



# **Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma (MEM-TP project)**

**EC contract no. 2013 62 09**

## **Revised interim report**

**Covering the reporting period from  
March 2014 to December 2014  
With an update of activities taking place from  
January to March 2015**

**Reporting date  
Final revision March 27, 2015**

**Riitta-Liisa Kolehmainen-Aitken  
Project coordinator**



## Contents

Introduction	1
Administrative and budget matters	2
Achieved project results	4
Project management mechanisms	4
Completed work packages	4
WP1: Migrant and ethnic minorities review report (Deliverable 1)	4
WP2: Review of existing training materials (Deliverable 2)	5
WP3: Training programme for health professionals and health care providers (Deliverable 3)	6
Work package in process	6
WP4: Training workshop programme and content (Deliverable 4)	6
Additional activities	6
Work programme planned for the following period	7
 Annex 1	
Deliverable 1: WP1 Synthesis report and appendices of the migrant and ethnic minorities review	
 Annex 2	
Deliverable 2: WP2 Review of existing training materials	
 Annex 3	
Deliverable 3: WP3 New training package: Table of contents	
 Annex 4	
Deliverable 4: WP4 Training of trainers workshop programme and content	
 Annex 5	
Draft schedule for the pilot training	
 Annex 6	
Draft design for the evaluation of the training plan	
 Annex 7	
Draft plan for the final dissemination workshop	
 Annex 8	
Planned work programme for the following period	



# **Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma (MEM-TP project)**

**EC contract no. 2013 62 09**

## **Interim report (Deliverable 6)**

### **Introduction**

The aim of the MEM-TP project is to improve access and quality of health services for migrants and ethnic minorities in the European Union by reviewing, developing, testing and evaluating training in migrant and ethnic minority health for front-line health professionals, and disseminating the project results.

The European Commission (EC) awarded the project in late December 2013 to a consortium of institutions under a service contract. The consortium consists of the Andalusian School of Public Health (EASP) as the lead partner, and the University of Copenhagen (Faculty of Health and Medical Sciences), Azienda Unitn Sanitaria Locale Reggio Emilia in Italy and University of Amsterdam (Academisch Medisch Centrum) as members. The International Organization of Migration (IOM), European Public Health Alliance (EPHA), Jagiellonian University in Poland, National Institute of Public Health of Romania, and Trnava University in Slovakia collaborate with the project as subcontractors.

The kick-off meeting was held in Luxembourg on February 26, 2014. The inception report (Deliverable 0) was submitted to the EC in March 2014. An extraordinary meeting of the Advisory Group (AG) was held in Granada, Spain, on 11 April 2014, taking advantage of the attendance of many AG members in EUPHA's 5<sup>th</sup> Conference on Migrant and Ethnic Minority Health at the EASP. Dr. Isabel de la Mata, Principal Advisor for Public Health in EU/SANCO attended the meeting.

From April to September 2014, the consortium partners responsible for Deliverables 1 and 2 (review of the migrant and ethnic minorities situation in the EU and review of existing training materials, respectively) conducted the reviews and documented them. The final reports were revised based on feedback received from the EU and other consortium members, suffering various modifications to be finally approved on March, 6 2015 (teleconference); on March 12, 2015 was confirmed this approval through electronic communication. The reports can be downloaded from the MEM-TP project website (<http://www.mem-tp.org>).



The development of the training programme (Deliverable 3) took place between August and November 2014. The final outline of content was agreed on the 19<sup>th</sup> of November. Teaching material was further developed in December 2014 and revised in January 2015 to take account of feedback received, to have the first version of the set of materials to be tested in the ToT

The training of trainers workshop was scheduled and held between 28 and 30 January 2015 at the EASP in Granada, Spain. The participants include three selected health trainers from each of the six countries that will participate in the follow-on pilot training. These are Denmark, Italy, Poland, Rumania, Slovakia and Spain. Following the workshop, the trained trainers will adapt the training package (Deliverable 4) and run pilot training programmes in their own countries between March and April of 2015. The country-level pilots will then be evaluated (Deliverable 5).

## **Administrative and budget matters**

The EASP has signed the following agreements and subcontracts with consortium members and subcontractors:

1. The Consortium Agreement between a) Escuela Andaluza de Salud Paluduz (Spain) Registration number: ES A-18049635, b) Faculty of Health and Medical Sciences, University of Copenhagen (Denmark) Registration number: 29 979812; c) Azienda Unitn Sanitaria Locale Reggio Emilia - AUSL (Italy) Registration number: 01598570354; and d) Academisch Medisch Centrum bij Universiteit van Amsterdam (Netherlands) Registration number: NL-004627672B01 was signed on December 28, 2014
2. Subcontract to EAHC Contract Nr. 2013 62 09 between a) Escuela Andaluza de Salud Paludaa (Spain) Registration number: ES A-18049635 and b) Jagiellonian University Medical College (Poland) signed on May 19, 2014.
3. Subcontract to EAHC Contract Nr. 2013 62 09 between a) Escuela Andaluza de Salud Paludaa (Spain) Registration number: ES A-18049635 and b) Trnava University Registration number: ES A-18049635 and b) n a) 014.72B01 was signed on December
4. Subcontract to EAHC Contract Nr. 2013 62 09 between a) Escuela Andaluza de Salud Paludaa (Spain) Registration number: ES A-18049635 and b) National Institute for Public Health (Romania) signed on April 16, 2014.
5. Subcontract to EAHC Contract Nr. 2013 62 09 between a) Escuela Andaluza de Salud Paludaa (Spain) Registration number: ES A-18049635 and b) European Public Health Alliance signed on May 10, 2014.





6. Subcontract to EAHC Contract Nr. 2013 62 09 between a) Escuela Andaluza de Salud Pública (Spain) Registration number: ES A-18049635 and b) International Organization for Migration signed on June 13, 2014.

The EASP has made the following bank transfers:

1. On June 12, 2014, three bank transfers to the following consortium members: Faculty of Health and Medical Sciences, University of Copenhagen (Denmark), Azienda Unitn Sanitaria Locale Reggio Emilia - AUSL (Italy) and Academisch Medisch Centrum bij Universiteit van Amsterdam (Netherlands). The amount of each transfer was 12.000,00 EUR.
2. On June 12, 2014, four bank transfers to the following subcontracting institutions: Jagiellonian University Medical College; Faculty of Health Care and Social Work, National Institute for Public Health and European Public Health Alliance. The amount of each transfer was of 3.000,00 EUR.
3. On June 12, 2014, one bank transfer to the International Organization for Migration for 12.000,00 EUR.

The following meetings and teleconferences were held after the kick-off meeting in Luxembourg on February 26, 2014:

- Teleconference between EASP and CHAFEA on April 8, 2014.
- Meeting of the Organisational Management Committee (OMC) on April 9, 2014 at EASP.
- Meeting between Advisory Group (AG) and Dr. Isabel de la Mata (in conjunction with the 5th European Conference of EUPHA) on April 11, 2014.
- Teleconference between CHAFEA and the OMC on September 22, 2014 regarding WP1 and WP2.
- Teleconference between the Advisory Group members, on January 21, 2015, and then with CHAFEA, to discuss organizational aspects and the final contents of the ToT.
- Teleconference between all members of the Organisational Management Committee (OMC), on February 25, 2015, to review recent changes in WP1 and WP2 and evaluate results of the ToT held the previous month in Granada.
- Teleconference between CHAFEA, EC/SANTE, the EASP team and representatives of the Danish partner, on March 6, 2015, to review and provisionally approve WP1 and WP sent to CHAFEA after incorporating the changes suggested by it and consortium members and for final approval of the Interim Report. The final Interim Report will be submitted to CHAFEA as soon as the agreed to modifications have been incorporated.



Between teleconferences, the OMC members have worked together using the space set aside for this purpose on the MEM-TP website. The EASP team managing the MEM-TP project has met weekly.

In the April 4, 2014 teleconference with CHAFE A, the EASP, as the consortium lead partner, brought to the EC's attention their concern about the EC contract stipulation, stating that interim funding could only be made available after the country pilots were done. This inability to front-fund the pilots was proving to be an obstacle to organising them in some countries. After deliberation, the EC determined that the constraint could be addressed by slightly modifying the wording without having to amend the contract. The revised wording allows the Interim Report, which is to include a draft evaluation framework, to be submitted to the EC prior to the field tests. The Interim payment will be released, when the submitted Interim Report has been accepted by the EC.

## Achieved project results

### Project management mechanisms

The following project management mechanisms have been set up and are functioning:

1. Organisational Management Committee and an Advisory Group,
2. Signed consortium agreement, subcontracts and terms of reference,
3. Manual of Rules and Procedures,
4. Communication plan addressing both internal and external communication, and
5. Project website (<http://www.mem-tp.org>), designed and managed by the EASP to disseminate information on the development of the work packages, give updated information to the consortium members and CHAFAE, and facilitates communication between the Expert Working Group (EWG) members. The website contains all relevant project management documents and final deliverables. A closed area allows collaboration between the consortium members.

### Completed work packages

The work packages WP1, WP2, and WP3 have been completed, and WP4 is ready in draft form. The final reports of WP1 and WP2 can be downloaded from the MEM-TP project website (<http://www.mem-tp.org>).

#### *WP1: Migrant and ethnic minorities review report (Deliverable 1)*

The search that formed the basis of the review covered EU projects and project reports, information from national authorities and international agencies in Europe. It also included publications on good practice during the last 10 years with special relevance for training programs in Europe. The Ministry of Health web sites of all European member states and all relevant EU Agencies and international organisations were examined. EU member states were contacted through the contact points identified in the technical proposal.

The review covers the characteristics of migrants and ethnic minorities in Europe, the state of health and health determinants, relevant legal and policy frameworks, barriers to access, factors undermining the quality of health service delivery, and good practices in addressing such barriers and factors. It concludes by suggesting a European framework for collaboration on migrant and ethnic minority health.

The report emphasises that the following factors are important in equipping health professionals to better meet the needs of migrants and ethnic minorities:

1. Socioeconomic factors need to be taken into consideration in any interventions to tackle health inequalities.

2. Health professionals need to receive background information for their country on the number and nature of migrants and ethnic minorities, as well as their health needs, because the numbers and types of migrants in Europe vary from country to country.
3. Services and interventions should be specifically targeted to migrant and ethnic minority populations, or their success may be limited. This is especially the case for very vulnerable groups such as the Roma.
4. Health professionals at all levels of an organisation should be aware of the barriers that migrants and ethnic minorities face. Individual health workers, however, cannot make improvements in the quality of care without the support of the whole organisation.
5. Training materials should reflect and describe the shift towards 'diversity sensitivity' (an intersectional approach) rather than remain exclusively focused on the support of the whole.
6. Health professionals should work in an intersectoral way, wherever possible, in order to tackle health inequalities.
7. Countries could be encouraged to mainstream the adaptation of health systems to the needs of migrants and ethnic minorities by developing a European framework for collaboration on health.

The WP1 was finally approved in March 2015, as has been mentioned

#### *WP2: Review of existing training materials (Deliverable 2)*

The main aim of the training materials review was to identify, select and assess existing good quality training programmes that address the particular issues related to improving access and quality of health care delivery for migrants and ethnic minorities. The review covered the last 10 years and comprised four main stages: (1) a review of published and unpublished literature; (2) a survey addressing national contact persons, and representatives of international organisations and NGOs aimed at identifying and describing existing training programmes; (3) an analysis of information collected; and (4) an assessment of the quality of the training programmes identified. The quality assessment was done using criteria that covered the pedagogical approach of the training, its educational content, structure, participant characteristics, and evaluation. Good training practices produced in EU member states were identified as part of the review.

The final WP2 report points out that, training programmes are characterised by low levels of participant involvement in training development, delivery, and evaluation. The main professional groups addressed are health professionals, but the general tendency is to address training programmes to a multi-professional audience. Cultural competence continues as the broad conceptual approach for training programmes, but alternate approaches such as intersectionality and person-centeredness are emergent. Training programmes are not systematically focusing on outcomes in training design, implementation and evaluation.



They are also poorly linked to key organisational and policy support mechanisms.

The WP1 was finally approved in March 2015, as has been mentioned

*WP3: Training programme for health professionals and health care providers (Deliverable 3)*

The Expert Working Group (EWG) for WP3 was set up and led by the EASP. Its first task was to review the challenges regarding access to health care services for migrants and ethnic minorities throughout the EU, as well as the best training practices. This review was done in light of the WP1 and WP2 final reports, including proposals for improvement obtained even after the conclusion of ToT, from partners and CHAFAE Next, the EWG developed a consensus regarding the implications of the findings of these work packages for the new training programme. The final detailed outline of the contents for the new training package was then developed in close collaboration with CHAFAE. This table of contents is included as Annex 3.

**Work package in process**

*WP4: Training workshop programme and content (Deliverable 4)*

The training of trainers workshop will be held at the Andalusian School of Public Health in Granada, Spain. The workshop programme and content have been finalised in close collaboration with the contracting authority. The programme with the content headings is included as Annex 4. The actual training material for the defined content of the workshop has been developed and is currently being revised in light of feedback. All training materials will be in English.

Concurrent with planning the training of trainers workshop, the EASP with its partners commenced the planning of the country-level pilot training programme. This includes designing the face-to-face training sessions, the guidelines for recruiting the participants, a brochure with the training content and the format for inviting participants. The draft pilot training schedule is included in Annex 5.

The WP4 partners have designed the methodology for evaluating the piloting of the training programme. The draft methodology can be found in Annex 6.



## **Additional activities**

*Final dissemination workshop:* Annex 7 describes the preparatory work and a draft plan for arranging the final dissemination workshop, prepared by IOM with support of EPHA. The proposal is to hold the workshop in September 2015 either in Luxembourg or in Brussels.

*Project representation:* Ainhoa Ruiz Azarola presented the MEM-TP project in the *Conference on health inequities and vulnerability: Capacity building & interventions among EU Member States*. The conference was held from 20 to 21 October 2014 in Rome under the auspices of the EU Italian presidency.

## **Work programme planned for the following period**

As shown in Annex 8, the immediate next programme activity at the time it was filed provisional interim report (December 2014) is the Training of Trainers workshop. It has been held at the Andalusian School of Public Health from January 28 to 30, 2015. In this workshop, the MEM-TP training package was shared with three trainers from each of six pilot countries, as well as with 5-6 additional trainees, sponsored by the IOM.

Country-level piloting of the training package is scheduled to take place from March to April 2015 with planning starting in February. The pilots will be evaluated and the training materials updated in light of the evaluation findings. The evaluation report will be finalised by the end of May 2015. The updating of the material will proceed parallel to the preparation of the evaluation report and will be completed in time for the dissemination workshop.

The dissemination workshop is planned for the second half of September in 2015. It will be held either in Luxembourg or in Brussels. The report of the dissemination workshop will be ready by the end of 2015.

The preparation of the final report will start in August 2015. It will be completed after the report of the dissemination workshop has been finalised in order to incorporate any insights from the workshop. The submission of the final report is planned to take place in January 2016 with the final administrative report being submitted in March 2016.



## **Annex 1**

Deliverable 1: WP1 Synthesis report and appendices of the migrant and ethnic minorities review



# Synthesis Report

## Work package 1 MEM-TP project

Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma

Authors: Claire Mock-Muñoz de Luna,  
David Ingleby, Emma Graval, Allan Krasnik

Date: February 23, 2015



Co-funded by  
the Health Programme  
of the European Union





## Table of contents

Table of contents .....	1
Executive Summary.....	5
Introduction.....	16
Chapter 1: Migrants and ethnic minorities in Europe.....	20
1.1. Definition of a migrant.....	20
1.2. Different types of migrants.....	22
1.3. Development of migration in Europe .....	23
1.4. Statistics on migration .....	27
1.4.1. Total migration.....	28
1.4.2. Asylum claims .....	28
1.4.3. Irregular migrants.....	28
1.4.4. Proportion of EU migrants and ‘Third Country Nationals’ .....	29
1.5. Demographic characteristics of migrants.....	30
1.5.1. Gender.....	30
1.5.2. Age .....	30
1.5.3. Socioeconomic position .....	31
1.6. Ethnic minorities.....	33
1.6.1. Definitions .....	33
1.6.2. Vulnerable minority groups.....	36
1.6.3. Which countries collect data on ethnicity in census forms and population registers? .....	38
1.6.4. Main types of research on health and ethnic minorities in Europe.....	39
1.7. Descendants of Migrants.....	42
1.8. The Roma population in Europe.....	44
1.9. Statistics on the Roma population .....	45
1.9.1. Age .....	46
1.9.2. Social position.....	48
Chapter 2: State of health and health determinants.....	49
2.1. General issues.....	49
2.1.1. Gaps in the data.....	49

2.1.2. The relation between poor health and shortcomings in health service provision .....	50
2.1.3 Changing assumptions regarding the importance of different determinants of health.....	51
2.2. Health inequalities affecting migrants and ethnic minorities and their determinants .....	54
2.2.1. The 'healthy migrant effect' .....	54
2.2.2. The lack of main effects.....	54
2.3. Differences found.....	55
2.3.1. General measures of health.....	55
2.3.2. Non-communicable diseases .....	57
2.3.5. Communicable diseases.....	60
2.3.6. Maternal and child health .....	63
2.3.7. Mental health.....	64
2.3.8. Occupational health and safety.....	66
2.4. Health inequalities affecting the descendants of migrants.....	67
2.4.1. Findings from the UK.....	67
2.4.2. Findings from the Netherlands.....	68
2.4.3. Findings from other countries .....	69
2.5. Health determinants.....	70
2.5.1. Location of determinants .....	70
2.5.2. Nature of determinants.....	71
2.6. Health inequalities affecting Roma and national ethnic minorities, and their determinants .....	76
2.6.1. General issues .....	76
2.6.2. Differences found .....	77
2.6.3. Health determinants .....	79
Chapter 3: Legal and policy framework relating to migrant and ethnic minority health in the EU .....	81
3.1. Importance of the international dimension.....	81
3.1.1. Inherent weaknesses of international laws and initiatives .....	81
3.1.2. Constructive versus coercive power of legal instruments .....	83
3.1.3. The complex nature of governance in health systems .....	83
3.2. International, regional and national legal frameworks.....	83
3.2.1. International level.....	83
3.2.2. Regional (European) level .....	85
3.2.3. National level.....	86
3.3. International and regional policy initiatives .....	89
3.3.1. International level.....	90

3.3.2. Regional (European) level .....	91
3.3.3. National level.....	95
3.4. Legal instruments and policy initiatives specifically addressing health inequalities of ethnic minorities, including the Roma.....	96
Chapter 4: Barriers to accessing health services and good practices addressing them .....	99
4.1. Dimensions of access.....	99
4.1.1. General issues concerning access .....	101
4.2. Examples of barriers to access and good practices to address them .....	104
4.2.1. Lack of information, poor 'health literacy' .....	104
4.2.2. Practical barriers .....	107
4.2.3. Language barriers .....	109
4.2.4. Discrimination and mistrust.....	109
Chapter 5. Factors undermining the quality of health service delivery and good practices addressing them.....	111
5.1. What is meant by 'quality'? .....	111
5.2. Factors undermining quality and good practices addressing them.....	112
5.2.1. Cultural barriers .....	112
5.2.2. Language barriers .....	115
5.2.3. Barriers between the health system and migrant or ethnic minority communities.....	117
Chapter 6. Developing a European framework for collaboration on migrant and ethnic minority health .....	120

*Appendix I: Migrants and Ethnic minorities in Europe: Demographic data,*

*Appendix II: Migrants and Ethnic minorities in Europe: State of health*

*Appendix III: Legal and policy frameworks relating to migrant and ethnic minority health in the EU*

*Appendix IV: Utilisation of health services, barriers to access and good practices addressing them*

*Appendix V: Good practice in cultural competency training for health professionals - literature and EU funded projects*

*Appendix VI: EU funded projects addressing migrant and ethnic minorities' health*

## List of figures

Figure 1 Economic growth and immigration in Europe beginning in the 1950's and 1960's	24
Figure 2 Economic growth and immigration in Europe beginning in the 1980's and 1990's	25
Figure 3 Economic growth and immigration after the 2000's in Europe	26
Figure 4 Variation in asylum claims lodged in 44 industrialized countries 1990-2012	28
Figure 5 Percentage of migrants who are third-country nationals (2013)	29
Figure 6 Age structure of the national and non-national population, EU-27, 1 January 2012 (%)	31
Figure 7 At-risk-of-poverty rate among migrants, by region of origin, 2010 income year	32
Figure 8 EU member states with largest Roma and Traveller populations (2010)	46
Figure 9 Population pyramids in Europe: Roma community and the European Union	47
Figure 10 Roma and non Roma Households with severe material deprivation in Europe, 2011	48
Figure 11 Different exposures during the life course on the health of migrants	71
Figure 12 'Rainbow' diagram showing social determinants of migrant health, WHO 2010	74
Figure 13 Conceptual framework for migrant and ethnic minority health in Europe	121

## List of tables

Table 1 Risk factors for migrants' health	75
---	----

## **Executive Summary**

### **1. Brief overview of the report**

This report was compiled by the University of Copenhagen's Research Centre for Migration, Ethnicity and Health (MESU), in collaboration with experts from the University of Amsterdam based at the Academic Medical Centre (AMC) and the Amsterdam Institute for Social Science Research (AISSR). It forms part of the first work package of the project MEM-TP (*Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma*). The title of WP1 is *Review of the migrant and ethnic minorities' situation in the EU and identifying common challenges and best practices to provide an overview of the issues of relevance to the development of training for health professionals*. This WP resulted in two deliverables: firstly the present report, and secondly a series of Appendices providing detailed information to accompany it. The report has the following components:

**Introduction.** This outlines the challenge presented to health systems by steadily increasing migration to the European Union, as well as by the existence of substantial ethnic minorities in many Member States. Inequalities in health and health care affecting these groups have recently been exacerbated by the financial and economic crisis. These inequalities call for concerted action at European and national levels, including the development of training programmes to further capacity-building.

**Chapter 1** provides definitions of the terms used in the report and outlines the way in which migration has developed in different Member States from World War II to the present, in order to illuminate the divergent national approaches to migrants and ethnic minorities and their health problems that have arisen in each country. It describes basic demographic characteristics of the current migrant population. In relation to ethnic minorities, the chapter discusses the concept of 'ethnic groups' and singles out for particular attention the Roma, describing briefly their history and demographic characteristics.

**Chapter 2** is concerned with the state of health of migrants and ethnic minorities in Europe, as well as the main factors affecting their health. It analyses the shortcomings of the present knowledge base and presents a brief overview of the most important research findings, as well as introducing the theoretical frameworks developed to analyse the determinants of health problems.

**Chapter 3** describes the development of the legal and policy framework within which notions of 'good practice' in this area have developed, distinguishing international, European and national levels. It traces the gradual shifts that have taken place in the way problems are formulated and solutions proposed.

**Chapter 4** focuses on the problems that migrants and ethnic minorities (in particular, Roma) may encounter in trying to access health services and identifies a number of good practices from literature and EU projects to address these problems.

**Chapter 5** analyses the ways in which health service delivery may need to be adapted to ensure a better match between the services and the needs of migrants and ethnic minorities.

**Chapter 6** provides an outline for a proposed Framework for European collaboration for training health professionals, which will be further elaborated on in subsequent work packages.

To supplement the report, the following information has been provided in the Appendices.

**Appendix I.** Detailed statistics on the distribution of the migrant and Roma population in Europe and their demographic characteristics (Chapter I)

**Appendix II.** Epidemiological findings on the main diseases and health problems affecting migrants and ethnic minorities in Europe (Chapter 2).

**Appendix III.** Legal and policy frameworks relating to migrant and ethnic minority health in the EU at international, European and national levels (Chapter 3).

**Appendix IV.** Information about the utilization of health services by migrants and ethnic minorities; barriers to accessing health services and good practices developed to address them (Chapter 4).

**Appendix V.** Improving the matching of health service delivery to the needs of migrants and ethnic minorities (Chapter 5).

This report draws heavily, though not exclusively, on the body of knowledge that has been built up by the substantial number of EU funded projects that have been carried out in recent years, particularly in the last decade.

**Appendix VI** provides a list of these projects and analyses their content.

The methodology used for this project was based mostly on desk research. For the literature reviews contained in the Appendices a number of databases listing scientific publications were searched (e.g. PubMed, Science Direct, Elsevier), as well as grey literature. The report also draws on material developed in the course of the COST Actions IS0603 (*Health and Social Care for Migrants and Ethnic Minorities in Europe - HOME*) and IS1103 (*Adapting European health systems to diversity - ADAPT*).

## **2. Summary of findings in each area**

### **Introduction**

This section outlines the background and context of the current project. As the proportion of migrants and ethnic minorities in Europe grows, so does the need for health systems to adapt to increasingly diverse populations with diverse needs. The health of migrants has come to the attention of health systems in different ways, with approaches differing according to the region in Europe, the number and type of migrants involved, their countries of origin and other factors.

Migrants and ethnic minorities represent a wide range of groups. The category ‘ethnic minority’ can refer to migrants and their descendants as well as to national and indigenous minorities, who, though distinct, are often affected by many of the same issues. Although few generalizations can be made about this very heterogeneous population, there is, for example, a consensus regarding the overall lower economic status held by most migrant and ethnic minority populations in comparison to the majority population. Research also points to an increased risk of developing a number of chronic as well as acute health conditions in this population when compared to the national averages. Mortality and life expectancy rates vary too: for the Roma, for example, data on life expectancy across Europe is estimated to range from 7-20 fewer years than for non-Roma.<sup>1</sup> In the case of migrants, even if many are healthy upon arrival, lifestyle factors and living conditions may over time lead to a variety of health problems.

Moreover, many of these inequalities in health are on the rise. Migrants and ethnic minorities tend to suffer from multiple forms of disadvantage, and this is a major factor influencing their health. In times of crisis when socioeconomic inequalities are increasing, they face even greater inequalities in health. Under ‘austerity’ policies, the most vulnerable groups in society absorb the main impact of spending cuts in the public services sector – in particular when these policy measures limit access to key services such as health care.<sup>2</sup>

In order to properly address the health inequalities experienced by migrants and ethnic minorities in Europe, there is a growing consensus that the increased health risks to which they are exposed have to be identified and the underlying causes investigated. This requires changes in the way health data are routinely collected, as well as increased research efforts. The determinants of ill-health that are discovered need to be tackled through prevention, health promotion and the implementation of an intersectoral “health in all policies” approach focused on the social determinants of health. A further challenge lies in the fact that legal entitlement to health care does not by itself ensure access to good quality services. Here, a key concern is identifying the problems migrants and ethnic minorities may have in gaining adequate and timely access to health services, as well as the shortcomings that exist in the quality and appropriateness of the services they receive. These groups all too often provide an illustration of the “Inverse Care Law” formulated in 1971 by Julian Tudor Hart<sup>3</sup>: “the availability of good medical care tends to vary inversely with the need for it in the population served”.

All these tasks require substantial capacity building concerning knowledge and expertise on the challenges posed by increasingly diverse populations and the health problems they face. Health systems must improve their understanding of how best to protect the health of migrants and ethnic minorities and meet their needs for adequate care. Through effective dissemination and training programmes, they must also ensure that this understanding is shared by health workers of all kinds and at all levels. However, focusing exclusively on front-line professionals ignores their need for back-up and support from all levels of the organisation. This implies that systematic training and education,

<sup>1</sup> Matrix Consulting. *Roma Health Report*. European Commission, Health and Consumers. [http://ec.europa.eu/chafea/documents/health/roma-health-report-2014\\_en.pdf](http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf) (accessed on 23<sup>rd</sup> of September, 2014)

<sup>2</sup> Eurofound (2013). *Impacts of the crisis on access to healthcare services in the EU*, Dublin.

<sup>3</sup> Hart, J.T. (1971). The inverse care law. *The Lancet*, Volume 297, Issue 7696, Pages 405 – 412.

not only of health workers, but also of policy-makers, managers and researchers, is required to bring about change. In this review we will attempt to summarise the most important issues in the study of migrant and ethnic minority health, and to review the current 'state of the art' in regard to our knowledge about these issues. The review will highlight in particular issues to which attention needs to be paid in training courses aimed at health professionals in mainstream organisations.

## **Chapter 1. Migrants and ethnic minorities in Europe**

This chapter gives a brief sketch of post-war migration to Europe and discusses the ethnic minorities present in the region. The number of migrants in the EU has been on the increase since the Second World War, amounting in 2013 to just over 10% of the total population<sup>4</sup>. Approximately half of these migrants are women, while in general, both migrant and ethnic minority populations tend to be younger than the majority populations.

The terms 'migrant' and 'ethnic minority' are complex and definitions often vary from country to country. Regarding migrants, this report starts from the definition used by the UN, World Bank, OECD and EU, which define an (international) migrant as "a person who changes his or her country of usual residence". Migrants may be classified in terms of the grounds on which they receive a residence permit, for example labour migrants, students, migrants arriving for family reunification or formation or asylum seekers. Most irregular (or 'undocumented') migrants have at some time held a valid permit.

Migration to Europe has developed in very different ways in different countries – firstly in terms of the period during which it started to increase, secondly in terms of its volume, and thirdly in terms of the types of migration involved. Patterns of migration are constantly shifting, so that stereotypical assumptions about migrants formed in one period may be quite misleading in another.

Beginning in the 1950's and 1960's, North-western European countries saw the arrival of large numbers of 'guest workers' from Southern Europe, Turkey and North Africa, as well as migrants from European colonies or ex-colonies. These migrants helped to power the economic growth that Europe enjoyed until the oil crisis of 1973. Large numbers of 'guest workers' in fact remained in North-west Europe, and many of them were also joined by family members. Given the initial expectation that they would return home, no efforts had been made to encourage their integration. When economic growth slowed down in the 1970's, severe restrictions were placed on labour migration from non-Western countries; family reunion or formation and asylum-seeking became the main grounds for migration from these countries.

In the 1980's and 1990's net migration started to increase in a number of other countries, namely those who had recently transitioned to democracy and subsequently joined the EU (Spain, Greece and Portugal), as well as a few of the countries formerly under Soviet occupation (Bulgaria, the Czech Republic and Slovakia) and Finland.

The issue of migrants' health gained importance in different countries in different ways. Initially, attention focused mainly on 'guest workers' because of the increased health risks many of them faced,

---

<sup>4</sup> Source: Eurostat [migr\_pop3ctb]



as well as the linguistic and cultural barriers experienced in their encounters with health services. In response to concern voiced by health professionals, the first conference on Migrant Health was organized in The Hague in 1983 by the Dutch Government and the WHO Regional Office for Europe<sup>5</sup>. Some countries (including France, Germany and Austria) adopted a 'passive' approach to the problems, expecting migrants to adapt to the existing health systems, while countries with a more 'active' policy (such as Netherlands and Sweden) made considerable efforts to address the issue of migrant health within the framework of their 'multicultural' integration policies.

In the second wave of migration in the 1980's and 1990's, Spain, Portugal and Italy responded actively by granting all migrants (including irregular ones) access to their health system and by collecting data on and adapting services to the needs of migrants. Others, such as Greece, relied on NGO's to address many of these needs.

The complex political, demographic and economic changes since 2000, including the addition of 13 new member states to the EU, have led to an increasingly positive migration balance (except in Slovenia, Poland and the Baltic States). Concerning asylum seekers and irregular migrants, worsening economic, climatic and political conditions in many non-European countries have led to an increase in recent years. These developments, as well as the increasingly 'circular' nature of migration and the emerging 'super-diversity' of populations in large urban areas, represent significant challenges for the health care systems of the countries involved. Training programmes must always bear in mind these differences in the history, quantity and nature of migration flows in order to effectively address the resulting challenges.

### *Ethnic minorities in Europe*

The term 'ethnic minority' is used to cover many different kinds of groups. There are widely differing views about what ethnicity is, which ethnic groups exist, and who should be regarded as a member of them. Different types of 'ethnic group' can be distinguished: *indigenous peoples* are groups which may have lived in a country as long as, or even longer than, the majority (or dominant) ethnic group. Other ethnic minorities can result from migration, or from the redrawing of national borders (as happened on a large scale during and after the First and Second World Wars, the break-up of the Soviet Union and the Balkan Wars).

Because of the lack of shared understandings in this field, it is impossible to make a definitive list of the ethnic minorities that exist in Europe. Moreover, studies on health have only been carried out on a few minorities (most of them 'indigenous') – although in the UK and the Netherlands the variable 'ethnicity' is commonly used in health research. In this report special attention is paid to the Roma, for three reasons. Firstly, the group is much larger than any other ethnic minority in Europe (10-12 million). Secondly, Roma experience an extreme degree of social disadvantage and discrimination. Thirdly, data on other European minorities is sparse, whereas there is a growing body of research on the inequalities in health experienced by Roma in Europe.

---

<sup>5</sup> Colledge M, Van Geuns HA, Svensson PG, eds. (1986). *Migration and health: towards an understanding of the health care needs of ethnic minorities. Proceedings of a consultative group on ethnic minorities* (The Hague, Netherlands, November 28–30, 1983). Copenhagen, WHO Regional Office for Europe.

It is safe to say, however, that many ethnic minorities in Europe – however they are defined – experience some of the same socioeconomic disadvantages and prejudices as the Roma, leading to inequalities in health and barriers to quality health care. The Sami in Northern Norway, Sweden and Finland provide an example of this. Health professionals should be trained to understand the particular socioeconomic conditions, health risks and barriers to health care experienced by the ethnic minorities present in the countries where they practice.

## Chapter 2. State of health and health determinants

Despite significant efforts to collect information on the health of migrants and ethnic minorities over the last decade, limitations in the data persist. What we do know is that those with the greatest need for good health care are often those who are least able to access it. Health services need to ensure that the needs of migrants and ethnic minorities, with their known health vulnerabilities, are met.

### *Increasing focus on the role of socioeconomic determinants of health*

Over the last two decades a shift in focus has taken place amongst researchers and policy makers. Increasingly, the emphasis has moved 'upstream', i.e. focusing on fundamental determinants of health, such as those described in the 'Marmot Report' on the social determinants of health.<sup>6</sup> Epidemiological research into the causes of ill-health, especially the role of social disadvantage, has become more central. Furthermore, there is growing emphasis on the need for macro-level policies to improve the social, economic and legal situation of migrants and ethnic minorities.

### *Health inequalities affecting migrants, their descendants, and ethnic minorities*

While migrant status may have a positive association with health (the so-called 'healthy migrant effect'), migration tends to have a negative effect on an individual's health. The main findings identified in our abbreviated literature review include the following:

- **General measures such as mortality and life expectancy, and self-perceived health:** while no overall generalisations can be made, many (but not all) studies show higher mortality rates for migrants, and that migrants assess their own health less favourably than do the host population.
- **Non-communicable diseases, such as cardiovascular diseases, diabetes and cancer:** Research studies indicate an overall increase in incidence in migrants with age for the first two diseases, and an often lower risk of developing cancer.
- **Communicable diseases:** Despite data limitations, research sometimes shows a higher risk of HIV, tuberculosis, and other diseases such as Hepatitis B, amongst migrants and ethnic minorities.
- **Maternal and child health:** Migrant women experience a higher risk of maternal mortality, and newborns less favourable outcomes, for example in terms of low birth weight, premature birth, and perinatal mortality.
- **Mental health:** Research has identified an overall higher incidence of depression, anxiety disorders, schizophrenia, and PTSD (post-traumatic stress disorder).

<sup>6</sup> CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva, World Health Organization

Many different kinds of factors may underlie the prevalence of disease among migrant and ethnic minority groups. The origin of health problems, in the case of migrants, may lie in the country of origin, the journey or in the host country. Given the increasing tendency in studies of migrant and ethnic minority health to focus on more 'upstream' risk factors underlying health problems, the strategies for combating them should involve intersectoral interventions going beyond the health sector itself, e.g. education, housing and the labour market.

### **Chapter 3. Legal and policy framework relating to migrant and ethnic minority health in the EU**

Because the ability of migrants and ethnic minorities to influence national legislation is restricted, legal instruments and policy initiatives aimed at protecting their health often originate at the international level. For a number of reasons, however, international laws and conventions are of limited effectiveness when it comes to changing realities on the ground in the field of health. Yet legal action may not be the best way to get things changed anyway. Beyond the sphere of legislation, many policy initiatives have been launched since the 1990's to promote constructive changes in health systems that will enable them to respond better to the needs of increasingly diverse populations. Most of these policy initiatives have been focused on migrants, though some also relate to ethnic minorities such as Roma. Concerning Roma, since the end of the 1990's there has been a sustained effort at European level to promote policies that will support integration and better health for this group.

A gradual shift of perspective can be discerned in all these policy initiatives. Firstly, whereas early initiatives tended to involve short-term, localised, 'one-off' interventions and categorical (separate) provisions for migrants and ethnic minorities – a sort of 'first-aid' approach - the accent has come to lie on 'mainstreaming' of provisions. This promotes their sustainability and universal availability. In keeping with this, a 'whole organisation approach' has been adopted, stressing that not just individual health workers but entire organisations have to learn to adapt to diversity. This includes measures on the individual as well as the organisational level to eliminate discrimination in access and quality of health care against migrants and ethnic minorities. Intersectoral collaboration between different agencies concerned with social protection and policy-making is also required.

At the same time, within the field of Public Health 'upstream' causes of illness have come to be increasingly stressed by epidemiologists, while policy-makers have sought remedies at the macro-social level using the 'health-in-all-policies' (HiaP) principle to tackle the social determinants of health. This type of thinking, which emphasises legal, political and economic inequalities, has yet to gain a firm foothold in approaches to 'vulnerable groups' such as migrants and ethnic minorities.

However, one promising sign is the adoption of an 'intersectional' approach to health care delivery. Whereas diversity was traditionally viewed through the narrow lens of 'cultural differences', health workers are now urged to take account of *all* aspects of a person's social context and position in society. In this way, work tackling migration- and ethnicity-linked inequities can form a common front with work on other kinds of inequity, such as those linked to socioeconomic disadvantage, social exclusion, gender, age, education, disability, sexual orientation etc.

## Chapter 4. Barriers to accessing health services and good practices addressing them

Access to and quality of health services are expressions that refer to two different steps in the process of using health services. The first, access, refers to the process of getting through the door, so to speak, while the issue of quality arises once a person has got inside the door, i.e. after overcoming any barriers to access. However, the relation between the two concepts is often blurred, as, for example, when perception of poor quality of services acts as a barrier for individuals seeking access. Moreover, factors such as language play a role both in gaining access and in ensuring the quality of communication between patient and health professional.

Whether and how effectively migrants and ethnic minorities access health services (and subsequently, the quality of care they receive), is important for a number of reasons, not least of which is the fact that ill health may negatively affect participation and outcomes in education, work, and society in general.

A significant body of research and a good number of EU funded initiatives have aimed to identify barriers to access and good practices for overcoming them. Below is a short summary of key findings.

Typical barriers to access include the following:

- Lack of information or low health literacy: both professionals and health service users may not know about or understand the relevant entitlements to accessing health services. Also, stigma surrounding certain health issues such as mental health, may act as barriers amongst certain groups, e.g. Roma.<sup>7</sup>
- Practical barriers, such as distance and transportation, opening hours, ID and insurance, complicated registration procedures, limited health services in migration detention centres, etc.
- Discrimination and mistrust: both factors may limit access, both by direct acts of discrimination and by perceptions or expectations of such acts.
- Language barriers: inability to understand printed forms and folders, or to communicate adequately with health professionals, may lead to potentially disastrous misunderstandings when access to health services is sought.

Good practices in tackling barriers to access:

- Overcoming information barriers – e.g. strategic translation and distribution of information about health and health services, innovative health education models, cultural mediators working to reach populations.
- Overcoming practical barriers – e.g. use of mobile health units to overcome geographical barriers, educating health professionals at all levels about entitlements, and introduction of structural flexibility to enable health professionals to take care of patients whose entitlement may be in question, or who can't afford eventual fees.
- Overcoming language barriers – e.g. translating material regarding gaining access to health care, such as registration forms, information about how the health system functions, etc., as well as interpretation at entry points, such as reception.
- Overcoming discrimination and distrust – e.g. participation of migrant and ethnic minority groups in different aspects of health service design, delivery and evaluation, community-based

---

<sup>7</sup> *ibid.*

approaches aiming to mobilise the health resources already existing within communities, cultural mediators who can narrow the gap between health providers and communities.

## Chapter 5. Factors undermining the quality of health services and good practices addressing them

The *quality* of health services refers to user and health professional satisfaction, as well as the extent to which the treatment process is properly carried out, avoiding noncompliance and dropout, and leading to optimal outcomes. In order for health services to be able to do their work most effectively, individual needs and context, i.e. a patient-centred approach, should be a prime consideration.

Some of the most frequently encountered factors undermining the quality of health services include:

- *Difficult and ineffective interactions* – The view that ‘cultural differences’ are the primary cause of problems in the interactions between migrants and ethnic minorities on the one side, and health professionals on the other, has in recent years given way to a more complex vision in which many other aspects of a patient’s social and personal situation need to be taken into account.
- *Language barriers* – As we saw in relation to access, language barriers do not simply undermine quality but constitute a substantial threat to patient safety.

Good practices addressing factors undermining the quality of health services:

- *Teaching cultural competence or ‘diversity sensitivity’ to health professionals* - In order to improve the capacity of care providers to meet the diverse needs of their diverse users, experts have suggested that cultural competence has to be redefined. They propose the development of an improved ‘sensitivity to diversity’, encompassing gender, age, religion, disability, sexuality and socioeconomic position.<sup>8, 9</sup> However, focusing exclusively on front-line professionals ignores their need for back-up and support from all levels of the organisation. This implies that systematic training and education, not only of health workers, but also of policy-makers, managers and researchers, is required to bring about change.
- *Language barriers* – a number of tools have been developed and implemented for overcoming oral and written language barriers, ranging from the translation of key forms and health information, to different interpreter tools, such as face-to-face and telephone interpretation, and bilingual health professionals. Cultural mediators have been used successfully as interpreters for Roma who only speak Romani. Generally, using relatives as interpreters should be avoided.

<sup>8</sup> Chiarenza, A. (2012). Developments in the concept of ‘cultural competence.’ In: Ingleby, D. et al (eds.). *Inequalities in health care for migrants and ethnic minorities*, Vol. 2. COST Series on Health and Diversity. Antwerp: Garant Publishers

<sup>9</sup> Renschler, I., Cattacin, S. (2007). Comprehensive ‘difference sensitivity’ in health systems. In: Bjorngren-Cuadra, C, Cattacin, S. (eds). *Migration and Health: difference sensitivity from an organizational perspective*. Malmo: IMER: 37-41 (<http://hdl.handle.net/2043/4289>, accessed 28/7/14).

## Conclusions

This Work Package has attempted to give an overview of the inequalities in health and health care for migrants and ethnic minorities across Europe. In training health professionals to equip them with the skills, knowledge and understanding to better meet the needs of migrants and ethnic minorities, the following factors need consideration:

1. Increasingly, researchers, policy makers and service providers are recognizing the multiple layers of diversity in these groups, and looking 'upstream' in terms of the determinants of health. This means that any interventions to tackle health inequalities needs to take into consideration socioeconomic factors such as education, labour market participation, and housing, as well as legal situation, migrant status, ethnicity, gender, religion and sexual orientation.
2. The numbers and types of migrants in Europe vary from country to country, and this implies different priorities for initiatives addressing their needs. "One size fits all" is unlikely to be a good formula for developing training programmes in the European area. Health professionals at all levels should keep the nature and specific needs of migrant and ethnic minority populations in mind when designing and implementing interventions. This means that they need to receive background information for their country on the number and nature of migrants and ethnic minorities, as well as their health needs.
3. While legislation and policy may guarantee some form of entitlement to health services for migrants and ethnic minorities, it does not guarantee the actual access to, appropriateness, and quality of these services. This also applies to preventive and health promotion interventions. If services and interventions are not specifically targeted to migrant and ethnic minority populations, research demonstrates that their success may be limited. This is especially the case for very vulnerable groups such as the Roma, who experience a great number of barriers to accessing health services compared to non-Roma, despite the fact that most of them are national citizens of a Member State and thus should be entitled to these services.
4. In order for health professionals at all levels of an organisation to be able to ensure equitable access to and quality of health care, they should be aware of the barriers that migrants and ethnic minorities face. Organisations should be structured in such a way that they can equip health professionals with the training, support and flexibility to tackle these barriers. However, the primary responsibility for removing barriers to access must lie with the organisations themselves and with the health system they are part of, and improvements in the quality of care cannot be made by individual health workers without the support of the whole organisation.
5. In training health professionals to work more effectively with migrants and ethnic minorities, training materials should reflect and describe the shift towards 'diversity sensitivity' (an *intersectional* approach) rather than continuing to teach a curriculum exclusively focused on 'cultural' differences.

6. Health care systems are just one of a number of health determinants, though a significant one, impacting the health outcomes of migrants and ethnic minorities. Other social determinants also play a significant role. Therefore, in order to tackle health inequalities, health professionals should work in an intersectoral way wherever possible, promoting a 'joined-up' approach to the different factors at play in the lives of migrants and ethnic minorities. In practice, this could, for example, imply close collaboration with social services, schools, families, and community organisations.
7. Developing a European framework for collaboration on migrant and ethnic minority health could encourage countries to mainstream the adaptation of health systems to the needs of these groups. Through the use of standardised tools and indicators, such as the C2ME assessments, MIPEX and Equi-Health's Country Reports (the last two from the 'Big Picture' project), countries could, for example, more easily identify gaps in training, deploy the appropriate training curriculum, evaluate training results across different indicators, and compare experiences and results with other countries in the framework.



## Introduction

### *The challenge*

Global migration is increasing and accelerating: according to the United Nations<sup>10</sup>, in 2013 there were 232 million international migrants in the world, comprising 3.2% of the total population. As a result, societies are becoming more and more diverse – culturally, ethnically, and linguistically. For Europe, as a region of destination for many migrants, this trend presents many challenges and opportunities. Absorbing these newcomers and integrating them into society has become a key priority.

Media and politics often treat the subject of migration and ethnic minorities in a negative way, and especially in the recent EU elections anti-immigration parties have made considerable gains. The fact remains, however, that many European countries have come to rely on migrants to counteract falling birth rates and ageing societies. For sender countries, remittances often make up a large share of their GDP and play a vital role in their development.

While migrants make up a part of the increasing diversity of European countries, the offspring of migrants as well as national and indigenous ethnic minorities are other groups that, though distinct, are affected by many of the same issues. For example, as we shall see below, migrants and ethnic minorities in general are more likely to live in poverty than non-migrants and the majority population. The Roma, as Europe's largest ethnic minority of approximately 11 million, experience the highest levels of deprivation in Europe. According to a 2006 United Nations report<sup>11</sup>, 40% of Roma in Europe live in poverty, and 15 % in extreme poverty.

Extensive research also points to the fact that migrants and ethnic minorities face an increased risk of developing a number of chronic as well as acute health conditions, when compared to the national averages. In some countries, for example, the Roma have a life expectancy that is on average ten years less than that of non-Roma.<sup>12,13</sup> In the case of migrants, while a "healthy migrant effect" is sometimes observed among newcomers, any such differences tend to be short-lived, as other factors related to life-style and living conditions may lead over time to a variety of health problems such as elevated rates of obesity, diabetes and heart disease. Although few generalizations can be made about this very heterogeneous population, when looking in detail and disaggregating age, gender and specific groups, notable differences in health patterns emerge compared to the non-migrant and majority population. Chapter 2 discusses the epidemiological findings in more detail.

<sup>10</sup> United Nations, Department of Economic and Social Affairs, Population Division (2013). *Trends in International Migrant Stock: The 2013 Revision*. New York: UN.

<sup>11</sup> United Nations Development Programme (2006). *At Risk: Roma and the Displaced in Southeast Europe*. Bratislava: Regional Bureau for Europe.

<sup>12</sup> Matrix Knowledge (2014). *Roma Health Report*. Consumers, Health and Food Executive Agency and DG SANCO.

<sup>13</sup> Simko, V., Ginter, E. (2010) Short life expectancy and metabolic syndrome in Romanies (Gypsies) in Slovakia. *Central European Journal of Public Health*, 18 (1): 16-18.



Moreover, many of these inequalities in health are on the rise. Migrants and ethnic minorities tend to suffer from multiple forms of disadvantage, and this is a major factor influencing their health. As a result, especially in times of crisis when socioeconomic inequalities are increasing, they face even greater inequalities in health. As a result of 'austerity' policies, the most vulnerable groups in society absorb the main impact of spending cuts and privatisation in the public services sector – in particular when these policy measures limit access to key services such as health care.<sup>14</sup> Recent research on the state of public health services in EU member states hardest hit by austerity, such as Greece, confirms that it is the most vulnerable populations who are most exposed to the adverse effect of public spending budget costs on health.<sup>15</sup>

With regard to irregular or 'undocumented' migrants, the global economic crisis has led to greater inequalities between countries at an international level, while restrictions on migration have also increased because migrants are seen to compete for scarce jobs. As the 'push' factors for migration get stronger, and the restrictions on migration are tightened, the number of irregular migrants goes up. Such migrants, because of the precariousness of their situation as well as the perilous journeys many have made to reach the EU, are often found to be in ill-health and to experience difficulties and poor quality when accessing health services.<sup>16, 17</sup>

Health service providers and health professionals in the front line may not always be prepared or feel knowledgeable enough to be able to take into account the differences in culture, religion, language, socioeconomic status embodied by some of the patients they come into contact with. Research strongly suggests that the work practices of a great number of health professionals continue to be informed by stereotypical perceptions of migrants and ethnic minorities, and to include questionable methods such as using family members as interpreters.<sup>18</sup> An EU funded project entitled 'Best Practice in Health Care Services for Immigrants in Europe' (EUGATE) (see Appendix VI for more details) found that health professionals, to a great extent, consider training and knowledge about cultural sensitivity, entitlements to health care, and collaboration with interpreters and social services, to be necessary to improve the quality of health services delivered to migrants and ethnic minorities.<sup>19</sup>

<sup>14</sup> Eurofound (2013). *Impacts of the crisis on access to healthcare services in the EU*, Dublin.

<sup>15</sup> Kentikelenis, A. et al. (2011). "Health Effects of the Economic Crisis: Omens of a Greek Tragedy." *The Lancet*: Volume 378, Issue 9801, 1457 – 1458.

<sup>16</sup> Cuadra, CB. (2011). Right of access to health care for undocumented migrants in the EU: a comparative study of national policies. *European Journal of Public Health*, Vol. 22, No. 2, 267-271.

<sup>17</sup> Suess, A. et al. (2014) The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context. *European Journal of Public Health*, 1-9.

<sup>18</sup> Durieux-Paillard, S. "Differences in language, religious beliefs, and culture: the need for culturally responsive health services." In Rechel, B. et al (Eds.) (2011). *Migration and health in the European Union. European Observatory on Health Systems and Policies Series*. Maidenhead: McGraw Hill.

<sup>19</sup> Priebe et al. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. *BMC Public Health*, 11:187.

## ***Responding to the challenge***

In order to properly address the health inequalities experienced by migrants and ethnic minorities in Europe, there is a growing consensus (described in Chapter 3) that the increased health risks to which they are exposed have to be identified and the underlying causes investigated. This requires changes in the way health data are routinely collected, as well as increased research efforts. The determinants of ill-health that are discovered need to be tackled through prevention, health promotion and the implementation of intersectoral migrant health policies, addressing the needs of individual migrant groups, as well as the wider social determinants of health.<sup>20,21</sup> A further challenge lies in identifying the problems migrants and ethnic minorities often experience in gaining adequate and timely access to health services, as well as the shortcomings that exist in the quality and appropriateness of the services they receive. As far as health services are concerned, these groups all too often provide an illustration of the “Inverse Care Law” formulated in 1971 by Julian Tudor Hart<sup>22</sup>: “the availability of good medical care tends to vary inversely with the need for it in the population served”.

All these tasks require substantial capacity building concerning knowledge and expertise on the challenges posed by increasingly diverse populations and the health problems they face. Health systems must improve their understanding of how best to protect the health of migrants and ethnic minorities within their borders and to meet their needs for adequate care. In this review we will attempt to summarise the most important issues in the study of migrant and ethnic minority health, and to review the current ‘state of the art’ in regard to our knowledge about these issues. The review will highlight in particular issues to which attention needs to be paid in training courses aimed at health professionals who deal with migrant and minority populations in mainstream health care services.

## ***The development of concern for migrant and ethnic minority health***

The topic of migration and health did not become a significant item on the European research and policy-making agenda until the last quarter of the 20<sup>th</sup> century. However, efforts to understand these issues did not appear overnight. Since colonial times, academic centres in Europe have studied tropical medicine, medical anthropology, *Ethnomedizin* and similar topics in Third World countries. As the number of migrants in Europe increased after World War II, many of these centres started trying to apply their knowledge to issues of migrant health. Another influence came from across the Atlantic: during this period the intensive concern with minority health in the USA, ignited by the Civil Rights Movement and the Civil Rights Act in the 1960’s, also had considerable influence on European work on migrant health (especially through the notion of ‘cultural competence’). However, it is important to note that this American work dealt with ‘race and ethnicity’ rather than migration status as such. With the exception of the UK, European countries tend to view the term ‘race’ with downright disapproval,

<sup>20</sup> Rechel, B. *et al.* (2013). Migration and health in an increasingly diverse Europe. *The Lancet*: Vol 381.

<sup>21</sup> Council of the European Union. (2010). *Council conclusions on Equity and Health in All Policies: Solidarity in Health*. 2010. [http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/lssa/114994.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lssa/114994.pdf) (accessed Oct. 7, 2014).

<sup>22</sup> Hart, J.T. (1971). The inverse care law. *The Lancet*, Volume 297, Issue 7696, Pages 405 – 412.

and ‘ethnicity’ with considerable ambivalence; on the European continent the focus has mainly been on migrants as such.

The development of knowledge and expertise in Europe concerning migrant and ethnic minority health shows wide disparities between countries. Training programmes need to take account of these differences and to facilitate the transfer of appropriate knowledge and ‘good practices’ from countries in which they are well-developed to those in which they are scarce (see Chapter 6 for a proposed European framework for collaboration on migrant and ethnic minority health). Moreover, two EU level initiatives, Culturally Competent in Medical Education (C2ME) and the ‘Big Picture’ project of ADAPT (see Chapter 3) will assist in identifying the need for training and the topics which require particular attention, given the diverse challenges faced in each country (e.g. number of migrants, nature and needs of the migrant and ethnic minority population, and the level of existing expertise and provisions). Concerning Roma, we see that the most concern about their health problems has arisen in countries with large populations of Roma. Even in these countries, however, it is only since the late 1990’s that Roma health has become an important item on the research and policy agenda (see Chapter 3).

Not only does the *number* of migrants influence the attention paid to migrant health: the *type* of migration also influences the particular health issues that are focused on in each country. For example, there are striking differences between the work on migrant health found in different regions of Europe. In North-west Europe, the migrants of the 1950’s and 1960’s have now reached old age: many of them are particularly liable to the chronic non-communicable diseases (e.g. diabetes, cardiovascular disorders and cancer) that are common among the elderly. As a result, the UK and Germany (for example) have built up substantial expertise on these topics. Quite different kinds of expertise are sought after in countries on the Southern borders of Europe, in particular those experiencing an influx of irregular migration from other parts of the world. Here, infectious disease, sexual and reproductive health, and the effects of destitution and detention are a greater cause for concern than the problems of old age. Another illustration is the case of Sweden, which from the 1970’s onwards became home to large numbers of refugees; here, special attention has been paid to the health problems that accompany forced migration.

## Chapter 1: Migrants and ethnic minorities in Europe

### 1.1. Definition of a migrant

The UN, World Bank, OECD and EU define an (international) migrant as “a person who changes his or her country of usual residence”.<sup>23</sup> ‘Usual residence’ is defined in different ways by different countries, but a person staying only a few months (usually up to three) will normally be classed as a ‘visitor’ rather than a ‘migrant’. An exception may apply to short-term migrants employed in agriculture for seasonal work.

Migrants may remain in the host country (‘settlers’), move on to another country (‘transit migrants’), or move back and forth between home and host countries (‘circular migrants’). As we will see in this chapter, such patterns of migration are constantly shifting: stereotypical assumptions about migrants, their numbers and patterns of movement formed in one period may be quite misleading in another period.

The definition of ‘migrant’ used in this report is explained below. In population registers, two criteria may be used for identifying persons who have changed their country of usual residence: *country of birth* and *nationality*.

#### **a. ‘Foreign-born’ or ‘foreigner’?**

- Nationality is an unreliable indicator because migrants may acquire the nationality of the country to which they have moved. Moreover, since not all children born to migrant parents in the EU acquire the nationality of the host country as a birthright (*jus soli*), some of these children can be natives of the host country while being denied its nationality. They are then classified as ‘foreigners’ despite the fact that they may never have set foot outside their country of birth.
- Country of birth is also an imperfect indicator of migration because it overlooks ‘return migration’ (when a person returns to their country of birth after a long period abroad). Despite this, ‘country of birth’ is generally regarded as a more reliable indicator than ‘nationality’.

UN statistics on migration relate to “the number of people living in a country or area other than that in which they were born. If the number of foreign-born was not available, the estimate refers to the number of people living in a country other than that of their citizenship”<sup>24</sup>. Most epidemiological research also uses country of birth to identify migrants, only using nationality when country of birth is not available.

<sup>23</sup> UN (1998). *Recommendations on Statistics of International Migration – Revision 1*. United Nations Publication ST/ESA/STAT/SER.M/58/ Rev.1, New York.

<sup>24</sup> UN DESA (2010) *Migration Profiles Common Set of Indicators*.

[http://esa.un.org/MigGMGProfiles/Definitions%20and%20Sources/definitions\\_sources.htm](http://esa.un.org/MigGMGProfiles/Definitions%20and%20Sources/definitions_sources.htm)

Though definitions do not differ significantly between UN agencies and the EU, there are nevertheless important differences in the way migration statistics are presented.

- Whereas UN agencies combine statistics on ‘foreign-born’ and ‘foreign’ in the same dataset (cf the above quotation), Eurostat presents statistics based on the two indicators in separate datasets. We have also kept the indicators separate, but report only figures for ‘foreign-born’.
- UN agencies present mid-year estimates of migrant stock, while Eurostat presents annual totals at 1st January. This report uses Eurostat data on migrant stock.
- We do not, however, follow the convention which Eurostat introduced in 2011 for reporting the total of migrants in the EU as a whole, in which migrants from other EU member states are not regarded as coming from ‘foreign countries’. Unlike the totals for individual countries, Eurostat’s grand total for the EU27 (data set **migr\_pop3ctb**) refers only to migrants from outside the EU. In effect, this convention treats the EU as a single country and regards migration within the EU as internal, not international. By contrast, the totals we give for migrants in the EU are arrived at by summing the totals in the separate member states.

#### **b. Long-term, short-term or neither?**

The 1998 UN recommendations proposed that the category of migrants should be further subdivided into ‘long-term’ and ‘short-term’ migrants. “A long-term migrant is a person who migrates for a period of at least one year. A short-term migrant, on the other hand, is a person who moves to a country other than that of his or her usual residence for a period of at least three months but less than one year, except in cases where the movement to that country is for purposes of recreation, holiday, visits to friends and relatives, business, medical treatment or religious pilgrimage. The nature of the duration measure – whether it is the expected duration of stay, the duration of the permit granted upon entry or the actual duration of stay in the host country – is not specified”.<sup>25</sup>

In the global context migration statistics may be compiled in many different ways, using a one-year criterion, a three-month criterion, or other criteria based on national policies. In the past, migration statistics in EU countries were also based on varying criteria, but since the implementation in 2008 of EC regulation 862/2007<sup>26</sup> member states have been required to submit migration statistics based on the above definition of ‘long-term’ migrants. As a result, EU statistics on migration ignore ‘short-term’ migrants, though it should be borne in mind that with changing patterns of migration, substantial numbers of migrants may be overlooked in this way<sup>27,28</sup>.

<sup>25</sup> Lemaitre, Georges (2005). “The Comparability of International Migration Statistics – Problems and Prospects”, *OECD Statistics Briefs*, July 2005, No. 9. Organisation for Economic Co-operation and Development, Paris.

<sup>26</sup> <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:199:0023:0029:EN:PDF>

<sup>27</sup> Thierry Xavier, Herm Anne, Kupiszewska Dorota, Nowok Beata and Poulain Michel (2005), *How the UN recommendations and the forthcoming EU regulation on international migration statistics are fulfilled in the 25 EU countries*. Paper presented at the XXV International Population Conference-UIESP, in Tours, 18th-23th July 2005, 24 p.

<sup>28</sup> EU definitions of ‘migrant’ can be found at the following locations:  
[http://ec.europa.eu/dgs/home-affairs/e-library/glossary/index\\_m\\_en.htm](http://ec.europa.eu/dgs/home-affairs/e-library/glossary/index_m_en.htm)  
[http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european\\_migration\\_network/glossary/index\\_m\\_en.htm](http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/glossary/index_m_en.htm)

## 1.2. Different types of migrants

The main classifications we shall use in this section are as follows.

### *Labour migrants and students*

Migrants with a residence permit issued for purposes of work or study may be divided into those originating in EU/EEA countries and those from other countries ('third-country nationals', referred to from here on as TCNs). In general, EU/EAA migrants enjoy more rights than TCNs, including their rights to access healthcare. However, EU national minorities with migrant backgrounds, such as the Roma, often face significant barriers in accessing healthcare.

### *Migrants arriving for family reunification or formation*

International conventions safeguard the right to family life and many migrants enter on these grounds. In the wake of the 1973 oil crisis and the subsequent recession, most European countries severely restricted labour migration from 'non-Western' countries, so that family reasons (together with asylum-seeking) became the main grounds for migration from those countries.

Prior to 1973, many unskilled labour migrants were recruited in European countries as 'guest workers' to remedy shortages of unskilled labour. For various reasons, a large proportion of them (especially those coming from outside Europe) did not return to their home countries. This group and their offspring are of particular concern today because their socioeconomic status (SES) usually remained low. Although their offspring tend to fare better, many have remained in a disadvantaged position<sup>29</sup>.

### *Asylum seekers*

Asylum seekers are persons applying for refugee status under the 1951 Geneva Refugee Convention. Those not granted this status may be awarded another (generally weaker) form of 'subsidiary' or 'humanitarian' protection; otherwise they will be required to leave the country. An unknown number, however, do not do so and continue to live in the country as irregular migrants.

There are wide variations in the number of asylum seekers coming to any given country, reflecting changing patterns of international humanitarian crises, the country's readiness to grant asylum or subsidiary/ humanitarian protection, and the country of origin of arriving asylum seekers. In 2013, Germany, France, Sweden, the United Kingdom and Italy registered 70% of all applicants<sup>30</sup>. In Section 1.4 we will describe changes in the influx of asylum seekers to Europe.

### *Irregular migrants*

This term is coming to be favoured over the term 'undocumented migrant' (UDM), since 'irregularity' is more often associated with having the 'wrong' papers than with having no papers at all. The term 'illegal migrant' is strongly disapproved of by international authorities, because it conflicts with the

<sup>29</sup> Liebig, T., Widmaier, S. (2009). "Children of Immigrants in the Labour Markets of EU and OECD Countries: An Overview." OECD Social, Employment and Migration Working Papers no. 97.

<sup>30</sup> Eurostat (2014). *Eurostat Newsrelease 46/2014 – 24 March 2014*. Luxembourg: Eurostat.



principle of equality before the law. No-one can be ‘illegal’ because of who they are.<sup>31</sup> Some writers find the term ‘migrants in an irregular situation’ less stigmatising; for the sake of brevity, we refer to irregular migrants.

‘Irregularity’ may arise because of entry without a valid entry permit, or residence without a valid residence permit. However, asylum seekers are exempted from penalties by the 1951 Geneva Refugee Convention “provided they present themselves without delay to the authorities and show good cause for their illegal entry or presence”<sup>32</sup>. In some situations, *either* working *or* being unemployed may invalidate a residence permit; estimates of irregular migration will therefore vary according to the extent to which they take violations of labour regulations into account<sup>33</sup>. Bureaucratic delays and errors may also result in ‘irregularity’.<sup>34</sup>

In the following sections we shall describe the development of post-war migration to Europe and present a number of statistics relating to migrants. We then examine briefly the demographic characteristics of migrants (sex, age and socioeconomic position).

### 1.3. Development of migration in Europe

In order to quantify migration, several different measures can be used. Firstly, we can consider either the annual rate of immigration to a country, or the total of ‘migrant stock’ (foreign-born residents) in that country at a certain point in time. If the rate of immigration is studied, this may also be expressed as a ‘net rate’, i.e. after subtracting the number of emigrants each year. In this report we focus on migrant stock, because this gives an indication of the size of the challenge for health systems.

#### *Development of post-war migration to Europe*

Migration to Europe has developed in very different ways in different countries – firstly in terms of the moment at which it started to increase, secondly in terms of its volume, and thirdly in terms of the types of migration involved. Training programmes must always bear in mind these differences in the history, quantity and nature of migration flows. In what follows we give a brief sketch of the main changes since World War Two.

Labour migration, in particular, tends to follow economic growth: a basic ‘pull factor’ for migration is the need for labour in a given country. Economic growth in Europe has not taken place uniformly, but has proceeded in phases. Figure 1 identifies (in **red**) the countries which experienced rapid economic growth and net immigration in the first phase (the 1950’s and 1960’s)<sup>35</sup>.

<sup>31</sup> PICUM Policy Brief. “Symptom, not the problem.” April 2007.

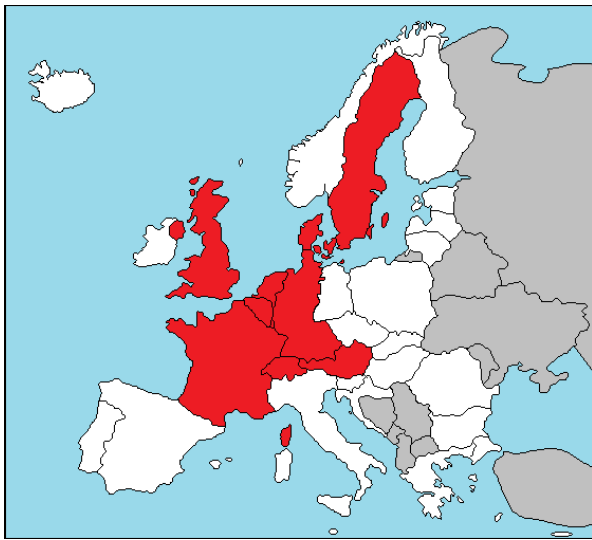
<sup>32</sup> 1951 Geneva Refugee Convention, Article 31 (1).

<sup>33</sup> Vogel, D. (2009). *Size and development of irregular migration to the EU*. Athens, Hellenic Foundation for European and Foreign Policy

<sup>34</sup> *ibid.*

<sup>35</sup> Countries outside the present EU28/EEA and Switzerland are shaded grey. Internal immigration within the former Soviet Union is not considered. Sources for Figures 1-3: Gropas, R. & Triandafyllidou, A., Eds. (2012). *European Immigration: A Sourcebook*. Farnham: Ashgate; Wanner, P. (2002). *Migration trends in Europe*. European Population Papers Series No. 7. Strasbourg: Council of Europe; UN DESA (2013). *Trends in International Migrant Stock: The 2013 Revision*.

Figure 1 Economic growth and immigration in Europe beginning in the 1950's and 1960's



This phase of European immigration mainly involved 'guest workers' from Southern Europe, Turkey and North Africa, as well as migrants from European colonies or ex-colonies. Migration to Sweden was primarily from other Scandinavian countries. Labour migration to these countries helped to power the phenomenal economic growth that took place in them from the 1950's until the oil crisis of 1973. 'Guest workers', as the name implies, were only meant to stay temporarily, so no effort was made to help them integrate, for example through integration programmes or language courses. However, many of them never returned to their country of origin, but instead settled down and were joined by their families.

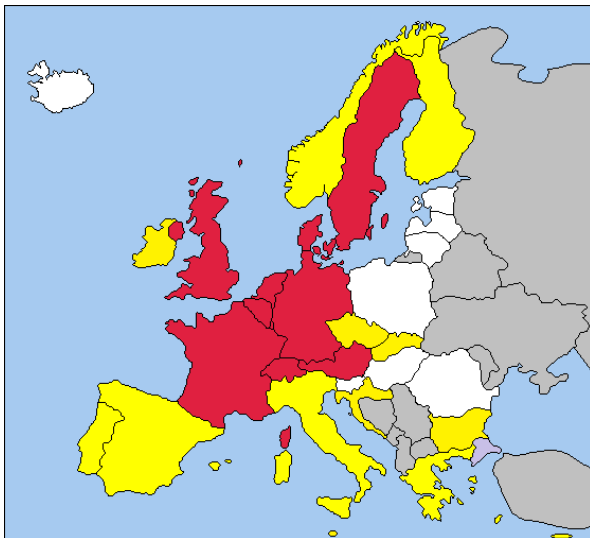
families.

Another component of migration to Europe in this period was 'post-colonial' migration. As a result of decolonisation, many settlers, administrators, military personnel and their families returned – sometimes in great haste, sometimes gradually – to Europe. Many were returning to their country of birth and were thus 'return migrants'. However, in the wake of decolonisation many citizens of former colonies also migrated to Europe, often making use of citizenship rights or favourable visa arrangements they enjoyed as former colonial subjects. The boundary between post-colonial and labour migration is therefore very indistinct. Of course, this type of migration is confined to former colonial powers such as the UK, France, Netherlands, Belgium, Spain, Portugal and Italy. Such migrants generally enjoy an advantage in terms of familiarity with the culture and language of the host country.

When economic growth slowed down in the 1970's – a process exacerbated by the 1973 oil crisis – severe restrictions were placed on labour migration from non-Western countries; as noted earlier, family reunion (or formation) and asylum-seeking became the main grounds for migration from these countries. During the 1980's and 1990's, however, a new group of European countries (marked in **yellow** in Fig. 2) experienced increasing immigration.



Figure 2 Economic growth and immigration in Europe beginning in the 1980's and 1990's



Almost all these countries had previously been characterised by *emigration*. Economic growth and immigration in Greece, Portugal and Spain was stimulated by these countries' transition to democracy in 1974-1975 and accession to the EU in the 1980's. Finland (like Sweden) joined the EU in 1995, while net migration to Norway also increased in the 1980's and 1990's. In the 1990's, after these countries gained independence from the Soviet bloc, a positive migration balance was recorded in Bulgaria, the Czech Republic and Slovakia.

How did these developments affect the growth of concern for the health of migrants? There were, and still are, great differences in the amount of attention paid to this issue. In the first period, attention focused mainly on the 'guest workers': their work was typically accompanied by increased health risks<sup>36</sup> and their encounter with the health services was complicated by linguistic and cultural barriers. In response to concern voiced by health professionals, the first conference on Migrant Health was organized in The Hague in 1983 by the Dutch Government and the WHO Regional Office for Europe<sup>37</sup>.

However, some countries were very slow to realise the importance of these issues. In a pioneering article published in 1992, Bollini<sup>38</sup> found a sharp contrast between countries adopting a 'passive' attitude (expecting immigrants to adapt to the health system designed for the 'native' population) and those with an 'active' policy (acknowledging the problems and undertaking action). In the first category (e.g. France, Germany and Austria) very little was done, apart from a few local and temporary initiatives. Among the 'active' countries, the Netherlands and Sweden adopted 'multicultural' integration policies in the 1970's and, in keeping with these policies, devoted much attention to migrant health. At the same time the UK, with its strong postcolonial and transatlantic ties, developed its own approach to diversity in health care based on 'race' and 'ethnicity'. We can conclude that having large numbers of migrants may be a necessary condition for the development of interest in their health, but it is not a sufficient one.

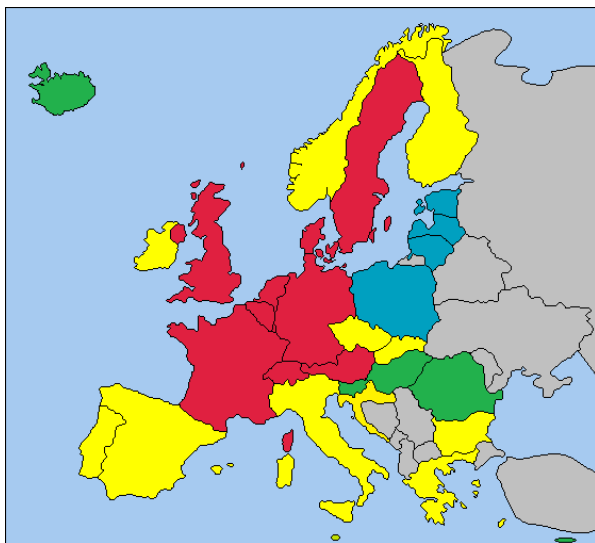
<sup>36</sup> Bollini, P., & Siem H. (1995). No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities On The Eve of the Year 2000. *Social Science & Medicine* (41)6, 819-828.

<sup>37</sup> Colledge, M., Van Geuns, HA., Svensson, PG., eds. (1986). *Migration and health: towards an understanding of the health care needs of ethnic minorities. Proceedings of a consultative group on ethnic minorities* (The Hague, Netherlands, November 28–30, 1983). Copenhagen, WHO Regional Office for Europe.

<sup>38</sup> Bollini, P. (1992). Health Policies for Immigrant Populations in the 1990s. A Comparative Study in Seven Receiving Countries. *International Migration*, Vol. 30 (Special Issue: Migration and Health in the 1990s), 103-119.

In the countries marked in yellow in Fig. 2, the response to an increase in migration was in some cases very prompt. Spain and Portugal granted all migrants – even irregular ones – access to their health systems; data on migrant health were collected and targeted policies were introduced. Norway and Finland also showed concern for the health of migrants, but in some countries the problem is left in the hands of the NGOs.

To conclude this brief review, countries which have experienced an increasingly positive migration balance since 2000 are shown in **green** on the map in Fig 3, while countries whose balance has remained (or become) negative are shown in **blue**.



**Figure 3 Economic growth and immigration in Europe after 2000**

Many political, demographic and economic changes have taken place in this period. Thirteen countries, most of them in Eastern and Central Europe and the Baltic region, joined the EU between 2004 and 2013. This had complex effects on migration. It made these countries more attractive for asylum seekers and irregular migrants, many of whom hoped to move on to Western Europe; it encouraged more of their nationals to emigrate to other EU countries; and in some cases it led to a certain amount of immigration from other EU countries. Iceland and Ireland enjoyed dramatic economic growth, followed by

equally dramatic crashes resulting from the 2007 financial crisis. These developments were mirrored in those countries by a sharp influx of migrants, followed by a (less pronounced) outflow. In the entire European area, the crisis has affected migration in complex ways.

Concerning asylum seekers and irregular migrants (so-called ‘mixed migration flows’), worsening economic, climatic and political conditions in many non-European countries have led to an increase in recent years. The most conspicuous illustration of this is the large number of ‘boat people’ crossing the Mediterranean to Southern Europe. At the same time – often in response to measures to deter the boat traffic – mixed migration over land across Europe’s Eastern borders has increased. This has presented new challenges to the health systems of the countries involved.

As we mentioned in the Introduction, the prolonged economic crisis which hit the EU after 2007 has had far-reaching consequences for the health of migrants. In many countries, policies have been adopted which have simultaneously weakened the social position of migrants and limited their access to health care. Anti-immigration sentiment has increased, health and social services have been cut, while already since the turn of the century ‘multiculturalism’ has been under attack from politicians of all persuasions.

All this would provide a serious setback to efforts to increase attention for migrant health, but it has been countered by another important development: the growth of international initiatives to promote ‘health equity’ in general, and better health for migrants and ethnic minorities in particular. Since 2000

increasing efforts have been made to link up initiatives in different countries and to further the exchange of knowledge and expertise about migrant health on a European level. In Chapter 3 we will describe these initiatives in more detail.

#### *The changing nature of international migration*

Two recent trends in international migration are highly relevant for the issue of migration health. Firstly, whereas most migrants traditionally tended to be 'settlers', there has been an increasing shift toward 'circular' or 'transient' migration<sup>39</sup>. Circular migration may involve regular trips back and forth between the host country and the home country: improved transportation facilities play an important role. This pattern is particularly characteristic of EU migrants and has major consequences for policies concerning integration and social protection. Ties with the home country may remain very strong. The EU Directorate General for Home Affairs published a report on the assessment of integration outcomes, using a series of indicators (the 'Zaragoza' Indicators) in the areas of employment, education, social inclusion and active citizenship that are meant to facilitate the evaluation and improvement of integration policies.<sup>40</sup>

The other phenomenon to note is what Vertovec<sup>41</sup> calls 'super-diversity'. Whereas fifty years ago the numbers of countries sending and receiving migrants was fairly limited, today there is hardly a country in the world which is not affected by migration. In the major capitals of Europe, hundreds of different languages may be spoken. Within each migrant nationality there will also be a great deal of diversity in (for example) educational levels, skills, ages, religions, ethnicities, and many other characteristics that have traditionally been assumed to be homogenous. Approaches to migrant health developed in the previous century may need radical revision in order to encompass 'super-diversity'.<sup>42</sup> We will return to this topic in Chapter 5.

### 1.4. Statistics on migration

In this section we will mention some important statistics at European level concerning migration. More detailed figures are given in Appendix I.

<sup>39</sup> Newland, K. (2009). *Circular Migration and Human Development*, Human development research paper 2209/42, UNDP

<sup>40</sup> Huddleston, T., Niessen, J., Tjaden, J.D. (2013). Using EU Indicators of Immigrant Integration. DG HOME Final Report. [http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/general/docs/final\\_report\\_on\\_using\\_eu\\_indicators\\_of\\_immigrant\\_integration\\_june\\_2013\\_en.pdf](http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/general/docs/final_report_on_using_eu_indicators_of_immigrant_integration_june_2013_en.pdf) (Accessed on 20 February, 2015).

<sup>41</sup> Vertovec, S. (2010). Towards post-multiculturalism? Changing communities, conditions and contexts of diversity. *International Social Science Journal*, 61: 83–95.

<sup>42</sup> Chiarenza, A. (2012). Developments in the concept of 'cultural competence.' In: Ingleby, D. et al (eds.). *Inequalities in health care for migrants and ethnic minorities*, Vol. 2. COST Series on Health and Diversity. Antwerp: Garant Publishers

### 1.4.1. Total migration

At the beginning of 2013, the total of migrant stock in the EU27 was 50,872,674, i.e. 10.1% of the total population<sup>43</sup>. (Figures for the EU28, i.e. including Croatia, relate to the period after 1<sup>st</sup> January 2014 and are not yet available). Maps presented in Appendix I show the variations in the percentage of migrants in each country.

### 1.4.2. Asylum claims

Figure 4 Variation in asylum claims lodged in 44 industrialized countries 1990-2012

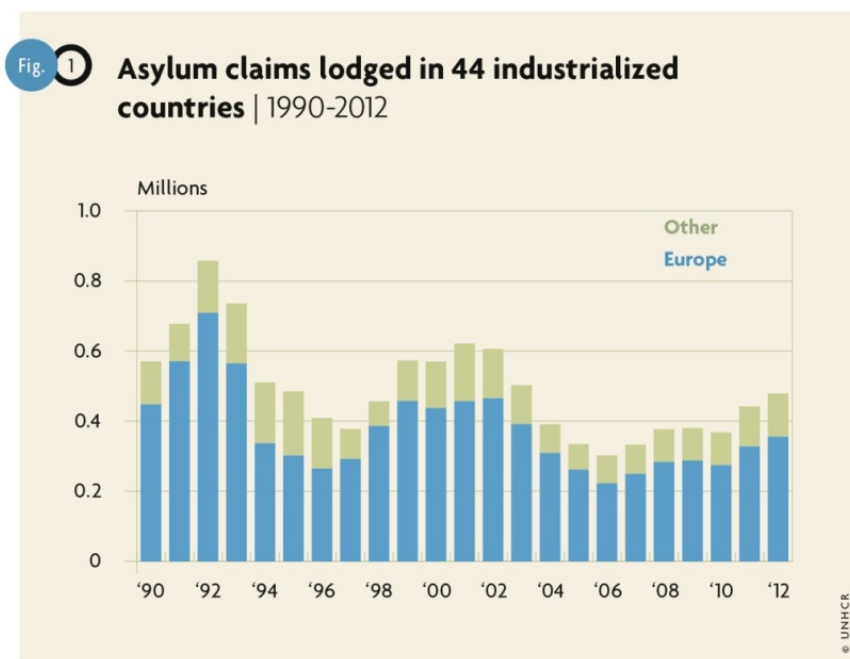


Figure 4 shows fluctuations in asylum claims between 1990 and 2012.<sup>44</sup> Figures for 2013 (not shown) continued the increase that started in 2010 and reached the highest level in Europe for a decade<sup>45</sup>. (Note that the definition of 'Europe' in this graph includes 38 countries). The main countries of origin of asylum seekers were Syria, Russian Federation, Afghanistan, Iraq and Serbia/Kosovo.

### 1.4.3. Irregular migrants

Contrary to popular assumptions, only a small proportion of irregular migrants are 'unauthorized entrants'. Of the estimated 5 to 8 million irregular migrants in Europe, most have overstayed their visas or remained in the country after their asylum application failed.<sup>46</sup> Numbers of irregular migrants are intrinsically hard to estimate, but this group is estimated to make up approximately 1% of the

<sup>43</sup> Source: Eurostat [migr\_pop3ctb]

<sup>44</sup> UNHCR (2013). *Asylum Trends 2012. Levels and Trends in Industrialized Countries*. New York: United Nations High Commissioner for Refugees.

<sup>45</sup> UNHCR (2014). *Asylum Trends 2013. Levels and Trends in Industrialized Countries*. New York: United Nations High Commissioner for Refugees.

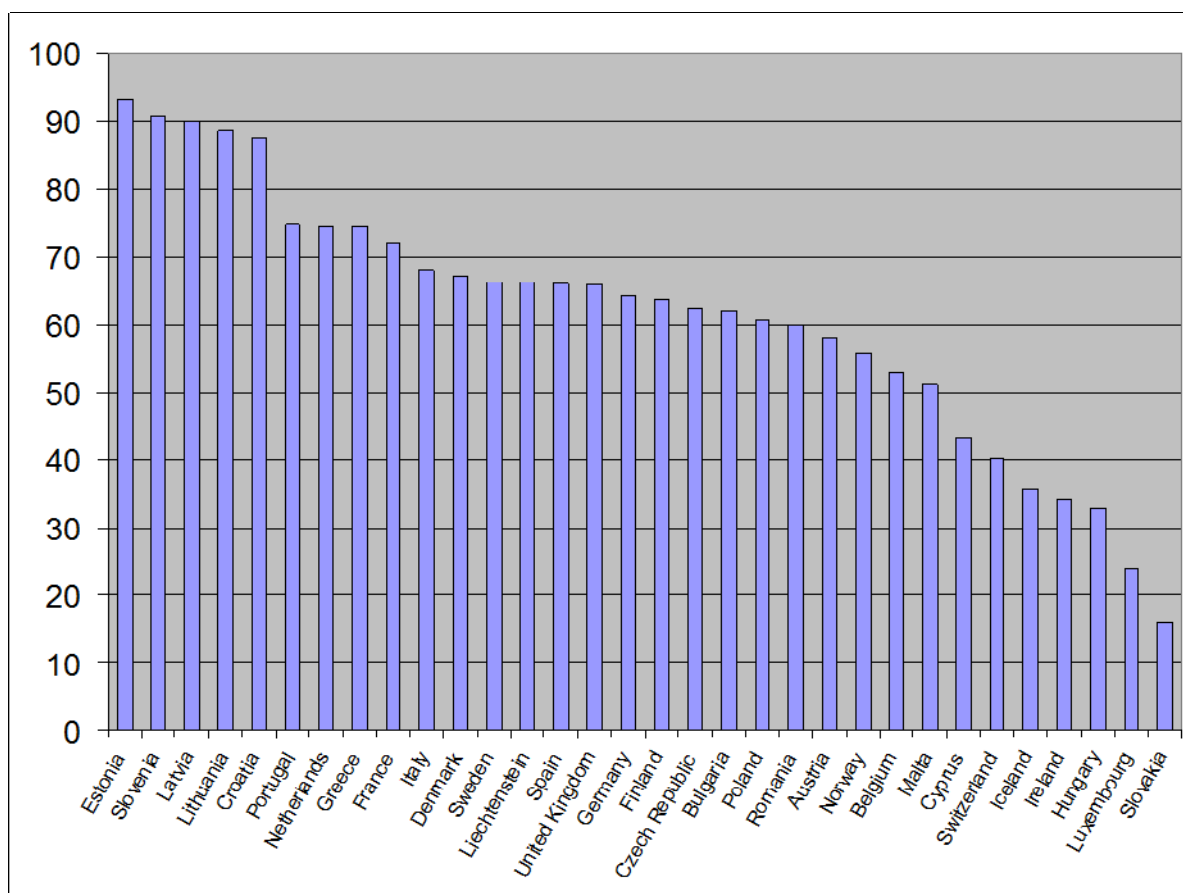
<sup>46</sup> <http://picum.org/en/our-work/who-are-undocumented-migrants/>

population of the EU<sup>47</sup>. In certain countries, regularization campaigns reduce the total numbers from time to time.

#### 1.4.4. Proportion of EU migrants and 'Third Country Nationals'

In the EU27 as a whole, 6.7% of migrant stock comprised persons born in another EU country in 2013, while 3.4% were third-country nationals. Detailed figures are given in Appendix I. The following figure shows the relative proportions of EU migrants and TCN's in 2013, in EEA countries and Switzerland as well as the EU27.

Figure 5 Percentage of migrants who are third-country nationals (2013) <sup>48</sup>



It can be seen from Fig. 5 that in 25 countries third-country nationals (TCN) predominate, whereas in 7 countries most of the migrants originate from other EU countries.

<sup>47</sup> Düvell, F. (2009). *Irregular migration in northern Europe: overview and comparison*. Oxford, University of Oxford Centre on Migration, Policy and Society

<sup>48</sup> Source: Eurostat [migr\_pop3ctb]

Regarding the first group, one reason for the high percentage of TCNs in Estonia, Latvia and Lithuania is the inclusion in the category ‘migrants’ of many people born in other former Soviet republics who were living in the country at the time of the break-up of the Soviet Union after 1989. Within the Soviet Union they had been ‘internal migrants’; suddenly they found themselves reclassified as ‘international migrants’. From a scientific point of view, there may be a case for reclassifying these so-called ‘statistical migrants’ as members of a national minority rather than migrants; however, scientific considerations do not always coincide with political ones.

### 1.5. Demographic characteristics of migrants

#### 1.5.1. Gender

Women make up approximately half of the migrants in Europe (50% in 2013 according to Eurostat).<sup>49</sup> However in some countries, female migrants outnumber males, e.g. Cyprus, Italy, Spain and Ireland. Research has shown that a great number of female migrants are domestic workers or personal care workers, and that these forms of employment often expose the migrants to exploitation and abuse from employers, leading to possible health inequalities. The vulnerability of domestic labour migrants is compounded by the fact that in many countries, domestic work is not classified as a form of employment for the purpose of obtaining a work permit, thus forcing domestic workers into irregular conditions without a legal residence permit. As such, they are more vulnerable to face exclusion from access to health services and other social welfare services.<sup>50</sup> In Chapter 2 we present more detailed findings showing the role gender plays in health outcomes for migrants and ethnic minorities, as well as gender specific health and health care access issues affecting certain migrant and ethnic minority groups, e.g. maternal and child health, and female genital mutilation and cutting (FGM).

#### 1.5.2. Age

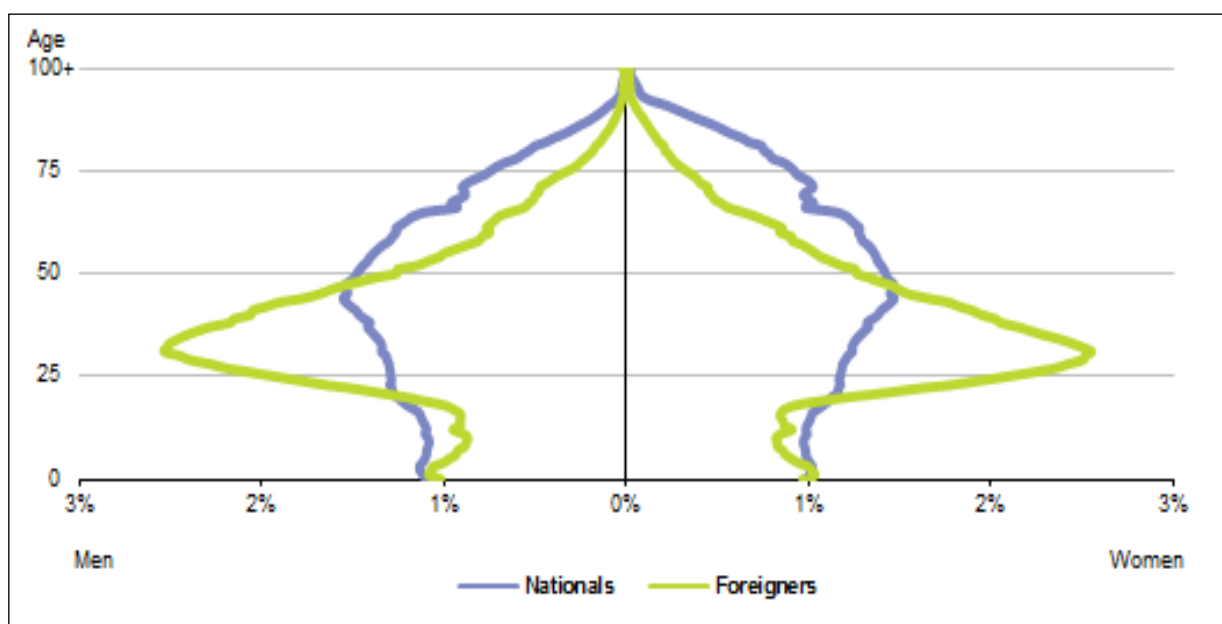
In general, migrants tend to be younger than the native population. This phenomenon is especially pronounced in the EU, with its rapidly ageing ‘native’ population. Indeed, without migration there would be steadily fewer younger people working and paying taxes to support the elderly and retired (whose need for social support and healthcare is much greater). Moreover, migrants themselves will tend to consume less health care than natives: the highest costs<sup>51</sup> are incurred in early childhood and old age - categories in which migrants are under-represented. The following ‘population pyramid’ shows the distribution of age differences.

<sup>49</sup> Flanders, O.A. (2011). Immigration to EU Member States down by 6% and emigration up by 13% in 2008. Eurostat, available at <http://bit.ly/1tRsWGm>

<sup>50</sup> Kouta, C., Kaite, C. (2012). Health issues among female migrant domestic workers. In: Ingleby, D., et al (eds). *Health inequalities and risk factors among migrants and ethnic minorities*, Vol. 1. COST Series on Health and Diversity. Antwerp: Garant Publishers.

<sup>51</sup> Yamamoto, D.H. (2013). *Health Care Costs – From Birth to Death*. Schaumburg, Illinois: Society of Actuaries. [http://www.healthcostinstitute.org/files/Age-Curve-Study\\_0.pdf](http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf)

Figure 6. Age structure of the national and non-national population, EU-27, 1 January 2012 (%)



Source : (Eurostat, <http://bit.ly/1qfH8dC>)

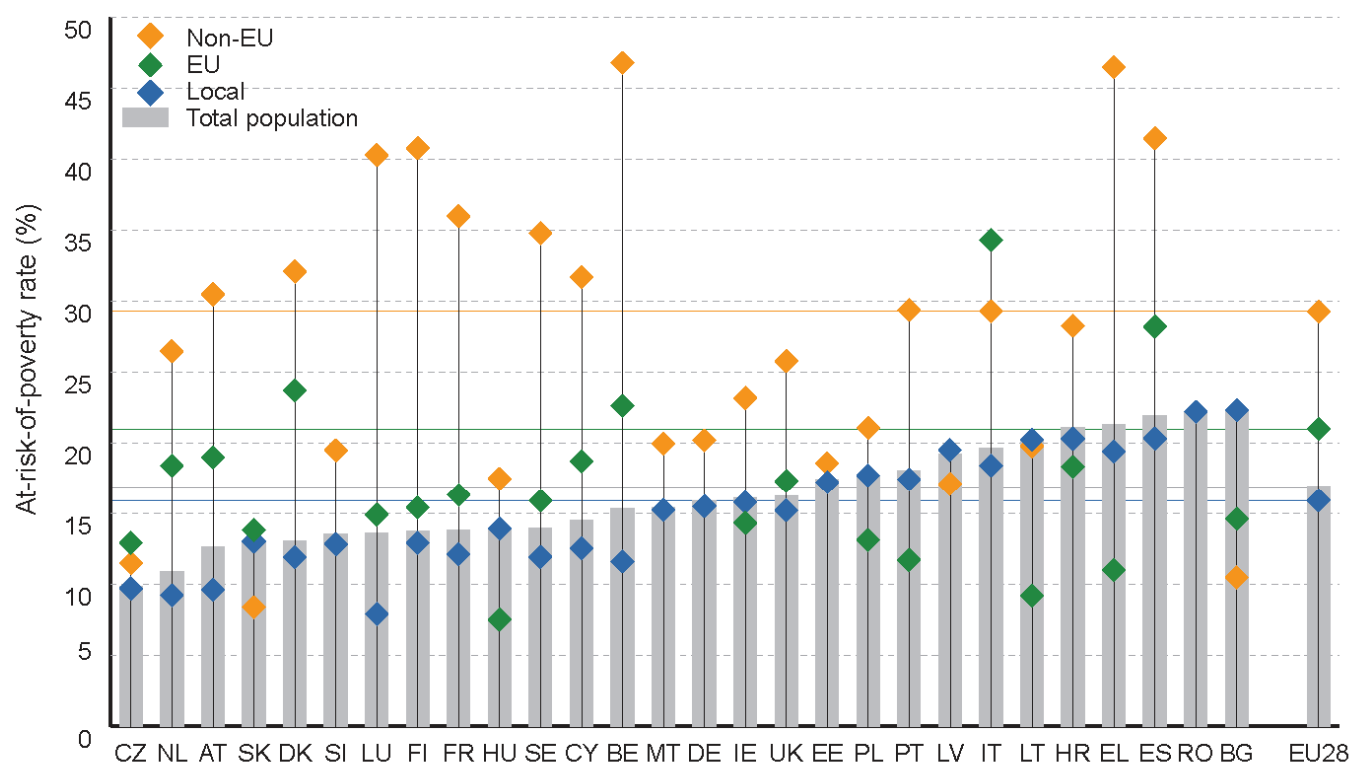
### 1.5.3. Socioeconomic position

On average, the socioeconomic status (SES) of migrants is lower than that of 'native-born' people, though it may actually be higher in some groups and there are marked individual differences<sup>52</sup>. The following graph shows migrants' risk of poverty in 2010.

<sup>52</sup> Eurostat, (2011). *Migrants in Europe. A statistical portrait of the first and second generation*. Luxembourg: Eurostat.



Figure 7 At-risk-of-poverty rate among migrants, by region of origin, 2010 income year<sup>53</sup>



Note: Estimates are based on a low number of observations (20-49) in Slovakia (for non-EU) and Bulgaria (for EU). Estimates for Romania (for EU and non-EU) are omitted due to a very low number of observations (<20). Data for Ireland refers to EU-SILC 2010.

Source: European Commission, Eurostat, cross sectional EU-SILC 2011 UDB August 2013

#### EU Social Situation Monitor

A large proportion of the health disadvantages experienced by migrants is related to their generally unfavourable socioeconomic position. However, this factor does not explain all the differences found; moreover (as we shall see) there are some respects in which certain migrant and minority groups actually enjoy lower (age-corrected) health risks.

<sup>53</sup> Source: EU Social Situation Monitor, <http://bit.ly/1x1mhgh>



## 1.6. Ethnic minorities

### 1.6.1. Definitions

The term ‘ethnic minority’ is used to refer to a wide range of disparate groups. Whereas the term ‘migrant’ can be defined quite precisely for scientific purposes, there are widely differing views about what ethnicity is, which ethnic groups exist, and who should be regarded as a member of them. For these reasons alone, it is in most countries harder to find useful data on ethnic minorities than on migrants. An additional problem is that in many countries, the collection of data on ethnic minorities is controversial. Insight into these competing conceptions, as well as the historical and political issues that underlie them, is essential for anyone seeking to understand the relationship between health and ethnicity, so we begin with an introduction to this topic

Social scientists distinguish between two contrasting approaches to ethnicity<sup>54</sup>. The classic (‘primordial’) approach maintains that people can be accurately classified as members of an ethnic group on the basis of objective characteristics. ‘Instrumental’ approaches, by contrast, regard ethnicity as a social construction and/or an individual choice, the boundaries of which are negotiated in a pragmatic way. Within the latter approach, the views of the Norwegian anthropologist Fredrik Barth<sup>55</sup> have been particularly influential. For Barth, the boundaries of ethnic groups are the *outcome* as well as the *cause* of confrontations. “Rather than taking identities and boundaries for granted, Barth is concerned with understanding how difference is organized during and arises out of interaction.....thus, collective identification is inherently political”.<sup>56</sup>

One or more of the following characteristics are typically used to define the boundaries of an ethnic group.

- **Race.** Because of its association with Nazi doctrines of racial supremacy, the concept of ‘race’ fell into discredit after the Second World War. However, it is still used as a census category and in health surveys in the USA and UK<sup>57</sup>. In both countries, the racial categories ‘Black’ and ‘White’ are used alongside other terms referring to geographical origin such as ‘Caribbean’ or ‘African’, or (in the USA) language community (‘Hispanic’). Since 1970 in the USA and 1991 in the UK, respondents have been allowed to decide for themselves the census category to which they wish to be assigned (‘self-definition’). The same procedure is currently followed in most

<sup>54</sup> Scott, J.G.M. (1990). A resynthesis of the primordial and circumstantial approaches to ethnic group solidarity: towards an explanatory model. *Ethnic and Racial Studies*, (13)2, 147-71.

<sup>55</sup> Barth, F. (1969). *Ethnic groups and boundaries. The social organization of culture difference*. Oslo: Universitetsforlaget.

<sup>56</sup> De Anca, C. (2012). *Beyond Tribalism: Managing Identities in a Diverse World*. London: Palgrave Macmillan, p. 39.

<sup>57</sup> The EU subtitles *Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin* as the ‘Racial Equality Directive’. However, no definition is given either of race or ethnic origin, and the two terms are used interchangeably

European countries, though it is not uncommon for census enumerators to ‘correct’ the categories people choose<sup>58</sup>.

- **Ancestry or ‘heritage’.** Defining ethnicity in these terms implies not only a genetic component, but also a cultural one. A shared cultural heritage is often seen as central to an ethnic group, and its maintenance may be regarded as a question of human rights.
- **Region or country of origin.** Some ethnic groups are referred to by the area from which they or their ancestors originated. For example, migrants may be designated as ‘ethnic Chinese’ if they come *either* from Chinese-speaking countries *or* from one of the many countries to which Chinese have been emigrating for centuries.

Some migration is not voluntary but forced, as in the case of groups that are displaced in wartime to other countries and are subsequently unwilling or unable to repatriate. In Europe after World War Two, an estimated 11 million ‘displaced persons’ remained in countries to which they had fled or been transported for slave labour or extermination in concentration camps<sup>59</sup>. Until it was amended in 1967, the 1951 Geneva Refugee Convention<sup>60</sup> related only to these people, many of whom settled in other countries rather than returning to their homeland.

Another type of minority may be formed by citizens of a country who are left behind when its borders are redrawn, or when – as in the case of Yugoslavia, the Soviet Union or the Austro-Hungarian Empire – it ceases to exist altogether. Still more examples are provided by colonial settlers who remain in a country after it obtains independence. All these groups may remain together and continue to speak their original language, but over time they may also be incorporated without much friction into the host society.

- **Religion.** Ethnic boundaries may be drawn in terms of the faith that a group adheres to (e.g. Jews, Muslims, Christians, Hindus).
- **Language or dialect.** Within a country, language may be regarded as the defining characteristic of an ethnic group (e.g. French-speaking Canadians or Walloons and Flemish in Belgium).
- The term **indigenous minorities** refers to groups that have been present in a country as long as the majority ethnic group – or, in the case of ‘Native Americans’ and ‘Aboriginals’, even longer.

From the above it is clear that in theory, ethnic groups can arise in a great variety of different ways. In addition, ethnic identities can intersect, giving rise (for example) to religious or linguistic subgroups within populations of a given national origin. Given the continual movement of peoples and national boundaries throughout history and the vast number of different religions, languages and dialects that exist, it is clear that in practice, far fewer ethnic groups are recognised as such than the number which

<sup>58</sup> Ahmed, P., Feliciano, C. and Emigh, R. J. (2006). *Internal and External Ethnic Assessments in Eastern Europe*. On-Line Working Paper Series, California Center for Population Research.  
<http://escholarship.org/uc/item/7r9331q0>

<sup>59</sup> McDowell, L. (2005). *Hard Labour: the forgotten voices of Latvian migrant ‘volunteer’ workers*. Portland: Cavendish Publishing.

<sup>60</sup> UNHCR, (2011). *The 1951 Convention relating to the status of refugees and its 1967 Protocol*. Geneva: Office of the UN High Commissioner for Refugees.

is theoretically possible. One reason for this is that whereas some groups hold tightly together, others become incorporated relatively quickly into the mainstream.

It is therefore important to realise that although persons migrating from one country to another may form an identifiable *statistical* group, this does not mean that they also form a distinct *social* group. Though it is possible to classify people in terms of their genetic or cultural characteristics, area of origin, religion, or language, this does not necessarily mean that those who are classified in the same way are members of anything resembling a 'community', with individuals belonging to a specific social context characterised by meaningful interrelations. A great deal of health research on so-called 'ethnic groups' therefore does not study the membership of a social group at all – only the variable 'country of birth'. As Barth implies, it is mainly when struggles arise over power and privilege that membership of an ethnic group becomes a salient issue. This typically occurs when one group is perceived as a challenge to another, provoking both groups to assert and defend their identities.

Another point concerns the extent to which findings on the health of ethnic groups may differ between countries. While the same name may be used for ethnic groups in different countries, this does not mean that they can be regarded as the same group. Their migration history may be very different, as well as their patterns of integration into the host society. For example, refugees who fled to Sweden from dictatorial regimes in Latin American countries during the 1970's are unlikely to have much in common with people from the same countries who came to Spain as labour migrants during the economic boom starting in the late 1990's. In general, people migrating from former colonies to the old colonial power may be familiar with the language, education system and customs of the host country, while acculturation can be a much harder task for the same group migrating to a different European country. For example, Turkish immigrants in one European country may differ from those in another with regard to their region of origin in Turkey and the associated background characteristics and experiences.

Studies across European countries on health issues related to ethnicity are therefore difficult and methodologically challenging due to differences in definitions and available data, as well as variations in the determinants of health across 'similar' ethnic groups in different countries and within ethnic groups in each country. However, if the methodological challenges can be successfully dealt with, such cross-country studies can provide new insights into important determinants of health and the quality of health care. The Migrant Health Observatory project (MEHO)<sup>61</sup> (2007-2009) pioneered this approach with studies of five health conditions in ethnic groups across Europe.

Results from such studies show that although country of birth predicts some of the variation in health outcomes, there are important variations between different countries of residence. These may reflect differences in the background characteristics of the ethnic minority populations in each country, their socioeconomic position, and in health policies affecting them. A cross-national study of neonatal outcomes in mothers of Turkish origin revealed differences according to whether national integration policies were 'active' or 'passive'<sup>62</sup>. International comparative studies on comparable ethnic groups may produce important new hypotheses on the role of cultural, social and environmental factors and provide insight in the most effective organization and provision of culturally sensitive health care. Confirming hypotheses generated by such research, however, will require more in-depth studies – often based on qualitative methods in local settings<sup>63</sup>.

<sup>61</sup> Main website (temporarily unavailable): <http://www.meho.eu.com>. Summary: <http://ec.europa.eu/chafea/news/news137.html>

<sup>62</sup> Villadsen, S.F. *et al*, (2010). Cross-country variation in stillbirth and neonatal mortality in offspring of Turkish migrants in northern Europe. *European Journal of Public Health*, 20(5):530–535.

<sup>63</sup> Salway, S., *et* (2011). Contributions and challenges of cross-national comparative research in migration, ethnicity and health: insights from a study of maternity experiences and outcomes. *BMC Public Health*, 11:514.

### 1.6.2. Vulnerable minority groups

During the past two centuries, but mainly since 1945, a body of international human rights law has been developed to protect the rights of ethnic minorities who are nationals of the country in which they live and occupy vulnerable, disadvantaged or marginalized positions. Alongside the UN Conventions defending the rights of children, women and refugees, a number of conventions and other legal instruments have been created to protect such 'national minorities' from persecution and further their emancipation.

The definition of 'minority' used by the United Nations since 1979<sup>64</sup>, which is also shared by EC agencies such as the FRA<sup>65</sup>, is a group which is

numerically inferior to the rest of the population of a State, in a non-dominant position, whose members – being nationals of a State – possess ethnic, religious or linguistic characteristics differing from those of the rest of the population and show, if only implicitly, a sense of solidarity, directed towards preserving their culture, traditions, religion or language.

In line with these conventions, some countries formally recognise the existence of certain minorities living within their borders and take policy measures to protect their rights. Perhaps the most large-scale recent example of this is the 'Decade of Roma Inclusion', a policy initiative implemented by a group of 11 countries between 2005 and 2015 (see Appendix III).

However, recognising a group as a national minority remains the prerogative of individual States: moreover, it is not a step governments take lightly. In the words of Dieter Kugelman:<sup>66</sup>

States are reluctant to acknowledge rights of minorities because they try to avoid risks for their territorial integrity. The fight of minorities for their rights has given rise to armed conflicts. These dangers and experiences made minority protection one of the most complicated subjects of international law.

One reason why governments may refuse to recognise such groups is the perceived threat of separatism. As Kugelman reminds us, the breakup of a country is often a bloody affair; it may also carry grave disadvantages for all concerned. Traditionally, the nation most resistant to the recognition of ethnic groups – indeed, to the concept itself – has been France, on the grounds that ethnicity *in itself* threatens the 'unity and indivisibility of the Republic'.<sup>67</sup>

A second kind of danger which governments may perceive in ethnic minorities concerns social cohesion. The 'cultural heritage' of the group in question may be seen not as an enrichment, but as a threat to what the dominant majority perceives as its own culture. As political support for

<sup>64</sup> See Caportori, F., (1991), *Study on the Rights of Persons Belonging to Ethnic, Religious and Linguistic Minorities*. New York: United Nations, para. 568.

<sup>65</sup> <http://fra.europa.eu/en/joinedup/about/glossary?title=m>

<sup>66</sup> Kugelman, D. (2007). The protection of minorities and indigenous peoples respecting cultural diversity. In Bogdandy A.V. and Wolfrum, R. (Eds.). *Max Planck Yearbook of United Nations Law*, Vol. 11: 235.

<sup>67</sup> "Unité, indivisibilité de la République, Liberté, Égalité, Fraternité ou la mort". Motto adopted by the Republic, 22 September 1792.

multiculturalism has declined in Europe<sup>68</sup>, so has the climate for minority rights become increasingly sceptical.

Finally, it should not be assumed automatically that an ethnic minority is disadvantaged or vulnerable. Like migrants themselves, ethnic minorities resulting from migration vary greatly in their demographic characteristics. At one extreme, large numbers of poorly educated labour migrants have been recruited in certain periods and countries, for example as ‘guest workers’ during the 1960’s in Northwestern Europe. The social position of these workers was unfavourable and because they were not expected to stay permanently, little or no effort was made to help them integrate. The disadvantages of this group may persist into the second or third generation. At the other extreme, other groups (such as Indians in the UK and recent Chinese migrants in many countries) may reflect positive selection biases and have higher levels of ‘social capital’, so that they achieve even better results in terms of education and occupation than the native population. This diversity is also reflected in health outcomes, which can be better as well as worse than those of the majority population<sup>69</sup>. On balance, however, ethnic minorities – like migrants – tend to be more often socially disadvantaged than privileged.

From the above it should be clear why there is no consensus about how many ‘ethnic minorities’ exist in Europe and how they should be defined. The answer to these questions is political rather than scientific, and it is hard to collect systematic data using concepts which by their very nature are contested.

Another tension in this field is that identifying a group as an ‘ethnic minority’ and collecting data on its members can be seen either as an instrument of oppression or of emancipation. In the worst case, registration of ethnicity can be a potential instrument of genocide or ‘ethnic cleansing’. During the Second World War, population registers in many countries made it easier for the Nazis to round up and deport Jews, Roma and other groups for extermination. After the war ended this led to widespread revulsion against the practice of ethnic registration, and in some countries the opposition continues to this day.

Supporters of ethnic registration argue, however, that without collecting ethnic data there is no way to develop evidence-based policies to help the groups in question.<sup>70</sup> In addition, they argue that the laws that are alleged to prohibit the collection of ethnic data are not really as far-reaching or strict as is often claimed. In 2007 the Council of Europe’s ‘European Commission against Racism and Intolerance’ (ECRI) published a survey among member states which concluded that such a strict interpretation of the law was ‘exaggerated’;<sup>71</sup> the EU has adopted the same position<sup>72</sup>.

However, the opposition to collecting ethnic data is not purely legalistic, nor is it solely based on anxieties from the past. Today, data on ethnic minorities can be used by xenophobic and populist politicians to incite hostility against them, for example by presenting misleading statistics on health, unemployment or criminal convictions. Moreover, health workers may resent having to collect such

<sup>68</sup> Joppke, C. (2007). Immigrants and Civic Integration in Western Europe. In Banting, K.G., Courchene, T.J., and Seidle, F.L. (eds.), *Belonging? Diversity, Recognition and Shared Citizenship in Canada*. Montreal: Institute for Research on Public Policy, 321–350.

<sup>69</sup> Bhopal R (2009). Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *European Journal of Public Health*, 19:2:140–143.

<sup>70</sup> McDonald, C., Negrin, K. (2010) *No Data No Progress – Country Findings*. Open Society Institute: Roma Initiatives Office.

<sup>71</sup> Simon, P. (2007). *‘Ethnic’ statistics and data protection in the Council of Europe countries*. Strasbourg: Council of Europe.

<sup>72</sup> European Commission, (2006). *Communication (COM (2006) 643) on the application of Directive 2000/43/EC*. Brussels: European Commission.



data: this activity is sometimes seen as intruding on patients' privacy and undermining the professional relationship with them<sup>73,74</sup>

### 1.6.3. Which countries collect data on ethnicity in census forms and population registers?

A 2007 Council of Europe report<sup>75</sup> classified European countries into three main categories regarding the collection of information on ethnicity and/or language<sup>76</sup>.

1. Most western and southern European countries are classified as 'state-centred', "since they make the link with the state a criterion for (political or geographical) identification." These countries tend to register only nationality or citizenship, not ethnicity.
2. A second group comprises "the countries which emerged from the wreckage of the former Austro-Hungarian and Soviet empires (sometimes both) or which are in the Balkans". These countries often collect ethnic data, focusing mainly on minorities formed by geopolitical upheavals.
3. A third group, 'post-migration multicultural', uses classifications "designed to reflect the recent history of immigration, whether post-colonial or, more traditionally, labour migration". This group overlaps with the first one: within it, only Ireland and the UK identify 'ethnicity' directly using census categories. In other countries, country of birth is used as an indicator of ethnicity. When this is done, however, studies of 'ethnic groups' are in fact no more than studies of migrants disaggregated by origin. Only 'first-generation' migrants are included; no distinction is made between different ethnic groups originating from the same country, and there is no recognition of groups which may originate from several countries, such as ethnic Chinese.

The unique system used in the Netherlands to define ethnicity also uses country of birth as a criterion, but in addition it includes the children of migrants. The category 'allochtonous' applies to people who were *either* born to non-Dutch parents outside the Netherlands, *or* who have at least one parent born outside the Netherlands. Use of this concept enables data to be collected on migrants and their immediate offspring: it therefore adds something to studies relating only to migration. A limitation, however, is that only the first two generations of each ethnic group are taken into account.

EU migration statistics collected by EUROSTAT include data on international migration, population stocks of national and foreign (non-national) citizens and data relating to the acquisition of citizenship in the EU-27 countries.<sup>77</sup> EUROSTAT data does not include statistics on ethnicity. A more recent

<sup>73</sup> Johnson, M. (2012). Problems and barriers in the collection of ethnicity and migration related data. In Ingleby, D. et al (eds). *Health inequalities and risk factors among migrants and ethnic minorities*, Vol. 1. COST Series on Health and Diversity. Antwerp: Garant Publishers.

<sup>74</sup> European Centre for Disease Prevention and Control (2011). Improving HIV data comparability in migrant populations and ethnic minorities in EU/EEA/EFTA countries: findings from a literature review and expert panel. Stockholm: ECDC.

<sup>75</sup> Simon, *op.cit.*, p. 37.

<sup>76</sup> Another survey of data-collection policies is provided in Mladovsky, P. (2007). *Migration and health in the EU*. London: LSE Research Note.

<sup>77</sup> [http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration\\_and\\_migrant\\_population\\_statistics#Foreign\\_and\\_foreign-born\\_population](http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics#Foreign_and_foreign-born_population)

study<sup>78</sup> gives the following overview of EU countries' registration practices. The second group corresponds to category 1 of the countries surveyed in the CoE report:

- All EU countries register citizenship and country of birth
- Ethnicity is not registered in France, Germany, Belgium (Wallonia), Luxembourg, Spain, Portugal, Italy, Greece, Malta, and Sweden. Finland and Denmark only register ethnicity in the case of asylum seekers.
- No data on language: Belgium, the Netherlands, France, Germany, Portugal, Sweden, Italy, Greece.
- No data on religion: Germany, France, Luxembourg, Denmark, Sweden, Spain, Greece, Italy, Malta.

Within the discipline of epidemiology there is a strong tradition of research on ethnicity and health, but examination of what is meant by 'ethnicity' reveals several different meanings. In the USA and UK the term usually refers to 'minorities', operationalised in terms of racial, ethnic or linguistic census categories. Since the census categories are based on self-definition, they are capable of reflecting an individual's identification with a group. In most other countries, however, 'ethnicity' usually refers either to membership of an indigenous group or to the country of birth of a migrant. As we have seen the latter variable is a poor indicator of ethnicity, since several different ethnic groups may originate from the same country, while some ethnic groups may originate from many different countries. A further objection is that 'country of birth' is a fixed and objectively defined variable, whereas group identification is a changeable subjective phenomenon that is better captured by using self-definition<sup>79</sup>.

#### 1.6.4. Main types of research on health and ethnic minorities in Europe

Broadly speaking, studies on ethnic minorities and health in Europe fall into four main categories:

##### 1) British studies based on (self-ascribed) census categories

Research on ethnicity in the UK resembles that in the USA, in that it is based on self-ascribed classification according to census categories. These categories do not distinguish between migrants and their descendants, still less between different types of migrant such as labour migrants, asylum seekers, refugees, or undocumented migrants. As a result, research on the health of migrants in the USA and UK is relatively underdeveloped<sup>80</sup>.

There are copious findings relating to health among ethnic minority groups in the UK, but the extent to which they are relevant to other countries is not known. Firstly, the ethnic categories used in the UK are not used anywhere else, and it would be difficult to assemble health data on the same groups in other countries. Secondly, even if a group with the same geographical origin could be identified in another country, it might have come into being in a different way, at different times, and with different outcomes in terms of social position.

<sup>78</sup> Abdikeeva, A. (2014). *Measure, Plan, Act. How data collection can support racial equality*. Brussels: European Network Against Racism (ENAR).

<sup>79</sup> Bhopal, R. (2014). *Migration, ethnicity, race, and health in multicultural societies*. Oxford: Oxford University Press, pp. 78-79.

<sup>80</sup> Jayaweera, H. (2011). *Health of Migrants in the UK: What Do We Know?* Migration Observatory Briefing, COMPAS, University of Oxford, UK, March 2011. However, the situation is changing: this is reflected in the change in the title of the second edition of Raj Bhopal's classic handbook *Ethnicity, Race, and Health in Multicultural Societies* (2007), now called *Migration, Ethnicity, Race, and Health in Multicultural Societies* (2014).



## 2) Studies using country of birth as a proxy for ethnicity

The use of ‘country of origin’ as a proxy for ethnicity creates *statistical* groups, but these do not necessarily correspond to any *social* groups; moreover, additional information must be collected in order to distinguish different ethnic groups coming from the same country<sup>81</sup> or those that come from several countries. It may matter a lot, for example, whether a migrant belongs to the Christian, Sunni Muslim or Shiite Muslim population of Syria, or to the Creole or Hindustani population of Surinam.

In some studies, *nationality* is used as a proxy for ethnicity. However, this indicator has all the disadvantages associated with country of birth, as well as another very serious one: many migrants may acquire the nationality of the host country after a certain period. This will create biases of unknown magnitude in the results.

As with research from the UK, the relevance of such studies to the ‘same’ groups living in different countries is questionable. In essence, these studies are nothing other than studies of migration which take country of origin into account. They do not supplement or complement studies of migrants – rather, they *are* studies of migrants, but under a different name. Nevertheless, Dutch research is uniquely informative because it enables both migrants and the first generation of their descendants to be studied.

## 3) Studies of national minorities in the countries where these are recognised.

As we have seen, the recognition of national minorities (i.e. those not formed by recent migration) depends mainly on political considerations rather than scientific ones. For example, some research is available on indigenous minorities such as the Sami in Scandinavia, while Roma populations in Europe – after years of neglect – are now the focus of a great deal of research and policymaking. In Chapter 4 we discuss health research on both these groups.

However, the main ethnic minority singled out for attention in this report are the Roma. There are two reasons for this. Firstly, the group is much larger than any other ethnic minority in Europe (10-12 million), and secondly, Roma experience an extreme and persistent degree of social disadvantage and discrimination. In the words of a UNDP Human Development Report <sup>82</sup>, “the situation of Gypsy, Roma and Traveller groups must be seen as a scar on the human development record of European nations”. Their disadvantage extends across the fields of education, health, employment, housing and political participation.

A point we have stressed for all ethnic groups applies equally to the Roma. There may be considerable variations within and between countries in the populations studied, reflecting differences in both their historical origin and their current social position. ‘Roma health’ is therefore no more than a convenient shorthand term bracketing together results from many different groups.

<sup>81</sup> Stronks, K., Glasgow, I.K. and Klazinga, N.(2004). *The identification of ethnic groups in health research, additional to the country of birth classification*. Amsterdam: University of Amsterdam, Department of Social Medicine.

<sup>82</sup> Stewart K. (2010). *Human Development in Europe*. New York, United Nations Development Programme (Human Development Research Paper 2010/7)

#### 4) Studies of ethnic minorities in the Baltic States, Central and Eastern Europe and the Balkans.

These countries correspond to category 2 in the Council of Europe report summarised above. In the less prosperous of these countries, emigration is much more common than immigration: few immigrants settle long enough to form significant 'ethnic minorities'. Many of these immigrants may be unauthorised entrants in transit, hoping to reach more wealthy EU Member States. However, larger numbers of migrants settle in the more prosperous countries in this group (particularly Austria, Hungary and the Czech Republic).

Alongside the ethnic minorities formed by recent migration, and numerically often more important than them, are those which were created by geopolitical upheavals in the twentieth century.

- **Austria** recognises Croatian, Slovenian, Hungarian, Czech and Slovakian minorities (the historical origins of which lie in the Austro-Hungarian Empire), in addition to the Roma population. However, such recognition is a politically controversial issue. Separate data on the health of these populations does not appear to be collected.<sup>83</sup>
- In **Latvia** and **Estonia**, large minorities were formed by former citizens of the Soviet Union who were left stateless when that nation broke up. These groups are counted by UN DESA as 'migrants', which explains the high percentage of migrants attributed to Latvia (13.8% in 2013) and Estonia (15.0%). However, the number of Russians who have moved to these countries since 1991 is far lower (in Latvia probably only 1-2%<sup>84</sup>). The social position of these Russian-speaking minorities is not necessarily disadvantaged or vulnerable (their former social position was in fact relatively privileged), but Russian authorities often intervene on their behalf<sup>85</sup>.
- In **the entire Balkan region**, large population groups were displaced by the 'Third Balkan War' of 1991 – 2001. While many returned to their former countries, some did not and remained to form ethnic minorities. Bosnia-Herzegovina is still divided between the Bosnian Serb republic and a federation of Bosnian Croats and Muslims.
- The Turkish minority in **Bulgaria**, which comprises about 8% of the population, could also be added to this list, although its origin lies in much earlier upheavals (the Ottoman conquest of the Balkans in the late 14th and early 15th centuries).<sup>86</sup>

In many of these countries, very little is known about the state of health of either migrants or ethnic minorities, the health services available to them, and their utilization of these services. Where research exists, it may not be published in international journals or in English. We will not attempt to provide examples in this report: an important task for those developing training materials in such countries will be to locate such material representing issues related to their own countries.

In conclusion, we may note that research on the health of ethnic minorities – however they are defined – faces a large number of obstacles. Attention for 'national minorities' may be impeded by the

<sup>83</sup> Personal communication by Dr. Ursula Trummer, Center for Health and Migration, Vienna, 2nd January 2015.

<sup>84</sup> Personal communication by Mr. Ilmars Mezs (Head of IOM, Latvia), 27th October 2014.

<sup>85</sup> Immigration and Refugee Board of Canada. (2006). *Latvia: Treatment of ethnic Russians; whether ethnic Russians face discrimination; availability of state protection (January 2004 - December 2005)*. <http://www.refworld.org/docid/45f1477325.html>

<sup>86</sup> Can, T., Todorov, M.S.(2004). *Turks of Bulgaria: Assimilation Policy and Linguistic Oppression*. Syracuse University

ambivalent attitude of national governments towards the very existence of these minorities. They may be difficult to identify in official registers, while data on their social situation, health status and access to health care may simply not be collected. The fact that little is known about their situation may easily lead to the mistaken conclusion that there is no reason to be concerned about it.

The same applies to minorities resulting from migration – which include not only the migrants themselves, but also their children and later descendants. The offspring of migrants, in particular, tend to suffer from both conceptual and statistical invisibility. They do not belong in the category ‘migrants’; nor do they always satisfy the sociological criteria for being a ‘group’ or the legal criteria for being a ‘minority’. In their case, too, the fact that it is difficult to identify them and study their problems does not mean that they do not have any. When groups formed by migration remain tightly-knit and inward-looking, their integration into the host society may be impeded: but when a lack of contact, identification and solidarity with each other is combined with non-acceptance by the majority population, descendants of migrants may become marginalised – with all the problems that this entails.

The reasons why there is a such a shortage of data on the social and health situation of descendants of migrants can be summarised as follows:

- I. When ‘country of birth’ is used as a proxy for ‘ethnicity’ – as it is in most epidemiological research – the offspring of migrants are completely ignored.
- II. In the few countries where data on health are disaggregated in terms of self-ascribed ethnicity, no distinction is usually made between migrants and their descendants. This applies especially to the UK, the source of most epidemiological studies on ethnicity. In Dutch data on ethnic minorities (*allochtonen*) it is possible to distinguish migrants from specific countries from their children, but these data have several shortcomings:
  - a. ethnic variations within the country of origin are ignored
  - b. the fact that ethnic groups can come from a number of different countries is overlooked;
  - c. only the first generation of migrants’ offspring are included; and
  - d. only the groups which have traditionally been numerous in the Netherlands are studied.

### 1.7. Descendants of Migrants

As we saw in Chapter 1, large-scale immigration to Europe did not begin until the 1950’s. Most of the European-born descendants of migrants are therefore either the children or grandchildren of migrants. Confusingly, the first generation of such descendants is normally labelled the ‘second generation’, though clearly they are not ‘second generation migrants’ because they have not migrated.

Several large-scale research projects were set up after 2000 in response to concern about the unfavourable integration outcomes of many of the ‘second generation’. These projects focused mainly on educational attainment and labour market integration. In Europe, the project *The Integration of the European Second Generation (TIES)*<sup>87</sup> set up a database of more than 10,000 respondents in 8 countries to remedy the lack of data on this group. The OECD’s PISA programme<sup>88</sup> (*Programme for*

<sup>87</sup> [www.TIESproject.eu](http://www.TIESproject.eu)

<sup>88</sup> <http://www.oecd.org/pisa>

*International Student Assessment*) has since 2000 collected data on student attainment in up to 65 countries, devoting particular attention to children who have migrated and 'second-generation' children.

These and other projects have provided more information about the second generation, though unfortunately not much about their health status and utilisation of health care. Some important findings concerning Europe are as follows<sup>89</sup>:

- The parents of the second generation mostly come from low- and middle-income countries, in particular Turkey and Morocco. However, migration in recent decades has become much more diverse: other countries besides those from which the 'guest workers' of the 1950's and 1960's originated are increasingly represented in the total.
- The parents' educational and occupational status is generally below the average level of the host country population. The second generation tend to do better in these respects than their parents, but still not as well as the majority population. By contrast, in non-European OECD countries (Australia, Canada, New Zealand and the United States), their achievements are at least on a par with those of native children.
- In terms of educational outcomes, the disadvantage of the second generation relative to children of natives is most marked in Austria, Belgium, Denmark, Germany, Luxembourg and the Netherlands. All of these are countries in which large numbers of 'guest workers' were recruited in the last century (see section 1.3). France, the UK, Sweden and Switzerland also recruited 'guest workers' but the second generation in those countries appears to be less disadvantaged. This may be because many immigrants to France and the UK came from former colonies and were already familiar with the language and culture, while in Sweden, temporary labour was recruited mainly from other Nordic countries. Many guest workers in Switzerland came from Italy or Spain and were subject to laws that prevented them from settling down<sup>90</sup>. As the name implies, 'guest workers' in Western Europe were not expected to stay and so far from being helped to integrate, they were actively discouraged from doing so. It took a long time for the host countries to acknowledge their presence, and even longer for them to develop policies to promote integration.
- The fact that the second generation is socially disadvantaged in Europe<sup>91</sup> but not in other OECD countries can be interpreted either as a result of differing policies governing the recruitment of migrants, or differing opportunities for integration, or both. Whatever the reason, it suggests that the health of this group in Europe is likely to be worse than that of the offspring of natives.

<sup>89</sup> Liebig, T., Widmaier, S. (2009). "Children of Immigrants in the Labour Markets of EU and OECD Countries: An Overview." OECD Social, Employment and Migration Working Papers no. 97.

<sup>90</sup> D. Efionayi, J.M. Niederberger and P. Wanner (2005) Switzerland Faces Common European Challenges. *Migration Information Source*, 1/2/2005. <http://www.migrationpolicy.org/article/switzerland-faces-common-european-challenges>

<sup>91</sup> With the exception of Switzerland (*op. cit.*).

- Another indication of the disadvantaged position of the second generation in Europe concerns youth unemployment rates. In 2009 these were 1.6 times higher for children of migrants than for children of natives. Youth unemployment in Europe has increased dramatically as a result of the crisis: in 2014, according to Eurostat<sup>92</sup>, figures in Spain and Greece were above 50%. Figures for young people of migrant origin in these countries could thus be as high as 75%, meaning that most members of this group have no job and little prospect of ever getting one. Given the well-established negative relationship between unemployment and health this also suggests increased health problems in this group, which clearly deserves to be regarded as 'vulnerable'.
- The disadvantage of children of migrants on the labour market in Europe is not fully explained by differences in educational attainment. It is hard to avoid the conclusion that discrimination plays a role.

Although health issues concerning the second generation are very poorly documented, we will describe in Section 2.4 some findings concerning their state of health. Section 4.1.1 examines findings concerning access to health and utilisation of healthcare.

### 1.8. The Roma population in Europe

Present-day Roma, described by the Council of Europe<sup>93</sup> as “a mosaic of diverse groups”, are considered to have descended from groups which left Northern India around the 11<sup>th</sup> century and migrated westwards, reaching Europe at the end of the 13<sup>th</sup> century and spreading out in many directions. In most of the countries where they attempted to settle they were subjected to systematic persecution, enslavement and exclusion, going as far as what we would now call ‘ethnic cleansing’ and genocide. The extermination by the Nazis of an unknown number of Roma (estimated at between 500.000 and 1.500.000) in 1936-1945 was thus the culmination of a virtually unbroken history of nearly seven centuries of persecution.

Although they are dispersed over the whole of Europe, the largest populations of Roma are found in Central and Eastern Europe. Under Soviet rule attempts were made to forcibly integrate Roma as well as other ethnic minorities, such as the indigenous people of the northern and Arctic territories of Russia, into the majority population (“Russification”).<sup>94</sup> Nevertheless, communism had certain advantages for the Roma, including the suppression of ethnic rivalries and nationalism and the introduction of a system of social protection and welfare<sup>95</sup>. With the breakup of the Soviet Union in 1989 and the turbulent transition to capitalism that followed, their economic situation worsened and ethnic hatreds were again unleashed. Towards the end of the 20<sup>th</sup> century, international organisations

<sup>92</sup> Eurostat Newsrelease Euroindicators 1/2015 (January 2015), <http://ec.europa.eu/eurostat/documents/2995521/6454659/3-07012015-AP-EN.pdf/f4d2866e-0562-49f5-8f29-67e1be16f50a>

<sup>93</sup> Council of Europe (undated). *Defending Roma Human Rights in Europe*. <http://bit.ly/1nUJway>

<sup>94</sup> Vakhtin, N. (1992). *Native Peoples of the Russian Far North*. London: Minority Rights Group

<sup>95</sup> Council of Europe (undated) *Factsheets on Roma History*. <http://bit.ly/1n4ktvA>

promoted coordinated policy initiatives to improve the lot of Roma, leading to the ‘Decade of Roma Integration’ in 2005-2010. With the accession to the EU of several countries with large Roma populations in 2004 and 2007, the European Commission acquired an active role in influencing the policy agenda on Roma (see Chapter 3).

Unfortunately the social history lived by Roma continues into the present: many Roma still live in poverty and levels of education and employment are very low. Health-wise, these social determinants add up and lead to significant health inequalities compared to non-Roma. In addition, mutual distrust between Roma and non-Roma persists, and anti-Roma sentiments, always present, have recently flared up and reached the political level – as demonstrated by the demolition of Roma shanty towns in France and Italy in 2010, and the subsequent deportation of Roma EU citizens to Romania and Bulgaria.<sup>96</sup> Roma provide perhaps the most extreme example of Tudor Hart’s ‘inverse care law’<sup>97</sup>: while their social and material living conditions lead to an extremely poor state of health, their access to good quality health services is also seriously hampered.

### *1.9. Statistics on the Roma population*

For several reasons, it is difficult even to collect data on the number of Roma in each country, let alone on their demographic or other characteristics. In the first place, certain countries prohibit the collection of such data: this is a legacy of the Holocaust, which was greatly facilitated by population registers containing lists of Jews or Gypsies. In view of recent developments, researchers who argue that we do not need to worry about such things ever happening again would seem to be displaying a certain amount of political naiveté. The dilemma for policy-makers, however, is that as long as the situation of such groups is not monitored, it is difficult to take steps to improve it. Adequate monitoring of the social conditions and health of ethnic minority groups is considered essential to be able to respond effectively to their problems<sup>98</sup>.

Another problem is that it is difficult to be sure of the reliability and validity of such data. Self-ascription is not considered reliable because many Roma – especially those living in mainstream society – may be reluctant to disclose their origins. Some countries use residence in a Roma settlement as a proxy for Roma ethnicity, but this will give a distorted picture of the group’s situation. In this area we must be constantly aware that *all data have to be treated with more than the usual degree of caution regarding their reliability and validity*.

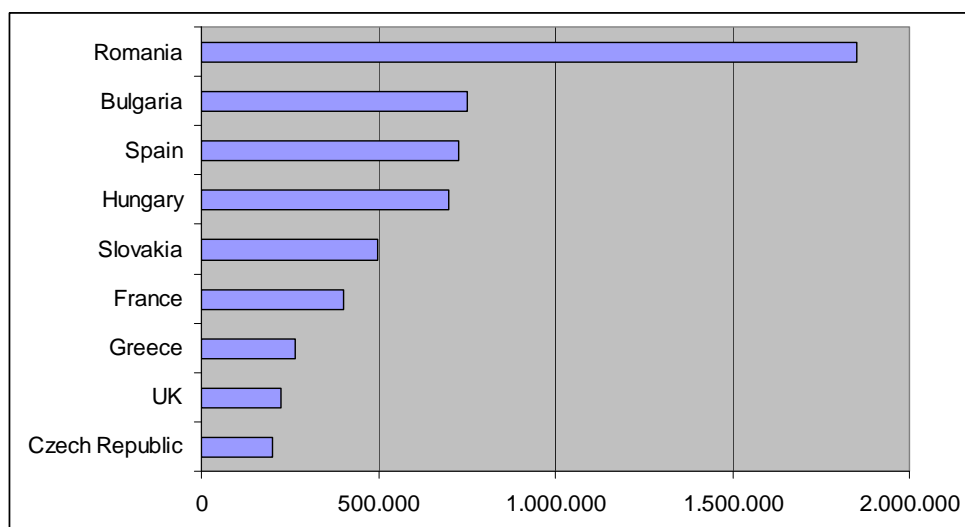
---

<sup>96</sup> Parekh, 2011.

<sup>97</sup> Hart, 1971.

<sup>98</sup> OSF(2010). No Data—No Progress. Country Findings. Data Collection in Countries Participating in the Decade of Roma Inclusion, 2005–2015. <http://osf.to/1uyswGX>





**Figure 8 EU member states with the largest Roma and Traveller populations (2010)**

Although these numbers are only a guideline, we can identify the main countries in the EU where Roma live. Figure 8 shows estimates of population size made by the Council of Europe in 2010: it should be noted that numbers refer to the combined category “Roma and Travellers”. The heterogeneity of the different groups which are conventionally described as ‘Roma’ is described in a Glossary published by the Council of Europe<sup>99</sup>.

In section Appendix I, the full table is given showing numbers and percentages for each European country (source: Council of Europe, 2010), together with a map

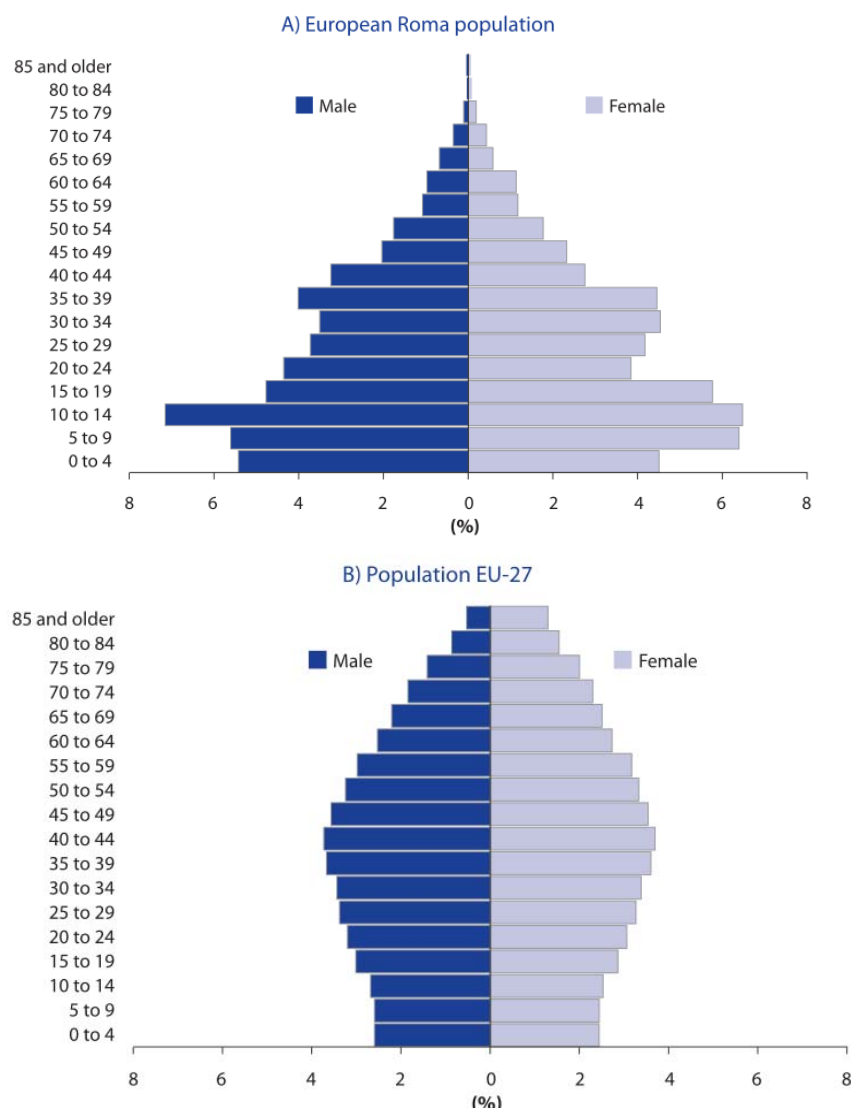
### 1.9.1. Age

As the following population pyramids show (Fig.9), the age distribution of Roma differs markedly from the EU average: in some ways it resembles more closely profiles found in impoverished third-world countries (which tend to be triangular, rather than a pear-shaped distribution as in wealthier countries). The proportion of children is much higher, while at the top of the pyramid it can be seen that Roma live much shorter lives than other inhabitants of the EU.

<sup>99</sup> See <http://www.coe.int/t/dg3/romatravellers/Source/documents/GlossaryRoma.doc>



Figure 9 Population pyramids in Europe: Roma community and the European Union<sup>100</sup>

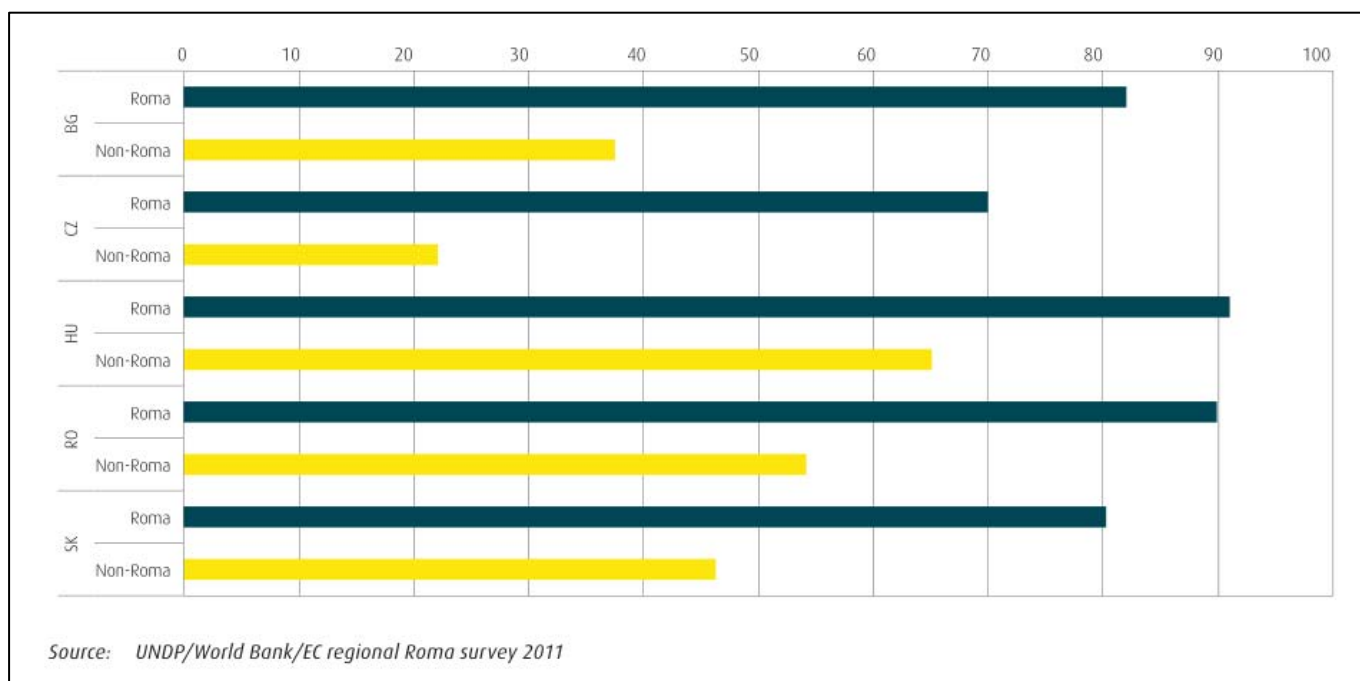


<sup>100</sup> Figures extracted from the report *Health and the Roma Community: Analysis of the situation in Europe*, 2009. p. 17. Based on Eurostat data from 2008.

### 1.9.2. Social position

A great deal of information has been collected in the last ten years on the social position of Roma. For reasons of space we limit ourselves to one graph<sup>101</sup> (Fig. 10): it shows the percentage of Roma households classified as suffering “severe material deprivation”, compared with the non-Roma population, in five countries.

**Figure 10 Roma and non-Roma households with severe material deprivation in Europe, 2011**



<sup>101</sup> FRA (2012). *The situation of Roma in 11 EU Member States - Survey results at a glance.*

## Chapter 2: State of health and health determinants

In this section we will review the findings of research on health inequalities affecting migrants and ethnic minorities, in particular Roma, examining both the differences found and their hypothesised causes. We begin with discussion of some general issues relating to these topics.

### 2.1. General issues

#### 2.1.1. Gaps in the data

Although the amount of information available on the health of migrants and ethnic minorities in Europe has increased considerably in the last decade, this information still has serious limitations. Firstly, many issues have only been studied in certain countries or not at all. Second, research is hampered by the difficulty of obtaining the necessary data: health statistics are seldom categorized according to the ethnicity or migration status of the people concerned, and often it is not possible to link them with databases that do contain such variables.

A major EU project aiming to review the adequacy of information in this field, the **Migration and Ethnic Health Observatory (MEHO)**, was completed in 2010<sup>102</sup>. Work Package 4 reviewed the data available and provided maps showing coverage in each country. Not surprisingly, the most widely available data on migrant and ethnic minority health concern dependent variables that are relatively easy to collect, such as self-reported health status, life expectancy or mortality. The availability of data on specific health conditions varies much more between countries.

As far as migrants' health is concerned, the volume of European research on this topic has increased greatly since the turn of the century, but (as the MEHO project showed) there are still many gaps. In different countries and databases, data may be disaggregated in terms of migrant status, country of birth, country of origin, ethnicity, nationality, or a combination of any or all of these. When ethnicity is recorded, the categories used and their definition may vary from country to country: moreover, research traditions do not always keep up with demographic changes, such as changes in the size and number of ethnic groups. In the UK (as in the Netherlands), a large body of research focuses on ethnicity: much of it, however, makes no distinction between migrants and their offspring<sup>103,104</sup>. The recording of national or indigenous minority ethnic status depends on a number of factors, such as the integrationist tendencies of the central government (i.e. non-recording of ethnicity to promote a

<sup>102</sup> Migrant and Ethnic Health Observatory (MEHO). Website: <http://www.meho.eu.com/> (temporarily unavailable). See also Nielsen, S.S., Krasnik, A., Rosano, A. (2009). Registry data for cross-country comparisons of migrants' healthcare utilization in the EU: A survey study of availability and content. *BMC Health Serv Res*; 9:210.

<sup>103</sup> Bhopal, R. 2014. *Migration, ethnicity, race, and health in multicultural societies*. Oxford: Oxford University Press.

<sup>104</sup> Jayaweera, H. (2014) *Better Health Briefing 19: Health and access to health care of migrants in the UK*. London: Race Equality Foundation.

unified national identity, e.g. Spain and France),<sup>105</sup> and the administrative status of the territories they inhabit. For example, in the North Scandinavian region, Sami territories have their own parliaments and maintain voter registers that include ethnicity data: in the north of Sweden ethnicity and ancestry is recorded by the Sami Parliament as well as by Statistics Sweden.<sup>106</sup> However, most countries in Europe do not record ethnicity in census or other population registers (see section 1.6.3)

Data on the Roma population in Europe is particularly limited, which impacts negatively on the ability of countries to assess the situation of Roma and to monitor the effects of policies intended to improve their situation. Several factors impede the collection of reliable and comparable data on Roma populations and their health, including restrictive interpretations of legislation governing data collection and privacy protection, as well as an excessive dependence on (sometimes highly unreliable) census data. In addition, there is a reluctance to use other sources of data which may be more reliable than official national-level sources, such as intergovernmental sources (UNDP, CoE, UNICEF, etc.) and academic or NGO publications and materials based on independent data collection.<sup>107</sup>

During its **2007-8 Decade of Roma Inclusion Presidency**, Hungary identified the need for a framework of indicators applicable at a transnational level by which to measure the implementation and progress of the Decade's Roma inclusion policies. In response, Decade member countries formed the Decade Indicator Working Group, which in 2009 published a report<sup>108</sup> describing mechanisms that Decade members could use to chart implementation and progress of Roma inclusion policies. While subsequent Presidencies have called for the need for monitoring and indicators, in the end, individual countries are responsible for the establishment of reliable monitoring mechanisms for collecting comparable data that is disaggregated for ethnicity.<sup>109</sup> The European Commission's 2014 **Report on the implementation of the EU Framework for National Roma Integration Strategies**, pointed out the continued lack of systematic data collection on health of Roma compared to the general population, data which is essential to the monitoring of Roma health and health inequalities.<sup>110</sup>

### 2.1.2. The relation between poor health and shortcomings in health service provision

It is often argued that shortcomings in health services for migrants and ethnic minorities (especially Roma) must be addressed because of the heightened health risks known to affect these groups. While

<sup>105</sup> Morning, A. (2008). Ethnic Classification in Global Perspective: A Cross-National Survey of the 2000 Census Round. *Population Research Policy Review* 27:239–272

<sup>106</sup> Sjolander, P. (2011). What is known about the health and living conditions of the indigenous people of northern Scandinavia, the Sami? *Global Health Action*, Vol. 4.

<sup>107</sup> McDonald, C., Negrin, K. (2010). *No Data No Progress – Country Findings*. Open Society Institute: Roma Initiatives Office.

<sup>108</sup> Kahanec, M. (2009). The Decade of Roma Inclusion: A framework for progress measurement and options for data collection. Bonn: Institute for the study of labor (IZA).

<sup>109</sup> *Ibid.*

<sup>110</sup> Report on the implementation of the EU Framework for National Roma Integration Strategies. European Commission, Directorate-General for Justice (2014). [http://ec.europa.eu/justice/discrimination/files/roma\\_implement\\_strategies2014\\_en.pdf](http://ec.europa.eu/justice/discrimination/files/roma_implement_strategies2014_en.pdf) (Accessed 23 February, 2015).

increased health needs certainly justify increased attention to these needs, the converse is not true: if a group's state of health is not particularly poor, this does not mean there is no need to worry about the health services available to them.

The reason for this is that the majority of conditions that health services treat are the result of simply being human, rather than of belonging to a specific group. Accidents, infections, complications in childbirth, genetic defects and the natural deterioration of the body in old age can affect anybody. Poor access to good-quality care is not only a problem when groups are exposed to heightened health risks.

However, in these cases it does become *more* of a problem. Here again we encounter the 'Inverse Care Law' <sup>111</sup> referred to earlier: those with the greatest need for good health care are often those who are least able to get it. Migrants and ethnic minorities sometimes experience special needs and vulnerabilities which justify greater attention to the services provided - but as a matter of principle, equity in health service provision does not have to be justified by evidence of heightened needs. It is a question of rights; the universal human right to health and the unacceptability of discrimination in service provision between groups.

### 2.1.3 Changing assumptions regarding the importance of different determinants of health

Among researchers in this area, there has been a gradual shift during the last two decades in the emphasis placed on different types of determinant.

#### 2.1.3.1. Health service provision

As we saw in the previous paragraph, emphasis has often been placed on the connection between inadequate health care for migrants and ethnic minorities and poor health. Improving care has been seen as the key to improving health. So, for example, efforts in the UK to improve mental health care for 'Black and Minority Ethnic' (BME) groups were regarded by many as having failed when evidence emerged of continuing elevated rates of admission for serious mental illness<sup>112</sup>.

Improving service delivery, however, may not have much impact on the overall prevalence of a health problem. The impact is likely to vary greatly, depending on the context and the nature of the health problem. If we are talking about containing an epidemic which can be effectively combated by known treatments, the impact may be very high; but improvements in service delivery will have much less impact on persistent, non-communicable illnesses which are due to age-related degeneration or deeply-rooted environmental factors – problems that by their nature may be hard to eradicate through treatment.

In research concerning migrant and minority ethnic health, a shift of attention can be observed in the last 15 years from shortcomings in health care to more fundamental determinants of health. As we

<sup>111</sup> Tudor Hart (1971).

<sup>112</sup> Singh, S.P. and Burns, T. (2006). Race and mental health: there is more to race than racism. *British Medical Journal*, 333(7569): 648–651.

shall see in the next chapter, a corresponding shift has occurred in *interventions* aimed at improving the health of these groups. One could say that the focus has moved ‘upstream’, in the sense that more fundamental determinants of health are being studied. This has much to do with the influence of the ‘social determinants of health’ movement associated with the ‘Marmot Report’<sup>113</sup>.

In the Health Programme (2003-2013) migrants and ethnic minorities were classed as ‘vulnerable groups’. Projects for such groups (in particular the earlier ones) tended to focus on shortcomings in health service delivery (including targeted health promotion)<sup>114</sup>. Examples are the two **CORRELATION projects** (2005-2008, 2009-2010) which studied the need for improved access to high-quality treatment, as well as harm reduction and prevention of infection, among high-risk groups such as intravenous drug users and sex workers (including migrants). Early research on Roma also tended to focus on poor access to good quality services as a cause of health problems. By contrast, later projects, such as *Health and the Roma Community (2007-2009)* and *Reports on health status of the Roma population (2012-2013)* placed more emphasis on the need for more epidemiological research into the causes of ill-health, especially the role of social disadvantage.

### 2.1.3.2. Lifestyle factors and harm reduction

The importance of *prevention* has been widely emphasised in health policy-making circles since the WHO’s 1978 ‘Declaration of Alma Ata’<sup>115</sup> and even before. However, preventive measures can be of different kinds. Some are targeted at individuals and aim to induce *behavioural change*. This can either have the aim of harm reduction or illness prevention (aims which are sometimes hard to distinguish from each other). Recently there has been a great increase in attention to behavioural (‘lifestyle’) factors as determinants of both communicable and non-communicable illnesses. Much importance has been attached to ensuring that health promotion interventions reach and influence migrants and ethnic minorities effectively.

From an epidemiological point of view, however, interventions targeting the behaviour of individuals may not be as effective in the long term as attention to the ‘causes of the causes’, i.e. fundamental social factors influencing illness. Whitehead<sup>116</sup> distinguishes four levels at which health inequities can be tackled: strengthening individuals, strengthening communities, improving living and working conditions, and promoting healthy macro-policies. In keeping with the shift towards more ‘upstream’ factors in epidemiological research, there is growing emphasis on the need for macro-policies to improve the social, economic and legal situation of migrants and ethnic minorities. This has blurred the dividing-line between ‘health interventions’ and other efforts to tackle the disadvantaged situation of these groups.

<sup>113</sup> CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva, World Health Organization

<sup>114</sup> Consumers, Health and Food Executive Agency (2014). *Action on health inequalities in the European Union*. European Union. <http://bit.ly/1vYIQBf>

<sup>115</sup> WHO (1978). *Declaration of Alma-Ata*. Geneva, World Health Organization.

<sup>116</sup> Whitehead, M. (2007). A typology of actions to tackle social inequalities in health. *Journal of Epidemiology and Community Health* 2007; 61: 473–478.

### 2.1.3.3. Social determinants of health and the influence of SES

Despite this shift ‘upstream’, the emphasis on deeper structural determinants of health inequities has mainly been linked to the enormous differences in health and longevity between those at the top and bottom of the socioeconomic ladder. Meanwhile, most research on migration and ethnicity has continued to be preoccupied with service provision, ‘cultural’ factors, lifestyles and the immediate effects of migration. Researchers into SES differences have tended to overlook the fact that social disadvantage and migrant status (or ethnicity) are closely linked<sup>117</sup>. However, the poverty and social exclusion experienced by most Roma is well documented, and migrant households experience poverty with much greater frequency than native households<sup>118</sup>. For this reasons, researchers investigating the ‘social gradient’ need to pay more attention to stratification in terms of ethnicity and citizenship, while those dealing with migrants and ethnic minorities need to be specially aware of the role of low SES in the genesis of health problems. Although earlier studies neglected these interactions, it is becoming increasingly common to control for SES when studying migration and ethnicity.<sup>119</sup> While some of the observed differences disappear when this is done, others do not.<sup>120</sup>

However, measuring the SES of migrants and members of ethnic minorities groups is far from straightforward. It is not even clear whether the methods of measuring SES developed for majority populations are valid for migrants and ethnic minorities. As one epidemiologist put it, “conventional measures of socioeconomic position may actually serve to conceal the socioeconomic disadvantage experienced by ethnic minority groups, rather than expose it.”<sup>121</sup>

A common mistake in this area is to assume that if health differences in migrant or ethnic minority groups disappear statistically when SES is controlled for, the ‘real’ determinants of health are socioeconomic ones and policies need not take account of migrant status or ethnicity. In statistical terms, SES is assumed to be a ‘confounder’. Yet a different interpretation is possible and in fact more likely – that SES is not a confounder but a *mediator*, part of the causal chain between migration status or ethnicity and health. This will be the case if membership of these groups to some extent determines a person’s SES, which is precisely what mechanisms of social exclusion do. In addition, there may be a *direct* relationship between discrimination and poor health.<sup>122</sup> In any case, measures to reduce health inequalities may need to be specially adapted in order to reach migrant and ethnic minority groups effectively.

The conclusion must be that policies to reduce socioeconomic health inequalities which do not take migrant status and ethnicity into account can only have limited success in countries where these

<sup>117</sup> Ingleby, D. (2012). Migration, ethnicity and the ‘social determinants of health’ agenda. *Psychosocial Intervention/Intervención Psicosocial* 21(3), 331-341

<sup>118</sup> Sainsbury, D. (2012). *Welfare States and Immigrant Rights: The Politics of Inclusion and Exclusion*. Oxford: Oxford University Press.

<sup>119</sup> Földes, M., Covaci, A. (2012). Research on Roma health and access to healthcare: state of the art and future challenges. *International Journal of Public Health* 57: 37-39.

<sup>120</sup> Nazroo, J. Y. (2003). Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. In *The Sociology of Health and Illness: A Reader*, ed. M. Bury and J. Gabe, 145-160. London: Routledge.

<sup>121</sup> Karlsen S., Nazroo J.Y. (2002). Agency and structure: the impact of ethnic identity and racism on the health of ethnic minority people. *Sociology of Health & Illness*, 24:1:1-20

<sup>122</sup> Pascoe, E.A., Smart Richman, L. (2009). Perceived discrimination and health: a meta-analytic review. *Psychological Bulletin*, 135:4:531-554.



groups are numerically significant and are not treated equitably<sup>123,124</sup>. We will return to the theme of levels of explanation and intervention in Section 2.4 below.

## 2.2. Health inequalities affecting migrants and ethnic minorities and their determinants

We will first consider some general findings of research on the health of migrants and ethnic minorities. It should be borne in mind that in the scientific literature, these categories to a large extent overlap: much research on ethnicity is at the same time research on migration, because it uses ‘country of birth’ as an indicator of ethnicity (see Section 1.6.4).

### 2.2.1. The ‘healthy migrant effect’

In some respects, migrants as a group may appear to be in better health immediately after arrival than native-born populations. Usually, their health then declines gradually to the level found in the native population. This well-known phenomenon<sup>125</sup> may reflect at least three factors:

- The fact that migrants tend to be younger and for that reason less likely to be ill;
- Possible selection (e.g. by countries or companies screening out migrants who are ill, or self-selection of less healthy individuals who do not migrate);
- A lower prevalence of certain illnesses in the sender country.

Whether these factors are relevant will depend on the particular group migrating, the identity of the origin and host countries, and the health condition being studied. For this reason, a ‘healthy migrant effect’ is by no means found in all studies. And as we shall see, many factors increase the risk of ill-health before or during migration and thus work in the opposite direction.

### 2.2.2. The lack of main effects

In the area of migrant and ethnic minority health, few straightforward generalizations can be made. The effects found depend to a large extent on the health problems studied, the origin and host countries involved, the sex and age of the migrants in question, as well as their reason for migration, legal status and socioeconomic position (SES). Moreover, the health problems of first-generation migrants may differ from those of their descendants.

---

<sup>123</sup> Masseria, *et al* (2010).

<sup>124</sup> Földes, *et al* (2012).

<sup>125</sup> See e.g. Fennelly, K. (2005). The healthy migrant effect. *University of Minnesota, Healthy Generations Newsletter*, 5:3 ([http://www.epi.umn.edu/mch/resources/hg/hg\\_immi.pdf](http://www.epi.umn.edu/mch/resources/hg/hg_immi.pdf), accessed 11<sup>th</sup> July 2014). Kennedy, S., McDonald, J.T., Biddle, N. (2006). *The healthy immigrant effect and immigrant selection: evidence from four countries*. Hamilton, McMaster University (Social and Economic Dimensions of an Aging Population Research Papers 164; <http://ideas.repec.org/p/mcm/sedapp/164.html>, accessed 11<sup>th</sup> July 2014).

It is not even the case that where differences are found, they are always in the direction of worse health for migrants. Bhopal<sup>126</sup> asserts: “We need to sustain the beneficial aspects of minority ethnic group cultures (e.g. taboo on smoking in Sikhs). Where minorities exhibit the lowest rates of disease or risk factors they should provide the goal for other groups to emulate”. However, the fact that no simple generalizations are available in no way weakens the point that the burden of ill health among certain migrant and ethnic minority groups is often unacceptably large.

### 2.3. Differences found

As seen above, migrant status may (statistically speaking) have a positive association with health, but the influence of migration on an individual's health is nevertheless usually negative. Data collection in this area is still lacking in systematic methodology, which has led to a lack of high quality studies at the European level. The literature review carried out in this project (see Appendix II) gives some examples of the differences found in health outcomes between migrants and host country populations. Methodology is seldom standardised across countries, which limits the generalisability of the results. A landmark study in this respect was the MEHO project mentioned throughout this chapter and described in detail in Appendix VI, which studied the following health domains: mortality, cardiovascular disease and diabetes, infectious diseases, cancer, self-perceived health and health care use<sup>127</sup>. Below we give a selection of important findings, gathered from the literature review and other sources<sup>128</sup>. Of course, this quick sketch makes no claim to be exhaustive.

#### 2.3.1. General measures of health

Clinical data, which concern diagnoses made by qualified professionals, are seldom disaggregated by migrant status or ethnicity and may suffer from biases because of variations in care utilization and the difficulty of estimating denominators (i.e. the proportion of migrants in the underlying population)<sup>129</sup>. For these reasons, much research on migrant and ethnic minority health focuses on variables that are relatively easy to collect for the population as a whole, such as self-reported health status, life expectancy or mortality. Such data can be collected from individuals themselves or from national ‘vital statistics’ (registries of births and deaths). However, these indicators of health status may also be subject to biases. Mortality rates, for example, may be underestimated because of ‘salmon bias’ (the tendency of some migrants to return to their country of origin as they become older and less

<sup>126</sup> Bhopal, R. (2009). Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *European Journal of Public Health*, 19:2:140–143.

<sup>127</sup> Migrant and Ethnic Health Observatory (MEHO). Website: <http://www.meho.eu.com/> (temporarily unavailable).

<sup>128</sup> Overviews on migrants' state of health are provided by (e.g.) Rechel, B., Mladovsky, P., Devillé, W., Rijks, B., Petrova-Benedict, R., McKee, M. (2011). *Migration and health in the European Union*. Buckingham: Open University Press; Gushulak, B., Pace, P., Weekers, J. (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe; Bhopal (2014, *op cit*).

<sup>129</sup> Ingleby, D. (2009) *European Research on Migration and Health*. Brussels: International Organisation for Migration. <http://www.migrant-health-europe.org/background-papers/research-on-migration-health.html>

healthy).<sup>130</sup> Self-reported health status is also an imprecise measure, because there are no objective criteria for ‘feeling well’ or ‘feeling unwell’; there may be significant cross-cultural differences in the way such judgements are made.<sup>131</sup>

### **2.3.1.1. Mortality and life expectancy**

Death certificates are not a reliable indicator of the prevalence of specific illnesses, because the causes of death are often oversimplified.<sup>132</sup> Nevertheless, many studies have made use of this indicator. A Dutch study<sup>133</sup> found that life expectancy was longer than for native Dutch in seven out of ten non-Western migrant groups. The authors concluded that “migrant health could be benefiting from the favourable socioeconomic, public health and health-care conditions in The Netherlands, but not yet be affected by the higher risks of cancer and cardiovascular disease associated with prosperity.” However, there are many studies showing higher mortality rates for migrants as a result of a number of different factors. For example, postpartum maternal mortality rates amongst foreign (sub-Saharan, Asia, North and South America) women in France were twice as high compared to non-foreigners.<sup>134</sup> This study suggests that inferior medical attention may have been a factor in these elevated mortality rates. These findings were echoed in the UK, where two major triannual studies into maternal mortality showed that women in minority ethnic groups were at significantly greater risk than the majority population.<sup>135, 136</sup> In particular Black African and, to a lesser extent, Black Caribbean women had significantly higher mortality rates than White women. Potential causes for these elevated rates included the later engagement with maternity services, and migration trajectories and circumstances of some Black African women who may have been newly arrived refugees or asylum seekers. Furthermore, many migrant groups experience higher diabetes mortality. The research on migrant mortality from diabetes mellitus in several European countries, conducted by the University of Amsterdam as part of the MEHO project, found that rates were particularly high in migrants from North Africa, the Caribbean, the Indian subcontinent and countries with a low gross domestic product (GDP).<sup>137</sup>

### **2.3.1.2. Self-perceived health**

This variable is included in the standard data-set for the European Union Statistics on Income and Living Conditions (SILC).<sup>138</sup> A fair amount of research is available on the self-perceived general health of migrants, and as SILC data become better implemented in EU countries, more can be expected. Most

<sup>130</sup> Bhopal, R. (2014, *op. cit.*), p. 135.

<sup>131</sup> Ramírez, M., Ford, M.E., Stewart, A.L. and Teresi, J.A. (2005). Measurement Issues in Health Disparities Research. *Health Services Research*, 40(5), 1640-1657.

<sup>132</sup> Bhopal, R. (*op. cit.*), p. 142

<sup>133</sup> Mackenbach, J. P., Bos, V., Garssen, M. J., Kunst, A. E. (2005). Mortality among non-western migrants in The Netherlands. *Nederlands Tijdschrift Geneeskunde*, 149(17):917-23.

<sup>134</sup> Philibert, M., Deneux-Tharaux, C., Bouvier-Colle, M. (2008) Can excess maternal mortality among women of foreign nationality be explained by suboptimal obstetric care? *BJOG* 115:1411–1418.

<sup>135</sup> Ge, L. (2007) Saving mothers’ lives: reviewing maternal deaths to make childbirth safer - 2003–2005. London: CEMACH.

<sup>136</sup> Centre for Maternal and Child Enquiries (2011). Saving Mothers’ Lives: Reviewing deaths to make motherhood safer: 2006–2008. *BJOG*, 118(s1):1–203.

<sup>137</sup> Vandenheede, H. *et al.* (2012). Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *European Journal of Epidemiology* 27, 109–117.

<sup>138</sup> Website: [http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu\\_silc](http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu_silc)

studies have found that migrants' judgements of their own health tend to be less favourable than those of the host population. A large part of this difference disappears when socioeconomic differences are controlled for, but in many studies the effect is not entirely removed.<sup>139</sup> A similar conclusion was drawn by the MEHO sub-study on self-reported health status of migrants and ethnic minorities, based on a literature review of European studies.<sup>140</sup> A striking exception is provided by a study in Belgium, which found that when migrants' living conditions were also controlled for, self-reported health actually seemed to be better.<sup>141</sup>

### 2.3.2. Non-communicable diseases

Several overviews on non-communicable diseases among migrants in Europe are available.<sup>142</sup> The incidence of many of these diseases increases with age, and the growing volume of research on this topic is connected to the increasing numbers of older migrants in Europe.

#### 2.3.2.1. Cardiovascular diseases

Cardiovascular diseases (CVD) are one of the major health threats which have been found to be elevated in many (but not all) migrant and ethnic minority groups. The risk of CVD mortality among migrants varies across Europe and according to the migrants' country of origin. Thus, Surinamese and Antilleans have a higher risk of CVD mortality compared to the native population in the host country, while Moroccans have a lower risk<sup>143</sup>. However, differences found depend not only on the country of birth, but also on the destination country; similar findings were reported both in the original MEHO study on CVD<sup>144</sup>, and in a later extension of the study<sup>145</sup>.

Much research currently focuses on the complex interaction of factors which may underlie the higher risks of CVD among certain migrant and ethnic minority groups.<sup>146</sup> For example, research points to an elevated risk for developing diabetes and CVD amongst children of non-Western migrants residing in

<sup>139</sup> See e.g. Devillé, W. *et al.* (2006). Perceived health and consultation of GPs among ethnic minorities compared to the general population in the Netherlands. In: Westert, G.P., Jabaaij, L., François, G., eds. *Morbidity, performance and quality in primary care*. Oxford, Radcliffe Publishing Ltd:85–96.

<sup>140</sup> Nielsen, S.S., Krasnik, A. (2010). Poorer self-perceived health among migrants and ethnic minorities versus the majority population in Europe: a systematic review. *International Journal of Public Health*, 55 (5): 357–371.

<sup>141</sup> Lorant, V., Van Oyen, H., Thomas, I. (2008). Contextual factors and immigrants' health status: double jeopardy. *Health & Place*, 14:4:678–692.

<sup>142</sup> See e.g. Kunst, A., Stronks, K. and Agyemang, C. (2011) Non-communicable diseases. In: Rechel *et al.* (2011), *op. cit.*, 101–120; Carballo, M. (2009a). Non-communicable diseases. In: Fernandes, A., Pereira Miguel, J., eds. (2009). *Health and migration in the European Union: better health for all in an inclusive society*. Lisbon, Instituto Nacional de Saúde Doutor Ricardo Jorge:71–81

<sup>143</sup> Ujic-Voortman, J.K., Baan, C.A., Seidell, J.C., Verhoeff, A.P. (2012). Obesity and cardiovascular disease risk among Turkish and Moroccan migrant groups in Europe: a systematic review. *Obesity Reviews* 13, 2–16.

<sup>144</sup> Bhopal RS, Rafnsson SB, Agyemang C, et al. (2011). Mortality from circulatory diseases by specific country of birth across six European countries: test of concept. *Eur J Public Health* 22:353–9.

<sup>145</sup> Rafnsson, S.B., Bhopal, R.S., Agyemang, C., Fagot-Campagna, A., Harding, S., Hammar, N., Kunst, A.E. *et al.* (2013). Sizable variations in circulatory disease mortality by region and country of birth in six European countries. *Eur J Public Health*, 23 (4) 594 - 605.

<sup>146</sup> Bhopal, R. (2014, *op. cit.*),

Europe. Recently, the Child Health and Heart Study (CHASE) in England sought to identify the association between low birthweight and risk markers for diabetes and CVD, as a way to explain the ethnic differences that exist. The study found that lower birthweight was in fact strongly associated with higher risk for developing diabetes and cardiovascular diseases, and that lower birthweights were more prevalent amongst children with South Asian (Indian, Pakistani and Bangladeshi) and Black African Caribbean children, compared to White European children residing in the UK. However, the study provided no conclusive evidence that these findings explain the higher prevalence of these diseases amongst South Asians and Black African Caribbeans compared to White Europeans residing in the UK. Other possible explanations suggested were life style factors such as energy consumption, physical exercise and diet.

### 2.3.2.2. Diabetes

As we saw in relation to mortality rates (Section 2.3.1.1), diabetes is particularly common among migrants. Age-standardised diabetes prevalence is higher in migrant populations in all the reviews studied, regardless of the country of origin of migrants<sup>147,148</sup>. The European Union is supporting research in this field (**Project RODAM** and **GIFTS**) to identify the determinants of such differences.

### 2.3.2.3. Cancer

Cancer risk is often found to be lower in migrant populations<sup>149</sup>, reflecting the fact that most types of cancer tend to be less common in many of the developing countries from which migrants often originate. However, a review conducted for the MEHO project showed that “migrants from non-western countries were more prone to cancers that are related to infections experienced in early life, such as liver, cervical and stomach cancer. In contrast, migrants of non-western origin were less likely to suffer from cancers related to a western lifestyle, e.g. colorectal, breast and prostate cancer”.<sup>150</sup> Likewise, a UK study on cancer rates among people born in different countries found variations in rates for different groups of migrants and types of cancer. While findings indicated an overall lower mortality for all cancers combined among people born in Bangladesh (except for lung cancer in men), India, Pakistan or China/Hong Kong, and lower lung cancer mortality among people born in West Africa or the West Indies, women born in West Africa and men born in West Africa or the West Indies experienced higher breast cancer mortality and higher prostate cancer mortality respectively.<sup>151</sup>

The latter study is based on country of birth, since death certificates in the UK report only country of birth and not ethnicity. Therefore, the figures for those born in England and Wales will also include descendents of migrants. For many types of cancer, incidence rates differ between non-industrialised and industrialised countries: incidence rates among migrants tend to change in the direction of the rate in the country to which they migrate (providing further evidence for the role of environmental

<sup>147</sup> Vandenheede, H. *et al.* (2012). Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *European Journal of Epidemiology* 27, 109–117.

<sup>148</sup> Rechel *et al* (*op. cit.*), 2011

<sup>149</sup> *ibid*, p. 258.

<sup>150</sup> Arnold, M., Razum, O., Coebergh, J.W. (2010). Cancer risk diversity in non-western migrants to Europe: an overview of the literature. *Eur J Cancer* 46:2647–59

<sup>151</sup> Wild, S.H. *et al* (2006). Mortality from all cancers and lung, colorectal, breast and prostate cancer by country of birth in England and Wales, 2001–2003 *British Journal of Cancer* 94, 1079 – 1085



factors in certain forms of cancer). For example, rates of breast cancer even increase among women migrating from the low-risk south of Italy to the higher-risk north.<sup>152</sup>

Screening programmes can play an important role in the detection and early treatment of many types of cancer and it is often reported that migrants' participation in these programmes is lower than that of the majority population.<sup>153</sup> As with all screening programmes, there is often debate about the effectiveness of programmes which aim to detect cancer. Depending on the incidence in the group being screened and the aggressiveness of the type of cancer involved, it is possible that the risks of unnecessary treatment as a result of false-positives (as well as the anxiety and disruption this causes) may outweigh the advantages of early detection. Since these advantages and disadvantages involve a subjective element, it is increasingly regarded as good practice to allow individuals themselves to participate in the decision as to whether they should be screened. "Women cannot be expected to make an informed choice about participation in a screening programme unless they are given sufficient and adequate information." <sup>154</sup>

With migrants and ethnic minorities there is a real possibility that the incidence of cancer in their group may differ from that among the general population. The aggressiveness of the predominant type of cancer may also differ: for example, controversy has arisen in England over the minimum age for screening of Black women, among whom there is said to be a raised incidence (mainly among UK-born groups) of aggressive forms of breast cancer at an early age<sup>155</sup>. How screening policies should best take account of these differences is not clear.

A recent article<sup>156</sup>, based on many studies showing that breast cancer incidence is lower among Turkish migrants to Germany, argues that screening for this group may be less effective than for natives. However, rather than introducing different screening guidelines for these migrants (which could be experienced as stigmatising), the article recommends the provision of adapted information. Conversely, in response to the threefold elevation of the incidence of prostate cancer among Black African and Caribbean men in the UK, advocacy groups have called for programmes to increase awareness among the affected communities of the risks and the available screening methods<sup>157</sup>.

As with all health problems, cancer rates for migrants or ethnic minorities vary by destination country as well as by country of origin, possibly reflecting differences in the accessibility and quality of health

<sup>152</sup> Kolonel, L.N. and Wilkens, L.R. (2006), Migrant studies. In: Schottenfeld D, Fraumeni JF Jr (eds) *Cancer epidemiology and prevention*, 3rd edn. Oxford University Press, Inc., New York, pp 189--201

<sup>153</sup> Nørredam, M., Nielsen, S. and Krasnik, A. (2010). Migrants' utilization of somatic healthcare services in Europe – a systematic review. *European Journal of Public Health*, 20(5): 555–63.

<sup>154</sup> European Commission (2006) European guidelines for quality assurance in breast cancer screening and diagnosis (fourth edition). <http://www.euref.org/european-guidelines>

<sup>155</sup> D. Ingleby (2008) Early onset of breast cancer in Black British women: how reliable are the findings? *British Journal of Cancer* 99, 986–987.

<sup>156</sup> Berens, E-M, Spallek, J. and Razum, O. (2012). Breast cancer screening among immigrant women: do we need specific approaches in risk communication? In Ingleby, D., Krasnik, A., Lorant, V. & Razum, O. (Eds.) *Health inequalities and risk factors among migrants and ethnic minorities. COST Series on Health and Diversity, Volume I* (pp. 304–318). Antwerp/Apeldoorn: Garant.

<sup>157</sup> Prostate Cancer in BME Communities Parliamentary Stakeholder Group (2012). *Prostate Cancer in BME Communities: Raising Awareness and Improving Outcomes*. [http://www.bmeprostatecancer.com/resource/downloads/Prostate\\_Cancer\\_in\\_BME\\_Communities\\_Report.pdf](http://www.bmeprostatecancer.com/resource/downloads/Prostate_Cancer_in_BME_Communities_Report.pdf)

services (including screening programmes) for such groups. Another systematic review carried out in the framework of the MEHO project, comparing Turkish-born migrants in Belgium, Denmark, France and the Netherlands<sup>158</sup>, showed that while all-cancer mortality rates were overall lower for Turkish migrants than for the local-born populations, for some types of cancer rates were higher. For example, rates for stomach cancer were higher for Turkish men in France and the Netherlands. Further research is urgently needed to explore the connections between cancer incidence, migrant status, ethnicity, country of origin, socioeconomic position and the length of stay in the host country.

### 2.3.5. Communicable diseases

On this topic, too, several overview articles are available.<sup>159</sup> Communicable diseases among migrants have always been a politically sensitive issue. The earliest initiatives on migrant health, such as the screening of US immigrants at Ellis Island from 1891-1930, were motivated by fears that ‘import diseases’ could infect the host population, while chronically ill or disabled individuals could become a burden on the community. Later in the century, such practices were frequently criticised because of their inaccuracy and lack of respect for human rights, as well as their often dubious scientific basis<sup>160</sup>. At the same time, the success of campaigns to eradicate infectious diseases in the developing world further reduced concern about ‘import diseases’. However, the resurgence of global epidemics (for example of TB, HIV/Aids or hepatitis) toward the end of the 20<sup>th</sup> century showed this relaxed attitude to be premature.

There is thus a renewed interest in the prevalence of infectious disease among migrants and the potential of screening, early detection and prevention. The European Centre for Disease Prevention and Control (ECDC) recently undertook an extensive overview of this area<sup>161</sup>. Serious and widespread data limitations were noted. Often it was possible to calculate the relative proportions of carriers of a disease who were migrants or non-migrants, but uncertainty about the denominators made it impossible to convert these figures into prevalence rates.

This issue is particularly worrying given the fact that many conditions are vaccine-preventable. As long as adequate information remains unavailable on prevalence rates and the take-up of vaccination programmes by migrants, it will be impossible to remedy important gaps in coverage. The ECDC has looked extensively into the obstacles to MMR vaccination coverage among hard to reach populations at the European level.<sup>162</sup> They identified the following main barriers: discrimination; administrative and financial problems; language or literacy difficulties; lack of cultural knowledge; lack of information

<sup>158</sup> Spalleck, J. *et al* (2012) Cancer mortality trends among Turkish immigrants in four European countries and in Turkey. *European Journal of Epidemiology* 27(12):915-21.

<sup>159</sup> See e.g. Wörman, A. & Krämer, A (2011). Communicable diseases, in Rechel *et al* (op. cit.), 2011: 121-138; Carballo, M. (2009b). Communicable diseases, in: Fernandes, A., Pereira Miguel, J., eds. *Health and migration in the European Union: better health for all in an inclusive society*. Lisbon, Instituto Nacional de Saúde Doutor Ricardo Jorge:53-69

<sup>160</sup> Bateman-House, A., Fairchild, A. (2008). Medical Examination of Immigrants at Ellis Island. *Virtual Mentor* 10(4), 235-241.

<sup>161</sup> ECDC (2014a) Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA. European Centre for Disease Prevention and Control.

<sup>162</sup> European Centre for Disease Prevention and Control (2013a). Review of outbreaks and barriers to MMR vaccination coverage among hard-to-reach populations in Europe. Stockholm: ECDC.



on health and vaccination; religious beliefs; a fatalistic approach to life or a distorted risk perception in relation to vaccines and vaccine-preventable diseases among some individuals and groups. The EC's **AURORA project**<sup>163</sup> promotes the use of evidence-based prevention for cervical cancer (in which transmission of the human papilloma virus or HPV plays an important role) through the exchange of information and expertise at European level. The project evaluated HPV vaccination programmes in five of the participating countries (Italy, Greece, Slovenia, Latvia and Romania) and found that the implementation of a public health education campaign to prepare the population for the vaccination programmes was key to their success or failure.<sup>164</sup> Other European level projects looking at the vaccination coverage and at the presence of specific programmes or regulations supporting the vaccination coverage of migrants and nomadic groups, include the **EpiSouth Project** and the **Promovax** project. **Episouth**<sup>165</sup> found that, of the 26 participating countries in the area of the Mediterranean and the Balkans, 20 had no specific regulations supporting vaccination programmes for migrant and nomadic groups, while 12 countries reported the presence of special programmes promoting vaccination coverage among those groups. Furthermore, findings indicated that even if regular migrants had equal entitlements to vaccines as the general population in 18 of 22 countries that responded, access to vaccines and vaccine uptake was still patchy, especially among some groups, e.g. Roma, irregular migrants. The study's findings include the identification of a number of barriers to vaccination. **Promovax's** aims include the improvement of the knowledge base regarding barriers to vaccination coverage, and the development of recommendations for policy makers regarding the vaccination of hard to reach groups, including migrants.<sup>166</sup> A toolkit for health professionals developed as part of the project aims contribute to the wide dissemination of information regarding vaccinations to hard to reach groups, by assisting health professionals to assess the immunisation needs of these groups and thus increase vaccination rates.<sup>167</sup> At the national level, although vaccination coverage was found to be largely adequate in the Netherlands<sup>168</sup>, other studies have shown that programmes sometimes do not reach migrants and ethnic minorities effectively<sup>169</sup>. For example, the adult immigrant population from Latin America has been found to be especially susceptible to rubella, as most countries in Latin America only adopted Rubella vaccine since 2002. Subsequently, in 2003, an increase in rubella notifications was detected in Madrid among women born in Latin America. None of the women had been vaccinated against Rubella.<sup>170</sup> Similarly, in the UK, ethnic minorities are at an increased risk of rubella susceptibility, possibly because they migrated

<sup>163</sup> [www.aurora-project.eu](http://www.aurora-project.eu) (accessed 15/1/2015)

<sup>164</sup> *ibid*

<sup>165</sup> EpiSouth Network (2009). EpiSouth Project: Assessment of Countries Migration Status Profile and Vaccination Access of Mobile Population. [http://www.episouth.org/outputs/wp7/WP7\\_9\\_Report\\_Assessment\\_Countries\\_Migration.pdf](http://www.episouth.org/outputs/wp7/WP7_9_Report_Assessment_Countries_Migration.pdf) (Accessed 18 February, 2015).

<sup>166</sup> <http://www.promovax.eu/index.php/promovax/main> (Accessed 18 February, 2015).

<sup>167</sup> [http://www.promovax.eu/toolkits/HCW\\_english\\_web.pdf](http://www.promovax.eu/toolkits/HCW_english_web.pdf) (Accessed 18 February, 2015).

<sup>168</sup> Verweij A, Singels LW (2009). Preventie gericht op allochtonen: Wat is het bereik? In: Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM, <http://www.nationaalkompas.nl>> Nationaal Kompas Volksgezondheid\Preventie\Gericht op doelgroepen\Allochtonen (accessed 15/1/2015)

<sup>169</sup> Borrás, E., *et al.* (2007). Vaccination coverage in indigenous and immigrant children under 3 years of age in Catalonia (Spain). *Vaccine*, 25(16): 3240–3.

<sup>170</sup> Lemos, C. *et al* (2004). New Features of Rubella in Spain: Evidence of an outbreak. *Eurosurveillance*, Vol. 9, Issue 4.

from countries with no rubella vaccination in their immunization programme, or when they were above the age of routine MMR in the UK.<sup>171</sup>

#### **2.3.5.1. HIV**

Despite the methodological problems just noted, many studies have found that certain groups of migrants have a higher risk of HIV infection. HIV is mainly concentrated in key populations at higher risk of HIV infection such as men who have sex with men, people originating from generalized epidemic countries (mainly sub-Saharan Africa) and other migrants, and PWID and their sexual partners.<sup>172</sup> This is often connected with a raised prevalence of HIV in the countries from which migrants originate, but infections may also be contracted in the host country.<sup>173</sup> In fact, the main ways for transmission of HIV in Europe are unsafe sex among men who have sex with men and unsafe injecting drug use. Migrants tend to not be highly represented in either risk group.<sup>174</sup> However, migration remains an influential factor when considering heterosexual transmission: migrants from high HIV prevalence countries accounted for 40% of all cases of transmitted HIV in Western Europe between 2007 and 2011.<sup>175</sup> In those countries with the highest prevalence of migrants among the HIV statistics ( Belgium, Cyprus, France, Ireland, Luxembourg, Malta, Sweden and the UK), migrants from Africa (sub-Saharan) seemed to be the group most at risk, and of having acquired the infection in their country of origin.<sup>176</sup> A large study in Spain, found that among migrants with HIV, female sex-workers originating from Latin America were most at risk.<sup>177</sup> In terms of the disease's progression to AIDS, and subsequently potential AIDS mortality, migrants are over-represented, with especially high rates of deaths from AIDS among sub-Saharan Africans. However these rates varied according to EU country: e.g. sub-Saharan Africans in the UK come primarily from Nigeria and Ghana (lower prevalence of HIV), whereas in Portugal they originate mostly from Cape Verde, Mozambique and Angola (higher prevalence of HIV).<sup>178</sup>

#### **2.3.5.2. Tuberculosis**

Tuberculosis notifications rates are higher in foreign born population than in native born population in Europe, with, on average, twice as many males as females among all TB cases reported.<sup>179</sup> Infected patients are mainly from countries where TB is less well controlled, in Asia, Africa and Europe (outside the EU)<sup>180</sup>. In 2008, the total number of new cases of TB in the WHO European region was 461,645, (52.2 per 100,000 population) with the highest rates observed in countries of the former Soviet

<sup>171</sup> Byrne, L. *et al.* (2012). Seroprevalence of low rubella IgG antibody levels among antenatal women in England tested by NHS Blood and Transplant: 2004-2009. Is rubella susceptibility increasing? *Vaccine* 30; 161-167.

<sup>172</sup> European Centre for Disease Prevention and Control/WHO Regional Office for Europe (2014b). HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC.

<sup>173</sup> ECDC (2014a), *op.cit.*

<sup>174</sup> Wörmann, T., Krämer, A. (2011). Communicable diseases. In: Rechel, B. *et al* (eds.). Migration and health in the European Union. European observatory on health systems and policies. Open University Press.

<sup>175</sup> ECDC (2014a), *op cit*

<sup>176</sup> *ibid*

<sup>177</sup> *ibid*

<sup>178</sup> *ibid*

<sup>179</sup> European Centre for Disease Prevention and Control/WHO Regional Office for Europe (2014c). Tuberculosis surveillance and monitoring in Europe 2014. Stockholm: ECDC.

<sup>180</sup> ECDC (2014a), *op.cit.*

Union.<sup>181</sup> Within the WHO European Region, an estimated 353 000 new TB cases were recorded in 2012, equivalent to an average of 39.4 cases per 100 000 population.<sup>182</sup> These figures mark a significant increase from 2008, when the incidence rate averaged 16.7 per 100,000, with the highest rates in Romania (115.1), Lithuania, Latvia, Bulgaria and Estonia (33.1).<sup>183</sup> In the WHO European countries where TB surveillance data includes information on migrant status of persons with TB, the average percentage of all cases that were found in people of foreign origin in 2008 was over 20%.<sup>184</sup> In some countries this was much higher. For example, in Germany, approximately 46% of all new reported cases of TB in 2004 were born outside of Germany (many in countries of the former Soviet Union and the Russian Federation) and 35% had foreign citizenship. Children with foreign citizenship in Germany also face a high risk of TB infection.

### 2.3.5.3. Other infectious diseases

The ECDC report mentioned above<sup>185</sup> also concluded that a higher risk of hepatitis B, malaria and Chagas disease may affect certain migrant groups. No increased risks of gonorrhoea and syphilis were found, however, and no reliable evidence was available on measles, rubella and hepatitis C. For an up-to-date and comprehensive overview of the epidemiological situation in the European Union relating to communicable diseases of public health importance, the ECDC's 2012 Annual Epidemiological Report presents an analysis of surveillance data from 2010 and of communicable disease threats detected in 2011.<sup>186</sup> For vaccine preventable diseases it reports an overall declining or stable trend in reported incidence of confirmed cases. More specifically, tetanus and diphtheria cases were rare, except for Italy where 57 cases of tetanus were reported in 2010. Rubella and mumps also showed a decline in rate of new infections, though the report stresses that the burden of disease is hard to assess due to variations in surveillance systems and reporting, and particularly low rates of laboratory confirmation. The report is intended primarily for policymakers, health service leaders, epidemiologists and researchers, and identifies opportunities where continued or increased public health responses may be needed to decrease the burden of these diseases.

### 2.3.6. Maternal and child health

A recent study by Médecins du Monde explored in detail the challenges and vulnerabilities faced by the thousands of individuals and families accessing their clinics all over Europe. Most of those accessing health services in Médecins du Monde clinics are migrants, but not all. Findings indicated that women and children were especially vulnerable as access to antenatal care for pregnant women and to essential childhood vaccinations are currently not universally guaranteed in the EU.<sup>187</sup>

<sup>181</sup> Wörmann & Krämer (2011), *op.cit.*

<sup>182</sup> ECDC (2014c), *op.cit.*

<sup>183</sup> ECDC (2014a), *op.cit.*

<sup>184</sup> *ibid*

<sup>185</sup> *ibid*

<sup>186</sup> European Centre for Disease Prevention and Control (2013b). Annual Epidemiological Report 2012. Reporting on 2010 surveillance data and 2011 epidemic intelligence data. Stockholm: ECDC.

<sup>187</sup> Chauvin P, Simonnot N, Douay C, Vanbiervliet F. (2014). *Access to healthcare for people facing multiple vulnerability factors in 27 cities across 10 countries. Report on the social and medical data gathered in 2013 in eight European countries, Turkey and Canada.* Paris: International network of Médecins du monde.

Migrant women in general are exposed to a higher risk of maternal mortality<sup>188</sup>, while in many migrant groups worse outcomes are also found in relation to low birth weight, premature birth, perinatal mortality and morbidity and congenital malformations<sup>189,190</sup>. However, as we saw in Section 1.6.2, rates of stillbirth and neonatal mortality among groups of migrant origin also vary between different countries of destination, which may reflect differences between European countries in the accessibility and quality of health care for pregnant women in those groups.<sup>191</sup> With regard to screening for different types of cancer such as cervical and breast cancer, one study conducted in the UK found that ethnicity was the only statistically significant predictor when researchers compared women who had had some screening with those who had had none. In other words, white women were significantly more likely to have had a cervical smear than other groups of women.<sup>192</sup> Nevertheless, as another UK study illustrates, screening rates among different ethnic minority groups vary significantly. While South Asian women were in the focus for low screening rates, a closer look at how they compared to women from other ethnic groups in areas of high ethnic density, revealed that the rate of women who had never attended either breast or cervical cancer screening was significantly higher among women from other ethnic groups.<sup>193</sup> As a result, subsequent studies have explored screening rates for women from other ethnic groups in the UK.

The obstetric complications associated with female genital mutilation or cutting (FGM) also present challenges to health service providers. They require specialist knowledge about the potential health risks to mother and child, the legal and ethical frameworks surrounding this issue, and the most effective ways of meeting the health needs of the women subjected to or at risk of this procedure. This is in order to ensure qualified and effective preventive measures against FGM, and coping with the effects of the mutilation. (See Section 2.5.2.2.)

### 2.3.7. Mental health

#### 2.3.7.1. General issues

A fundamental issue affecting research on the mental health problems of migrants and ethnic minorities is that cultures and countries vary in the way they conceptualise such problems, the types

<sup>188</sup> Pedersen, G.S., Grøntved, A., Mortensen, L.H., Andersen, A.-M.N., Rich-Edwards, J., (2013). Maternal Mortality Among Migrants in Western Europe: A Meta-Analysis. *Matern Child Health J* 1–11.

<sup>189</sup> Bollini, P., Pampallona, S., Wanner, P., Kupelnick, B., (2009). Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. *Social Science & Medicine* 68, 452–4

<sup>190</sup> Reeske, A., Razum, O. (2011). Maternal and child health – from conception to first birthday. In Rechel et al. (2011), op. cit., 139–144

<sup>191</sup> Villadsen SF, et al (2010). Cross-country variation in stillbirth and neonatal mortality in offspring of Turkish migrants in northern Europe. *European Journal of Public Health*, 20(5):530–535.

<sup>192</sup> Moser, K., Patnick, J., Beral, V. (2009). Inequalities in reported use of breast and cervical screening in Great Britain: analysis of cross sectional survey data. *British Medical Journal* 338:b2025

<sup>193</sup> Webb, R., Richardson, J., Esmail, A. and Pickles, A. (2004) Uptake for cervical screening by ethnicity and place-of-birth: a population-based cross-sectional study. *Journal of Public Health (Oxford)*, 26(3): 293–6.

that they recognise and the way distress and disability is expressed<sup>194</sup>. Whereas the presence or absence of physical diseases can be decided on the basis of objective biological indicators, psychiatric diagnosis has to rely on interpretation and judgement<sup>195</sup>. This involves taking into account relevant cross-cultural variations: the evidence base in this area is not well developed. For this reason, research on mental health among migrants and ethnic minorities is less well developed than on other topics. (The **MEHO project**, for example, did not include mental health among the conditions it studied). **Project PROMO** (Best Practice in Promoting Mental Health in Socially Marginalized People in Europe) has chosen to focus on social marginalization as a starting point for approaching determinants of mental ill health, and asylum seekers, irregular migrants, and refugees are explicitly included, as are long-term unemployed, homeless, street sex workers, and travelling communities.<sup>196</sup> Its objectives, in short, are the delivery of health and social care for people with mental health problems who experience exclusion and marginalization in society. For more information on the project outcomes and access to the project deliverables, please see <http://www.promostudy.org/outcomes/index.html>)

### **2.3.7.2. Depression and anxiety disorders**

These so-called ‘common mental illnesses’ are often hard to distinguish from “normal reactions to abnormal situations”. Appendix II lists a number of studies showing higher prevalences of depression and anxiety among migrants. It is known that social disadvantage and lower SES are associated with depression, but it is not clear how many of the problems among migrants can be accounted for in such terms. Some studies<sup>197</sup> have shown that perceived discrimination or racism can increase rates of common mental disorders.

### **2.3.7.3. Schizophrenia and related psychotic disorders**

Although the overall prevalence of these disorders is low (around 1%), raised levels are found in some migrant groups. Many studies in the UK, the Netherlands, Sweden and Denmark have shown that young males from non-Western countries are particularly at risk<sup>198</sup>.

### **2.3.7.4. Post-traumatic stress disorder (PTSD) and refugee mental health problems**

It is often assumed that the main mental health problems of refugees and asylum seekers are post-traumatic disorders resulting from harrowing experiences in their country of origin. Although a meta-analysis<sup>199</sup> showed a prevalence of 9% among refugees, which is around ten times higher than in the general population, another meta-analysis<sup>200</sup> concluded that rates of depression were twice as high

<sup>194</sup> Bhugra, D., Gupta, S. (eds.) (2006). *Migration and Mental Health*. London and New York: Cambridge University Press

<sup>195</sup> Horwitz, A.V., Wakefield, J.C. (2006). The epidemic in mental illness: clinical fact or survey artifact? *Contexts*, 5(1): 19-23.

<sup>196</sup> <http://www.promostudy.org/project/> (Accessed 23 February, 2015).

<sup>197</sup> E.g. Karlsen, S. et al. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine*, 35:12:1795–1803

<sup>198</sup> Ingleby, D. (2008). *New perspectives on migration, ethnicity and schizophrenia*. Willy Brandt Series of Working Papers in International Migration and Ethnic Relations 1/08, IMER/MIM, Malmö University, Sweden.

<sup>199</sup> Fazel, M., Wheeler, J., Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, 365:9467:1309–1314.

<sup>200</sup> Lindert, J. et al. (2009). Depression and anxiety in labor migrants and refugees – a systematic review and meta-analysis. *Social Science & Medicine*, 69:2:246–257.

among refugees as among labour migrants (44% versus 20%). The same was true for anxiety disorders (40% versus 21%). Mental health problems among refugees are thus not simply a matter of post-traumatic stress reactions. Moreover, the origin of these problems may lie not in the country of origin, but in experiences endured during the flight and the asylum application procedure<sup>201</sup>.

### 2.3.8. Occupational health and safety

This is another area in which migrants are exposed to increased health risks. Many migrants work in so-called “3D jobs” – “dirty, demanding and dangerous”<sup>202</sup>. According to a recent overview of the topic<sup>203</sup>, migrant workers experience higher rates of industrial accidents, injuries and work-related diseases. Because of their precarious employment conditions and poorer access to health services, many work-related illnesses may go unreported and treated. The **European Agency for Safety and Health at Work (OSHA)** explores the challenges faced by migrants, regular and irregular, their employers and co-workers, in the health care sector, and lists the following areas as requiring special health and safety attention: cultural (e.g. language-related) barriers to communication and training in OSH; the high prevalence of overtime work and related risks for accidents and ill health among migrant workers; and cooperation and leadership in multicultural teams and guidance on cultural diversity issues at work.<sup>204</sup>

<sup>201</sup> Ingleby, D. (ed.) (2005) *Forced migration and mental health: rethinking the care of refugees and displaced persons*. New York: Springer.

<sup>202</sup> McCauley, L.A. (2005) Immigrant workers in the United States: recent trends, vulnerable populations, and challenges for occupational health. *Journal of the American Association of Occupational Health Nurses*, 53(7), 313–19.

<sup>203</sup> Agudelo-Suárez, A.A., Ronda-Pérez, E. & Benavides, F.G. (2011). Occupational health. In: Rechel et al., *op cit.*, 155-168.

<sup>204</sup> De Jong, *et al* (2014). Current and emerging issues in the healthcare sector, including home and community care. European Agency for Safety and Health at Work. <https://osha.europa.eu/en/publications/reports/current-and-emerging-occupational-safety-and-health-osh-issues-in-the-healthcare-sector-including-home-and-community-care> (Accessed 15 February 2015).



## 2.4. Health inequalities affecting the descendants of migrants

In this section we focus on the ‘second generation’, i.e. the European-born children of migrants (many of whom have of course now reached adulthood). As we saw in Chapter 1, this group tends to be invisible in statistics on health: they are by definition excluded from studies of migrants, while studies that disaggregate people on the basis of self-ascribed ethnicity tend to lump together migrants and their offspring born in the host country. In the Netherlands separate analysis is possible using registry data, while in several countries studies have been set up using specially recruited samples.

### 2.4.1. Findings from the UK

We begin with a recent summary<sup>205</sup> of the main findings of UK research on ethnic differences in general, in which no distinction is made between migrants and their UK-born descendants.

- Generally poorer health among non-White minorities, with Bangladeshi people having the poorest health, followed by Pakistani, Black Caribbean, Indian and Chinese people;
- High, but variable, rates of diabetes across all non-White groups;
- High rates of heart disease among ‘South Asian’ people, but particularly among Bangladeshi and Pakistani people;
- High rates of hypertension and stroke among Caribbean and African people, but low rates of overall mortality, and mortality from coronary heart disease, for men born in the Caribbean;
- Low rates of respiratory illnesses across all non-White groups;
- High rates of admission to psychiatric hospitals with a diagnosis of psychotic illness for young Black Caribbean men;
- High rates of suicide among young women born in South Asia, or, more particularly, born in India;
- High rates of sexually transmitted illnesses among Black Caribbean people; and
- High rates of congenital abnormality and childhood disability among Muslim children.

The author of this summary goes on to say that “in contrast to research focussing on possible genetic or cultural underpinnings of ethnic differences in health, there is now considerable evidence that the social and economic inequalities faced by ethnic minority groups make a substantial contribution to ethnic inequalities in health”.<sup>206</sup> It is not clear, however, what differences there are (if any) between migrants and their descendants.

Some light on this question may be shed by a specially set up longitudinal study called DASH (Determinants of young Adult Social well-being and Health)<sup>207</sup>. DASH examines how social, environmental and biological factors affect the health and well-being of young people from different

<sup>205</sup> Taken from James Y. Nazroo (2014). *Ethnic Inequalities in Health: Addressing a Significant Gap in Current Evidence and Policy* In *If you could do one thing... Nine local actions to reduce health inequalities*. London: British Academy, p. 94. [http://www.britac.ac.uk/policy/Health\\_Inequalities.cfm](http://www.britac.ac.uk/policy/Health_Inequalities.cfm)

<sup>206</sup> *Ibid*, p. 96.

<sup>207</sup> <http://dash.sphsu.mrc.ac.uk>



social and ethnic backgrounds in London. The highly multicultural environment of London may not be representative of other parts of the UK, let alone of Europe, but this study of over 6000 children born around 1990 has nevertheless produced extremely interesting findings.

- In adolescence, Black African and Black Caribbean girls were more likely to be overweight than participants from other ethnic groups. Contributory factors included skipping breakfast, drinking too many carbonated soft drinks and not eating enough fruit and vegetables. Girls from all ethnic backgrounds were far less likely to do any physical activity than boys.
- Although still within normal ranges, blood pressure rose faster over time for ethnic minority than White British children (cf the findings reported above on cardiovascular diseases).
- Contrary to many findings of poorer mental health among ethnic minorities, adolescent boys from ethnic minorities (particularly Black African boys) tended to report better mental health than White British children despite coming from poorer families and neighbourhoods. Positive factors identified were caring parents, doing things together as a family and having friends from different ethnic groups. Experiences of racism had a negative effect on mental health in all ethnicities.
- By their early 20s just as many or even more ethnic minorities completed a university degree compared with the White British, despite more deprivation in childhood.

The last finding not only runs contrary to the average results from the TIES and PISA projects (see section 1.7), but suggests – together with the preceding finding on mental health – that some groups of migrant origin obtain *better* outcomes after allowance is made for their socioeconomic conditions. In a Belgian study<sup>208</sup>, it was found that the self-reported health of migrants was actually better than that of natives when differences in their living conditions were controlled for.

#### 2.4.2. Findings from the Netherlands

In the Netherlands data are available on the health of the four main groups of migrant origin: those originating in Turkey, Morocco, Suriname, and the Dutch Antilles and Aruba. Data on children born in the Netherlands with a mother and/or father who was born in the above countries are also collected, enabling the characteristics of the second generation to be studied. Some of the main findings are as follows.

- In terms of education and employment, the second generation does less well than people of Dutch origin, although those of Surinamese origin do better than the other three groups<sup>209</sup>.

<sup>208</sup> Lorant V, Van Oyen H, Thomas I.(2008). Contextual factors and immigrants' health status: double jeopardy. *Health & Place*, 14:4:678–692.

<sup>209</sup> Nederlands Jeugdinstituut (2009). Culturele diversiteit in opgroeien en opvoeden: feiten en cijfers. Nederlands Jeugdinstituut, 2009.

- We have already noted that a higher proportion of non-Western migrants are diagnosed as 'psychotic' than the majority population. Dutch research shows the raised incidence to be even higher in the second generation<sup>210, 211</sup>.
- Regarding behavioural risk factors, the usual expectation is that rates of risky behaviour in the second generation will converge towards the rates found in the majority population. A study in 2007 found this to be true in relation to smoking in Turkish men, overweight in Turkish and Moroccan women and physical inactivity in Turkish women. Alcohol consumption, however, remained low in all subgroups and did not converge towards the higher rates in the host population. In addition, there was a reversed trend among Turkish women regarding smoking: the second generation smoked significantly more, while the first generation did not differ from ethnic Dutch.<sup>212</sup>
- In 2004-2005, the infant mortality rate for first-generation mothers with a non-western background was 4.7 times higher than the rate for native Dutch mothers; for second-generation mothers it was still 2.9 times higher<sup>213</sup>. These findings are compatible with those reported for 1995-2000: in this earlier period, a comparison of first- and second generation mothers from the four main (non-western) ethnic minority groups<sup>214</sup> showed that only among Surinamese mothers was there a significant decline in infant mortality rates between the first and second generation. These persistent rates of increased infant mortality in groups with a migrant background may be contributing to the poor perinatal mortality ranking of the Netherlands compared to other European countries (rather than the popularity of home birth in the Netherlands<sup>215</sup>). In section 4.1.1. we discuss the relevance to this of shortcomings in preventive services and health education for migrants.

### 2.4.3. Findings from other countries

A large study conducted in Denmark from 2004-2008 sought to portray the health status of first and second generation migrants compared to that of the majority Danish population.<sup>216</sup> The findings of this study reflect clearly the complexity of the issue of migrant and ethnic minority health, as the country of origin, gender, age and generation of migrant are just some of the factors influencing the state of health of migrants and ethnic minorities.

<sup>210</sup> Veling, W., Selten, J. P., Veen, N., Laan, W., Blom, J. D. & Hoek, H. W. (2006). Incidence of schizophrenia among ethnic minorities in the Netherlands: a four-year first-contact study. *Schizophr. Res.* 86, 189-193.

<sup>211</sup> Selten, J. P., Laan, W., Kupka, R., Smeets, H. & van Os, J. (2011). Meer kans op depressie en psychose bij allochtonen. *Ned Tijdschr Geneesk.* 155.

<sup>212</sup> Hosper K, Nierkens V, Nicolaou M, Stronks K. (2007). Behavioural risk factors in two generations of non-Western migrants: do trends converge towards the host population? *Eur J Epidemiol*, 22(3), p. 163-72

<sup>213</sup> Statistics Netherlands Webmagazine, 17 November 2009. <http://www.cbs.nl/en-GB/menu/themas/dossiers/allochtonen/publicaties/artikelen/archief/2009/2009-2964-wm.htm>

<sup>214</sup> Troe, J.W.M., *et al* (2004). Ethnic differences in infant mortality in relation to degree of acculturation. *Ethnicity & Health*, 9, Supplement 1, p. S13.

<sup>215</sup> de Jonge, A., *et al* (2013). Perinatal mortality rate in the Netherlands compared to other European countries: a secondary analysis of Euro-PERISTAT data. *Midwifery* 29(8):1011-8.

<sup>216</sup> Singhammer, J. *et al* (2008). Etniske minoriteters sundhed. Partnerskabet for undersøgelse av etniske minoriteters sundhed, Center for Folkesundhed

The study relied on data collected from a nation-wide survey of nearly 5,000 individuals. Descendants of migrants from Turkey and Pakistan were included in the study, as they make up the largest group of migrants' descendants in Denmark. The main findings included no significant difference in self-perceived health between descendants of Turkish and Pakistani migrants and ethnic Danes aged 18-39. However, across all groups, the older the migrants and their descendants, the greater the differences in perceived health when compared to ethnic Danes, i.e. the older the migrants, the more likely they were to rate their health as poor.

The data on diseases, chronic conditions and life style revealed a more complex picture of the health issues affecting descendants of migrants and their life-style practices. While many patterns were similar for migrants and their descendants, some notable differences did emerge. While the disease burden of three or more chronic illnesses was between 24-45% higher for all migrant groups compared to Danes, it was slightly lower among 18-39 year-old descendants of Pakistani and Turkish migrants.

In terms of life-style habits, the percentage of Turkish and Pakistani male descendants who reported to be daily smokers was slightly higher than migrants in general, and significantly higher compared to Danish men, while the percentage of descendants who never consumed alcohol was more than four times higher than the percentage of Danes who do not drink alcohol, for both women and men. Rates of physical activity were also higher among all migrants compared to Danes, and among descendants aged 18-39, rates of physical activity were significantly higher than that of Danes.

## [2.5. Health determinants](#)

### **2.5.1. Location of determinants**

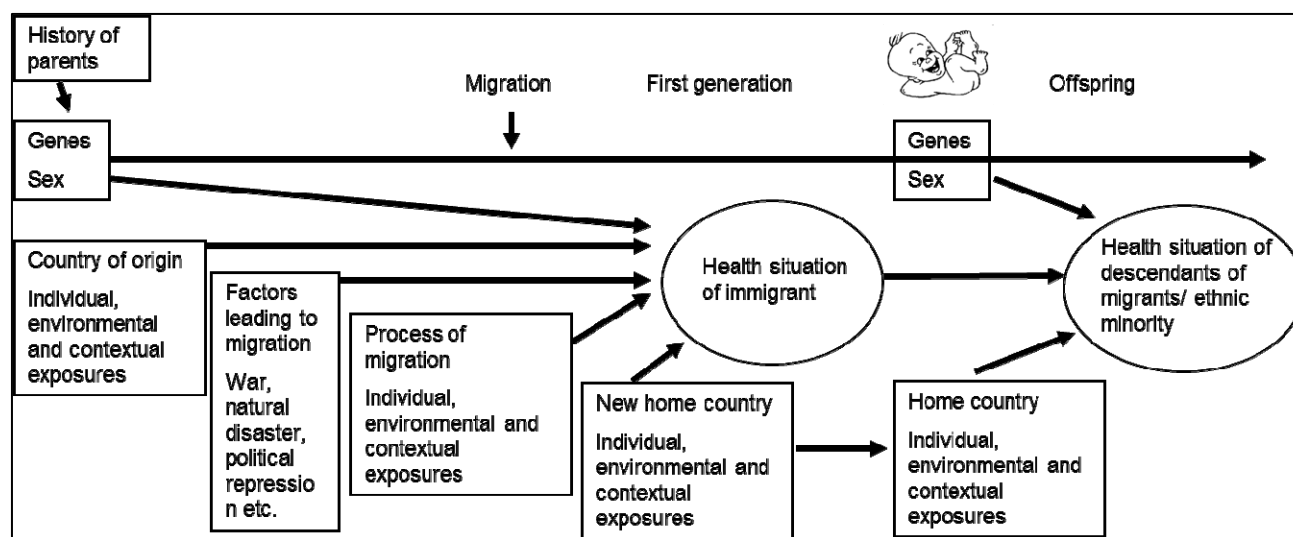
The origin of health problems may lie in the country of origin, the journey, or in the host country.<sup>217</sup> The 'life-course' perspective<sup>218</sup> considers that there may be highly complex interactions between all three factors. The diagram below illustrates the complexity of these determinants of migrant health. It must also be borne in mind that these factors do not affect health directly, but through various intervening variables and pathways: this complicates the analysis still further.

<sup>217</sup> Gushulak, B., Pace, P., Weekers, J. (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe.

<sup>218</sup> Reeske, A. and Spallek, J. (2012) Obesity among migrant children and adolescents: a life-course perspective on obesity development. In: Ingleby, D., Krasnik, A., Lorant, V. & Razum, O. (Eds.) *Health inequalities and risk factors among migrants and ethnic minorities. COST Series on Health and Diversity, Volume I* (pp. 237-256). Antwerp/Apeldoorn: Garant

Figure 11 Different exposures during the life course on the health of migrants

(Adapted from Reeske & Spallek, 2012<sup>29</sup>)



### 2.5.2. Nature of determinants

Many different kinds of factors may underlie the prevalence of disease among migrant groups.

#### 2.5.2.1. Genetic factors

The traditional concept of ‘race’ - a putative biological factor determining the characteristics of large population groups - has been widely discredited on scientific grounds<sup>219</sup>. If the concept still has any use at all, it is to refer to social constructions which, though unwarranted in biological terms, are nevertheless real in their social effects. However, particular genetic differences may well be the key to understanding differences between population groups in their vulnerability to certain diseases. It has long been known that sickle-cell anaemia occurs predominately in African Americans, while Tay-Sachs disease is mainly found in Ashkenazi Jews. Developments in genetic profiling will undoubtedly discover more such links, though intermarriage and complex interactions with other factors weaken the impact of any such effects.

#### 2.5.2.2. Cultural factors

Differences in lifestyle linked to ‘culture’ have been a popular type of explanation in the study of migrants’ health. Again, some quite strong connections can be found: for example, the difference in smoking habits between men and women in traditional Bangladeshi and Pakistani communities is reflected in marked sex differences in lung cancer incidence.<sup>220</sup> As Bhopal points out<sup>221</sup>, many cultural

<sup>219</sup> Bhopal, R. (2002). Revisiting race/ethnicity as a variable in health research. *Am J Public Health*. 92(2):156–157.

<sup>220</sup> Jack, R.H., Davies, E.A. & 1 Møller, H. (2011) Lung cancer incidence and survival in different ethnic groups in South East England. *British Journal of Cancer* 105, 1049–1053.

<sup>221</sup> Bhopal, R. (2014) *op cit*.

traditions (such as prohibitions on alcohol and sexual promiscuity) can have a positive influence on health.

Female genital mutilation or cutting (FGM) is perhaps the most well-known example of a practice that negatively affects health and is linked to traditional cultures. FGM procedures include the partial or total removal of the external genital organs for cultural or other non-therapeutic reasons. The practice has severe short- and long-term physical and psychological consequences for the victims.<sup>222</sup> Over 140 million women are affected by this practice, both in the countries where these practices originate (countries in Africa and the Middle East), and also in migration destinations. Due to under-reporting and the lack of reliable comparable data, no exact figures exist on the prevalence of FGM in Europe. However, it is safe to say that thousands of women and girls in Europe live with the effects of FGM or face the risk of undergoing the procedure in a European country or in Africa or the Middle East.<sup>223</sup> The largest groups of women and girls originating from countries in which the practice of FGM is widespread live in the following EU countries: Austria, Belgium, Denmark, Germany, Spain, Finland, France, Ireland, Italy, the Netherlands, Portugal, Sweden and the United Kingdom.<sup>224</sup> The health impacts of FGM are well documented. Research has linked FGM with an increased risk in complications during childbirth, e.g. prolonged labour, obstetric lacerations, obstetric haemorrhage, and difficult delivery.<sup>225</sup> Midwives especially should be trained in how to prepare for potential delivery complications associated with FGM.

While FGM is a clear example of a culture-bound practice linked to a health problem, there are two main problems with explanations of ill-health in terms of 'culture'. Firstly, the notion that each ethnic group or country of origin is associated with a stable and homogeneous culture has come under fire in recent decades, as we will see in relation to the concept of 'cultural competence'. Secondly, lifestyles are not practised in a vacuum: healthy eating, for example, is not just a personal choice but also depends on the availability and affordability of the right foodstuffs, as well as having the time and facilities to prepare them. Advertising and social pressures are also powerful determinants of behaviour.

Religious beliefs may also exert an impact on health and health seeking behaviours, both in positive and negative ways. For example, a study on the non-biomedical procreation beliefs of infertile Middle Eastern migrants in Western European societies, and the possible effects of these beliefs on the experience of seeking and engaging in fertility treatment, found that some Islamic beliefs on procreation might have an impact on the use of artificial reproductive technologies such as sperm donations.<sup>226</sup> The opposition of the Catholic Church to artificial methods of birth control has had

<sup>222</sup> As defined by the World Health Organisation, 1998.

<sup>223</sup> Leye, E. (2006). Health care in Europe for women with genital mutilation. *Health Care for Women International*, 27:4. Pg. 362-378.

<sup>224</sup> [http://ec.europa.eu/justice/gender-equality/gender-violence/eliminating-female-genital-mutilation/index\\_en.htm](http://ec.europa.eu/justice/gender-equality/gender-violence/eliminating-female-genital-mutilation/index_en.htm) (accessed 18 February, 2015).

<sup>225</sup> Berg, R.C. *et al* (2014). An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting. *Obstetrics and Gynecology International*, Volume 2014

<sup>226</sup> Van Rooij, F.B., van Balen, F., Hermanns, J.M.A. (2004). A review of Islamic Middle Eastern migrants: traditional and religious cultural beliefs about procreation in the context of infertility treatment. *Journal of Reproductive and Infant Psychology*. Vol. 22:4.

consequences throughout the world for the prevention of infection by condom use and the avoidance of unwanted pregnancies.

Some cultural beliefs may be misunderstood as resistance to care.<sup>227</sup> For example, Sudanese women in Canada were found to perceive pregnancy and delivery as natural processes that do not necessarily call for intensified contact with health services.

Another study explored the impact of cultural factors on the interactions between health professionals and Somali women in Finland.<sup>228</sup> Physicians, nurses and midwives described situations where cultural norms on both sides hampered, delayed or prevented the delivery of adequate care in a timely manner. Most Somali women were reported to request female gynaecologists, for example. Other examples included different communication styles, the taboo of hand-shaking and other forms of physical contact with male physicians, as well as religious beliefs related to childbirth).

However, as the composition of migrant and ethnic minority populations varies from country to country, as does the degree of integration among groups and individuals, as well as their adherence to traditional or cultural practices, health professionals should avoid relying on cultural stereotypes and instead approach those they come into contact with in a patient-centered way, remaining alert to different forms of diversity. On a health services level, identifying specific needs of a community or a group, such as for example, communities known to practice FGM, targeted and well-informed strategies should be devised in collaboration with civil society actors. For more detailed information on the role of culture in health service delivery see **Section 5.2.1**.

#### **2.5.2.3. Health system factors**

Health may be impaired by shortcomings of the health system in providing adequate prevention programmes, health education and promotion, or health services that are accessible and of high quality.

#### **2.5.2.4. Social determinants**

The 'rainbow diagram' of Dahlgren and Whitehead<sup>229</sup> is a way of representing the social determinants of health that has gained widespread influence since it was first presented in 1991. In the WHO's 2010 Policy Briefing on migrant and ethnic minority health<sup>230</sup> this diagram was adapted to show the social determinants of migrant health. This is reproduced below.

<sup>227</sup> Higginbottom, G.M. *et al* (2013). "I have to do what I believe": Sudanese women's beliefs and resistance to hegemonic practices at home and during experiences of maternity care in Canada. *BMC Pregnancy Childbirth*. 13:51.

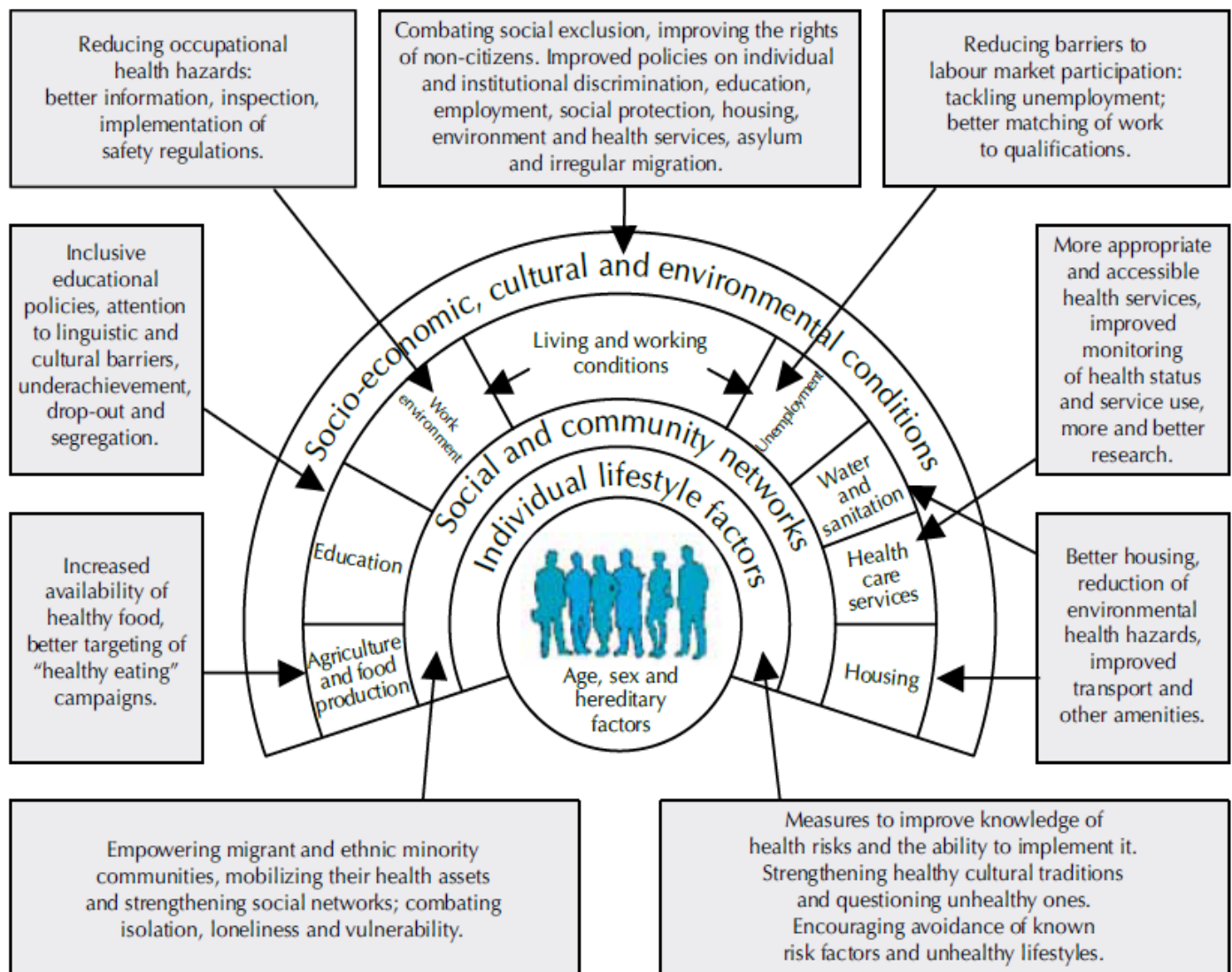
<sup>228</sup> Degni, F. *et al* (2012). Communication and Cultural Issues in Providing Reproductive Health Care to Immigrant Women: Health Care Providers' Experiences in Meeting Somali Women Living in Finland. *Journal of Immigrant and Minority Health*. Volume 14, Issue 2. Pg. 330-343.

<sup>229</sup> Dahlgren, G., Whitehead, M. (1991) *Policies and strategies to promote social equity in health*. Institute for Future Studies, Stockholm.

<sup>230</sup> WHO (2010), *op. cit.*



Figure 12 'Rainbow' diagram showing social determinants of migrant health, WHO 2010<sup>1</sup>





The information in the Rainbow diagram can also be represented in the form of a table (below). Here, a distinction has been made between determinants which have a ‘direct’ effect (i.e. those which specifically affect migrants) and those with an ‘indirect effect’ (i.e. those which affect people in occupying disadvantaged socioeconomic positions, and affect migrants disproportionately because many migrants are likely to be in such positions).

**Table 1 Risk factors for migrants’ health**

	<b>Direct determinants</b>	<b>Indirect determinants</b>
<b>Nutrition</b>	Lack of targeted health promotion, unawareness of dangers of Western food, too little variation in diet.	<b>Healthy food unavailable, unaffordable, or too time-consuming; necessity of relying on processed and ready-made food</b>
<b>Education</b>	Non-recognition of qualifications, inequities in education system (e.g. unfair assessments, lack of opportunity for newcomers to catch up)	<b>Barriers to good education (schooling and training) for the less well-off.</b>
<b>Work environment</b>	Lack of targeted safety measures at work (e.g. bilingual instructions and warnings). Discrimination on the work floor.	<b>Low-paid jobs often dangerous as well as poorly regulated and inspected</b>
<b>Living and working conditions</b>	Diverse forms of social exclusion based on ethnicity or migrant status. Some connected with immigration policy, e.g. detention (which is a health threat in itself) or difficult family reunion.	<b>Diverse forms of social exclusion based on low socioeconomic status</b>
<b>Employment</b>	Discrimination in hiring and promotion, non-recognition of qualifications	<b>Precarious work, long hours, strenuous and stressful work, poor working conditions</b>
<b>Water, sanitation, housing</b>	Discrimination in allocation of housing, fewer rights for non-citizens	<b>Poorer neighbourhoods are unhealthy ones</b>
<b>Health services</b>	Fewer entitlements, poorer accessibility of services, lower quality (lack of ‘difference sensitivity’). Inadequate screening and vaccination programmes.	<b>Health services insufficiently adapted to those with low language ability, ‘health literacy’ and social capital</b>
<b>Social and community networks</b>	Networks may be weakened by uprooting. Segregation helps social contact but makes upward social mobility harder	<b>Lack of leisure time, low participation in community activities, less social capital</b>
<b>Individual lifestyle factors</b>	<b>Lack of effectively targeted health promotion. Cultural habits may undermine but also support health</b>	<b>Lack of effectively targeted health promotion. ‘Unhealthy lifestyles’ have determinants further upstream.</b>

As we saw in Section 2.1.3, there is an increasing tendency in studies of migrant and ethnic minority health to focus on more ‘upstream’ risk factors underlying health problems, as well as strategies for combating them – which almost always involve intersectoral interventions going beyond the health sector itself.

## **2.6. Health inequalities affecting Roma and national ethnic minorities, and their determinants**

### **2.6.1. General issues**

Surveys and national level research have identified general trends in the state of health and health determinants characteristic of Roma communities in Europe.<sup>231</sup> Even though most of the research on Roma is not comparable at a European level, some generalisations are well documented.<sup>232</sup> Roma in Europe suffer significant health inequalities when compared to the majority non-Roma population. Roma women are generally worse off in terms of health compared to Roma men and the general population, especially considering the higher rates of maternal health risks and outcomes, as well as higher rates of domestic violence.<sup>233</sup> While genetic or cultural determinants of health and ethnicity may explain some of the inequalities in health compared to non-Roma populations, social and environmental determinants also play a significant role, such as lower income, poor living conditions, discrimination and racism, and barriers to accessing health services.<sup>234,235</sup> These factors may help to explain the lower life expectancy, the incidence of certain infectious diseases (such as tuberculosis and hepatitis) generally associated with poor living conditions, as well as the prevalence and earlier appearance of some chronic conditions less frequent in non-Roma populations, as well as maternal and child morbidity and mortality.<sup>236</sup>

In terms of data collection on Roma communities in Europe, a number of obstacles stand in the way. As discussed in Section 2.1.1., population data collection in many countries in Europe does not disaggregate data by ethnicity, and where it does, Roma may try to hide their ethnicity in order to avoid stigmatisation. Furthermore, census data tend to undercount Roma. Historical misuse of data on certain populations, for purposes of persecution or worse, has inspired some countries to prohibit the

<sup>231</sup> Open Society Institute. (no date) *Left Out: Roma and Access to health care in Eastern and South Eastern Europe*. Public Health Program.

<sup>232</sup> Fésüs, G. *et al.* (2012) Policies to improve the health and well-being of Roma people: The European experience. *Health Policy* 105: 25-32.

<sup>233</sup> Matrix Consulting (2014). Roma Health Report. European Commission: Consumer, Health and Food Executive Agency.

<sup>234</sup> Voko, Z. *et al.* (2009) Does socioeconomic status fully mediate the effect of ethnicity on the health of Roma people in Hungary? *J Epidemiol Community Health*; 63: 455-460.

<sup>235</sup> Masseria, C., Mladovsky, P., Hernández-Quevedo, C. (2009) The socio-economic determinants of the health status of Roma in comparison with non-Roma in Bulgaria, Hungary and Romania. *European Journal of Public Health*, Vol. 20, No. 5: 549-554.

<sup>236</sup> Schaaf, M. (2007) *Confronting a Hidden Disease: TB in Roma Communities*. Open Society Institute: Roma Health Project.

recording of ethnic or race-related data. In addition, there is a lack of agreement regarding the terminology and definitions used when referring to Roma minorities.<sup>237</sup>

EU projects such as "**Health and the Roma Community, Analysis of the Situation in Europe**" (see Appendix VI) worked to overcome the challenges of collecting empirical and comparable data on the health of Roma communities, by systematically collecting and comparing qualitative and quantitative data obtained in the seven participating countries. Some of the findings of this project are discussed below in *Section 2.4. Differences found* and for the literature on the state of health of Roma populations in Europe, see Appendix II.

As mentioned in Chapter 1, research on national ethnic minorities is quite limited, in part due to the fact that many of these minority groups are not recognised and not all groups experience inequalities. The Sami, an indigenous minority group in the north of Norway, Finland and Sweden however, has been the subject of numerous studies. The University of Tromsø's Centre for Sami Health Research has conducted extensive research on the Sami's health status and the barriers they experience in accessing health services. The **project SAMINOR**, a population-based study of health and living conditions in areas with both Sami and Norwegian inhabitants in Norway, collected data from 2002-2004. Findings on self-reported health indicated that Sami respondents reported to be in worse health than Norwegian respondents, and Sami women more so than men. Additional findings included experiences of discrimination in encounters with health services (especially reported by Sami women), and language barriers.<sup>238</sup>

## 2.6.2. Differences found

### 2.6.2.1. General measures of health

In general, as has been stated above, Roma have a significantly worse health profile when compared to non-Roma. On average, Roma are estimated to live approximately 10 years less than non-Roma.<sup>239</sup> However, mortality rates and life expectancy estimates vary across and within countries, as well as in different groups within the Roma populations. For example, estimates in Austria suggested mortality rates 14% higher for Roma at the regional level than for the rest of the country. Poorly integrated Roma living in settlements with poor living conditions in Slovakia were found to have a mortality rate twice to three times as high as that of well-integrated Roma, and higher infant mortality rates were found in Bulgaria, Slovakia, Hungary and the Czech Republic.<sup>240</sup>

Research, over time, has gone from covering communicable diseases, child health and genetic disorders, to non-communicable diseases, chronic illnesses and related risk factors. The role of

<sup>237</sup> Kallayova, D., Bosak, L. (2012) Improvement of health services for Roma communities in Slovakia. In: Ingleby, D. et al (eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity*. Antwerpen: Garant Publishers.

<sup>238</sup> Hansen, K., Melhus, M., Lund, E. (2010) Ethnicity, self-reported health, discrimination and socioeconomic status: a study of Sami and non-Sami Norwegian populations. *International Journal of Circumpolar Health*, North America, 69.

<sup>239</sup> Masseria et al (2010).

<sup>240</sup> Matrix Consulting (2014). Roma Health Report. European Commission: Consumer, Health and Food Executive Agency.

ethnicity and socioeconomic determinants in Roma health has been explored extensively, though given the limitations of reliable data collection, most of the findings are inconclusive. Nevertheless, they clearly point towards the need for intersectoral interventions to tackle the social determinants of Roma health.<sup>241, 242</sup> Little attention has been paid to protective factors with regard to Roma health, such as the role of family and women.<sup>243</sup> The dual discrimination suffered by Roma women (because of their ethnicity and gender) is, however, documented.<sup>244, 245</sup>

Below is presented an overview of the main health issues affecting Roma populations in Europe, as identified through literature and EU reports. A more detailed overview of these is included in the literature review in Appendix II, and in the reports published based on the results of the EU funded projects **Roma Health Report: Health status of the Roma population and data collection in the Member States of the European Union**, and **Health and the Roma Community: analysis of the situation in Europe** (See Appendix VI for a full description of the projects and outcomes).

### 2.6.2.2. Non-communicable diseases

Research into non-communicable diseases affecting the Roma is still quite limited, despite repeated calls over the last decade for more studies in this field.<sup>246,247</sup> However, studies suggest that the prevalence of chronic diseases such as cardiovascular disease, diabetes, obesity, hypertension and asthma is higher in the Roma populations than in the non-Roma.<sup>248,249</sup> Gender and age play an important part, with Roma women experiencing a higher prevalence of some of these health problems than Roma men. UNDP findings reported Roma over the age of 65 suffered a steeper increase in chronic diseases and related problems than non-Roma (70% vs. 56% respectively).<sup>250</sup> In terms of social determinants of health, factors associated with poverty such as poor living conditions, poor diet and malnutrition are listed by the **Roma Health Report** as potentially leading to chronic conditions such as obesity, hypertension, diabetes and CVD. Factors associated with poor living conditions, such as damp, cold and poor quality housing may contribute to respiratory disease or musculoskeletal diseases, according to the same report. In addition the above listed effects of poverty and poor living conditions, lifestyle related factors such as smoking, drug and alcohol use, and limited physical activity were found to be influential in the development of the health conditions listed above.

<sup>241</sup> Földes *et al* (2012).

<sup>242</sup> Masseria *et al* (2010).

<sup>243</sup> Dobranici, M., Buzea, A., Popescu, R. (2012). The cardiovascular risk factors of the Roma (Gypsies) people in Central-Eastern Europe: A review of the published literature. *Journal of Medicine and Life* Vol. 5, Issue 4: 382-389.

<sup>244</sup> Surdu, L., Surdu, M. (2006) Broadening the agenda: the status of Romani women in Romania. Budapest: Open Society Institute.

<sup>245</sup> European Roma Rights Centre (2006). "Ambulance not on the way. The disgrace of health care for Roma" in Europe. Budapest: European Roma Rights Centre.

<sup>246,247</sup> Parekh *et al* (2011).

<sup>247</sup> Hajioff, S., McKee, M. (2000) The health of the Roma people: a review of the published literature. *J Epidemiol Community Health*; 54: 864-869.

<sup>248</sup> Zeljko, H.M. *et al* (2013) Age trends in prevalence of cardiovascular risk factors in Roma minority population of Croatia. *Economics and Human Biology* 11: 326-336.

<sup>249</sup> Dobranici *et al* (2012).

<sup>250</sup> Matrix Consulting (2014).

### 2.6.2.3. Mental illnesses: general considerations

As with non-communicable diseases, there is a dearth of research into the mental health of Roma in Europe. Links have been suggested between low socioeconomic status (SES) of Roma and its negative impact on mental health, as well as the impact of discrimination and racism on mental health.<sup>251</sup> Furthermore, in terms of prevention and care, Roma populations' social representation of mental health and well-being, e.g. the importance of family and social network, are found to be of significance in the development and implementation of interventions.<sup>252,253</sup>

### 2.6.2.4. Communicable diseases

The early emphasis of research on Roma health was more suggestive of the threat posed to the general population by the higher prevalence of communicable diseases in Roma populations, than of their health needs.<sup>254</sup> Nevertheless, research reports higher rates of infectious diseases such as measles and hepatitis A, as well as a higher risk of outbreaks of infectious diseases, especially amongst Roma living in segregated conditions. Available evidence on vaccination shows that, with the exception of Croatia, Hungary and the Czech Republic, overall rates of childhood vaccination uptake in Europe is lower or much lower in the Roma populations. The limited evidence existing related to rates of HIV/AIDS points to faster disease progression.<sup>255</sup>

More recent research in the area of communicable diseases has explored the health determinants that lead to higher rates of certain communicable diseases in Roma populations. These studies point to factors related to low SES and the living conditions associated with poverty, and other socioeconomic determinants such as access to health services, as possible explanations.<sup>256</sup> Research results strongly recommend the need for targeted preventive and care interventions to decrease the marginalisation that is found to lead to drug use and crime, and to improve the lives and survival rates of those living with infectious diseases.<sup>257, 258</sup>

## 2.6.3. Health determinants

Given the well documented and persistent inequalities in health between Roma and non-Roma in Europe, the focus of research (and of policy interventions such as the Decade of Roma Inclusion) has lately shifted towards social determinants of health. Findings, however, are inconclusive, and

<sup>251</sup> Skodova, Z. *et al* (2010). Psychosocial factors of coronary heart disease and quality of life among Roma coronary patients: a study matched by socioeconomic position. *International Journal of Public Health*; 55(5): 373-80

<sup>252</sup> Monteiro, A.P. *et al* (2013). Promotion of mental health in Roma people: social representations of mental health and wellbeing in a Roma community. *European Psychiatry: Abstracts of the 21th European Congress of Psychiatry*.

<sup>253</sup> Smith, D., Ruston, A. (2013). 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/Travellers, networks and healthcare utilisation. *Sociology of Health and Illness*, Vol. 35; 8:1196-1210.

<sup>254</sup> Hajioff *et al* (2000).

<sup>255</sup> Matrix Consulting (2014). The Roma Health Report. Consumers, health and food executive agency.

<sup>256</sup> Casals, M. *et al* (2011). Incidence of infectious diseases and survival among Roma population: a longitudinal cohort study. *The European Journal of Public Health*, 1-6.

<sup>257</sup> *Ibid.*

<sup>258</sup> *Ibid.*

researchers have not yet been able to answer the question concerning the extent to which Roma health disadvantages are linked to their ethnicity or to more general issues such as SES and other factors affecting disadvantaged groups in general.<sup>259</sup>

What research *can* prove is that Roma have low levels of education and skills, often leading to long-term unemployment and increasing levels of poverty.<sup>260</sup> Roma generally lack adequate living conditions, with the most severely overcrowded accommodation reported in Slovakia and Hungary.<sup>261</sup> Many Roma are found to live in marginalised communities with limited access to basic services.<sup>262</sup> Roma children especially, face many barriers when trying to access health care.<sup>263</sup> The discrimination, racism and exclusion faced by this community is also a strong determinant of health. Based on these known factors, recommendations have been made for more integrated, multi-sectoral solutions.<sup>264, 265</sup>

For the Sami, research has shown, that while their health differs little from that of the majority population, one significant risk factor is their livelihood, namely reindeer herding. This activity can be hazardous and leads to the observed higher rates of injuries from herding accidents.<sup>266</sup>

Work towards addressing the social and economic exclusion lived by many ethnic minorities and especially the Roma, has focused on combating discrimination based on gender, racial or ethnic origin, religion or belief, disability, age or sexual orientation (see Appendix III for more details on the **Decade of Roma Inclusion**). Strategies to increase labour market participation and participation in social, cultural and political life are at the centre of European initiatives for social protection and social inclusion. For example, the Treaty of Lisbon, which came into force in 2009, reaffirmed the importance of combating social exclusion and discrimination. Progress, however, continues to be slow and inconsistent.<sup>267</sup>

Policy measures put forth by the EU include educating the public and effectively enforcing legislation on discrimination against migrants and ethnic minorities, the implementation of educational policies that will facilitate the integration of migrant and ethnic minority children in mainstream schools, employment policies that will removed the barriers to employment affecting them, social protection policies, housing and equitable health policies, that ensure access and quality of health services for all groups.<sup>268</sup> The EU **Directorate-General of Home Affairs** has published guidelines for monitoring the integration of immigrants and evaluating the effectiveness and outcomes of integration policies. The

---

<sup>259</sup> Masseria *et al* (2010).

<sup>260</sup> Matrix Consulting (2014).

<sup>261</sup> *ibid*

<sup>262</sup> Kallayova, D., Bosak, L. (2012). Improvements of health services for Roma communities in Slovakia. In: Ingleby, D. et al (eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities*. COST Series on Health and Diversity. Antwerpen: Garant Publishers.

<sup>263</sup> Rechel, B. *et al* (2009). Access to health care for Roma children in Central and Eastern Europe: findings from a qualitative study in Bulgaria. *International Journal for Equity in Health*, 8: 24.

<sup>264</sup> *Ibid*.

<sup>265</sup> Masseria *et al* (2010).

<sup>266</sup> Sjölander, P. (2009). What is known about the health and living conditions of the indigenous people of northern Scandinavia, the Sami? *Global health Action* 4.

<sup>267</sup> WHO (2010). *How health systems can address health inequities linked to migration and ethnicity*. Copenhagen: WHO Regional Office for Europe. <http://bit.ly/hKAe3T>

<sup>268</sup> *Ibid*.



report presents a tool that countries can use, the ‘Zaragoza’ European Integration Indicators, that aims to help policy makers and other stakeholders assess the societal integration outcomes of national integration policies, as reflected in for example education, employment and democratic participation outcomes.<sup>269</sup>

## **Chapter 3: Legal and policy framework relating to migrant and ethnic minority health in the EU**

### **3.1. Importance of the international dimension**

Legal instruments and policy initiatives aimed at protecting the health of migrants and ethnic minorities often originate at the international or regional, rather than national, level. Even after years of residence, it may be difficult or impossible for them to obtain citizenship and the rights that go with it: in important ways, they are *disenfranchised* and have no voice. This disenfranchisement is most pronounced among irregular migrants who, for all intents and purposes, represent an invisible and silent group, excluded from political and social life. Irregular migrants have very few rights, and those which they have they are generally afraid to claim because of the risk of detection and deportation. Most ‘national minorities’ do have citizenship, but they are by definition numerically weak and may face additional obstacles to getting their voice heard in law-making institutions. As a result, the interests of both migrants and ethnic minorities tend to be poorly represented in national legislation. Therefore, action by international organisations and agencies is often necessary to ensure that the rights and interests of these groups are respected.

#### **3.1.1. Inherent weaknesses of international laws and initiatives**

There is a large body of human rights conventions and legal instruments applying to migrant and ethnic minority health, but in spite of their existence there are still serious inequalities in the state of health of these groups and their access to adequate and appropriate health care. Despite good intentions, the effectiveness of these instruments remains disappointingly limited. There are two main reasons for this ‘implementation gap’.

Firstly, in order to be enforceable – to have ‘clout’ – an international or regional legal instrument has to be ‘justiciable’. It must be possible to bring a case to court under it. For several reasons, however, it is often difficult, if not impossible, to claim the rights granted by such instruments in court. Several hurdles have to be overcome:

---

<sup>269</sup> Huddleston, T., Niessen, J., Tjaden, J.D. (2013). "Using EU Indicators of Immigrant Integration." Report for DG Home Affairs. [http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/general/docs/final\\_report\\_on\\_using\\_eu\\_indicators\\_of\\_immigrant\\_integration\\_june\\_2013\\_en.pdf](http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/general/docs/final_report_on_using_eu_indicators_of_immigrant_integration_june_2013_en.pdf) (Accessed 19 February, 2015).



- The country in which one resides must have ratified the instrument in question. In the EU, the majority of such instruments have been accepted by all member states, but there are some exceptions. For example, the *Charter of Fundamental Rights of the European Union* (2000) was implemented by the Lisbon Treaty of 2009, but the UK and Poland succeeded in obtaining a protocol which in theory prevented any of their national legislation from being deemed illegal under the Charter. On a global level, the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* was adopted by the UN in 1990. In 2014, 64 countries had ratified it or announced their intention to do so, but all were primarily 'sender' countries. Not a single migrant-receiving state in Western Europe, North America, or the Persian Gulf has ratified the Convention<sup>270</sup>. This instrument to protect the rights of migrants is therefore recognised only by the countries they come from, not the countries they go to, and is effectively impotent. In general, countries often insist on 'reservations' which limit their compliance with the provisions of a legal instrument.
- Transposing international law into domestic law can be a very slow and imperfect process - and even then, bringing a case before a domestic court will require a substantial investment of time and resources. Bringing a case before an international court requires an even greater investment, which few migrants or members of ethnic minorities can mobilise. Also, years may go by before a verdict is delivered - and when it is, it may be simply ignored.
- Many legal instruments, conventions and declarations are much less binding than they appear to be at first sight. Often it has only been possible to obtain widespread acceptance of them by judicious watering-down, using qualifying phrases such as "to an extent consistent with national legislation".
- The powers of the EU in matters relating to health systems are in any case limited by the principle of 'subsidiarity', which gives member states freedom to regulate their health systems in virtually any way they like. "Measures intended to harmonize healthcare policies across the EU are actually forbidden in the EU Treaty<sup>271</sup>."

A second kind of 'implementation gap' concerns the actual carrying-out of a legal decision. For example, a country may introduce legislation to extend health coverage to irregular migrants, but many factors may still prevent these migrants from benefiting from it. Health workers may not know or understand the details of the legislation; there may be no monitoring of compliance, or sanctions for non-compliance; migrants themselves may simply not know about the law; or they may be too afraid of being reported to the authorities to make use of it. For all migrants and ethnic minorities, procedural issues such as out-of-pocket payments or complicated bureaucratic procedures may form obstacles to equitable access to health care services.<sup>272</sup> We will examine these obstacles more closely in Chapter 4.

<sup>270</sup> <http://bit.ly/1m6qOXQ>

<sup>271</sup> Global Health Europe (2010). Does subsidiarity trump solidarity? (News article). Available at <http://bit.ly/1xLVZ03>

<sup>272</sup> Rechel, B. *et al* (2013). Migration and Health in an increasingly diverse Europe. *The Lancet*, Vol. 381; 1235-1245.

### 3.1.2. Constructive versus coercive power of legal instruments

It would be a mistake, however, to regard the function of international legal instruments as purely coercive, i.e. compelling people to do certain things and refrain from doing others. Such instruments are also intended to inspire and guide – to set out a vision and a framework which will encourage governments and others to bring about the desired state of affairs. Taking the argument a step further, it is possible for initiatives or measures that have no binding force whatsoever to have as much (or more) impact on shaping policies as legal instruments. To do this they must carry authority, and increasingly they must back up this authority by providing evidence for their recommendations. The many declarations and resolutions of the World Health Organization, for example – a body with very limited coercive powers but a great deal of authority – fall into this category.

That is why in this chapter we consider not only legal frameworks affecting health systems, but also the much more numerous category of ‘policy initiatives’ – actions which have set out to advocate for change, propose standards, disseminate guidelines and facilitate action, in order to guide and inspire the many actors that influence health policy.

### 3.1.3. The complex nature of governance in health systems

This second type of initiatives, which we call policy-making rather than law-making, may be even more important than legal instruments, for the following reason: health systems are seldom hierarchically structured, top-down organisations which can be altered by simply changing national legislation. When it comes to the rules governing entitlement to health care coverage, such measures may indeed be appropriate – but when we are concerned with removing practical obstacles to access and improving the quality of care, laws may not have much traction. This is because the governance of health systems is often complex, involving many actors and stakeholders. As well as national government, policies may be shaped by professional organisations, insurance providers, local health authorities, service providers, and organisations responsible for teaching and accreditation. Depending on the country, the principle of ‘subsidiarity’ may be found to a large extent *within* the health system itself.

## 3.2. International, regional and national legal frameworks

### 3.2.1. International level

The right to health is a fundamental human right, incorporated in many international legal instruments (for more details see Appendix III). We describe here the main instruments.

The **International Covenant on Economic, Social and Cultural Rights** (ICESCR, 1966) states that everyone has the right to “the enjoyment of the highest attainable standard of physical and mental

health". The capacity to enjoy good health is also related to other inalienable rights such as the right to food, housing, safe working conditions or education, and the health status of individuals depends on the fulfilment of these interconnected rights. The failure to provide one of these rights may impact negatively on the health of individuals, which implies that an intersectoral approach must be taken to the fulfilment of the right to health. Finally, the scope of the ICESCR regarding the right to health also covers the *availability*, *accessibility* (including *affordability*), *acceptability* and *quality* of healthcare services<sup>273</sup>. Attention for the issue of 'affordability' was a very important (and surprisingly late) afterthought. Without it, the right to access services could be interpreted simply as giving people the right to use them: the problem of the crippling bills that may face users, especially in countries such as the USA where many people had no insurance coverage, was simply swept under the carpet.

The **International Convention on the Elimination of All Forms of Racial Discrimination** (CERD, 1963) commits signatories to eliminating all forms of racial discrimination, including of course those affecting health or health care. Moreover, states parties have to ensure that all legislative guarantees against racial discrimination apply to everyone, regardless of their migration status or nationality<sup>274</sup>. The instrument also applies to national minorities.

The international legal framework also includes specific instruments dedicated to targeted populations experiencing vulnerabilities and in need of extra protection, such as children, women or minorities. Thus, the **Convention on the Rights of the Child** (CRC, 1989) requires that accessible, high-quality health care should be provided for all children. The **Convention on the Elimination of All Forms of Discrimination Against Women** (CEDAW, 1979) specifies that access to healthcare should be provided "on the basis of equality of men and women". These conventions also stipulate that care must be provided to meet the special needs of these populations according to their increased vulnerability, in order to promote equality among human beings.

UN instruments (apart from the CERD) which protect the rights of minorities include the following:

In the **International Covenant on Civil and Political Rights** (ICCPR, 1966), article 27 provided that "In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language". According to Kugelman<sup>275</sup>, "most of the prominent cases in which article 27 ICCPR was applied are cases concerning indigenous issues."

The **United Nations Declaration on the rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities** (1992) refers to minorities based on national or ethnic, cultural, religious and linguistic identity and urges States to protect their existence.

<sup>273</sup> OHCHR (2000) *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000. New York: United Nations, Office of the High Commissioner for Human Rights.

<sup>274</sup> ICERD, 64th session, General Recommendation No. 30 on Discrimination against Non-Citizens, CERD/C/64/Misc.11/rev.3, 2004, para. 7

<sup>275</sup> Kugelman, D. (2007). The protection of minorities and indigenous peoples respecting cultural diversity. In Bogdandy A.V. and Wolfrum, R. (Eds.). *Max Planck Yearbook of United Nations Law*, Vol. 11: 262.

The **Declaration on the Rights of Indigenous Peoples** was adopted by the UN General Assembly in 2007. Although not legally binding, the declaration sets a standard of treatment and protection of indigenous peoples around the world, based on the respect of fundamental human rights. The declaration is meant as a tool against discrimination, marginalisation and the violation of human rights, and refers to both individual and collective rights of indigenous peoples. Furthermore, it recognises their rights to culture, identity, language, employment, health, education and highlights "the rights of indigenous peoples to maintain and strengthen their own institutions, cultures and traditions, and to pursue their development in keeping with their own needs and aspirations".<sup>276</sup>

International legal instruments highlight protection of health, including universal access to healthcare, as a key measure of the degree to which countries uphold fundamental human rights. But the strength of this framework is limited by the high degree of discretion allowed to countries in their interpretation and implementation of the law, and the absence of strategies to combat multiple discrimination. Even though some of the texts are particularly oriented against discrimination (gender, race, age, sexual orientation, disability, religion, etc.), none of them combat multiple discriminations, leading to gaps in the framework. Moreover these instruments are not designed to be translated as operational policy strategies under national laws, thus further reducing their scope of influence.

### 3.2.2. Regional (European) level

Two separate bodies are concerned with regional legislation in Europe: the Council of Europe (CoE), covering 47 member states, and the European Union (EU), covering 28. However, accession to the EU implies acceptance of the main CoE instrument, the **European Convention for the Protection of Human Rights and Fundamental Freedoms** (ECHR). These two bodies have introduced several legal instruments intended to ensure the protection of health and minimum standards of access to health care for all.

- The **European Convention for the Protection of Human Rights and Fundamental Freedoms** (ECHR) (CoE, 1950).
- The **European Social Charter** (CoE, 1961, revised 1996) guarantees access to healthcare for everyone in article 11 and 13, and some provisions are expressly made for migrant workers and their family in article 19. However, nine EU members states have not accepted all provisions of the Charter (see Appendix), in particular article 13 referring to the provision of medical assistance regardless of the legal status of individuals.
- The **Framework Convention for the Protection of National Minorities** (CoE, 1998) is a key treaty with regard to national and indigenous minorities. While most CoE member countries have ratified the treaty, 8 countries (France, Turkey, Belgium, Iceland, Luxembourg, Andorra and Monaco have not).<sup>277, 278</sup>
- The **Charter of Fundamental Rights of the European Union** (EU, 2000), implemented by the Treaty on the Functioning of the European Union (2009), refers to the right to health and right

<sup>276</sup> "United Nations adopts Declaration on Rights of Indigenous Peoples". United Nations News Centre, 13 September 2007. <http://www.un.org/press/en/2007/ga10612.doc.htm> (accessed: 8 October, 2014)

<sup>277</sup> <http://www.refworld.org/publisher/COESFCPNM.html> (accessed on January 15, 2015)

<sup>278</sup> <http://www.coe.int/en/web/minorities/home>

of access to health services, including emergency care, preventive care and medical treatment. However it only applies, “under the conditions established by national laws and practices”.

- The **Treaty on European Union – Maastricht Treaty** (EU, 1992) recognizes and commits members to the promotion of the human rights of all those living in the EU, including the rights of persons belonging to minorities (Article 2). The treaty also commits members to respecting the EU's cultural and linguistic diversity, and promoting cultural heritage. The Treaty also refers to the Union's recognition of the rights (including health and right of access to health services), freedoms and principles set out in the **Charter of Fundamental Rights** of the European Union (see above), including the prohibition of discrimination on the basis of membership in a national minority.<sup>279</sup>

In addition, the following European Commission Directives (which are binding on all member states) relate to the health of migrants and ethnic minorities (see Appendix III for details):

- **Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin** (the ‘race directive’).
- **Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers.**
- **The “Returns Directive” of 2008 (Directive 2008/115/EC of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals).**
- **Proposed Council Directive of July 2008 on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation** (the ‘equality directive’). The directive is still under negotiation in Council.<sup>280, 281</sup>

### 3.2.3. National level

#### Entitlement

Legal measures relating to the provision of health services to migrants and ethnic minorities are mostly concerned with the issue of *entitlement*, that is to say the possibilities for migrants in different categories – legal migrants, asylum seekers and irregular migrants – to participate in the national system of coverage for health service costs. The **European Migration Network's** 2014 report *Migrant access to social security and healthcare: policies and practice*, provides a very detailed map of the policies and administrative practices that shape third-country nationals’ access to social security, including healthcare.<sup>282</sup>

Two main systems of coverage are currently in force in EU member states: tax-based ‘Beveridge’ systems and social insurance-based ‘Bismarck’ systems. The main difference between these lies in the

<sup>279</sup> [http://europa.eu/about-eu/basic-information/decision-making/treaties/index\\_en.htm](http://europa.eu/about-eu/basic-information/decision-making/treaties/index_en.htm) (Accessed: 6 October, 2014).

<sup>280</sup> [http://ec.europa.eu/justice/newsroom/discrimination/news/150216\\_en.htm](http://ec.europa.eu/justice/newsroom/discrimination/news/150216_en.htm) (Accessed: 20 February, 2015).

<sup>281</sup> [http://fra.europa.eu/sites/default/files/fra-2013-opinion-eu-equality-directives\\_en.pdf](http://fra.europa.eu/sites/default/files/fra-2013-opinion-eu-equality-directives_en.pdf) (Accessed: 20 February, 2015).

<sup>282</sup> European Migration Network (2014). *Migrant access to social security and healthcare: policies and practice*. DG Home, European Commission.

extent to which the State finances, owns and runs health services. However, it is not the case that one of these systems has clear-cut advantages over the other when it comes to the entitlements of migrants. This issue is further discussed in Appendix III.

‘Out-of-pocket’ (OOP) payments in the sense of co-payments at point of supply – may be levied within both types of system. Usually these are open and above board, but they may take the form of informal (‘under-the-table’) payments. In some countries these would be called bribes, but in others they are regarded as normal expressions of gratitude. Unless generous exemptions and ceilings are available, OOP payments can have highly inequitable effects: effectively, they undo the very principle of collective coverage for health costs. Migrants and ethnic minorities, whether regular or irregular, to the extent that they may be less well off than the majority population (as shown in Section 1.5.3), may be particularly hard-hit by OOP payments. Another very important issue is that formal entitlement to care does not always guarantee effective access: this is the topic of Chapter 4.

We will briefly discuss the entitlements of different categories of migrants separately. A comprehensive survey on this topic has not been carried out until recently: the ‘Big Picture’ project, which is a collaboration between the COST Action ADAPT, the IOM’s **EQUI-HEALTH** project, and the Migration Policy Group (MPG), is currently collecting data which will be published in a new ‘Health strand’ in the forthcoming edition of the MIPEx index, as well as in Country Reports to be published by the EQUI-HEALTH project (Appendices III and VI provide more details about these projects). The following information is therefore provisional.

#### *Legal migrants*

This category refers to those granted a regular visa or residence permit for work, study, family reunion or other purposes. In EU/EEA countries there is an important difference between legal migrants who are nationals of another EU/EEA country and others (‘third country nationals’ or TCN’s). Health care entitlements which EU/EEA migrants have in their home country are transferable to the host country, in line with the EU’s *Directive 2011/24/EU on patients’ rights in cross-border healthcare*. Under the provisions of this Directive, patients from another EU country should enjoy equal treatment with the citizens of the country in which they are treated. However, they are only entitled to the treatments to which they are entitled at home, and can only be reimbursed (by their home country) up to the level of the costs of the same treatment at home. TCN’s must either be admitted to the host country’s coverage system or take out private health insurance (which is almost always more expensive). For TCN’s, the difficulty and expense of obtaining adequate coverage varies considerably between countries.

#### *Asylum seekers*

Up to a point, free health care is provided to asylum seekers (who, as long as their application is being processed, are in care of the State). The 2003 EC Minimum Standards Directive (see previous section and Appendix III) requires member states to provide at least free emergency care to this group, and to pay special attention to the needs of ‘vulnerable’ asylum seekers. However, there are considerable variations in the extent of the care provided and the conditions attached to it – for example, whether it



is available outside asylum-seeker centres. An earlier overview of coverage for asylum seekers was published in 2006.<sup>283</sup>

### *Irregular migrants*

The greatest variations in entitlement are found in this category. Several major surveys and reports, mostly carried out by NGO's<sup>284</sup>, have dealt with issue in the past decade: the project **NOWHERELAND**, co-financed by the EC (EAHC), summarised all the available information in 2009 (see Appendix VI). While a small group of countries allow irregular migrants access to the same range of services as nationals, most countries restrict provisions to emergency care, while some require that irregular migrants pay even for that. To a large extent, it is left to NGO's to provide rudimentary services for such migrants. However, many countries apply special provisions for particularly vulnerable groups, such as women and children, people with TB or HIV, and victims of torture or trafficking.

Although the entitlements for migrants and ethnic minorities are a matter of national legislation, it is important that health workers of all kinds and at all levels should be well informed about them. For two reasons, they need to know what rights to care an individual has: firstly, to make sure those rights are being respected; and secondly, to fully understand the situation the person is in and be able to respond appropriately to it. For this reason it will be important to facilitate the transfer of findings from the 'Big Picture' project to the MEM-TP project, and to ensure that this material is available to trainees.

### **Other aspects regulated by national legislations**

Besides entitlement, other aspects of health systems affecting migrants and ethnic minorities may be embodied in national legislation, although many national-level policies may be introduced by other bodies than governments and their agencies (for example professional bodies, insurers or service provider organisations).

- Many countries have laws on 'informed consent' which require that patients should understand and agree to their treatment. This can be regarded as requiring the provision of interpreters, but whether the law is actually interpreted in this way is a different question. At most, laws on 'informed consent' can be cited as an argument in favour of providing free or subsidised interpreters.
- Some countries have laws stipulating the health care must be given in a way that respects religious or cultural differences, which in effect mandates 'sensitivity to diversity'.
- Collection of data on migrant status or ethnicity may be regulated by law.
- Laws may also require health workers to report irregular migrants, or even forbid aid to them, thus impeding access for this group.

However, the fact that such legal measures exist in the statute book does not always mean that they are enforced or taken very seriously in day-to-day health service practice.

<sup>283</sup> Norredam, M., Mygind, A & Krasnik, A. (2006) Access to health care for asylum seekers in the European Union — a comparative study of country policies. *Eur J Public Health* 16(3): 285-289.

<sup>284</sup> A list of these projects was compiled by the project **MIGHEALTHNET**: see <http://bit.ly/1o4VW0m>

## Discrimination in health care

Anti-discrimination legislation, to the extent that it covers ‘institutional’ or ‘indirect’ discrimination rather than only the ‘individual’ or ‘direct’ kinds, may have some leverage when it comes to inequities in service provision. The EC ‘Race Directive’ of 2000 implicitly required all countries to tackle such inequities, but so far this has had little effect on national legislation in the field of health. An exception is the UK Equalities Act, which requires providers of all public services not only to forbid discrimination of all kinds, but to take active measures to monitor and combat it.

The EU Fundamental Rights Agency (FRA) has undertaken several studies of discrimination in health care, focusing both on *indirect or institutional discrimination* (unfairness in the way the health system is organised) and *individual or direct discrimination* (hostile or unfriendly behaviour by health staff, rooted in prejudice).

- The first round of the **EU-Midis Survey**<sup>285</sup>, based on data from 2008, reported that 17% of Roma had experienced discrimination by health care staff in the last 12 months. Generally speaking Roma report the highest levels of discrimination, but 24% of North Africans living in Italy answered positively to the same question.
- The FRA report on **Inequalities and multiple discrimination in access to and quality of health care**<sup>286</sup> (2013) tackled for the first time the question of *multiple* discrimination. European anti-discrimination legislation focuses on sex, age, disability, religion or belief, race or ethnic origin, and sexual orientation: however, it does not consider discrimination based on multiple grounds (e.g. being an elderly female migrant). Not only may the strength of the resulting discrimination be more than the sum of the separate effects: it may also have a qualitatively different character (cf the notion of ‘intersectionality’ is discussed in section 5.2.1.). This pioneering study was carried out in five countries and considered sex, ethnicity or migrant status, disabilities and age, as well as combinations of these characteristics. It provided qualitative information on the types of barriers created by multiple discrimination and recommended stronger measures to deal with it.

### 3.3. International and regional policy initiatives

We list here the main policy initiatives and their contribution to the framework regulating migrant and ethnic minority health. (Those relating specifically to Roma are listed in the following section.) Appendix III contains a more complete inventory of initiatives.

<sup>285</sup> FRA(2009). *EU MIDIS: European Union Minorities and Discrimination Survey (Main Results Report)*. Vienna: EU Fundamental Rights Agency.

<sup>286</sup> FRA (2013). *Inequalities and multiple discrimination in access to and quality of health care*. Vienna: EU Fundamental Rights Agency.

### 3.3.1. International level

#### World Health Organization (WHO)

The World Health Organization has published valuable general recommendations and instruments such as the WHO Constitution 1946, the Declaration of Alma Ata 1978, the Tallinn Charter 2008 and the Rio Political Declaration on Social Determinants of Health 2011. These documents stress the need for universal health care coverage, the importance of primary care and prevention, and the priority that should be given to tackling the underlying social causes of inequalities.

The first specific initiative of WHO in relation to migrant health was the 1983 conference organised by WHO Euro and the Dutch Government in The Hague<sup>287</sup>. In 2003 WHO also published the document *International Migration, Health and Human Rights*<sup>288</sup>, which provided an overview of some of the key challenges for policy-makers in addressing the linkages between migration, health and human rights.

In 2008 Resolution 61.17 of the World Health Assembly on Migrant Health was passed<sup>289</sup>. This resolution listed 9 recommendations for member states and 11 for the WHO, covering a broad spectrum of policy measures needed to tackle problems of migrant health. These recommendations placed the onus for improving migrant health not only on health professionals, but also on service provider organisations, national governments and international agencies, collaborating centres, academic institutions, civil society and other key partners. Intersectoral cooperation between the health sector and other sectors was advocated.

The resolution was revisited three years later in a Global Consultation organised by WHO and IOM in Madrid (April 2010). This meeting resulted in a 112-page report<sup>290</sup> analysing in detail the 'state of the art' in relation to the issues named in Resolution 61.17. There was no follow-up to this report on a global level (reportedly because of a lack of support from member states), but WHO Euro has since started several initiatives on migrant health (see Appendix). A 35-page policy briefing entitled *How health systems can address health inequities linked to migration and ethnicity*<sup>291</sup> was published in 2010.

#### International Organization for Migration (IOM)

The IOM has a long history of work in the area of migrant health and the Appendix describes many of its initiatives, most of which are at the level of projects. Two projects spanning the whole of Europe and resulting in wide-ranging policy recommendations were **AMAC** (Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities, 2008-2009), which culminated in an EU-level Consultation in Lisbon<sup>292</sup>, and **Equi-Health** (Fostering health provision for Migrants, the provision for Migrants, the Roma and other vulnerable groups, 2013-2015)<sup>293</sup>. As part of Equi-Health, an additional strand on Health is being added to the MIPEX instrument (Migrant

<sup>287</sup> Colledge, M., Van Geuns, H.A., Svensson, P.G., eds. (1986). *Migration and health: towards an understanding of the health care needs of ethnic minorities. Proceedings of a consultative group on ethnic minorities (The Hague, Netherlands, November 28–30, 1983)*. Copenhagen, WHO Regional Office for Europe

<sup>288</sup> <http://www.who.int/hhr/activities/en/FINAL-Migrants-English-June04.pdf>

<sup>289</sup> [http://apps.who.int/gb/ebwha/pdf\\_files/A61/A61\\_R17-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf)

<sup>290</sup> [http://www.who.int/hac/events/consultation\\_report\\_health\\_migrants\\_colour\\_web.pdf](http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf)

<sup>291</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/127526/e94497.pdf](http://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf)

<sup>292</sup> <http://www.migrant-health-europe.org/>

<sup>293</sup> <http://equi-health.eea.iom.int/>

Integration Policy Index). Both these projects received financial support from the European Commission (EC).

### 3.3.2. Regional (European) level

#### 3.3.2.1. Council of Europe

Above we have listed several legal instruments of the Council of Europe which are relevant to the protection of migrant and ethnic minority health. The Council has also issued three sets of recommendations which do not have legal force, but are intended as guidelines and standards for member states:

#### **Recommendation 1503 (2001)[1] of the Parliamentary Assembly regarding Health conditions of migrants and refugees in Europe**

This recommendation<sup>294</sup> noted that “migrants are particularly vulnerable to health problems” and expressed concern about the lack of comprehensive health policies concerning migrants and refugees. Many migrants (particular ‘clandestine’ ones) fall outside the scope of existing health and social services. Health services must be socially and culturally adjusted to the needs of migrants and refugees. Governments were urged to take a wide range of measures to tackle this situation.

#### **Recommendation Rec2006(18) of the Committee of Ministers to Member States on health services in a multicultural society**

This recommendation<sup>295</sup> advocated for a shift from a narrow emphasis on ‘cultural competence’ in health care (“an approach that is limited to dealing with minority-linked cultural diversity”) to “a general diversity-based approach – that is, one that takes into account all sources of diversity that may be relevant to health and health care issues”. In keeping with this, it adopted “a broad definition of culture that recognises cultural subcategories based on shared attributes (such as gender) or shared life experiences (such as education, occupation, socioeconomic status, trauma, homelessness, being without ID papers)”. It expressed concern that “a narrow focus on cultural issues denies the importance of class or socioeconomic status, age, sexual orientation, gender, religion, geographic location, physical and mental ability that may all distinctly affect any group’s health needs, interests and concerns”. Emphasis was placed on “diversity issues that are relevant for the organisation of health care services”. This document was remarkable in its adoption of a system-focused, intersectional and intersectoral view of migrant health policy, before such thinking was widely accepted in other circles.

#### **Recommendation CM/Rec(2011)13 of the Committee of Ministers to member states on mobility, migration and access to health care<sup>296</sup>**

This recommendation built on the previous two and on many other recent initiatives by international and regional bodies. It made 14 recommendations, explained in 23 guidelines and an Explanatory Memorandum with 57 action points. The content was divided into 6 categories:

<sup>294</sup> <http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta01/EREC1503.htm>

<sup>295</sup> <https://wcd.coe.int/ViewDoc.jsp?id=1062769&BackC>

<sup>296</sup> <https://wcd.coe.int/ViewDoc.jsp?id=1872157>

1. Improving knowledge about migrants and their situation
2. Migrants' state of health
3. Entitlement to health service provision
4. Accessibility of the health system
5. Quality of health services
6. General measures to promote change

This document provided the basis for the MIPEX Health Strand which is being developed as a joint venture<sup>297</sup> by the IOM's Equi-Health project, COST Action IS1103 ADAPT ("Adapting European health systems to diversity"), and the Migration Policy Group (MPG) which publishes MIPEX. These recommendations were characterised by a strong emphasis on an integrated approach. Migrant health must be mainstreamed within all parts of the health system; 'joined-up' health and social services are required; within service providers a 'whole organisation' approach should be adopted; and participation by users in the design and delivery of health services is essential.

Prior to publishing these recommendations, the Council of Europe was also responsible for the **Bratislava Declaration on Health, Human Rights and Migration**<sup>298</sup> (2007), which encouraged countries to take measures to address migrants' health needs regardless of their legal status, and to promote equity in healthcare access by tackling the practical obstacles preventing migrants from receiving the appropriate care that EU and international frameworks entitle them to. A year earlier in 2006, the Parliamentary Assembly had published **Resolution 1509 on Human Rights of irregular migrants**<sup>299</sup>, which argued that "emergency health care should be available to irregular migrants and states should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly".

### 3.3.2.2. European Union

Apart from the legal instruments described above, many policy initiatives have been launched by the European Commission and its agencies.

From 2003-2013 the **Directorate-General for Health and Consumers (DG SANCO)** supported projects on health inequalities in its Health Programme. These are described in Appendix V and provide much of the information contained in this Report. A brochure describing them has been published by the EAHC<sup>300</sup>.

Several EC reports have tackled health inequalities and their social determinants in recent years.<sup>301, 302</sup> In 2009 the **EC Communication Solidarity in health: reducing health inequalities in the EU** was published. This Communication incorporated both of the approaches to health inequalities current at the time – one in terms of 'vulnerable groups' (including migrants and minorities), focusing mainly on inequalities in health care and the need for better access, treatment and prevention; the other in terms

<sup>297</sup> <http://ec.europa.eu/eahc/news/news292.html>

<sup>298</sup> [http://www.coe.int/T/DG3/Health%5CSource%5Cdeclaration\\_en.pdf](http://www.coe.int/T/DG3/Health%5CSource%5Cdeclaration_en.pdf)

<sup>299</sup> <http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta06/eres1509.htm>

<sup>300</sup> [http://ec.europa.eu/eahc/documents/health/health-inequality-brochure\\_en.pdf](http://ec.europa.eu/eahc/documents/health/health-inequality-brochure_en.pdf)

<sup>301</sup> [http://ec.europa.eu/health/social\\_determinants/docs/report\\_healthinequalities\\_swd\\_2013\\_328\\_en.pdf](http://ec.europa.eu/health/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf)

<sup>302</sup> <http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1396946539740&uri=CELEX:52009DC0567>

of ‘the socioeconomic gradient’, focusing on the effect of class differences and the need for intersectoral action on the social determinants of health. These two approaches were described in the EAHC brochure mentioned above.

Many other policy initiatives by the EC and its agencies are described in the Appendix.

As well as the European Commission, the **European Parliament** passed the **Resolution of 8 March 2011 on reducing health inequalities in the EU (2010/2089(INI))**<sup>303</sup>. This resolution contained 78 recommendations addressing a very wide range of issues, including support for access to healthcare for undocumented migrants.

### EU Presidency Conferences

The presidency of the European Union is held by member states on a half-yearly rotating basis. During their presidencies, member states may launch policy initiatives which are at the same time national actions *and* EU actions. A number of presidencies have chosen to focus on health inequalities, in particular those affecting migrants and ethnic minorities.

**UK Presidency 2005:** a conference on Mental Health Inequalities in Europe was held at Stansted Airport on 7-8 November 2005. The programme reflected the dualism of current approaches to health inequalities: the first day was devoted to ‘Migrant Mental Health’<sup>304</sup> and the second to “Government Action to Tackle Mental Health Inequalities”<sup>305</sup>, which discussed social disadvantage and social exclusion but did not mention migration and ethnicity.

**Finnish Presidency 2006:** promotion of the “Health in All Policies” (HiAP) approach. Taking an intersectoral approach to the social determinants of health has become a central feature of contemporary approaches to health inequalities, and the EU Treaty obliges all EU policies to adhere to the HiAP approach<sup>306</sup>.

**Portuguese Presidency 2007:** organisation of the conference “Health and migration in European Union: better health for all in an inclusive society”<sup>307</sup>. This event was attended by 300 people and resulted in major publications and a closing declaration. There was direct input to the Bratislava Declaration and WHA Resolution 61.17 (see above), as well as the conclusions on “Health and migration in the EU”<sup>308</sup> published by the Council of the European Union (not to be confused with the Council of Europe). The conference stressed the importance of going beyond isolated ‘good practices’ in order to mainstream migrant health in policies across the health system. It also called for cross-sectoral action – a “Health in All Policies” approach – and stressed the importance of data collection and research. However, nothing was said about migrants’ participation in policy-making and service delivery

<sup>303</sup> *Ibid.*

<sup>304</sup> [http://www.triestesalutementale.it/english/doc/2005\\_eur-mentalhealthinequalities\\_1.pdf](http://www.triestesalutementale.it/english/doc/2005_eur-mentalhealthinequalities_1.pdf)

<sup>305</sup> [http://www.triestesalutementale.it/english/doc/2005\\_eur-mentalhealthinequalities\\_2.pdf](http://www.triestesalutementale.it/english/doc/2005_eur-mentalhealthinequalities_2.pdf)

<sup>306</sup> [http://www.health-inequalities.eu/healthequity/en/policies/health\\_in\\_all\\_policies/](http://www.health-inequalities.eu/healthequity/en/policies/health_in_all_policies/)

<sup>307</sup> <http://www.insa.pt/sites/INSA/Portugues/Publicacoes/Outros/Paginas/HealthMigrationEU2.aspx>

<sup>308</sup> <http://bit.ly/1pwUIbB>



**Spanish Presidency 2010:** publication of the report “Equity in Health: Monitoring social determinants of health and the reduction of health inequalities”<sup>309</sup>. This report combined an approach to health inequalities in terms of socioeconomic differences with attention for vulnerable groups. This demonstrates the tendency of work on migrants and ethnic minorities in the past decade to shift ‘upstream’, i.e. to consider more fundamental and long-term approaches to the health problems of these groups.

A report was published in 2012 describing the Portuguese and Spanish Presidency Conferences, the IOM’s EU-level Consultation (AMAC, 2010), the WHO/IOM Global Consultation (2010) and several other recent policy initiatives<sup>310</sup>.

The **Greek Presidency** and **Italian Presidency** during 2014 also organised activities around the theme of migrant health, though on a smaller scale than those organised earlier by Portugal and Spain. Both countries stressed the urgent need to cope with the health needs of the increasing ‘mixed migration’ streams (irregular migrants and asylum seekers) arriving at Europe’s Southern borders.

To conclude this section we will attempt to summarise the main tendencies that can be discerned in the policy initiatives undertaken since 2000.

- All these initiatives have tried to draw the attention of politicians, policy-makers and the public to the needs of migrants and ethnic minorities. This ‘agenda-setting’ function continues to be important – in fact, its importance is probably increasing, given the increase in negative attitudes to migration as a result of the crisis and the cuts in health service funding, resulting in a drift towards inequity rather than equity.
- Also noticeable is an increasing focus on ‘mainstreaming’ measures to protect the health of migrants and ethnic minorities, rather than relying on short-term, localised, ‘one-off’ interventions or categorical (separate) provisions for these groups. This reflects growing awareness that migration is here to stay, and that ethnic minorities must be regarded as an integral part of society.
- A logical consequence of ‘mainstreaming’ is the ‘whole organisation approach’, which stresses that adaptation to diversity is a task involving all components of a service provider organisation or health authority. In addition, an integrated, ‘joined-up’ approach to migrants’ problems is emphasised, involving collaboration between different agencies concerned with social protection and policy-making.
- The involvement of health service users and migrant groups is stressed in some initiatives, though many fail to mention this topic at all.
- Thinking about health has been transformed in this century by the rise of attention for the social determinants of health. ‘Upstream’ causes of illness have been increasingly stressed by epidemiologists, while policy-makers have sought remedies at the macro-social level using the ‘health-in-all-policies’ (HiaP) principle. However, those who think along these lines tend to focus more on socioeconomic inequities than on the effects of migrant status or ethnicity. The HiaP principle is less well worked out in relation to migrants and ethnic minorities than it is in relation to SES, though there are signs of more cross-fertilisation between these fields (for

<sup>309</sup> <http://bit.ly/1o0ZqQJ>

<sup>310</sup> Peiro, M-J. and Benedict, R. (2010). Migrant health policy: The Portuguese and Spanish EU Presidencies. *Eurohealth* 16(1), 1-4. [http://www.gla.ac.uk/media/media\\_177502\\_en.pdf](http://www.gla.ac.uk/media/media_177502_en.pdf)

example, the introduction of the concepts ‘intersectoral’ and ‘intersectional’ in the discourse on migrants and ethnic minorities).

### 3.3.3. National level

This section examines the extent to which the policies regulating health services for migrants and ethnic minorities (and other policies affecting their state of health) reflect the standards and guidelines which have been developed in the policy initiatives described above. Like section 3.2.3 on legal frameworks, this is the topic with which the ongoing ‘Big Picture’ project is concerned. There does exist a literature on the strengths and shortcomings of policies in various European countries, but only a small number of countries have up to now been investigated from this point of view and the dimensions examined vary from study to study. The ‘Big Picture’ project, on the other hand, sets out to cover all the issues covered by the 2011 Council of Europe Recommendations and to do so in a standardised way in all EU/EEA countries.

We are concerned here with the readiness of policy-makers in each country to tackle inequities in their health system affecting migrants and ethnic minorities. What is the level of adaptation to diversity? A ‘road map’ has been outlined by the series of policy initiatives described above, but are any countries following it? Is ‘adaption to diversity’ increasing? Because the results of the Big Picture project are not yet available, we will not risk any generalisations here. Some findings, however, are already beginning to emerge:

- There are enormous differences in the ‘diversity sensitivity’ of health systems: in many country, the principle seems to be totally unknown.. Very often, these are countries with little experience of migration – but this is by no means always the case. In some countries the principle that “all patients must be treated identically” appears to dominate.
- Provision of good entitlements for migrants is not always accompanied by efforts to adapt services to their needs, although this is usually the case.
- An extremely important variable influencing the overall ‘migrant-friendliness’ of health systems is the GDP per capita. Poor countries give migrants fewer entitlements (even compared with the level for their own citizens) and make less effort to adapt services to the needs of migrants. It should be borne in mind that the variations in GDP in the EU are enormous, ranging from rich countries like Luxembourg and Norway (264 and 191 respectively, compared to the EU average of 100), and Bulgaria and Romania on the other extreme (47 and 54 compare to the EU average of 100). (Based on EUROSTAT data for GDP per capita, purchasing power adjusted, in 2013).

To sum up, the degree to which action is needed in EU countries, and the issues such actions should focus on, appear to vary greatly. A ‘one-size-fits-all’ approach is as unlikely to be productive here as it is in health care itself.

### 3.4. Legal instruments and policy initiatives specifically addressing health inequalities of ethnic minorities, including the Roma

Many, if not most, of the legal instruments and policy initiatives discussed above also apply to ethnic minorities such as the Roma. Obviously, instruments dealing exclusively with migration apply only to ethnic minority members who migrate, but the fact is that a growing number of Roma do indeed migrate, now that accession of their countries of residence to the EU makes it much easier to do so.

A number of international and European instruments exist to protect the rights of indigenous, traditional and national minorities, but because most members of ethnic minorities have national citizenship there are few specific measures at national level. However, some countries have laws regulating the collection and use of ethnic data. As far as policy initiatives are concerned, most of these (especially since 2000) relate to the Roma, as a result of their large numbers, extreme poverty and their presence in most European countries. In this section we will discuss the main policy initiatives targeting the Roma. Since policies have developed in a number of phases, this will be done in chronological order.

It was not until the 1970's that a 'Romani Movement' arose to bring together Roma communities and advocate for their interests. The 1990's saw the first attempts to form political parties to obtain a voice in government<sup>311</sup>. In the same period, international organisations became increasingly involved in the situation of Roma in Europe, for example:

- The Council of Europe has concerned itself with Roma issues since 1969 and has launched numerous initiatives to promote their rights, such as for example the **Recommendation 1203 (1993) on Gypsies in Europe**<sup>312</sup>.
- The Organisation for Security and Co-operation in Europe (OSCE) has been involved with Roma since the 1990's. In 2000 it published a major **Report on the situation of Roma and Sinti in the OSCE Area**<sup>313</sup>.
- The United Nations Development Programme (UNDP) has focused on collecting and analysing data to underpin policies on Roma. The document **Avoiding the Dependency Trap: The Roma Human Development Report**<sup>314</sup> provided robust statistical evidence of the challenges faced by Roma in respect of illiteracy, infant mortality and malnutrition.

<sup>311</sup> The information in this section draws on the Council of Europe Roma fact sheets (undated), available at [http://www.coe.int/t/dg4/education/roma/histoculture\\_EN.asp](http://www.coe.int/t/dg4/education/roma/histoculture_EN.asp)

<sup>312</sup> <http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta93/erec1203.htm>

<sup>313</sup> <http://www.osce.org/hcnm/42063?download=true>

<sup>314</sup> <http://hdr.undp.org/en/content/avoiding-dependency-trap>

During the 1990's NGO's also started to become involved on a large scale with the problems of Roma. A key actor was (and still is) the **Open Society Institute (OSI)** (now the Open Society Foundations), set up in 1993 and financed by the philanthropist George Soros.

The World Bank, OSI and the European Commission joined forces to organise the 2003 conference "Roma in an Expanding Europe: Challenges for the Future" in Budapest. This conference was attended by 500 people (125 of them Roma), representing a wide range of NGO's, international organisations and governments. The involvement of the EC was connected with the fact that there were plans for several countries with large Roma populations to join the EU during the first decade of the 21<sup>st</sup> century.

The momentum generated by the Budapest conference led to a policy initiative, the **Decade of Roma Inclusion**, which runs from 2005-2015. The 8 founder countries were Bulgaria, Croatia, the Czech Republic, Hungary, FYR Macedonia, Romania, Serbia and Montenegro, and Slovakia (since joined by Albania, Bosnia & Herzegovina and Spain). All signed a commitment to closing the gap in welfare and living conditions between the Roma and non-Roma populations and putting an end to the cycle of poverty and exclusion. Each country formulated a national Decade Action Plan for the priority areas of education, employment, health and housing.

From 2009 onwards the European Commission became more involved with Roma inclusion. In that year the EU's **European Roma Platform** was set up, with strong civil society representation. In the same year the **Fundamental Rights Agency (FRA)** issued a report<sup>315</sup> proving that Roma experience the highest levels of discrimination in Europe. This report was based on the findings of the agency's *European Union Minorities and Discrimination Survey (EU-MIDIS)*.

The European Commission set up the **EC Roma Internal Task Force** following its 7 April 2010 **Communication on the Roma**<sup>316</sup>, which was adopted just before the Second Roma Summit in Cordoba in Spain. The Task Force was charged with investigating the use of EU funds for Roma integration and identifying ways to improve the funds' effectiveness. Its first reports on the situation were highly critical.

In 2011 the EU published the **EU Framework for National Roma Integration Strategies (NRIS)**<sup>317</sup> up to 2020. Member States were requested to present by the end of 2011 national Roma integration strategies that would include "EU Roma integration goals, with targeted actions and sufficient funding" and a "robust monitoring mechanism to ensure concrete results for Roma". A year later, the FRA, UNDP and World Bank published a joint report on the social position and human rights of Roma (*The situation of Roma in 11 EU Member States: Survey results at a glance*)<sup>318</sup>, showing that although slight improvements had taken place in some countries, the overall situation of Roma remained grim.

We may note that the entry of the EC into the policy-making process is generating two parallel but overlapping sets of 'road maps': countries are now required to produce not only 'Decade of Roma

<sup>315</sup> <http://fra.europa.eu/en/publication/2009/eu-midis-data-focus-report-1-roma>

<sup>316</sup> [http://europa.eu/rapid/press-release\\_MEMO-10-121\\_en.htm](http://europa.eu/rapid/press-release_MEMO-10-121_en.htm)

<sup>317</sup> [http://ec.europa.eu/justice/policies/discrimination/docs/com\\_2011\\_173\\_en.pdf](http://ec.europa.eu/justice/policies/discrimination/docs/com_2011_173_en.pdf)

<sup>318</sup> [http://fra.europa.eu/sites/default/files/fra\\_uploads/2099-FRA-2012-Roma-at-a-glance\\_EN.pdf](http://fra.europa.eu/sites/default/files/fra_uploads/2099-FRA-2012-Roma-at-a-glance_EN.pdf)

Inclusion National Action Plans’, but also ‘National Roma Integration Strategies’. These plans, however, tend to be closely related to each other.

The following year, in 2012, the EC published a Communication reviewing the national integration strategies<sup>319</sup>. This showed that programmes on health were mainly focused on improving access to health care. However, as we noted above (Section 2.1.3.2), the recent emphasis on ‘social determinants of health’ and ‘health in all policies’ has called in question the distinction between ‘health interventions’ and other efforts to tackle social disadvantage. Health is thus an aspect of the other priority areas (education, employment, housing).

The emphasis on critical evaluation of what had been achieved so far was also seen in the work of the Decade Secretariat, which in 2012 introduced what it called ‘shadow reporting’<sup>320</sup> – civil society monitoring reports on the implementation of Decade of Roma Inclusion National Action Plans and National Roma Integration Strategies (NRIS). The 2014 EC **Roma Health Report** included a part dedicated to data collection, which includes an overview of what actions countries and supranational bodies are taking to improve data collection on the health of Roma, followed by a series of recommendations for how to improve data collection and coordination.<sup>321</sup>

Two other ongoing initiatives will be mentioned in this overview. WHO Euro is carrying out an **Interagency coordination initiative**, which is developing training for health professionals seeking to deliver more equitable health services to all. The four principles of the initiative (see Appendix II, section 2.1.1) reflect the latest ‘state of the art’ in thinking about how to tackle health inequalities:

1. The initiative adopts an **intersectional approach**: besides focusing on Roma, it also considers other groups experiencing poverty and social exclusion;
2. It recognises the need for a **whole organisation approach**, because as well as involving ‘hands-on’ health-professionals it trains administrators, managers, researchers and policy-makers;
3. It encourages **user participation** by engaging Roma and other civil-society organizations as active partners; and
4. It adopts an **integrated, intersectoral, multilateral** approach by also involving partner agencies.

Secondly, the IOM’s project **Equi-Health**<sup>322</sup> combines critical evaluation of NRIS with a training component (see Appendix). Again, a **whole organization approach** is adopted in these evaluations, as the progress of national health plans is assessed at all implementation levels. Additionally, user participation and an **integrated, intersectoral, multilateral** approach feature prominently in the project’s aims and methodology, as key stakeholders (governmental and non-governmental) are

<sup>319</sup> [http://ec.europa.eu/justice/discrimination/files/roma\\_nat\\_integration\\_strat\\_en.pdf](http://ec.europa.eu/justice/discrimination/files/roma_nat_integration_strat_en.pdf)

<sup>320</sup> <http://www.romadecade.org/civilsocietymonitoring>

<sup>321</sup> European Commission (2014). Roma Health Report.

[http://ec.europa.eu/health/social\\_determinants/docs/2014\\_roma\\_health\\_report\\_en.pdf](http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf) (Accessed: 22 February, 2015).

<sup>322</sup> <http://equi-health.eea.iom.int/>

involved. Future funding priorities in the area of Roma health under EU structural and social cohesion funds will be identified based on the project's results.



## Chapter 4: Barriers to accessing health services and good practices addressing them

### 4.1. Dimensions of access

An often-used definition of access to health services is as follows<sup>323</sup>: “Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health”. Although the right to receive health care was laid down in the *International Covenant on Economic, Social and Cultural Rights* in 1966, the Covenant did not specify in detail how this right should be implemented. However, as we saw in the previous chapter, a General Comment was adopted in 2000<sup>324</sup> setting out that care must be *available, accessible, acceptability* and of adequate *quality* (often abbreviated to ‘AAAQ’). In this chapter we are concerned with the second requirement, accessibility, which the General Comment divides into four overlapping dimensions: *non-discrimination, physical accessibility, economical accessibility (affordability)* and *information accessibility*.

The most fundamental of these dimensions is economical accessibility or affordability. Because health care costs can be extremely high, whether care is affordable mainly depends on a person’s entitlement to health care ‘coverage’, i.e. their inclusion in a collective system of risk-sharing that protects them from catastrophic costs. In many parts of the world such systems do not exist: health care which is not provided free has to be paid for at the point of supply. In EU member states, however, coverage for health care is available to almost everybody (although types of migrants such as asylum seekers and irregular migrants may not be allowed to participate in the same schemes as nationals).

Coverage embodies two kinds of solidarity, ‘horizontal’ and ‘vertical’<sup>325</sup>. The ‘horizontal’ kind is the solidarity of healthy people with those who become ill, which is the essence of the very idea of coverage. Indeed, healthy people may not opt out of such a system, because their contributions are necessary to pay for the care of the sick. Moreover, in most state-regulated (as opposed to commercial) risk-sharing schemes, those who are ill or disabled must be allowed to join the system on the same terms as the healthy. Exclusion or extra charges for those with pre-existing conditions undermine the principle of ‘horizontal solidarity’. Most state-regulated systems, whether tax-based or insurance-based, also build in a degree of ‘vertical’ solidarity, by which the rich subsidise the poor. Premiums or taxes are made ‘progressive’, so that the burden they represent for poor people is not greater than for

<sup>323</sup> Gulliford, M. *et al* (2002). What does “access to health care” mean? *Journal of Health Services Research & Policy*, 7(3), 186–188.

<sup>324</sup> OHCHR (2000) *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000*. New York: United Nations, Office of the High Commissioner for Human Rights.

<sup>325</sup> Ter Meulen, R., Arts, W. A. & Muffels, R. J. A. (eds.) (2001). *Solidarity in Health and Social Care in Europe*. Dordrecht/Boston/London: Kluwer.

rich people. Introducing payments at the point of supply ('out-of-pocket' payments) undermines both kinds of solidarity, though these effects may be mitigated by exemptions for chronically ill or poor people.

Affordability is such a basic dimension of access to health services that it is often discussed separately under the heading of 'entitlement' or 'coverage'. It is usually regulated at national level, although in some countries regional governments may have a say in laying down the rules. Legal entitlements to health care coverage in European countries were dealt with in Chapter 3 in the section on national legal or policy frameworks: they will not be discussed again here. That does not mean, however, that the question of entitlement is unrelated to all the other dimensions of access. The General Comment referred to the four dimensions as 'overlapping'<sup>326</sup>, because they may interact with each other. For example, a migrant or member of an ethnic minority who is entitled to care may be prevented from using it if he or she is discriminated against, unable to reach the service provider, or kept in the dark about their rights and how to exercise them. In the rest of this chapter we will focus on barriers to access *other than* entitlement.

#### 4.1.1. General issues concerning access

##### *Access to preventive services and health education*

It is important to stress that access concerns health 'services' and not simply health 'care'. Prevention, screening, health education and health promotion are services for the entire population, not just for those in need of care. In these cases, however, 'access' takes on a different meaning. Whereas it is the individual who seeks the health care provider, preventive and educational programmes go in search of the individual. If they succeed in finding him or her, the individual has 'access' to them. Usually, because these services are in the public interest, they are provided free of charge (up to a certain basic level): the issue of coverage in the sense of financial support is therefore not relevant. However, it is important whether these services have universal coverage in the sense that all members of the population are legally entitled to receive them. In general, nationals (including ethnic minorities) do have such entitlement, but some groups of migrants (especially asylum seekers and irregular migrants) may not be permitted to use preventive and educational services or may remain out of reach of these services. As we will describe further down in this section, developing culturally adapted services in prevention, health promotion and education can help expand the accessibility of these services and increase the likelihood of participation of hard to reach groups.

##### *Who creates the barriers – the user or the system?*

Sometimes barriers to accessing services will result from a person's own attitudes or beliefs (their preferred 'help-seeking behaviour').<sup>327</sup> Such barriers are often referred to as 'demand-side', in order to distinguish them from the 'supply-side' barriers which are created by the health system. For example, a person may not realise they need care, they may wrongly think they are not entitled to it, or they may not regard the available health services as appropriate sources of help.

<sup>326</sup> OHCHR (2000), paragraph 12b.

<sup>327</sup> Nørredam, (2011)

However, to a certain extent these barriers can be reduced by efforts on the part of the health system to provide information, increase health literacy, and overcome unjustified reluctance to seek care. For this reason the distinction between ‘demand-side’ and ‘supply-side’ barriers is not as clear as it looks at first sight. In the end, it becomes a question of who is regarded as *responsible* for solving problems of access. Health systems with what Bollini<sup>328</sup> referred to as a ‘passive’ response to diversity leave the responsibility with the user; this usually goes along with the attitude that migrants and ethnic minorities should *assimilate*. Systems adopting an ‘active’ response take on much of the responsibility for removing barriers to access themselves: this approach is often inspired by a ‘multicultural’ approach, using a two-way concept of *integration*.

#### *Measuring barriers to access*

The existence of barriers to access can be established in two ways – directly or indirectly. The *direct* method involves asking migrants whether they were able to access services when they needed them. Appendix IV gives examples of EU-funded projects that collected qualitative data from migrants and ethnic minorities regarding access to health services, such as **Healthy Inclusion** or **Promovax**. Sometimes NGO’s may be able to provide such data on the basis of what they are told by migrants and ethnic minorities (see information in Appendix VI on the projects **NowHereLand** and **Averroes**). Research using ‘direct’ methods has revealed a great deal about the barriers that exist, although it may not always show whether the barriers identified are greater for migrants and ethnic minorities than for the majority population. For example, migrants may say they are put off by long waiting lists, inconvenient opening times, hard-to-reach services or the reluctance of health professionals to give treatment without first carrying out lengthy tests. However, many other health service users may experience the same barriers.

The *indirect* method of identifying barriers involves comparing the rate of utilisation of services by migrants or ethnic minorities with that of the majority population. However, to use this method it is necessary to allow for the fact that differences in utilisation may simply be the result of differences in need. For example, in a country where geriatric services are hardly ever used by migrants, this could arise simply because few migrants are elderly – not because there are access problems. Service utilisation is determined by both need and access, and it is impossible to estimate one of these parameters without knowing the other.

Data on service utilisation often show that the population of service users does not reflect the composition of the population for which the service is supposed to cater: in particular, migrants and ethnic minorities may be under-represented. In Table 1 of Appendix 4 data are presented from a wide range of European studies on health service utilisation by migrants and ethnic minorities. These studies are classified by country and type of service. However, in many cases it is not possible to determine whether differences in service use reflect differences in need or in access. For example, several studies report increased use of GP services by migrant and ethnic minority patients. Is this because such patients have more health problems, or because they have a lower threshold for seeking help? Or is the increased use due to ‘revolving-door patients’, who keep coming back to the GP because their health problem has not been resolved? Screening participation among ethnic minority women is

<sup>328</sup> Bollini, P. (1992). Health Policies for Immigrant Populations in the 1990s. A Comparative Study in Seven Receiving Countries. *International Migration*, Vol. 30 (Special Issue: Migration and Health in the 1990s), 103-119.

known to be lower than for non-ethnic minority women, however, cervical and breast cancer rates vary depending on ethnic minority group, but are clearly lower among some ethnic minorities as shown in Chapter 2.

Another phenomenon visible in Table 1 is the increased tendency in some countries for migrants and/or ethnic minorities to use accident and emergency departments. This too is difficult to interpret. It could be due to the fact that these groups experience more barriers to accessing primary care, so that the A&E department becomes in effect their substitute for the general practitioner or community health centre. Or it could be because their health needs really are more acute – perhaps as a result of the same barriers to access, leading to help only being sought when the need for it becomes overwhelming<sup>329</sup>. More serious symptoms at first contact can sometimes be found elsewhere in other services, however, which gives a clearer indication that something is deterring people from seeking help when problems have not yet become acute<sup>330</sup>.

In the next chapter we will discuss good practices for improving the *quality* of health services for migrants and ethnic minorities. These issues arise once a person has got inside the door, as it were, of the service provider, i.e. when any barriers to access have been overcome. However, the issues of ‘access’ and ‘quality’ are not entirely distinct. Firstly, if the quality of a service is poor – or is *perceived* as being poor – this will create a barrier to accessing it. Secondly, there are some factors which affect both access and quality. The most obvious ones are language barriers: these may prevent a migrant from obtaining crucial information about health problems, entitlements, health services and ways to get help. Once inside the door, as we will see in the next chapter, language barriers may prevent mutual understanding between patients and health professionals.

#### 4.1.1. Barriers to access for the descendants of migrants

Learning how and when to use health services is an important aspect of integration in the host society<sup>331</sup>. Since the ‘second generation’ is born in the host country and has the opportunity from birth to become familiar with its language, culture and health services, it is to be expected that their patterns of health service utilisation will be closer to those of the majority than those of their parents. Moreover, as natives of their country of residence they are more likely to have entitlement to coverage for health care. However, although few studies are available of differences between these patterns in the first and second generations, it is clear that some differences from the majority population persist.

For example, one area in which differences have been found in the Netherlands concerns perinatal care. Regular check-ups during pregnancy are important in reducing childbirth complications and effectively managing complications when they do arise. We saw in section 2.4.2. that among mothers of non-Western origin, rates of infant death were only slightly lower in the second generation than in the first. This is related to findings that these mothers make less use of preventive services during

<sup>329</sup> Nørredam, M., Nielsen, S.S., Krasnik, A. (2009). Migrants' utilisation of somatic health care services – a systematic review. *European Journal for Public Health*, Vol. 20 (5): 555-563.

<sup>330</sup> Nørredam, M. *et al* (2010a). Excess use of coercive measures in psychiatry among migrants compared with native Danes. *Acta Psychiatrica Scandinavica*, 121 (2): 143-151

<sup>331</sup> Ingleby, D. (2012). Acquiring health literacy as a moral task. *International Journal of Migration, Health and Social Care*, 8(1), 22-32.

pregnancy as well as maternity care<sup>332</sup>. The age at which mothers have children, and the number of children that they have, are more similar to native Dutch mothers in the second generation than the first: compared to their own mothers, second-generation women have fewer children and at a later age. Nevertheless, they still make too little use of preventive services and receive less health education. Mothers were inadequately informed over the importance of prenatal checkups and the services available. Less use was also made of maternity care after the birth. Despite the fact that they were born in the Netherlands, it is clear that these mothers are not being effectively reached and influenced by preventive services and health education. This is particularly worrying given the recent policy in the Netherlands of cutting back targeted interventions for migrants<sup>333</sup>.

#### **4.2. Examples of barriers to access and good practices to address them**

In Table 2 of Appendix 4 the results of a review of the European literature on barriers to access for migrants and ethnic minorities are presented. Table 3 gives examples of projects that have put forward solutions to these access problems. We describe here the main barriers that have been found and some of the solutions proposed for them, drawing on these and other sources.

It should be noted at the outset that measures to improve access may need to be taken at different levels in the health system. Some problems may have to be tackled by national governments (especially when they concern legislation or nation-wide programmes). Others may be primarily a task for service provider organisations (in particular the leadership, policy-makers and managers). Relatively few problems of access can be tackled by individual health workers themselves, for the basic reason that those who do not succeed in overcoming access problems never come in contact with a health worker.

##### **4.2.1. Lack of information, poor ‘health literacy’**

First, a note on the term ‘health literacy’. This is defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and [access] services needed to prevent or treat illness”<sup>334</sup>. Poor health literacy implies a lack of knowledge about health, illness and the health care system. It leads to the following difficulties in accessing healthcare: not knowing the connection between risky behaviours and health, not being able to locate providers and services, not knowing the meaning of application forms, notices, and brochures, not being able to fill out complex health forms, or to share medical history with

<sup>332</sup> A.J.M. Waelput, P.W. Achterberg (2007). *Etniciteit en zorg rondom zwangerschap en geboorte: een verkenning van Nederlands onderzoek*. RIVM: Centrum Volksgezondheid Toekomst Verkenningen.

<sup>333</sup> D. Ingleby (2009), Migranten en etnische minderheden in de Nederlandse gezondheidszorg: een internationaal perspectief. In: A. Sbiti & I. Boedjarath (red.), *Gekleurde Gekte. 25 jaar werken aan interculturele GGZ*, 100-117. Rotterdam: MIKADO.

<sup>334</sup> U.S. Department of Health and Human Services (2013, December). *About Health Literacy*. Health Resources and Services Administration. Retrieved from <http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html>

providers<sup>335</sup>. Sometimes, low language proficiency can be an important factor preventing migrants from improving their health literacy.

Often, however, migrant and ethnic minority users are regarded as having 'low health literacy' when the root of the problem may be simply that they have not been provided with adequate information. Such information needs to address the following issues:

- a) Entitlements and the procedures necessary to claim them.
- b) How to use the health system (e.g. whether specialist care can be accessed directly or only through a 'gatekeeper').
- c) Health maintenance in specific conditions (living with diabetes, cancer etc.).
- d) Health education and health promotion: how to recognise problems, when to seek help, how to look after one's own health.

A great deal of research, much of it supported by the EU, has been carried out in the last decade on shortcomings in the information available to migrants as well as 'good practices' to overcome them. The European Health Literacy Project has been conducting research on the conceptualisation of health literacy and sharing knowledge on the subject. They also conducted a European health literacy survey, which resulted in comprehensive report, and featured the following findings:<sup>336</sup>

"The first time data on health literacy in eight countries generated interesting and relevant results. Almost one in two, on average 47%, has risk of limited health literacy across the eight countries and the levels vary between the countries. In certain subgroups of the populations there are higher risks, such as among elderly, among people with low levels of education, among people with low socio-economic status and among people considering having a bad health."<sup>337</sup>

An important finding is that such information often needs to be *targeted*: the language used, the means of dissemination, and the content may all have to be adapted in order to reach migrants effectively.<sup>338,339,340</sup> Some of these interventions also call for intersectoral and intersectional approaches, requiring the engagement of policy makers and key stakeholders outside the health sector and at all levels of health organisations, and looking at health inequalities through a wider 'diversity' lens. Other interventions involve front-line health professionals who come into contact with the target group in their daily work, and representatives of the communities they serve.

<sup>335</sup> Institute of Medicine, (2004). *Health Literacy: A Prescription to End Confusion*. Washington DC: Institute of Medicine.

<sup>336</sup> European Health Literacy Survey (2012).

<http://www.maastrichtuniversity.nl/web/Institutes/FHML/CAPHRI/DepartmentsCAPHRI/InternationalHealth/ResearchINTEALTH/Projects/HealthLiteracyHLSEU/HealthLiteracyHLSEU.htm> (Accessed: February 23, 2015).

<sup>337</sup> *Ibid.*

<sup>338</sup> Priebe, S. *et al* (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC Public Health*, 11:187.

<sup>339</sup> Mladovsky, P. *et al* (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.

<sup>340</sup> Netto, G., *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, 25: 248-57



The case study below illustrates how one regional government in Spain developed and implemented a migrant health policy programmes to improve the knowledge and information available on migrant health, in order to promote equal access to and better quality of health services.

### Case Study: Catalonia and the Master Plan for Immigration and Health<sup>341</sup>

Catalonia, in the face of a rapidly growing migrant population, was one of the first regional governments to implement migrant health policy. In 2005 it adopted a regional policy, the Master Plan for Immigration and Health (MPIH) to adapt its health care system to the increasing numbers of migrants, and promoted organisational change with the help of clear political commitment.

The Catalan health system is characterised by a high degree of autonomy from the central government, and its guiding vision is that of universal access to all residents of Catalonia, free of cost. Everyone residing in Catalonia is thus eligible to receive a personal health care card, which guarantees access to free health care. Pregnant women and children under 18 do not have to prove residence in the region in order to get a personal health care card. However, recognising that a series of factors characteristic of migrants, such as their culture, religion, language, different ways of interpreting health and illness, may create barriers to accessing health services, the Catalan government developed a plan for improving access to and quality of health services provided to migrants: the Master Plan for Immigration and Health. The plan aimed to create a strong knowledge base about the health situation of migrants in Catalonia and subsequently be able to develop strategies for adapting the health system to their needs. A vigorous programme of research over a number of years, including the analysis of health records and other data such as perceptions and needs of healthcare professionals, produced a series of reports and publications. Based on these outcomes, a list of recommendations was produced and subsequently three areas of intervention were defined and implemented as part of an action plan for 2007-2010: 1) reception, 2) mediation and 3) professional training.

- 1) Reception: The aim here was to break down the barriers to access to health services for migrants, through the improvement, coordination and adaptation of information regarding health, health services and entitlement.
- 2) The mediation plan: The role of intercultural mediator was incorporated as a key element for facilitating intercultural relations, especially in the case of new arrivals where great linguistic and cultural barriers may impede access and quality of care. Evaluation results for the initial phase (2008-2011) emphasised the relevance and responsiveness of the mediator programme, both in terms of the needs of migrants and of health professionals. Recommendations included the increase in number of mediators, and the extension of the programme throughout the entire region.
- 3) Training for professionals in health care services: To improve the knowledge and skills needed to achieve a level of cultural competence required to guarantee quality of care for all, a training course was developed and taught by the Institute of Health Studies. The course was delivered throughout the regions, in a coordinated way, through the regional health actors.

Funding for the programme was provided by a public-private partnership with La Caixa Foundation. At present, despite the lack of specific budget allocations for the implementation of the migrant health policies described above, and the austerity measures resulting from the economic crisis, the MPIH continues to be implemented. In this next phase, research will focus on the impact of austerity of vulnerable migrant groups, and on planning actions to address health problems arising as a result of austerity measures.

Recommendations for tackling lack of information and poor 'health literacy' include the following:

- Information on entitlements, the health system, and prevention/health promotion information should be provided in the appropriate languages and distributed strategically to reach the maximum number of target groups (identified as good practice by health practitioners in 16 European countries through the **EUGATE project**, see Appendix 3). Possible means of

<sup>341</sup> Lizana, T. (2011). Developing a migrant health policy for Catalonia. In: Inequalities in health care for migrants and ethnic minorities. COST Series on Health and Diversity, Vol. 2. Antwerp: Garant Publishers

distributing information include brochures, websites and public announcements, as well as workshops on health and the health care system in introductory language courses for newly arrived migrants. (See Appendix 3 for information on EU funded project **AVERROES** which set up **the HUMA network** of NGOs charged with disseminating knowledge about access to health care)

- When implementing a prevention programme, such as HPV vaccination, the public should be well informed beforehand on why the programme is being implemented, what the benefits are of participating and the risks associated with not participating. The **Aurora** project identified the lack of appropriate education campaigns previous to the implementation of HPV vaccination programmes as a significant factor in the low HPV vaccination rates that resulted from the programmes.<sup>342</sup>
- Innovative health education models such as “**With Migrants for Migrants**” or the **MiMi Programme**, have been used to train transcultural mediators, who organise and conduct information and education sessions on HIV/AIDS for the targeted groups (see the project **AIDS and Mobility** in Appendix 3),
- **Cultural or health mediators** have been used successfully in a number of countries to link services and hard to reach communities, such as the Roma, and thus improve access to health services (see more information on **NGO-led Roma Health Mediator initiatives** in Appendix VI). They have been found to play a key role in helping communities to understand and navigate the health system, as well as clarifying issues of entitlement and assisting with national insurance enrolment procedures.<sup>343</sup>

#### 4.2.2. Practical barriers

Typical practical barriers to accessing health services that have been identified in research include the following:

- Geographical barriers affect especially populations living in isolated areas with limited access to health services, or those who rely on public transport to reach services but cannot afford it.<sup>344</sup> Mobile health units have been found to be an effective means of bringing services to especially vulnerable groups.<sup>345</sup>
- Opening hours of health care providers often do not reflect the working hours of migrants who might be in precarious employment and might face problems in getting time off work, e.g. loss of salary for hours gone from the job, conflict with management, or losing their job.
- Overly complicated registration procedures and lack of needed documentation have been cited as serious obstacles for Roma populations accessing health services<sup>346, 347</sup>.

<sup>342</sup> [www.aurora-project.eu](http://www.aurora-project.eu) (accessed on 15 January, 2015)

<sup>343</sup> How health systems can address health inequities linked to migration and ethnicity. Copenhagen, WHO Regional Office for Europe, 2010.

<sup>344</sup> Schaaf, M. (2007). *Confronting a hidden disease: TB in Roma Communities*. Research report: Roma Health Project, Open Society Institute.

<sup>345</sup> For more details, see NOWHERELAND project, Country Report: Portugal. Policies on health care for undocumented migrants.

<sup>346</sup> Kingston, L., Cohen, E., Morley, C. (2010). Limitations on universality: the "right to health" and the necessity of legal nationality. *BMC International Health and Human Rights*, 10 (11).

- Screening participation amongst ethnic minorities in some countries is found to be generally lower compared to the general population.<sup>348</sup> Fear, lack of information, and misunderstanding of risk are cited as possible barriers to accessing timely screening. In the UK, an intervention targeting women living in one of the most deprived and ethnically diverse borough of London with very low breast cancer screening rates, used telephone reminders. Through culturally and language adapted telephone reminders, the intervention managed to significantly improve breast cancer screening attendance.
- In order to improve screening coverage, research encourages the routine collection within general practice of additional sociodemographic information to aid monitoring of inequalities in screening coverage and inform policies to correct them.<sup>349</sup>
- For irregular migrants, going to a health care provider may carry with it the risk of being reported to authorities. In some countries, health professionals are required to report such migrants. Even where this is not the case, in the absence of reassurances to the contrary irregular migrants are liable to assume that such a risk is present.
- Even when irregular migrants have the right to (certain forms of) care, health professionals may not be aware of these rights or feel obliged to respect them. Work done by **PICUM**, **NowHereLand** and the **HUMA network** (amongst others) explores in detail the entitlements and health of irregular migrants in Europe (see Appendix 3). The project **EUGATE** recommended educating health professionals at *all* levels about entitlements for different groups of migrants (see Appendix 5),
- Migrants in detention may face obstacles to accessing the health services they need because of limited provision and availability of health providers<sup>350</sup>.
- Health services providers may be unfamiliar with certain medical procedures which may be needed by a small group, such as for example defibulation for women who have undergone female genital mutilation (FGM) or cutting. Defibulation is a routine procedure in countries where FGM is widespread: women are often defibulated (or ‘opened up’) when they get married and/or are pregnant. After migrating to countries where FGM is not practiced, women with FGM may not have access to this procedure for a variety of reasons, and consequently, may encounter problems during childbirth.<sup>351</sup>

A further problem of access stems from the increasing fragmentation of disciplines and specialties within the health system.<sup>352</sup> Migrants and ethnic minorities may experience difficulties in trying to navigate the system of referrals and appointments with several providers in different locations. In some countries, “one stop” services for migrants are provided to reduce the risk that patients will “fall

<sup>347</sup> Kühlbrandt, C., Footman, K., Rechel, B., McKee, M. (2014). An examination of Roma health insurance status in Central and Eastern Europe. *Eur J Public Health*;24(5):707-12.

<sup>348</sup> Offman, J. *et al* (2014). A telephone reminder intervention to improve breast screening information and access. *Public Health*;128(11):1017-22.

<sup>349</sup> Moser, K., Patnick, J. and Beral, V. (2009) Inequalities in reported use of breast and cervical screening in Great Britain: analysis of cross sectional survey data. *British Medical Journal*, 338: b2025.

<sup>350</sup> Jesuit Refugee Service Europe, (2010). *Becoming Vulnerable in Detention*. Report of the DEVAS project (co-financed by the EC, European Refugee Fund). Available at <http://bit.ly/100Jo31>

<sup>351</sup> <sup>351</sup> Leye, E. (2006). Health care in Europe for women with genital mutilation. *Health Care for Women International*, 27:4. Pg. 362-378.

<sup>352</sup> Mladovsky, P. *et al*, (2012b). Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy*, 105: 1-9.

through the cracks” (e.g. the Migrant Helpline in London, Migrant Health Clinic in Copenhagen). However, separate provision for migrant and ethnic minority patients could also lead to mainstream services over-relying on migrant clinics rather than addressing issues of diversity in their organisations. A related issue is the poor integration of health and social care services in many countries. Many migrants have a need for several different kinds of help, but may be daunted by the task of negotiating two or more separate access procedures.<sup>353</sup>

#### 4.2.3. Language barriers

We will discuss use of interpreters in the next chapter (on service quality). However, interpretation or translated materials may be necessary in order to get into care, e.g. to communicate with staff at reception, negotiate registration procedures, and read information about getting access to care.

#### 4.2.4. Discrimination and mistrust

Many migrants and ethnic minorities experience discrimination in trying to access health services, according to research.<sup>354, 355</sup> Reports of denial of services, or making available a limited and sometimes inferior range of services for certain groups, are common in a number of countries with high percentages of Roma.<sup>356</sup> Mistrust of healthcare services and professionals may develop as a result of expectations of discrimination, and thus also act as a deterrent to seeking treatment for vulnerable groups. Trust is widely recognised to be essential for good care, but there may be a *structural, general* lack of trust between migrant and ethnic minority communities and public authorities, based on linguistic or cultural differences<sup>357</sup> or more deeply-rooted and long-standing antagonisms.<sup>358</sup>

Both discrimination by health workers and mistrust on the part of users reflect a less-than-deal relationship between those working in the health system and the communities they serve. A number of good practices have been recommended to improve this relationship.

- The involvement of migrant and ethnic minority groups in the design and/or delivery of services is often cited as a key tool for improving access and quality of health services. However, these groups are usually poorly represented in the ‘participatory spaces’ designed to further such involvement<sup>359</sup>. Some projects aim to reduce the gap between health services and migrants and ethnic minorities. Community-based approaches – which aim to mobilise the health resources that communities already possess, rather than simply teaching people to

<sup>353</sup> Priebe *et al* (2011)

<sup>354</sup> European Roma Rights Centre (2006). *Ambulance not on the way. The disgrace of health care for Roma in Europe*. Budapest: Roma Rights Centre.

<sup>355</sup> Kosa, K., Adany, R. (2007). Studying vulnerable populations: lessons from the Roma minority. *Epidemiology* 18: 290-9

<sup>356</sup> Public Health Fact Sheet. *Left Out: Roma and access to health care in Eastern and South Eastern Europe*. Open Society Institute, Public Health Program, Roma Health Project. (no date)

<sup>357</sup> Priebe *et al* (2011).

<sup>358</sup> Ingleby, D. (2008). *New perspectives on migration, ethnicity and schizophrenia*. Willy Brandt Series of Working Papers in International Migration and Ethnic Relations 1/08, IMER/MIM, Malmö University, Sweden

<sup>359</sup> De Freitas, C. (2011) *Participation in mental health care by ethnic minority users: Case studies from the Netherlands and Brazil*, Utrecht: Utrecht University (PhD Thesis),

become consumers of resources developed by others – are particularly promising in this respect<sup>360</sup>.

- A number of EU projects have aimed to improve user involvement in the design, implementation and evaluation of health services, especially migrant and ethnic minority involvement (see Appendix IV). **EURO HIV EDAT**, for example, will engage service providers and clients alike in the evaluation and design of improved services, and tools for how to access the services. **Aurora**, **TAMPEP** and **TUBIDU** also involve local stakeholders such as civil society and community organisations in their research, planning and development of interventions addressing cervical cancer (Aurora) and communicable diseases (TAMPEP, TUBIDU) in vulnerable populations. (See the case study below for a more detailed plan for how to successfully involve stakeholders in intervention planning and development)

Training of health professionals as well as migrants and ethnic minorities can help to reduce direct discrimination and mistrust, by raising awareness of the prejudices people have that they are not aware of, and equipping them with the knowledge and skills needed for diversity-sensitive health care. For more information on good practices in cultural competence training for health professionals, see Appendix V.

Cultural mediators, discussed in more detail in the next chapter, can also play a role in facilitating participation and engagement of migrants and ethnic minorities in health care services, and thus reducing mistrust and discrimination.

---

<sup>360</sup> Garcia Ramirez, M., Hatzidimitriadou, E. (2009). User involvement and Empowerment in Health Care Practices with Ethnic Minority Groups: A Community Approach. *International Journal of Migration, Health and Social Care*. 5; 2-5

## **Chapter 5. Factors undermining the quality of health service delivery and good practices addressing them**

### **5.1. What is meant by ‘quality’?**

The quality of health services can be assessed in many different ways. The most commonly used approach (the ‘Donabedian model’<sup>361</sup>) distinguishes three aspects of quality: structure, process and outcome. ‘Structure’ refers to resources such as buildings, equipment and staff, ‘process’ to the actions carried out in service delivery, and ‘outcome’ to the effectiveness of these actions in improving health. In the present context we are mainly concerned with process and outcome, because the structures within which MEMs are treated are to a large extent the same as those used by everybody else.

Assessing outcomes – discovering whether a given practice improves the effectiveness of care for MEMs – is the hardest kind of assessment to carry out, because it requires a controlled comparison of methods and their outcomes, possibly with long-term follow-up. In practice, such studies are difficult to set up: many contaminating and confounding factors have to be controlled for, ethical problems arise, and studies tend to be very expensive. Attention therefore usually focuses on process, and in particular two aspects: (1) the extent to which the procedures for diagnosis and treatment are properly carried out, avoiding erroneous diagnosis, noncompliance and dropout; and (2) the satisfaction (of both users and health professionals) with the treatment.

A fundamental principle of health service provision in diverse societies is that **providing the same care to all does not guarantee quality**. It is certainly a step forward from the situation in which sub-standard care is regarded as acceptable for certain groups of patients. However, unless the care is matched to the different characteristics and situation of different patients, providing the same care to all will amount to providing inferior care to some. Good care must be ‘matched’ or ‘appropriate’<sup>362</sup> in certain ways. The notion of ‘patient-centeredness’ has received increasing emphasis in recent years, particularly among agencies responsible for accreditation of service providers. In many countries, however, few attempts are made to apply this principle to the needs of MEMs (see Chapter 3). Even though these groups may be given legal access to health services, the help offered is not ‘targeted’ or ‘tailored’ in any way.

As was pointed out in the previous section, the same factors which create barriers to access may also undermine the quality of care. This concerns in particular language barriers, poor health literacy, discrimination and mistrust.

<sup>361</sup> Donabedian, A. (1988). The quality of care. How can it be assessed? *JAMA : The Journal of the American Medical Association* 260 (12): 1743–8.

<sup>362</sup> Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press.



## 5.2. Factors undermining quality and good practices addressing them

### 5.2.1. Cultural barriers

Important changes have taken place over the last 30 or 40 years in the way ‘culture’ has been understood. During much of this period, ‘cultural differences’ (conceptualised in a certain way) have been considered to be the main barrier standing between MEM patients and health service providers.<sup>363</sup> In this conceptualisation, ‘culture’ is a relatively fixed and homogeneous set of characteristics that migrants bring with them, like baggage, from their country of origin. Language, religious beliefs, diet, hygiene practices and gender roles are typical items in this ‘cultural baggage’. Unawareness of these cultural characteristics was seen as hampering the delivery of appropriate care. Knowledge of different cultures was proposed as the way to tackle this barrier, and textbooks on different cultures became the main training tools for health professionals.

This view of the role of culture in health services for MEM has increasingly come under fire since the 1990’s. Rather than labelling and stereotyping patients according to simplistic conceptualisations of culture, attention has been drawn to the diversity within cultures, the fluid and many-layered nature of culture, and migrants’ interactions with the host country culture – which gives rise to new, ‘hybrid’ cultures and identities.

At the same time, given the increase in the number and diversity of sending countries, becoming a culturally competent health provider has become increasingly difficult for those who try to follow the traditional text-book approach. A different approach has come to the fore, which proposes that little of use can be learned about a patient’s culture from books. Instead, the first task is seen as understanding one’s *own* culture: in this way one can become better able to accept and understand that of others. As in ‘patient-centered care’, the way to overcome cultural barriers is to take the time to get to know the patient better.<sup>364</sup> The appropriate attitude for health professionals is therefore one of ‘cultural humility’ - “a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves”<sup>365</sup> (p. 118).

It is important to note that abandoning a static, stereotypical view of MEM ‘cultures’ does not mean abandoning the concept of culture altogether in favour of a purely individual-centred approach. MEMs are likely to appreciate a health worker who knows and respects their traditions and shows an informed interest in their country of origin. In addition, although a huge variety of cultural and ethnic groups can be found across Europe, large migrant communities often gravitate to specific locations,

<sup>363</sup> This section draws on Ingleby, D. (2012). Introduction by series editor. In: D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity, Volume II* (pp. 9-28). Antwerp/Apeldoorn: Garant.

<sup>364</sup> Saha, S., Beach, M.C., Cooper, L.A. (2009). Patient centeredness, cultural competence, and healthcare quality. *Journal of the National Medical Association*, 100 (11): 1275-85

<sup>365</sup> Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117-125.

making it possible for service providers to focus on the needs of particular groups without necessarily pigeon-holing them according to rigid stereotypes.

An example is the case of migrant communities that originate from countries where FGM is practiced. Health providers catering to these communities need to have a thorough understanding of the practice itself, who is affected by it, the health implications of the procedure, and how to meet the needs of women who have undergone or are at risk of undergoing FGM. Literature has identified several factors that may inhibit the provision of adequate care for women with FGM<sup>366</sup> :

1. Lack of knowledge about FGM among health care professionals
2. Health professionals' personal emotions and feelings regarding this cultural practice, e.g. anger, fear of dealing with culturally sensitive topic, powerlessness.
3. Lack of technical guidance for caring for women with FGM
4. Lack of knowledge of the health care expectations and needs of affected communities
5. Lack of coordination and coherence among health and social services, other agencies (e.g. schools, police, immigration), policymakers, and civil society, prevent an integrated approach to prevention and care.

Similarly, in order to optimize the healthcare given to infertile migrant couples, clinicians should be aware of the possible impact of non-biomedical beliefs concerning procreation, both on treatment issues and on the specific psycho-cultural stress associated with childlessness.<sup>367</sup>

Along with this radical change in the way 'culture' is conceptualised, the concept of cultural competence has evolved into a more comprehensive notion involving not only 'knowledge' but also skills and attitudes (often referred to by the acronym KAS)<sup>368</sup>. In addition, the concept has been broadened to encompass not only individual caregivers, but organizations too. Indeed, the '*National standards on culturally and linguistically appropriate services (CLAS)*'<sup>369</sup> – which have had a major influence on health care not only in the United States, but also in Europe – are primarily addressed to service provider organisations, as are the '*Equity Standards*' developed by the HPH-WHO Task Force on Migrant-Friendly and Culturally Competent Health Care (TF MFCCH).<sup>370</sup> The 'whole organisation approach'<sup>371</sup> stresses that health care is given by individuals who are part of a team. According to this approach, focussing exclusively on 'front-line' professionals ignores their need for back-up and support from all levels of the organisation. This implies that systematic training and education, not

<sup>366</sup> Leye, E. (2006). Health care in Europe for women with genital mutilation. *Health Care for Women International*, 27:4. Pg. 362-378.

<sup>367</sup> Van Rooij, 2004.

<sup>368</sup> Expert Panel on Cultural Competence Education for Students in Medicine and Public Health (2012). *Cultural competence education for students in medicine and public health: Report of an expert panel*. Washington, D.C.: Association of American Medical Colleges and Association of Schools of Public Health.

<sup>369</sup> OMH (2000). *National standards on culturally and linguistically appropriate services (CLAS) in health care*. Washington, United States Department of Health and Human Services.

<sup>370</sup> Website: <http://bit.ly/1A6PdFq>

<sup>371</sup> Mladovsky, P. et al (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.

only of health workers but also of policy-makers, managers and researchers, is required to bring about these changes.<sup>372</sup>

The most recent development in the concept of 'cultural competence' has called into doubt the very centrality of the concept of 'culture' itself, arguing instead for the adoption of an 'intersectional' approach.<sup>373</sup> This approach calls for a more general improvement in the health system's 'sensitivity to diversity', encompassing gender, age, religion, disability, sexuality and socio-economic position.<sup>374</sup> It arose as a logical development of the call for health systems to recognise the 'super-diversity' of modern migrant populations (referred to in Chapter 1). If the differences in educational level, legal status, gender, age (etc.) within migrant or ethnic minority groups need to be considered, why should these factors not be considered as important in their own right? Such an approach extends the notion of 'sensitivity' beyond MEM alone to the whole society. (This view was also voiced in the Council of Europe's 2006 Recommendations on 'Health care in a multicultural society', discussed in Chapter 3, and in the 2013 revision of the CLAS Standards<sup>375</sup>). The notion of 'intersectionality'<sup>376,377</sup> implies furthermore that different dimensions of diversity do not simply have an additive effect, but may also interact with each other: the effects of low educational level, for example, may differ between male and female migrants.

### ***Addressing culture- and diversity-related barriers to quality in health services***

Cultural competence or diversity sensitivity may have a positive impact on the following barriers to quality:

- It may facilitate communication about different frames of reference regarding health.
- It may help professionals to overcome deeply-rooted prejudices.
- It may help to bridge the gap between widely differing understandings of health and illness in general, as well as the nature, manifestations, causes, effects and social meanings of particular illnesses.
- It may help to reconcile conflicting expectations concerning appropriate behaviour for doctors and patients.

Promoting cultural competence or diversity sensitivity at the level of both organisations and individuals is seen as a central component of the changes which have to be made in order to adapt services to users with widely varying beliefs, expectations, needs and social positions. It is also

<sup>372</sup> Cattacin, S., Chiarenza, A. and Domenig, D. (2013). "Equity Standards for Health Care Organisations: a Theoretical Framework." *Diversity and Equality in Health and Care* 10(4): 249-258.

<sup>373</sup> Chiarenza, A. (2012). Developments in the concept of 'cultural competence'. In: D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity, Volume II* (pp. 66-81). Antwerp/Apeldoorn: Garant.

<sup>374</sup> Renschler, I., Cattacin, S. (2007). Comprehensive 'difference sensitivity' in health systems. In: Bjornsgren-Cuadra, C, Cattacin, S. (eds). *Migration and Health: difference sensitivity from an organizational perspective*. Malmö: IMER: 37-41 (<http://hdl.handle.net/2043/4289>, accessed 28/7/14).

<sup>375</sup> <https://www.thinkculturalhealth.hhs.gov/>

<sup>376</sup> Malmusi D, Borrell C, Benach J. (2010). Migration-related health inequalities: showing the complex interactions between gender, social class and place of origin. *Social Science and Medicine* 71, 1610-9.

<sup>377</sup> Iyer, A., Sen, G., Ostlin, P. (2008). The intersections of gender and class in health status and health care. *Global Public Health*, 3(S1):13-24.

important for targeting health promotion interventions for migrants, so as to take into account the different ways in which people perceive and experience health problems.<sup>378</sup>

### 5.2.2. Language barriers

Miscommunication due to language barriers is a common and costly problem affecting the accessibility and quality of health services for migrants and ethnic minorities. Research from the US has shown that billions of dollars are lost annually due to communication problems often arising from language differences, leading to faulty diagnoses, lack of compliance with therapies, lower patient safety and lower treatment satisfaction in patients and providers. According to the Institute for Healthcare Communication (IHC)<sup>379</sup>,

Research evidence indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies show that the clinician's ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. Further, communication among healthcare team members influences the quality of working relationships, job satisfaction and has a profound impact on patient safety.

Understanding what is said in health service encounters is often a challenge even when the patient and health professional share the same language. For migrants, basic fluency in the language of the host country may not be enough to effectively communicate their health problem or understand what the health professional says. In addition, in some countries, language proficiency has become a politically sensitive topic and a symbol of integration. Although learning the language of their host country is essential for integration, and some migrants may need help or encouragement to do so, language proficiency should not be a precondition for accessing and receiving adequate care.

To overcome language barriers in health services and ensure quality of care is not compromised by communication problems, a number of interventions have been successful. For **written materials**, for example, the following methods can be used:

- Translation of written materials such as forms, information brochures, health promotion or educational materials.
- Introduction of pictures and diagrams, or informative videos to facilitate understanding, and provide alternatives to written materials in case of illiteracy.

However, it is unreasonable to expect that health care providers will provide translated materials in every language that is spoken in the area they serve. In areas with large MEM populations, the number of languages spoken is simply too high. Health care providers should then prioritise translation of

<sup>378</sup> Netto, G. *et al* (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*.

<sup>379</sup> IHC (2011). *Impact of Communication in Healthcare*. Available at <http://bit.ly/1o6nHGj>

written materials for the largest language groups, and find alternative means of meeting the communication needs of patients belonging to smaller language groups.

Concerning **interactions** in health care, a variety of methods have been proposed for overcoming language barriers.<sup>380</sup>

**Professional face-to-face interpretation** is considered most accurate, but requires setting aside resources, and planning in advance, which is not always possible in emergency situations, leading to possible delays. To ensure the effectiveness face-to-face interpretation, health professionals should receive training in how to use interpreters. It should be noted that in some instances, using an interpreter from the same community as the patient, may inhibit open communication for confidentiality reasons.

**Professional interpretation by telephone** can be the solution for situations where logistical planning is not possible, for example when ambulance personnel need interpretation. Despite the challenges of not being able to read non-verbal communication, costs can be reduced considerably by not having an interpreter physically present.

**Informal face-to-face interpretation** is perhaps the most widely-used method, but most controversial, as the reliance on family members is fraught with problems stemming from confidentiality issues, the appropriateness of using children as interpreters. Sometimes, a member of staff in the healthcare setting is called upon to act as an interpreter. Given the lack of training and skills of informal interpreters, relying on them can lead to serious misunderstandings with dire consequences.

**Bilingual professionals** with a command of the migrant or minority patient's language present many advantages over the above-mentioned methods. However, their proficiency in the migrant's language needs to be quite high, and the range of languages catered for can only be slightly increased by this method. Here again, if one is dealing with large minority groups such as Spanish-speakers in the United States or Russian-speakers in Latvia or Estonia, this may not be a serious drawback.

**'Cultural mediators'** are health workers who not only provide linguistic interpretation, but mediate actively between health professionals and service users. They are concerned with overcoming not only language barriers, but also cultural and social ones. The minorities concerned must be fairly large, but this method has many advantages and the role of "cultural mediators" may be varied and extensive, involving trying to help caregivers and users understand each other's point of view and offering advice on ways to solve problems. Some may even operate independently of medical professionals and function as a kind of "gatekeeper". European countries where cultural mediation seems to be a favoured approach include Belgium, France, Ireland, Italy, the Netherlands, Spain and the United Kingdom. Many Roma speak only Romani, and in countries with high numbers of Roma, cultural mediation initiatives have been quite successful in helping to bridge the language gap..

---

<sup>380</sup> Ingleby, D. (2011). Good practice in health service provision for migrants. In: Rechel, B. et al (eds). *Migration and Health in the European Union*. European Observatory on Health Systems and Policies Series. Maidenhead: Open University Press.

We should note that even if the health worker understands the need for an interpreter, it is necessary for the management of the organisation they work in to solve the logistic problems of arranging one and paying the bill. To be efficient, in fact, interpretation facilities may have to be organised at national level, so the issue becomes one that cannot be solved at the level of local managements. Moreover, health workers need training in order to be able to work effectively with interpreters, and this training has to be organised as well.

In spite of numerous demonstrations of the need for and usefulness of interpreters, not enough use is made of them<sup>381</sup>. This reluctance may have a number of causes. People often have the illusion of understanding each other when in fact they do not; the importance of good communication may not be appreciated; the practical problems of organising an interpreter may be regarded as outweighing the advantages. A major problem is cost. Where no assistance is available from government or health insurers, service provider organisations may decide to save money by restricting the use of interpreters.

Legal measures and professional standards, where they exist, do not seem to be enough to overcome all the factors that discourage the use of interpreters. More effective arguments may be provided by the financial considerations mentioned earlier. A growing body of literature in the USA, matched by an increasing number of studies in Europe, have shown that a small investment in the costs of interpretation may pay itself back many times by making health care more cost-effective.

Ongoing projects, such as **Equi-Health** and its sub-project “*Cost analysis of health care provision to migrants and ethnic minorities*” conducted by the Centre for Health and Migration and the International Organisation for Migration (IOM), are in the process of conducting cost analysis studies to establish a consensus on “acceptable standards of health care provision.” Identifying the cost of not providing adequate interpreter services may provide the much needed economic stimulus to mainstreaming these kinds of services.

### 5.2.3. Barriers between the health system and migrant or ethnic minority communities

As we noted when discussing problems of access in Chapter 4, barriers may exist not simply at the individual level, but also at the level of health services and communities. In section 4.2.4 it was noted that the involvement of migrant and ethnic minority groups in the design and delivery of services seems to be a key tool for improving both access and quality.

Increasingly, a high value is coming to be placed on ‘user participation’ in health services<sup>382</sup>. There is a drive to make the relationship between health services and their users one of partnership. In order to improve policies and increase their acceptance and effectiveness, users must become more than passive consumers of care: they should take active responsibility for their own health,

<sup>381</sup> Meeuwesen, L., *et al* (2012). Interpreting in health and social care: policies and interventions in five European countries. In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 158–70). Antwerp-Apeldoorn, Belgium: Garant Publishers.

<sup>382</sup> WHO (2006). *Ninth futures forum on health systems governance and public participation*, Copenhagen: WHO Regional Office for Europe.



and when they become ill they should contribute actively to their treatment. In addition, they should come to think of themselves as ‘owners’ of the health system itself. To further this change, ‘participatory spaces’ (representative bodies, etc.) have been created to allow service users to contribute to designing and running services.

However, migrants and ethnic minorities are usually poorly represented in these ‘participatory spaces’. They are often reluctant to join in, and when they do their voice tends to be ignored or ineffective.<sup>383</sup> The lack of involvement from migrant and ethnic minority communities seems to be the Achilles heel of many efforts to improve health and health service delivery for these groups. In Chapter 4 we described several EU-supported projects which set out to tackle this problem. However, such efforts are few and far between: as a rule, research is carried out ‘on’ minority communities instead of ‘with’ them, and interventions are designed and implemented from above.

It is notable that in some major documents outlining a ‘road map’ for improving migrant health (see Chapter 3), the issue of user participation or community involvement has not even been mentioned. Resolution WHA61.17 (2008) seems to envisage a purely ‘top-down’ approach to the health of migrants, although the topic of participation did receive some attention at the WHO/IOM Global Consultation in 2010. In relation to interventions for Roma, however, attention is paid much more consistently to user involvement. A recent statement by the European Commission<sup>384</sup> spoke of measures

to promote the empowerment, active involvement and necessary participation of Roma themselves, at all levels of policy development, decision-making and implementation of measures, including by raising awareness of their rights and duties, as well as to consolidate the capacity of Roma NGOs and encourage the better involvement of civil society and all other stakeholders.

Nevertheless, to judge from the assessments that are emerging of projects to further Roma inclusion, this commitment to community participation appears easier to make on paper than to realise in practice. This is not difficult to understand, given that one is dealing with a group with a long history of segregation and exclusion. However, it is essential that for projects to be successful, they should be ‘owned’ by the community they are meant to benefit. Health workers dealing with migrants and ethnic minorities need to learn about the approaches that exist to empower communities and encourage participation, for example in the traditions of Community Psychology and Community-Based Participatory Research<sup>385</sup>.

<sup>383</sup> De Freitas, (2011).

<sup>384</sup> European Commission, (2011). *Council conclusions on an EU Framework for National Roma Integration Strategies up to 2020*. Brussels: European Commission.

<sup>385</sup> Faridi, Z. (2007) Community-based participatory research: necessary next steps. *Preventing Chronic Disease*, 4(3). Available at [http://www.cdc.gov/pcd/issues/2007/jul/06\\_0182.htm](http://www.cdc.gov/pcd/issues/2007/jul/06_0182.htm)

## **Case Study: The Aurora project – Good practices for involving key stakeholders in the planning and development of a cervical cancer prevention and control programme.<sup>386</sup>**

As part of its aim of promoting cervical cancer screening in the new EU Member States, the project identified and analysed good practices and strategies for developing and implementing cervical cancer prevention and control programmes. To summarise the good practices, a framework has been built for the development of a complete programme, including the following key areas of action: 1) policy, 2) planning the programme, 3) preparing to launch the programme, and 4) Implementation. The first three areas of action include very detailed guidelines for how to involve key stakeholders. A summary of these guidelines is provided below:

- 1) Policy: Engage high-level stakeholders
  - a. Involving public scientific committees and societies may bring credibility to the message
  - b. To increase public interest and media coverage, enlist the commitment of a celebrity
  - c. Invest time in acquiring the support for nation, regional and local authorities.
  - d. Involving another national government (e.g. US Agency for International Development) as a supporter might aid the implementation of the objectives of an intervention.
- 2) Planning the programme: Engage local stakeholders
  - a. Involving health care professionals and/or mediators from the start and regularly seeking their input throughout the project, will promote the participation of hard-to-reach (HTR) populations and thus may contribute to positive project outcomes.
  - b. Increase engagement through direct incentives, e.g. rewarding participants.
  - c. Non-profit organisations may play an especially important role helping to reach HTR populations.
  - d. Volunteers can play a key role in awareness raising through low budget, community events.
  - e. Involving previously inactive new stakeholders, such as GPs, nurses, teachers, etc., as they may remain engaged and committed to further interventions.
- 3) Preparing the launch of the programme: Provide orientation for community, stakeholders and staff, and ensure their training and availability.
  - a. Create a well-defined and recognisable identity for your programme, e.g. a logo that is featured at events and on information materials associated with the programme.

<sup>386</sup> Ilardi, M., Kovacs, Z. (2009). A European Network on cervical cancer surveillance and control in the new Member States. D4 – Report about the good practices identified and analyzed. Consumers, Health, and Food Executive Agency. [www.aurora-project.edu](http://www.aurora-project.edu) (accessed on 2 January, 2015).

## **Chapter 6. Developing a European framework for collaboration on migrant and ethnic minority health**

The MEM-TP project will provide information and inspiration for shaping, running and evaluating training programmes for health professionals and other key actors in order to equip them with the necessary knowledge and skills to meet the health needs of migrants and ethnic minorities in Europe.

To promote the sustainability and continual development of the training packages, the actors involved in the training aspect of MEM-TP could initiate a European level collaboration, based on sound, interprofessional collaboration theories.

Research in the field of interprofessional collaboration suggests that theories applying to health care settings have in common several concepts underpinning the processes that characterize different forms of collaboration.<sup>387</sup> These concepts are 'sharing', 'partnership', 'interdependency', and 'power'. Sharing refers to a range of processes, from information and decision-making sharing, to shared responsibilities and philosophy. Partnership as a central notion of collaboration implies the coming together of two or more partners in a 'collaborative undertaking' characterized by an authentic and constructive relationship, requiring honest and open communication, mutual trust and respect. Interdependency refers to the concept of actors depending on each other in their common goal of addressing health care users' needs. Power, as a concept in collaborative relationships, implies the empowerment of each partner, based on the experience and knowledge that is created and shared

The training programs will mainly take place in national, regional and local settings according to the national traditions and procedures for postgraduate training. In order to support these activities, it will be relevant to establish a sharing platform including information and up-dated learning material as indicated in figure 13. The sharing platform would also include and make extensive use of assessment and evaluation tools such as the C2ME assessment tool and the MIPEX indicators tool, as well as potential training materials from, for example, the 'Big Picture' project and Mighealth net.

A sustainable platform requires some kind of organizational set-up, characterised by partnership working, in a suitable European migrant health research institution (university, research centre) or a larger organization focusing on migrant health, in collaboration with a relevant EU-agency and possibly the WHO office for the European Region. Additionally, it would be relevant to offer regular European courses on specific aspects of migrant and ethnic minority health targeting national and local trainers and key nation experts. This could be offered by national institutions/universities and perhaps coordinated by an international public health organization like ASPHER (Association of Schools of Public Health in the European Region) or EUPHA (the European Public Health Association, Section of Migrant and Ethnic Minority Health) - in collaboration with other organisations such as

---

<sup>387</sup> D'Amour, D. *et al* (2005) The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal for Interprofessional Care*, May, Supplement 1: 116-131.

EPHA and IOM. During the remaining MEM-TP project the possibilities for involving such institutions/organizations in a European framework will be further examined.

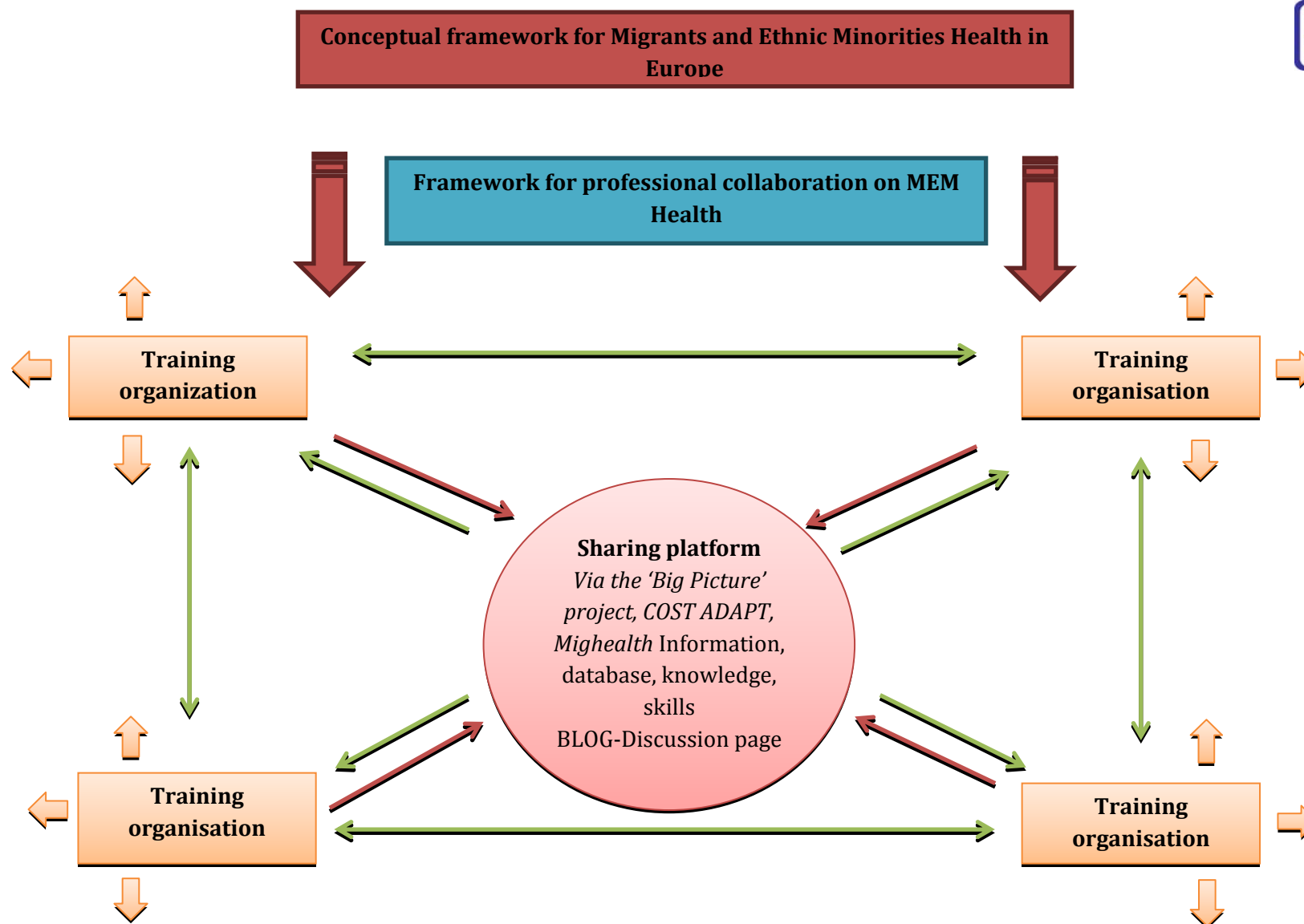


Figure 13 Conceptual framework for MEM health in Europe

# Appendix I WP1 MEM-TP

## Migrants and ethnic minorities: Demographic data

Clara Mock-Muñoz de Luna, Adele Bodewes,  
Emma Graval & David Ingleby

13 October 2014



Co-funded by  
the Health Programme  
of the European Union





## **Table of contents**

<i>1. Overview of migrant population in the EU</i>	<i>2</i>
<i>2. Overview of the Roma population in the EU</i>	<i>6</i>

## **List of tables**

<i>Table 1 Foreign-born population in 2013</i>	<i>2</i>
<i>Table 2 Countries of origin of Non-EU nationals and asylum seekers (2013)</i>	<i>4</i>
<i>Table 3 Number of Roma in Europe 2010 - data from the Council of Europe, Roma and Travellers division</i>	<i>6</i>
<i>Table 4 Summary table Roma population by EU Member State</i>	<i>9</i>
<i>Table 5 Roma in Europe, by age (minors: age 15 and under; adult: age 16 and above)*</i>	<i>10</i>

# 1. Overview of migrant population in the EU

Table 1 Foreign-born population in 2013

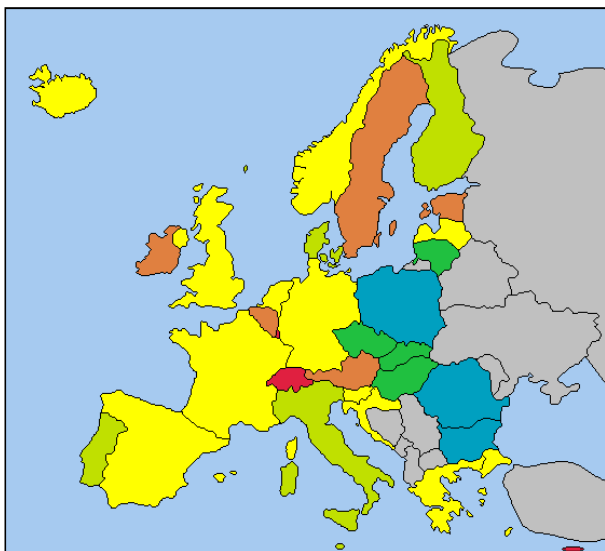
Country	Total population	Foreign-born*					
		Total	%	Born in (other) EU states	%	Born in a non-EU country	%
<b>European Union (27)</b>	<b>502.899.726</b>	<b>50.872.674</b>	<b>10,1</b>	<b>17.334.807</b>	<b>3,4</b>	<b>33.537.867</b>	<b>6,7</b>
Belgium	11.161.642	1.747.641	15,7	820.088	7,3	927.553	8,3
Bulgaria	7.284.552	96.113	1,3	36.558	0,5	59.555	0,8
Czech Republic	10.516.125	387.337	3,7	145.991	1,4	241.346	2,3
Denmark	5.602.628	548.411	9,8	180.073	3,2	368.338	6,6
Germany	82.020.578	10.201.192	12,4	3.635.265	4,4	6.565.927	8,0
Estonia	1.320.174	198.411	15,0	13.238	1,0	185.173	14,0
Ireland	4.591.087	736.375	16,0	484.715	10,6	251.660	5,5
Greece	11.062.508	1.235.426	11,2	314.527	2,8	920.899	8,3
Spain	46.727.890	6.174.740	13,2	2.099.090	4,5	4.075.650	8,7
France	65.578.819	7.537.795	11,5	2.103.920	3,2	5.433.875	8,3
Italy	59.685.227	5.695.883	9,5	1.814.154	3,0	3.881.729	6,5
Cyprus	865.878	200.842	23,2	113.848	13,1	86.994	10,0
Latvia	2.023.825	279.227	13,8	27.681	1,4	251.546	12,4
Lithuania	2.971.905	140.221	4,7	15.842	0,5	124.379	4,2
Luxembourg	537.039	227.461	42,4	173.361	32,3	54.100	10,1
Hungary	9.908.798	423.317	4,3	284.174	2,9	139.143	1,4
Malta	421.364	37.705	8,9	18.399	4,4	19.306	4,6
Netherlands	16.779.575	1.927.728	11,5	490.043	2,9	1.437.685	8,6
Austria	8.451.149	1.362.185	16,1	573.228	6,8	788.957	9,3
Poland	38.533.299	678.946	1,8	267.006	0,7	411.940	1,1
Portugal	10.487.289	881.440	8,4	221.423	2,1	660.017	6,3
Romania	20.020.074	182.939	0,9	73.157	0,4	109.782	0,5
Slovenia	2.058.821	232.703	11,3	21.226	1,0	211.477	10,3
Slovakia	5.410.836	158.164	2,9	132.705	2,5	25.459	0,5
Finland	5.426.674	279.743	5,2	101.592	1,9	178.151	3,3
Sweden	9.555.893	1.472.353	15,4	495.803	5,2	976.550	10,2
United Kingdom	63.896.077	7.828.376	12,3	2.677.700	4,2	5.150.676	8,1
Croatia	4.262.140	574.383	13,5	70.530	1,7	503.853	11,8
Iceland	321.857	35.319	11,0	22.686	7,0	12.633	3,9
Liechtenstein	36.838	23.109	62,7	7.794	21,2	15.315	41,6
Norway	5.049.223	662.526	13,1	292.640	5,8	369.886	7,3
Switzerland	8.039.060	2.102.964	26,2	1.257.194	15,6	845.770	10,5

Source: Eurostat [migr\_pop3ctb]

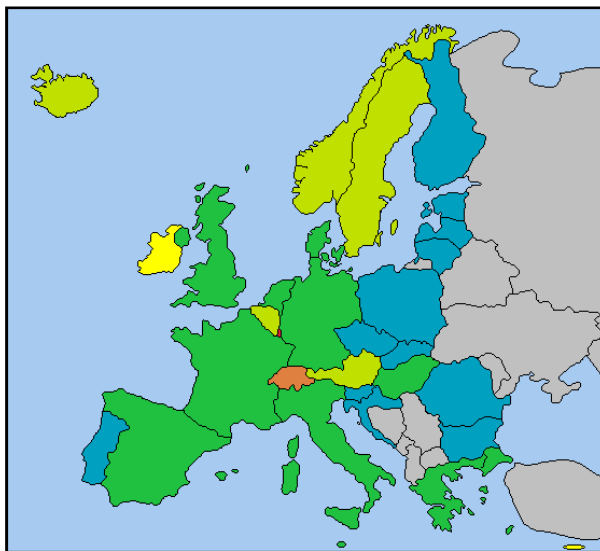
\* Total number of persons born abroad, usually resident in the reporting country on 1 January.

## Maps showing percentage of migrants in EU27 + Croatia in 2013

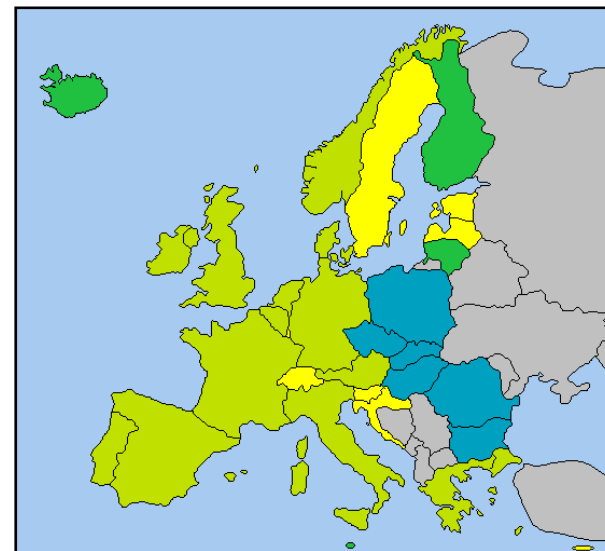
Total foreign-born residents



Born in (other) EU countries



Born in a non-EU country



**Key to colours:** Blue < 2.5%, dark green 2.5 < 5%, light green 5 < 10%, yellow 10 < 15%, orange 15-20%, red > 20%

Source: Based on data from

Table 2 Countries of origin of Non-EU nationals and asylum seekers (2013)

Country	Non-EU nationals (TCN) 2013			Asylum and new asylum applicants 2013****	
	Total non-EU nationals (N)	% of the country's population	Countries of origin of non-EU nationals (by year) ##	Total (N)	Country of origin of asylum seekers (by year)
EU 27	20 389 558	4.0	1 983 240 Turkey 1 384 935 Morocco 724 428 China 650 710 India 634 851 Ukraine 589 634 Russia 464 149 Albania 408 491 Serbia 407 133 Pakistan 406 266 United States	434 305	
Austria	581 102	6.89	Serbia, Bosnia-Herzegovina, United States, Africa, Asia (2011)	17 520	Afghanistan, Russia, Pakistan, Syria, Iran (2012)
Belgium	446 531	4.01	Morocco, Turkey, Russia, China (2013)	21 215	Afghanistan, Guinea (2011)
Bulgaria	32 623	0.46	-	7 145	-
Croatia	18 351	0.45	Bosnia and Herzegovina, Serbia, Macedonia and Kosovo (2011)	1080	-
Cyprus	57 091	6.64	-	1 255	-
Czech Republic	260 986	2.49	Russia, Ukraine, United States, Serbia, Vietnam, Kazakhstan (2011)	710	Ukraine, Belarus, Russia, Vietnam (2011)
Denmark	228 363	4.61	Turkey, Philippines (2010)	7230	Syria, Somalia (2012)
Estonia	189 623	14.35	Russia, Ukraine, China, United States (2009)	95	-
Finland	118 259	2.17	Russia, Ukraine, Somali, Thailand, India, Afghanistan, Vietnam (2011)	3 220	Iraq (2012)
France	2 683 266	4.09	Algeria, Morocco, Tunisia, China, Turkey, Africa (2011)	66 265	Bangladesh, Congo, Armenia, Sri Lanka, Russia (2011)

Germany	4 673 287	5.70	Turkey, United States, China, Russia (2011)	126 995	-
Greece	658 583	5.96	Albania, Russia, Egypt, Ukraine, India, Georgia, Philippines (2011)	8 225	-
Hungary	61 169	0.62	Ukraine, United States, China, Serbia, Turkey, Russia (2011)	18 900	Afghanistan, Kosovo, Magreb countries (2011)
Ireland	165 155	3.58	-	920	Nigeria, Pakistan, China(2012)
Italy	3 101 252	5.19	Ukraine, Morocco, Moldova, China, Albania, India, Peru, Pakistan, Philippines (2010)	26 620	Tunisia, Libya (2011)
Latvia	309 921	15.31	Russia, Ukraine (2010)	195	-
Luxembourg	18 351	0.64	Serbia (2011)	1070	Serbia, Yugoslavia, Macedonia, Kosovo, Montenegro (2011)
Lithuania	32 623	6.09	Russia, Belarus, Ukraine, United States (2011)	400	-
Malta	10 195	2.28	-	2245	-
Netherlands	334 389	1.99	Morocco, Turkey, Surinam, Antilles (2013)	17 160	Syria, Somalia (2013)
Poland	40 779	0.10	Ukraine, China, Belarus, Vietnam, Russia, Turkey, Armenia, India, United States (2011)	15 245	Russia (2011)
Portugal	316 038	3.01	Brazil, Cape Verde, Guinea- Bissau, Sao Tome and Principe, China (2011)	505	-
Romania	50 974	0.26	Moldova, United States, Turkey, China, Canada, Syria (2010)	1 495	Algeria, Morocco and Afghanistan (2012)
Slovakia	16 312	0.31	Ukraine, Serbia, China, Korea, Russia, Vietnam (2011)	440	Somalia, Afghanistan, Georgia, Moldova, Russia, India (2011)
Slovenia	83 597	4.10	Bosnia and Herzegovina, Serbia, Yugoslavia, Ukraine, Russia (2011)	270	-
Spain	3 011 538	6.45	Morocco, Pakistan, China, Colombia, Dominican Republic, Brazil (2011)	4 495	-
Sweden	377 207	3.95	Iraq, China, Thailand, Iran (2011)	54 365	Somalia, Syria, Afghanistan (2012)
UK	2 507 916	3.93	India, Pakistan (2012)	30 110	Pakistan, Iran, Sri Lanka (2011)

**Sources: OECD data, non- EU foreign nationals are selected from the top 10 of foreign nationals per country.**

## 2. Overview of the Roma population in the EU

The table below shows the number of Roma by country in Europe. The numbers are mostly based on estimates, as there is no reliable and harmonized registration of Roma across Europe.

**Table 3 Number of Roma in Europe 2010 - data from the Council of Europe, Roma and Travellers division (updated: 14/09/2010)**

European countries	Total country population (July 2009)	Official number (last census)	Minimum estimate (source in footnotes)	Maximum estimate (source in footnotes)	Average estimate	% of total population (from average figure)
<i>Turkey</i>	71.892.807	4 656 (1945)	500.000	5.000.000	<b>2.750.000</b>	<b>3,83%</b>
<i>Romania</i>	22.246.862	535 140 (2002)	1.200.000	2.500.000	<b>1.850.000</b>	<b>8,32%</b>
<i>Russian Federation</i>	140.702.094	182 617 (2002)	450.000	1.200.000	<b>825.000</b>	<b>0,59%</b>
<i>Bulgaria</i>	7.262.675	370 908 (2001)	700.000	800.000	<b>750.000</b>	<b>10,33%</b>
<i>Spain</i>	46.157.822	No data available	650.000	800.000	<b>725.000</b>	<b>1,57%</b>
<i>Hungary</i>	9.930.915	190 046 (2001)	400.000	1.000.000	<b>700.000</b>	<b>7,05%</b>
<i>Serbia (excl. Kosovo)</i>	7.334.935	108 193 (2002)	400.000	800.000	<b>600.000</b>	<b>8,18%</b>
<i>Slovak Republic</i>	5.455.407	89 920 (2001)	400.000	600.000	<b>500.000</b>	<b>9,17%</b>
<i>France</i>	64.057.790	No data available	300.000	500.000	<b>400.000</b>	<b>0,62%</b>
<i>Greece</i>	10.722.816	No data available	180.000	350.000	<b>265.000</b>	<b>2,47%</b>
<i>Ukraine</i>	45.994.287	47 917 (2001)	120.000	400.000	<b>260.000</b>	<b>0,57%</b>
<i>United Kingdom</i>	60.943.912	No data available	150.000	300.000	<b>225.000</b>	<b>0,37%</b>
<i>Czech Republic</i>	10.220.911	11 718 (2001)	150.000	250.000	<b>200.000</b>	<b>1,96%</b>
<i>"The former Yugoslav Republic of Macedonia"</i>	2.061.315	53 879 (2002)	135.500	260.000	<b>197.750</b>	<b>9,59%</b>
<i>Italy</i>	59.619.290	No data available	110.000	170.000	<b>140.000</b>	<b>0,23%</b>
<i>Albania</i>	3.619.778	1261 (2001)	80.000	150.000	<b>115.000</b>	<b>3,18%</b>
<i>Moldova</i>	4.324.450	12 280 (2004)	15.000	200.000	<b>107.500</b>	<b>2,49%</b>
<i>Germany</i>	82.400.996	No data available	70.000	140.000	<b>105.000</b>	<b>0,13%</b>
<i>Portugal</i>	10.676.910	No data available	40.000	70.000	<b>55.000</b>	<b>0,52%</b>
<i>Bosnia and Herzegovina</i>	4.590.310	8 864 (1991)	40.000	60.000	<b>50.000</b>	<b>1,09%</b>
<i>Sweden</i>	9.276.509	No data available	35.000	50.000	<b>42.500</b>	<b>0,46%</b>
<i>Belarus</i>	9.685.768	No data available	10.000	70.000	<b>40.000</b>	<b>0,41%</b>



European countries	Total country population (July 2009)	Official number (last census)	Minimum estimate (source in footnotes)	Maximum estimate (source in footnotes)	Average estimate	% of total population (from average figure)
<i>The Netherlands</i>	16.645.313	No data available	32.000	48.000	<b>40.000</b>	<b>0,24%</b>
<i>"Kosovo"</i>	2.542.711	45 745 (1991)	25.000	50.000	<b>37.500</b>	<b>1,47%</b>
<i>Poland</i>	38.500.696	12 731(2002)	15.000	60.000	<b>37.500</b>	<b>0,10%</b>
<i>Ireland</i>	4.156.119	22 435 (2006)	32.000	43.000	<b>37.500</b>	<b>0,90%</b>
<i>Croatia</i>	4.491.543	9 463 (2001)	30.000	40.000	<b>35.000</b>	<b>0,78%</b>
<i>Switzerland</i>	7.581.520	No data available	25.000	35.000	<b>30.000</b>	<b>0,40%</b>
<i>Belgium</i>	10.414.336	No data available	20.000	40.000	<b>30.000</b>	<b>0,29%</b>
<i>Austria</i>	8.205.533	No data available	20.000	30.000	<b>25.000</b>	<b>0,30%</b>
<i>Montenegro</i>	678.177	2 826 (2003)	15.000	25.000	<b>20.000</b>	<b>2,95%</b>
<i>Latvia</i>	2.245.423	8 205 (2000)	13.000	16.000	<b>14.500</b>	<b>0,65%</b>
<i>Finland</i>	5.244.749	No data available	10.000	12.000	<b>11.000</b>	<b>0,21%</b>
<i>Norway</i>	4.644.457	No data available	4.500	15.700	<b>10.100</b>	<b>0,22%</b>
<i>Slovenia</i>	2.007.711	3 246 (2002)	7.000	10.000	<b>8.500</b>	<b>0,42%</b>
<i>Denmark</i>	5.484.723	No data available	1.000	10.000	<b>5.500</b>	<b>0,10%</b>
<i>Lithuania</i>	3.565.205	2 571 (2001)	2.000	4.000	<b>3.000</b>	<b>0,08%</b>
<i>Georgia</i>	4.630.841	1 744 (1989)	2.000	2.500	<b>2.250</b>	<b>0,05%</b>
<i>Azerbaijan</i>	8.177.717	No data available	2.000	2.000	<b>2.000</b>	<b>0,02%</b>
<i>Armenia</i>	2.968.586	No data available	2.000	2.000	<b>2.000</b>	<b>0,07%</b>
<i>Cyprus</i>	792.604	560 (1960)	1.000	1.500	<b>1.250</b>	<b>0,16%</b>
<i>Estonia</i>	1.307.605	584 (2009)	1.000	1.500	<b>1.250</b>	<b>0,10%</b>
<i>Luxembourg</i>	486.006	No data available	100	500	<b>300</b>	<b>0,06%</b>
<i>Andorra</i>	72.413	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>Iceland</i>	304.367	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>Liechtenstein</i>	34.498	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>Malta</i>	403.532	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>Monaco</i>	32.796	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>San Marino</i>	29.973	No data available	0	0	<b>0</b>	<b>0,00%</b>
<i>Total in Europe</i>	<b>824.827.713</b>		<b>6.395.100</b>	<b>16.118.700</b>	<b>11.256.900</b>	<b>1,36%</b>
<i>European Union area</i>			<b>4.359.100</b>	<b>7.456.500</b>	<b>5.907.800</b>	<b>1,18%</b>
<i>Council of Europe area</i>			<b>6.360.100</b>	<b>15.998.700</b>	<b>11.179.400</b>	<b>1,37%</b>

The table below gives an overview of the estimated Roma population in EU countries. The concentration of Roma is higher in Central and Eastern Europe. The country with the highest number of Roma is Romania; as a percentage of the population, Bulgaria has the highest proportion of Roma.

The countries of West and Southern Europe are also home to significant numbers of Roma (both nomadic and sedentary), though in some countries they may represent only a small percentage of the total population.

**Table 4 Summary table Roma population by EU Member State**

<b>EU Member State</b>	<b>No. of Roma</b>	<b>% of total population</b>
<b>Bulgaria</b>	750 000	10,33
<b>Slovakia</b>	500 000	9,17
<b>Romania</b>	1 850 000	8,32
<b>Hungary</b>	700 000	7,05
<b>Greece</b>	265 000	2,47
<b>Czech Republic</b>	200 000	1,96
<b>Spain</b>	725 000	1,57
<b>Ireland</b>	37 500	0,90
<b>Croatia</b>	35 000	0,78
<b>Latvia</b>	14 500	0,65
<b>France</b>	400 000	0,62
<b>Portugal</b>	55 000	0,53
<b>Sweden</b>	42 500	0,46
<b>Slovenia</b>	8 500	0,42
<b>UK</b>	225 000	0,37
<b>Austria</b>	25 000	0,30
<b>Belgium</b>	30 000	0,29
<b>The Netherlands</b>	40 000	0,24
<b>Italy</b>	140 000	0,23
<b>Finland</b>	11 000	0,21
<b>Cyprus</b>	1 250	0,16
<b>Germany</b>	105 000	0,13
<b>Denmark</b>	5 500	0,10
<b>Poland</b>	37 500	0,10
<b>Estonia</b>	1 250	0,10
<b>Lithuania</b>	3 000	0,08
<b>Luxembourg</b>	300	0,06
<b>Malta</b>	no data available	

**\*\* Source:** European Council of Europe Roma and Travellers Division, October 2010

One of the main characteristics of the Roma population in Europe is that more of half the population is under 16, as the table below illustrates (see table 4 below). However, these figures are derived at in different ways from the figures presented in the table above, and collected by the Council of Europe. (For more details on the methods used to collect the data, please consult the report from which they were extracted (title cited below the figures)).

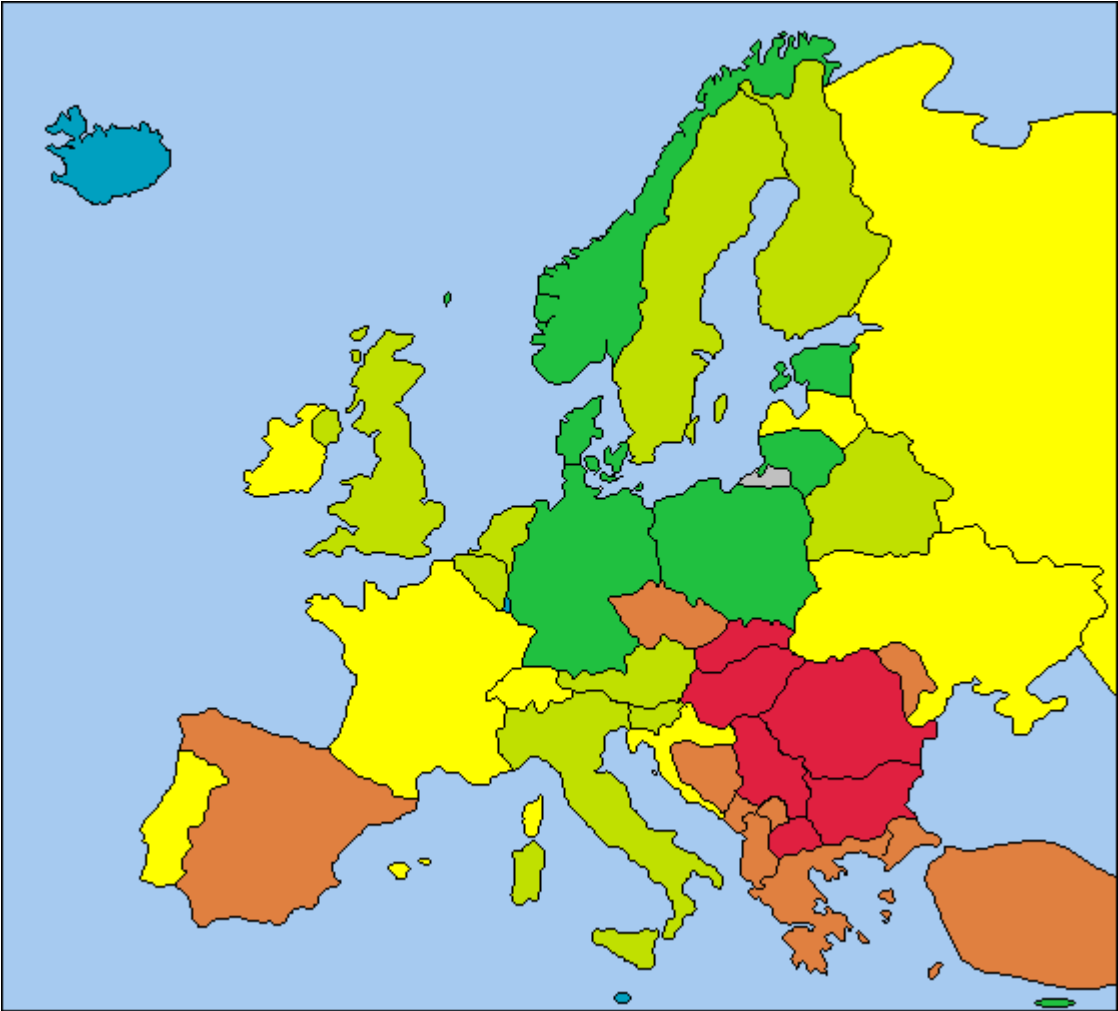
Table 5 Roma in Europe, by age (minors: age 15 and under; adult: age 16 and above)\*

	Households	Roma population	Minors	Adults
<b>Roma Europe</b>	623,589	2,795,233	1,728,086	1,067,147
<b>Greece</b>	23,105	125,000	67,937	57,063
<b>Portugal</b>	7,154	33,338	19,312	14,026
<b>Czech Republic</b>	56,235	230,000	146,227	83,773
<b>Slovakia</b>	55,846	320,000	184,669	135,331
<b>Romania</b>	248,227	1,050,000	621,358	428,642
<b>Bulgaria</b>	76,319	370,908	253,977	116,931
<b>Spain</b>	156,703	665,987	434,606	231,381

\*Source: *Health and the Roma Community: Analysis of the situation in Europe*, 2009. Pg. 13.

**Map showing density of Roma population (%) in the European area**

Based on data from the Council of Europe (2010)



**Key to colours:**

> 5%	Red
> 1%	Orange
> .5%	Yellow
> .2%	Light Green
> .1%	Dark Green
unknown	Blue

# Appendix II WP1 MEM-TP

## Migrants and ethnic minorities: Health status

Clara Mock-Muñoz de Luna, Adee Bodewes,  
Emma Graval & David Ingleby  
13 October, 2014



**Table of contents**

**Contents**

[1. Migrant and Ethnic minorities: State of health literature review](#) ..... 14

[2. Roma state of health](#)..... 18

**List of tables**

[Table 1. Overview of studies regarding health status of migrants and ethnic minorities at European and national level](#) ..... 15

Table 2. [Literature review on Roma state of health](#) ..... **Error! Bookmark not defined.**



## **1. Migrant and Ethnic minorities: State of health literature review**

**Table 1: Overview of studies regarding health status of migrants and ethnic minorities at European and national level**

	Country	Authors and year	Data source and covered year(s)	Main outcomes
<b>Mental health</b>	European overview*	Levecque et al. 2013 <sup>[43]</sup>	Survey, 2006-2007	<ul style="list-style-type: none"> <li>- First generation EU and non-EU migrants experience higher levels of depression.</li> <li>- Second-generation migrants and natives show similar risk profiles.</li> </ul>
	The Netherlands	Driessen 2011 <sup>[44]</sup>	Survey data	<ul style="list-style-type: none"> <li>- Turkish and Moroccan elderly found to suffer more from depression.</li> <li>- Poor mental health of Turkish and Moroccan descent.</li> </ul>
	Spain	Jurado et al. 2013 <sup>[45]</sup>	Survey, 2009-2011	- Common mental disorders higher among female migrants, with odds of 3.6 and 2.9 respectively, for Latin Americans and for Moroccan and other African women.
	Austria	Kerkenaar et al. 2013 <sup>[2]</sup>	Survey, 2011-2011	- Female migrants from Eastern Europe, first and second generation, had a higher prevalence of dysphoric disorders
	Germany	Tselmin et al. 2007 <sup>[46]</sup>	Literature review	- The Jewish refugees demonstrated the highest rates of depression and anxiety and the highest levels of awakening cortisol
	Belgium	Levecque et al. 2007 <sup>[47]</sup>	Survey, 2001	- Depression and generalised anxiety are more prevalent in the population originating from Turkey and Morocco
<b>Tuberculosis</b>	European overview	ECDC, 2014 <sup>[48]</sup>	Surveillance data and literature review	<p>In 2011:</p> <ul style="list-style-type: none"> <li>- More than 70% of the TB cases in migrants were reported in countries such as Cyprus, Iceland, The Netherlands, Norway, Sweden and the UK.</li> <li>- TB diagnosis rates are higher in foreign-born than native born populations</li> <li>- Migrant TB cases are mainly found to originate from Asia, Africa and other parts of the European regions.</li> </ul>
	The Netherlands	Slump et al. 2012 <sup>[49]</sup>	Surveillance data	<p>In 2012:</p> <ul style="list-style-type: none"> <li>- 73% of the TB patients were born abroad. TB is found mainly among Somali, with an incidence rate of 500 times higher compared to the Dutch population.</li> </ul>
	UK	ECDC, 2014 <sup>[48]</sup>	Surveillance data and literature review	<p>In 2010:</p> <ul style="list-style-type: none"> <li>- 57% of the foreign-born TB cases came from southern Asia</li> <li>- 27% of the foreign born TB cases came from sub-Saharan Africa</li> </ul>

<b>HIV</b>	European overview	ECDC, 2014 <sup>[48]</sup>	Surveillance data and literature review	Between 2007-2011: - Migrants represent 39% of the reported HIV cases. - Increase observed among migrants from Latin America, central and Eastern Europe, decrease among sub-Saharan Africa migrants. - 92% of HIV cases in migrants were reported by countries in western Europe.
	UK	ECDC, 2014 <sup>[48]</sup>  Wagner et al. 2011 <sup>[50]</sup>	Surveillance data and literature review  Surveillance and survey data	- Between 2004 and 2006 reported HIV cases involved sub-Saharan African migrants.  - In 2010: 60% of the newly diagnosed cases of HIV incidence were born abroad.
<b>Diabetes</b>	European overview**	Vandenheede et al. 2012 <sup>[51]</sup>	Mortality data	- Higher diabetes mortality in migrant populations compared to local-born populations. Mortality rate ratios (MRRs) were highest in migrants originating from either the Caribbean or South Asia.
	The Netherlands	Rechel et al. 2011 <sup>[52]</sup> Goossen et al. 2014	Literature and registry data Registry data	- More diabetes among Turkish, Moroccan, Surinamese and Antilleans. - Higher risk of diabetes among asylum seekers
	Denmark	Kristensen et al. 2007 <sup>[53]</sup>	Registry data	- Lebanese and Turkish immigrants had a much higher prevalence of Type 2 diabetes and worse glycaemic regulation.
<b>Cancer</b>	The Netherlands	Rechel et al. 2011 <sup>[52]</sup>	Literature and registry data	- 20-40% lower cancer incidence rates for non-western migrants. - Cancer mortality 53% lower among Moroccans, 15% lower among Surinamese. - 50% lower lung cancer mortality among migrant men and 80% lower among migrant women.
	Germany	Rechel et al. 2011 <sup>[52]</sup> Ott et al. 2008 <sup>[54]</sup>	Literature and registry data Registry data	- 60% lower skin cancer incidence among Turkish migrants. - Elevated mortality from viral hepatitis and from stomach and liver cancer among migrants of the Former Soviet Union
<b>Cardiovascular disease</b>	The Netherlands	Rechel et al. 2011 <sup>[52]</sup>	Literature and registry data	- Mortality rates from cardiovascular diseases are 13% higher among Surinamese and 50% lower among Moroccan males. - High stroke mortality among Surinamese and Antilleans.
	France	Ujcic-Voortman et al. 2012 <sup>[55]</sup>	Literature data	- CVD mortality lower among Moroccan men.

	UK	Rechel et al. 2011 <sup>[52]</sup>	Literature and registry data	- Stroke mortality 200% higher among west African males, 100% higher among Caribbean migrants.
	Spain	Rechel et al. 2011 <sup>[52]</sup>	Literature and registry data	- Lower mortality rates from cardiovascular diseases among migrants from northern Africa and South America. - Higher rates among migrants from Asia, Caribbean and sub-Saharan Africa.
	Sweden	Rechel et al. 2011 <sup>[52]</sup>	Literature and registry data	- Myocardial infarction 50% higher among Turkish and South Asian men, 20-30% lower among north African and southeast Asian men.
<b>Obesity</b>	The Netherlands	Dijkshoorn et al. 2013 <sup>[56]</sup>	Survey data	- Overweight (including obesity) was more prevalent in most 2nd generation migrant subgroups (Surinamese, Turkish, Moroccans), except for Moroccan men. - Obesity rates among second-generation migrant men were similar to those among the Dutch. - Second-generation migrant women were more often obese.
<b>Maternal Health</b>	France, Germany, Netherlands, Spain, Switzerland, U.K.	Pedersen G et al 2013	Meta-analysis	- Migrant women in Western European countries have a higher risk of maternal mortality. - Double risk of dying during or after pregnancy. - Migrant have a higher risk of dying from direct as opposed to indirect causes.
	Austria, Belgium, Denmark, France, Germany, Italy, Netherlands, Norway, Spain, Sweden, Switzerland, U.K.	Bollini P et al 2009	Literature review	- As compared to native women, immigrant women showed a clear disadvantage for all the outcomes considered: 43% higher risk of low birth weight, 24% of pre-term delivery, 50% of perinatal mortality, and 61% of congenital malformations.
<p>*Depression comparison of 20 European countries: Sweden, Portugal, Belgium, the Netherlands, UK, Finland, Norway, Spain, France, Germany, Switzerland, Ireland, Estonia, Hungary, Slovenia, Denmark, Austria, Poland, Slovakia and Cyprus.</p> <p>**Diabetes: Belgium, Denmark, England, France, Netherlands, Scotland and Spain.</p>				

## **2. Roma state of health**

Similarly to migrants, some ethnic minorities, especially the Roma population, experience poorer health status compared to the general population in Europe. The differences in disease prevalence among Roma and non-Roma have been linked to a variety of factors (as is demonstrated in Chapter 2 and 4) such as socioeconomic factors, lifestyle-related factors such as exposure to tobacco, alcohol, poor living conditions, as well as various obstacles to accessing appropriate health care services. Discrimination also impacts on the health outcomes of the Roma.

The literature review in the following table presents the main findings regarding the state of health of Roma, and the principal differences observed when compared to the general population (non-Roma). The approach chosen in the review is not systematic but thematic in order to give an overview of the topic.

Research focus	Countries	Authors	Years covered	Methods	Main results
<b>Socio-economic determinants of health</b>	Bulgaria, Hungary, Romania	Masseria, C., Mladowsky, P., Hernández-Quevedo, C. 2010	2004	Non-linear models were estimated for three different health indicators: self-reported health compared to previous year; probability for reporting chronic disease; feeling threatened by illness because of sanitary and hygienic circumstances. Ethnic origin was self-reported. Data set from UNDP household survey on Roma.	<b>Roma significantly more likely to report worse health in any indicator than non-Roma everywhere.</b> Socio-economic factors to a lesser degree impacted on reporting of chronic conditions. Being Roma was main determinant for feeling threatened by illness in Hungary and Romania only.
	Hungary	Vokó, Z. et al. 2009	2003-2004	Comparative health interview surveys on representative samples of the Hungarian population and inhabitants of Roma settlements. Logistic regression models applied to study whether the relationship between Roma ethnicity and health is fully mediated by socioeconomic status and whether Roma ethnicity modifies the association between socioeconomic status and health.	<b>Socioeconomic status is a strong determinant of health of people living in Roma settlements in Hungary.</b> It fully explains their worse health status, but only partially determines less healthy behaviors such as smoking.
<b>Health inequalities</b>	Europe	Parekh, N., Rose, T. 2011	2000-2010	N.A.	<b>Large gap exists in all indicators of socio-economic development and health between Roma and non-Roma</b> Targeted interventions are needed Need for more detailed research on causes of inequalities
	Scotland	Smart, H., Titterton, M., Clark, C. 2003		Systematic literature review	Existing research was found to be out-of-date Few empirical studies of health of Gypsy/Traveller population in Scotland. Focus on health beliefs and culture, rather than on material problems of poverty and social exclusion.
	Slovakia	Kolarcik, P. et al. 2010	2007	Cross-sectional study among Roma from separated and segregated settlements in Eastern	<b>Roma girls had lower rates of smoking, drinking and drug use than non-Roma girls, but higher rates of physical inactivity.</b> For Roma boys, drug use is less

				Slovakia, and non-Roma adolescents. Effect of ethnicity and parental education on smoking, drinking, drug use and physical activity was analysed separately for boys and girls using logistic regression and adjusted for social desirability.	prevalent, but differences for other health endangering activities were insignificant. Effects of parental education and social desirability were small.
Roma women	Carrasco-Garrido, P. et al. 2010	2006	Cross-sectional, epidemiological study from the 2006 Spanish National Health Survey and first National health Survey in Roma population	<b>Roma women more likely to suffer from obesity, depression and migraine.</b> Significantly higher values for alcohol consumption than non-Roma women. <b>Significantly lower rates of .smear test and mammography</b>	
Pediatric health	Pelzer Moukagni, M. et al. 2010	2004	Comparison of a gypsy population with a sedentary control group with a relatively low socio-economic level. Study based on oral investigation and health records for each child.	For gypsy children (GC), pregnancy care lacking. GC more often referred to neonatology unit at birth. GC smaller at birth, and remain smaller until 6 years old. Breastfed more, and hospitalised more often for ORL and gastrointestinal infections.	
	Rambousková, J. et al. 2009	2000-2002	Maternal interviews and food frequency questionnaire, maternal blood samples, physical measurements of mothers and infants	Pregnancy duration 1 week shorter for Roma women. <b>Lower birth weight and shorter length for Roma infants.</b> <b>Higher smoking prevalence among Roma mothers.</b> Less frequent use of food supplements, and lower blood concentrations of folate in Roma mothers.	
Cardiovascular health	Zeljko, H.M., et al. 2013	2005-2006	Dataset collected during multidisciplinary anthropological and epidemiological community-based investigation of Roma adults. Comparable data from two large population based surveys were used for comparison with the general Croatian population. Prevalence of hypertension and BMI was measured within four separate age	<b>Compared to the general population, Roma bear a high cardiovascular disease (CVD) risk factors load related to smoking and high glucose level, with important sex and age patterns.</b> Roma women show higher CVD risks, and 18-34 year-olds higher BMI. In the oldest age group (65+), there is a lower prevalence of all, bar one, of the	



			groups.	investigated CVD factors.
	Dobranici, M., Buzea, A., Popescu, R. 2012	2000-2011	Search of published literature on cardiovascular risk factors in Roma people, using PubMed, from January 2000-July 2011.	Based on the literature concerning classical risk factors for CVD, <b>Roma experience a higher prevalence of CVD risk factors than non-Roma, and consequently a higher cardiovascular morbidity rate.</b>
	Skodova, Z. et al. 2010	2004-2007	Roma and non-Roma from low and high socioeconomic status (SES) were included. GHQ-28 used to measure psychosocial well-being, Maastricht interview for vital exhaustion, type D questionnaire, and Cook-Medley scale for personality, and SF-36 for health-related quality of life (HRQL). ANOVA and linear regression used.	Roma scored poorly compared to non-Roma in psychosocial well-being, vital exhaustion and HRQL. Differences could to a substantial extent be explained by SES.
<b>Communicable diseases</b>	Casals, M. et al. 2011	1985 -2008	Incidence of several health problems were assessed by means of retrospective cohort study. 380 individuals included in a 1985 TB outbreak where followed until 2008, with questionnaires. Cox proportional hazards mixed models were employed in the multivariate survival analysis.	High incidence of AIDS, TB, Intravenous drug use, imprisonment and poor survival rates observed among Roma. Family found to be an important factor influencing survival rates.
	Amirkhanian, Y.A. et al. 2013	2007-2010	Social networks were identified through ethnographic observation and identification of initial 'seed' in Roma neighborhood setting. Participants were interviewed	HIV prevention interventions directed towards high-risk social networks of Roma are needed to prevent HIV infection from becoming more widely established.
<b>Measles</b>	Lim, T, et al. 2013	2009-2010	National ecological and regional individual-level data for 206 measles cases (of which 90% in Roma population) was assembled to disentangle underlying drivers of the outbreak and reasons for the medical complications that occurred. Also conducted a logistical regression analysis of date from individuals with medical complications.	Ecological socio-economic predictors were not associated with measles cases by region, despite considerable variation in number of medical complications. Mother's education, immunization status of child, and household with income decreased risk of medical complications from measles.
<b>Smoking</b>	Paulik, E. et al. 2011	2009	Cross-sectional survey conducted among Roma and non-Roma. Chi-square tests and logistical regression were applied to compare populations groups.	Prevalence of smoking is significantly higher and support for tobacco control measures significantly lower in Roma population. Targeted public health interventions taking into account lower educational levels and cultural beliefs are needed to change attitudes towards smoking.
<b>Tuberculosis</b>	Marta Schaaf, World Lung Foundation	2006	Known sources of grey literature were consulted, as well as PubMed and Google searches. Relevant conference abstracts. Interview and	Series of recommendations and guidelines for policymakers, advocates and NGOs for addressing TB among Roma and other marginalized populations.

			discussion transcripts.	
<b>Good practice in access to health care</b>	Kelly, J.A. et al. 2006	2003-2005	Field teams conducted systematic ethnographic observations in meeting places throughout one of Bulgaria's poorest Roma settlements. Networks were identified through 'indexes'. HIV risk assessments, psychosocial scales, interview to assess sexual risk, tests and treatments for STDs	Reported prevalence of unprotected intercourse fell more in the intervention group than in control group. Effects remain strong at long term follow-up.
	Flecha, A. 2013	2006-2011	Four-year longitudinal case study of a school located in a low SES area with high concentration of Roma inhabitants. Quantitative and qualitative data sets collected yearly. Study conducted using Communicative Methodology to promote egalitarian dialogue between researchers and subjects.	Intervention allowed Roma to reinforce and enrich specific strategies like improving family cohesion and strengthening their identity, and improving their health.
	Fésüs, G., Östlin, P., McKee, M., Ádány, R. 2012		Review of published literature. Review of policy documents from national and international organisations and NGOs. Series of semi-structured interviews conducted with national and international policymakers and representatives of civil society organisations.	Health policies to reduce health inequalities for Roma people should be aligned with education, economic, labour market, housing, environmental and territorial development policies and form part of comprehensive policy frameworks allowing for effective integration.

# Appendix III

## WP1 MEM-TP

---

Legal and policy frameworks relating to  
migrant and ethnic minority health in the EU

Authors: Claire Mock-Muñoz de Luna,  
Emma Graval, David Ingleby

Date : October 13, 2014



## Table of contents

1. <a href="#">Legal framework</a>	25
1.1. <a href="#">International instruments</a>	25
1.2. <a href="#">Regional instruments</a>	26
2. <a href="#">Policy initiatives</a>	28
2.1. <a href="#">International level</a>	28
2.1.1. <a href="#">World Health Organization</a>	28
2.1.2. <a href="#">International Organization for Migration</a>	30
2.2. <a href="#">Regional level</a>	31
2.3. <a href="#">Regional – EC agencies</a>	32
2.3.1. <a href="#">European Centre for Disease Control (ECDC)</a>	32
2.3.2. <a href="#">European Union Agency for Fundamental Rights (FRA)</a>	32
2.3.3. <a href="#">European Centre for Disease Prevention and Control (ECDC)</a>	34
2.3.4. <a href="#">European Agency for Safety and Health at Work</a>	34
2.3.5. <a href="#">European Foundation for the improvement of living and working conditions</a>	35
2.3.6. <a href="#">European Institute for Gender Equality (EIGE)</a>	35
2.3.7. <a href="#">European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)</a>	35
2.4. <a href="#">NGOs – Regional level</a>	36
2.4.1. <a href="#">Médecins du Monde</a>	36
2.4.2. <a href="#">PICUM</a>	36
2.4.3. <a href="#">Jesuit Refugee Service</a>	36
2.4.4. <a href="#">International Centre for Migration and Health (ICMH)</a>	37
2.4.5. <a href="#">International Centre for Migration Policy Development (ICMPD)</a>	37
2.5. <a href="#">European organisations and initiatives in the area of Roma Health</a>	38
2.5.1. <a href="#">International Organisations</a>	38
2.5.2. <a href="#">Regional organisations</a>	40

### Tables:

<i>Table I. Percentage of government-administered health expenditure from 'general government spending'</i>	26
<i>Table II. Percentage of total health expenses covered by "out-of-pocket" payments</i>	28

## 1. Legal framework

### 1.1. International instruments

A number of international and regional legal instruments exist that are relevant to the health of migrants and ethnic minorities. These human rights treaties (including the monitoring and accountability mechanisms related to them) are key tools for protecting the human right to health. A comprehensive report published by the **International Organisation for Migration** in 2013 entitled "International Migration, Health and Human Rights"<sup>1</sup> describes in detail many of the international and regional legal instruments and implementation instruments that play a crucial role in protecting and ensuring the right to health for everyone living in the EU.

We begin with International instruments relevant to the right to health, almost all of which have been signed and ratified by all EU member states.

a. **Universal Declaration of Human Rights (UDHR)**, 1948. This document, proclaimed by the United Nations General Assembly, sets out a common standard of fundamental human rights for all peoples and all nations, to be universally protected. In 1966 the UDHR was split into two different and legally binding instruments: the International Covenant of Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). The two covenants recognize a number of rights that are directly or indirectly related to the right to health (see descriptions below). All three instruments together form the International Bill of Human Rights.

b. **International Covenant of Economic, Social and Cultural Rights (ICESCR)**, 1966. Signed by 160 countries, the ICESCR explicitly articulates the right to health in international human rights law in Article 12: "the right of everyone to the enjoyment of the highest attainable standards of physical and mental health." Additional rights in the ICESCR, which are essential to the realization of the highest attainable standard of health, are the rights to food, housing, safe and healthy working conditions and education. An addition was made to the covenant in 2000<sup>2</sup> listing the specification of the characteristics required of public health and health-care facilities: availability, accessibility (including affordability), acceptability and quality. The issue of 'affordability' is important because previous instruments often spoke of rights to health care without specifying who should pay for it.

c. **International Covenant on Civil and Political Rights (ICCPR)**, 1966. Several rights stipulated in the ICCPR are essential to the realization of the right to health. These include the rights to information, privacy, freedom of movement and security of persons. These rights are applicable to all individuals within the signatories' territory and subject to their jurisdiction.

d. **International Convention on the Elimination of All forms of Racial Discrimination (ICERD)**, 1965. Signatories commit to eliminating all forms of racial discrimination. Moreover, states parties have to ensure that all legislative guarantees against racial discrimination apply to everyone, regardless of their migration status or nationality<sup>3</sup>.

---

<sup>1</sup> Oberoi, P. et al (2013). **International Migration, Health and Human Rights**. Geneva: International Organisation for Migration.

<sup>2</sup> The right to the highest attainable standard of health. General Comment No. 14. Committee on Economic, Social and Cultural Rights (2000)

<sup>3</sup> ICERD, 64 th session, General Recommendation No. 30 on Discrimination against Non-Citizens, CERD/C/64/Misc.11/rev.3, 2004, para. 7

e. **Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)**, 1979. The convention applies to all women, regardless of whether they are citizens or not, and includes provisions eliminating discrimination against women in health care related domains, such as "family planning, pregnancy, confinement and the post-natal period, granting free services, including adequate nutrition during pregnancy and lactation where necessary". However, its main concern is to ensure that the same rights are accorded to men and women, rather than ensuring a high level of rights for all. Moreover, it does not go into the question of who should pay for health services.

f. **The Framework Convention for the Protection of National Minorities** is a key treaty with regard to national and indigenous minorities. While most Council of Europe member countries have signed on to the treaty, France, Turkey, Andorra and Monaco have not.

g. **Convention on the Rights of the Child (CRC)**, 1990 is nearly universally ratified, states the child's right to the 'highest attainable standard of health' and includes a comprehensive framework for protection for all children within each states parties' jurisdiction. Rights stipulated in the convention must be respected and ensured, without discrimination, and regardless of a child's or his/her parents' or legal guardians' race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

The **Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families** (1990) also contains provisions relating to the right to health, but it is not further discussed here because it has not been ratified by any EU member states.

## 1.2. Regional (European) instruments<sup>45</sup>

The following legal instruments relate to the right to health in the EU.

a. **European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)**, 1950. Enforced by the European Court of Human Rights, the convention contains provisions related to health, such as "the right to life, the prohibition of torture and inhumane and degrading treatment or punishment, and the right to respect for private and family life".

b. The **Treaty on European Union – Maastricht Treaty (TEU)** (Signed 1992, entered into force 1993) states that the "*Union is founded on the value of respect for human dignity [...], equality [...] and respect for human rights, including the rights of persons belonging to minorities*" (Article 2 TEU). Furthermore, it commits the Union to promote these values, combat social exclusion and discrimination, respect its cultural and linguistic diversity, safeguard and enhance Europe's cultural heritage and uphold and promote its values in its relations with the wider world. The Treaty also refers to the Union's recognition of the rights (including health and right of access to health services), freedoms and principles set out in the **Charter of Fundamental Rights** of the European Union (see above), including the

---

<sup>4</sup> Oberoi et al (2013). Pg. 60.

<sup>5</sup> Migrants in an irregular situation: Access to healthcare in 10 European Union Member States. European Union Agency for Fundamental Rights. 2011. [http://fra.europa.eu/sites/default/files/fra\\_uploads/1771-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare\\_EN.pdf](http://fra.europa.eu/sites/default/files/fra_uploads/1771-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf) (Accessed 14/4/14)

prohibition of discrimination on the basis of membership in a national minority (Article 21 of the Charter).<sup>6, 7</sup>

**c. European Social Charter (ESC)**, 1961 (revised 1996). The right to health is explicitly stipulated in Part 1, Article 10 and Part 2, Article 11 of the Charter, and its application is monitored by the European Committee of Social Rights. However, eight of the members of the EU, namely Cyprus, Estonia, Lithuania, Poland, Romania, Slovakia and Slovenia, did not sign article 13 referring to the provision of medical assistance regardless of the legal status of individuals.

**d. Charter of Fundamental Rights of the European Union**, 2000. The Charter states that everyone has a right to access preventive health care and to receive medical attention, “under the conditions established by national laws and practices”. A protocol was adopted in 2009 which aimed to limit the operation of the Charter in Poland and the UK.

Three additional EC Directives regulate non-discrimination in health care, as well as the health of asylum seekers and of migrants in detention.

**a. Council Directive 2000/43/EC of 29 June 2000** implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (the ‘race directive’). This Directive includes provisions relating to access to health care. Importantly, the Directive covers ‘indirect’ as well as ‘direct’ discrimination. Indirect discrimination is caused “where an apparently neutral provision, criterion or practice is likely to put someone at a particular disadvantage compared with other persons”. The assumption in health services that “one size fits all” often amounts to a form of indirect discrimination.

**b. Council Directive 2003/9/EC of 27 January 2003** laying down minimum standards for the reception of asylum seekers. This directive requires that “material reception conditions and medical and psychological care will be guaranteed during all types of procedures (regular, admissibility, accelerated and appeal procedures), in order to ensure a standard of living adequate for the health and well-being of the applicants and their families.” Moreover, special medical and psychological care must be given to pregnant women, minors, the mentally ill, the disabled and victims of rape and other forms of violence.” “Persons with special needs” receive particular attention. The Directive also states: “If his/her economic situation permits it, the Member State could decide that the applicant should contribute partially or totally to the cost of the material reception conditions and medical and psychological care.

**c. The “Returns Directive” of 2008** (Directive 2008/115/EC of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals). This directive attempted to harmonise the procedures used by member states to deport irregular migrants. Predictably, it led to a lowering of standards in some countries and a raising of them in others. In relation to health, it laid down requirements relating to length and conditions of detention, as well as requirements for “emergency health care and essential treatment of illness”, in particular for “vulnerable persons”.

---

<sup>6</sup> [http://europa.eu/about-eu/basic-information/decision-making/treaties/index\\_en.htm](http://europa.eu/about-eu/basic-information/decision-making/treaties/index_en.htm) (Accessed: 6 October, 2014).

<sup>7</sup> European Commission, The European instrument for democracy and human rights. *The European Union and the protection of the rights of persons belonging to minorities*. [http://www.eidhr.eu/files/dmfile/minorities-guide\\_en.pdf](http://www.eidhr.eu/files/dmfile/minorities-guide_en.pdf) (accessed 9 October, 2014)



## 2. Policy initiatives

### 2.1. International level

#### 2.1.1. *World Health Organization*

Health 2020: The European health policy framework, Health 2020 calls for the creation of supportive environments and resilient communities as one of its four priority areas for policy action. Improving the conditions in which migrants and Roma populations live, grow, work and age is a key factor in improving their health and well-being, as well as reducing the health inequalities in the Region.

Public Health Aspects of Migration in Europe (PHAME) project: WHO/Europe is working closely with Member States to strengthen the health sector's preparedness and the public health capacity to better address emergency-related migration. The project is implemented within the new WHO European health policy framework of Health 2020 and draws particular attention to reducing health inequalities and ensuring people-centred health systems. It does so, by conducting assessment missions in the Member States that are receiving or may receive large undocumented populations, to coordinate the health response to migration by identifying best practices and potential gaps in the public health sector before establishing contingency plans. PHAME aims to support the work of policy-makers, health planners, local health professionals and others who are responsible for providing quality health care to migrants. Its final objective is to develop expertise and capacity, as well as to identify and fill potential gaps in health-service delivery, including those for the prevention, diagnosis, monitoring and management of disease.

PHAME publications:

- PHAME Newsletter: Published quarterly in collaboration with WHO/Europe and the University of Pécs, the newsletter brings together knowledge and best practices in the field of migration and health, as well as promoting cross-national political dialogue on migration.
- WHO/Europe has published a number of reports based on the PHAME assessment of health system preparedness of those countries experiencing large influxes of illegal migrants (e.g Italy, Turkey, Greece). Several publications provide guidelines for how health services can better equip health professionals to meet the needs of newly arrived migrants. Key publications are listed below:

#### **Increased influx of migrants at the Greek–Turkish border**

Upon request from the Greek Ministry of Health and Social Solidarity, a joint European Centre for Disease Prevention and Control (ECDC) and WHO Regional Office for Europe mission was undertaken to Greece to assess the situation related to the increased migration at the Greek–Turkish border.

#### **Toolkit for country health workforce strengthening**

The health workforce plays a central and critical role in improving access to quality health care for the population. Mechanisms for optimizing the skills and skill-mix of health professionals will be essential to strengthening health systems and achieving better health outcomes.

## **Increased influx of migrants in Lampedusa, Italy**

The main objectives of this mission were to review the current situation of the displaced populations arriving in Italy as a result of the crisis in north Africa; and to assess the level of preparedness of the Italian health system to cope with the public health consequences of a potential mass influx.

## **Assessment of health systems' crisis preparedness: Turkey**

In 2008, with the support of the European Commission Directorate-General for Health and Consumers, WHO launched a project, "Support to health security, preparedness planning and crises management in EU, EU accession and neighbouring (ENP) countries", with the aim of improving preparedness for public health emergencies in EU Member States and selected EU accession and ENP countries in the WHO European Region.

## **United Nations interagency health-needs-assessment mission, Turkey**

The primary goals of the mission were: to gain a better understanding of the capacities existing in the camps, including the health services provided, and the functioning of the referral system; and, on the basis of the findings, identify how the United Nations agencies could contribute to upporting activities related to safeguarding the health of the more than 138 000 Syrian citizens living in Turkey at the time of the mission.

## **How health systems can address health inequities linked to migration and ethnicity**

There are about 75 million migrants in the WHO European Region, amounting to 8.4% of the total population and 39% of all migrants worldwide. This briefing describes how, to tackle such health inequities, health systems must not only improve the services available to migrants and ethnic minorities, but also address the social determinants of health across many sectors.

## **Guide to tailoring immunization programmes**

The TIP guide provides tools to identify susceptible populations, determine barriers to vaccination and implement evidence-based interventions (2013)

## **Roma health website**

WHO/Europe's programme on vulnerability and health created the Roma health website, to raise awareness of the unacceptable living conditions of Roma populations and to disseminate knowledge and expertise for improving their health. The website features a News section that lists the latest information in the field of Roma health, including news of recent research publications, meetings, events, and other developments. The website also publishes a quarterly newsletter called the Roma Health Newsletter, with the aim of sharing information and resources that are relevant to improving Roma health, and thus provide support for current efforts to strengthen the health components of national Roma integration strategies or sets of policy measures in the EU and action plans for the Decade of Roma Inclusion. The newsletter includes information on events, resources and reports, professional opportunities, feature stories and issues in focus, and the latest research on Roma health.

The newsletter is published by WHO/Europe in cooperation with the European Commission – Directorate-General for Health and Consumers and the Interuniversity Institute of Social Development and Peace at the University of Alicante, Spain. It is produced as an output of the Interagency Coordination Initiative "Scaling up action towards MDGs 4 and 5 in the context of the Decade of Roma Inclusion and in support of the EU national Roma integration strategies", which is

facilitated by WHO in cooperation with other United Nations agencies and the International Organization for Migration (IOM).

### ***2.1.2. International Organization for Migration***

IOM works extensively in the area of migration and health, worldwide. Their overall strategic objectives in the field are closely aligned with IOM's public health approach addressing migrants and host communities. The objectives and approaches are as follows:

1. Monitoring migrant health: Research and information dissemination
2. Enable conducive policy and legal frameworks on migrant health: Advocacy for policy development
3. Strengthen migrant friendly health systems: Health service delivery and capacity building
4. Facilitate partnerships, networks and multi-country frameworks on migrant health: Strengthening inter-country coordination and partnership.

IOM's public health approach is summarized as follows:

1. To avoid disparities in health status and access to health services between migrants and the host population.
2. To ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population.
3. To put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations. This is of particular relevance in situations of forced migration resulting from disasters or conflict.
4. To minimize the negative health outcomes of the migration process on migrants' health outcomes. Migration generally renders migrants more vulnerable to health risks and exposes them to potential hazards and greater stress arising from displacement, and adaptation to new environments.

IOM works with partners from the following sectors:

- Government
- Regional economic communities
- Universities
- The United Nations

A great number of projects have been developed and implemented by IOM worldwide in the field of migration and health. The following selection of projects has been carried out in Europe:

#### **Managing the Impact of Migration on the Healthcare System of Moldova (2009-2010)**

Contributed to improve the healthcare system in the Republic of Moldova as well as the general health of migrants.

#### **Educational Campaign to Improve Health and Medical Care for Asylum Seekers in Poland – 2nd Phase (2010-2011)**

Aims to maximize the effectiveness of medical care and improve access of asylum seekers to healthcare services by raising their awareness of health promotion and medical care system.

### **Increasing Public Health Safety alongside the New Easter European Borderline (2007-2010)**

Aimed to minimize public health risks posed by migration along the borders of an enlarged European Union and to build capacity in order to promote human rights based provision of appropriate and adequate health care to migrants.

### **Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities (AMAC) (2008-2009)**

Reviewed migrant health challenges and priorities in Europe (access to care, research, workforce capacity building, maternal and child care, mental health) and issued related policy and practice recommendations.

### **Equi-Health (See Appendix VI)**

## **2.2. Regional (European) level**

### **Council of Europe**

The Council of Europe is the continent's leading human rights organisation. It includes 47 member states, 28 of which are members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law.

#### *Mission*

The Council of Europe advocates freedom of expression and of the media, freedom of assembly, equality, and the protection of minorities. It has launched campaigns on issues such as child protection, online hate speech, and the rights of the Roma, Europe's largest minority. The Council of Europe helps member states fight corruption and terrorism and undertake necessary judicial reforms. Its group of constitutional experts, known as the Venice Commission, offers legal advice to countries throughout the world.

The Council of Europe promotes human rights through international conventions, such as the Convention on Preventing and Combating Violence against Women and Domestic Violence and the Convention on Cybercrime. It monitors member states' progress in these areas and makes recommendations through independent expert monitoring bodies.

#### **Key publications**

- Recommendation 1503 (2001){1} of the Parliamentary Assembly regarding Health conditions of migrants and refugees in Europe
- Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society
- Recommendation CM/Rec (2011) 13 of the Committee of Ministers to member states on mobility, migration and access to health care.
- The Bratislava Declaration on Health, Human Rights and Migration, 2007, which encourages countries to take measures to address migrants health needs regardless of their legal status, and promotes equity in healthcare access.

### **European Union**

For initiatives launched by the European Agency for Health and Consumers (DG SANCO) in the period 2003-2013, please see Appendix VI.

## **2.3. Regional – EC agencies**

### ***2.3.1. European Centre for Disease Control (ECDC)***

The European Centre of Disease Prevention and Control (ECDC) was established in 2005. It is an EU agency with aim to strengthen Europe's defences against infectious diseases. It is seated in Stockholm, Sweden.

#### *Mission*

ECDC's mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases.

In order to achieve this mission, ECDC works in partnership with national health protection bodies across Europe to strengthen and develop continent-wide disease surveillance and early warning systems. By working with experts throughout Europe, ECDC pools Europe's health knowledge, so as to develop authoritative scientific opinions about the risks posed by current and emerging infectious diseases.

As part of the EU's wider efforts to reduce inequalities among its citizens, ECDC prioritises work on health inequalities in relation to infectious disease.

Socio-economic factors play a role in the distribution of infectious diseases. ECDC works with EU Member States to identify and target vulnerable population groups in order to reduce the societal burden created by health inequalities.

Work covering numerous vulnerable groups is conducted by ECDC. Migrants, for example, can face many challenges that can have an impact on their health. Language barriers, cultural differences and a perceived lack of access to information and services, as well as stigma or discrimination, can all present challenges on health outcomes, both for individuals and on a regional, national or international level. The EU Roma population is also a priority vulnerable group. An estimated 10-12 million European citizens are Roma, which makes the group one of Europe's largest ethnic minorities and one that is highly marginalised in numerous aspects of everyday life. Roma are more likely to be exposed to agents that cause communicable disease; more vulnerable to becoming ill if exposed and, once sick, Roma are less likely to have access to effective, high-quality health services.

Key publications include:

- Thematic Report: Migrants - Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress (20 Sep 2013).
- Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions (26 Aug 2013).
- Health inequalities, the financial crisis, and infectious disease in Europe (7 Oct 2013).
- Responses to HIV and migration in western industrialised countries: current challenges, promising practices, future directions (30 Jan 2013)

### ***2.3.2. European Union Agency for Fundamental Rights (FRA)***

The FRA provides the EU institutions and Member States with independent, evidence-based advice on fundamental rights. The aim is to contribute towards ensuring full respect for fundamental rights across the EU.

To do this, the FRA performs the following main tasks:

- collecting and analysing information and data;
- providing assistance and expertise;
- communicating and raising rights awareness.

#### *Anti-discrimination theme*

FRA research provides evidence of racism and related intolerances, as well as the unequal treatment of ethnic minorities in all areas of life, including access to health care, while the agency's studies also supply information about initiatives against discrimination in key areas of social life.

- EU Minorities & Discrimination Survey (EU-MIDIS), 2010
- DATA in Focus Report: Multiple Discrimination in Healthcare
- Fundamental Rights: Challenges and achievements 2012

#### *Ethnic minority/Roma theme*

FRA has a role contributing to the EU Framework for National Roma Integration Strategies, monitoring and assisting EU-wide efforts to implement the EU's plan for Roma integration

- Multi-annual Roma Programme (2008 & 2011)
- The situation of Roma EU citizens moving to and settling in other EU member states (2009)

Projects funded by FRA

### **Inequalities and Multiple Discrimination in Access to Health (2010-2011)**

Funding: European Union Agency for Fundamental Rights (FRA)

Project Coordination: Middlesex University (case study UK)

Project Partners: ICMPD and Research Institute of the Red Cross (case study Austria), Gender Studies o.p.s (case study Czech Republic), Research and Development Centre for Care of Older People (FOU äldre nor, case study Sweden) and University of Bologna (case study Italy)

This project seeks to identify barriers to access to health care services, as well as the quality of care received by the target group. It will also map the initiatives undertaken by Member States at policy level aimed at enabling and improving access to and quality of health services for target groups. Finally, the project will explore the ways in which health professionals address the care needs of the target group.

#### **Aim of the study**

- To gain a better understanding of particular vulnerabilities resulting from the intersection of ethnic origin, age and gender in access to health care and quality of care in five EU-Member States (Austria, Czech Republic, Italy, Sweden and the UK)
- To formulate recommendations how this situation can be improved.

#### **Methods**

300 interviews with health professionals, policy makers and health users  
analysis of literature, evidence, legal context and  
mapping of policy initiatives in the 5 Member States and at the EU level.

#### **Outcomes**

- Summary report (mainly targeted at policy makers; it includes evidence-based advice for tackling issues and cases of multiple and intersectional discrimination)
- Comparative report (overview of legal and policy instruments dealing with multiple discriminations across the EU)
- 5 Country thematic fact files including recommendations for good practice and policies applicable in the five countries and more widely in the European Union.

- Good practice handbook based on evidence collected through the research (selection of good practices effectively addressing multiple discriminations across the EU)

### **Publications**

- Christina Hollomey, Bernhard Perchinig, Edith Enzenhofer (2014): Research Summary - Inequalities and Multiple Discriminations in Access to Health - Austria. Vienna: ICMPD.
- Albert Kraler, Julia Edthofer, Edith Enzenhofer, Bernhard Perchinig (2014): Background Report - Inequalities and Multiple Discriminations in Access to Health in Austria. Vienna: ICMPD and Research Institute of the Red Cross.
- European Union Agency for Fundamental Rights (2013): Inequalities and multiple discriminations in access to and quality of healthcare. Vienna: FRA.

### ***2.3.3. European Centre for Disease Prevention and Control (ECDC)***

As part of the EU's wider efforts to reduce inequalities among its citizens, ECDC prioritises work on health inequalities in relation to infectious disease. Socio-economic factors play a role in the distribution of infectious diseases. ECDC works with EU Member States to identify and target vulnerable population groups in order to reduce the societal burden created by health inequalities. Migrants and Roma are included in the category of vulnerable populations.

ECDC projects on MEM health include:

- A comprehensive approach to HIV/STI prevention in the context of sexual health in the EU/EEA (2013)
- Health inequalities, the financial crisis, and infectious disease in Europe (2013)
- Migrant health series: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA Member States (2011)
- Migrant health series: Access to HIV prevention, treatment and care for migrant populations in EU/EEA countries (2009)

### ***2.3.4. European Agency for Safety and Health at Work***

The agency recognizes the contribution of migrant labour to economies world-wide, as well as the risks and poor working conditions to which many migrant workers are exposed. A number of research projects explore the effects of these working conditions on migrants' health. Studies also address ways in which diverse work-settings can promote health and improve working conditions for migrant workers.

Projects and publications on MEM health include:

- Literature study on migrant workers (2007)
- Diverse cultures at work: Ensuring safety and health through leadership and participation
- Factsheet series to raise awareness of risks and preventative measures associated with traditionally high risk jobs, such as construction, cleaning, etc. that rely heavily on migrant labour.



### ***2.3.5. European Foundation for the improvement of living and working conditions***

This agency provides information, advice and expertise – on living and working conditions, industrial relations and managing change in Europe – for key actors in the field of EU social policy on the basis of comparative information, research and analysis.

Priority areas:

- Increasing labour market participation and combating unemployment by creating jobs, improving labour market functioning and promoting integration
- Improving working conditions and making work sustainable throughout the life course
- Developing industrial relations to ensure equitable and productive solutions in a changing policy context
- Improving standards of living and promoting social cohesion in the face of economic disparities and social inequalities

**Publications on MEM health include:**

- Quality of life in ethnically diverse neighborhoods (2007)
- Equality and Diversity in Jobs and Services: City policies for migrants in Europe (2008)
- Impact of the crisis on access to healthcare services (2014)

### ***2.3.6. European Institute for Gender Equality (EIGE)***

EIGE supports the EU and its Member States in their efforts to promote gender equality, to fight discrimination based on sex and to raise awareness about gender equality issues.

Its tasks are to collect and analyse comparable data on gender issues, to develop methodological tools, in particular for the integration of the gender dimension in all policy areas, to facilitate the exchange of best practices and dialogue among stakeholders, and to raise awareness among EU citizens.

**Projects on migrant and ethnic minority health**

- Female Genital Mutilation in the European Union and Croatia

### ***2.3.7. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)***

EMCDDA provides the Community and EU member states with 'factual, objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences. They collect, register and analyse information on 'emerging trends,' particularly in polydrug use, and the combined use of licit and illicit psychoactive substances. EMCDDA also offers information on best practice in the EU Member States and facilitate exchange of such practice between them.

**Projects on migrant and ethnic minority health include:**

- Project: Drugs and Social Exclusion- Focusing on minorities (2000-2002)
- Drugs and vulnerable groups of young people (2008)
- Drug prevention interventions targeting minority ethnic populations: issues raised by 33 case studies (2013)
- Best Practices Portal: includes best practices in drug-related prevention programmes in Europe, targeting ethnic minorities, refugees, asylum seekers, migrants.

## **2.4. NGOs – Regional level**

### **2.4.1. *Médecins du Monde***

Médecins du Monde is an international NGO created in 1980 in Paris. Its actions are broad and worldwide and include interventions on conflicts and crisis, maternal and child health, infectious diseases and migrant health. More particularly in Europe MDM is working with undocumented migrants and Roma communities in France, Greece and Romania. This organization also plays a strong role in advocating undocumented migrant right to health in Europe. It also leads some European projects such as AVERORES which created the HUMANETWORK.

#### **Key readings:**

- Access to healthcare in Europe in time of crisis and rising xenophobia, 2013. URL: [http://issuu.com/doctorsoftheworld/docs/mdm\\_report\\_access\\_healthcare\\_in\\_times\\_of\\_crisis\\_an](http://issuu.com/doctorsoftheworld/docs/mdm_report_access_healthcare_in_times_of_crisis_an)
- Access to Healthcare for Undocumented Migrants in 11 European countries, 2009

### **2.4.2. *PICUM***

PICUM - the Platform for International Cooperation on Undocumented Migrants, is a non-governmental organisation (NGO) that aims to promote respect for the human rights of undocumented migrants within Europe. PICUM provides a direct link between the grassroots level, where undocumented migrants' experience is most visible, and the European level, where policies relating to them are deliberated. PICUM reports on issues regarding undocumented migrants through its members' experiences and simultaneously monitors developments within the European institutions.

#### **Key readings:**

- Children First and Foremost

URL: <http://picum.org/picum.org/uploads/publication/Children%20First%20and%20Foremost.pdf>

- Access to healthcare for undocumented migrants, 2007, Report.

[http://picum.org/picum.org/uploads/publication/Access%20to%20Health%20Care%20for%20Undocumented%20Migrants%202007%20EN\\_1.pdf](http://picum.org/picum.org/uploads/publication/Access%20to%20Health%20Care%20for%20Undocumented%20Migrants%202007%20EN_1.pdf)

### **2.4.3. *Jesuit Refugee Service***

The Jesuit Refugee Service (JRS) is an international Catholic organisation with a mission to accompany, serve and advocate on behalf of refugees and other forcibly displaced persons. JRS undertakes services at national and regional levels with the support of an international office in Rome. JRS programmes are found in 50 countries, providing assistance to: refugees in camps and cities, individuals displaced within their own countries, asylum seekers in cities, and to those held in detention centres. The main areas of work are in the field of education, emergency assistance, healthcare, livelihood activities and social services. JRS also contributes to refugee research at the University of Oxford.

The JRS provide data of migration from newly EU members state such as Croatia. Indeed those data are valuable since Croatia has not been included in the previous EU projects and research addressing migrants needs or migrants data collection.

**Key readings:**

- Jesuit Refugee Service, From Back Door to Front Door: Forced Migration Routes Through Macedonia to Croatia, June 2013, available at: <http://www.refworld.org/docid/52453e7e4.html>
- Jesuit Refugee Service, Safe and Secure: How do Refugees Experience Europe's Borders? Modern challenges to protection and the 1951 Refugee Convention, December 2011, available at: <http://www.refworld.org/docid/4f0c12172.html>

#### ***2.4.4. International Centre for Migration and Health (ICMH)***

This Swiss-based non-profit institution that was established in 1995. Its mandate is to work on research, training and policy advocacy in all areas related to migration and health. ICMH has a broad network of members and cooperating partners in all regions of the world. It works with this network to ensure that the challenge of migration and health is managed in a technically and ethically sound way

#### ***2.4.5. International Centre for Migration Policy Development (ICMPD)***

The organization was founded in 1993, upon the initiative of Austria and Switzerland, to serve as a support mechanism for informal consultations, and to provide expertise and efficient services in the newly emerging landscape of multilateral cooperation on migration and asylum issues. The purpose of ICMPD is to promote innovative, comprehensive and sustainable migration policies and to function as a service exchange mechanism for governments and organizations.

**Members**

Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, The former Yugoslav Republic of Macedonia, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Sweden and Switzerland

**Aims:**

- Facilitating early warning,
- Combating root causes of migration,
- Harmonizing entry control measures
- Coordinating alien, asylum and refugee policies

**Methods**

- Analyze current and potential migratory flows to European receiving countries,
- Follow and examine the situation in the major countries of origin of migrants
- Develop measures for the improved recognition and control of migratory movements.

**Current ICMPD projects related to migration and health**

- Inequalities and Multiple Discrimination in Access to Health (2010-2011)(See Section 2.3 on European agencies, for more information)

## 2.5. Organisations and initiatives in the area of Roma Health

### 2.5.1. *International Organisations*

#### 2.5.1.1 *United Nations Population Fund (UNFPA)* - [www.unfpa.org](http://www.unfpa.org)

UNFPA advocates for the equal rights of Roma, and in particular for the health and empowerment of women and children. This year the Fund supported the international “Roma Health Conference – 2012 – Towards Better Health of Roma People”. Together with relevant stakeholders working to improve Roma health, UNFPA drafted the “Skopje Roma Health Declaration” to ensure joint ownership moving forward. The Skopje Declaration aims to catalyze the process of raising awareness and advocating for increased action on Roma health. The Declaration is supported in all countries that have signed on to the Decade for Roma Inclusion initiative, a political commitment by European governments to improve the socio-economic status and social inclusion of Roma. UNFPA delivers policy advice, guidance, training and support to empower partners and colleagues in the field.

For more information on the Skopje Roma Health Declaration, please see:  
[http://www.romadecade.org/cms/upload/file/9378\\_file10\\_declaration-eng.pdf](http://www.romadecade.org/cms/upload/file/9378_file10_declaration-eng.pdf)

#### 2.5.1.2 *World Health Organization – Vulnerability and Health Programme*

- **Interagency Coordination Initiative "Scaling up action towards MDGs 4 and 5 in the context of the Decade of Roma Inclusion and in support of the EU national Roma integration strategies:"**

WHO facilitates this initiative, which involves the United Nations Population Fund (UNFPA), Office of the High Commissioner for Human Rights (OHCHR), United Nations Development Programme (UNDP), United Nations Children’s Fund (UNICEF) and International Organization for Migration (IOM). The initiative includes activities such as the development of training and training materials for health professionals seeking to deliver more equitable health services to all, and the publication of the Roma Health Newsletter (see below for more details).

The initiative

- applies the principle of explicit but not exclusive targeting, which implies focusing on socially disadvantaged Roma as a target group while not excluding other groups experiencing poverty and social exclusion;
- builds the capacity of policy-makers, health professionals and administrators in countries taking part in the Decade of Roma Inclusion to carry out the health action plans of the Decade and the commitments of national Roma integration strategies on health,
- engages Roma and other civil-society organizations as active partners; and
- maximizes and builds the capacity of partner agencies (multilateral organizations) to address Roma health through coordinated action.

***Publications that have resulted from the interagency initiative include:***

Ministry of Health, Social Services and Equality. Methodological Guide to integrate Equity into Health Strategies, Programmes and Activities. Version 1. Madrid 2012. (available online at [http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/ornadaPresent\\_Guia2012/docs/Methodological\\_Guide\\_Equity\\_SPAs.pdf](http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/ornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf))

#### - **Roma Health Newsletter**

Roma are Europe's largest ethnic minority: an estimated 12 to 15 million Roma live in Europe. There is evidence that Roma can experience significant inequities in health system access, exposure to risk factors and health outcomes. Adverse social conditions such as poverty and exclusion contribute to these inequities.

The purpose of this newsletter is to share information and resources relevant to improving Roma health, and thereby support current efforts to strengthen the health components of national Roma integration strategies or sets of policy measures in the EU and action plans for the Decade of Roma Inclusion.

The newsletter is published by WHO/Europe in cooperation with the European Commission – Directorate-General for Health and Consumers and the Interuniversity Institute of Social Development and Peace at the University of Alicante, Spain. It is produced as an output of the Interagency Coordination Initiative "Scaling up action towards MDGs 4 and 5 in the context of the Decade of Roma Inclusion and in support of the EU national Roma integration strategies", which is facilitated by WHO in cooperation with other

#### **2.5.1.3 International Organisation for Migration (IOM) - [www.iom.org](http://www.iom.org)**

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As the leading international organization for migration, IOM acts with its partners in the international community to:

- Assist in meeting the growing operational challenges of migration management.
- Advance understanding of migration issues.
- Encourage social and economic development through migration.
- Uphold the human dignity and well-being of migrants.

IOM promotes Roma rights and equal access to health through a number of projects, including:

#### - **Equi-Health Project (2013-2016)**

It Aim to improve access to quality health care services for migrants, Roma and other vulnerable ethnic minority groups, including irregular migrants, in the European Union (EU), the European Economic Area (EEA), and Croatia and Turkey.

Please say more about what Equi-health is doing with Roma

The ROMA HEALTH sub-action focuses on promoting dialogue among key stakeholders (governmental and non-governmental groups) on Roma health issues. 8 Progress reports on national strategies (with health focus), 4 case studies on good practices and exchange of experiences as per identified priorities in support of the implementation of national health plans will allow EU MS to better monitor, share and strengthen their respective national approaches. A training package for healthcare providers will develop competencies in working with ethnic minorities, including Roma.

**TARGET COUNTRIES:** EU countries with high percentage of Roma nationals and EU MS with high percentage of Roma migrants

**COUNTRIES COVERED:** Belgium, Bulgaria, Czech Republic, Italy, Slovakia, Spain

## ***2.5.2. Regional organisations***

### ***2.5.2.1. Fundación Secretariado Gitano (FSG) [www.gitanos.org](http://www.gitanos.org)***

The organization started in 1960 and was legally established as an association in 1982.

The mission of the FSG is the integral promotion of the Roma community on the basis of respect and support for their cultural identity.

Its mission is to promote the access of Roma to rights, services, goods and social resources on an equal footing with the rest of the citizenry. To this end, the FSG develops all kinds of actions that contribute to achieving the full citizenship of Roma, to improving their living conditions, to promoting equal treatment and to preventing any form of discrimination, while promoting the recognition of the cultural identity of the Roma community. The diversity of our society renders interculturalism increasingly relevant, so we must project adequately the intercultural character of our organisation, both as our hallmark and as a proposal for society as a whole.

The FSG advocates an intercultural society where Roma persons freely and fully exercise their citizenship and contribute to the enrichment of universal culture. Therefore, the values that guide its actions are:

- Human dignity
- Justice
- Solidarity
- Inter-culturalism

In order to pursue its equal rights and opportunities, and anti-discrimination objectives, the foundation is active in the following areas:

- Programmes and services that improve living conditions and enhance equal opportunities
- The fight against discrimination and the defence of rights
- International dimension
- Influence policy, influence society
- Promotion of culture and social participation
- Deepen the intercultural character of the organisation, work within and through diversity
- Organisational development
- Economic sustainability

In the area of Health and access to health services, FSG recognizes that insufficient comparable data exists on the health status of the Roma, and that this lack of data acts as a barrier to the effective design and implementation of health interventions in Roma communities. It has therefore prioritized addressing this data deficit. FSG initiated in 2006, in collaboration with the Spanish Ministry of Health and Consumption, the first national population health survey of the Roma community in Spain. Based on this survey, a report entitled Towards health equity. Reducing inequality in one generation in the Roma Community (Hacia la equidad en salud. Disminuir las desigualdades en una generación en la comunidad gitana).

In 2009 FSG published Health and the Roma Community, analysis of the situation in Europe, based on a collaborative project financed by the EU, and including partners in Bulgaria, Czech Republic, Greece Portugal, Romania, Slovakia and Spain.

On a regional level, the FSG works closely with public level actors and Roma communities in Spain to promote equal access and quality of healthcare, through a combination of improved practices amongst public service providers, but also amongst the Roma communities themselves. FSG is active in the following areas of work:



- Technical assistance and assessment for public and private health entities working with Roma population
- Health promotion at the local level – promoting health literacy, healthy lifestyle, and prevention practices through workshops
- Drug addiction prevention
- Development of training materials for health professionals working with Roma, as well as for Roma themselves
- International collaborative projects to promote exchange of good practices amongst EU member states and accession countries with high concentrations of Roma.
- Awareness raising amongst Roma about HIV and AIDS, as well as support work aimed at HIV and AIDS infected member of the Roma community and their families. Training for health professionals working in the field of HIV and AIDS prevention and care.
- Research and analysis on social determinants and their role in health inequalities experienced by the Roma

#### **2.5.2.2. European Roma Rights Centre - [www.errc.org](http://www.errc.org)**

The European Roma Rights Centre (ERRC) is an international public interest law organization working to combat anti-Romani racism and human rights abuse of Roma through strategic litigation, research and policy development, advocacy and human rights education.

Since its establishment in 1996, the ERRC has endeavored to provide Roma with the tools necessary to combat discrimination and achieve equal access to justice, education, housing, health care and public services.

The ERRC has consultative status with the Council of Europe, as well as with the Economic and Social Council of the United Nations.

The ERRC's thematic priorities for 2013-2017 include:

- State response to violence and hate speech
- Access to education
- Access to housing
- Free movement and migration
- Identity documents
- Women's and children's rights
- Disaggregated data collection

In the area of health, ERRC has published research on health inequalities and calls for the need for disaggregated data, disaggregated by ethnicity as well as by other factors, in order to highlight the indirect discrimination which Roma experience in their encounters with health services. Their research also suggests the legal frameworks by which such data collection could be conducted. Furthermore, ERRC constantly monitors EU member states' compliance with international, European and national Human Rights instruments to ensure equal rights and access to entitlements to Roma minorities.

#### **2.5.2.3. Open Society Foundation – Roma Health Project - [www.opensocietyfoundation.org](http://www.opensocietyfoundation.org)**

The OSF has been instrumental in bringing the Roma issue to the forefront in European Union policy making through its spearheading of the 'Decade of Roma Inclusion' initiative as well as a number of other initiatives aimed at combating discrimination and inequality towards Roma, and promote Roma integration. Initiatives include the Roma Education Fund, a number of Roma integration projects, the European Roma Institute to preserve and rebuild Roma culture.



The Open Society Public Health Program aims to build societies committed to inclusion, human rights, and justice, in which health-related laws, policies, and practices are evidence-based and reflect these values. The program works to advance the health and human rights of marginalized people by building the capacity of civil society leaders and organizations, and by advocating for greater accountability and transparency in health policy and practice.

### **Law and Health Initiative**

The Open Society Public Health Program's Law and Health Initiative supports legal strategies to advance the health and human rights of marginalized and vulnerable groups worldwide. The initiative works to develop individual and organizational leadership in the field of health and human rights, pilot innovative access to justice tools as health interventions, advocate for rights-based legal protections that improve health, and leverage sustainable funding for other health and human rights efforts.

### **"Roma Leadership in Health: A generation of health professionals"**

The aim of the project is to support the education of Roma students in medical schools in Eastern Europe. The project includes an advocacy training element that encourages Roma medical students to become Roma health experts, as well as a mentoring scheme that matches Roma medical students with medical school professors to promote good academic results.

*2.5.2.4 Romani CRISS – Centre for Social Interventions and Studies, Romania* - <http://www.romanicriss.org/en/>

Romani CRISS is a non-governmental organization established on April 4th, 1993, which defends and promotes the rights of Roma in Romania by providing legal assistance in cases of abuse and works to combat and prevent racial discrimination against Roma in all areas of public life, including the fields of education, employment, housing and health.

The founding members of the organization are: Roma Ethnic Federation (FER), Research Center of Roma/Gypsies from the Rene Descartes University in Paris, and the Sociology Institute of the Romanian Academy.

Since its inception, the organisation addressed the problems faced by the Roma population from a human rights perspective, by using specific tools such as conflict resolution, mediation, litigation, and advocacy.

The organisation's main areas of activity are as follows:

- Documentation, monitoring and legal assistance in cases of human rights violations (including abuse or violence) against Roma minority
- Activities to improve Roma children's access to education, including projects that targets pre-school children (center for early childhood development), primary and middle school children (catching up activities, intercultural activities, summer camps for children, after school centers), teenagers (training and empowerment courses, assistance in implementing community development projects, debates). All projects militate for school desegregation and interculturality.
- Activities for Roma's access to health-care services. Romani CRISS supports the implementation of the Roma health mediation programme, initiated by the organisation in 1997. The programme became public policy in 2002 and best practice example at European level, thus taken over by several countries.

Romani CRISS has implemented a number of projects on Roma health, including:

- Review of the determinants for vaccination uptake and successful interventions for increasing childhood vaccination coverage among Roma, 2011-2012 in collaboration with ECDC

#### **2.5.2.5. Amalipe – Centre for interethnic dialogue and tolerance-** [www.amalipe](http://www.amalipe)

Bulgarian NGO working for equal integration of Roma in Bulgarian society. Through their work they aim to promote the broader inclusion of Roma issues in national policy. Amalipe is a member of the European Roma Platform, and is active in Bulgaria in a number of areas, including health. Projects address issues including HIV, tuberculosis, as well as monitoring of access and quality of health services for Roma. Also collaborates on an international level in projects addressing health and health inequalities of Roma populations.

#### **2.5.2.6. The European Roma and Travellers Forum (ERTF)** [www.ertf.org](http://www.ertf.org)

The forum represents Roma communities in Europe. In 2004, the Council of Europe Committee of Ministers agreed to establish close and privileged relations with the European Roma and Travellers Forum through a Partnership Agreement. The Forum receives assistance in terms of financial and human resources, and has a privileged access to the various bodies and organs of the Council of Europe which deal with matters concerning Roma and Travellers. In February 2005, the Forum opened its Secretariat in Strasbourg within the Council of Europe's premises.

In terms of Roma health, the Forum has been active in ensuring EU member states comply with their legal obligations towards its citizens, by monitoring human rights at a national level. Recently, the Forum has lodged a formal collective complaint with the European Committee of Social Rights, which is responsible for ensuring that States comply with the provisions of the European Social Charter. The complaint alleges discriminatory housing practices towards Roma in the Czech Republic, which in turn negatively impacts on their access to health services and education.

The ERTF goals are:

- To establish a fair and democratic representation of Roma in Europe;
- To achieve a fair and equal participation of Roma at all levels of policy making at national and international level;
- To achieve an improvement of the living conditions of Roma and related groups;
- To achieve the social integration of Roma on the basis of full equality and mutual respect;
- To make governments and international organisations more aware of their responsibilities toward Roma as their citizens and more responsive toward their needs;
- To become recognised as the key political partner and interlocutor by national governments and international organisations on any issues affecting Roma;
- To achieve official recognition of the Roma as a European people and of Romanes as a European language;
- To achieve official recognition of the Romani Holocaust

#### **2.5.2.6. Romahealthnet.org**

A website that brings together a wealth of resources and data on health of the Roma communities across Europe.

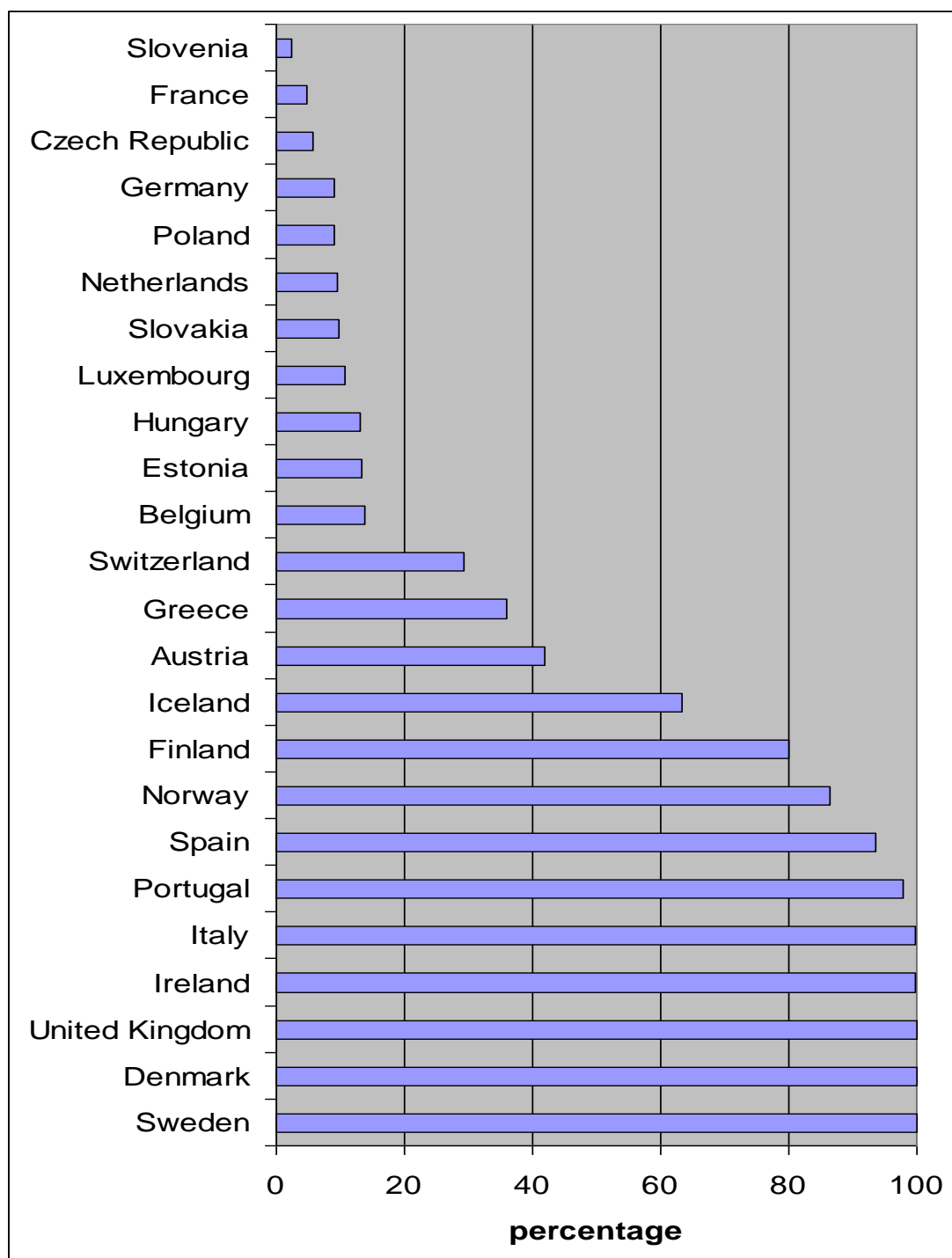
### 3. Different types of health system in Europe

In EU/EEA countries more than half of total health expenditure (THE) is administered by government, whether the money is raised by taxation (Beveridge system) or government-regulated Social Health Insurance (Bismarck system). Confusingly perhaps, social health insurance may be organised by private companies: it is nevertheless called 'government-administered' because these companies have to submit to government regulation. However, Cyprus is an exception to this rule: only 43,1% of health expenses were administered by government in 2011, the rest mainly by independent or commercial insurance schemes.

In Beveridge systems, the government pays for health costs out of general government expenditure (which is mainly raised by taxation), though social insurance schemes may account for a small percentage of expenditure. In Bismarckian systems it is the other way round. Some countries occupy an in-between position, often because a social insurance scheme is operated for employed persons but a tax-based system exists for others. The following graph shows the proportion of government-administered expenditure which is made up by general government expenditure. The countries at the bottom of the list are those with a "National Health Service".

**Table I. Percentage of government-administered health expenditure from 'general government spending'**

(Data from OECD for 2011)<sup>8</sup>



<sup>8</sup> OECD iLibrary Statistics, 2014. Paris: Organization for Economic Cooperation and Development, <http://www.oecd-ilibrary.org/statistics>

In this figure 11 countries can be seen to have a 'Bismarckian' system, 9 a 'Beveridge' system, while 4 have a combination of both. Some EU/EEA countries are not shown because they are not covered by OECD health statistics. Of these, Bulgaria, Croatia and Romania have social insurance-based systems; Cyprus and Lithuania have mixed systems; while in Latvia and Malta most expenditure is tax-financed<sup>9</sup>.

Which type of system offers better health coverage to migrants and ethnic minorities? The answer to this question needs to be established empirically, and at the time of writing data from the 'Big Picture' project currently being carried out by ADAPT, Equi-Health and the Migration Policy Group are not yet complete. Even when they are, careful analysis will be necessary to find out whether any differences found are directly due to the type of system, or the result of confounding by other variables. However, there seems to be no *a priori* reason why entitlements for migrants should be more generous in one system than in the other. (This is even more true for ethnic minorities, because their members are usually national citizens.)

What is also relevant, however, is the degree of financial equity in each system, i.e. the extent to which the burden of health expenses is matched for rich and poor. If the method of financing of the health system is not 'progressive' (i.e. adjusted so that costs are lower for poorer people), then the costs of care will be a higher burden for these people. As we saw in Chapter 1, migrants and ethnic minorities are over-represented among the lower income groups. However, a Beveridge system might be largely financed by sales taxes – which, in contrast to income tax, are not progressive – and many Bismarckian systems incorporate refunds, exemptions, or lower premiums for those of limited means.

There is another source of inequity that can be present in both systems, that is to say the use of out-of-pocket (OOP) payments or "payments at point of supply". As a result of the crisis, OOP payments have crept up in many European countries, so that socioeconomic inequities in health systems have increased. The following graph shows the wide variations in the percentage of total expenditure covered by OOP payments. (Again, countries not covered by the OECD are missing, as well as the Netherlands, for which figures are not given.) It will be seen from this graph that low OOP payments characterise some Bismarckian systems (e.g. France, Luxembourg, Germany), while high ones are found in the National Health Services of Portugal and Spain. An intriguing finding from preliminary analyses in the 'Big Picture' project is that high OOP payments tend to characterise the most unequal societies (measured in terms of their Gini coefficients). This is striking, because it is precisely in countries with extreme differences between rich and poor that the system of health care funding need to be progressive – whereas the opposite seems to be the case.

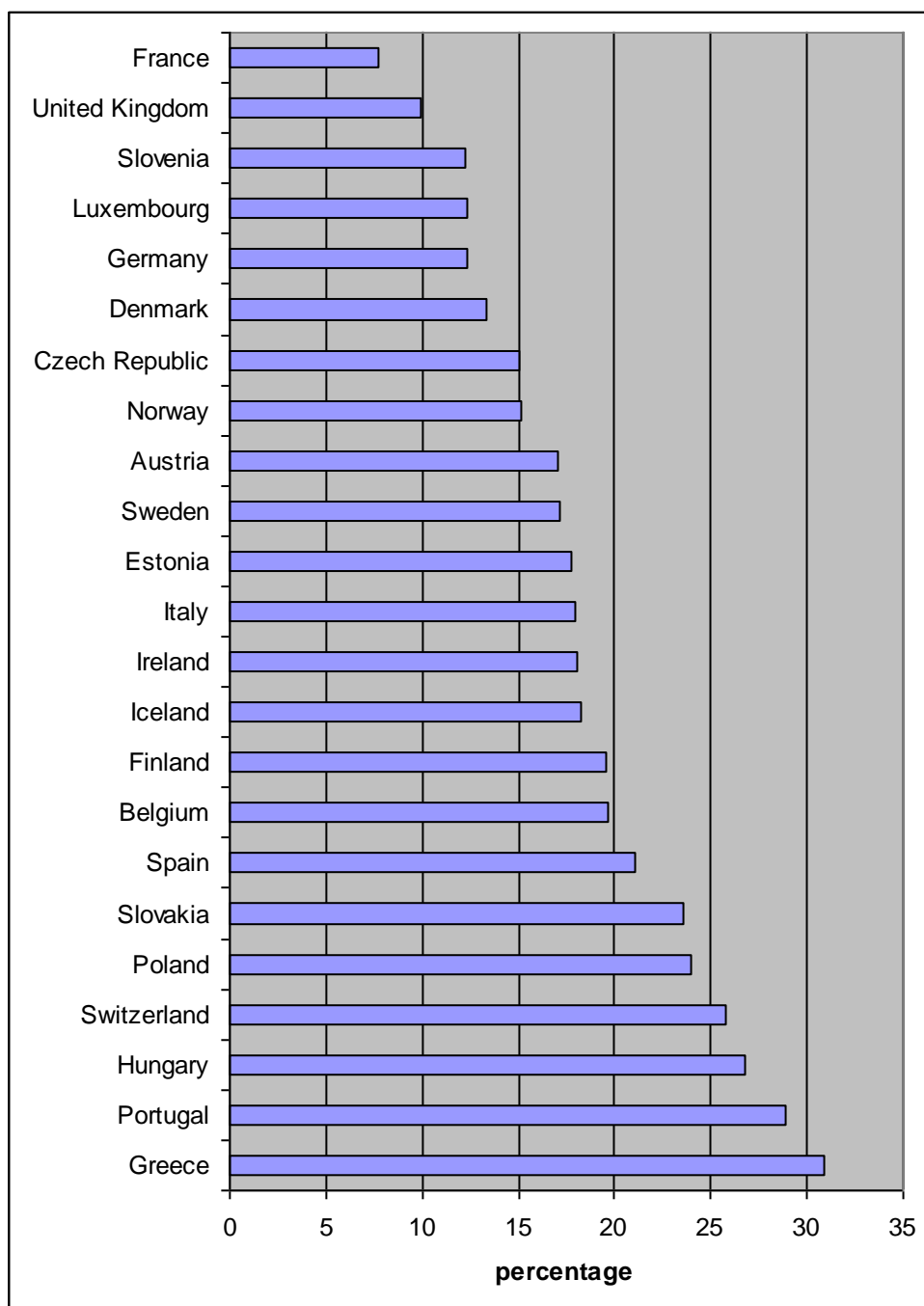
Even this, however, is not the whole story. OOP payments in themselves are highly regressive, i.e. they burden the poor more than the rich. Nevertheless, they can be modified by introducing exemptions and discounts for people of limited means. Such payments can be even more unfair for the sick, because they represent in effect a tax on sickness: however, this can also be countered to some extent by exemptions and ceilings.

---

<sup>9</sup> Information from the European Observatory of Health Systems and Policies (<http://www.euro.who.int/en/about-us/partners/observatory> )

**Table II. Percentage of total health expenses covered by “out-of-pocket” payments**

(Data: OECD, 2011, *ibid.*)



## 4. Variables included in the MIPEX Health Strand questionnaire

### Variables included in the MIPEX Health Strand questionnaire

This MIPEX Health Strand is a component of the 'Big Picture' project, which is a collaboration between the COST Action ADAPT, the IOM's **EQUI-HEALTH** project, and the Migration Policy Group (MPG). The results from this survey will shortly be available. As part of the 'Big Picture' project, qualitative information will also be provided in Country Reports to be published by the EQUI-HEALTH project. The following list gives an overview of the policy indicators that make up the MIPEX Health Strand.

#### A. Entitlement to health services

- 1) Entitlements for legal migrants (in the EU/EAA: "third-country migrants")
- 2) Entitlements for asylum seekers
- 3) Entitlements for undocumented migrants
- 4) Special entitlements for vulnerable groups
- 5) Additional administrative procedures
- 6) Out-of-pocket payments

#### B. Policies to facilitate access

- 7) Information for service providers about migrants' entitlements
- 8) Targeted information for migrants concerning entitlements and use of health services
- 9) Targeting of health education and health promotion for migrants
- 10) Measures to reduce practical obstacles to access / provision of cultural mediators
- 11) No obligation to report undocumented migrants / No sanctions against helping undocumented migrants

#### C. Responsive health services

- 12) Requirement to provide qualified interpreters
- 13) Requirement for 'culturally competent' or 'diversity-sensitive' services
- 14) Training and education of health service staff
- 15) Involvement of migrants in information provision, service design and delivery
- 16) Encouraging diversity in the health service workforce
- 17) Development of capacity and methods
- 18) Specific forms of the above

#### D. Measures to achieve change

- 19) Collection of data on migrant health
- 20) Support for research on migrant health
- 21) 'Health in all policies' approach
- 22) Whole organisation approach
- 23) Leadership by government
- 24) Policy involving stakeholders (especially migrants) in the design of national or regional migrant health policies.



# Appendix IV

## WP1 MEM-TP

---

Utilisation of health services, barriers to  
access and good practices to address them

Authors: Claire Mock-Muñoz de Luna,  
Emma Graval, David Ingleby

Date : October 13, 2014



## Table of contents

### Contents

<a href="#">1. Migrants' use of health care services</a> .....	51
<a href="#">2. Barriers to accessing health care – a literature review</a> .....	60
<a href="#">3. Review of good practices from EU-funded projects on how to improve access to health care system for migrants and ethnic minorities</a> .....	63

### **3. Migrants' use of health care services**

This section presents a literature review on migrant and ethnic minority use of health care services in European countries where these data are available.

Few studies have yet been conducted at the European level because of the lack of harmonisation of data collection standards relating to information on migrant and ethnic minorities.

The following results show the differences in the use of health services between several migrant groups and the native population of host countries. Services are categorised into the following types:

- General Practitioner (GP)
- Emergency
- Gynaecological
- Paediatric
- Mental health

Table 1 Overview of studies regarding use of health services of migrants per country.

Country	Health care service	Author(s) and published year	Utilization indicator	Country of origin	Data source and covered year(s)	Covariates*	Major outcomes
<b>SHARE</b> (Austria, Belgium, Denmark, France, Germany, Greece, Italy, Netherlands, Spain, Sweden, Switzerland)	<b>GP</b>	Sole-Auro et al. 2009 <sup>[1]</sup>	GP visits	Immigrants – not further specified	Survey, 2004	a,b,c,d,e	- Higher GP visits among elderly immigrants (above 50 years) in Belgium, Denmark, Germany, the Netherlands and Sweden (and Switzerland)
<b>Austria</b>	<b>GP</b>	Kerkenaar et al. <sup>[2]</sup>	Primary and secondary health care services use	First and second generation immigrants from Western (Belgium, France, Germany, Ireland, Italy, Luxembourg, Netherlands, Portugal, Scandinavia, Spain, Switzerland and the UK, USA, Canada and Australia) and Eastern Europe (Greece, Georgia, Turkey and the former Eastern Bloc countries)	Survey, 2010-2011	a,b,c,e	- Female migrants from Eastern Europe, first and second generation, had a higher prevalence of dysphoric disorders.  - Having a dysphoric disorder was associated with a higher utilization of primary and secondary health care services among migrant and Austrian women, but not among men.
	<b>Gynaecological care</b>	Oberaigner et al. 2013 <sup>[3]</sup>	Obstetric care	Ex-Yugoslavia, Turkey, Eastern Europe, Asia, Africa, America, other (European) countries	Survey 2009	a,b,e	- The first care visit after the 12th week of pregnancy was higher in migrant groups  - Vaginal delivery was more frequent in migrants from ex-Yugoslavia (78 %) and Turkey (83 %)  - Episiotomy was more frequently performed in

							migrants from other countries
<b>The Netherlands</b>	<b>GP</b>	Uiters et al. 2006 <sup>[4]</sup>	Any GP use (No further specification)	Morocco, Turkey, Surinam and Antilles.	Survey, 2001	a,b,c,e	- Higher GP service use among Turkish, Antilleans, Moroccans and Surinamese migrants
		Denktas et al. 2009 <sup>[5]</sup>	GP service	Morocco, Turkey, Surinam and Antilles	Survey, 2003	a,b,e	- Immigrant elderly show a higher use of GP services
		Gerritsen et al. 2009 <sup>[6]</sup>	GP contact	Morocco, Surinam, Turkey, Antilles	Survey, 2000-2002	a,b,c,d,e	- Moroccan and Antillean women more often contacted a GP compared to the men of these countries
		Klaufus et al. 2014 <sup>[7]</sup>	GP contact previous year	Morocco, Turkey, Surinam and Antilles	Survey, 2008	a,b,c,e	- More GP consultations among the migrant groups with a medium to high risk of common mental disorders.
		Uijen et al. 2008 <sup>[8]</sup>	GP contact for airway-related problems	Turkey, Morocco, Surinam	Registry, 2000-2002	a,b,e	- Immigrants tend to have less airway-related general practice contact
	<b>Gynaecological care</b>	Temel et al. 2013 <sup>[9]</sup>	Preconception care	Morocco, Turkey, Surinam and Antilles	Survey, 2009-2010	a,b,e	- Intention to attend preconception care was higher in Turkish and Moroccan women, a higher maternal age and a positive attitude. No relationship, multiparity with adverse outcome, high educational level, having paid work and a high barrier experience are related to a lower intention

		Alderliesten et al. 2007 <sup>[10]</sup>	First antenatal visit	Morocco, Turkey, Antilles, Surinam, Ghana, other non-Western, other Western	Survey, 2003-2004	a,b,e	All migrant groups were later in starting antenatal care during the whole duration of pregnancy
		Chote et al. 2009 <sup>[11]</sup>	Antenatal care	Surinam- Hindustani, Surinam- Creole, Turkey, Morocco, Cape-Verdi, Antilles	Survey, 2002-2006	a,e	More women in ethnic minority groups make less adequate use of antenatal care, except in Surinamese-Hindustani and Turkish women
	<b>Mental health care</b>	Schellingerhout. 2004 <sup>[12]</sup>	Contact with a mental health care worker the past 12 months	Morocco, Turkey, Surinam, Antilles and Moluccan Islands	Survey, 2003	a,b	- Turkish and Moroccans seem to make less use of mental health care
		Koopmans et al. 2012 <sup>[13]</sup>	Contact with outpatient mental health care services the past 12 months	Morocco, Turkey, Antilles, Surinamese	Survey, 2001-2003	a,b,c,e	- Lower levels of outpatient mental health care in all migrant groups
		Laban et al. 2007 <sup>[14]</sup>	Psychiatric services (mental health professional); in-patient services: hospital admission physical health, hospital admission mental health	Iraqi asylum seekers	Survey, 2001	a,b,e	- Iraqi asylum seekers have a low level of mental health service use, despite the high levels of psychiatric disorders and other health indicators, especially within the group that stayed in the asylum procedure for over 2 years
		Gerritsen et al. 2009 <sup>[15]</sup>	Ambulatory mental health care contact	Morocco, Surinam, Turkey, Antilles	Survey, 2000-2002	a,b,c,d,e	- Women from Morocco more often contacted ambulatory mental health care than men from this country
		Klaufus et al. 2014 <sup>[7]</sup>	Mental health care specialist	Morocco, Turkey, Surinam and Antilles	Survey, 2008	a,b,c,e	- Migrants with medium to high risk for common mental disorders more often visit a mental health care specialist

		De Haan et al. 2012 <sup>[16]</sup>	Youth mental health care	Morocco, Turkey, Surinam, Antilles, other non- native western, other non-native non-western, other African countries	Registry, 2009	n.i	- 2 <sup>nd</sup> generation Moroccans make less use of mental health care than the 1 <sup>st</sup> generation Moroccans.
		Fasseart et al. 2009 <sup>[17]</sup>	Mental health services use	Turkey, Morocco and other	Survey, 2004	a,b,c,e	- Female children from Moroccan, Turkish and other non-native western descent were less likely to enter mental health care
		Van der Post et al. 2011 <sup>[18]</sup>	Psychiatric emergency compulsory admission	Morocco, Turkey, Surinam, Antilles, Sub-Saharan Africa, other non-Western and other Western	Registry, 2004-2006		- For CMD, ethnic groups were equally likely to access specialised mental health services  - For psychological distress, Moroccan migrants reported less uptake of primary care services
<b>Denmark</b>	<b>GP</b>	Nielsen et al. 2012 <sup>[19]</sup>	GP contact	Yugoslavia, Iran, Iraq, Lebanon, Pakistan, Somalia, Turkey; and Turkish and Pakistani descendants	Registry and survey, 2007	a,b,e	- Increased use of GP services among most immigrant groups
	<b>Emergency care</b>	Nielsen et al. 2012 <sup>[19]</sup>	ER contact	Yugoslavia, Iran, Iraq, Lebanon, Pakistan, Somalia, Turkey; and Turkish and Pakistani descendants	Registry and survey, 2007	a,b,e	- Increased use of ER by immigrants
		Norredam et al. 2007 <sup>[20]</sup>	ER visits	Western, Middle Eastern, other Western (WHO guideline)	Survey, 2004-2005	n.i	- Migrants have more irrelevant ER claims, presumably because of barriers in access to primary care



	<b>Mental health</b>	Nielsen et al. 2014 <sup>[21]</sup>	Psychiatric and psychological care	Labour immigrants from Pakistan and Turkey and immigrants from Iran, Iraq, Lebanon and Somalia	Survey and registry, 2007	a,b,c,e	<ul style="list-style-type: none"> <li>- For psychiatrists, all immigrant women had increased use, while labour-immigrant men had decreased use</li> <li>- For psychologists, immigrant men from RGC had increased use, while labour-immigrant women had decreased use</li> </ul>
<b>Germany</b>	<b>GP</b>	Glaesmer et al. 2011 <sup>[22]</sup>	GP visits	First and second generation immigrants – not further specified	Survey, 2007	a,b	- First generation immigrants more frequently use general practitioners (GPs) than the second generation immigrants
	<b>Mental health care</b>	Wittig et al. 2008 <sup>[23]</sup>	Mental health care institutions	Poland, Vietnam	Survey, 2004	a,b,e	- Psychosocial and medical institutions are visited less by Polish and Vietnamese immigrants
<b>Italy</b>	<b>GP</b>	De Luca et al. 2012 <sup>[24]</sup>	GP visits	Albania, Morocco, Romania, born- EU 25, born non EU, Africa, America, Asia	Survey, 2004-2005	a,b,c,d,e	- No differences
	<b>Emergency care</b>	De Luca et al. 2012 <sup>[24]</sup>	Emergency room utilization	Albania, Morocco, Romania, born- EU 25, born non EU, Africa, America, Asia	Survey, 2004-2005	a,b,c,d,e	<ul style="list-style-type: none"> <li>- Higher ER utilization among immigrants</li> <li>- More ER visits among first-generation immigrants</li> </ul>
		Signorotto 2010 <sup>[25]</sup>	Emergency related services	Albania, Romania, Morocco, non-EU countries, Africa, Asia, Latin America	Survey, 2004-2005	a,b,e	- Higher use of emergency related services among male immigrants
		Bonvicini et al. 2011 <sup>[26]</sup>	Emergency room services	Immigrants from developing countries and temporary immigrants with residence and citizenship in developing country	Registry, 2007-2010	n.i	<ul style="list-style-type: none"> <li>- More access of the ER services among immigrants</li> <li>- More non-urgent accesses among immigrants</li> </ul>

	<b>Paediatric care</b>	Grassino et al. 2009 <sup>[27]</sup>	Paediatric emergency department visit	Northern en sub-Saharan Africa, Nile Valley/Arabian countries, China, Asia, India, Pakistan, Sri Lanka, non-UE Eastern European countries	Survey, 2007	n.i	- No observed differences of access
	<b>Gynaecological care</b>	Signorotto 2010 <sup>[25]</sup>	Obstetric services	Albania, Romania, Morocco, non-EU countries, Africa, Asia, Latin America	Survey, 2004-2005	a,b,e	- Immigrant women over use obstetric services, but undergo less visits to monitor the pregnancy
<b>Spain</b>	<b>GP</b>	Munoz et al. 2012 <sup>[28]</sup>	GP consultations	Before 2004 EU, after 2004 EU, Maghreb, Africa, Latin America and Asia	Registry, 2008	a,b,d	- More consultations with GPs among immigrants  - People coming from the Maghreb and the rest of Africa requested the most consultations involving a GP and nurse  - Immigrants from Asia had the lowest numbers of consultations with a GP
		Hernandez-Quevedo et al. 2008 <sup>[29]</sup>	GP visits	Latin America, European Union, other non European countries, North America, Oceania, Africa, Asia	Survey, 2003 and 2006	a,b,c,d,e	- Latin American and European Union individuals report a higher probability of a GP visit  - Nationals from Europe, North America and Oceania report a lower probability of visiting the GP
		Anton et al. 2010 <sup>[30]</sup>	GP visits	EU 15 immigrant and non-EU immigrant	Survey, 2006-2007	a,b,c,d,e	- No differences regarding GP visits among migrants
		Sanz et al. 2011 <sup>[31]</sup>	GP service	Western countries, Eastern Europe, Latin America, North Africa, Sub-Saharan Africa and Asia/Oceania	Survey, 2006	a,b,c,d,e	- Sub-Saharan women use more often GP services

	<b>Emergency care</b>	Hernandez-Quevedo et al. 2008 <sup>[29]</sup>	Hospital emergency services	Latin America, European Union, other non European countries, North America, Oceania, Africa, Asia	Survey, 2003 and 2006	a,b,c,d,e	- Latin Americans and Africans have higher probabilities of an emergency visit. - Citizens from the European Union and Europe report lower probabilities of visiting hospital emergency services.
		Buron et al. 2008 <sup>[32]</sup>	Emergency department utilization	Foreign-born – not further specified	Registry, 2004	a,b	- Lower emergency department utilization rates
		Anton et al. 2010 <sup>[30]</sup>	Emergency room visits	EU 15 immigrant and non-EU immigrant	Survey, 2006-2007	a,b,c,d,e	- More emergency room visits among migrants
		Sanz et al. 2011 <sup>[31]</sup>	Emergency services	Western countries, Eastern Europe, Latin America, North Africa, Sub-Saharan Africa and Asia/Oceania	Survey, 2006	a,b,c,d,e	- Latin American men and Sub-Saharan women use more often emergency services
		Aerny Perreten et al. 2010 <sup>[15]</sup>	Emergency facilities	Immigrants of medium-to-low income countries	Survey, 2007	a,b,	-Attendance at emergency facilities was less frequent in men and women with less residence time than in those with longer residence
<b>Portugal</b>	<b>Gynaecological care</b>	Almeida et al. 2014 <sup>[33]</sup>	Obstetric care	Brazil, Eastern Europe, Africa	Survey and Registry, 2012	n.i	- Immigrant women were more likely to have their first pregnancy appointment after 12weeks of pregnancy and to have fewer than three prenatal visits, more likely to have had a caesarean delivery, perinatal laceration or postpartum haemorrhage
<b>UK</b>	<b>GP</b>	Chan Aung et al. 2010 <sup>[34]</sup>	GP contact	Burmese migrants	Survey, 2009	a,b,c,e	- Low rate of GP services use during the last episode of illness among Burmese migrants
		Nazroo et al. 2009 <sup>[35]</sup>	GP visit past 2 weeks	Pakistan, India, Bangladesh	Survey, 2004	a,b,e	- No differences were found of GP services use among Indian, Pakistani and Bangladeshi

	<b>Gynaecological care</b>	Shah et al. 2011 <sup>[36]</sup>	Obstetric outcomes	China	Survey, 2006-2008	n,i	<ul style="list-style-type: none"> <li>- Chinese women accessed less health care during their pregnancy. Chinese women were also less likely to deliver by caesarean section, but more likely to have a perinatal tear</li> <li>- Poles were less likely to have a Caesarean section and more likely to have a spontaneous vaginal or instrumental delivery</li> <li>- Minority women access antenatal care later in pregnancy, fewer antenatal checks, less ultrasound scans and less screening</li> <li>- African women were more likely to deliver by emergency caesarean section</li> </ul>
		Gorman et al. 2014 <sup>[37]</sup>	Maternity care	Poland	Registry, 2004-2009	b,e	
		Henderson et al. 2013 <sup>[38]</sup>	Maternity care	India, Pakistan, Bangladesh, Caribbean, Africa, other	Survey, 2010	b,e	
<b>Sweden</b>	<b>Gynaecological care</b>	Rassjo et al. 2013 <sup>[39]</sup>	Maternity health services	Somali immigrant women	Registry, 2001-2009	a,b	<ul style="list-style-type: none"> <li>-Somali women booked later and made less visits for antenatal care. Emergency caesarean section, especially before start of labour, high perinatal mortality with seven versus one perinatal deaths and small for date infants was more prevalent</li> </ul>
		Ny et al. 2007 <sup>[40]</sup>	Antenatal care	Eastern- and Southern Europe, Iraq, Lebanon, Asia	Registry, 2000 - 2003	a,b,e	<ul style="list-style-type: none"> <li>- Lower utilisation of planned antenatal care was found among some groups of foreign-born women</li> <li>- Women born in Eastern and Southern Europe, Iraq and Lebanon, and Asia had fewer antenatal visits than recommended, and all foreign-born women (except for women born in Iraq and Lebanon, and South and Central America) had a late first visit</li> <li>- Foreign-born women had, in general, fewer unplanned visits to a physician at the delivery ward</li> <li>- Women originating from Asia, Iraq and Lebanon, and</li> </ul>

							Africa had higher utilisation visits to midwives at the delivery ward
<p>* Adjusted for covariates:</p> <ol style="list-style-type: none"> <li>Sex</li> <li>Age</li> <li>Socio-economic factors</li> <li>Health status</li> <li>Other factors</li> </ol> <p>n.i = no information</p> <p>#We like to refer to a the systematic reviews Norredam et al. <sup>[41]</sup> and Uiters et al. <sup>[42]</sup> for studies regarding (somatic) health care services use which also contains studies with survey or registry data before 2001.</p>							

## 2. Barriers to accessing health care – a literature review

**Table 2 : Barriers to accessing healthcare for MEM - Literature review**

Title	Authors	Year of publication	Country	Obstacles identified	Other results
<b>The health of recent migrants from resource-poor countries</b>	Chi Eziefula Mike Brown	2009	United Kingdom	<ul style="list-style-type: none"> <li>-Culture differences in Doctor's perceptions and role.</li> <li>-Ambiguity concerning healthcare entitlement</li> <li>-Language</li> <li>-Stigma</li> <li>-Dispersal programs for refugees</li> <li>-Poverty</li> </ul>	<ul style="list-style-type: none"> <li>-Profile of the main disease affecting migrant</li> <li>-Highlight the fact that screening and access to healthcare system for migrant should focus on primary care because it is cost effective</li> </ul>
<b>Bridging obstacles to transcultural caring relationships—Tools discovered through interviews with staff in paediatric oncology care</b>	Pergerta P., Ekbladb S., Enskaörc K. and Olle Bjoärka	2007	Sweden	<ul style="list-style-type: none"> <li>-Obstacles are conditions that can hamper mutual understanding and damage or even block the relationship's further development</li> <li>-Include linguistic, cultural and religious, social, and organizational obstacles</li> </ul>	<ul style="list-style-type: none"> <li>-Use by staff of "bridging method" to overcome cultural obstacles.</li> <li>-Set of communication, transcultural and organization tools to "bridge" obstacles</li> </ul>
<b>Sexual and reproductive health of migrant: does the EU care?</b>	Keygne I., Guieu A., Ooms G., Vettenburg N., Temmerman M. and Roelenss	2013	28 European Countries	<ul style="list-style-type: none"> <li>-lack of transparency</li> <li>-criminalization of migrants</li> <li>-gaps between EU laws and national applications</li> <li>-out pocket payment</li> <li>-language barrier</li> <li>-lack of information</li> </ul>	<ul style="list-style-type: none"> <li>Recommendation to bridge obstacle and improve access to healthcare for migrants at : <ul style="list-style-type: none"> <li>-individual and interpersonal level</li> <li>-organizational level</li> <li>-societies level</li> </ul> </li> </ul>

	K.			-complexity of healthcare system	
<b>Migration and health in an increasingly diverse Europe</b>	Rechel B., Mladovsky P., Ingleby D., Mackenbach J.P. and Mckee M.	2013	WHO European region	-inadequate legal entitlement -no mechanism to ensure respect of entitlement (no minimum standards meets) -users fees -administrative complexity -language barriers -lack of information -gaps in health literacy -social exclusion -discriminations	
<b>How health systems can address health inequalities linked to migration and ethnicity</b>	WHO	2010	WHO European Region	-Individual discriminations -Institutional discrimination -Help seeking behaviour difference -Language barriers -Social and cultural barriers -Lack of information about Health system procedure in host country -Stigma fear -Practical barriers (financial, waiting list, schedule, transport, location of healthcare service) -Perception of health system : trust issue	Good practices identification  Basement of the quality of delivered services to migrants  Measures to promote equity in health services  Priorities for further research
<b>QUALITY IN AND EQUALITY OF ACCESS TO HEALTHCARE SERVICES</b>	HealthQUEST project M. Huber, A. Stanciole, K. Wahlbeck, N. Tamsma, F. Torres, E Jelfs J. Bremner	2008	Finland Germany Greece Netherlands Poland Romania Spain United Kingdom	-Requirements for obtaining residency -Literacy, cultural and language barriers -Administrative and bureaucratic complexity	
<b>Migration: A social determinant of migrant's health</b>	Davies A., Basteb A. and Frattini C.	2010	EU	-Poverty -Social exclusion -entitlement to care and accessibility of services lack of information -mobility -communication barriers	

				<ul style="list-style-type: none"> <li>-gap in cultural perception and practices of health</li> <li>-lack of information about preventive services</li> </ul>	
<b>Access to healthcare in europe in time of crisis and rising xenophobia</b>	Doctor of the World Chauvin P.	2013	Belgium, France Germany Greece Netherland Spain, Sweden Switzerland UK	<ul style="list-style-type: none"> <li>-Language</li> <li>-Limited mobility due to the fear of being arrested ( UDM)</li> <li>-Denial of access and racism</li> </ul>	<ul style="list-style-type: none"> <li>-impact of the economic and social crisis on access to healthcare in Europe for people confronted with vulnerability factors</li> <li>-analysis of social and medical data collected in 2012 (source MdM)</li> <li>-Destitute European citizen and access to healthcare</li> <li>-Rise of Xenophobia as the crisis deepens</li> <li>-time for action</li> </ul>
<b>Good practice in health care for migrant. Views and experiences of care professionals in 16 European countries</b>	Priebe S et al	2011	Austria, Belgium, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Poland, Portugal, Spain, Sweden, United Kingdom	<ul style="list-style-type: none"> <li>-Langage</li> <li>-Difficulties in arranging care for migrant without health care coverage</li> <li>-Social deprivation and traumatic experiences</li> <li>-Lack of familiarity with the healthcare system</li> <li>-Different understanding of illness and treatment</li> <li>-Cultural differences</li> <li>-Negative attitude of staff and patients</li> <li>-Lack of access to medical history</li> </ul>	Component of good practices: <ul style="list-style-type: none"> <li>-Organisational flexibility with sufficient time and resources</li> <li>-Interpreting services</li> <li>-Working with families and social services</li> <li>-Cultural awareness of staff</li> <li>-Education programmes and information material for migrants</li> <li>-Clear guideline on health entitlement of different group of migrants</li> </ul>



### **3. Review of good practices from EU-funded projects on how to improve access to health care system for migrants and ethnic minorities - Project materials to improve access to health services**

#### **AIDS and Mobility**

The project focuses on migrant health education regarding HIV transmission, screening and treatment.

- Key materials:

-A&M guide book(available in 16 languages):

[http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/a\\_m\\_guidebook/A\\_M\\_Guidebook\\_English.pdf](http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/a_m_guidebook/A_M_Guidebook_English.pdf)

It has been written to assist people from many cultural and language backgrounds, especially young people and their families, to better protect themselves. It also aims to take away fear, to enable dialogue and to help in fighting stigma and discrimination against people living with HIV, AIDS or hepatitis

-A&M Master toolkit:

[http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/master\\_toolkit/A\\_M\\_Master\\_Toolkit\\_Guiding\\_Document.pdf](http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/master_toolkit/A_M_Master_Toolkit_Guiding_Document.pdf)

This toolkit is a pedagogic support to help health professional to train peer mediators in a logic of community health program, helping them to overcome cultural barriers.

#### **AURORA**

This project includes a training course programme for health professional to improve understanding of the needs of “hard to reach” groups concerning cervical cancer screening. The training programme deals with the issue of cultural differences and the necessity to build cultural competencies.

- Key materials:

Report about the Good Practices identified and analyzed [http://www.aurora-project.eu/upload/deliverables/D4\\_Report\\_about\\_the\\_Good\\_Practices\\_identified\\_and\\_analyzed.pdf](http://www.aurora-project.eu/upload/deliverables/D4_Report_about_the_Good_Practices_identified_and_analyzed.pdf)

#### **COBATEST**

The aim of this project is to foster good practices in the development of HIV community based voluntary counseling.

- Key material

A guide to doing it better in our CBVCT centres

<http://www.cobatest.org/documents.php?group=00000012>

#### **Healthy inclusion**

This project aims at developing health promotion actions targeting migrant.

- Key materials

Good practices Guide (in German)

[http://www.rotekreuz.at/fileadmin/user\\_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI\\_recommendations\\_AT\\_dr.uck%202pdf.pdf](http://www.rotekreuz.at/fileadmin/user_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI_recommendations_AT_dr.uck%202pdf.pdf)

## **PROMOVAX**

The project aims at promoting migrant immunization.

- Key materials

Toolkits for migrants and health care professionals

[http://www.promovax.eu/toolkits/MT\\_english\\_web.pdf](http://www.promovax.eu/toolkits/MT_english_web.pdf) (migrants)

[http://www.promovax.eu/toolkits/HCW\\_english\\_web.pdf](http://www.promovax.eu/toolkits/HCW_english_web.pdf) (professionals)

## **TAMPEP**

The aim of this project is to reduce the HIV vulnerability of migrant and mobile sex workers through the development, exchange, promotion and implementation of appropriate policies and interventions across Europe.

- Key materials

European Good Practice Manual with examples of comprehensive intervention strategies adaptable to various settings.

<http://tampep.eu/documents.asp?section=trainingmanuals>

For all resources published as part of this project :

<http://tampep.eu/documents.asp?section=resources>

# Appendix V

## WP1 MEM-TP

---

Good practice in improving health service  
delivery to migrants and ethnic minorities -  
literature and EU funded projects

Authors: Claire Mock-Muñoz de Luna,  
Emma Graval, David Ingleby

Date : October 13, 2014



## Table of Contents

1. <a href="#">Introduction</a> .....	67
2. <a href="#">International literature review on best practices to improve migrant and ethnic minorities access to the healthcare system</a> .....	68
3. <a href="#">Review of good training practices from the EU-funded projects</a> .....	72

## 1. Introduction

For the purposes of this project, the aim of which is to develop training in ‘cultural competence’ or ‘diversity sensitivity’ for health professionals, the search for good practices will focus on examples of work carried out in the area of adapting health services to diversity through training of health professionals.

At present, few initiatives that have been labeled as ‘best’ or ‘good’ practices have actually been evaluated properly.<sup>10</sup> The heterogeneity of training interventions in health care settings and the variations in the descriptions of key elements (e.g. cultural competencies, definition of migrants and ethnic minorities) has made assessment and evaluation of their effectiveness very challenging, and the quality of resulting evidence low.<sup>11</sup> In the field of Roma health in Europe, however, a small number of initiatives (e.g. cultural mediators) have been evaluated, adopted at national level, and replicated in several countries.

With regard to cultural competence education and training for health professionals, several standards have been developed to assess the appropriateness and effectiveness of the training methods and materials, with regard to ultimate health outcomes for patients, health professional outcomes and healthcare organisation outcomes<sup>12</sup>.

There are frequent recommendations in the literature that the values of cultural competence or diversity sensitivity need to be addressed and adopted not only at the individual level, but also at the level of health systems and service provider organisations, so that these values will become an integral part of the organisational culture and value base.<sup>13,14</sup>

---

<sup>10</sup> Fortier J. P., Bishop, D. (2003). *Setting the agenda for research on cultural competence in health care: final report*. Edited by C. Brach. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.

<sup>11</sup> Beach MC, Price EG, Gary TL, et al (2005). Cultural competence: a systematic review of health care provider educational interventions. *Med Care*;43(4):356–73.

<sup>12</sup> Horvat L, Horey D, Romios P, Kis-Rigo J. (2011). Cultural competence education for health professionals. Cochrane Database of Systematic Reviews, Issue 10. Art. No: CD009405

<sup>13</sup> Seeleman MC. (2014) *Cultural competence and diversity responsiveness: how to make a difference in health care?* PhD Thesis Academic Medical Centre, University of Amsterdam. Available at: <http://dare.uva.nl/record/468191>.

<sup>14</sup> Mladovsky, P. et al (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.

## **2. International literature review on best practices to improve migrant and ethnic minorities access to the healthcare system**

**Mladovsky, P., Ingleby, D., McKee, M., Rechel, B. (2012). Good Practices in migrant health: the European experience. *Clinical Medicine* Vol. 12, No 3: 248-252.**

Best practices in improving access to and responsiveness of healthcare for migrants and ethnic minorities:

- Introduce more diversity into health workforce
- Health services should establish outreach programmes into migrant communities, as well as involve migrant community groups on patient platforms and consultative bodies
- Effective and targeted health promotion interventions amongst migrant and minority ethnic groups, targeting specific health issues

Good practices for health professionals: Overcoming barriers to access

- Mobile health units to reach the 'hard to reach' communities
- Non-governmental organisations such as Doctors of the World and the International Red Cross have set up clinics for undocumented migrants and failed asylum seekers who have lost all entitlements to healthcare or are only eligible to limited, emergency provision.
- Critics of the above two examples of how to reach the 'hard to reach' communities, argue that these 'stop-gap' measures, often not sustainable and reliant on voluntary commitments of professionals, prevent governments from having to change their stance on health and social entitlements for undocumented migrants and failed asylum seekers.

Bridging cultural barriers to healthcare:

- Incorporating cultural competence into basic training of all health professionals, or providing in-service training at a later stage
- Viewing 'cultural competence' not as fluency in a number of 'cultures' (often leading to stereotyping), but rather as a set of skills and attitudes in cross-cultural communication, respect and openness to difference, and other relevant knowledge.
- The integration and use of cultural mediators in healthcare has been shown to help patients of migrant and ethnic minority background to navigate the health system and improve interaction with the healthcare services and the patient health outcomes.

**Priebe, S. et al (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC Public Health*, 11:187.**

Health practitioners who participated in the project mentioned the following 'good practices' already in place in their work environments or as recommendations for how the services could be improved:

- Organisational flexibility with sufficient time and resources
- Good interpreting services
- Working with families and social services

- Cultural awareness of staff
- Education programmes and information material for migrants
- Positive and stable relationship with staff
- Clear guidelines on care entitlements of different groups of migrants

**Bennegadi, R. (2009). Cultural Competence and Training in Mental Health Practice in Europe: Strategies to implement Competence and Empower Practitioners. International Organization for Migration (IOM) Background Paper**

Developed within the framework of the IOM project "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities."

In designing a training programme in cultural competence for mental health practitioners, the author suggests the following factors should be considered to ensure the most effective form of training for any healthcare service structure:

- The specificity of the targeted migrant population
- The access to mental healthcare services for migrants and refugees
- The availability of mental healthcare services for migrants and refugees
- The availability of formal education training in cultural competence for mental healthcare professionals and related professions (psychiatrists, psychologists, social workers, nurses, etc.)
- Local healthcare systems, their funding and the availability of services specifically catering to migrants
- Crucial element to successful professional development and overall organizational practice: Cultural competence training must be validated by on-site professional supervision so that new skills are implemented and assessed in real-life situations.

In mental healthcare, the use of language interpreting and intercultural mediation is especially important as a tool in patient assessment and diagnosis.

Innovative strategies and best practices:

*Case Study A. Centre Françoise Minkowska (Paris)*

Key elements of the training provided by the centre:

- Training modules include: Socio-cultural Module, Psycho-sociological Module, Psycho-anthropological Module, Psychopathological Module, and Ethical Module
- Goals of the training include: acquisition of analytical tools to confront cultural representations of mental illness, improvement of intercultural management in the mental care practice with migrants, overcoming intercultural communication obstacles and developing relational capacities in intercultural situations.
- Multidisciplinary training team made up of psychiatrists, psychologists, social workers, anthropologists, sociologists, ethnographers and philosophers. Outside experts working on intercultural issues from a clinical medical anthropological perspective
- Innovative multi-media training tool (AMECLIN) on intercultural settings and relationships, for the training of any healthcare professional



**Suurmond, J. et al (2010). Cultural Competence among nurse practitioners working with asylum seekers. *Nurse Education Today*: 30 821-826**

This article explores the cultural competences nurse practitioners identified as key to being able to effectively work with patients who are asylum seekers. They identified a number of areas they needed more competence in:

- Knowledge:
  - Political and humanitarian situation in countries of origin
  - Epidemiology and manifestations of disease related to country of origin
  - Health effects of being a refugee
- Attitudes
  - Juridical context in host country
  - How culture shapes behavior and thinking in individuals
  - Awareness of one's own prejudice and stereotypes
- Skills
  - How to develop trust with asylum seekers
  - Asking about sensitive issues such as traumatic experiences, personal problems
  - Clarifying expectations from health care
  - Transferring information in an intelligible way, and when necessary, involving an interpreter
  - Flexibility and creativity in dealing with new situations

**Seeleman, C. et al (2011). Teaching communication with ethnic minority patients: Ten recommendations. *Medical Teacher* 33: 814-819.**

This article describes the reported experiences and ideas of professionals involved in the training of cultural competence of medical students at Dutch and Belgian medical schools. The ten recommendations for teaching communication with ethnic minority patients are based on questionnaires filled out by these professionals.

Recommendations:

- a) *Develop a clear view on the content of the training.* How does the organization envision 'culturally competent medical communication'? Training should be developed based on a clear conceptualization of differences and commonalities existing between general medical communication and communication with patients of migrant and minority ethnic background.
- b) *Teach all students.* All students training to become physicians should develop skills in culturally competent communication with patients. This subject should therefore figure as a part of standard medical curriculum, at all levels and to all students.
- c) *Stimulate awareness of cultural and personal biases.* Training should explore the following two areas of awareness: i) Students' awareness of their own cultural background and perspectives, ii) Students' awareness of their attitudes towards individuals from ethnic minority backgrounds, as a starting point for further reflection in group sessions.
- d) *Stimulate an attitude of openness, interest and respect.* These three attitudes are essential for effectively applying learned communication skills in a practical setting. These attitudes are key to understanding patients' perspectives and preventing hasty judgement.

- e) *Listen, explore and check.* Avoiding misunderstanding in key elements of communication: language, and interpretation of what is said (shared meaning of words). Teaching the need for asking additional, exploring questions to ensure mutual understanding.
- f) *Practice with a professional interpreter.* Learning why and when an interpreter is needed, and how to communicate with a patient through interpreters.
- g) *Acquire knowledge at a meta-level.* Knowledge of supposed characteristics of different cultures can lead to stereotyping. Therefore, training should emphasize a higher level understanding of aspects of culture, such as theories on mechanisms that influence health and health care in patients from ethnic minorities.
- h) *Offer a variety of educational experiences.* Use of innovative learning methods such as role-play and communication exercises
- i) *Conditions at classroom level: Safety is crucial.* In order for students to feel comfortable in reflecting on their own assumptions and moral values, a classroom environment must feel safe and facilitate a supportive and open learning environment.
- j) *Stereotyping is a persistent pitfall.* Teachers must enable students to examine and learn to deal with their own stereotypes.

### **3. Review of good training practices from the EU-funded projects**

#### **Guide to work with the Roma community in health services**

The goal of this project is to build competencies regarding the Roma culture to allow the health professionals to better address their needs

- Key training materials

Handbook for Action in the Area of Health Services with the Roma Community

<http://www.romanicriss.org/PDF/Guia%20trabajar%20con%20servicios%20sanitarios%20-gitanos%20ingles.pdf>

#### **IENE**

The goal of this project is to design cultural competency training material for nurses.

- Key training materials:

Good practices manual

<http://www.ieneproject.eu/download/Outputs/Good%20Practice%20Manual.pdf>

Training plan

<http://www.ieneproject.eu/teaching.php>

#### **TAMPEP**

The international network created thanks to this projects aims at reducing the HIV vulnerability of migrant sex workers. To reach this goal, training materials were developed by the network.

- Key training materials:

Cultural mediators in the area of prostitution, transnational training

[http://tampep.eu/documents/transnational\\_training.pdf](http://tampep.eu/documents/transnational_training.pdf)

Skills, Training and Good Practice Tools

[http://tampep.eu/documents/Skills\\_Training\\_Good\\_Practice\\_Tools\\_in\\_Europe.pdf](http://tampep.eu/documents/Skills_Training_Good_Practice_Tools_in_Europe.pdf)

#### **TRICC**

This projects aims at promoting bilingual and cultural competencies of health professionals.

- Key training materials

TRICC International Handbook

[http://www.tricc-eu.net/download/International\\_handbook\\_tricc.pdf](http://www.tricc-eu.net/download/International_handbook_tricc.pdf)

#### **T-Share**

This project aims at fostering and developing a transcultural approach of care with a particular attention to women and mental health.

- Key training materials

Training protocol

<http://www.tshare.eu/drupal/en/training>

# Appendix VI

## WP1 MEM-TP

---

### EU-funded projects addressing migrant and ethnic minority health

Authors: Claire Mock-Muñoz de Luna,  
Emma Graval, David Ingleby

Date : October 13, 2014



## Introduction

This appendix summarizes the main EU-funded projects, their results, publications and other materials produced during their realisation. It has been designed to help the MEM-TP project's stakeholders and beneficiaries to identify the materials and data available at the European Union level.

Most of the EU-funded projects target both migrants and ethnic minorities in their own right but a number of them include migrants and ethnic minorities as “vulnerable groups”. In order to clarify the situation and help readers in their research we divided the projects into two categories:

- MEM projects: this category contains projects targeting migrants or migrants and ethnic minorities in their own right or as a sub group of “vulnerable populations”
- Roma projects: this category contains projects targeting the Roma community specifically.

The following table gives the themes in each project; it can be used as reading guidance for identifying specific projects according to their topics or funders. According to the specifications of the MEM-TP project proposal, we classify the EU projects according to five main themes:

- Addressing health inequalities of MEM at the policy level
- Addressing health inequalities of MEM at the implementation level
- Research on MEM health
- Networking
- Training

Each project may deal with more than one theme.

**Table 1: EU-funded projects on migrants and ethnic minorities by research theme and funding source.**

(Projects dealing exclusively with Roma are listed after the MEM projects)

Projects	Addressing health inequalities of MEM at policy level	Addressing health inequalities of MEM at implementation level	Research on MEM health	Networking	Training
<b>DG SANCO</b>					
AIDS&MOBILITY	X	X		X	X
AMAC	X		X	X	
AURORA					X
AVEROES	X	X		X	
BORDERNETWORK	X	X		X	X
COBATEST HIV		X			X
CORRELATION I & II	X		X		X
EQUI HEALTH	X		X	X	
EQUITY ACTION	X		X		
eQuity		X			X
EUGATE			X		X
EURO HIV EDAT			X		
HEALTHY INCLUSION		X	X		
IMPACT		X			X
MEHO			X	X	
MIGHEALTHNET		X	X	X	
MFH		X			X
NOWHERELAND			X		X
PROMOVAX		X			X
TAMPED		X		X	X
TUBIDU		X		X	X
<b>DG EAC</b>					
CHANCE		X			X
C2ME		X			X
EQUITY					X
IENE I					X
IENE II				X	X
TRANSFORM					X
TRICC		X		X	X
T-SHARE				X	X
<b>DG HOME</b>					
HEALTHCARE FOR ASYLUM SEEKERS IN THE EU		X	X	X	
HEALTHY AND WEALTHY TOGETHER		X	X	X	X

PROTECT	X			X	X
<b>DG EMPL</b>					
BETTER HEALTH FOR BETTER INTEGRATION HEALTHQUEST	X	X	X	X	X
<b>DG R &amp; I (FP7)</b>					
COHEMI	X			X	
COST ADAPT	X	X	X	X	
COST HOME		X	X	X	
EPIMIGRANT			X		
EUNAM			X	X	
EUROCOORD			X	X	
GIFT		X	X	X	
RESTORE			X		X
RODAM			X	X	
SOPHIE	X	X	X		
<b>PROJECTS DEALING EXCLUSIVELY WITH ROMA</b>					
<b>DG SANCO</b>					
GUIDE TO WORK WITH ROMA COMMUNITY IN HEALTH SERVICES HEALTH AND THE ROMA COMMUNITY : ANALYSIS OF THE SITUATION IN EUROPE IMPROVE ACCESS TO HEALTH FOR THE ROMA MINORITY ROMA HEALTH SRAP		X	X	X	X
<b>DG JUST</b>					
FROM WORDS TO PRACTICES		X	X		
<b>Total of EU-funded initiatives by theme</b>	<b>13</b>	<b>26</b>	<b>27</b>	<b>27</b>	<b>26</b>

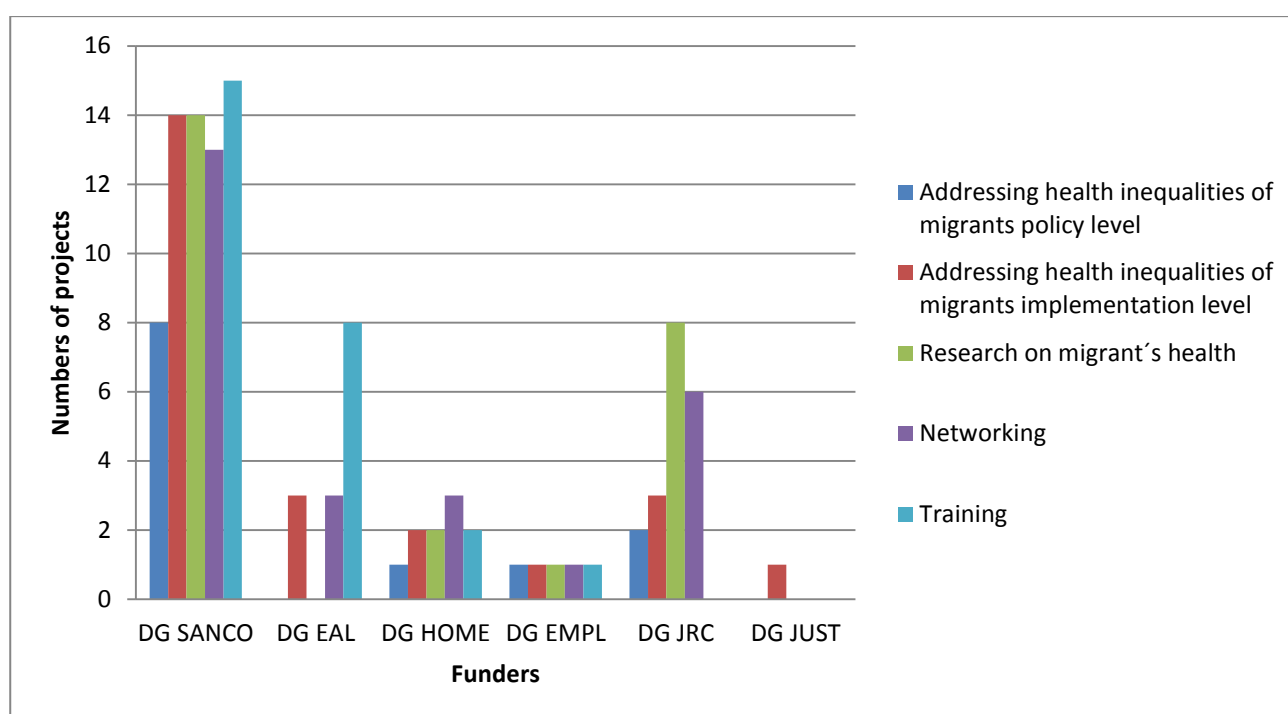
## 1. Presentation of the EU-funded projects

A number of EU funded projects specifically addressing migrants and ethnic minorities and health were identified. The main types of EU funded projects could be grouped into the following topic areas: collecting new data and improving databases; prevention; health promotion; improving access to health entitlements; and improving quality of health services. Most projects covered more than one topic area, e.g. new data on disease patterns and prevention recommendations.

Several trends can be observed, especially in the most recent projects:

- Increasingly, projects are moving away from explicitly targeting migrants and ethnic minorities, instead choosing to use the more general and inclusive term "vulnerable groups."
- Projects are addressing risk factors to a greater extent, as opposed to target groups
- Inequalities in general and their socio-economic determinants are increasingly the focus of new projects, looking at structural explanations and interventions, rather than the characteristics of vulnerable groups and individuals.

**Figure 1: Distribution of themes covered in the EU funded projects by funding sources**



The above graph shows that DG SANCO is the main funder of migrant and ethnic minority health projects, but other DGs also play a significant role, such as DG RESEARCH, especially in fundamental research. This kind of representation (Fig. 1) underlines the existing synergies between the different EU institutions.



## 1- Projects funded by DG SANCO

### AIDS and Mobility

Title of the project	AIDS & MOBILITY
Website	<a href="http://www.aidsmobility.org/index.php">http://www.aidsmobility.org/index.php</a>
Research collaborator <sup>s</sup>	<p>Leader : Ethno-Medizinisches Zentrum</p> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- European AIDS Treatment Group (EATG, Brussels), Belgium</li> <li>- Fondet til bekaempelse af aids (AIDS-Fondet, Copenhagen), Denmark</li> <li>- International Organization for Migration (IOM, Brussels), Belgium</li> <li>- National Institute for Health, Migration and Poverty (NIHMP, Rome), Italy</li> <li>- MTU AIDS-I Tugikeskus (AISC, AIDS INFORMATION &amp; SUPPORT CENTER, Tallin), Estonia</li> <li>- Naz Project London (NPL, London), UK</li> <li>- Yeniden Sağlık ve Eğitim Derneği(Yeniden, Istanbul), Turkey</li> <li>- Terrence Higgins Trust (THT, London associated partner until 2009), UK</li> </ul>
Funders	EC DG SANCO
Duration	2007-2010
Aim of the project	<p>The main aim of AIDS &amp; Mobility Europe is to <b>reduce HIV vulnerability of migrant and mobile populations in Europe</b>, through the development, implementation and promotion of appropriate policies and measures within a European wide network of experts. The project had a particular focus on young people between the age of 16 and 25 because they are particularly vulnerable to sexually transmitted infections (including HIV), and because they have a high capacity to adapt to change and to influence their social environment. Associated partners in six European countries worked with migrant communities and relevant stakeholders using capacity building through transcultural mediators to reduce discrimination and stigma, to improve HIV-related knowledge and to promote behaviour change to reduce HIV infection risks. The transcultural mediation approach aimed to improve health literacy and migrant awareness by involving migrants themselves in delivering health promotion to their own communities.</p> <p>The project developed, implemented and evaluated an innovative health education model based on the MiMi programme “With Migrants for Migrants” which was, as a best practice model, subject to the WHO case study in 2010. The aim of this programme was to train transcultural mediators who are then used for organising and conducting information and education sessions on HIV/AIDS for the target groups.</p> <ul style="list-style-type: none"> <li>• to develop an innovative health education model for migrants and ethnic minorities;</li> <li>• to implement structured transcultural mediator training and to conduct educational group sessions on HIV/AIDS;</li> <li>• to strengthen the existing network structures of HIV prevention among migrants;</li> <li>• to evaluate the performance and disseminate the results;</li> <li>• to design adequate strategies to assure continuity of the approach and to influence</li> </ul>

European and national policy making.	
<b>Methods</b>	<ol style="list-style-type: none"> <li>1) A set of learning activities carried out at national and regional levels, with pan-European methodologies and guidance, based on the principles of migrant participation and empowerment.</li> <li>2) A standardized curriculum developed by the Ethno-Medical Centre (EMZ), was used to train mediators in six European countries.</li> <li>3) Community based and multilingual HIV prevention sessions led by mediators, which were then evaluated with multilingual questionnaires.</li> <li>4) The Master Toolkit Advisory Group, Policy Development, Advisory Board and External Evaluation ensured that the project was properly monitored throughout, and the evidence disseminated widely, in order to inform policy and sustain the capacity building efforts beyond the project itself.</li> </ol>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- development and implementation of an innovative education programme, based on the “With Migrants for Migrants (MiMi)” programme, for training transcultural mediators, involving a great number of migrants with low language skills and education background.</li> <li>- Target group awareness and knowledge of topics like HIV, STIs, Hepatitis, Harm Reduction and Reproductive Health was increased.</li> <li>- confidence of the community in health services and professionals was also increased.</li> <li>- local health authorities, institutions and professionals benefitted from the project by improving the capacity to cooperate with transcultural mediators and their communities.</li> <li>- a sustainability plan was prepared to empower migrant and minority communities, build social cohesion, encourage civic society participation, promote the status of transcultural mediators, and provide a cost-effective method of HIV prevention in the context of migration.</li> <li>- development of regional networks which acted as platforms for transcultural mediator trainings involving 116 mediators who then conducted 240 community information sessions with 3427 participants.</li> </ul>
<b>Publications</b>	<ul style="list-style-type: none"> <li>- reports on reviews concerning educational programs on HIV prevention for migrants, and the strategies adopted by project partners.</li> <li>- resource material in 15 languages, such as a guidebook, a slide-kit and a Master toolkit  <a href="http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/a_m_guidebook/A_M_Guidebook_English.pdf">http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/a_m_guidebook/A_M_Guidebook_English.pdf</a>  <a href="http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/master_toolkit/A_M_Master_Toolkit_Guiding_Document.pdf">http://www.aidsmobility.org/fileadmin/Public/DOCS/Publications/master_toolkit/A_M_Master_Toolkit_Guiding_Document.pdf</a> </li> <li>- policy recommendations were made accessible for supporting community based education and interventions through the use of transcultural mediators.</li> </ul>

Title of the project		AMAC - Assisting Migrants and Communities	
Website		<a href="http://www.migrant-health-europe.org/">http://www.migrant-health-europe.org/</a>	
Research collaborator s	Leader:	- International Organization for Migration (IOM)	
	Others partners:	<ul style="list-style-type: none"><li>- Centre for Ethnicity and Health, University of</li><li>- Central Lancashire, Preston, United Kingdom</li><li>- Centre Françoise Minkowska, Paris, France</li><li>- Center for Science, Society and Citizenship (CSSC), Rome, Italy</li><li>- Erasmus University, Health Care Evaluation Department, Rotterdam, the Netherlands</li><li>- European Research Centre on Migration and Ethnic Relations, Utrecht University, the Netherlands</li><li>- Ludwig Boltzmann Institute for the Sociology of Health and Medicine at the Institute for Sociology, University of Vienna, Austria</li></ul>	
Funders		European Commission, DG SANCO	
Duration		2008/2009	
Target		Migration Health experts, policy makers, health professionals	
Aim of the project	There are four main objective to reach:		
	<ul style="list-style-type: none"><li>- To review recent initiatives in Migration Health</li><li>- To create a forum to give Migration Health expert the opportunity to exchange, discuss cases and best practices and draft policy recommendations</li><li>- To network professionals from the EU institutions, academics, NGO, governments and international organizations.</li><li>- To disseminate background papers and workshop results</li></ul>		
Methods	<ul style="list-style-type: none"><li>- Review report of the policy environment following the high level migration-health related conferences and consultations of 2007</li><li>- Seven background papers</li><li>- Three workshops organized to review background papers, best practices and areas for further research, and formulate policy recommendations</li><li>- Final EU-level consultation to engage multidisciplinary stakeholders, present the workshop results, develop action points for integrating the recommendations into national and EU-level migration health-related strategies</li><li>- Report on the results of the workshops</li></ul>		
Outcomes	EU level policy brief		
	<a href="http://www.migrant-health-europe.org/files/EU-Level%20Consultation%20Brief.pdf">http://www.migrant-health-europe.org/files/EU-Level%20Consultation%20Brief.pdf</a>		
Publications	Final report		
	<a href="http://www.migrant-health-europe.org/files/AMAC%20Public%20Report.pdf">http://www.migrant-health-europe.org/files/AMAC%20Public%20Report.pdf</a>		
Publications		Background papers:	
		Migration: A Social Determinant of the Health of Migrants, Anita A. Davies, Anna Basten and	

Chiara Frattini, IOM. [http://www.migrant-health-europe.org/files/Migration%20a%20Determinant%20of%20Health\\_Background%20Paper\(1\).pdf](http://www.migrant-health-europe.org/files/Migration%20a%20Determinant%20of%20Health_Background%20Paper(1).pdf)

European Research on Migration and Health, David Ingleby, University of Utrecht, Netherlands. [http://www.migrant-health-europe.org/files/Research%20on%20Migrant%20Health\\_Background%20Paper.pdf](http://www.migrant-health-europe.org/files/Research%20on%20Migrant%20Health_Background%20Paper.pdf)

Developing a Public Health Workforce to Address Migrant Health Needs in Europe, María Teresa Gijón Sánchez, Sandra Pinzón Pulido and Riitta Liisa Kolehmainen Aitken, Andalusian Public Health School, EASP; Jacqueline Weekers and Daniel López Acuña, WHO; and Roumyana Petrova Benedict and María José Peiro, IOM [http://www.migrant-health-europe.org/files/Capacity%20Building%20in%20Healthcare\\_Background%20Paper\(2\).pdf](http://www.migrant-health-europe.org/files/Capacity%20Building%20in%20Healthcare_Background%20Paper(2).pdf)

Migration and the Right to Health in Europe, Paola Pace and Sam Shapiro, IOM. [http://www.migrant-health-europe.org/files/Right%20to%20Health\\_Background%20Paper.pdf](http://www.migrant-health-europe.org/files/Right%20to%20Health_Background%20Paper.pdf)

Improving health care for migrant populations using practice innovations and strategic alliances to drive change: The U.S. case, Julia Puebla Fortier, Resources for Cross Cultural Health Care. [http://www.migrant-health-europe.org/files/The%20US%20Case\\_Background%20Paper\(2\).pdf](http://www.migrant-health-europe.org/files/The%20US%20Case_Background%20Paper(2).pdf)

Health Care for Undocumented Migrants in the EU: Concepts and Cases, Ursula Karl-Trummer, Birgit Metzler, Sonja Novak-Zezula, Centre for Health and Migration, Danube-University Krems, Austria. [http://www.migrant-health-europe.org/files/Health%20Care%20for%20Undocumented%20Migrants\\_Background%20Paper\(6\).pdf](http://www.migrant-health-europe.org/files/Health%20Care%20for%20Undocumented%20Migrants_Background%20Paper(6).pdf)

Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Competence and Empower Practitioners, Rachid Bennegadi, Françoise Minkowska Centre, France. [http://www.migrant-health-europe.org/files/Mental%20Health%20Practice\\_Background%20Paper\(1\).pdf](http://www.migrant-health-europe.org/files/Mental%20Health%20Practice_Background%20Paper(1).pdf)

Maternal and Child Healthcare for Immigrant Populations, Machado M.C., High Commissioner for Health, Portugal; A. Fernandes, New University of Lisbon; B. Padilla, CIES/ISCTE-IUL; S. Dias, I. Gomes, New University of Lisbon; A. Dias, Ministry of Health, Portugal; M. Oliveira da Silva, New University of Lisbon. [http://www.migrant-health-europe.org/files/Maternal%20and%20Child%20Care\\_Background%20Paper\(1\).pdf](http://www.migrant-health-europe.org/files/Maternal%20and%20Child%20Care_Background%20Paper(1).pdf)

Ensuring the Right of Migrant Children to Health Care: The Response of Hospitals and Health services, Ana Isabel Fernandes Guerreiro, Meyer University Children's Hospital, Italy; Fabrizio Simonelli, Rosa Gloria Suárez López de Vergara, Alberto Armas Navarro, Sara Darias Curvo, Anna Zappulla, Anders Hjern, Lynda Stokes and P.J. Boyle (Health Promotion Programme, WHO Collaborating Centre for Health Promotion, Capacity Building in Child and Adolescent Health). [http://www.migrant-health-europe.org/files/Children%20Rights%20in%20Healthcare%20Settings\\_Background%20Paper.pdf](http://www.migrant-health-europe.org/files/Children%20Rights%20in%20Healthcare%20Settings_Background%20Paper.pdf)

Foreign-born Children in Europe: An Overview from the Health Behaviour in School-Aged Children (HBSC) Study, Michal Molcho, New University of Ireland, Galway; Thoroddur Bjarnason, Francesca Cristini, Margarida Gaspar de Matos, Theadora Koller, Carmen Moreno, Saoirse Nic Gabhainn, Massimo Santinello (HBSC Study Group). [http://www.migrant-health-europe.org/files/Adolescents%20Health%20Behaviour\\_Background%20Paper\(6\).pdf](http://www.migrant-health-europe.org/files/Adolescents%20Health%20Behaviour_Background%20Paper(6).pdf)

## AURORA

Title of the project		Aurora
Website		<a href="http://www.aurora-project.eu/en/web/aurora-project-24">http://www.aurora-project.eu/en/web/aurora-project-24</a>
Research collaborators	<ul style="list-style-type: none"><li>- National Observatory for Women's Health, Italy</li><li>- Society for Oncology Patients “Dzivibas koks”, Latvia</li><li>- Istituto Europeo per lo Sviluppo Socio-Economico, Italy</li><li>- Stefan S. Nicolau Institute of Virology, Romania</li><li>- Jessenius Faculty of Medicine Comenius University in Martin Slova, Slovak Republic</li><li>- Bulgarian Family Planning and Sexual Health association, Bulgaria</li><li>- The Institute of Preventive Medicine, Environmental and Occupational Health – Prolepsis, Greece</li><li>- RESEARCH UNIT IN BEHAVIOUR &amp; SOCIAL ISSUES, Cyprus</li><li>- Društvo ŠKUC, Slovenia</li><li>- RIPH based in Usti nad Labem, Czech Republic</li><li>- Centrul PROFILAXIA, Romania</li><li>- DEKUT, Hungary</li><li>- Uniwersytet Łódzki, Poland</li><li>- Bulgarian Academy of Sciences, Bulgaria</li></ul>	
Funders	European Commission DG SANCO	
Duration		
Target	Women and hard to reach groups of women (Roma, Migrant, socio-economic disadvantaged...)	
Aim of the project	AURORA project aims to define a common and feasible strategy on how to promote Cervical Cancer Screening in the New EU Member States targeting women in the reproductive age (30-69 years old) and ensuring the coverage of the hard to reach groups	
Methods	<ol style="list-style-type: none"><li>1- Analysis of the local context studying the literature in the participating countries concerning Cervical Cancer Epidemiology.</li><li>2- Identification and analysis of good practices and strategies in the fight against Cervical Cancer on how to promote the Cervical Cancer Screening among the project target groups.</li><li>3- AURORA will organise a training course for healthcare professionals.</li><li>4- AURORA will organise a training course for advocacy leaders.</li><li>5- AURORA consortium will establish a network of pilot centres already performing Cervical Cancer Screening to test the AURORA methodology involving trained, during the project, healthcare professionals.</li><li>6- An E-Learning environment will be developed to serve all the users of the participating countries interested to be trained on the project issues.</li></ol>	

<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- To local context to organize more effective training courses and prevention activities in the participating countries, to identify good practices.</li> <li>- To increase in the participating countries the number of cervical screening tests thanks to the sharing of the good practices and the transfer of the project results to the not participating countries,</li> <li>- To train healthcare professionals and advocacy leaders, increase the number of screened people thanks to the pilot action and finally,</li> <li>- To transfer the knowledge of AURORA partners to the healthcare professionals of the participating countries thanks to the e-learning environment</li> </ul>
<b>Publications</b>	<p>All publication here</p> <p><a href="http://www.aurora-project.eu/en/web/deliverables-42">http://www.aurora-project.eu/en/web/deliverables-42</a></p>

## Averroes

Title of the project	
Averroes - equal access to healthcare	
Website	<a href="http://ec.europa.eu/health/highlights/2012/8/news_20120907_avveroes_en.htm">http://ec.europa.eu/health/highlights/2012/8/news_20120907_avveroes_en.htm</a>
Research collaborators	<ul style="list-style-type: none"> <li>- MdM European network, represented in 11 EU member States: France, Spain, Belgium, Greece, Portugal, Germany, United-Kingdom, the Netherlands, Italy, Sweden and Cyprus</li> <li>- Partners identified or to be identified during the project through exploratory missions in: Malta, Poland, Hungary, Austria, Finland, Czech Republic, Romania, and Slovenia</li> </ul>
Funders	European Commission, DG SANCO
Duration	2008/2011
Target	Asylum seekers and undocumented migrants in the European Union
Aim of the project	<ol style="list-style-type: none"> <li>1. To promote exchange of knowledge and expertise on migrants' health in 19 EU member states</li> <li>2. To improve knowledge about the EU and member states' policies and legislations concerning health and migration</li> <li>3. To improve knowledge of practices concerning asylum seekers' and undocumented migrants' access to healthcare</li> <li>4. To promote the improvement of asylum seekers and undocumented migrants' access to healthcare in the EU</li> </ol>
Methods	<p><b>Specific objective 1: To promote exchange of knowledge and expertise on migrants' health in 19 EU member states</b></p> <ul style="list-style-type: none"> <li>- Working in an NGO network sharing a common project and charter</li> <li>- Integrating new NGO partners from 6 EU member States</li> <li>- Organising support missions twice a year for the network NGOs</li> <li>- Organising Workshops bringing together all network members</li> <li>- Conducting common surveys</li> <li>- Creating and animating the project's website</li> </ul> <p><b>Specific objective 2: To improve knowledge about the EU and member states' policies and legislations concerning health and migration</b></p> <ul style="list-style-type: none"> <li>-Collecting data on national policies and legislations through the NGOs members of the network</li> <li>-Collecting data on European policies and legislations</li> <li>-Publishing a report on the member States policies and legislations concerning health and Migration</li> </ul> <p><b>Specific objective 3 : To improve knowledge of practices concerning asylum seekers' and undocumented migrants' access to healthcare</b></p> <ul style="list-style-type: none"> <li>-Strengthening the work of MdM European Observatory on Access to Health Care, and integrating new partners into this observatory</li> <li>-Collecting quantitative and qualitative data in 19 member states of the EU</li> <li>-Publishing MdM European Observatory survey on the access to healthcare of</li> </ul>



	<p>undocumented migrants and asylum seekers in year 3</p> <p><b>Specific objective 4: To promote the improvement of asylum seekers and undocumented migrants' access to healthcare in the EU</b></p> <ul style="list-style-type: none"> <li>-Organising a conference in each of the member states of the network, bringing together decision makers and experts in the field of health and migration</li> <li>-At European level, organising 2 conferences (project year 2 and 3) bringing together experts and representatives of EU institutions.</li> <li>-Disseminating the projects results through the publications and the project's websites</li> </ul>
<b>Outcomes</b>	<p>The project will set up a European NGOs network (covering 19 EU member states) aimed at improving knowledge and sensitization on foreigners' access to health care and seriously ill foreigners' protection against deportation in the EU.</p> <p>It will produce a comparative study on the EU and Member State's political trends and legislations on migrants' access to health care.</p> <p>Furthermore the project will perform and publish a survey on asylum seekers' and undocumented migrants' effective access to health care in the European Union is published.</p> <p>The project will create an awareness about the project's message is created amongst European and national policy-makers concerned and public health professionals.</p>
<b>Publications</b>	<p>ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS AND ASYLUM SEEKERS IN 10 EU COUNTRIES</p> <p><a href="http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf">http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf</a></p>
<b>Other relevant informations</b>	<p>Averroes in the former project which create HUMA-network</p>

## Bordernetwork

Bordernetwork	
<b>Title of the project</b>	
<b>Website</b>	<a href="http://www.bordernet.eu/BORDERNETwork_2010-2012/">http://www.bordernet.eu/BORDERNETwork_2010-2012/</a>
<b>Research collaborator s</b>	<p><b>Leader</b></p> <ul style="list-style-type: none"> <li>- SPI Forschung gGmbH (SPI Research gGmbH), Germany</li> </ul> <p><b>Other partners:</b></p> <ul style="list-style-type: none"> <li>- AIDS Hilfe Wien (AHW), Austria</li> <li>- Health and Social Development Foundation (HESED), Bulgaria</li> <li>- National Institute for Health Development (NIHD), Estonia</li> <li>- AIDS-I Tugikeskus (AISC), Estonia</li> <li>- Robert-Koch Institut (RKI), Germany</li> <li>- Verein zur Forderung der Prävention im AIDS und Suchtbereich in Mecklenburg Vorpommern E.V. (MAT-LAKOST), Germany</li> <li>- Aids-Hilfe Potsdam e.V. (AHP), Germany</li> <li>- Latvia's Association for Family Planning and Sexual Health "Papardes zieds" (PZ), Latvia</li> <li>- Samodzielny Publiczny Wojewódzki Szpital w Szczecinie (SPWSZ), Poland</li> <li>- Stowarzyszenie POMOST Rzeszowie (POMOST), Poland</li> <li>- Asociatia Romana Anti SIDA (ARAS), Romania</li> <li>- Civil Association PRIMA (C.A. PRIMA), Slovakia</li> </ul>
<b>Funders</b>	European Commission, DG SANCO
<b>Duration</b>	2010/2012
<b>Target</b>	Health professionals
<b>Aim of the project</b>	<p>The main goal is to improve prevention, diagnostic and treatment of HIV/AIDS (incl. co-infections) and STIs through bridging gaps in practice, policies and cross-country cooperation and enhancing capacity in interdisciplinary response (medical, prevention, research.)</p> <p>Given that highly active prevention is the main vehicle to decrease HIV rates, the project aims to:</p> <ul style="list-style-type: none"> <li>- Boost regional networks in public health sector and mobilise civil society resources in order to increase the impact of local response;</li> <li>- Enhance links between epidemiological and behavioural research and evidence-based interventions;</li> <li>- Improve coordination of practices for better quality assurance in prevention measures;</li> <li>- Forge better links between diagnostic and treatment systems</li> </ul>
<b>Methods</b>	<p>Project divided in 10 work packages which include:</p> <ul style="list-style-type: none"> <li>- A desk review report</li> <li>- Questionnaire assessment</li> <li>- Questionnaire for sentinelle surveillance of STI patient</li> <li>- Questionnaire concerning sex worker behaviour</li> </ul>

**Outcomes**

Final report

[http://bordnet.eu/cms/media/uploads//pdf/BORDERNETwork\\_Final\\_Report\\_WP9.pdf](http://bordnet.eu/cms/media/uploads//pdf/BORDERNETwork_Final_Report_WP9.pdf)

Seminars and conferences

All the material available here [http://bordnet.eu/Project2010-2012\\_Deliverables/](http://bordnet.eu/Project2010-2012_Deliverables/)

## COBATEST HIV

Title of the project		HIV COBATEST
Website		<a href="http://www.cobatest.org/project.php">http://www.cobatest.org/project.php</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Center for Epidemiological Studies on HIV/AIDS and STI of Catalonia (CEEISCAT). Catalonia, Spain</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Projecte dels NOMS-Hispanosida (NGO), Spain</li> <li>- Regional centre for Health Promotion (GOV), Italy</li> <li>- AIDES (NGO), France</li> <li>- National Institute of Public Health (GOV), Slovenia</li> <li>- Institute of Sexology (GOV), Czech Republic</li> <li>- The National AIDS Centre (GOV), Poland</li> <li>- STOP AIDS (NGO), Denmark</li> <li>- AIDS-Hilfe NRW (NGO), Germany</li> </ul>	
<b>Funders</b>	European Commission, DG SANCO	
<b>Duration</b>	2010/2013	
<b>Target</b>	At risk populations groups (migrants, sex workers, social disadvantaged group)	
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>- To gain a thorough understanding of Community Based Voluntary Counselling (CBVCT ) and Testing programmes and services in different countries.</li> <li>- To identify and describe good practices in the implementation of CBVCT.</li> <li>- To identify a core group of indicators that can be used to monitor and evaluate CBVCT.</li> <li>- To establish a network of community-based VCT in which to perform operational research.</li> <li>- To assess the acceptability, feasibility and impact of introducing oral rapid test technologies at community-based VCT</li> </ul>	
<b>Methods</b>	<p>Qualitative study to assess implementation of CBVCT services</p> <p>Mapping of CBVCT services</p> <p>Code of good practices</p>	
<b>Outcomes</b>	<p>The action focused on partner services in 8 European countries, but the project outputs in terms of harmonised data collection instruments, codes of good practice and core indicators for monitoring and evaluation could be easily applicable to other settings. Overall the HIV-COBATEST project contributed to consolidate the concept and value of community based testing in Europe.</p>	
<b>Publications</b>	<p>All deliverables and publications including final report available here:</p> <p><a href="http://www.cobatest.org/documents.php">http://www.cobatest.org/documents.php</a></p>	

## CORRELATION I & II

Title of the project		CORRELATION II
<b>Website</b>		<a href="http://www.correlation-net.org/">http://www.correlation-net.org/</a>
<b>Research collaborators</b>		<ul style="list-style-type: none"> <li>- Oslo kommune, Rusmiddelstatens kompetansesenter (The Competence Centre of the city of Oslo Agency for Alcohol and Drug Addiction Services) - CC-AADAS, <b>Norway</b></li> <li>- Developing Initiatives for Support in the Community - DISC, <b>United Kingdom</b></li> <li>- European AIDS Treatment Group - EATG, <b>Belgium</b></li> <li>- Central and Eastern European Harm Reduction Network - EHRN, <b>Lithuania</b></li> <li>- Fixpunkt - Verein für suchtbegleitende Hilfen e.V. - FIXPUNKT, <b>Germany</b></li> <li>- Government of Catalonia, Department of Health - DHAGC, <b>Spain</b></li> <li>- Rotterdam Public Health Service - MPHS, <b>Netherlands</b></li> <li>- Stichting (Foundation) CVO - CVO, <b>Netherlands</b></li> <li>- Svenska Brukarföreningen (Swedish Drug Users Union) - SBF, <b>Sweden</b></li> <li>- Trimbos Instituut, Netherlands Institute of Mental Health and Addiction - TRIMBOS, <b>Netherlands</b></li> <li>- AUTO SUPPORT et reduction des risques parmi les USAGERS DE DROGUES, <b>France</b></li> </ul>
<b>Funders</b>		European Commission – EU Health Programmes 2008-2013
<b>Duration</b>		2008-2013
<b>Aim of the project</b>		The overall aim of Correlation II is to tackle health inequalities in Europe and to improve prevention, care and treatment services, targeting blood-borne infectious diseases (BBID), in particular Hepatitis C and HIV/AIDS among vulnerable and high-risk populations (e.g. drug users and young people at risk).
<b>Methods</b>		<p>The project will approach the issue from different angles and with interventions, which have already been identified as effective, such as outreach/early intervention, e-health and peer support. The project will:</p> <ul style="list-style-type: none"> <li>• Review models of good practice</li> <li>• Implement field testing's</li> <li>• Develop guidance documents</li> <li>• Develop and implement training modules</li> <li>• Support and strengthen capacities of health service providers</li> <li>• Influencing policy agendas by formulating evidence based policy recommendations</li> </ul>
<b>Outcomes</b>		<p>The knowledge base of existing evidence and methodologies in the field of BBID will be extended and the quality of health promotions regarding BBID towards vulnerable and risk groups will improve as well as the capacity of service providers and other players in the field of health promotion, prevention, care and treatment... Policies regarding BBID strategies on European and national level will be influenced. In particular:</p> <p>A platform of exchange and mutual support between service providers, peer educators and other stakeholders is established</p> <p>A documentation center with information of existing evidence and methodologies in the field of outreach interventions, e-health and peer support and hepatitis C</p>

	<p>prevention strategies is provided</p> <p>Innovative interventions and training methodologies in the field of outreach, eHealth, peer support, hepatitis C prevention are developed and implemented</p> <p>Policy recommendations towards effective, evidence based policies in the field are developed and disseminated</p>
<b>Publications</b>	<p>All the publications, tools and products available here:</p> <p><a href="http://www.correlation-net.org/index.php?option=com_content&amp;view=article&amp;id=15&amp;Itemid=5">http://www.correlation-net.org/index.php?option=com_content&amp;view=article&amp;id=15&amp;Itemid=5</a></p>
<b>Other relevant informations (...)</b>	<p>Evaluation tools of the project :</p> <p><a href="http://www.correlation-net.org/index.php?option=com_content&amp;view=article&amp;id=87&amp;Itemid=58">http://www.correlation-net.org/index.php?option=com_content&amp;view=article&amp;id=87&amp;Itemid=58</a></p>

## Equi Health

<b>Title of the project</b>	<b>Equi Health -Fostering health provision for migrants, the Roma, and other vulnerable groups.</b>
<b>Website</b>	<a href="http://equi-health.eea.iom.int/">http://equi-health.eea.iom.int/</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- International Organization for Migration</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Council of Europe</li> <li>- Northern Dimension Partnership in Public Health and Social Well-being</li> <li>- WHO Europe</li> <li>- UN Interagency Working Group on Roma Rights to Health</li> <li>- European Asylum Support Office</li> <li>- European Centre for Disease Prevention and Control</li> <li>- Fundamental Rights Agency</li> <li>- Frontex</li> <li>- Andalusian School of Public Health (EASP), Spain</li> <li>- COST ADAPT project</li> <li>- Migration Policy Group</li> </ul>
<b>Funders</b>	<ul style="list-style-type: none"> <li>- European Commission, DG SANCO</li> <li>- Federal Public Service Health, Belgium</li> <li>- Ministry of Health, Italy</li> <li>- Direcção-Geral da Saúde, Portugal</li> <li>- Administração Regional de Saúde do Norte, Portugal</li> <li>- Gulbenkian Foundation, Portugal</li> <li>- EEA Grants Norway Grants</li> </ul>
<b>Duration</b>	2013/2016
<b>Target</b>	Migrants, Roma and other vulnerable groups
<b>Aim of the project</b>	<p>The objective of the EQUI-HEALTH action is to improve the access and appropriateness of health care services, health promotion and prevention to meet the needs of migrants, the Roma and other vulnerable ethnic minority groups, including irregular migrants residing in the EU/EEA.</p> <p>The EQUI-HEALTH action is divided in 3 sub-actions:</p> <p>1) <b>MIGRANT HEALTH at SOUTHERN EU BORDERS sub-action</b> aims building a comprehensive multi-sectorial approach in upholding migrant and public health: situational assessments, discussions about data collection mechanisms and referral systems as well as prioritization of capacity building needs are planned to increase the understanding of migrant, occupational and public health, including in open/closed centers and border facilities, and enhance the capacity</p>

	<p>of public health authorities, law enforcement services and healthcare providers.</p> <p>TARGET COUNTRIES: Southern EU Member States COUNTRIES COVERED: Bulgaria, Croatia, Greece, Italy, Malta, Spain, and Portugal (in certain activities)</p> <p>2) <b>The ROMA HEALTH sub-action</b> focuses on promoting dialogue among key stakeholders (governmental and non-governmental groups) on Roma health issues. 8 Progress reports on national strategies (with health focus), 4 case studies on good practices and exchange of experiences as per identified priorities in support of the implementation of national health plans will allow EU MS to better monitor, share and strengthen their respective national approaches. A training package for healthcare providers will develop competencies in working with ethnic minorities, including Roma.</p> <p>TARGET COUNTRIES: EU countries with high percentage of Roma nationals and EU MS with high percentage of Roma migrants CONTRIES COVERED: Belgium, Bulgaria, Czech Republic, Italy, Slovakia, Spain</p> <p>3) <b>Under the MIGRANT HEALTH sub-action</b>, available information on national legal and policy frameworks will be aggregated in the form of country briefs for policy makers linking to the MIPEX (Migrant Integration Policy) index by developing a health strand. Thematic study on cost analysis of healthcare provisions to migrants and ethnic minorities in support of consensus guidelines on access to healthcare services for those in undocumented situation will foster a harmonized EU approach to access to and provision of healthcare for migrants, Roma and other vulnerable ethnic minority groups</p>
<b>Methods</b>	
<b>Outcomes</b>	<p>Migrant Health:</p> <p>1) Available information on national, legal and policy frameworks will be aggregated in the form of 30 country briefs for policy makers linking to the Migrant Integration Policy Index - MIPEX by developing a health standard. The International Organization for Migration, the Migration Policy Group and the research network ADAPT (COST Action IS1103, "Adapting European health systems to diversity") have agreed to work together to enrich the next edition of the Migrant Integration Policy Index (MIPEX) with a new strand on health. More info is available at: <a href="http://equi-health.eea.iom.int/index.php/news-events/183-health-strand-of-mipex">http://equi-health.eea.iom.int/index.php/news-events/183-health-strand-of-mipex</a></p> <p>2) Thematic case study on cost analysis of healthcare provisions to migrants and ethnic minorities. The call for tender has been launched and the research is about to start.</p> <p>3) Consensus guidelines between the member states on access to health services for irregular migrants. This is a consensus document on "acceptable standards of healthcare provision" for irregular migrants, built on the basis of an evaluation of existing models of healthcare provisions and the thematic study on cost analysis.</p> <p>4) An EU-level consultation is planned with multidisciplinary stakeholders,</p>



where the project results and background papers will be presented, and action points for integrating the developed recommendations into national and EU-level migration health-related strategies will be identified

#### Southern EU borders

The EQUI-HEALTH project will work with public sector actors in the Southern EU Member States fostering multisectoral dialogue at regional and national level. Situational assessments will increase understanding of the priorities for improving migrant health in detention and border facilities and therefore public health and security.

Building on the evidence, data collection mechanisms and referral systems will be discussed and further capacity building needs prioritized such as tailored training packages and cascading or trainings for law enforcement authorities and health professionals

#### Roma Health:

8 Progress country reports on national strategies for Roma health as well as 4 case studies on good practices in support of the implementation of national strategies will allow EU Member States to better monitor share and strengthen their national approaches. Moreover, recommendations for future priority funding for Roma health under EU structural and social cohesion funds will be formulated on the basis of project results.

#### **Publications**

## Equity Action

Equity Action	
<b>Title of the project</b>	
<b>Website</b>	<a href="http://www.equityaction-project.eu/">http://www.equityaction-project.eu/</a>
<b>Research collaborators</b>	<ul style="list-style-type: none"> <li>- Euronethealth ( European network of institutions, organizations for health in Europe</li> <li>- Public Federal Service for Health, Food chain, Safety and Environment, Belgium</li> <li>- Institute of Public Health, Czech Republic</li> <li>- Department of Health, England</li> <li>- National Institute for Health and Welfare, Finland</li> <li>- Direction Générale de la Santé, France</li> <li>- Federal Center for Health Education, Germany</li> <li>- National Center for Social Research, Greece</li> <li>- National Institute for Health Development, Hungary</li> <li>- Institute of Public Health in Ireland</li> <li>- Azienda Ospedaliera Universitaria Integrata Verona, Italy</li> <li>- Azienda Sanitaria Locale TO3 Regione Piemonte, Struttura Complessa a direzione Universitaria Epidemiologia, Italy</li> <li>- Agenzie Nazionale per i Servizi Sanitari Regionali, Italy</li> <li>- Centre for disease prevention and control, Latvia</li> <li>- National Institute for Public Health and the Environment, Neitherlands</li> <li>- Norwegian Directorate of Health, Norway</li> <li>- National Institute of Public Health - National Institute of Hygiene, Poland</li> <li>- Scottish Executive, Scotland</li> <li>- Directorate General for Public Health and Foreign Health, Ministry of Health and Social Policy, Spain</li> <li>- La Fundacion Vasca de Innovacion e Investigation Sanitarias, Spain</li> <li>- Region Västra Gotaland, Sweden</li> <li>- Swedish National Institute of Public Health, Sweden</li> <li>- Welsh Government, Wales</li> <li>- WHO European Office for Investment for Health and Development, Italy</li> </ul>
<b>Funders</b>	The total programme funding is approximately €3.6 million, of which €1.7 million comes from the European Commission DG SANCO and €1.9 million has been contributed by the partners involved.(UK Health Forum/Health Action Partnership International)
<b>Duration</b>	February 2011, February 2014
<b>Target</b>	<ul style="list-style-type: none"> <li>- Policy makers</li> <li>- National and regional organizations which struggle health inequalities</li> </ul>
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>- Reducing health inequalities by helping to improve national and regional policies</li> <li>- Delivering practical outcome that improve policy making and implementation by tackling health inequalities across social determinant of health</li> </ul>
<b>Methods</b>	<p><b>Tools</b> – building capability and improving policy at Member State and EU level – with a focus on Health Impact Assessments, Health Equity Audits and Health Inequality Strategies</p> <p><b>Regions</b> – identifying and supporting regional approaches to address health inequalities – including influencing the EU structural fund programme, starting in 2014</p>

	<p><b>Stakeholders</b> – engaging scientific experts to develop a European research agenda on the effectiveness of intersectoral action to support policy makers</p> <p><b>Knowledge</b> – facilitating the transfer of scientific and technical knowledge and evidence to policymakers to promote and embed the Social Determinants of Health (SDoH) agenda</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Design of a guidance tool for structural funds comprehension website <a href="http://fundsforhealth.eu/">http://fundsforhealth.eu/</a></li> <li>- Design of a database to review European actions on health inequalities : website <a href="http://www.health-inequalities.eu/HEALTHEQUITY/EN/good_practice_database/">http://www.health-inequalities.eu/HEALTHEQUITY/EN/good_practice_database/</a> Conference of the 23rd of January gathering all experts, researchers, officials policy makers and key stakeholder to present the conclusion of the project</li> <li>- Website gathering all information about health inequalities in Europe <a href="http://www.health-inequalities.eu/HEALTHEQUITY/EN/home/">http://www.health-inequalities.eu/HEALTHEQUITY/EN/home/</a></li> </ul>
<b>Publications</b>	<p>Case study in European countries : What are regions in the EU doing to reduce Health inequalities <a href="http://members.kwitelle.be/HEALTHEQUITY/images/equityactionregionalcase_studyoverviewreport.pdf">http://members.kwitelle.be/HEALTHEQUITY/images/equityactionregionalcase_studyoverviewreport.pdf</a></p> <p>Final report of the project concerning the review of structural funds <a href="http://www.equityaction-project.eu/regions/structural-funds/">http://www.equityaction-project.eu/regions/structural-funds/</a></p> <p>All the other publications : <a href="http://www.equityaction-project.eu/about/downloads/">http://www.equityaction-project.eu/about/downloads/</a></p>
<b>Other relevant informations (</b>	<p>This project is completed by the " Crossing bridge project "which aim to promote "health in all policies" approach</p>

Title of the project		EUGATE
<b>Website</b>	<a href="http://www.eugate.org.uk/outcomes/index.html">http://www.eugate.org.uk/outcomes/index.html</a>	
<b>Project coordinator</b>	Unit for Social and Community Psychiatry, Barts and The London School of Medicine, Queen Mary College, University of London, UK.	
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Barts and The London School of Medicine and Dentistry (Queen Mary, University of London)</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Ludwig Boltzmann Society, Vienna</li> <li>- Université Catholique de Louvain</li> <li>- Department of Health Services Research, University of Copenhagen</li> <li>- National Research and Development Centre for Welfare and Health (STAKES)</li> <li>- Maison Blanche Hospital (Etablissement public de sante Maison Blanche)</li> <li>- Project team at Charité, University Medicine Berlin, Clinic for Psychiatry and Psychotherapy</li> <li>- The National School of Public Health (NSPH) in Athens</li> <li>- The University of Debrecen (UD) School of Public Health, Hungary</li> <li>- Agency for Public Health of Lazio Region – Italy</li> <li>- Kaunas University of Medicine (KMU)</li> <li>- Netherlands Institute for Health Services Research (NIVEL)</li> <li>- Institute of Psychiatry and Neurology, Warsaw</li> <li>- Medical School, University of Porto (FMUP)</li> <li>- The Barcelona Public Health Agency (ASPB)</li> <li>- Karolinska Institutet (Sweden)</li> </ul>	
<b>Funders</b>	EU DG SANCO 699 968 euros	
<b>Duration</b>	2007/2010	
<b>Target</b>	Policy makers, health professionals, researchers	
<b>Aim of the project</b>	EUGATE will bring together a multidisciplinary consortium from 16 EU member states to consolidate the currently fragmented knowledge in the field and identify best practice of health care for different immigrant populations. It will review legislation, policies, and funding arrangements, assess systems of health care services, and compare models of best practice across European countries for the people concerned. EUGATE will define guidelines for best practice and disseminate the findings widely among the relevant stakeholder groups in Europe	
<b>Methods</b>	<p>The project has three parts of data collection and one final part of synthesizing and interpreting all finding to reach conclusions on recommendations for best practice of health care for immigrants:</p> <ul style="list-style-type: none"> <li>- A document research of legislation and directives in the participating European countries</li> <li>- Delphi process of expert opinion on what constitutes best health care for immigrants in Europe</li> </ul>	

	<ul style="list-style-type: none"> <li>- Interviews with practitioners in health services</li> <li>- Synthesis of findings and conclusions on recommendations for best practice of health care for immigrants in Europe</li> </ul>
<b>Outcomes</b>	Eugate Database on Policies and Legislation
<b>Publications</b>	<p><b>Compendium of Best Practices and recommendations for service delivery to migrants and ethnic minorities</b></p> <p><b>WP5 - Eugate Questionnaire on Policies and Legislation</b>  The EUGATE Questionnaire for the identification of legislation and policies was designed to map and assess existing legislation and policies on health care for immigrants in EUGATE partners' countries. Its aim was to collect information on the legal provisions to receive health care for persons belonging to the EUGATE target groups.</p> <p><b>Eugate Database on Policies and Legislation</b>  The EUGATE Database of Policies and Legislation is a tool for comparing existing legislation and policies regulating delivery of care to immigrants within the 16 partners' countries. It was structured so to allow complex queries (some pre-determined queries can be made on line). The database was created and populated using the EUGATE Questionnaire on Policies and Legislation (see above). Besides displaying the results in a comparable way, it also hosts the full text of all referenced documents in their original language. Relevant sections have been translated into English and can be downloaded separately.</p> <p><b>WP6 - Eugate Questionnaire on Services</b>  Tool for mapping service organisation, utilization and monitoring mechanisms</p>

## EURO HIV EDAT

<b>Title of the project</b>	<b>EURO HIV EDAT - Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe</b>
<b>Website</b>	<a href="http://ec.europa.eu/eahc/projects/database.html?prjno=20131101">http://ec.europa.eu/eahc/projects/database.html?prjno=20131101</a>
<b>Research collaborators</b>	<p>Leader: Fundació Institut d'Investigació en Ciències de la Salut Germans Trias i Pujol</p> <p>Other partners :</p> <ul style="list-style-type: none"> <li>- AIDS-Hilfe NRW e.V., <b>Germany</b></li> <li>- ARAS - Romanian Association Against AIDS, <b>Romania</b></li> <li>- Association AIDES, <b>France</b></li> <li>- Catalan Institute of Oncology, <b>Spain</b></li> <li>- Consorcio Centro de Investigación Biomédica en Red del Área de Epidemiología y Salud Pública, <b>Spain</b></li> <li>- Društvo Kulturno, informacijsko in svetovalno središče Legebitra, <b>Slovenia</b></li> <li>- Fondet til bekæmpelse af AIDS., <b>Denmark</b></li> <li>- GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA – Pedro Santos, <b>Portugal</b></li> <li>- Institute of Tropical Medicine, <b>Belgium</b></li> <li>- Instituto de Salud Carlos III, <b>Spain</b></li> <li>- National Institute of Public Health, <b>Slovenia</b></li> <li>- Projecte dels NOMS-Hispanosida, <b>Spain</b></li> </ul>
<b>Funders</b>	<p>EC – EU Health Programme 2008-2013</p> <p>1 179 927,00 euros</p>
<b>Duration</b>	2014-2017
<b>Aim of the project</b>	The overall purpose of the project is to generate operational knowledge to better understand the role and impact of Community Based Voluntary Counselling and Testing services (CBVCTs) across Europe, as well as to study the use of innovative strategies based on new technologies and social networks, to increase early HIV/STI diagnosis and treatment among the most vulnerable groups.
<b>Methods</b>	<p>Obj.1. A qualitative and a quantitative study will be performed among COBATEST network's members. Data to estimate the COBATEST indicators will be collected.</p> <p>Obj.2. A subset of Checkpoints will participate in a prospective study collecting standardized data of HIV negative clients that will get tested at least once a year.</p> <p>Obj.3. A qualitative study among managers and clients of Checkpoints will be performed through interviews and focal groups.</p> <p>Obj.4. A toolkit for implementation of Checkpoints will be developed after a literature review and an expert's meeting. Training sessions will be held.</p> <p>Obj.5. Literature review, interviews with migrants and key informants and a survey will be made.</p> <p>Obj.6.1. A KAB survey and interviews will be performed among potential users and CBVCTs' Stakeholders.</p> <p>Obj.6.2. Oral fluid samples of MSM and migrants will be collected through outreach activities. Result will be provided through a website. Participants will be able to repeat the test after 4/12 months. An implementation manual for an integrated strategy for HIV Testing will be developed.</p>
<b>Outcomes</b>	Outcomes of the he Euro HIV EDAT Project will contribute to decrease HIV/STI

transmission, to improve clinical outcomes and to promote equity across Europe. Specific guidelines and manuals will be developed targeted for MSM and migrants, two of the most affected groups by the HIV/STI epidemics in Europe. The project will contribute to the improvement of CBVCT services and will inform policy makers to better contextualize these interventions within their national HIV Prevention Programs. Crucial data to better design preventive interventions aimed at increasing test uptake among MSM and migrants will be provided. Information on acceptability, feasibility and effectiveness of innovative interventions as self-testing and outreach interventions and the use of new technologies for results and counseling delivery will be made. Specific manuals will be done. Overall, the project outcomes will provide operational data and implementation manuals and guidelines to improve the effectiveness and scale up of testing and linkage to care programs, as well as some new tools to increase access to them.

**Publications**

confidential

## Healthy Inclusion

Healthy Inclusion	
<b>Title of the project</b>	
<b>Website</b>	<a href="http://www.redcross.eu/en/News-Events/Red-Cross-Success-Stories/Healthy-Inclusion/">http://www.redcross.eu/en/News-Events/Red-Cross-Success-Stories/Healthy-Inclusion/</a> <a href="http://www.rotekreuz.at/wien/forschungsinstitut-des-roten-kreuzes/projekte/abgeschlossene-projekte/healthy-inclusion/?sword_list[]=healthy&amp;sword_list[]=inclusion&amp;no_cache=1">http://www.rotekreuz.at/wien/forschungsinstitut-des-roten-kreuzes/projekte/abgeschlossene-projekte/healthy-inclusion/?sword_list[]=healthy&amp;sword_list[]=inclusion&amp;no_cache=1</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Austrian Red Cross</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- National Institute of Public Health; Prague, Czech Republic</li> <li>- Mhtconsult ApS: Helsingor, Denmark</li> <li>- Tartu University, Department of Public Health; Tartu, Estonia</li> <li>- Institut für Soziale Infrastruktur; Frankfurt am Main, Germany</li> <li>- Studio Come S.r.l.; Rome, Italy</li> <li>- Trnava University, Faculty of Health Care and Social Work; Trnava, Slovakia</li> <li>- Stichting dr. Hilda Verwey-Jonker Instituut; Utrecht, The Netherlands</li> </ul>
<b>Funders</b>	European Commission DG SANCO EU Public Health Programme 2003/2008 Fund Gesunden Austria
<b>Duration</b>	2008/2010
<b>Target</b>	All type of migrants
<b>Aim</b>	<ul style="list-style-type: none"> <li>- Provide information about migrants' perceived barriers for participating in health promotion interventions as well as about facilitating factors</li> <li>- Provide examples of good practice and suggested means of enhancing migrants' participation in health promotion interventions</li> <li>- Develop specific recommendations on how health promotion interventions at the community level can be adapted to better meet the needs of migrants.</li> </ul>
<b>Methods</b>	<ul style="list-style-type: none"> <li>- A literature review of national literature concerned with the particular situations regarding migration and health promotion in each country involved in the project</li> <li>- Interviews with representatives of organisations providing health promotion interventions</li> <li>- Interviews with migrants who do and who do not have access to these interventions in their mother-tongues</li> <li>- Support of an "Advisory Board" of various experts of migration, health promotion etc.</li> <li>- Delphi-rounds with participation of various experts of migration, health promotion etc.</li> </ul>
<b>Outcomes</b>	Identification of aspects in the planning and implementation of local health-promoting Offers should be considered to achieve better migrants as a target group
<b>Publications</b>	<p>Healthy Inclusion project result :</p> <a href="http://www.rotekreuz.at/fileadmin/user_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI%20European%20Report_final.pdf">http://www.rotekreuz.at/fileadmin/user_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI%20European%20Report_final.pdf</a>



	<p>Good practices Guide (in German)</p> <p><a href="http://www.rotekreuz.at/fileadmin/user_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI_recommendations_AT_dr.uck%20pdf.pdf">http://www.rotekreuz.at/fileadmin/user_upload/LV/Wien/Metanavigation/Forschungsinstitut/Projektbilder/HI_recommendations_AT_dr.uck%20pdf.pdf</a></p>
<b>Other relevant informations</b>	<p>Most of the available information is in German.</p>

## Imp.Ac.T

<b>Title of the project</b>	<b>Imp.Ac.T – Improving access to TB and HIV testing for marginalized groups</b>	
<b>Website</b>	<a href="http://www.projectimpact.eu/">http://www.projectimpact.eu/</a>	
<b>Research collaborator s</b>	<ul style="list-style-type: none"> <li>- Gruppo Abele, NGO, Italy</li> <li>- Villa Maraini Foundation, NGO, Italy</li> <li>- De Regenboog Groep, NGO, Netherlands</li> <li>- Odysseus, NGO, Slovakia</li> <li>- SANANIM, NGO, Czech Republic</li> </ul>	
<b>Funders</b>	European Commission, DG SANCO	
<b>Duration</b>	2010/2012	
<b>Aim of the project</b>	The project's general objective is to improve the access to HIV and TB testing, prevention, treatment and care for two risk groups, such as problem drug users and migrants drug users. DUs, particularly migrants, have specific needs and encounter specific challenges for testing, care and treatment.	
<b>Methods</b>	<p>The main and partners will experiment the provision of rapid HIV test and TB testing (through clinical screening and sputum smear collection) to DUs and migrants DUs in street units and drop-in centers, to assess the effectiveness of such kind of interventions in terms of percentage of persons tested and number of new diagnosed cases.</p> <p>A common methodology will be developed and used by all the partners, both for the implementation of the testing and for the assessment of its effectiveness. At this regard, the project will contribute to identify specific determinants of late presentation for testing and care by most-at-risk groups, and main determinants of timely diagnosis and entry into care.</p>	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Developing a model to improve the effectiveness of HIV/TB testing and counseling for drug users and migrant drug users.</li> <li>- Improving access to treatment and care by fostering closer cooperation between organizations that work with drug users.</li> <li>- Increasing the percentage of users that have access to testing</li> </ul>	
<b>Publications</b>	<ul style="list-style-type: none"> <li>- Guide Manual on HIV and TB Testing for DUs and migrants in low-threshold services</li> <li>- IMPACT Evaluation report</li> <li>- Project “Imp.Ac.T. – Improving Access to HIV/TB testing for marginalized groups” WORK PLAN</li> <li>- Training manual on HIV/TB rapid testing of DUs/migrants in low-threshold services</li> <li>- Improving Access to HIV/ TB testing for marginalized groups</li> </ul> <p>Available here: <a href="http://www.projectimpact.eu/key_publi.html">http://www.projectimpact.eu/key_publi.html</a></p>	

<b>Title of the project</b>	<b>Mighealthnet - Information network on good practice in health care for migrants and minorities in Europe</b>
<b>Website</b>	<a href="http://mighealth.net/index.php?title=Main_Page">http://mighealth.net/index.php?title=Main_Page</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- National Kapodistrian University of Athens, Greece (also covering Romania)</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Univerzita Karlova v Praze, Czech Republic</li> <li>- National Institute of Public Health, Denmark</li> <li>- Bielefeld University, Germany</li> <li>- Semmelweis University Faculty of Health Sciences, Hungary (also covering Bulgaria)</li> <li>- Utrecht University, Netherlands</li> <li>- Ullevaal University Hospital, Norway</li> <li>- Jagiellonian University Medical College, Poland(also covering Lithuania)</li> <li>- Faculdade de Letras da Universidade de Lisboa, Portugal</li> <li>- Internationel Migration och Etniska Relationer , Sweden(also covering Switzerland)</li> <li>- Baskent University , Turkey</li> <li>- Queen Mary University London and Middlesex University, UK</li> </ul>
<b>Funders</b>	European Commission, DG SANCO
<b>Duration</b>	2007/2009
<b>Target</b>	The stakeholders and beneficiaries of this project are health care professionals, policy makers, including health authorities, researchers, educators, and (representatives of) migrants and minority groups. The project will offer them easy access to a dynamically evolving body of knowledge and a virtual network of expertise, which they can draw upon when intending to develop good practices.
<b>Aim of the project</b>	<p>The MIGHEALTHNET project aims to stimulate the exchange of knowledge on migrant and minority health through the development of interactive data bases in each of the participating countries. These 'wikis' will contain the following sorts of data:</p> <ul style="list-style-type: none"> <li>Background information concerning migrant and minority populations</li> <li>The state of health of migrants and minorities</li> <li>The health care system and the entitlement of migrants and minorities to health care</li> <li>Accessibility of health care</li> <li>Quality of care: 'good practices' developed to improve the matching of service provisions to the needs of migrants and minorities</li> <li>Achieving change: centres of expertise, general reports and policy documents, journals, training programs, E-mail groups etc</li> </ul>
<b>Methods</b>	In the present era, Internet has become the primary medium for information exchange. In each participating country, the project will therefore set up an open-access, cumulative data base or 'wiki' concerned with health care for migrants and ethnic minorities. The wikis to be developed in this project will provide a knowledge base and an instrument for locating expertise and forming networks. They will use the national language(s) of the country in question. Links will also be provided to wikis in other countries, so that users can look over the border to see what has been discovered and developed elsewhere. Summaries in English of the 'state of the art' in each country (research, activities and best practices) will be posted

(and updated) on a central site. This site will also host information about issues that are not limited to one country, as well as some information concerning countries such as the U.S.A., Canada, Australia and New Zealand.

In order both to disseminate the results of the project and obtain feedback on them, the project will organize meetings in each of the 16 countries concerned, to be attended by representatives of the stakeholders and beneficiaries. At the European level, a final meeting will be organized with the same aim.

<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Country reports</li> <li>- Website database</li> </ul>
-----------------	---

<b>Publications</b>	<p>Bulgaria: Bulgarian version -- English summary  Czech Republic: Czech version -- English summary  Denmark: Danish version -- English summary  Germany: German version -- English summary  Greece: Greek version -- English summary  Hungary: Hungarian version --English summary  Lithuania: Lithuanian version -- English version  Netherlands: Dutch version -- English summary  Norway: Norwegian version -- English summary  Poland: Polish version -- English summary  Portugal: Portuguese version -- English summary  Romania: Romanian version -- English summary  Sweden: English version  Switzerland: English version  Turkey: Turkish version -- English version  United Kingdom: English version</p>
---------------------	--

<b>Title of the project</b>	<b>MEHO- Migrant and Ethnic Health Observatory</b>		
<b>Website</b>	<a href="http://www.meho.eu.com/">http://www.meho.eu.com/</a>		
<b>Research collaborators</b>	<p>Leader</p> <ul style="list-style-type: none"> <li>- Department of Health Policy and Management, Erasmus Medical Centre, Rotterdam, The Netherlands</li> </ul> <p>Other partners</p> <ul style="list-style-type: none"> <li>- Faculty for Life Sciences, Hamburg University of Applied Sciences, Germany (mortality)</li> <li>- Department of Public Health Medicine, University of Bielefeld, Germany (Infectious diseases)</li> <li>- University of Edinburgh Medical School, United Kingdom (Cardiovascular diseases and diabetes)</li> <li>- School of Public Health, University of Bielefeld, Germany (Cancer))</li> <li>- Faculty of Health Sciences - Institute of Public Health Department of Health Services - University of Copenhagen (Self-perceived health and health care use)</li> <li>- Institute of Hygiene, Slovakia (The health of Roma)</li> </ul>		
<b>Funders</b>	European Commission, DG SANCO		
<b>Duration</b>	2007/2010		
<b>Target</b>			
<b>Aim of the project</b>	The main objective of MEHO is to develop indicators to monitor the health status of immigrant/ethnic minority groups in Europe. Therefore existing health related databases and surveys will be used and a European network of epidemiological observatories on migrants' health will be established. This network will generate a European overview of comparable and exchangeable data on socio-demographic and health profile of immigrant/ethnic minority groups for selected health problems.		
<b>Methods</b>	<ul style="list-style-type: none"> <li>- to take a census of available health and health care data sources which include socio-demographic information on ethnic groups and immigrants in EU countries;</li> <li>- to identify criteria for an operational definition of ethnic groups and immigrants which can be comparable among EU countries;</li> <li>- to define strategies of analysis and indicators to assess the health status of ethnic groups and immigrants and to compare it with that of the indigenous populations across EU countries</li> </ul>		
<b>Outcomes</b>	<p>All reports are available here:</p> <p><a href="http://www.meho.eu.com/">http://www.meho.eu.com/</a></p>		
<b>Publications</b>	<p>Koopmans G, Foets M. Migrant and ethnic minorities health observatory (MEHO project) . Eur J Public Health 2009 December 1;19(6):667-70</p> <p>Nielsen SS, Krasnik A, Rosano A. Registry data for cross-country comparisons of migrants' healthcare utilization in the EU: A survey study of availability and content. BMC Health Serv Res 2009 Nov 18;9:210.</p> <p>Rafnsson SB, Bhopal RS. Large-scale epidemiological data on cardiovascular diseases and diabetes in migrant and ethnic minority groups in europe. Eur J Public Health 2009 October 1;19(5):484-91.</p>		

## Migrant Friendly Hospitals

Title of the project		Migrant Friendly Hospitals
Website		<a href="http://www.mfh-eu.net/public/home.htm">http://www.mfh-eu.net/public/home.htm</a>
Research collaborators		<ul style="list-style-type: none"> <li>- Health Authority of Reggio Emilia, Italy</li> <li>- Ludwig Boltzmann Institute for Sociology of Health and Medicine, Austria</li> <li>- Hospital's partners from the following countries: Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain, Sweden and the UK</li> </ul>
Funders		EU Commission via DG SANCO Austrian State
Duration		2002/2005
Target		Documented and undocumented migrants
Aim		Implementation of actions to : <ul style="list-style-type: none"> <li>• improve interpreting services</li> <li>• Migrant Friendly information and training for mother- child care</li> <li>• Staff training toward cultural competences</li> </ul>
Methods		<ul style="list-style-type: none"> <li>- Implementation and evaluation of evidences - experiences based on interventions.</li> <li>- Use of benchmarking process to identify good practices across EU members.</li> <li>- tools format: expertise and consultation</li> </ul>
Outcomes		<p>Interpretariat services  <a href="http://www.mfh-eu.net/public/files/experiences_results_tools/spa_interpreting/2_SPA_Pathway.pdf">http://www.mfh-eu.net/public/files/experiences_results_tools/spa_interpreting/2_SPA_Pathway.pdf</a></p> <p>Training for mother  <a href="http://www.mfh-eu.net/public/files/experiences_results_tools/spb_motherchild/06_Supporting_Tools/ST1_healthlit_factsheet_6.pdf">http://www.mfh-eu.net/public/files/experiences_results_tools/spb_motherchild/06_Supporting_Tools/ST1_healthlit_factsheet_6.pdf</a></p> <p>Staff training toward cultural competences <a href="http://www.mfh-eu.net/public/files/experiences_results_tools/spc_training/SPC_factsheet.pdf">http://www.mfh-eu.net/public/files/experiences_results_tools/spc_training/SPC_factsheet.pdf</a></p>
Publications		<p>The experience of each hospitals:  <a href="http://www.mfh-eu.net/public/experiences_results_tools/12_pilot_hospitals_experiences.htm">http://www.mfh-eu.net/public/experiences_results_tools/12_pilot_hospitals_experiences.htm</a></p> <p>Project Summary:  <a href="http://www.mfh-eu.net/public/files/mfh-summary.pdf">http://www.mfh-eu.net/public/files/mfh-summary.pdf</a></p>
Other relevant information		<p>To assure sustainability of the MFH movement, a Task Force on Migrant Friendly Hospitals has been established in the framework of the WHO Network on Health Promoting Hospitals.</p> <p>Further MFH activities:  <a href="http://www.mfh-eu.net/public/further_mfh_activities.htm">http://www.mfh-eu.net/public/further_mfh_activities.htm</a></p>

## NowHereLand

<b>Title of the project</b>	Heathcare in NowHereLand, improving services for undocumented migrants in the EU
<b>Website</b>	<a href="http://www.nowhereland.info/?service=restart">http://www.nowhereland.info/?service=restart</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Centre for Health and Migration, University of Krems, Austria</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Azienda Unità Sanitaria Locale di Reggio Emilia, Italy</li> <li>- Centro de Investigacao e Estudos de Sociologia, Portugal</li> <li>- Malmö Institute for Studies of Migration, Sweden</li> <li>- Platform for International Cooperation on Undocumented Migrants, Belgium</li> <li>- Faculty of Health and Social Science, University of Brighton, UK</li> </ul>
<b>Funders</b>	EU Commission : programme for community action in the field of Public Health DG SANCO
<b>Duration</b>	2008/2010
<b>Target</b>	Policy makers at EU and nationals levels
<b>Aim of the project</b>	The project aims at creating a knowledge base for providing, exchanging and developing good practice of health care services for UDM through
<b>Methods</b>	<ul style="list-style-type: none"> <li>- Drawing a landscape of the legal and financial frameworks on national level in the EU 27 under which health care services/providers act</li> <li>- Gaining an overview about needs and strategies of UDM in getting access to health care services, compiling experiences from NGOs and other advocacy groups from their work with undocumented migrants (from European to local level)</li> <li>- Collecting existing practice of health services in the EU on regional and local level in a database and identifying transferable models of good practice</li> </ul>
<b>Outcomes</b>	<p>Website with access to all the data mentioned above: policy, practice and demographic data about migrant in Europe <a href="http://www.nowhereland.info/?service=restart">http://www.nowhereland.info/?service=restart</a></p> <p>Practice database: <a href="http://www.nowhereland.info/?i_ca_id=416">http://www.nowhereland.info/?i_ca_id=416</a></p> <p>Policy matrix <a href="http://www.nowhereland.info/?i_ca_id=368">http://www.nowhereland.info/?i_ca_id=368</a></p> <p>Demographic data: <a href="http://www.nowhereland.info/?i_ca_id=389">http://www.nowhereland.info/?i_ca_id=389</a></p>
<b>Publications</b>	<p>Report: Migration and Health in NowHereLand <a href="http://ec.europa.eu/eahc/documents/news/Book_NowHerecare.pdf">http://ec.europa.eu/eahc/documents/news/Book_NowHerecare.pdf</a></p>

## PROMOVAX

Title of the project	
<b>PROMOVAX</b> promoting vaccinations among migrant populations in Europe	
<b>Website</b>	<a href="http://www.promovax.eu/">http://www.promovax.eu/</a>
<b>Research collaborators</b>	Leader: - Institute for preventive medicine, environmental and occupational health, Prolepsis, Greece Other partners: - Technische Universität Dresden - Germany - Università degli Studi di Sassari - Italy - The SINTEF Foundation - Norway - Nofer Institute of Occupational Medicine - Poland - University of Zagreb, Medical School - Croatia - RUBSI—Research Unit in Behaviour and Social Issues - Cyprus - University of Pécs - Hungary - Università degli Studi di Milano - Italy - Istituto Superiore di Sanità - Italy - Cyprus University of Technology -
<b>Funders</b>	European Commission, via DG Sanco program 2008-2013.
<b>Duration</b>	2010/2013
<b>Target</b>	- Documented migrant of the EU - Healthcare workers and care giver providing health services for migrants - Policy makers
<b>Aim of the project</b>	To promote immunizations among migrant populations in Europe, thus contributing to the elimination of vaccine preventable diseases in the region and reducing social inequality in population's health.
<b>Methods</b>	- Identify and record the immunization needs of migrant populations; develop methodology for assessment of each migrant's immunization needs. - Evaluate migrants' access to immunization in the EU countries. - Analyse available legislative context and identify gaps. - Identify and exchange best practices in the field of migrant immunization promotion. - Enhance health care professionals' and other migrant care givers' knowledge about immunization needs for European migrants. - Improve the knowledge of EU migrant populations on immunizations.
<b>Outcomes</b>	Toolkits for immigrants and health care professionals <a href="http://www.promovax.eu/toolkits/MT_english_web.pdf">http://www.promovax.eu/toolkits/MT_english_web.pdf</a> (migrants) <a href="http://www.promovax.eu/toolkits/HCW_english_web.pdf">http://www.promovax.eu/toolkits/HCW_english_web.pdf</a> (professionals) Overview of policies across EU <a href="http://www.promovax.eu/pdfs/HOSTING_COUNTRIES.pdf">http://www.promovax.eu/pdfs/HOSTING_COUNTRIES.pdf</a> <a href="http://www.promovax.eu/pdfs/COUNTRIESofORIGIN.pdf">http://www.promovax.eu/pdfs/COUNTRIESofORIGIN.pdf</a> - Best practices evaluation <a href="http://www.promovax.eu/index.php/promovax/vaccination/vac3">http://www.promovax.eu/index.php/promovax/vaccination/vac3</a>



## TAMPEP

Title of the project		TAMPEP
Website		<a href="http://tampep.eu/index.asp">http://tampep.eu/index.asp</a>
Research collaborators	<p>National coordinators represented in 25 countries of Europe :</p> <ul style="list-style-type: none"> <li>- Austria</li> <li>- Belgium</li> <li>- Czech Republic</li> <li>- Denmark</li> <li>- Estonia</li> <li>- Finland</li> <li>- France</li> <li>- Germany</li> <li>- Greece</li> <li>- Hungary</li> <li>- Italy</li> <li>- Latvia</li> <li>- Lithuania</li> <li>- Netherlands</li> <li>- Norway</li> <li>- Poland</li> <li>- Portugal</li> <li>- Romania</li> <li>- Slovakia</li> <li>- Slovenia</li> <li>- Spain</li> <li>- Switzerland</li> <li>- UK</li> <li>- Ukraine</li> </ul> <p>Detailed contact list here: <a href="http://tampep.eu/network.asp?section=network&amp;nco=all">http://tampep.eu/network.asp?section=network&amp;nco=all</a></p>	
Funders	European Commission, DG SANCO	
Duration	1993/2009	
Target	Migrant and mobile sex workers, health & social professionals and organisations working with this vulnerable population	
Aim of the project	<p>TAMPEP is a network of community-based service providers and sex workers' organisations operating in 25 European countries. The main objective of TAMPEP is to reduce the HIV vulnerability of migrant and mobile sex workers through the development, exchange, promotion and implementation of appropriate policies and interventions across Europe, and specifically:</p> <ul style="list-style-type: none"> <li>- To consolidate and further develop targeted HIV/STI prevention measures, health promotion interventions for migrant and mobile sex workers in Europe.</li> <li>- To examine and analyse the situation of prostitution in Europe based on mapping of the prostitution scene and legal framework on migration, sex work and HIV policies and the</li> </ul>	

	<p>identification risk factors and levels of vulnerability that determine the barriers to access to prevention measures and care.</p> <ul style="list-style-type: none"> <li>- To facilitate the sharing of knowledge, experience, and good practices among service providers and community-based organisations on pan-European level.</li> <li>- To consolidate and enhance the network of 25 countries in Europe.</li> <li>- To promote human rights and equality in public health policies and accessibility for migrant and mobile sex workers</li> </ul>
<b>Methods</b>	<p>Activities are run at the national level with the support of a common European methodology and guidance</p> <p>Main activities: community research, targeted intervention, advocacy.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- A pan-European response to legal, health and social care needs of (migrant and mobile) sex workers in a framework of cooperation between 26 partners.</li> <li>- Strengthening the capacities of service providers and community based organisations for effective interventions and strategies for HIV/STI prevention among (migrant and mobile) sex workers and their clients.</li> <li>- Comprehensive and updated assessment of the prostitution scene through qualitative and quantitative data gathered across the network of 25 countries.</li> <li>- Comprehensive and updated assessment of legal framework regarding migration, sex work, and HIV/STIs on national and European levels.</li> <li>- Exchange of experiences and skills within the network and beyond through the production of a European Good Practice Manual with examples of comprehensive intervention strategies adaptable to various settings and countries.</li> </ul> <p>Materials available here: <a href="http://tampep.eu/documents.asp?section=trainingmanuals">http://tampep.eu/documents.asp?section=trainingmanuals</a></p> <ul style="list-style-type: none"> <li>- Exchange of skills and experience in relation to cross border prostitution at bi-lateral and regional and European level, thereby enhancing the capacity of health and social care service providers to respond to the needs of sex workers in this particular environment.</li> </ul> <p>All ressources available here:  <a href="http://tampep.eu/documents.asp?section=resources">http://tampep.eu/documents.asp?section=resources</a></p>

## TUBIDU

Title of the project	<b>TUBIDU</b> Empowering public health system and civil society to fight tuberculosis epidemic among vulnerable groups"
Website	<a href="http://www.tai.ee/en/tubidu">http://www.tai.ee/en/tubidu</a>
Research collaborators	Leader: - National Institute of Health Development, Estonia Other partners: - Dose of love Association, Bulgaria - Estonian Network of People living with HIV, Estonia - Finnish Lung Health Association, Finland - Institute of Hygiene, Lithuania - Tuberculosis Foundation, Latvia - Romanian Angel appeal, Romania
Funders	European Commission DG SANCO
Duration	2011/2014
Target	Injecting drug users, people living with HIV, but also general population. Health specialists in governmental and non- governmental organizations, local municipalities, research institutions and community based organizations personnel will be reached through respective organizations.
Aim of the project	Enhancing horizontal, vertical and cross-border collaboration in the field of TB, injecting drug use and HIV. - Describing the TB and HIV related knowledge and behaviour, identifying the barriers to access to TB and HIV related health care services among IDUs and PLHIV. - Raising the awareness of TB and HIV related prevention, treatment and care among vulnerable groups and PLHIV, general population and professionals on services and policy level. - Raising the awareness of TB and HIV among community based organizations and health care and public health institutions personnel. - Developing guidance for TB-prevention activities for community based organizations working with IDUs and PLHIV and providing recommendations for policy makers on future actions in the field.
Methods	Project management: Work Packages (WP) 1-3 National and international networking: WP 4 Research: WP 5 Information distribution and awareness rising: WP 6 Training: WP 7 Development of guidance and recommendations: WP 8
Outcomes	Results of the project management and evaluation will be distributed to the national and international stakeholders and policy makers.  Report on TB and HIV situation among vulnerable groups in the project area.

Study report on TB and HIV related knowledge and behaviours in Estonia, Latvia, Lithuania, Bulgaria and Romania.

Information booklets and leaflets with basic information on TB for vulnerable groups, general population, and professionals

Detailed training materials and program for community based organizations, health and social care workers. Recommendations for professional education and continuous training contents for specialists.

Guidelines provide guidance on TB infection control and intensified case finding in community based organizations working with IDUs and they include guidelines for monitoring and evaluation of these activities.

**Publications**

## 2- Projects funded by DG EAC

### CHANCE

<b>Title of the project</b>	CHANCE – Ms in migrant health: addressing new challenges in Europe
<b>Website</b>	<a href="http://www.mighealth-unipecs.hu/chance">http://www.mighealth-unipecs.hu/chance</a>
<b>Research collaborator s</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- University of Pécs, Hungary</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Danube University Krems, Austria</li> <li>- Pavol Jozef Šafárik University in Košice, Slovakia</li> <li>- Medizinische Universität Graz, Austria</li> <li>- Ernst-Moritz-Arndt-Universität Greifswald, Germany</li> <li>- University of East Anglia, United Kingdom</li> </ul> <p>Associated partner:</p> <ul style="list-style-type: none"> <li>- EURIPA (European Rural and Isolated Practitioners Association)</li> </ul>
<b>Funders</b>	European Commission, DG EAC
<b>Duration</b>	2010/2013
<b>Target</b>	Health professionals especially general practitioners
<b>Aim of the project</b>	<p>To develop and implement a master degree in Migration Health. The program will be built on 6 competencies:</p> <ul style="list-style-type: none"> <li>- Clinical and public health assessment;</li> <li>- Epidemiology and research methodology;</li> <li>- Environmental medicine and occupational health;</li> <li>- Economic / health economic impact of migration;</li> <li>- Organization and systems management;</li> <li>- Social and behavioural aspects of migration including multicultural, multi-religious aspects and their health / mental health impact.</li> </ul>
<b>Methods</b>	<ul style="list-style-type: none"> <li>- Following the kick off workshop a web site will be designed, continuously updated for providing information about the program, the new curriculum and the possibilities how to join to the training.</li> <li>- During the curriculum development process each of the participating institution coordinating one or more core competency module(s), will host workshops on the given thematic modules.</li> <li>- EU level conference will be held where the program will be introduced and discussed.</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Interdisciplinary basic modules;</li> <li>- Master of Migration Health curriculum with training manuals</li> <li>- A set of background materials for facilitating the education</li> <li>- Program web page</li> </ul>
<b>Publications</b>	Final report:
<b>Other information</b>	The main objective of the CHANCE program is in synergy with the WHO Public Health Aspects of Migration in Europe (PHAME) project that aims to strengthen countries' capacities to manage large and sudden influxes of migrants

## C2ME

<b>Title of the project</b>	<b>C2ME - Culturally Competent in Medical Education</b>		
<b>Website</b>	<a href="http://www.mighealth-unipecs.hu/c2me">http://www.mighealth-unipecs.hu/c2me</a>		
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Academic Medical Centre/University of Amsterdam, Amsterdam, Netherlands</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Stichting VU VUMC, Amsterdam</li> <li>- University of Leicester, Leicester</li> <li>- Universitiy of Antwerp, Wilrijk</li> <li>- Justus-Liebig-Universität Gießen, Gießen</li> <li>- University of Limerick, Limerick</li> <li>- University of Edinburgh, Edinburgh</li> <li>- Hopitaux University of Genova, Genova</li> <li>- University of Sevilla, Sevilla</li> <li>- University of Copenhagen, Copenhagen</li> <li>- University of Pecs, Pecs,</li> <li>- Norwegian Centre for Minority Health</li> <li>- University of Maryland College Park School of Public Health, Maryland</li> </ul>		
<b>Funders</b>	European Commission, DG EAC		
<b>Duration</b>	2013/2015		
<b>Target</b>	Health professionals		
<b>Aim of the project</b>	The overall aim of the project is to develop an overarching faculty development programme for faculty staff as well as educational leaders that develops design principles to implement cultural competencies (CC) in the curriculum. To realize that, competent faculty staff is needed as well as a facilitating organization that takes care that (a) CC content is implemented effectively in curricula and (b) faculty staff is supported to optimally accomplish their tasks		
<b>Methods</b>	No info on the overall strategy to develop the project		
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Support faculty in their tasks in order to provide the most optimal education to students by developing design principles about how to teach CC (WP2; see model below).</li> <li>- Providing design principles to support educational leaders (e.g. education directors, curriculum developers, deans) to implement CC content effectively in curricula</li> </ul>		
<b>Publications</b>	<p>Seeleman C, Suurmond J, Stronks K. Cultural competence: a conceptual framework for teaching and learning. Med Educ. 2009;43:229-237.</p> <p>Suurmond J, Seeleman C, Rupp I, Goosen S, Stronks K. Cultural competence among nurse practitioners working with asylum seekers. Nurse Educ Today 2010;30(8):821-6.</p>		

Title of the project		eQUITY
<b>Website</b>	<a href="http://equitytools.eu/">http://equitytools.eu/</a>	
<b>Research collaborators</b>	University College Zealand, Danmark Soroe Health Center Katholieke Hogeschool Leuven, Belgium Oslo and Arkershus University College, Norway Escola Superior de Tecnologia da Saude de Lisboa, Portugal University of Iceland, Iceland	
<b>Funders</b>	DG EAC	
<b>Duration</b>	2013	
<b>Target</b>	Marginalised citizens, public health and health promotion professionals	
<b>Aim of the project</b>	Empowering marginalised citizens and health care professional by using m-learning in health care	
<b>Methods</b>	<p>An online survey was designed and disseminated in the country of each project partner .</p> <p>Each partner was asked to invite 5 health care workers, belonging to our target group, in order to test and assess the knowledge base.</p> <p>Therefor questions about education, age and the use of digital resources and devices are included. Besides that, questions about their profession and experience can help to interpret the choices they make and the evaluation they give towards layout and content. Because an important aim of the project is to empower health care workers and to improve the collaboration between colleagues, inter and intra professional, questions that measure these items were also added to the list.</p>	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Knowledge base on a website: <a href="http://www.equitytools.eu">www.equitytools.eu</a></li> <li>• Smart phone apps: Min mad</li> <li>• Training tools in communication, creation of interdisciplinary work team, Change management.</li> <li>• Each country application/ initiative: <a href="http://equitytools.eu/category/nationalpages/">http://equitytools.eu/category/nationalpages/</a></li> </ul>	
<b>Publications</b>	<p>Report  <a href="http://equitytools.eu/wp-content/uploads/2014/01/Report-on-piloting-the-knowledgebase.pdf">http://equitytools.eu/wp-content/uploads/2014/01/Report-on-piloting-the-knowledgebase.pdf</a>            Website with all training package: <a href="http://www.equitytools.eu">www.equitytools.eu</a></p>	

## IENE I & II

<b>Title of the project</b>		<b>Intercultural Education for nurses in Europe (1)</b>
<b>Website</b>	<a href="http://www.ieneproject.eu/">http://www.ieneproject.eu/</a>	
<b>Research collaborators</b>	<p>Middlesex University          (Pr. Irena Papadopoulos, coordinator)          Edunet          Arbeiterwohlfahrt Schleswig-Holstein (AWO)          Eurocenter Training and Partnership 21 Century          Katholieke Hogeschool Zuid-West-Vlaanderen (KATHO)          Vocational School "Sfantul Stefan"</p>	
<b>Funders</b>	<p>European Commission          Edunet          Eurocenter Training and Partnership 21 Century</p>	
<b>Duration</b>	2007 / 2010	
<b>Target</b>	<ul style="list-style-type: none"> <li>• Nurses in IVET, focusing on nurses being in European mobility or in traineeship placement in companies.</li> <li>• Nurses involved in the European labour market , working in different countries.</li> <li>• Nurses and other medical workers, which are often in contact with patients with different cultures and language.</li> </ul>	
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>• To identify the training needs of nurses from different European countries.</li> <li>• To develop new methodological approaches of intercultural education in Europe.</li> <li>• To set up and develop an online platform with information and training which supports the use of learning and training materials and facilitates sharing experience and practices in organizing training activities for nurses on intercultural issues.</li> <li>• To create a learning platform, which contains a learning guide and other materials and tools for intercultural education, which will be used to increase the quality of linguistic and cultural competences of nurses?</li> <li>• To promote the exchange of experience and good practice between partners in creating and implementing a European model for intercultural training.</li> <li>• To develop training materials and a guide useful for trainers which are involved in the intercultural education and training of nurses.</li> <li>• To improve the link between work and education, makers in the field.</li> <li>• To allow further cooperation between partners in the European</li> </ul>	
<b>Methods</b>	<ul style="list-style-type: none"> <li>• Research in the field of IVET and CVET of nurses;</li> <li>• Collecting the documents and links related to training programmes and materials in the field of language and cultural training at the European and national level according to the nurses' professional standards and competences;</li> <li>• Conducting a survey on the needs of intercultural education and training</li> <li>• Creating learning materials and tools for intercultural education of nurses;</li> <li>• Designing and organizing cultural activities for nurses being in European mobility and company placements or working in intercultural contexts;</li> </ul>	



	<ul style="list-style-type: none"> <li>• Evaluating the learning and educational materials through activities conducted in each country;</li> <li>• Creating and developing the multilingual website and posting on it information, documents, learning materials and tools for the intercultural education of nurses;</li> <li>• Translating the materials and the dictionary posted on the web site in all countries' languages;</li> <li>• Collecting materials for the best practice manual and publishing it in all partner countries</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• A multilingual website, informative guide , learning platform with learning materials and tools for the intercultural education of nurses;</li> <li>• A report on the research on the needs of intercultural education and training of the nurses;</li> <li>• An online informative guide containing information, documents and links related to the European common tools, national level tools in the field of IVET and CVET of the nurses;</li> <li>• A web based learning guide and materials on intercultural topics for self-learning and training activities of nurses;</li> <li>• A multilingual multimedia glossary necessary in the nurses' work in multicultural contexts;</li> <li>• A model of training activities and materials for nurses being in European mobility (Leonardo mobility pilot projects) and in placements companies or working in the intercultural context;</li> <li>• A good practice manual for intercultural training activities for nurses;</li> </ul>
<b>Publications</b>	<p>Research report:  <a href="http://www.ieneproject.eu/download/Outputs/Report%20of%20the%20research.pdf">http://www.ieneproject.eu/download/Outputs/Report%20of%20the%20research.pdf</a>            Good practices Manual  <a href="http://www.ieneproject.eu/download/Outputs/Good%20Practice%20Manual.pdf">http://www.ieneproject.eu/download/Outputs/Good%20Practice%20Manual.pdf</a>            Intercultural Model  <a href="http://www.ieneproject.eu/download/Outputs/intercultural%20model.pdf">http://www.ieneproject.eu/download/Outputs/intercultural%20model.pdf</a>            INTERCULTURAL EDUCATIONAL NEEDS OF NURSES AND OTHER HEALTH PROFESSIONALS IN EUROPE  <a href="http://www.ieneproject.eu/download/Outputs/IENE%20Survey%20Report.pdf">http://www.ieneproject.eu/download/Outputs/IENE%20Survey%20Report.pdf</a></p>
<b>Other relevant informations</b>	This project is followed by IENE 2

<b>Title of the project</b>	<b>Intercultural Education for nurses in Europe (2)</b>		
<b>Website</b>	<a href="http://www.ieneproject.eu/">http://www.ieneproject.eu/</a>		
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Middlesex University (Pr. Irena Papadopoulos, coordinator)</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Edunet</li> <li>- Arbeiterwohlfahrt Schleswig-Holstein (AWO)</li> <li>- Katholieke Hogeschool Zuid-West-Vlaanderen (KATHO)</li> <li>- SOFEO Santé Social</li> </ul>		
<b>Funders</b>	European Commission		
<b>Duration</b>	2007/2013		
<b>Target</b>	<ul style="list-style-type: none"> <li>- VET teachers and trainers participating in the training needs analysis</li> <li>- Decision makers, managers and representatives of institutions employing nurses participating in the training needs analysis</li> <li>- VET teachers and trainers participating in the training workshops</li> <li>- VET teachers and trainers participating in the implementation of PPT/IENE Model</li> <li>- VET schools or CVET institutions participating in the implementation of PPT/IENE Model</li> <li>- Teachers and trainers participating in the evaluation of the outputs (TOT model)</li> <li>- Nurses and health care professionals will participate in testing and evaluating the PTT/IENE model</li> <li>- Teachers and trainers participating in the dissemination activities</li> <li>- VET organizations receiving information about the project and its outputs on a regular base</li> <li>- Representatives of VET system and stakeholders participating in the final conference</li> </ul>		
<b>Aim of the project</b>	<p>The Transfer of Innovation project IENE 2 adapts and integrates the innovative transcultural nursing education model developed in the previous Leonardo da Vinci Partnership project IENE 1 - "Intercultural Education of Nurses and Medical Staff in Europe".</p> <p>The specific objectives of the project are:</p> <ul style="list-style-type: none"> <li>• to identify the training needs of teachers and trainers from the partners' countries and detect the specific competences necessary to provide transcultural education to various categories of nurses and health care professionals;</li> <li>• to create the methodology and content of a Training of Trainers (ToT) in order to prepare teachers and trainers to teach transversal competences and to implement the PTT/IENE Model of transcultural nursing education in health education systems;</li> <li>• to implement and evaluate the ToT Model during the training workshops organized in Belgium, Germany, Romania and France;</li> <li>• to pilot the adapted innovative PTT/IENE Model in some public and private organisations of initial and continuous education of nurses and health care professionals from partners' countries and to facilitate the transfer of the PTT/IENE model to IVET and CVET systems;</li> <li>• to create a wide impact of the project outputs on the key policy makers and influencers at national and EU level</li> </ul>		

<b>Methods</b>	<ul style="list-style-type: none"> <li>• First, a training module and training materials will be created and workshops will be organized in each of the four countries for teachers and trainers to learn how to implement the trans-cultural PTT/IENE model;</li> <li>• Secondly, with the help of the trainers and teachers already prepared, the PTT/IENE model will be piloted and tested in some public and private organisations of initial and continuous education of nurses and health care professionals from the partners' countries: Belgium, Germany, Romania and France;</li> <li>• Finally, the final products will be available for integration in regional, national and European IVET and CVET systems. The transfer will be enhanced through dissemination and valorisation activities, including a European conference organised at the end of the project.</li> <li>• In the preparation stage of the transfer, the partners will do a diagnosis of the needs of teachers and trainers from the project countries. The results of this research will be used to design the objectives of the Training of Trainers (ToT).</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• development of a transcultural training needs analysis from teacher perspectives</li> <li>• creation of an intensive training method (ToT model)</li> <li>• Implantation of the PTT/IENE model in different cultural contexts</li> </ul>
<b>Publications</b>	<p>Training methodology  <a href="http://www.ieneproject.eu/download/Outputs/Training%20methodology_EN.pdf">http://www.ieneproject.eu/download/Outputs/Training%20methodology_EN.pdf</a></p> <p>Guide for implementation strategy  <a href="http://www.ieneproject.eu/download/Outputs/Guide%20for%20the%20implementation%20plan.pdf">http://www.ieneproject.eu/download/Outputs/Guide%20for%20the%20implementation%20plan.pdf</a></p> <p>Brochure with project results  <a href="http://www.ieneproject.eu/download/Conference/Conference%20Brochure.pdf">http://www.ieneproject.eu/download/Conference/Conference%20Brochure.pdf</a></p>

## TRANSFORM

Title of the project      Training requirement and nurses skills for mobility (TRANSFORM)	
<b>Website</b>	<a href="http://www.transformnursing.eu/transform/home.aspx">http://www.transformnursing.eu/transform/home.aspx</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- University of Nottingham, UK</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Hogeschool GENT, Belgium</li> <li>- St Angela College, Ireland</li> <li>- Mikkelin ammattikorkeakoulu, Finland</li> <li>- Fachhochschule Bielefeld, Germany</li> <li>- Escola Superior de Enfermagem do Porto, Portugal</li> <li>- Dokuz Eylül Üniversitesi Hemşirelik Yüksekokulu, Turkey</li> </ul>
<b>Funders</b>	European Commission DG EAC
<b>Duration</b>	September 2010/ September 2012
<b>Target</b>	Nursing school / Nursing teachers in Europe
<b>Aim of the project</b>	To develop a set of key skills and competences for nurses to enable them to deal effectively with the social and cultural issues of an increasingly diverse workforce and client base
<b>Methods</b>	<p>The four 'D' model for inquiry</p> <ul style="list-style-type: none"> <li>• Discovery - Identifying &amp; Valuing the best of what is</li> <li>• Dream - Envisioning what might be</li> <li>• Design - Deciding what should be</li> <li>• Delivery - Innovating what will be</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Identification of training requirements and nursing skills for mobility* for healthcare.</li> <li>- The framework will be mapped to the European Qualifications Framework, and validation in the Europass system will be explored.</li> </ul>
<b>Publications</b>	<p>Posters:</p> <p><a href="http://www.transformnursing.eu/transform/documents/transform-poster-english-feb-2012.pdf">http://www.transformnursing.eu/transform/documents/transform-poster-english-feb-2012.pdf</a></p> <p><a href="http://www.transformnursing.eu/transform/documents/transform-sharing-learning-and-appreciating-difference-in-a-nursing-european-project.pdf">http://www.transformnursing.eu/transform/documents/transform-sharing-learning-and-appreciating-difference-in-a-nursing-european-project.pdf</a></p> <p>Report:</p> <p><a href="http://www.transformnursing.eu/transform/documents/leonardo-partnerships-progress-report.pdf">http://www.transformnursing.eu/transform/documents/leonardo-partnerships-progress-report.pdf</a></p>
<b>Other relevant informations</b>	<p>lessons learned</p> <ul style="list-style-type: none"> <li>• Develop strong student network built in from beginning of project</li> <li>• Evaluation process from beginning to end of project to capture richness of discussion</li> <li>• More inclusive involvement from workplace/practice—this is not always possible but could be explored</li> </ul>

- Maximising Multiple Voices through capturing depth of knowledge and learning which may have been lost communicating in an international project
- Involvement of patients—future project
- Greater visibility of project in own countries—through dissemination
- Significance/Notoriety of work product—another project
- Collect stories by capturing richness of discussions and memories - food for thought

<b>Title of the project</b>	<b>TRICC -Training Intercultural and Bilingual Competencies in Health and Social Care</b>
<b>Website</b>	<a href="http://www.tricc-eu.net/">http://www.tricc-eu.net/</a>
<b>Research collaborators</b>	<p>Leader :</p> <ul style="list-style-type: none"> <li>- Utrecht University, Utrecht, the Netherlands</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Boğaziçi University, Istanbul, Turkey</li> <li>- COOSS Marche, Ancona, Italy</li> <li>- dock europe e.V, Hamburg, Germany</li> <li>- PPRE Limited, London, Great Britain</li> </ul>
<b>Funding</b>	European Commission, DG EAC
<b>Duration</b>	2008/2010
<b>Target</b>	Health and social professionals
<b>Aim of the project</b>	<p>The aims of this project are:</p> <ul style="list-style-type: none"> <li>- to acknowledge, support and enhance migrants' informal bilingual and intercultural competencies</li> <li>- to develop non-formal adult education courses,</li> <li>- to test the training methodologies, based on varied forms of learning techniques, and</li> <li>- to make these courses ready for implementation for any European minority groups dealing with multilingualism.</li> </ul>
<b>Methods</b>	The assessment of training needs is based on earlier findings within the previous project BICOM as well as scientific studies and publications on ad hoc interpreting. This knowledge was extended in the TRICC project by conducting group and individual interviews with different target groups to develop the training modules geared to the respective needs. Featured here are the interview guidelines used, as well as the training needs assessed in interviews and discussions with different target groups
<b>Outcomes</b>	<p>All pedagogic material available here:  <a href="http://www.tricc-eu.net/products.html">http://www.tricc-eu.net/products.html</a></p> <p>Recommendations from each country on the following topic here:  <a href="http://www.tricc-eu.net/outcomes.html">http://www.tricc-eu.net/outcomes.html</a></p> <ul style="list-style-type: none"> <li>- for integrating multilingual competencies</li> <li>- for medical interpreting policy and the training of community and medical interpreters</li> </ul>
<b>Publications</b>	<p>Training in Intercultural and Bilingual Competencies in Health and Social Care (TRICC)  <a href="http://www.tricc-eu.net/download/TRICC_Handbook_UK.pdf">http://www.tricc-eu.net/download/TRICC_Handbook_UK.pdf</a></p>
<b>Others relevant information</b>	<p>This project is the continuity of the BICOM project 2005/2007 on promoting bilingual and intercultural competencies in Public Health  <a href="http://www.bicom-eu.net/">http://www.bicom-eu.net/</a></p>

## T-SHARE

Title of the project		T-share Transcultural Skills for Health and Care
<b>Website</b>	<a href="http://tshare.eu/drupal/en">http://tshare.eu/drupal/en</a>	
<b>Research collaborators</b>	<ul style="list-style-type: none"> <li>- Centre médico-psycho-social Françoise MINKOWSKA , France</li> <li>- Nakmi, Norway</li> <li>- Associazione F. Fanon, Italy</li> <li>- Azienda Sanitaria Locale NA 2 Nord, Italy</li> <li>- ASSOCIAZIONE CULTURALE CENTRO SHEN, Italy</li> <li>- ARACNE Associazione di promozione sociale, Italy</li> <li>- KULTURNO DRUSTVO GMAJNA , Slovenia</li> <li>- Centre em Rede de Investigação em Antropologia, Portugal</li> </ul>	
<b>Funding</b>	European Commission, DG EAC, Leonardo project	
<b>Duration</b>	2009/2011	
<b>Target</b>	<ul style="list-style-type: none"> <li>- Professionals and practitioners from the public health sector: doctors, psychiatrists, midwives, psychologists, nurses</li> <li>- Cultural Mediators</li> <li>- Immigrants experts in the field of health and care</li> <li>- Immigrant users of health services and social services, public and private</li> <li>- Professors, researchers and university students</li> <li>- Key players of social and social-health systems and services</li> <li>- Key players of health policy</li> <li>- Key players of policies for social inclusion, immigration, equal opportunities</li> <li>- Key players of Vocational and Education Training systems</li> </ul>	
<b>Aim of the project</b>	<p>To promote and develop transcultural approach to cure in health care services in Europe, with particular attention to women's health and mental health.</p> <p>The goal is to help respond to emerging training needs in the sector, linked to the increase of users immigrants living in Europe and their demand for health care, prevention, but also of inclusion, participation and shared planning of health services.</p>	
<b>Methods</b>	Questionnaires disseminated among the diverse research teams and collaborating partners	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Development of methodologies and tools for the establishment and training of inter-professional and cross-cultural teams working in the health care service.</li> <li>- Recognition of competences learned in a non-formal and informal settings both from practitioners and from cultural mediators</li> </ul>	
<b>Publications</b>	<p>T-share progress report:  <a href="http://tshare.eu/drupal/sites/default/files/T-share_progress_report.pdf">http://tshare.eu/drupal/sites/default/files/T-share_progress_report.pdf</a>            Standard and guideline for practice and training  <a href="http://tshare.eu/drupal/sites/default/files/confidencial/WP11_co/MIOLO_TSHARE_216paginas.pdf">http://tshare.eu/drupal/sites/default/files/confidencial/WP11_co/MIOLO_TSHARE_216paginas.pdf</a>            Research report and methological tools:  <a href="http://tshare.eu/drupal/en/node/238">http://tshare.eu/drupal/en/node/238</a></p>	
<b>Other relevant</b>	Include an analysis of cultural representation, skills and needs of migrant communities, relating to the field of health and care in the key sector.	

### 3- Projects funded by DG HOME

#### Health Care for Asylum Seekers in the EU

Title of the project	
Health Care for Asylum Seekers in the EU	
<b>Research collaborators</b>	The Austrian Red Cross, in partnership with the Red Cross EU Office and Red Cross National Societies of Belgium, Bulgaria, France and the United Kingdom
<b>Funders</b>	DG HOME
<b>Duration</b>	15 MONTHS, on-going
<b>Aim of the project</b>	<p>Project focused on the mental health care of asylum seekers in the European Union, with a special emphasis on the needs of survivors of torture, persons with missing family members and the elderly and frail.</p> <p>The project aimed to facilitate opportunities for exchange of information and to raise awareness and improve knowledge of the importance of mental health care in the reception of asylum seekers.</p>
<b>Methods</b>	<ol style="list-style-type: none"> <li>1) The first phase of the project involved gathering information from European organisations offering mental health services to the three target groups (survivors of torture, persons with missing family members, and the elderly and frail).</li> <li>2) Conference, which took place 30 June – 2 July 2009 in Vienna, to which practitioners from all EU Member States were invited; participants included representatives from Government and Non-Government organisations and from Red Cross National Societies.</li> <li>3) Through the exchange of information and participation in workshops at the conference, the project identified key aspects of best practice in the field of mental health care for asylum seekers.</li> <li>4) The conference also served as a forum for strengthening cooperation between different service providers in the Governmental and Non-Governmental sectors.</li> <li>5) Based on the information gathered in the questionnaire and in the conference workshops, a set of recommendations and guidance notes concerning mental health care and treatment of asylum seekers and refugees were developed, with a focus on the special needs of the three target groups.</li> </ol>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Project recommendations for professionals</li> <li>- Guidance notes for implementation of project recommendations (targeted at organisations, including therapeutic and public health services)</li> </ul>
<b>Publications</b>	<ul style="list-style-type: none"> <li>- Project recommendations for professionals</li> <li>- Guidance notes for implementation of project recommendations (targeted at organisations, including therapeutic and public health services)</li> </ul>



## PROTECT

<b>Title of the project</b>	<b>PROTECT: Process of Recognition and Orientation of Torture Victims in European Countries to facilitate Care and Treatment - raising Awareness, changing Behaviours, providing with Learning, building on Experience.</b>
<b>Website</b>	<a href="http://protect-able.eu/">http://protect-able.eu/</a>
<b>Project collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Parcours d'Exil (FR)</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- CORDELIA foundation for the rehabilitation of torture victims (HU)</li> <li>- Assistance Centre for Torture Survivor – ACET (BG)</li> <li>- France Terre d'Asile – FTDA (FR)</li> <li>- ACCEM (ES)</li> <li>- Svenska Röda Korset (SE)</li> <li>- Fundacja Miedzynarodowa Inicjatywa (PL)</li> <li>- Consiglio Italiano Rifugiati (IT)</li> <li>- Odysseus Academic Network (BE)</li> <li>- Medical Foundation for the care of the Victims of torture (UK)</li> </ul>
<b>Funders</b>	EC- European Refugee Fund
<b>Duration</b>	On-going
<b>Aim of the project</b>	<p>The project PROTECT-ABLE aims at disseminating to a large scale the PROTECT tool and process by providing trainings in 9 Member States, and by carrying out lobbying and networking actions at the International, European and National level.</p> <p>The project proposes first to develop a training method on the PROTECT tool for non-medical staff (social workers, volunteers, immigration officers, lawyers) and to train 18 trainers from 10 organizations specialised in the medical and psychological treatment of vulnerable asylum seekers in 9 Member States (Bulgaria, Germany, France, Sweden, Italy, Poland, Hungary, United Kingdom, Spain).</p>
<b>Methods</b>	<ul style="list-style-type: none"> <li>- Development of a simple and pragmatic questionnaire tool (PROTECT tool), enabling professionals making first contact with the asylum seekers to evaluate state of psychological vulnerability.</li> <li>- Based on initial evaluation, migrants considered "at risk" will be referred to a health professional able to confirm this first evaluation.</li> <li>- PROTECT tool to be disseminated to partner states, to non-medical staff, and trainers from medical and psychological services.</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- Improve the access to psychological, medical care and provide adapted material conditions to those vulnerable asylum seekers.</li> </ul>
<b>Publications</b>	

## Healthy and wealthy together

Healthy and Wealthy together	
<b>Title of the project</b>	
<b>Website</b>	<a href="http://www.ludenet.org/archives/qeceran/projects/healthywealthy/healtywealthyindex.htm">http://www.ludenet.org/archives/qeceran/projects/healthywealthy/healtywealthyindex.htm</a>
<b>Project collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Belfast Health and Social Care Trust;</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Exfini Poli;</li> <li>- Comune di Milano;</li> <li>- Provincia di Piacenza;</li> <li>- University of Birmingham;</li> <li>- Réseau Samdarra;</li> <li>- QeC-ERAN.</li> </ul>
<b>Funders</b>	EC- European Fund for integration of third country nationals
<b>Duration</b>	2008-2011
<b>Aim of the project</b>	The overall aim of this project is to establish a thematic exchange network of public and private local actors working with or for migrants on the issue of health and poverty. This thematic network serves to establish a transnational exchange programme which will facilitate transfer of data, experience, good practice and policies and which will also provide tools and knowledge for the empowerment of local actors in the fields of developing better approaches to poverty and health inequalities among migrants.
<b>Methods</b>	<ol style="list-style-type: none"> <li>1. Establish local partnerships in partner locations engaging migrants, representatives of migrants associations, healthcare professionals, local politicians and other involved stakeholders;</li> <li>2. Each local forum will undertake a local mapping in order to identify three most relevant issues in the field of Migrants health and poverty that need to be dealt within their location;</li> <li>3. Transnational exchange programme will be built upon the findings of partners' local mappings, consisting of three transnational workshops and an on-line interactive platform (blogs, chats, individual profiles);</li> <li>4. Dissemination of information: after each workshop summaries will be provided in booklets (translated into local languages and distributed in the places of interest) and on the website, and a final report will provide conclusions about the whole project.</li> </ol>
<b>Outcomes</b>	<p>Production of three common module reports related to the poverty and health inequalities of migrants, to be published online;</p> <ul style="list-style-type: none"> <li>- Online database providing access to at least 20 good practice case studies and links to relevant documentation and at least 30 organisations;</li> <li>- Transnational peer review programme, with 80 participants in the transnational workshop programme and 120 participants involved in the programme of online support activities;</li> <li>- 8 local mapping reports, which capture the current context, barriers and actions being undertaken in relation to the theme;</li> <li>- 8 local action plans;</li> </ul>
<b>Publications</b>	

## 4- Projects funded by DG EMPL

### Better Health for Better Integration

Title of the project		Better Health for Better Integration
<b>Website</b>		<a href="http://www.bhbi.eu/">http://www.bhbi.eu/</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Fondazione Giacomo Brodolini</li> </ul> <p>Other partners</p> <ul style="list-style-type: none"> <li>- National Institute of Adult Continuing Education, UK</li> <li>- South West Public Health Observatory, UK</li> <li>- Department of Community Medicine and Public Health, Orebro County Council, Sweden</li> <li>- Civil Society Development Foundation, Romania</li> </ul>	
<b>Funders</b>	European Commission (part of the PROGRESS program which is a financial instrument of the European Commission, DG Employment and Social Affairs, to support the development of EU policies in the following fields: employment, social inclusion, working condition, anti-discrimination, gender equality)	
<b>Duration</b>	December 2010/ December 2012	
<b>Target</b>	Women belonging to ethnic minorities (here ethnic minority is defined as someone belonging to the second generation of immigration or historical ethnics eg the Roma) who present a high risk of health inequalities.	
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>- Contribute to improving the capacity of partners and other relevant stakeholders in designing gender mainstreamed strategies to tackle health inequalities</li> <li>- Build capacities to improve health equity</li> </ul>	
<b>Methods</b>	<ul style="list-style-type: none"> <li>- Mutual learning approach and participatory approach to policy design</li> <li>- Analysis of their respective national/regional situations and of the learning process spurred by the exchange of best practices, partners will have the opportunity to discuss across the partnership the actions/strategies that could be developed.</li> </ul>	
<b>Outcomes</b>	<p>Recommendations in four fields for members States and policy makers:</p> <ul style="list-style-type: none"> <li>- Regulatory context</li> <li>- Services provided</li> <li>- Governance and leadership</li> <li>- Integration of policies.</li> </ul> <p><a href="http://www.bhbi.eu/sites/default/files/documents/Handbook_EN_0.pdf">http://www.bhbi.eu/sites/default/files/documents/Handbook_EN_0.pdf</a></p>	
<b>Publications</b>	<p>Catalogue of good practices:</p> <p><a href="http://www.bhbi.eu/sites/default/files/Catalogue_EN.pdf">http://www.bhbi.eu/sites/default/files/Catalogue_EN.pdf</a></p> <p>Countries reports</p> <p><a href="http://www.bhbi.eu/search-key-documents">http://www.bhbi.eu/search-key-documents</a></p>	

	<p>Final handbook:  <a href="http://www.bhbi.eu/sites/default/files/documents/Handbook_EN_0.pdf">http://www.bhbi.eu/sites/default/files/documents/Handbook_EN_0.pdf</a></p>
<b>Other relevant informations</b>	<p>The project was targeted women belonging to ethnic minorities, but finally in most of the project the target was extended to all the ethnic community.</p> <p><b>There is not a systematically assessment method for all the projects , so there are no real measure of the impact of the reported initiatives</b></p>

## HealthQuest

<b>Title of the project</b>	<b>HealthQuest - Quality in and Equality of Access to Healthcare Services</b>	
<b>Website</b>	<a href="http://www.ehma.org/?q=node/54">http://www.ehma.org/?q=node/54</a>	
<b>Research collaborators</b>	<p><b>Leaders:</b></p> <ul style="list-style-type: none"> <li>- European Health Management Association (EHMA)</li> <li>- European Centre for Social Welfare Policy and Research National Institute of Public Health &amp; the Environment (RIVM), The Netherlands</li> </ul> <p><b>Other partners:</b></p> <ul style="list-style-type: none"> <li>- University of York, Centre for Health Economics, UK</li> <li>- Centre for Social and Economic Research (CASE), Poland</li> <li>- Institute of Public Health, Romania</li> <li>- The Association of Sickness Funds for Employers (VdAK), Germany –</li> <li>- National Research &amp; Development Centre for Welfare &amp; Health (STAKES), Finland</li> <li>- Andalusian School of Public Health, Spain</li> <li>- National School of Public Health, Greece</li> <li>- National Institute of Public Health &amp; the Environment (RIVM), The Netherlands</li> </ul>	
<b>Funding</b>	European Commission, DG EMPL	
<b>Duration</b>	2007/2008	
<b>Target</b>	Vulnerable groups (socio-economic disadvantaged group, migrants, ethnic minorities...)	
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>- To identify and analyse barriers to access to health care services which are faced by vulnerable groups in society, and especially those most exposed to social exclusion;</li> <li>- To examine the barriers that stem from health service supply as well as from the demand side;</li> <li>- To explore the extent to which the organisation of healthcare systems ease or reinforce such barriers, particularly on the demand side;</li> <li>- To review the various policy initiatives taken by the Member States to realise the objective of access for all;</li> <li>- To highlight and describe the most effective policy measures to ensure access to health care to the most disadvantaged;</li> <li>- To help to determine the extent to which increased access to and quality of health care services can make to combating poverty and social exclusion and increasing social inclusion.</li> <li>- Using one particular vulnerable group (those suffering mental illness) develop an in-depth analysis bringing together the interplay of different dimensions of health problems, barriers, and risk of social exclusion, and illustrating the impact of the conclusions reached during the project.</li> </ul>	
<b>Methods</b>	No mention of the method use in this project	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- final report,</li> </ul>	

	<ul style="list-style-type: none"> <li>- eight country studies analyse the following countries: Finland, Germany, Greece, Netherlands, Poland, Spain, Romania, and United Kingdom.</li> </ul>
<b>Publications</b>	<p>Anderson E. Stanciole, Manfred Huber Access to Health Care for Migrants, Ethnic Minorities, and Asylum Seekers in Europe</p> <p><a href="http://www.euro.centre.org/data/1254748286_82982.pdf">http://www.euro.centre.org/data/1254748286_82982.pdf</a></p>

## 5- Projects funded by DG RESEARCH

### COHEMI

<b>Title of the project</b>	<b>COHEMI – Coordinating resources to assess and improve health status of migrants from Latin America</b>
<b>Website</b>	<a href="http://www.cohemi-project.eu/Default.aspx">http://www.cohemi-project.eu/Default.aspx</a>
<b>Research collaborators</b>	<p>Leader: "Mario Negri" Institute for Pharmacological Research of Milan, Italy.</p> <p>Others partners:</p> <ul style="list-style-type: none"> <li>- Istituto di Ricerche Farmacologiche Mario Negri (IRFMN), Italy</li> <li>- Centre for Tropical Diseases, S.Cuore Hospital, Negrar, Verona (CTD), Italy</li> <li>- University of Florence, Division of Infectious Diseases (UFDID), Florence, Italy</li> <li>- Fundació Clinic pera la Recerca Biomèdica (FCRB), Italy</li> <li>- University of Amsterdam(UvA), The Netherlands</li> <li>- Department of Clinical Parasitology, Hospital for Tropical Diseases, University College London Hospitals NHS Foundation Trust (UCLH), UK</li> <li>- Fundacion Salud Y Desarrollo (FUNSAD/CECOMET),</li> <li>- EcuadorThe Universidad Peruana Cayetano Heredia (UPCH), Peru</li> <li>- Taller de Educacion y Comunicacion TEK0-GUARANI (TEKO), Bolivia</li> <li>- The Applied Studies and Social Development Collettive (CEADES), Bolivia</li> </ul>
<b>Funders</b>	European Comission DG SANCO
<b>Duration</b>	2010/2013
<b>Aim of the project</b>	<p>COHEMI's general objective is to coordinate referral centers (both in Europe and Latin America) dealing with diseases specific to Latin American countries, as well as other infectious and non-infectious diseases affecting LA migrants, and centers investigating migrant health generally (researching health systems, reproductive and child health, anthropological and psycho-social problems).</p> <p>Through coordinating these groups COHEMI aims to provide a clear understanding of the full migration cycle in relation to the health systems in Europe and Latin America and to suggest general and specific (disease-driven) policies to address the priority aspects of ill-health in the migrant population.</p>
<b>Methods</b>	<p>The overall strategic approach will be developed on a 3-step methodology, horizontal to the overall work plan:</p> <ol style="list-style-type: none"> <li>1. Analysis and synthesis,</li> <li>2. Networking and awareness,</li> <li>3. Wider communication.</li> </ol>
<b>Outcomes</b>	COHEMI aims to provide a clear picture of the full migration cycle in relation with the health systems in Europe and Latin America and to suggest specific (disease-driven) policies to address the priority aspects of ill-health in the migrant population.

<b>Publications</b>	<p><b>2011</b></p> <p>Basile L et al. Chagas disease in European countries: the challenge of a surveillance system. <i>Euro Surveill</i> 2011; 16:pii=19968</p> <p>Angheben A et al. Chagas disease in Italy: breaking an epidemiological silence. <i>Euro Surveill</i> 2011; 16:pii=19969</p> <p>Bonati M, Severino F. Current state of health status of Latin American migrants in Europe (COHEMI) <i>Tropical Medicine &amp; International Health</i> 2011 16(suppl1):48</p> <p>Zammarchi L et al. Taenia solium seroprevalence in immigrant and foreign adopted children in Florence, Italy <i>Trop Med Int Health</i> 2011; 16(Suppl. 1):218</p> <p>Gotuzzo E et al. Current state of infectious diseases related to Latin American migrants in Europe: neglected parasitic diseases and TB. <i>Trop Med Int Health</i> 2011; 16(Suppl. 1):48</p> <p>Moreira J et al. Extended review of hypertension and cardiovascular risk in Bolivia, Ecuador and Peru. <i>Trop Med Int Health</i> 2011; 16 (Suppl. 1):48</p> <p><b>2012</b></p> <p>Bonati M, Confalonieri V. Global rights for global diseases. The shortage of benznidazole case. <i>Eur J Public Health, e-letter</i> 26 January 2012</p> <p>Buonfrate D et al. Imported Strongyloidiasis: epidemiology, presentations, and treatment. <i>Curr Infect Dis Rep</i> 2012 14(3): 356-62</p> <p>Kitchen AD et al. The early implementation of Trypanosoma cruzi antibody screening of donors and donation within England: preempting a problem <i>Transfusion</i> 2012 52(9): 1931-9</p> <p>Bruno E et al. Epilepsy-associated stigma in Bolivia: A community-based study among the Guarani population-An international League Against Epilepsy/International Bureau for Epilepsy/World Health Organization Global Campaign Against Epilepsy Regional Project. <i>Epilepsy Behav</i> 2012; 25:131-36</p> <p>Bruno E et al. Neurocysticercosis and epilepsy in Latin America and Europe. <i>XLIII Congress of the Italian Neurological Society 2012. Neurological sciences; supplement volume 33: S410</i></p> <p><b>2013</b></p> <p>Ventura-Garcia L, et al. Socio-Cultural Aspects of Chagas Disease: A Systematic Review of Qualitative Research. <i>PLoS NTD</i> 2013; 7(9):e2410</p> <p>Requena-Méndez A, et al. Evaluating Chagas disease progression and cure through biomarkers: a systematic review. <i>Expert Rev Anti infect Ther</i> 2013; 11(9):957-76</p> <p>Pinazo MJ, et al. Immunosuppression and Chagas disease: A Management Challenge. <i>PLoS NTD</i> 2013; 7(1): e1965</p>
---------------------	---



## COST Action ADAPT

Title of the project		COST ADAPT
<b>Website</b>	<a href="http://www.cost.eu/domains_actions/isch/Actions/IS1103">http://www.cost.eu/domains_actions/isch/Actions/IS1103</a>	
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- David Ingleby, University of Amsterdam, Netherlands</li> </ul> <p>Other partner:</p> <ul style="list-style-type: none"> <li>- Academics and international organisations from 28 Europeans countries</li> </ul> <p>List of partners available here:  <a href="http://www.cost.eu/domains_actions/isch/Actions/IS1103?parties">http://www.cost.eu/domains_actions/isch/Actions/IS1103?parties</a> </p>	
<b>Funding</b>	European Commission, DG JRC	
<b>Duration</b>	2011/2015	
<b>Target</b>	Policy makers, researchers, health professionals, managers	
<b>Aim of the project</b>	<p>This Action aims to promote the adoption and implementation of policies responding to this increased diversity. It builds on the achievements of COST Action HOM), which reviewed health inequalities among migrants and ethnic minorities as well as the measures designed to remedy them. ADAPT will take this work forward, identifying obstacles to translating this knowledge into action.</p> <p>This Action will make practical recommendations for promoting change. Interdisciplinary teams will identify bottlenecks and missed opportunities, while the pan-European nature of COST will provide a unique opportunity to identify the factors driving policy and implementation.</p>	
<b>Methods</b>	<p>The Action aims to stimulate interdisciplinary and international scientific cooperation on the three research tasks just described. To this end, it will:</p> <ul style="list-style-type: none"> <li>- Set up a scientific network to address these three tasks;</li> <li>- Formulate and carry out a collaborative work programme;</li> <li>- Prepare new joint applications for national and international funding;</li> <li>- Organise Meetings, Workshops, Training Schools, Conferences and publications to further work plans and disseminate the results of the Action.</li> <li>-</li> </ul>	
<b>Outcomes</b>	The results will have implications for effective policy making and organizational change, not only in health but also in other fields of public policy.	
<b>Publications</b>	No available publications yet	

## COST Action HOME

<b>Title of the project</b>	<b>COST HOME-Health and Social Care for Migrants and Ethnic Minorities in Europe</b>
<b>Website</b>	<a href="http://www.cost.eu/domains_actions/isch/Actions/IS0603">http://www.cost.eu/domains_actions/isch/Actions/IS0603</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- David Ingleby, University of Amsterdam, Netherlands</li> </ul> <p>Other partner:</p> <ul style="list-style-type: none"> <li>- Academics and international organisations from 29 European countries</li> </ul> <p>List of partners available here:</p> <p><a href="http://www.cost.eu/domains_actions/isch/Actions/IS0603?parties">http://www.cost.eu/domains_actions/isch/Actions/IS0603?parties</a></p>
<b>Funding</b>	European Commission, DG JRC
<b>Duration</b>	2007/2011
<b>Target</b>	Policy makers, researchers, health professionals, managers
<b>Aim of the project</b>	<p>This Action will bring together an international group of experts to consolidate and review work carried out so far, identify blind spots and persistent problems, and recommend ways forward.</p> <p>This Action aims to facilitate high-level contacts between researchers in the field and stimulating international and interdisciplinary collaboration. Its aim is not simply to add more findings to those already accumulated, but to consolidate and critically reflect on the work that has been done so far, as well as to indicate directions for future work</p> <p>Details available on this technical document</p> <p><a href="http://w3.cost.eu/fileadmin/domain_files/ISCH/Action_IS0603/mou/IS0603-e.pdf">http://w3.cost.eu/fileadmin/domain_files/ISCH/Action_IS0603/mou/IS0603-e.pdf</a></p>
<b>Methods</b>	<p>The project is divided into three area of study:</p> <ul style="list-style-type: none"> <li>- Social context and policies relating to migrants</li> <li>- Migrants' state of health and its determinants</li> <li>- Health care for migrants and ways of improving it.</li> </ul>
<b>Outcomes</b>	<p>To produce 'state of the art' reports on the most urgent themes and will organize workshops, conferences, joint publications and training activities to discuss and disseminate its findings</p> <p>Progress report COST HOME</p> <p><a href="http://w3.cost.eu/fileadmin/domain_files/ISCH/Action_IS0603/progress_report/progress_report-IS0603.pdf">http://w3.cost.eu/fileadmin/domain_files/ISCH/Action_IS0603/progress_report/progress_report-IS0603.pdf</a></p>
<b>Publications</b>	<p>COST Series on Health and Diversity Volume 1: Health Inequalities and Risk Factors among Migrants and Ethnic Minorities</p> <p><a href="http://www.cost.eu/media/publications/12-16-COST-Series-on-Health-and-Diversity-Volume-1-Health-Inequalities-and-Risk-Factors-among-Migrants-and-Ethnic-Minorities">http://www.cost.eu/media/publications/12-16-COST-Series-on-Health-and-Diversity-Volume-1-Health-Inequalities-and-Risk-Factors-among-Migrants-and-Ethnic-Minorities</a></p> <p>COST Series on Health and Diversity Volume 2: Inequalities in Health Care for Migrants and Ethnic Minorities</p> <p><a href="http://www.cost.eu/media/publications/12-15-COST-Series-on-Health-and-Diversity-Volume-2-Inequalities-in-Health-Care-for-Migrants-and-Ethnic-Minorities">http://www.cost.eu/media/publications/12-15-COST-Series-on-Health-and-Diversity-Volume-2-Inequalities-in-Health-Care-for-Migrants-and-Ethnic-Minorities</a></p>

## Epi Migrant

Title of the project		Epi Migrant
<b>Website</b>		<a href="http://www.epimigrant.eu/welcome">http://www.epimigrant.eu/welcome</a>
<b>Research collaborators</b>	-	<ul style="list-style-type: none"> <li>Imperial College of Science, Technology and Medicine, United Kingdom</li> <li>Oxford University, United Kingdom</li> <li>Devki Devi Foundation, India</li> <li>University of Milan, Italy</li> <li>Oulu University, Finland</li> <li>University of Helsinki, Finland</li> <li>Baker IDI Heart and Diabetes Institute, Australia</li> <li>Cambridge University, United Kingdom</li> <li>National University of Singapore, Singapore</li> <li>University of Kelaniya, Sri Lanka</li> <li>CellCentric, United Kingdom</li> <li>National Centre for Global Health and Medicine, Japan</li> <li>University of Mauritius, Mauritius</li> </ul>
<b>Funders</b>		DG JRC
<b>Duration</b>		2011/2014
<b>Target</b>		South Asian migrants
<b>Aim of the project</b>		This project focuses on identification of epigenetic risk factors underlying the increased rates of type-2 diabetes (T2D) amongst South Asians in their home countries, migrants to Europe and other parts of the world. Known environmental and genetic factors explain only a small part of the increased risk of T2D among South Asians, who constitute the highest numbers of people with T2D worldwide.
<b>Methods</b>		<ul style="list-style-type: none"> <li>(1) Coordination, management and scientific management</li> <li>(2) Data generation – measurement of epigenetic markers</li> <li>(3) Data analysis to identify epigenetic markers associated with T2D</li> <li>(4) Risk factors underlying T2D amongst South Asians in different settings</li> <li>(5) Power considerations</li> </ul>
<b>Outcomes</b>		This research will improve understanding of epigenetic mechanisms underlying T2D, and may enable development of novel biomarkers and therapeutic strategies to reduce the burden of T2D amongst South Asians worldwide
<b>Publications</b>		

Title of the project		EUNAM- EU and North African Migrants: Health and Health Systems
<b>Website</b>		
<b>Research collaborators</b>	Institut National de Santé Publique - INSP (Algeria) Ain Shams University (Egypt) Institut de recherche et documentation en économie de la santé – IRDES (France) Deutsches Krebsforschungszentrum (Germany) Institut Pasteur du Maroc (Morocco) Lunds Universitet (Sweden) Centre d'Etudes et Recherches Perspectives (Tunisia) Institut National de Santé Publique (Algeria) Institut de recherche et documentation en économie de la santé (France)	
<b>Funders</b>	7 <sup>th</sup> Research Framework Program DG JRC	
<b>Duration</b>	2011/2015	
<b>Target</b>	North African migrants	
<b>Aim of the project</b>	Some migrants may experience several host countries and some return to the country of origin. Thus it is important to survey well-being, health status, disease panorama and use of health services of immigrants compared to the native population; such analyses would be incomplete without casting a view on the same indicators and parameters in the country of origin. Thus for this project we have collected a team of experts to cover health aspects of the full cycle of migration, viewing the health situation in Egypt, Tunisia, Algeria and Morocco as representatives of the Mediterranean North African (NA) partner countries, the origins of vast numbers of immigrants in EU.	
<b>Methods</b>	The team has experience on a variety of health and disease measures and it has an access to a variety of survey and register material relating to population health, disease patterns and function of health care systems. Many of the surveys and diseases registers have been carried out/constructed by the present partners who thus possess unique sources of data.	
<b>Outcomes</b>	The team will be in the position to respond to the expectations of the call by reviewing health effects of migration from the country of origin to the host country and coming up with scientifically valid state-of-the-art evaluations and appropriate recommendations for scientific and health policy measures in improving the conditions for the EU immigrants	
<b>Publications</b>	Zaccagni L. Weight status and perception of body image in children: the effect of maternal immigrant status. Nutrition Journal 2012; 11:85.  Hemminki K, Sundquist J, Mousavi SM. Breast Cancer Histology in Immigrants to Sweden: Do Ethnic Differences Exist? Breast J 2012;18:392-3.	

Mousavi SM, Sundquist K, Hemminki K. Morbidity and mortality in gynecological cancers among first- and second-generation immigrants in Sweden. *Int J Cancer* 2012;131:497-504.

Mousavi SM, Sundquist K, Hemminki K. Does the risk of stomach cancer remain among second-generation immigrants in Sweden? *Gastric Cancer* 2012;15:213-5.

Mousavi SM, Fallah M, Sundquist K, Hemminki K. Age- and time- dependent changes in cancer incidence among immigrants to Sweden: Colorectal, lung, breast and prostate cancers. *Int J Cancer* 2012;131:E122-8.

Mousavi SM, Sundquist K, Hemminki K. Risk of lung cancer by histology among immigrants to Sweden. *Lung Cancer* 2012;76:159-64.

Li X, Sundquist K, Sundquist J. Risks of small-for-gestational-age births in immigrants: a nationwide epidemiological study in Sweden. *Scand J Public Health* 2012;40(7):634-40.

Li X, Sundquist J, Sundquist K. Immigrants and preterm births: a nationwide epidemiological study in Sweden. *Matern Child Health J* 2013;17(6):1052-8.

Hemminki K, Li X, Försti A, Sundquist J, Sundquist K. Incidence of hereditary amyloidosis and autoinflammatory diseases in Sweden: endemic and imported diseases. *BMC Med Genet* 2013;14(1):88.

Hemminki K, Ankerst DP, Sundquist J, Mousavi SM. Prostate cancer incidence and survival in immigrants to Sweden. *World J Urol* 2013;31:1483-8.

Mousavi SM, Sundquist J, Hemminki K. Cancer incidence among Turkish, Chilean, and North African first-generation immigrants in Sweden compared with residents in the countries of origin and native Swedes. *Eur J Cancer Prev* 2013;22:1-7.

Mousavi SM, Försti A, Sundquist J, Hemminki K. Ethnic differences in breast cancer risk and survival: A study on immigrants in Sweden. *Acta Oncol* 2013;52:1637-42.

Mousavi SM, Försti A, Sundquist K, Hemminki K. Do reproductive factors influence T, N, and m classes of ductal and lobular breast cancers? A nation-wide follow-up study. *PLoS One* 2013;8:e58867

Mousavi SM, Sundquist J, Hemminki K. Risk of Kaposi sarcoma among immigrants to Sweden. *Acta Derm Venereol* 2013

Li X, Sundquist J, Zöller B, Bennet L, Sundquist K. Risk of hospitalization for type 2 diabetes in first- and second-generation immigrants in Sweden: a nationwide follow-up study. *J Diabetes Complications* 2013;27(1):49-53.

Li X, Memarian E, Sundquist J, Zöller B, Sundquist K. Neighborhood deprivation and childhood autism: A nationwide study from Sweden. *J Psychiatr Res* 2014;53:187-92.

Li X, Sjöstedt C, Sundquist J, Zöller B, Sundquist K. Risk of epilepsy in first- and second-generation immigrants in Sweden: a nationwide follow-up study. Submitted

Memarian E, Calling S, Sundquist S, Sundquist J, Li X. Country of origin and bariatric surgery in Sweden during 1990-2010. Manuscript

Gualdi-Russo E, Zaccagni L., Dallari GV, Toselli S. Anthropometric parameters in relation to glycaemic status and lipid profile in a multi-ethnic sample in Italy. Public Health Nutrition 2014; Apr 24:1-8. [Epub ahead of print].

Gualdi-Russo E., Toselli S., Masotti S., Marzouk D., Sundquist K., Sundquist J. Health, growth and psychosocial adaptation of immigrant children. Eur J Pub Health 2014; in press.

Toselli S, Gualdi Russo E, Marzouk D, Sundquist J, Sundquist K. Psychosocial health among immigrants in Central and Southern Europe. Eur J Pub Health 2014; in press.

Toselli S, Gualdi Russo E, Boulos DNK, Anwar WA, Lakhous C , Jaouadi I, Khyatti M, Hemminki K. Prevalence of overweight and obesity in adults from North Africa. Eur J Pub Health 2014; in press.

Gualdi-Russo E, Zaccagni L., Manzon VS, Masotti S, Rinaldo N, Khyatti M. Obesity and physical activity in children of immigrants. Eur J Pub Health 2014; in press.

## EUROCOORD

Title of the project		EUROCOORD
<b>Website</b>		<a href="http://www.eurocoord.net/default.aspx">http://www.eurocoord.net/default.aspx</a>
<b>Project collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- University College London, United Kingdom</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- University of Minsk, Belarus</li> <li>- St. Pierre University Hospital, Belgium</li> <li>- Københavns Universitet, Denmark</li> <li>- Cadpeople A/S, Denmark</li> <li>- Université Victor Segalen Bordeaux 2, France</li> <li>- INSERM, France</li> <li>- University of Bonn, Germany</li> <li>- Robert Koch Institut, Germany</li> <li>- National and Kapodistrian University of Athens, Greece</li> <li>- Fondazione PENTA, Italy</li> <li>- ICoNA Foundation, Italy</li> <li>- Academic Medical Center, Netherlands</li> <li>- Stichting HIV Monitoring, Netherlands</li> <li>- National Institute of Public Health, National Institute of Hygiene, Poland</li> <li>- Romanian Angel Appeal Foundation, Romania</li> <li>- St. Petersburg City AIDS Centre, Russian Federation</li> <li>- Fundació Privada Clínic per a la Recerca Biomèdica, Spain</li> <li>- Instituto de Salud Carlos III, Spain</li> <li>- Karolinska Institute, Sweden</li> <li>- University of Zurich, Switzerland</li> <li>- Perinatal Prevention of AIDS Initiative, Ukraine</li> <li>- Medical Research Council, United Kingdom</li> <li>- Genome Research Limited, United Kingdom</li> </ul>	
<b>Funders</b>	European Commission , 7 <sup>th</sup> Framework for Research, DG JRC	
<b>Duration</b>	2011/2015	
<b>Aim of the project</b>	<p>The overarching aim of EuroCoord is to use the scientific strengths of each collaboration to ensure that the best, most competitive research is performed. Such a large, integrated network has allowed a common virtual database to be established, which currently has access to data from over 250,000 HIV-infected individuals from many different settings across Europe and beyond.</p> <p>EuroCoord's multidisciplinary approach allows the following key areas of HIV research to be addressed, aimed at improving the management and life of HIV-infected individuals, whilst allowing us to explore differences within sub-groups:</p> <ul style="list-style-type: none"> <li>- Characterising HIV infected populations in Europe (including the epidemiology of different subtypes)</li> </ul>	

	<ul style="list-style-type: none"> <li>- Improving our understanding of pathogenesis (including understanding the mechanisms of non-progression)</li> <li>- Documenting uptake of and response to therapy</li> <li>- Evaluating the implications of long-term HIV infection and exposure to therapy</li> <li>- Assessing the implications of specific management strategies</li> <li>- Improving the management of hepatitis co-infection</li> <li>- Tuberculosis (TB) among HIV-infected patients</li> <li>- HIV and AIDS in migrant populations in Europe</li> <li>- Modelling the HIV infected population in Europe.</li> </ul> <p>The Network also aims to use its expertise to establish training programmes to improve research skills. These will include courses in statistical techniques to allow researchers to undertake observational research of the highest calibre, and to provide basic and updated laboratory and clinical training to aid the management of HIV-infected patients</p>
<b>Methods</b>	The project is divided in 15 work package, package number 14 is dedicated to migrant health
<b>Outcomes</b>	<p>This WP14 aims to prevent HIV infection, and improve diagnosis and prognosis of migrant populations living with HIV in Europe by providing evidence to support policy development at European level. It also aims to determine the likely country of HIV acquisition for migrant populations and identify barriers to HIV prevention, testing, and treatment.</p> <p>Key outcomes and their determinants will be studied by geographical origin and sex:</p> <ul style="list-style-type: none"> <li>- Appropriateness of initiation of HAART</li> <li>- Virological and immunological responses to HAART</li> <li>- All-cause and cause-specific mortality</li> <li>- Appropriateness of prevention of mother-to-child transmission (PMTCT) interventions</li> <li>- MTCT and pregnancy outcomes, and model the relationships between the characteristics of the European cities migrants live in with the previous HIV-related outcomes</li> </ul>
<b>Publications</b>	<p>All publications are available here:</p> <p><a href="http://www.eurocoord.net/publications_presentations.aspx">http://www.eurocoord.net/publications_presentations.aspx</a></p>



## GIFTS

<b>Title of the project</b>	<b>GIFTS- Genomic and lifestyle predictors of foetal outcome relevant to diabetes and obesity and their relevance to prevention strategies in South Asian peoples</b>
<b>Website</b>	<a href="http://www.gifts-project.eu/drupal/">http://www.gifts-project.eu/drupal/</a>
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>- Queen Mary and Westfield College, University of London, United-Kingdom</li> <li>- University of Southampton, United-Kingdom</li> <li>- London School of Hygiene and Tropical Medicine, United-Kingdom</li> <li>- University of Exeter, United Kingdom</li> <li>- University of East London, United-Kingdom</li> <li>- University College London, United-Kingdom</li> <li>- Instruct AG, Munchen, Germany</li> <li>- Technical University Dresden, Germany</li> <li>- University of Oslo, Norway</li> <li>- University of Helsinki, Finland</li> <li>- King Edward Memorial Hospital, Pune, India</li> <li>- Centre for Cellular and Molecular Biology, India</li> <li>- Public Health Foundation, India</li> <li>- Baqai Medical University, Karachi, Pakistan</li> <li>- Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders, Dhaka, Bangladesh</li> <li>- BAP Health Outcomes Research S.L., Spain</li> </ul>
<b>Funders</b>	European Commission , 7 <sup>th</sup> Framework for Research, DG JRC
<b>Duration</b>	2012/2015
<b>Aim of the project</b>	<p>GIFTS has been established to improve diabetes prevention through an enhanced understanding of early life programming. Three key objectives of the program, which will enable this ambition to be achieved, are outlined here:</p> <ul style="list-style-type: none"> <li>- Use of results generated by GIFTS to inform public health policy via guideline development in Europe and South Asia.</li> <li>- Dissemination of key outputs to stake holders in diabetes prevention, including healthcare professionals and South Asian communities.</li> <li>- Use of the results and expertise gained from GIFTS to design a large-scale pragmatic intervention for diabetes prevention in people of South Asian origin</li> </ul>
<b>Methods</b>	<p>GIFTS is divided into eleven work packages (WPs), themselves grouped into four major components:</p> <ol style="list-style-type: none"> <li>1.Co-ordination and Management (WP 1)</li> <li>2.Lifestyle and Nutrition from Pre-conception to Early Childhood (WP 2-4)</li> <li>3.Characterisation of Gene and Environment Interactions (WP 5-7)</li> <li>4.Clinical Translation of the Findings of GIFTS Programme (WP 8-11)</li> </ol>
<b>Outcomes</b>	A comprehensive dataset describing the nutritional status of pregnant South Asian women and the effect this has on their offspring will be realised. This knowledge, when combined with that from the trial interventions, which are designed to assess whether it is possible to correct nutritional deficiencies during pregnancy, will

inform the design of a robust, pragmatic intervention aimed at diabetes prevention in pregnancy.

The quantitative result of WP2 and WP3 will be used in the context of qualitative results from WP9 and WP10. These work packages will provide an insight into the views of South Asian women in relation to accessing antenatal care in Europe and diabetes in pregnancy. Incorporating what is learnt from this qualitative research will give the intervention the maximum possibility of being not only effective, but also meeting the needs of the target population, and being successful in a real-world environment.

The planned health economic analysis will assess the affordability of this intervention, in both Europe and South Asia. This will facilitate influencing public health policy to introduce recommendations arising from this research.

The genetic and epigenetic information gained will improve understanding in the field of gene-environment interaction and may give rise to the possibility of this being used in a clinical setting.

Stakeholders in diabetes prevention will be able to learn about results of the GIFTS programme through dissemination of information. This will take the form of the website, peer-reviewed publications and the development of an e-learning portal. In addition, existing diabetes prevention curriculums will be revised.

**Publications**

All publications available here: <http://www.gifts-project.eu/drupal/?q=media-center>

## RESTORE

<b>Title of the project</b>		<b>RESTORE</b> REsearch into implementation STRategies to support patients of different ORigins and language background in a variety of European primary care settings
<b>Website</b>		<a href="http://www.fp7restore.eu/">http://www.fp7restore.eu/</a>
<b>Research collaborators</b>	-	<ul style="list-style-type: none"> <li>University of Limerick</li> <li>Univ. of Crete</li> <li>Univ. of Glasgow</li> <li>National Univ. of Ireland</li> <li>Univ. of Liverpool</li> <li>Radboud Univ. Nijmegen</li> <li>Medical Univ. of Vienna</li> <li>Pintail Ltd, Dublin</li> </ul>
<b>Funders</b>		EC – FP7 2,990,590 euros and the RESTORE consortium members.
<b>Duration</b>		2011- 2015
<b>Aim of the project</b>	<p>This project is concerned with optimising the delivery of primary healthcare to European citizens who are migrants who experience language and cultural barriers in host countries. We focus on the implementation of evidence-based health information (e.g. guidelines to enhance communication in cross-cultural consultations) and interventions (e.g. training initiatives on interculturalism and the use of paid interpreters) designed to address language and cultural barriers in primary care settings.</p> <p>We explore how these are translated (or not) into routine practice in primary care settings. We will investigate and support implementation processes for these using a unique combination of contemporary social theory, the Normalization Process Theory and a participatory research methodology.</p> <p>Project Objectives:</p> <ul style="list-style-type: none"> <li>• What guidelines and/or training initiatives are currently available in our partner countries that have been generated by primary care research in a way that was inclusive of all key stakeholders?</li> <li>• How are the guidelines and/or training initiatives translated into practice by primary care staff? What are the processes of implementation, 'on the ground' in routine practice?</li> <li>• What is the capacity of primary care settings in different countries (and, therefore, different organisational contexts) to incorporate implementation processes within their current organisational arrangement?</li> <li>• Is the implementation work for guidelines and/or training initiatives sustainable - leading to normalised use of these technologies in routine practice?</li> <li>• What are the benefits (if any) of using NPT and PLA to investigate and support implementation processes? There will be co-operation between</li> </ul>	

	<p>an inter-disciplinary team of experienced researchers, across 6 European health care settings with different organizational contexts and capacities to respond to this implementation work.</p>
<b>Methods</b>	<p>Participatory Learning and Action methodology and Normalisation Process Theory social theory will be used in an integrated manner in RESTORE to foster dialogue around each of NPTs' constructs in order that all stakeholders are engaging with each other to constructively inform thinking and action for the implementation work in hand. See below, how the theory and methodology inform the work packages in the project:</p> <p><i>WP2: Training</i> The objective of this WP is to train consortium partners and researchers about NPT and in PLA approaches and techniques.</p> <p><i>WP3: Coherence</i> The objective of this WP is to determine with stakeholders how they conceptualise guidelines and/or training initiatives designed to support communication in cross-cultural consultations in terms of the role, content and applicability of these guidelines and/or training initiatives in their everyday work settings.</p> <p><i>WP4: Cognitive Participation</i> The objective of this WP is to determine with relevant stakeholders: what factors promote or inhibit their engagement with the training interventions and/or guidelines identified in WP3?</p> <p><i>WP5: Collective Action</i> The objective of this WP is to determine with participants: how will the intervention which they have co-designed and 'signed up' for (during WP3 and WP4) affect their routine work?</p> <p><i>WP6: Reflexive Monitoring</i> The objective of this WP is to determine with participants: how do they perceive the intervention once they have been using it for some time?</p> <p><i>WP7: Policy Analysis &amp; Guidelines</i> The objective of this WP is to conduct a comprehensive analysis of policy issues in RESTORE and to formulate new EU policy guidance.</p> <p><i>WP8: Dissemination</i> The objective of this WP is to promote wide and effective public knowledge of RESTORE and, also, the potential commercial exploitation of the project's results.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- 3 newsletters to target audience in primary healthcare of migrants</li> <li>- Dissemination of empirical testing of NPT and PLA as combined partner tools for investigating and supporting implementation processes</li> <li>- Portfolio of guidances and training initiatives that address language and</li> </ul>

	cultural barriers in primary care, available on RESTORE website. Target audiences: professionals in clinical interventions, undergraduate and postgraduate training
<b>Publications</b>	<p>O'Donnell C, Burns N, Dowrick C, Lionis C, MacFarlane A: <i>RESTORE team. Health-care access for migrants in Europe. The Lancet. August 2013.</i></p> <p>van den Muijsenbergh M, van Weel-Baumgarten E, Burns N, O'Donnell C, Mair F, Spiegel W, Lionis C, Dowrick C, O'Reilly-de Brún M, de Brun T, MacFarlane A: <i>Communication in cross-cultural consultations in primary care in Europe: the case for improvement. Prim Health Care Res Dev. April 2013.</i></p> <p>MacFarlane A, O'Donnell C, Mair F, O'Reilly-de Brún M, de Brún T, Spiegel W, van den Muijsenbergh M, van Weel-Baumgarten E, Lionis C, Burns N, Gravenhorst K, Princz C, eunissen E, van den Driessen Mareeuw F, Saridaki A, Papadakaki M, Vlahadi M, Dowrick C: <i>Research into implementation strategies to support patients of different origins and language background in a variety of European primary care settings. Implement Sci. November 2012.</i></p>

## Rodam

<b>Title of the project</b>	<b>RODAM - Type 2 diabetes and obesity among sub-Saharan African native and migrant populations: dissection of environment and endogenous predisposition</b>
<b>Website</b>	<a href="http://www.rod-am.eu/">http://www.rod-am.eu/</a>
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Academisch Medisch Centrum bij de Universiteit van Amsterdam, Netherlands</li> </ul> <p>Other partners:</p> <ul style="list-style-type: none"> <li>- Kwame Nkrumah University of Science and Technology Kumasi, Ghana</li> <li>- Charite - Universitaetsmedizin Berlin, Germany</li> <li>- London School Of Hygiene And Tropical Medicine, UK</li> <li>- Deutsches Institut fuer Ernahrungsforschung Potsdam Rehbrücke, Germany</li> <li>- The Regional Institute for Population Studies (RIPS), University Of Ghana</li> <li>- Imagenes GmbH Incorporation</li> </ul>
<b>Funders</b>	European Commission, DG JRC
<b>Duration</b>	2012/2015
<b>Target</b>	Saharan African natives
<b>Aim of the project</b>	The RODAM (acronym for Research on Obesity & Diabetes among African Migrants) is a Seventh Framework Programme (FP-7) collaborative project with 8 partners from 3 European countries and 2 African countries addresses these fundamental health issues among a homogeneous, and one of the largest SSA migrant groups in Europe (i.e. Ghanaians).
<b>Methods</b>	In a multi-centre study, 6,250 Ghanaians aged >25 years will be re-recruited in rural and urban Ghana, Germany, the Netherlands, and the UK. The differences in prevalence rates within Ghana on the one hand, and three European countries on the other, will allow us to unravel environmental, lifestyle and (epi)genetic as well as social factors in relation to T2D and obesity.
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>- To assess differences in the prevalence of Type II diabetes and obesity among Ghanaian migrants in three European countries (Germany, Netherlands and the UK) and their compatriots in both rural and urban Ghana;</li> <li>- To identify relevant (epi)genetic, biochemical, nutrition and lifestyle factors as well as social factors and their relative contribution to the risks of Type II diabetes and obesity among Ghanaians living in different locations, and to identify differences in the respective risk factor contributions between these locations;</li> <li>- To explore the presence of interactions between (epi)genetic and lifestyle factors, particularly dietary behaviour and physical activity, in resident and migrating Ghanaians;</li> <li>- To gain in-depth insight into perception and knowledge of Type II diabetes and obesity among Ghanaian migrants and their compatriots in rural and urban Ghana. Use all new insights based on our findings to inform targeted intervention and prevention, and to provide a basis for improving diagnosis and treatment.</li> </ul>
<b>Publications</b>	<p>Agyemang C, Beune E, Meeks K, et al. Rationale and cross-sectional study design of the Research on Obesity and type 2 Diabetes among African Migrants: the RODAM study. <i>BMJ Open</i> 2014; 4</p> <p>Agyemang C, de-Graft Aikins A, Bhopal R. Ethnicity and cardiovascular health research: pushing the boundaries by including comparison populations in the countries of origin. <i>Ethn Health</i> 2012; 17(6): 579-96.</p>

## SOPHIE

<b>Title of the project</b>	<b>SOPHIE-Evaluating the Impact of Structural Policies on Health Inequalities</b>	
<b>Website</b>	<a href="http://www.sophie-project.eu/index.htm">http://www.sophie-project.eu/index.htm</a>	
<b>Research collaborators</b>	<p>Leader:</p> <ul style="list-style-type: none"> <li>- Agencia de Salut Publica de Barcelona, Spain</li> </ul> <p>Others partners :</p> <ul style="list-style-type: none"> <li>- Charles University, Czech Republic</li> <li>- Academic Medical Centre, University of Amsterdam, Netherlands</li> </ul>	
<b>Funders</b>	European Commission, DG JRC	
<b>Duration</b>	2010/2013	
<b>Target</b>	Academics and policy makers	
<b>Aim of the project</b>	<p>SOPHIE is a research project funded from the European Community's Seventh Framework Programme. It aims to generate new evidence on the impact of structural policies on health inequalities, and to develop innovative methodologies for the evaluation of these policies in Europe.</p> <p>One of the workpackages is dedicated to Migration Health and its aims are:</p> <ul style="list-style-type: none"> <li>- To generate evidence on the relationship between the orientation of public laws and policies on immigration control and integration and the health of migrant populations in Europe.</li> <li>- To identify specific examples of the impact of macro-economic and social policies, and especially of the economic downturn and public services cutbacks, on the health of migrants and its determinants.</li> <li>- To ensure that all strands of SOPHIE explicitly consider migrant status and origin, together with other dimensions of social inequality, in the evaluation of the impact of structural policies.</li> </ul>	
<b>Methods</b>	<ul style="list-style-type: none"> <li>- Review of the potential links between immigration policies and immigrants' health.</li> <li>- Cross-country analyses of the health of immigrants and its descendants by typology of immigration policies.</li> <li>- National analyses of the impact of macro-economic and social policies on immigrants' health.</li> </ul>	
<b>Outcomes</b>	No result yet.	
<b>Publications</b>	<p>Davide Malmusi, Laia Palència Do different immigrant integration policies impact on migrants' health? A test with a European general population survey (abstract)</p> <p>Dzúrová, D.; Winkler, P.; Drbohlav, D. Immigrants' Access to Health Insurance: No Equality without Awareness. Int. J. Environ. Res. Public Health 2014, 11, 7144-7153.</p>	

## 6- Projects to address Roma needs, funded by DG SANCO

### Roma Health Report: Health status of the Roma population. Data collection in the Member States of the European Union.

Title of the project	Roma Health Report: Health status of the Roma population. Data collection in the Member States of the European Union
<b>Website</b>	<a href="http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf">http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf</a>
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>- Matrix Knowledge</li> <li>- Centre for the Study of Democracy</li> <li>- The European Health Alliance</li> <li>- Consumers, Health and Food Executive Agency</li> <li>- DG Sanco</li> </ul>
<b>Funders</b>	European Commission, DG SANCO
<b>Duration</b>	2014
<b>Aim of the project</b>	The purpose of the report is to provide an evidence-based review of literature on Roma health, covering 2008-13, covering a number of indicators including mortality and life expectancy, prevalence of major infectious diseases, access and use of health services and prevention programmes, and health factors related to the role of women in the Roma community.
<b>Methods</b>	A two-step methodology was employed: 1) Desk research based on the review of secondary data (a literature review); and 2) Fieldwork collecting primary data through semi-structured interviews.
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Overall results indicate that the Roma populations in Europe generally:               <ul style="list-style-type: none"> <li>i) Suffer greater exposure to wider determinants of ill health (e.g. socio-economic and environmental);</li> <li>ii) Live less healthy lifestyles. For further, more detailed findings for each indicator, please see the report's Executive Summary.</li> <li>iii) Have poorer access to and lower uptake of primary care and preventive health services.</li> <li>iv) Suffer poorer health outcomes, in terms of morbidity from both infectious and chronic diseases, and shorter life expectancy.</li> </ul> </li> </ul> <p>For further, more detailed findings for each indicator, please see the Report.</p>
<b>Publications</b>	<ul style="list-style-type: none"> <li>• Roma Health Report</li> <li>• Roma Health Report Executive Summary</li> </ul>



**Health and the Roma Community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain.**

<b>Title of the project</b>	Health and the Roma Community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain
<b>Website</b>	<a href="http://www.gitanos.org/european_programmes/health/">http://www.gitanos.org/european_programmes/health/</a>
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>- EXFINI POLI – Local Authorities for Social, Cultural, Tourist, Environmental and Agricultural Development, Greece</li> <li>- Fundación Secretariado Gitano (FSG), Spain</li> <li>- Office of the Council for Roma Community Affairs, Czech Republic</li> <li>- PDCS – Partners for Democratic Change, Slovakia</li> <li>- Rede Europeia Anti-Probreza (REAPN), Portugal</li> <li>- Romani Criss – Roma Centre for Social Interventions and Studies, Romania</li> <li>- The health of Romany People Foundation (THRPF), Bulgaria</li> </ul>
<b>Funders</b>	European Commission, DG SANCO
<b>Duration</b>	2007 - 2010
<b>Aim of the project</b>	The aim of the project is to have reliable and objective data in regard to the health situation of Roma, and the use made of and access to health care resources. This will allow the identification of real needs and the establishment of priority actions.
<b>Methods</b>	Primary research through a survey given to members of Europe's Roma population. Through direct or indirect interviews of 7604 Roma of all ages and from seven European member states. Subsequently, statistically relevant data was extracted and extrapolated to the entire Roma community.
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Greater understanding of the situation of Roma persons with regard to their health (both objectively and subjectively)</li> <li>• Overview of access to and use of the principal health services</li> <li>• Data on prevalent diseases and prominent aspects of Roma lifestyles.</li> <li>• Opportunity to compare with the other seven participating countries, as well as with other existing data in the EU.</li> </ul>
<b>Publications</b>	<ul style="list-style-type: none"> <li>• Transnational Report: Health and the Roma Community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain</li> <li>• National Reports in the languages of the partner countries</li> <li>• Leaflet</li> </ul>
<b>Other relevant informations</b>	Final Report Interim Report External Evaluation Report

## Guide to work with the Roma Community in Health Services

<b>Title of the project</b>	<b>Guide to work with the Roma Community in Health Services</b>
<b>Website</b>	
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>- Fundación Secretariado Gitano</li> <li>- Spanish Ministry for Health and Consumption (Ministerio de Sanidad y Consumo)</li> </ul>
<b>Funders</b>	European Commission DG SANCO
<b>Duration</b>	2003/2008
<b>Target</b>	Healthcare providers
<b>Aim of the project</b>	Raising the awareness and building the capacity of health-care providers concerning the specific characteristics of the Roma population, providing them with the tools they need to make their daily work easier, and the launching of a line of research to provide reliable data on the health status of the Roma community to be compared with the data on the majority society so as to be able to undertake more tailored initiatives with this group.
<b>Methods</b>	Litterature review Case studies Questionners to health-care provider
<b>Outcomes</b>	Good practices recommendations
<b>Publications</b>	Handbook for Action in the Area of HealthServices with the Roma Community <a href="http://www.romanicriss.org/PDF/Guia%20trabajar%20con%20servicios%20sanitarios%20-gitanos%20ingles.pdf">http://www.romanicriss.org/PDF/Guia%20trabajar%20con%20servicios%20sanitarios%20-gitanos%20ingles.pdf</a>

Title of the project <b>Addiction prevention within Roma and Sinti Communities (SRAP)</b>	
<b>Website</b>	<a href="http://srap-project.eu/">http://srap-project.eu/</a>
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>• MUNICIPALITY OF BOLOGNA, Italy</li> <li>• European Forum for Urban Security (EFUS)</li> <li>• SOCIETÀ DOLCE, Italy</li> <li>• FUNDACIÓN SECRETARIADO GITANO, Spain</li> <li>• HORS LA RUE, France</li> <li>• Health and Social Development Foundation (HESED)</li> <li>• ROMA PUBLIC COUNCIL KUPATE, Bulgaria</li> <li>• FOUNDATIA PARADA, Romania</li> <li>• RIC NOVO MESTO, Slovenia</li> <li>• TRNAVA UNIVERSITY, Slovakia</li> <li>• CITY OF VENICE, Italy</li> </ul>
<b>Funders</b>	European Commission – Health Programme DG SANCO
<b>Duration</b>	2010 - 2013
<b>Aim of the project</b>	<ul style="list-style-type: none"> <li>- To understand better young Roma people's attitude and behaviour towards drugs, and analyse the factors that trigger drug abuse, thanks to a research conducted throughout Europe, in the countries of the partners of the SRAP project</li> <li>- To transfer this research and knowledge in Europe</li> <li>- To strengthen the prevention skills of young Roma and improve the intercultural health approach of healthcare workers</li> <li>- To raise awareness among public health decision-makers, and among civil society, about the specific needs of young Roma, and to promote health and prevention policies and actions catered to those needs</li> <li>- To promote the inclusion of this issue in the research agenda and the adoption of evidence-based approaches in mainstream policies</li> </ul>
<b>Methods</b>	A research and evidence based intervention methodology for addiction prevention that includes primary and secondary research on addiction among Roma and Sinti, and capacity building to improve intercultural responses of health services and limit the barriers to access to addiction prevention services in Europe.
<b>Outcomes</b>	<ol style="list-style-type: none"> <li>1. A better understanding of the phenomenon of addiction among young Roma: what triggers consumption and how young Roma use drugs</li> <li>2. A transferable intervention methodology tailored to the needs of young Roma, available to health workers in Europe</li> <li>3. Train health workers to enable them to relate to young Roma and provide Roma Communities with information on health and addiction services</li> <li>4. Enroll young Roma in prevention actions, and raise their awareness about the effects of use/abuse of drugs</li> </ol>

	<ol style="list-style-type: none"> <li>5. Ensure that young Roma know about health services, and what they can get from them</li> <li>6. Set up a pan-European network dedicated to addiction prevention and harm reduction among young Roma</li> <li>7. Raise awareness among policy makers and decision makers working in the areas of health, addiction and research about the issue of drug use/abuse among young Roma people.</li> </ol>
<b>Publications</b>	<ul style="list-style-type: none"> <li>• Health, prevention of addiction, and Roma youth in European countries</li> <li>• SRAP Final Publication: Addiction among Roma and Sinti communities. Why it matters.</li> <li>• Understanding drug addiction in Roma and Sinti communities – a research report.</li> <li>• Visual research with young Roma – the Collage</li> </ul>
<b>Other relevant informations</b>	<p>In order to keep the momentum and strengthen prevention among Roma communities, the partners have set up a permanent exchange network. More information at <a href="http://srp-project.eu/the-srap-european-network/">http://srp-project.eu/the-srap-european-network/</a></p>

## Improved Access to Health Care for the Roma Minority in the Slovak Republic

<b>Title of the project</b>	<b>Improved Access to Health Care for the Roma Minority in the Slovak Republic</b>	
<b>Website</b>	www.health.gov.sk	
<b>Project collaborators</b>	<ul style="list-style-type: none"> <li>- EXFINI POLI – Local Authorities for Social, Cultural, Tourist, Environmental and Agricultural Development, Greece</li> <li>- Fundación Secretariado Gitano (FSG), Spain</li> <li>- Office of the Council for Roma Community Affairs, Czech Republic</li> <li>- PDCS – Partners for Democratic Change, Slovakia</li> <li>- Rede Europeia Anti-Probreza (REAPN), Portugal</li> <li>- Romani Criss – Roma Centre for Social Interventions and Studies, Romania</li> <li>- The health of Romany People Foundation (THRPF), Bulgaria</li> </ul>	
<b>Funders</b>	European Commission, Public Health Programme, Executive Agency for Health and Consumers (EAHC)	
<b>Duration</b>	2007 - 2010	
<b>Aim of the project</b>	The aim of the project is to have reliable and objective data in regard to the health situation of Roma, and the use made of and access to health care resources. This will allow the identification of real needs and the establishment of priority actions.	
<b>Methods</b>	Primary research through a survey given to members of Europe's Roma population. Through direct or indirect interviews of 7604 Roma of all ages and from seven European member states. Subsequently, statistically relevant data was extracted and extrapolated to the entire Roma community.	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Greater understanding of the situation of Roma persons with regard to their health (both objectively and subjectively)</li> <li>• Overview of access to and use of the principal health services</li> <li>• Data on prevalent diseases and prominent aspects of Roma lifestyles.</li> <li>• Opportunity to compare with the other seven participating countries, as well as with other existing data in the EU.</li> </ul>	
<b>Publications</b>	<ul style="list-style-type: none"> <li>• Transnational Report: Health and the Roma Community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain</li> <li>• National Reports in the languages of the partner countries</li> <li>• Leaflet</li> </ul>	
<b>Other relevant informations</b>	Final Report Interim Report External Evaluation Report	

## 7- Projects to address Roma needs, funded by DG JUST

### From Words to Practice: Acting for Roma Equality and Integration

Title of the project		From words to practice: acting for Roma equality and integration
Website		<a href="http://www.erionet.eu/from-words-to-practice">http://www.erionet.eu/from-words-to-practice</a>
Research collaborators	-	European Roma Information Office
Funders		European Commission, DG Justice
Duration		2014 12 months
	-	<ul style="list-style-type: none"> <li>Roma, particularly the young and women</li> <li>European society as a whole – i.e. EU institutions, national, local and regional authorities,</li> <li>Professionals working with/for Roma (e.g. teachers, social workers) and the</li> <li>Civil society</li> </ul>
Aim of the project	To promote social inclusion and equality of Roma communities in Europe by:	<ul style="list-style-type: none"> <li>Advocate to improve the National Roma Integration Strategies (NRIS) implementation at local level</li> <li>Foster the effective implementation of anti-discrimination legislation</li> <li>Promote the active equal participation of Roma representatives, especially the young and women, in the NRIS implementation and other anti-discrimination policies as well as in the fight against discrimination</li> <li>Raise awareness about the needs and concerns of Roma and the existence of the appropriate tools to address these issues</li> </ul>
Methods		No mention of the methodology used to archive
Outcomes	-	<ul style="list-style-type: none"> <li>Mission trips to meet with national/local authorities as aimed at ensuring the NRIS transposition, the implementation of the Council Recommendation and the participation of Roma</li> <li>Community meetings to identify the needs of and realities for Roma</li> <li>Roundtables with local/regional authorities</li> <li>Advocacy training for Roma</li> <li>Workshop with Equality Bodies</li> </ul>
Publications	Deliverables	<ul style="list-style-type: none"> <li>Template letters for Roma activists to pressure national and local authorities to implement the NRIS and EC Council Recommendation, and involve Roma</li> <li>Advocacy handbook for Roma activists</li> <li>Paper “Implementation of the National Roma Integration Strategies: challenges and solutions for local authorities”</li> <li>Paper “Implementing the Race Equality Directive: challenges and solutions for Equality Bodies”</li> <li>4 newsletters</li> <li>Factsheet about the European Year 2014 and the situation of Roma women</li> </ul> <p>–</p> <p><a href="http://cloud2.snappages.com/ecc3fa83da15cf423fe3aaa342f545fa355b24f3/Factsheet_Roma%20women%20and%20reconciling%20work%20with%20family%20life_EN.pdf">http://cloud2.snappages.com/ecc3fa83da15cf423fe3aaa342f545fa355b24f3/Factsheet_Roma%20women%20and%20reconciling%20work%20with%20family%20life_EN.pdf</a></p>



## **Annex 2**

### **Deliverable 2: WP2 Review of existing training materials**



Founded by the European Union  
in the frame of the EU Health  
Programme (2008-2013)



**MEM-TP - TRAINING PACKAGES FOR HEALTH PROFESSIONALS TO IMPROVE ACCESS AND  
QUALITY OF HEALTH SERVICES FOR MIGRANT AND ETHNIC MINORITIES  
INCLUDING THE ROMA**

**WP 2 - Training materials development: review of existing training materials**

**FINAL REPORT**

**Authors:**

**AUSL of Reggio Emilia: Antonio Chiarenza, Lidia Horvat, Anna Ciannameo, Gianluca Vaccaro**  
**Academic Medical centre - University of Amsterdam: Katja Lanting, Adele Bodewes, Jeanine Suurmond**





## **EXECUTIVE SUMMARY**

### **Background**

The global phenomenon of migration has dramatically changed the European social context in which health care professionals operate. European states are, therefore, facing a growing need to effectively train healthcare professionals so they are able to understand and respond adequately to a range of different needs, issues and situations and support change in health service delivery. Many EU Member States have adopted specific initiatives which include training programmes to develop the awareness, knowledge and skills of health professionals. There is, however, considerable variation in these policies and activities and few examples of evaluation of the quality of these training courses. There is clearly a potential for EU added value in analysing the experience to date in such training initiatives and in developing and testing appropriate training packages.

### **Aim of the review**

The main aim of this review is to identify, select and assess existing good quality training programmes, which address the particular issues related to improving access and quality of health care delivery for migrants and ethnic minorities. It is important to clarify that the general aim was not to determine the extent of training activity, neither to analyse the situation in the 28 EU countries nor to evaluate the effectiveness of the training programmes identified. Rather the objective was to provide an overview of the training materials in EU in order to identify a group of "good quality" programmes.

### **Search strategy**

The review and analysis of training materials comprises four main stages: (1) a review of published and unpublished literature; (2) a survey addressing national contact persons, and representatives of international organisations and NGOs aimed at identifying and describing existing training programmes; (3) an analysis of information collected; (4) an assessment of the quality of the training programmes identified.

### **Selection criteria**

The criteria for selecting information regarding both the literature review and the survey were developed in accordance with a conceptual framework developed by Horvat, et al (2014) and adapted for this review. Seven key domains that describe the core components of training programmes have been identified: training description; training development and delivery; participants' characteristics of and trainers; training approach; educational content; structure of the intervention; evaluation and outcomes.

### **Analysis and quality assessment**

The collection of data was based on a survey addressed to key persons in the 28 EU MS and representatives of relevant international organisations aimed to identify from 1 to 3 the most important training courses in their country or organisation in the last 10 years. The survey results have been organised into the 7 domains in order to describe and analyse them and to discuss trends, strengths and weaknesses. Finally, the identified programmes have been evaluated against a set of criteria in order to identify a group of "good quality" programmes. The quality of the training programmes has been evaluated through their capacity to link the development of individual competences to developments in the organisation, the community and policy.

### **Key findings**

Training programmes are characterised by low levels of participant involvement in training development, delivery, evaluation. The main professional groups addressed by the programmes are health professionals; however, the general tendency appears to address training programmes to a multi-professional audience. Whilst cultural competence continues as the broad conceptual approach for training programmes, alternate approaches such intersectionality and person centeredness are emergent. Training programmes are not systematically focusing on outcomes in training design, implementation and evaluation. Finally, training programmes are poorly linked to key organisational and policy support mechanisms.

## TABLE OF CONTENTS

Chapter 1	BACKGROUND	4
Chapter 2	AIM AND SCOPE OF THE REVIEW	12
Chapter 3	LITERATURE REVIEW	16
Chapter 4	SURVEY FOR COLLECTING INFORMATION ON EXISTING TRAINING MATERIALS	26
	Domain 1: Training description	28
	Domain 2: Training development and delivery	30
	Domain 3: Participant characteristics	33
	Domain 4: Training approach	36
	Domain 5: Educational content	40
	Domain 6: Training course structure	45
	Domain 7: Evaluation and outcomes	51
Chapter 5	DISCUSSION AND MAIN FINDINGS	55
	Survey's key findings: trends, strengths and weaknesses	59
Chapter 6	ASSESSMENT OF THE TRAINING PROGRAMMES	62
	Aims and quality criteria of the assessment of training programmes	62
	Methods for assessing quality of collected training programmes	65
	Quality dimension 1: individual development	66
	Quality dimension 2: organisational development	71
	Quality dimension 3: community development	76
	Quality dimension 4: policy development	81
	Overall quality assessment of training programmes	86
	RECOMMENDATIONS	92
	ACTION GUIDE FOR THE DEVELOPMENT AND DELIVERY OF EFFECTIVE TRAINING PROGRAMMES	93
	APPENDICES	97

## Chapter 1: BACKGROUND

### ***Why is it important to place particular attention on improving the competence of health professionals on issues related to improving access and quality of health care delivery for migrants and ethnic minorities?***

The global phenomenon of migration has dramatically changed the European social context in which health care professionals operate. Although most migrants are relatively healthy when they first arrive in their host country, they risk deteriorating to poorer health compared to the average population because of the conditions surrounding the migration process. These migrant groups are more vulnerable, due to their often lower socio-economic status, and the conditions of poverty they may have abandoned are often to be re-encountered in their new host countries. This vulnerability is at times compounded by traumatic migration experiences, by the feeling of exclusion in the place of arrival, and moreover by a lack of adequate social support due to the absence of integration and specific socio-health policies (Mladovsky, 2009). The vulnerability of asylum seekers and migrants in irregular status tends to be even more pronounced. Social exclusion, discrimination, poor living conditions and poverty in general all impact on the health, mental health and social adjustment of migrants in the host community (WHO, 2010).

This vulnerability is further exacerbated by a lack of access to and appropriateness of health services and by the quality of the health care received. Experience in recent years has shown that migrant patients and members of minority ethnic communities, such as the Roma people, tend to receive lower quality levels of health care compared to host country nationals due to legal and/or administrative barriers, the lack of information about available services, the absence of appropriate accessibility to services, and the lack of knowledge and skills of health professionals to work effectively with such diverse populations. Therefore, health and social services find themselves increasingly faced with the specific vulnerability of migrants and other minority groups who run a greater risk of not receiving adequate service in diagnosis, care and prevention because of their minority status, their socio-economic position, communication difficulties and lack of familiarity with health systems (Mladowky et al, 2012; Ingleby et al, 2012).

European states are, therefore, facing a growing need to effectively train healthcare professionals so they are able to understand and respond adequately to a range of different needs, issues and situations and support change in health service delivery. Such training needs to cover, amongst other things, the special needs of migrants and ethnic minorities, knowledge and competencies of medical conditions prevalent in migrant and ethnic minority populations, knowledge and competences about other relevant conditions, health professional competencies, as well as, managerial and administrative competencies. Furthermore, access and quality of health care for migrants and ethnic minorities varies greatly from one European state to another. Therefore, training processes for health care professionals need to be shaped consistently at European, national and local levels, through policy measures in which responsibilities are clearly defined and through practical guidelines, at individual and organisational levels, indicating pathways to achieve improvement.

### ***European framework for training policy***

Relevant institutions such as the Council of Europe<sup>1</sup>, the World Health Organization (WHO)<sup>2</sup>, the International Organization for Migration (IOM)<sup>3</sup>, the European Commission, Consumers, Health and Food

---

<sup>1</sup> Recommendation CM/Rec(2011)13 of the Committee of Ministers to member states on mobility, migration and access to health care <https://wcd.coe.int/ViewDoc.jsp?id=1872157>

Executive Agency (CHAFEA)<sup>4</sup> in cooperation with several European Ministries of Health have designed the framework within which health care has to be ensured for everyone, focusing on the following key points: 1) equity (Whitehead M, Dahlgren G, 2006), 2) improving access to services, and 3) addressing the uneven distribution of health and disease among the population (within and between countries). On the one hand, this framework displays the interconnection between social determinants, reflecting socio-economic status (EC, 2009; Health 2020, 2011; EU, Marmot Report, 2010), the legal status of migrant groups (IOM, 2013) and inequalities in health, and health care, that lead to the social distances, which separate people according to the uneven distribution of resources, rights and responsibilities. On the other hand, the framework draws attention to the fundamental principle defined by article 25 of the Universal Declaration of Human Rights that the right to health is a very basic one. EU legislation assigns ultimate responsibility to the member States for the organization and delivery of health care, as well as access and the quality of medical care, however the Lisbon Treaty does indicate protection of human health as EU fundamental and restate the common values of solidarity and equity.

The same institutions emphasize that knowledge construction and education play a crucial role in the training of health care staff for social and political reasons (IOM, 2010).<sup>5</sup> The overwhelming importance of training activities in this regard has been recognised by the European Council. The Council in its conclusions on health and migration (2007) invited the Commission to include in the implementation of the new Health Strategy activities aimed at improving knowledge of migrant health and developing initiatives in health promotion, prevention and migrants' access to care. In the Council Conclusions *"Equity and Health in All Policies: Solidarity in Health"* adopted in May 2010, Member States and the Commission were invited to develop actions to *"enhance public health capacities and promote training on the equity in health approach across different political sectors"*<sup>6</sup>. These objectives can be achieved through a *system* approach, which emphasizes the need for a multisectoral or "joined-up" approach to care provision (WHO, 2010).

### ***Developing the health professionals' competences for dealing with diverse and vulnerable populations***

Developing health professional's competences to deal effectively with diverse and vulnerable populations requires, on the one hand, a shift in focus from a disease-oriented specialist approach, to a an interdisciplinary one and a system approach (WHO, Tallin Charter, 2008) , and on the other hand, a move away from 'cultural competence' towards an approach that integrates the person's "life-world", socioeconomic circumstances, and social and physical environment (CE, 2006 Recommendations of the Committee of Ministers to Member States on health services in a multicultural society, Strasbourg Council of Europe). The collective imagination, marked by the presence of supposed exotic pathologies, which had to be controlled and addressed in terms of 'surveillance', have influenced the development of educational programs to date, focusing practitioner training on endemic pathological cases presumed typical of the areas of origin of the various migrant populations. Disease-oriented specialist approaches have generally been encouraged with a focus on single diseases and targeted groups of population, thus adopting an *emergency* policy working through targeted attempts rather than through an organic strategy. This approach, while apparently responding temporarily to the emergence of "exceptional cases", displays a profound inadequacy

---

<sup>2</sup> The 2008 Resolution of the World Health Assembly on the "Health of migrants" called for a number of steps to improve migrant health, including ensuring equitable access to health services (World Health Assembly 2008).

[http://www.who.int/hac/techguidance/health\\_of\\_migrants/en/](http://www.who.int/hac/techguidance/health_of_migrants/en/) [http://apps.who.int/gb/ebwha/pdf\\_files/A61/A61\\_R17-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf)

<sup>3</sup> The International Organization of Migrants (IOM). 2013. "International Migration, Health and Human Rights", Geneva.

<sup>4</sup> CHAFEA (2014). "Action on Health Inequalities in the EU".

<sup>5</sup> IOM 2010. "Training Modules on Migration and Health for Health Professionals", Brussels.

<sup>6</sup> [http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/lsa/114994.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/114994.pdf)

towards more structural organisational changes, and underlines the need to strengthen health-system emergency preparedness and to ensure the coordination of all actors involved. To this end, WHO recommends developing health-system capacity for crisis management (WHO, 2012). Furthermore, most of the afflictions which have an impact on migrants and ethnic minorities in countries of destination derive from the lack of responsiveness of health systems to diversity, from poverty and conditions of psychological, physical, social and material discomfort encountered in these countries, where socio-economic variables bear a heavy burden on the distance separating the National health care services from migrants (Mladowsky P., et al, 2012; Ingleby D., et al, 2012). Nevertheless, current medical education remains tied to a strong biomedical logic, increasingly inadequate for dealing with the growing emergence of transnational, multidimensional and transversal situations and consequent issues (Stefanini A., et al., 2009). An interdisciplinary approach to training for health professionals is recommended by Stefanini et al. (2009) in order to enable them to deal more effectively with the needs of the community, by developing the ability to better understand the complex network which characterizes personal experiences and creating the context for the development of fair, sustainable, comprehensive and successful solutions.

It is also important to underline the crucial role that health care professionals can play with reference to the previously-discussed health disparities, as health care professionals and their organizations may have a role in shaping and changing the health care system. Health care services can serve as promoters of equity, but may also contribute to reiterating disparities which characterize society at large, as staff are not free of socio-cultural notions bound to their personal experiences (Das V., 1999), the filter through which they operate (Fassin D., 2008). Professional training in medical care, thus, represents a crucial strategy in order to reduce distortions in the delivery and fruition of health care services particularly in contexts with multiple fragilities (FRA, 2013). Training can also serve as a strategy for cooperation at different levels, connecting with the policy domain, which in turn should be linked to the educational and research domains (Saultz J.W., 2003). This kind of *systemic* approach, transversal and integrated, where educational, health care and management fields communicate, promotes forms of care and organizational strategies that are flexible yet appropriate for specific local contexts (Mladovsky P., Ingleby D., McKee M., Rechel B., 2012). This methodology would help erase the borders between disciplines and fill in the current gap not only between services and communities but also between health care and social issues (Ceccim R.B. and Feuerwerke L., 2004). Training should not simply aim at integrating educational curricula with new competences, but should also focus on emphasizing the role of a pedagogical approach able to favour the involvement of patients and other relevant stakeholders in order to define the most effective strategies to contextualise and transform notions of health. This goal is more easily achieved when multi-professional integration and the 'legitimacy' of other disciplines is permitted within the therapeutic context, providing for a co-operational dialogue between health professionals, managers and the decision makers.

Much consideration is given nowadays to the connection between culture, migration and policy, yet often tending to generate the false premise that migrants have specific and fixed categories merely because they belong to certain ethnic groups. The inevitable risks triggered by this assumption may lead to the idea that migrants irremediably differ from others; that *alterity* comes to be regarded as a theoretically and practically insurmountable horizon (Fassin D., 2000, 2001) thus leading to a search for standardised solutions and to the development of a cultural competence<sup>7</sup> seen as a sort of technical skill/expertise that can be taught, learned and applied. For health professionals becoming culturally competent means engaging in a developmental process towards an endpoint of cultural proficiency, assuming that acquiring cultural

---

<sup>7</sup> The now classical definition provided by Cross et al. (1989) identifies cultural competence as *"a set of congruent behaviours, attitudes, and policies that come together in a system or agency or among professionals and enables the system, agency, or professionals to work effectively in cross-cultural situations"*.

knowledge will result in competent practice. This definition of cultural competence stresses the importance of culture and the knowledge about cultures; however it is unclear what sense practitioners actually make of such abstract concepts in practice.

Limitations with the adoption of the concept of cultural competence have, in fact, been highlighted in recent literature (Chiarenza, 2012). One major problem with this idea of “cultural competence”, is that it suggests culture can be reduced to a technical skill in which health staff can be trained to develop relevant expertise (Kleinman & Benson, 2006). Other critics point out that despite being a core requirement for practice in many health and welfare settings, there is limited evidence of the effectiveness of training in cultural competence and whether this form of practice actually improves service delivery and patient outcomes (Anderson et al., 2003; Beach et al., 2005; Horvat, 2014). Moreover, Simon and Mosavel (2008) contend that focusing on cultural differences has detracted attention from the role of socio-economic factors in determining health status.

### ***Mediating between health and social services and diverse and vulnerable populations***

Within European integration policies, many countries have introduced the use of *mediation services* as a strategy able to ensure mutual understanding, improving equal opportunities, preventing discrimination and acknowledging differences. This strategy has resulted in the development of specific professional figures in the fields of education, labour, administration, law and also in social and health care services, whose role is to help overcome a series of barriers separating services from users, to lay the way for improvement in the overall access to services and how they are used, and finally help reduce existing disparities.

Intercultural mediators and interpreters are among the most frequent of the new professional figures as it is often assumed that communication barriers, together with low socio-economic conditions, play a central role in impeding understanding of how services work and can be used. These are fundamental figures mediating between health professionals and health care users in clinical encounters. These barriers, moreover, have an impact on communication between providers and migrants, on comprehension, adherence and satisfaction, on success, suitability and quality of service used. Yet, in EU member states, the roles mediators should ideally perform and their training has generally received little attention to date and certain European training experiences have shown that, in general, health care professionals seem to have very little awareness of the mediators’ role (Verrept, H., 2012). The lack of attention to training is true not only regarding mere linguistic interpretation but above all when mediators have to interpret the social context, deal with sensitive and emotional situations, be familiar with the terminology of various public services, and understand the socio-economic, legal and ethical framework. Indeed, mediators have to try – as *community agents*, as *integration agents* – to help migrants to negotiate meanings (Leanza Y., 2005) and ‘new narratives’ in the interaction, increasing providers’ and patients’ opportunities for active participation (Baraldi, C., Gavioli, L. 2012).

If, on the one hand, training for mediators improves individual multilingual and intercultural competencies, on the other hand their training process ought to fulfil the purpose of building a role which can be acknowledged by other professionals (Bischoff & Hudelson, 2010)<sup>8</sup>. It is, therefore, important that the training process addresses mediators and other professionals at the same time, in order to create a shared and legitimized inter-professional space which can be acknowledged by the whole system. As far as relevant methodologies are concerned, the most successful ones appear to be the following: knowledge transfer,

---

<sup>8</sup> Bischoff, A. and Hudelson, P. (2010), Communicating with foreign language-speaking patients: is access to professional interpreters enough?, *Journal of Travel Medicine*, 17(1), 15-20

demonstrations, forum and image theatre, case discussions; all strategies based on personal experiences and local examples to enable - as participants – exploration of reciprocal challenging work situations, to frame together problems and solutions and consolidate networks (Meeuwesen L., et al, 2012).

In particular, within the social and health care scenario, other professionals have been awarded the role of 'bridge', in this case inter-connecting and mediating between communities and services and between citizens and institutions. These professionals are thought to have a more active role in the process of connecting the community, services and various social actors. These figures have been defined differently according to the different needs addressed in the various contexts of care. Examples are the 'Link workers' in Scotland; the 'Community health educators' in the UK; the 'Aides medico-psychologique' or 'Auxiliaires de vie sociale' in France; the 'Agentes de salud' in Spain; the 'Agenti di salute' and 'Operatori di strada' in Italy; 'zorgconsulenten' in the Netherlands and the 'Roma health mediators' in Eastern European Countries.

On a broader level, it emerges how these figures play the role of facilitator in the community, and can serve as a resource for the organization, planning, realization and assessment of social and health care interventions because they master not only the linguistic and cultural knowledge of certain populations, but also understand the various social and economic factors, complexity of circumstances and difficulties of the contexts in which the target population lives. This approach may be envisaged as a kind of *proactive health care*, tending to move patients towards an empowering approach which aims at recognizing health care needs, including those unexpressed: a delivery of health care focusing on primary care principles and prevention measures, involving people in the therapeutic process, promoting the knowledge and the resources shared by the community, such as NGOs, associations and families. (Maciocco G. 2006).

A valuable experience concerns the Roma health programs with their Roma Health Mediator (Open Society Foundations, 2011). They are members of the Roma community and they are trained to liaise between the community and the health system. The training programmes are focused on maternal, reproductive, and child health topics; specific diseases of public health importance such as chronic diseases; health promotion. Thanks to a comprehensive and integrated approach, training programmes are also focused on key determinants of Roma health; patients' rights; entitlements, insurance and health care legislation; social protection systems; domestic violence, addiction concerns and trafficking; patients' needs assessment; communication skills; health and multiculturalism. This allows them to act both on an individual and social level. Literature argues that Roma health mediation, if implemented in conjunction with other programmes to address poverty, discrimination, and health equity, can address some of the structural inequities that shape Roma health (Open Society Foundations, 2011).

## **Conclusion**

It is clear that, we are facing an important challenge as far as the organisational domains and the policies regarding training for health care professionals are concerned. Embedded within a broader integrated approach based on the concept of person and community, training has to ensure that professionals are able to understand and take part in complex processes, both on the collective and individual level. Many EU Member States have adopted specific initiatives which include training programmes to develop the awareness, knowledge and skills of health professionals. There is, however, considerable variation in these policies and activities and few examples of evaluation of the quality of these training courses. There is clearly a potential for EU added value in analysing the experience to date in such training initiatives and in developing and testing appropriate training packages.

## **References**

AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., et al. (2003). Culturally competent healthcare systems: a systematic review. *American Journal of Preventive Medicine*, 24, 3S, 68-79.
- Baraldi C., Gavioli L. (2012), "Assessing linguistic and cultural". *Inequalities in Health Care for Migrants and Ethnic Minorities*, COST Series Vol. 2, 144-157.
- Beach, M.C., Price, E.G., Gary, T.L. et al. (2005). Cultural Competence: a systematic review of health care provider educational interventions. *Medical Care*, 43, 4, 356-373.
- Bischoff A., Hudelson P. (2010), "Communicating With Foreign Language-Speaking Patients: Is Access to Professional Interpreters Enough?". *Journal of travel medicine*, 17 (1), 15-20.
- Ceccim RB., Feuerwerke L. (2004), "A four-way approach to training in the health field: teaching, management, care, and social control". *Physis*, vol.14, n.1.
- CoE (2006) Recommendation Rec2006(18) of the Committee of Ministers to member states on health services in a multicultural society. Strasbourg: Council of Europe.
- CoE. (2007), "Health and Migration in the EU", Brussels.
- CoE. (2010), "Council conclusions on Equity and Health in All Policies: Solidarity in Health", Brussels.
- Consumers, Health and Food Executive Agency. (2014), "Action on Health Inequalities in the EU", CHAFAEA.
- Chiarenza A. (2012), "Developments in the concept of cultural competence", in Ingleby D., Chiarenza A., Devillé W., Kotsioni I. (Eds.), Volume 2. *Inequalities in health care for migrants and ethnic minorities*, COST Series on Health and Diversity, Antwerp – Apeldoorn, Garant Publishers, 66-81.
- Das V. (1999), "Public good, ethics, and everyday life: Beyond the boundaries of bioethics", *Daedalus*, 128 (4): 99-133.
- EU Commission (2009). *Solidarity in health: reducing health inequalities in EU*, EU Commission, Bussels
- Eurohealth. (2010), "Migration and health in the European Union", Volume 16, Number 1.
- European Union (EU). (2013), "The report should be cited as: Health inequalities in the EU — Final report of a consortium". Consortium lead: Sir Michael Marmot, European Commission.
- Fassin D. (2000), "Les politiques de l'ethnopsychiatrie. La psyché africaine, des colonies britanniques aux banlieues françaises", *L'Homme*, 153, p. 231-250.
- Fassin D. 2001. "The biopolitics of otherness: undocumented foreigners and racial discrimination in French public debate", pp. 3-7, *Anthropology Today* 17(1).
- Fassin D. (2008), "The elementary forms of care. An empirical approach to ethics in a South African hospitals", *Social Science & Medicine*, 67: 262-270.
- FRA. (2013), "Inequalities and multiple discrimination in access to and quality of healthcare", European Union Agency for Fundamental Rights.
- Horvat L, Horey D, Romios P, Kis-Rigo J. (2014) Cultural competence education for health professionals. *The Cochrane database of systematic reviews*, 5, CD009405.
- Ingleby A., Krasnik A., Lorant V., Razum O. (Eds.) (2012), Volume 1: "Health inequalities and risk factors among migrants and ethnic minorities", COST Series on Health and Diversity, Antwerp- Apeldoorn, Garant Publishers.
- Ingleby D., Chiarenza A., Devillé W., Kotsioni I. (Eds.) (2012), Volume 2: "Inequalities in health care for migrants and ethnic minorities", COST Series on Health and Diversity, Antwerp – Apeldoorn, Garant Publishers.



- IOM. (2006), "Migration and the Right to Health in Europe", Background Paper, International Organization for Migration, Brussels.
- IOM. (2010), "Training Modules on Migration and Health for Health Professionals", International Organization for Migration, Brussels.
- IOM. (2013), "International Migration, Health and Human Rights", International Organization for Migration, Geneva.
- Kleinman A., Benson P. (2006), "Anthropology in the clinic: the problem of cultural competency and how to fix it". *PLoS medicine*, 3(10), e294.
- Leanza Y. (2005), "Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers". *Interpreting*, 7(2), 167-192.
- Maciocco G. (2006), "From waiting to pro-active health care. The main road to build the second pillar of health system", *Annali di igiene: medicina preventiva e di comunita*, 19(6), 551-557.
- Marmot M. (2010). *Fair Society, Healthy Lives: the Marmot review; strategic review of health inequalities in England post-2010*. [S.l.] : The Marmot Review, 2010.
- Meeuwesen L., Ani E., Cesaroni F., Jonathan Ross JE. (2012), "Interpreting in health and social care: policies and interventions", *Inequalities in Health Care for Migrants and Ethnic Minorities*, COST Series Vol. 2, 158-170.
- Mladovsky P. (2009), "*A framework for analysing migrant health policies in Europe*". *Health Policy*, 93 (1). pp. 55-63.
- Mladovsky P., Ingleby D., McKee M., Bernd R. (2012), "*Good practices in migrant health: the European experience*". *Clinical Medicine*, 12 (3). pp. 248-252.
- Mladovsky P., Rechel B., Ingleby D, McKee M. (2012), "*Responding to diversity: an exploratory study of migrant health policies in Europe*". *Health Policy*, 105 (1). pp. 1-9.
- Open Society Foundations. (2011), "Roma Health Mediators. Successes and Challenges", NY.
- Rechel B., Mladovsky P., Devillé W., Rijks B., Petrova-Benedic L., McKe M. (eds.) (2011), "Migration and Health in the European Union, Mc Graw Hill Open University Press, NY.
- Saultz JW. (2003), "Defining and Measuring Interprofessional Continuity of Care", *Ann Fam Med* 2003;1 (3):134-43.
- Simon, C., & Mosavel, M. (2008). Key ethical and conceptual issues in the forging of 'culturally competent' community health initiatives: A South African example. *Cambridge Quarterly of Healthcare Ethics*, 17(2), 195-205.
- Stefanini A., Cattaneo A., Maciocco G, Bodini C, Martino A. (2009), "Teaching Global Health at Schools of Health and Human Sciences". *Health and Development Special Issue*, July 2009, 20-24.
- Truong M, Paradies Y, Priest N. (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*, 3;14:99.
- Verrept H. (2012), "Notes on the employment of intercultural mediators and interpreters in health care". *Inequalities in Health Care for Migrants and Ethnic Minorities*, COST Series vol. 2, 115-127.
- Whitehead M., Dahlgren G. (2006), "Concepts and principles for tackling social inequities in health: Levelling up Part 1", World Health Organization WHO, Copenhagen.
- World Health Organization. (2008), "Tallin Charter: Health Systems for Health and Wealth", WHO. Tallin.
- World Health Organization. (2010), "Health of migrants: the way forward: report of a global consultation", WHO. Madrid.
- AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

World Health Organization (2010). How health systems can address health inequities linked to migration and ethnicity. Copenhagen, World Health Organisation Regional Office Europe.

World Health Organization. (2011), "The new European policy for health – Health 2020: Vision, values, main directions and approaches", WHO. EUR/RC61/9.

## **CHAPTER 2: AIM AND SCOPE OF THE REVIEW**

### ***Aim***

The main aim of this review is to identify, select and assess existing good quality training programmes, which address the particular issues related to improving access and quality of health care delivery for migrants and ethnic minorities.

### ***Objectives***

- To provide an overview of selected training materials developed and implemented during the last 10 years in the 28 Member States of the EU.
- To identify good quality training materials through the review of published and unpublished literature.
- To analyse the training materials collected in order to identify trends, gaps and success factors.
- To assess the training materials collected using a set of quality criteria
- To produce a directory of training materials selected with the quality criteria
- To propose recommendations and action guidelines for the development of innovative training programmes.

### ***Scope of the review***

The review covers the training materials developed for training health professionals (including health mediators for the Roma or cultural mediators) during the last ten years in the 28 member states of the EU. It includes materials aiming to increase health professionals' awareness and sensitivity of migrant and ethnic minority issues, developing managerial and administrative competencies related to the specific health rights and needs of migrant and ethnic minorities, improving knowledge and competencies of health conditions prevalent in migrant and ethnic minority populations, (including, mental health, and transmissible diseases, like TB or HIV), increasing awareness of barriers to healthcare access specific to migrant and ethnic minorities (including primary care and emergency care), etc. It does not include material that has been developed specifically for information or education of migrants or ethnic minorities themselves, with the exception of the Roma health mediators and cultural mediators, as the focus is on delivery of health care and not on individual health seeking behaviour.

While the aim was not to undertake an in-depth analysis of training in every country, the purpose of this review is to ensure that good quality materials existing in EU countries had been identified and considered. The review has also taken into account relevant initiatives by international organisations, such as WHO Europe, IOM, NGOs, such as PICUM, and national networks, such as The Network of Roma Health Mediators. The review covers training materials developed at European, national, regional, and local level with the aim of identifying good practices, success and failure factors.

### ***Review strategy and analysis***

The review and analysis of training materials comprises four main stages:

- A review of published and unpublished literature.
- A survey addressing national contact persons, and representatives of International organisations and NGOs aimed at identifying and describing existing training programmes.

- An analysis of information collected based on the conceptual framework by Horvat et al. (2014) comprising seven domains that describe core components of training programmes aimed at improving access and quality of health care for migrants.
- An assessment of the quality of the training material collected.

Specific criteria for assessing quality of the training materials have been developed and used to select programmes to be included in the “Directory of good practices” containing all relevant information for each component of the training material selected, i.e.: Training description; Training development and delivery; Participants’ characteristics of and trainers; Approach; Educational content; Structure of the intervention; Evaluation and outcomes.

### ***Criteria and tool for selecting information***

The criteria for selecting information regarding both the literature review and the survey were developed in accordance with the conceptual framework developed by Horvat, et al (2014) in their Cochrane Systematic Review, titled “Cultural competence education for health professionals” which investigated the effect of cultural competence education interventions for health professionals on patient-related outcomes, health professional outcomes, and healthcare organisation outcomes. A four-dimensional framework was developed for their review to provide consistency in describing and assessing the education interventions. The four core domains and their components included:

- Educational content (knowledge, assessment and application, skills)
- Pedagogical approach
- Intervention structure (delivery and format, frequency and timing, assessment and evaluation, organisational support)
- Participants

This framework was adapted for use as the basis for our literature review and survey template design and analysis for the review of training materials in order to provide a consistent approach to collect, describe and assess them.

In developing the conceptual framework for this review we identified seven key domains that describe the core components of training programmes aimed at improving access and quality of health care for migrants.

1. Training description
2. Training development and delivery
3. Participant characteristics
4. Training approach
5. Educational content
6. Training course structure
7. Evaluation and outcomes

Within each domain a number of components are considered, that can, at times, be interdependent.

1. Training description. This domain is concerned with describing the main aim and training objectives of the programme; the training needs identified and addressed; as well as the training modules.
2. Training development and delivery. This domain is concerned with describing the organisations, which developed and delivered the training programme: the location, scope, setting and funding of the programme.
3. Participant characteristics. This domain is concerned with describing the participants involved in training programmes, including trainers or experts delivering the intervention, as well as the participants

engaged in the intervention as the target audience, such as health professionals, cultural mediators, Roma health mediators, etc.

4. Training approach. This domain in our framework is concerned with the broad conceptual model adopted for the training; the pedagogical approach that underpins it, and the focus of the training. The broad conceptual approach indicates if a training intervention is included in a broad organisational strategy such as cultural competence or migrant-friendliness, equity and diversity, patient-centeredness, quality or intersectionality. The pedagogical approach examines the teaching and learning method used in an intervention, and any theoretical constructs and principles that underpin it, for example, if a culturally-inclusive approach is adopted to investigate cultural biases in instructional practices that may be experiential, instructive, or didactic. The focus on the training component of this domain indicates whether the training course mainly addresses general awareness and knowledge improvements; specific health care issues; specific sub-group needs; or specific aspects of health care access. The focus of training used has 4 components:
  - a. General awareness and knowledge training, which focuses on developing generic skills and sensitivity to assist in interaction with any migrant and ethnic minority patient the health professional may encounter.
  - b. Health care specific training, which focuses on specific health conditions prevalent in migrant and ethnic minority populations, including mental health, emergency care, transmissible diseases, child and mother health, etc.
  - c. Sub-group specific training, which focuses on a single migrant or ethnic group, such as non-nationals, minorities and Roma or specific vulnerable groups, such as asylum seekers, undocumented migrants, victims of torture or human trafficking, to increase participants' knowledge, understanding and ability to function effectively in that environment or with that group.
  - d. Health service access specific training, which focuses on developing awareness and knowledge among staff about formal and informal barriers limiting the access and quality of health care for migrants and ethnic minorities.
5. Educational content. This domain has four key components: Sensitivity and awareness; types of knowledge; assessment and application; and the skills needed for competent practice by a health professional.
  - a. Sensitivity and awareness component is about providing health staff with insight into myths and beliefs about migrants and/or ethnic minorities and/or Roma people; understanding individual values, beliefs, behaviours and basic assumptions; understanding (human) differences and similarities; addressing own identity and prejudices; self-reflection and self-critique in the relationship with the other.
  - b. Types of knowledge: A key challenge for health professionals' training is to clarify the relationship between specific knowledge about particular migrant or ethnic groups, and generic knowledge required in any clinical encounter at any time and with any/all patients, without resorting to stereotypes. This requires knowledge content to cover core concepts or models deemed central to understanding migrants and ethnic minority's needs and situation. These might include: migration status and the right to health care; cultural competence; models of health and illness; the socio-cultural context of health disparities; epidemiology; social determinants; constructs of racism and prejudice; and specific theoretical models such as explanatory models of health and illness; patient centeredness and consumer participation.
  - c. Application of knowledge: This component refers to an intervention addressing the capacity to use the acquired knowledge in a reflective and transformative manner. The inclusion of this component in an intervention aims to help participants apply acquired theoretical knowledge to relevant environmental, population, organisational, professional and systemic contexts.

d. Skills: This component comprises two subsets: inter- and intra-personal skill development. An intervention can teach inter-personal skills to help people work with others, such as advanced communication, negotiation or collaboration. An example in this context is building skills to work effectively with cultural or health mediators. An intervention can also teach intra-personal skills to help individuals cope with situations. This can include cultural self-assessment and reflection, and deconstructing stereotypes.

6. Structure of the intervention. This domain describes the intervention using three components:
  - a. Method of delivery and format, such as experimental or didactic method, lectures, discussions, work groups or online participation;
  - b. Frequency and timing, such as single events, series of workshops, or ongoing training;
  - c. Organisational support, including links to organisational policies and procedures; whether the training intervention is embedded within a professional development program of the organisation; the use of mentoring and peer support processes; links to formal professional accreditation points or qualifications; and if participation is voluntary or mandatory.
7. Evaluation and outcomes. This domain includes the method of quality assessment such as pre-training surveys or pre- and post-tests; the evaluation method used, such as specific assessment tools and if they are validated or not. The outcomes component is concerned with identifying what types of outcomes for the patients, the staff and the organisation were measured as part of the intervention.

These domains and their key components serve to illustrate and describe what may be considered as identifiable core components of training programmes which are aimed at improving access and quality of health care for migrants.

### **Conceptual Framework**

<b>Seven Domains</b>						
<b>Training description</b>	<b>Training development and delivery</b>	<b>Participant characteristics</b>	<b>Training Approach</b>	<b>Educational content</b>	<b>Training course structure</b>	<b>Evaluation and outcomes</b>
a. Aims and objectives b. Training needs c. Training curricula.	a. Structure of training development b. Delivery	a. Workforce targeted b. Trainers or experts delivering training c. Participants involved in development d. Participants involved in delivery of training	1. Pedagogical approach 2. Broad conceptual framework 3. Focus of training: a. General awareness/ knowledge b. Health care specific c. Sub-group specific d. Health service access specific	a. Sensitivity / awareness b. Types of knowledge c. Application of knowledge d. Skills	a. Method of delivery b. Format c. Organisational support d. Frequency /duration e. Certification f. Tuition fees g. Attendance – voluntary or mandatory	1. How training is evaluated 2. Type of outcomes measured a. Patient related b. Staff related c. Organisation related

## CHAPTER 3: LITERATURE REVIEW

A literature review is performed on European training materials developed for the training of health professionals to improve access and quality of health services for migrants and ethnic minorities (MEM), including the Roma, developed between years 2004-2013 at a regional, national and/or European level. In Appendix II a schematic overview has been made per source.

### ***Methodology***

A desktop search was performed (July 15<sup>th</sup> until August 5<sup>th</sup>) for scientific published and unpublished, 'grey literature', material. The search was conducted electronically in PubMed, by hand in Google and Google Scholar and on key websites<sup>9</sup>. The desktop search was performed in English, German and French. These languages were chosen for pragmatic reasons; these were the familiar languages. Two European networks were e-mailed: the Health-Equity-Network (HEN) and the Transcultural network. Additionally, the reference lists of the obtained articles were screened for other studies/articles. Conjointly, all references in Horvat et al. (2014) were checked in case they applied to our criteria.

Inclusion criteria were: (i) the training was targeted at improvement of health care for migrants and ethnic minorities; (ii) delivered in Europe; (iii) published 2004-2013; (iv) for health professionals - postgraduate trainings. Included were articles and descriptions regarding training programmes for health care professionals in five health care domains<sup>10</sup>: mental health, paediatric care, GP care, gynaecological care and emergency care. Besides health professionals, intercultural health mediators and Roma health mediators were included as well. Sources were excluded if they (i) described training on migrants and ethnic minorities in other non-health settings (e.g. educational sector), (ii) were for undergraduates, (iii) were conducted prior to the year 2004 or (iv) were non-European. Random clinical trial (RCT) studies were also included. Editorials, comments reviews or guidelines were excluded. Due to a limited time frame, the literature review is not exhaustive nor a systematic review. The aim was not to undertake an in-depth analysis of every country. The review identifies and considers training materials developed at European, national, regional, and local level with the aim of identifying trends, gaps and success factors.

### ***Conceptual framework for literature review***

For the purpose of analysis of the found training materials, the seven domains developed according to the conceptual framework by Horvat were used (see page 15 of this report).

### ***Results***

Following the criteria as described, in total 17 training programmes were detected. Of these 17, six were articles that were published in scientific journals. The other eleven were regarded as 'grey literature'. Four of the 17 training programmes were found via the MEM-TP national contact persons that were approached to collect information by means of the templates (see Chapter 4). Four sources contained not enough data to report on all components of the conceptual framework of this desktop search, but were included in the analysis. Nine training programmes from the Netherlands were found, two from UK, two from Italy, one

---

<sup>9</sup> In Appendices Ia and Ib the search terms are displayed in flow charts.

<sup>10</sup> According to the Meeting minutes (CHAFEA, 26.2.2014), special emphasis must be given to primary health care, emergency care, obstetrics and gynaecology, and paediatrics.

from France, one from Portugal, one from Slovenia and one from Sweden<sup>11</sup>.

Four of the training programmes identified were part of T-SHaRE - **T**ranscultural **S**kills for **H**ealth and **C**a**R**E, a LLP - Leonardo da Vinci Multilateral Projects for Development of Innovation project (November 2009 - April 2012). This work was based on the evidence that migrants and ethnic minorities presently do not receive the health care that best responds to their needs. The T-SHaRE project intends to help overcome gaps in practice and training by disseminating theoretical and methodological guidelines and tools that can be used by stakeholders (see [www.tshare.eu](http://www.tshare.eu)). Unfortunately, when the writing of the report on this current review had nearly finished, we were informed about a large training programme: the EU funded project, **R**Esearch into implementation **S**Trategies to support patients of different **O**Rigins and language background in a variety of **E**uropean primary care settings (RESTORE) (2011-2015), with a website containing information on (guidelines and) training programmes.<sup>12</sup> In the next section a short summary of the analysis of the training programmes is given. Extensive results are displayed in Appendix II 'Overview of studies and literature regarding cultural competence training of health care professionals in Europe'.

### ***Domain 1: Training description.***

In the majority of training programmes the objectives were at the staff-related level, for example, to better equip health professionals with tools to provide adequate care or to raise awareness about diversity and racism among people. The retrieved training programmes aimed to improve knowledge, skills and attitudes of health professionals in delivering culturally competent care. In addition, a differentiation between the concepts *general competence* and *(inter)cultural competence* of health professionals was reported. Depending on the definition of this competence the training courses had different objectives, or the aim was more broadly defined, also incorporating the patient-level, to decrease inequalities in care provided (Harmsen et al., 2005). The vast majority of training needs were identified through situational analysis. Patient/user needs assessment as a means to identify training needs was noted twice, and epidemiologic analysis was observed once. Only one training programme reported on training needs that were identified by organisation analysis. The number of modules of the training courses varied from three to eight. There was also substantial variation in the interpretation of 'module': a module could be one of six subjects in a one-day training course or a module could be a whole day training as part of a week's training course.

### ***Domain 2: Training development and delivery***

In all but one case the training developer was the same as the training deliverer. In the one other case, the national association of Dutch municipalities (VNG) had developed a project and a (daughter) regional health

---

<sup>11</sup> See Appendix II 'Overview of studies and literature regarding cultural competence training of health care professionals in Europe'.

<sup>12</sup> The RESTORE website contains information on (guidelines and) training programmes:

(i) *Now we're talking. Interpreting guidelines for staff of NHS Scotland* (2008), which can be used to enhance knowledge on working with interpreters.

(ii) *New European migrants and the NHS: Learning from each other*. Teacher's manual. Together with DVD. (2009). Aimed at midwives, doctors, nurses, social workers. (Scotland).

(iii) *Transcultural Health Care Practice*. An educational resource for nurses and health care practitioners' (2004) (England), addresses child health, mental health, the social and cultural context, politics of diversity and race equality management.

(iv) *Improving access to healthcare for migrants: a toolkit*. (England) with Eight modules, including Understanding asylum and migration, Communication skills and Roma.

(v) *E-learning program intercultural care* (2012) (the Netherlands) for mental health practitioners with four modules and two tests of ten Questions each. Focus on knowledge on communication, interpreters, racism.

(vi) a workshop for GP's on medically unexplained symptoms (2012) (the Netherlands), 3.5 hours on knowledge, insight and role play



organisation (GGD Rijnmond) together with an academic institution delivered the training programme. The majority of training programmes were developed and delivered by an academic institution. In one case, an NGO developed and delivered the training programme. The Dutch association for residential and home care organizations and infant and child health clinics (ACTIZ) was reported in one training programme, as developer and deliverer. The vast majority of training was delivered at a local level. All deliveries were in urban areas. One training was delivered at a national level and one at a European level, and all other trainings were delivered at a local or larger urban level. The sources were centred in Western-Europe, deriving from the Netherlands (nine), the United Kingdom (two), Italy (two), France (one), Sweden (one) and Portugal (one). Slovenia was the only East-European country we detected one report on, which was an inventory on the possibility of implementing cultural mediation in the Slovenian health care system; this was part of a (TSHaRE) project at European level. The funding most frequently came from a health centre or another government related health institution. The four TSHaRE training programmes were funded by the EU.

### ***Domain 3: Participant characteristics***

#### *Workforce targeted*

A distinction between the targeted workforce and the professional background of actual participants was seldom reported. Most training programmes only reported on actual participants. In three cases, only targeted workforce was recorded. In the majority of the training programmes, participants were nurses, doctors (mostly GP's, paediatricians, psychiatrists) and psychologists. To a lesser extent, (psycho- and occupational) therapists, social workers, researchers/scientists were reported. In one case, anthropologists, sociologists, ethnographers and philosophers were reported as targeted workforce. In two training programmes (Webb et al., 2003 and Ingleby & Kramer, 2006), managers were reported as participants/targeted workforce. Doctors in training to become paediatricians were identified as targeted workforce in one training programme. Intercultural mediators were mentioned in all T-SHaRE sources (except the Slovenian) which is not surprising as T-SHaRE was aimed at cultural mediation. In the Slovenian case the broad conceptual framework was cultural mediation, i.e. to explore how cultural mediation could be implemented in the Slovenian health system, where it was previously not recognised as a need. Rather, professionals working with, for example, refugees sometimes (inter)mediate voluntarily when necessary / on the occasion. Involving a multidisciplinary audience in the training was reported to have a good effect on evaluation and learning outcomes, because the complexity of good access and quality of care for migrants and ethnic minorities (MEM) can best be illustrated from different professional perspectives. Moreover, this multidisciplinary audience facilitates the concreteness of problems/challenges at different levels.

#### *Facilitators*

The majority of the training programmes were reported to be facilitated by psychologists. Some, but not the majority of the facilitators were psychotherapists. Other professional backgrounds that were reported (in order of the times reported) were (medical) anthropologists, doctors, social scientists and experts in migration. In many cases the training team was multidisciplinary. Noteworthy is the fact that only one study reported the facilitation by nurses. The involvement of managers in the delivery of the training was also reported in one case. The beneficial effect of a multi-ethnic team of facilitators (parallel to the targeted migrant group) was reported in one training programme.

#### *Involvement of different actors in the development and delivery of the training*

Involvement of interpreters in the development or delivery was reported in only one training programme (Bertens et al., 2012). Only one other training programme (Ingleby & Kramer, 2006) reported involvement of migrant group representatives in the development of the training programme. Involvement of

AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

intercultural mediators, migrant group representatives and NGO representatives in the delivery of the training course were also reported in this training programme (Ingleby & Kramer, 2006).

### ***Domain 3: Approach***

In many training programmes no information was retrieved on the Pedagogical approach that was used. In two training programmes the 'linking theory to practice' approach was found. Also several approaches were observed that are linked to the learning-by-doing approach: participatory learning, self-learning, in-vivo (inductive) learning, and the Deming cycle for quality of care improvement<sup>13</sup>.

#### *Broad conceptual framework*

Kleinman's explanatory models of illness and disease and, to a much lesser extent, medical anthropological knowledge in general, are reported to inform the conceptual framework in the majority of training programmes. The training programmes are mostly centred on increasing competence in providing good quality health care ethnic and minority patients (e.g. cultural competence). Several concepts were used. The widely used term cultural competence (CC) was most often observed in the European training descriptions, although several scholars were referred to regarding the definitions of CC: (i) Campinha-Bacote's (2002) five levels were explicitly mentioned (in Berlin et al., 2010); (ii) Betancourt (2003) (in Sellegger & Bonke, 2011); (iii) Cross et al., 1989 and Sue et al., 1992 (in Owiti et al., 2013); (iv) Culturally Appropriate Hypertension Education (Beune et al., 2010); and (v) Giger & Davidhager (1988) (in Peters, 2013). Intercultural communication as a conceptual framework was identified three times (Harmsen et al., 2005; Bertens et al., 2012; Dahhan et al., 2013). Diversity sensitivity was detected (Celik et al., 2012) and diversity competence was noted (Sempertegui et al., 2013). Culturally Appropriate Hypertension Education (CAHE) (Beune et al., 2010), was reported once. Pinto's three-step method was noted once (Harmsen et al., 2005). Intersectionality was also observed (Ingleby & Kramer, 2006). These latter terms emphasize the broadness of diversity (with)in and between people. Diversity in the latter concepts is considered as an intersection of core aspects such as culture, religion, gender, age, sexuality, socioeconomic status (SES), and disability. All training programmes that were part of TSHaRE used the framework of cultural or intercultural mediation. These terms were both used within the same country report (Portugal) of the TSHaRE reports). No other training programme reported a focus on (inter)cultural mediation.

#### *Focus of training programmes*

Knowledge was most often (nine times) identified to be the general focus of trainings. Awareness was often detected as well (seven times). One training programme (Ingleby & Kramer, 2006) focused on expanding knowledge and competence to work effectively with Roma. No other training programmes reported a focus on the Roma people as a specific ethnic group. Nine sources were found on primary health care, four on paediatrics, and four on mental health care. In nine cases, specific information on targeted ethnic minority groups was found, four of which were from the Netherlands (Peters, 2013; Beune, 2010; Harmsen, 2005; Sempertegui, 2013). Targeted ethnic minority groups in these training programmes were people from Turkish, Moroccan, Surinamese, (and in two also Cape Verdian and Netherlands Antillian) descent. In a training programme for health professionals from the UK (Webb, 2003) children from black or ethnic minority groups were targeted as a group of focus. Another training programme focused on multicultural children (Association Frantz Fanon, 2012). Asylum seekers or refugees were explicitly mentioned three times (CRIA, 2012; Bennegadi, 2009; Ingleby & Kramer, 2006). No training programmes were found that had a

---

<sup>13</sup> The Deming cycle for quality of care improvement consists of five stages: \*unawareness \*awareness \*plan \*do \*study \*act.  
AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

specific focus on health service access.

### **Domain 5: Educational content**

The educational content of most training courses was knowledge-based. More than half of the training programmes found contained knowledge on culture and cultural knowledge. Various themes were equally reported as knowledge content of the training programmes: i.e. migration and the right to health care, the social-cultural context of health inequalities, determinants of health, and constructs of racism were all reported as part of the educational content in three or four training programmes. The two knowledge-based themes that were least frequently found were morbidity and mortality, and genetic diseases. Awareness-raising was part of most trainings as well, albeit to a lesser extent. Understanding human differences and similarities are the topics most often found. Training in the application of knowledge and skills was least often reported. Intrapersonal skills (such as cultural self-assessment and reflection) were reported only twice (Berlin et al., 2010, Harmsen et al., 2005), as opposed to interpersonal skills (e.g. communication skills), which was reported five times. Three training programmes did not provide any information in educational content.

### **Domain 6: Training course structure**

All sources found reported on face-to-face training programmes / courses. One distance training course (e-learning) was reported, on Female Genital Mutilation (GGD/GHOR). The majority of training courses reported lectures, and all training courses reported discussion / work groups as a method for delivery. Case scenarios were reported nine times, clinical experience was represented in five training courses, whereas role play was mentioned in six training courses. Handbooks were reported, as well as video, PPT presentations and practical exercises. Not all training programmes reported information on the format of delivery. Only one training (Celik et al., 2012) reported a link to organisational support: to a policy document, care protocol and guideline evaluation 'Diversity glasses'. The duration of the training programmes found varied from three hours to more than ten sessions of one day each. Most often found were training programmes that lasted from two to three days. Some, but not the majority, of the training included a follow-up, e.g. a training on the job part, or a follow-up training session after an interval. Follow-up measurements were done in some of the training courses we found, widely ranging from one day (Peters, 2013, Webb et al., 2003), two weeks (Harmsen et al., 2005), four weeks (Berlin et al., 2010), six weeks (Association Frantz Fanon, 2012), three months (Sempertegui et al., 2013), seven months (Owiti et al., 2013) and three years (Celik et al., 2012). In the majority of training programmes no information was found on the awarding of certificates at completion. No information was found on the tuition fees for individuals or organisations. All but one training course was based on voluntary participation. The exception here was the Cultural Consultation Service that was passively mandatory: *"94 clinicians by the (...) mental health teams were not only expected but also invited to take part in the intervention"* (Owiti et al., 2013, p.7).

### **Domain 7: Evaluation and outcomes**

All retrospective evaluation methods were based on self-reporting, i.e. personally reported changes. Some of the evaluations concerned knowledge, and attitude was evaluated to a lesser extent. In all cases a positive effect was reported. Different levels of training outcomes were detected: staff-related, patient-related, and organisation-related outcomes. All but two training programmes were solely evaluated on the level of staff-related outcomes, the individual development. Congruence between the training programme and professional learning outcomes were reported in the vast majority of training courses. Only one of the training courses (Harmsen et al., 2005) was evaluated on patient health care outcomes. Only one other

AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

training (Ingleby & Kramer, 2006) was evaluated on organisational outcomes as well, besides the staff-related level. When the aim of the training was both at individual and at organisational level, the training proved to sort effect on both levels too, as in the TSHaRE training (Aversana et al., 2012). One training (Celik et al., 2012) was evaluated by triangulation: one of the three means was - besides a pre and post survey and an oral evaluation after every module - a longitudinal post hoc evaluation, namely an interview with the program coordinators after three years.

### *Evaluation tools*

The use of several<sup>14</sup> evaluation tools was reported:

- Clinical Cultural Competence Training Evaluation Questionnaire-pre (CCCTQ-PRE) and Clinical Cultural Competence Training Evaluation Questionnaire-post (CCCTQ-POST) (Krajic, 2005).
- An adapted version of Resident Physicians' Preparedness to Provide Cross-Cultural Care<sup>15</sup> (RPPCC) (Weissman, 2005) (in Beune et al., 2010).
- An adapted version of Tool for Assessing Cultural Competence Training (TACCT) (Association of American Medical Colleges, 2005) (in Owiti et al., 2013)<sup>16</sup>

Other tools or concepts that were represented:

- AMACLIN (Minkowska Multimedia Tool) – interactive multimedia tool (in Bennegadi, 2009)
- CCS (Cultural Consultation Service) – elaborative multidisciplinary service (in Owiti et al., 2013)
- EREA (Equal Rights Equal Access pack) - training course (in Webb et al., 2003)
- CAHE (Culturally Appropriate Hypertension Education) – training package (in Beune et al., 2010).

Extensive results are displayed in Appendix II 'Overview of studies and literature regarding cultural competence training of health care professionals in Europe'.

### **Limitations**

The number of training courses that were found in this literature search was low (four derive from the same European TSHaRE project). Our results indicate that little material is available on the internet, as training programmes are not, as a rule, published on the internet. Furthermore, the low number of training courses found in the literature and on the Internet may derive from the fact that many educational programmes are not linked to any specific legislation or organisational policies or actions. The need to consolidate existing training programmes does not appear to have been hitherto identified.

The commitment of training to the theme of cultural competence / diversity sensitivity / equity / intersectionality is not consistent across all layers of organisations. Contrary to arguments (Chiarenza, 2012; Ingleby, 2012) in scientific research regarding the necessity of equity and intersectionality in health care at organisational and societal level, it remains unclear who or which organisational body is to be held accountable for the implementation. Economical, legal, financial and moral incentives regarding the field of equity in care are not in the flow of organisational policies or legislation.

---

<sup>14</sup> These instruments may not be suitable for all medical professions. None of the instruments have been validated to our knowledge

<sup>15</sup> This instrument was previously used to measure effects of cross-cultural training among physicians in academic health centres. It measures attitudes and perceived competence with regard to culturally appropriate health care in general. A drawback of these instruments may be that the questions were not always appropriate for all kinds of professions, such as (non-clinical) GP's, and nurses (Beune, 2010).

<sup>16</sup> Domain V of the TACCT on Cross-Cultural Clinical Skills self-assessment survey for staff, with each item having a correspondent Likert scale (strongly disagree, moderately disagree, moderately agree and strongly agree) on which staff can rate their competence.

No evidence was found from Central and Eastern Europe, except one training course from Slovenia (Kulturno Društvo (KD) Gmajna, 2012). One possible reason could be the low prioritisation in these health care *systems* of intercultural health care and cultural mediators (as was suggested in KD Gmajna, 2012). Another reason could be that the materials are not published in any of the languages that we searched in. It was reported that no language barriers were experienced between MEMs and regular inhabitants as the languages spoken in Slovenia are related and understood by most. Because of this language similarity, the perception could persist that the need for training in CC is not necessary. This may also be the case in other Central and Eastern European countries.

No training programmes were reported on Roma as a targeted migrant or ethnic minority group (although one training programme (Ingleby & Kramer, 2006) reported a focus on expanding knowledge and competence to work effectively with Roma). This may be because of the languages we searched in - we didn't search in e.g. Spanish, Bulgarian or Hungarian. All sources that were found were written in English. Only short hand-searches were done in French and German. Our search strategy implies limited retrieval of information. It is therefore likely that not all training programmes were identified. Furthermore, many of the sources that may have been of interest could not be included in the analysis, because these were non-European (e.g. from the USA or from Australia) or were targeted at undergraduates (e.g. at students from medical schools). Two sources (Sempertegui et al., 2013, Bennegadi, 2009) were incomplete (e.g. found in the form of a Powerpoint presentation), and a full analysis of these was not possible.

## **Discussion**

In defining what is needed to provide good quality health care for MEM, the distinction between general or (inter)cultural competence may reflect the scientific discussion on the evidence-base / feasibility of the construct of cultural competence (CC) (see for example Chiarenza, 2012). Given the different descriptions of CC given, this review shows that there is no concordance on what the subject of CC is exactly defined by. The term CC continues to be used in the USA where the term originated from, but in Europe other terms have arisen as well, such as equity, diversity sensitivity, super-diversity and intersectionality, implying a broader conceptualisation (see Chiarenza, 2012; Seeleman, 2014, p.153-156; Vertovec, 2007; Ingleby, 2012).

There is an abundance of international literature related to cultural competency and the importance of its integration into all levels of health care (Truong et al., 2014). In our review, in only two cases, managers were reported as participants/targeted workforce in the training courses. The low number of management level participants in the training programmes can be identified as a gap in this overview of training programmes. A recent systematic review by Truong et al. (2014) included training programmes involving health administrators and support staff. Truong et al. found that four of 19 reviews included studies that examined organisational level interventions, such as (in Anderson et al., 2003) culturally adapting health programmes for patients and employment of bilingual community health workers, and Pearson et al. (2007) looked at the structures and processes within health care settings, e.g. nursing, that support the development of culturally competent practices.

It is of vital importance to address not only the professional in the front line on the front line but also decision makers and those in charge of implementation policy, as it is at the organisational level that change can be made. For example, a nurse must be given time in his/her daily time schedule to elicit patients'

explanatory model of illness<sup>17</sup> in an interview with a patient. The extra time that this additional interview takes must be consolidated in some policy, otherwise the nurse will actually have no time to do this – and training on the use of the interview to elicit patients' explanatory model of illness seems to make no sense then, as it will not be used in the nurse's practice.

The two knowledge-based themes that were least often found were morbidity and mortality, and genetic diseases. This may be due to the lack of horizontal and vertical integration of the theme of MEM care in health organisations and training programmes. The finding that in most cases the trainer is an MD, whereas the trainee is a nurse, is remarkable. There seems to be a lack of nurse trainers.

(Almost) all retrospective evaluation methods were self-reporting, personally reported changes. The possibility exists that participants have reported what they believe to be the most socially acceptable, but this may not reflect their cultural competencies in practice (Capell et al. 2007; Kumas-Tan et al., 2007). A recent review of reviews found that it is difficult to determine the extent to which knowledge and skills learnt from training programmes impact on patient or client outcomes (Truong et al., 2014). Most studies measure CC by using tools that have not been validated. Results of CC training could be interpreted more accurately if validated tools have been used (Gozu et al., 2007). Moreover, self-perceived skillfulness may not be suitable to measure skills.

It would be preferable to design new research that measures the correlation between self-assessment and patient ratings for example (Brach & Fraser, 2000; Geron, 2002). In addition, a relation between skillfulness and provider knowledge, training, positive attitudes, and role-modeling, suggests that skillfulness is superior to other cultural-competency measures (Weissman et al., 2005; Chun et al., 2010; Casillas et al., 2014). It is surprising therefore that only a limited number of skills were evaluated. It would be interesting to assess changes in skills, by means of, for example, peer observation, or even more thoroughly, video observation. By means of the latter evaluation method, a thorough learning effect may be attained, not only in the peers but in the person being observed as well, as he/she can perceive audio visually what happened while performing the skill.

Overall, not much material on existing training programmes was found on the internet. This may be due to our search strategy, but it could also derive from the temporary nature of the training programmes on MEMs health. As seen in the results of the literature review, only two training programmes (Ingleby & Kramer, 2006; Dahhan et al., 2013) reported a link to organisational support. Many training initiatives are not linked to any organisational policies, activities or management review and they just disappear after a while. There was not much follow up evaluation. As gaining cultural competence is an ongoing process, it is recommended that cultural competence is assessed by ongoing training and staff development with multiple assessments over a period of time (Campinha-Bacote, 2002). Developments on an organisational level are in progress. Worldwide, several assessment instruments have been developed and implemented to assess organisations regarding MEM health care (see for an unexhaustive overview for example Seeleman 2014, p. 109-145). This should be an incentive for the development of good practice training programmes in the upcoming years.

Historically, the EU project 'Migrant Friendly Hospitals' ([www.mfh-eu.net](http://www.mfh-eu.net)) succeeded in putting migrant-friendly culturally competent health care and health promotion higher on the European health policy agenda in 12 European countries (Northern, Western and Southern European countries) by bringing together

---

<sup>17</sup> Based on Kleinman's Explanatory Model format, see e.g. Beune et al., 2010. Owiti et al. (2013) used the Barts Explanatory Model Inventory (BEMI) to generate emic narratives (Rüdel et al., 2009).

hospitals, a scientific institution, experts, international organisations and networks. The 'Declaration of Amsterdam' was developed and supported by several parties. In this Declaration crucial points for the successful development of services and organisational cultures are stated, putting the quality of services for MEM on the agenda of hospital organisations.

## References

- Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J. (2003) Culturally competent healthcare systems. A systematic review. *American Journal of Preventative Medicine*, 24(3S):68–79.
- Association of American Medical Colleges (2005) *Tool for Assessing Cultural Competence Training (TACCT)*. Available at: [http://www.aamc.org/download/54344/data/tacct\\_pdf.pdf](http://www.aamc.org/download/54344/data/tacct_pdf.pdf) (Accessed 2<sup>nd</sup> September 2014).
- Beagan BL. (2003) 'Is it worth getting a big fuss over? Everyday racism in medical school. *Medical Education*; 37:852-860.
- Brach C, Fraser I. (2000) Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model. *Medical Care Research and Review*, 57(Suppl 1):181-217.
- Campinha-Bacote J. (2002) The process of cultural competence in the delivery of healthcare services: a model of care. *Journal of Transcultural Nursing*; 13: 181–184.
- Capell J, Veenstra G, Dean E. (2007) Cultural competence in healthcare: critical analysis of the construct, its assessment and implications. *Journal of Theory Construction & Testing*, vol. 11, no. 1, pp. 30–37, 2007.
- Casillas A, Paroz S, Green AR, Wolff H, Weber O, Faucherre F, Ninane F, Bodenmann P. (2014) Cultural competency of health-care providers in a Swiss University Hospital: self-assessed cross-cultural skillfulness in a cross-sectional study. *BMC Medical Education*, 30;14:19. doi: 10.1186/1472-6920-14-19.
- Chiarenza, A. (2012) Developments in the concept of 'cultural competence.' In: Ingleby, D. et al (eds.). *Inequalities in health care for migrants and ethnic minorities*, Vol. 2. COST Series on Health and Diversity. Antwerp: Garant Publishers.
- Chun MB, Yamada AM, Huh J, Hew C, Tasaka S. (2010) Using the cross-cultural care survey to assess cultural competency in graduate medical education. *J Graduate Medical Education*, 2(1):96-101.
- Cross TL, Bazron BJ, Dennis KW, et al. (1989) *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. CASSP Technical Assistance Center, Georgetown University, Child Development Center, Washington, DC.
- Geron SM. (2002) Cultural competency: how is it measured? Does it make a difference? *Generations*, vol. 26, no. 3, pp. 39–45.
- Gozu A, Beach MC, Price EG, Gary TL, Robinson K, Palacio A, Smarth C, Jenckes M, Feuerstein C, Bass EB, Powe NR, Cooper LA. (2007) Self-administered instruments to measure cultural competence of health professionals: a systematic review. *Teaching and Learning in Medicine*;19(2):180-90.
- Horvat L, Horey D, Romios P, Kis-Rigo J. (2014) Cultural competence education for health professionals. *The Cochrane database of systematic reviews*, 5, CD009405.
- Hudelson P, Perneger T, Kolly V, Perron NJ. (2012) Self-assessed competency at working with a medical interpreter is not associated with knowledge of good practice. *PLoS One*;7(6):e38973. doi: 10.1371/journal.pone.0038973. Epub 2012 Jun 8.

- Ingleby, D. (2012) Introduction by series editor. In: D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity, Volume II* (pp. 9-28). Antwerp/Apeldoorn: Garant
- Kai J, Spencer J, Woodward N. (2001) Wrestling with ethnic diversity: towards empowering health educators. *Medical Education*; 35:262-271.
- Krajic K, Strassmayr C, Karl-Tummer U, Noval-Zezula S, Pelikan JM. (2005) Improving ethnocultural competence of hospital staff by training: experiences from the European "Migrant-friendly Hospitals" project. *Diversity in Health and Social Care*, 2, 3, pp. 279-290.
- Kuma-Tan Z, Beagan B, Loppie C, MacLeod A, Frank B. (2007) Measures of cultural competence: examining hidden assumptions. *Academic Medicine*, vol. 82, no. 6, pp. 548-557, 2007.
- Pearson A, Srivastava R, Craig D, Tucker D, Grinspun D, Bajnok I, Griffin P, Long L, Porritt K, Han T, Gi AA. (2007). Systematic review on embracing cultural diversity for developing and sustaining a healthy work environment in healthcare. *International Journal of Evidence-Based Healthcare*, 5:54-91.
- Rüdel K., Bhui K. & Priebe S. (2009) Concept, development and application of a new mixed method assessment of cultural variations in illness perceptions: Barts Explanatory Model Interview. *Journal of Health Psychology* **14**, 336-347.
- Seeleman MC. (2014) *Cultural competence and diversity responsiveness: how to make a difference in health care?* PhD Thesis Academic Medical Centre, University of Amsterdam. Available at: <http://dare.uva.nl/record/468191>.
- Sue DW, Arredondo P, McDavis RJ. (1992) Multicultural competencies/standards: a pressing need. *Journal of Counseling and Development* 70, 477-486.
- Truong M, Paradies Y, Priest N. (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*, 3;14:99.
- Vertovec S. (2007) Super-diversity and its implications. *Ethnic and Racial Studies*; 30(6): 1024-54.
- Weissman JS, Betancourt J, Campbell EG, Park ER, Kim M, Clarridge B, Blumenthal D, Lee KC, Maina AW. (2005) Resident physicians' preparedness to provide cross-cultural care. *JAMA*, 294:1058-1067.



## **CHAPTER 4: SURVEY FOR COLLECTING INFORMATION ON EXISTING TRAINING MATERIALS**

### ***Aim and objectives***

The general aim of the survey was to collect information about the selected training programmes developed and delivered in Europe during the last 10 years, in order to allow for a critical review. The purpose was to review training programmes and materials targeting health professionals and care mediators, focusing on the issues of access to services and quality of health care for migrants and ethnic minority groups, including the Roma. At this stage it is important to clarify that the general aim was not to determine the extent of training activity, neither to analyse the situation in the 28 EU countries nor to evaluate the effectiveness of the training programmes identified. Rather the objective was to provide an overview of good training practice in EU, to describe and analyse this according to a specifically designed conceptual framework in order to discuss trends, strengths and weaknesses and, finally to evaluate them against a set of proposed criteria in order to identify a group of “good quality” programmes. The identified “good quality” programmes formed the content of a directory of training materials that can be used as a reference for the development of future programmes.

### ***Search methods and source of information***

The survey addressed a number of key persons in the 28 EU MS and representatives of relevant international organisations and NGOs who were asked to select from 1 to 3 the most important training courses in their country or organisation that had taken place (or are still taking place) in the period 2003-2014. The key persons contacted were expert researchers, health service providers, health policy advisors and advocates of migrant, Roma and other ethnic minority’s health needs and situation. All those contacted were well known to the WP 2 leaders or were indicated by them, and had an acknowledged (long standing) expertise in the field as they were involved in networks or projects addressing the particular issues of health and health care delivery of MEMs. Particularly, they were members of the 2 COST Actions, HOME (2007-2011) and ADAPT (2012-2015); the HPH (Health Promoting Hospitals and Health Services) Task Force on Migrant-Friendly and Culturally Competent Health Care; the IOM national networks; and the C2ME project.

The key persons were asked to use a specific template to collect information on their selected training courses and to add any additional material, such as extensive course description, training resources, and website links. Between the beginning of July and the beginning of August 2014 the templates were sent to key persons of the 28 EU Member States and to representatives of WHO Europe (Copenhagen and Venice), IOM (International Organisation of Migration), PICUM (Platform for International Cooperation on Undocumented Migrants), FRA (European Union Agency for Fundamental Rights), ICMPD (International Centre for Migration Policy Development), Doctors of the World, The Roma Initiative Office of the Open Society Foundations in Europe, and the Global Fund to fight AIDS, Tuberculosis and Malaria. In total we sent out 100 template and we received 65 completed.

### ***Description and analysis of survey results***

The survey results are organised into the 7 domains, including their core components (ranging from 1-4 in some domains) and variables (separate items within each domain). In total there are 37 variables that describe the main results. They are presented as follows:

*Domain 1: Training description*

Aim and objectives of the training

Training needs

How training needs were identified?

Number and titles of thematic modules

*Domain 2: Training development and delivery*

Type of training developer

Type of training deliverer

Level of training delivery

In which country/countries was training delivered

Date of the first delivery

Number of times training was delivered between 2004-2013

Setting of delivery

Funding source

*Domain 3: Participant characteristics*

Workforce targeted with the training

Trainers (who delivered the intervention)

Involvement in development of training

Involvement in delivery of training

*Domain 4: Approach*

Pedagogical approach adopted for training

Broad conceptual framework adopted for the training

Focus of training

*Domain 5: Educational content*

Sensitivity and awareness

Knowledge

Application of knowledge

Skills

*Domain 6: Training course structure*

Methodology for delivery

Formats (training resources)

Organisational support

Frequency

Duration of each course

Certificate and credits

Tuition fee

Participation

Availability of training

*Domain 7: Evaluation and outcomes*

Was the training evaluated?

How was training evaluated?

What type of outcomes of the training were measured?

AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

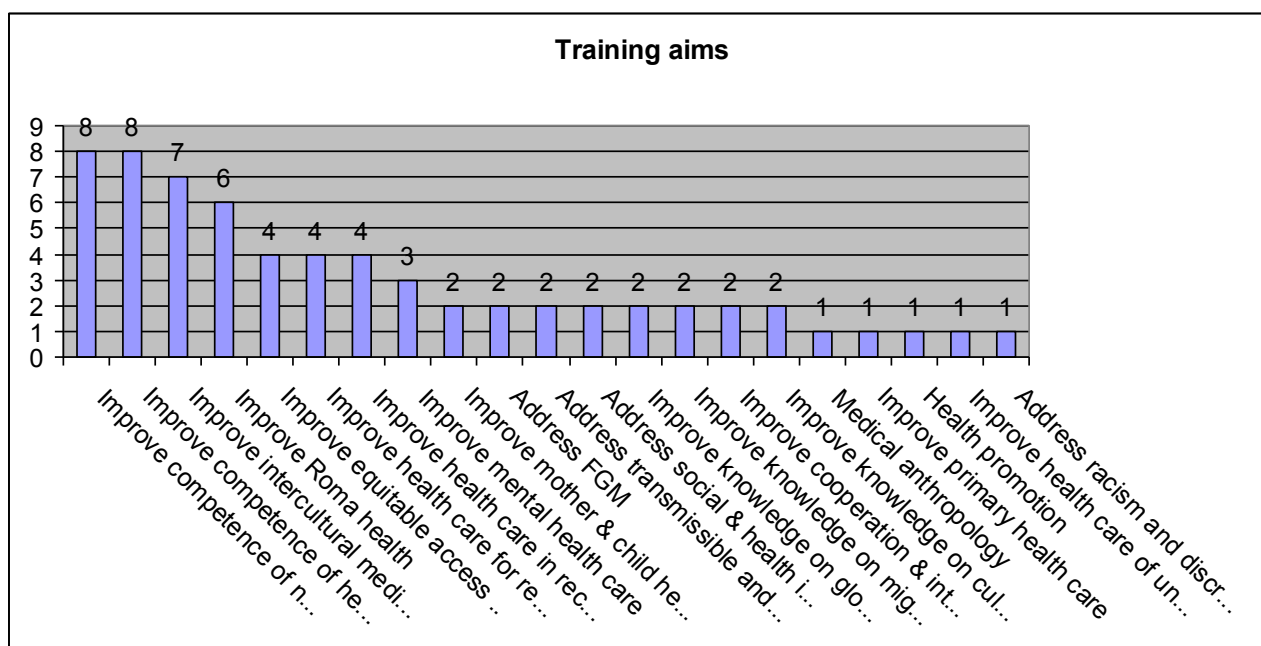
Methods used for measuring outcomes  
 Anticipated training outcomes and actual training outcomes  
 Additional information

### ***Domain 1: Training description***

The 65 training programmes selected had a variety of aims that are listed in the table below. Sixteen of the training programmes aimed at improving the competences of nurses and health professionals in dealing with migrants and ethnic minorities; 7 aimed to improve intercultural mediation and communication in health care; 6 addressed the specific issue of Roma health; 4 addressed the particular issues related to accessibility; 4 aimed at improving health care for refugees and asylum seekers, and 1 for undocumented migrants; 4 focused on the specific issue of health care in reception centres and 3 on mental health, particularly concerning victims of trauma and human trafficking. A number of courses aimed at improving migrant women's health: 2 focused on Female Genital Mutilation (FGM), and 4 on mother and child care. Other training programmes focused on tackling the issues of social inequalities, global health and the impact of migration on public health; and at improving cooperation between institutions and integration between health and social services. Finally a number of courses aimed at improving health care for these vulnerable groups by enhancing staff knowledge of medical anthropology, health promotion, and individual and institutional discriminations.

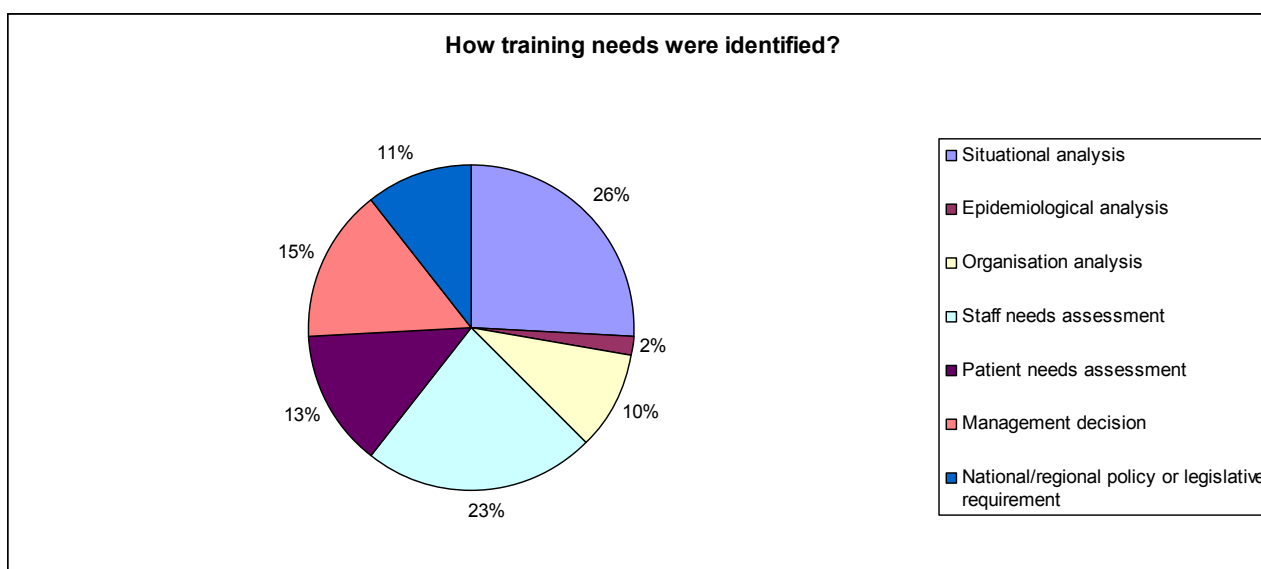
#### *Training aim and objectives*

<b>Training aim</b>	<b>Total</b>	<b>Percent</b>
Improve competence of nurses	8	12%
Improve competence of health professionals	8	12%
Improve intercultural mediation or communication	7	11%
Improve Roma health	6	9%
Improve equitable access to healthcare	4	6%
Improve health care for refugees & asylum seekers	4	6%
Improve health care in reception centres	4	6%
Improve mental health care	3	5%
Improve mother & child health	2	3%
Address FGM	2	3%
Address transmissible and tropical diseases	2	3%
Address social & health inequalities	2	3%
Improve knowledge on global health & international migration	2	3%
Improve knowledge on migration and public health	2	3%
Improve cooperation & integration	2	3%
Improve knowledge on culture and diversity	2	3%
Medical anthropology	1	2%
Improve primary health care	1	2%
Health promotion	1	2%
Improve health care of undocumented migrants	1	2%
Address racism and discrimination	1	2%
Total	65	100%



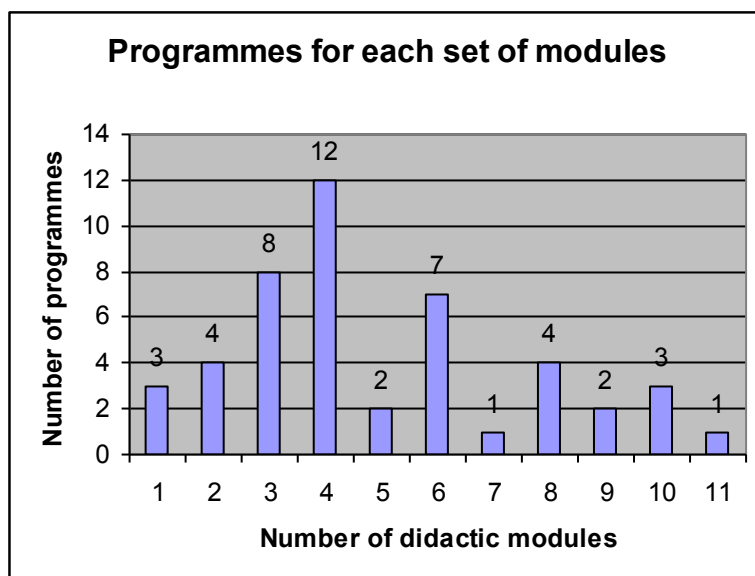
### Training needs

The methods most frequently used to identify training needs were situational analysis (26%) and Staff needs' assessment. Patients' needs analysis was used in 15% of cases and organisational analysis in 10% of cases. It's interesting to note that training needs were defined by management decisions in 15% of cases and by policy or legislative requirements in 11% of cases. Epidemiological analysis was used only in 2% of cases.



### Training modules

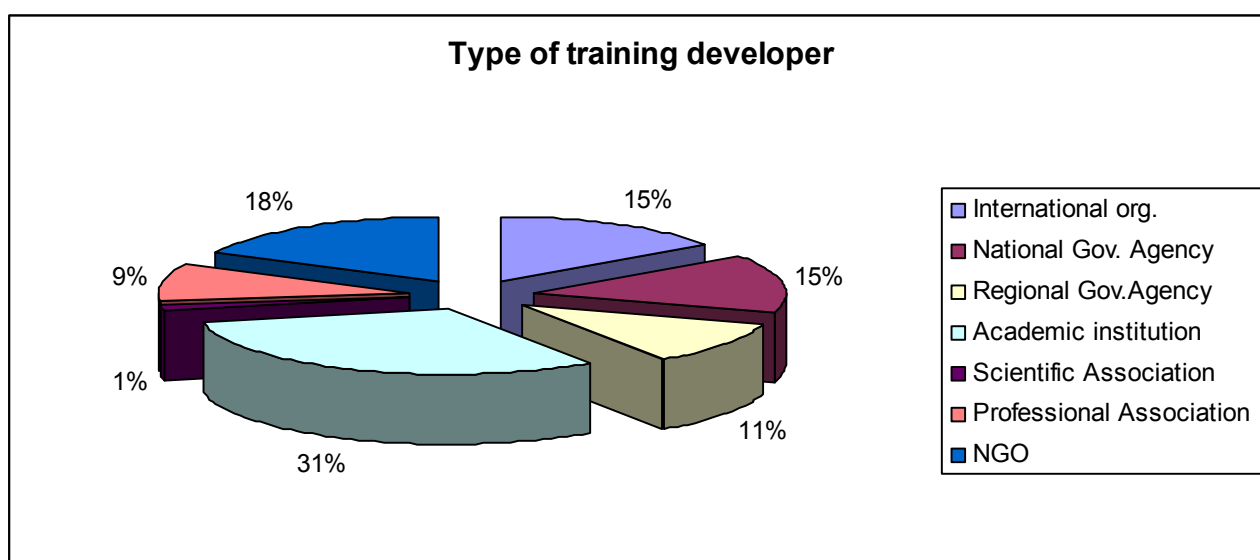
The majority of programmes (83%) were organised around a number of didactic modules that ranged between 1 and 6. Only 11 programmes had more than 6 didactic modules, representing the 17% of the total number of programmes.



## ***Domain 2: Training development and delivery***

### *Type of training developer*

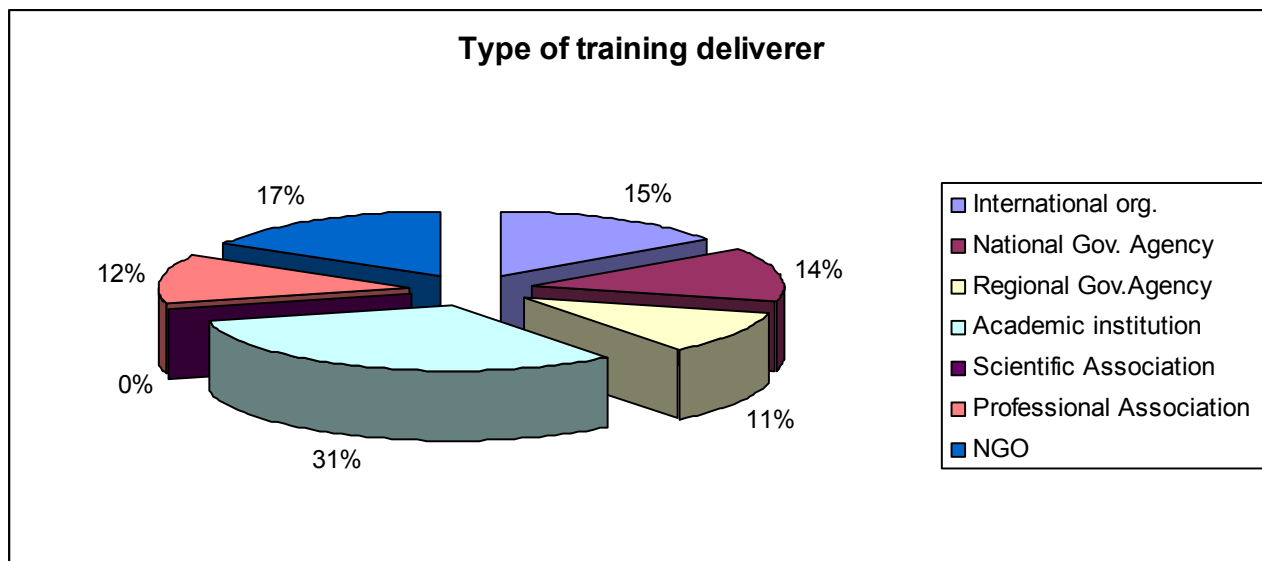
Various types of developer were equally engaged in the development of the training programmes. Apart from Scientific Associations, which were involved only in 1 case, all the others had a relevant role in developing the programmes, Academic Institutions (31%), together National and Regional Governmental Agencies (26%), NGOs (18%), International Organisations, such as IOM and WHO Europe (15%), and Professional Associations (9%).



### *Type of training deliverer*

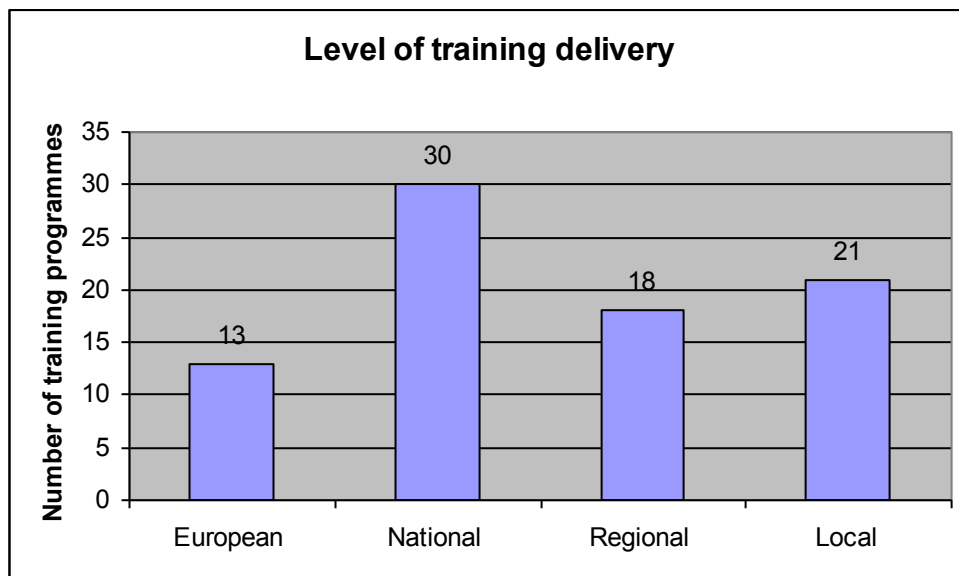
The distribution of results describing the type of training deliverer is similar to the type of training developer: The Scientific Associations did not deliver any programme at all, Academic Institutions in 31% of cases,

together National and Regional Governmental Agencies (25%), NGOs (17%), International Organisations, such as IOM and WHO Europe (15%), and Professional Associations (12%).



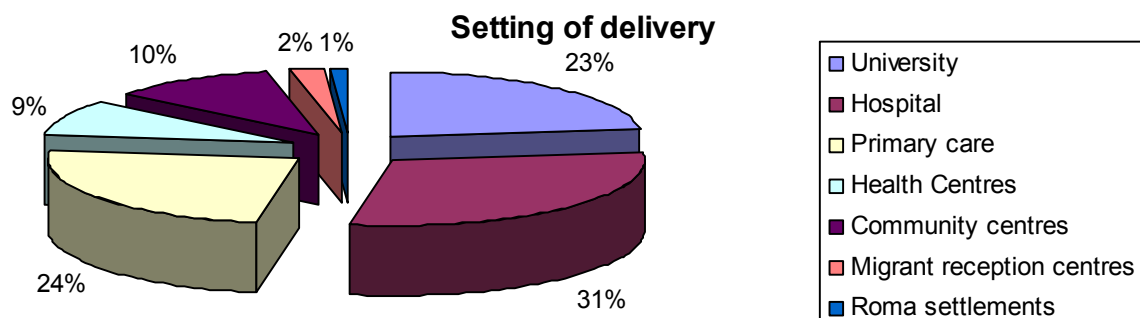
#### *Level of training delivery*

The majority of the training programmes, 36%, were delivered at national level, 26% at local level, 22% at regional level, and 16% at European level.



#### *Setting of delivery*

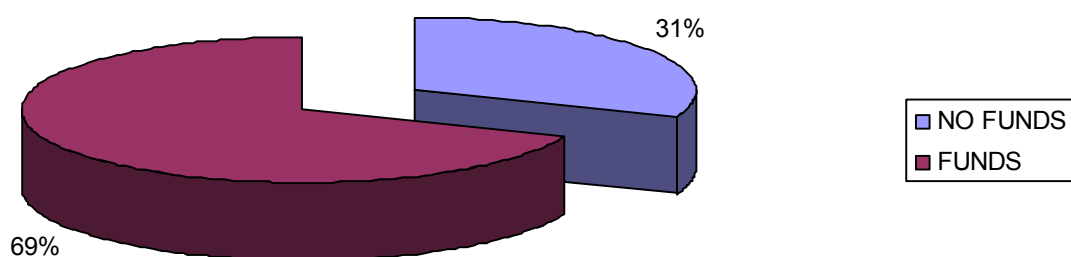
The majority of the training programmes, 31%, were delivered in Hospitals, 24% in Primary Care, 23% in University, 10% in Community settings, 9% in Health Centres, 2% in Migrant Reception Centres, and 1% in Roma people settlements.

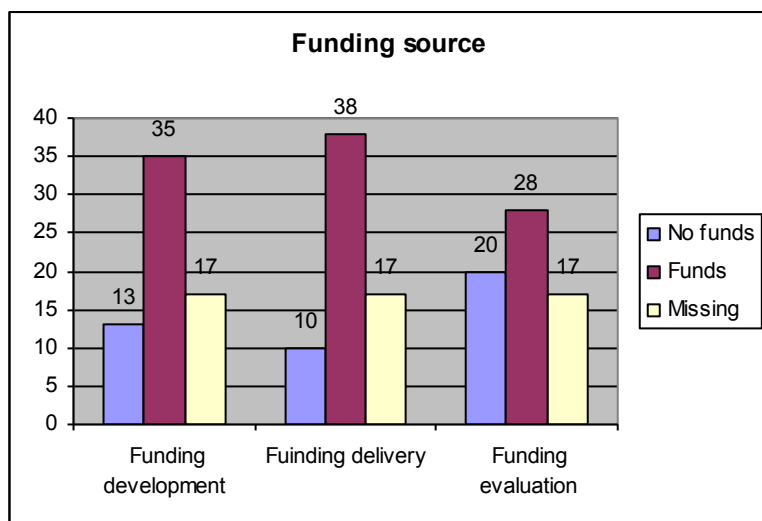


### *Funding source*

20 programmes out of 65, representing the 31% of cases, had no funds at all for the development, delivery and evaluation of the training programmes. Of those that received funding, 35 had funds for the development, 38 for the delivery and 28 for the evaluation of the training programme.

### **Funded programmes**

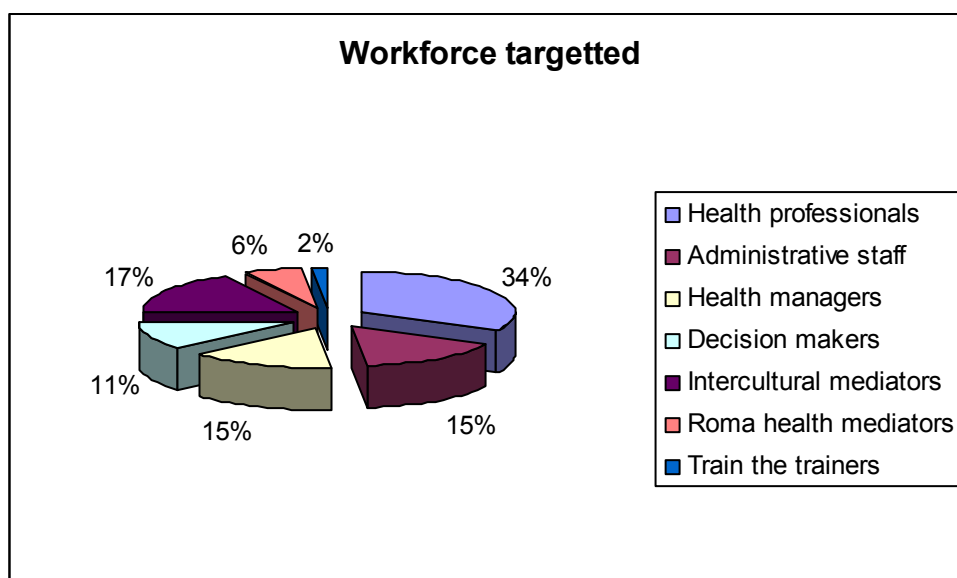




### **Domain 3: Participant characteristics**

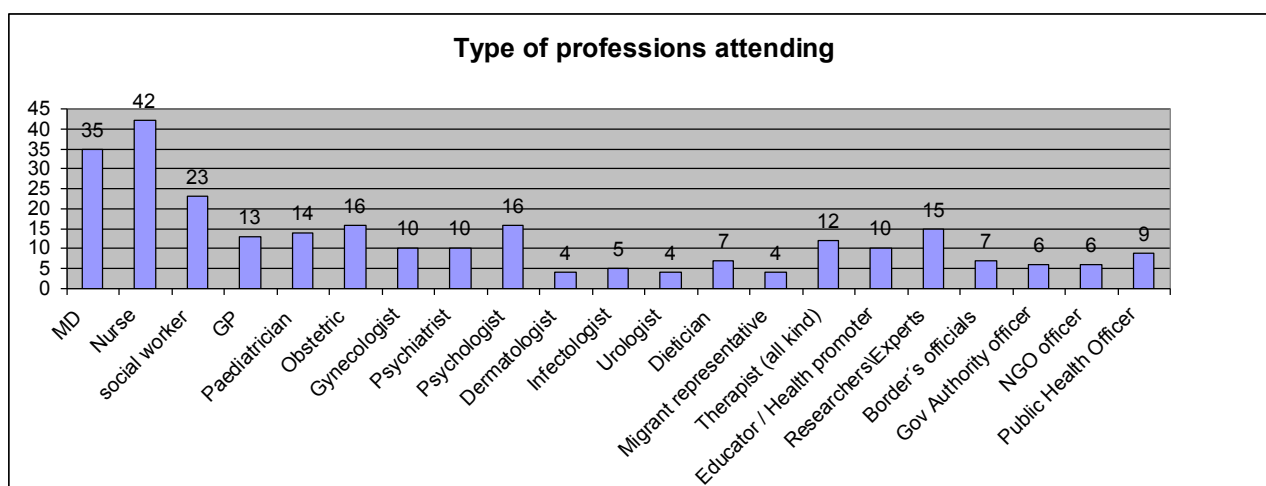
#### *Workforce targeted with the training*

The majority of the workforce targeted with the training programmes, 34%, were Health professionals, 17% Intercultural mediators, 15% Administrative or technical staff, 15% Health managers, 11% Decision makers (top management), 6% Roma Health mediators, and 2% Trainers of trainers.



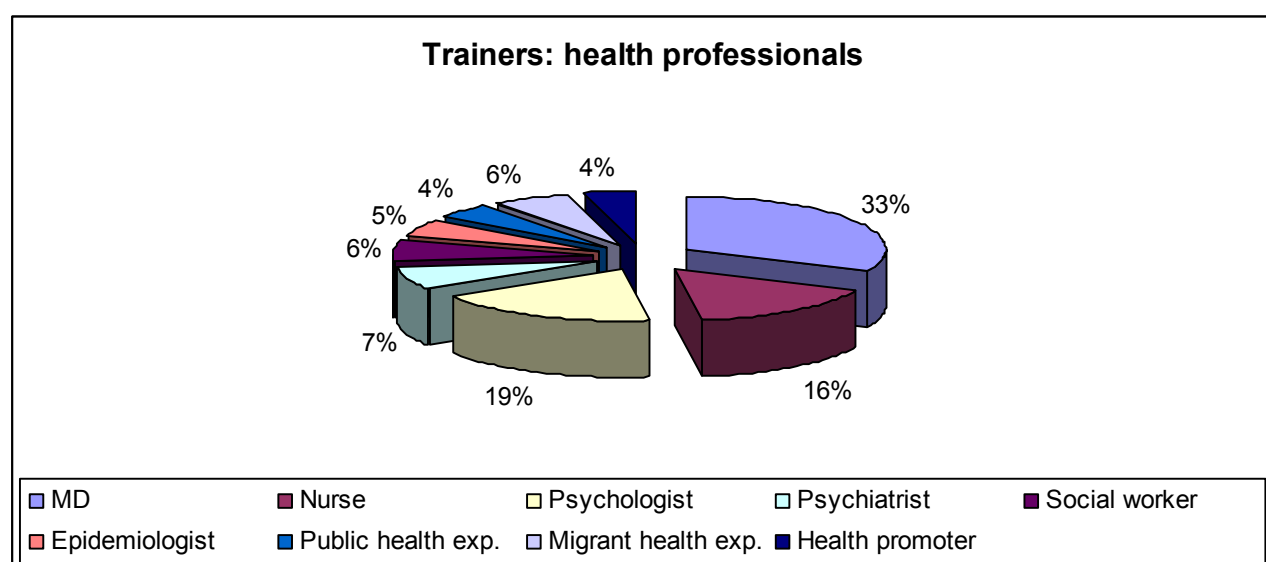
The three more represented professions attending the training programmes were Nurses, 16%, Medical doctors, 13%, and Social workers, 9%. The professionals attending, 6%, were General Practitioners, 6% Paediatricians, 6% Psychologists, 4% Gynaecologists, 4% Psychiatrists. Among the other health professions, there is a significant presence of Obstetrics, Therapists (e.g. occupational therapists), and Health educators. It is also worth to note that some of these training programmes were attended by Governmental authority (e.g. Ministry of Health/Interior officers), Public health officers and NGOs' officers.



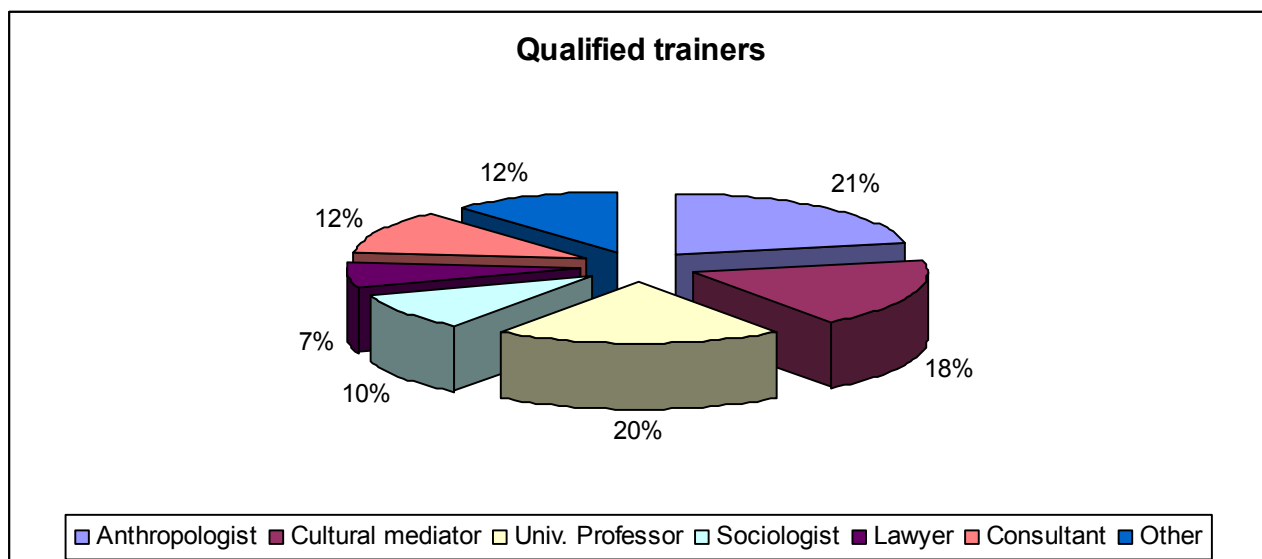


### *Trainers (who delivered the intervention)*

The largest group of the trainers belonging to the health professionals, 33%, were Medical Doctors of various specialities, 19% were Psychologists, 16% were Nurses, 7% Chartists, 6% Migrant Health experts, 6% Social workers, 5% Epidemiologists, 4% Public Health experts, and 4% Health promoters.

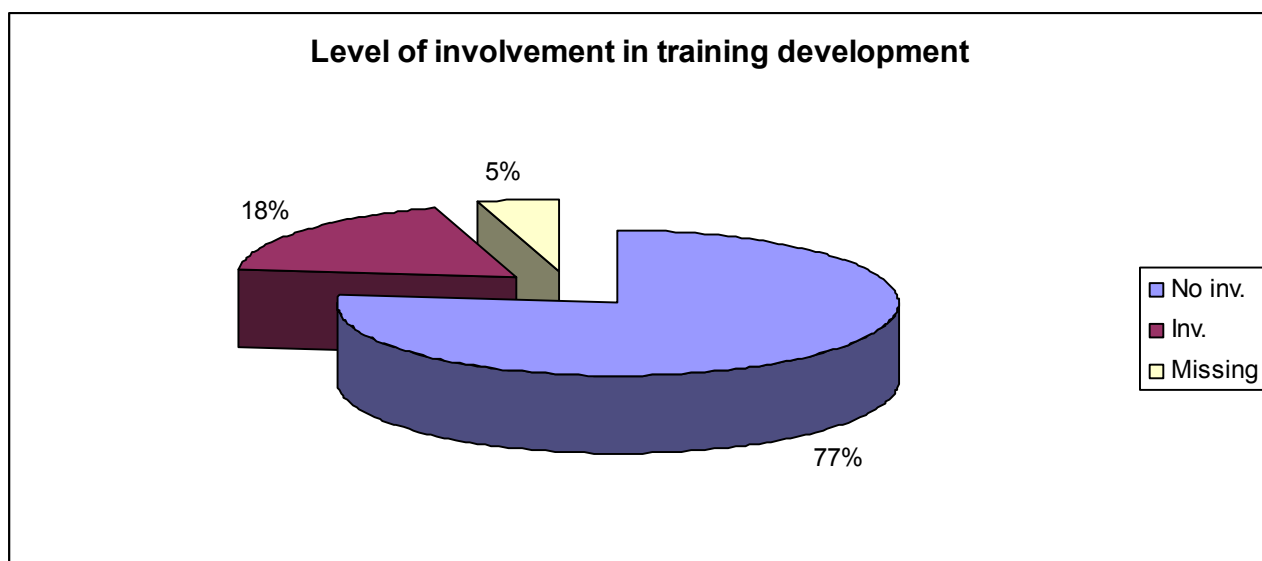


The type of qualified trainers more used in the training programmes were Anthropologists 21%, followed by University professors of various disciplines, 20% and Cultural Mediators, 18%. Experts in other fields (reported as consultants), 12%, Sociologists, 10% and Lawyers, 7%. Other type of trainers included, Economists, Philosophers, Art-therapists, Managers and Priests.



#### *Involvement in development of training*

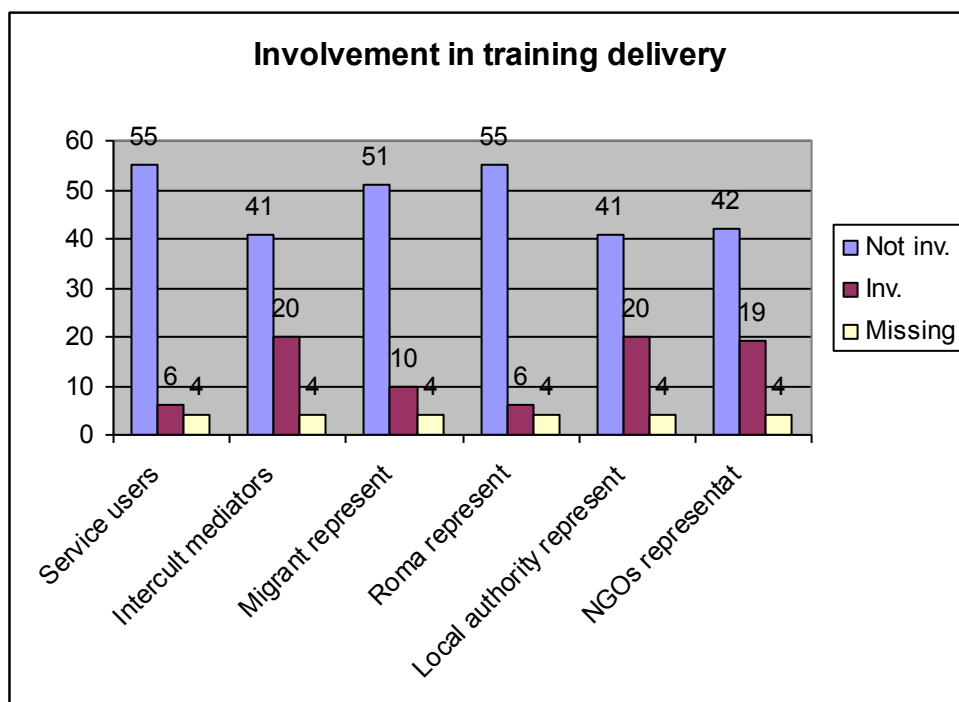
The general level of involvement of relevant stakeholders and service users is quite low, 18%. NGO representatives are the more frequently involved group in the development of the training programmes, being involved in 21 of the 65 programmes identified, Cultural Mediators in 17, Local Authority representatives in 15, Migrant representatives in 8, Roma representatives in 2.





#### *Involvement in delivery of training*

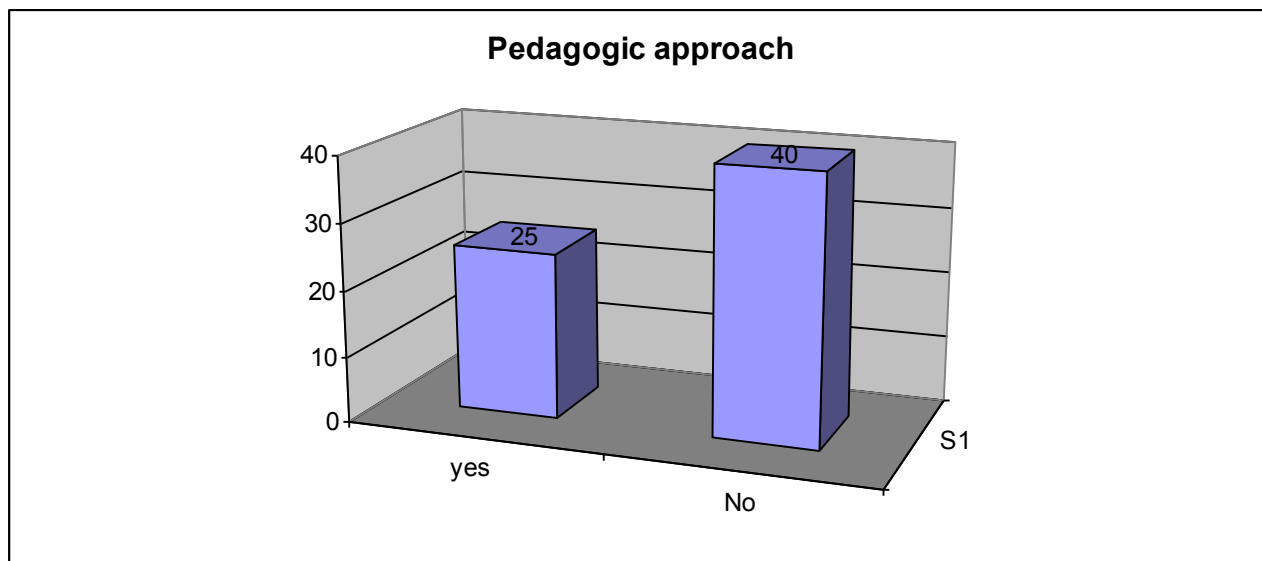
The level of involvement and the distribution of groups involved are quite similar for training delivery. Local Authority representatives (20 times), NGO representatives (19 times) and Cultural Mediators (20 times) are the more frequently involved group in the delivery of the training programmes. Migrant representatives 10 times, Service users and Roma representatives 6 times.



#### **Domain 4: Training approach**

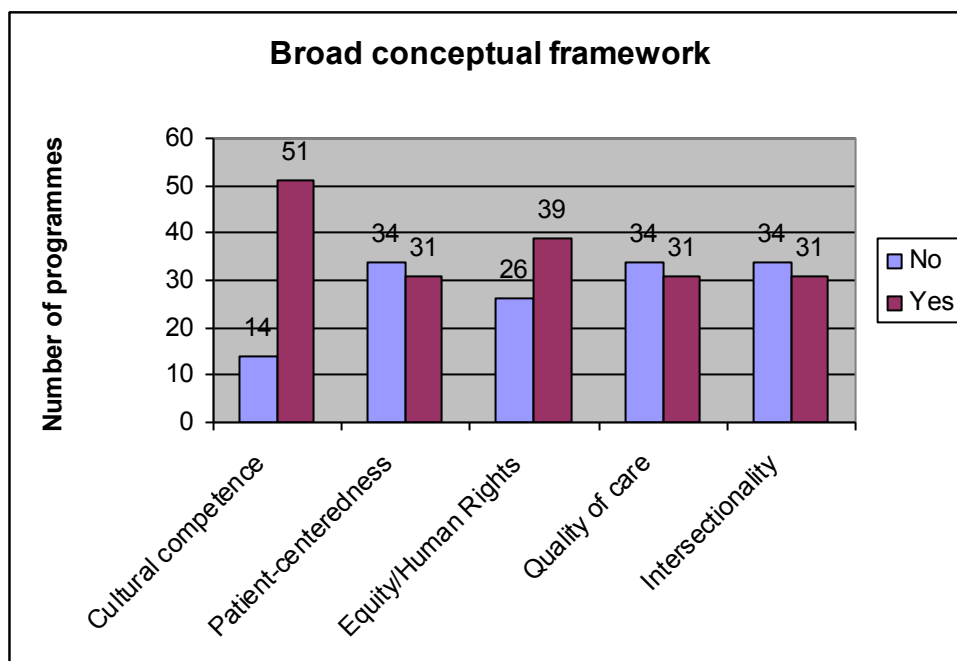
##### *Pedagogical approach adopted for training*

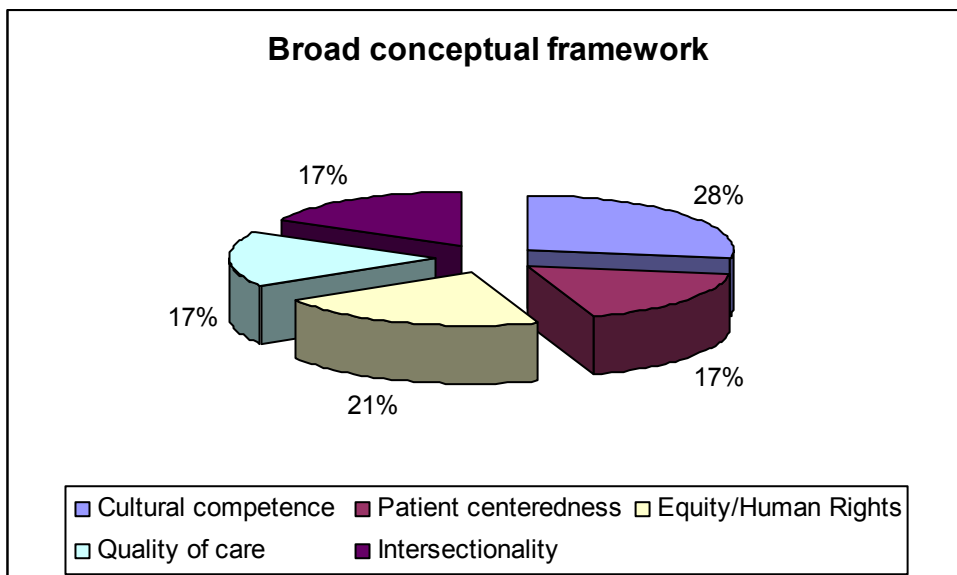
25 of the training programmes described their pedagogical approach, including the teaching and learning method used, and the theoretical constructs and principles that underpin it. The other 40 programmes just described the methods of training delivery.



*Broad conceptual framework adopted for the training*

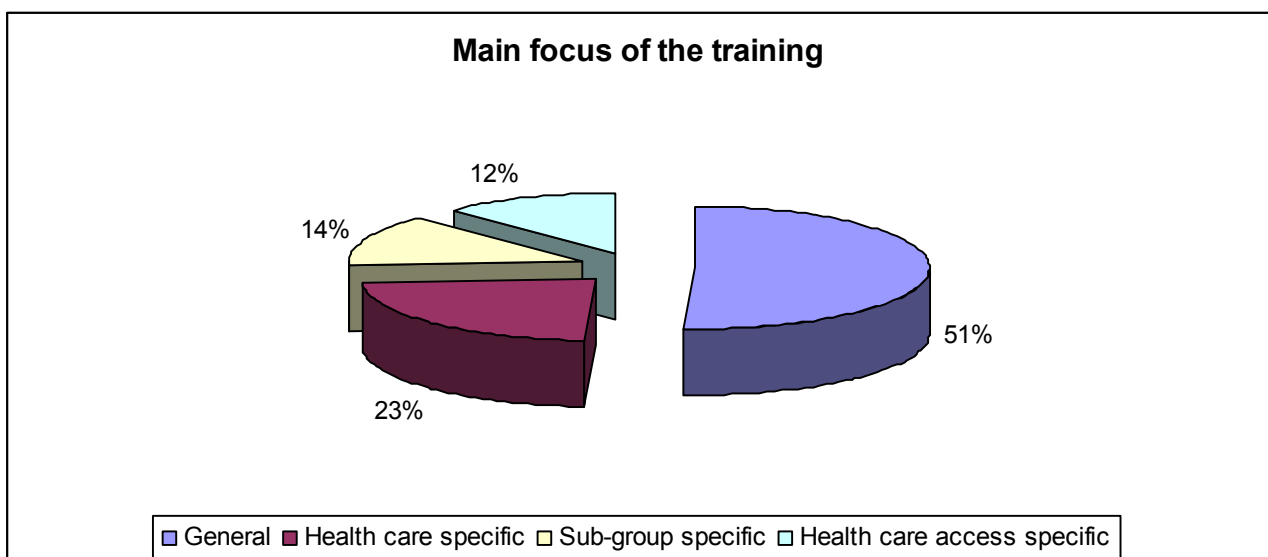
Cultural competence proved to be the most, 28%, adopted framework for the training programmes identified, followed by the Equity/Human Rights approach, 21%. Patient-centeredness, Quality of care and Intersectionality, were indicated in the 17% of cases (See appendix for definitions).

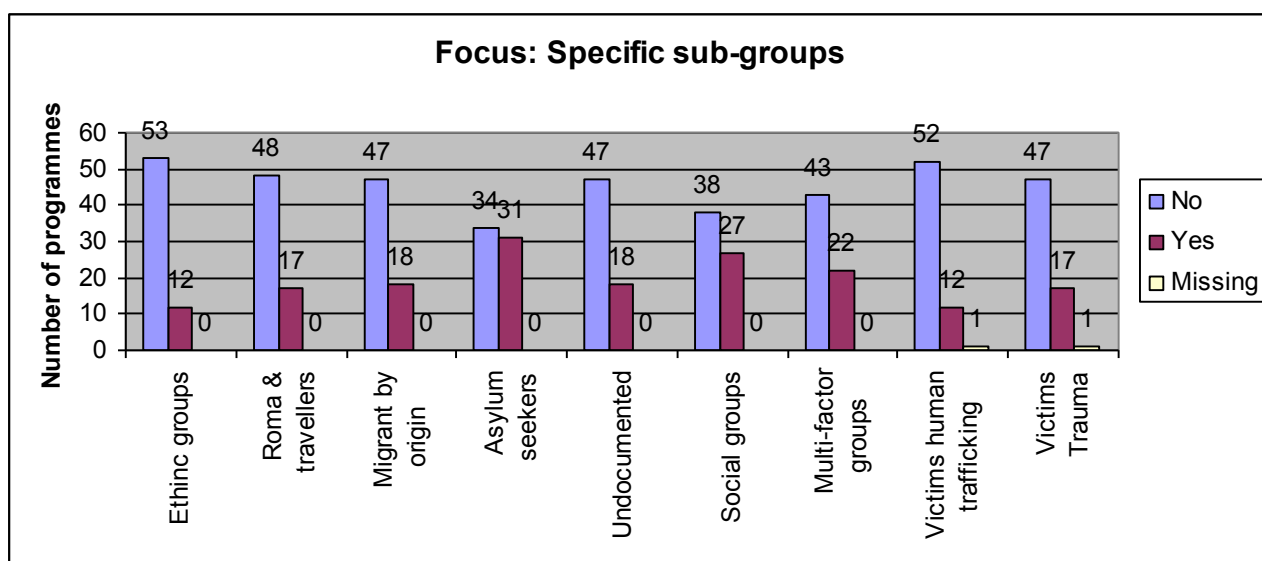
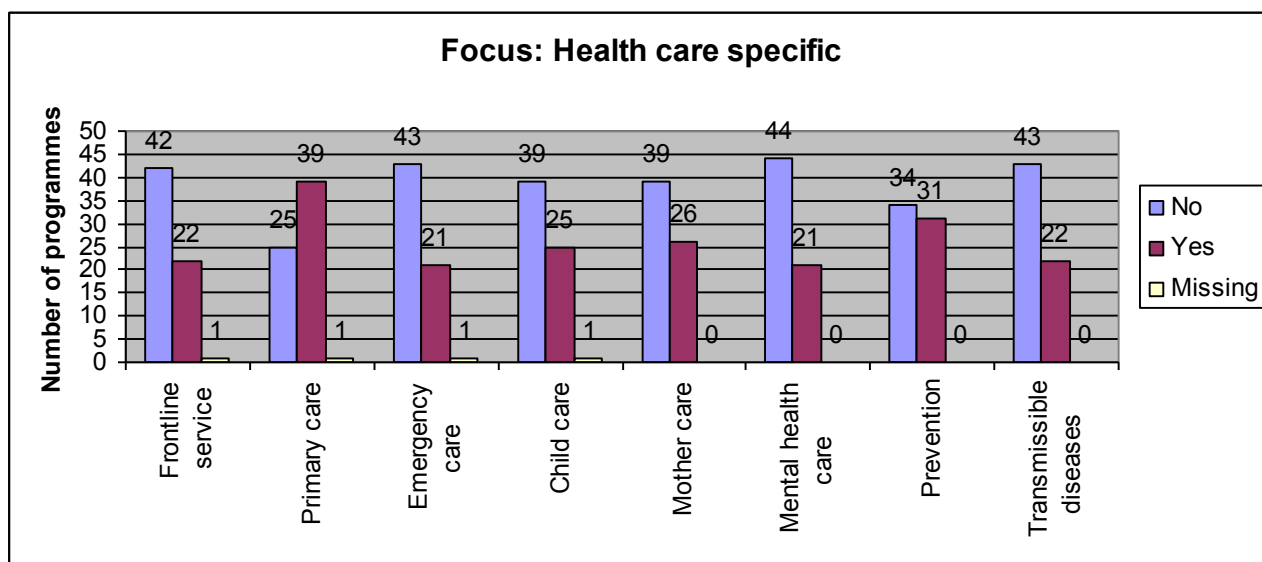
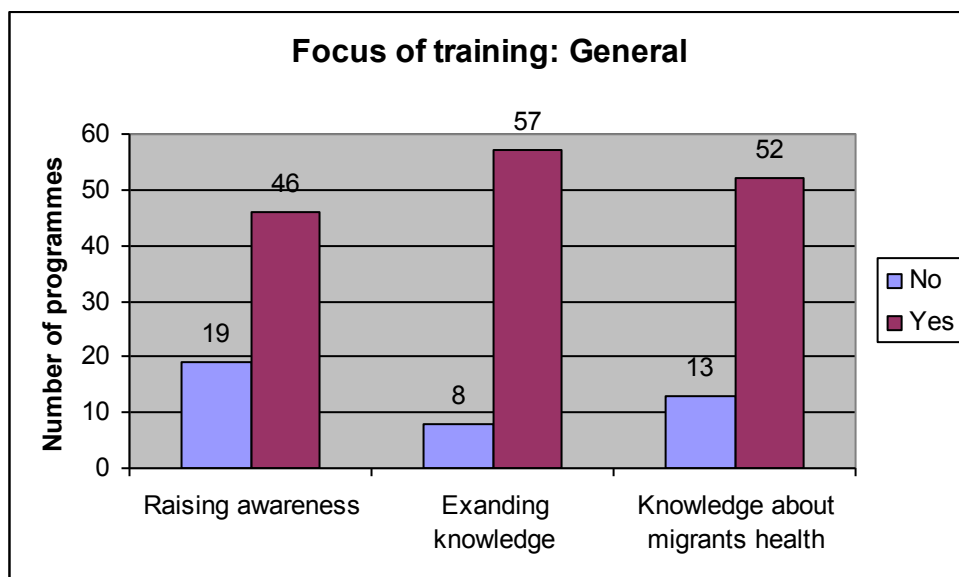


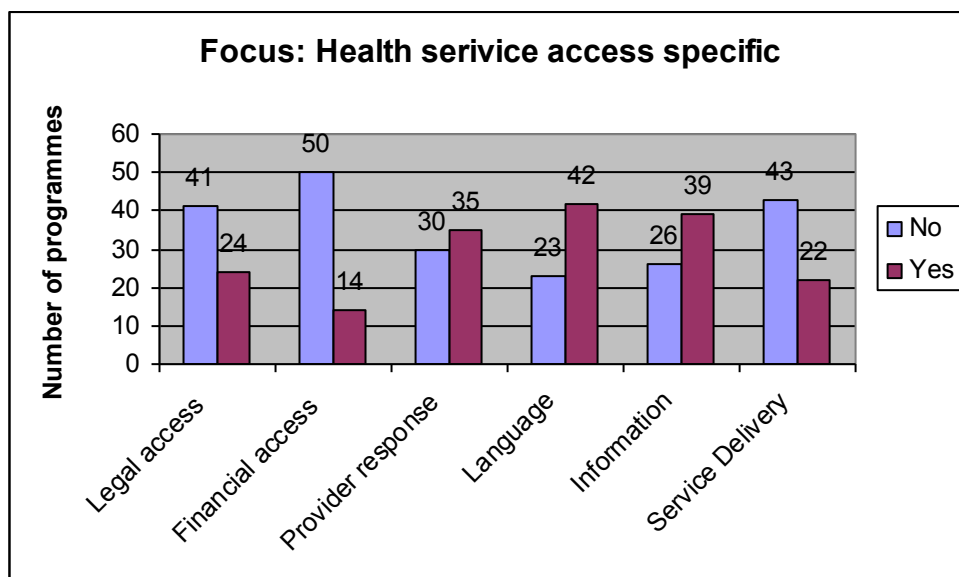


### *Focus of training*

The majority, 51%, of the training programmes focused on general improvement of awareness and expansion on knowledge to work with migrants and about migrants' health and situation. 23% of the programmes focused on specific health care services, such as primary care, emergency care, mother and child care, mental health care, prevention and transmissible diseases. 9% of the programmes focused on specific sub-groups identified by ethnicity or country of origin; by migration status, such as asylum seekers and undocumented migrants; by social status or multi-factors of inequality, such as victims of human trafficking and trauma, pregnant migrant women or children with undocumented parents. Finally, 8% of the programmes focused on specific issues related to health care services' access, such as legal and financial barriers, provider responsiveness, language and information barriers and barriers at service organisation and delivery level.



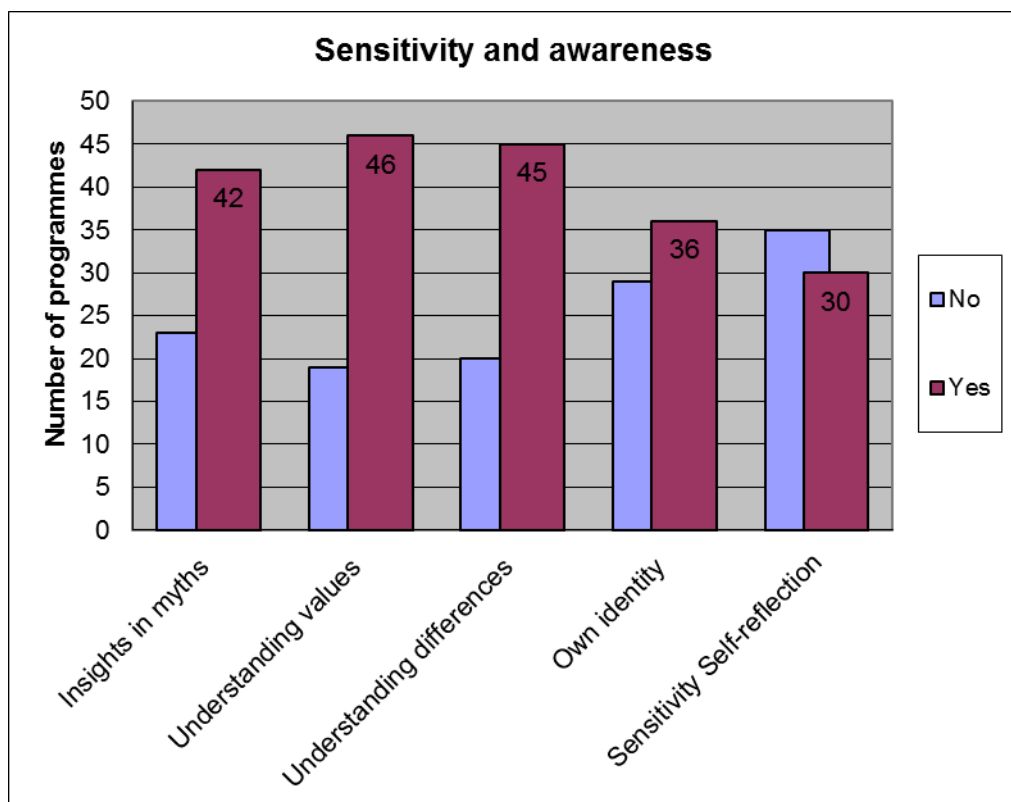




### **Domain 5: Educational content**

#### *Sensitivity and awareness*

Overall the majority (70%) report on one or more aspects of the component Sensitivity and awareness. Understanding individual values, beliefs, behaviours and basic assumptions was most addressed: in 46 trainings (70%). Understanding (human) differences and similarities was addressed slightly less, in 45 cases (69%). Insight in myths and beliefs about migrants/ethnic minorities/Roma people was represented (42 times, 65%). Addressing one's own identity and prejudices was reported 36 times (55%). In less than half of training courses, 30 times is 46%, attention was paid to Self-reflection and self-critique in relationship with the other. Interesting is the relation between the *high* frequency of 'Understanding individual values, beliefs, behaviours and basic assumptions' (70%) and 'Understanding (human) differences and similarities' (69%) and the *low* reporting of Self-reflection and self-critique in relationship with the other (46%).



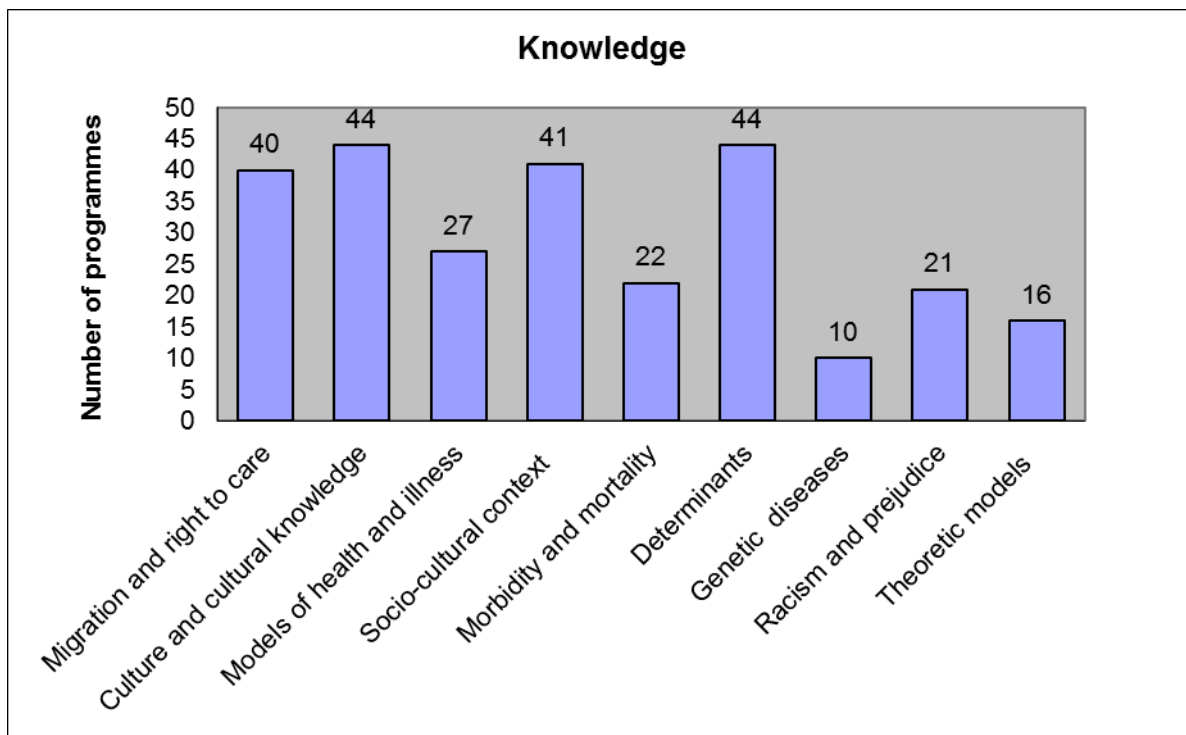
The template offered an option to specify the component Sensitivity and awareness, see the table below for the results:

Diversity, intersectionality	1 time
Negotiating values, identities and outcomes	1 time
Health behaviours; views about illness and sickness	3 times
Practice in rising awareness on prejudices. Discussion on ethical aspects of equity/accessibility and financing of care;	1 time
E-learning covers all of these areas though not in much depth. Because it is text-based it cannot effectively encourage self-reflection to any great extent	2 times

### *Knowledge*

Considering the knowledge-part of the educational content, four most reported themes emerge: Migration and the right to health care (62%), Culture and cultural knowledge (68%), the social-cultural context of health inequalities (63%) and Determinants of health (68%). The Models of health and illness were reported in 42% of the cases. This implies a substantial anthropological component in the reported 42% of trainings. These Models of health and illness could show overlap with Specific theoretic models such as explanatory models of health and illness, but this component was reported only 16 times (25%). We cannot simply add those two together. Knowledge about 'Morbidity and mortality patterns' was represented 22 times. Constructs of racism and prejudice was detected in only 32% of the trainings (21 times). Least attention is paid to Specific genetic diseases (10 times, 15%). Interesting in the component "Knowledge" is that the most themes represented in the trainings are non-biomedical.





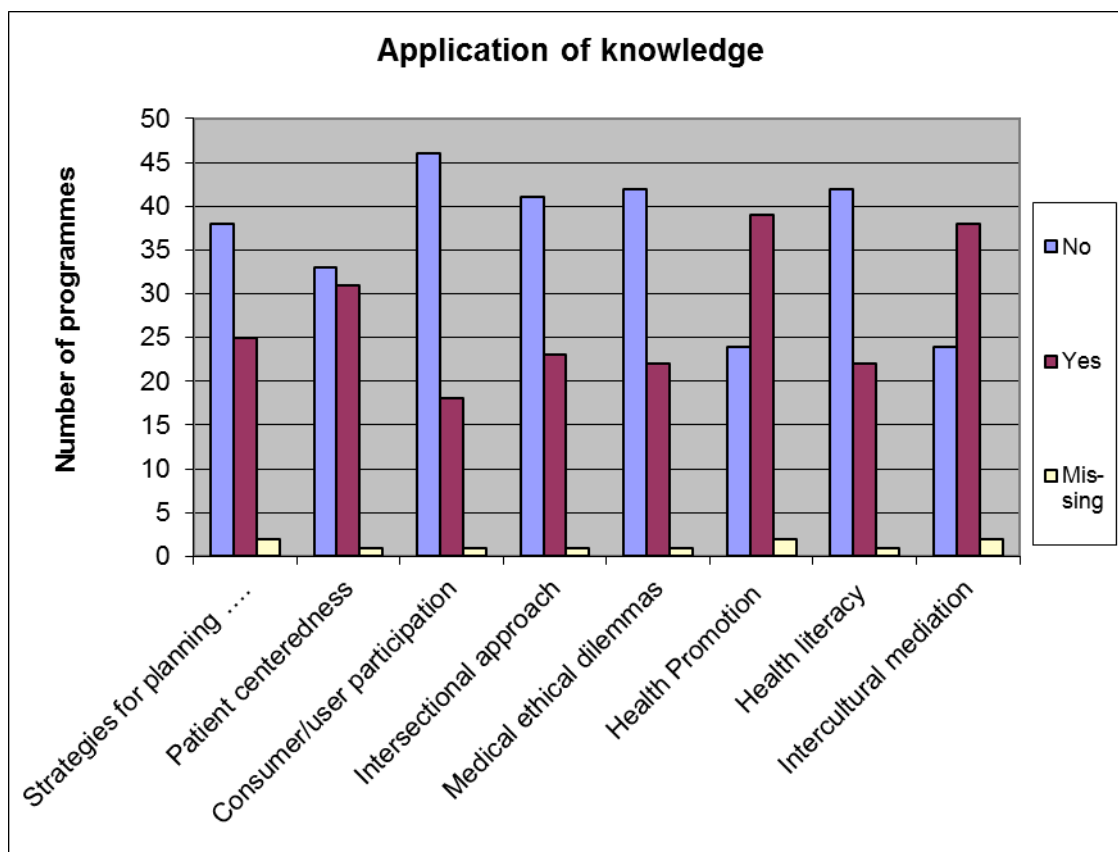
The template offered an option to specify the component Knowledge. Three aspects were represented:

- Theoretical model of cultural competence;
- Occupational health; and
- Risk factors for suicide.

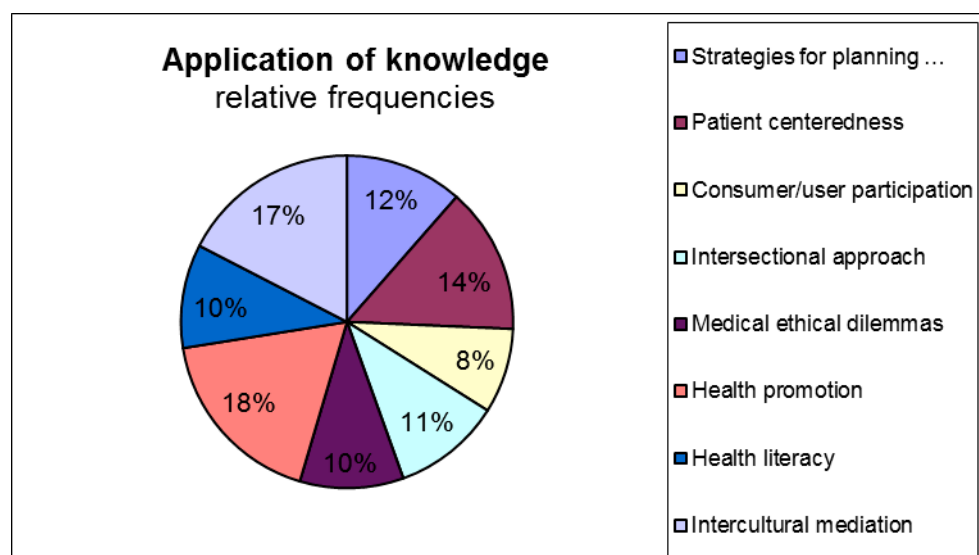
#### *Application of knowledge*

Intercultural mediation and health promotion are by far the most identified (both in 60% of the training programmes) in the component Application of knowledge. This may be the case because, as mentioned in the component above Targeted Workforce, many of the training courses we found were targeted at intercultural mediators (48%) or Roma mediators (15%).

The broad and trending-topic Patient centeredness is reported in almost half of all trainings (31 times, 48%). The Intersectional approach, Medical ethical dilemmas and Health literacy are reported equally (23, 22 and 22 times, 35% and 34%). As displayed in the histogram below the variable Application of knowledge, Strategies for planning, and implementation of activities in contexts was reported 25 times. Least reported was Consumer/user participation (18 times, 28%).



In the pie chart below one can see that the elements of the component Application of knowledge are fairly equally distributed, the variable Consumer/user participation being relatively least reported (18 times, is 8% of the total of 218 times the variables of the component Application of knowledge were reported).



The template offered an option to specify the variable Strategies for planning and implementation of activities (...), see the table below for the results:

Building connections to NGOs and migrant organisations	2 times
Useful checklists for health professionals, interview questions and guidance	1 time

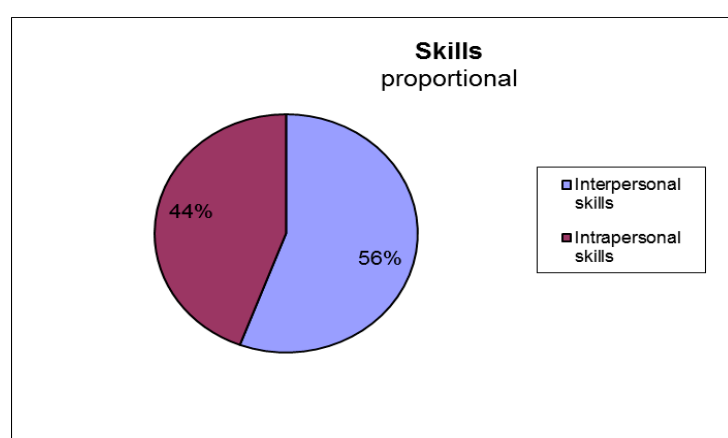
How to achieve good communication – tone of voice, body language, verbal and non-verbal communication in the workplace	1 time
Role playing, Professional work scenarios, Professional charts, Team supervision	1 time
Ability to work in interdisciplinary and inter-institutional teams in order to coordinate health and social interventions	1 time

The template offered an option to specify the component Application of knowledge, three aspects were reported in this:

- Conducting research and teaching students;
- The training developed knowledge about the potential for plans, policies and decisions to impact on different people in the community;
- Capacity building (2 times)

### *Skills*

Interpersonal skills were reported 39 times (60%) and intrapersonal skills 31 times (48%).



The template offered an option to specify the variable Interpersonal skills, see the table below for the results:

Tips in communication with asylum seekers and refugees, women and girls affected by Female Genital Mutilation	1 time
How to recognise prejudice and discrimination in the workplace, how to apply skills to promote good communication	1 time
clinical and documentation skills relevant to victims of torture	1 time
Training of communication skills needed for mediation and health education practice	5 times
Based on the cultural competence approach and understanding of the transference/counter-transference dynamic in interactions	1 time
Working with interpreters	2 times
Intercultural communication skills	1 time
Working with NGOs	1 time
Diversity management	1 time
Mainly practicing communication skills by role-play	1 time

The template offered an option to specify the variable Intrapersonal skills, see the table below for the results:

Deconstructing stereotypes, attitudes	2 times
Understanding of the transference/counter-transference dynamic in interactions, reflexivity based on the cultural competence approach, "critical incidents" method	1 time
Self-reflection about ethnocentrism	1 time
Understanding diversity, acceptance; openness, tolerance	1 time

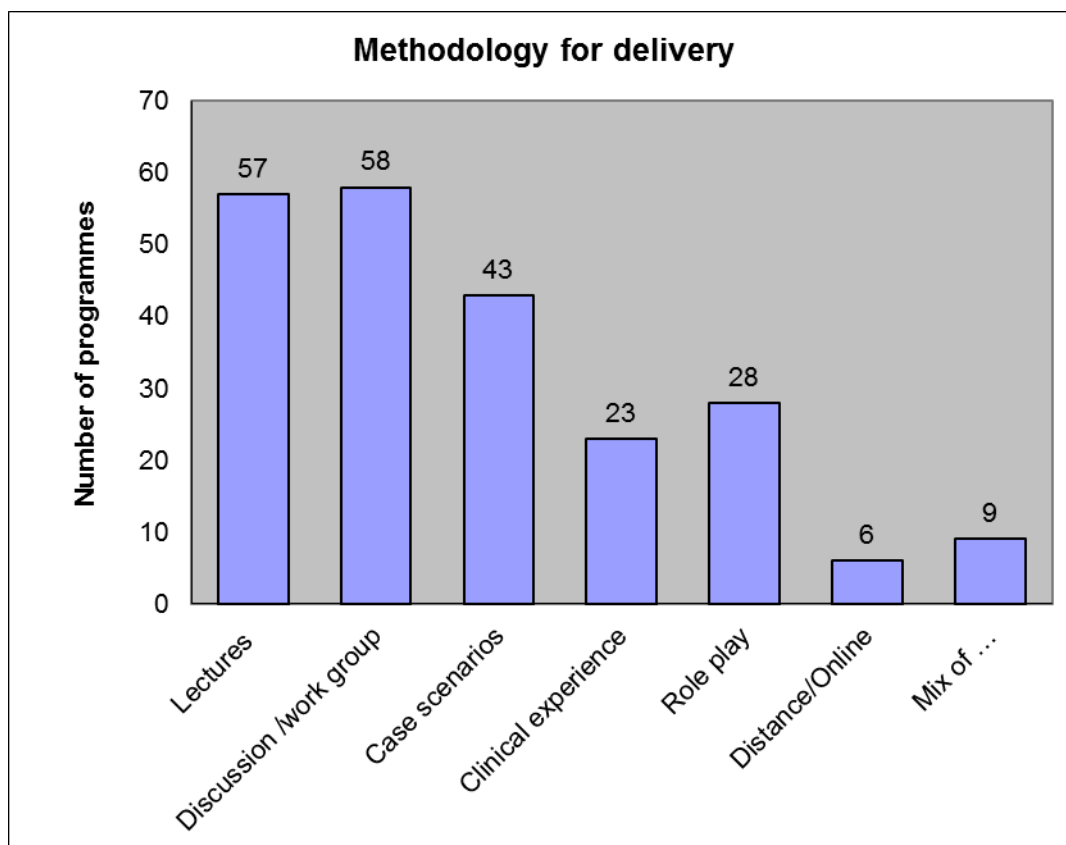
The tables here above show that less specification is reported on intrapersonal skills (5 times) when compared with the interpersonal skills (15 times). What is mentioned as a specification of intrapersonal skills is mostly suggested as an example specification in the template design.

In the Intrapersonal skills variable, the specifications that are mentioned (e.g.: Reflection, Attitudes and Deconstructing stereotypes) show an overlap with all variables of the Awareness and sensitivity component of the domain Educational content (described above). Overall the intrapersonal skills correspond with the Awareness and sensitivity component, mostly with the variables understanding individual values and understanding human differences.

## ***Domain 6: Structure of the intervention***

### *Methodology for delivery*

In the majority of training courses lectures (57 times, 88%) and discussions/work group (58 times, 89%) are used as a methodology for delivery. Case scenarios are reported in 66% (43 times) of training programmes. Role play was reported in 43% (28 times). Clinical experience is reported 23 times (35%), whereas in the component of Training needs development Situational analysis and Staff needs assessment were reported in together almost half of the training courses (49%). A mix of methods was reported 9 times (14%). Distance/online methodology was reported in few training courses (6 times, 9%).



The template offered an option to specify the variable Mix of ..., see the table below for the results:

Lectures, Discussion/work group and Case scenarios	4 times
Lectures, Discussion/work group, Case scenarios and Role play	1 time

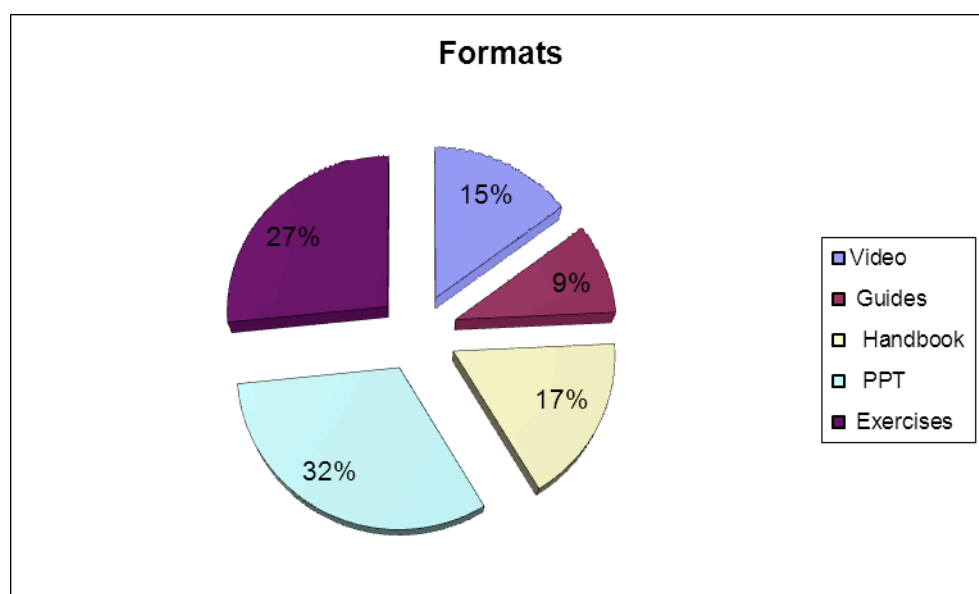
The template offered an option to specify the variable Other methodology for delivery, see the table below for the results:

Interviews with migrants / results from previous research studies
Simulation games, field visits
Homework after and before each session and one self-chosen practice improvement project during the whole year - this is done mostly by small groups of participants
Testing of the tool on participants' own examples

### *Formats*

Considering the format that was used, there is a wide variation among the categories.

Most reported format is the PowerPoint (PPT) presentation (54 times, 83%) which coincides with the most reported method of delivery: lectures and discussion/work group. Exercises are reported in 69% (45 times). A handbook is represented in 45%, video in 38%. Content guides are least reported, only in 25% of training courses.



The template offered an option to specify the component Formats, see the table below for the results:

Visit to NGO's
Virtual presentations, self-assessment quizzes, links to report, and audio-visual material
E-learning, legal cases, legal standards
E-learning, discussion forum
Good practice examples
Supporting materials on content (briefs, reports)

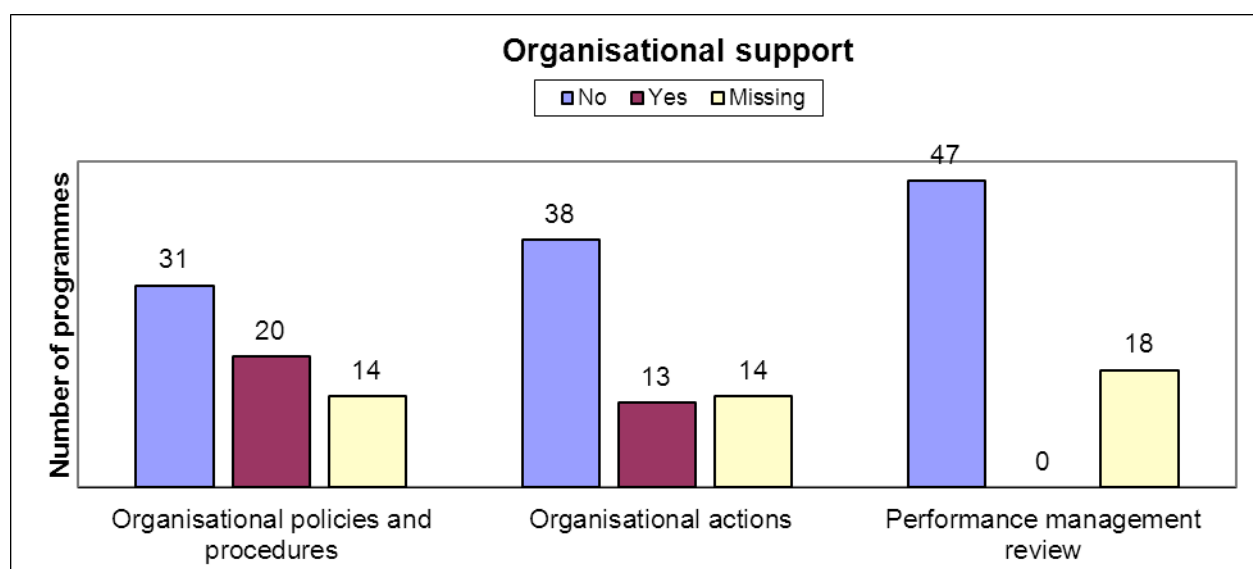
E-learning was mentioned three times as a format. There was overlap in one training course: on the component Methodology for delivery was reported Distance/online in the case of that particular training course. The visit to NGO's seems logical, as NGO's are in most cases the developer of the training.

### *Organisational support*

As a whole, the component Organisational support is not often reported in the 65 templates.

In 20 programmes out of 65, representing 31% of the cases, Links to organisational policies and procedures were detected. Links to any other organisational actions (for example mentoring support, the professional development program) were identified in 20% of the cases.

No links to performance management review (for example incentive policy) was represented.



The template offered an option to specify the variable Links to organisational policies and procedures, see the table below for the results:

Links to legislation, multi-sectorial guidelines etc.	1 time
Links to the national Government's policy on migrant integration	1 time
Reports from Migrant health clinic	
Life-long learning	1 time
Event organised within a multicentre project financed by the Ministry of Health	1 time
CEO and Medical Directors were invited to discuss the outcomes of the training and to make hypothesis on future policy measures connected to them.	1 time
IASC guidelines on MHPSS in Emergency settings and related tools	
National policy on equality and diversity, Health Inequalities Strategy and/or equality impact assessment	5 times
IOM	2 times
Hospital districts have obligation of the staff training in Finland (based on the law)	2 times
Tends to be integrated in the hospital's continuing education program	1 time

NB: It is noteworthy that in seven of the 20 cases links to national policy was reported (see footnote 17).

The template offered an option to specify the variable Links to any other organisational actions, see the table below for the results:

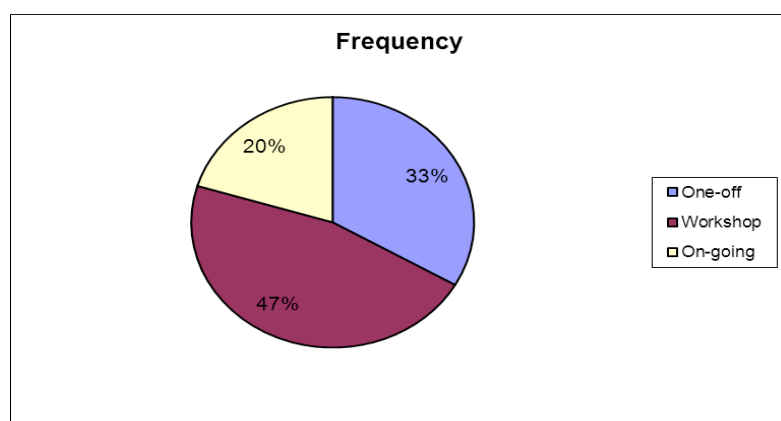
Most participants get subsidies for the workshop fees from their employees out of the training budget and participate during their working time	1 time
Links to ministry of health responsibilities as determined by the migrant integration policy <sup>18</sup>	1 time
Supervision and acute contact to migrant health clinic	1 time
Links to professional development programs	1 time
Competence Centre	1 time

<sup>18</sup> This is also a link to national policy, that is why the number of links to national policies in the previous section ('Links to organisational policies and procedures' is adds up to seven)

Development of recommendations for the organisation	1 time
IOM MHPSS assessment tools & interagency tools	1 time
Linked to monitoring of all new policies, plans and decisions developed by NHS Lothian to ensure compliance with legislation	1 time
Hospital districts have obligation of the staff training in Finland (based on the law)	2 times
The professional development program	1 time

### Frequency

47% of the training courses (32) consisted of a series of workshops/seminars/course in a limited time period. 33% of the training courses (23) was a one-off training event, and in 20% of the cases the course (14) consisted of on-going training. Four training courses (6%) reported being a one-off event, containing a series of workshops/seminars/courses in a limited time period. Three training courses reported no data regarding the frequency of the course.



The template offered an option to specify the component Frequency, see the table below for the results:

As an annual start of the course
Whenever possible
Once or a number of times at the hospitals and primary care centres our service is collaborating with

### Duration of each course

Most of the training courses (26 times, 40%) reported a course duration of 1-3 days. In four cases the duration was half a day. Besides the long-term courses, mostly Master courses that lasted from one to 2,5 years, there were five courses that last (a period of ranging from) three weeks to one year. In this period there were several sessions. See the table below:

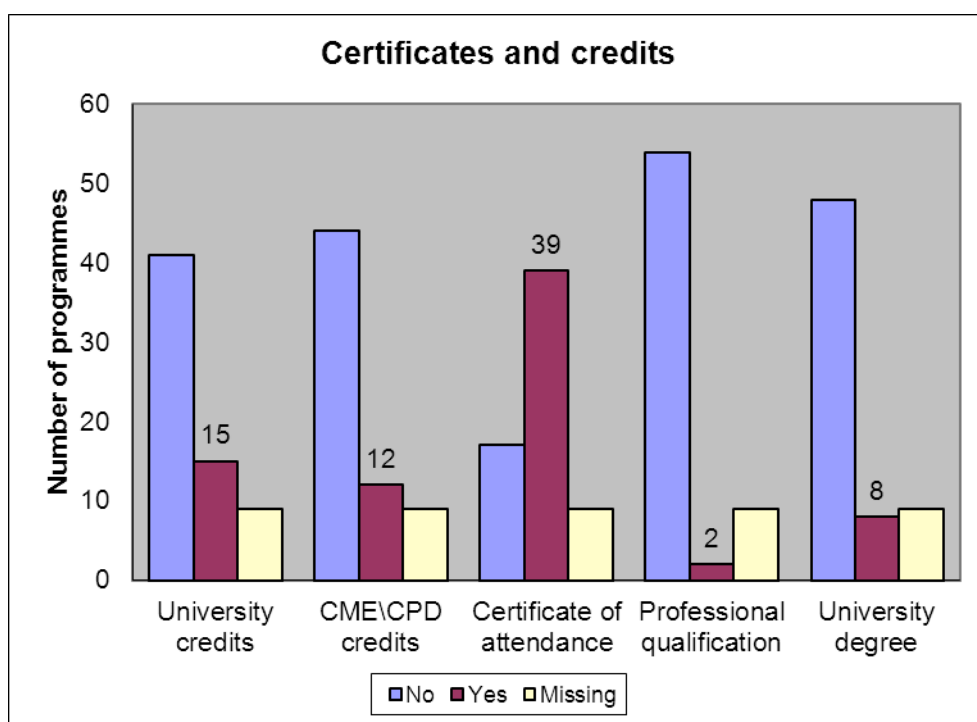
Duration of each course:	Represented:
2-2,5 years (master's courses)	2 times
One year	4 times
348 hours	1 time
One year training, once a month for 2 days	1 time



Conducted from Nov 2012 to Oct 2013	1 time
One-two weeks	4 times
8 sessions of 4,5 hour spread over 1 year	1 time
4-6 days	6 times
3-4 days	1 time
2-3 days	15 times
1 day	11 times
½ day, 1 day, 2 days or 3 days	1 time
3-4 hours	3 times
Initially one full day, then reduced to a half day	1 time
1 hour x 10 sessions	1 time
Completion of the e-module typically takes 1-2 hours	1 time
One day for 6 months	1 time
One day for three weeks	1 time

### *Certificate and credits*

The certificate of attendance was most reported: 39 times (60%). University credits were found 15 times (23%), CME/CPD credits twelve times (18%), a university degree in 12% of cases. Finally, a professional qualification was identified two times. In a relatively large number of cases (nine, corresponding to 14%) no data were reported on this component Certificates and credits.



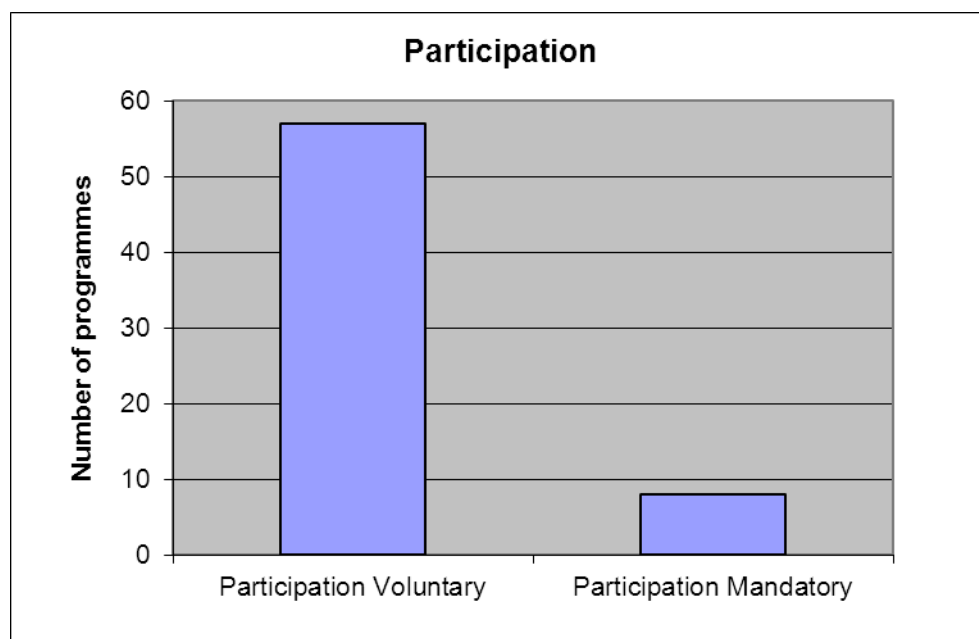
### *Tuition fee*

About one third of the cases (34%) reported tuition fee. Nine times (14%) tuition fee for individuals was noted, ranging from 'free for hospital staff/students 20€/externals 40€', 65€, 400€ and 770€ for two days, 1650€ for two weeks. Individual tuition fees for Master courses range from 1000€ (2 years) to 9000€ and AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

12500€ for a Master's course with the duration of one year. Many individuals' tuition fees are sponsored by the organisations. Seven times (11%) a tuition fee for organisations was identified. The reported amounts varied from 398€ to 1600€.

### *Participation*

The vast majority, 88%, of cases reported voluntary participation. In the other seven cases mandatory participation was mentioned.



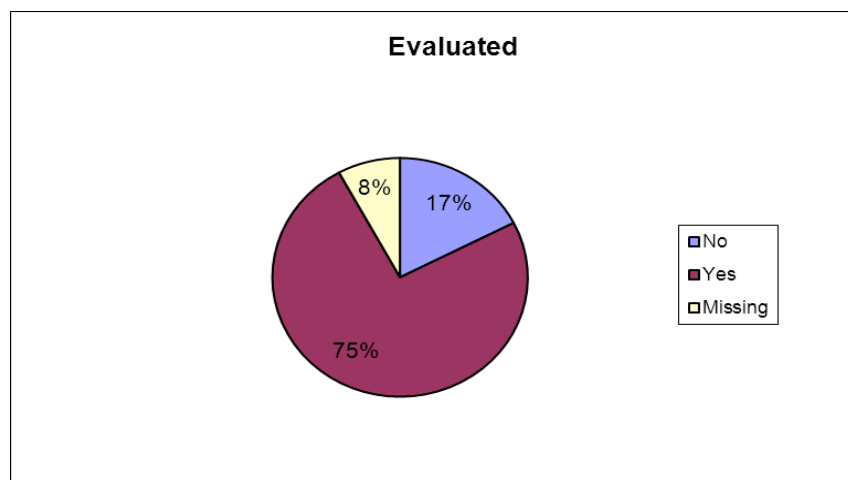
The template offered an option to specify the variable Mandatory participation; below are the represented specifications:

The participation of GPs and nurses was a municipality task. The municipality should ensure the participation of GPs and nurses. The Participation of Roma Health Mediators was voluntary	1 time
Participants must pass through a competitive process - conducted by the Scuola Superiore Sant'Anna and the IOM - in order to be admitted to the course. Once admitted, attendance of at least 80% of classes is mandatory in order to get the final certificate	1 time
When delivered as part of BSc Nursing course	3 times, all from Malta
All staff are required to complete the e-module on beginning their employment with NHS Lothian (as part of induction) and then every two years afterwards. Compliance is limited, with only around 40% of staff actually meeting this requirement	1 time

### **Domain 7: Evaluation and outcomes**

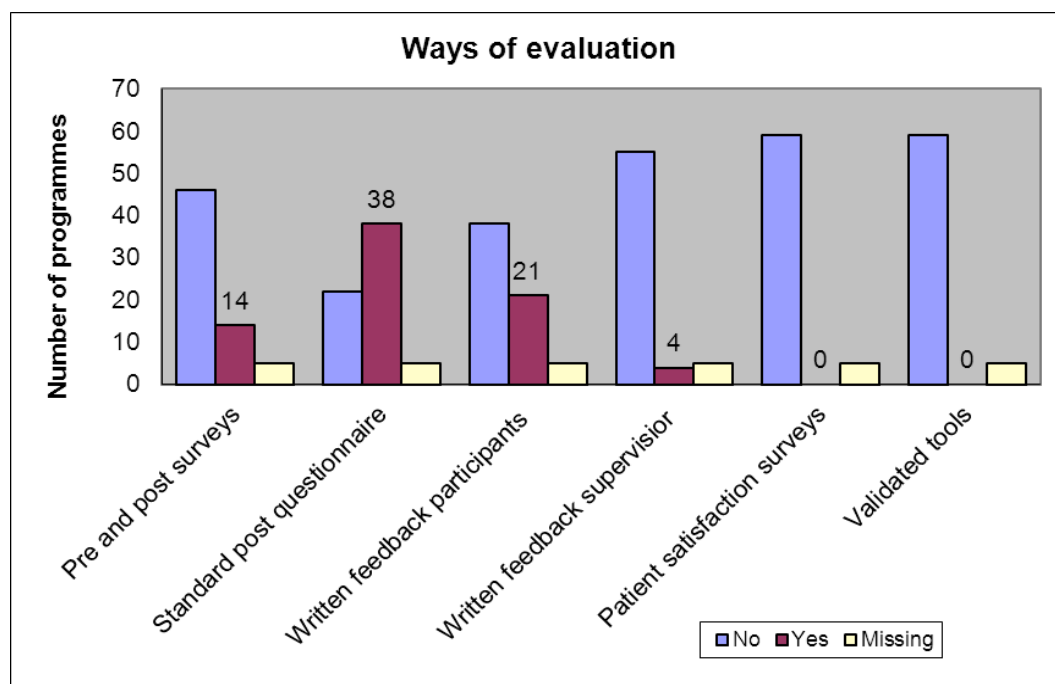
*Was the training evaluated?*

The majority of training courses, 75% which is 47 times, was evaluated. In 17% of the cases the training was not evaluated. And in 8% of the cases (five times) no information was provided on the occurrence of an evaluation.



#### *How was the training evaluated?*

Most identified was a standard post training questionnaire, in 58% of the cases, which is 38 times. In 32% (21 times) of cases written feedback from participants was reported. Pre-and-post surveys were detected 14 times, which is 22%. Written feedback from supervisors or managers was seldom found, only in four cases. In several cases the use of more than one evaluation method was represented. In all four cases in which written feedback from supervisors or managers was reported, three or more evaluation methods were reported. Patient satisfaction surveys were never reported as a means of evaluation. Moreover, no validated evaluation tools were reported.



The template offered an option to specify how the training was evaluated, see the table below for the results:

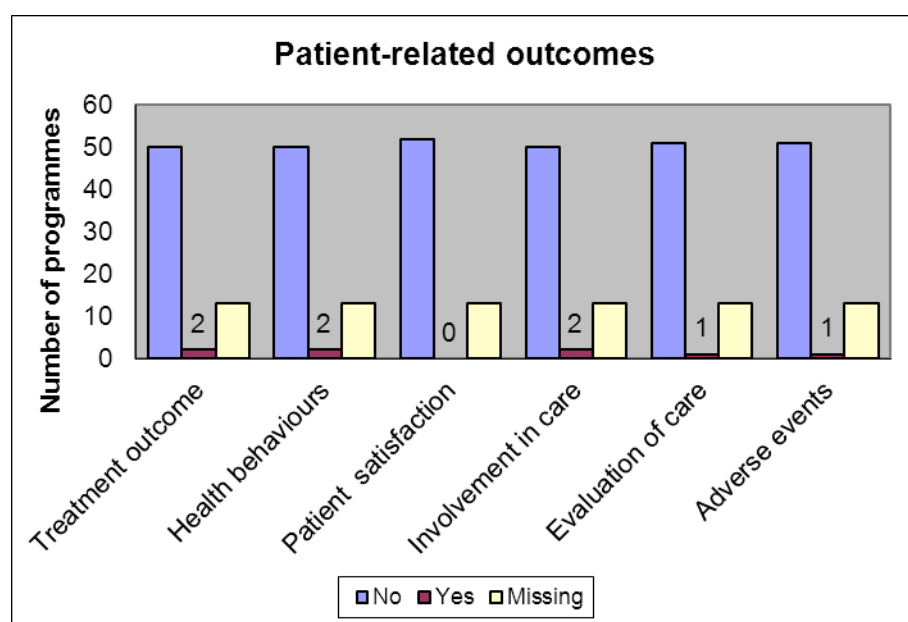
Oral evaluation at the end of the last training day was reported	2 times
Qualitative interviews with participants	1 time
Qualitative evaluation with focus group interviews and analysis of reflective diaries	1 time
Oral and written evaluation, ongoing in every session on satisfaction and on performance and structure, by the scientific coordinator and the project officer (management)	1 time
Evaluation was taken care of by project coordinator (management)	1 time
Internal evaluation involving feedback from recent training participants	2 times
External evaluation carried out by another NHS organisation, involving a focus group of recent training participants	1 time
Oral feedback of participants at the end of the session (no other means of evaluation)	3 times
Oral evaluation after the final training (duration of total training 2 days)	1 time

### *What type of outcomes of the training were measured?*

Given our findings (see above) that 75% of the training courses were evaluated, the representations on the three subcomponents (here below) are interesting; indicating that not much was reported on the types of outcomes that were measured.

### *Patient-related outcomes*

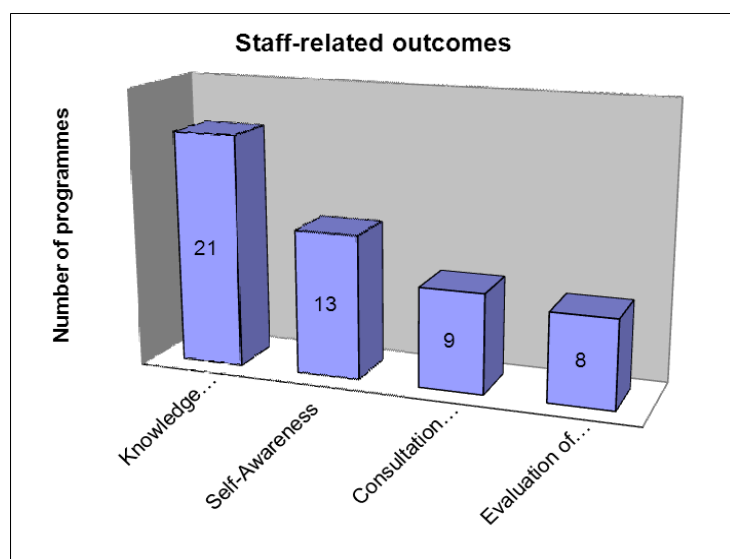
In only two cases (3%) patient related outcomes were represented. Treatment outcome, health behaviours and involvement in care were reported twice. Evaluation of care and Adverse events were found once. Effects of the training on patient satisfaction was never detected. In 13 cases the data on patient-related outcomes were not provided, as respondents did not fill out this part of the template. Although the template offered an option to specify the variable patient-related outcomes, no specifications were found.



### *Staff-related outcomes*

The variable Knowledge and understanding was most found on the sub-component Staff-related outcomes: in 21 cases, still representing only one-third of all training programmes, 32%. Lower was the number of AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

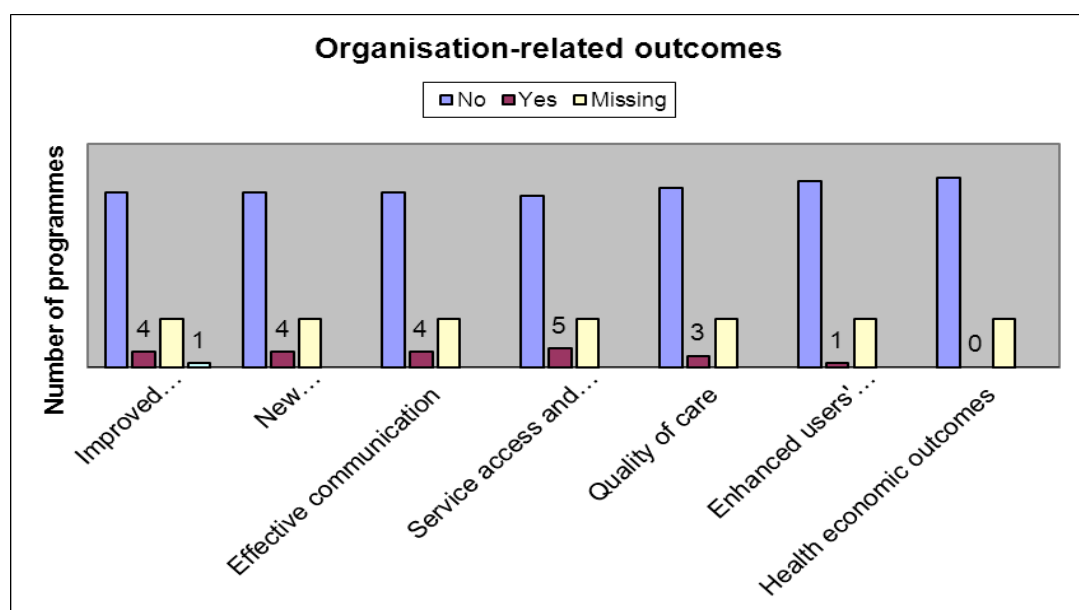
reporting on Self-awareness of their own culture and the culture of bio-medicine and its impact on patients, this was detected in 20%, 13 times. Consultation processes and Evaluation of processes and outcomes were observed nine and eight times respectively (12% and 14%). No data on any staff-related outcome were reported in 13 training programmes.



In one (IOM) training programme it was reported that "outcome measurement are under discussion".

#### *Organisation-related outcomes*

Considering Organisation-related outcomes the number of cases represented was again very low. Service access and utilisation was noted five times (8%). Organisation-related outcomes as Improved policies and procedures, New programmes interventions and guidelines and Effective patient-provider communication were each reported four times (6%). Quality of health care was reported in three of the cases (5%). Enhanced users' involvement was represented only one time, and Health economic outcomes were never represented. In 13 templates no data on Organisation-related outcomes were provided.



## CHAPTER 5: DISCUSSION AND MAIN FINDINGS OF THE SURVEY

As described in the results section, the domains of the conceptual framework developed for this review were addressed in some way by most training programmes. The following discussion highlights some of the strengths, gaps and overall trends extrapolated from the results. It is not an exhaustive analysis of each variable within each domain. Further analysis of key quality dimensions and correlations of variables within and across domains is discussed in the next chapter.

### ***Domain 1. Training description***

*Aims and objectives:* A wide variety of training aims and objectives were described, the most common focusing on improving the competence and skills of health care professionals. There was a lower level of focus on improving the health of and health care access for vulnerable communities such as refugees, asylum seekers and the Roma. Aims such as addressing racism and discrimination and improving healthcare for undocumented migrants, was very low (only 2%).

*Training need:* Within the training description domain the process of determining training need can be described as a continuum with several approaches described. Undertaking a situational analysis and responding to policy and legislative needs (both 26%) at one end, responding to patient needs and management decisions (both 15%) in the centre, and undertaking an organisational analysis (10%) towards the end and epidemiological analysis at the very end in only in 2% of cases. This is of note, given that in many countries current epidemiological data ascribing under-service utilisation and poorer health outcomes to specific migrant, ethnic minority and indigenous groups is robust and accessible. The issue here is that despite the availability of this data, holistic and systemic approaches to addressing this issue is still underdeveloped.

### ***Domain 2. Training development and delivery***

*Type of training developer:* Training development is dominated by academic institutions and national or regional government agencies. Of note in this regard is the relatively low level of involvement of other agencies such as NGOs (18%), international organisations, such as IOM and WHO Europe (15%) who arguably may have specific knowledge and expertise in health disparities and healthcare access inequities for migrant, ethnic minority and vulnerable groups.

*Setting of delivery:* There are low levels of training delivered in other mainstream settings such as in Community settings (10%), Health Centres (9%) and in non-mainstream settings such as Migrant Reception Centres (2%) and only one training programme were delivered in a Roma people settlement.

*Funding source:* Less than half of the training programmes allocated funding and resources to the evaluation component (only 28 programmes) comparative to funds allocated to the training development and delivery component. This is of note as we have previously described the overall lack of focus on evaluation and outcomes inherent in many training programmes. It is clearly imperative to be able to establish what the training programme achieved and how it did this. This issue also correlates directly to the aforementioned lack of focus on specified outcomes for training and an underdeveloped evidence base in this field linking education interventions to improved health outcomes despite the number and diversity of training programmes developed over the years.

### ***Domain 3. Participant Characteristics***

*Workforce targeted with the training:* The main professional groups addressed by the programmes were health professionals, including MDs, nurses and psychologists, intercultural mediators and Roma Health mediators. However, the general tendency appears to address training programmes to a multi-professional audience. In many cases, even when the training programme was meant to address issues concerning specific health professionals, such as nurses or medical doctors, other professionals were included, such as social workers, intercultural mediators or administrative staff.

*Involvement in development of training:* Generally there is a low level of involvement of relevant stakeholders and service users in the training development process. Cultural Mediators were involved in the development of only 17 programmes, Local Authority representatives in 15, Migrant representatives in 8, Roma representatives in only 2 training programmes. This is a significant gap area as presumably patients, community members, cultural mediators and specific group representatives such as the Roma are ideally placed to provide unique insights, experience and knowledge for health care improvement strategies for communities.

*Involvement in delivery of training:* A similar picture emerges for the level of involvement in training delivery. Cultural Mediators (20) are the more frequently involved group in the delivery of the training programmes, Migrant representatives (10), however, overall their participation is low. Service users and Roma representatives were involved in the development of only 6 training programmes making them the least involved groups in training delivery.

A number of studies have more recently explored the benefits of multifaceted education interventions that can be directed to health care professionals and participants /patients (Harmsen 2005) to improve patient engagement and result in improved mutual understanding between healthcare professionals and patients. Further, a recent systematic review whose authors synthesised the evidence of effects on training health professionals to be more patient-centred, found modest support for the observation that multifaceted interventions have an effect that is not found with training for providers only (Dwamena 2012). Greater awareness and understanding of the role of Roma Health mediators, Cultural mediators and service users and patients as key and valuable participants in training programmes is therefore warranted.

#### **Domain 4. Approach**

*Pedagogical approach:* An absence of a clearly articulated pedagogical approach was noted. Only 25 training programmes described their pedagogical approach including the teaching and learning method used, and the theoretical constructs and principles that underpin it. Most other programmes (40) described the methods of training delivery. This perhaps indicates the use of the term pedagogy as synonymous with styles and methods of teaching with many training developers. It is difficult therefore to illicit further analysis about whether the teaching and learning approaches were culturally inclusive and or if there was a pedagogical approach that emphasised the involvement of patients and other relevant stakeholders. It would appear however, that this may not be the case if we view the correlation between patient centeredness as a concept which was covered in almost half of all trainings (48%) and the low level of consumer/user participation content (covered in only 28% of training programmes).

*Broad conceptual approach:* There is a continued focus on cultural competence as the broad conceptual approach for training programmes. This is not surprising as it has gained momentum over the years, despite the range of limitations inherent in this concept and approach that we have described previously. On note is the lower reporting of other conceptual approaches. Intersectionality as a conceptual approach was indicated in only 17% of the training programmes, as were patient centeredness and quality of care. However, the concept of intersectionality has more recently gained recognition as a dynamic and responsive conceptual approach to multiple and concurrent aspects of diversity (Chiarenza 2012) in migrant, ethnic minority and vulnerable groups. Patient centeredness is also congruent with co-related concepts such as responsiveness, equity and personalised health care and has been seen as a strategy that is inclusive of but

not exclusive to cultural and linguistic dimensions. The concept of Quality of care (a mainstream concept) has also been shown to be compromised for migrant and ethnic minority patients through an increasing evidence attributing a higher "trajectory of accident opportunity" and/or adverse events" to migrant and ethnic minority patients compared with mainstream patients (Divi 2007).

*Focus of training:* The focus of training included four components: general, health care or intervention specific, sub-group specific, and health care access specific. The vast majority of training programmes had a general focus (51%) of improving awareness and expansion the knowledge and capacity of healthcare professionals to either work with migrants or to be more informed about migrants' health and situation. Notably, a low level of programmes (8%) focused on barriers to healthcare access such as language and, information, legal or financial barriers. This lack of focus on barriers is made more prescient when we review other low reporting areas such as the involvement of key stakeholders, mediators, and services users/patients in training programme development and delivery.

### **Domain 5. Educational content**

The educational content comprised four components: sensitivity and awareness; knowledge; application of knowledge; and skills.

*Sensitivity and awareness:* A high level of training programmes (70%) described one or more aspects of this component which included: raising awareness; expanding knowledge and competence to work effectively with migrants, ethnic minorities and Roma; and knowledge about migrants' health and situation. Only half of the training programmes, covered self-reflection and self-critique (46%) although there was high reporting of 'understanding individual values, beliefs, behaviours and basic assumptions' (70%) and 'understanding (human) differences and similarities' (69%). This low correlation between these variables does raise questions of how possible it is to understand individual values and differences between individuals if a focus on the capacity for self-reflection and self-critique is low.

*Knowledge:* A strong anthropological approach underlies the knowledge component (42%) as does a non-biomedical focus. The most popular knowledge content areas not surprisingly included: migration and the right to health care; culture and cultural knowledge; the social-cultural context of health inequalities; and determinants of health, each with a reported rate of over 60%. The converse can be said for constructs of racism and prejudice, which was included in 21 programmes. This is of note as there is a growing body of research examining the effects of racism and prejudice on health and mental health and well-being (e.g. Van Dijk et al. 2011).<sup>20</sup> The exploration of theoretical models of cultural competence was also low, even though cultural competence was cited as the most frequently utilised conceptual approach to training.

*Application of knowledge:* Intercultural mediation and health promotion were the most frequently reported (60%) variables across the training programmes, however consumer/user participation was the least reported (in 18 programmes) variable in this component. In the development of future training courses it would be recommendable to involve consumers/users more intensively, as these are the people the training courses are designed for in the end. These groups of people are to benefit from the effects of the training courses, so they will likely be of help when participating in the training course.

*Skills:* A focus on both interpersonal and intrapersonal skills was evident though the intrapersonal skills area was less well specified.

### **Domain 6. Training course structure:**

---

<sup>20</sup> van Dijk TK, Agyemang C, de Wit M, Hosper K. The relationship between perceived discrimination and depressive symptoms among young Turkish-Dutch and Moroccan-Dutch. Eur J Public Health. 2011 Aug;21(4):477-83.



*Methodology for delivery and formats:* Unsurprisingly, the more traditional forms of delivery were cited including lectures, discussions, case scenarios and role plays. Clinical experience as a method was low and reported in only 35% of programmes. There was also very low distance or online delivery methods reported in only six training programmes. Typically didactic formats were most common.

*Organisational support:* Overall there was little reporting on the organisational support component. Only 20 training programmes (31%) in total reported links to organisational policies and procedures. Lower still were links to any other organisational actions such as mentoring support (20%) and no links to performance management review were recorded. Together with the high propensity for voluntary attendance (participation in training programmes was mandatory in only seven programmes) and the most frequently reported means of credits being a Certificate of attendance (implying that no participant achievement or assessment was measured), this does raise questions as to the value and importance placed upon this type of training by organisations; how organisations support staff in professional development opportunities and how they monitor and measure their progress; how learning outcomes are sustained by linking them to organisational policies and improvement processes; and finally, how organisations can improve service delivery for patients. These aspects should be implemented in organisations. National governments could perhaps play a role in this; to make (formats or facilitations for) assessments of these aspects, as an incentive for policy or curriculum developers.

It is noteworthy that in 7 of the 20 cases links to national policies were reported, these derive from Cyprus, the UK (Scotland) and Spain.

*Frequency and duration:* The majority of training programmes were conducted over 1-3 days (40%) and comprised a mix of workshops, or seminars. The more typical type of training as one-off events comprised 35% of the training programmes. Of note, were a very small number of courses that were conducted over a slightly longer period but there was considerable heterogeneity in both frequency and duration to draw any generalizable conclusions. On-going training programmes were in the main tertiary studies such as Master courses.

*Certificate and credits:* A certificate of attendance was given to participants in 60% of the training programmes. As mentioned before, this implies that no participant achievement (e.g. an assessment or a test) was necessary in order to successfully finish/complete the training course. A low level of continuing medical education or professional development points were reported for courses (only 22%). When correlated to the low level results for the aforementioned organisational support component this becomes more significant. In a relatively large number of 9 cases (14%) no data were reported on this component Certificates and credits. This finding is also to be correlated with the low level of organisational support, this therefore illustrates the nature of these training courses.

## ***Domain 7. Evaluation and outcomes:***

*Evaluation:* Though training was generally evaluated (75%), most often it was through the rather typical and standard post training questionnaire method (58%). This is useful to illicit immediate responses from training participants, but it is very limited in assessing the impact of learning and the application of knowledge, sensitivity awareness and skills over time and in actual practice. It does not give any insights as to how health care professionals changed their behaviour or practice or if it had any effect in health care delivery, access or outcomes. Neither does it give insight in actual competencies and behaviours as evaluation methods used self-assessed competencies. However, these instruments are proven to be an inadequate predictor of actual competencies of care providers (e.g. Hudelson et al. 2012).<sup>21</sup> Interestingly

---

<sup>21</sup> Hudelson P, Perneger T, Kolly V, Perron NJ. Self-assessed competency at working with a medical interpreter is not associated  
AUSL Reggio Emilia Italy / AMC University of Amsterdam NL

written feedback from supervisors or managers was utilised though only in four programmes. There was also no indication of other forms of evaluation occurring at other intervals post initial training. Overall, 17% of programmes were not evaluated at all and no use of validated evaluation tools was reported. Of particular note, patient satisfaction surveys were never reported as a means of evaluation (0%).

*Patient-related outcomes:* Reporting on patient related outcomes occurred in only two training programmes, as were treatment outcomes, health behaviours and involvement in care. Evaluation of care and adverse events were represented once. Effects of the training on patient satisfaction were not reported in any training programme.

*Staff-related outcomes:* Although knowledge and understanding was the most reported outcome for staff it was only reported in only 21 training programmes (less than a third). Reporting on self-awareness of one's own culture and the culture of bio-medicine and its impact on patients was also low (20%). Other processes such consultation processes and evaluation of processes and outcomes were also seldom reported.

*Organisation-related outcomes:* The number of programmes reported organisation outcomes was very low. Of those reported service access and utilisation were represented five times (8%) improved policies and procedures, new programmes interventions and guidelines and effective patient-provider communication were each reported four times (6%). Quality of health care was reported in three of the cases (5%) and enhanced users' involvement was reported only once.

Our data collection may have been biased, as a consequence of familiarity. In the results one can see that many received templates derived from countries where the international networks (such as ADAPT, HPH-TF MFH) are represented.

Our review is unable to analyse the impact of the training programmes in terms of outcomes as this is beyond the scope of this review. We have however, included outcomes in our conceptual framework and survey template to signify their centrality in training development, design and delivery. Despite a wealth of training programmes designed to improve access and quality of health care delivery for migrants and ethnic minorities, few training programmes have moved beyond assessing outcomes for healthcare professionals at a basic level, and fewer still have embedded more detailed evaluation strategies to capture evidence for patient/client outcomes and health care access or utilisation outcomes (Truong 2014). Future training programme development should strive to embed a focus on outcomes in its design, delivery and evaluation methods and involve patients and stakeholders in the training process.

### ***Survey's key findings: trends, strengths and weaknesses***

From the above discussion a number of key findings which are interdependent and at times mutually reinforcing are described below.

- Training programmes are characterised by low levels of participant involvement in training development, delivery, evaluation. This also correlates to the low level of training content, knowledge and application of knowledge relating to the role of consumer participation and engagement in healthcare and effective consumer participation strategies.
- Training programmes are usually directed only to healthcare professionals, indicating a traditional, singular or mainstream approach to training. Multifaceted training programmes where interventions may be directed to service users/patients as well as health professionals were not found. Recent review and research findings that multifaceted and more innovative training approaches that involve

---

with knowledge of good practice. PLoS One. 2012;7(6):e38973. doi: 10.1371/journal.pone.0038973. Epub 2012 Jun 8.

both healthcare professionals and their patients may offer greater and more meaningful outcomes. Additionally, health care managers and other policy makers are underrepresented in training and should also be included. New approaches to training are both timely and necessary.

Settings for training delivery are also traditional and typical, such as hospitals for example. Whilst these may of course be the most relevant and expedient settings to deliver training (in places of work), and may be very effective in maximising participation, there is little evidence of atypical or innovative training settings being utilised. Increasingly training programmes may need to be delivered in variety of settings and with a variety of outreach approaches to maximise stakeholder involvement and effect.

- The central role of pedagogy in training programme development and content is underdeveloped. As we have discussed previously the pedagogical approach examines the teaching and learning method used in an intervention, and is concerned with articulating the theoretical constructs and principles that underpin it. For example, if a culturally-inclusive approach is adopted to investigate cultural biases in instructional practices that may be experiential, instructive, or didactic. Too few programmes clearly articulate a pedagogical approach, using the term to describe teaching and learning styles broadly.
- Whilst cultural competence continues as the broad conceptual approach for training programmes, alternate approaches such as intersectionality and person centeredness are emergent.
- Training programmes are not systematically focusing on outcomes in training design, implementation and evaluation. Outcomes for staff, patients/communities and healthcare organisations are not being adequately built into the structure and development of training programmes at the outset. In particular, a focus on a range of outcomes for patients and healthcare organisations is absent from most training programmes.
- Training programmes are poorly linked to key organisational support mechanisms such as quality improvement planning and monitoring processes, policies and procedures relating to professional development, performance monitoring, peer support, appropriate certification and recognition of learning. Moreover there is an absence of evidence of how organisations receive and monitor value from such training programmes in health care access and service delivery improvements.
- Training programmes are generally under-evaluated. If they are evaluated, they are generally reliant on one dimensional pre and post training surveys that may not offer sufficient insights or meaning nor any measure of reflection, learning and resultant changes or improvement over time. Absence of the utilisation of validated tools for evaluation is problematic, particularly as they are currently more readily available.
- Resources are disproportionately allocated within training programmes. A larger proportion of resources are allocated to the initial development and subsequent delivery of the training programme. Far fewer resources are allocated to or obtained for evaluating programmes per se or investigating their impact or outcomes for different cohorts.
- Insufficient links to policy and legislative requirements

- There seems to be an insufficient focus on racism and discrimination and its relationship to health and well-being or barriers to healthcare. Medical educators may tend to teach cultural sensitivity but avoid more challenging issues such as prejudice and racism (Kai et al. 2001).<sup>22</sup> This may be reinforced by the resistance from participants who may prefer a 'recipe' approach with an emphasis on the passive acquisition of knowledge about different ethnic groups rather than an approach that prompt reflection and examination of own attitudes (Shapiro et al. 2002).<sup>23</sup>
- There seems to be a lack of training on sensitive topics that care providers feel insecure and incompetent about when providing care to ethnic and minority patients (e.g. palliative care, breaking bad news) (Rollins et al. 2013).<sup>24</sup>
- Finally, while most trainings are focussed on teaching general cultural competencies to health care professionals, the question arises whether this type of training should not be delivered in an earlier phase, namely in the medical and the nursing curricula. While most medical and nursing schools pay some attention to cultural competencies, a systematic approach is lacking and in general is still a blind spot in medical curricula (e.g. Paternotte et al. 2014).<sup>25</sup>

---

<sup>22</sup> Kai J, Spencer J, Woodward N. Wrestling with ethnic diversity: towards empowering health educators. *Med Educ* 2001; 35:262-271.

<sup>23</sup> Shapiro J, Hollingshead J, Morrison EH. Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education* 2002; 36:749-759.

<sup>24</sup> Rollins et al; Are faculty prepared for cross-cultural conversations and care. *Fam Medicine*, 2013, nv/dec/ vol 45, no 10, 728-731.

<sup>25</sup> Paternotte E, Fokkema JP, Van Loon KA, Van Dulmen S, Scheele F. Cultural diversity: blind spot in medical curriculum documents, a document analysis. *BMC Medical Education* 2014, 14:176.

## CHAPTER 6. ASSESSMENT OF THE TRAINING PROGRAMMES

### ***Introduction***

As noted in various recent reviews (Horvat et al, 2104; Truong, 2014; Lie, 2010), assessing the quality and impact of education interventions aimed at improving access and quality of health care for migrants remains a challenging task despite the proliferation in education models and training delivery. This is largely due to the considerable heterogeneity in training programmes including their rationale; development and delivery; participant characteristics; approach; educational content; structure; evaluation and outcomes.

To address this challenge we used our aforementioned conceptual framework (see page 15) as the basis for data collection and extraction of training programmes developed and delivered in Europe over the last ten years. The domains and their key components served to illustrate and describe what may be considered as identifiable core components of training programmes aimed at improving access and quality of health care for migrants. This has enabled us to provide a consistent approach in the data collection process to both describe and analyse data within and across the domains. The survey and data collection process aimed to ensure that all good quality materials existing in EU countries were identified and considered. The aim of this review is not to evaluate the effectiveness of the training programmes in terms of outcomes, rather to evaluate the quality of the process of development of training. An assessment of the impact of the training programmes on a range of outcomes is beyond the scope of this review and the methodology employed, indeed relevant data is unavailable for that purpose. An evaluation of the *quality* of the training will, however, enable us to identify training programmes to be included in the "Directory of Good Practices".

### ***Aims and quality criteria of the assessment of training programmes***

The general criteria used to evaluate the quality of training courses refer to the application of an integrated systemic vision of core dimensions of care (individual, organisational, community, policy). Within each of the dimensions identified, value has been placed on experiences, which were not limited to merely producing information and competences relating to single cultural aspects, or to specific pathological problems, or to specific migrant groups or specific professional categories, or to specific health care issues. On the contrary, the focus has been to identify experiences which create a mutual correlation between these elements, in conformity with the premise that it is only through an integrated, system approach that it is possible to produce knowledge, competences and practices able to transform and to effectively improve access and reduce inequality in health. As illustrated in the previous sections, in fact, improvements in individual competences for professionals fails to achieve their full potential unless they are housed within an organisational structure which confers legitimacy, creating an enabling environment in which these very competences can be applied. The organisational structures themselves need at the same time a policy framework open to the formulation of organisational change. As care pathways are situated within a much vaster network of needs, relations, and services which go beyond the confines of the health services as such, equal importance has been given to the community development dimension, implying a connection between health services and other stakeholders, including patients, institutions and other existing resources in the local territory.

This vision is in line with the "whole-organisation-approach" emphasized in recent international policy reports (WHO, 2010 Health of migrants – the way forward: report of global consultation), national strategy plans (e.g. Ireland, UK, Scotland), recommendations from research (MFH project, 2002-2004, COST Action HOME, 2007-2011) and health care service networks (HPH-TF MFCCH). As stated in the WHO policy brief (2010) on how health systems should address health inequalities linked to migration and ethnicity, "*In the*

*past, efforts typically focused on enhancing the "cultural competence" of the individual caregiver, but experience has shown that this has little benefit if nothing is done to change the rest of the organisation. ... Moreover, improvements must be systematic and sustainable: adequate resources must be allocated to them and changes must be embedded in policy at all levels, from national to institutional and professional".* Furthermore, this vision is also in line with the "health-system-approach" described in the Tallin Charter (Health systems for health and wealth, 2008) which stresses the need for a multisectoral or integrated approach to health care provision, because the health problems of migrants and ethnic minorities, such as the Roma people, are frequently rooted in social and living conditions requiring coordination between health services, social services, local authorities, and NGOs

According to both the whole-organisation and the health system approach, knowledge and actions must be evaluated for their potential effects on the functioning of the entire system, supporting a continuum of care and ultimately for their effect on health outcomes. All parts of a health system are interrelated and dynamically linked. The health systems framework is meant to ensure that dynamic interactions are considered across the entire system, and to minimize the risk of neglecting important parts of that system during any analysis or intervention.<sup>26</sup> Therefore, services and training programmes should be integrated as a whole in order to guarantee the needs of each individual patient, carer and also other actors in the community. Within this approach, every actor should be aware of the inter-dependency between those four dimensions of care (individual, organisational, community, policy), since any measure taken has an impact on the whole system dynamics. There should, therefore, be a consistent striving to achieve coherence of the educational contents and knowledge, of priorities, of roles and responsibilities, and of resources and evaluation mechanisms. Furthermore, since there are many difficulties in translating theoretical knowledge into practices, service users, managers and practitioners should be constantly involved in training programmes at strategic levels.<sup>27</sup>

Based on the overall aims described in the previous paragraph, the following four quality dimensions related to improving access and quality of health care delivery for migrants and ethnic minorities have been identified:

1. *Individual development.* A good training course should aim at improving individual competences in order to allow health care professionals and health mediators to respond to the diverse needs of migrants, ethnic minority groups, such as Roma people, in a sensitive, effective and non-judgemental way. It should improve knowledge and understanding (e.g. attitudes, behaviour, confidence), and capacity to provide person centred care and potentially improve job satisfaction. Individual development is seen as the ability to understand not only patients' cultural elements, but also elements of their emotional and relational state, as well as the social and economic conditions, which impact the care pathway. Individual development is considered moreover as an active and self-reflective position on the part of the health professionals with respect to health care, in relation to their own visions, cultural categories and professional needs. Finally, individual development is the ability to work in inter-disciplinary teams, sharing the care pathway with other professional figures and disciplines (a mirror dimension of the community dimension concerning, in this case, the single professional). Value has consequently been

---

26 [http://www.wpro.who.int/health\\_services/action/regional\\_strategy\\_health\\_systems\\_primary\\_health\\_care\\_chapter4.pdf](http://www.wpro.who.int/health_services/action/regional_strategy_health_systems_primary_health_care_chapter4.pdf)

27 NHS Modernisation Agency (2002). Improvement leaders guide: process mapping, analysis and redesign.- WHO. 2007. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action, Geneva: WHO: [http://who.int/healthsystems/strategy/everybodys\\_business.pdf](http://who.int/healthsystems/strategy/everybodys_business.pdf)

placed on those experiences, for example, which correlate patients' needs with the needs of health care professionals', or on other experiences, which have correlated cultural competence while centring on the individual patient with attention to the issue of equity or social determinants, human rights, quality of care, health promotion, and the community. On the same basis, value has been placed on those experiences, which have fostered interaction between various disciplines, care levels, professionals in health care and other professionals. In terms of training structure, value has been placed on the ability to adopt more active and participatory methods, building networks, dialogue, and cooperation between the various participants.

2. *Organisational development.* A good training course should link individual improvements of the workforce to organisational development and adaptation in order to maximise the effect of reducing the barriers in the access and quality of health care delivery for migrants and ethnic minorities. It should lead to improved patient and community service access, utilisation and quality and safety measures. Organisational development is seen as the ability to enable interaction between levels of service organization and the levels of needs on the part of both professionals and patients. Emphasis has been given therefore to experiences which correlate organisational issues with issues of barriers to access (legal, economic etc) or which involve users and health provider responsiveness. Within this dimension, value has been placed on the explicit involvement on the part of the organisation in training courses, as participants, either in the assessment phase, or by making the courses mandatory for certain professional figures.
3. *Community development.* A good training course should improve the capacity of health professionals to address the issues of migrant and ethnic minority health and health care inequalities in cooperation with other professions, services and agencies in the territory where vulnerable groups live in both a temporary or stabilised way. Community development refers to the capacity for interaction between various stakeholders. It refers above all to the capacity for dialogue between the international, national, regional and local context, the capacity for interaction between the environment of health care and other environments, to the capacity of the health care professional to understand the patient's broader needs to be able to inform, guide and refer, where necessary, to other social agents who can intervene on other aspects beyond the realm of health care in the strictest sense. It is essential to be able to build networks with other social agents and territorial organisations. Also in this case, particular value has been placed on training courses, which have created the opportunity for sharing, participation, dialogue. This dimension refers explicitly to an integrated approach to patients and to health where dialogue between service users, health professionals, local authorities, NGOs, migrant representatives etc. is vital. In this dimension, the correlation between specialist services and primary health care is also important, in order to contribute to continuity of care and better use of territorial social and health resources.
4. *Policy development.* A good training course should be embedded in a broader policy strategy addressing these issues at organisational as well as governmental level. Policy development refers to the construction of a formal framework, which provides legitimacy for this vision of health care and health care organisations. Emphasis has been given, therefore, to training courses, which have involved the policy level in the development of training, promoting an understanding of needs and the active processes contained within the other afore-mentioned dimensions (individual, organisational, community). Value has been placed on experiences, which have engaged national and local government both in the development phase and in sustaining the courses in which the aim of training has been to inform policy in an integrated way.

## ***Methods for assessing quality of training programmes***

In order to evaluate the quality of the 65 training programmes, a number of significant correlations between variables related to the four dimensions of quality have been identified within the seven domains. Rather than assigning a score to the mere reporting of single variables, the congruence between variables, as, for example, in the component "Sensitivity and awareness" of the domain "Educational content" was measured. For "individual development", the presence of the correlation between "Understanding individual values, beliefs, behaviours and basic assumptions" AND "Addressing own identity and prejudices" AND/OR "Self-reflection and self-critique in the relationship with the other" was evaluated as a quality element. Each correlation identified made it possible to assign a score to the relevant training programme for each of the four dimensions of quality within the seven domains of the training programmes and then a total score to each programme. (See appendix for a full description of all correlations used for the evaluation)

To trace patterns of correlations between different values as indicators of a holistic perspective on the dimensions of quality, it was necessary to address two methodological issues:

- How to assign scores to the training courses that reflect the conceptual and evaluative assumptions previously described (dimensions of quality).
- How to identify those latent factors, namely those theoretical multidimensional constructs previously postulated which we named "quality dimensions" in the relationship between the observed variables.

The first issue was addressed by recurring to the logic of Boolean algebra, considering the fact that we deal with dichotomous categorical variables in a disjunctive way. A Boolean variable is a binary variable that can assume only two logical values that will be denoted by 0 and 1. So that the conjunction of two variables  $x$  AND  $y$  is equal to 1 if  $x=y=1$  and 0 if otherwise; the disjunction of two variables  $x$  OR  $y$  is equal to 0 if  $x=y=0$  and 1 otherwise.

The second issue was addressed by combining factor and scale analysis. The aim was to measure how a dimension of quality was saturated (semantically covered) in individual training courses. According to this analysis, the dimensions of quality are "latent variables", i.e. configurations of the relationships among variables that must be "semantically covered" and, "algebraically linked" in order to ensure the greatest possible number of correlations between the observed variables in the "seven domains". This type of analysis allowed us to measure the level of coverage of these "configurations" in the training programmes and how far they were from an average standard of quality. The average standard of quality was identified in consideration of the actual level of scores achieved by the training programmes identified with respect to each dimension of quality, rather than the total scores achievable. Thus we aimed to ensure a more balanced evaluation, more centred on the potential expressed by the 65 programmes, rather than on an ideal standard.

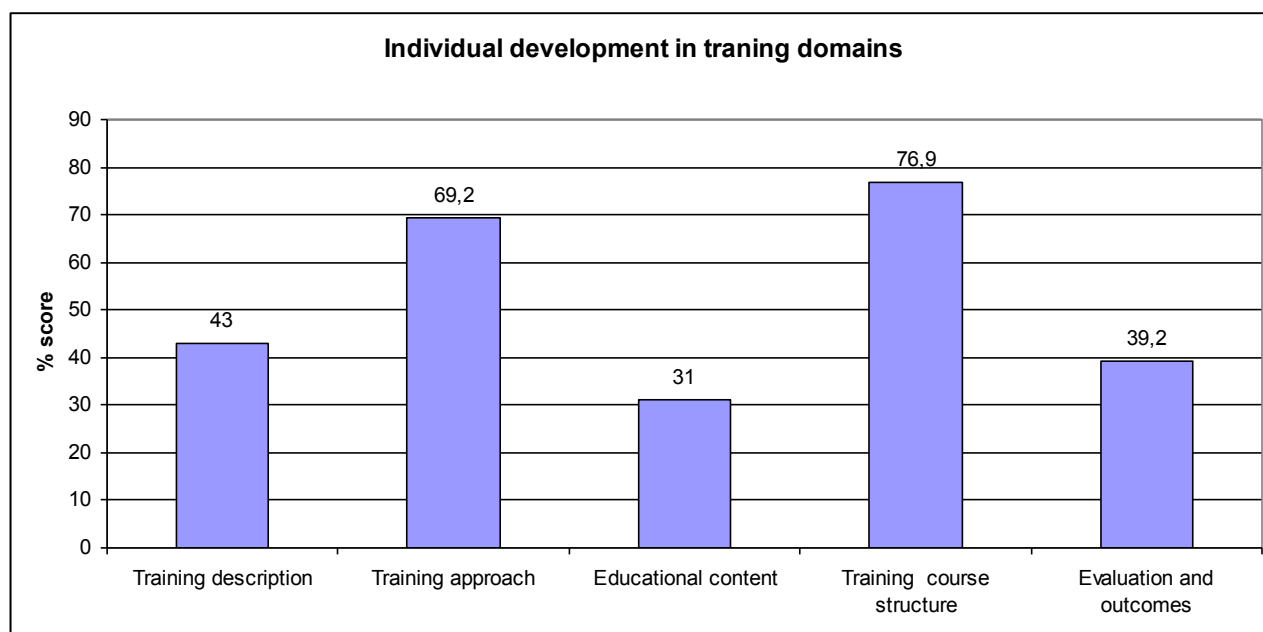
According to this methodology, the distribution of scores allowed us to list the training programmes in a hierarchical order, from the highest to the lowest score achieved. In evaluating the quality of the training programmes, firstly we calculated the arithmetic mean of the scores achieved by the programmes in order to identify the central tendency of the distribution of scores, secondly we divided the programmes into two groups encompassing those that fell above and those under the score mean, and finally we grouped the programmes in five frequency classes around the score mean: (1) low score, (2) medium-low score, (3) medium score, (4) medium-high score and (5) high score. Finally, the quality assessment results allowed us to list the training programmes collected according to the score achieved in the seven domains, and to create a "Directory of quality training programmes". The Directory will form a searchable database that allows retrieving information on the training programmes by "domains", "domains' components", and "quality dimensions".



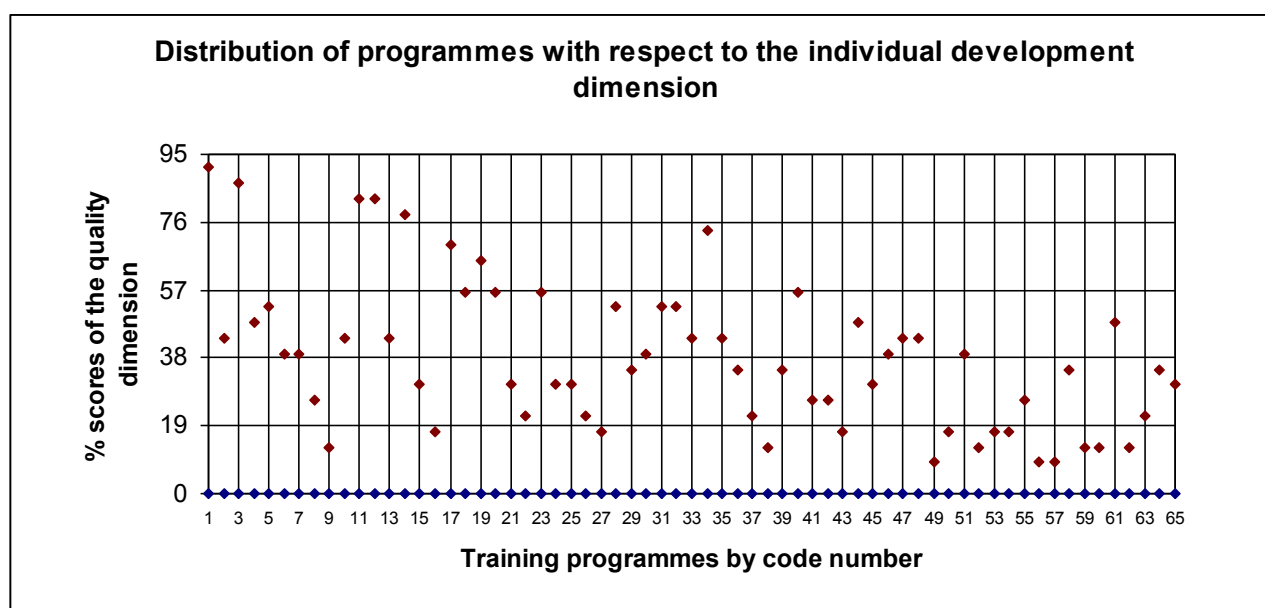
## Quality dimension 1: individual development

Correlations between variables related to the dimension of “individual development” identified in the relevant domains.

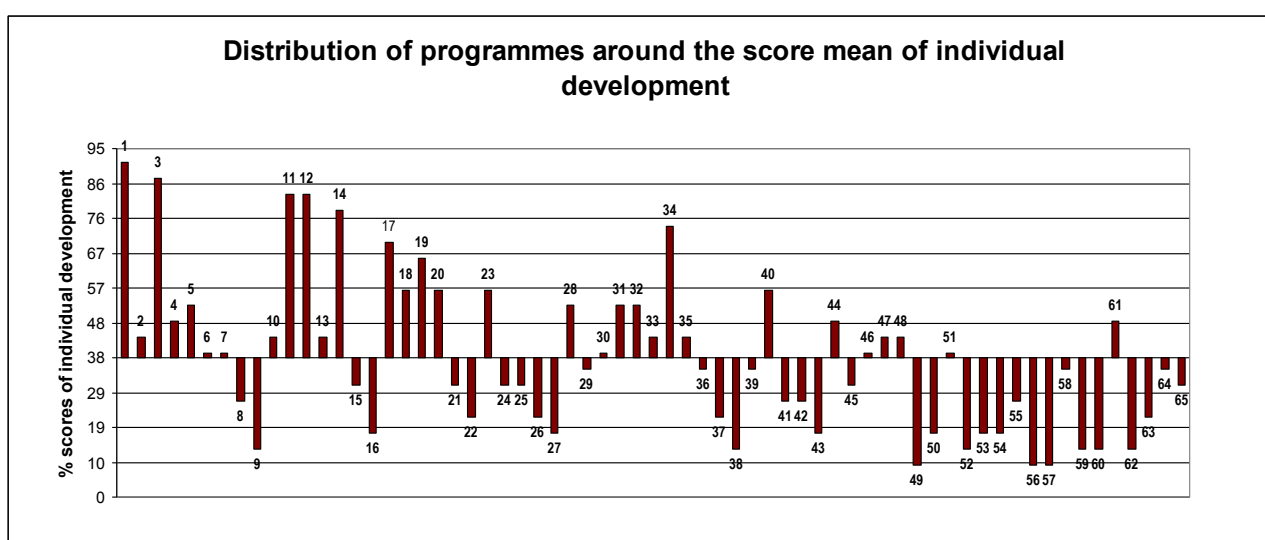
Quality dimensions	DOMAINS CONSIDERED					Total scores
	Training description	Training approach	Educational content	Training course structure	Evaluation and outcomes	
Individual development	28\65	45\65	343\1105	100\130	51\130	567\1495
	43%	69.2%	31%	76.9%	39.2%	37.9%



The graph shows the general level of individual development in the domains. As noted previously, individual development is traced by the identification of correlations between variables demonstrating, for example, not only the existence of specific knowledge within the educational content of a training programme but also the effort to inter-relate them in order to facilitate the construction of argumentative knowledge and collaborative learning in the targeted workforce. This type of individual development was mostly achieved in the domain “Training approach” 69.2%, and in the domain of “Training course structure”, 76.9%. The result relating to the “Training approach” shows the level of integration of cultural competence with other models, such as patient-centeredness, equity, quality of care, human rights or intersectionality, when defining the conceptual framework of the training programme. The result relating to the domain “Training structure” shows the extent to which the programmes adopted more active and participatory methods for training delivery. To a lesser extent this kind of individual development was achieved in the domain of “Training description”, 43%, “Educational content”, 31%, and “Evaluation and outcomes”, 39.2%. The first shows, for example, the extent to which the analysis of patients’ needs was related to the needs of health care professionals when defining training needs. The second shows, among other things, the extent of integration of educational contents, such as “understanding individual values, beliefs, behaviours” with “addressing own identity, prejudice” and “self-reflection and self-critique”; or the integration of “socio-cultural contexts” with “health inequalities”, “right to health”, “determinants of health”, “racisms and prejudice”. Finally, the result achieved in “Evaluation and outcomes”, shows the extent of integration between traditional pre-post evaluation methods and patient-staff-organisation outcomes.



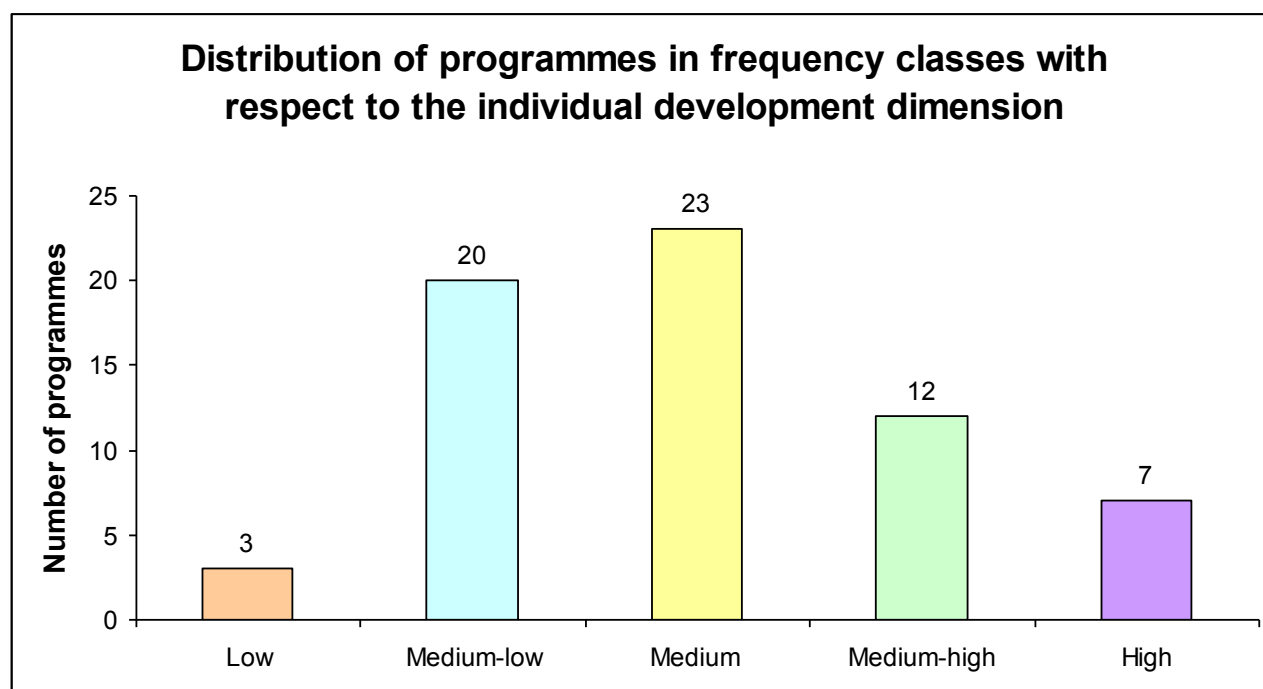
The graph shows the distribution of the 65 programmes based on the percentage score achieved in all domains relating to the quality dimension of “individual development”.



The distribution of scores of the 65 training programmes is shown by dividing them into two groups around the arithmetic mean, 37.9%, of all scores, calculated considering the highest and the lowest scores identified. The graph clearly shows the programmes that fall above and under the score mean. The highest score, 91%, is achieved by the training programme with number code 1 and the lowest, 9% by the training programmes with code numbers 49, 56 and 57.

< 9.5%	Low
9.5%-28.5%	Medium-low
28.5%-47.5%	Medium
47.5%-66.6%	Medium-high
> 66.5%	High

The level of quality of the 65 training programmes relating to the dimension of “individual development” is defined by their positioning within the five frequency classes created around the score mean, 37.9%.



The graph shows the number of programmes within each of the frequency classes.

QUALITY ASSESSMENT BY INDIVIDUAL DEVELOPMENT			
CODE	Country of contact person	Title of the training programme	% score
1	Austria	University Master-Course “Transcultural Medicine and Diversity Care”	91
3	WHO	WHO/Europe multi-country training on reorienting strategies, programmes and activities on Millennium Development Goals 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population	87
11	Denmark	NO TITLE	83
12	Denmark	The ethnical patient coordinator team	83
14	France	Cultural competence for health and social services	78
34	Scotland	NHS Lothian Health Inequalities Training	74
17	Hungary	Interculturality Training for Health Care Professionals	70
19	IOM	Training modules on migration and health for health professionals (PHBLM Project 2007-2010) and parallel training for Border Guards with similar and different modules	65
18	Hungary	Interdisciplinary Training on Social Inclusion (ITSI)	57
20	IOM	Training on Migration and Health for Health Professionals (EQUI-HEALTH project)	57
23	Italy	New dimensions of care in pluricultural contexts	57
40	Spain	Master in “International Migration and Health: and Strategies of Intervention”	57
5	Bulgaria	Improving the skills and knowledge of GPs and nurses how to work better with Roma community. Creating team between GP, nurses and Roma Health Mediators	52

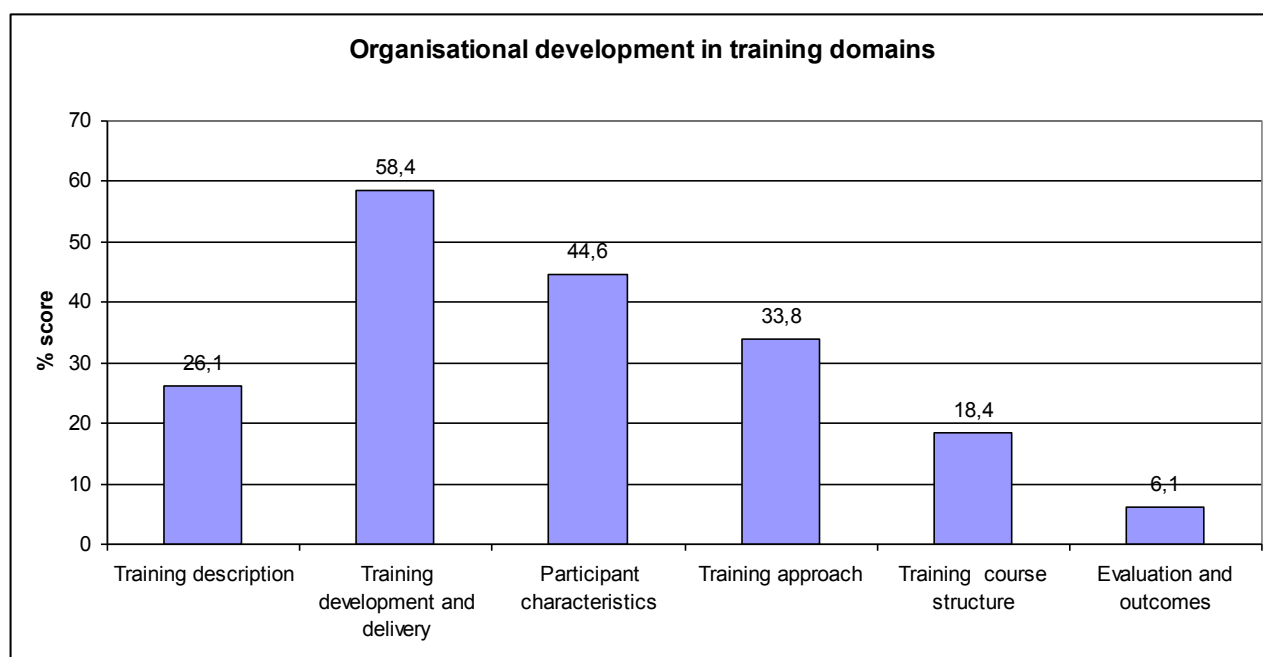
28	Malta	Training Programme for Cultural Mediators in Health Care	52
31	Malta	Like Mother...Like Daughter?? FGM for stakeholders working with female migrants	52
32	Malta	MARENOSTRUM: Receiving and taking care	52
4	Austria	Transcultural competency for health professionals especially nursing staff	48
44	Spain	Intercultural training seminars for professionals of the Aragonese Health Service conducted by the Intercultural Mediation Service Support (SAMI) of Adunare Foundation and financed by the Ministry of Labour and Social Affairs and the Government of Aragon.	48
61	Belgium	Health mediation training within the framework of the national program of health mediation	48
2	Austria	Managing Diversity	43
10	Czech Republic	Roma Social Health Assistant (mediator) - pilot training course in 2005-2007	43
13	France	Formations de Migrations Santé Alsace	43
33	Netherlands	Masterclass Huisartsen in achterstandswijken (Masterclass for GPcare in deprived areas)	43
35	Scotland	NHS Lothian LearnPro e-learning module on equality & diversity	43
47	Spain	Handbook for Action in the Area of Health Services with the Roma Community	43
48	Spain	Health, Addiction Prevention and Roma Youth in Europe	43
6	Cyprus	United to END FGM e-Learning Course	39
7	Cyprus	Training workshop: Cultural competency of Community Nurses	39
30	Malta	Promoting Breastfeeding amongst Migrant Women	39
46	Spain	A guide of health intervention strategies for Roma women	39
51	UK	Therapy across languages and cultures with and without an interpreter	39
<b>SCORE MEAN 37.9%</b>			
29	Malta	Addressing Migrant Health Issues	35
36	Scotland	Equality Impact Assessment Training	35
39	Spain	Master of Global Health	35
58	Netherlands	Suicide prevention in asylum seekers centres – a train the trainers course	35
64	Ireland	Anti Racism and Intercultural Training; Awareness Raising	35
15	France	Diplôme Universitaire "psychiatrie et compétences transculturelles"	30
21	Italy	Corso Nazionale di Mediazione Transculturale – Progetto PASS	30
24	Italy	Linee d'intervento transculturali nell'assistenza di base e nel materno infantile	30
25	Italy	Programma Regionale di Formazione degli operatori socio sanitari sull'assistenza sanitaria ai cittadini stranieri	30
45	Spain	Training to improve health care for migrant population	30
65	Ireland	Introduction to cultural diversity in health care training programme	30
8	Cyprus	Diversity and multiculturalism in the work context	26
41	Spain	Master on Health Promotion	26
42	Spain	University Master in Anthropology: Culture, migration and health	26
55	Italy	PRISMA: "Practical – theoretical training to prepare experts on Migration and HIV"	26
22	Italy	Malattie infettive neglette tra cronicità, latenza e riemergenza	22
26	Italy	XVI CORSO INTERNAZIONALE DI MEDICINA TRANSCULTURALE. Dal ben-essere all'essere. Note a margine su un mondo in trasformazione	22
37	Slovakia	PHBLM project: "Increasing Public Health Safety Alongside the New Eastern European Border Line",	22

		2007- 2009	
63	Netherlands	Ethnic diversity in your practice	22
16	Greece	MSc in Transcultural Nursing, Faculty of Nursing, University of Athens	17
27	Italy	Psychosocial Interventions in Migration, Displacement and Emergency	17
43	Spain	On line service training, for people specialist in immigration, interculturalidad and diversity	17
50	Sweden	Refugee Mental health and Mental health Care	17
53	WHO	Impact of the economic crisis on the determinants of health and response strategies in Europe	17
54	Italy	ARTEMIS: Training course for cultural mediators and health community workers	17
9	Cyprus	Training of public officers for identifying torture and special needs in victims of torture	13
38	Slovakia	Enhancing intercultural skills and regional cooperation professionals working with migrants IV.	13
52	WHO	Migration: a Public Health perspective	13
59	Finland	How to meet death at different religions and cultures – backgrounds and practices (Kuoleman kohtaaminen eri uskonnoissa ja kulttuureissa . käytännöt ja taustat)	13
60	Finland	Migrant refugees psychiatric care (Pakolaistaustaisten maahanmuuttajien psykiatrinen hoito)	13
62	PICUM	Access to health care for undocumented migrants in Europe (at times with focus on care for undocumented women (or sexual and reproductive health) and/or care for undocumented children)	13
49	Sweden	Transcultural psychiatry. Migration, mental illness and trauma	9
56	Slovenia	Homecare nursing of socially disadvantaged population groups	9
57	Slovenia	Care for vulnerable population groups	9

## Quality dimension 2: organisational development

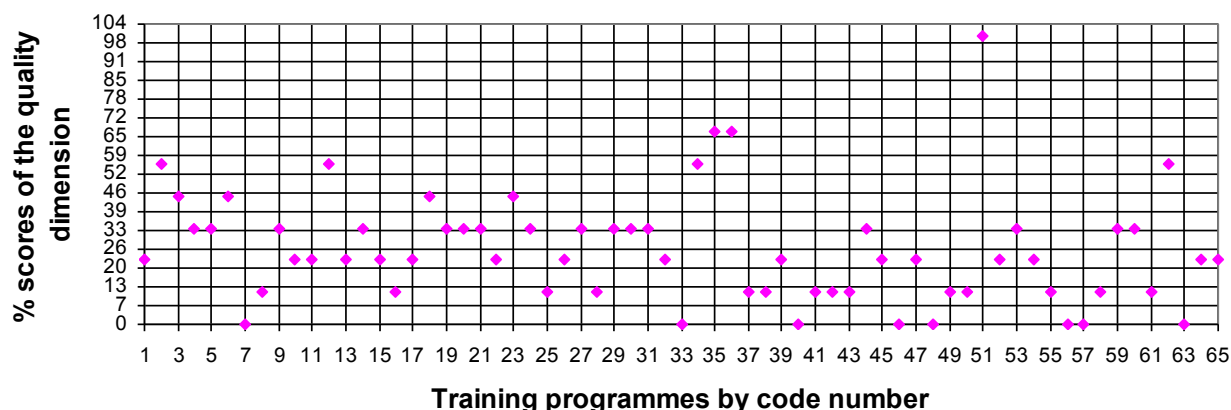
Correlations between variables related to the dimension of “organisational development” identified in the relevant domains.

Quality dimension	DOMAINS CONSIDERED						Total scores
	Training description	Training development and delivery	Participant characteristics	Training approach	Training course structure	Evaluation and outcomes	
Organisational development	17\65	38\65	29\65	22\65	36\195	8\130	150\585
	26.1%	58.4%	44.6%	33.8%	18.4%	6.1%	25.6%



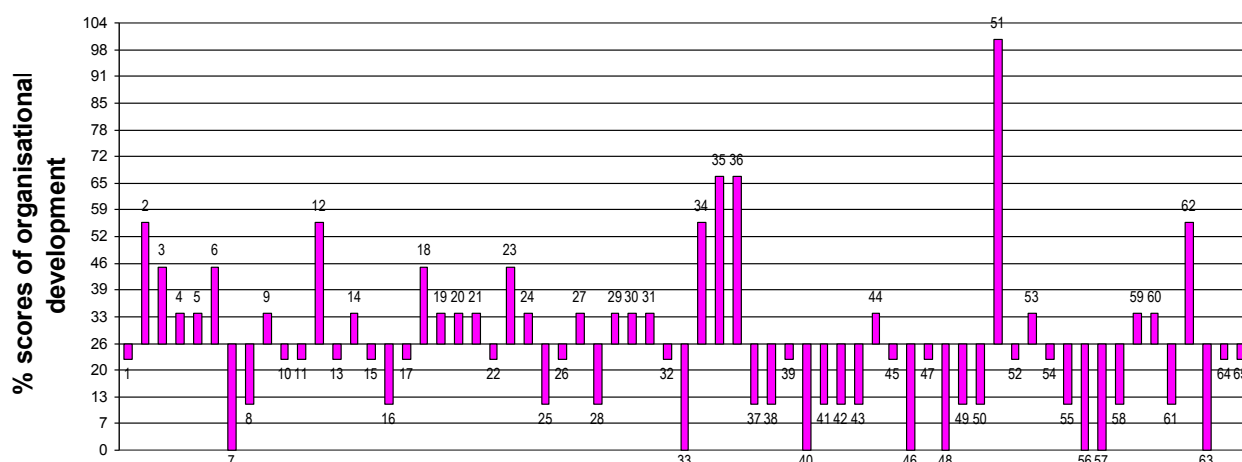
The graph shows the general level of organisational development in the domains. As noted previously, organisational development is traced through the identification of correlations between variables demonstrating how the training programme is able to link individual improvements of the workforce to organisational development and adaptation in order to maximise the effect on the barriers to access and quality of health care delivery for migrants and ethnic minorities. This type of organisational development related to training was mostly achieved in the domain “Training development and delivery”, 58.4 %, demonstrating a good level of support on the part of the organisation to the development and delivery of the training, although this support is not evident in the levels of funding supplied for training evaluation. This is also evident from the low level of percentage score achieved in the domain “Evaluation and outcomes”, 6.1%. It is also worth noting the good level of professionals’ integration in the targeted workforce as shown in the domain “Participants characteristics”, 44.8%, indicating the extent to which the programmes were addressed to a multi-professional audience, including not only health professionals but also health managers, administrative staff, decision makers and even government representatives. The 33.8% achieved in the domain “Training approach”, shows the extent to which the focus of training was addressed to the issues of service access in order to promote organisational change and to improve service delivery for patients. The percentage score achieved in the “Training course structure”, 18.4%, shows the extent to which the programmes aimed to sustain learning outcomes by linking them to organisational policies and improvement processes.

### Distribution of programmes with respect to the dimension of organisational development



The graph shows the distribution of the 65 programmes based on the percentage score achieved in all domains relating to the quality dimension of "organisational development".

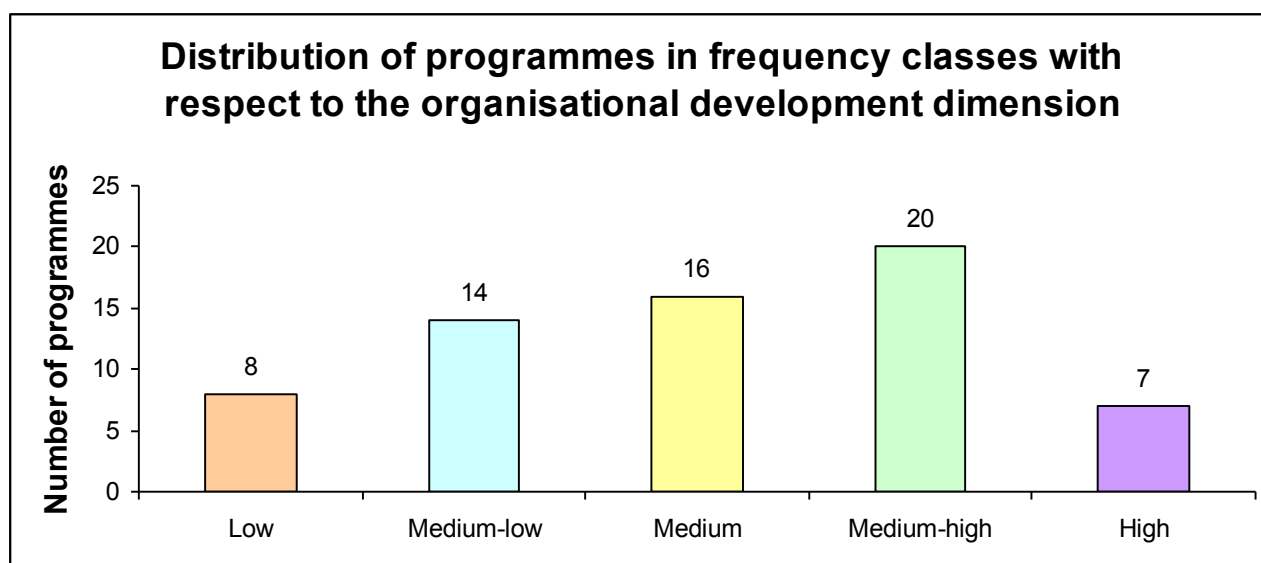
### Distribution of programmes around the score mean of organisational development



The distribution of scores of the 65 training programmes is shown by dividing them into two groups around the arithmetic mean, 25.6%, of all scores, calculated considering the highest and the lowest scores identified. The graph clearly shows the programmes that fall above and under the score mean. The highest score, 100%, is achieved by the training programme with number code 51 and the lowest, 0% by the training programmes with code number 7, 33, 40, 46, 48, 56, 57 and 63.

Low	< 6.5%
Medium-low	6.5%-19.5%
Medium	19.5%-32.5%
Medium-high	32.5%-45.5%
High	> 45.5%

The level of quality of the 65 training programmes relating to the dimension of “organisational development” is defined by their positioning within the five frequency classes created around the score mean, 25.6%.



The graph shows the number of programmes within each of the frequency classes.

QUALITY ASSESSMENT BY ORGANISATIONAL DEVELOPMENT			
CODE	Country of contact person	Title of the training programme	% score
51	UK	Therapy across languages and cultures with and without an interpreter	100
35	Scotland	NHS Lothian LearnPro e-learning module on equality & diversity	67
36	Scotland	Equality Impact Assessment Training	67
2	Austria	Managing Diversity	56
12	Denmark	The ethnical patient coordinator team	56
34	Scotland	NHS Lothian Health Inequalities Training	56
62	PICUM	Access to health care for undocumented migrants in Europe (at times with focus on care for undocumented women (or sexual and reproductive health) and/or care for undocumented children)	56
3	WHO	WHO/Europe multi-country training on reorienting strategies, programmes and activities on Millennium Development Goals 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population	44
6	Cyprus	United to END FGM e-Learning Course	44
18	Hungary	Interdisciplinary Training on Social Inclusion (ITSI)	44
23	Italy	New dimensions of care in pluricultural contexts	44
4	Austria	Transcultural competency for health professionals especially nursing staff	33
5	Bulgaria	Improving the skills and knowledge of GPs and nurses how to work better with Roma community. Creating team between GP, nurses and Roma Health Mediators	33
9	Cyprus	Training of public officers for identifying torture and special needs in victims of torture	33
14	France	Cultural competence for health and social services	33
19	IOM	Training modules on migration and health for health professionals (PHBLM Project 2007-2010) and parallel training for Border Guards with similar and different modules	33
20	IOM	Training on Migration and Health for Health Professionals (EQUI-HEALTH project)	33
21	Italy	Corso Nazionale di Mediazione Transculturale – Progetto PASS	33



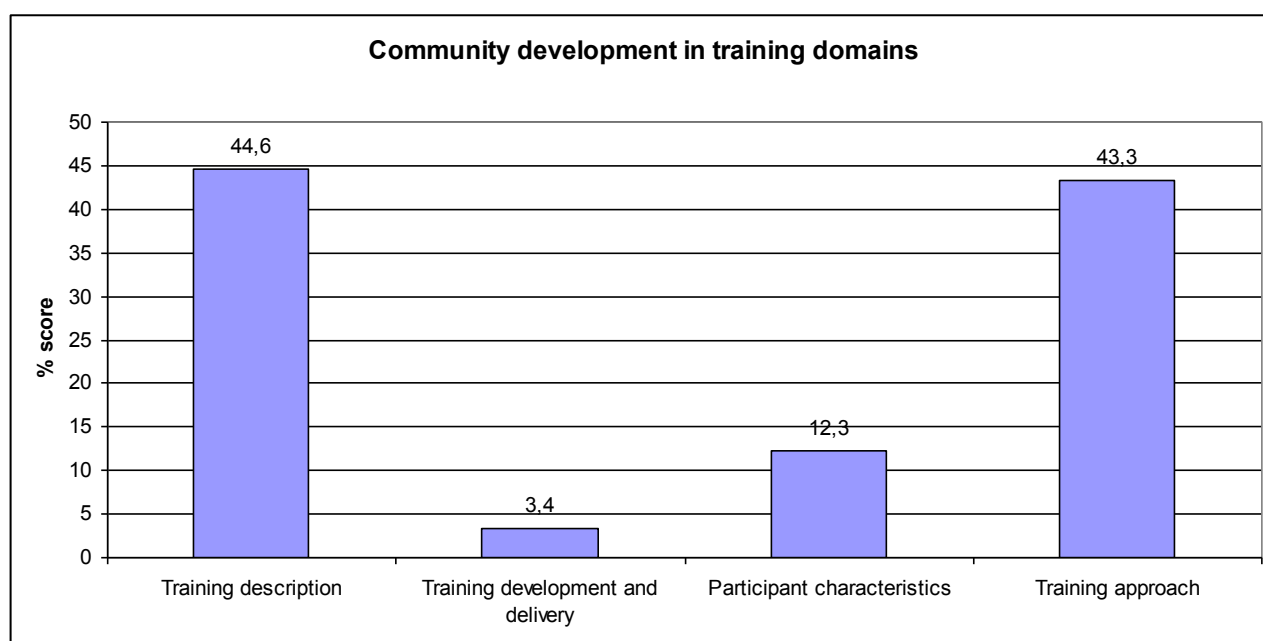
24	Italy	Linee d'intervento transculturali nell'assistenza di base e nel materno infantile	33
27	Italy	Psychosocial Interventions in Migration, Displacement and Emergency	33
29	Malta	Addressing Migrant Health Issues	33
30	Malta	Promoting Breastfeeding amongst Migrant Women	33
31	Malta	Like Mother...Like Daughter?? FGM for stakeholders working with female migrants	33
44	Spain	Intercultural training seminars for professionals of the Aragonese Health Service conducted by the Intercultural Mediation Service Support (SAMI) of Adunare Foundation and financed by the Ministry of Labour and Social Affairs and the Government of Aragon.	33
53	WHO	Impact of the economic crisis on the determinants of health and response strategies in Europe	33
59	Finland	How to meet death at different religions and cultures – backgrounds and practices (Kuoleman kohtaaminen eri uskonnoissa ja kulttuureissa . käytännöt ja taustat)	33
60	Finland	Migrant refugees psychiatric care (Pakolaistaustaisten maahanmuuttajien psykiatrinen hoito)	33
<b>SCORE MEAN 25.6%</b>			
1	Austria	University Master-Course "Transcultural Medicine and Diversity Care"	22
10	Czech Republic	Roma Social Health Assistant (mediator) - pilot training course in 2005-2007	22
11	Denmark	NO TITLE	22
13	France	Formations de Migrations Santé Alsace	22
15	France	Diplôme Universitaire "psychiatrie et compétences transculturelles"	22
17	Hungary	Interculturality Training for Health Care Professionals	22
22	Italy	Malattie infettive neglette tra cronicità, latenza e riemergenza	22
26	Italy	XVI CORSO INTERNAZIONALE DI MEDICINA TRANSCULTURALE. Dal ben-essere all'essere. Note a margine su un mondo in trasformazione	22
32	Malta	MARENOSTRUM: Receiving and taking care	22
39	Spain	Master of Global Health	22
45	Spain	Training to improve health care for migrant population	22
47	Spain	Handbook for Action in the Area of Health Services with the Roma Community	22
52	WHO	Migration: a Public Health perspective	22
54	Italy	ARTEMIS: Training course for cultural mediators and health community workers	22
64	Ireland	Anti Racism and Intercultural Training; Awareness Raising	22
65	Ireland	Introduction to cultural diversity in health care training programme	22
8	Cyprus	Diversity and multiculturalism in the work context	11
16	Greece	MSc in Transcultural Nursing, Faculty of Nursing, University of Athens	11
25	Italy	Programma Regionale di Formazione degli operatori socio sanitari sull'assistenza sanitaria ai cittadini stranieri	11
28	Malta	Training Programme for Cultural Mediators in Health Care	11
37	Slovakia	PHBLM project: "Increasing Public Health Safety Alongside the New Eastern European Border Line", 2007- 2009	11
38	Slovakia	Enhancing intercultural skills and regional cooperation professionals working with migrants IV.	11
41	Spain	Master on Health Promotion	11
42	Spain	University Master in Anthropology: Culture, migration and health	11
43	Spain	On line service training, for people specialist in immigration, interculturalidad and diversity	11
49	Sweden	Transcultural psychiatry. Migration, mental illness and trauma	11
50	Sweden	Refugee Mental health and Mental health Care	11
55	Italy	PRISMA: "Practical – theoretical training to prepare experts on Migration and HIV"	11
58	Netherlands	Suicide prevention in asylum seekers centres – a train the trainers course	11
61	Belgium	health mediation training within the framework of the national program of health mediation	11
7	Cyprus	Training workshop: Cultural competency of Community Nurses	0
33	Netherlands	Masterclass Huisartsen in achterstandswijken (Masterclass for GPcare in deprived areas)	0

40	Spain	Master in "International Migration and Health: and Strategies of Intervention"	0
46	Spain	A guide of health intervention strategies for Roma women	0
48	Spain	Health, Addiction Prevention and Roma Youth in Europe	0
56	Slovenia	Homecare nursing of socially disadvantaged population groups	0
57	Slovenia	Care for vulnerable population groups	0
63	Netherlands	Ethnic diversity in your practice	0

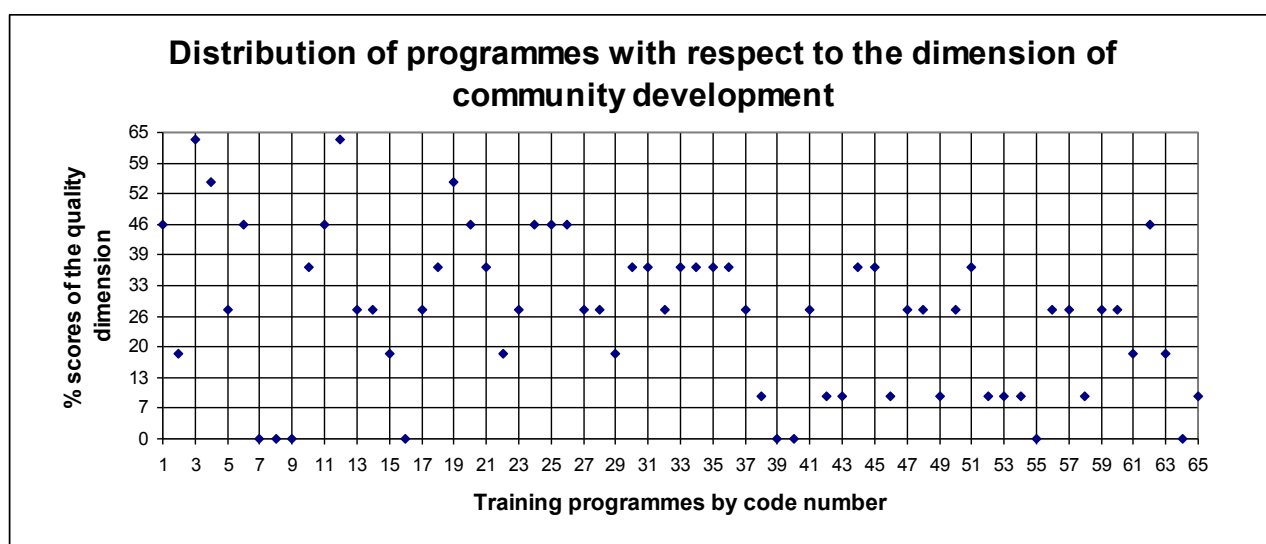
### Quality dimension 3: community development

Correlations between variables related to the dimension of “community development” identified in the relevant domains.

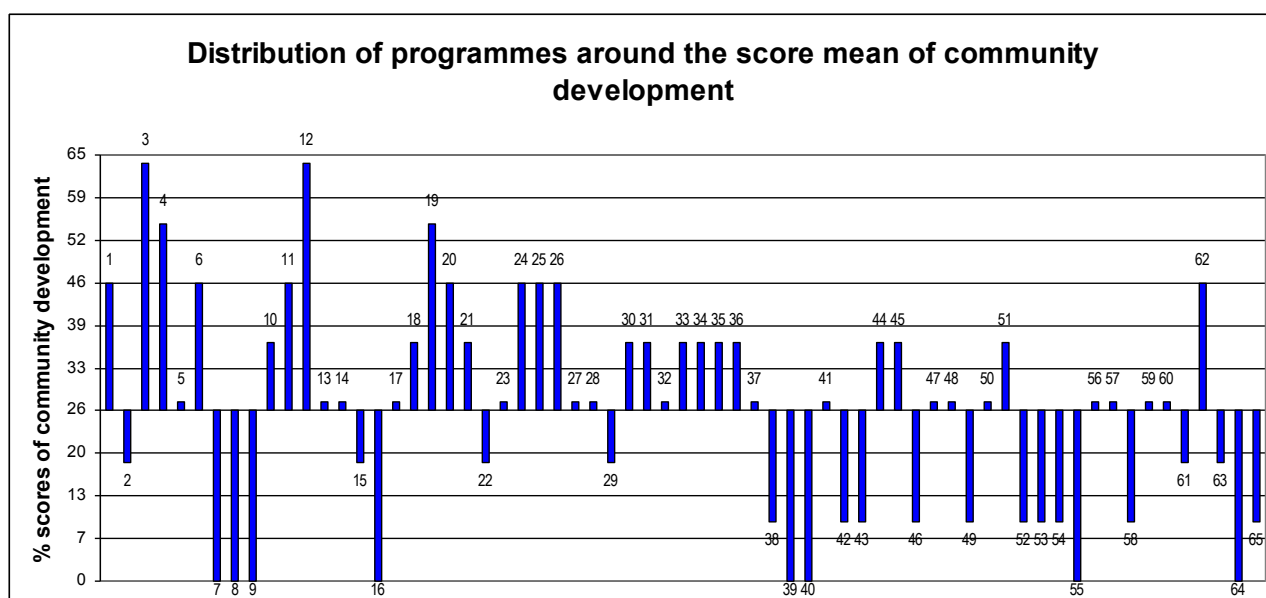
Quality dimension	DOMAINS CONSIDERED				Total scores
	Training description	Training development and delivery	Participant characteristics	Training approach	
Community development	29\65	9\260	8\65	141\325	187\715
	44.6%	3.4%	12.3%	43.3%	26.1%



The graph shows the general level of community development in the domains. Community development refers to the capacity for interaction between various stakeholders. It refers above all to the capacity for dialogue between the international, national, and local context, the capacity for interaction between health care and other services, the capacity of health professionals to cooperate with other agencies and services in the community. The graph shows that community development is only partially addressed by the programmes identified. Community development is well represented in the domain “Training description”, 44.6%, where training needs were identified by integrating information drawn from situational analysis, epidemiological data and patient/user’s needs assessment. Similarly, a good level of community development through training is identified in the domain “Training approach”, 43.3 %, where the extent of integration of primary health care with front-line services and specialists’ services is higher when the focus of training addresses specific health care issues; or when the focus of training is addressing specific sub-groups, i.e. the needs of migrants and ethnic minorities are addressed considering the needs of groups identified by multi-factors (e.g.: pregnant migrant women, elderly migrants, children with undocumented/uninsured parents). The identified programmes that scored low in the domain “Training development and delivery”, 3.4%, show a low level of an integrated type of involvement of relevant organisations, such as international organisations (e.g.: WHO, IOM), regional and national government agencies, or academic institutions, as well as relevant stakeholders, 12.3%, such as service users, intercultural mediators, migrant, NGOs and local authority representatives.



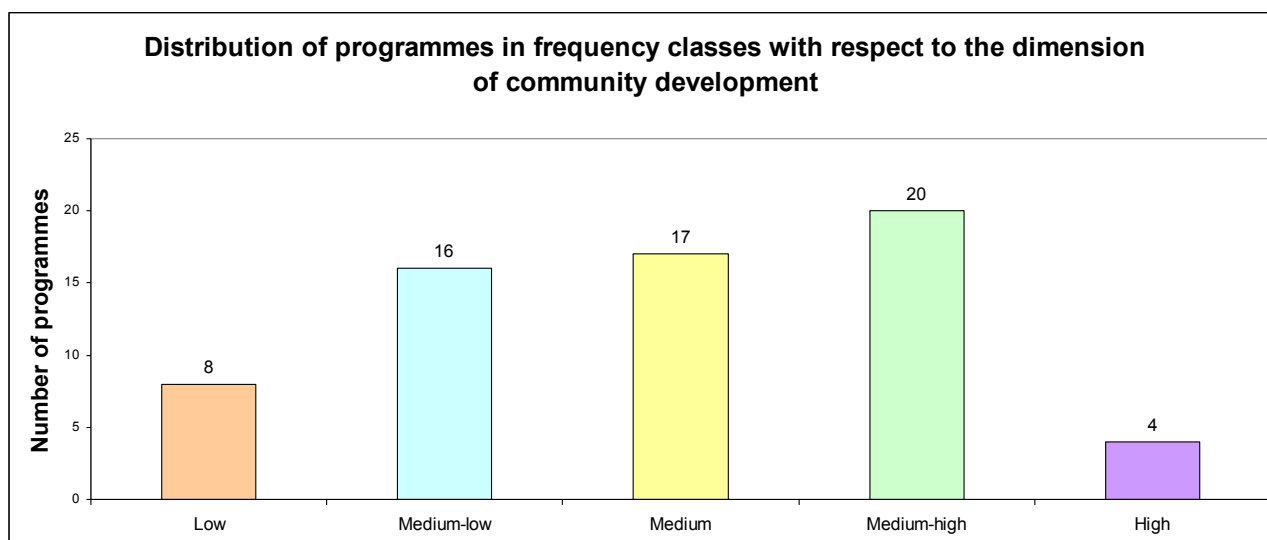
The graph shows the distribution of the 65 programmes based on the percentage score achieved in all domains relating to the quality dimension of "community development".



The distribution of scores of the 65 training programmes is shown by dividing them into two groups around the arithmetic mean, 26.1%, of all scores, calculated considering the highest and the lowest scores identified. The graph clearly shows the programmes that fall above and under the score mean. The highest score, 64%, is achieved by the training programmes with number code 3 and 12 and the lowest, 0% by the training programmes with code number 7, 8, 9, 16, 39, 40, 55 and 64.

Low	<6.5
Medium-low	6.5%-19.5%
Medium	19,5%-32,5%
Medium-high	32.5%-45.5%
High	> 45.5%

The level of quality of the 65 training programmes relating to the dimension of “community development” is defined by their positioning within the five frequency classes created around the score mean, 26.1%.



The graph shows the number of programmes within each of the frequency classes.

QUALITY ASSESSMENT BY COMMUNITY DEVELOPMENT			
CODE	Country of contact person	Title of the training programme	% score
3	WHO	WHO/Europe multi-country training on reorienting strategies, programmes and activities on Millennium Development Goals 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population	64
12	Denmark	The ethnical patient coordinator team	64
4	Austria	Transcultural competency for health professionals especially nursing staff	55
19	IOM	Training modules on migration and health for health professionals (PHBLM Project 2007-2010) and parallel training for Border Guards with similar and different modules	55
1	Austria	University Master-Course “Transcultural Medicine and Diversity Care”	45
6	Cyprus	United to END FGM e-Learning Course	45
11	Denmark	NO TITLE	45
20	IOM	Training on Migration and Health for Health Professionals (EQUI-HEALTH project)	45
24	Italy	Linee d'intervento transculturali nell'assistenza di base e nel materno infantile	45
25	Italy	Programma Regionale di Formazione degli operatori socio sanitari sull'assistenza sanitaria ai cittadini stranieri	45
26	Italy	XVI CORSO INTERNAZIONALE DI MEDICINA TRANSCULTURALE. Dal ben-essere all'essere. Note a margine su un mondo in trasformazione	45
62	PICUM	Access to health care for undocumented migrants in Europe (at times with focus on care for undocumented women (or sexual and reproductive health) and/or care for undocumented children)	45
10	Czech Republic	Roma Social Health Assistant (mediator) - pilot training course in 2005-2007	36
18	Hungary	Interdisciplinary Training on Social Inclusion (ITSI)	36
21	Italy	Corso Nazionale di Mediazione Transculturale – Progetto PASS	36
30	Malta	Promoting Breastfeeding amongst Migrant Women	36
31	Malta	Like Mother...Like Daughter?? FGM for stakeholders working with female migrants	36

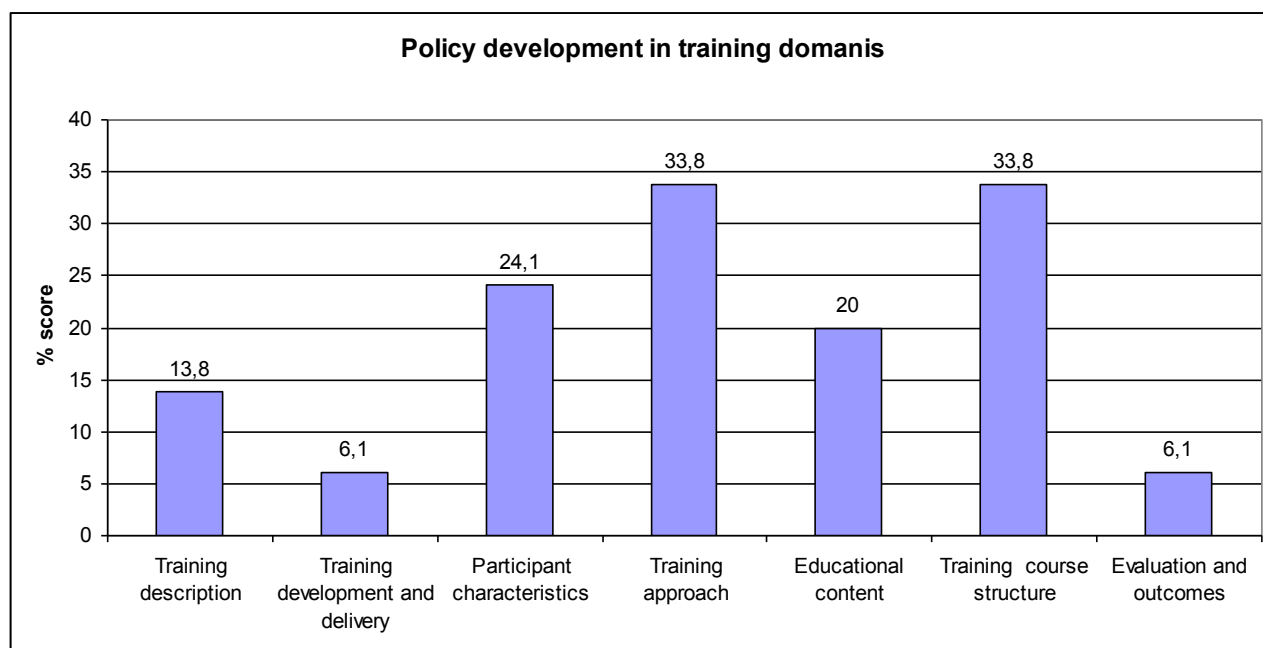
33	Netherlands	Masterclass Huisartsen in achterstandswijken (Masterclass for GPcare in deprived areas)	36
34	Scotland	NHS Lothian Health Inequalities Training	36
35	Scotland	NHS Lothian LearnPro e-learning module on equality & diversity	36
36	Scotland	Equality Impact Assessment Training	36
44	Spain	Intercultural training seminars for professionals of the Aragonese Health Service conducted by the Intercultural Mediation Service Support (SAMI) of Adunare Foundation and financed by the Ministry of Labour and Social Affairs and the Government of Aragon.	36
45	Spain	Training to improve health care for migrant population	36
51	UK	Therapy across languages and cultures with and without an interpreter	36
5	Bulgaria	Improving the skills and knowledge of GPs and nurses how to work better with Roma community. Creating team between GP, nurses and Roma Health Mediators	27
13	France	Formations de Migrations Santé Alsace	27
14	France	Cultural competence for health and social services	27
17	Hungary	Interculturality Training for Health Care Professionals	27
23	Italy	New dimensions of care in pluricultural contexts	27
27	Italy	Psychosocial Interventions in Migration, Displacement and Emergency	27
28	Malta	Training Programme for Cultural Mediators in Health Care	27
32	Malta	MARENOSTRUM: Receiving and taking care	27
37	Slovakia	PHBLM project: "Increasing Public Health Safety Alongside the New Eastern European Border Line", 2007- 2009	27
41	Spain	Master on Health Promotion	27
47	Spain	Handbook for Action in the Area of Health Services with the Roma Community	27
48	Spain	Health, Addiction Prevention and Roma Youth in Europe	27
50	Sweden	Refugee Mental health and Mental health Care	27
56	Slovenia	Homecare nursing of socially disadvantaged population groups	27
57	Slovenia	Care for vulnerable population groups	27
59	Finland	How to meet death at different religions and cultures – backgrounds and practices (Kuoleman kohtaaminen eri uskonnoissa ja kulttuureissa . käytännöt ja taustat)	27
60	Finland	Migrant refugees psychiatric care (Pakolaistaustaisten maahanmuuttajien psykiatrinen hoito)	27
<b>SCORE MEAN 26.1%</b>			
2	Austria	Managing Diversity	18
15	France	Diplôme Universitaire "psychiatrie et compétences transculturelles"	18
22	Italy	Malattie infettive neglette tra cronicità, latenza e riemergenza	18
29	Malta	Addressing Migrant Health Issues	18
61	Belgium	Health mediation training within the framework of the national program of health mediation	18
63	Netherlands	Ethnic diversity in your practice	18
38	Slovakia	Enhancing intercultural skills and regional cooperation professionals working with migrants IV.	9
42	Spain	University Master in Anthropology: Culture, migration and health	9
43	Spain	On line service training, for people specialist in immigration, interculturalidad and diversity	9
46	Spain	A guide of health intervention strategies for Roma women	9
49	Sweden	Transcultural psychiatry. Migration, mental illness and trauma	9
52	WHO	Migration: a Public Health perspective	9
53	WHO	Impact of the economic crisis on the determinants of health and response strategies in Europe	9
54	Italy	ARTEMIS: Training course for cultural mediators and health community workers	9
58	Netherlands	Suicide prevention in asylum seekers centres – a train the trainers course	9
65	Ireland	Introduction to cultural diversity in health care training programme	9
7	Cyprus	Training workshop: Cultural competency of Community Nurses	0
8	Cyprus	Diversity and multiculturalism in the work context	0

9	Cyprus	Training of public officers for identifying torture and special needs in victims of torture	0
16	Greece	MSc in Transcultural Nursing, Faculty of Nursing, University of Athens	0
39	Spain	Master of Global Health	0
40	Spain	Master in "International Migration and Health: and Strategies of Intervention"	0
55	Italy	PRISMA: "Practical – theoretical training to prepare experts on Migration and HIV"	0
64	Ireland	Anti Racism and Intercultural Training; Awareness Raising	0

### Quality dimension 4: policy development

Correlations between variables related to the dimension of “policy development” identified in the relevant domains.

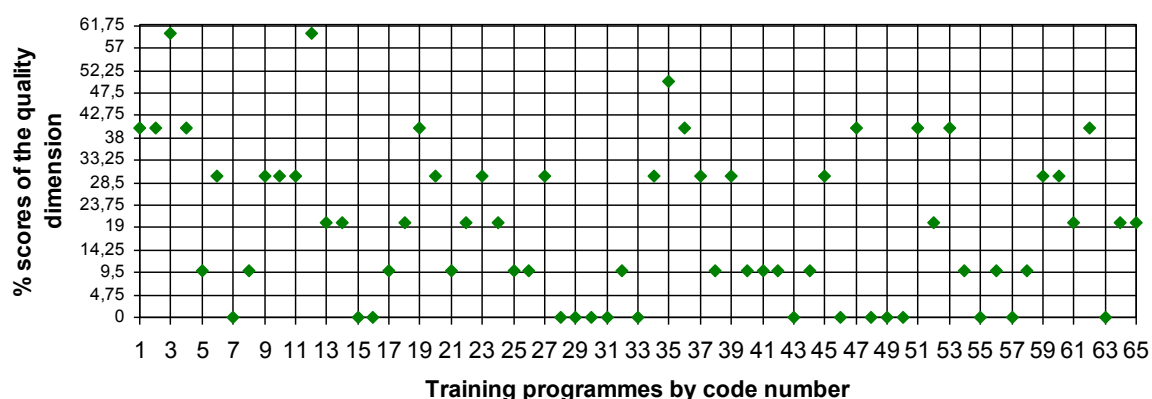
Quality dimension	DOMAINS CONSIDERED							Total scores
	Training description	Training development and delivery	Participant characteristics	Training approach	Educational content	Training course structure	Evaluation and outcomes	
Policy development	9\65	8\130	47\195	22\65	13\65	22\65	4\65	125\650
	13.8%	6.1%	24.1%	33.8%	20%	33.8%	6.1%	19.2%



The graph shows the general level of policy development in the domains. Policy development refers to the creation of a formal framework, which provides legitimacy for an effective training policy for health care organisations. Therefore, policy development is traced through the identification of correlations between variables demonstrating how the training programme is able to connect health professional improvements with existing or improved policy measures. In the domain “Training description” in 13.8% of cases the programmes indicate they have referred to national/regional policy or legislative requirements together with other methods of analysis for the identification of training needs. A low level of reliance on national and international policies is noted in the domain “Training development and delivery”, 6.1%. A greater effort to favour the relationship between the programmes and the policy level is found in the domain “Participants characteristics”, 24.1%, where a certain level of involvement of decision makers, authority and government representatives is reported in the training audience. A remarkable attempt to connect policy to training is traced in the domain “Training approach”, 33.8%, where the focus of training programmes when addressing the issue of access to health care, not only was centred on language and communication barriers but also on legal and financial barriers. The domain “Educational content” shows that when the programmes aimed to improve the capacity of individuals to apply knowledge, in 20% of cases they included teaching of strategic planning of inter-sectoral interventions, thus fostering the integration of policies. It is worthy of note that in 33.8% of cases training programmes were able to establish links with organisational policies or actions, as demonstrated in the domain “Training structure”. Finally, the low level policy development in the domain “Evaluation and Outcomes”, 6.1%, is of little surprise as the impact of training programme is hardly measured in terms of improved policies and procedures.

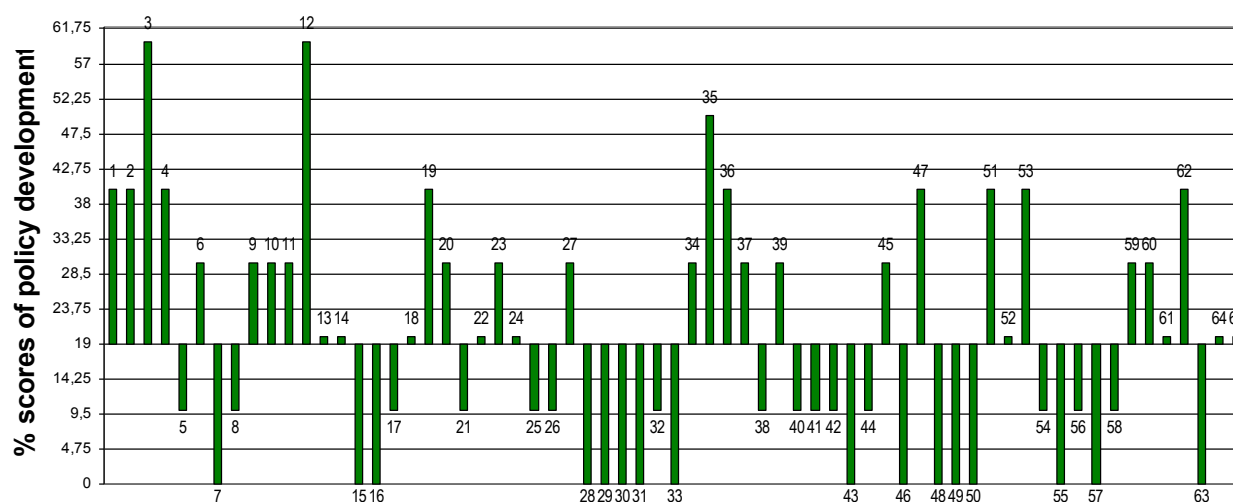


**Distribution of programmes with respect to the dimension of policy development**



The graph shows the distribution of the 65 programmes based on the percentage score achieved in all domains relating to the quality dimension of “policy development”.

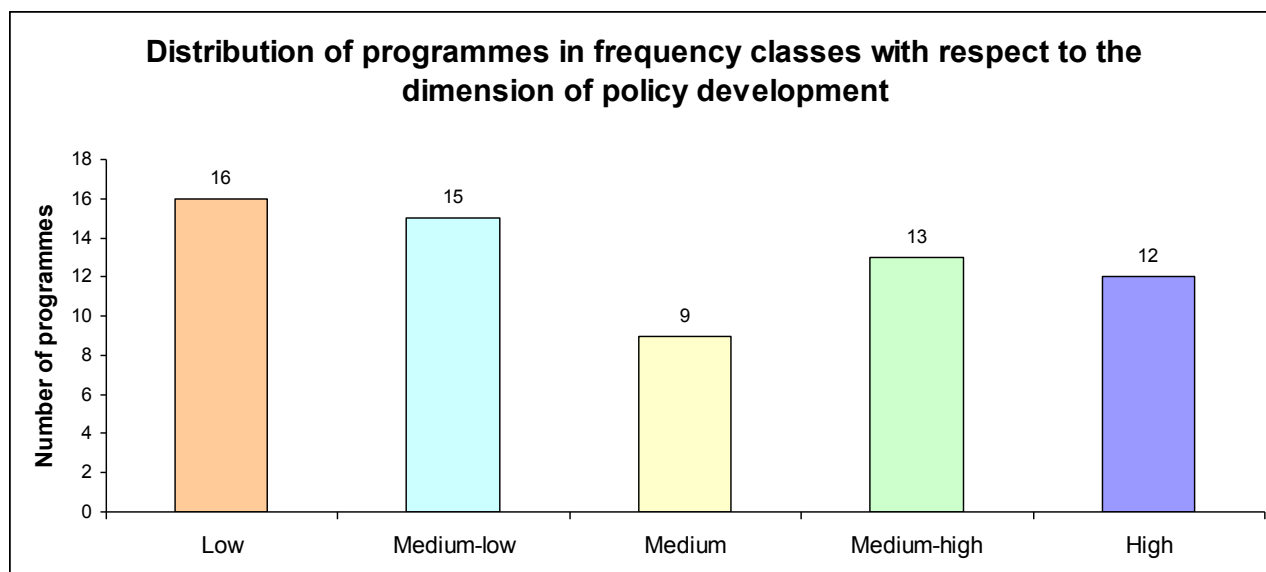
**Distribution of programmes around the score mean of the policy development dimension**



The distribution of scores of the 65 training programmes is shown by dividing them into two groups around the arithmetic mean, 19.2%, of all scores, calculated considering the highest and the lowest scores identified. The graph clearly shows the programmes that fall above and under the score mean. The highest score, 60%, is achieved by the training programmes with number code 3 and 12 and the lowest, 0%, by the training programmes with code number 7, 15, 16, 28, 29, 30, 31, 33, 43, 46, 48, 49, 50, 55, 57 and 63.

Low	< 4.75%
Medium-low	4.75%-14.25%
Medium	14.25%-23.75%
Medium-high	23.75%-33.25%
High	> 33.25%

The level of quality of the 65 training programmes relating to the dimension of “policy development” is defined by their positioning within the five frequency classes created around the score mean, 19.2%.



The graph shows the number of programmes within each of the frequency classes.

QUALITY ASSESSMENT BY POLICY DEVELOPMENT			
CODE	Country of contact person	Title of the training programme	% score
3	WHO	WHO/Europe multi-country training on reorienting strategies, programmes and activities on Millennium Development Goals 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population	60
12	Denmark	The ethnical patient coordinator team	60
35	Scotland	NHS Lothian LearnPro e-learning module on equality & diversity	50
1	Austria	University Master-Course "Transcultural Medicine and Diversity Care"	40
2	Austria	Managing Diversity	40
4	Austria	Transcultural competency for health professionals especially nursing staff	40
19	IOM	Training modules on migration and health for health professionals (PHBLM Project 2007-2010) and parallel training for Border Guards with similar and different modules	40
36	Scotland	Equality Impact Assessment Training	40
47	Spain	Handbook for Action in the Area of Health Services with the Roma Community	40
51	UK	Therapy across languages and cultures with and without an interpreter	40
53	WHO	Impact of the economic crisis on the determinants of health and response strategies in Europe	40
62	PICUM	Access to health care for undocumented migrants in Europe (at times with focus on care for undocumented women (or sexual and reproductive health) and/or care for undocumented children)	40
6	Cyprus	United to END FGM e-Learning Course	30
9	Cyprus	Training of public officers for identifying torture and special needs in victims of torture	30
10	Czech Republic	Roma Social Health Assistant (mediator) - pilot training course in 2005-2007	30
11	Denmark	NO TITLE	30
20	IOM	Training on Migration and Health for Health Professionals (EQUI-HEALTH project)	30

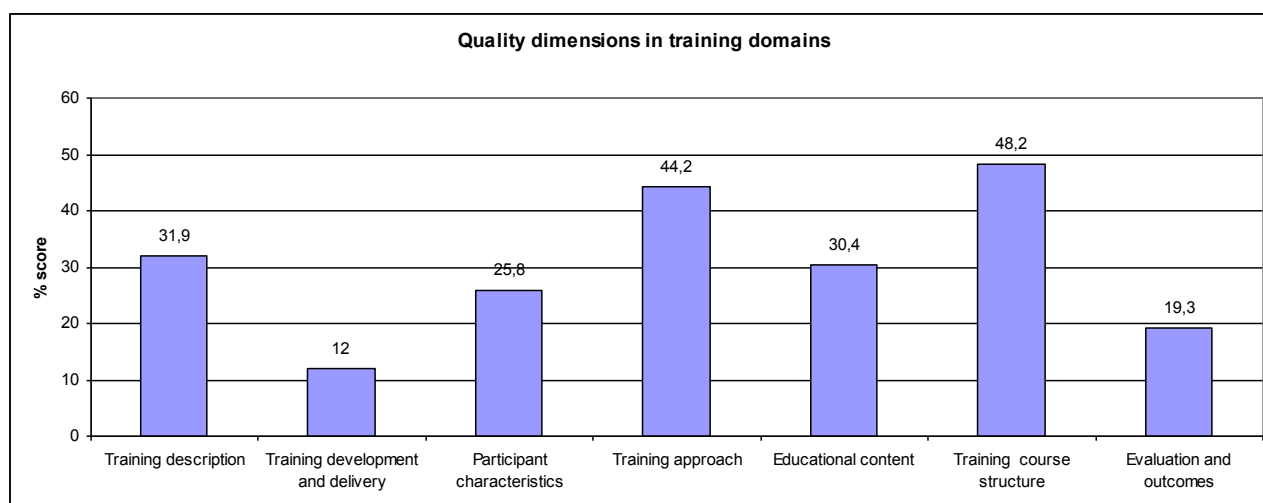
23	Italy	New dimensions of care in pluricultural contexts	30
27	Italy	Psychosocial Interventions in Migration, Displacement and Emergency	30
34	Scotland	NHS Lothian Health Inequalities Training	30
37	Slovakia	PHBLM project: "Increasing Public Health Safety Alongside the New Eastern European Border Line", 2007- 2009	30
39	Spain	Master of Global Health	30
45	Spain	Training to improve health care for migrant population	30
59	Finland	How to meet death at different religions and cultures – backgrounds and practices (Kuoleman kohtaaminen eri uskonnoissa ja kulttuureissa . käytännöt ja taustat)	30
60	Finland	Migrant refugees psychiatric care (Pakolaistaustaisten maahanmuuttajien psykiatrinen hoito)	30
13	France	Formations de Migrations Santé Alsace	20
14	France	Cultural competence for health and social services	20
18	Hungary	Interdisciplinary Training on Social Inclusion (ITSI)	20
22	Italy	Malattie infettive neglette tra cronicità, latenza e riemergenza	20
24	Italy	Linee d'intervento transculturali nell'assistenza di base e nel materno infantile	20
52	WHO	Migration: a Public Health perspective	20
61	Belgium	Health mediation training within the framework of the national program of health mediation	20
64	Ireland	Anti Racism and Intercultural Training; Awareness Raising	20
65	Ireland	Introduction to cultural diversity in health care training programme	20
<b>SCORE MEAN 19.2%</b>			
5	Bulgaria	Improving the skills and knowledge of GPs and nurses how to work better with Roma community. Creating team between GP, nurses and Roma Health Mediators	10
8	Cyprus	Diversity and multiculturalism in the work context	10
17	Hungary	Interculturality Training for Health Care Professionals	10
21	Italy	Corso Nazionale di Mediazione Transculturale – Progetto PASS	10
25	Italy	Programma Regionale di Formazione degli operatori socio sanitari sull'assistenza sanitaria ai cittadini stranieri	10
26	Italy	XVI CORSO INTERNAZIONALE DI MEDICINA TRANSCULTURALE. Dal ben-essere all'essere. Note a margine su un mondo in trasformazione	10
32	Malta	MARENOSTRUM: Receiving and taking care	10
38	Slovakia	Enhancing intercultural skills and regional cooperation professionals working with migrants IV.	10
40	Spain	Master in "International Migration and Health: and Strategies of Intervention"	10
41	Spain	Master on Health Promotion	10
42	Spain	University Master in Anthropology: Culture, migration and health	10
44	Spain	Intercultural training seminars for professionals of the Aragonese Health Service conducted by the Intercultural Mediation Service Support (SAMI) of Adunare Foundation and financed by the Ministry of Labour and Social Affairs and the Government of Aragon.	10
54	Italy	ARTEMIS: Training course for cultural mediators and health community workers	10
56	Slovenia	Homecare nursing of socially disadvantaged population groups	10
58	Netherlands	Suicide prevention in asylum seekers centres – a train the trainers course	10
7	Cyprus	Training workshop: Cultural competency of Community Nurses	0
15	France	Diplôme Universitaire "psychiatrie et compétences transculturelles"	0
16	Greece	MSc in Transcultural Nursing, Faculty of Nursing, University of Athens	0
28	Malta	Training Programme for Cultural Mediators in Health Care	0
29	Malta	Addressing Migrant Health Issues	0
30	Malta	Promoting Breastfeeding amongst Migrant Women	0
31	Malta	Like Mother...Like Daughter?? FGM for stakeholders working with female migrants	0
33	Netherlands	Masterclass Huisartsen in achterstandswijken (Masterclass for GPcare in deprived areas)	0
43	Spain	On line service training, for people specialist in immigration, interculturalidad and diversity	0

46	Spain	A guide of health intervention strategies for Roma women	0
48	Spain	Health, Addiction Prevention and Roma Youth in Europe	0
49	Sweden	Transcultural psychiatry. Migration, mental illness and trauma	0
50	Sweden	Refugee Mental health and Mental health Care	0
55	Italy	PRISMA: "Practical – theoretical training to prepare experts on Migration and HIV"	0
57	Slovenia	Care for vulnerable population groups	0
63	Netherlands	Ethnic diversity in your practice	0

## Overall quality assessment of training programmes

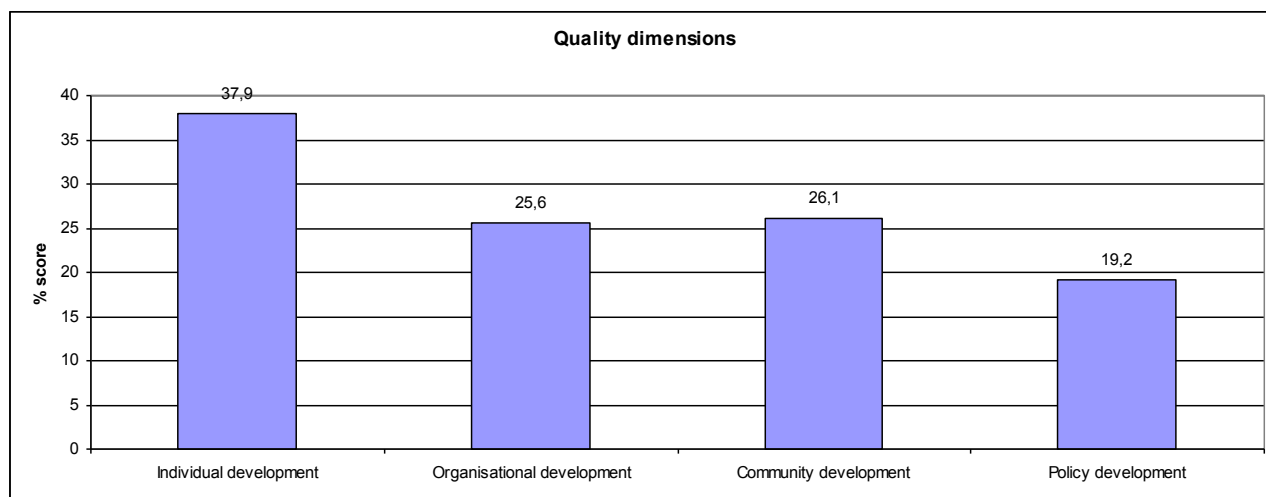
Percentage of correlations between variables relating to the four quality dimensions identified in the domains

Quality dimensions	SEVEN DOMAINS							Total scores
	Training description	Training development and delivery	Participant characteristics	Training approach	Educational content	Training course structure	Evaluation and outcomes	
All	83\260	55\455	84\325	230\520	356\1170	188\390	63\325	1029\3445
	31.9%	12%	25.8%	44.2%	30.4%	48.2%	19.3%	29.8%

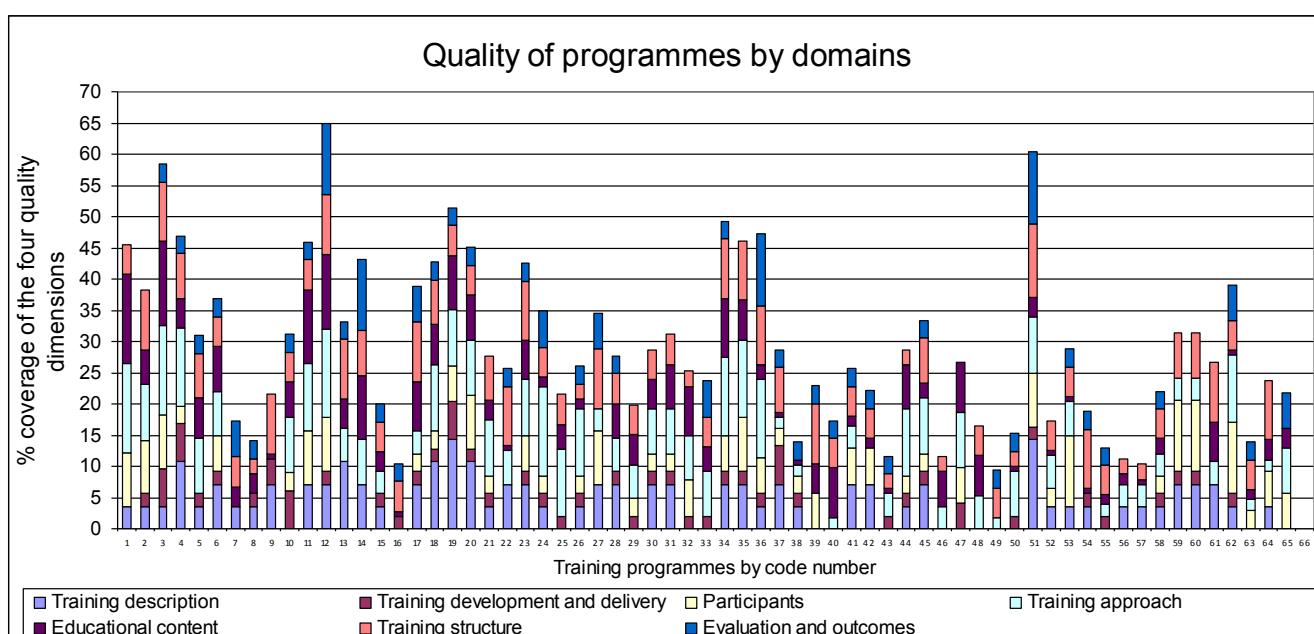


The graph shows the general level of quality relating to the four quality dimensions in the domains. The quality of the training programmes is evaluated through their capacity to link the development of individual competences to developments in the organisation, the community and policy. The aim was to identify experiences which succeeded in creating a mutual correlation between the four dimensions of care (individual, organisational, community, policy) based on the premise that it is only through an integrated, system approach that it is possible to produce knowledge, competences and practices able to transform and to effectively improve access and reduce inequality in health. This type of integration was mostly achieved in the domain "Training course structure", 48.2%, and the domain "Training approach", 44.2%. The first shows the extent to which correlations between the four dimensions of care were addressed in the definition of the methods of delivery and formats of training, as well as in the identification of organisational support mechanisms, such as quality improvement planning, procedures relating to professional development, performance monitoring, appropriate certification and recognition of learning. The second shows the extent to which this integrated approach was addressed in the identification of the theoretical constructs and principles that underpin the pedagogical approach, as well as in the definition of the conceptual framework and the focus of training. To a lesser extent this type of integration is traced in the domain "Training description", 31.9%; "Participants characteristics", 25.8%; and "Educational content", 30.4%, showing the level of integration demonstrated by the training programmes when defining the training needs, the composition of the workforce targeted and the team of trainers, and the main components of the educational content. As noted previously, the low results in the domain "Training development and delivery", 12%, and the domain "Evaluation and outcomes", 19.3%, indicate the low level of participation and involvement in training development and delivery, and general lack of focus on outcomes in training design.

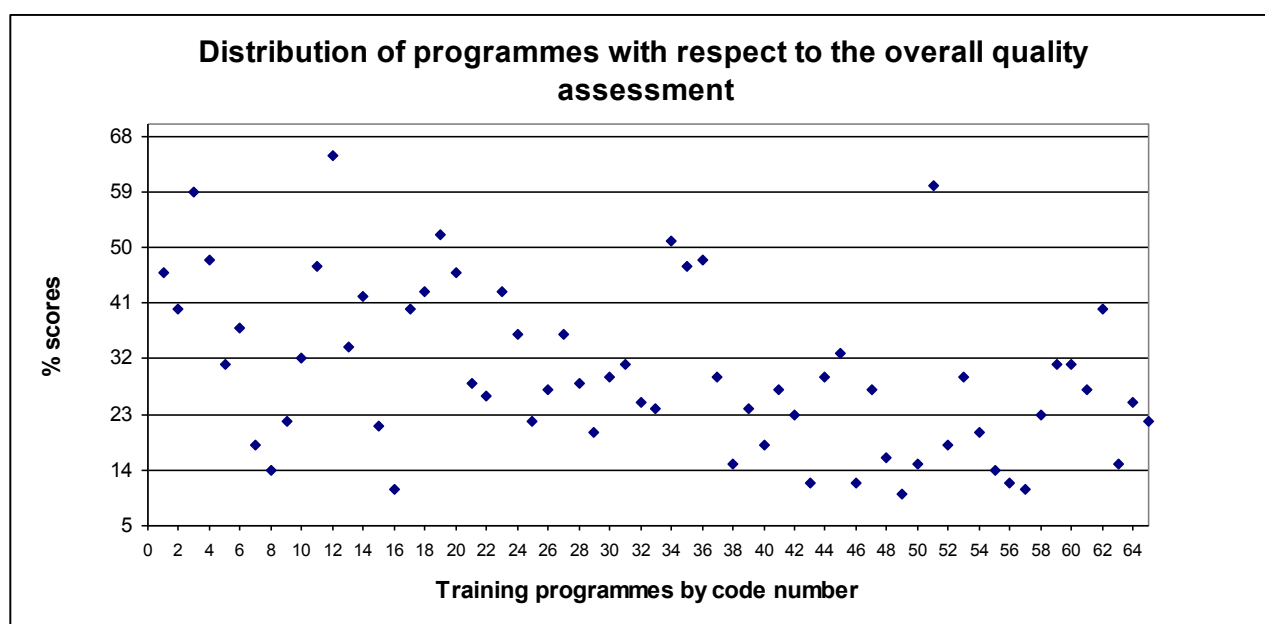
Domains	FOUR QUALITY DIMENSIONS				Total scores
	Individual development	Organisational development	Community development	Policy development	
All	567\1495	150\585	187\715	125\650	1029\3445
	37.9%	25.6%	26.1	19.2%	29.8%



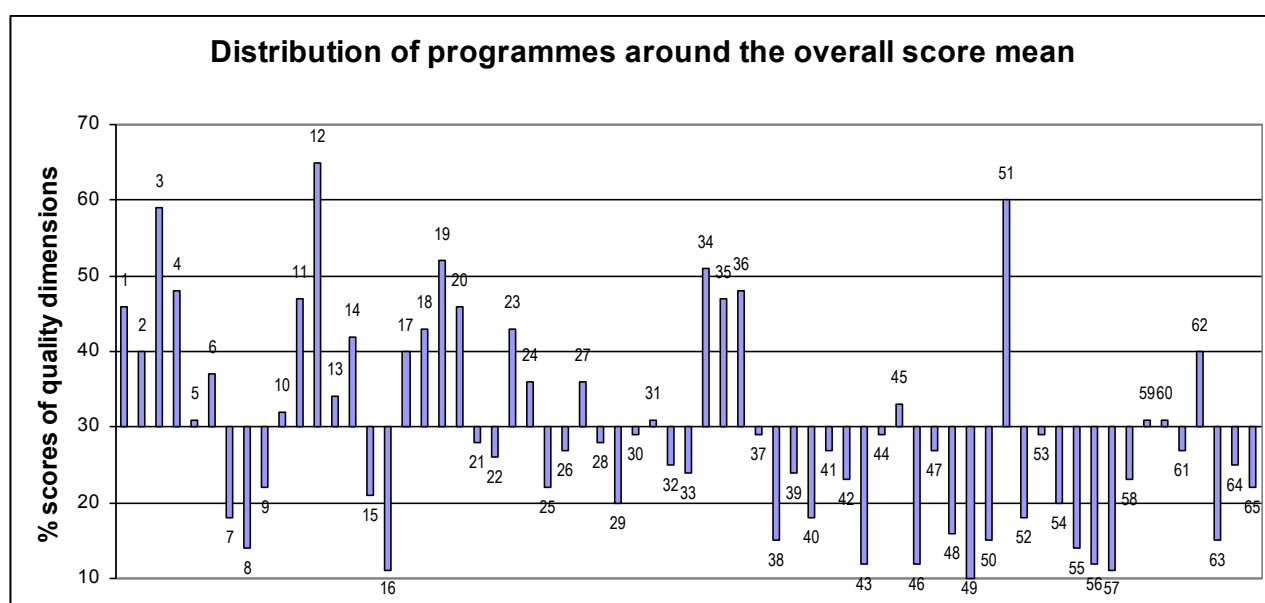
The graph shows the level of quality demonstrated by the 65 training programmes in relation to the four dimensions identified: individual development, 37.9%, organisational development, 25.6%, community development, 26.1% and policy development, 19.2%. The total score achieved is only 29.8%.



The graph shows the overall score achieved by the 65 training programmes relating to the four dimensions of quality in the relevant domains.



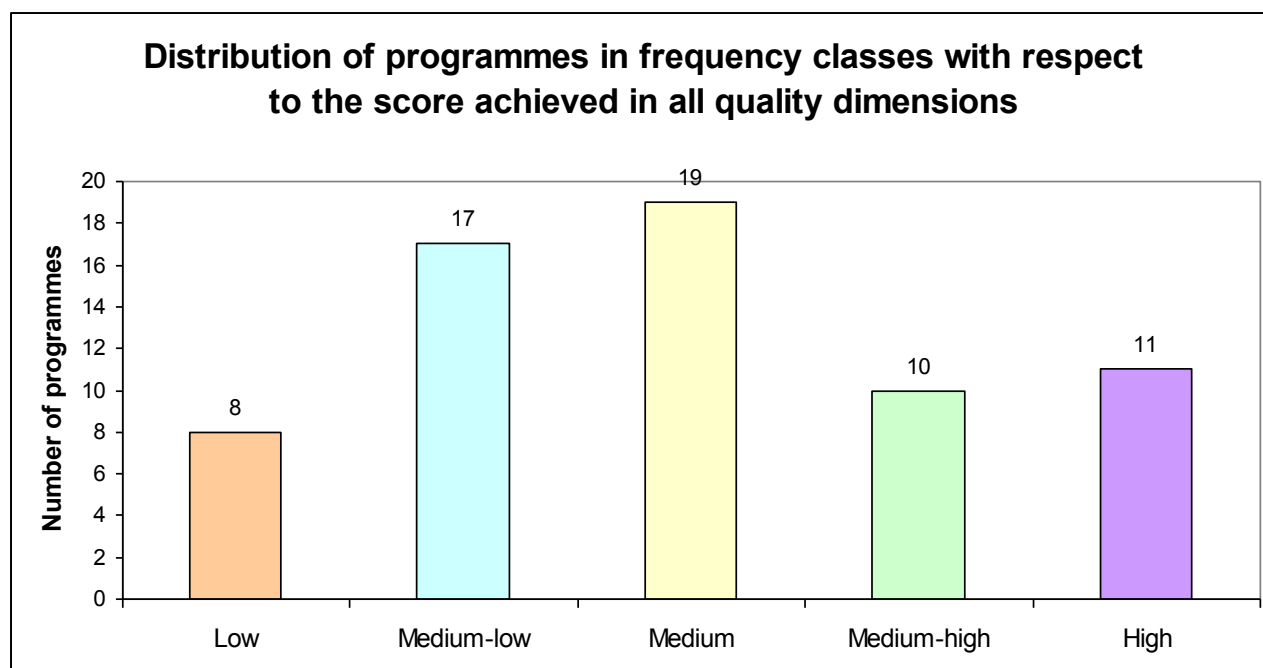
The graph shows the distribution of the 65 programmes based on the percentage score achieved in all domains relating to all quality dimensions.



The distribution of the scores of the 65 training programmes is shown by dividing them into two groups around the arithmetic mean, 29.8%, of all scores, calculated considering the highest and the lowest scores identified. The graph clearly shows the programmes that fall above and under the score mean. The highest score, 65%, is achieved by the training programme with number code 12 and the lowest, 10%, by the training programme with code number 49.

Low	< 14.25%
Medium-low	14.25%-24.75%
Medium	24.75%-35.25%
Medium-high	35.25%-45.75%
High	> 45.75%

The level of quality of the 65 training programmes relating to all dimensions of quality is defined by their positioning within the five frequency classes created around the score mean, 29.8%.



The graph shows the number of programmes within each of the frequency classes.

OVERALL QUALITY ASSESSMENT			
CODE	Country of contact person	Title of the training programme	% score
12	Denmark	The ethnical patient coordinator team	65
51	UK	Therapy across languages and cultures with and without an interpreter	60
3	WHO	WHO/Europe multi-country training on reorienting strategies, programmes and activities on Millennium Development Goals 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population	59
19	IOM	Training modules on migration and health for health professionals (PHBLM Project 2007-2010) and parallel training for Border Guards with similar and different modules	52
34	Scotland	NHS Lothian Health Inequalities Training	51
36	Scotland	Equality Impact Assessment Training	48
4	Austria	Transcultural competency for health professionals especially nursing staff	48
35	Scotland	NHS Lothian LearnPro e-learning module on equality & diversity	47
11	Denmark	NO TITLE	47
20	IOM	Training on Migration and Health for Health Professionals (EQUI-HEALTH project)	46
1	Austria	University Master-Course "Transcultural Medicine and Diversity Care"	46
23	Italy	New dimensions of care in pluricultural contexts	43
18	Hungary	Interdisciplinary Training on Social Inclusion (ITSI)	43
14	France	Cultural competence for health and social services	42
62	PICUM	Access to health care for undocumented migrants in Europe (at times with focus on care for undocumented women (or sexual and reproductive health) and/or care for undocumented children)	40
17	Hungary	Interculturality Training for Health Care Professionals	40



2	Austria	Managing Diversity	40
6	Cyprus	United to END FGM e-Learning Course	37
27	Italy	Psychosocial Interventions in Migration, Displacement and Emergency	36
24	Italy	Linee d'intervento transculturali nell'assistenza di base e nel materno infantile	36
13	France	Formations de Migrations Santé Alsace	34
45	Spain	Training to improve health care for migrant population	33
10	Czech Republic	Roma Social Health Assistant (mediator) - pilot training course in 2005-2007	32
60	Finland	Migrant refugees psychiatric care (Pakolaistaustaisten maahanmuuttajien psykiatrinen hoito)	31
59	Finland	How to meet death at different religions and cultures – backgrounds and practices (Kuoleman kohtaaminen eri uskonnoissa ja kulttuureissa . käytännöt ja taustat)	31
31	Malta	Like Mother...Like Daughter?? FGM for stakeholders working with female migrants	31
5	Bulgaria	Improving the skills and knowledge of GPs and nurses how to work better with Roma community. Creating team between GP, nurses and Roma Health Mediators	31
53	WHO	Impact of the economic crisis on the determinants of health and response strategies in Europe	29
44	Spain	Intercultural training seminars for professionals of the Aragonese Health Service conducted by the Intercultural Mediation Service Support (SAMI) of Adunare Foundation and financed by the Ministry of Labour and Social Affairs and the Government of Aragon.	29
37	Slovakia	PHBLM project: "Increasing Public Health Safety Alongside the New Eastern European Border Line", 2007- 2009	29
30	Malta	Promoting Breastfeeding amongst Migrant Women	29
<b>SCORE MEAN 29.8%</b>			
28	Malta	Training Programme for Cultural Mediators in Health Care	28
21	Italy	Corso Nazionale di Mediazione Transculturale – Progetto PASS	28
61	Belgium	health mediation training within the framework of the national program of health mediation	27
47	Spain	Handbook for Action in the Area of Health Services with the Roma Community	27
41	Spain	Master on Health Promotion	27
26	Italy	XVI CORSO INTERNAZIONALE DI MEDICINA TRANSCULTURALE. Dal ben-essere all'essere. Note a margine su un mondo in trasformazione	27
22	Italy	Malattie infettive neglette tra cronicità, latenza e riemergenza	26
64	Ireland	Anti Racism and Intercultural Training; Awareness Raising	25
32	Malta	MARENOSTRUM: Receiving and taking care	25
33	Netherlands	Masterclass Huisartsen in achterstandswijken (Masterclass for GPcare in deprived areas)	24
39	Spain	Master of Global Health	24
58	Netherlands	Suicide prevention in asylum seekers centres – a train the trainers course	23
42	Spain	University Master in Anthropology: Culture, migration and health	23
65	Ireland	Introduction to cultural diversity in health care training programme	22
25	Italy	Programma Regionale di Formazione degli operatori socio sanitari sull'assistenza sanitaria ai cittadini stranieri	22
9	Cyprus	Training of public officers for identifying torture and special needs in victims of torture	22
15	France	Diplôme Universitaire "psychiatrie et compétences transculturelles"	21
54	Italy	ARTEMIS: Training course for cultural mediators and health community workers	20
29	Malta	Addressing Migrant Health Issues	20
52	WHO	Migration: a Public Health perspective	18
40	Spain	Master in "International Migration and Health: and Strategies of Intervention"	18
7	Cyprus	Training workshop: Cultural competency of Community Nurses	18
48	Spain	Health, Addiction Prevention and Roma Youth in Europe	16
63	Netherlands	Ethnic diversity in your practice	15
50	Sweden	Refugee Mental health and Mental health Care	15

38	Slovakia	Enhancing intercultural skills and regional cooperation professionals working with migrants IV.	<b>15</b>
55	Italy	PRISMA: "Practical – theoretical training to prepare experts on Migration and HIV"	<b>14</b>
8	Cyprus	Diversity and multiculturalism in the work context	<b>14</b>
56	Slovenia	Homecare nursing of socially disadvantaged population groups	<b>12</b>
46	Spain	A guide of health intervention strategies for Roma women	<b>12</b>
43	Spain	On line service training, for people specialist in immigration, interculturalidad and diversity	<b>12</b>
57	Slovenia	Care for vulnerable population groups	<b>11</b>
16	Greece	MSc in Transcultural Nursing, Faculty of Nursing, University of Athens	<b>11</b>
49	Sweden	Transcultural psychiatry. Migration, mental illness and trauma	<b>10</b>

## RECOMMENDATIONS

### **Develop a diversity responsiveness management framework, guidelines and resources.**

This will enable systems and organisations to incorporate diversity responsiveness and migrant-friendly training into organisational policy and development. Health care service delivery and training programmes should be integrated as a whole in order to ensure effective response to the needs of patients, carers, health professionals and the community. A care provider may be trained but if organisational support is lacking (for example if the use of an interpreter is not facilitated by the organisation) the impact of the training will be limited.

### **Develop a diversity responsiveness assessment framework**

Health care organisations should adopt a comprehensive framework for measuring and monitoring their capacity to improve accessibility, utilization and quality of health care for migrants and ethnic minorities. (e.g.: equity standards in health care)

### **Promote the implementation of a whole-organisation and health-system approach**

The design, delivery and outcomes of training courses should be able to link individual improvements of the workforce to organisational, community and policy development in order to maximise the effect of reducing the barriers in the access and quality of health care delivery for migrants and ethnic minorities.

### **Promote training programmes and resources for managing diversity and intercultural communication.**

Health care organisations should ensure that staff at all levels, improve awareness, acquire knowledge and build capacity to address issues related to access and quality of care for migrants, ethnic minorities and other vulnerable groups. It is, also, important that the training process addresses intercultural and health/social mediators and other health care professionals at the same time, in order to create a shared and legitimized inter-professional space which can be acknowledged by the whole system.

### **Involve service users and stakeholders in training planning, development and evaluation.**

Since care strategies involve a vast network of needs, relations and services, that go beyond the confines of the health services as such, training programmes should foster the cooperation of health professionals with other social actors, institutions and existing resources in the community.

### **Develop a clear rationale and a consistent pedagogical approach for the training programme.**

Training should not simply aim at integrating educational curricula with new knowledge and competences, but should also focus on emphasizing the role of a pedagogical approach able to define the teaching and learning methods used in an intervention and the theoretical constructs and principles that underpin it.

### **Embed a focus on outcomes in training design, delivery and evaluation methods.**

Training programmes should embed a clear focus on outcomes for healthcare professionals as well as patients, and health care organisations.

### **Allocate appropriate resource funding to the development, delivery and evaluation of the training.**

***While not a topic of this review we recommend that students are being trained in diversity responsiveness in medical and nursing schools and that curricula should systematically address these issues.***

## **ACTION GUIDE FOR THE DEVELOPMENT AND DELIVERY OF EFFECTIVE TRAINING**

### **HOW training objectives should be identified**

Needs assessment results constitute important material for the development of specific objectives and design for training. Training needs should be based on analysis of actual incidents/problems that patients, staff, organisations have encountered in providing service to MEMs. Case studies that are drawn directly from experience are a particularly powerful tool for practicing the skills taught in training.

### **WHO should develop the training programme**

Developing the training programme is a crucial task for the training provider, but the planning should be done in cooperation with relevant organisations and stakeholders at various levels to ensure that training content and design refers to the specific needs of health care service and MEMs.

### **WHO should participate**

As to whether a single- or multi-professional approach should be preferred, we would suggest a multi-professional, cross-hierarchical general approach at the beginning of training addressing the issues of access and quality of care delivery for MEMs. This would set the context for an understanding of the complexity and relevance of such training from many different perspectives.

### **WHO should conduct the course**

In general, what is minimally required is a professional trainer who has good knowledge of and background in MEMs issues. Familiarity with the routines and procedures in a health care setting, so that she or he can relate adequately to the challenges of everyday work for the various professions represented. The results of the review show a trend leading toward a recommendation for a team approach with a trainer team that is "mixed" with respect to professional and academic qualifications.

### **HOW should work be organised**

The course should promote cognitive and emotional learning, which suggests the use of diverse and interactive educational methods such as case studies, role plays (up to drama elements), discussions, panel discussions to demonstrate different perspectives, the use of guest speakers on certain topics, etc.

### **WHAT content should be included**

*Sensitivity and awareness* of culturally diverse backgrounds (health professional vs. lay patient, level of education, ethnicity, national origin, socio-economic class, gender, age, migration history, migration status and entitlement, etc.) and their influence on people's perceptions, interpretation of and behaviour in the world. It is crucial to make sure from the first that participants develop an awareness of the fact that their impressions, assumptions, prejudices, etc., are influenced by their own specific cultural backgrounds. These cultural backgrounds may include profession, social class, gender, age, etc.

*Knowledge* about problem areas, such as migration and rights to health care; the socio-cultural context of migrants' and ethnic minorities' health; morbidity and mortality patterns; determinants of health among migrants and ethnic minorities; construct of racism and prejudice; high prevalent diseases like diabetes. An awareness of a tendency to address 'easy' topics (e.g. knowledge about ethnic groups) rather than addressing more challenging issues such as racism, stereotypes and discrimination is useful. Self-reflection and self-critique could be incorporated into every training course as an important aspect of awareness.

*Application of knowledge* refers to addressing the capacity to use the acquired knowledge in a reflective and transformative manner. The inclusion of this component into training aims to help participants apply acquired theoretical knowledge in developing strategies for planning and implementing actions in relation to workplace, population, professional, organisational and systemic contexts. Medical anthropological knowledge should be present in both the knowledge and skills teaching part of each course.

*Skills:* This component comprises two subsets: inter- and intra-personal skill development. Certain interventions can teach inter-personal skills to help people work with others, such as advanced communication, negotiation or collaboration. An example in this context is building skills to work effectively with cultural or health mediators. Other interventions can also teach intra-personal skills to help individuals cope with situations. This can include cultural self-assessment and reflection, and deconstructing stereotypes.

## **HOW the intervention should be structured**

*Methods of delivery:* As far as relevant methodologies are concerned, the most successful ones appear to be the following: knowledge transfer, demonstrations, forum and image theatre, case discussions; all strategies based on personal experiences and local examples to enable - as participants – exploration of mutually challenging work situations, to frame together problems and solutions and consolidate networks. Diversity of educational methods also recognizes participants' different learning styles. Size and make-up of groups that work together in group activities should vary in the course. The purpose of each activity, exercise and lecture should be made clear to every participant. Embedded learning (combination of online learning and face to face meetings may be considered).

*Duration:* The review results show a variety on the overall length of the courses, nevertheless the recommended length of in-service training courses ranges between 8 hours (1 day) to full week; training should cover a longer period rather than a one-time event; we suggest approximately 20 hours (2 and ½ days). We suggest offering the course in several modules over several days, which allows the participants an opportunity for reflection and practice between two modules. Training may be more sustainable, covering a longer period with different integrated follow up sessions, when it includes a period of practice learning. As outlined above we propose a follow up meeting after 1 – 4 weeks (depending on frequency of contacts with migrant or ethnic minority patients) to work on problems and/or further issues.

*Participation:* Voluntary or mandatory participation; unselected health care staff or staff of specific departments; single- or multi-professional approach. We propose participation that, although it is voluntary, is heavily championed by the management of the health care organisation or department.

## **HOW the intervention should be evaluated**

*Process evaluation:* Basis: self-rating by participating staff but other forms of assessment (by peers or by patients) should be considered. Start courses with a group discussion; with specific needs assessment and baseline for evaluation; with a multi-perspective approach (from doctors to administrative staff). End courses with group discussions with trained staff: what differences do the participants see in comparison to the start of the course? Use specific methods and tools, e.g.: pre-post questionnaires, written feedback from participants and/or from supervisors, patient-satisfaction survey.

*Impact evaluation:* Training programmes should have a clear focus on outcomes for patients, healthcare professionals, and health care organisations. For patients/service users: treatment outcomes if training programmes are disease specific; involvement in care (healthcare decision making) evaluations of care by patients and users. For healthcare professionals: use validated instruments and differentiate between self-

assessed competencies and competencies assessed by others (peers, patients etc). For healthcare organisations: measure the impact of these types of interventions on healthcare organisations, as these are likely to affect uptake and sustainability.

## **WHO is responsible for what**

### *The training project (team) coordinator*

- Facilitate and support the process
- Negotiate with senior and department-level management
- Select a trainer or team of trainers in collaboration with top management
- Achieve agreement on aims, content, and design with the trainer (team) and with all relevant stakeholders (NGOs representatives, migrant and ethnic minorities' representatives, staff representatives, etc)
- Achieve agreement on evaluation with all relevant stakeholders including oneself, the training project coordinator, the evaluation specialists, ...

### *Department/health service management*

- Select a trainer or a team of trainers with project coordinator
- Decide with trainer/-team upon voluntary/compulsory participation
- Provide for a selection of participants for training with trainer/-team
- Support organisational change by linking the training programme to policies and procedures, actions and service performance assessment.

### *Trainer or team of trainers*

- Develop design and content, rules and forms of participation together with the Head Human Resources and/or training project co-ordinator (in agreement with all relevant stakeholders)
- Conduct needs assessment
- Develop specific objectives
- Decide if specific content and design is needed for the different target groups, which include clinical staff such as doctors, nurses and others, as well as other, non-clinical staff who are involved in direct communication with patients and their relatives.
- Decide on the specific design and sequence of each work session
- Conduct training
- Conduct evaluation at the end of the training

### *Staff representatives*

- Agree and support
- Support organisational development

### *Users / Community representatives (NGOs, Local Authority, ...)*

- Agree and support
- Collaborate in developing and delivering training
- Support the public presentation of results to all health care service staff and to other stakeholders at the end of the training

### *Senior management*

- Give the issue and the intervention high priority on the health care service agenda
- Decide whether participation will be considered as work hours
- Decide about financial resources, trainers, rooms, equipment, etc.

- Provide resources for supportive actions
- Discuss about issues of transfer and sustainability
- Provide public support on the symbolic level as well for organisational policy and management development and promote diversity responsiveness at all levels
- Facilitate application of awareness and skills in everyday routines of the health care service – for example, by including continuous professional development into standards or by setting aside resources such as working time.
- Support the public presentation of results to all health care staff at the end of the training process.

## APPENDICES

Appendix Ia	Training programmes on migrants and ethnic minorities (including Roma), PubMed search
Appendix Ib	Training programmes on migrants and ethnic minorities (including Roma), Google and Google Scholar search
Appendix II	Overview of studies and literature regarding cultural competence training of health care professionals in Europe
Appendix III	Quality criteria: correlations for each of the four dimensions of quality
Appendix IV	List of participating organisations
Appendix V	Directory of quality training materials
Appendix VI	Survey template





### **Annex 3**

Deliverable 3: WP3 New training package: Table of contents



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



**Training Materials**

**Core Contents**

**PREPARED BY:**

EASP Team

Andalusian School of Public Health, March 23<sup>rd</sup> 2015



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



## Training Materials: Core Contents

Contents and activities for the 20 hours face-to-face training will be adapted and translated in the six piloting countries following the indications shown below:

1. The **essential core contents** from Modules 1-4 will be piloted in the national trainings, complemented with contents from Additional Modules pending on every country's specific context.
2. Culture and context specific aspects related to access and quality of health services are to be taken into account for the piloting in the national context:
  - a. Identification of cultural and social issues, structure of the Healthcare System and context specific aspects in migrants' and ethnic minorities health and health care, related to the own local, regional and national context.
  - b. Development of strategies for improving access and quality of health services for migrants' and ethnic minorities' health and healthcare related to the own local, regional or national socioeconomic and cultural context.
  - c. Identification of shared priorities at the local, regional, national and European context related to migrants' and ethnic minorities' health and healthcare.
  - d. Identification of target groups (Additional Module 1) and specific health concerns (Additional Modules 2) relevant in the own national context, to be included in the training materials.
3. Focus of the training is on skills development and management of change, following the national context. For this purpose, the training should be based on an *experiential and participatory pedagogical approach*. Therefore, the proposed distribution between presentations and activities is 50%/50%.



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



REPUBLIC OF TURKEY  
MINISTRY OF HEALTH  
GENEL SAĞLIK DAİRESİ BAŞKANLIĞI



SERVICE UNIVERSITAIRE REGIONAL  
HEALTH PROGRAMME  
Assessment of Health Services and Quality of Health Care



UNIVERSITY OF  
COPENHAGEN



<b>Module 1:</b> <b>Sensitivity and Awareness</b> <b>of Cultural and Other Forms of Diversity</b>  Time: 5 hours  <i>(Proposed distribution between presentations and activities: 50% / 50%. The proposed time distribution for each presentation / activity, as well as the proposed slides are indicative. The presentations should contain the listed core contents).</i>		
Unit 1: Diversity		
Objectives of the presentation		
<ul style="list-style-type: none"> <li>To introduce the concepts of “culture”, “ethnic groups and minorities”, “migrants” and their background.</li> <li>To introduce the concept of “intersectionality” and its application in the field of health care for migrants and ethnic minorities.</li> <li>To introduce the concepts of “stereotypes and generalisations”, “prejudices” and “discrimination”.</li> </ul>		
Objectives of the activities		
<ul style="list-style-type: none"> <li>To reflect on the opportunities and difficulties for applying the intersectionality concept in the own professional practice, as well as the own social position / trajectory.</li> <li>To identify barriers and strategies for taking into account intersectionality in the health care practice.</li> <li>To open a space for reflection on strategies against discrimination in health care oriented towards cultural and ethnic diversity.</li> </ul>		
Format and Proposed Time Distribution	Core Contents	Proposed Slides
Presentation (50 min)	<ul style="list-style-type: none"> <li>Concepts: <ul style="list-style-type: none"> <li>Culture</li> <li>Ethnic groups and minorities</li> <li>Migrants and their background</li> </ul> </li> </ul>	1-9
	<ul style="list-style-type: none"> <li>Concept: <ul style="list-style-type: none"> <li>Intersectionality</li> </ul> </li> </ul>	11-15, 18-19



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



	<ul style="list-style-type: none"> <li>○ Application in the field of health care for migrants and ethnic minorities</li> </ul>	
Activities (90 min)	<ul style="list-style-type: none"> <li>• <b>Individual activity and group discussion</b> <ul style="list-style-type: none"> <li>○ Application of the intersectionality concept to the own professional context, as well as to the own personal and professional position.</li> </ul> </li> <li>• <b>Nominal group</b> <ul style="list-style-type: none"> <li>○ Identification of barriers and strategies for taking into account intersectionality in the health care practice</li> </ul> </li> <li>• <b>Video Screening “Tzafar”</b> <ul style="list-style-type: none"> <li>○ Space for reflection on strategies against discrimination in health care oriented towards cultural and ethnic diversity.</li> </ul> </li> </ul>	16,17,21 (Templates)
Presentation (30 min)	<ul style="list-style-type: none"> <li>• Concepts           <ul style="list-style-type: none"> <li>○ Stereotypes and generalisations.</li> <li>○ Prejudices</li> <li>○ Discrimination</li> </ul> </li> </ul>	25-28,30,31
Activity (20 min)	<ul style="list-style-type: none"> <li>• <b>Discrimination</b> <ul style="list-style-type: none"> <li>○ Open a space for reflection on strategies against discrimination in health care oriented towards cultural and ethnic diversity, regarding national context (<i>awareness raising, laws and practical experiences</i>).</li> </ul> </li> </ul>	29
<b>Unit 2: Intercultural competence and diversity sensitivity</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>• To introduce the concepts of “multiculturalism”, “interculturalism”, “cultural competence”, “intercultural competence” and “diversity sensitivity”, and the shifts in their use.</li> <li>• To provide the key elements for understanding the influence of cultural backgrounds on the perceptions and behaviours of health professionals and patients.</li> <li>• To introduce the concepts of “health promotion”, “health education” and relate them with cultural diversity and interculturality.</li> </ul>		



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTRY OF HEALTH OF THE REPUBLIC OF TURKEY



Objectives of the activities		
<ul style="list-style-type: none"> <li>To present different concepts related to the topic.</li> <li>To introduce the concept of “<i>Cultural Awareness</i>” and to apply “<i>The Process of Cultural Competence in the Delivery of Healthcare Services Model</i>”.</li> <li>To identify aspects related to the positive contribution of interculturality and sensitivity to diversity.</li> </ul>		
Format and Proposed Time Distribution	Core Contents	Proposed Slides
Activity 1 (20 min)	<ul style="list-style-type: none"> <li>Brainstorming of the concepts multiculturalism, interculturalism, cultural competence, intercultural competence, difference and diversity (<i>in the plenary</i>).</li> </ul> <p><i>If there is enough time, we propose you to add activity 2, as a complementary activity, not included in the assessment process.</i></p>	4  (Activity 2: Slide 10)
Presentation (30 min)	<ul style="list-style-type: none"> <li>Introduction of the concepts:               <ul style="list-style-type: none"> <li>Multiculturalism</li> <li>Interculturalism</li> <li>Cultural competence</li> <li>Intercultural competence</li> <li>Diversity sensitivity</li> </ul> </li> <li>Shifts in their use.</li> </ul>	5-9, 11-12
Activity (25 min)	<p>Cultural Awareness</p> <ul style="list-style-type: none"> <li>Application of “<i>The Process of Cultural Competence in the Delivery of Healthcare Services Model</i>”</li> </ul>	18-22
Presentation and activity (30 min)	<ul style="list-style-type: none"> <li>Aspects related to the positive contribution of interculturality and sensitivity to diversity.</li> </ul>	25-30
Presentation (25 min)	<ul style="list-style-type: none"> <li>Introduction of the concepts:               <ul style="list-style-type: none"> <li>Health promotion</li> <li>Health education</li> </ul> </li> <li>Relationship with cultural diversity and interculturality.</li> </ul>	32-37



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTERIO DE SANIDAD Y POLÍTICA SOCIAL



<b>Module 2:</b> <b>Knowledge about Migrants, Ethnic Minorities and their Health</b>  Time: 5 hours <i>(Data of Module 2 need to be adapted to specific demographic characteristics of their migrant population and ethnic minorities, the specific health outcomes and morbidity/mortality patterns. Contents from Additional Module 2 have to be added to this content adapted to the specific health concerns of the local context).</i>		
Unit 1: Migrants' and ethnic minorities' health problems and health determinants		
Objectives of the presentation		
<ul style="list-style-type: none"> <li>To describe basic demographic characteristics of the current migrant population and ethnic minorities.</li> <li>To identify major trends and health concerns in the state of health of migrants and ethnic minorities, with focus on chronic diseases, communicable diseases, mental health and reproductive health.</li> </ul>		
Objectives of the activities		
<ul style="list-style-type: none"> <li>To apply the acquired knowledge to clinical practice.</li> </ul>		
Format and Proposed Time Distribution	Core Contents	Proposed Slides
Presentation (30 min)	<ul style="list-style-type: none"> <li>Social context of migrants and ethnic minorities</li> <li>Social determinants of health</li> <li>Needs and frequent types of health problems of migrants and ethnic minorities</li> <li>Morbidity and mortality patterns</li> </ul>	M2, U1 3-6 (with local data) 7-12 14-20 (with local data)
Presentation (30 min)	Country specific chronic diseases of the migrant and ethnic minorities' population.	AM2, U1 3-13 (with local data)
Presentation (30 min)	Country specific communicable diseases of the migrant and ethnic minorities' population.	AM2, U2 3-21 (with local data)



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



YÜKSEKÖĞRETİM VE KÜLTÜR BAKANLIĞI  
T.C. SAĞLIK BAKANLIĞI  
MİLLÎ EĞİTİM BAKANLIĞI



Presentation (30 min)	Country specific mental health concerns for the migrant and ethnic minorities population.	AM2, U3 3-15 (with local data)
Presentation (30 min)	Country specific reproductive health concerns for the migrant and ethnic minorities population.	AM2, U4 3-16 (with local data)
Presentation (30 min)	Country specific children's health concerns for the migrant and ethnic minorities population.	
Activity (30 min)	<ul style="list-style-type: none"> <li>Work in small groups to identify experiences related to the specific health concerns.</li> <li>Representation and discussion in plenary</li> </ul>	
<b>Unit 2: Migrants' and ethnic minorities' use of health care</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>To describe the main patterns of use of health care services by migrant population and ethnic minorities according to the literature.</li> <li>To identify barriers of access to health care.</li> </ul>		
<b>Objectives of the activities</b>		
<ul style="list-style-type: none"> <li>To show the previous knowledge of participants about patterns of use of health care of migrants and ethnic minorities.</li> <li>To identify barriers of access to health care and strategies to overcome those barriers.</li> </ul>		
<b>Format and Proposed Time Distribution</b>	<b>Core Contents</b>	<b>Proposed Slides</b>
Presentation (40 min)	<ul style="list-style-type: none"> <li>Patterns of health services usage</li> <li>Barriers of access to health care</li> </ul>	3-12 (with data from local context)



Activity 1 (15 min)	Brainstorming in plenary to reflect previous knowledge on patterns of use of health care.	
Activity 2 (35 min)	Nominal group about identification of barriers in the participant's context.	



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



HEALTHY LIVES REGIONAL  
HEALTH PROGRAMME  
HEALTHY LIVES REGIONAL  
HEALTH PROGRAMME



UNIVERSITY OF  
COPENHAGEN



<b>Module 3:</b> <b>Professional Skills</b>  Time: 5 hours  <i>(We suggest you to focus on activities as the contents of this Module require an <b>experiential pedagogical approach</b>. Each Unit includes various activities prepared to address different professional skills. We propose a selection of the activities related to the core contents that you can adapt according to the level of skills' development of the trainees and complement with other)</i>		
Unit 1: Intrapersonal skill development		
Objectives of the presentation		
<ul style="list-style-type: none"> <li>• To identify key elements in communicating with migrants or ethnic minority patients.</li> <li>• To recognise techniques related to intrapersonal outcomes aiming to improving health professional-patient interactions in culturally diverse contexts.</li> </ul>		
Objectives of the activities		
<ul style="list-style-type: none"> <li>• To identify the role of stereotypes in the communication with migrants and ethnic minorities.</li> <li>• To identify communication and intrapersonal skills (empathy, active/reflective listening).</li> <li>• To acquire the ability to manage stress situations in the health professional-migrant/ethnic minority patients interaction.</li> </ul>		
Format and Proposed Time Distribution	Core Contents	Proposed Slides
Presentation (30 min)	<ul style="list-style-type: none"> <li>• Key elements in communication.</li> <li>• Empathy.</li> <li>• Active/Reflective listening.</li> </ul>	5-10, 12-15, 17-18, 20-22
Activity (20 min)	Group work on confronting labels and stereotypes in the patient-professional interaction.	
Activity (30 min)	Work in small groups and group work on empathic process with migrant and ethnic minority patients.	



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTERE DE LA SANTE  
T.C. SAĞLIK BAKANLIĞI



MINISTERE DE LA SANTE  
T.C. SAĞLIK BAKANLIĞI



MINISTERE DE LA SANTE  
T.C. SAĞLIK BAKANLIĞI

UNIVERSITY OF  
COPENHAGEN



Activity (40 min)	Work in small groups and group work on reflective listening with migrant and ethnic minority patients.	
Activity (30 min)	Individual work and group work on self-control techniques	
<b>Unit 2: Interpersonal skill development</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>• To identify barriers and facilitators to communication according to the literature.</li> <li>• To identify aspects of conflict regulation and negotiation processes.</li> </ul>		
<b>Objectives of the activities</b>		
<ul style="list-style-type: none"> <li>• To practice the negotiation and collaboration skills of the participants.</li> <li>• To contribute with examples of good practices in the interpersonal communication.</li> <li>• To think over the application of the negotiation process to the trainees' context.</li> <li>• To think over the behaviors involved in conflict management.</li> </ul>		
<b>Format and Proposed Time Distribution</b>	<b>Core Contents</b>	<b>Proposed Slides</b>
Presentation (30 min)	<ul style="list-style-type: none"> <li>• Barriers and facilitators to communication</li> <li>• Negotiation/collaboration</li> <li>• Conflict management</li> </ul>	5, 8-10, 12, 14-19, 22
Activity (30 min)	Work in small groups and group discussion o key elements affecting interpersonal communication.	
Activity (20 min)	Brainstorming to identify the barriers to effective communication that participants face in their daily practise.	
Activity (30 min)	Individual and group work on the negotiation process.	

Activity (30 min)	Individual work and group discussion about solving specific problems.	
----------------------	---	--

DRAFT



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTERE DE LA SANTE  
REPUBLIQUE DE TURQUIE



## Module 4: Knowledge Application

Time: 5 hours

*(Proposed distribution between presentations and activities: 50% / 50%. The proposed time distribution for each presentation / activity, as well as the proposed slides are indicative. The training sessions should contain the listed core contents and activities).*

### Unit 1: Strategies and procedures for people-centered health care services oriented towards cultural and ethnic diversity

#### Objectives of the presentation

- To introduce the concept of “people-centered health care” and its application in the field of migrants’ and ethnic minorities’ health care.
- To present different models of health care for migrants and ethnic minorities, including a model of “diversity sensitive people-centered health care” / “people-centered health care oriented towards cultural and ethnic diversity”.
- To introduce related frameworks, such as a Human Rights framework, social determinants of health model, community participation approaches, as well as a model of intercultural ethics.

#### Objectives of the activities

- To reflect on the opportunities and limitation of different models of health care services and health policies addressed to migrants and ethnic minorities, and their application to the own professional context.

Format and Proposed Time Distribution	Core Contents	Proposed Slides
Activity (20 min)	Video Screening and Discussion	3-4
Presentation (20 min)	<ul style="list-style-type: none"> <li>• People-centered health care <ul style="list-style-type: none"> <li>○ Concept</li> <li>○ Terms</li> <li>○ Principles</li> </ul> </li> </ul>	5-8
	<ul style="list-style-type: none"> <li>• People-centered approaches in health care for</li> </ul>	9-14,



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



HEALTH CARE TRAINING PACKAGES  
HEALTH CARE TRAINING PACKAGES



UNIVERSITY OF  
COPENHAGEN



	migrants and ethnic minorities <ul style="list-style-type: none"> <li>○ Conceptual shifts</li> <li>○ Policies levels</li> <li>○ Related frameworks (<i>overview: slide 14</i>)</li> </ul>	34-39
<b>Unit 2: Development of strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>• To present strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities.</li> </ul>		
<b>Objectives of the activities</b>		
<ul style="list-style-type: none"> <li>• To open a discussion on experiences, opportunities, and limitations for intercultural mediation.</li> <li>• To open a space for reflection on strategies against discrimination in health care oriented towards cultural and ethnic diversity.</li> <li>• To reflect on the opportunities and limitations for applying organizational change related to cultural and ethnic diversity in one's own institutional context.</li> <li>• To open a reflection on strategies for resolving daily situations in health care oriented towards cultural and ethnic diversity.</li> <li>• To identify strategies for implementing health care oriented towards cultural and ethnic diversity.</li> </ul>		
Presentation (30 min)	Health care oriented towards cultural and ethnic diversity <ul style="list-style-type: none"> <li>• Relevant aspects</li> </ul> <p><i>Please mention all relevant aspects briefly (overview: slide 3), and present the following strategies more in detail:</i></p> <ul style="list-style-type: none"> <li>○ Access to health care</li> <li>○ Continuity of care</li> <li>○ Translation services</li> <li>○ Community interpreting</li> <li>○ Cultural / Intercultural mediation</li> <li>○ Discrimination</li> <li>○ Service Organization and Change Management</li> </ul>	1-8, 11-16, 18-21, 23-25, 34-39
Activity (20 min)	<ul style="list-style-type: none"> <li>• Activity 4: Case Studies</li> </ul>	31



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



	Activity 4 is proposed as core activity. The other activities proposed in Unit 2 can be introduced as complementary activities, without being included in the assessment process.	
<b>Unit 3: Public health, health prevention and promotion from multidisciplinary perspectives</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>To present strategies and Best Practices related to health prevention and promotion oriented towards cultural and ethnic diversity from multidisciplinary perspectives.</li> </ul>		
<b>Objectives of the activities</b>		
<ul style="list-style-type: none"> <li>To open a reflection on conflict situations in health prevention and health promotion interventions oriented towards cultural and ethnic diversity, and strategies to resolve the situation.</li> </ul>		
Presentation (30 min)	<ul style="list-style-type: none"> <li>Health prevention and promotion oriented towards cultural and ethnic diversity: <ul style="list-style-type: none"> <li>Conceptual model</li> </ul> </li> <li>Health prevention oriented towards cultural and ethnic diversity: <ul style="list-style-type: none"> <li>Relevant aspects and strategies</li> </ul> </li> <li>Health promotion oriented towards cultural and ethnic diversity: <ul style="list-style-type: none"> <li>Definition</li> <li>Strategies</li> </ul> </li> <li>Reduction of health inequalities: <ul style="list-style-type: none"> <li>Strategies and Best Practices</li> </ul> </li> </ul>	1-10, 13-14
Activity (40 min)	<p>Role playing:</p> <ul style="list-style-type: none"> <li>Identification of a situation related to health promotion and prevention oriented towards cultural and ethnic diversity and strategies for reinforcing positive health habits.</li> <li>Development of a role playing scene and representation in the plenary.</li> </ul>	11



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTERIJE ZDRAVLJA  
REPUBLICA TURCIJE



REPUBLICA TURCIJE



REPUBLICA TURCIJE



REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

REPUBLICA TURCIJE

Unit 4: Quality of health care taking diversity into account		
Objectives of the presentation		
<ul style="list-style-type: none"> <li>To present relevant aspects of quality oriented towards cultural and ethnic diversity, assessment methodologies and strategies.</li> </ul>		
Objectives of the activities		
<ul style="list-style-type: none"> <li>To open a discussion on experiences, opportunities and limitations of assessment methods for quality of health care oriented to cultural and ethnic diversity.</li> </ul>		
Presentation (20 min)	<ul style="list-style-type: none"> <li>Quality of health care oriented towards cultural and ethnic diversity               <ul style="list-style-type: none"> <li>Relevant aspects</li> </ul> </li> <li>Access to and quality of health care for migrants and ethnic minorities               <ul style="list-style-type: none"> <li>Analysis of the current situation</li> <li>Strategies and Best Practices</li> </ul> </li> <li>Quality assessment               <ul style="list-style-type: none"> <li>Current situation of assessment practices</li> <li>Assessment models (<i>overview: slide 9</i>)</li> <li>Limitations and challenges of quality assessment</li> </ul> </li> </ul>	1-9, 19, 22-26
Activity	<i>The activity proposed in Unit 4 can be introduced as complementary activity if there is enough time, without being included in the assessment process.</i>	20
Unit 5: Community-based approaches, promotion of user and community participation and involvement		
Objectives of the presentation		
<ul style="list-style-type: none"> <li>To introduce the topic (community-based approaches, promotion of users, community participation and involvement).</li> <li>To introduce the fundamentals of community-based approaches.</li> <li>To introduce concepts and relevant aspects related to community-based approaches.</li> </ul>		
Objectives of the activities		
<ul style="list-style-type: none"> <li>To enhance awareness of the concepts 'community' and 'participation'.</li> </ul>		





Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



<ul style="list-style-type: none"> <li>To reflect on challenges related to being a migrant, ethnic minority, including the Roma in European societies and healthcare system, attitudes and stereotypes.</li> <li>To open a reflection on community-based approaches.</li> <li>To reflect on power/control relationships and the relativity of choices.</li> </ul>		
Presentation (30 min)	<ul style="list-style-type: none"> <li>Introduction.</li> <li>The fundamentals of community-based approaches</li> <li>Definitions and relevant aspects related to community development and community-based approaches.</li> <li>Concepts and relevant aspects related to involvement and participation.</li> <li>Challenges and limitations of community-based approaches.</li> <li>Strategies for community-based approaches.</li> </ul>	1-2, 4, 7, 13-19, 21-26, 30-31
Activities (15 min + 15 min)	<ul style="list-style-type: none"> <li>Activity 1: Exchange in pairs about the own community.</li> <li>Activity 4: Power / Control Relationships and Relativity, Part II.</li> </ul> <p><i>Activity 1 and 4 are proposed as core activities. The other activities included in Unit 5, as well as the videos, can be introduced as complementary activities if there is enough time, without being included in the assessment process.</i></p>	3, 27-28
<b>Unit 6: Intersectoral approach</b>		
<b>Objectives of the presentation</b>		
<ul style="list-style-type: none"> <li>To introduce the concept of “intersectorality” and relevant applications to health care and health policies addressed to migrants and ethnic minorities.</li> </ul>		
<b>Objectives of the activities</b>		
<ul style="list-style-type: none"> <li>To identify relevant stakeholders for intersectoral action related to the health of migrants and ethnic minorities in the own context, as well as opportunities, barriers, resources and strategies.</li> </ul>		
Presentation (20 min)	<b>Intersectoral Action</b> <ul style="list-style-type: none"> <li>Concept</li> <li>Opportunities and limitations</li> <li>Strategies</li> </ul>	1-10, 13-14



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



MINISTERIO DE SALUD Y POLÍTICA SOCIAL



AM



SERVICES UNIVERSITÉS REGIONALES



UNIVERSITY OF COPENHAGEN

UNIVERSITY OF COPENHAGEN

UNIVERSITY OF COPENHAGEN

UNIVERSITY OF COPENHAGEN

	<ul style="list-style-type: none"><li>• Relevance</li><li>• Recommendations</li><li>• Constructing an intersectoral action plan</li></ul>	
Activity (40 min)	Mapping stakeholders and resources for an intersectoral action	11

DRAFT



## **Annex 4**

Deliverable 4: WP4 Training of train ers workshop programme and content

## TRAINING OF TRAINERS WORKSHOP

MEM-TP, TRAINING PACKAGES FOR HEALTH PROFESSIONALS TO IMPROVE ACCESS AND QUALITY OF HEALTH SERVICES FOR MIGRANTS AND ETHNIC MINORITIES, INCLUDING THE ROMA

Granada, January 28-30, 2015



Escuela Andaluza de Salud Pública  
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES



SERVIZIO SANITARIO REGIONALE  
EMILIA-ROMAGNA  
Azienda Unità Sanitaria Locale di Reggio Emilia

UNIVERSITY OF  
COPENHAGEN



JAGIELLONIAN UNIVERSITY  
MEDICAL COLLEGE



MEM-TP, TRAINING PACKAGES FOR HEALTH PROFESSIONAL TO IMPROVE  
ACCESS AND QUALITY OF HEALTH SERVICES FOR MIGRANTS AND ETHNIC  
MINORITIES, INCLUDING THE ROMA

# TRAINING OF TRAINERS WORKSHOP

ANDALUSIAN SCHOOL OF PUBLIC HEALTH,  
GRANADA, JANUARY 28-30, 2015

## TRAINING OF TRAINERS WORKSHOP

MEM-TP, TRAINING PACKAGES FOR HEALTH PROFESSIONALS TO IMPROVE ACCESS AND QUALITY OF  
HEALTH SERVICES FOR MIGRANTS AND ETHNIC MINORITIES, INCLUDING THE ROMA  
Granada, January 28-30, 2015



### FACILITATORS

<b>Ainhoa Ruiz Azarola</b>	MEM-TP Project Team Andalusian School of Public Health
<b>Alfredo Ruiz Gutiérrez</b>	MEM-TP Project Technical Support Andalusian School of Public Health
<b>Amets Suess</b>	MEM-TP Project Team Andalusian School of Public Health
<b>María Victoria Ruiz López</b>	MEM-TP Project Collaborator Andalusian School of Public Health
<b>Olga Leralta Piñán</b>	MEM-TP Project Team Andalusian School of Public Health

### COORDINATION

<b>Riitta-Liisa Kolehmainen-Aitken</b>	MEM-TP Project Coordination
<b>José Ignacio Oleaga Usategui</b>	MEM-TP Project Team Coordination

### ADMINISTRATIVE SUPPORT

<b>María Ángeles Cantón Gálvez</b>	MEM-TP Project Administrative Assistant +34 958 027 400 angeles.canton.easp@juntadeandalucia.es
------------------------------------	---



### PARTICIPANTS

---

Caludio Baraldi	Italy
Pilar Baraza	Spain
Rossella Celmi	IOM
Antonio Chiarenza	Italy
Alexandra Cucu	Rumania
Adriana Galan	Rumania
Luis Andrés Gimeno	Spain
Andrej Kallay	Slovakia
Daniella Kallayova	Slovakia
Ewa Kocot	Poland
Mirjana Lana Kosanovic-Licina	Croatia
Marek Majdan	Slovakia
Bibiana Navarro	Spain
Claire Muñoz de Luna	Denmark
Lidia Onofrey	Rumania
Daniela Penickova	Czech Republic
Ivan Pitesa	IOM
Ivo Quaranta	Italy
Flavia Riccardo	Italy
Marina Rota	IOM
Karolina Skora	Poland
Anna Szetela	Poland
Kathrine Vitus	Denmark
Hanne Winther Frederiksen	Denmark



## MEM-TP PROJECT BACKGROUND

The aim of the MEM-TP project is to improve access and quality of health services for migrants and ethnic minorities in the European Union by reviewing, developing, testing and evaluating training in migrant and ethnic minority health for front-line health professionals, and disseminating the project results.

The European Commission (EC) awarded the project in late December 2013 to a consortium of institutions under a service contract. The consortium consists of the Andalusian School of Public Health (EASP) as the lead partner, and the University of Copenhagen (Faculty of Health and Medical Sciences), Azienda Unità Sanitaria Locale Reggio Emilia in Italy and University of Amsterdam (Academisch Medisch Centrum) as members. The International Organization of Migration (IOM), European Public Health Alliance (EPHA), Jagiellonian University in Poland, National Institute of Public Health of Romania, and Trnava University in Slovakia collaborate with the project as subcontractors.

### **MEM-TP Project - General objective:**

- Facilitate access to and improve the quality of health services for migrants and ethnic minorities (MEM) in the European Union, and reduce observed inequities.

### **MEM-TP Project - Specific objectives:**

- Present an overview of the situation of MEM in Europe regarding their access to and use of health services and the extent to which services are adapted to their specific needs.
- Building on previous experience, create a framework, a training programme and validated teaching-learning materials for health care providers, aimed at improving the accessibility, quality and appropriateness of care provided to MEM in the EU.
- Develop and apply a structured process that enables those with primary responsibility for the training and continuing education of health care providers in each country to take ownership of their training programme through active adaptation of the materials to their local situation and needs.

### **MEM-TP Project – Work Packages (WP):**

- WP 1: Review of the migrant and ethnic minorities situation in the EU (April – September 2014)
- WP 2: Review of existing training materials (April – September 2014)
- WP 3: Development of a training programme for health professionals and health care providers (August – December 2014).



- WP4: Training of trainers workshop (ToT), Granada, January 28-30, 2015, piloting of training programmes in 6 member states and evaluation (March 2015 – May 2015)
- WP5: Final versions of the materials, evaluation report and dissemination of results (June 2015 – March 2016).

## TRAINING OF TRAINERS (TOT): GENERAL OBJECTIVE

- Pilot the training package that will be used in country-level pilots and strengthen training skills of the national trainers who will undertake or support these pilots.

## TRAINING OF TRAINERS WORKSHOP (TOT): SPECIFIC OBJECTIVES

Upon completion of training, trainees will be able to:

- Provide training that strengthens intercultural competencies and greater diversity awareness.
- Prepare public presentations.
- Be able to use teaching tools which are most used in the best evaluated teaching programs in the European context.
- Apply training outcome evaluation techniques.

## TRAINING OF TRAINERS (TOT): PARTICIPANT PROFILE

Three selected health trainers from each of the six countries that will participate in the follow-on pilot training (Denmark, Italy, Poland, Romania, Slovakia and Spain).

## TRAINING OF TRAINERS (TOT): MODES OF TRAINING

The Training of Trainers consists of:

1. Face-to-face phase: Training of Trainers Workshop (ToT)
2. Virtual phase





In the Training of Trainers Workshop (ToT), the following modes of training will be used:

- Overview of the training materials contents.
- Introduction to the most relevant interactive training methodologies, applied to the training contents of each module.
- Introduction to presentation techniques.
- Presentation of the virtual platform.
- Introduction to piloting methodologies.
- Presentation of evaluation tools.
- Workshop evaluation.

The virtual phase consists of the following tasks, which will be completed using the virtual platform:

- Completing the evaluation tools.
- Adapting the training materials to the national context.
- Translating the training materials.

## TRAINING HOURS

40 hours, 20 in face-to-face format and 20 hours virtual format.

## VENUE

**Andalusian School of Public Health**  
**Cuesta del Observatorio, 4**  
**1011 Granada**  
**Spain**  
**+34 958 027 400**  
[www.easp.es](http://www.easp.es)



**1**

Wednesday, January 28, 2015

### INSTITUTIONAL REPRESENTATIVES

*Carlos Artundo Purroy, Chief Executive Officer, Andalusian School of Public Health*  
*Riitta-Liisa Kolehmainen-Aitken, MEM-TP Project Coordination*  
*José Ignacio Oleaga Usategui, MEM-TP Project Team Coordination*

### FACILITATORS

*Ainhua Ruiz Azarola, MEM-TP Project Team*  
*Amets Suess, MEM-TP Project Team*  
*Olga Leralta Piñán, MEM-TP Project Team*

### AGENDA

9:00	Welcome
9:15	Presentation of the Workshop and Participants
10:00	Overview: Contents of Module 1
10:30	Coffee Break
11:00	Teaching Methodologies Applied to Module 1
13:00	Lunch
14:00	Overview: Contents of Module 2
14:30	Teaching Methodologies Applied to Module 2
16:00	End of the Session

### Social Programme

16:15	Bus from Andalusian School of Public Health to Alhambra
17:00	Alhambra Guided Visit



**2**

Thursday, January 29, 2015

### FACILITATORS

*Ainhua Ruiz Azarola, MEM-TP Project Team*

*Amets Suess, MEM-TP Project Team*

*Olga Leralta Piñán, MEM-TP Project Team*

### AGENDA

9:00	Recap of the Previous Day
9:15	Overview: Contents of Module 3
9:45	Teaching Methodologies Applied to Module 3
11:00	Coffee Break
11:30	Teaching Methodologies Applied to Module 3
13:00	Lunch
14:00	Overview: Contents of Module 4
14:30	Teaching Methodologies applied to Module 4
17:00	End of the Session

### Social Programme

20:30 Dinner at Mirador de Morayma, Calle Pianista García Carillo, 2, Granada



**3**

Friday, January 30, 2015

## FACILITATORS

*Ainhua Ruiz Azarola, MEM-TP Project Team*  
*Amets Suess, MEM-TP Project Team*  
*Olga Leralta Piñán, MEM-TP Project Team*  
*Maria Victoria Ruiz López, MEM-TP Project Collaboration*  
*Alfredo Ruiz, Technical Support MEM-TP Project*

## AGENDA

9:00	Recap of the Previous Day
9:15	Presentation of the Virtual Platform
10:15	Piloting Methodologies
11:00	Coffee Break
11:30	Teaching Methodologies: Presentation Techniques
12:00	Presentation Training
13:00	Lunch
14:00	Overview: Contents of Additional Modules
14:30	Teaching Methodologies applied to Additional Modules
16:00	Presentation of Evaluation Tools
16:15	Teaching Quality Questionnaire
16:30	Conclusions
17:00	End of the Session



## **Annex 5**

Draft schedule for the pilot training



Escuela Andaluza de Salud Pública  
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES



SERVIZIO SANITARIO REGIONALE  
EMILIA-ROMAGNA  
Azienda Unità Sanitaria Locale di Reggio Emilia

UNIVERSITY OF  
COPENHAGEN



JAGIELLONIAN UNIVERSITY  
MEDICAL COLLEGE



**MEM-TP, TRAINING PACKAGES FOR HEALTH PROFESSIONAL TO IMPROVE  
ACCESS AND QUALITY OF HEALTH SERVICES FOR MIGRANTS AND ETHNIC  
MINORITIES, INCLUDING THE ROMA**

# **PILOT TRAINING**

**PLACE, CITY, DATE, 2015**



### FACILITATORS

**Example: Ainhoa Ruiz Azarola** MEM-TP Project Team  
Andalusian School of Public Health

### COORDINATION

**Example: Riitta-Liisa Kolehmainen-Aitken** MEM-TP Project Coordination

**José Ignacio Oleaga Usategui** MEM-TP Project Team Coordination

### ADMINISTRATIVE SUPPORT

**Example: María Ángeles Cantón Gálvez** MEM-TP Project Administrative Assistant  
+34 958 027 400  
angeles.canton.easp@juntadeandalucia.es



## PARTICIPANTS

---

Include selected participants and their place of origin

Example Bibiana Navarro Spain





## MEM-TP PROJECT BACKGROUND

The aim of the MEM-TP project is to improve access and quality of health services for migrants and ethnic minorities in the European Union by reviewing, developing, testing and evaluating training in migrant and ethnic minority health for front-line health professionals, and disseminating the project results.

The European Commission (EC) awarded the project in late December 2013 to a consortium of institutions under a service contract. The consortium consists of the Andalusian School of Public Health (EASP) as the lead partner, and the University of Copenhagen (Faculty of Health and Medical Sciences), Azienda Unità Sanitaria Locale Reggio Emilia in Italy and University of Amsterdam (Academisch Medisch Centrum) as members. The International Organization of Migration (IOM), European Public Health Alliance (EPHA), Jagiellonian University in Poland, National Institute of Public Health of Romania, and Trnava University in Slovakia collaborate with the project as subcontractors.

### **MEM-TP Project - General objective:**

- Facilitate access to and improve the quality of health services for migrants and ethnic minorities (MEM) in the European Union, and reduce observed inequities.

### **MEM-TP Project - Specific objectives:**

- Present an overview of the situation of MEM in Europe regarding their access to and use of health services and the extent to which services are adapted to their specific needs.
- Building on previous experience, create a framework, a training programme and validated teaching-learning materials for health care providers, aimed at improving the accessibility, quality and appropriateness of care provided to MEM in the EU.
- Develop and apply a structured process that enables those with primary responsibility for the training and continuing education of health care providers in each country to take ownership of their training programme through active adaptation of the materials to their local situation and needs.

### **MEM-TP Project – Work Packages (WP):**

- WP 1: Review of the migrant and ethnic minorities situation in the EU (April – September 2014)
- WP 2: Review of existing training materials (April – September 2014)
- WP 3: Development of a training programme for health professionals and health care providers (August – December 2014).



- WP4: Training of trainers workshop (ToT), Granada, January 28-30, 2015, piloting of training programmes in 6 member states and evaluation (March 2015 – May 2015)
- WP5: Final versions of the materials, evaluation report and dissemination of results (June 2015 – March 2016).

## PILOT TRAINING: GENERAL OBJECTIVE

- **Pilot the training package in country-level for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma**

## PILOT TRAINING OF: SPECIFIC OBJECTIVES

**Upon completion of training, trainees will be able to:**

- **Strengthening intercultural competencies and greater diversity awareness.**

## TRAINING HOURS

20 hours in face-to-face format and the possibility of review materials in a virtual format.

## VENUE

Example:

**Andalusian School of Public Health**  
**Cuesta del Observatorio, 4**  
**1011 Granada**  
**Spain**  
**+34 958 027 400**  
[www.easp.es](http://www.easp.es)



## AGENDA

### Day 1:

#### Morning (4 hrs. 8:30-12:30)

- Presentation (course, participants and virtual campus)
- Pre-test questionnaire online
- Module 1 (3 hrs.): Sensitivity and Awareness of Cultural and Other Forms of Diversity
  - Unit 1: Diversity

#### Afternoon (3 hrs. 13:30-16:30)

- Module 1 (2 hrs.) Sensitivity and Awareness of Cultural and Other Forms of Diversity
  - Unit 2: Intercultural Competence and Diversity Sensitivity
- Module 2 (1 hr. ) Knowledge about migrants, ethnic minorities and their health
  - Unit 1: Migrants' and ethnic minorities' health problems and health determinants

### Day 2:

#### Morning (4 hrs. 8:30-12:30)

##### Wrap up

- Module 2 (4 hrs.) Knowledge about migrants, ethnic minorities and their health
  - Unit 2: Migrants' and ethnic minorities' use of health care

#### Afternoon (3 hrs. 13:30-16:30)

- Module 3 (3 hrs.) Professional Skills
  - Unit 1: Intrapersonal skill development



## Day 3:

### Morning (4 hrs. 8:30-12:30)

#### Wrap up

- Module 3 (2 hrs.) Professional Skills
  - Unit 2: Interpersonal skill development
- Module 4 (2'5 hrs.) Knowledge Application
  - Unit 1: Strategies and Procedures for People-Centered Health Care Services Oriented towards Cultural and Ethnic Diversity
  - Unit 2: Development of strategies for planning and implementing actions related to one's own workplace and daily professional practice with migrants and ethnic minorities
  - Unit 3: Public Health, Health Prevention and Promotion from Multidisciplinary Perspectives

### Afternoon (2 hrs. 13:30-16:30)

- Module 4 (2'5 hrs.) Knowledge Application
  - Unit 4: Quality of health taking diversity into account
  - Unit 5: Community-based approaches, promotion of user and community participation and involvement
  - Unit 6: Intersectoral Approach
- Evaluation of face to face sessions
- Post-test questionnaire online

### VIRTUAL FOLLOW-UP

- Evaluation of teaching quality and trainees satisfaction
- Evaluation of the training materials adapted to the local situation
- Trainers and trainees feedback for the training materials



## **Annex 6**

Draft design for the evaluation of the training plan



Co-funded by  
the Health Programme  
of the European Union

Migrants & Ethnic Minorities  
Training Packages



Ministero della Sanità  
CONSULENZA DI SANITÀ PUBBLICA E POLITICHE SOCIALI



## Annex 6

**Draft Design for the evaluation of the training plan**



<b>Draft Design for the evaluation of the training plan</b>		
<b>MEM-TP</b>		
	<b>PILOT PROGRAMS</b>	<b>FINAL TRAINING PLAN</b>
<i>What we evaluate</i>	Training materials	Knowledge, professional profile and training needs, quality and satisfaction regarding teaching activities, transference
<i>When</i>		
<b>BEFORE</b>	<ul style="list-style-type: none"> <li><b>Prior profesional profile and training needs (ONLINE QUESTIONNAIRE 1)</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Prior profesional profile and training needs (ONLINE QUESTIONNAIRE 2)</b></li> </ul>
<b>DURING</b>	<ul style="list-style-type: none"> <li><b>Evaluating the quality of materials used (ONLINE QUESTIONNAIRE 3)</b></li> </ul>	
<b>AFTER</b>	<ul style="list-style-type: none"> <li><b>Post-training needs (ONLINE QUESTIONNAIRE 1)</b></li> <li><b>Satisfaction and quality regarding the teaching (EASP QUESTIONNAIRE)</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Post- profesional profile training needs (ONLINE QUESTIONNAIRE 1)</b></li> <li><b>What was learned after the training (ONLINE QUESTIONNAIRE 2))</b></li> <li><b>Satisfaction and quality regarding the teaching (EASP QUESTIONNAIRE)</b></li> <li><b>Transference: 3-6 months later a group of colleagues, supervisors and persons in charge will be selected to participate in a semi-structured interview to evaluate to what extent knowledge and practices imparted in the training plan had a transformative impact on their work (Interview script).</b></li> </ul>



## **Annex 7**

Description of the preparatory work for the final dissemination workshop



***Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma (MEM-TP)***

***Deliverable 7 (D7) Dissemination workshop for government experts***

***Deliverable 8 (D8): Report from the dissemination workshop to share the results with national authorities***

***Plan for the one-day dissemination workshop  
First draft for comments***

**Preliminary design of the dissemination workshop**

**1. Location and time**

- Location: Brussels, EC conference room (Which one?)
- Date: Friday, 25 September 2015
- Time: From 9:00 to 17:00
- Language: English (Will simultaneous translation be necessary?)

**2. Organiser**

- EASP with the support of IOM and EPHA and in coordination with CHAFEA
  - IOM is responsible for the logistical and administrative organization, including lunch and coffee breaks, as well as the organization of travel/accommodation of selected participants
  - EPHA is responsible for acting as the rapporteur and preparing the draft workshop report.
- (Will CHAFEA appoint someone to coordinate invitations with IOM or will IOM be responsible for sending out all invitations, regardless of who does the inviting and pays the participant cost?)

**3. Purpose of the workshop**

- Share the final model training package with the participants,
- Review the main evaluation findings of the country-level pilots,
- Examine the implications of the project experience in regard to specific strategies, programmes or actions required to improve the competence of front-line health professionals at national and European levels.
- (Does this reflect what EC sees as the purpose of the workshop?)

**4. Content of the agenda**

- Overview of the content of the training package and the piloting,
- Review of the evaluation findings of the pilot training,
- Discussion and debate on the required strategies, programmes and actions,
- Discussion of sustainability of project outcomes, etc.
- (What other topics does EC want included on the agenda?)

## 5. Participants

- Maximum 50 persons; four groups:
  - Group 1: Invited and paid out of project budget for the workshop (EASP)
    - Total of app. 25, depending on the costs
    - Two from each of the six pilot countries, for a total of 12, representing national or regional health and education authorities, as relevant
    - (Who else? Representatives from neighbouring countries, e.g. Czech Republic? Relevant NGOs? Professional associations? Academia??)
    - Presenters (as relevant and if not consortium members)
  - Group 2: Invited but NOT paid out of project resources
    - DG/SANTE, DG/EAC, DG/EMPL, FRA
    - (Who else?)
  - Group 3: Consortium members; paid out of project budget for the workshop (EASP)
    - Two from EASP
    - One each from Copenhagen, Amsterdam and Italy
    - David Ingleby
  - Group 4: Workshop organisers; paid out of subcontractors' budget (IOM and EPHA)
    - IOM 1 participant and 1 administrative/logistics person
    - EPHA 1 person

## 6. Budget considerations

- EASP budget for total participant costs (including consortium members) = EUR23000
- IOM subcontract for designing and organising the workshop = EUR10336
- EPHA subcontract for the preparation of the workshop report = EUR5168
- Cost of bringing one participant to the workshop
  - Travel from/to place of origin
  - Transport to/from airport
  - Travel insurance
  - Accommodation (maximum two nights)
  - Daily per diem or cost of provided meals
  - Workshop materials for each participant (format to be decided),
  - Certificate of participation (as necessary)

## TASKS AND TIMELINE (March – September 2015)

Task	Responsible	Timing
Invite consortium partners to suggest invitees to the workshop from partner health authorities and other relevant agencies	IOM with EASP support	March – April 2015
Draw upon RESTORE Closing Conference outcomes and ensure synergies with Equi-Health training developments in the preparation of the workshop	IOM	March – April 2015
Hold a conference call with CHAFEA to discuss workshop structure, participants and invited speakers	EASP	April 22 or April 29, 2015
Continue internal coordination regarding agenda, participant list and speakers	IOM with EASP and EPHA	April – May 2015
Finalise draft agenda, participant list, speakers and strategy for disseminating project results through the workshop	IOM jointly with EASP and EPHA	May 2015
Share finalised draft agenda, participant list and speakers with CHAFEA for review. Ask CHAFEA/DG SANTE to select additional participants, as relevant.	IOM jointly with EASP and EPHA	May 2015
Agree on the final agenda, participant list and speakers	EASP with CHAFEA	June 18, 2015
Send out invitations and coordinate interventions of presenters	IOM	June 2015
Organise logistics (venue, catering, interpretation services, etc.)	IOM	July – August 2015
Liaise with EPHA on the work of the rapporteur and the preparation of the conference report	IOM	July – August 2015
Fine-tune workshop planning via a conference call	IOM with EASP and EPHA	First or second week of September 2015
Run the workshop	IOM jointly with CHAFEA/DG SANTE, EASP and EPHA	September 25, 2015
Prepare a draft conference report and send to EASP	EPHA	October 2015



## **Annex 8**

Planned work programme for the following period

MEM - TP	YEAR 2015												YEAR 2016		
Final version 8 april 14	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
Month	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
<b>WP 0</b> Coordination and management															
<b>WP4 Training of trainers, pilot training programmes and evaluation. Selection of trainers and trainees</b>															
Training of trainers workshop (TT)	TT														
<b>Deliverable (D4)</b> - Training workshop programme and content			PT	PT											
<b>Deliverable (D5)</b> – Report of the evaluation of the piloting of training programme in 6 States															
<b>Deliverable (D6)</b> – Interim Report															
<b>WP 5 Final versions of the materials, the evaluation report summarising the challenges and opportunities during the pilot trainings, and dissemination of the results</b>															
<b>Deliverable 7 (D7)</b> – Dissemination workshop for government experts									W						
<b>Deliverable 8 (D8)</b> – Report from the dissemination workshop to share the results with national authorities.															
<b>Deliverable 9 (D9)</b> - The Final Report should include.....													FR		
<b>Deliverable 10 (D10)</b> – Final Administrative Report shortly describing financial and administrative matters relating to the contract implementation														FR	

EASP		TT Training of trainers
All countries		PT Pilot Workshops
DK		FR: Final Report
IT AND NL		DR: Draft Report
OIM - EPHA		W: Dissemination workshop