalunya*.

Lurgain, J.G. et al. (2024). Exploring cultural competence barriers in the primary care sexual and reproductive health centres in Catalonia, Spain: perspectives from immigrant women and healthcare providers. *Int J Equity Health* 23, 206. <https://doi.org/10.1186/s12939-024-02290-5>

Name	Commitment of the Government of the Generalitat of Catalonia for a country free of racism. 70 measures for social and institutional transformation (Commitment of the Government of the Generalitat of Catalonia for a country free of racism. 70 measures for social and institutional transformation)
Scope	Catalonia
Issuing body	Government of the Generalitat of Catalonia
Validity / Publication	Since 2023 (in force)
Text	
This commitment includes the following measures:	
Measure 14. To prepare a study on the impact of racism on mental health , with the aim of reviewing individualized intervention models and making progress in addressing the structural effects of racism on mental health.	
Measure 15. Conduct an analysis of the impact of racism on self-harming behaviors and suicide prevention and introduce the available racism variables.	

Measure 16. **Update the approach and transcultural mediation in health**, guaranteeing non-discrimination, expanding translation services and communication strategies from the recognition and respect for the autonomy of people and the diversity of religious beliefs and cultural practices.

Commentary

For the first time, the Generalitat de Catalunya is addressing racism in a cross-cutting way through political action, with the involvement of all government departments. This action plan with 70 measures for a country free from racism is fully aligned with international conventions and treaties on human rights. These measures are divided into three main axes:

1. Equitable access to rights and material living conditions (32 measures)
2. Democratic memory, knowledge of racism and reparation (22 measures)
3. Transformation of administrations (16 measures)

Among these 70 measures, only three indirectly deal with cultural and language barriers in healthcare (see above). Among these three, only one addresses the need for “transcultural mediation” in health, referring to enhancing its approach by guaranteeing non-discrimination and expanding translation services and communication strategies.

Name	<u>Instruction 2/2024 of the Catalan Health Service to guarantee compliance with the linguistic rights of users and patients of the public health system of Catalonia, and the regulations on official language uses and language knowledge of healthcare professionals</u> (Instrucció 02/2024. Mesures dirigides a promoure el compliment dels drets lingüístics dels usuaris i pacients del sistema sanitari integral d'utilització pública de Catalunya (SISCAT))
Scope	Catalonia
Issuing body	Catalan Health Service (Catsalut), Generalitat of Catalonia
Validity / Publication	Since 2024 (in force)
Text	
The instruction states that:	
II. Language has an obvious importance and impact on any aspect of people's social life. Within the sphere of health care itself, it acquires special relevance from a double perspective. Firstly, due to the need to facilitate an affective and emotional environment of maximum proximity to users of public health services in circumstances of stress or concern that place them in an objective plane of vulnerability. Secondly, from a strictly pragmatic approach, in the sense of guaranteeing fluidity in communication and, consequently, the adequate identification of health problems and the same effectiveness of assistance. Good communication and the ability to understand and establish a complete and empathetic connection with citizens is considered to be a fundamental component of healthcare and one of the guarantees of its quality. It is also a determining element of patient safety. Recent international studies have found that unsatisfactory communication is the main source of errors in healthcare, especially in acute clinical care. Satisfactory communication involves relating to the patient in the language in which they feel most comfortable, and providing care in the patient's own language promotes closeness and trust between patients and professionals, and also that patients follow the prescribed treatments. There is increasing evidence that good communication, which includes the linguistic competence of healthcare professionals in the patients' language, is essential for improving quality standards. Ensuring	

care provided in the patients' language is therefore directly associated with promoting the conditions required to improve health indicators.

Commentary

The purpose of this Instruction is to establish actions to protect the linguistic rights of the population living in Catalonia who receive healthcare from the Catalan Health Service and to monitor compliance with them. These language rights apply to the three official languages in Catalonia, that is, Catalan, Spanish and Occitan (Aranese). No mention is made here of communication barriers or rights with respect to other languages, let alone any linguistic figure. This Instruction is binding for healthcare service providers that are part of SISCAT, as they are obliged to comply with the guidelines established by CatSalut by virtue of the agreements, conventions or management assignments under this entity. In this sense, the Instruction obliges these entities to guarantee that patients and users can be treated in the official language of their choice (Catalan or Spanish, and Aranese); to incorporate language clauses in contracts and agreements that establish the obligation to respect these language rights; and to develop a Language Management Plan that includes measures to ensure compliance with language rights, such as staff training and monitoring and evaluation mechanisms.

Name	Plan to guarantee the knowledge and use of Catalan in the public health system of Catalonia 2024-2026 (Pla per garantir el coneixement i l'ús del català en el sistema públic de salut de Catalunya 2024-2026)
Scope	Catalonia
Issuing body	Department of Health, Generalitat of Catalonia
Validity / Publication	Since 2024 until 2026
Text	
The plan states the following: 31. Promote multilingual care for users of the public health system The arrival of new citizens in Catalonia and the diversity of origins has generated new needs for public services in general and the public health system in particular, especially to guarantee communication in healthcare and the safety of medical procedures. It is necessary to manage multilingualism within the framework of official languages. Several studies show that not addressing language barriers - through professional interpreters or language mediators - has important consequences in terms of quality, efficiency and cost of healthcare. It is necessary to assess the linguistic competence of healthcare professionals with diverse origins and knowledge of various languages in order to efficiently direct this knowledge to guarantee communication with newly arrived users. a. Include non-official languages in the inventory of languages that healthcare professionals know and can use to improve care for the immigrant and foreign population who have language difficulties when receiving care. Introduction of the language knowledge question in the survey to be carried out by the ICS, the Hospital Clínic and the UAB. b. Analysis of the languages spoken by the communities served in the various health centers. c. Development of the cultural mediators program, adapted to the needs of the territory, and in agreement with other institutions.	

- d. **Training, where appropriate, in different languages.**
- e. **Dissemination and promotion of the interpretation and translation services in other languages** of the **061 Salut Respon**, which currently provides services in more than ninety languages.
- f. **Basic health information in non-official languages to facilitate access to the health system for immigrant populations.**
- g. Definition of **criteria for the publication of certain materials and content in other languages.**
- h. **Dissemination of the Guide on institutional and professional language uses** in the Generalitat de Catalunya and the public sector that depends on it.

Commentary

This Plan aims to guarantee the knowledge and use of Catalan in the public healthcare system of Catalonia. With 4 axes of action and 33 measures, it seeks to provide for language training for professionals and ensure that users of the public healthcare system can receive oral and written communication in Catalan (and the other official languages), ensuring that their language rights are guaranteed. Although the text focuses on the need to improve the use of Catalan in healthcare services, eight measures concerning non-official languages are also considered (see above). Similarly, the text acknowledges that not addressing language barriers—through professional interpreters or intercultural mediators—has important consequences in terms of quality, efficiency and cost of healthcare. The body responsible for the implementation of these measures is the Department of Health, and the indicators to assess the eight goals referred to above are: the number of telephone interpreting services provided by 061, the number of professionals (%) who can provide care to patients in non-official languages, and the number of linguistic mediation services.

Related references:

Departament de Cultura (2024). *Salut presenta el Pla per garantir el coneixement i l'ús del català en el sistema públic de salut de Catalunya 2024-2026*. Web de Llengua Catalana de la Generalitat de Catalunya. <https://llengua.gencat.cat/ca/detalls/noticia/catala-en-el-sistema-public-de-salut> [last visited: 12/04/2025]

Name	National Pact for the Catalan Language (Pacte Nacional per la Llengua)
Scope	Catalonia
Issuing body	Government of the Generalitat de Catalunya
Validity / Publication	Since 2025 (in force)
Text	
The objective 7 of the pact states that:	
7. Health and social health care: Guarantee the linguistic rights of patients , of people in situations of vulnerability and dependency, and achieve the normal use of Catalan as the professional language of the sector. Specific objectives of the field:	

7.1. To train the students of health professional degrees and cycles and the resident staff (MIR, PIR, LLIR and IIR) trained in Catalonia so that they achieve competence in Catalan and know the linguistic rights and duties necessary to practice in Catalonia (see scope 11, Universities and research).

7.2. Progressively provide the language skills and knowledge of the necessary language rights and duties to staff already hired who do not have them.

7.3. Ensure that linguistic rights and active linguistic availability are guaranteed in health centers in Catalonia.

7.4. Guarantee that in the health centers and services of the public health system of Catalonia, Catalan is used as the normal institutional and working language.

7.5. Develop the necessary materials to facilitate the linguistic training of health professionals and their work in Catalan.

Commentary

This Pact attempts to protect the language rights of the patients that make use of the public healthcare system in Catalonia. Although these rights could be applied to any language, the fact is that the text refers only to Catalan, whose availability can be in danger due to the widespread use of Spanish among healthcare professionals.

The notion of a language barrier must be approached critically in this context, since the vast majority of Catalan speakers have a good command of Spanish. The protection of these linguistic rights therefore appears to be more closely related to the situation of diglossia in Catalan healthcare settings, where the use of Catalan is declining.

The solution proposed by this Pact is to increase training in the Catalan language both for healthcare professionals and newcomers. No specific mention is made to intermediary figures who could eventually provide translation or interpreting between Catalan and Spanish.

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