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

MODULE 4

Knowledge Application

UNIT 1: Strategies and Procedures for People-Centered Health Care Services Oriented towards Cultural and Ethnic Diversity

Guidelines

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Module 4, Knowledge Application
Unit 1: Strategies and Procedures for People-Centered Health Care Services Oriented towards Cultural and Ethnic Diversity

1. Objectives and Methods

1. Objectives

Objectives of the Presentation

- To introduce the concept of "people-centered health care" and its application in the field of migrants' and ethic 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.

1.1. Methods

The time previewed for Module 4 is 5 hours, approx. 50 min. for each Unit. The training materials of each Unit are composed of presentations, activities, videos and recommended / complementary readings and audiovisual material.

Each Unit includes one or more activities. Due to time limitations, you will not be able to carry out all activities. We recommend you to select the presentation contents and activities you consider most interesting and distribute the time for presentations and activities. We suggest you to leave enough time for activities and discussions, approx. 50% of the session.

Time	Objectives	Activities	Sources
20 min.	• 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.	**Activity** in three parts: • Presentation of the methodology • Video Screening • Discussion *(Slides 3-4)*	Projector, laptop, screen. Video: *"Two blue crocodiles and the gap in the system"*

Time	Objectives	Activities	Sources
30 min.	• To introduce the concept of "people-centered health care" and its application in the field of migrants' and ethic 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 and diversity-sensitive ethics.	**Presentation** "Strategies and Procedures for People-Centered Health Care Services Oriented towards Cultural and Ethnic Diversity" and questions *(Slides 5-33)*	Projector, laptop, screen. M4_U1_Presentation M4_U1_Additional_ Material

2. Presentation

Slide 1: Title page.

Slide 2: Outline of the session

3. Activity

Video Screening and Group Discussion

Slide 3: The activity consists of three parts:

1. **Presentation of the methodology** *(in plenary)*

2. **Video screening** *(in plenary)*

Video: *"Two blue crocodiles and the gap in the system"*

Produced by: IGIV, Implementation Guidelines for Intersectional Peer Violence Preventive Work, Education and Culture Lifelong Learning Programme, 2011.
https://www.youtube.com/watch?v=byRjVKsM14Q

(also available in: German, French, Slovenian and Italian at: http://igiv.dissens.de/index.php?id=105).

3. Group Discussion *(in plenary)*

Slide 4: After the video screening, a group discussion (in plenary) is proposed, including the following questions:

- Do you think the situation described in the video could happen in your own country / regional context?
- What advantages and limitations can you identify in culture- ethnic-specific health care services, in self-organized health care services or in health care services oriented towards cultural and ethnic diversity and reduction of health inequalities?
- Do you think it could be useful to work with a mixed model?
- Which model do you think is most adequate in your country / regional context? Which adaptation would be necessary to implement it?

4. Presentation

Slide 5: In a Policy Paper published by WHO West Pacific Region Office (WHO-WPRO)[1], ***"People-Centered Health Care"*** is defined as *"The overall vision for people-centred health care is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system is designed around stakeholder needs and enables individuals, families and communities to collaborate with health practitioners and health care organizations in the public, private and not-for-profit health and related sectors in driving improvements in the quality and responsiveness of health care. People-centred health care is rooted in universally held values and principles which are enshrined in international law, such as human rights and dignity, nondiscrimination, participation and empowerment, access and equity, and a partnership of equals."*

Slide 6: In the recent bibliography, **different terms** are used, among them *"person-centered health care", "patient-centered health care"* or *"people-centered health care".* In this presentation, the term *"people-centered health care"* is chosen, for being considered as the most inclusive term.

Slide 7: The WHO-WPRO Policy Paper[2] identifies as **relevant aspects of people-centered health care** 1. The culture of care and communication, including informed decision making, respect for privacy and dignity, as well as response to needs in a holistic manner, 2. The establishment of responsible, responsive and accountable services, based on the principle of accessibility, affordability and ethics, as well as 3. The creation of supportive health care

[1] WHO-WPRO, World Health Organization, West Pacific Region Office. People-Centred Health Care: A policy framework. Geneva: WHO, 2007.
http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf (retrieved: March 5, 2015).
[2] WHO-WPRO 2007, op. cit.

environments, including strong primary care services and a stakeholders' involvement in health services planning, policy development and quality improvement.

Slide 8: In the same document[3], the following **domains for development** regarding **people-centered health care** are highlighted: 1. Individuals, families and communities, with special focus on improving health literacy, participation in decision making in the own health care process, self-management and self-care skills, as well as community participation, 2. Health practitioners, with emphasis on holistic care and quality, safe and ethical services, 3. Health care organizations, with specific focus on promoting comfortable environments, coordination, multidisciplinary teams, patient education, standards for quality, safe and ethical services, models of care and leadership, as well as 4. Health systems, with the aim of strengthening primary care, improving access to health care, building a strong evidence base, achieving a rational technology use and accountability, as well as establishing standards and monitoring health care quality.

Slide 9: Recent studies[4,5,6,7,8] analyse the opportunities of applying the **model of people-centered health care** to the area of **migrants' and ethnic minorities' health care.** Taking into account the diversity of migration and ethnic experiences, as well as the frequent situation of social vulnerability of migrants and ethnic minorities, the relevance of people-centered approaches is highlighted.

Slide 10: Beach, Saha and Cooper[9] review the relationship between the concepts of **patient-centeredness** and **cultural competence.** They identify patient-centeredness, described as an approach that emerged in the 1960s, as *"understanding the patient as a unique person, exploring the patient's experience of illness, finding common ground regarding treatment through shared decision-making, and an emphasis on building the doctor–patient relationship. In essence, patient-centeredness involves perceiving and evaluating health care from the patient's perspective and then adapting care to meet the needs and expectations of patients"*, as well as, on the level of health services *"respect for patients' values, preferences, and expressed needs; coordination and integration of care; provision of information and education; and involvement of friends and family".*

As the primary aim of the cultural competence movement, initiated in the early 1990s, Beach, Saha and Cooper[10] highlight the reduction of ethnic and cultural disparities in health care and the elimination of *"cultural and linguistic barriers between health care providers and patients".* An initial focus on *"culture-centered, rather than patient-centered care (…) proved to be a*

[3] WHO-WPRO 2007, op. cit.
[4] Beach MC, Saha S, Cooper LA. The role and relationship of cultural competence and patient-centeredness in health care quality. New York, Washington: The Commonwealth Fund, 2006.
[5] Bischoff A. Caring for migrant and minority patients in European hospitals. A review of effective interventions. MFH – Migrant Friendly Hospitals, a European initiative to promote health and health literacy for migrants and ethnic minorities. Neuchâtel, Basel: MFH, 2003. http://mfh-eu.univie.ac.at/public/files/mfh_literature_review.pdf (reviewed: December 16, 2014).
[6] Lood Q, Ivanoff SD, Dellenborg L, Mårtensson L. Health-promotion in the context of ageing and migration: a call for person-centred integrated practice. International Journal of Integrated Care 2014. URN:NBN:NL:UI:10-1-114771
[7] Koitzsch Jensen N, Johansen KS, Kastrup M, Krasnik A, Morredam M. Patient Experienced Continuity of Care in the Psychiatric Healthcare System – A Study Including Immigrants, Refugees and Ethnic Danes. Int J Environ Res Public Health 2014;11:9739-9759.
[8] Renzaho AMN, Romios P, Crock C, Sønderlund AL. The effectiveness of cultural competence programs in ethnic minority patient-centered health care – a systematic review of the literature. International Journal for Quality in Health Care 2013;25(3):261-269.
[9] Beach, Saha, Cooper 2006, op. cit., p. vi – vii.
[10] Beach, Saha, Cooper 2006, op. cit., p. vi – vii.

drawback" for *"leading providers to stereotype and make inappropriate assumptions". Therefore, "the cultural competence movement tempered this emphasis on specific cultural groups and expanded in scope to include all people of color, particularly those most affected by racial disparities in the quality of health care".* Apart from *"cultural and other barriers between patients and health care providers",* they identify barriers *"between entire communities and health care systems",* raising the need of designing *"culturally competent health care systems"*

As **shared aspects** between both concepts, the authors[11] identify the **aim of improving health care quality**. In case of the patient-centeredness movement, they observe a focus on providing individualized care and emphasizing on user-provider relationship. As the primary goal of the cultural competence movement, the authors mention to *"increase health equity and reduce disparities by concentrating on people of color and other disadvantaged populations".* According to the authors, both dimensions are intertwined: *"To deliver individualized care, a provider must take into account the diversity of patients' perspectives",* and *"to the extent cultural competence enhances the ability of health care systems and providers to address individual patients' preferences and goals, care should also become more patient-centered".*

Renzaho, Romios, Crock and Sønderlund[12] analyze the **effectiveness of cultural competence programmes** in ethnic minorities' patient-centered health care. They observed an increasing knowledge, awareness and cultural sensitivity in practitioners. Regarding an analysis of an impact on health outcome, the need of further research is identified.

Slide 11: As described in Module 1, over the last years a **conceptual shift** from **cultural competence** and intercultural competence towards **cultural diversity, cultural sensitivity, difference sensitivity** or **diversity sensitivity** can be observed[13,14,15,16,17,18,19,20]. In the **framework of cultural competence***,* a specific consideration of the knowledge regarding the

[11] Beach, Saha, Cooper 2006, op. cit., p. vi – vii.
[12] Renzaho, Romios, Crock, Sønderlund 2013, op. cit.
[13] Papadopoulos I (ed). Transcultural Health and Social Care: Development of Culturally Competent Practitioners. Churchill Livingstone Elsevier: Edinburgh, 2006, quoted in: IENE, Intercultural Education of Nurses in Europe, 2014, n.p. http://www.ieneproject.eu/glossary-term.php?termID=11 (retrieved: March 5, 2015).
[14] UNESCO, United Nations Educational, Scientific and Cultural Organization. Intercultural Competences. Conceptual and Operational Framework. Paris: UNESCO, 2013.
http://unesdoc.unesco.org/images/0021/002197/219768e.pdf (retrieved: March 5, 2015).
[15] UNESCO, United Nations Educational, Scientific and Cultural Organization. UNESCO Universal Declaration on Cultural Diversity. Paris: UNESCO, 2001.
http://unesdoc.unesco.org/images/0012/001271/127162e.pdf (retrieved: March 5, 2015).
[16] WHO, World Health Organization. WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance. Health and freedom from discrimination. Health & Human Rights Publication Series Issue No. 2, Geneva: WHO, 2001.
http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf
(retrieved: March 5, 2015).
[17] Council of Europe. Recommendation Rec2006(18) of the Committee of Ministers to Member States on health services in a multicultural society. https://wcd.coe.int/ViewDoc.jsp?id=1062769&BackC (retrieved: March 5, 2015).
[18] Renschler I, Cattacin S. Comprehensive 'difference sensitivity' in health systems. In: Bjorngren-Cuadra C, Cattacin S (eds). Migration and Health: difference sensitivity from an organizational perspective, p. 37-41. Malmo: IMER, 2007.
[19] Chiarenza A. Developments in the concept of 'cultural competence'. In: Ingleby D, Chiarenza A, Devillé W, Kotsioni I (eds). Inequalities in health care for migrants and ethnic minorities, Vol. 2, p. 66-81. COST Series on Health and Diversity. Antwerp: Garant Publishers, 2012.
[20] 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, 2015a. http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: March 5, 2015).

migrants' or ethnic minorities specific cultural and ethnic background is observed, accompanied by health policies focused on providing specialized health care services. The **intercultural competence approach** focuses on the dynamics of interaction between different cultures and a health care provision aimed to address health care needs in intercultural contexts. The **cultural diversity model** is based on the recognition of diversity as a positive social contribution, with health policies focused on addressing health care needs from a diversity perspective. The concepts of **cultural sensitivity, difference sensitivity** or **diversity sensitivity** prioritize the awareness of diversity and the intersectional character of social inequalities, accompanied by health policies aimed to reduce transversal and interconnected social inequalities.

Definitions of the concepts are included in M1_U2_Additional Material, as well as in M4_U1_Additional_Material.

Slide 12: Taking into account this shift from a model of cultural competence and intercultural competence to approaches based on cultural diversity, cultural sensitivity, difference sensitivity or diversity sensitivity, a change from a health care model addressed to specific cultural and ethnic groups towards a health care focused on social inequalities, social determinants of health and intersectionalities, as well as a conceptual evolution from patient-centered health care to people-centered health care, in this Module the terms ***"people-centered health care oriented towards cultural and ethnic diversity"*** or ***"diversity sensitive people-centered health care"*** will be used. The concepts are used taking into account the socially constructed, historically and contextually specific and changeable character of cultural and ethnic diversity.

Slide 13: Health care policies and interventions addressed to migrants and ethnic minorities, among them approaches of people-centered health care oriented towards cultural and ethnic diversity, are developed and implemented on several **policy levels**, including international bodies such as UN General Assembly, WHO or the UN Human Rights Council, European institutions, among them the European Commission, Council of Europe, European Parliament and WHO-Europe, national and regional governments, as well as local health and social services, contributing an international and European Human Rights and strategic framework, national and regional policies, as well as community-based interventions. Professional networks / associations, as well as civil society networks / organizations participate in the development and lobbying for people-centered health care oriented towards cultural diversity on international, European, national, regional and local levels.

Slide 14: A people-centered health care model oriented towards cultural and ethnic diversity is related to several other **related theoretical frameworks**, such as a Human Rights framework, a model of social determinants of health, the concept of intersectionality, intersectoral approaches, community participation models, as well as intercultural and diversity-sensitive ethics. In the following slides, these different frameworks and their application to health care oriented towards cultural diversity will be reviewed.

In the following slides, the related frameworks are described more in detail. Taking into account the time limits, we propose you to select those frameworks that are relevant in your context, and present them more in-depth.

Slide 15: Regarding a **Human Rights Framework**[21,22,23,24], a broad range of conventions and strategic documents can be observed, both at an international and European level.

The documents can be differentiated according to their geographic scope (international or European), the format (conventions / covenants, regulations, declarations and recommendations, reports, etc.), the presence or not of a legally binding status, as well as the population group addressed. In most of the general documents, migrants and ethnic minorities, including migrants in an irregularized situation, are implicitly included, despite of not being mentioned explicitly. Furthermore, documents with a specific focus on migrants or ethnic minorities can be identified.

A selection of relevant international and European strategic documents are listed in M4_U1_ Additional Material.

Slide 16: As an example of a relevant general document related to accessibility and quality of health care, the **International Covenant on Economic, Social and Cultural Rights (CESCR)**[25], approved in 1966 and entered into force in 1976, can be highlighted, for establishing in Art. 12.1. *"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".* This document includes migrants and ethnic minorities implicitly, without quoting them explicitly, but establish principles relevant for these population groups.

The quotations in this and the following slides are not necessarily meant to be read completely during the presentation, the idea is to highlight relevant aspects.

Slide 17: The **Committee on Economic, Social and Cultural Rights,** in its ***General Comment Nº 14 (2000), The right to the highest attainable standard of health***[26]*,* refers to health as a fundamental human right, *"closely related to and interdependent upon the realization of other human rights"*. As interrelated and essential elements of the right to health, the following aspects are identified: 1. Availability of health care, 2. Accessibility, including nondiscrimination, physical, economic and information accessibility, 3. Acceptability, defined as follows: *"All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned",* as well as 4. Quality of health care.

[21] FRA, European Union Agency for Fundamental Rights. Fundamental Rights of Migrants in an Irregular Situation in the European Union. Luxembourg: Publications Office of the European Union, 2011. http://fra.europa.eu/sites/default/files/fra_uploads/1827-FRA_2011_Migrants_in_an_irregular_situation_EN.pdf (retrieved: March 5, 2015)

[22] Mock-Muñoz de Luna C, et al. 2015a, op. cit.

[23] Mock-Muñoz de Luna C, Bodewes A, Graval E, Ingleby D. Appendices I-VI, Synthesis Repport. 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.

[24] Suess A, Ruiz Pérez I, Ruiz Azarola A, March Cerdà JC. The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context. European Journal of Public Health 2014;24(5):712-720. doi: 10.1093/eurpub/cku036.

[25] UN, United Nations. International Covenant on Economic, Social and Cultural Rights, 1966 [1976]. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (retrieved: March 5, 2015).

[26] CECSR, Committee on Economic, Cultural and Social Rights. General Comment Nº 14 (2000). The right to the highest attainable standard of health, p. 1-4. http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11 (retrieved: March 5, 2015).

Slide 18: The General Comment Nº 14 underlines the constraints in the full realization of the right to health due to the limits of available resources, establishing the principle of its **progressive realization.** In consequence, retrogressive measures are not permissible. In case of being taken, the States are obliged to undergo *"the most careful consideration of all alternatives".* A specific reference to migrants and minority groups is included in the following sentence:

> In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs.[27]

Slide 19: As examples of strategic documents specifically focused on migrant populations, the **International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families**[28], approved in 1990, can be mentioned. As a limitation of this document, the lack of ratification by migrants' reception countries has been underlined[29]. As another relevant strategic document focused on migrants, the Resolution of the World Health Assembly ***WHA 61.17 Health of Migrants***[30], approved in 2008, can be highlighted.

The following quotations are included in M4_U1_Additional_Material.

> Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment". As a limitation, the lack of ratification by migrants' reception countries can be identified[31].

> The Sixty-first World Health Assembly, (…)
> CALLS UPON Member States:
> (1) to promote migrant-sensitive health policies;
> (2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
> (3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
> 4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
> (5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
> (6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
> (7) to train health professionals to deal with the health issues associated with population movements

[27] CECSR 2000, p. 10, op. cit.
[28] UN, United Nations. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990, n.p. http://www2.ohchr.org/english/bodies/cmw/cmw.htm (retrieved: March 5, 2015).
[29] Mock-Muñoz de Luna, et al. 2015a, op .cit.
[30] World Health Assembly. WHA 61.17 Health of Migrants, 24 May 2008. http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf (retrieved: March 5, 2015).
[31] Mock-Muñoz de Luna, et al. 2015a, op .cit.

(8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
(9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals; [32]

Regarding ethnic minorities, the **International Convention on the Elimination of All Forms of Racial Discrimination**[33] can be highlighted, approved in 1965 and entered into force in 1969, which condemns all forms of racial discrimination, understood as *"distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin",* assuring the "right to public health, medical care, social security and social services" *"without distinction as to race, colour, or national or ethnic origin".*

On a European level, the **EU Framework for National Roma Integration Strategies**[34], approved 2011, can be identified as a reference point regarding ethnic minorities policies.

The following quotations are included in M4_U1_Additional_Material.

Art. 1.1. In this Convention, the term "racial discrimination" shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life. (…)
Art. 2.1. States Parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races, and, to this end: (a) Each State Party undertakes to engage in no act or practice of racial discrimination against persons, groups of persons or institutions and to en sure that all public authorities and public institutions, national and local, shall act in conformity with this obligation; (…)
Art. 5
In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (…)
(iv) The right to public health, medical care, social security and social services; [35]

The Council of the European Union (…)
Invites the Member States:
20. to improve the social and economic situation of Roma by pursuing a mainstreaming approach in the fields of education, employment, housing, and healthcare, taking into account, where appropriate, the Common Basic Principles on Roma Inclusion, as well as by ensuring equal access to quality services, and to apply an integrated approach to these policies and make the best use of the funds and resources available;
21. to set or continue working towards their goals, in accordance with the Member States' policies, in the fields of education, employment, healthcare and housing with a view to closing the gaps between marginalised Roma communities and the general population.

[32] World Health Assembly. WHA 61.17 Health of Migrants, 24 May 2008. http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf (retrieved: March 5, 2015).
[33] UN, United Nations. International Convention on the Elimination of All Forms of Racial Discrimination, 1965 [1969]. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx (retrieved: March 5, 2015).
[34] Council of the European Union. EU Framework for National Roma Integration Strategies (NRIS), 2011. http://register.consilium.europa.eu/doc/srv?l=EN&f=ST%2010658%202011%20INIT (retrieved: March 5, 2015).
[35] UN, United Nations. International Convention on the Elimination of All Forms of Racial Discrimination, 1965 [1969]. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx (retrieved: March 5, 2015).

> Particular attention should be paid to the need to ensure equal access in practice. The goals could focus on the following priority areas, paying special attention to the gender dimension: (…)
> (c) access to healthcare, with particular reference to quality healthcare including preventive healthcare and health education;[36]

Slide 20: Recent studies[37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55] analyze **health policies and interventions** related to the access to health and health of migrants and ethnic minorities in the European context from a **Human Rights perspective.**

[36] Council of the European Union. EU Framework for National Roma Integration Strategies (NRIS), 2011. http://register.consilium.europa.eu/doc/srv?l=EN&f=ST%2010658%202011%20INIT (retrieved: March 5, 2015).
[37] IOM, International Organization for Migration, WHO, World Health Organization; UNHRC, United Nations Human Rights Office of the High Commissioner. International Migration, Health and Human Rights. Geneva: IOM, 2013. http://www.ohchr.org/Documents/Issues/Migration/WHO_IOM_UNOHCHRPublication.pdf (retrieved: March 5, 2015).
[38] Biswas D, Toebes B, Hjern A, Ascher H, Norredam M. Access to health care for undocumented migrants from a human rights perspective: a comparative study of Denmark, Sweden, and the Netherlands. Health and Human Rights 2012;14:2:49-60.
[39] Cuadra BC. Right of access to health care for undocumented migrants in EU: a comparative study of national policies. Eur J Public Health 2011;22:267–271.
[40] Dauvrin M, Lorant V, Sandhu S, et al. Health care for irregular migrants: pragmatism across Europe. A qualitative study. BMC Res Notes 2012;5:99.
[41] Duvell, Triandafyllidou, Vollmer, 2008, op. cit.
[42] FRA 2011a, op. cit.
[43] FRA, European Union Agency for Fundamental Rights. Migrants in an Irregular Situation: Access to Health Care in 10 European Union Member States. Luxembourg: Publications Office of the European Union, 2011b. http://fra.europa.eu/sites/default/files/fra_uploads/1771-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf (retrieved: March 5, 2015).
[44] HUMA Network, Health for Undocumented Migrants and Asylum Seekers, Collantes S. Are Undocumented Migrants and Asylum Seekers Entitled to Access Health Care in the EU? A Comparative Overview in 16 Countries. Paris, Brussels, Madrid: HUMA Network, 2010. http://www.epim.info/wp-content/uploads/2011/02/HUMA-Publication-Comparative-Overview-16-Countries-2010.pdf (retrieved: March 5, 2015).
[45] Karl-Trummer U, Novak-Zezula S. Health Care in Nowhereland. Improving Services for Undocumented Migrants in the EU. Vienna: Centre for Health and Migration, 2010.
[46] Médicins du Monde (Doctors of the World), European Observatory on Access to Health Care, Chauvin P, Parizot I, Simonnot N. Access to Health Care for Undocumented Migrants in 11 European Countries. Paris: Médicins du Monde, 2009. . http://mdmgreece.gr/attachments/283_huma%20en.pdf (retrieved: March 5, 2015).
[47] Médicins du Monde (Doctors of the World), Chauvin P, Mestre MC, Simonnot N. Access to Health Care for Vulnerable Groups in the European Union in 2012. An Overview of the Condition of Persons Excluded from Health Care Systems in the EU. Paris: Médicins du Monde, 2012. http://www.doktersvandewereld.be/sites/www.doktersvandewereld.be/files/publicatie/attachments/eu_vulnerable_groups_2012_mdm.pdf (retrieved: March 5, 2015).
[48] Médicins du Monde (Doctors of the World), Chauvin D, Simonnot N, Vanbiervliet F, et al. Access to Health Care in Europe in Times of Crisis and Rising Xenophobia: An Overview of the Situation of People Excluded from Health Care Systems. Paris: Médicins du Monde, 2013. http://b.3cdn.net/droftheworld/d137240498b91ca33e_jhm62yjg1.pdf (retrieved: March 5, 2015).
[49] PICUM, Platform for International Cooperation on Undocumented Migrants. Access to Health Care for undocumented Migrants in Europe: The Key Role of Local and Regional Authorities. Brussels: PICUM, 2014. http://picum.org/picum.org/uploads/publication/PolicyBrief_Local%20and%20Regional%20Authorities_AccessHealthCare_UndocumentedMigrants_Oct.2014.pdf (retrieved: March 5, 2015).
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They observe an uneven fulfillment of the right to health and health care for migrants in an irregularized situation across Europe *(for further information see: Additional Module 1: Target Groups, Unit 2).*

Regarding ethnic minorities, barriers to accessing and utilizing health care services are identified, including experiences of discrimination, denial and exclusion from health care services, which limit the fulfillment of the right to the highest attainable standard of health.

The reviewed studies identify **limitations in the fulfillment of the international and European strategic framework** due to a frequent lack of legally binding character or ratification of the documents.

Slide 21: The **Human Rights perspective** is identified as an important framework for improving access to health care for migrants and ethnic minorities. The reports recommend an implementation of policies and interventions addressed to providing **access to health care for all people living in Europe, regardless of their nationality, administrative status or ethnicity**, as well as **eliminating barriers for effective access to health care**.

Slide 22: WHO refers to another framework that maintains a close relationship to people-centered health care oriented towards cultural and ethnic diversity: the **social determinants of health model**[56,57].

As presented in Module 2, the social determinants of health model analyzes different determinants on health with potential impact on equity in health and well-being. The model distinguishes between 1. **Structural determinants of health**, including the socioeconomic and political context, composed by governance, macroeconomic policies, social policies, public policies, and culture and societal values, as well as the socioeconomic position, including social class, gender, ethnicity, education, occupation and income, and 2. **Intermediary determinants,** including material circumstances, behaviors and biological factors, as well as psychosocial factors.

Slide 23: In a Policy Paper published by WHO, World Health Organization in 2010[58], an **adaptation of the model of social determinants of health to migrants' and ethnic minorities'**

http://www.coe.int/t/commissioner/source/prems/prems79611_GBR_CouvHumanRightsOfRoma_WEB.pdf (retrieved: March 5, 2015).

[54] FRA, European Union Fundamental Rights Agency, UNDP, United Nations Development Programme. The situation of Roma in 11 EU Member States. Survey results at a glance. Luxembourg: Publications Office of the European Union, 2012. http://fra.europa.eu/sites/default/files/fra_uploads/2099-FRA-2012-Roma-at-a-glance_EN.pdf (retrieved: March 5, 2015).

[55] DHSSPS, Department of Health, Social Services and Public Safety. DHSSPS Equality and Human Rights Strategy and Action Plan. Section 3. Ethnicity, Equality & Human Rights: Access to Health and Social Services in Northern Ireland. 2007. http://www.dhsspsni.gov.uk/ehr-sect3.pdf (retrieved: March 5, 2015).

[56] WHO, World Health Organization. Commission on Social Determinants of Health. Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva: WHO, 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf (retrieved: March 5, 2015).

[57] WHO, World Health Organization. A conceptual framework for action on the social determinants of health. Discussion Paper Series on Social Determinants of Health 2. Geneva: WHO, 2010a. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf (retrieved: March 5, 2015).

[58] WHO, World Health Organization. How health systems can address health inequities linked to migration and ethnicity. Briefing on policy issues produced through the WHO/European Commission equity project. Copenhagen: WHO Regional Office for Europe, 2010b. http://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf (retrieved: March 5, 2015).

health is presented, based on the rainbow figure developed by Dahlgren and Whitehead[59], is completed by policy measures proposed to tackle social determinants of health for migrants and ethnic minorities, including the following aspects: 1. Reducing occupational health hazard, 2. Combating social exclusion and improving the rights of non-citizens, 3. Reducing barriers to labor market participation, creating more appropriate and accessible health services; 4. Improving housing conditions, 5. Improving knowledge of health risks, strengthening healthy cultural traditions and questioning unhealthy ones, 6. empowering migrant and ethnic minority communities, 7. Increasing the availability of healthy food and 8. Promoting inclusive educational policies.

Slide 24: The **social determinants of health framework** has been frequently applied in the **analysis of migrants' and ethnic minorities' health care and health**[60,61,62,63]. The revised studies analyze the impact of different social determinants on migrants' and ethnic minorities' health and health care. Regarding migrants, an impact of the limitation of access to health care of migrants in an irregularized situation on their vulnerability to marginalization, poverty and illness is stated. In relation to ethnic minorities, the authors identify a negative impact of dynamics of discrimination and prejudice against Roma population on their human rights, self-determination and health inequities. At the same time, a tendency to reduce social determinants of health to socioeconomic factors is observed, without taking into account the migration background or ethnicity, or viceversa, reducing socioeconomic inequalities to cultural or ethnic aspects.

Slide 25: Within a social determinants of health framework, the reviewed studies highlight the relevance of **policies and interventions on the social determinants of health** to achieve greater health equity, recommending to address processes of exclusion rather than focusing the characteristics of the excluded groups, including migrants or ethnic minorities. Furthermore, the alignment of health policies focused on reducing health inequalities with education, economic, labor, housing and environmental policies is proposed. Finally, the authors underline the relevance of integrated, intersectional, multivariate and multilevel approaches to tackle health inequities.

Slide 26: Consideration of **intersectionalities** can be identified as a relevant aspect of a people-centered health care oriented towards cultural and ethnic diversity. As described in Module 1, there are a broad range of experiences regarding an **application of intersectional approaches** to health research related to migrants and ethnic minorities[64,65,66,67,68,69,70,71], professional training[72], health care[73,74,75,76,77] and health policies[78,79,80].

[59] Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Background document to WHO – Strategy Paper for Europe. Stockholm: Institute for Futures Studies, 1991.
[60] Marmot M, Allan J, Bell R, Bloomer E, Goldblatt P, on behalf of the Consortium for the European Review of Social Determinants of Health and the Health Divide. WHO European review of social determinants of health and the health divide. Lancet 2012;380(15):1011-1029.
[61] Ingleby D. Ethnicity, Migration and the 'Social Determinants of Health' Agenda. Psychosocial Intervention 2012;21(3):331-341.
[62] Fésüs G, Östlin P, McKee M, Ádány R. Policies to improve the health and well-being of Roma people: The European experience. Health Policy 2012;105:25-32.
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[66] Bauer GR. Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. Social Science & Medicine 2014;110:10-17.

Slide 27: Furthermore, **intersectoral collaboration** constitutes a relevant element in people-centered health care oriented towards cultural and ethnic diversity, including interaction between the health care and education system, social services, legal system and media, as well as with the broader family and social context[81]. In Unit 6 of this Module, intersectoral approaches will be discussed more in detail.

Slide 28: The **promotion of community participation** has been identified as one of the core domains of development of people-centered health care[82]. Arnstein[83] developed in 1969 a ladder of citizen participation which serves as a reference point for further participation models[84]. Arnstein distinguishes between degrees of non-participation (manipulation and therapy), degrees of tokenism (information, consultation, placation), as well as degrees of citizen power (partnership, delegated power, citizen control). Applying the model to migrants' and ethnic minorities' participation in health care policies, examples for the different levels of participation can be identified, including *"Informing"* (e.g. health promotion and prevention campaigns, information on legal changes), *"Consultation"* (e.g. surveys on health related issues); *"Partnership"* (Participatory Action Research, participation in health related projects), *"Delegated power"* (e.g. participation in project design, development and assessment), as well as *"Citizen control"* (e.g. participation in health policies decision making).

In the next Units, different forms and levels of migrants' and ethnic minorities' participation in health research, policies and interventions will be named. Unit 5 focuses on presenting

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[71] Rosenfield S. Triple jeopardy? Mental health at the intersection of gender, race, and class. Social Science & Medicine 2012;74(11):1791-1801.
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[78] Hankivsky, op. cit.
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[80] Viruell Fuentes, et al., op. cit.
[81] Marmot et al. 2012, op. cit.
[82] WHO-WPRO 2007, op. cit.
[83] Arnstein SR. A Ladder of Citizen Participation. JAIP 1969;35(4):216 – 224.
[84] Cornwall, A. (2008). Unpacking 'Participation': modes, meanings and practices. Community Development Journal 43(3):269-283.

different experiences of community participation in health care oriented towards cultural and ethnic diversity.

Slide 29: A model of people-centered health care oriented towards cultural and ethnic diversity focuses specifically on **ethical aspects and deontological principles.** An emerging bibliography on **intercultural and diversity-sensitive ethics**[85,86,87,88,89,90,91,92,93,94,95,96] reflects specific ethical concerns in health care organization, health care practice, and health research oriented towards cultural and ethnic diversity.

Slide 30: Within the framework of bioethical principles developed by Beauchaump and Childress[97] (autonomy, beneficence, non-maleficence and justice), the discussion on **ethical principles** in a **health care organization** oriented towards cultural and ethnic diversity[98,99,100,101] puts a specific attention on the principle of justice. The limitation of health care entitlements for **migrants** in an 'irregular' situation is considered as a contradiction with ethical and deontological principles, Human Rights and the principle of social responsibility and non discrimination. The need for global solidarity is underlined, including the recognition of health care entitlements and social rights of migrants, considered especially relevant due to the interdependence in a globalized world. In relation to **ethnic minorities**, the need for fulfilling the principles established by the Committee on Economic, Social and Cultural Rights is stressed, including the principle of no discrimination and cultural acceptability, established by the Committee on Economic, Social and Cultural Rights.

[85] Dwyer J. Illegal Immigrants, Health Care, and Social Responsibility. Hasting Center Report 2004:34-41.
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[97] Beauchamp TL, Childress JF. Principles of Biomedical Ethics. Oxford: Oxford University Press, 2012 [1979].
[98] Dwyer 2004, op. cit.
[99] Eckenwiler et al. 2012, op. cit.
[100] Wild 2011, op. cit.
[101] European Roma Rights Center 2006, op. cit.

Slide 31: In a **health care practice** oriented towards cultural and ethnic diversity[102,103,104,105], several **ethical and deontological principles** are identified. In relation to health care for **migrants**[106,107], the authors highlight the importance of reducing legal, structural, linguistic and cultural barriers in the access to health care, as well as the relevance of an adequate intercultural competence of health professionals. Ethical conflicts in professional practice are identified in age assessment procedures and in relation to legal regulations that exclude migrants from access to health care.

Regarding **health care practice with ethnic minorities**[108,109], specific ethical aspects are underlined, among them the ethical responsibility of serving all users equally, reducing health care disparities and addressing the needs and preferences of ethnic minorities. With the aim of reducing situations of discrimination and exclusion from health care, the relevance of applying medical ethical codes of conduct in the health care practice with ethnic minority populations is stressed. The increase of ethnic diversity within the professional field is identified as another relevant aspect.

Slide 32: Regarding **research with migrants and ethnic minorities**[110,111,112,113,114,115,116], several **ethical conflicts** are identified.

In relation to **research with migrants**[117,118,119,120,121], the authors highlight the limitation of informed consents in multilingual contexts, the contradiction between an analysis of cultural differences and the duty of non-discrimination, as well as the risk of abuse in research due to the specific situation of vulnerability of migrants and asylum seekers. They underline the relevance of guaranteeing confidentiality and privacy. During the interview process, the relevance of intercultural communication and ethical sensitivity is stressed, as well as the need for taking into account the potential impact of a re-narration of traumatic experiences. In case of research with migrants in an 'irregular situation', potential ethical conflicts related to the administrative situation are identified. Furthermore, the relevance of participatory approaches is highlighted, taking into account specific ethical aspects in the participation process. Finally, the articles include reflections on the social position, cultural background, identity and role of the researcher, ethical aspects related to an insider / outsider role and power relationships in the interview process.

[102] Wild 2011, op. cit.
[103] Berlinger et al. 2013, op. cit.
[104] Bostick et al. 2006, op. cit.
[105] European Roma Rights Centre 2006, op. cit.
[106] Wild 2011, op. cit.
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[109] European Roma Rights Centre 2006, op. cit.
[110] Wild 2011, op. cit.
[111] Van Liempt et al. 2009, op cit.
[112] Duvell et al. 2008, op. cit.
[113] Pechurina 2014, op. cit.
[114] Marshall et al. 2004, op. cit.
[115] NHS Greater Glasgow 2004, op. cit.
[116] Bhopal 2008, op. cit.
[117] Wild 2011, op. cit.
[118] Van Liempt et al. 2009, op cit.
[119] Duvell et al. 2008, op. cit.
[120] Pechurina 2014, op. cit.
[121] Marshall et al. 2004, op. cit.

Slide 33: Regarding **research with ethnic minorities**[122,123], the relevance of an understanding of the culture and needs of the ethnic minority community is underlined, as well as the importance of using appropriate and culturally sensitive methodologies, including the guarantee of confidentiality and privacy, a critical review of the used terminologies and categorization processes categories, as well as a consideration of the potential impact of sensitive topics on the community being researched. An active involvement of the ethnic minority community in the research design and process is recommended. In the publication process, the relevance of facilitating a dissemination of the results in the involved communities is highlighted.

Slide 34: Thank you and questions.

Slide 35-40: References.

Slide 41: European Commission Disclaimer.

4. Readings

Recommended readings:

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Complementary readings:

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