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

MODULE 2: KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH
Unit 2: Migrants' and ethnic minorities' use of health care.

Guidelines

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Unit 2: Migrants' and ethnic minorities' use of health care.

1. Objectives and Methods

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1.1. Objectives

Objectives of the Presentation:

- To identify major trends in use of health care services by migrant population and ethnic minorities
- To describe the main barriers to access for those populations according to the literature

Objectives of the Activities:

- To analyse the effect of the barriers identified in the video
- To identify barriers for access to health for migrants and ethnic minorities in every specific region / country.

1.2. Methods

The estimated time required for Module 2 is 5 hours, approx. 3 hours for Unit 1 and 2 hours for Unit 2. The training materials of each Unit are composed of presentations, activities, videos and recommended lectures.

Data of Unit 2 has to be adapted to specific use of health care services patterns and barriers identified at local/national level. There are two compulsory activities in this Unit, but we suggest the use of the video screening proposed to introduce a participatory pedagogical approach.

Time	Objetives	Activities	Sources
30 minutes	To identify major trends in use of health care services by migrant population and ethnic minorities.	Brain storming • Presentation of the methodology • Brainstorming in plenary (15 min.) • Presentation of contents (**slides 3-4**) and questions	Projector, laptop, screen.
25 minutes	To describe the main barriers to access for those populations according to the literature	Presentation (**slides 5-13**) questions and conclusions	Projector, laptop, screen.

35 minutes	To identify barriers for access to health for migrants and ethnic minorities in every specific region / country.	Activity in three parts: • Presentation of the methodology • Small Groups: Nominal group technique • Plenary: Wrap up and discussion	Projector, laptop, screen. Cards, markers, flip chart, adhesive (spray), self-adhesive dots.

Presentation

Slide 1 *Information for this document was obtained from Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015.*

Slide 2 Outline of contents

Slide 3 Patterns of health services usage

Activity 1: Brainstorming.

- Ask the participants to comment on their previous knowledge about patterns of health usage in their local context.

Presentation

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 the case of **migrant populations**, a review of recent scientific bibliography[1],[2],[3],[4],[5] stated a lower access to health prevention and promotion services, in comparison with the general population. *More information available in Module 4 Unit 3.*

In many cases it is not possible to determine whether differences in service use reflect differences in need or in access e.g. several studies report increased use of GP services by migrant and ethnic minority patients. Is this because such patients have more health

[1] OSF, Open Society Foundations (2011). Roma Health Mediators. Successes and challenges. Available at: http://www.opensocietyfoundations.org/sites/default/files/roma-health-mediators-20111022.pdf (retrieved: March 5, 2015).

[2] OSF, Open Society Foundations (2005). Mediating Romani Health: Policy and Program Opportunities. Available at: http://www.opensocietyfoundations.org/sites/default/files/roma_health_mediators.pdf (retrieved: March 5, 2015)

[3] Martin Y, Collet TH, Bodenmann P, Blum MR, Zimmerli L, Gaspoz JM, Battegay E, Cornuz J, Rodondi N (2014). The lower quality of preventive care among forced migrants in a country with universal healthcare coverage. Preventive Medicine;59:19-24.

[4] Phillips AL, Kumar D, Patel S, Arya M (2014). Using text messages to improve patient-doctor communication among racial and ethnic minority adults: An innovative solution to increase influenza vaccinations. Preventive Medicine;69:117-119.

[5] Champion J, Harlin B, Collins JI (2013). Sexual risk behaviour and STI health literacy among ethnic minority adolescent women. Applied Nursing research;26:204-209.

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? Opening hours of health care providers often do not reflect the working hours of migrants and ethnic minorities who are 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.

Data reflects the increased tendency in some countries for migrants and/or ethnic minorities to use accident and emergency departments. Other studies show less use of primary care services than national population, for all age groups and regardless of the country of origin[6]. 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[7]. More serious symptoms at first contact can sometimes be found elsewhere in other services, which gives a clearer indication that something is deterring people from seeking help when problems have not yet become acute[8].

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.[9]

Available data on patterns of service usage by migrants is shown in "Utilisation of health services, barriers to access and good practices to address them"[10].

Patterns of use for the descendants of migrants

Learning how and when to use health services is an important aspect of integration in the host society[11]. 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

[6] Gimeno-Feliu, LA, Magallón-Botaya, R et al (2012). Differences in the use of primary care services between Spanish National and Inmigrant patients. Inmigrant Minority Health

[7] 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.

[8] 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

[9] European Migration Network (2014). Migrant access to social security and healthcare: policies and practice. DG Home, European Commission.

[10] Mock-Muñoz de Luna C, Bodewes A, Graval E, Ingleby D (2015). Appendices I-VI, Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015b. Available at: http://www.mem-tp.org/pluginfile.php/620/mod_resource/content/1/MEM-TP_Synthesis_Report_Appendices_I-VI.pdf (retrieved 19th March, 2015)

[11] Ingleby, D. (2012). Acquiring health literacy as a moral task. *International Journal of Migration, Health and Social Care,* 8(1), 22-32.

complications and effectively managing complications when they do arise. 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 pregnancy as well as maternity care[12]. 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.

Slide 4 Regarding ethnic minorities, patterns of access and use of health services is not homogenous across the Roma populations in the 31 countries, implying different impacts on Roma health and experience of health care. The level of marginalisation or integration of the Roma populations appears to be a crucial factor. Evidence also shows that patterns of health care utilisation among Roma differs from the general population, for instance including higher levels of use of acute hospital services, perhaps as the result of lower levels of engagement with or access to preventive care[13].

Slide 5 Barriers of access to health care

Introduction

An often-used definition of access to health services is as follows[14]: *"Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health".* Accessibility has several dimensions (non-discrimination, physical accessibility, economical accessibility (affordability) and information accessibility). Among them, the most fundamental 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'. Affordability is often discussed 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. Exclusion, extra charges or payments at the point of services supply ("out of pocket" payments) affects negatively the access to health care, especially for those more vulnerable.

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 general, nationals (including ethnic minorities) do have such entitlement, but some groups of migrants (especially "irregular" migrants) may not be permitted to use preventive and educational services.

Sometimes barriers to accessing services will result from a person's own attitudes or beliefs. 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. To a certain extent these barriers can be reduced by efforts on the part of the health

[12] 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.

[13] European Commission, Health and Consumers (2014). Roma Health Report. Available at: http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf (accessed on 25th of November, 2014)

[14] Gulliford, M. et al (2002). What does "access to health care" mean? *Journal of Health Services Research & Policy*, *7*(3), 186–188.

system to provide information, increase health literacy, and overcome unjustified reluctance to seek care.

Presentation

The reduction of legal, structural, linguistic and cultural barriers in the access to health care is described as an ethical imperative[15]. *For a more detailed description of ethical aspects and deontological principles in health care organization, health care practice and health research oriented towards cultural and ethical diversity, please see Module 4, Unit 1.*

The main barriers that have been found in the review of the European literature are described next.

Slide 6 Legal barriers

Legal measures relating to the provision of health services to migrants and ethnic minorities are mostly concerned with the issue of *entitlement:* 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.

- *Legal* migrants

Those granted a regular visa or residence permit for work, study, family reunion or other purposes. There is an important difference between *legal* migrants who are nationals of an EU/EAA country and 'third country nationals'. The entitlements which EU/EEA migrants have in their home country are automatically transferable to the host country, while 'third country nationals' must either be admitted to the host country's coverage system or take out private health insurance. For 'third country nationals', 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 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 e.g. whether it is available outside asylum-seeker centres. An earlier overview of coverage for asylum seekers was published in 2006[16].

- "Irregular" migrants

The greatest variations in entitlement are found in this category. 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

[15] Wild V. (2011) Challenging bioethicists' agenda: The example of immigration, health care and ethics. Bioethics Forum;4(2):64-65.

[16] 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.

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.

Besides entitlement, there are other aspects in national legislation of health systems that may affect migrants and ethnic minorities:

- Anti-discrimination legislation, to the extent that it covers 'institutional' or 'indirect' discrimination rather than only the 'individual' or 'direct' sort, may affect equity in service provision.
- 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 in some cases.
- Laws may require health workers to report "irregular" migrants, or even forbid aid to them, thus impeding access for this group.
- 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 is also sometimes regulated by law.

Slide 7 Lack of information, poor 'health literacy'

"Health literacy" 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"[17]. Poor health literacy implies a lack of knowledge about health, illness and the health care system. It leads to:

- 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 providers[18].

For all migrants limited language skills and lack of knowledge of occupational health and safety practices are related to greater risk of on-the-job injury unreported occupational health injuries[19].

Sometimes, low language proficiency can be an important factor preventing migrants from improving their health literacy. Often, however, migrant 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 use 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.

[17] U.S. Department of Health and Human Services (2013). About Health Literacy. Health Resources and Services Administration. Available at: http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html (retrieved July, 24, 2015)

[18] Institute of Medicine, (2004). Health Literacy: A Prescription to End Confusion. Washington DC: Institute of Medicine.

[19] 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.

Information available to migrants 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[20,21,22].

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.[23]

Slide 8 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, those who rely on public transport to reach services but cannot afford it[24].
- Opening hours of health care providers often do not reflect the working hours of migrants and ethnic minorities who are 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[25, 26].
- 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.
- Migrants in detention may face obstacles to accessing the health services they need because of limited provision and availability of health providers[27].
- A further problem of access stems from the increasing fragmentation of disciplines and specialties within the health system[28]. Migrants and ethnic minorities may experience

[20] 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.

[21] Mladovsky, P. et al (2012a). Good practices in migrant health: the European experience. *Clinical Medicine*, Vol 12, No. 3: 248-52.

[22] Netto, G., et al (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioral interventions. *Health Promotion Internationa*l, 25: 248-57

[23] Leye, E. (2006). Health care in Europe for women with genital mutilation. Health Care for Women International, 27:4. Pg. 362-378.

[24] Schaaf, M. (2007). *Confronting a hidden disease: TB in Roma Communities*. Research report: Roma Health Project, Open Society Institute.

[25] 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).

[26] 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.

[27] 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://detention-in-europe.org/index.php?option=com_content&view=article&id=220&Itemid=242 (retrieved: July 24, 2015)

[28] Mladovsky et al, (2012b). Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy*, 105: 1-9.

difficulties in trying to navigate the system of referrals and appointments with several providers in different locations.

Slide 9 Cultural barriers

Over the last 30 or 40 years 'cultural differences' have been considered to be the main barrier standing between migrant and ethnic minorities' patients and health service providers.[29] 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'. 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.

Cultural competence or diversity sensitivity may have a positive impact on the following barriers:

- 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 health professionals and patients and their families.

Slide 10 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, leading to faulty diagnoses, lack of compliance with therapies, lower patient safety and lower treatment satisfaction in patients and providers[30].

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. 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.

Concerning mental illnesses, the recognition, diagnosis and management is highly dependent on the linguistic and cultural competency of the health care sector[31].

In spite of numerous demonstrations of the need for and usefulness of interpreters and health mediators, cost is a major problem and not enough use is made of them[32]. This reluctance may have a number of causes:

[29] 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.

[30] IHC (2011). Impact of Communication in Healthcare. Available at http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (retrieved: July, 19 2015).

[31] 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.

- 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.

Slide 11 Discrimination and mistrust

Many migrants and ethnic minorities experience discrimination in trying to access health services, according to research[33,34]. 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[35].

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[36] or more deeply-rooted and long-standing antagonisms[37]. 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.

Slide 12 Barriers between the health system and migrant or ethnic minority communities

Increasingly, a high value is coming to be placed on 'user participation' in health services[38]. 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 should take active responsibility for their own health, 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" have been created to allow service users to contribute to designing and running services.

Barriers to immunization among mobile communities are mostly informal such as lack of information and lack of trust in authorities. Disaggregation of data collection is still a major issue to be addressed.[39]

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[40]. Furthermore, in general research is carried out 'on' them instead of 'with' them, and interventions are designed and implemented from above.

[32] 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.

[33] European Roma Rights Centre (2006). Ambulance not on the way. The disgrace of health care for Roma in Europe. Budapest: Roma Rights Centre.

[34] Kosa, K., Adany, R. (2007). Studying vulnerable populations: lessons from the Roma minority. *Epidemiology* 18: 290-9

[35] Public Health Fact Sheet (no date). Left Out: Roma and access to health care in Eastern and South Eastern Europe. Open Society Institute, Public Health Program, Roma Health Project.

[36] Priebe et al (2011). Op cit

[37] 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

[38] WHO (2006). Ninth futures forum on health systems governance and public participation, Copenhagen: WHO Regional Office for Europe.

[39] Riccardo F, Dente M.G., Kojouharova M, Fabiani M, Alfonsi V, Kurchatova A, Vladimirova N, Declich S (2012). Migrant's access to immunization in Mediterranean Countries. Health Policy; 105:17– 24.

[40] De Freitas (2011).

Activity 3. Nominal group

Description: To identify barriers for access to health for migrants and ethnic minorities in every specific region / country.
Time: 35 min.

The activity consists of three parts:

1. Presentation of the methodology
Method: Nominal group technique.
Moderation: 1-2 facilitators / group.
Materials: Cards, markers, flip chart, adhesive (spray), self-adhesive dots.

2. Identification and prioritization of strategies for improving access to health care for migrant and ethnic minority population groups in situation of social vulnerability, in small groups *(8-10 people)*
Technique:

- The participants are invited to write down the 3 most relevant strategies they identify for improving access to health care for migrant and ethnic minority population groups in situation of social vulnerability in their region / country *(one idea / card).*
- The facilitators collect the cards, reading and arranging the named aspects by topics on a flip chart.
- The participants are asked to prioritize the most important strategies *(3 dots / person).*
- The participants choose a rapporteur, in charge of summarizing the most relevant aspects in the plenary.

3. Wrap up and discussion in plenary

- Wrap up: The rapporteur of each small group provides a summary of the results, in three sentences.
- Group discussion.

Once finished, we suggest to leave the flip chart visible for later referral during Module 4 session, when strategies for intervention are presented.

Slide 14: Thank you and questions

Slide 15: References.

Readings

Recommended readings:

- Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015. Available at: http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: July 24, 2015)
- Mock-Muñoz de Luna C, Ingleby D, Graval e. Appendix IV Utilisation of health services, barriers to access and good practices to address them. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015b. Available at http://www.mem-tp.org/pluginfile.php/620/mod_resource/content/1/MEM-TP_Synthesis_Report_Appendices_I-VI.pdf (retrieved: July 24, 2015)

- **Video:** *T-SHaRe: Percorsi Salutari.* Short video report of the workshop held in Naples on 1/04/2012 within the project T-SHaRe funded by European Union. Available at: https://www.youtube.com/watch?v=zXLqE9D5pZA&feature=youtu.be

Complementary readings:

- Open Society Foundations (2011). Roma Health Mediators. Successes and challenges. Available at: http://www.opensocietyfoundations.org/sites/default/files/roma-health-mediators-20111022.pdf (retrieved: March 5, 2015).
- Open Society Foundations (2005). Mediating Romani Health: Policy and Program Opportunities. Available at: http://www.opensocietyfoundations.org/sites/default/files/roma_health_mediators.pdf (retrieved: March 5, 2015)
- Martin Y, Collet TH, Bodenmann P, Blum MR, Zimmerli L, Gaspoz JM, Battegay E, Cornuz J, Rodondi N. (2014) The lower quality of preventive care among forced migrants in a country with universal healthcare coverage. Preventive Medicine;59:19-24.
- Phillips AL, Kumar D, Patel S, Arya M (2014). Using text messages to improve patient-doctor communication among racial and ethnic minority adults: An innovative solution to increase influenza vaccinations. Preventive Medicine;69:117-119.
- Champion J, Harlin B, Collins JI (2013). Sexual risk behaviour and STI health literacy among ethnic minority adolescent women. Applied Nursing research;26:204-209.
- European Roma Rights Centre (2006). Ambulance not on the way. The disgrace of health care for Roma in Europe. Budapest: Roma Rights Centre.
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