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Better health for all in an inclusive society

GOOD PRACTICES ON HEALTH AND MIGRATION IN THE EU

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Better health for all in an inclusive society"

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Good Practices on Health & Migration in the EU

Introduction

Aims

The aim of this report is to discuss issues of health and migration with reference to some of the interventions that EU member states have found to be effective in the field. Thus, the ultimate goal is to improve migrant health and health care in member states, primarily by sharing and exchanging different experiences but also by identifying the pitfalls of health systems when accounting for migrant health.

In general many overarching drawbacks have been identified in health systems that seem to be common in most of the countries, from communication obstacles triggered by languages barriers but also cultural and socio-economic issues that lead to increasing vulnerability of the migrant population. Thus there are many questions arising from those limitations.

It must be said that the field of health and migration is a rather new and complex ground. Health and migration issues have been either approached by different policy fields, or have been ignored. Thus, there is a lack of a comprehensive approach that leads to an integrated way to face the new situations, and hence, it is about time to get into action. Even if good practices are neither the solution nor the approach to take for future action, they are concrete ways of interventions that have been adopted as a response to new situations, mainly, but not only, where and when the state has been absent.

Health & Migration

International migration has jumped to the centre of international and national political agendas in the last decade. For the EU member states, international migration is a common reality, even if the characteristics of the flows differ in origin, quantity, intensity, qualifications, status, among other factors. In the EU, migration is related to both, demographic and economic challenges with two-folded scopes: protecting human rights and fostering economic growth. However, growth ought to be sustainable and promote equity and should not be reached at the expenses of some for the benefit of others. If this is to be fully accomplished, migrant health becomes a central issue as it has been proven that where population growth has taken place, it has been due to migration. Moreover, following European values and principles, all human beings should fully enjoy as good a state of health as possible.

Having said this, it is important to recognise that the planning and adoption of policies to deal with the mobility of people and their health are a priority. The arrival of newcomers with different cultures and practices implies a two-way street in terms of integration and adaptation: host societies adapt to these changes at the same time that newcomers adapt to a new environment and become familiar with the practices and cultures of the receiving societies.

Transition to the new life in a new country is a difficult period because it embodies several adjustments. Upon arrival migrants need to solve some issues such as finding housing and work, becoming familiar with means of transportation, learning a new language, understanding how public services work including how to gain access to health information and services; many migrants while adjusting still have to deal with unresolved issues or family matters at the county of origin. Furthermore, living in a new country usually implies a change from the known environment at home (climate, exposure to different risks to their health, changes in life style, new eating habits, etc.) that adds stress to an already stressful situation.

All of these changes are important, however those that relate to changes in migrants' health status, the determinants of their health and on how to attain access to services are our main preoccupations. Previous research has identified a 'healthy migrant effect' (also known as the 'migrant health paradox'), which indicates that when immigrants arrive to the country of destination, their health status is usually better than that of nationals (Chen and Wilkins 1996). So one could wonder what happens after arrival. On the other hand, other studies have emphasised that the intersection of health and migration is very specific because populations differ greatly (Carballo et al. 1998), especially when considering that migrants in general are populations that usually face situations of vulnerability. Consequently, the health status of some migrants deteriorates in the country of destination due to several factors (namely the determinants of health). As widely known, health depends on a combination of inter-linked factors that are usually divided into specific groups: constitutional factors, individual lifestyles, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental conditions. One obvious corollary is that some health determinants are more relevant and specific for migrants than for the general population. However, on the other hand, migrant are also part of the host society.

From the public policy standpoint, it is important to improve the health and well-being of all people living in a given society, including both, EU citizens and migrants from any country residing in the EU. As part of the host society, migrants are affected by local policies or the lack of them. In this report, we will refer to as 'migrants' those people living in the EU who are from non-EU countries and their descendents. Other concepts commonly used are immigrants and ethnic minorities.

Defining Good Practices

In the last few decades, it has been suggested that in addition to describing and identifying social problems, it is fundamental to identify good/best practices, that is, activities, projects or ways of action that can be considered successful in dealing with such problems or phenomena, thus making a positive contribution to the issue at hand. We believe that the framework of good/best practices could be a useful tool, not only as a way of learning and disseminating knowledge but also because it "supplies practical ways of partnerships between communities, governments and the private sector" (UNESCO 2006). There are many advantages and positive aspects about good practices.

In this sense, several international organizations find helpful to identify GOOD/BEST PRACTICES as a way to help others to deal with similar issues by the dissemination of what has been called horizontal knowledge. However, in terms of methodology, it is important to define two aspects. On the one hand the concept of good/best practices adopted in order to agree upon certain aspects and features which are necessary to establish a common base and criteria for selection and evaluation. On the other hand, as the selected knowledge is horizontal and does not occur in a vacuum of values, it has epistemological consequences, thus it is important not only to describe techniques and tools for performing given activity, but also to make explicit the world-view or norms of validity and values implicit in those practices. Good or Best Practices are useful because they

> "provide a much-needed link between research and policy-making by inspiring decision-makers with successful initiatives and model projects that can make an innovative and sustainable contribution to actually solving problems in society" (Paul de Guchteneire and Saori Terada, UNESCO 2006).

The importance of good/best Practices has been pinpointed many times in research and in policy making, however there is not much written about theoretical frameworks or even common elements that a good/best practice should have, especially in the field of health and migration. In many cases reports mention good/best practices in their titles and contents, but without providing a definition or understanding of what a good/best practice really is or means. Thus, authors of good/best practices assume a meaning for this concept without making it explicit, as if the adjective good or best is self-defined.

Even if there are different models (implicit or explicit) for good/best practices, some can be applied to any situation and others are very specific to certain terrains such as poverty, housing, and the environment, among others. As a general framework, we adopt the UNESCO model developed for best practices in immigration planning because identifying the same target population is fundamental. Additionally, the model responds to our principles. Following UNESCO, the four main characteristics are:

1. Best Practices are innovative. A Best Practice has developed new and creative solutions to common problems that are consequence of immigration, poverty and social exclusion.
2. Best Practices make a difference. A Best Practice demonstrates a positive and tangible impact on the living conditions, quality of life or environment of the individuals, groups or communities concerned.
3. Best Practices have a sustainable effect. A Best Practice contributes to sustained eradication of poverty or social exclusion, especially by the involvement of participants.
4. Best Practices have the potential for replication. A Best Practice serves as a model for generating policies and initiatives elsewhere.

Even if the model provides a useful framework and defines some characteristics that are relevant, we considered it essential to have a common blueprint that provides authors and readers with more information than the aforementioned features and whether each practice meets them. Therefore, we designed a matrix that included several aspects that guided the process of writing the good/best practice, in the first place, and reading or understanding it, in the second place. This blueprint enabled us to have at least a set of aspects in order to compare and assess the degree to which practices could be considered 'good' or 'best'.

Moreover, we believed that in addition to identifying the above four characteristics, it is fundamental to identify the values that underlie the design of the good/best practice. Values would enable authors and readers to understand principles informing the practices that could be fundamental for replication, and offer information about the choices, principles, philosophy that guide the conception of a given practice.

From Best to Good Practices

When we began our project, we used the concept of 'best practice' but this was changed later on. The existing literature uses both concepts, 'best' and 'good', although there is not an in depth discussion about the actual utilization of one or the other. In the process of building up this report, and having discussed the issue with the authors and/or practitioners involved, we opted to use the term 'good' rather than 'best'.

Several reasons made us believe that good is a more adequate adjective for what we are referring. In the first place, 'best' tacitly implies that there are other ways and that the selected one is better that the others. 'Best' also suggests the existence of a hierarchy, and we did not have a complete set of practices to rank. Secondly, 'best' would imply that all the criteria presented above are met by all the selected practices. However, this was not the case for most of the examples found: for most of the selected practices, at least one of the criteria was not completely met. Thirdly, 'best' would also imply that a given practice is a better way to do things compared to other approaches. This is not necessarily true either, as practices respond to specific needs in given situations, and it was not possible for us to compare and evaluate.

Thus, due to the multiplicity of situations that indicated that the cases or practices selected could not or should not be thought as 'best', we opted for the word 'good'. Using this definition we could include practices that may be a solution to some issues or problems but that do not necessarily meet the four criteria listed above. As the practices are a product of their environment, reality and circumstances, they are relative, and could be more or less creative, more or less sustainable or more or less replicable. On the other hand, in most cases, good practices make a difference for the populations involved, at least compared with what was available before the practice was in place. A more exhaustive commentary and analysis on the process and on the good practices will be presented in latter sections of this report.

Methodology

This report results from a long process that started when Portugal submitted a project to the European Commission for the organisation of some key events during its Presidency of the EU Council. The project included the organisation of a conference on Health and Migration (Lisbon, 27-28 September 2007) which would generate preparatory work, namely, the commission of two reports. The first of the reports focuses on demographic, and epidemiological issues as well as policies regarding health and migration. The second one, this present volume, is a study of Good Practices on Health and Migration in the EU.

The general methodology of works to prepare the conference and the reports comprised some working meetings which were hosted by the DG SANCO in Luxembourg in January and May. The meetings were attended, in addition to the representatives from the Portuguese Health Group and the Commission, by the consultants and the European national focal points. These European national focal points constituted an informal network, and were appointed by each national Health Ministry. The idea was to share with Member States (MS) the process of organizing the conference and show the advances of the reports, thus adopting a bottom-up approach.

For the present report on Good Practices, the main input came from the national focal points. In the first meeting held in January, we asked them for help in identifying practices in the field of Health and Migration in their own countries. Thus the report was deliberately organised in a way that would allow for the direct contribution of MS.

As already mentioned, there were two general meetings with national focal points in Luxembourg. In the first one, the editors presented important information to the focal points: models on health services provision and a base matrix to identify good practices. Also, in the first meeting, national focal points were divided into two working groups to discuss issues that could be relevant, i.e. to use some examples of good practices from their own experience, to discuss the involvement of MS, the articulation with governmental and non-governmental agencies, among others. That first discussion proved to be very challenging but also productive, and deadlines were set for the reception of samples. Following that meeting, the matrix including some basic information was sent to each national focal point. Member States then had some time to identify practices and to ask individual organizations and authors to complete and send the identified practices.

After MS and some international organizations sent the sample of matrix of good practices filled out, a first selection of samples was made and a meeting with authors was scheduled. This meeting took place in Brussels and was very helpful as it turned out to be creative, dynamic and crucial for getting to an agreement not only in the final version of the matrix, but to gain consensus on the shift from ‘best’ to ‘good’ practices, as mentioned above. A second deadline was set for sending the new version of the practices to fit the new matrix.

During the second meeting with national focal points and DG SANCO in Luxembourg, the editors summarised and explain what had been done and the criteria behind the selection of Good Practices. Also, the editors highlighted some possible directions of the conclusions, especially some regarding policies and the weak role of the state in the promotion of migration health.

Good Practices Matrix

The editors selected two possible matrixes that could be the base or guide for organizing and describing the Good Practices. One was the UNESCO Model and the other one was the State Department of Health and Human Services of the United States (Table 1).

Table 1 – Best Practices Models

UNESCO Model	US Department of Health and Humana Services Model
Composition of the practice Approach Purpose/objective Main Partner Other partners (community, NGO, etc.) Stakeholders Cost Time-frame Geographical scope Administrative data about the organization Contacts (organization and people) Culture sensitivity/specificity Strengths Weakness Lessons learned Brief Description of how it works	Introduction Goals & objectives Model Results Conclusions Future References (optional) For further information contact:

Based on the two matrixes presented above, the editors proposed the following matrix which combines elements of both and others that were believed to be relevant for the field of migration health. The main objective of the matrix was to identify fields that were important both for authors and readers in summarising relevant information on the good practices.

Matrix for Best Practices

- Introduction
- Goals and Objectives
- Field or Health Determinant
- Scope
- Provider
- Model
- Resources
- Management
- Indicators
- Results
- Conclusions
- Future
- References (optional)
- Contact

As a consequence of the fruitful discussions that the editors had with the majority of the authors in Brussels, some changes were introduced to this initial matrix. These changes supported the shift from 'best' to 'good' practices and also gave alternative ways to provide information for some of the fields that were problematic or more complex in some cases, such as giving the opportunity to offer testimonies and pictures as a different way to illustrate results and success. In this sense, the new fields incorporated were ‘lessons learned’ and an ‘annex’ section that would provide information to the editors for a better comprehension of the practice, mainly to be used when writing the conclusions, but that would not be published. It follows the matrix adopted for Good Practices.

Matrix for Good Practices (Model adopted)

Introduction: background information about the specific public health problem, its significance and impact, population(s) affected, and trends

Goals and Objectives: state what you seek to achieve as a result of your efforts to solve the public health problem

Model: describe the approach being taken or framework of procedures being used to address the public health problem

Field or determinant: indicate the field(s) or determinant(s) involved in the practice (i.e. prevention, promotion, maternal health, etc.)

Scope: explain the scope of the model, that is, level of centralization, decentralization, etc. that is appropriate (i.e. national, regional, local, etc.)

Provider: indicate whether the provider is a public, private or non-governmental institution, or if it is a partnership of several

Resources: describe the main financial aspects of the practice (i.e. sources of funding, etc.)

Management: indicate how decisions are made, and how they are implemented. Are interested stakeholders taken into account somehow?

Indicators: indicate if there is a way to measure or control the effect of the practice (if possible, state the before and after).

Results: Discuss the basis for determining the success of your model in terms of measurable outcomes. Use no more than one graphic, preferably in JPEG or GIF format, and not more than 400x400 pixels in size.

Conclusions: briefly summarize the meaning of your results and potential implications for public health practice and policy.

Future: outline steps that you may take to extend or further improve the model.

References (optional): provide no more than five citations.

Lessons learned: provide advice from experience, identify weaknesses and strengths thinking in replication/application.

Testimony / Picture: attach a testimony of a migrant who has taken advantage of the good practice. If you wish, you may also attach a picture.

For additional information, please contact: provide the author’s name, title, mailing address, e-mail address, and telephone number

Annex: not to be included in the publication but to be sent with the Good Practice. This section aims at providing fundamental information to editors, as authors will write details that include advantages/disadvantages, problems, etc, encountered through experience and that will be key for editors to write conclusions and make recommendations.

Analysis

Criteria for selecting a 'Good Practice'

Since the beginning some criteria was made explicit by the editors for the selection of the good practices cases. The issues and aspects that the editors would consider were varied, and included from geographical regions within Europe to scope (national, local, international), from target population among migrants to types of interventions in migrant health. These criteria were taken into account for the selection. However, for the analysis of these good practices, in addition to these criteria, other aspects can be added as well (conditions that the good practice pretends to solve, type of organization that carries out the good practice, type of funding and management, etc.).

As editors did not select the good practices cases in MS, this aspect of the selection process was not under their control. In the meetings, national focal points were asked to identify good practice in the area of health and migration, but they were given freedom on which ones to choose or select. Thus this face of the selection process needs to be recognised as biased and limited. Nevertheless, it was never the purpose of the report to do a complete survey or have a representative sample of all the good practice experiences in place in all EU member states. Thus this is a limitation of the report and of the analysis that can be carried out with this set of good practices. On the positive side, these good practices are examples of the variety of possible good practices in spite of all limitations.

Analysing the Good Practices

With the collaboration of national focal points, a total of 55 good practices were collected by the editors based on the existence of at least three of the four characteristics set by the UNESCO model to define a good practice (de Guchteneire and Terada, 2006). In this report we present the selected 35 good practices. This selection became necessary because not all requirements set by the editors in the matrix presented above were fulfilled.

As the good practices included in this report do not reflect an exhaustive inventory of all good practices in the EU countries the main question regarding their analysis lies more on what can be learned from them than on the thorough evaluation of accomplishments and shortcomings.

Good practices are in essence innovations. Which lessons can we learn from reviewing these innovations? Firstly, *diversity*. Good practices point out several fields and ways through which health care systems can be improved. Secondly, *commitment*. Good practices bring out the assurance that human resources, both at an individual and collective level, can be activated to undertake action in favour of a better system. Thirdly, *competency*. Good practices show that a substantial bulk of knowledge and skills for implementing change exists. We proceed with a closer look into each of these aspects.

1. Diversity

The most striking aspect regarding good practices lies on the diversity that characterizes them. Good practices accrue a highly diversified set of interventions designed to respond to the needs of many different target populations at multiple levels. This leaves no doubt as to the vast range of possibilities through which health care systems can be improved. On the other hand, it points out the urgent need for health care systems to promote structural change. Good practices often flourish where statutory responses fall short and problems abound. In this sense, they are not only able to point the way to introduce change but they also identify critical areas in need for intervention.

The good practices presented in this report vary widely in terms of target populations, aims, scope and organization and on geographic distribution.

a. Target Populations

Good practices focus on several target populations. These include refugees and asylum seekers, undocumented and irregular migrants, disadvantaged populations, women and children and adolescents.

Good practices are more or less equally distributed over these groups often focusing on several of them at the time with the exception of undocumented and irregular migrants. Where practices exist for this population they tend to target for it exclusively. This suggests that undocumented and irregular migrants in particular experience greater vulnerability both in terms of health status and access to care when compared to other migrant groups. Good practices developed for this population stress the need for promoting health literacy and empower migrants in these circumstances, including information dissemination on their rights.

b. Aims

The aims of good practices in place are virtually set in all fields associated with health and health care: research, information dissemination, training, illness prevention, health promotion, health access and quality of service delivery. This shows the important challenge posed by ‘multicultural’ societies to health care systems. The ongoing processes of globalisation, worldwide migration and EU expansion are leading to an increase of ethno-cultural differences in the EU countries and there is a need to re-think health care delivery towards more culturally-competent and flexible services. Good practices offer unprecedented expertise and knowledge on how to deliver care to migrant populations and in identifying the fields in which this need appears more urgently.

Access to care appears to be one of the major concerns at present, judging from the number of good practices that sets it as one of their main goals. While undocumented and irregular migrants seem to be most affected by the lack of access to care, this problem is not exclusive to them. Good practices alert us to the fact that even migrants with full entitlement to health care have difficulties navigating health care systems. These difficulties derive from the lack of information about where to get treatment, complex administrative procedures, discrimination and cultural and linguistic barriers. These problems might be counteracted by creating more user friendly-services, providing culturally-sensitive training to the staff, promoting health literacy and user involvement and developing new policies able to accommodate the changing needs of an ever-more diverse population in the EU.

c. Scope and organization

The scope of good practices is connected to two different aspects: administrative organization and the type of care. On the one hand, good practices differ in the formal way national administrative systems are set in each country, thus good practices are national, regional or local, and inclusively, if they transcend the national boundaries as we found, they are transnational or international. On the other hand, good practices either exist within public institutions or are offered by Non-Governmental Organization (NGOs). Good practices provided by NGOs tend to have a more limited scope, operating at a more local level while governmental good practices reach up more easily to national levels. In the case of the latter these might be more or less centralised, depending on state policy.

It is important to mention the active role and involvement of NGOs on migrant health which is often on the forefront in attending migrants' needs. While this might prove highly beneficial as a result of a greater accent on bottom-up approaches which attempt to involve all stakeholders and to promote horizontal relationships, this must not conceal the fact that more often than not, NGOs operate as substitutes where public care falls short and where there is a vacuum of state intervention. The responsibility of EU MS towards migrant health must be reinforced within the international agenda, bearing in mind the danger of an increasingly weaker public health care system with possible consequences for population health protection and health gains.

d. Geographic distribution

There is a significant variability between different geographic regions[1] in the EU concerning the good practices in place (or the lack of them) as a result of social, political and historical aspects associated with migration flows.

North-west countries, where migration has been present since the 1950s, tend to have a well-established set of good practices. These concern the use of cultural mediators, translation of health-related information and a considerable investment on research through the creating knowledge and expertise centres on migrant health. On the other end, are countries such as Lithuania, Estonia and Latvia where good practices are absent perhaps as a consequence of the novelty of the migration phenomena.

Some of the countries which have recently joined the EU have been confronted with an urgent need to tackle problems associated with human trafficking (e.g. high risk for HIV/AIDS transmission). These countries have focused on the dissemination of information in the main languages of their migrant populations.

Southern countries, and in particular Spain and Italy, appear to experience a boom of good practices. Migration to these countries is a relatively new phenomena following a long history of emigration. The right to health and access to care for all, including irregular and undocumented migrants, have been two of the chief concerns in these countries.

Despite the scope and organization of Good Practices and their geographic distribution, it is worth mentioning that most good practices are experiences from metropolitan and urban areas, reinforcing the idea that migration tend to be an urban phenomenon.

2. Commitment

The vast array of good practices currently in place in the EU would not exist if it was not for the enormous dedication of individuals and groups who invest a great deal of energy and enthusiasm in the search for solutions. One might argue that health care staff are only doing their job but those in the field will know that when the appropriate resources are scarce, this demands a considerable amount of perseverance and creativeness. This suggests a great deal of willingness among health service personnel to adapt to the demands of changing social conditions. New policies will not have to be forced on a reluctant workforce, provided their aim and rationale is made perfectly clear and that they involve all personnel, from the receptionist to the surgeon in chief.

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[1] We have adopted the following classification for EU geographical regions: North-West, East, Central, and Southern Europe.

3. Competency

Good practices tend to arise out of identified problems which remain unanswered. In this sense, they work as a kind of pilot projects, generating possible solutions which can be implemented and tested on the ground. The novelty and variety of these solutions turns them into a resourceful ‘pool of knowledge’ from where policy-makers and state officials can draw evidence-based data to design informed policies. Furthermore, it demonstrates the availability of widespread expertise, a valuable asset when putting in practice new policies.

Two other aspects are worth of attention in this section: the dissemination of knowledge and user involvement on good practices.

Dissemination

Most will agree that is extremely important that innovation in migrant health should be cumulative. Yet, side by side with the lack of a systematic evaluation of good practices’ achievements there seems to be an overall scarcity of user-friendly channels able to facilitate the dissemination of the knowledge gathered.

What often occurs is that promising interventions fizzle out when funding ends and whole initiatives elapse, only to be rediscovered some years later by another party who again will have to re-think the do’s and don’ts of this kind of intervention. In other words, it is essential to learn from past mistakes and capitalize on existing knowledge instead of continually ‘reinventing the wheel’.

A similar point can be made about European cooperation. At present, because of language barriers and lack of international cooperation, experience gained in one country may be overlooked in another. A pioneer venture at this level was the project on ‘Good practices in mental health and social care for refugees and asylum seekers’ which as well as research, included the exchange of two good practices between the Netherlands and the UK. The authors concluded that in spite of marked variation between and within countries the transfer of good practices in the EU is not only possible but extremely fruitful (see Watters *et al.*, 2003). Another effort in this direction is this report, even if does not pretend to provide a complete survey.

To enhance the transferability of good practices it is imperative that comprehensive databases on all aspects related to migrant health and networks are created. In this domain, the COST Action HOME and the project MIGHEALTHNET constitute cutting-edge initiatives. Set up with the specific purpose of countering the fragmentation of efforts in the field of migrant health and good practices caused by disciplinary, national and linguistic divisions, these projects aim at creating a network of different stakeholders who will exchange and make available knowledge in this field through the creation of wikis (interactive web sites) and national and international meetings and conferences. Similar projects are presently being evaluated by the Commission.

User Involvement

The obvious question when discussing user involvement in good practices is how bottom-up are they i.e. are they needs-driven? And if they are, to what extent are users involved? It seems fair to say that good practices at a local level devised by NGOs tend to provide services based on users’ identified needs, rather than simply reflecting the enthusiasm of a group of ‘good-doers’. At the national level of governmental good practices user engagement is not so evident. In ‘smaller’ good practices relationships tend to be more horizontal enhancing a different view of power (less concentrated and more fluid), which in turn facilitates users' voices. Nevertheless, the extent to which users are involved in the planning, implementation and evaluation of these good practices is not known.

User involvement is a particularly relevant issue when discussing health care for typically vulnerable and unassisted populations, often referred to as 'hard-to-reach groups'. These groups are not only unable to access care but care providers often experience difficulty in reaching out for them or are simply unaware of them and their problems. As we have seen, migrants appear to have less access to care services compared to native populations and where user involvement in health care exists migrants are often underrepresented (Crawford *et al.*, 2003) or experience token participation (Minas, Silove and Kunst, 1993 in Sozomenou *et al.*, 2000).

Within Europe, the UK appears to be one of the MS at the forefront when it comes to recognising the relevance of user engagement in health care. The British government has recently released a plan to promote "user and public involvement at all levels of the health and social care system, and to create a system which enables more people to become involved and have their voices heard" (DH, 2006).

Users hold untapped resources which can be mobilized to raise awareness for neglected health problems, disseminate information about available care, and generate new and more comprehensive care solutions (Frankisch *et al.*, 2002). Participation has also been noted to increase communities' level of responsibility and consciousness regarding their own health (Blakeney and Patterson, 1972 in Sozomenou *et al.*, 2000; WHO, 1985). Given the current state of affairs these are particularly important aspects to take into consideration in migrant health. In the future, we hope good practices as well as all practices, will establish a thorough commitment with the promotion of user involvement.

Limitations of the Good Practice Approach

As mentioned previously, good practices compile a relevant and diverse body of knowledge and competencies. However, most practices are set at a micro-level and are transitory. Good practices are interim solutions and they must not be seen as 'end products' or as the sole catalyst for change.

While the lack of policies might be advantageous (a heavily regulated system can diminish the scope for action within care), falling short on structural support (e.g. policies, funds, new institutions) can be even more dramatic as it is likely that for each good practice that succeeds another ten fade away.

Good practices must been seen as 'inspiring muses'. They point the right way through the fog, but it must not be expected that they steer the ship. Good practices have the ability to formulate new routes and assess difficulties and benefits but they are not improvements in themselves. The need for structural change and new policies together with systematic research and training of staff is crucial.

Limitations of the good practices themselves have been already pinpointed. However, in order to avoid misunderstanding, other conclusions can be drawn concerning what good practices should not be or represent. First of all, it should be mentioned that the cases presented here and compiled in the Annex of this report, summarised and expressed the opinion of the authors. In this sense the choice of words and approach they use are not necessarily shared by the editors. One clear example is the different words or adjectives used in the description of a specific target population such as 'irregular' or 'undocumented' migrants. As it could be noted, some practices incorporate the word 'illegal'. The adoption of each of these words is in itself a statement. We, as editors, respected the option of each author.

Another aspect that should be discussed about good practices is that even if we did have a complete overview of all the ´good practices´ that have been devised at the moment, it would only describe what is happening now and would not be a blueprint for the future. Good practices do not allow forecasting. There are three reasons for this:

First, the good practices that have been generated to date reflect the constraints of the opportunities and the availability of funding. Most of them arise at rather low levels in the system (at the level of individual service providers), or outside the system altogether (within non-governmental organizations). To get higher-level policies changed is much more difficult and requires campaigns, lobbying, political influence and much more money than most innovators or enthusiastic and philanthropic initiatives are able to gain. For example, few good practices concern changes in medical training, education, professional requirements, etc., because this would mean changing national policies and legislation. Nevertheless, there is nothing to stop people from offering short courses, seminars, among others, on a ´freelance´ basis, and which can provide inspiration for reforms at national level at a later stage. In spite of these limitations, small-scale, grass-roots initiatives have an indispensable function in pointing the way for the development of broader, structural improvements.

Second, this exemplary function of good practices should not be taken too literally. We can illustrate this by using the analogy of a leaking roof. Problems come to light when health systems designed for a (more or less) homogenous population have to deal with new and different users. Remedies are devised for these problems, but they tend to be short-term, small-scale and local: people use the means they have at their disposal. If one discovers a leaking roof, the best remedy in the short term may be to cover it with a sheet of plastic. But that does not mean that in the future, all new houses should be built with a sheet of plastic over the roof. Rather, *structural* improvements should be made, making use of the experience gained in grass-roots innovations. The form the structural improvement takes may be different from the form of the original intervention: only certain insights and innovations may be taken over.

Third, the needs which good practices address tend to be chosen in a somewhat arbitrary, selective way. Innovations are seldom a reaction to an objective assessment of needs based on comprehensive statistics, still less to the needs which are felt by users to be most acute. On the contrary, they depend on the good feelings and interests of those social innovators who are entrepreneurs of initiatives in which they have an interest, even if altruistic and humanitarian.

All these reasons lead us to believe that even the identification of good practices is an important step, to have a real impact, structural changes must be sought.

The importance of structural change: why “good practices” are not enough

The good practices illustrated in this report have mostly been devised by service providers or professionals in response to their perceptions of the need for change. Very few of them have been developed in response to policy directives from above. This is only to be expected, because the people who are in contact with the day-to-day realities of health care are usually the ones who first become aware of the shortcomings of existing service provision and are motivated to make things better. There is much more awareness of the need for change at the ‘coal face’ than at the level of management and government policy (though as we shall see later in the migrant policy cases, countries differ widely in this respect).

The advantage of innovations generated at this ‘grass-roots’ level is that they can count on a high level of individual commitment, inventiveness and relevance. Nobody who reads these reports can fail to be impressed by the high level of dedication to the cause of migrant health which they display, and the creativity of the solutions that have been found.

But there are disadvantages too. ‘Grass-roots’ initiatives often have an arbitrary character: they may improve service provision for one particular group, or in one particular place, but not for all groups in all places. Facilities for migrants will be provided in City A, while City B – perhaps only a short distance away – may have nothing on offer, in spite of an equally high level of need. In the Migrant Friendly Hospitals Project, this experimental or exemplary character was explicit: the project set out to achieve change in a single hospital within each of the participating countries, but did not (and could not) aim directly to improve services throughout the whole country.

In contrast, the few good practices in this report which were developed at government level, such as the Finnish initiative on interpreter services, did have universal scope – but such ‘top-down’ initiatives constitute a small minority of all innovations. The improvements in service provision which arise through ‘grass-roots’ initiatives tend to be localised, limited and – and we have seen – to a certain extent arbitrary. Although one of the criteria we have used for good practices is that they should be *replicable,* this is a fairly abstract requirement; it does not guarantee that they will, in fact, be replicated across the board.

Whereas most initiatives are not ‘top-down’, they can hardly be described as ‘bottom-up’, if by this is meant that they originate from the users. Most initiatives originate at an intermediate level, i.e. from the organisations or individuals providing services. While it is true that people in day-to-day contact with migrants may be more aware of their needs than managers and planners, this is not always the case. The greatest needs may exist among the migrants who are *not* seen by health care workers: the ones who are not entitled to care, who do not know how to find it or are unable to do so, or whose needs are not addressed by the existing services. Contacts with service providers may therefore not be the ideal context for an exploration of unmet needs. In general, far too little attention is paid to the voice of users themselves in the planning of services for migrants (cf. Watters & Ingleby, 2004).

Another disadvantage of most of the innovations we have surveyed is their temporary character. Although *sustainability* is one of our criteria for a good practice, this too is a somewhat abstract requirement: it only means that there are good prospects for sustaining the intervention – not that concrete guarantees of continuity exist. This is logical, because the agencies that finance such projects are seldom able to write a blank cheque to enable the work to be continued indefinitely.

Apart from a few unexpected success stories, most good practices turn out to be much less sustainable in practice than the project organisers had hoped or claimed. The turnover of promising interventions is therefore high. Large numbers of initiatives in the field of migrant health have been made by individuals or small groups, relying on their own enthusiasm and a minimum of official support. Because these initiatives are not structurally embedded, the personnel involved often work under intense pressure and are liable to burnout or disillusionment: when they go, there may be nobody to take their place.

Most of the good practices in this area are financed on a temporary project basis: when the funds run out, the project “fades out like a nightlight”, in the words of Van Dijk et al. (2000). Grant-giving agencies may feel it is time to give other applicants a chance, while management may have become accustomed to depend on the external financing and be reluctant to take on new burdens. In this area we can also observe the statistical phenomenon of ‘regression to the mean’. Bold new projects arise because of an exceptional, more or less coincidental, combination of inspired innovators and sympathetic financers. When the time comes to renew the funds, however, the financers may have been replaced by less sympathetic ones: other priorities may have replaced migrant health on the agenda and the political climate may have changed.

All of these considerations imply that it is crucial that innovations aimed at improving migrant health should be *structurally embedded* in the policies of service providers, health authorities and governments, if they are to have adequate coverage and a sustained impact. As can be seen in the Annex to this report, individual creativity and personal dedication have led to some truly impressive innovative projects – but these initiatives have to be backed up by support from the highest levels of management and government if the effort is not to be wasted.

Unfortunately, the need to improve migrant health care has come to the fore during a period in which health services are under enormous pressure to cut their costs and ´streamline´ their ways of working - which all too often means providing only a basic, standardised level of service that takes little account of special needs. The question of contact time is a case in point. Workers in this field are unanimous in their call for more time and effort to be devoted to consultations with migrant patients, in order to overcome communication problems and cultural differences and to obtain insight into the migrant's special situation. However, such an appeal is likely to fall on deaf ears in a period when managers are busy trying to reduce the contact time available to *all* users and to standardise working methods with the help of universal diagnostic instruments and protocols. To make matters worse, the political climate may be unfavourable – or even strongly hostile – to any suggestion that special resources should be made available to migrants. Rational calculations showing that such measures can, in the long run, actually save money, have little impact when decisions are swayed by hostile emotions concerning migrants.

Our conclusion is therefore that in order to back up the impressive array of good practices which have been generated, there must be firm 'top-down' support for improving migrant health, embedded in policy-making at all levels. Such 'migrant-friendly' policies do not have to specify *in detail* the form which innovations take: usually it is better for the detailed initiatives to be generated by service providers and users, who are in touch with conditions 'on the ground'. However, even this is not always the case. It may be that a particular need only becomes visible to health planners with a sophisticated apparatus of epidemiological data-gathering at their disposal. Such data may play an important role in highlighting the need for attention to cardio-vascular disorders, cancer, perinatal mortality and morbidity, psychoses and infectious diseases among migrants (to name but a few conditions).

Policies concerning migrant health

When we examine the state of policies concerning the health of migrants and ethnic minorities in Europe at the present time, we see that improving this topic has only recently started to appear on the agenda. The following brief overview is only intended as a very rough sketch: it does not intend to be complete or any way definitive. Despite some pioneering efforts, there is an acute need for a wide-ranging, in-depth survey of existing policies in this field. To start with, however, certain important conceptual distinctions can be made.

1. What do we mean by 'policy'?

A large number of organisations have an impact on migrant health. Those explicitly concerned with health include agencies at European, national, regional, and local levels, as well as insurance companies, professional bodies, individual service providers and NGOs. All of these agencies may have policies which impact directly or indirectly on migrant health. Moreover, even agencies that are not explicitly concerned with health can have a crucial impact: legislation and practices concerning (for example) immigration, discrimination, equality of opportunities, industrial safety, housing and welfare, among others, can all influence strongly the health of migrants.

This means that it is extremely difficult to generalise about migrant health policy in a particular country. For example, there may be strong regional differences: typically, more attention is paid to migrant health in areas with a high concentration of migrants. Even within the same region, one individual hospital or primary care agency may have an outstanding policy on migrant care, while others – perhaps even encouraged by the existence of the 'good' service provider – do nothing at all.

Another complication is the fact that policy directives on paper often bear little relation to the reality on the ground. Governments may legislate to give migrants unconditional access to health care – but the receptionist at the entrance to the hospital may not know about these rules or feel like implementing them. Sometimes the reverse is true: individual doctors and nurses may turn a blind eye to the rules when it comes to helping patients who, formally speaking, have no right to help. Service providers may have a legal obligation to fulfil various legislative obligations concerning equality and diversity, while in practice nobody monitors what they do or takes action when they fail to meet their obligations. Here too, the reverse situation can be found: 'progressive' hospitals and clinics may go far beyond their statutory requirements in providing good quality care to migrants and minorities.

2. What are the main areas in which policy can be made?

As mentioned above, policy on migrant health has a number of possible dimensions, of which the following are perhaps the most significant.

a. Control of infectious disease

Until only a few decades ago, this topic was regarded as virtually synonymous with 'migrant health'. In this perspective, migrants are viewed primarily as a threat to the rest of the population, while screening, prevention and treatment of infectious disease are the most important instruments of policy.

More recently, of course, other perspectives on migrant health have come to the fore, in the light of which this approach by itself seems – both politically and in medical terms – one-sided or even primitive. It would be good news if the approach were as irrelevant as its critics sometimes suggest, but unfortunately the global epidemics of HIV/AIDS, tuberculosis and hepatitis which began to arise in the 1980's and 1990's have given it renewed importance. However, some of the identified Good Practices fall within this category: Greece, Slovenia, the Slovak Republic and Malta.

The ‘policy referential’[2] underlying the control of infectious disease concerns the protection of the population as a whole. This may seem like a self-evidently desirable goal, but it becomes a controversial one when juxtaposed alongside three other goals. One concerns the protection of the human rights of those who may be prevented from migrating; a second concerns limits on entitlement to health care for non-nationals (particularly undocumented migrants); and a third concerns the universal human right to health and health care. The ensuing conflicts of values ensure that this area of policy will provide an arena for intense political debate for many years to come.

b. Tackling the environmental determinants of ill-health among migrants.

The policy referential in this case concerns the maintenance of public health in general and the right to health of the migrant population in particular.

Some of the determinants of ill-health among migrants can be related to the **disadvantaged socio-economic position** which many of them occupy in the host country. To this extent, policies directed at migrant health should be incorporated in general policies designed to combat the negative health effects of socio-economic inequality. Unfortunately, both at the level of scientific theory and practical initiatives, there is often little connection between these two approaches. In practice, we found very few practices with this approach. One is the Portuguese project on community intervention in a housing project that is based on a global intervention perspective, not designed only for migrants but for vulnerable populations, including migrants.

Another determinant of ill-health which has recently received much scientific attention (notably in the UK and Sweden, following the publication of research carried out in the USA) is **discrimination.** In most countries efforts to combat discrimination are based on human rights considerations: however, to the extent that discrimination is actually capable of undermining mental and physical health, it should be considered as a public health problem too. For example the Good Practice presented by the IOM investigated discrimination towards migrants and religious and ethnic minorities in health care services, and the Swedish case on international health advisor that includes in their multi-level goals, to combat inequalities.

Not all the determinants of ill-health among migrants have to do with environmental disadvantages. Some have to do with life-style, access to health care and beliefs about health. (It is important to note, incidentally, that not all ‘cultural’ influences on health are negative: low alcohol consumption among Muslims exempts this group from many health problems that burden other groups). The area of **health promotion** has particular importance in migrant health policy because of the need to ensure that migrants are optimally informed about health problems and the best ways of preventing and treating them. For example in the case of the Healthy Cities network, organised under the WHO-Europe, some projects develop health promotion activities aimed at influencing some of the migrants’ risk behaviours. Also the German Good Practice which encourages healthy eating among adolescents of migrant descent, and again the Swedish experience of international health advisor that includes a section on raising awareness on healthy life styles, among other issues.

Consequently, the promotion of health in all policies specifically addressing migrant health might mitigate the negative effects of health determinants for these vulnerable populations.

c. Entitlement to health care for (different categories of) migrants.

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[2] The term “policy referential” is used by Björngren Cuadra & Cattacin (2007), Cattacin et al. (2007) and other authors to refer to the value system underlying a policy. Such a value system is always embedded in a particular conceptual framework, system of assumptions or ideology.

Although the biggest obstacle to health care for migrants is often the fact that they are excluded from the free or subsidised health services available to others, it is noticeable that very few of the good practices that have been developed in the field of migrant health care concern themselves with this issue of *entitlement* to care. The reason for this is that most innovations, as we have seen, are generated at the level of individual service providers or NGO's, whereas the rules which determine entitlement are almost always laid down by governments. The most that other actors can do is to lobby for changes in the rules, or to devise ways of reducing their negative impact. Some of the Good Practices are breaking through this path are the ones presented in the Annex by *Médicins du Monde* and PICUM, namely for undocumented or irregular migrants, but also the services provided for refugees and asylum seekers in both of the practices from the UK. In addition to these practices, others intent to provide services and reach migrants in general, as the health improvement plan for migrants in Leganes, Spain, the Health Support Office of CNAI, in Portugal and the ethnic health educators/care consultants in the Netherlands.

Furthermore, experience indicates that many of the good practices in place target very specific groups, namely those perceived as more vulnerable, such as women and children, some of them focusing on even more specific health issues such as HIV/AIDs or female genital mutilation. There are several examples in this field: the Romanian, the APF from the Algarve region in Portugal, the campaign against female genital mutilation in France, the Immediate Intervention Project in the Netherlands, and the Swedish project on multidisciplinary treatment model for asylum seeking children. Another group identified by the good practices as vulnerable are adolescents, with the German example on healthy eating, and the MIKADO project on the empowerment of adolescents in the deprived areas of Eindhoven, in the Netherlands.

d. Accessibility and quality of service provision.

This theme in migrant health policy is a relatively new one. Whereas in the traditional immigration countries (Canada, the USA, Australia and New Zealand), policies in this area have been in place for decades, in many European countries the theme is non-existent. In such countries, attention for migrant health is limited to controlling infectious disease or including migrants in the health system: the notion of adapting the health system to enable it to better meet their needs is not yet on the agenda. Nevertheless, even in such countries many initiatives and good practices have been devised at 'grass-roots' level to improve migrant health. The realisation has grown that existing service provisions designed for the majority indigenous population often fail to meet the needs of other groups (Watters, 2002): the services may not be accessible, appropriate or effective. As we shall see below, NGO's often play a central role when formal health services fail to address the problems of migrant health. Examples can be found across the board, namely practices such as MIKADO in the Netherlands and the Well-Being Project in Manchester, in the UK. However, some governmental and collaboration/partnership initiatives have proved important, such as the governmental French practice with cultural mediators and the partnership between Salud y Familia in Catalonia, Spain with the government, among others.

e. Education and research

Although institutions of education and research do not themselves provide health care, their contribution to the health care system is absolutely fundamental. This is particularly true in the relatively new field of migrant health. Interventions need a secure knowledge base, and this necessitates sustained research effort on migrants' state of health and on processes and outcomes in care delivery. Training and education of health service personnel must include adequate attention to these issues.

Unfortunately, at the present time migrant health is conspicuous by its absence from most curricula in the field of medical education and other health professional training, while the amount of attention paid to migrant health by researchers varies enormously between countries. The setting-up of 'centres of excellence' and specialised institutions for research on migrant health can play an important role in promoting the formation of an adequate body of knowledge. One interesting example is the Portuguese Good Practice “GIS” which disseminates information and research findings among a network of researchers, care-givers, community organisers and advocates while also organises seminars and workshops on topics of migrant health. Other examples of this type of practices are the Migrant Friendly Hospital and the Taskforce purposely created to follow up the original project, which among their aims included training and education for the health staff, and the project on international health advisors in Sweden which also includes as a goal to train (and employ) migrants for this specific duty, taking advantages of their competences.

f. International Cooperation

This topic is an old theme of international relations which has come to the forefront lately and needs special consideration and negotiation between countries of origin, transit and destination and among different sectors/ministries within governments. Migration is a complex phenomenon and thus it requires a comprehensive understanding and approach in many different fronts that should lead to cooperation and agreements of different natures. One important aspect, but not the only one, is cooperation and international aid on health issues such as vaccination, health promotion, disease prevention and treatment between countries of destination and origin. One good example is the Italian Good Practice that promotes cooperation between Italy and Ethiopia.

Another aspect is the training of the health professionals by international teams that takes place at origin as a way to avoid or foster the brain-drain of the health workforce of countries already in a disadvantageous situation. The Gulbenkian Foundation in Lisbon has already carried out this type of training with Cape Verde and is planning similar events in the near future with other countries.

One more aspect within the international cooperation field is the recognition of qualifications/diplomas of health professionals coming from non-EU countries. Without encouraging the recruitment of health professional from other countries, this issue becomes important as many doctors or nurses or other health professionals may be already living as migrants in the EU and could be fully integrated in the health sector in a more productive and efficient way for both, the migrants themselves who would prefer to work in their fields, and for the host society that usually needs health professionals anyway. One excellent example is the Portuguese partnership presented in the Annex, between the Jesuit Refugee Services and the Gulbenkian Foundation.

3. Differences in migrant health policy

We have already called attention to the fact that European work on migrant health lags behind that in Canada, the USA, Australia and New Zealand. While each of these countries could regard themselves as virtually ‘a nation of immigrants’, some European countries have been reluctant to acknowledge the existence of migration as a structural phenomenon – even on a small scale. The tendency has been to treat migration as an incidental, temporary, or accidental phenomenon. In recent decades, of course, this standpoint has rapidly become untenable – even for countries which never had many migrants in the past.

Because there are strong regional variations in the nature and size of the migrant population in Europe, it is not surprising that the amount of attention paid to migrant health issues varies greatly. Here we suggest some broad distinctions that can be made, although considerable variations *within* regions make it impossible to make any confident generalisations.

- In the countries of **North-western Europe** (with some exceptions such as Finland and – until recently – Ireland), migrant populations tend to be well-established and to form a significant part of the population. Their origins lie in labour migration during the industrial boom of 1950-1973, ex-colonial migration, forced migration and family reunification. In these countries, migration and integration policy is a long-standing, complex and controversial political issue, also accompanied by substantial research activity.
- Most **Southern European** countries have until the 1990's tended to be predominantly countries of *emigration,* but the reverse is becoming more and more the case. Democratisation, economic expansion and long, permeable borders have all played a part in the recent influx of immigrants to Southern European countries. In these countries, policies on migration tend to be less established; the debate on the politics of immigration is relatively recent. Health and social care provisions often have less resources than in the North-West – though this does not necessarily mean that policies are less inclusive. These countries have a history of three decades of National Health Services that is being currently challenged by the new waves of migration. Consequently, the debate on migrant health is very much part of the agenda.
- In **Eastern Europe** immigration is often a new phenomenon, influenced by factors such as break-up of the Soviet Union and the successive enlargements of the EU. In certain countries it is still far outweighed by emigration. However, there often exist substantial *ethnic minorities,* comprising long-standing communities of foreign nationals as well as Roma communities. In this respect, the large-scale population displacements and boundary revisions resulting from World War II are still very much visible. In addition, asylum seekers, migrants in transition and labour migrants are becoming increasingly numerous. In these countries, policy making on migrants and minorities is in a state of flux. For many countries, accession to the EU (or the prospect of such accession) has had had a strong effect on emigration, immigration and policy making.

In order to show how complex the factors are and what potential impact may have on migration health policy, we will now single out a few countries within each region in order to highlight some aspects of their policies.

North-West Europe:

The United Kingdom and the Netherlands

It is instructive to compare these two countries, in which the levels and types of immigration are broadly speaking comparable. We should note at the outset that the way these issues are talked about in the UK differs from the usage in most other European countries. For example, discrimination and health differences tend to be referred to as 'racial', even when religion (e.g. Muslim, Catholic) and national origin (e.g. Irish, Polish) may be more relevant. The word 'migrant' is reserved for recent arrivals; the term 'black and minority ethnic (BME) groups' is used to refer to more established communities of migrant origin.

In both countries, considerable attention has been paid since the 1970's to the health problems of migrants and ethnic minorities. A sizeable community of health workers and researchers has concerned itself with this topic. However, whereas in the Netherlands this activity has mostly arisen at 'grass-roots' level, in the UK it also enjoys a strong measure of 'top-down' support. Policies addressing diversity in health care receive substantial government funding and are embedded in a firm legal framework. Since 2000, all public authorities have had a legally enforceable 'general duty' to eliminate unlawful racial discrimination, promote equality of opportunity and good relations between persons of different racial groups, and ensure 'racial equality' in employment, training and promotion. Within the National Health Service this has resulted in a large number of initiatives addressing problems of health care and diversity (DH, 2003 & 2005).

The reasons for this high level of government involvement in the UK are too complex to be discussed here (see Ingleby 2006). Two important factors, however, are the 'top-down' character of policy making in the NHS and the relatively strong political influence of BME groups.

In The Netherlands, by contrast, the health service has traditionally been a much looser and less centralised system of interlocking agencies, while migrants and ethnic minorities have not built up a level of political influence in any way comparable to that found in the UK. Despite this situation, in 2000 the Health Minister of the day announced a number of government-financed measures to improve health care for migrants and ethnic minorities. However, these policies were reversed or abandoned by the government which came to power in 2002 in the wake of the assassination of the politician Pim Fortuyn. 'Migrant-friendly' policies were now regarded as the problem, not the solution, while central government sought to reduce its role in health and social care even further. It is too soon to say what line will be adopted by the government which was elected in 2007.

Central Europe:

France

From the end of the 80s, NGOs such as Doctors of the World or the French Red Cross set up free medical consultations for the destitute especially foreigners without identity papers. These measures for health care and social welfare appeared in state-run hospitals such as the Baudelaire's consultation at the Saint Antoine's hospital.

In 1998, a law against exclusions established the measures PASS more widely in order to reach all the men and women with no resources and no information.

The creation of the Universal Medical Coverage (C.M.U) ensures that any legal resident in France who is not covered by another mandatory health care insurance scheme, has access to the health care insurance to cover all medical costs: the basic CMU that extends eligibility for social security health insurance to low income people on the basis of legal residence in France and no more on the basis of professional activity and led to the PASS' evolution toward access to health care for all the foreigners without papers. The reimbursement of their medical expenses is completed by the creation of A.M.E.

Established in January, 1, 2000 after the coming into force of the July 27, 1999 the law creating the Universal Medical Coverage, the State Medical Care (A.M.E) provides healthcare insurance to people who do not meet the conditions to get universal healthcare insurance, that is all the foreigners whose papers are not in order.

A patient has to fulfil two conditions based on resources and residence basis to take advantage of A.M.E. He/she must have been living in France for over three months and earning less than 597,16€ per month.

The State medical Care gives access to the reimbursement of medical healthcare and especially medical consultations given by hospitals or not, medical examinations, medicines, nursing or dental care, hospital care. Beneficiaries of A.M.E are not required to advance healthcare expenses and they can choose their service providers. The Act that should define the proportion of medical expenses payable by the patient has not been promulgated yet. As a result, the medical expenses payable are reimbursed at 100% on the basis of health insurance responsibility rate.

The benefit of the State Medical Care is not automatic: a request must be presented and all the written proof of identity, residence and resources must be provided because statements on the honour are not admitted anymore. State Medical Care is granted by the French Social Security Office of the beneficiary's residence.

State Medical Care is allocated for one year and can be renewed each year on request and concerns the beneficiary but also the relatives. At the end of June 2005, 170 000 beneficiaries of State Medical Care were counted.

Undocumented residents living in France for less than three months are the beneficiaries of free health care insurance for first care whose absence could put in danger a vital forecast or lead to a serious and durable deterioration of the health of the person or the new born child.

All the medical care delivered to undocumented residents is undertaken by the French government who reimburses the French Social Security Offices. In 2006, the supplies allocated to the State Medical Care were more than 230 millions of euros.

Southern Europe

Portugal and Greece

Migrant health was not an issue in southern European countries until the 1990s when migration flows to those countries began to intensify and health care workers were confronted with newcomers whose cultural, social and linguistic backgrounds were not only diverse but also unfamiliar.

Portugal and Greece are two interesting cases worth of comparing given the existence of some tight similarities but also some sharp differences. In both countries, most policy addressing migrants' health started to be implemented in the beginning of the 2000s. Initially, policy was concerned mainly with regulating migrants' entitlement to health care and policy-makers recognised no need for nationwide multicultural programmes like those existing elsewhere in the EU. NGOs and a few local government initiatives were exemplary in providing the only culturally-sensitive care available in these countries (Ingleby *et al.,* 2005). This situation has changed in the case of Portugal as we will show below.

Although considerable attention has been put to migrants' entitlement to health care in both Greece and Portugal some differences can be identified. Whilst in Portugal specific directives were set to grant all migrants, including irregulars and undocumented, the right to health and health care (ACIME, 2002) in Greece formal access to free-of-charge services of the national health care system for migrants is dependant on registered employment, regular status and insurance coverage, except in emergency situations (Hatziprokopiou, 2004a). Additionally, Greek policy differentiates between Ethnic Greek migrants and other migrants when it comes to health care provision for the uninsured. The former are eligible for a special welfare programme for low-income people which allow them to benefit from care services. The latter must pay for services in full and these are often much too costly for most. Even though the number of migrants with a regularised status and insurance in Greece has been growing (Hatziprokopiou, 2004b) this structural policy has a negative impact excluding many uninsured migrants from appropriate health care and differentiating between 'first' and 'second' class migrants.

Aside from the differences on health care entitlement policy problems with migrants' access to care persist at the ground-level in both Portugal and Greece. Language barriers, migrants' difficulties to attain relevant information on how to navigate the health system and insufficient training and diffusion of cultural sensitivity among professionals are problems common to both (IAPAD, 2002; De Freitas, 2003; Ormond, 2004). Portugal is also confronted with difficulties in enforcing the law and the denial of care to undocumented migrants is not infrequent (Fonseca *et al.,* 2005). Bureaucracy, overcrowding and the inadequate infrastructure of the health care system in Greece affect migrants' access to care (Hatziprokopiou, 2004a). In addition, health care officers and practitioners view migrants as a 'threat' to the existing structures (Psimmenos and Kasimati, 2003) and this is coupled with an overall resistance of the wider population to a multicultural society (Coenders, Lubbers and Scheepers, 2003). These circumstances have been pushing migrants in Portugal and Greece into hospital emergency units (De Freitas, 2003; Hatziprokopiou, 2004a) putting their health at greater risk and overflowing the available services.

Once again, it is important to re-state the role of not-for-profit organizations in delivering adequate care to migrants in these countries.

Migrant and health minorities' health problems in Portugal have recently been the focus of attention from 'top-down' structures breaking away from the 'assimilationist model by default'[3] (De Freitas, 2006) that characterised the Portuguese health care system. The 'Integration Plan for Migrants', recently approved by the government, involved a set of measures that address diversity in health care provision (ACIDI, 2007). Two of these measures concern a serious attempt to diversify care from within – the appointment of cultural mediators of migrant origin in health care centres and hospitals in areas with a high representation of migrant populations and the hiring of migrant medical doctors. Access to care by migrants has deserved special attention showing a thorough commitment from the government to resolve the most pressuring issues currently at hand. It is important to evaluate the impact of these policies on access and on the quality of care in the future.

Regarding Greece, there seems to be an urgent need for greater engagement of public authorities in promoting migrants' access to care, developing culturally-sensitive training programmes for professionals and enforcing anti-discrimination measures.

Eastern Europe and countries of recent incorporation

Poland

The phenomenon of migration is a new situation in these countries, so policies tend to be more incipient. As research has highlighted, in health policy analysis there is an inseparability of policy and political context (Collins et al., 1999; Sen, 2003), and this becomes more visible and evident for recently incorporated MS, many of which face a double transition: a post communist regime and the incorporation to the EU. In this sense, Poland can be taken as an example.

During the last years (mainly between 2002 and 2004) and due to its incorporation to the EU, Poland has developed new pieces of legislation on migrants and health care accessibility, aiming at regulating who is entitled to gain access to health care services financed with public funds. The Polish health system is organised at the national level with regional branches and is based on general health insurance known as the National Health Fund (NFZ). The NFZ is the institution responsible for assuring health services for insured persons and members of their families and assures refund of medicines within assigned financial means. Thus coverage is guarantee for insured residents and EU travellers. Uninsured people, including migrants, can only access services very limited services reserved for sudden illness, injury, intoxication, life threat or childbirth.

Research indicates that even if solidarity and equity were the baseline for health care reform in Poland in 1999, which substituted a model of central state funding by a social insurance model, the health system has witnessed increasing health inequalities (Watson 2006). As co-payments have increased, a selective reduction of access to care has become more widely spread, mainly among the poor and vulnerable population.

Even if only basic entitlements are provided to migrants in Poland, some positive steps have been taken with regards to international cooperation on health insurances. International agreements have been reached with

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[3] The lack of nationwide multicultural health care programmes was not a consequence of deliberate governmental policy but rather a result of the lack of policy on the field of migrant health. The health care system was operating as it was first 'programmed', i.e. to attend the needs of considerably more homogenous population, providing the same care to everybody. Using a metaphor from the field of informatics, the system was running 'by default'. Its assimilationist character was not intentional but accidental (De Freitas, 2006).

Albania, former Yugoslavia and the Russian Federation, although they focus on reciprocity and emergencies. On the other hand, from the Polish point of view, there is a preoccupation with the exodus of Polish health professional that migrate to other EU countries.

Because migration has increased in the last few years in Poland (as pinpointed in Report I), health issues are expected to arise in the near future and new policies will certainly have to be designed as a response. In this sense, learning from what other MS have already done is a valuable option.

This policy briefing helps to better understand and explain the type, timing, target population and organisation of the Good Practices presented in the Annex. History plays a role in many ways, not only on determining how well-established some policies may be, but also in understanding approaches and the relationship with more settled groups such as those coming from the former colonies. Thus it is not a surprise that in some countries, mainly in the North-West and Central Europe, good practices were in place much earlier than in other countries (e.g. southern and recently incorporated countries). Yet, although the former countries may already have legal frameworks that allow to intervene when situations of discrimination or bad quality treatment arise some of the same difficulties are still inherent to both. One such example are the problems with ensuring long-term funding to guarantee the sustainability of good practices.

For the countries of Southern Europe, emigration shifted into immigration, changing rapidly their realities. However, this sudden change has propelled them to create numerous and diverse arrays of good practices that provide concrete answers to their new social reality. In this sense, these countries have been really prolific.

On the other extreme, countries of Eastern Europe and those of recent incorporation to the EU are experiencing, in general, several challenges simultaneously: from the readjustment to the end of the socialist era to the transition of becoming a member of the EU, including the experience of migration (both emigration or immigration). All these factors in combination have contributed to bring about new and challenging social phenomena. One of these new realities is human trafficking which has become more common and widespread in recent years in those countries, so it should not be a surprise that some of the few practices that are in place target this very vulnerable population. Other practices identified follow the traditional approach of focusing mainly on the control of infectious diseases.

Conclusions

What are the possible conclusion to draw from all the above? Certainly many general ideas and some recommendations. First, as it emerges from the previous developments, Good Practices are excellent, practical and creative solutions designed and implemented by NGOs, individuals or the state to solve problematic issues in the field of migrant health. They have been devised to counter the shortcomings in the mainstream toolkits or policies already in place for the majority of the population and that do not respond to the needs of specific groups. Thus, it is important to recognise their value. **Good Practices in migrant health are extraordinary contributions that can guide future structural change**.

Of the many problems affecting the field of health and migration, the most critical one seems to be the limited access of migrants to care. As we have seen, many of the Good Practices aim at counteracting the problem of accessibility. If couple with the issue of quality, these limitations become more notorious and acute.

The discussion on 'quality' brings into the debate issues of discrimination and equity which translate into different temporal dimensions: what we have at present and what the next generations will be able to attain.

Lessons taken from these experiences indicate that it is fundamental to reinforce the public health perspective of migrant health regardless of politics or ideological views. While health protection and health threats are a competence of the EU as a whole, the capacity to foster and reinforce accessibility, quality and equity of all residents to care is a competence and responsibility of MS. These two levels and aspects complement one another. One way for public health to achieve its goals is to encompass within its domain, human and social rights.

Fair and adequate health care systems, need to take into consideration the needs of EU citizens and migrants alike as a condition for achieving better health for all. In this sense, it is critical that when health systems may need to be redesigned in some of their features to enable them to respond to the challenge of integration at MS level and therefore in the EU, the needs of all are considered.

It is crucial to recognise that health and health related problems pose challenges that over span the scope of intervention of health ministries alone. It is important to promote collaborations between the different ministries in order to face these challenges and to have coherent and overarching policies. A vision based on 'health in all policies' may contribute to foster a change in this direction. **Health gains, particularly in the case of migrant populations, should not exclusively be carried on the sole domain of health sectors but should be the result of a combination of policies and interventions from different sectors and ministries.** As mentioned before, health determinants and the state of health transcend the restricted definition of disease.

Most Good Practices in place point to a weak or timid role of the state in migrant health. This issue brings to the forefront a serious debate on what the role of the state should be, on the one hand, and what position the civil society should have when state response fall short, on the other hand. **Europeans need to reach an agreement about the role and responsibilities awarded to each party**. We believe that fruitful partnerships can be established between the two without this meaning a dismissal of responsibility of the state in the field of migrant health.

Good Practices also indicate that migration is a much evident phenomenon in metropolitan areas. **Most of the Good Practices are in place in metropolitan/urban areas**. This shows the importance of designing policies and interventions on migration and health which take into account specific local needs in local areas as oppose to adopting exclusively a national perspective. However, it is also important to consider other types of migration, namely seasonal migration and the needs of migrants in rural areas.

One health field where consensus is more obvious is women and children health, including maternal care, family planning and new born & infant care (immunisation, nutrition and hygiene). This is a positive aspect that becomes evident in the Good Practices since women and children are more vulnerable groups. Interventions that target these groups allow for more health gains because impact on the future generations.

Even if health professionals and the health workforce was not the main focus of the Good Practices identified, some conclusions may be sketched. **There is an increasing need to reinforce international cooperation among countries of origin and destination with regard to the management of health workforce**. Initiatives and policies are being developed to: avoid brain-drain of health professionals, to build health systems' capacity in the countries of origin, allow technology transfer to improve the quality of life at the country of origin, among others.

Thus, **an overall conclusion lies in re-stating the importance of placing migrant health in the EU policy and research agendas**. This would certainly enable the exchange of experiences and data among EU MS in the future and would assist on the design of more culturally sensitive training and services in the EU. In this context, the knowledge gathered by Good Practices in both, old and new countries of immigration within the EU, becomes an asset and a drive for action. **The final objective of those Good Practices is the same: to improve the health of migrants in the EU either by facilitating and enhancing integration or by reducing health inequalities, and overall, by improving health outcomes.**

10 Recommendations

- MS and the EU should promote the compilation and analysis of Good Practices in migration and health for designing future policies.
- MS and the EU should link issues of accessibility, quality and equity when planning health policies, also in the field of migrant health.
- MS might consider designing their health systems taking into account the needs pose by new migration flows and other vulnerable populations.
- MS and the EU should promote intersectorial policies for better health outcomes. ‘Health in all policies’ is the guiding principle.
- MS and the EU should foster an in-depth debate on the boundaries of state and civil society responsibilities and duties on providing health services to specific populations.
- MS and the EU should identify the ‘right’ geographical and administrative levels for health policies, namely the specificities for metropolitan/urban areas.
- MS should consider paying particular attention to the health of migrant women and children.
- MS and the EU should encourage cultural sensitive training of the health workforce for accommodating migrants’ needs and a better integration.
- MS should promote users’ involvement in service design, planning and evaluation. This allows for the empowerment of migrants and the development of needs-driven care and it enhances the responsiveness of services.
- MS and the EU should actively promote research in the field of migrant health as a way to assist evidence-informed policy making.

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ANNEX

GOOD PRACTICES CASES

INDEX

TRANSANTIONAL CASES

COUNTRY CASES

PORTUGAL

TRANSNATIONAL CASES

IOM International Organization for Migration

EQUALITY IN HEALTH

INTERNATIONAL ORGANIZATION FOR MIGRATION

Introduction

The Equality in Health project investigated discrimination towards immigrants, religious and ethnic minorities in healthcare services. Whilst the World Migration Report (2005) states ‘well-managed migration health, including public health, promotes understanding, cohesion and inclusion in mixed communities. Investing in migration health can make good economic sense and be an aid to effective integration of migrants in their communities’, it is widely noted that discrimination can have the reverse effect.

Equality in Health was a pilot project which took place over two years (first year: preparatory, second year: implementation) from 2004 to 2006. It aimed at tackling such detrimental inequalities, by elaborating a scientifically sound tool to accurately monitor and assess discriminatory healthcare practices in the EU. This was particularly innovative, as at the EU level, there is no standard procedure for data collection on the topic.

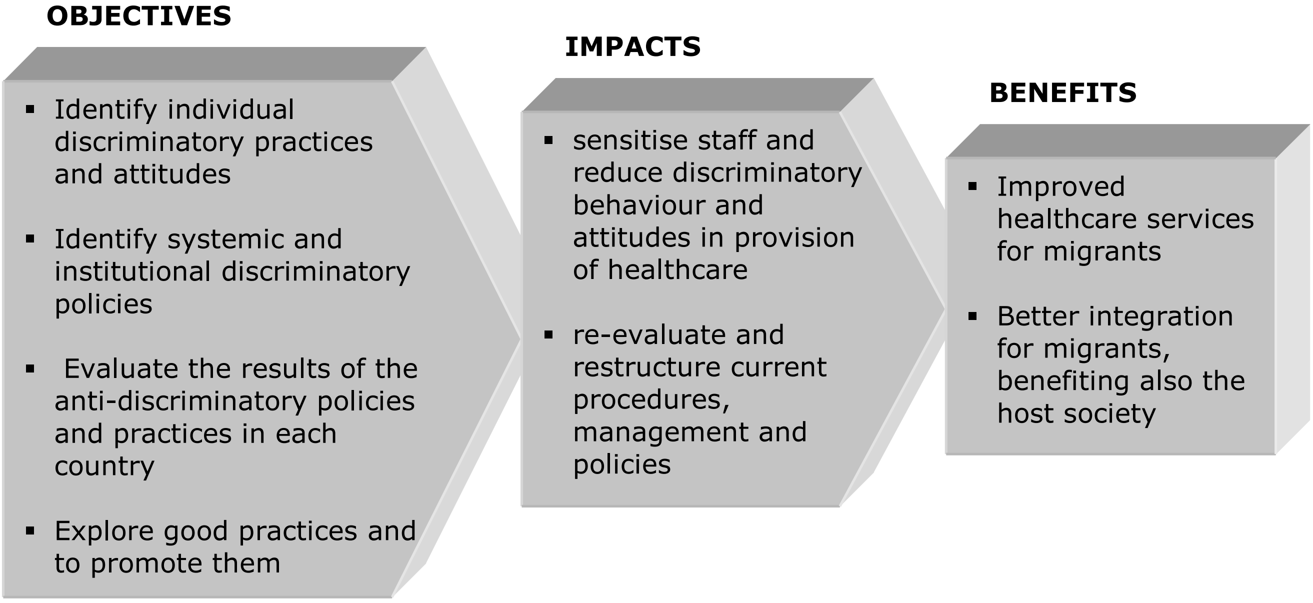
The EU countries participating in the study represented diverse contexts of immigration and levels of integration, thus they were considered ideal to develop and test a monitoring and assessment tool on discriminatory policies and practices. Italy and Greece are both countries which have experienced recent influxes of migration. Yet both countries have the lowest rates in Europe of promoting equal opportunity in all areas of social services (European Monitoring Centre on Racism and Xenophobia). In contrast, Finland has had relatively steady rates of migration over a longer period they have one of the highest promotions of equality in Europe (*ibid*).

Goals and Objectives

The General objective of the Equality in Health project was to **develop a Monitoring and Assessment tool (MAT)** in order to ultimately achieve fair treatment of immigrants, ethnic minorities and different religious population groups in healthcare services across Europe.

More specifically, the MAT was formulated to detect and investigate discriminatory policies, attitudes and practices at every level of healthcare services. Through doing this, it was further aimed to:

Figure 1. Objectives, impacts and benefits of Equality in Health



OBJECTIVES

- Identify individual discriminatory practices and attitudes
- Identify systemic and institutional discriminatory policies
- Evaluate the results of the anti-discriminatory policies and practices in each country
- Explore good practices and to promote them

IMPACTS

- sensitise staff and reduce discriminatory behaviour and attitudes in provision of healthcare
- re-evaluate and restructure current procedures, management and policies

BENEFITS

- Improved healthcare services for migrants
- Better integration for migrants, benefiting also the host society

The development and testing of the MAT was aimed to impact local and national healthcare services, whilst also producing a tool adaptable for research in other EU member states.

Model of Research

The Monitoring and Assessment Tool was developed with an integrated approach in mind, in order to provide a balanced view of the healthcare services. In practice this meant not only the collection and assessment of personal opinions and levels of satisfaction from the users of healthcare services, but also, by involving people in working in the field, to assess the state-of-the-art regarding discrimination and medical practice. As a result an easy to use, low cost, accurate and reliable tool was developed to identify discriminatory practices.

The research was carried out by each country according to 4 components, which were then cross-tabulated to gain more general findings regarding discrimination.

Components

The model used to develop a MAT tool applicable to each country context was based **on 4 components** which **spanned 3 key levels** of: policy making, management and practice. The 4 components were as follows:

Component 1

The establishment and operation of a National Observatory of Discrimination in each country with the participation of representatives from relevant key entities: public authorities, non-governmental organisations (NGOs), civil society organisations (CSOs), representatives of immigrant and religious communities and various experts (Systemic level).

Component 2

The development of a qualitative tool and its pilot deployment, based on a semi-structured interview, aimed at detecting any possible institutional discriminatory policies and practices via interviews with key-persons from the highest administration staff of healthcare institutions, NGOs and policy makers. (Systemic level).

Component 3

The development of a structured questionnaire intended to measure discriminatory attitudes and behaviours of health professionals and personnel and its pilot deployment. (Individual level)

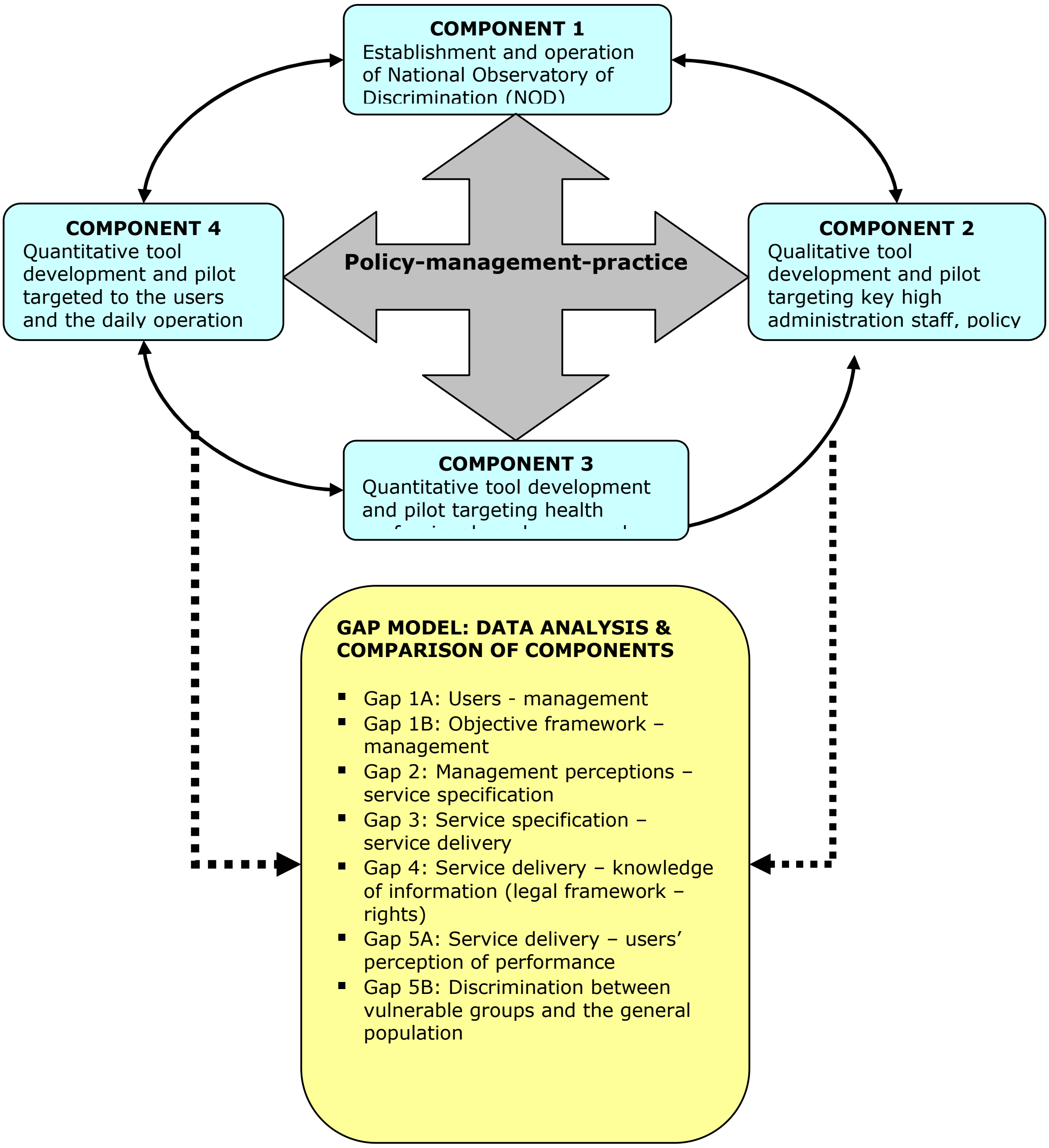
Component 4

The structured questionnaire assessing discriminatory practices in the daily operation of the health care system by interviewing healthcare system users (native and non-native) and its pilot deployment. (Individual level)

Gap Model

In addition to the research and analysis of every component, all 4 components were compared together using a 'GAP Model' of data analysis. This cross tabulated all the national results from the 4 components and further from all the 3 countries' results, with 5 key variables considered to impact discrimination (see details in fig. 2).

Figure 2. Representation of research model



Field or determinant

The practice is aimed towards the detection and subsequent prevention of discriminatory attitudes, policies and practices in the healthcare provision of immigrants in EU countries. Furthermore, as a result of this detection it aims at sensitisation and subsequent recommendations for good practice to influence policy and decision making in the health sectors and at local, national and EU governmental level.

Scope and provider

The Equality in Health project and the MAT tool which was developed covered local and national provision of public healthcare across all levels from users and civil society actors to practitioners and policy makers. It further envisioned an EU approach, by research and comparison between the 3 member states involved and subsequent dissemination at EU level.

Resources

The Equality in Health project was part financed by the EC Directorate General for Employment and Social Affairs under the the framework of the Community Action Programme to Combat Discrimination 2001 – 2006.

The principle resources in terms of personnel and activity costs for the second year of the project, the research implementation, were as follows:

Table 1: Principle resources to commit for 1 year of research implementation

Scientific/Transnational Coordinator:	**National Coordinator**
Personnel expenses (part-time over 12 months)	
Project coordinator	Project coordinator
Cultural mediator	Researcher/ Interviewer
2 Researchers/Interviewers	Cultural mediator
Webmaster	
Scientific adviser responsible for component 2	
Scientific adviser responsible for components 2	
Administrator/Finance officer	
Meeting expenses	
Travel, accommodation and subsistence	Travel, accommodation and subsistence
Other external services (interpretation, catering at meetings)	Other external services (interpretation, catering at meetings)
Publication and dissemination expenses	
Information dissemination costs	—

Please note that the number of personnel and other expenses such as meetings, are dependent on the size and scope of the project. The resources listed above are relative to a project with 3 partners in different countries lead by an overall scientific coordinator. The interviews and questionnaires in each country were only conducted at a local level, therefore if these research activities were to be extended nationwide, this would also impact the required resources.

Management

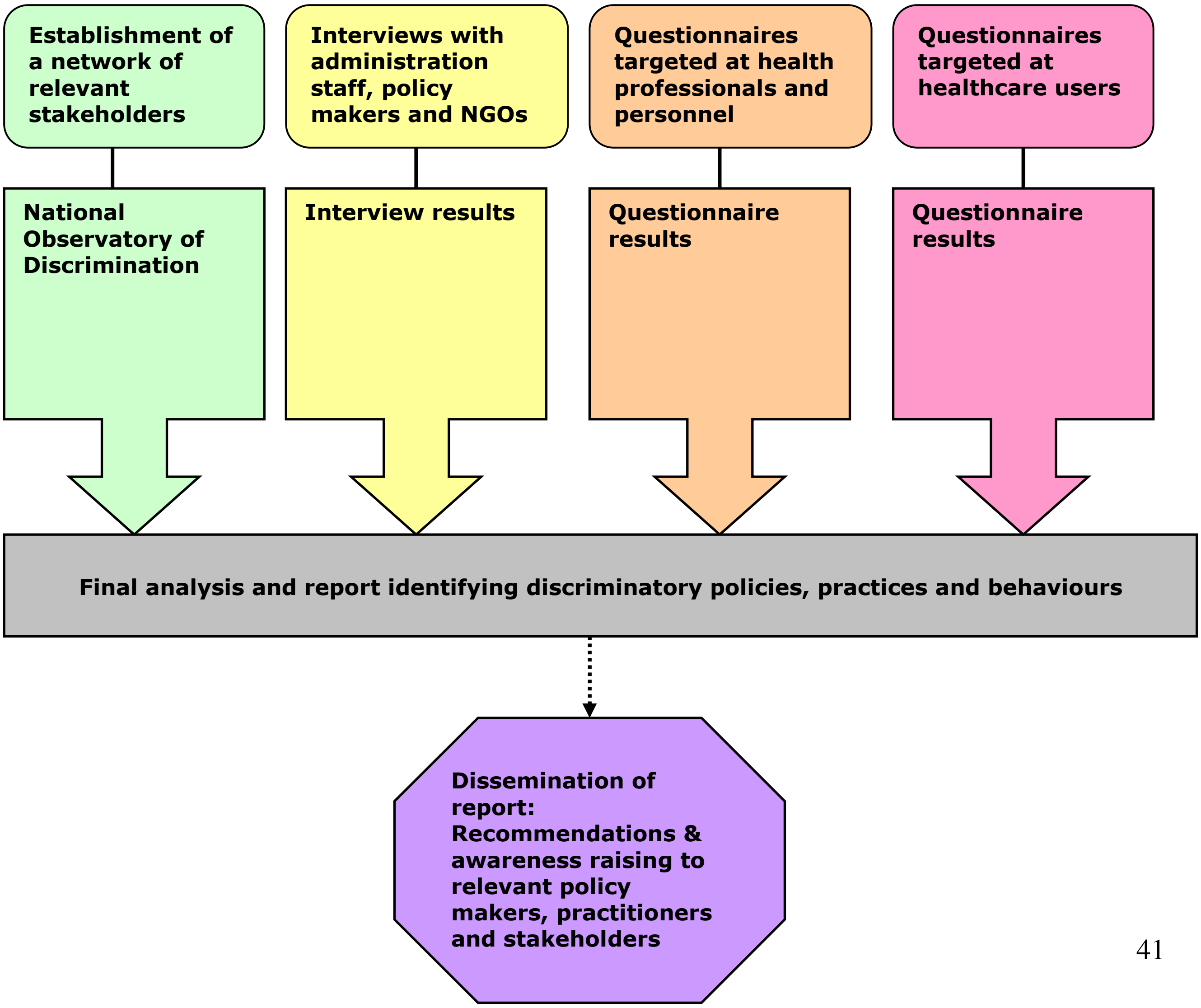
The overall management of the Equality in Health project was coordinated by the University Research Institute of Urban Environment and Human Resources (UEHR), who acted as the scientific coordinator for the International Organization for Migration (IOM) partners in Finland, Greece and Italy. Project decision making was shared between all partners, by participation to the project's steering committee. National management duties were delegated to one of the above partners in each country. Their tasks involved the implementation of project activities at a national level, including coordination as well as research and reporting.

Stakeholders were also involved and consulted in the project. Component 1, the National Observatories of Discrimination (NOD), entailed regular meetings of representatives from government structures, trade unions, religion, migrant communities, civil society actors (including NGOs) and health experts alongside the national project implementation staff. The NODs were included in the discussions about the research at each national level across the entirety of the project.

Results

Given that it was a research project, the measurable outcomes are related to the activities of the research implementation and subsequent analysis and recommendations produced.

Figure 3. The implementation of the MAT tool: determination of success and measurable outcomes



Conclusions

As previously described, the research and its analysis were multi-levelled. Thus conclusions were arrived at in 2 different ways:

1. **Components:** Findings and recommendations were made on the basis of each separate component, in every country and then these were compared on a transnational level (see table 1 below).
2. **Gap Model:** This cross tabulated all the national results from the 4 components and further from all the 3 countries' results, with 5 key variables considered to impact discrimination.

Table 2. Component Conclusions
Findings according to the 4 different components in all 3 countries of analysis and potential implications/recommendations for public health practices and policy

FINDINGS	POTENTIAL IMPLICATIONS/RECOMMENDATIONS
COMPONENT 1 Establishment and operation of National Observatory of Discrimination (NOD)	
Lack of cultural/language knowledge: Participants to the NOD highlighted the lack of organized information dissemination as well as the health service's staff lack of knowledge about cultural differences, including language communication.	▪ Disseminate information addressed to migrants and especially to undocumented immigrants. ▪ Introduce intercultural mediators to facilitate communication between health providers and users (with regards to cultural differences as well as language difficulties).
Gap between legislation and practice: In Italy and Greece a gap between legislation and practice was reported and the Observatories found the healthcare systems in both countries inadequate to address the needs of migrants. In contrast however, the Finnish observatory reported an efficient service and no such gaps.	▪ Consistency between legislation and practice is a step towards an efficient healthcare system for all users at every level.
COMPONENT 2 Qualitative tool development and pilot targeting key high administration staff, policy makers and NGOs	
Wide variation in administration and provision, especially as regards inequalities.	▪ Improvements aimed at promoting efficiency and effectiveness and the use of proper indicators. ▪ Better support for prevention services, with emphasis on the local level, especially the role of local government. ▪ More funds and better management of resources. ▪ Adequacy and quality of staff, especially nurses. ▪ More awareness about the importance of gender and gendered practices. ▪ Ensure that monitoring and control mechanisms actually work.
The National Health Service (NHS) does not seem to involve built–in discrimination. However, the inherent inequalities which exist in each country require positive action to support vulnerable populations in their efforts to seek and obtain proper healthcare. Nevertheless, regional and local authorities were more outspoken about the difficulties faced by immigrants and other vulnerable people. In addition, **NGOs are more sensitive to discrimination present,** as they are more user orientated, whilst people working in the health services are less aware of these dynamics	▪ NGOs and municipalities should take the leading role and act as 'anti-discrimination agents'. ▪ Introduce an Ombudsman for Health and Welfare. ▪ Better knowledge and support on the side of providers and users would be a valuable contribution to the promotion of good service provision. ▪ Develop health services at the local level and promote user participation. ▪ Move towards a more user-oriented approach in the planning and provision of healthcare systems.
Inequality in access, information and facilities. Poverty and	▪ Create different ways of promoting information about antidiscrimination

deprivation seem to be the main elements associated with discrimination, rather than ethnicity and other characteristics. However, as the immigrant community and minorities often fall into this social demographic, they are more likely to be affected. Their lack of awareness can be further exacerbated by **language and communication obstacles.**	legislation and rights for the vulnerable populations, including the production of easy-to-use guides in different languages. ▪ Implement programmes to inform people working in the health services about national legislation and the EU directives. ▪ Educate health professionals to take a multicultural outlook. ▪ Train special cultural and linguistic mediators to work in the NHS services. ▪ Promote the recruitment of health professionals from the nationalities of immigrants and from the minority populations. ▪ Promote special positive measures, specific to the target populations in each country, based on assessment and knowledge of their needs and prevailing social relations.
Bureaucracy and red tape was found to affect the provision of healthcare to migrant groups.	▪ Avoid bureaucratic red tape and ensuring that users can actually handle complex systems, especially those who are most vulnerable.
COMPONENT 3 Quantitative tool development and pilot targeting health professionals and personnel	
Lack of resources. Most health professionals find themselves working in systems which need financial and organisational improvements.	▪ Review of financial and organizational resources in healthcare in order to promote more time to patients, especially Italy and Finland.
Ignorance about national and EU anti-discrimination legislation. More than half the respondents (just over 50% in Finland, up to more than 80% in Greece) were not aware of national anti-discrimination legislation and likewise were uninformed about the relevant EU Directives.	▪ Make information about legislation and rights more readily available and made more prominent, i.e display the information in the workplace.
COMPONENT 4 Quantitative tool development and pilot targeted to the users and the daily operation of the healthcare system	
Patients from all three countries are in general not aware of their rights (both natives and non-native users). They do not know how to make a formal complaint or what course to follow when something goes wrong. Users in minority groups are especially impacted, as they are less familiar with the procedures in the delivery of local health services.	▪ More information and education in different languages about the rights and procedures for migrants in the healthcare systems.
Low satisfaction with administrative procedures. Levels of satisfaction with doctors and nurses are substantially higher in all three countries than satisfaction with administrative procedures.	▪ Review and improvement of administrative procedures in the NHS.

Gap Model Conclusions

The Gap Model compared information from all 4 components both nationally and at a comparative level between Finland, Greece and Italy. The main findings from the Gap Model analysis were as follows:

Gap 1B: Objective framework - management

There are undoubted deficits in implementation of anti-discrimination policy at present.

Gap 2: Management perceptions – service specification

There was no evidence of shortfalls that would give rise to discriminatory behaviour, since any deficiencies should affect all users equally. Nonetheless, there appeared to be a lack of measures such as the production of information material in a variety of languages, which means the minority groups under analysis can perceive discrimination due to lack of knowledge and understanding.

Gap 3: Service specification – service delivery

The difficulties in implementing policy do not arise because of reluctance on the part of the staff to do so. Rather, lack of funding and the inherent structural weaknesses of the health systems are to blame.

Gap 4: Service delivery – knowledge of information (legal framework – rights)

Legislation and EU Directives appear not to be well known and apparently no great effort has been made to provide this information to the health professionals.

Gap 5A: Service delivery – users' perception of performance

There did not appear to be any important divergence of opinion between the health professionals responsible for delivering the service and the users who received the service.

Gap 5B: Discrimination between vulnerable groups and the general population

Results from parts of the patients' questionnaire (especially in Greece) did indicate certain differences in the care delivered to different groups.

1.10 Lessons learned and future activities

General Recommended Guidelines for Investigation

- The MAT developed in *Equality in Health* is an integrated tool consisting of four components. The research requires the application of all four components within the same time period.
- The sizes of the samples necessary for the quantitative Components 3 and 4 can be determined by the usual statistical methods and will depend on various factors, including the desired geographical coverage of the investigation and the number of vulnerable groups to be examined in detail in Component 4.
- The budget for the research must be adequate. In particular, it must be sufficient to ensure that field work can be carried out on a sufficiently large scale and that an adequate number of well-trained researchers are available to carry out the field work. Also, problems of communication must be considered in relation to Component 4. Especially, the possible need to provide versions of the questionnaire in various languages, administered by appropriate researchers, should be taken into account in the planning; it may add a significant amount to the budget.
- Depending on the chosen mode of access to the target populations in Components 3 and 4, various issues of obtaining permission to conduct the research may arise. The relevant procedures and conditions vary between countries and possibly even within countries. It is necessary to

establish beforehand what has to be done, otherwise the execution of the research may be delayed or even turn out to be impossible.

- Issues of data protection and confidentiality are fundamental to research and are always taken into account in planning. However, there may be variations between countries in this respect too. Again, it is necessary to establish beforehand what the technical requirements are for this type of research.
- The research will in most cases be conducted as a partnership. The obligations and rights of each partner should be clear from the outset. Amongst other things, this includes the question of ownership of the data and the use that will be made of them. The rules and requirements of the funding agencies may well be involved, so this is another issue that can only be pointed out and left to be resolved under local conditions as appropriate.

Strengths, weaknesses and suggested improvements

The four-component structure of the monitoring and assessment tool is recommended, as each component approaches the issues from a different aspect and provides valuable information by itself, as well as in combination and contrast with the other components. Nonetheless, there are some strengths and weaknesses that were encountered which should be considered in future replication:

Table 3. Component strengths, weaknesses and suggested improvements

Strengths	**Weaknesses**	**Suggested Improvements**
COMPONENT 1 Establishment and operation of National Observatory of Discrimination (NOD)		
Arouse great interest.	Difficult to maintain attendance at the meetings at a satisfactory level.	A planned programme of invited speakers.
COMPONENT 2 Qualitative tool development and pilot targeting key high administration staff, policy makers and NGOs		
Provides crucial information about policy and its implementation. This component is vital in order to interpret the results from other components (especially 3 and 4).	It is possible if the MAT is used regularly that the same informants are being called upon	The discussion can focus on recent changes and developments, rather than repeating the entire interview.
COMPONENT 3 Quantitative tool development and pilot targeting health professionals and personnel		
Provides information on their own attitudes towards discrimination and the target groups, and on their knowledge and opinions of the legislation and policy. Without this information, it will not be possible to identify reasons for failures in the system (comparison with component 2) and much of the data from component 4 would be hard to interpret.	Information collection can be difficult due to the time constraints of these professionals and personnel.	Working timetables should be investigated and the questionnaire of component 3 has to be kept short, so that busy people are not discouraged from answering. Therefore care should be exercised in adding questions of local interest to the proposed questionnaire.
COMPONENT 4 Quantitative tool development and pilot targeted to the users and the daily operation of the healthcare system		

Without this information, the entire monitoring exercise loses its point.	Many of the practical problems in using the MAT in the field are concentrated in this Component. Difficulties are presented by issues of language and by the need to recruit respondents and conduct interviews under stressful conditions.	Problems of this kind can only be overcome by well-trained fieldworkers who possess the necessary skills. This Component therefore highlights the need to ensure that the monitoring and assessment exercise is adequately supported.

Gap Model: Strengths, weaknesses and suggested improvements

The Gap Model produced interesting findings about discrimination, and was vital to the comparison and assessment of the research results as a whole. However, its conclusions consisted mainly of general observations as opposed to identifying the existence of concrete indicators of discrimination. Therefore, a recommendation would be to integrate other factors into the model, such as the reality of healthcare practice and policies, in order to identify EU minimum standard parameters on which to detect the presence of discrimination from the data.

Extension of the research

The Equality in Health project was revolved towards developing and pilot testing a Monitoring and Assessment tool to assess discriminatory practices in healthcare services, which had as one of its objectives enabling replication in other EU member states. Before extension to other country contexts, the above-mentioned suggested improvements for the research implementation should be considered.

Future research across the EU, could further establish new variables for investigation, like comparison between regions (i.e. North and South Europe) and eventually between all the member states in order to influence EU policy.

In addition, one of the findings of the Equality in Health project was that there was a possible association between deviations from the expected level of medical care and the various characteristics of minority groups. With respect to this point, differences between the three participating countries were encountered. In Finland, patients from the Russian minority complained much more than the Finnish majority and in contrast to the other minority groups. In Greece and Italy, Muslims and non-natives were those who complained least. In the case of Greece, Albanians behaved in the same way as native Greeks, unlike other non-native minority groups. Such differentiation is a topic remaining to be analysed in detail in future research, when larger sample sizes will give higher statistical power to the study and the type of population groups may be more representative of the population under scrutiny.

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- *Equality in Health official website* (for all official documents, including the comparative report and more project information: http://www.uehr.panteion.gr/equality/

- *World Migration 2005, Costs and Benefits of International Migration*, 2005, International Organization for Migration

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migrant-friendly hospitals

MIGRANT FRIENDLY HOSPITALS

Introduction

Numerous studies prove that there is a relationship between migration and ethno-cultural diversity on the one hand and health status and healthcare quality on the other.
Due to worldwide migration, globalisation and European expansion, communities in Europe are becoming more and more diverse – and posing challenges for health systems and services alike. Both service users and providers are facing problems: language barriers and misunderstandings due to cultural diversity, a scarcity of resources and low levels of minority purchasing-power and entitlements. On the provider side, this emerges as new challenges for professionals and for the management as well as for quality assurance and improvement – especially for hospitals which play a particularly important role in serving this segment of the population.

Goals and Objectives

1. To locally initiate a process of organisational development towards becoming a Migrant Friendly Hospital and implement pilot interventions selected in a stakeholder approach.
2. To regionally/nationally support other hospitals in their quality development towards migrant friendliness by compiling practical, transferable knowledge and instruments.
3. To actively contribute to putting migrant friendly, culturally competent healthcare and health promotion higher up on the European health policy agenda

Model

A process of organisational development was started (the “**overall project**” developing migrant-friendly hospitals), including the following steps:

- Project teams were established in all partner hospitals in order to develop a basic structure.
- For a first diagnosis of problems and needs, as well as existing solutions - structures and process regulations - within the partner hospitals, a needs assessment was conducted that integrated the perspectives of clients, staff and the hospital management.
- Along with the needs assessment, a literature review on available knowledge relating to problems and possible solutions of health and healthcare related to migrant/minority status was provided.
- A generic assessment instrument was developed in order to obtain a first diagnosis on structures and process regulations at the organisational level. The Migrant Friendly Quality Questionnaire (MFQQ)1 assesses the status quo of overall “migrant-friendliness” (see the definition above) of services and (quality) management structures. MF Indicators are

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[1] Available via the MFH website www.mfh-eu.net and the website www.hph-hc.cc.

defined on two levels: The level of services and the level of facilitating quality structures. The MFQQ is available in two versions: the original English version, consisting of 163 Items, covers basic items and specific items of special interest for single partner hospitals. A short German form consisting of 67 items was developed in the framework of an initiative of the Austrian Ministry of Health. (Karl-Trummer/Schulze/Krajic et al. 2006)[2]

Based on the results of the needs assessments, the literature review and the MFQQ assessment, three specific intervention areas were selected (**"subprojects"**)

1) Subproject A: Facilitate communication: improve the interpreting services
2) Subproject B: Empower clients: migrant friendly information and training for mother and child care
3) Subproject C: Facilitate understanding: staff training towards cultural competence

Field or determinant

Health promotion for migrants and ethnic minorities, organisational development, quality improvement, interpreting services, patient training for maternal health, staff training

Scope

Organisation, European hospitals

Provider*:* partnership of 12 hospitals and a scientific institute, coordinated by the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine, University of Vienna

Austria: Kaiser-Franz-Josef-Spital, Vienna
Germany: Immanuel-Krankenhaus GmbH, Rheumaklinik Berlin-Wannsee, Berlin
Denmark: Kolding Hospital, Kolding
Greece: Hospital "Spiliopoulio Agia Eleni", Athens
Spain: Hospital Punta de Europa, Algeciras-Cádiz
Finland: Turku University Hospital, Turku
France: Hôptial Avicenne, Paris
Ireland: James Connolly Hospital, Blanchardstown
Italy: Presidio Ospedaliero della Provincia di Reggio Emilia, Reggio Emilia
The Netherlands: Academic Medical Center, Amsterdam
Sweden: Uppsala University Hospital, Psychiatric Centre, Uppsala
United Kingdom: Bradford Hospitals NHS Trust, Bradford

Resources

The project was funded by the European Commission – DG Health and Consumer Protection and the Austrian Federal Ministry for Education, Science and Culture (BMBWK). Regional project activities were financed by the partner hospitals

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[2] Both forms were included in the Manual for Swiss Health Care Institutions: (Diversity and equality of opportunities. Basic principles for shaping successful action in the microcosm of health institutions, Publication of the Swiss Federal Office of Public Health SFOPH and the Swiss Hospital Association H+, Editor: P. Saladin in cooperation with Renate Bühlmann, Janine Dahinden, Rahel Gall Azmat, Gerhard Ebner and Joachim Wohnhas, Published in German, French and Italian). Free copies of the Swiss manual can be ordered at: H+ Die Spitäler der Schweiz, Geschäftsstelle, Lorrainestr. 4 A, CH-3013 Bern; geschaeftsstelle@hplus.ch

Management

Project decisions were made in a project steering group. On the level of partner hospitals, decisions were taken by the hospital management in cooperation with the project group members

Indicators

Both for the overall project as for the subprojects indicators to measure effects were developed. Overall project/Indicators in the MFQQ:

- Interpreting services available at the hospital
- Information for hospital access and information in hospital
- Hotel services
- Medical/nursing treatment
- Discharge Management
- MF patient education/health promotion/empowerment
- General quality system
- MF budget
- Written MF policy
- Management Structure
- Marketing of MF
- MF training and education for staff
- Monitoring of migrant clientele
- Partnerships and partner alliances

Subproject A: Improvement of interpreting services
Indicators from a pre- and post-intervention staff survey (see section results)

Subproject B: Empowerment of clients: migrant friendly information and training for mother and child care
Indicators from a post-intervention client survey and staff survey (see section results)

Subproject C: Staff training towards cultural competence
Indicators from a pre- and post-intervention staff survey (see section results)

Results

Overall project

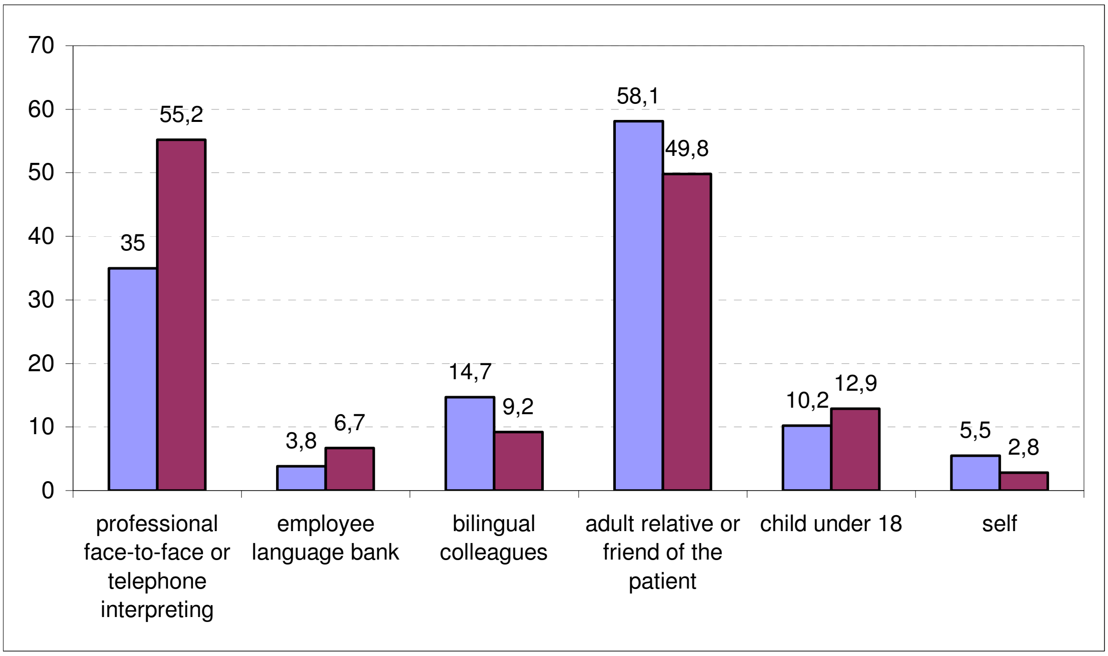
One central result is that monitoring itself makes a difference. The process of using the MFQQ and discussing the results fostered awareness of crucial elements of organisational structures and processes. It also provided direction where to go and created energy for changes. Some hospitals used the results of the first assessment as engine for further action. They integrated migrant-friendliness criteria into their strategy development (definitions of common values, EFQM self-assessment, strategic aims and Balanced Scorecard); they improved hotel and religious services for an ethnically diverse clientele, and implemented adequate information material (translation of relevant information about the department, discharge and follow-up procedures, improving signposts using pictograms).

Results from the second assessment after one year of project work also showed that considerable progress is possible in a rather short time frame. One project hospital used the dynamics of the European project to implement a comprehensive interpreting service practically "from scratch".
In all hospitals, changes related to their engagement in thematically focused "sub-projects" of the MFH project were apparent.

Subproject A: Interpreting Services

General evaluation results of the pre- and post-intervention staff survey show that the implemented measures proved to be effective. Comparison of the baseline and second staff surveys shows that the assignment of professional interpreters increased by 20.2%, with a concurrent decrease of nearly 10% in the occurrence of interpreting being provided by adult relatives and friends (see Figure 1). However, a 2% increase could be observed in the use of children under the age of 18 as interpreters.

Figure 1: Resources used to facilitate communication with patients with limited command of the local language; Before and after implementation of measures



The rate of responses stating that interpreters were available in a timely manner (always or often) increased by 17%.
Improvements were observed in all the defined quality indicators of interpreting services, such as the interpreter's introduction and role explanation, an accurate transmittance of information, the interpreter's clarification, clarification of cultural beliefs and the interpreter's identification of patients' further needs.
The overall rating of interpreting services improved, with the number of responses rating them as either excellent or very good increasing from 26% to 47%.
55% of staff members identified an improvement in their work situation as a result of the measures implemented in the context of the sub-project.

(For a more detailed description see Novak-Zezula/Schulze/Karl-Trummer et al. 2006)

Subproject B: migrant friendly information and training for mother and child care

Evaluations showed that women who attended training courses and used the information material were very satisfied with all the quality dimensions ((1) appropriate access to services, (2) relevant information, (3) culturally sensitive design and format of information, and (4) an empowering and culturally sensitive relationship between providers and clients) and experienced a remarkable improvement in their knowledge. Access is an issue that needs to be worked on further, however, because even though the courses were free of charge and women were supported by various measures including child care, participation rates were low. One hypothesis is that influence from husbands and/or family, who often decide whether such courses are taken or not, might have led to low participation rates. Further development should therefore take the important role that men play in mother and child care into account.
(For a more detailed description see Karl-Trummer/Krajic/Novak-Zezula et al. 2006)

Subproject C: Staff training towards cultural competence

Feasibility could be demonstrated; acceptability among staff varied in the hospitals but altogether a total of 149 staff members participated.
Quality was operational in terms of the following dimensions: content, structure, number of training units, qualification of trainers, composition of participating staff, management support, systematic needs assessment at the department level, integration in ongoing quality assurance, etc. Quality was measured as "conformity with the recommendations of the pathway" and, so defined, varied extensively, mainly due to a very narrow project time-frame that forced hospitals to rely on readily available resources.
Effectiveness could be confirmed by improvements in the staff's self-rated awareness, knowledge, skills and comfort levels concerning cultural diversity issues, as well as by increases in interest levels regarding cultural competence and in the staff's self-rated ability to cope with work demands.
Cost-effectiveness: while external training costs were low, developmental costs were rather high, despite personal costs being mainly covered through voluntary work.
Sustainability: training was recognised as an effective way of equipping staff with important competencies and although this will be continued, it will be modified in all the participating hospitals.
(For a more detailed description see Krajic/Straßmayr/Karl-Trummer et al. 2005)

Conclusions

A "Migrant Friendly Hospital"
1) values diversity by accepting people with diverse backgrounds as principally
equal members of society;
2) identifies the needs of people with diverse backgrounds and monitors and develops services in accordance with these needs;
3) compensates for disadvantages arising from diverse backgrounds.
The underlying central value is sensitivity to difference.
Referring to the key elements of organisational development – organisational reflection, system improvement, planning and self-analysis – the difference sensitivity of an organisation means to:

- define differences in their relation to a desired outcome: good care and good health for people who are different
- actively monitor/analyse for differences
- develop/adapt strategies that cope with difference in a way that the desired outcome is supported
- evaluate measures taken in relation to the stated objectives

*General comments and recommendations from experience are summarised in the Amsterdam Declaration (**http://www.mfh-eu.net/public/european_recommendations.htm**)*

Future

In December 2004, European recommendations for a migrant friendly health policy at hospital level and for other stakeholders were launched as the "**Amsterdam Declaration Towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe**".
The document starts with a summarised analysis of the current situation of hospital services for migrants and ethnic minorities in Europe and highlights quality-related problems for patients and staff. It assumes that improving quality for migrants and ethnic minorities as specific vulnerable groups would also serve the general interest of all patients in more personalised services, which is an issue high on the agenda of healthcare quality development and reform and especially the WHO Network of Health Promoting Hospitals. The Declaration argues that everybody would benefit if hospitals became more responsive to the ethnic, cultural and social differences of patients and staff.
In the second part of the Amsterdam Declaration, recommendations are made for specific contributions from the main stakeholders - hospital management, hospital staff and professional associations, health policy and administration, patient and migrant/minority organisations and the health sciences. The Declaration was welcomed at the MFH project's closing conference by a large number of European and international organisations: the European Commission, DG Health and Consumer Protection, WHO Centre for Integrated Care (WHO), International Labour Organisation (ILO), International Organisation for Migration – IOM, International Alliance of Patients' Organisations (IAPO), Standing Committee of the Hospitals of the EU (HOPE), International Union of Health Promotion and Education (IUHPE), Migrants Rights International, United for Intercultural Action, PaceMaker in Global Health. Partners expressed their expectation that the Amsterdam Declaration would serve as a European platform for improving hospital and healthcare services for migrants and ethnic minorities. The final text is available in this report in eleven European languages (German, Greek, Danish, Spanish, Finnish, French, English, Italian, Dutch, Swedish and Portuguese): http://www.mfh-eu.net/public/european_recommendations.htm

In May 2004, The Emilia-Romagna Network of HPH proposed the implementation of a **Task Force on Migrant Friendly and Culturally Competent Healthcare** at the 10th WHO Workshop for the Coordinators of the National / Regional Networks of HPH which took place in Moscow on 26th May 2004. The proposal was welcomed by the WHO European Office for Integrated Health Care Services, ensured the scientific support of the Ludwig Boltzmann Institute in Vienna, and received wide interest at a specific thematic session organised during the 12th International HPH Conference in Moscow.

The Task Force brings together practitioners, managers, scientists and community representatives with specific expertise and competence in policy-relevant knowledge in the field. It aims at keeping the issue on the agenda of the HPH network by providing inputs at workshops and conferences at European, national and local levels. It also aims at the development of specific tools (like the MFQQ form) that help the implementation and evaluation of policies, services, research activities and practices addressing migrant friendliness/cultural competence issues at the local, national and European levels. The Task Force is coordinated by the Emilia-Romagna Network of HPH, represented by the Health Authority of Reggio Emilia[3].

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Migrant-Friendliness Quality Questionnaire, (MFQQ), © LBIMGS 2003, 2004
Short Form Migrant-Friendliness Quality Questionnaire (SF-MFQQ), © LBIMGS 2006

Lessons learned

For a migrant and ethnically diverse population, healthcare is not only influenced by political or culturally defined social frameworks on the one hand and individual preferences and skills on the other. The organisational level plays a major role and thus has to be specifically addressed. The MFH project has demonstrated that healthcare organisations will take action if they understand that cultural diversity and migration related issues impact on their core processes of healthcare delivery. Consequently, this should
lead to changes in the self definition of the organisation and account for the inclusion of cultural diversity in the organisation's vision and quality criteria for monitoring and improvement.

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WHO-HPH TASK FORCE ON MIGRANT-FRIENDLY AND CULTURALLY COMPETENT HEALTHCARE

Introduction:

Migrants and ethnic minorities often suffer from poorer health compared to that of the average population. In addition to being more vulnerable due to low socio-economic position, unclear legal status and problematic migration experiences, research consistently shows that there are problems concerning health, health services and health promotion for these groups and that these issues have not been systematically tackled in European health systems. Experience in recent years show that even when services are available and access is granted, migrants may not use them because they do not know about or understand them, or because the services offered are not adequate to their cultural and religious beliefs. Therefore, health organisations are finding themselves increasingly faced with the specific vulnerability of migrants 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. However, this disparity in access to health care and services can be diminished by creating culturally competent health care services, sensitive to diversity, which are able to transcend the linguistic and cultural barriers as demonstrated by the European Commission project ”Migrant Friendly Hospitals” (MFH) 2002-2005. The issues of responding appropriately and equitably to diverse communities are ones that have plagued many service providers, however, the project has shown that there is a genuine commitment on behalf of healthcare providers across Europe to developing policies, procedures and practices for culturally competent healthcare. Indeed, healthcare organisations have developed many examples of good practice at local levels that need to be disseminated and further developed at a European level. To sustain this momentum, a “Task Force on Migrant-Friendly and Culturally Competent Hospitals” (TF MFCCH) has been set up within the framework of the Health Promoting Hospital Network (HPH) of WHO Europe. The idea of creating a Task Force originated from the desire to continue working on these themes in a comparative international context after the conclusion of the MFH project, and to build on this experience in order to facilitate the diffusion of policies and experiences and stimulate new partnerships for future initiatives.

Goals and Objectives:

The general aim of the Task Force on MFCCH is to support member organisations in developing policies, systems and competences for the provision and delivery of accessible health care to patients from diverse communities by fostering cooperation and sharing good practices in areas of common interest. Specific objectives are: To identify priority areas of concern in accessibility of health services and quality of care for migrants. To collect and make available examples of good practices and policies relating to selected areas. To share experiences, inform and participate in public events. To foster cooperation and alliances between internal and external networks. To promote the development of practice oriented knowledge and tools in selected areas of common interest.

Model

As the main aim of the TF is to foster cooperation between healthcare organisations; to facilitate dissemination of good policies and practices and to promote the development of practical knowledge and quality tools, it was decided to organise activities around working groups which had to focus on six main themes of concern:

1. Policy and service development (WG leader Dr Werner Schmidt, Germany))
2. Professional training and development (WG leader Mrs Gurwinder Gill, Canada)
3. Intercultural communication (WG leader Mr James Robinson, UK)
4. Patient and community empowerment (WG leader Dr Lai Fong Chiu, UK)
5. Research and evaluation (WG leader Dr Antonio Chiarenza, Italy)
6. Trans-cultural psychiatry. (WG leader Dr Manuel Fernandez, Sweden)

On each theme, the Working Groups aim to develop practical knowledge and tools to help healthcare organisation to become more sensitive and responsive to diversity by gathering models of effective interventions in healthcare, identifying problems and priorities to progress and making recommendations for possible solutions. A three step work plan was assigned to working group leaders in order to achieve this goal: **1)** to collect existing models of good policy and practice and make them available on the Task Force Web site; **2)** to categorise the material collected and argue for an explicit rationale in an orientation paper; **3)** to make a proposal for the development of effective interventions and quality tools (standards, idicators, guidances...) to be supported by specific projects. Annual workshops are organised to allow Working Groups to present progress and to share information with other WGs. Twice a year business meetings are organised to monitor and assess the activities of the WGs and to adjust the global work programme. A final international conference will be organised to present the outcomes of the four years pathway of the TF.

Field or determinant

Ethnic minorities and migrants health and health promotion. Equality of access and of quality care. Linguistic and cultural barriers. Low levels of health literacy among migrants and ethnic minorities. Low levels of cultural competence among healthcare staff.

Scope

The TF on MFCCH brings together professionals and managers in health services and researchers with specific competences and knowledge able to give guidance on matters of policy, strategy and practice to healthcare organisations, hospitals, primary care services and community services.

Provider

The Task Force is established within the international HPH network with a specific mandate for coordination assigned to the HPH regional network of Emilia-Romagna (Italy) by the General Assembly and the Governance Board of the international HPH network. The provider is a governmental organisation, being the Health Authority of Reggio Emilia, which is the coordinating institution of the regional HPH network of Emilia Romagna.

Resources

The TF activities receive financial support from the regional HPH network of Emilia-Romagna (Italy).

Management

A coordinator, nominated by the Governance Board of the international WHO-HPH network, is responsible for the management of the TF and remains in force for 4 years. The co-ordinator of the Task Force MFCCH leads actions and develops a strategic plan with the support of the WHO Collaborating Centre for Health Promotion in Hospitals and Health Care at the LBISHM University of Vienna. At the set up of the TF, an Advisory Board was created in order to support the coordinator in the decision making process. The Advisory Board informs decisions and briefs the coordinator on issues arising out of the strategic direction and supports the coordinator and the rest of the group on any issues. The Advisory Board consists of a group of core members representing organisations particularly committed to “Migrant-Friendliness” and “Cultural Competence” issues and prepared to invest in disseminating MFCCH concepts, experiences and tools and further developing them, primarily within the HPH network, with the HPH national and regional networks as the main partners for dissemination. Leaders of the six working groups are members of the Advisory Board.

Indicators

The work of the TF is assessed in a brief annual report produced by the coordinator for the WHO-HPH Governance Board and at the end of the four year mandate, there is an overall evaluation of the work carried out to determine its continuation or termination.

Results

The TF MFCCH has developed a strategic work plan for the achievement of goals and specific objectives. It has worked to create partnerships and international contacts, and all working groups have worked according to the defined strategy. To inform and communicate knowledge and experience, the task force has participated in various national and international conferences and workshops during the last year. WG leaders have started to review existing knowledge and to collect examples of good practice and policies and have selected priorities relevant to their topic area. Working Group leaders are in the process of developing “orientation papers” containing a critical overview of the material collected in order to prepare an initial proposal for the development of effective interventions and quality tools for healthcare organisations. For external communication, the Task Force will soon have a specific web site linked to the WHO CC in Vienna, and, for internal communication, a discussion forum at the WHO CC Copenhagen website.

The TF MFCCH has organised five business meetings, parallel and poster sessions and thematic workshops in occasion of the HPH conferences :

- In Dublin (May 2005). 2 parallel sessions and 1 poster session were organised at the 13^ HPH international conference. At the first TF business meeting, a draft constitution and a strategic work plan were presented by the TF coordinator and agreed upon by TF participants. An Advisory Board was created and WG leaders were nominated.

- In Courmayeur, Italy (October 2005) 1 parallel and poster session were organised within the 9^ Italian HPH conference. A TF business meeting and a workshop were organised to discussed and further develop the proposals presented by the six WG leaders.
- In Palanga, Lithuania (May 2006) 2 parallel sessions and 1 poster session were organised at the 14^ HPH international conference. A TF business meeting and a workshop were organised to allow WG leaders to present progress on their work.
- In Berlin, Germany (December 2006) a thematic workshop was organised by the leader of the WG on "Policy and service development" where the other TF members and international experts presented and discussed examples of good practice on the specific issue. At the TF business meeting the overall work plan was assessed.
- In Vienna, Austria (April 2007) 3 parallel sessions, 1 poster session and a workshop were organised at the 15^ HPH international conference. At the TF business meeting the presentation format of the orientation papers was agreed upon.

Conclusions

Although the work plan of the TF is less then half way, the model chosen with its intermediate results can already prove useful for healthcare organisations. European experience on delivering quality services for migrants and ethnic minorities is made visible through the internet web site and shared through discussions in public events. At the end of the four year period, European healthcare organisations will be able to benefit from the products developed by the TF, i.e. accessible documents on the web site, orientation papers and proposals for the development of effective interventions and quality tools that can be implemented by healthcare organisations.

Future

At the end of the 4 year work plan the orientation papers produced be the working groups will provide the basis for the development of effective interventions, standards, indicators and guidance for implementing MFCCH.

Lessons learned

Better to do this after the end of the project.

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SURVEY ON UNDOCUMENTED MIGRANTS ACCESS TO HEALTH CARE IN EUROPE

EUROPEAN OBSERVATORY ON ACCESS TO HEALTH CARE

Introduction

The EU estimates a presence of 4.5 to 8 million undocumented migrants with 500 000 new entries per year[4]. This population's health status is generally more precarious than that of nationals because of following reasons:
-imported pathologies (tropical diseases like bilharzias, drepanocytosis; infectious diseases such as HIV/AIDS, tuberculosis, hepatitis...);
-crisis situations they have been confronted with and their consequences (for instance: war, political violence, separation and death in the family, hunger which can cause major physical and psychological trauma);
-precarious living conditions (during their migratory journey and in host countries), which expose them more to health risks than nationals.

Moreover, most EU countries health mechanisms tend to reinforce migrants' exclusion: Asylum seekers and undocumented migrants access to healthcare is much more restricted than it is for nationals. In some countries, they can only access emergency care; in others, even if access to healthcare is in the law, it is usually not very effective because of various factors -lack of information ; treatments cost; complex administrative procedures; fear to be discriminated or denounced ; language and cultural barriers; insufficient and inappropriate sanitary services for the victims of violence.
Besides, EU countries have not all set-up yet efficient mechanism to protect seriously ill foreigners against deportation to countries where they cannot have access to appropriate treatments.
Overall, this situation represents a public health risk for the EU population since it can jeopardise the EU fight against epidemics and communicable diseases. Moreover, excluding migrants from access to prevention and primary healthcare actually increases public health cost, as they can only access emergency care and therefore, when they suffer from diseases' complications, which usually requires costly treatment.

Goals and objectives

Goal:
-To obtain access to health care on equal terms for all people living in the EU, especially for those in precarious situations and regardless of their administrative status.

Objectives:

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[4] Source : EU Commission Website http://www.europa.eu/rapid/pressReleasesAction.do?
Press Release, 16-05-2007.

- To improve migrants' access to health care, and in particular undocumented migrants',
- To obtain the setting up of protection mechanisms for seriously ill foreigners against deportation when they cannot be treated in their countries of origin, and to guarantee them access to treatment in Europe.

The **European Observatory on Access to Health Care (EOAHC)** will help to document the people in precarious situations' difficulties to access health care in Europe. The evidence is based on field observations, surveys and face-to-face interviews with the most vulnerable people in order to convince governments and European institutions of the need to improve access to prevention and health care

An objective look at their access to health care in the various EU countries should help to identify the most favourable measures and practices for an effective public health policy, and the European Union could be inspired by them to improve health conditions throughout its territory.

Model

In 2005-06, the **EOAHC** developed and conducted a statistical survey of undocumented migrants in seven countries. At the same time, the patients interviewed described what care he/she has received until then and how he/she could access it. And MDM also gathered information on national health care access laws.

This is the first EOAHC survey. It mobilised almost all the MDMs in Europe.
The entire MDM network joined forces and worked on this issue, taking account of their differences and trying to overcome them. There are many disparities between countries involving:

- Legislation governing access to health care,
- Legislation implementation modalities,
- Populations encountered and their problems,
- Field teams' practices,
- Local contexts,
- Methods of intervention,
- Definition of concepts,
- Vocabulary used,
- Language, which can lead to different understandings and interpretations of situations.

The questionnaire used to collect the data resulted from many months of discussions and a working seminar attended by one representative from each MDM to implement the survey on a common foundation. It was translated into 6 languages.

The analysis of the collected data has been carried out by two experts in health and precarity, an epidemiologist and a sociologist.

The survey's intermediate findings were shared and discussed with all the MDMs during a workshop, so that everybody could contribute to the analysis.

Field or determinant

MDM is present in 12 European countries[5]. In each of them, the organisation is carrying out health projects for vulnerable populations with difficulties to access prevention and health care. MDM teams in Europe run programmes for Romas, homeless people, drug users, prostitutes, isolated people without financial resources, poor migrants in regular and irregular situations, children suffering from lead poisoning, children without access to vaccinations, etc.

** : Presence in 30 towns throughout the territory*
*** : Presence in 15 towns throughout the territory*

Scope

Questionnaires were administered from July 2005 to February 2006 by volunteers in MDM centres or by staff members of partner organisations in 19 cities in 7 EU member states (Belgium, France, Greece, Italy, Portugal, Spain, United-Kingdom). A total of 835 individuals were surveyed.

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[5] Belgium, Cyprus, France, Germany, Greece, Italy, the Netherlands, Portugal, Spain, Sweden, Switzerland, and the United Kingdom,

Provider

MDM is an international humanitarian organisation whose purpose is to treat the most vulnerable populations in situation of crisis and exclusion worldwide, and in every country where it has presence.

Resources

The EOAHC budget is divided in 5 main parts:
1/ Organisation of annual workshops with the teams (travel expenses), on topics defined according to the work progress: discussion on the data collection tools and methodology; or sharing the intermediate results of the surveys,
2/ Data analysis (fees): contracted experts in health and precarity,
3/ Translation of the reports in the languages of the countries concerned by the survey (fees),
4/ Publication of the report in the languages of the countries concerned by the survey (publication and graphism fees),
5/ Human Resources.

In 2006, the EOAHC budget was 90 000 euros. The project was partly funded by the French Health and Social Affairs Ministries, which allocated a 14 600 euros global grant to the MDM "France Mission Coordination[6]". The rest of the budget was provided by MDM private donors.

Management

The MDM International Board of Directors, which includes all the associations presidents, sets up the EOAHC priorities and policy objectives.

Five types of actors are involved:

1) France Mission Coordination –MDM France:

Three FMC part-time representatives are in charge of the project's implementation and monitoring. MDM France also supports the **EOAHC** offering an IT officer and a public health doctor services as well as some of its general departments' services (such as its human resources, accounting, communication and logistics departments).
Besides, it also receives the support of the International Secretariat, which is in charge of the MDM International Network's coordination.

2) Project team

The project team is in charge of ensuring the project's coherence, according to the activities implemented in the field. It also ensures the project various stages' implementation and prepares common tools… It includes one member from each of the following delegations: MDM Belgium, France, Greece, Portugal and Spain.

3) Countries referees

They are the MDM contact persons in direct relation with the project team and they are in charge of the coordination of the survey and the data collection in their respective countries. They discuss and

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[6] The MDM France's service in charge of the project implementation and monitoring.

validate the data collection tools and the survey's results. They also identify and appoint the field referees.

4) Field referees
They are in charge of the operational implementation of the surveys.

5) Over 100 persons in charge of the data collection *(assistants, social workers, psychologists, doctors, persons in charge of the data entry)*

→ A total of 140 volunteers and employees worked on the 2005-2006 survey. This explains the necessity to set up consensual and adapted processes: annual workshops, monthly teleconferences, drafting of quarterly updates, regular communication.

Beneficiaries' participation:

The beneficiaries accept to answer to the questions and to describe the difficulties encountered to access health care.

Indicators

In 2005-2007 :
- 1 survey carried out in 2005-2006 including 835 people, in 7 countries: Belgium, France, Greece, Italy, Portugal, Spain, and the United Kingdom.
- 1 report on access to health care of the people in precarious administrative situations in Europe, published in summer 2007.

Results

The living conditions of the persons surveyed are difficult. Some 40% consider their housing situation precarious and 11% are homeless. Almost all of them are living below the poverty threshold.

By and large, **the persons surveyed are not aware of their rights.**
One-third is unaware of their right to health coverage. Most do not know that they are entitled to free HIV screening and nearly two-thirds are unaware that HIV treatments are free. Child immunisation is another area where information is lacking. Only a small majority of the population concerned by this issue knows their children are entitled to free vaccinations and/or where to go for them.

Most of the people surveyed do not have health care coverage either because they lack information about their rights or have not undertaken the process to obtain these, or because the administrative procedures are still under way.

This survey shows that **two people in 10 perceive their health as poor or very poor.** The main disorders mentioned are digestive, musculoskeletal, psychological or for women, gynaecological. **Only one-third of the people suffering from a chronic health problem is currently receiving treatment.** Nearly half of the people stating that they have at least one health problem suffered as a consequence of the **delay in recourse to care**.

We asked people what they did to obtain care the last time they were ill; 75% consulted a doctor and 20% did not.

During the last health problem, **one person in ten met with a refusal of treatment from health care professionals.** Some of those health problems were emergencies (in particular, fractures and burns, but also pregnancies and personality disorders), serious illnesses (insulin-dependant diabetes, viral hepatitis) or acute infectious diseases (sinusitis, pneumonia).

The most frequent obstacles to health care access and treatment continuity voiced by the people surveyed are lack of knowledge about their rights, lack of knowledge about where to go for treatment, treatment cost, administrative problems, fear of being reported to the authorities and of discrimination, and linguistic and cultural barriers.

Conclusions

The findings show the advantages of this kind of survey, considering the lack of national surveys and the inexistence of European comparative surveys on the social, health and medical situations of foreign nationals living in Europe in precarious administrative situations.

All the observations, descriptive statistics and testimonials point in the same direction: This population is very insecure, lives in difficult conditions, has significant health care needs and usually lacks health care coverage.

Now we must be able to use this survey's findings in order to improve public health policies in Europe so that they definitively remove obstacles to care tied to the administrative status of the people living on its territory.

Today in order to avoid having to treat people in emergency -which represents unaffordable human and financial costs-, we must convince policy makers and European citizens of the necessity to provide all people living in precarious conditions with access to prevention and health care. Pathologies do not consider people's administrative status before infecting them: A coherent public health policy should take into account the harmful impact of group of persons (children and adults) that are not vaccinated, not medically followed and not treated.

Future

We are now planning to continue and reinforce the MdM European Observatory's activities by:

- Extending the network involved in this project's implementation to other EU member states where MdM is present, but also to several other member states.
- Conducting new European surveys including a major one on asylum seekers' and undocumented migrants' access to healthcare in the EU, that will cover a much larger number of member states (19)
- Developing more network advocacy activities at national and EU levels and covering a much larger number of member states (19).

Lessons learned

This first EOAHC report showed that despite some methodology difficulties due to the diversity of the situations encountered, the local legislations, the types of programmes implemented in the field, it was possible to gather global and coherent knowledge on the most vulnerable migrants' -the undocumented migrants'- difficulties to access health care. We actually proved that health professionals, volunteers, in 7 countries, could use the same language, the same data base and give together an overall picture of the chronic and acute health problems that populations are confronted with.

During the survey we observed a lack of data about the situation of children and pregnant women. Children are always the most vulnerable, whether in terms of exclusion, poverty and health. Their immunisation coverage is unsatisfactory. That is why in 2007 we will probably have to conduct a specific children's survey on how the European Union's institutions care for their health.

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MIGRANT HEALTH IN THE URBAN CONTEXT

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Introduction

Migrants are a heterogeneous group, meaning they come from a multitude of different ethnic and cultural backgrounds. The migration history can also vary extremely, from experience of war and torture to the relatively privileged examples of professionals migrating into a host country with a job already secured. Migrants' legal status in European countries can vary from full access to all health care to complete exclusion except for acute emergency medical services.
The constitution of the World Health Organization (1946) states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition", in other words, that access to health care is a human right

Migrants face a variety of barriers to access health care services and health promotion in their host country. Barriers identified in migrant health studies, additionally to language barriers and lack of understanding of the health care system in the host country, are often similar to those of other socially disadvantaged groups. Migrants are often unemployed or not allowed to work and live in poor housing facilities, which can further add to social exclusion and negatively influence a multitude of other determinants of health(1). Community based health promotion interventions have been shown to be effective in improving determinants of health as well as reduce known barriers to access health care(2).

This chapter demonstrates a number of "learning points" for effective community interventions based on the experiences of a number of migrant health case studies generated from the WHO Healthy Cities Project in a number of different EU states.

The WHO Healthy Cities approach (http://www.euro.who.int/healthy-cities) gives special emphasis on health inequalities, social exclusion and the needs of vulnerable and disadvantaged groups such as migrants and ethnic minorities. Migrants' health is an area of concern and priority for the cities belonging to the WHO Healthy Cities Network. Many issues relating to the health and wellbeing of migrants are best dealt with at the local level. Municipal governments can play a key role in that respect. Healthy Cities advocate the development of policies and comprehensive partnership-based programmes that address inequalities and vulnerable groups drawing on the contribution of public and voluntary sectors.

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Seixal , Portugal
"Saúde sobre Rodas"-Health on Wheels,

- Community intervention project through which clinical and social aid is provided to disadvantaged populations in the entire municipality of Seixal via mobile vans, therefore removing some of the barriers to accessing health care.
- The project cares for disadvantaged migrant, Gypsy/traveller and native populations.
- The project covers the following areas: Health Education; Vaccination; Maternal Health. Monitoring; Child Health Monitoring; Post-Natal Visits; Early Diagnosis Testing; Diabetes Monitoring; High Blood Pressure Monitoring; Family Planning. Neighbour relations; Community support (inter-peers); Proximity to formal institutions and qualified technicians; Organisation of community structures, Support and social dynamics.
- This project is promoted by a multi-disciplinary team consisting of health and social welfare officers from the three municipalities.
- **Learning point:**
  This project has reduced access barriers to disadvantaged populations from both migrant and originally resident populations.

Migrants in the Urban Setting

Most people today live in cities or urban regions, globally this accounts for ca 50% of populations, in the EU it is estimated that up to 80% live in cities or larger urban areas(3).

The European Commission's Urban Audit(4) describes how the proportion of migrants per total population in cities has been increasing steadily in the last decades. Migrants are often attracted to urban settings because of the availability of work, housing and already resident migrant populations with the hope of better chances for social and cultural networking. It is known, that the vast majority of migrants in Europe live in urbanized areas. The urban setting is of particular relevance to the health and wellbeing of migrant populations in terms of living conditions, access to health care services and social inclusion and support.

Morbidity of Migrants:

Often little is known about the health status of migrant populations due to lack of systematic data(2). Where data exists, it often shows greater health needs in certain chronic diseases like Diabetes Mellitus, infectious diseases like TB and often in Mental Health. This is despite the finding that migrant populations often have a younger age profile than the host population.

There is, however, a lack of consistency in the findings about migrants' morbidity patterns in the literature, some studies showing no marked difference from the host countries population, some even showing lower prevalence of certain diseases, e.g. for depression.(5)

Many European Union cities are also now faced with an ageing first generation migrant population from within and from outside the EU, for whom few specific health plans or provisions exist.

There are perceptions in some European States that infectious diseases carried by migrants pose a threat to public health in the host country. Although it has been recognized, that from a certain proportion of migrants in a population some public health practices such as e.g. vaccination against Tuberculosis might have to change because of changed prevalence of the disease, the overall threat to public health has been assessed as very low(1). This might, however, not always be recognized and effective health protection work and communication is essential to prevent inappropriate fear of communicable diseases in the host population.

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"Role of community health agents in the control of tuberculosis in immigrants"

- Foreign-born population in Barcelona 17 %.
- Migrants constituted 41.7% of TB incidence in 2006, which represents a rapid increase compared to preceding years.
- An investigator coordinates the five community health agents care officers, who will deal with conatct tracing for migrants with different languages and/or other types of socio-cultural communication difficulties (one for Latin America, one for Asiatic countries, one for North Africa, one for Sub-Saharan Africa, and the last one for Eastern Europe).
- Results will be determined by the increase in proportion of cases who finish a treatment course and where contacts have been traced.
- The results are likely to be transferable to other Cities and other infectious disease control fields.

Learning point:

- **This project has increased both the proportion of treatments carried through as well as the number of contacts traced by addressing specific health and communication needs of migrant subgroups, thus also reducing the risk of exposure of the host population to active cases of TB when compared to previously conducted practices.**
-

Migrants might be exposed to health risks before, during and after migration from their home to the host country. Multiple losses and strains in the migration process may result in a negative stress response and risk behaviour, which makes migrants a particularly vulnerable group in health promotion and disease prevention(2).

Risk Perception, Health Promotion and Target Group Involvement

As migrants often face psychosocial stressors, such as belonging to a low social class, being unemployed and belonging to a minority with often low social capital or support, such acute difficulties are often prioritized and risk behaviour issues, such as e.g. smoking and physical activities are not seen as important by the migrants themselves(5).

Health Promotion activities aimed at influencing risk behaviours are often conducted by planners who are sometimes far removed from the target groups. Reasons for this distance are marginalisation, difference in social status and education, limited knowledge of the areas of residence and last but not least language barriers.

As with access to health care migrants should be considered to have a right to access and be the target of health promoting activities. Target group involvement, even at the planning stage, increases the chances of a health promoting activity to have the desired outcome(6).

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Healthy Cities Network Spain

Immigration Health and City Project 2005/2006

The project objectives were as follows:

- analysis of phenomenon of immigration and its impact on the city
- analysis of effectiveness of strategies which allow integration of migrants into civil and political life
- to exchange experiences and good practices
- to propose actions to challenge the situation with the governing board of the Spanish national network

Methods:

- stakeholder seminar
- webpage for project/innovation reporting and exchange of experiences
- use of interim results to advocate conclusions to further stakeholders (like the MoH) and to strengthen the position of local government with regard to migrant health issues

Learning Points:

- **costs and benefits of immigration are unequally distributed among different social groups**
- **it is important to strengthen and not damage social cohesion, activities aimed at improving migrants health must also benefit other disadvantaged groups with no migration background**
- **Quantitative and qualitative insufficiencies were identified in public services such as education, healthcare and housing depending on the scale of new arrivals in localities. Resources need to be re-allocated to address these insufficiencies.**
- **Gender specific issues have been identified as well as issues of discrimination impacting on migrant health. These pose specific challenges which must be met**
- **Presence of unregistered migrants might impinge on some of the social achievements of legal migrants and the originally resident population. Integration must be carried out without detriment to the local resident population. This also can contribute to avoiding conflict between different socially disadvantaged groups**

Integration of migrants encompasses three key ideas:

1. Integration is a dynamic social process, prolonged over time, which must e continuously reproduced and renovated
2. Integration requires a two way effort in adaptation to a new reality, both for the migrant and the resident populations
3. The framework for integration must be based on national and European basic values. “The dignity of the person, the inviolable rights which are inherent, the free development of the personality, respect for the law and rights of others, are the foundation of political order and social peace”

These are the elements that comprise the framework of basic values and rules within which the mutual adaptation process represented by integration must be developed

Conclusion:
The cities' networks are a powerful instrument to advocate for more integrated and participatory immigrant policies at a regional and national level.

Access to Health Care:

Multiple factors exist influencing access to health care, including legal barriers, depending on the migrant's immigration status.
As with other disadvantaged populations migrants often lack physical (transport) and or financial means to access health care in the traditional way of the host country.
Other formal barriers to health care might include user's fees.
Informal barriers include language, psychological and socio-cultural factors.
It is known that even immigrants with full rights to health care in the host country, such as "within EU labour migrants", have difficulties navigating the host countries health care system, or might navigate it in the "wrong" way. Health illiteracy of disadvantaged groups including migrants is known to be expensive for health care systems(7).

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Copenhagen, Denmark
"Health in your own language"(peer education project for health promotion)

- 14% of the Copenhagen population stems from non EU countries (70,000).
- Many different migrant groups, the largest group numbers 8200.
- Health needs assessment showed problems with smoking, physical activity, nutrition, dental and reproductive health.
- Traditional health promotion services were underused by migrants.

Objectives:

- Improve the health status of migrants through providing information to and taking up dialogue with migrant groups.
- Gain experience in peer education in health promotion among ethnic minorities.

Assumption:

- Using members of the target group would be more acceptable for the group and facilitate access to the group.

Results:

- All candidates fulfilled the education criteria.
- Most educators have subsequently been active and in 2006 about 4000 citizens from target groups participated in a meeting with health educators.
- Participants learned something new and interesting and wanted to attend further meetings.
- The assumption of acceptability and access was confirmed.
- The evaluation showed transfer of knowledge to participants, a positive health effect on the educators, some change in work place habits (food, exercise) and increased knowledge in the Public Health Office on migrant health issues.
- Realization that peer education should be supplemented with additional elements, like individual counselling, improved environments etc.

Learning points:

- **Helped to provide highly motivated health educators to migrant communities.**
- **Many have to be trained to enable coverage of many languages and to reduce vulnerability to busy free lance educators.**

- **Contact between public health office and peer educators has created feeling of common cause and community.**
- **A professional project co-ordinator is important to enable regular exchange of experiences and provide additional training.**
- **Peers do not "automatically" have access to the target group.**
- **Recruiting the "right" peers is crucial and high quality training must be provided.**
- **The "Danish version" of peer education constitutes an interesting opening of a channel to the target groups.**

Target Group Involvement through Community Approach

Often migrants live in local communities in which a large proportion of the population has a migration background. A community approach can be useful as a starting point for health care and disease prevention activities, as health needs, but also cultural preferences and perceptions are potentially easier to assess. Local community centres and networks (e.g. churches, mosques, clubs etc.) which are already accepted in the community, can serve as useful links and allies for health interventions, which may lead to greater acceptance and ultimately effectiveness of the activity.(8, 9, 10, 11).

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Turku, Finland
Monikas-"Many Dimensions"(Multi-cultural Public and Private Cooperation Project)

- The project aims to create a shared understanding and joint practices for health promoting activities to both the public sector dealing with migrant issues as well as the migrants' groups and representatives themselves- resulting in a transferable model for different sectors of public services as well as for different locations.
- Partnership of public and private, governmental and non-governmental organizations, i.e. the migrants' associations and informal groups.
- Migrants comprise ca 4.2 % of the population of Turku, the highest percentage in Finland.
- As elsewhere in Finland, the migrants tend to be underserved in relation to use of the Health system services in Turku, particularly with regard to risk behaviours i.e. use of tobacco, alcohol and drugs.
- The focus of the project is on empowerment to deal with the wider Finnish public sector, capacity building and health promotion.
- The model is financed by the Finnish Health Ministry and evaluated yearly over a three year period.
- **Learning point:**
  The developed model is hoped to be applicable in all public administrations, but especially in health promotion across sector boundaries. By empowering migrants to find appropriate support especially in health care and health promotion services it is hoped that negative health effects of migration are cushioned compared to the expected level without community intervention.

Conclusions

Although there is still a lack of a comprehensive evidence base on such basics as morbidity, mortality and risk behaviours among migrants in the EU, coinciding with sketchy knowledge about the effects of health promotion and disease prevention for this group, the above case studies and a review of the literature show that there are many options for useful interventions and a multitude of good practice examples of what is currently being done in this field.

The sharing of experiences of what works and what might not have worked is essential to increase the knowledge base for future activities. At the same time it is important to build evaluation into the planning process for future projects, again, to increase the future evidence base. Giving priority and visibility to the health needs of migrants is important, however it is important to address this issue in a systematic way and as part of a comprehensive approach to health development that puts emphasis on health inequalities, participative governance and social inclusion.

The WHO European Region Healthy Cities Network advocates and supports the development of innovative policies and programmes for the health of migrants and provides a laboratory of ideas and know-how and an international platform for learning and sharing of experiences from committed cities across the European Region.

Salamanca, Spain

"Health Promotion among immigrant people"

- Forming of a immigrant women group to assess health and social needs
- Assessing access problems to public services
- Assessing culturally specific nutrition issues
- Increasing health literacy
- Developing values and personal skills
- Assessing mental health needs of the migrant population
- Assessing and addressing barriers to health
- Assessing vaccination status and needs
- Training health mediators from within the migrant community
- Also specific short course for the elderly migrant population

Methods:

- Bottom up not top down approach
- Recognizing the population as the main agent of change
- "Knowing –acting-transforming" method to sensitize participants about own situation and mobilize action

Additionally the information gathered has resulted in the production of an "Information Booklet" for Migrants

- Comprehensive free booklet for migrants available in different languages
- Information about rights, health insurance cards, other required documents and how to obtain them, health centres, specialists, emergencies, Doctor's surgeries, Medicines, health promotion, sexual health, children's health, pregnancy, addresses of health centres
- Also provides information about work, trade unions, social care and other migrant relevant organizations and institutions

Learning points:

- **The methods have proved efficient to gain an in depth knowledge of causes of health inequalities in immigrant populations**
- **It was possible to increase numbers and uptake of vaccinations, maternity care and regular health checks in men and women**
- **Persons who have participated in the programme perceive themselves to be in better health now**
- **Successful creation of social support networks, supporting children and the elderly amongst others**
- **Additional support has been established for persons with mental health needs who have experienced trauma during the migration process**

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Important points for mobilizing action

- Recognize the importance and added-value of the key role of local governments and local action with regard to migrants' health and support the development of systematic solutions that are based on the principles of equity and social solidarity.
- Include efforts to reduce structural and cultural barriers in the health care system limiting migrants' access to health care – with a special emphasis on vulnerable groups like refugees and asylum seekers.
- Combine interventions on multiple levels – individuals, local communities and society.
- Base the interventions on the target groups' needs and wishes.
- Take into consideration migrants' social conditions and possibilities for action.
- Include a focus on migrants' risk perceptions.
- Include broader societal efforts which may have positive effects on migrants' health – such as recognition and inclusion of migrants resulting in better psychosocial circumstances for migrants.

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PICUM
PLATFORM FOR INTERNATIONAL COOPERATION ON UNDOCUMENTED MIGRANTS

PICUM

The mission of the Platform for International Cooperation on Undocumented Migrants is to promote respect for the human rights of undocumented migrants within Europe.
PICUM considers the following international treaties and conventions as basic values:
International Convention for the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW), Universal Declaration of Human Rights (UDHR), European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), Convention on the Rights of the Child (CRC), International Covenant on Economic, Social and Cultural Rights (ICESR), International Covenant on Civil and Political Rights (ICCPR), European Social Charter (ESC), Convention relating to the Status of Refugees, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).
The social rights of citizens as expressed in the constitutions of the national states involved will be taken into account as well.

Aim

The aim of PICUM is threefold:

1. To promote respect for the basic social rights (such as the right to health care, the right to shelter, the right to education and training, the right to a minimum subsistence, the right to family life, the right to moral and physical integrity, the right to legal aid, the right to organise and the right to fair labour conditions) of undocumented migrants
2. To promote regularisation of undocumented migrants
3. To promote respect for human rights and humane treatment during the process of involuntary return of undocumented migrants

Methods

PICUM seeks to achieve this aim by:

1. Gathering information on law and practice regarding social rights, detention and deportation of irregular immigrants, and the possibilities of regularisation of their residence.
2. Developing a centre of expertise in these fields with a view to providing the members of PICUM and other interested parties with expertise, advice and support.

3. Strengthening networking between organisations dealing with undocumented migrants in Europe.
4. Formulating recommendations for improving the legal and social position of these immigrants, in accordance with the national constitutions and international treaties. These recommendations are to be presented to the relevant authorities, to other organisations and to the public at large.

PICUM aims to promote the basic social rights of undocumented migrants, such as:

- the right to shelter
- the right to health care
- the right to fair labor conditions
- the right to organize
- the right to education and training
- the right to a minimum subsistence
- the right to family life
- the right to moral and physical integrity
- the right to legal aid

PICUM is a network of individuals supporting undocumented migrants in Europe. The individuals are PICUM's ordinary members and affiliated members in Austria, Belgium, Germany, Spain, France, Denmark, Italy, the Netherlands, Romania, Sweden, Serbia, Ireland, Switzerland, and the United Kingdom, as well as representatives of international organizations.

PICUM works as platform in different countries trough local organizations. We present here two cases of good practices; one case is PHAROS in the Netherlands and the other case is The Immigrant Support Unit, in Algeciras Cadiz Spain

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PHAROS, THE NETHERLANDS.

Introduction

In the Netherlands there are an estimated 125 to 225 thousand undocumented migrants (Leerkes et al. 2004). They are generally in a worse state of health than people with a residence permit. It is regulated by law that undocumented migrants should receive medically necessary care, even if they cannot pay for it themselves. In practice however it appears that their access to care still leaves much to be desired. The most important reason for this is the inadequate financing of this care and the lack of knowledge about the regulations on the part of the care providers and the target groups themselves.

Goals and Objectives

Pharos is a Dutch organisation specialised in the field of health care for refugees, asylum seekers, undocumented migrants and other migrants. Pharos' mission is to assist professionals and organisations that want to improve the provision of (health) care and services to refugees and migrants. To that end, we develop practically applicable knowledge and methodologies, which we pass on by offering information, training and advice. By doing so, Pharos strives to:

- improve the health of refugees and migrants (or to reduce health disadvantages)
- make the health care system more accessible to refugees and (undocumented) migrants

In order to change the inadequate financing and lack of knowledge concerning the care to undocumented migrants, Pharos has developed LAMPION. By its success it can be considered a good practice. Since two years now Pharos accommodates LAMPION, a national information and advisory point that was set up to provide information to care providers, undocumented migrants and their families. It also functions as a means of registration of impediments concerning the accessibility of care, and as a valuable tool towards policymakers.

Model

Pharos employs a multidisciplinary, integral approach. We seek co-operation with professionals and organisations within and beyond healthcare service providers (stakeholders), ranging from the level of implementation to policymaking; from general practitioners and physicians, nurses, mental health care professionals, social workers, outreach workers, primary and secondary education teachers to child welfare personnel, immigration and naturalisation officials and other government officials.

Pharos conveys her expertise both on a national and international level.

<u>The need for LAMPION</u>. Health care workers and volunteers are confronted with many health related problems of undocumented migrants. A number of organisations in this field, including Pharos, joint forces in 2004 and set up 'Lampion', a national information and advisory service (website and helpdesk) for the care of undocumented migrants. Pharos administers this service.

Health care workers, volunteers and undocumented migrants them-selves consult the Lampion helpdesk. Lampion provides information and advice and refers to relevant partner organisations when necessary.
Frequently asked questions (FAQ) regarding financial issues, juridical matters, housing and basic medical rights can be found on the website www.lampion.info.
For more complex questions one can address to the Lampion helpdesk, by phone or e-mail. Most questions concern financial issues in the health care for undocumented migrants and also the ones related to access to:

- hospital care
- care for pregnancy and delivery
- mental health care in general
- psychosocial care for children

The high number of questions that reached Lampion, confirms that there is a lack of information on health care issues of undocumented migrants. This implies that Lampion fulfils a need; it is a source of information for health care workers, volunteers and undocumented migrants.
Lampion also has an important role in asking attention for and notifying the authorities and other relevant parties on bottlenecks and trends in the access of health care for undocumented migrants.
Related to the signals coming from LAMPION Pharos decided to start other activities like:

Developing a medical file for undocumented migrants for the purpose of guaranteeing the proper handing over to other care providers and the continuity of the treatment, in co-operation with Doctors of the World and the University of Nijmegen

- Accommodating the secretariat of the Klazinga Committee (Commissie Klazinga). The Klazinga Committee consists of the representatives of medical professional groups (general practitioners, specialists, hospitals etc.). This committee works on clarification of the concept of medically necessary care and the development of handles and criteria for practical implementation of this concept.
- Organising meetings on the theme undocumented migrants and issuing publications about the care provided for undocumented migrants written by authoritative authors. One example of these is the publication by Van den Muijsenberg “Sick and no papers: Health care for people without valid residence papers” (Pharos, 2004).
- Exploring how care is provided for undocumented migrants in a number of Dutch municipalities. In addition, examining to what extent an integral approach concerning undocumented migrants is desirable. Extra attention will be paid to vulnerable groups, in particular to illegal children and illegal women.

Field or determinant

Pharos provides the following services:
prevention
information / education
identify bottlenecks and agenda-setting in the political arena in accessibility of care; bottlenecks & impediments
Referring to relevant organisations

Scope

Lampion is a formal co-operation between several national organisations. Members of the platform are the National Mental Health Organisation (GGZ Nederland) and the National Primary Healthcare Organisation (GGD Nederland), the General Practitioners Association (LHV), the SOA/AIDS organisation, the Dutch Council for Refugees, the Health Inspector General and *Koppelingsfonds* (A State-owned financial provision targeted at reimbursement of healthcare costs to undocumented migrants). A few other national organisations are also part of the platform and cooperate on demand.

Provider

Pharos accommodates LAMPION; is the provider of the services administered. Pharos is a non-governmental institution.

Resources

LAMPION in fact involves many different organisations. The service as a whole delivered by Pharos (see MODEL) is financed through public funding.

Management

Contacts by the LAMPION team (2 fte Pharos) with the organisations involved are formalized and regular. From the start of LAMPION, two years ago, a Steering Committee existing of the 10 collaborating organisations has the leading position. The Steering Committee met four times in 2006. Subjects discussed were:

- Incoming indicators concerning the consequences of the new healthcare insurance on undocumented migrants;
- developments within the group of undocumented migrants and the concerns about uninsured new EU-member state citizens
- the analysis of the recording data from LAMPION (notably the questions asked)
- consultation with MDM (the NGO Doctors of the World) concerning the development of ‘a medical passport’ for undocumented migrants
- correspondences with the Minister of Alien Affairs and the Minister of Public Health, and with the Healthcare Inspector-General.

Indicators

In how far the answer given to our clients (the users of the LAMPION-website or helpdesk) affects or satisfies their need is difficult to measure. The LAMPION-service delivered is sometimes a referral to one of the collaborating organisations. We need funding to be able to do an effect measurement.

Results

Enclosed is the LAMPION Annual Report 2006 - unfortunately only available in Dutch. Due to time-pressure it is impossible to arrange translation now. Table 1 is an overview of the frequent of web use by theme. Table 2 gives an overview of the clients, Table 3 their designated problems,

Table 4 the referrals to allied organisations and stakeholders and Table 5 is about the profile of the clients.

Conclusions

The experiences of Lampion show the importance of:

- providing information on the rights of undocumented migrants to hospitals, general practitioners, midwifes, social workers, schools, outpatient & ambulatory clinics;
- providing information to undocumented migrants on their rights to health care;
- providing information on the rights of health care for specific, vulnerable groups of undocumented migrants, e.g. pregnant women and children;
- monitoring bottlenecks and trends in the health care for undocumented migrants;
- informing and advising (health care) policy makers and authorities;
- Disseminating and sharing information amongst health care professionals and organisations.

Future

We want to know more about our clients. Questions can be asked anonymously so we know little neither about their background nor about the effect / result of their contact with LAMPION. We wish to know more about what exactly they need to know so we can anticipate better to the demands of our clients.

References

1. Lampion has be named by the State Secretary of Aliens Affairs, Ms Albayrak, during the parliamentary debate about the costs versus the need, accessibility, affordability and duty to provide for medical necessary care to undocumented migrants and other non-healthcare-assured citizens.
2. Lampion is mentioned in the press. The *Volkskrant*, a major newspaper in The Netherlands, for instance publicised in 2006 about LAMPION in relation to the need of healthcare to undocumented migrants and uninsured persons on the 25th of January, the 18th of July and the 5th of October.

Lessons learned

The high number of claims received by the *Koppelingsfonds* puts the system of reimbursement under pressure. An extension of the *Koppelingsfonds* or an adaptation of the existing arrangements with the different health care providers and institutions is currently part of the discussions between parliament and government. The data registered by LAMPION is serving in finding solutions.

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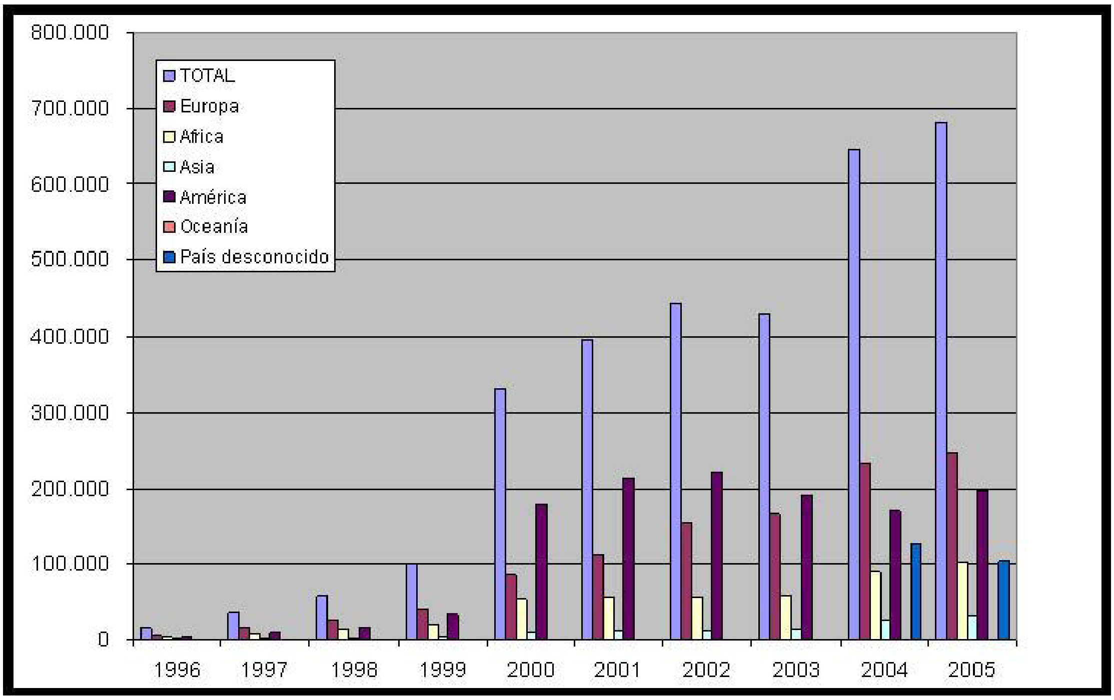
THE IMMIGRANT SUPPORT UNIT

AREA DE GESTION SANITARIA DEL CAMPO DE GIBALTRAR, ALGECIRAS CADIZ SPAIN

Introduction

1) Background information

Here in Spain, the experience of massive immigration is comparatively new. We have traditionally been among the migrant producer countries. But in the past few years, we have been experiencing the increase in the number of immigrants with "controlled" or "legal" residence in Spain, in addition to those of irregular entrance. The following chart clearly shows the growth of immigration in the last ten years.



Something is clearly changing its shape, and a response is necessary not only from the society, but from the health systems as well. Two initiatives in this sense have been "Migrant Friendly Hospitals", and "PICUM 's EU health care for UDM project", and our organization has been partner in both interesting experiences.

Firstly, in the Migrant Friendly Hospitals, we are among 12 hospitals from the entire EU, as a really wide network of hospitals with a great diversity in ownership, different local policies on diversity and health issues, different local populations.

Secondly, at PICUM's project, the network is as wide and diverse as the MFH, but including now not only health care providers, but health care policy makers, migrant advocacy groups and NGOs working in the field of provision of health care to these populations.

We find great similarities among partners since both projects are facing migration and health issues all over the EU: communication with migrants, issues of cultural diversity, lack of structures for migrant health care and lack of adequate patient information.

We are the Health Authority District of Campo de Gibraltar (AGS-Campo de Gibraltar), located at the very South of Spain where only 18 km separate us from the African shore.

Every year more than two million people cross the strait of Gibraltar from Spain to Morocco and backwards, especially during the summer months.
Some of those migrants are mainly workers and their families going to visit their relatives in Morocco.

Our hospital provides health care to undocumented migrants (UDM), right after they have entered irregularly our territory using our coast, or via the Algeciras harbour. A few years ago, our hospital attended to just these migrants, but later we starting getting those coming from central European countries, and nowadays they come from Spain as well. Also our health coverage area is changing from a transit area to a settlement one.

The answer to the question “Why did we get involved in those two projects regarding health care for migrant populations?” is evident. We are looking for solutions to the challenge of a growing diversity of populations in health care systems. We are convinced that our service must be sensitive to the demands of social forces, patient organisations, immigrant representatives, and clients since the service must be adapted to the population it serves.

We found during our experience in Hospital Punta de Europa –AGS Campo de Gibraltar- that equitable is not always equal. Even in the very –by comparison- friendly environment the Andalusian society represents for migrants, there are obstacles between the health care provider and the migrant customer and its social networks. These obstacles lay into one or more of these categories, which are closely linked: obstacles referred to language, to culture, to knowledge, or to organisation.

In the case of language barrier (verbal communication and/or information), the health system has to:

- Ensure that the health workers provide the patient and/or relatives with a complete and actual understanding of his/her pathology, the recommendations on how to deal with it, or how should it be best prevented.
- Accurately elicit from the patient information concerning his/her state of health, so that we can ensure that the client obtains a suitable or an appropriate response from the health care system.

Clinical communication must work –effectively- for both parties and in both directions, preserving the confidentiality of the information.

But cultural barriers are present there too. Do the patients know which their specific health needs are? The answer might be: “not always”.
We should make the reflection to ourselves of what happens when the healthcare provider and the patient have a different concept of health/disease. Some pathologies are not thought as a disease in some cultures. Lack of awareness among staff enhances this cultural barrier.

Staff must take into account that when experiencing a cross cultural encounter, some personal factors have an influence on patient care. And those personal factors prejudice both parties: patient and staff as well. Health services must be sensitive and respectful with cultural needs of the client if they want to be effective, and ensure adherence of the patient to treatment.

Staff must improve their knowledge of prevalent pathologies among migrant populations –imported and tropical disease, reactive or from adaptation, those of genetic basis- but has to know how to work with interpreters or with ethnic consultants/cultural mediators as well, what can be expected from them… and what not. And must be aware that there is a cultural dimension in every human encounter, and enhance the need of training in cultural diversity.

And they have to know –staff and clients- which resources are available for them in the system, to help both parties overcome the above mentioned barriers. We are using public money, are we are responsible of how and in what it is spent. And public money is a finite resource. Equity/equal access to health resources should be achieved having this in mind.
We are at he end talking about change, at very different levels, and change always generate stress, expectations and some degree of uncertainty, even fear, outside and inside the health system.

Goals and Objectives

- Accept the challenge of change
- Send a clear message to all stakeholders: "We care."
- Improve the quality of service to migrant and ethnic minority populations -and thus improve the quality of the whole service
- Integrate our hospital in European quality development networks
- Exchange experiences/expertise with other institutions and social actors in the field
- Collect and promote resources already in place that may not be widely known to all stakeholders.
- Reduce staff workload by reducing the stress of staff during cross-cultural encounters
- Increase conflict management skills of our staff
- Include cultural diversity as a dimension to be addressed by health care workers in their curriculum
- Develop systematic and permanent needs assessment/monitoring for our migrant clientele
- Increase the level of comfort of migrant clientele and staff
- Reduce malpractice possibilities
- Reduce the costs due to unnecessary complementary tests
- Reduce the average rate of hospital stay
- Reduce the number of unnecessary stays
- Systematically incorporate the views of health professionals, patients, patients' relatives, social networks and advocacy groups in planning healthcare services
- Address traditional topics from a multidisciplinary approach: medical, nursing, social work, administration, food services…
- Reinforce links between hospital and social actors
- Reinforce links between hospital and primary care services
- Acknowledge social actors' voices within the health system

Model

The Immigrant Support Unit -ISU-at AGS Campo de Gibraltar has been in our development plans since September '04, as a natural/logical follow up of our local Migrant Friendly hospitals project and as a container or focal point for every further migrant health-related activity. The unit is not designed to provide direct health care to migrants, since that it is a task already included in normal procedures in all public health care institutions in Andalusia.

The unit is aiming at research and analysis of inequities in access to health care for migrant populations in our coverage area, and development of improvement proposals that can help to eliminate those inequities, promote healthy lifestyles among migrant populations, and follow the recommendations contained in the Amsterdam Declaration, its design was developed and advised closely by the local focal person for the MFH and PICUM project as well, who also works as a head nurse in one of our hospitals.

The ISU is, since July '07, coordinated by a former local politician who is also a nurse. Among the staff there is a RN, who besides been an administrative with migrant background is a social worker.

Located in Algeciras, the unit work covers the topic of migration and health all over the AGS Campo de Gibraltar, and its staff moving down there has been of the problems facing nowadays and where improvements may be needed.

The Immigrant Support Unit is in the framework of the general policy of the Andalusian Public Health Service (SSPA), and the Andalusian government, which is actively promoting the integration of migrant communities in Andalusia.

In the issue of the health care, in which Andalusia has full competencies, migrant populations have access to the same level of care as that of the local population. In case of irregular stay in our territory, the UDM can obtain a special card that provides him/her with full access to health care for a period of six months and the card is renewable.

Migrant pregnant women and migrant minors have full access to health care in the SSPA.

Of course, all emergency care is guaranteed at the SSPA and covered free of charge for the migrant patient, regardless the administrative status. A lot of multilanguage documentation has been produced by the Consejeria de Salud (Andalusian ministry of Health), in order to reinforce the integration of these communities in our health care system: portable clinical history, informed consent, brochures on prevention of STDs & AIDS, the morning-after pill, multilanguage clinical interview sheet, rights of women in Andalusia, guide for healthcare to migrants, the charter of rights and duties in the Andalusian Public Health System, etc.

Many of these documents can be downloaded from:

http://www.sas.junta-andalucia.es/principal/documentosAcc.asp?pagina=gr_cartaderechosydeberes

http://www.sas.juntaandalucia.es/library/plantillas/externa.asp?pag=

http://www.juntadeandalucia.es/salud&url_ex=1

http://www.cgob.juntaandalucia.es/gobernacion/opencms/portal/PoliticasMigratorias/Publicaciones/2plandeinmigracion?entrada=tematica&tematica=63

While some of these documents, such as the "multilanguage informed consent" and the "multilanguage charter of rights and duties" were created directly at Hospital Punta de Europa –customer support unit-, most have been produced under the umbrella of the agreement on health care for migrants in Andalusia, signed up among Consejeria de Salud, worker unions, NGOs, which started at the end of the 1990s and has been changing and improving Andalusian plans for Migration which we use today.

Field or determinant

Health promotion, equity, accessibility, cultural diversity, cultural competency, undocumented migrants, prevention, prenatal health care, unaccompanied minors are some of the fields involved in practice.

Scope of the model

The Immigrant Support Unit is a local implementation at the AGS Campo de Gibraltar. It is a part of the implementation of the Andalusian plan for migration 2005-2009 in the province of Cadiz. So, it is a local activity integrated in the regional framework of the Andalusian Plan for Immigration 2005-2009.

Provider

Our unit is integrated in a public ownership health service, the Andalusian Public Health System (SSPA), and has a policy of full equality in access to our public service, ensuring free health care to all people, including undocumented migrants.

Through other public organisations like Foundation "Progreso y Salud", and different agreements with worker unions and NGO's, Andalusia has been making a serious effort to integrate migrant communities and improve their health status, and they are clearly stated in the "II Plan Integral para la Inmigracion en Andalucia" and the "Estatuto de la Comunidad Autonoma de Andalucia".

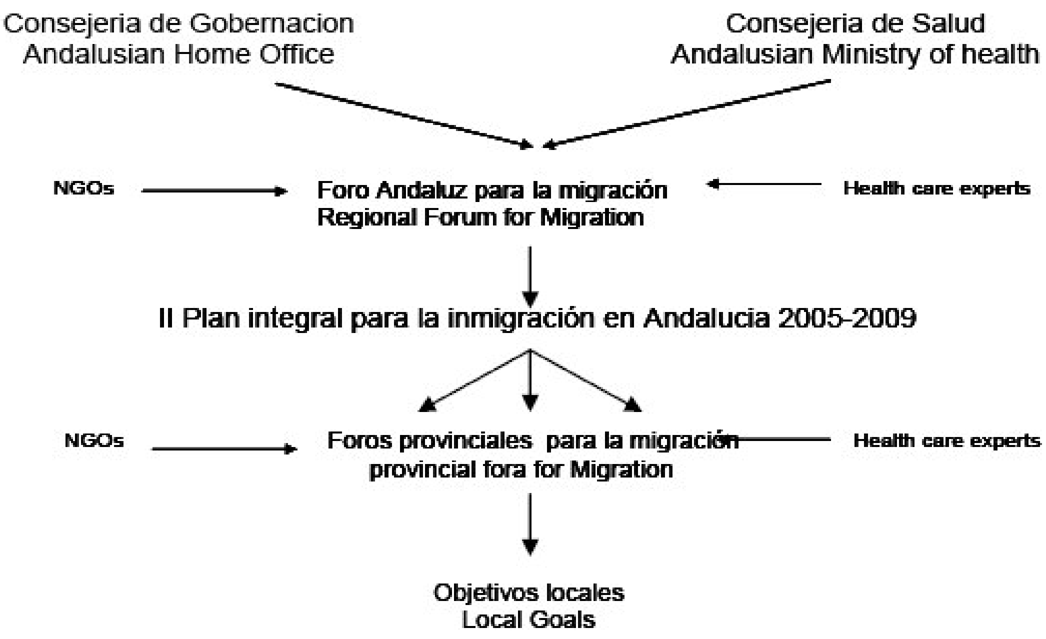
Resources

AGS Campo de Gibraltar is integrated in the SSPA -Andalusian Public Health System- and is fully covered with public budget, collected via taxes.

However, due to our geographical location, among one of the EU borders, some EU additional funding are obtained for some specific purpose -e.g. the OPE (Operación Paso del Estrecho, a series facilities and staff to support migrant workers and their families during their return in holidays to Morocco through the Strait Of Gibraltar).

Management

Decisions are made according to the general policy of the SSPA on the field of migration and health.

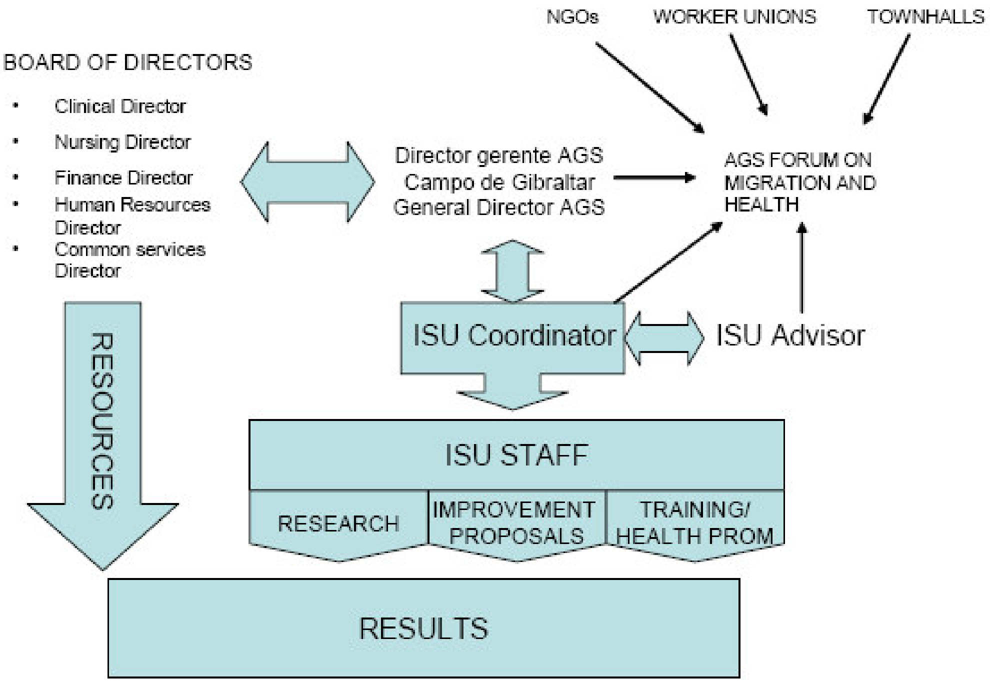


A general plan is designed -in co-operation among Andalusia government, NGOs, workers unions, health care providers, social workers, different governmental departments... (for a period of around four-five years, which is common and the reference for the whole Andalusia Community) the "Plan Integral para la Inmigracion en Andalucía", of which we are now implementing the second edition (the first one was 2001-2004 and the second one is for the period 2005-2009).

There are different units with similar internal composition in all the provinces of Andalucía, this can be seen if we take a closer look to the local perspective in the development of the plan and the accomplishment of the different goals. As not all the provinces are facing the same challenges, not all the provinces have the same goals.

We, at the AGS Campo de Gibraltar, go one step forward with our Immigrant Support Unit, and repeat again the matrix at the very local level, so we have an advisory board for the ISU which is a local forum with representatives from our hospitals, our health care centers, local NGOs, worker unions, and town halls from our coverage area. Final decisions are of course responsibility of the SSPA, which means the AGS Campo de Gibraltar and the staff of the Immigrant Support Unit.

All the decisions are implemented using the normal/routine resources available in the SSPA. Direct healthcare for migrant populations is always provided into the normal/routine procedures. New procedures or routines are created only when necessary:



We are not intending to create a parallel health care system for migrants, on the contrary, we are convinced that the health care for migrant populations has to be fully integrated and be provided into the same networks as that for the rest of our population.

Indicators

-MFQQ-D: the Migrant Friendliness Quality Questionnaire
-CCCTQ-PRE Clinical Cultural Competency Training Questionnaire
-CCCTEQ-POST Clinical Cultural Competency Training Evaluation Questionnaire
-Reporting Template: EU Health Care for UDM

The first three documents, as well as evaluation results (baseline, and after initial implementation of measures) are available for download in several EU languages at ***www.mfh-eu.net*** .

The reporting template is a document produced at the EU Health Care for UDM PICUM's project, available from PICUM.

Conclusions

Health care institutions are in fact living organisms, made of people, and it is these people what defines the institutions and the society they live in. Societies are in permanent change, and health services must evolve together with them. Diversity implies that there are disparities among us – and similarities as well.

Some of the disparities that exist, however, make certain groups of people more vulnerable than others. In the framework of this ISU the relevant disparities have to do with health status, health literacy, and access to health resources.

Migrant-Friendly Hospitals and the PICUM *EU Health Care for UDM* project have been examples of how we can respond and what kinds of responses we need in order to honour our commitment as health care providers to the populations we serve. Speaking about migration, cultural diversity and health care, we are addressing larger issues of demography, politics, economy, etc.

As we set out on this path, we begin a discourse on the human and absolutely personal dimension. A clinical encounter with the patient and his/her relatives is in the end a personal interaction between people.

As health workers, we often play one particular role in this dialogue. The directions we take and the progress we make in this relationship depends to a great extent on our professional skills to accurately assess the complexity of each individual's needs, obtaining and producing feedback, and communicating in an effective way.

A more person-focused way of delivering our health services, being more aware of the existing disparities – and similarities – among individuals as well as of our own prejudices and stereotyping will be an important tool for improving our clinical and personal performance.

But the improvements have to be present in the organisations as well: linking our health institutions more closely to the communities we serve; giving the real owners a voice inside the system and a way to improve it; providing the necessary human and material resources to make the changes real and to support them; assessing or monitoring client needs; appropriately addressing complaints; developing sensible and adequate professional and non-professional educational programs. All of these will be measures we can improve not only the state of health of the communities we serve, but also the level of comfort of professionals and the use that both groups make of health resources.

We have been working in the framework of projects aiming at the integration of migrant populations in health-related issues. By doing so, we have already improved the quality of service that we are offering to our migrant clientele in our health authority district and have focused on the equality and adequacy of the health services provided to our customers.

Our task with this ISU is now to go further in the long run of improving migrant populations' access to our public and free health resources here in Andalusia. All the improvements that have been made with the aim of reaching equality in immigrants' and ethnic minorities' health status are, in the end, returned as benefits to the whole population.

Realising the concepts developed in the Amsterdam Declaration in our daily practice will prove beneficial regardless of what origin or ethnic group is or which the target population is. This implies that by developing a migrant-friendly health care service, we obtain a really positive collateral effect: in fact, we are developing a friendly health care service, and perhaps friendly societies.

Future

Interpreting: most of the work now focuses on the line of providing our staff and our patients with safe, confident systems to communicate in a clinical setting, preserving the confidentiality of the clinical information. A mobile telephone interpreting service is already in place, available 24 hours a day and 7 days a week. A software-based clinical translation system is about to be introduced in the following months in our health care authority district using our intranet, in a evaluation and improvement project in which we will co-operate again with several hospitals and other health care providers all over the EU.

Training: cultural diversity issues and language courses are already on normal programs of our CPE department, but even more will be produced by agreements with local NGOs, professional organisations like the College of Nursing (Colegio de Enfermeria) in Cadiz, and other government departments working on the field of migration. But training must not be only for staff, patients and relatives need training as well, available in a language they can understand and being respectful with their cultural beliefs: diabetes, mother and child – multilanguage guides for migrant mother are already on production- , prevention of STD, unwanted pregnancy…

Monitoring of our migrant clientele: This is a very sensitive issue, so we are planning it for a long term, and in a very careful way. We need to have a database, not only of the demography of our migrant population, but a more precise description of who is our migrant customer; an updated profile of the kind of resources demanded from us, where and when, so we can respond adequately to this demand providing human, material, and knowledge resources where and when needed.

Networking: keeping clean communication channels with our local NGOs, other governmental departments in the field of migration and health, local politicians, other health care, educational, or research institutions. The local forum on migration and health must become a powerful feedback instrument and a way to share knowledge and expertise.

Lessons learned

Look for previous work

NGOs, workers unions, public organisations in the field of cultural diversity, and for your local policies on diversity and health.

We are not working alone. Our hospital is integrated in a public ownership health service, which has already a policy of equality in access to our public service, which ensures a free health care to all people, even in the case of irregular entrance to our country.

It is important to underline that within their limitations, health organisations must provide the necessary human, material and knowledge resources to ensure an adequate provision of service. The provision of service must be based on normal procedures, a model not based in charity or other parallel systems, but on the respect to a citizen's or client's rights.

Equitable is not always equal

Services must meet the needs of patient in very different areas. Different needs require different response. Migrant populations are not homogeneous, so do not make the mistake of going from one stereotype into another. Not all the migrant populations are facing the same challenges. Populations are moving in different geographical contexts, their administrative situations may be different, as with their economic situation, demography, geographical distribution as well. There are no "magic recipes" in store, as we should then go from one stereotype into another. You must always address the issue from your local perspective, tailoring to your local situation.

Develop your response addressing the specific needs of stakeholders - which is patients, its social networks, relatives, staff and managers of the health care organization and the organization itself- and integrate it into the existing local policies dealing with diversity and health.

Learn where you are

In the framework of the MFH experience an evaluation tool was developed, that can provide you with an overview of where your organization is, towards where you are moving, and in what magnitude -the Migrant Friendliness Quality Questionnaire (MFQQ-D) – towards a culturally competent organization.

Learn from the experiences of patients, of other health care organizations, of staff, from expertise networks, from advocacy groups or other institutions working in the field of migration and health

Include cultural diversity as a topic to be addressed

Cultural diversity should be addressed in medical and nursing academic curriculum and in CPE routine as well. The health services should focus on integrity, on the complexity of the total needs of the individual as a whole person.

Overcome the barriers

1. Between hospital and social networks, as the cultural background of the patient is another dimension to be met by the health care provider. Social and cultural networks may be used to strengthen community action.

One option is that of hiring a cultural mediator or an ethnic consultant, or contacting the leaders of the communities. They may well play the role of a link between the communities and the health system.

2. Between primary care and hospital level. The hospital is usually a transition step. The patient will eventually go back to his/her social environment, out of reach of the hospital.

3. Among hospital services avoid idle resources, due to a lack of awareness of resources available.

Look for an organisational change

Little can be achieved if the changes introduced do not consolidate in the organisation. Sustainability is guaranteed only if organisational support is achieved as well, and the directive levels are brought onboard of this experience.

Develop partnership strategies

Our societies are interrelated; health care cannot be an exception to this asseveration. The health cannot be ensured by the health care sector alone. The actions must be co-ordinated with other social forces: NGOs, governments, advocacy groups, local authorities, media…

Develop a supporting group

Create a multidisciplinary group (with physicians, nurses, social workers, staff representatives, directive representatives, migrant representatives, worker unions…) champions of change aiming at

- putting the cultural diversity issues up in the hospital organisation agenda.
- monitoring, promoting and expanding the areas of improvement on cultural diversity
- conduct satisfaction surveys
- integrating/coordinating the activities of hospital/primary care/ NGOs and other organisations in the field.

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COUNTRY CASES

Medimmigrant

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS: THE BELGIUM SYSTEM

Introduction

Art. 57 § 2 of the Belgian Organic Law on the Centre of Social Welfare (CSWF) of 8 July 1976 provides that undocumented migrants have the right to 'Urgent Medical Help'. The Royal decree of 12 December 1996 further specifies that 'urgent medical help' includes preventative and curative care, ambulatory care and hospitalisations. 'The Royal Decree was put into effect on the 10th of January 1997.

Content of Urgent Medical Help

The terminology used has brought confusion. The word "urgent" gives the impression that only accurate or emergency cases are taken into account. However, the concept is much broader and it encompasses a wide variety of care provisions: medical examination, operation, childbirth, physiotherapy, medication, test and exams etc. Exceptions are some medical materials, dental prosthesis, etc. as well as some types of medicines.[i] In an official document, the administration explains that it is included even "the assistance that it is necessary to avoid a health situation that is dangerous for a person or his/her circle"[ii].

Explanation of the procedure

There are four actors involved: the Centre of Social Welfare (CSWF), the medical care provider, the ministry of Social Integration and of course the undocumented migrant himself.
The Social Welfare Centres are public services that you can find in every commune. For certain categories of people who ask support to the CSWF they get money from the government. They have a high degree of autonomy in the implementation of the procedure of Urgent Medical Help.

a-) General rule

The undocumented migrant takes contact with the Centre for Social Welfare (CSWF) of the actual place of residence in advance to obtain an agreement of pay for the future care he needs. The CSWF starts a social inquiry and will check by way of a house visit if the undocumented migrant lives on their territory, if the person concerned has insufficient financial means and if the person concerned lives illegally on the territory. This social inquiry is not exclusively for this procedure but set up by the CSWF after every demand of support.

The person concerned has to provide to the CSWF a certificate filled in by a doctor that mentions the words ‘urgent medical help’ and the medical care he needs in the future. This certificate is required by the ministry of social integration for the repayment of the costs to the CSWF. Some CSWF have the good practice to orientate the person concerned directly to a health care provider with who they have an agreement. In that case, the health care provider sends the attestation of Urgent Medical Help as quick as possible to the CSWF. Other CSWF demands the attestation of urgent medical help before they start the social inquiry and before they agree to pay the medical costs.

The social welfare centre has to make a decision in thirty days about if they agree on paying or not medical assistance. They will also specify if the validity of the document is just for one consultation or for a longer but determined period of time. A negative decision can be challenged before the labour court.

The CPAS will pay the health care provider and will get reimbursed by the ministry of social integration. The CSWF has to inform the ministry before 45 days after the positive decision in order to be reimbursed.

b-) Exceptional procedure

If the situation of the undocumented person is like that that he needs medical assistance he can go directly to the hospital. He has to inform the care provider or social assistant that he is not allied to any public health insurance and that he does not dispose of sufficient financial means to pay the bill. In these situations, the health care provider (or social service) in the hospital shall do a small inquiry and issue the attestation of ‘urgent medical help’ which will be sent to the competent CSWF which in most cases is the CSWF located in the hospital area. This CSWF shall base themselves on the information given by the hospital to fulfil there social enquiry. The CSWF has to inform the ministry before 45 days after the provided medical help so the care provider has to inform the CSWF even faster.

Some difficulties in according to the procedure

The Social Welfare Centres have a high degree of autonomy in the implementation of the applicable legislation to the extent that there is not a sole procedure to get “urgent medical help” but different ones.
Care providers and undocumented migrants are not always aware of the existence of a law on ‘urgent medical help’ or are encouraged by the administration of the procedure. Some other problems arise from the fact that the term “urgent” is not defined.

Conclusion

Indeed, the procedure to access health care takes sometimes long and has numerous steps and is not the ideal way to have access to health care. But due to this, a lot of undocumented migrants are helped and not forced to use some other methods to obtain health care. It is up to the government, NGO’s and local authorities to ameliorate this procedure or to find new ways to establish efficient access to health care.

Good Practice from an NGO

The organisation ***Medimmigrant***[1] seeks to have the right to health care for undocumented migrants and people with a precarious residence status embedded in the legislation and have it concretely implemented by social services and other public institutions.

Besides providing information about entitlements to access health care, *Medimmigrant* actively mediates to speed up the procedure to access health care. Their assistance is specifically addressed to residents or organisations located in the Brussels Capital Region.

Medimmigrant also works at structural level. To this aim, it takes part of numerous platforms and initiatives at national level and makes regular recommendations to the government in the field of access to health care with the aim of achieving better implementation of the law as well as of raising awareness amongst the different stakeholders. Part of this work also focuses on stay permits on medical reasons. This organisation is committed to uphold the right to stay and the right to social services for people who are unable to return to their country of origin as a result of their illness. It also lobbies for the establishment of a European medical database with information covering the accessibility and availability of necessary treatments and medicines in the countries of origin.

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[1] We refer to a constantly changinglist established by the National Institute for Health and Disability Insurance (*INAMI-Institut national d’assurance maladie-invalidité).* Nonetheless, the Centre of Social Welfare who has a big role to play in this procedure is always free to go beyond and assume the extra cost for those care services not comprised within this list.

[1] “Même l’aide nécessaire pour éviter une situation médicale dangereuse pour une personne ou son entourage relève de l’aide médicale urgente. See *Circulaire* of 20 May 1997 clarifying the Royal Order on urgent medical assistance.

[1] This contribution is based on a text written by Picum (www.picum.org).

MINISTRY OF
SOCIAL AFFAIRS AND HEALTH
Finland

INTERPRETING SERVICES FOR IMMIGRANTS USING HEALTH SERVICES IN FINLAND

By Satu Koskenkorva, Ministry of Social Affairs and Health, Finland

Introduction – General background information

The foreign population in Finland is still small compared with many other European countries, about 2.2 per cent of the total population (ca 120,000 people). About 20,800 people have arrived in the country for refugee reasons, and the Ingermanland Finns (return migrants) from the former Soviet Union number approximately 25,000. People have also immigrated to Finland through marriage, for work or studies.

Within the Finnish public health service system, health care services directed to immigrants are integrated into the ordinary health services. Under the Primary Health Care Act, the municipal authorities are responsible for organizing health care services. In cities and larger municipalities, private health care services are also available. Each resident in the county has the right to public health care offered by the county health centers. For example, general practice, health counseling, nursing, rehabilitation services, mental health services, ambulance service and school health care are all part of this basic health care system. In larger cities and municipalities - where the majority of immigrants are living - there are separate service units for immigrants. Health care professionals expressly specialized in immigrants' health care needs are working in these units. The municipalities use different methods for informing immigrants about health care services: they provide information brochures and web-sites in different languages, hot-lines for health care related questions and/or information centers for immigrants.

National instructions for health service providers - for example maternity health care/prenatal clinics, child health clinics, school health care and student health care - include a separate chapter on the needs of immigrant families. The basic principle is that health care professionals should get acquainted with the different cultures immigrants come from, and that clients' and families' cultural and individual features are taken into account. The principle is to reserve more time for them than for average Finnish families, in order to get

sufficiently acquainted with the clients' culture, to adopt an individual approach and to have courage to ask the client how things would be done in their own culture in a similar situation.
For immigrants using health services there are interpreter services available. They are particularly recommended in the beginning of the immigrant's stay or when the situation involves serious diseases. The interpreters should be professional, not family members, relatives or friends.

Goals and Objectives

The aim of interpreting and translation services is to ensure immigrants - as users of public services provided by society - a status equal to the majority population. Since the basic goal is that immigrants should learn enough Finnish or Swedish as soon as possible in order to be able to use services independently, the Ministry of Labour recommends that interpreter services should be provided mainly at the initial stage. There are, however, persons among immigrants/refugees whose capacity to learn the local language(s) is reduced due to a disability, long-term illness or mental illness. Some refugee groups, such as mothers taking care of their young children at home, have reduced opportunities to study a new language. The recommendation is that these groups should be offered interpreter services for a longer time. There is no time limit set for the reimbursement of the costs by the state.

Field or determinant

Interpretation is offered for all health care and prevention services when needed.

Scope

The scope of the practice is national covering the entire country. All municipalities in Finland are obliged to provide interpretation services to refugees and immigrants staying in the municipality.

Provider

The integration of immigrants and reception of asylum seekers is the responsibility of the Ministry of Labor and its area of administration. Practical integration is done in the municipalities. The work is palled together with employment offices, and integration plans for immigrants in working age are done there. Organizing and providing interpreting services for refugees and other immigrants are the responsibility of the place of residence (municipality).

Model

There are several legal acts that give immigrants the right to interpreting services, when he/she is using health and social care services in Finland (Administrative Procedure Act, Non-Discrimination Act see annex). The Act on the Status and Rights of Patients (1992/785, section 3) says that "The mother tongue of the patient, his/her individual needs and culture have to be taken into account according to possibilities in his/her medical care and other treatment".

The system was developed as the need for interpretation gradually increased. Ministries have given the municipalities, which are responsible for the implementation, instructions on how to provide the services. For refugees and asylums seekers the financing comes from the state, in case of other immigrants from the municipalities. Act on the Integration of Immigrants and Reception of Asylum Seekers (1999/439, amended 2002/118, section 19) lists interpretation services as one service amongst others that are provided to the refugees and asylum seekers. Reimbursement of these services to the municipalities by the state is regulated by an act. Interpreting as such is not a subjective right to anyone else but deaf persons. Interpreting services

Based on several legal acts both health care personnel and customers have a right to request interpreting services when they think it is necessary to guarantee the quality of the service. When an immigrant has his/her first contact with the municipalities' health services, the authorities will make a note in his personal file whether interpretation is required in the future. This is done in order to notify other health care personnel to reserve an interpreter for when meeting that customer. Also for example a referral to a doctor should include a request for interpreting services.

The need for community interpreting in languages that are spoken only by a small number of people, increased once the reception of quota refugees became established in the mid-1980s. From the beginning of the 90's, the number of asylum seekers in Finland began to grow. Interpreters were sought from among refugees who had arrived earlier in the country and who already had had time to learn the local language(s).

The first interpreter centre was set up in the beginning of the 1990s. The centre was run as a commercial enterprise and its services were acquired under a contract of purchase. The aim of this operation was to provide interpreting and translation services to all the municipalities having received refugees, as well as to the reception centers for asylum seekers.

The number of asylum seekers and refugees grew dramatically between 1992 and 1994, as did the need for interpreter services. The need also increased due to the re-immigration of Ingermanland Finns from the former Soviet Union. Regional interpreter centers were developed in order to produce the extra interpreting and translation services. The services developed to include different forms of distance interpreting (telephone and on-screen interpreting) in addition to traditional on-the-spot face-to-face interpreting. The new methods allow scarce interpreter resources to be put to the best use. At present, there are a total of eight regional interpreter centers in Finland. Local authorities maintain regional interpreter centers. Normally the largest town in a region is responsible for running the centre, and it provides services to a geographical area with appropriate means of communication.

In addition to the interpreter services provided by the public sector, several private persons – some of them immigrants – have set up interpreter and translation service enterprises that provide language services in languages spoken by refugees, and there are also a great number of freelance interpreters in the field.

Resources

The state only finances interpreting and translation services to immigrants with refugee status and to Ingermanland Finns from the former Soviet Union, and only for use by social welfare and health departments and for familiarization during the initial stage of immigration. Those municipalities having organized language services may apply for compensation for interpreting and translation from the state, irrespective of whether the service has been purchased from an public sector interpreter centre or from a private enterprise. The relevant regional Employment and Economic Development Centre pays for the services.

The municipality is responsible for organizing and compensating interpreting services to all other immigrants living in the municipality area. They have to include the costs for interpreting services in their yearly budgets.

Management

Every municipality sets out the amount invested in interpretation services in its yearly budget. The interpretation centers are municipal, and thus the management procedures are equal to and part of municipal decision-making. Private companies follow normal company law and procedures.

Indicators

The Ministry of Labor has compiled statistics on the number of hours of interpreting and translated pages, as well as the number of users of services since 1995. Unfortunately there are no separate statistics on how much of the services are used by the health care sector. In general, the numbers of users and the need for interpretation is increasing.

Regional interpreting centers gave 123 127 hours of interpreting services in 2006, out of which 32,3 % was used by the health sector. In addition they produced 11 420 pages of translations (4,5 % for the health sector). Municipalities have also bought services from the private sector, but the amount is considerably less than services provided by the regional centers.

Results

There are no comprehensive studies available on the use of interpreter services, but the increased use of the services as such, and the feedback received by health care professionals, indicates how the situation has developed.

For this report we got feedback from the officials in the Citizen Service Center of the city of Vantaa[1]. The officials of the center underlined that using interpreting services is fundamental for patients' rights and for the correct transfer of information and good quality of care. The use of interpreters has increased also due to a better awareness by health care professionals of their right to request interpreting services when they have difficulties to communicate with a customer.

Conclusions

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[1] Vantaa is 4th largest city in Finland, it is situated in the metropolitan area of Helsinki, and its Citizens Service Centre is a center for immigrant's information.

Public regional interpreting centers and private enterprises offer interpreting services. Health care professionals, other officials and customers can make a request for interpreting services when the feel it is necessary. The state covers the costs for refugees and asylum seekers; for all other immigrants the municipalities are responsible for the costs.

Interpreting services are indispensable for guaranteeing patients' rights and good quality services. The need of interpreting services has been, and is increasing in Finland.

There is still no research available on the use of interpreting services in the health sector.

Future

Although interpreter services have developed favorably, much remains to be done. Interpreter services are provided for all immigrants, but most assuredly for those with refugee status, since the organizer is compensated by the state. Financing of interpreting services for other immigrants depends on each individual municipality's will and ability to reserve funds for the services in its yearly budget. Therefore different groups of immigrants may be in an unequal position in regard to interpreting and translation services. The capacity of service providers to organize and finance interpreter services varies. Lack of money is often referred to when an interpreter is not engaged, and relatives, family members, and even children of clients may be used as interpreters.

According to the experience from interpreter centers, one of the most problematic areas is health service. Health care issues are often very intimate and culturally colored. Interpreting is sometimes needed also for the culture and not only for the language.

In order to ensure services in native languages, a greater number of employees with immigrant background should be employed in different service sectors, in particular in health care. Interpreter services should be used primarily at the initial stage of immigration and in particularly difficult situations of communication.

At present Finland does not have a permanent training system for immigrants arriving from outside Europe, who are interested in the occupation of community interpreter but lack the basic education required for university studies. Actual interpreter training is only available at universities. The one-year interpreter courses organized at present, mainly in the form of adult education, are too short, and they limit the choice of students. The occupational title of an interpreter in not protected by law, so anyone may call him/herself an interpreter and give interpreter services.

An example

Helsinki District Community Interpreting Centre
E-mail: tulkkikeskus@vantaa.fi
Home site: http//www.vantaa.fi/tulkki

The Helsinki Region Interpreting Centre offers services for authorities that deal with foreigners. In addition to translation services and interpreting at settings, they offer telephone and on-screen translating services. They provide services in emergency cases also outside regular office-hours, during evenings and weekends. The centre provides tailor-made and customized intercultural communication trainings for its customers (the authorities and the immigrants).

References

Instructions of the Ministry of Labour (in Finnish and Swedish) www.mol.fi/migration
Instructions for authorities (in Finnish and Swedish) www.mol.fi/migration
Instructions for immigrants (in several languages) www.mol.fi/migration
Quality handbook for municipal interpreter centers (in Finnish) www.mol.fi/migration
Codes of Ethics (SKTL) www.sktl.net

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Legislation regulating the interpretation and health services for immigrants

- Administrative Procedure Act (2003/434, sections 13, 26, 69) that includes provisions on confidentially obligation for representatives and assistants, interpreting and translation, as well as on breach of the confidentiality obligation;
- Administrative Judicial Procedure Act (1996/586, section 77) that deals with interpreting and translation;
- Aliens Act (2004/301, section 10, 203) that deals with the use of interpreters and translators and interpreting and translation;
- Act on Pre-trial Investigation (1987/449, section 37);
- Act on the Status and Rights of Patients (1992/785, section 5) that deals with the patients' right of access to information;
- Act on the Status and Rights of Social Welfare Clients (812/2000, section 5) that deals with the clients' right to obtain information on the different measures that can be applied in their case;
- Act on the Integration of Immigrants and Reception of Asylum Seekers (1999/439, amended 2002/118, section 19) that deals with the content of reception;
- Government Decision on refugees and certain other immigrants and on compensation of the costs of organizing reception for asylum seekers (1999/512).
- There are references to interpreting and translation and to confidentiality obligation in the Penal Code, the Language Act and the Services and Assistance for the Disabled Act and Decree.
- Non-Discrimination Act entered into force in 2004 laying down provisions that the relevant authorities shall prepare a non-discrimination plan to promote ethnic equality. The plan shall include measures to ensure ethnic minorities and immigrants an equitable access to the services planned, guided and produced by authorities. Such measures are, for instance, interpreter services, brochures and other information in different languages, services in the own language and development of electronic communication and information.

Liberté • Égalité • Fraternité
RÉPUBLIQUE FRANÇAISE

MINISTÈRE DE LA SANTÉ,
DE LA JEUNESSE
ET DES SPORTS

STOP FEMALE SEXUAL MUTILATIONS IN FRANCE AN INTERDEPARTMENTAL AND MULTIDISCIPLINARY MOBILISATION

Introduction

1. Female sexual mutilations: an old but still topical issue, as revealed by the figures.

According to the estimations of February 2006 made by the UNICEF, 130 million young girls and women throughout the world have suffered from a sexual mutilation and each year 3 million young girls are or could be subjected to this practice.
According to the WHO, 5% of the excised women and young girls, which represents 5 to 7 millions, live in northern countries where they have immigrated: European countries such as Germany, Belgium, France, Great Britain, Sweden, Switzerland but also Canada, United States and Australia.
In France, in 2002, according to the Group for sexual mutilations abolition (GAMS), 60 000 women and young girls would or could be mutilated. 9 French regions are mostly concerned by that issue (see appendix 1). The populations from Senegal, Mali, Ivory Coast and Mauritania are the most numerous but others come from Benin, Central African Republic, Egypt, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Nigeria, Uganda, Sierra Leone, Somalia, Tanzania, Chad and Togo.

2. Female sexual mutilations: an infringement of the human fundamental right to physical integrity but also a health challenge.

In 2002, The World Health Organisation expressed in its report on violence and health 9 recommendations to avert violence. The first one invited the States to “elaborate and implement a national action plan against violence, and follow its enforcement”. This recommendation has fully found its place in France in the law dated 9th of August 2004 on public health policy, which has decided on 5 strategic plans among which a plan aiming at limiting the health impact of violence.

The works preliminary to the elaboration of that plan have admitted the importance of the female sexual mutilations theme as a real public health challenge and expressed recommendations aiming at destroying them in France by 2010.
The experts from the Commission in charge of focusing their thought on the relations between violence and gender, have both noted the important progresses made where these efforts were expended (because it is not a new topic) and emphasized we had to remain on the look-out.

Today, actually, neither the human rights defenders, nor the public health actors just find out the existence of these practices and their consequences on health or even on life for the victims.
In France, the raising of this issue dates from about thirty years when the immigrated workers' spouses coming from Sub-Saharan Africa started settling on the territory in the context of the family reunification. As from that period, in parallel to the judicial settlement of excision cases and to the legal proceedings of excisors and excised young girls' parents, African and French women join forces against female sexual mutilations focussing on raising concerned populations' awareness on the risk for life and on the excision practice's consequences on women and future child's health.
Today, thanks to the combination of the effects of the law assertion and enforcement and of the associations and professionals' constantly renewed educational work, the excision practice on the French soil has undoubtedly receded, although it has not disappeared. It is even to be feared that it has put up with the French law, in some way, considering that the excision that is condemned on the territory can be carried out during holidays in the country of origin.
In addition, new migrants, coming from countries where female sexual mutilations are carried out, land on the territory and settle in regions where these practices' effects were seldom or even simply not observed. The health professionals, particularly gynaecologists, obstetricians and midwives are obviously more powerless than their colleagues who, having been treating excised or infibulated parturient for ten, twenty or even thirty years, have acquired certain know-how.

This context of both persistent female sexual mutilations and evolution of the issue has been the source of the Minister for Health's determination of reinforcing the actors already involved and mobilizing others, and elaborating an actions strategy aiming at fighting against any new mutilation in France.

Goals and objectives

Elaborating an actions strategy aiming at destroying the female sexual mutilations in France by 2012

Field or determinant

- Averting the appearance of new genital mutilations of young girls in France or during their stay in their family country of origin;
- Organising the support for women having been subjected to genital mutilations and proposing them an opportunity of surgical and psychological recovery.

Scope

An action developed on **two** levels: national and regional.

At the **national** level: through a mobilization:

- various ministerial departments concerned by that issue: ministries for health, women's rights, justice, home affairs, foreign affairs, tourism and education;
- national associations representing women coming from concerned communities, and intervening to them on that matter;
- health professionals through their professional organisations and learned societies.

At the **9 targeted regions** level, the same mobilization of actors identified at the national level has developed.

Provider

The action is boosted by the **Ministry for Health** but in association with:

- the health professionals (physicians, midwives, paediatric nurses, nurses, paediatric auxiliary nurses…);
- the social sector's professionals (social service's assistant, educators…);
- the specialised associations intervening to women (Group for female sexual mutilations abolition, French movement for family planning…);
- the health institutions (public and private sectors);
- the interveners within the legal, police forces, education, tourism…fields.

Model

A shared diagnosis at various levels:

- Interdepartmental
- Interprofessional
- Regions
- Associations representing the concerned publics

For a public health policy's definition

A will:

1. Elaborating an actions strategy that takes into account the needs of the main actors, which are:

    - the concerned publics;
    - the professionals facing the female sexual mutilations issue;
    - the professionals able to act before;

2. Elaborating an interdepartmental actions strategy;

3. Elaborating an operative actions strategy.

A strategy:

- defining the priorities of actions with the mentioned actors;
- defining the priorities on the basis of a diagnosis at the national level and further diagnosis at the 9 targeted regions level;
- strengthening the commitment of ministries already involved;
- including new ministries in the process.

A major issue:
- averting any condemnation towards the concerned populations.

A challenge:
- 9 months to mobilize.

The action:

A **national symposium** organised on that theme on the 4th of December 2006 in Paris.
This symposium aims at:

- boosting a process and a collective awareness on this public health issue;
- acknowledging the actions already started by the various actors;
- identifying the other European countries' practices;
- identifying the needs and expectations
- listing the proposals of measures to be included in the actions strategy for the fight against female sexual mutilations.

Regional symposiums organised in the 9 targeted regions between December 2006 and February 2007.
Their objectives:

- completing the diagnosis made at the national level;
- enriching the proposals of measures identified by the national symposium.

Resources

The Ministry of Health and Solidarities (Directorate General for Health) has provided the financing of the action.

Management

A pilot
The Ministry of Health and Solidarities, and the Directorate General for Health in particular.
Authorities for tendency and actions follow-up
At the national level:

- an interdepartmental piloting committee (*COPIL*) responsible for specifying the national symposium's content and elaborating the actions strategy;
- a coordination committee between the most directly concerned ministries in order to mutualise the actions already in course (Ministry of Health and Solidarities and Ministry responsible for Social Cohesion and Parity);
- a working group with the representatives of the 9 concerned regions in charge of the coordination of central and regional actions.

At the regional level:
- inter directions piloting committees

Indicators
- Number of mobilized ministries
- Number of European countries mobilized for the national symposium
- Number of participants in the national symposium
- Number of regions which have organised a symposium
- Number of participants in the regional symposium
- Part of the health professionals which have participated in the symposiums

Results

7 ministries
3 European countries: Norway, Spain and United Kingdom
400 participants in the national symposium
9 regional symposiums made between December 2006 and May 2007
3000 participants in the regional symposiums
70% of the participants are health professionals (midwives, obstetrician gynaecologists, paediatricians, nurses…)

Conclusions

This approach has allowed drawing the 4 main lines of an interdepartmental actions strategy:
- Better knowledge for better action;
- Prevention against any new sexual mutilations on young girls living in France;
- Improvement of the treatment for women having been subjected to female sexual mutilation;
- Development of cooperation at European and International level.

Future

This mobilization around a public health issue specific to certain migrant communities has allowed creating new institutional partnerships both with health and social professionals and associations representing women.
This process and the networks which have developed shall be beneficial for public health actions, more generally:
- in favour of women's health (policy on contraception, access to termination of pregnancy, fight against violence to women…);
- in favour of the migrants' health (prevention of tuberculosis, saturnism, cancers screenings…)
The Pays de Loire region has already relied on this network to start prevention actions against violence to women.

Lessons learned

Among the facilitator elements for this “practice” enforcement:

- an important political carriage that has allowed mobilizing the other ministries, despite the short time granted to organise the symposiums;
- the partners’ motivation (associations, professionals…);
- the whole actors’ straightaway association for the definition of objectives, particularly through the establishment of follow-up authorities (piloting committees);
- the permanent concern shared by the whole actors of averting any condemnations of the migrants.

Testimony - Women’s speech:

The COPIL has made a remarkable work. As a member, I saw it materialize and galvanize itself by one only conviction shared by all: we have to stop that.

Another positive point: African women felt they were understood in their pain without however being considered as victims, considering we have fully participated in the organisation and the running of this symposium.

Let’s make sure the action will not stop there, as millions of young girls and women rely on us.

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MINISTÈRE DE LA SANTÉ,
DE LA JEUNESSE
ET DES SPORTS

PUBLIC HEALTH MEDIATORS PROGRAMME TO FACILITATE ACCESS TO PREVENTION AND HEALTH CARE FOR PRECARIOUS POPULATION

Introduction

Certain social groups suffer from health inequalities and do not enough use the prevention and health care structures. Within those groups, we notice lots of migrant people, particularly because of their unfavourable economic and social situation.
Several mechanisms are at stake, which contribute to the difficulties to access the health system:

- Obstacles in the resort to health system, related to an individual or collective precarious situation;
- Various forms of ill communication between the sanitary institutions and people, or the fact that supply does not match demand and needs of this group's members;
- Sometimes, a combination between these two previous phenomenon, raising a mutual distrust between people on one hand, physicians, health care workers, social workers on the other hand.

It is proven that late access to prevention, screening and health care is ominous as regards the evolution of diseases and the success of treatments.

This gap in the access to prevention structures, screening and health care is shown by the epidemiological data and the various studies about African migrants and HIV/AIDS.

That is why, since the early 2000, the national French programme against HIV holds in its priorities the improvement of the access to prevention and early health care for strangers living in France, in order to reduce the observed gaps with the French population.

This is in this context that an experience of training and follow-up of mediators in public health has been launched.

Goals and objectives

Main objectives:

Making access to prevention and health care easier for precarious people through the intervention of specially trained mediators whose mission is to liaise between the health system and people or groups experiencing specific difficulties in the access to prevention and health care.

Secondary objectives:

- Conceiving a relevant training programme.
- Recruiting as participants:
  - People from diverse fragile communities or very close to them;
  - Health professionals, social workers intervening to these communities;
- Defining, with the associations, the local authorities and the concerned sanitary and social institutions, the public health missions the mediators will be vested with, while privileging the themes about STD-HIV and access to health care.
- Assuring the training of mediators in public health, the expected results of which are:
  - Knowledge acquisition and updating;
  - Relevant use of resources and references;
  - Consideration of the prevention;
  - The development of individual and collective mediation in the public health approach;
  - The realisation of a project with a "health" theme directed at a determined public.
- At the end of their training, the mediators lead the activities and interventions corresponding to the project and are subjected to a follow-up.

Model

This experimentation is based on the hypothesis that the intervention of health mediators, trained, recognized and very close to people usually excluded from the prevention and the access to early treatments, must allow reducing the social and cultural distance between health care workers and patients, and improving the resort to health care and screening for the most precarious people.

Therefore, this is a community health approach. It consists on allowing active people within those groups to acquire and use the necessary instruments to help all the group's members overcoming the obstacles as regards the access to health care and prevention. The identification of the resource people, their training and the support towards their action are some determinant elements.

Experimentation led between 2001 and 2005 with 150 mediators divided among 3 French regions.

Field or determinant

Prevention, screening, access to health care within the field of fight against HIV-AIDS.

Scope

Conception and piloting: national.
Implementation: regional and local.

Provider

IMEA – Institute for Medicine and Applied Epidemiology, an NGO linked to the Faculty of Medicine Xavier-Bichat (Paris).

Resources

- Ministry of Health (*DGS* – Directorate General for Health);
- Inter-ministerial delegation for urban policy;
- Health Insurance (social security).

The cost for a health mediator's training, lasting at least 250 hours, is assessed at 7,000 euros (excluding salary).

Management

Inter-ministerial national piloting committee, in conjunction with the concerned regions and the experimentation's carrier.

Indicators

a) Number of persons having attended a complete training (basic and continuing);
b) Number of persons in contact with a public health mediator;
c) Number of persons who have had a benefit in matter of health (screening, effective treatment…);
d) Number of professionals from the structure to which the mediator is responsible, who rallied around the health issue followed by the mediator;
e) Number of persons physically supported;
f) Number of activities or group participations;
g) Number of problems having required a mediator's intervention within the health structure to be settled.

Results

a) 150 trained mediators;
b) 66 persons per public health mediator in 1 month;
c) in average, 28 persons per mediator in 1 month;
d) 30 mediators answer "at least 1" in 1 month;
e) in average, 19 persons per mediator in 1 month;
f) in average, 9 per mediator in 1 month;

g) in average, 7 problems per mediator in 1 month.

Conclusions

The 1-month observation allows noticing that for an average of 30 persons per mediator, the mediator's intervention had a direct effect:
- for the effective access to health care (physical support of people geographically or culturally remote from the health care places);
- to facilitate the professionals' and the institutions' response (help in the acquisition of rights, particularly in matter of Health Insurance);
- to encourage the screening and the prevention (allowing then to avoid hospital);
- to help people and professionals to better consider the environmental factors influencing health (unhealthy housing…).

The health mediators' intervention has also had an indirect positive effect on the health system through collecting information on the expectations, representations and behaviours of specific populations. The mediators have allowed this information returning to the local professionals or, at the national level, to the health policies-, the prevention messages-, etc.-makers.

The health mediators' usefulness for populations remote from the health system because of their socio-cultural situation is proven.
The mediators are all the more efficient since they belong to the concerned groups or are very close to them.
The social and health institutions have often seen the whole benefit they could draw from the mediators' intervention.

Future

Extending the mediators' missions to health themes other than HIV, through specific trainings.
Integrating items on health issues within the social and cultural mediator's training.
Making progress on issues about the social mediators' professionalization, at the national level.
Advocating actions based on public health mediators, at the regional level.

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Lessons learned

Success factors identified for the mediators' interventions to be efficient:

- Mediators' capacities:
  - Having a great knowledge about the publics to which they address (possibly sharing themselves some of these publics' characteristics);
  - Personal resources: dynamism, commitment and creativity;
  - Having completed a quality training in matter of health mediation, communication and fundamental knowledge.

- Capacities of the structure employing the mediators:
  - Management capacity;
  - Preferably being a structure dedicated to a specific public;
  - Having an institutional support and recognition.

Weaknesses identified in the experimental programme implemented in France:

- There is no professional status for health mediators (still experimental);
- The financing are uncertain and rarely perennial; the employment supports are precarious;
- It would be useful to institute a long-term tutorial system for the mediators' support and not only during the first months of the professional practice.

Please note that this experience greatly concerns migrants, both as mediators and beneficiaries. However, the programme has not been conceived as specific to migrants and the special recruitment of migrants as mediators has not been decided. Simply because they are particularly represented in the precarious populations, they are logically numerous among interveners and beneficiaries. But this approach averts discriminations (a programme "for

migrants") and emphasizes that the barriers against the access to health care and prevention are more socioeconomic than cultural or *a fortiori* ethnic.
Testimony: (collected by the evaluator)

A 30 year-old single mother with a 9 year-old son suffering from a minor mental retardation. The child is admitted in a medico-educational institute (*IME*), but the family has difficulty to accept the psychological support. Within the Gypsy community, this means "being insane". What was missing was a work of links, explanations between the school, the social worker, the mother and the parents for the child to be treated and monitored.

> *"I met the health mediator when she went to the Gypsy hamlet. She told me "Do you need me for papers?"*
>
> *I went to see her for dental caries. That was long, more than one month was required…I suppose it was because of the Universal Medical Coverage.*
>
> *I also come for Brahim, that's my son, he's ill; he suffers from a minor mental retardation. The health mediator advises me and goes with him to see the IME doctor.*
>
> *I had surgery, a cyst; the health mediator took an appointment and also went with me. Without her I wouldn't have done that.*
>
> *I often come here…to phone, I have no mobile phone.*
>
> *I'll tell about the health mediator to my sister, my neighbour, a friend. I'll tell them she can help you for your papers and so on."*

A 57 year-old woman, waiting for a divorce:

> *"I met the health mediator in front of the school, it was…an opportunity. I've had the possibility to talk about my problem, my husband left me, and he came back to Tunisia where I lived too.*
>
> *That was the descent into hell; I have no rights any more. I just wanted to sleep. Thanks to the health mediator I've been able to make decisions; it is someone you can trust.*
>
> *I was given sheltered in a house with no heating, which was humid, where the water flowed on walls, and where there was no hot water.*
>
> *I've lots of health problems, renal colic, depression, vertebras problems, osteoarthritis, and tendonitis.*
>
> *First, I went to MDM – Doctors of the World –, while I was waiting for the Universal Medical Coverage. The health mediator helped me finding housing, filing the application for the UMC, the health income support and then the COTOREP – technical committee for professional guidance and placement – upon advice of the doctor, and she went with me for the medical examination, the consultations…*

> *Lately, I told a friend to see the health mediator. She has housing problems and her child is ill. She couldn't stand anymore, she doesn't have UMC, and she works at night to pay the drugs for her son."*

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HEALTH PROMOTION FOR MIGRANT WOMEN

Gesundheitsförderung für Migrantinnen

Introduction

In Germany, nearly every seventh inhabitant comes from a migrant background. For women and girls, access to information about family planning and sexual education is not easy, but necessary if they are to live a self-determined life. Owing to language, cultural and other barriers it is quite difficult to reach the target groups with health promotion and prevention measures.

Goals and Objectives

The project aims to improve knowledge about sexual health and prevent unwanted pregnancy and STDs. The target is to support positive and self-determined sexuality. The main goal is to reach especially those women and girls who have no access to services and information. The objective is to strengthen these persons by improving their knowledge and self-determined action in the field of sexuality and sexual health.

Model

The project is addressed to persons of different nationalities and cultures and especially to women and girls. In order to reach the women and girls, the project relies on close cooperation with other organisations working in the multicultural context and uses the 'setting approach'. For example, the health promotion measures take place within the context of language courses. Settings like schools, kindergarten, meeting points of migrant organisations or even private flats are used to conduct the health promotion courses. The project strives to enable women to communicate about health without the need for an interpreter. Consequently, twice a year, the women are taught German vocabulary about the body, pregnancy and birth, the symptoms of STD and contraceptive methods. The vocabulary is only the starting point to enable them to later receive further information about physiology, the female cycle, contraception, the prevention of STDs, the structure of the German social and health system, genital female mutilation and the (sexual) education of their children. The main subjects of the courses are chosen by each group.

Field or determinant
Health promotion and prevention in the field of STDs, sexual education, birth control, genital mutilation.

Scope

The project can be used in urban areas.

Provider

The provider is a publicly funded private institution – 'pro familia' Bonn.

Resources

Public funding by the city of Bonn

Management

The provider uses its contacts with local migrant organisations and institutions (schools, public services, kindergartens and the like) to reach the migrant women. The choice of subjects is based on the needs of the target group.

Indicators

Because of the participants' poor language skills, evaluation is difficult. Nevertheless, their positive reaction is a measure of the project's usefulness. For example, in context of the courses, the women used the opportunities offered for personal advice to rule out the possibility of STD. Over a period of one and an half years, there was an increase in the interest shown by migrant women. Women with no contact to public health services independently asked for training courses or other information events.

Results

The access to health care services increased.

Conclusions

The project is highly useful for achieving a sustainable increase in the women's knowledge of health matters and for increasing their autonomy and self-determination.

Future

It is an ongoing project which can be recommended for reproduction. It should be extended to male target groups and their sexual and reproductive health.

References (optional)

The project 'Health promotion for migrants' has been chosen as model of good or best practice by several institutions such as:

- Bundesweiter Arbeitskreis Migration und öffentliche Gesundheit der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration (published)

Lessons learned

The value of using structures such existing language courses has been proven.

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WWW.GESUNDHEITLICHE-
CHANCENGLEICHHEIT.DE
Internetplattform

HEALTHY EATING CAN BE FUN

Gesund essen mit Freude

Introduction

By the beginning of the new millennium, no representative data on the health and development of children and adolescents in Germany were available. The German Federal Ministry of Health consequently commissioned the Robert Koch Institute to conduct a nation-wide study. Between May 2003 and May 2006, a total of 17,641 participants from 167 communities were enrolled. Among other things, the data include objective measures of social and migrant status. The results of the German Health Interview and Examination Survey for Children and Adolescents (KiGGS) indicate that 15% of children and adolescents between the ages of 3 to 17 are overweight, and 6,3% suffer from obesity. Children were at a higher risk of being overweight or obese if they had a lower socioeconomic status, a migration background, had not been breastfed or had parents who were also overweight. The risk of being obese in 3 to 17 year olds is about twice as high for children with a migration background. Within this group of migrants, Turkish children have an above-average tendency to suffer from obesity. In adulthood, these persons suffer more often from coronary, heart and other diseases. Healthy nutrition during childhood can prevent this.

Goals and Objectives

The aim of the project was to convey healthy eating habits to Turkish children through their parents' and in the home while recognizing cultural habits. The course was carried out in close collaboration with the school so that a second aim was to create a health-promoting school environment.

Model

The project is addressed to young Turkish adults (19-29 years) and adults (30–59 years). In Berlin, the Turkish population is the largest group of migrants. While conventional measures to improve nutrition in the Turkish population have not been very successful, especially due to language barriers, an intervention measure was created to explicitly integrate Turkish culture and tradition. In discussion groups and cooking courses, the Turkish women were introduced to healthy cooking. Through these measures, Turkish mothers did not only serve as a target group capable of providing access to health promotion for families with a Turkish background, they also widened these women's scope in other matters. The participants of the first training compiled a cookbook together.

Field or determinant

Health promotion and prevention in the field of nutrition. Healthy Lifestyle.

Scope

The project can be used in urban areas.

Provider

The provider is a publicly funded private institution in the capital of Germany – Gesundheit Berlin e.V.. It cooperates with statutory health insurance funds, the Turkish ambassador and the Turkish TV channel TD1.

Resources

Public sources, statutory heath insurance funds

Management

The provider uses the contacts with local migrant organisations to reach the migrant women. Networking was crucial to support the successful implementation and for sustainability.

Indicators

The model was evaluated, and the conclusions were that participants' knowledge and information about nutrition and healthy lifestyles consequently improved. It was possible to foster participants' motivation to assume the role of multipliers for their own communities. The project paved the way for further offers in the field of health and education. It was possible to encourage the migrants or socially disadvantaged families to play an active role in their relevant settings.

Results

The model was requested by about 500 NGOs nationwide for regional projects because of its positive conclusions. We have no knowledge about the number of cities which have implemented it so far.

Conclusions

The project is highly useful for achieving a sustained increase in knowledge about healthy eating.

Future

The project can be recommended for reproduction.

Lessons learned

Identification of factors which promote sustainability and help to establish the projects as they are: access to target groups, serious and determined engagement of cooperation partners, support from the 'setting-management' (e.g. school principals).

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Homepage www.health-inequalities.eu provides some helpful information about this project

THE CARE OF IMMIGRANTS WITH HIV/AIDS - GREECE

By Angelos Hatzakis, Kostas Athanasakis, Michael Igoumenides

Introduction

The European Union strives to deal with all kinds of pressing issues concerning immigrants. One of the most neglected issues is the one of their access to health care. This paper examines the situation in Greece, a country which holds a unique place in the migration arena, as it serves both as an intermediate station for immigrants on their way to other European countries, but also as a destination. As a result, there is a large and rapidly growing number of immigrants – both documented and undocumented – originating mainly from underdeveloped countries, where the prevalence of communicable diseases, such as HIV/AIDS, tuberculosis and hepatitis, is moderate to high. Obviously this poses a threat to the health status of all the people residing in Greece, and specific measures need to be taken in order to eliminate this threat as much as possible.

Goals and Objectives

From an ethical point of view, the ideal practice would be to secure equal access to health care resources for every individual; but realistically, this is a feasible goal at this moment. Therefore, the focus has to be directed on the most crucial public health issues, such as the administration of proper treatment for all immigrants – documented and undocumented – for life-threatening communicable diseases. This effort begins with the free treatment of immigrants suffering from HIV/AIDS, and is expected to be expanded to other cases.

Model

The Ministry of Interior Affairs is the basic governmental department which deals with general migration issues. It supervises the Hellenic Migration Policy Institute, an agency whose mission is “to research and understand the phenomenon of migration and conduct studies, which contribute to the design and implementation of a viable and realistic immigration policy within the European Union's framework.” Moreover, a specific department in the Ministry of Health and Social Solidarity is fully devoted to providing social support to vulnerable population groups, which includes access to health care for immigrants.

The basic statute which governs migration issues in Greece is 2910/2001, which, to put it crudely, is more “immigrant-friendly” compared to some of the older statutes. It was used as an instrument to award legal status to many undocumented immigrants and it made clear that all documented immigrants can be registered with the same social insurance agencies as Greek citizens, and enjoy the same rights (article 39, para.1). In general, health care is considered to be free in Greece: the National Health System offers a wide range of services for every insured individual. Therefore, documented immigrants have the right of free access to health care in a similar way that Greek citizens do, as mentioned above. However, in order to acquire legal status, the immigrants have to be in good health first, that is, not suffering from a disease which could pose a threat to public health according to the WHO standards. This can be proven by a certificate of good health which is issued by any public hospital or health centre, and it has to be noted that the financial burden of this document falls upon the immigrants (articles 21, 26). Nevertheless, after this somewhat bureaucratic procedure, immigrants can be insured and enjoy access to any public hospital.

In the case of undocumented immigrants, the situation becomes obviously more complicated. As in most European countries, the law states that immigrants who cannot prove that they lawfully reside in Greece do not have access to public hospitals or health centers; the only exception takes place for those who are in need of "immediate health care" (article 51, para.1). However, to the best of our knowledge, there is no official definition of what constitutes a case of "immediate health care". So it is left up to the head doctor of each public hospital to decide whether a case can be viewed as immediate or not. So it is clear that, officially, there is no guarantee for immigrants without legal status that they can be treated within the Greek National Health System.

In contrast with these rather obsolete articles, Greek legislation incorporates two highly progressive initiatives, namely, the case of juveniles and the case of HIV/AIDS patients. The former refers to free access to health care for children regardless of their legal status in Greece.. The latter, which is the core issue of this paper, is the initiative taken upon in the year 2001, which secures free hospital treatment, counseling, and proper medication for all immigrants, whether legal or not, who are HIV/AIDS patients. Furthermore, these patients are entitled to temporary work and stay permits. The legislator leaves it upon the judgment of the Minister of Health to include similar benefits for immigrants suffering from other infectious diseases which pose a threat to public health.

Field or Determinant

The field involved in this practice is mainly the health promotion for patients undergoing a progressively deteriorating and life-threatening health status, that is, HIV/AIDS, through the administration of proper treatment. Normally these specific patients could not acquire the appropriate care, due to their clandestine status. Moreover, this initiative focuses on prevention by protecting the public from a potentially lethal disease, through informing and educating the patients during the therapeutic course. Needless to say, the education of the HIV carriers in order to prevent the spread of the disease is a most effective way for the society to eliminate new cases. However, persuading the carriers to comply with safe social behaviour would be impossible if they were excluded from proper treatment just based on their illegal immigrant status. In other words, these patients are willing to respect the concept of public health only if they understand that the state respects their own health.

Scope

As previously stated in the description of the model, this initiative can be applied at a national level. The Greek NHS structures (hospitals, health centres, and specialised laboratories) can be effectively used for this purpose.

Provider

As expected, the main provider for this practice is the Greek NHS. However, for a more comprehensive approach, and especially in the case of undocumented immigrants, certain aids are to be expected from the Non-Governmental Organisations that are actively involved in the health care provisions for immigrants in Greece. These organisations offer basic medical support, functioning on a voluntary basis. One of their main contributions would be to direct HIV/AIDS patients to the appropriate NHS provider.

Resources

It is beyond doubt that the Greek NHS guarantees the universal coverage of health care needs for patients who are financially unable to cover their expenses. However, as noted above, there has always been a problem with the treatment of undocumented immigrants/patients. Through the practice in question this coverage is extended to undocumented immigrants suffering from HIV/AIDS. Therefore, the resources required for this practice shall be provided by public funding, in the exact way the rest of the NHS activities are funded.

Management

Decisions seem to be taken at two different levels; the governmental/ legislative level, and the institutional level, which is more individual patient-focused. The former refers to all the legal decisions describing the functioning of the Greek health care system and, consequently, the specific details of the practice in question. This means that governmental decision-makers and, ultimately, the heads of the Greek NHS constantly seek to set new rules in search of best results, taking into account various official evidence-based reports; however, due to the nature of legislation procedures, the process is remarkably slow and it cannot be expected to adapt to new challenges immediately (mainly referring to the adjustment of the legislation to the emerging data and the possible expansion of the practice to other cases of communicable diseases). On the other hand, at the institutional level, there is greater flexibility as to how decisions are made. Individual health care professionals are more sensitive towards the issue of undocumented immigrants, and are often able to speed-up the process, granted that they have at their disposal all the required laboratory tests and diagnoses. Thus, the appropriate decisions can be made in a more direct way, given that they are supported by proper medical documentation and, it goes without saying, a high level of responsibility demonstrated by health care professionals.

Indicators - Results

Due to the clandestine status of undocumented immigrants, it is extremely difficult to gather information related to specific numbers of patients involved in the process and the results of the applied practice. However, there exist valid hypotheses, based on the "prevention vs. treatment" model, that the practice is not only efficient but also cost-effective. Empirical evidence, provided by health care professionals, indicates that a growing number of undocumented immigrants receive the benefits of proper HIV/AIDS treatment in Greece.

Conclusions

Even though it still early to make any safe conclusions, we can definitely say that the practice in question has much to offer. First, from an individualistic-patient point of view, it secures proper treatment for critically ill patients, who would have no access to it otherwise. Therefore, humanitarian values, such as compassion and treatment for the vulnerable, are completely satisfied. Second, as far as society is concerned, it is an effective means to protect and to promote public health. When patients suffering from life-threatening communicable diseases are consistently educated and properly taken care of, the public is by and large safer.

Future

Future steps that should be considered in order to improve the specific practice should include the broadening of the patient cases eligible to be administered proper treatment and the empowerment of the NGOs' role. In regard to the former, communicable diseases such as tuberculosis and hepatitis need to be awarded proper attention, equivalent to their significance as public health threats. In regard to the latter, the NGOs could and should take their place as focal points between the undocumented immigrants and the Greek NHS.

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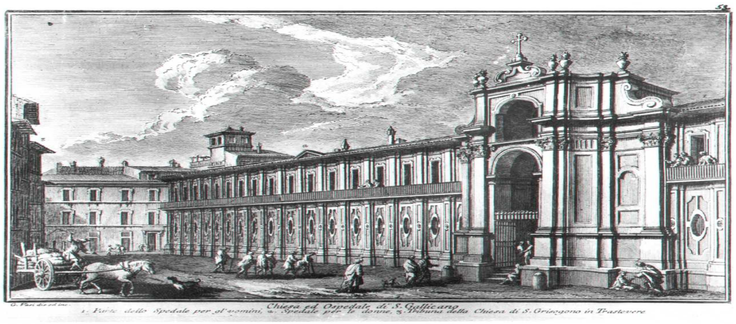

ITALIAN AND ETHIOPIAN ACTIVITIES OF THE SCIENTIFIC INSTITUTE SAN GALLICANO, ROME

Introduction

The average human lifespan has doubled over the past 200 years, and life expectancy is still increasing in most countries (Williams, 2004). The achievements of better health are, however, still very different between rich and poor countries and between groups within countries that are better off and less privileged.

In Europe, for example, major achievements have been made in reducing social inequities in mortality, as measured in absolute terms (Mackenbach et al., 2002). Certain relative differences in health between different socioeconomic groups have also been reduced and (even) almost eliminated for certain health indicators.

Despite some successes, major inequities in health still exist in all countries across Europe and, measured in relative terms, the general trend is increasing, rather than decreasing.

In Italy, for example, some recent analyses regarding the distribution among social classes of the National Health System's (NHS) performances seem to confirm what has been stated above:

- rates of admission to hospital in the lowest socio-economic and more underprivileged classes are greater by 50% in respect of the wealthier socio-economic classes;
- persons of lowest socio-economic level have, real needs and seriousness of disease being equal, fewer probabilities to receive effective and appropriate treatment;
- obvious social disadvantages in the access to the services of primary prevention, early diagnosis and timely and appropriate treatment; difficulty in the daily access to health services, for insufficient information on the structures and services available, the waiting lists, the charges.

The immigrant population in Italy has doubled each decade since the 1970s. At the end of 1991, there were 648,935 immigrants legally resident in Italy. By the end of 2001 they were 1,362,930 and, including the minors, the total number was 1,600,000, i.e. 2.8% of the population. According to the official data on immigration in Italy, in January 2006 there were 2,670,514 foreigners with a regular permit-of-stay (4.5% of the resident population) from nearly 190 different countries. Uncertain is the number of the irregular immigrants living today in Italy, assessed between 200,000 and 800,000.

The person making the choice of leaving his/her country to emigrate is normally a healthy young individual (75.6% below age 40), educated (50.8% have secondary or high school level, 14.8% have a degree, 86% speak a second language, English, French, Spanish or Italian). But the health standard shortly decreases owing to a series of 'risk factors': poverty diseases and other illnesses present in the host country, psychological problems, lack of work and income, poor housing, absence of the family, change of climate and eating habits. The 'healthy interval' between arrival in Italy and the first request for medical help, has decreased from 10-12 months in 1993-94, to 3-4 months in the last few years. The diseases resulting from this situation can be defined as 'stress and poverty related diseases'.

Goals and objectives

The main activities carried out in the last 30 years by the San Gallicano Institute were inspired by the Art. 3 of the Italian Constitution: "All citizens have equal social dignity and are equal in front of the law, regardless of sex, race, language, religion or political opinion, personal and social conditions". Moreover, Art. 32 (ibid.) underlines that "The Republic considers health as a fundamental right of the person and a public concern, and guarantees free treatment to the sick".

Accordingly, we started to work on the assumption that we have to introduce a solidarity pact among citizens, healthcare workers, public institutions, voluntary associations, European Union and the international community. Key points of that principle to be highlighted are:

- to reduce inequalities in the availability of the healthcare services;
- to foster adequate use of health services;
- the defence of the weakest and needy people;
- the advisability of promoting social and medical integration;
- the importance of investing in human resources and quality systems.

Besides our activities related to the mentioned key points we aimed at improving integration of health and social services, introducing more equity in the availability of healthcare services for the different categories of the needy (persons who live in conditions of particular disadvantage and are bound to forms of dependence on welfare assistance.) Among weak subjects a particular attention is given to immigrants, gypsies, homeless, refugees and asylum seekers, victims of torture and of prostitution trade, abandoned children and adolescents and other groups at higher risk of social exclusion.

Field

1. Facilitating access to the National Health System (NHS)
2. Reduction of the costs through appropriate interventions
3. Improving effectiveness of the results in terms of recovery of the patients, and in terms of reduction of the differences of the principal pathologies, with positive fall-out effect for the Public Health
4. Transcultural education to a responsible maternity and paternity
5. Tuberculosis prevention and treatment
6. HIV/AIDS and other Sexually Transmitted Infections (STI) prevention and treatment especially aimed at the disadvantaged people, Italians and Immigrants too

7. Prevention of work accidents in the immigrants
8. Immigrant education about their rights and opportunities within the Italian socio-sanitary system

Scope

The main scope of the San Gallicano Institute's activities is to reduce the health inequalities between poor and rich people in Italy as well as in other Countries like Ethiopia and other Developing Countries.
Indeed it is well known that poverty in Italy, as in Europe and in the world, is multidimensional and is linked not only to material deprivation but also to low educational achievement, poor health, vulnerability and exposure to environmental and occupational risks, as to voicelessness and powerlessness.
The implementation activities related to our scope facilitate the harmonization of the public and social services addressed to the needy people.

Provider

Many national and international agencies collaborate with the San Gallicano Institute considering the necessity to use a multidisciplinary approach in order to improve the public health.
Some of the most important are the following:

- WHO Regional Office for Europe (Venice)
- International Centre for Migration and Health (Geneva)
- International Society of Dermatology (ISD)
- Children Aid Society (New York)
- Tigray Regional Health Bureau (Mekelle-Ethiopia)
- Italian Minister of Health
- Italian Foreign Office Minister
- Istituto Superiore di Sanità (ISS)
- Lazio, Sicilia and Puglia Region governments
- Rome city Council
- National and International NGOs

Model

a- Main Activities in Italy

Since 1st January 1985 the Department (Dept.) of Preventive Medicine for Migration, Tourism and Tropical Dermatology was opened to all citizens, Italians and foreigners present in Italy, at San Gallicano Institute in Rome. The Dept. is actually one of the Collaborating Centres of the WHO European Office for Investment for Health and Development. Over many years, a new model for reducing the number of people suffering from dermatological and/or other diseases was developed at the Department. Medical examination and advice can be requested on the following specialities: dermatology, allergology, oncology, plastic surgery, internal diseases, infectious diseases, neurology, tropical diseases, sexology, sexually transmitted diseases, AIDS. Moreover laboratory tests can be performed such as microbiological, mycological, histo-pathological tests, x-rays, electronic microscopy and experimental tests on skin pathologies.

A network of public institutions and private organizations was established, working with disadvantaged people at many different levels: medical, social, psychological, anthropological, educational and occupational.

Also in the Department is a medical-anthropological Counselling Service, specially aimed at detecting and taking care of cultural disadvantage as a risk of onset of diseases. The Service avails itself of the help of anthropologists from Università "La Sapienza", Rome.

Every year, in collaboration with Regione Lazio Government and Rome City Council, the Dept. organises an International Course of Transcultural Medicine, addressed to socio-medical operators, public administrators, teachers, volunteers, with the aim of promoting interest, understanding and exchange of experiences about the complex reality of health care.

Since 1996 the Dept. has been assisted by linguistic-cultural mediators, who provide welcoming reception and translating facilities to foreign patients in their own language. They also facilitate cultural and interpretative understanding for diagnostic and therapeutic purpose. The main languages spoken are: French, English, Spanish, Portuguese, Arabic, Kurd, Lingala, Swahili, Tigrigna, Amharic, Filipino (Tagalong), Tamil, Bangladeshi, Serbo-Croatian, Bulgarian, Polish, Russian, Rumanian and Albanian.

b- Main Activities in Ethiopia

After a 20 years' collaboration on the health sector with the Ethiopian government and local NGOs, San Gallicano Institute has opened, in collaboration with the International Institute of Medical, Anthropological and Social Sciences (IISMAS onlus), on January 2005 the first dermatological hospital of northern Ethiopia, named Italian Dermatological Hospital (IDH).

The small hospital, initially located in a village near Mekele, the capital city of Tigray region, in May 2006, has moved to Ayder University Referral Hospital's compound, a new building in the city centre. It is provided with 30 beds for the inpatients department, two rooms for outpatients examination, a minor surgery room, a pharmacy, a microbiology laboratory, a library and a didactic area for training of medical students and health operators.

The service is free of charge. A team of local health workers and foreign dermatologists takes care of admitted patients and also deals with outpatients' examination.

As from September, 2005, an HIV Voluntary Counselling and Testing (VCT) service is available in the hospital and it is free of charge.

Microscopic investigations for fungal, protozoan and bacterial infections are performed in the hospital's laboratory, whereas biopsy specimens taken in doubtful cases for histological examination are sent to the San Gallicano Institute in Rome.

Theoretical and practical courses on dermatology and communicable diseases for training of medical doctors and regional health workers are periodically held in the hospital.

Resources

According to the legal status of the Health Public Institutions the Director of the Dept. is made responsible for attribution of objectives and relating budget by the Italian Ministry of Health.

The Dept. is also involved in many projects financed by other national and international Institutions (EU Commission, WHO, Istituto Superiore di Sanità, Region governments and City Councils).

Management

The San Gallicano Hospital is part of the Istituti Fisioterapici Ospitalieri (IFO) (http://www.ifo.it/) and the Director of the Dept. is responsible for the institutional activities to the General Director of IFO.

Indicators

Every year the Italian Ministry of Health evaluates the Institutional activities of the Dept. and considers the opportunity to invest financial resources, whose amounts depend on local circumstances and availability, for the activities of the Dept.
Besides this type of yearly evaluation it could be useful to consider the following recognitions, as an indirect measure of our activities:

- from 2001 the Dep. is the Italian branch office of the “Human Mobile Population Committee” of the International Society of Dermatology – New York;
- from 2002 the Dep. is a Collaborative Centre of the “International Centre for Migration and Health (ICMH)” WHO – Geneva;
- from 2004 the Dep. is a Collaborative Centre of the “European Office for Investment for Health and Development” WHO – Venice;
- from 2006 the Italian Ministry of Health established that the Dept. will be working as a National Reference Centre for “The Health promotion in immigrant populations and in order to confront the Poverty Diseases”.

Clinical results

a- In Italy

In the last 22 years the Dept. welcomed and visited 91,546 patients from 121 different Countries. Every year more than 9,000 people (immigrants, homeless, gypsies, victims of prostitution trade, abandoned children and adolescents, refugees/asylum seekers and victims of torture, women with some kind of female genital mutilation and other Italian and foreign disadvantaged people) receive a medical examination related to the following specialities: dermatology, allergology, oncology, plastic surgery, internal diseases, infectious diseases, neurology, tropical diseases, sexology, sexually transmitted diseases, AIDS.

b- In Ethiopia

From January 2005 to December 2006 we visited and treated 19,170 patients, on whom we performed 218 skin biopsies that were histologically examined at San Gallicano hospital and the results of which were sent by e-mail to the Ayder University Referral Hospital in addition to the necessary suggestions concerning treatment.
We provided the patient with all the necessary information to facilitate his/her understanding of his/her disease, particularly in order to assure compliance of the patient with treatment and to make him/her accept preventive behavioural habits; and, as a result, to minimize the worsening progression of the disease and to prevent transmission of some contagious diseases. Therefore, minimization of costs can be achieved by making sure that the patient has in fact started medical treatment and is taking the preventive measures suggested.

What we have learnt

Undoubtedly, there is by now a close link among complex phenomena such as the expansion of migrations worldwide, the increase of poverty in many countries, and the state of health of a population. These are complex relationships involving the ability of health system to confront the challenges emerging from the profound change which is sweeping through every country in the world.

The current migratory phenomena, which will certainly increase in the future, may constitute a significant risk of diffusion of diseases, in view of the fact that often the health communities are not adequately prepared to offer diagnoses and treatments. This particularly applies to contexts where human resources and diagnostic/therapeutic materials are very limited. In the interest of public health, it therefore becomes necessary to improve know-how and skills.
For this reason we must, as soon as possible and throughout the national territory, commit ourselves to the promotion and equity of health for millions of foreigners, some of whom are going to become new Italian citizens, and who are in any case already resident in Italy.
Moreover, investing in project of prevention, treatment and training of local personnel in poor countries, responds to an immediate need in the health sector as well as to the issue of human rights.

We must also consider the geographic position of Italy and the origin of migratory flows, mainly from Central and Eastern Europe and from North Africa: the presence of immigrants may in fact represent a positive challenge for a type of scientific research and medical assistance that do not exclude the less developed countries.
We must adopt a transnational methodology, specific to scientific, assistential an management research – in other words, from the laboratory to the patient's bedside – expanding it in term of space. The beneficiaries – patients and health system – could thus remain outside the European Union. To this end, we could develop new international partnerships to promote the association and improvement of the sanitary system of the countries of origin of the migrants, and use the new technology made available by the scientific community (telemedicine, Internet, etc.) to manage diagnostic/therapeutic problems. In this way, the Italian health community would fulfil its ethical and scientific duty to offer developing nations its own acquisitions and skills.

A further important issue: when dealing with immigrant patients' health, we must bear in mind their attitude towards illness, pain, suffering and fear of death, which is different from our own. All populations have a culturally specific perception of symptoms.
We must take into account the fact that often immigrants use somatic metaphors as a shortcut for expressing emotions and feelings, which they would not otherwise be able to communicate. Very often, they complain of cenestopathic symptoms (headaches, digestive troubles, vague and generalised pain, itching, a burning sensation when urinating, worries about their physical health), in the absence of objective evidence on examination. Illness, too, like culture, is perceived differently by the different individuals experiencing it.
In conclusion, we must promote the awareness that it is necessary to break this vicious circle, which reduces health levels in weaker sectors of the population as a result of disadvantaged living and working conditions. This, in turn, increases avoidable expenses of health assistance and worsens the socio-economic level of these groups. As far as health system are concerned, they must replace the vicious circle with a virtual one: the reduction of inequalities in health

would decrease avoidable expenses of health assistance, and increase the possibilities of social and work integration.

We must launch a health policy which fakes into account social determinants, environmental context and inequities present in the populations. We must favour the access to socio-sanitary services of individuals with different needs, who should receive appropriate and specific socio-sanitary interventions. At the same time, we must guarantee equal opportunities of access to populations, in order to reduce inequalities.

Moreover, we must review the health needs perceived by the population so as to demedicalise a health demand which is often artificially and irresponsibly the cause of unrestrained drug consumption, and of very expensive medical care, absolutely inappropriate, inefficient, often useless and at times harmful.

Finally, we must adopt a transcultural approach to the concepts of health and illness, so as to respond to people’s real health needs, taking account of their history, habits, social status and cultural background.

Conclusion

Considering the above clinical results and our working model in a multidisciplinary team with other social Institutions we could underline that in Rome as well as in Ethiopia, or other more highly constrained settings, two very important and fundamental principles:

1. attaining health objectives in any population depends above all on the provision of effective, efficient, accessible, viable and high-quality services by personnel present in sufficient numbers, perfectly educated and equitably allocated across different field activities and geographical regions.
2. Human Resources for Health issues are strongly linked to non-health policies and should be dealt with in the context of development and macroeconomic policies. But actions and plans must be financed by public agencies (Ministry of Health, and different domains of health systems such as Administrations of Regions, Provinces and Municipalities, Ministry of Justice, of the Interior, of Labour and Social Security and Ministry of Education) and by private institutions (Foundations, NGO, ONLUS, private for-profit and not-for-profit systems and other private social institutions).

Finally, in our experience it can be said that more evidence on the effectiveness of simple and inexpensive health interventions and on how best to implement them in highly constrained settings is needed. This should be a priority area for funding by donors and international public organisations, and has so far been largely neglected.

Future

In January 2007 the Minister of Health, Livia Turco has established a “Health National Institute for the promotion of health of migrant populations and the fight against the diseases of poverty”, utilizing to this end the very long experience of the Struttura Complessa di Medicina Preventiva delle Migrazioni, del Turismo e di Dermatologia Tropicale dell’Istituto San Gallicano (IRCCS), Rome. This Centre’s task will be that of developing initiatives directed to the promotion of health of the migrant populations and, at the same time, to the protection of the Italians’ health. The Centre will also deal with the monitoring and evaluation of the health needs of the migrant populations, in collaboration with the network of public research and with the valid experiences of the voluntary and private social sector. It will try out new models of sanitary assistance, in order to guarantee quick access to medical services, as well as the compatibility of the socio-cultural identity of these populations. It will take care of the training of socio-sanitary operators and of the formative counselling aimed at intercultural approaches. It will train linguistic-cultural mediators within teams of multidisciplinary socio-sanitary operators, and it will take advantage of their precious work. It will promote the collaboration among international networks of Institutes of scientific research, treatment and assistance for the improvement of the human mobile populations' health, involving in particular the World Health Organization.

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EMERGENCY MEDICAL SCREENING FOR IRREGULAR IMMIGRANTS IMMEDIATELY ON ARRIVAL IN MALTA

Introduction

Since 2002, irregular migrants originating from all over the African continent have been arriving on the Maltese shores at regular intervals, crowded in poor seaworthy boats. The desperate crossing of the Mediterranean Sea has been associated with a number of undocumented fatalities at sea.

Depending on the duration of the journey, these immigrants arrive in Malta exhausted, dehydrated and with various acute problems associated with the overcrowding on the boat such as cutaneous salt excoriation, fever, scabies, deterioration of respiratory conditions due to inhalation of diesel fumes and various aches and pains.

Goals

- Identify acutely ill individuals immediately on arrival in Malta
- Prevent spread of infectious diseases

Objectives

1. Screen all new immigrants immediately after arrival to identify those needing acute medical care
2. Identify immigrants with acute infectious diseases prior to admission to the Reception Centres
3. Set up a coordination link between the initial medical screen and the subsequent follow up by Public Health physicians

Model

Once a boat with immigrants is rescued, the Operations Room at the Armed Forces of Malta relays all the available information to the Principal Medical Officer within the Institutional Health Directorate. Information is given about the number of immigrants on board, their gender, presence of children, general physical condition and expected time and site of arrival. Immediately, the Accident and Emergency Department at St. Luke Hospital and the Emergency Response Team are activated. According to the seriousness of the cases, the teams are dispatched either to the port of entry for initial quick assessment and stabilization or if no acute cases are identified the teams are dispatched to the Medical Clinic within the Police General Headquarters, where immigrants are taken for registration and documentation.

The Emergency Response Team is a team of qualified emergency physicians who are on call 24 X 7 and are activated through block paging. If more help is needed various Non Government Organisations are called in. Any immigrant who needs stabilization for mild to moderate fever or dehydration are given respective care at the Medical clinic. Any one needing immediate medical care or further assessment is transferred to hospital with the ambulance which is on stand-by on site.

After the initial assessment, a medical report is issued with details of treatment given and of any person needing further follow up. This information is then relayed to the Principal Medical Officer who in turn forwards it to the Public Health Department, the Port Health Section and the Armed Forces of Malta medical doctors.

Field or determinant

At the initial medical examination, all immigrants are documented and screened for:

- Dehydration
- Any medical complaints such as cough and pains

The following parameters are taken

- Body temperature
- Heart rate
- Blood pressure

Medical examination focuses especially on the respiratory system and skin conditions but any other complaint is also assessed and examined.

Scope

Once the Armed Forces of Malta rescue a boat of immigrants, a coordinated line of response is activated with clear command and control. The Principal Medical Officer, who is on call round the clock, activates the Emergency Department at St. Luke Hospital, the Emergency Response Medical Team who is on call and any Non Government Organisation if deemed necessary. If the number of immigrants exceeds a certain threshold the Director General Health is activated to deploy more staff. This screening procedure avoids unnecessary referrals to the Emergency Department.

Provider

The staff responding to this screening if a Government Health Division Response but in particular instances such as when a large number of immigrants arrive altogether support from the Non-Government Organisations is sought through the Principal Medical Officer.

Resources

All funding is provided through by the Government Health Division and this includes paid salaries for the staff responding on site and those on call. It also includes costs of medical treatment which is offered.

Management

As mentioned above, the Health response is coordinated by the Principal Medical Officer. All problems that arise during the examination session is relayed between the staff on site and the Principal Medical Officer who in turn will address and refer the issues accordingly. Other problems encountered by the other emergency services are similarly coordinated.

Since there may be a delay from the time of arrival ashore to the moment they reach the medical clinic after being registered and documented, this close collaboration ensures that the medical resources are deployed at the right moment in time. This avoids unnecessary early activation.

Indicators

With the initial arrivals of irregular immigrants in large boat loads, the Emergency Response Team was not as yet established and medical doctors were deployed on a crisis basis from which ever department was available. This resulted in an unnecessary number of referrals to the Emergency Department in hospital. This resulted in an overload in the already busy Emergency Department and the dissipation of the other security personnel who had to accompany the immigrants.

Further more this early examination and subsequent reporting helped to triage all new arrivals to identify those who needed early Public Health attention and intervention with a subsequent decrease in the risk of transmission of infectious diseases to other persons in the Reception Centres.

Conclusions

The number of hospital referrals of Third Country Nationals immediately after arrival to Malta has shown a drastic decrease after the set up of the Emergency Response Team. This screening and triage got better with time as the operations of this team were refined with the experience its members acquired in collaboration with the other staff from the Health Division. This resulted in a decrease in the pressure of work load at the Accident and Emergency department which is already busy with its annual routine work of more than 110,000 patient cases annually. Furthermore the early alert and the early detection of potentially infected cases has decreased the chances of spread of communicable disease to other detainees within the Reception Centres. The whole chain of Command and Control between all the emergency services has resulted in improved collaboration and understanding between one and all with a resultant improved efficiency of operations and better health care provision to the newly arrived weary immigrant.

Future

Efforts are currently in progress by the Health Division to set up a separate reception centre where newly arrived immigrants are kept for one or two weeks until full public health screening and treatment of any diagnosed infectious disease is done. This cohorting will prevent unnecessary public health risks of transmission of communicable disease to the rest of the immigrant population and caring staff within the reception centre.

Lessons learnt

Since this team is operational round the clock, its members frequently respond even during the awkward early morning hours. Factors such as the fatigue and the psychological stress associated with the various risks inherent to the journey in the poor sea worthy boats and fear from arriving within the security services of a new country prohibit the medical examination from being carried out in the best of circumstances. This is further aggravated because of multiple layers of soiled and drenched clothes associated with the complete absence of sanitary facilities on the boats and communication barriers since these immigrants originate from the African continent with their various languages and dialects. Under ideal circumstances, new arrivals should first have a period of time where they can take showers, change clothes, have a period of rest and possibly a psychological debrief prior to the actual medical examination. With the current framework of having the medical examination carried out immediately after arrival, registration and documentation, within the confines of the Police Headquarters, this examination may be perceived as part of the whole security set up and together with the communication barrier may fail to establish rapport between the immigrant and the Health Care professional.

Child birth on board a patrol boat assisted by an Emergency Response Team doctor and midwife

Accident and Emergency Staff giving feeds to newly arrived exhausted children

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IMMEDIATE INTERVENTION PROJECT FOUNDATION POSITIVE WOMEN OF THE WORLD in collaboration with THE AMSTERDAM MEDICAL CENTRE, THE NETHERLANDS

Introduction

The perinatal hiv team of the Academic Medical Center (AMC) has been training midwives and midwifery students in the Netherlands, on all aspects of hiv-testing and pregnancy, for the past 10 years. Medical and psycho-social support has been offered with a focus on the needs of hiv–infected women and their children. However, feelings of isolation , especially those of migrant women, could not be met. Since over two years a collaboration started with hiv-infected women from PWW on the site and the support has improved importantly. Isolation is broken and sharing experiences proves to be empowering. Even to the most vulnerable women, those who are living illegally in the country,benefit greatly from this care.

Positive Women of the World (PWW) is a NGO, founded and run by migrant hiv-positive women, that supports female immigrants living with hiv and their children. It’s goal is to improve the quality of life of women living with hiv and their families through which they will be able to find a place within the Dutch multicultural society. The Project ‘Immediate Intervention’ of Positive Women of the World has been able to reach its target group efficiently in collaboration and at the site of Amsterdam Medical Centre. In a personal informal setting women are able to express emotions about the situation and ask questions, after which further support is provided. Additional monthly activities (see section “other activities”) provide a place for women to share their experiences in order to break through stigma and isolation. By connecting medical care on the one hand and psychosocial support by HIV-positive women at the site of the hospital on the other hand absolute confidentiality is guaranteed. Furthermore, valuable additional knowledge of the social and medical problems these women face, is obtained and shared confidentially.

Positive Women of the World is started in 2004 by Sylvia de Rugama, a Mexican refugee living with HIV herself.

Population

In 2006 12.000 persons lived in our country infected with hiv, 77% of whom are men (52% by homosexual contact) and 23 % women. More than half of the heterosexually infected patients are women. Women were about 7 years younger when diagnosed with hiv compared to men. The majority of men originated from the Netherlands , whereas the majority of women originated from sub Saharan Africa. In total, 749 women became pregnant. From 2004 HIV testing in pregnant women is part of the national first trimester testing procedure. Just over 100 children (to the age of 13) are living with hiv and 92% of them had at least one parent originating from outside the Netherlands. The population still grows over the years. (only 5.2 % of all patients were reported having intravenous drug use as mode of transmission) (HIV Monitoring Foundation 2006).

Values

Health care is viewed as a basic human right, regardless of nationality, legal position, sex, race or religion. PWW and the Amsterdam Medical Centre both follow a humanistic approach, which affirms the dignity and worth of all people, based on the ability to determine right and wrong by appeal to universal human qualities. Therefore PWW believes that the provider of psychosocial support should be a non-governmental, non-political and non-religious organization with diverse and useful partnerships within the medical communities, welfare bodies and local minority advocates.

In reaching women with hiv and their families the approach by PWW has to be personal and trustworthy in the framework of an interventionist. This means the ability and constant disposition to troubleshoot and resolve emergencies and crisis. In this fashion PWW manages to overcome bureaucratic limitations through which it is not possible to respond to an immediate demand of a constantly changing migrant population.

As one of the biggest ‘migrant friendly hospitals’, the AMC provides care for all, regardless of race, sex, nationality or legal position.

Furthermore in this project, there is a strong emphasis on maternal health, obtaining the wellbeing of mother and child, providing the tools for a healthy beginning and future development.

The determinant point is the implementation of the GIPA principle (Greater involvement of people living with hiv).

Goals

- Empowerment and guidance of women and their families on better understanding of health issues.
- Sharing for the first time personal experiences of coping and living with the HIV-diagnose.
- Encourage and facilitate the creation of new support networks in minority communities to overcome stigma and isolation.
- Stimulate further integration into the Dutch society

Strategy

Migrant (pregnant) women are reached in a neutral territory inside a hospital with 100% confidentiality being referred by medical professionals after informed consent.During the integrated outpatient clinic of the obstetrician, paediatrician and internist, customized personal care is provided, according to their nationality, ethnical and religious background, solely by women who are living with HIV themselves. PWW works in close cooperation and understanding between the patient, the interventionist, peers, coordinators and the medical personnel. They are equally involved in the decision making process concerning the patient.

Furthermore, PWW reaches immigrants living with hiv through fieldwork in refugee centres, churches, shelters and schools. For this purpose PWW works in close collaboration with the medical organisations in refugee centres (MOAs) and hiv counsellors throughout the Netherlands. Additionally, PWW gives prevention workshops in refugee centres and other organisations.

PWW takes a flexible approach towards the quick changes in the migrant population and consequential personal problems of women living with HIV. The organisation strives to be non-bureaucratic and pro-active in dealing with existing and future problems and crises in the field. Geographically speaking, this means that PWW provides care where it is needed. The organisation focuses mainly on the Amsterdam region, but is ready to intervene nationally where urgent help is needed.

Other Activities

Following the ‘Immediate Intervention’ PWW provides further care and activities. One of the essential activities is the monthly meeting where women with HIV and their children meet and share experiences. In this way they are able to create a new social network which makes it is easier for the women involved to cope with hiv and medicationtaking in their daily lives. Specific activities are organised during these meetings to encourage contact between women with hiv such as celebrations, film, drama, music and health education.

PWW focuses especially on maternal and childcare. Because of stigma and social isolation, pregnant women living with hiv often have to deal with their pregnancy without the help of family. The volunteers of PWW support the women throughout their pregnancy and sometimes even during labour.

Lessons learned

A migrant and minority population maximizes their use of the medical and social benefits available to them as a result of an outreach strategy of connection at the site of the medical treatment.

In the past it was challenging, sometimes impossible to communicate in a more intimate fashion with the patient on sensitive subjects, like sexual behaviour, motherhood, disclosure, traditional medicine and daily life habits. In practice, we find migrants and minorities to be more receptive and open, when they are far away from their place of residence and their community. In the context of newly created networks of women with hiv these issues are more efficiently addressed.

Generally speaking, NGO’s working within the field of hiv and aids work outside the scope of the medical care. In this way valuable knowledge, for example on treatment, cultural differences and psychosocial circumstances, is often lost. By connecting the support given by the NGO to the medical care, the hospital staff and the providers of psychosocial support, which is women living with HIV, benefit greatly in sharing their knowledge and exchanging information. This alternative approach has proven to be a breakthrough in dealing with the challenge of reaching the target group and addressing sensitive subjects. In this way, the medical care and psychosocial support are maximised and more effective.

Results

The results obtained in only 2.5 years are spectacular. In a short time the target group together with the medical personnel have experienced great improvement in the physical and mental health of the patients. Furthermore, doctors and nurses were able to measure improvements in the health of those patients, who have been referred to and cared for by the interventionist involved in the project.

For the women living with HIV this meant a better outlook on their future and prospects and overcoming isolation. The women have a better knowledge and understanding of the society in which they live and the role they play in it. They were able to create small support networks with people in similar living conditions. Additionally, there has been an improvement in the awareness and consciousness on the impact of the spreading of the disease.

Sofar 121 women were reached 79 in the AMC and 15 in other hospitals in Amsterdam and 27 outside Amsterdam.

Resources

So far, PWW has been depending on the energy and goodwill of many volunteers, which is the main resource of all the work done.

Formal bodies, through their bureaucracy, are less equipped to react to the reality of a changing and moving migrant population in wider Europe. PWW is partially supported by SOA-Aids/Aidsfonds NL and receives additional support from pharmaceutical companies. These resources however are limited and insufficient to warrant a healthy and developing organisation.

Implementation

The expertise acquired in the practice of ‘Immediate Intervention’ can be easily shared and put to work with the collaboration of local NGOs and the medical professionals in the medical centres. Guidance by a strong interventionist is needed however. Once more we emphasize the need of the implementation of the GIPA principle in this matter. Furthermore, as a starting point, a medical centre that would implement ‘Immediate Intervention’ needs to operate from a strong ethical point of view, which is to give care to all regardless the nationality or legal position.

Future

As an organisation, PWW needs to grow and create a sustainable foundation in order to cope with future developments. For this purpose, additional funding is needed in order to secure the work that is currently done by volunteers. In this respect, PWW is still a

vulnerable organisation. To strengthen the organisation, PWW will strive to find structural funding from local and governmental sources. For this purpose and to raise further awareness on the issue of immigrants and hiv, PWW and the AMC will continue to build bridges between them and government bodies and decision makers.
Furthermore, the method of 'Immediate Intervention' could be implemented, under the guidance of PWW and the AMC, in other hiv-treatment centres .

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ETHNIC HEALTH EDUCATORS/CARE CONSULTANTS IN THE NETHERLANDS

Introduction:
Of the sixteen million people living in the Netherlands, over three million are of foreign origin. Half of these have a non-Western background. Most immigrants are Turkish (370.000), Surinamese (334.000), Moroccan (330.000) and Antillean (130.000). A growing number of refugees come from countries such as Somalia, Ghana, Iraq, Iran and Bosnia.

Working with immigrants in the context of public health and health care is characterized by (among other factors) differences in language and culture. These differences may lead to obstacles like communication problems and limited use of health care. The project "Ethnic health educators/care consultants" is set up in reply to these obstacles. Tackling these obstacles is very important in view of the health conditions of immigrants.
In general immigrants are less healthy than indigenous Dutch people. They report poor health more often and there is a relatively high prevalence of heart diseases, diabetes and depression in this group. Infant morality is twice as high as in the indigenous Dutch population. Causes of death are different for the diverse immigrant groups.

Communication.
Interaction between immigrant patients and medical staff is often limited due to differences in language and culture and to lack of information about the Dutch health care system. These differences can give rise to misunderstandings, fear, unnecessary examinations, or even errors such as unwanted pregnancies. Both the patients and the staff experience these difficulties. The project "Ethnic health educators/care consultants" is aimed at coping with these difficulties. The project is directed at providing information on health care and health promotion for immigrants in their native language and in harmony with their own culture and values. The care consultants function as intermediaries between health care professionals and immigrant patients in an attempt to span the different expectations and conceptions.

Access to health promotion
Health promotion interventions aimed at the Dutch public in general do not always succeed in reaching the hard to reach, e.g. non western immigrants. Only interventions

tailored to both the needs and demands and to information channels used by this target group can possibly be successful. The ethnic health educators fit into this approach.

Goals and Objectives

The goal of the project “Ethnic health educators/care consultants” is twofold. The first goal is to inform immigrants about health matters and the Dutch health care system. The second goal is to improve the communication between patients and medical staff by bridging the language and cultural gap.

The main objectives are:

. To improve the level of knowledge among immigrants about health matters by providing tailored information in the native language and connected to the specific cultural background

. To contribute to the locus of control among immigrants by providing the opportunity to participate in group meetings and to share experiences with fellow immigrants

. To support immigrant patients in their contacts with medical staff by clarifying both the doctor’s advice and the patient’s questions

. To support the medical staff in their contacts with immigrant patients

. To promote expertise among the staff members by informing them about the specific health problems and related questions among the immigrants

Field or determinant

The project is carried out both in the context of public health (preventive health care and health promotion) as well as in the context of primary and secondary health care.

Preventive activities are generally carried out during group meetings and take place in community centres, schools, mosques, health care centres, etc. Several meetings are organised for the same group. On the whole groups are formed with immigrants from one ethnic background. Men and women usually attend separate meetings.

In the context of primary and secondary health care the ethnic care consultant generally gives advice on an individual basis (for instance when a patient is referred to them by a doctor).

Scope

Health Education for immigrants in the native language and connected to the specific cultural perspective (in Dutch: “voorlichting in de eigen taal en cultuur”) is widely available in the Netherlands. The project started in started in 1986 on a small scale. Nowadays, in all major cities, about 135 health educators occupy themselves with informing immigrants and their families about subjects concerning disease prevention, health promotion and child care and upbringing. Furthermore a total of 60 care consultants work in primary and secondary health care institutions.

Local and regional focal points

The ethnic health educators/care consultants operate from local or regional focal points which usually form part of the Municipal Health Councils. Sometimes they are employed by other institutions like health care institutions.

The focal points employ a (part-time) coordinator who takes care of the practical issues surrounding the educational meetings, coaches the ethnic health educators, takes care of their payment and training, and applies for and manages budgets.

National focal point
The local and regional focal points cooperate in a network coordinated by the National Institute for Health Promotion and Disease Prevention (NIGZ). This national focal point coordinates and supervises the basic and additional training of the educators/consultants. It produces the teaching materials and coaches the teachers.
Furthermore the national focus point advocates the importance of these educators/consultants among policy makers, health insurance companies and other financiers.

Provider

The local and regional focal points are public institutions. The national focal point is a non-governmental institution, partly financed by the government.
The actual implementation of activities takes place in several (mostly) public institutions, like community centres, schools, immigrant organisations and health care institutions.

Model

The approach consists of educational group meetings and of individual education both aimed at the patient and the health care worker.
Educational meetings are organised on demand of local institutions, like community centres, schools, immigrant organisations and health care institutions that work closely with the target group. The content of the meetings is decided upon by the members of the target group themselves. There is wide choice of topics, like organisation of health care, use of medicine, pregnancy and delivery, nutrition, diabetes, infectious diseases, healthy aging, child care and upbringing. Preferably this information is submitted during a session of meetings. This way subsequent aims like establishing an atmosphere of trust and enhancing empowerment can be reached.
In the setting of health care individual information is given on demand of the health care professional. In some cases meetings are organized for several patients with the same health problems. Furthermore the care consultant may be present in the doctor's surgery and give information to both the patient and the doctor. Sometimes the consultants visit patients at home so they can deliver more extensive information.

The ethnic health educators/care consultants are trained part-time for two years. They receive additional training on a regular basis. They are taught the contents of a variety of medical subjects and several educational skills. The teaching philosophy is based on the principles of adult education. Being from the same immigrant and ethnic background health educators/care consultants are able to "translate" the information to the everyday questions and worries of the immigrants. They understand the communication problems that occur between patients and doctors and are able to communicate with both sides.

Resources

Source of funding for the national focal point is the National Ministry of Health, Welfare and Sports (VWS).
The local and regional focal points are mostly funded by municipal budgets. Unfortunately, these budgets are rarely structural (project based funding). This presents a main bottleneck and accounts for the varying number of local projects carried out.
The implementation of the activities is funded by several partners: municipality, health insurance companies, health care centres, budgets from the national government aimed at supporting (doctors working in) poor neighbourhoods.

Management

There is a very close working relationship between all levels, from the national focal point to the members of the target group. Apart from the division of responsibilities as described above, the demands from the local/regional focal points direct – for a large part - the activities of the national focal point. And the demands of the ethnic educators and consultants direct the choice of activities for the local focal points. Also main stakeholders, such as general practitioners, take part in the decision making process.
Last but not least: the content of the educational meetings is decided upon by the immigrants who attend the meetings. Their needs and questions establish the program.

Indicators

The development and effect of the project is measured by the following indicators:

- number of educational meetings and the subjects required by the target group;
- number of referrals of immigrant patients by the health care professionals
- degree of contentment among both the patients and the health care professionals
- improvement of communication between patients and professionals
- increase in level of knowledge among the immigrants concerning the educational subject or information supplied
- change in care-seeking behaviour among immigrants
- increase in feeling of empowerment

Evaluations are carried out on local level. As a result reports and other publications refer to a variety of projects, ranging from small to more comprehensive programs.

Results

Since the start of the project in 1986 the number of participating cities has increased from 5 to 17 in the past years. The number of ethnic health educators/care consultants has increased from 30 to 195.
Annually the local focus points in the larger cities organise about 1000 group meetings. In smaller cities the average is about 200. All over about 60.000 educational contacts with immigrants take place annually.

The general conclusion of the evaluation of the *educational group meetings* is:

- This is an important approach, and in fact often the only way, to actually reach those immigrants, who are difficult to reach with general health education in the Dutch language.
- Through this project these groups are given the opportunity to get information on health (care), to ask questions in a setting where they feel at home and where they meet fellow citizens in the same position. Peer group support is an important side effect.

The general conclusion of the evaluation of *the intermediary function of the ethnic care consultant* is:

- The quality of care has improved because both the patient and the health care professional have a better understanding of the complaints;
- Because of this better understanding patients are more willing to accept the diagnosis and to follow the instructions.
- Patients are more able to solve simple medical problems themselves; therefore the amount of ‘unnecessary’ medical consults have declined
- Patients have a better understanding of the organisation of the Dutch health care system
- Patients are better equipped to take care of their health problems
- Health care professionals experience an improvement in the doctor-patient-relationship and better understanding of the cultural background of the patients.

In short: the project ethnic health educators/care consultants has conquered a stable position in the setting of public health and health care. All partners concerned are very positive about the results and convinced of the value of this approach.

Conclusions

The approach of the project ethnic health educators/care consultants fits into the widely recognized theory that tailor-made interventions, that are adapted to the needs of the target groups (or to individual needs) increase the effectiveness of health promotion.
This is especially important in groups that are normally difficult to access, such as immigrants.
The project contributes to more equal access. The first steps to bridge the gap between the immigrants and public health have been taken. Immigrants are better informed about health issues; they know where to find information and care and are able to communicate better with health care professionals. Furthermore, they are better equipped to manage their health problems.
More and more municipal health policy makers have turned their attention to this approach. This makes clear that policy makers take this approach seriously and put it forward as a solution to adequately reach immigrants. Unfortunately, this had not yet resulted in structural subsidizing

Future

Outline steps that you may take to extend the practice, further improve the model or suggest other possible applications of the model (i.e. applications to other populations, etc.)

The main focus for the near future is to realise structural financing of the project and to extend the project to more cities. This will be achieved by further advocacy and emphasising the positive results so far. Also, more comprehensive evaluation studies will be conducted in order to fortify this body of evidence.

Furthermore, this project is believed to be most successful if the function of ethnic health educators/care consultants is accepted as a part of the formal, regulated health care. Therefore the next step is to work on further professionalizing and job specification.

Lessons learned

Weaknesses:

So far, not all projects have structural funding. This means that the project's future is often uncertain. As a result, educators/consultants who function very well may choose a different kind of employment. The fact that the projects form no part of the formal health system makes it vulnerable to economy measures. Also, the body of evidence needs to be broadened in order to satisfy the demands of potential financiers.

Strengths:

The project has not only succeeded in reaching the hard-to-reach (immigrants), but also in increasing their knowledge on health matters and the level of empowerment. The project is a very good example of a tailored approach of health promotion.

It supports health care workers in the most practical sense by offering assistance that is very well informed and closely linked to the immigrant patients. It offers a solution to the (communication) problems and misunderstandings bound to the culture.

As a result it makes (public) health care more accessible for immigrants.

Testimony:

By a Turkish participant (female, 32 years old) of a group meeting on child care.

"Thanks to the meetings a new world has opened up. I have become a different person. It was the first time I discussed my problems with other women. I used to be tired all the time. I didn't take care of myself and sometimes stayed in bed all day. Now I have become a very active person, I go outside and meet people. I talk about what I learned at the meetings with other women. A lot of Turkish women are not aware of these advises on child care. "

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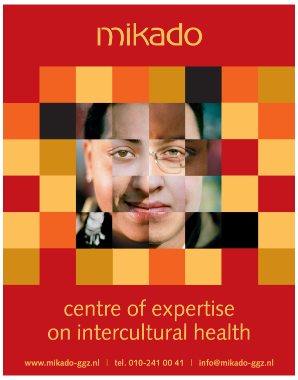

HAVE YOU GOT THE POWER? EMPOWERMENT OF MIGRANT ADOLESCENTS IN DEPRIVED AREAS OF THE CITY OF EINDHOVEN, THE NETHERLANDS.

Introduction

Forty to sixty percent of adolescents living in the large cities in The Netherlands are of migrant descent. Many migrant adolescents experience problems connecting with Dutch society. Especially boys are often stuck between the strict behavioural obligations at home and the liberties outside. Their frustration is often expressed in rebellious, and sometimes aggressive behaviour. Doing so, they cause nuisance to other citizens. Citizens project these negative experiences with a small group of migrant adolescents to all migrant adolescents. In some neighbourhoods, rebellious adolescents cause problems. If not treated, these adolescents may marginalise and develop psychological problems.

Migrant adolescents have an increased risk for marginalising. This is shown in the number of migrant adolescents in youth crimes and in the overrepresentation of migrant adolescents in lower levels of secondary education and premature school dropout. This increased risk for marginalisation is related to factors like, little social and/or intellectual skills, insufficient knowledge on societal norms, unfavourable socio-economical position, poor family functioning, difficulties in coping with individualistic Dutch society, their minority position and identification with low social status (Eldering & Knorth, 1997).

Goals and Objectives

Overall goal:

Prevent the marginalisation and development of psychological problems in migrant adolescents.

Objectives:

Moral values:

- Strengthen identity and enhance daily competences,
- Shift orientation of values
- Explicate personal moral values and get acquainted with other people's moral values

Identity:

- Shift from external to internal locus of control
- Develop a sense of pride and respect for their own culture and other people's cultures
- Develop knowledge on personal qualities and how to use them effectively
- Increase self consciousness
- Strengthen mind, body, and soul

Behaviour:

- Stimulate students to think before they act, and fight 'this is how we do things in my culture'-argumentation
- Learn to anticipate on the consequences of their behaviour for themselves and for others
- Develop behavioural alternatives
- Develop empathy
- Learn how to develop personally without harming other people's rights
- Learn the importance of a solid education

Field of intervention

Prevention

Scope

The model, training and evaluation materials were developed by the Trimbos Institute. These materials can be used troughout The Netherlands. The implementation of the model, however, has a regional scope. The Public Mental Health Service Eindhoven has had the most experience with implementing this model thusfar.

Provider

This project was carried out in a collaboration between the Public Mental Health Services and several private grassroot and youth organisations in the Eindhoven region.
Other partners in this project were: Mikado (Knowledge center on intercultural mental health), Eindhoven Municipality, CWI (Public Institute for Work and Income), Eindhoven Police department, Novadic-Kentron (Centre for treatment of substance abuse and addiction), Buro Halt (Youth crime prevention), Loket W (municipal organisation for information on welfare projects and legislation), Eindhoven Municipal Public Health Department, Trimbos Instituut (national knowledge organisation on mental health care).
Specific project organisation and management is described under 'Management'.

Model

In general, the model has been developed by the Trimbos Institute (De Kracht van Power, Henrike van Diest, John Wennink and Glenn Uiterloo, 2005). The model has been adapted and implemented in the Utrecht and Eindhoven regions. Public Mental

Health Services Eindhoven has had te most experience with implementing the model thusfar.
The program aims at migrant adolescents who display risk seeking behaviour and are at risk for marginalizing. Furthermore, the program aims at underachieving migrant adolesents. Marginalised and overtly aggressive adolescents were not part of the program (i.e recognized criminals).
The program consists of an empowerment training for migrant adolescents. In the training they learn social skills, strengthen their identity and social integration. Also, parents, teachers, friends and key figures in the communities were involved. In the training, attention is paid to cultural identity, relationships, healthy life style, education and work, and future perspectief. The parents were invited to educational meetings, which consists of information on the training and the request to support their children in their new behaviour and respond adequately to them.
Peer support is also part of the empowerment program. Adolescents that follow the training succesfully are invited to become an assistant trainer for other adolescents (Training of trainers-model). In doing so, the program creates positive role models.

The program's model distinguishes three levels of empowerment:

- Personal empowerment
- Interpersonal empowerment
- Political empowerment

Core values

Several core values lie at the basis of this program. We believe that:

- To invest in youth is to invest in the future.
- A multi-ethnic society is unavoidable and should be be celebrated instead of feared.
- Focus on qualities, skills and opportunities is more helpful than a focus on problems and failure.
- In the same respect, focus on 'changeable' maladaptive attitudes and behaviour is more helpful than a focus on 'unchangeable' personality traits.
- Everyone should have equal opportunities for succesful living.
- The best way to involve people is by bottom up instead of top down programs.
- To involve migrant adolescents the point of reference should be the experiences and way of living of the migrant adolescents.
- It is valuable to invest more in preventative interventions and not to wait untill secundairy intervention is needed. This is not only valuable from a moral but also from a cost-effective point of view.
- Regional projects allow for more flexibilty of the intervention. Nationwide intervention are too bureaucratic and will loose the match with the target population.

Resources

Funding is provided by the Eindhoven municipality and Public Mental Health Services Eindhoven

Management

Overall management was the responsibility of the Public Mental Health Services Eindhoven.

The program has been developed by the Trimbos Institute. Furthermore, they provide training and evaluation of the local projects. Local grassroot and youth organisations in the Eindhoven region were responsible for the projects activities, i.e. training of parents and students. Eindhoven Municipality and Public Mental Health Services Eindhoven provided the project finances. Mikado described the project in her Good Practices Publication series.

The other partners were invited to provide lectures in the training and were involved in the recruitement and readjustment of the students: CWI (Public Institute for Work and Income), Eindhoven Police department, Novadic-Kentron (Centre for treatment of substance abuse and addiction), Buro Halt (Youth crime prevention), Loket W (municipal organisation for information on welfare projects and legislation), Eindhoven Municipal Public Health Department.

Indicators

Satisfaction with the program:

- Number of applicants
- Program drop-out
- Number of spin-off projects

Effect on the students:

- Improved school results, decreased school drop out rates
- Improved identity using scores on the Twenty Statements Test (originated Kohn & McPartland, 1954)
- Improved coping styles using scores on the Utecht Coping List adapted for adolescents UCL-a (Bijstra, Jackson & Bosma, 1994).
- Decreased problem behaviour using scores on the Youth Self Report (Achenbach, 1993).

Effects on the neighbourhood:

- Less summary offences
- Lower levels of youth unemployment

Results

An evaluation on the effects of the program showed that the program:

- Increases feelings of control about the adolescent’s own life
- After the course the adolescents and their parents have better insight in their situation/way of life.
- The adolescents are more able to realise the consequences of their acts.
- The adolescents show more empathy for other people.
- The adolescents present less behavioural problems.

- The adolescents have a healthier lifestyle

Some quotes:

‘Without respect and appreciation for your own culture, you can’t respect and appreciate other people’s cultures’
‘First I was worried how other people should react to me. I do have another skin colour. After the training I could let go. I am who I am. And if you don’t like it, you’ll better accept it, because I can’t change it.’
‘An outsider can make you reflect on what you do good and what not. My mother was so preoccupied with her own situation that she didn’t see that her way of dealing with it didn’t work. Not with me, not with me in the home. In the training she learned: “This is how you can do it in another way”. Now we can talk to each other differently, in the language of empowerment, respecting others and ourselves.’
‘In my opinion applying for a job was an important subject, how to do that. And we also talked about education. Your perception changes after such a conversation. First I thought:”If I finish my school, that’ll be good enough”. But the trainer said to me:”Reach as high as you can!”. I know better what I want. I want to work as a counsellor. I want to feel that what I do means something to other people.’
‘If I don’t find a job, chances are high that I’ll fall back. That’s why that training is so important, to keep hope, to exchange experiences and advise, and to see that there are other young women in your situation.’

Conclusions and lessons learned

The following factors for the success of this program were determined:

- Program is connected to the adolescents’ own culture, their own experiences and their own way of living. Thereby one should take into account that different ethnic groups might require different types of trainers and different program content. The communication over the program should also be matched to the targeted adolescents.
- The program’s activities are located in deprived areas, that is, in or near the neighborhoods where the adolescents live themselves.
- It involves the adolescents’ social networks; their parents; it employs a community approach. In doing so, the program adopts a bottom-up instead of top-down approach and gives control and responsibility over the intervention to the people involved. The empowerment of the adolescents also empowers their social environment.
- The program stimulates a strong group cohesion. Group characteristics that might disrupt the group cohesion, such as strong differences between the group members in gender, age or intellectual abilities should be avoided or be dealt with pragmatically.
- Rigid implementation of the model will not result in the same positive outcomes as a flexible and creative implemetation will.
- Working with competent trainers and role models is essential. The trainer should be experienced, but also feel connected to the adolescents’ way of living. Furhermore, the trainer should feel confident enough to confront both adolescents and parents with negative or maladaptive attitudes or behaviour.

Finally, the trainer must be able to reflect on his/her own cultural background in order to tackle maladaptive cultural attitudes or behaviours.

- To avoid the risk of too much dependence to one particular trainer, assistant trainers should be employed.
- Because most of the targeted adolescents have short attention spans, active or participative group activities are preferred over passive group activities.
- The involvement of and the cooperation between different organisations active for these youths is essential.
- The program gives the adolescents skills to control their life, and realise a better future.

Future

The following recommendation for future application and improvement of the model were determined:

1) Structural evaluation of the program
2) Implementation of the program in deprived areas in other cities
3) Structural support for this program instead of temporary support
4) Adaptation of the program to ensure implementation in other European countries
5) Adaptation of the program to other (non-migrant) groups of marginalized adolescents (for instance in rural areas)

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ACCESS TO HEALTH CARE SERVICES FOR ALL MIGRANT PREGNANT WOMEN IN ROMANIA

Introduction

Migrant workers who generally are doing low salary jobs are facing many problems who are intensifies by there vulnerably position in society .With limited time work contract or as Agencies employed workers they receive small salary in bad work conditions compared with permanent employed workers. In this conditions health and security are a problem for emigrants.

Some migrants, who are in position of “temporary worker”, face difficulties in there attempt to obtain medical assistance in case of accidents and illness, because there is not a reciprocally agreement signed with worker origin country.

Other workers refuse medical treatment because they can not leave the workplace
The right of migrant to a decent minimum or adequate level of care, a government-as- last-resort approach is needed for them.

People who are uninsured or underinsured are more than twice as likely to report going without needed care because of costs. When they do receive medical care, they often spend a high fraction of income on out of pocket medical expenses and face financial difficulties. Uninsured people are often the only ones charged full price for health care; they do not benefit from discounts from providers negotiated by managed care plans, further raising access barriers and debt burdens for those who become sick.

Additional, language difficulties put a barrier in emigrant access to health services;

Translated health and treatment guidelines are important for migrant people. In order to manage their disease, for instance, emigrants must have health knowledge. They must know what an illness is, its causes, to have knowledge about medication, diet and exercise. Individuals must have current knowledge on illness complications to declare themselves to doctors.

Example of good practice for migrant supported by national unique health insurance fund are:

- pregnant and postpartum migrant women if have not any income or an income under minimum wages/ economy, are beneficiary of national unique health insurances, without any payment, in accordance with Romanian health laws;

- accordance with Romanian health laws, pregnancy and postpartum monitoring for migrant woman are performed even for those who are not health insured;

- Pregnant and postpartum migrant women are beneficiary of free treatments and free laboratory investigation if necessary even they can not pay for health insurance.

Goals and objectives

- Access to healthcare for all migrant women;
- Elimination of income, language, culture barriers that limit migrant access to health care services.

Field or determinant

Maternal and new born health

Scope

The scope is the health protection of migrant mother and her new born child. available at national level throw County Insurance Houses, part of National Health Insurances House.

Provider

The provider is the public one: the national unique health insurance fund.

Model

The Predisposing Vulnerable domain

Resources

The source of funding is the national unique health insurance fund who is obtain by 6% income tax for every ensured citizen.

Management of practice

The management of practices is performed by National Health Insurances House

Indicators

The indicators are demographic indicators which can be compared with resident population indicators and can give information about the results of this practice like:

- Migrant maternal death rate
- Migrant new born babies death rate

Results

The result is the health protection for all pregnant woman and new born babies including migrant people. Migrant maternal death rate and migrant new born babies death rate must be at the same level with general population. There are no epidemiological studies yet in this domain.

Conclusion

This good practice influence general population demographic and morbidity indicators.In absence of this good practice the number of death in pregnant woman and new born babies would be high and could affect the general population demographic and morbidity indicators.

Future

Maintain and improve this health good practice by improving specific legislation and diversify the health good practices for migrant people.

Lessons learned

Beside legislation, cultural sensitive approach of the migrant pregnant woman is very important for the success of this practice. In some cases pregnant woman have to be consulted by woman gynaecologist.

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MIGRANTS HEALTH IN THE SLOVAK REPUBLIC

Introduction

The Entry of the Slovak Republic into European Union brought changes in the solution of the Migration Health Policy. Besides protection of national interests of the Slovak Republic in the field of migrants health, the aims of the good practice project is to improve the access of migrants to prevention, public health and to health care services delivered by health care providers in Slovak Republic. The migrants have some specific health problem, which should be solved with systematic approach and measures.

Goals and Objectives:

The measures of the Ministry of the health Service of the Slovak Republic are grounded on the need to create health service conditions for migrants on the same level of health service provided in the other EU countries. This is also confirmed by the orientation of the measures towards international collaboration in the issue of approximation to the legislative strategy of the European Union. In the field of cooperation with partners, there is an effort to have a closer communication with Migration Office, mainly in securing contractual doctors working in retention and accommodation centres and in implementing measures associated with reducing health risks connected migrants.

Model - Measures to facilitate and finance healthcare for foreigners:

Healthcare for foreigners is provided to the extent and under the conditions laid down in the international treaties and applicable legal regulations for this area. For foreigners who are asylum seekers from countries with which the Slovak Republic has not made any agreement on free healthcare, healthcare is provided in compliance with the legal regulations applicable to this area under Act No 480/2002 on Asylum and on amendments to certain Acts.
Under *Section 22(5) of Act No 480/2002*, an asylum seeker is to be provided with emergency healthcare during the course of the asylum application procedure. In cases requiring special attention, where specific healthcare requirements are established upon an individual assessment of the asylum seeker's health status, the Ministry of Interior will pay the expense of any healthcare provided over and above the extent referred to the initial sentence above. The SR Ministry of the Interior will provide adequate healthcare to minors seeking asylum

who are the victims of abuse, neglect, exploitation, torture, cruelty, or inhuman and degrading treatment, or who suffer from the consequences of a military conflict.

The public health insurance of asylum seekers is governed by *Act No. 580/2004 on Health Insurance and on amendments to Act No. 95/2002 on Insurance and on amendments to certain Acts.* A foreigner having permanent residence within the territory of the Slovak Republic

- or employed with an employer domiciled in the Slovak Republic;
- or being a self-employed person;
- who is a person to whom asylum was granted;
- who is a student of another Member State, or a foreign student studying at a school in the Slovak Republic under an international treaty by which the Slovak Republic is bound;
- who is a foreign minor staying within the territory of the Slovak Republic without a legal representative or a natural person responsible for his/her upbringing, and who receives care in a facility in which he/she is placed under a decision of a court of law;
- a foreigner detained within the territory of the Slovak Republic; is to be insured under the public heath insurance scheme and to have the same rights and obligations associated with the provision of, and payment for, healthcare as an insured person who is a Slovak Republic national, as provided for in the applicable legal regulations.

Expenses for healthcare provided to persons subject to the asylum procedure are to be paid by the SR Ministry of Interior under *Act No 480/2002 on Asylum and amendments to certain Acts, as amended.*

Anyone who is not insured under the public heath insurance scheme, or to whom the applicable provisions of international treaties do not apply, is to pay for the healthcare so provided at “contractual prices”. It is left to the discretion of a foreigner to decide what form of insurance cover, if any, they will procure for their healthcare abroad. If a foreigner does not use a commercial health insurance option, they are required to pay the healthcare provider the full cost of any healthcare received.

Section 11(2) of Act No 576/2004 on Healthcare, services related to the provision of healthcare and on amendments to certain Acts, provides for the following: “The right to healthcare is guaranteed equally to everyone, in line with the principle of equal treatment in the provision of healthcare, as laid down in a specific regulation (Section 5 of Act No 365/2004 on Equal Treatment in certain areas and protection from discrimination, and on amendments to certain Acts). In accordance with the principle of equal treatment, any discrimination as a result of gender, religion or creed, marital status and civil status, colour of skin, language, political or other beliefs, involvement in any union activity on a national or social basis, health handicap, age, property, descent, or any other status is forbidden."

Where necessary, the Ministry of Health SR is to assist the Migration Office of the SR Ministry of Interior in providing contractual doctors for detention and residential centres.

Field or determinant

There is a certain risk of the occurrence of infectious diseases in detention and residential centres where migrants coming from different countries are gathered. Preventative measures and the application of appropriate crisis plans may reduce the health-related risks associated with the stay of migrants. Where a migrant shows signs of a transmissible disease, or comes from an area where there is a risk of the importation of a transmissible

disease into the Slovak Republic, the migrant is required to undergo a medical examination, including laboratory diagnostics and biological material sampling. The contractual doctor of the facility where migrants are accommodated is required to arrange the following:

- the initial medical examination of a migrant, including sampling and investigation of the circumstances relevant for the prevention of transmissible disease;
- where a transmissible disease has been diagnosed in a migrant, or the presence of a transmissible disease is suspected, or the migrant is suspected of being the bearer of infection, the isolation of the migrant or quarantine of the facility where the risk of putting public health at hazard due to the presence of a transmissible disease;
- preventative vaccination of children and adults;
- disinfection and pest control, including measures to prevent the transmission of an infectious disease from animals to humans;
- coordination of all their infection prevention activities with the appropriate public health authority, in accordance with the applicable legal regulations.

Resources

Contractual doctor for asylum seekers, including detained foreigners, stateless persons who have illegally entered, or illegally stay in, the territory of the Slovak Republic, shall be designated by the Migration Office of the Ministry of the Interior of the Slovak Republic. Contracts with healthcare providers for this purpose are to be made by the Migration Office of the SR Ministry of the Interior. The delivered health care for these groups of migrants to the contractual doctors are remunerated from financial resources of Migration Office of the Ministry of the Interior of the Slovak Republic.

Provider

The all primary health care providers (physicians) are private subjects, the hospitals are state owned or non profit (municipal) hospitals.

Management

The last couple off years and nowadays the Slovak government have been taken serious efforts to improve the cooperation between ministries, governmental and non governmental organisations in the issue of migration. Comprehensive approach have been recommended, because migration has become an integral part of economic and social development in EU countries. The need for better planning and management of migration has been widely recognised and is gradually being addressed by international and inter-government bodies. The health dimension of migration should receive more attention from receiving countries too.

In Slovakia is a strong need to acknowledge the health needs and health problems of migrants. The profile of migrants helps to identify some groups that are in a more vulnerable position, manly due to differential risks that they face. Migrants are more likely to suffer accidents, additionally if they are irregular, they become more vulnerable as if they are afraid of being

detected they are unlikely to come forward to claim labour or health rights. Refugees and asylum seekers encounter more mental risks and distress as consequence of war, torture, persecution, etc. Those who are subject of traffic or smuggling are confronted with exploitation and inhumane treatment that lead to over exposure to health risks.
To improve the health of migrants implementing of education activities is strongly needed on the both sides, for the health care proffesionals and for the migrants too.

In 2006 – 2008, the Slovak Health University, will continue its systematic educational activities for healthcare personnel who may, within the frame of the pursuit of their profession, influence the prevention of all forms of discrimination, racism, xenophobia and other manifestations of intolerance. The cyclical lectures will address direct and indirect discrimination prevention issues and the provision of healthcare in outpatient and bed healthcare facilities; the definition of discrimination and the international system of standards and the international human rights protection (UN International Convention on the Elimination of All Forms of Racial Discrimination and measures towards the elimination of racial discrimination in all its forms and the development of understanding among all races).

These measures aim at the comprehensive education of healthcare personnel, the prevention of all forms of racism, discrimination, xenophobia and other manifestations of intolerance in the provision of healthcare, and the creation of conditions for making adequate healthcare available to migrants, settlers and asylum seekers.
Awareness waking by migrants is strongly needed Some nongovernmental organisation are very active by helping migrants to solve problems related to the issues of housing, health, employment, human rights and education. These subjects can receive national or international (governmental or EU) support by realized project. As example the Non-governmental organization DOTYK (Touch) Slovak crisis centre published a multilingual leaflets for special group of migrants victims of trafficking or being forced to work under humiliating conditions. The aims of the non-governmental organization is delivering assistance and offering information for release from the criminal environment, psychological and social support, legal advice and basic health care. The Ministry of Health cooperated with non-governmental organization DOTYK and assured the dissemination of 9 000 leaflets to the primary health care providers, hospitals and nursing school and the other ministries acted on the same way too.

Indicators

Cooperation with nongovernmental organisation, which are active in the field of migrants needs will help by solving difficulties in access health services, assessment of migrants health needs and by creating suitable health indicators for migrants

Results

The legislative measures and preventive projects which were adapted in Slovak republic will improve the Health status of migrants in next few years.

Conclusions

The measures of the Ministry of the Health of the SR are grounded on the need to create health service conditions for migrants on the same level of health service provided in the other EU countries. The accessibility to healthcare should be broader and more universal (with emphasis in health promotion, prevention and treatment) in the next few years. This is also confirmed by the orientation of the measures towards international collaboration in the issue of approximation to the legislative strategy of the European Union.

The issue of migrants health will become more importance, in regard to economic and social development in Slovak republic.

The SR Ministry of Health cooperates with the Migration Office of the SR Ministry of the Interior in addressing the issues associated with the provision of healthcare to migrants. They are to maintain close communication in the implementation of tasks involved in the provision of healthcare to migrants.

INŠTITUT ZA VAROVANJE ZDRAVJA REPUBLIKE SLOVENIJE

Fondacija Robert
Žrtvam nevednosti in brezbrižnosti

PILOT PROJECT: PREVENTION OF THE SPREAD OF HIV/AIDS AND OTHER INFECTION DISEASES AMONG KEY VULNERABLE GROUPS IN SLOVENIA

Introduction

Slovenia is mostly a transit but becoming also a destination country for migrants. Balkan route, which goes through Bosnia, Croatia, Slovenia and continues further to the West through/to Italy, is the main land route for irregular migration.
Based on the Annual report of the National Working Group to Fight Trafficking in Human Beings there was 25 victims identified in Slovenia in 2004 and in addition the estimates suggest much higher number.
According to the Slovene Police report, there were 5.646 illegal border crossings in 2004, which represents 12, 6% of increase from the previous year.
The Ministry of the Interior reported, that there were 1.173 applications for asylum lodged in 2004 and 39 persons were granted asylum.

Slovenia is a low HIV/aids prevalence country The first two HIV/AIDS cases were reported in 1986 among Slovenian hemophiliacs who had received imported blood products. After the discovery of these cases, the state authorities began obligatorily screening of all donated blood for HIV antibodies, to guarantee safe blood transfusion. The same year anonymous and voluntary HIV testing became available.

The Slovenian AIDS prevention and care programme is integrated within existing health care structures and government departments and institutions.
As for anonymous HIV testing there was limited capacity, mainly for nationals. In practice it has happened that a migrant request for the HIV testing was rejected as they didn't have a sufficient standard of the health insurance.

Goals and Objectives

The aim of the HIV/AIDS prevention project which started in 2005 was the production of the information material through which the target group will be referred to the authorized organizations for further assistance.

The target groups of the project were vulnerable groups of the mobile population:

- victims of human trafficking
- irregular migrants
- asylum seekers and
- commercial sex workers.

The target group got the information brochure at various places where they live, spend their free time, acquire various services etc. Based on the contained information's they were able to benefit from the services provided at certain organizations and shape their policies and activities needed in the future.

Model

Research, prevention and intervention programme among migrant commercial sex workers in Slovenia; distribution of information materials and condoms, telephone counselling, anonymous testing.

Field of determinant

Health and social determinants.

Scope

The lack of information on how to address HIV/AIDS prevention activities among the target groups was also recognized by institutional authorities. With this project we were be able to fill the existing gap in the National Health System by informing the target groups about the HIV/AIDS transmission and promoting voluntary testing and counseling in the Clinic for Infection diseases also among the target group which has proved to be more vulnerable and under privileged.

One of the aims was to develop and distribute the information brochure on HIV/AIDS, which was developed in four different languages: English, Serbian, Russian and Slovene (languages identified based on the State migrant's statistics on their country of origin).

Another, more specific aim was also offer counseling in English, Serbian, and Russian once a week in the already existing anonymous telephone help line at the Aids Foundation Robert.

The development, translation and distribution of the information brochure addressed the issues such as:

- what is HIV and what AIDS,
- how it can be transmitted,
- how to protect yourself,
- testing possibilities,
- counseling possibilities
- which are the organizations in Slovenia that might help you etc.

Provider

The project was an initiative of the Slovenian Organization of Migration, AIDS Foundation Robert and Slovene Philanthropy.
The brochures and informations were distributed to the target groups through different governmental and non-governmental organizations such as:
- AIDS Foundation Robert
- Slovene Philanthropy-Center for the Promotion of Health
- Medical Clinic for people without health insurance and other relevant NGO's
- Clinic for Infection diseases
- Institute for Public Health
- Centre for Foreigners
- Asylum Home
- Foreign Embassies

and other

Resources

The mean resources were the enthusiasm and voluntary work of the key actors – the coordinator and other experts from the Infectious clinic, Aids foundation Robert and International office of migration. The financial resources for printing the brochures were from the Embassy of Netherlands in Slovenia and the City of Ljubljana.

Management

The project was managed by AIDS Foundation Robert and International organization of migration, office in Ljubljana. Professionals from different sectors and key organizations were invited. The project was supported by the Institute of Public Health in Ljubljana.

Indicators

-number of distributed information materials
- number of distributed condoms
- number of telephone counseling in foreign languages
- number of anonymous testing provided to migrant sex workers
- HIV prevalence and HIV incidence among migrant sex workers

Results

- research about the situation, problems and needs of migrant sex workers
- information brochure on HIV/AIDS developed, translated and distributed to the target groups
- distribution of free condoms to the target groups
- experts and decision makers were informed and supported free anonymous HIV testing
- development of communication strategy for migrant sex workers thou specific canals including bars, pimps

- target groups were informed about the HIV/AIDS transmission and possibilities of testing and telephone counseling in different languages
- target groups were informed and referred to the organizations working in this field in Slovenia.

Conclusions

Most of female sex workers on our country are migrants from East Europe. Sex work is an extremely dangerous profession. Sex workers are exposed to serious harms like drug use, blood borne diseases and STD, including AIDS, criminalization, and stigmatization. Successful and human-rights based strategies are avaible and include education, empowerment, prevention and condom distribution, accessibility of health services including free testing. and counselling. .

Future

We plan to evaluate the impact of the brochure on the knowledge of the transmission of diseases and prevention. In the future we will continue with the program and use it as a good practise for planning interventions among specific vulnerable groups to improve their accessibility of health case services.

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Lessons learned

With the involvement of different sectors an intervention can contribute to the reduction of harm correlated to sex work. Project has to refer to the specific needs of the target group. The best provider of the “grass root “ level are the NGOs with the support of experts and decision makers. For the sustainability of specific interventions long term and sufficient financial support is essential.

Testimony/picture

“I was confused and frightened to have got AIDS or hepatitis and that I have to die. After some anonymous telephone counselling and being HIV negative I decided to take myself in hand. I have hope and confidence now and plans to do something for my life. “

Testimony from Galina, 26 old sex worker from Ukraine

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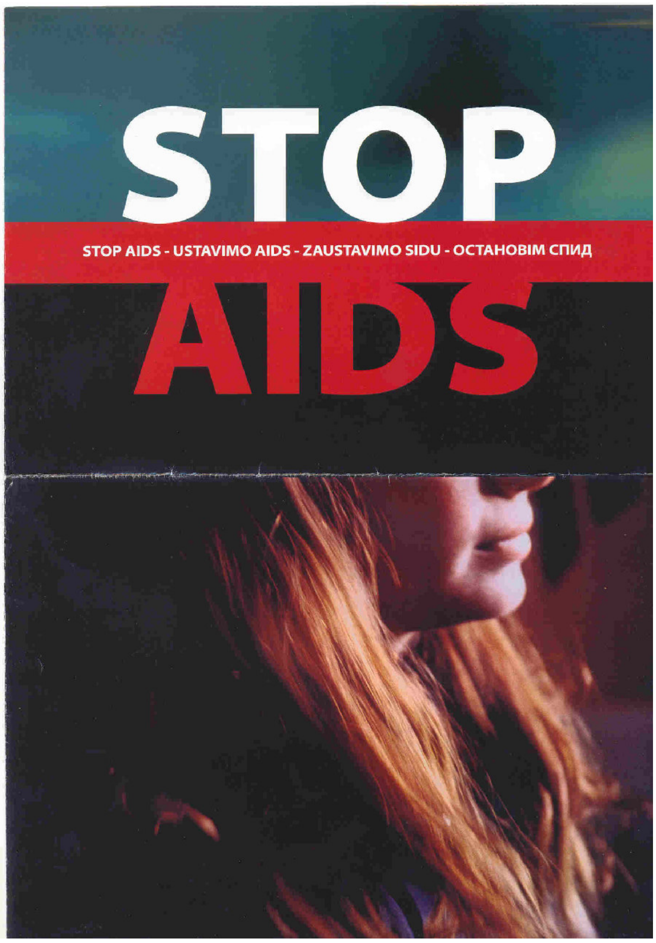

Associació Asociación
SALUD Y FAMILIA

MIGRANT FRIENDLY HEALTH CENTRES

Introduction

The "Migrant Friendly Health Centres" project was developed from 2003 to 2006 as a collaborative undertaking between the Asociación Salud y Familia (ASF) and the public health system (PHC) in Catalonia (Spain). ASF is a non-governmental, non-profit-making organisation which designs and promotes operational models for improved accessibility to and use of health services, targeting vulnerable groups as immigrants in social and cultural disadvantaged positions. In this project, twenty-five intercultural mediators have been working in five Hospitals and nineteen primary healthcare centres and have been offering direct intercultural support to more than 38.350 immigrant patients from de Magreb, Sub-Saharan Africa, Pakistan, Romania and China.

Objectives

- Improve general conditions for the provision of healthcare to the immigrant population.
- Increase the availability of culturally adapted services.
- Improve communication by breaking down language and cultural barriers between healthcare staff and immigrants.
- Reduce unnecessary burdens on workload through reduction of intercultural conflict.
- Increase appropriate use of services and the level of satisfaction among patients from the immigrant population.

Model

The frameworks of procedures being used to improve general conditions for the provision of healthcare to the immigrant population are:

- Broad availability of intercultural mediation services to provide support to immigrants and healthcare staff.
- Identifying the needs for intercultural adaptation of the health centres and hospital's services, products and routines.

Determinants

The determinants involved in this project are preventive and curative health care, health education and promotion specially on the fields of maternal and child health and family health.

Scope

This project is implemented at the regional and local level in Catalonia until now.

Provider

Joint leadership and partnership between the public healthcare system and Asociación Salud y Familia has been established in order to encourage collaboration and the sharing of knowledge, expertise and innovation.

Resources

The project is financed by social and public funding. The main stakeholders are Catalan Health Service and Women Institute of Spain.

Management

Public funding: Catalan Health Service and Women Institute of Spain.
Social funding: Obra Social "Caja Madrid".
Direction: Asociación Salud y Familia

Hospitals in collaboration:
HOSPITAL CLÍNIC MATERNIDAD (Barcelona).
HOSPITAL DEL MAR (Barcelona).
CENTRO PERE CAMPS (Barcelona).
HOSPITAL JOSEP TRUETA (Gerona).
HOSPITAL ARNAU DE VILANOVA (Lérida).

Primary healthcare centres in collaboration:

BARCELONA CITY:
CAP DRASSANES.
CAP RAVAL NORTE.
CAP CASC ANTIC.
CAP POBLE SEC.
CAP POBLE NOU.
CAP BESÓS.

BAIX LLOBREGAT (BARCELONA)
EAP CAN VIDALET.
EAP SANT ILDEFONS.
CAP LA FLORIDA.

CAP PUBILLA CASES.

GERONA:
CAP CAN GIBERT.

LÉRIDA:
CAP BALAGUER.
CAP MOLLERUSSA.
CAP CERVERA.
CAP RAMBLA FERRAN.
CUAP RAMBLA FERRAN.
CAP TÀRREGA.
SASSIR PRAT DE LA RIBA.
CAP GUISSONA.
CAP ALCARRÀS.
CAP SERÓS.
CAP AITONA.

The stakeholders are taken into account by means of periodical discussion of results and methods. The cooperative hospitals and Asociación Salud y Familia have created a emulation permanent group with the participation of managers.

Indicators

The quantitative development of the various activities carried out in the health centres and hospitals by the intercultural mediators as well as the characteristics of the immigrant attended are in a computerised database.

The qualitative development of the project is monitored by means of periodical advisory sessions which ASF holds within the various health centres and hospitals with the goal of fostering and improving the effectiveness of the collaborative project.

Results

- ➪ The activities carried out by the intercultural mediators -providing translation, information, support and intercultural mediation- have advanced rapidly. The variety of functions performed by the intercultural mediators has multiplied in tandem with an important rise in the number of immigrant patients attended to (38.350 people).
- ➪ The project is developed in 5 hospitals and 19 primary healthcare centres. The health staff members who use the intercultural mediation services with greatest frequency are doctors and nurses, followed quite far behind by the administrative staff working in patient reception and planning.
- ➪ The public healthcare system is adapting, interculturally, numerous information and health education material and it has initiated a revision process for procedures that generated intercultural conflict.
- ➪ There has been a notable increase in intercultural continued training for healthcare staff.

Year 2005	Year 2006
Users served: 28.335 people	**Users served: 8.492 people.**
Consultations made: 94.998	**Consultations made: 27.930**
Consultations for user: 3,9	**Consultations for user: 3,3**

Conclusions

The availability of permanent intercultural mediators within a stable "Migrant Friendly Health Centres" collaborative project offers immediate improvements in the care given to immigrant patients while simultaneously facilitating a specific and substantial development in staff members' cultural competencies through daily exposure and continued intercultural training. So, intercultural organisational development has become part of public healthcare system agenda.

The factors which contribute most to staff's use of intercultural mediation services are the presence of an active migrant friendly policy promoted by health centre management, the availability of stable intercultural mediators, and the external advisory sessions with ASF which foster a process of continual improvement.

Future

The experience of public healthcare system in collaboration with Asociación Salud y Familia provides a feasible and innovative model of good intercultural practice which can be expanded and adapted to other hospitals and health centres.

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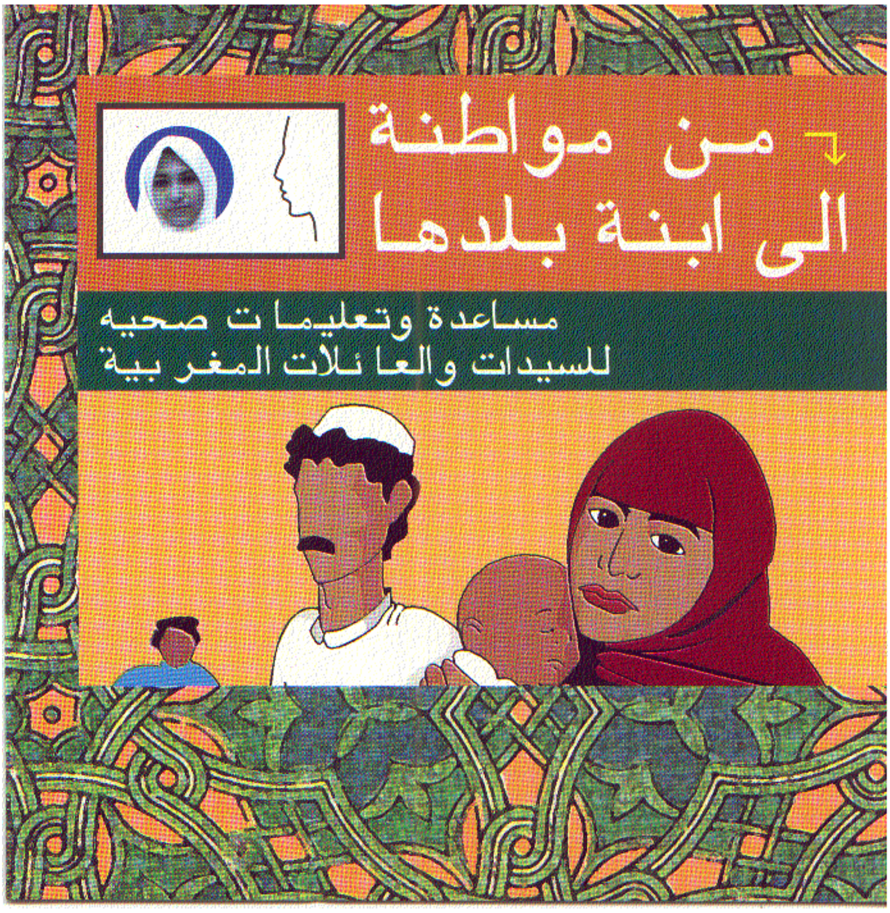
Lessons learned

- The partnership between hospitals, health care centres and Asociación Salud y Familia allows for the process to be assessed in real time and for short and medium-term detection and meeting of new needs for intercultural adaptation and Project visibility.

- Intercultural organizational development has come to stay in the institutional agenda of the hospitals and health care centres in collaboration.

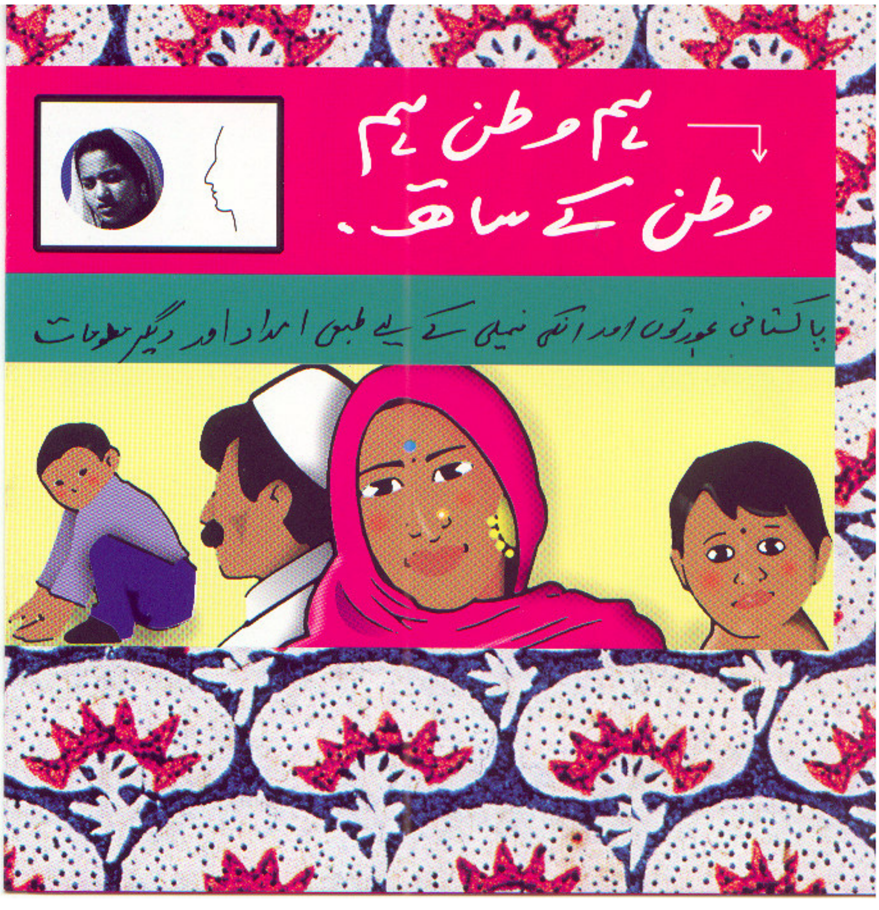
- The Project puts forward a sustainable model with financial and organizational aspects they that can be easily adapted in other health organizations around Europe.

Pictures



من مواطنة الى ابنة بلدها

مساعدة وتعليمات صحيه
للسيدات والعائلات المغربية



ہم وطن ہم وطن کے ساتھ۔

پاکستانی عورتوں اور انکی فیملی کے لیے طبی امداد اور دیگر معلومات

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RECS
Red Española de
Ciudades
Saludables

Ayuntamiento de Leganés
Delegación de Salud y Consumo

HEALTH IMPROVEMENT PLANS OF THE IMMIGRANT POPULATION IN THE CITY OF LEGANÉS

Introduction

Leganés is a municipality in the Metropolitan area of Madrid, which is located SW of the Capital of the Autonomous Community. Its proximity, combined with its excellent transport network (motorways, train, metro), have converted Leganés into a city with a growing population. According to the 2006 census, Leganés has a total population of 186,025 inhabitants. 21,330 are foreigners, which means, 11.5% of the total population, where there are significant differences in terms of age, gender, education levels, and employment:

- The average age of Spanish citizens is 10 years older than the foreign population, 15% of Leganés' total population between the ages 20-39 is constituted by immigrant population.
- The proportion of men and women is 116 men per 100 women, which varies according to nationalities.
- The average educational level is unequal according to nationalities and below the native population. In relation to employment levels, the activity rate is substantially higher than the native population, above all among women. On the other hand, their jobs are less stable.
- The concentration in the neighbourhoods is related to the social networks. Neighbourhoods such as La Fortuna, Centro, and San Nicasio support a greater proportion of the immigrant population.
- The average size of the households is 4.30 persons, which causes a certain degree of overcrowding, considering the average surface area of the residences which they occupy.

The trend is that there will be a continual major increase in the foreign population from Eastern European countries, specifically Rumania, in addition to the effects of family regrouping.

Independently of the competency framework, the Local Administration has become the “manager” of the migratory phenomenon and the Town Hall is where the immigrant population address their demands for the following services: Healthcare, Education, Housing, Employment, etc.

Citizenship and Immigration Plan.

The Leganés Town Council decided to prepare and approve an Immigration Plan with an integrated social and participation approach, which involves all the people in the neighbourhood, including the new neighbours in order to build a united, open, and diverse city with its own identity in an educational, healthy and sustainable way. This is the primary motive for the plan:

The size and importance of the immigrant population in the municipality and their impact on municipal services, as well as the native population's perception about this situation.
The Leganés Town Council has always shown a special awareness concerning the immigrant population. It must be taken into account that Leganés has always been a host city. During the early Sixties in the 20th Century, its population increased due to the persons who arrived from other geographical areas of Spain, where in 1970, the city grew from 5,000 to 175,000 inhabitants in a decade.
Foreign immigrants primarily began to populate the city in 1990; and their characteristics and needs are different. However, there is a common denominator which consists in the integration of new neighbours inside a new space as well as those who have been uprooted from their native lands. Consequently, the actions and programmes addressed to this population were already being developed in the Nineties, essentially in the social services sector.

In 2003, Leganés launched its Health Plan within the context of healthy cities. Based on the Diagnosis of the Health situation which has been achieved in this Plan, it has analysed the immigration phenomenon in the city as well as its short/medium term projection, and consequently, it includes specific actions addressed to the immigrant population in the First Municipal Health Plan (2005-2008).
Nevertheless, the need to provide an overall comprehensive response to the immigration phenomenon has motivated the Town Council to regroup all these varied initiatives into different Municipal intervention areas; consequently the **"2006-2009 Citizenship and Immigration Plan"(PCI)** was proposed and unanimously approved on the 20th of June 2006. It contains the objectives and actions of **2005-2008 Municipal Health Plan (PMS).**

General Objectives of PCI

1. To establish a **reception** system, to promote full **integration**, assure the population's access to the common basic services in conditions of **equality** with the rest of the population.
2. **To coordinate** the overall actions by the Town Council and other institutions.
3. To carry out actions arranged with all the **social agents.**
4. To introduce a gender perspective as the transversal axis of all the activities.
5. To fight against all forms of **exclusion,** encouraging **coexistence and social cohesion.**
6. To establish an **information system** which permits genuine knowledge of the situation.
7. To develop **cooperation policies for development** as a strategy to improve living conditions and the qualifications of the foreign population.

Intervention Areas

The Plan has been structured into 11 intervention areas: Reception, Employment, Education, Culture, **Health Care**, Housing, Social Services, Participation/Association Membership, Cooperation for Development, Awareness, and Institutional Organisation. The perspectives of gender and youth have been presented as its transversal axis.
Focusing on the **Health Care intervention** area, we highlight that immigration has had and continues to have a significant impact on the Health Care Services, which necessarily

involves the reorientation of these Services, which must be handled from the Local scope, due to the differences which exist among the zones.

Our legal system guarantees the right of Health Care assistance to foreigners (ORGANIC ACT 4/2000, of 11th of January, concerning the rights and freedoms of foreigners in Spain and their social integration). Art. 12 establishes that the foreigners who live in Spain and have registered in the Census Registry of the Municipality where they normally reside, possess the right to Health Care assistance in the same conditions as Spanish citizens.

In addition, the right to public Health Care assistance has been extended to the foreigners who are in Spain who are not registered in the Census Registry and who require urgent assistance in the case of suffering from serious diseases or accidents, regardless of their cause, and the continuity of this Health Care until the hospital release situation. Minors under the age of eighteen and pregnant foreign women also possess equal treatment during pregnancy, birth, and post-partum, when they are in this circumstance.

The registration in the Census Registry provides the right to a Health Care Card. Town Councils are in charge of managing this Census Registry. Census Registration is mandatory and allows new neighbours to access all the city services (Health Care assistance, education, employment, etc.) For this purpose, a major effort is being made to inform all the new neighbours who arrive in the city about the benefits involved in the Census registration and to facilitate their processing, since this can be performed in person in the Town Council Offices or by ordinary post, where in this case, it is possible to download the forms by Internet. In order to register in the Census Registry, it is necessary to present the following items, jointly with the properly completed form:

- The Foreign Residency/Work Permit or Passport. In the case of citizens from Member States of the EU, the National Identity Document in force.
- Contract of rental or purchase, or if you are not the Owner of the residence, an authorisation signed by the Owner, of age.

The Leganés Citizenship and Immigration Plan in the Health Care sector has the general aim to promote and guarantee the foreign population's access to the Health Care Programmes and Services, adapting and focusing them in order to provide quality attention.

Consequently, the **General Objective** is to guide the Municipal Health Care Services to provide quality attention to the immigrant population, which suitably handles the diversity of this collective.

Specific Objectives of PCI and PMS

- To know and consider the aspects which condition the **access and usage of the health care services** for the immigrant population.
- To develop information programmes and design **adherence strategies** for the programmes with a major impact on health: Maternity-Child Care, Paediatrics, Mental Health, Diet, Nutrition, Physical Activity, etc.
- To focus the **Health Care Promotion** programmes on the immigrant population.
- To stimulate the **participation** of the immigrant population in the Sectorial Council of Heath (Consejo Sectorial de Salud) and other participation organisations in the local scope.
- To develop policies for the identification and eradication of xenophobic attitudes by means of **Education in Values** in Schools, Cultural Centres, Civic Centres, Public Institutions, etc.
- To promote **the role of women** and their active participation in conditions of equality.

- To train the **Health Care Professional Staff** and implement the figure of **Mediator.**
- To work in **networks** at a Local, Regional, National, and European level.

Methodology

- Adaptation of the Health Care Assistance, Prevention, and Promotion Services in order to facilitate the reception of these new male and female neighbours, which prevents their exclusion and consequently, differences in their health levels.
- To encourage the use of these services with suitable procedures of communication, information, empathy, etc.

The Development Agent of these actions is the Town Council of Leganés, by means of the Health and Consumer Affairs Department in coordination with other Heath Care Institutions which provide services in the local territory and relying on all the social agents, which work in the health sector in the city. It has established a Political structure, which is headed by the Mayor and the Councillors of the respective Departments and a Technical structure.

Resources

This is essentially the municipalities with external contributions from other Public Administrations, by means of agreements and/or subsidies. From the different Municipal departments, once the annual activities have been determined, then the required expenditures will be committed.

Lessons learned

The Migration phenomenon should not be treated as a problem but rather as a complex phenomenon intimately linked with all the world's people where the main characters are the persons whose needs and rights must be recognised.
This complexity is especially evident in the City environment and the Local Administration's proximity to its citizens; it is the place where it is possible to combine a strategic vision, integrated action, and the participation of all the social agents.
We must be increasingly aware that the city has become more diverse and consequently less homogeneous which must inspire us to work with another vision in the local scope, which favours a cultural change, both at the political level by its incorporation in the political agenda as well as the traditional way of providing services to its citizens; thus abandoning isolated individual actions and promoting coordinated and synergetic actions.

Evaluation.
At least one year since the Plan's implementation, we have achieved the following results in these intervention areas.

Intervention Areas	Participants:	2005/2006 Actions/Results
Institutional Organisation	Citizenship Participation – Cooperation – District Meetings	Creation of Social Agent Boards
Institutional Organisation	All the Municipal Areas	Creation of a Technical Board
Hosting	Statistics	Publication of 20,000 hosting

	Computer Database – SAC*	guides in 6 languages. Digital Leganés Project/Citizen Assistance Service (SAC)*.
Culture	"La Fortuna" District Meeting – Institutions Network Cooperation – Citizen Assistance Service – Technical Board	Spanish Courses for Foreigners (6 courses – 95 registered participants) Contracting of Translation Service
Health	School Health Board Health Women/Childhood – IX Area Cooperation Social /Women's /Mental Health Services	Revision and adaptation of programmes in Schools according to itineraries. Preparation of Sexual Education and Immigration Programme. Mediator Courses: 25 participants/60 hours. Women's Assistance/Health Care Programme 87 interventions.
Citizen Participation	Technical Board	Aid for Immigrant Association Activities (8 projects)
Education	School Support	Aid to 12 Centres for Integration Promotion Activities
Childhood	Council of Childhood Affairs	Creation of "Leganés en Colores" ("Leganés in Colours") CD.
Education/Cooperation	Schools without Racism	10 centres
Communication	Citizenship Entities - Communication	Publication of 20 information brochures in 6 languages.

*2004 Dubai Good Practices Award.
http://habitat.aq.upm.es/dubai/04/bp1329.html

Conclusion:

The importance and status which the immigrant population are acquiring in the city and their impact in relation to the Municipal services, with special attention on Health Care services as well as in the Spanish citizen population, make it necessary to possess a reference framework: Strategic Plans, which are properly implemented and provide greater emphasis on the actions and projects which are developed at the local level and which have a major impact among these "new neighbours", which allows all parties to share their ideas, objectives, and methods. It permits the clear expression of the political commitment and foresees with sufficient advance notice all the required actions and measures which promote the integration and accommodation of the immigrant population.

The Health Care problems of the immigrant population, although they include groups which require special attention, are basically the same as the rest of the population, and they are very related to cultural factors as well as living conditions and customs, with the barriers that they encounter in their country of reception, thus it is necessary to perform the actions *focused on eliminating the barriers that cause these inequalities and encourage the access of these collectives to Health Care and other services in the same conditions as the rest of the population.*

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INTERNATIONAL HEALTH ADVISORS IN A MULTICULTURAL SOCIETY

Dissemination Project 2006-2007

Empowering migrants – health promotion and accessibility

Introduction

Studies indicate that public health is poorer among immigrants than among the average Swedish citizens. The migration process itself affects the health by high level of stress. Several reasons are to be found in the fact that immigrants are excluded in many senses. Immigrants have also suffered heavy losses e.g. economy, family and social position.

<u>City of Malmö – home of International Health Advisors</u>

City of Malmö is situated on the very south west coast in Sweden. 26% of the inhabitants are born in foreign countries. Health problems do not just affect the person suffering from poor health but also the whole family and especially the children. Poor health hinders people from participating in education activities and training programs, excludes people from the labour market, causes high costs for the society and interferes with economic growth.

Goals and Objectives

Raising awareness of healthy lifestyle and knowledge about the health care system

One idea to combat health inequalities was to raise knowledge among immigrants about health, self care, health promoting lifestyle – physic activities, healthy foods, sleeping habits, drugs – and about the Swedish health care system and how to use it. This resulted in a project called International Health Advisors, IHA.

Combating inequalities in health and reduce costs

The IHA projects aimed at combating inequalities in public health and promote health among immigrants. An equally important objective was to reduce the costs for the society in form of high costs for medical care and treatments, for unemployment due to ill health and for social problems caused by a large group of citizens being excluded form normal living conditions.

Taking advantage of immigrants competences and reducing unemployment

The IHA project was also expected to make use of immigrants with experiences and training in medicine and care from their countries of origin but being unemployed. They were not able to work in their former occupations as doctors, nurses, dentists, physiotherapists etc since they did not meet with the requirements for these occupations in Sweden. By employing theses immigrants and training them for the specific duty as International Health Advisors, IHAs, they could become self-supportive, use their abilities and contribute to the development of the society. The IHAs' multicultural and multilinguistic competences made them special and not interchangeable with others.

Model

IHAs are building bridges between immigrants and the major society. The framework of health advising activities is the introduction program inclusive the course *Swedish for immigrants.* This arena is used since it guarantees that the main part of immigrants will be addressed. Other very important arenas are primary health care centres and the child health care centres. By advising parents it is presumed that the effects will be sustainable.

Health advising activities in special classes, lead by people talking the mother tongue of the participants and having very much the same experiences from the time before migration and the migration process, is presumed to be effective, due to trust, since the advisors are being regarded reliable.

Health advising sessions are also offered to NGOs and performed in cooperation with NGOs, mainly organised on an ethnic basis.

Field or determinant

Health promotion, preventions to keep healthy, knowledge about the health care system and how to use it, about attitudes towards medical treatment contra life style factors for treating ailments, the medical staffs' different duties and competences and differences between bacteria and virus, and their different treatments, are areas covered. Mental health problems are brought up as well as sexual health and sexually transmitted diseases. It's regarded that knowledgeable persons can behave adequately within the system; make well grounded choices and take appropriate decisions.

Asylum seekers in Sweden are offered a health screening program consisting of a general examination and an interview about the individual's health as well as the health of the family if appropriate. An IHA is available at the Health care centre for asylum seekers, Vårdcentralen Flyktinghälsan. The advisory sessions deepen the information given by the nurses and aims at convey trust and security.
Asylum seekers are offered Swedish language tuition. IHAs give lessons, integrated in the educational program.

People with a permanent residence permit are offered Swedish language tuition, information about the society at large, the labour market and possibilities to practice in a workplace in an integrated package, often called introduction program. In Malmö the IHAs give lessons integrated in this program to promote health and combat inequalities in health. In these programs it is strongly stressed that the Swedish language teachers shall elaborate the content in this health advising sessions to deepen the understanding and to support the immigrants acquiring skills to deal with the health care services in Swedish. This will lead to more adequate treatment when needing care and it will lower the costs for interpretation in the health care system.

At child health care centres IHAs can explain more thoroughly the information given by the Swedish speaking staff and establish trust and security. IHAs invite to group sessions where they talk about bringing up children, about healthy foods, children's diseases, vaccination programs, about preventing health problems by e.g. not giving babies and children sweet drinks and biscuits.
IHAs work together with specialist care in order to produce material that can be used in classes for persons with certain diseases to teach them self treatment and how to lead a good life despite the health problem.
IHAs also produce information material in writing illustrated by pictures to support the advising sessions and to invite to new sessions.

Scope

IHAs in Malmö are organised as a unit within the primary health care. The work is performed within the legislation concerning the health sector. The content and the quality are guaranteed by the health authorities on the regional level overviewed by The National Board of Health and Welfare.

Provider

Health advising activities for immigrants are run by several municipalities and cities, very often in cooperation with Regional Boards of Health. By presenting the advisory activities within the introduction courses offered to almost every newly arrived immigrant – despite of legal status – a high number of the total group is reached.

Resources

The project was initially from 2001 funded by the National Metropolitan initiative, by the City of Malmö and the Regional Board of Health in Region Skåne. During the period 2002-2005 the Equal program within the European Social Fund has contributed to the funding and thereby have also asylum seekers become a target group.

Today is the health advising activity mainstream and funded equally by the City of Malmö and the Regional Board of Health in Region Skåne.

Management

IHAs are organised as a specialist unit within the primary health care and coordinated by a manager. The service can be ordered free of charge. The manager will prioritise the requests.

The health advising unit has during the establishing period been ruled by a special board. Today it is integrated in the normal democratic and organisational steering system for health service.

It has been very important to introduce and firmly establish trust and reliance between the permanent health care staff and the IHAs. It must be secured that IHAs are working in line with the public health regulation and legislation. The messages and advices must be unambiguous and correct.

Trust and reliance between teachers and IHAs is equally important. The teachers must also be well informed about the topics presented to be able to continue the health promoting work within their classes.

Equally important is that IHAs are confident in their roll and don't appear as doctors or nurses, as their occupation was in their country of origin, since this could cause a lot of confusion.

Indicators

So fare there is no controlled studies made on the result on an individual basis on the target group. A lot of evaluation studies are performed along the development of the health advising institution. The results are very unambiguous.

Stakeholders as nurses and doctors say that the health advising activities have relived the pressure and that they now are meeting with more knowledgeable patients and that they can refer patients to the IHAs to get more and deeper understanding of the treatment or why treatment isn't given.

Teachers likewise appreciate the effects by the IHAs work. A lot of questions, queries and anxiety addressed to teachers are now addressed to IHAs. Whether the immigrants being advised by IHAs have become healthier is not yet proved. But there are signs that they feel more secure and act more adequate.

Controlled studies and surveys to get information on the effects of IHAs' work is planed and will be performed autumn 2007 and in a longitudinal research three years ahead.

Results

Nurses in primary care centres in areas with a high population of immigrants confirm that people are more competent today in their contact with the primary health care.

Teachers in Swedish language classes say that the knowledge gained by the advising sessions has made students feel more safe and secure.
Confidence in understanding and acting in the new society is important for the integration process.
Immigrants express great appreciation about the International Health Advisors.
IHAs themselves feel proud of their work and possibilities to promote equal health.

Conclusions

IHA can make a difference. If health is increasing among immigrants more people will be able to enter the labour market and become self supportive. This will effect the integration and the economy on an individual as well as on a society level.
Costs for health care can stop rising or even decline when health care is used in an adequate way.
Patients feel that they are listened to and they feel secure with the diagnoses and treatment given.
If individuals in the target group change their life style, to be more health promoting, the IHAs work would even affect the public health at large.
Future

Today a project is running to disseminate the models and the results, and to influence other municipalities and regions to establish IHAs.
IHAs can be used by pharmacies and in services to elderly people who do not know Swedish very well or who has, due to diseases related to aging, forgotten the Swedish language.
There is also ongoing work to establish a nationwide training program to become IHA and to legitimise the profession.
The first steps to inform the EU Commission, DG Employment, Social Affairs and DG Equal Opportunities Justice, Freedom and Security to realise the possible effects of IHAs were taken 2005 within the ASPIRE! project, a transnational partnership within the Equal program. These ideas are also to be disseminated to DG Health and Consumer Protection.

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”The International Health Advisors offer the health care staff an opportunity to understand patients with different cultural background. At the same time they offer the patients an understanding of how Swedish health care system works.”
Ingemar Götestrand, Head of Primary health care, Region Skåne
We have noticed that the work performed by the International Health Advisors has resulted in asylum seekers requiring health care in a more adequate way. Now they know how to treat ailments themselves. That’s positive.
Gitty Hildingsson, nurse at the Health care centre for asylum seekers

Foto: Martin Israelsson

"In my native country people not usually lead a life that will be health promoting. You go to the doctor when being sick, but you don't expect the health care to help you to keep healthy. This is a new way of thinking."

Huda Mahdi,
International Health Advisor

Foto: Martin Israelsson

"Since we understand the background and culture of the immigrants and share their experiences of migration, people we advice rely on us."

Nangyalai Ghairat
International Health Advisor

Lessons learned

Weaknesses.
There is no nationwide training program to become International health advisors.
There is no acknowledge position for IHAs today.
The effects by the IHAs work has not yet been proved by controlled research studies.

Strengths
The IHAs are highly appreciated among health care staff.
Immigrants who have met with IHAs appreciate their advises and the possibility to be met with respect and understanding.

The organisation of the health advising sessions guarantee that a large number of immigrants will get the information.

Testimony form participants in health advising sessions

”We have learned so many things we did not even know existed.”

Foto: Martin Israelsson

”Many new things are interesting, rewarding and amusing. I learned about contraceptives, food and how to treat a cold…”

“The IHAs are fantastic! I would like to hear the information again because I didn’t feel too well and I could not concentrate during the lecture.”

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Child and adolescent psychiatry

PERVASIVE LOSS OF FUNCTION AMONG ASYLUM-SEEKING CHILDREN – A MULTI-DISCIPLINARY TREATMENT MODEL

Introduction

During 2002-2006, a group of asylum-seeking children in Sweden with pervasive loss of function emerged as a clinical condition. Areas of functioning involved were eating, drinking, walking and talking, self-hygiene and toileting, and social withdrawal.

As the children and their parents came to the Child- and Adolescent Psychiatry (CAP) for help, the symptoms shown were anxiety, sleeping-disturbances and depression, that proceeded to a severe withdrawal behaviour where the children lost contact with the surrounding world, didn't eat, drink or move and – in the most severe cases – had to be fed by naso-gastric tube (enteral nutrition), to secure the intake of nourishment.

It was obvious that not only the identified patient but also parents and siblings had psychiatric symptoms due to traumatic experiences in their home-countries, separation and loss of relatives, and the stressful condition of being in an asylum-seeking process.
The psychiatric symptoms of the parents often limited or obstructed the child-psychiatric interventions made, as the parents had little or no mental capacity to participate in the treatment of their child. Providing psychiatric treatment for the parents was therefore crucial to assure efficient interventions made by other care-givers.

In Stockholm the situation was even more alarming than in other parts of the country, as there were a lot of children with these symptoms attending care by the CAP, both as outpatients and inpatients. As the condition was- and still is - considered a child psychiatric problem the care was provided by CAP, but there were no specific guidelines for how the somatic condition that emerged as a result of the proceeding illness should be treated, or by whom that treatment should be provided. The somatic treatment was therefore insufficient. The psychiatric needs of the parents were also insufficient, as adult asylum- seekers only have the right to emergency medical services. The psycho-social stress for asylum-seeking families in Stockholm is also severed by the fact that there are no housing provided for asylum-seeking families or individuals by the immigration authorities. Therefore the families live as lodgers together with other families under poor conditions, and often have to move from one part of the town to another.

Goals and Objectives

In Stockholm the condition described increased substantially during 2003, and in spring 2004 the Stockholm County Council started a working-team of clinical specialists and representatives from the municipality, to out-line health services that could meet the needs of the identified patient and relatives.

The health services should accomplish:

- Intensive child-psychiatric treatment
- Somatic assessment and treatment
- Psychiatric assessment and treatment for the parents

The values and goals are to achieve an early rehabilitation of the pervasive loss of function with a family-oriented focus, by a multidisciplinary treatment-model.

Field or determinant

The fields are mental and somatic health with collaboration between these units as a determinant.

Scope and provider

The scope of the model is local as the assignment to coordinate the clinical units was given to CAP in Stockholm, by the Stockholm County Council, which is a public provider.
The activity is centralized as both somatic assessment and treatment, as well as psychiatric treatment of the parents are made by a few local units (se model below).
It is however also decentralized as the child-psychiatric treatment involves all local out-patient clinics.

Model

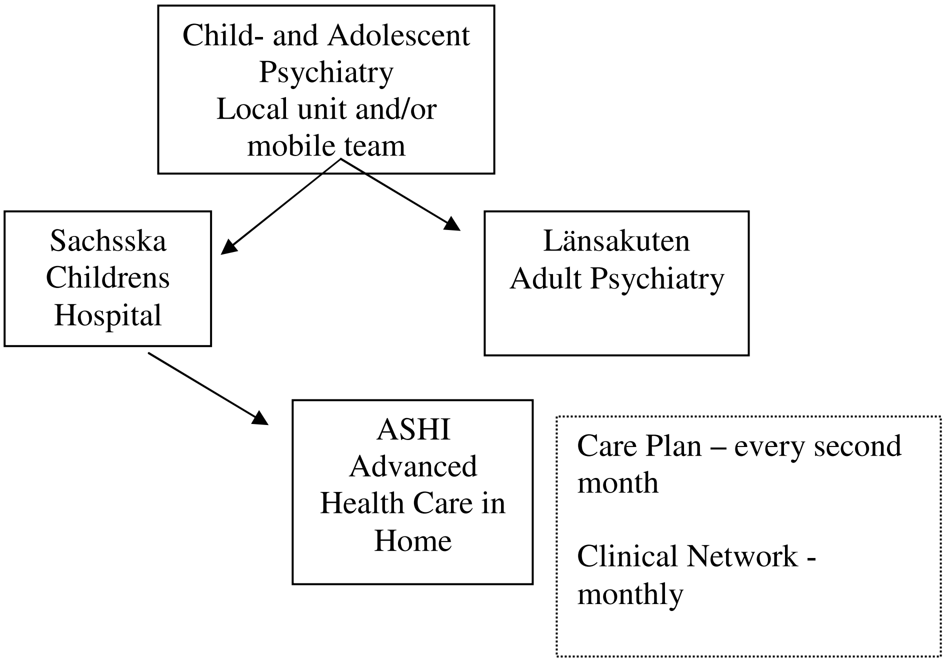
In march 2005, when the multidisciplinary treatment-model started, there were 50 children in Stockholm with severe withdrawal behaviour, children who had lost interest in the surrounding world, stopped communicating, had no interest in eating or drinking, and children who had to be fed with enteral nutrition, lying in bed giving no responses what so ever.
All these families had an ongoing contact with their local CAP- clinic; the starting point for the regional medical program addressed to the apathetic condition was therefore to expand the child-psychiatric treatment with paediatric assessment and efficient somatic treatment.
Providing somatic treatment was crucial in many ways, first of all to guarantee medical security for the child, but also to reassure the parents that their child's symptoms – and especially the obvious somatic symptoms – are taken care of. The child-psychiatric treatment must therefore take place in a context – in collaboration with other care-givers – and start with the apparent severe somatic symptoms of the child.

To reassure a more intensive child-psychiatric treatment a child-psychiatric mobile team was started in April 2005. The assignment of the mobile team is to work with intensive family-oriented interventions, with the purpose to strengthen the parents and reinforce their parental care-giving capacity. The mobile team meets the family 2- 4 times a week, in their home or at our day-care centre, and the work is carried out in the families' normal social structure, with the aim to reinforce the psycho-social resources of the family. Great emphasis is also given the collaboration with other care-givers, through monthly clinical network meetings.

The logistics of the multidisciplinary treatment- model:

When the CAP-clinic meet a child with severe withdrawal symptoms and/or pervasive loss of function, they refer the family to the Child-psychiatric mobile team for intensive child-psychiatric treatment. The mobile team consults Sachsska Children's Hospital for somatic assessment and ordination of sufficient somatic treatment. If necessary Sachsska also provides the support of the mobile somatic team, ASIH. Once or twice a week, the nurses of the mobile somatic team go to the child's home for a check-up of weight, nutrition, the intake of fluid and other somatic data.
CAP also makes sure that the parents are referred to Länsakuten, Psychiatric clinic for adults, for psychiatric assessment and treatment.

To reassure medical security, as well as to strengthen the collaboration between the clinical disciplines involved a Care Plan for the child and family is being made every month.
The clinical network can at some occasions also include representatives from the social welfare, school and immigration authorities.



The model is set within a framework of a multi-disciplinary out-patient treatment as the condition of pervasive loss of function itself, and the somatic symptoms emerged, doesn't demand in-patient treatment as long as efficient somatic care is given. The advantages with a multi-disciplinary out-patient treatment are the possibility to maintain a family-focus, meet the family in their own context and help them recreate a basic every-day structure, basic in that sense that the structure is a potential for the recovery of the family. Working in an out-patient setting also makes it possible to see the needs of the siblings, as they often are a group of risk, and need psycho-social support. In their home, the parents have better conditions of regaining strength as a parent, and feel like the expert of their child that they really are.

Close collaboration guarantees medical security in the out-patient model, in the extent of an in-patient treatment, but in-patient treatment – both psychiatric and somatic can be provided when needed.

Resources and management

The Stockholm County Council makes a budget of expected costs on the basis of the assessed needs of the population. The actual costs are financed by the state afterwards, as the costs for medical treatment of asylum-seeking individuals are paid by the immigrant authority.

The administrator at Stockholm County Council made the first financial guidelines, and gave assignment to the different clinical units; the administrator can still influence decisions made, but does that on the basis of information given by the co-ordinator.

The co-ordinator of the multidisciplinary treatment-model started a co-ordination-group with representatives from all units involved; this group meets on a monthly basis, and issues are both administrative and clinical.

Indicators and results

One of the most crucial determinants of this model is to achieve early rehabilitation. For a majority of children with pervasive loss of function rehabilitation is possible only after having received a permission to stay permanently in Sweden. A measure to control the effect of the practice is therefore to estimate the time of recuperation after PUT (permanent permission to stay), and to accomplish that we use a tool for assessment of the level of functioning over time – when the patient attends and thereafter on a monthly basis. Results also show, that the multidisciplinary out-patient model has made it possible for some children to start rehabilitation even before receiving permanent permission to stay.

For the children with the most severe withdrawal behaviour – those who have to be fed by naso-gastric tube – another way to control the effect of the practice is to measure the time between permission to stay and the suspension of naso-gastric feeding.

Conclusions and lessons learned

Working with asylum-seeking families with children with severe withdrawal behaviour and pervasive loss of function, in a multi-disciplinary out-patient model, has given valuable experiences applicable on a range of health-issues emerging in immigrant families.

Health problems in asylum-seeking families and immigrants is a context where you have to consider a wide range of aspects that can cause problems – individual vulnerability, family-dynamics, traumatic experiences, crisis and severe experiences due to the flight and migration itself, political consequences of the asylum-seeking process and insufficient social conditions.
These circumstances often cause a "break-down" in the family structure, in parental functioning and in the children's mental health. The symptoms manifested can be seen as different expressions determined by the individual, family- and socio-cultural context.
It is therefore of great importance to set up a care giving context which can identify and provide

support and treatment to a range of need; psychiatric, somatic as well as psychosocial.

With a well- developed collaboration between different clinical disciplines it is possible to meet and treat families with massive health problems – both mental and somatic – and still maintain – and reinforce – the autonomy of the family. This is of great importance as a severe experience for the immigrant family is the loss of autonomy, the loss of control. Inviting the care-givers to your home instead of being totally dependent in an in-patient clinic can be the turning point for recuperation.

The collaboration between adult psychiatry and child- and adolescent psychiatry also reinforces the family-focus – the condition cannot be regarded as "diseases being treated", but rather turning a" family break-down" to a" family survival".

The multidisciplinary out-patient treatment has a well-defined external structure and an internal flexibility that has resulted in both an efficient and dignified way of meeting immigrant families with severe health problems.

One of the mothers told us how she had experienced the treatment with these words:
"It breaks a mother's heart to see your teen-ager becoming an infant again; I was terrified that she was going to die. When you came to our home, I got the strength and support to be a mother again, and I was no longer afraid of her never recovering. With you here, we could sometime even laugh, and that helped."

Future

At this moment, a majority of families who have had children with severe withdrawal behaviour, have had a permanent permission to stay, and their children have either recuperated completely or are in a rehabilitation process. In Stockholm we see no tendency of a large amount of new children becoming ill. The assignment is now to focus on families in a "break-down phase" were the symptoms not yet have become as manifest.

The model can therefore serve as both a prevention of developing severe withdrawal behaviour, and a way to treat massive mental health and somatic problems in immigrant families.

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Leicester City NHS
Primary Care Trust

DEDICATED PRIMARY CARE SERVICE
FOR ASYLUM SEEKERS IN LEICESTER IN THE UK.

Introduction

Providing primary care services to asylum seekers in inner city Leicester has been a challenge. When asylum seekers first arrived in large numbers it was originally felt that integration into mainstream primary care was the appropriate model. However this traditional health model did not meet the health needs of this highly mobile, vulnerable and excluded group. Many asylum seekers found difficulties in registering with primary care services. A solution was sought not only to ease the pressure on mainstream services but to put in place a service which was totally led by client needs, and designed with the help of all the stakeholders including service users. The resultant nurse led service has developed new pathways and services without the barriers of historical models. The service works very closely and strategically with key stakeholders in both the statutory and voluntary sectors to design pathways for effective referrals between agencies.

Goals and objectives

The main objectives of the service were to:

- Provide access to primary care for all asylum seekers.
- Provide a consistent approach to public health issues.
- Provide equitable access to health promotion activities.
- Provide ongoing patient education about the NHS.
- Reduce inequality of service provision at all levels.
- Support client transition into mainstream practice when they receive Refugee status.

These objectives have been delivered using a culturally sensitive and holistic approach. To achieve this it was essential to create an environment which promoted trust, a sense of welcome and well being; providing an innovative multi disciplinary approach to a client group who have complex needs, language barriers, cultural differences and differing client expectations (being unfamiliar with the NHS and other agencies).

Model

Asylum seekers can experience poor access to primary care. They are often perceived as high users of GP time due to a number of factors including language difficulties, the stressors of being in the asylum system, complexity of their needs and lack of understanding of the health system. In Leicester there was no cohesive approach to access, public health or any health promotion activities for asylum seekers. Some clients had been registered at different practices all over the city although many were not registered with any practice.

A new approach was therefore needed to provide a consistent and welcoming environment which all new arrivals into Leicester had access to. The patient needs led model created an innovative skill mix approach which utilises the extended role of the nurse team and includes independent assessment, diagnosis and treatment including prescribing medications. This approach ensures that GP time is available for dealing with the more complex issues including mental health.

The ASSIST service came into being in June 2004. On registering with the service all new clients have a comprehensive health assessment which includes:

- clinical screening for TB;

All adult patients are offered :

- screening for blood borne viruses;
- mental health assessment.

With the use of language support ASSIST has been able to extend the range of services provided to clients to include those which had previously been inaccessible. This included access to the in-house drugs and alcohol worker, stop smoking clinics, sexual health, family planning and award winning specialist midwifery support.

ASSIST also employed its own Health Visitor which has enabled a systematic approach to children's health across the city and is preventing children with significant medical and social problems 'falling through the net'.

Mental Health

It was recognised early in the development of the service that mental health issues needed to be approached using a different model of care. Traditional approaches resulted in many distressed patients being referred to hospital unnecessarily, due to the lack of understanding of the issues. The service has developed with the Common Mental Health Problem Service (an innovative pathway providing specialist counselling support on-site) and which has significantly reduced referrals to secondary care. Patients are now having their complex mental health needs contained and managed within a primary care setting.

Scope

Asylum seekers are dispersed away from London and the South East of England to areas where accommodation is more readily available. Leicester is a dispersal centre in the East Midlands of England. The ASSIST service currently has 1400 clients registered. However, as this is a very mobile population group it is likely that the practice is looking after in excess of 2000 clients at any one time. ASSIST is the only dedicated Asylum Seeker Primary Care service in the East Midlands and one of three nationally.

Provider

The service is provided through Government funding.

Resources

Funding is provided by Leicester Primary Care Trust. Primary Care Trusts are English statutory bodies responsible for delivering health care and health improvements to their local area. Asylum seekers are entitled to access NHS care without charge while their claim or appeal is being considered.

Field

The key objectives are early recognition and intervention of problems. Health promotion is paramount within this client group. Key to engagement is provision of appropriate language support - this is offered to **every** patient at **every** point of contact with the service. All individuals are triaged within the service within 24 hours of making contact on **every** occasion.

Management

Service users continue to be fully involved in the design and implementation of the ASSIST service through focus groups and surveys.

Results / Outcomes

In the 3 years ASSIST has been open, there has been a vast improvement in many areas that had previously caused concern.

- All patients are screened for TB.
- All adult patients are offered screening for blood borne viruses and the take up rate has been 97% (HIV, Hep B, Hep C and syphilis) – these infections are known to be more prevalent in this client group.
- All children have been brought up to date with vaccinations.
- Referral to mental health services have significantly reduced with clients having their mental health needs managed in-house.
- In the last year ASSIST has also been a training organisation offering specialised placements to various professional groups.

Indicators

National Quality markers (Qof data) have exceeded the PCT average on immunisations and cytology targets (90%+ and 84%) and many other indices meet local and national targets.

The quality team's assessment concluded :

'that this is a very specialised practice with a unique client base, and an immense amount of hard work and dedication has been put into ensuring every possible service is tailor made to meet the clients' needs'.

There is a patient friendly environment and all staff are approachable, professional and extremely patient focused'.

'This was a very satisfying review, and it was encouraging to see such a high level of team working, and mutual respect not only for each other but for the patients'.

Amongst other awards, the service won the local Strategic Health Area Service award for innovation in primary care in 2005. There is no doubt that this service has a positive impact. The feedback from all agencies and the clients themselves demonstrate that the service has met many of its original aims.

Future

The service would like to further develop one-stop health and social care approaches, and help more with integration of refugees into the workplace. ASSIST is looking at how it can build on its existing mental health service model to respond to this need. The practice is also increasing its campaigning and awareness building work to influence the wider agenda locally. More research into this area is needed and as a service ASSIST is committed to becoming involved in this arena.

Lessons learnt

When asylum seekers first arrived in Leicester it was felt that direct integration into mainstream services was the way forward. However in practice this simply did not work. In focus groups asylum seekers repeated many times that they felt constantly criticised for not using services appropriately but no one had explained what was expected of them. A transition process is therefore needed to facilitate effective integration into the community.

Testimonies

Quote from a voluntary member of a local community organisation.

May I take this opportunity to thank you and your colleagues both on the behalf of the community and its leaders and myself individually. We value the excellent work and commitment shown by you and all the staff at ASSIST. Your work brings hope and comfort to both asylum seekers and refugees.

This is much appreciated by the service users as we had no-one to help or guide us due to the complexity of some of the issues. We thank you for your expert advice and assistance. I will continue to highlight the needs of asylum seekers at local and committee levels, particularly the needs of those persons who have come to the end of the appeals process. Often there is no system in operation to help them in such dire circumstances.

Conclusions

Mainstream GP services can be unwilling to accept large numbers of asylum seekers onto their books initially as their needs are seen as being complex and time consuming. They may not be equipped to offer the time and resources nor in some cases have the necessary skills required to deliver appropriate care. Thanks to the vision, funding and support of Leicester Primary Care Trust, ASSIST has been able to provide a service which is culturally sensitive and totally geared to the specific needs of asylum seekers. The results achieved would not be possible within the time constraints of most mainstream GP services.

Patients comments from the ASSIST survey include *'there should be more services like ASSIST who help people without judging them', 'they gave me my life back and they helped me to overcome some very bad experiences that I went through'.*

This high standard of care would not have been achieved without either sufficient time to address the client issues or without interpretation support. In order for time to be maximised efficiently, high levels of non hierarchal team working and skill mix have evolved. Nurse led triage and diagnosis skills ensure that problems are dealt with by the most appropriate clinician. This allows GPs more time to deal with the more complex issues e.g. 75% of all GP consultations are mental health related.

Inter-professional working has been one of the main elements in achieving the success of the service. The positive and close relationships the service has with all key stakeholders including refugee organisations, the voluntary sector, housing providers and statutory organisations, have enabled more beneficial ways of addressing and managing such complex issues

This model of care provision is sustainable and transferable to other areas, providing it is appropriately resourced, includes training and has commitment from all stakeholders involved.

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THE WELL-BEING PROJECT
AT REFUGEE ACTION, MANCHESTER

The Well Being project is an example of work in the UK by a charitable organisation partly funded by government.

Introduction

The experience of forced exile can lead to a vulnerability to mental health problems due to stressors at all three stages of refugee flight – before flight, during flight and in exile. Studies show that it is social conditions in the country of exile which are more likely to cause depression than the experience of trauma in the country of origin.(1,2) Social isolation and exclusion, poverty, racism both covert and overt, boredom and loss of status and a purpose in life, and the massive social loss of all that is familiar which has been described as 'cultural bereavement'(3), all contribute to the exacerbation of the natural distress felt by most refugees and people seeking asylum. The process of becoming a refugee can lead to a loss of self confidence and self esteem, and the resulting disempowerment can increase the already immense difficulty of building a new life in a new country.

Disempowered people are less likely to make health lifestyle choices, and will have difficulty in accessing mainstream health services. This may lead to inappropriate use of health services.

At the same time as attempting to empower refugees, the Well-being Project delivered awareness raising sessions to a variety of groups of workers, many of them health care professionals. However, refugees are, almost by definition, resourceful, resilient and courageous, and these were the qualities which the Well-being Project aimed to build on. (4)

Goals and Objectives

Many of the factors which affect the mental health of refugees are beyond the influence of health services or NGOs, and the project focused those factors on which it could have some effect.

Social isolation is a risk factor for mental health problems, and social support a preventive factor. The Well-being Project sought to alleviate isolation through participation in arts, sports, improving skills and cultural activities, enabling people to build up supportive social networks and thereby preventing distress from becoming a mental health problem. As well as reducing isolation, the activities also had benefits such as physical activity or creativity; engagement in physical exercise or creativity is good for mental health and wellbeing. The project also helped refugees to organise events, which increased co-operation and management skills as well as building bridges with the host community and enabling refugees to begin to understand the culture of the UK. All the activities were neutral and non-threatening and allowed the participants to show and develop expertise, and did not require a high level of fluency in the English language. Several activities were aimed at men; this was partly because a large proportion of people who come to the UK seeking asylum are young men, and partly because men find it difficult to discuss mental health problems.

Activities included:

- Dance – Ugandan women's dance group, Somali traditional dance group
- Football – several teams, some composed of particular nationalities, some mixed nationalities, some combining refugees and men from the host community. Seven teams play regularly. An annual Refugee Football World Cup is held during National Refugee Week in June which attracts about twenty teams.
- Music – taster sessions for DJ-ing. Music lessons for the Angolan community
- Outdoor activities – walks in the countryside, coach excursions, wild flower planting
- Swimming
- Gym
- Sewing
- Drama and arts
- Cookery classes for men – men from refugee countries of origin often do not know how to cook (5)
- Gardening
- Women's Fashion Event
- Ethiopian Orthodox Church National Festival

In total, the Project supported 34 groups and empowered members to take on organisational roles. 762 people participated in activities and 805 attending the events.

Field

The Well-being Project was a preventive mental health project which aimed to promote mental well-being and social inclusion.

Scope

This was a project for refugees and people seeking asylum who live in Greater Manchester, a large conurbation in the Northwest of England.

Provider

Refugee Action is a charity which works with refugees to build new lives in the UK, partly funded by the government.

Activities involved a wide variety of statutory and voluntary organisations, for example, Primary Care Trusts (the name for health authorities in England), Local Authorities, the Local Education Authority, Red Rose Forest (an environmental organisation), Community Arts Northwest, faith groups, Workers Educational Association, the Lake District National Park, local Football Associations.

Model

The project did not consciously adopt a particular model of working. The practice was based on the team members' long experience of working with refugees and asylum seekers, backed up by academic research and the involvement of refugees.

Resources

Funding was provided by two charitable foundations, Esme Fairburn and Lankelly, and the Home Office Purposeful Activities Fund. The other organisations
that were involved in activities contributed their workers' time and expertise.

Management

Decisions as to the nature of activities were taken after discussion with refugees and asylum seekers, together with discussions within the Well-being team. The Project initially had only one worker but funding from the Home Office allowed a team of two part-time and one full time development workers, managed by a Deputy Manager at Refugee Action, to be recruited.

Indicators

Before and after well being questionnaires were administered on some of the activities. The number of people attending activities, and the number of people enrolling for mainstream activities helped to indicate an increase in self esteem and self confidence of participants.

Results

Several of the activities have continued beyond the involvement of the Well-being Project. For example the football teams are ongoing; a further cookery course for men was funded by the Primary Care Trust and several other cookery courses for men have developed across the UK as a result of the example set by the Well-being Project; the women of the Ugandan Dance Group intend to constitute themselves as a community organisation to help others, and continue to dance at events; the Exodus refugee arts project which the Project helped to initiate continues to work with a wide range of refugee artists; the Ethiopian Orthodox Church successfully bid for funding and held another national festival.

All participants felt that they had benefited from the activities, and this was captured in questionnaires/discussions, quotes from which are noted below.

Transferability

The social exclusion and social isolation which pose a threat to the mental health of refugees are an inescapable component of forced exile and will be present in all Member States. These factors, and the disempowerment which results from them, are major determinants of health for this group of people. The Wellbeing Project's method of addressing this through involvement in creativity, physical exercise or purposeful activity, can be adapted to the resources available in any area of the EU. What is required is an acceptance of the important effects of isolation and exclusion, and a willingness to seek innovative solutions to this problem.

Lessons learned

- Addressing the determinants of mental health problems cannot be done by health services in isolation. The involvement of other agencies is essential for the success of any project which seeks to promote mental well-being.
- It is difficult to reach the most isolated and vulnerable refugees.
- Refugees and people seeking asylum lead chaotic and confusing lives; engaging people in activities requires the development of trust, time and perserverance.
- The most successful activities were those which involved refugees in the choice and planning.
- Empowering an individual can enable him/her to support others within their community.

Conclusions

Five quotes from participants help indicate the success of the project.

'It was wonderful. I never knew that there was anything pretty in the UK. Last night I slept for 8 hours for the first time since I cannot remember when' (French speaking African man, referred by the Medical Foundation for Care of Victims of Torture, after a trip to the Lake District.)

'I had problems with food. Now I eat much better, and my children enjoy my cooking. I cooked for a friend, and that made me feel so good.' (Man from Zimbabwe on the cookery course for men)

'When I was feeling low, counselling would not have helped me, but getting out and about did.' (Man from Zimbabwe after a walk in the country)

'We are like sisters now. Now we can help other people who are going through this nightmare.' (Ugandan woman, member of a dance group which still continues to perform)

'The team has been very good for me over the last few years. I have increased my fitness and made lots and lots of new friends. We have done really well in the league and this has made me feel proud. The team helps each other and we all support each other through bad times. My life would be very different without this project.' (20 year old man from Rwanda, International Manchester football project)

Future

The project will be modified slightly in view of what was learnt. Continued efforts will be made to reach the most isolated and vulnerable refugees and people seeking asylum. Before and after mapping of social contacts will be carried out with individuals. Volunteers will be recruited, both from the host community and people with refugee status. The UK Government is keen to promote volunteering by refugees; helping others is a very good way to improve self-esteem.

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JRS - Portugal
Serviço Jesuíta aos Refugiados

JRS
Jesuit Refugee Service

SERVIÇO JESUITA AOS REFUGIADOS

RECOGNITION OF QUALIFICATIONS OF IMMIGRANT DOCTORS

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Introduction

Although there is not an official survey on the qualifications of immigrants in the Portuguese territory, it is known that there are hundreds of legal immigrants with qualifications in the area of healthcare, aiming to live in Portugal on the long term. A large percentage of these immigrants have academic qualifications, which could be recognized as higher education degrees.

The possibility of bringing these highly qualified immigrants to the labor market would be a very enriching experience, as well an opportunity to address the lack of Portuguese professionals in the healthcare system.
It was with this in mind, that the Calouste Gulbenkian Foundation, together with the Jesuit Refugee Service in Portugal, brought together this Project of Recognition of Qualifications of Immigrant Doctors.

The implementation of this project started in June 2002 and ended in December 2005.

Goals and objectives

The main goal of the project was to create the necessary conditions that would not only enable immigrant doctors to work on their profession in Portugal (thus contributing towards their integration in the Portuguese society, through the recognition of their skills and qualifications), but also to address the shortage of qualified Portuguese professionals.
The target group were 120 immigrant doctors (with the exception of dental medicine, alternative medicines and veterinary medicine specialists) working in Portugal in other areas, other than medicine, and born in countries that don't have agreements with Portugal for the automatic recognition of equivalences.

Field

This project's field concerns the social and professional integration of highly qualified immigrants, namely doctors, through the promotion of the recognition of their degrees.

Scope

This project was implemented on a nationwide level, having included immigrants living in the South, Centre and North of Portugal; however, because the medical schools capable of providing the recognition of diplomas, were located in only 3 cities: Lisbon, Coimbra and Oporto, the main activities of this project had to be developed in these locations.

Provider

This project was implemented by the Jesuit Refugee Service in Portugal, a non-governmental institution, and financed by the Calouste Gulbenkian Foundation.

Model

The used methodology during the implementation of this project was based on an individual guidance base in each case. The background of each of the beneficiary doctors was known, and they were made aware of difficulties that were likely to appear in their academic and professional integration. Therefore, the project tried to provide tailor-made solutions for each of the 120 supported doctors.

Throughout the implementation of the project, several stages can be distinguished:

1.4.1) Candidate selection;
1.4.2) Gathering of all the required documents;
1.4.3) Delivery of the documentation to a Medical School;
1.4.4) Training period;
1.4.5) Final exam;
1.4.6) Registration in the Medical Council;
1.4.7) Professional integration;
1.4.8) Re-integration to those who did not pass through the final exam;

Resources

There were two kinds of support given to beneficiaries of the project: social and financial.
Calouste Gulbenkian Foundation provided financial support and it helped with:

- Cost of **translation** of the diploma, certificate of qualifications and program, as well as payment of the fees due for legalization of these translations. This support could reach a maximum value of 800€.
- Payment of **costs incurred with the payment of application fees**, up to a maximum of 300€.
- **Payment of books** recommended by the Medical Schools for the accomplishment of the periods of training and final examinations.
- **Scholarship during the training period for a** maximum of 9 months. This scholarship (500 €) was only paid against proof of attendance.
- Payment of **registration costs in the Medical Council** (maximum value of 200€)
- **Integration Scholarship** (maximum of 1000€), attributed to the immigrant doctor while awaiting the final decision of the medical council.
- Social support given by the Jesuit Refugee Service involved
- **Portuguese language courses with technical medical terms.** The goal was to provide immigrant doctors with language skills that would help them better integrate in the hospital environment.
- **Psychological support**
- **Partnerships with some medical colleagues,** in order to facilitate the access to internships**.**
- **Partnerships with the Migration Services (SEF),** in order to facilitate the renovation the visas.

- Frequent **contacts with the Medical Council** in order to facilitate the bureaucratic process;
- **Contacts with the Ministry of Health** in order to put the doctors in the labour market.

Management

Although the Jesuit Refugee Service had autonomy in the process of decision making, decisions were nevertheless made in consultation with the partner Foundation. It was very important for this project the recognition of the Foundation on the Portuguese society, which helped to break some barriers.

Indicators

One of the best ways to assess this project is to look at its success rate (89%), through the number of immigrant doctors that are now actually working in their profession and are fully integrated in the Portuguese society.

The Calouste Gulbenkian Foundation has also ordered an evaluation of the project from Coimbra University, during the implementation stage, and in 5 years another study is planned to assess the integration of the beneficiary doctors and their impact in society.

Results

It is legitimate to say that this project had an 89% success rate.

By analyzing the number of approvals and failures, we verify that there are some differences between the success rates in the different medical colleges.

In what concerns the **Faculdade de Medicina de Lisboa,** the rate of success is 61%. The **Faculdade de Medicina de Coimbra** shows a 92% success rate. As for the **Faculdade de Ciências Médicas da Universidade de Lisboa**, the rate of success is 90%. **Instituto de Ciências Bio-Médicas Abel Salazar** had a 92% success rate. And finally, the **Faculdade de Medicina do Porto** had a 100% of approvals.

Figure 1. Approvals in each Medical College

	Total	Approvals	Failures
F.Medicina Lisboa	*18*	11	7
F Medicina Coimbra	*25*	23	2
F Medicina Porto	*17*	17	0
F Ciências Médicas Lisboa	*31*	28	3
F Ciências Médicas Porto	*29*	27	2
Total	*120*	106	14

Conclusions

Being a pioneering project, it is only natural that some barriers and obstacles should arise which were had not been predicted originally. Nevertheless, we can say that, based on the cooperation and persistence of all the partnership members and immigrant doctors, a success rate of about 89% was achieved which represents 106 fully integrated doctors who are practicing medicine in several points of the Portuguese territory.

We can therefore admit that the goals of the Project have been achieved and in a certain way even surpassed. If, on the one hand, the necessary conditions were created for these doctors to have their qualifications recognized, allowing a better and more successful social and professional integration, on the other, we achieved a geographic dispersion of these health professionals, contributing to reduce the regional imbalance in access to healthcare.

Thanks to this project, it was also possible to create an office of support to the recognition of qualifications, which allows the Jesuit Refugee Service to respond efficiently to immigrants seeking to have their qualifications recognized in the Portuguese territory.

Future

Due to the success of this experience, it was possible to create a new project based on the qualifications of nurses. This new project started in 2005 and will end in June 2007.

Although the goals are the same, i.e., the social and professional integration of immigrant nurses and the reduction of the lack of Portuguese nursing staff, this new project shows significant improvements versus the previous one. Namely, it now focuses

- Not only on the individual nurse, but also on his/her family – in order to obtain a more successful integration;
- A more efficient and organized Portuguese language course;
- A wider development partnership which includes not only the NGO (Jesuit Refugee Service) and the co-financial partner (Calouste Gulbenkian Foundation), but also a Nursing School (Escola Superior de Enfermagem Francisco Gentil) and an employer (Hospital Fernando da Fonseca);
- Close follow-up of the professional integration in the labour market;

We can therefore conclude that the project's model of approach of recognition of qualifications of Immigrant Doctors is replicable in areas other than medicine. This project is therefore extremely important, enabling each country to benefit from the human capital of highly qualified professionals, in areas where there is a known shortage of these workers , and it can contribute towards full integration of the same professionals.

Lessons Learned

During the project, several **problems** were identified, namely in two main areas:

- Professional integration;
- Bureucratic and legal problems;

As a **solution** for these barriers we think it is important to develop:

- Agreements with the Health institutions or with the Ministry of Health in order to facilitate the entrance of recognized doctors in the labour market. (This when there is a time gap between the recognition and the entrance in the labour market – In Portugal doctors enter their internship in the beginning of each year. If a diploma is recognized in June, for example, the person would spend half a year waiting to enter the internship).
- Agreements with other medical institutions in order to accept doctors during this time gap;
- Agreements with the Migration Services (SEF), in order to renew visas without problems. (In the Portuguese context, a visa is only renewed if the person has a working contract. However these doctors during their training period where not working, so this might had been a problem if we didn't have a protocol with the Migration Services.
- Contacts with the Embassies and with the due Ministries in order to facilitate the legalization process of the documents needed.
- A sensibilization process in the workfloor as well as in society in general, in order to provide a better acceptance of the immigrant doctors.

We also **learned** from this project that it is important to:

- Work not only with the individual, but with the hole family in order to try to achieve a more complete integration process;
- Provide specific language courses, focusing on medical terms as well as on the culture of the country of destination;
- Have a small partnership but with key partners in order to have a more efficient and successful project. Partnerships too big, tend to have more difficulties in communication and in decision making process.

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PRESIDÊNCIA DO CONSELHO DE MINISTROS
ALTO COMISSARIADO PARA A IMIGRAÇÃO E DIALOGO INTERCULTURAL, I.P.

HEALTH SUPPORT OFFICE OF THE NATIONAL IMMIGRANT SUPPORT CENTRE OF PORTUGAL (CNAI)

HIGH COMMISSION FOR IMMIGRATION AND INTERCULTURAL DIALOGUE (ACIDI)

Introduction

The High Commission for Immigration and Ethnic Minorities (ACIME) - created in 1996 and reinforced in 2002 and in 2007 - is a State service with the main mission of promoting the integration of immigrants and promoting the intercultural dialogue in Portugal. ACIME, as a transversal intervention service, reports to the Prime-Minister and, since the first of June 2007 (last weak), became a Public Institute. In other words, the Portuguese State recognising the importance of this service to immigrants, reinforced ACIME powers and intervention. Since than a new institutional name was adopted: *High Commission for Immigration and Intercultural Dialogue* – ACIDI.

To accomplish the mission of integrating immigrants in Portugal, ACIDI assure the participation and cooperation of representative immigrant associations, social partners and State Services in the definition and assessment of policies on immigrants' social insertion and on prevention of exclusion and discrimination.[1]

Accordingly one of the main priorities of ACIDI work is to facilitate the immigrants contact with Public Administration and support services for the resolution of their problems regarding integration. The National Immigration Support Services (*Centros Nacionais de Apoio ao Imigrante - CNAI*) were set up in 2004 with that aim. Their establishment, in Lisbon and Porto, seeks to provide an integrated and efficient humanistic response to problems of integration posed by immigrants who have chosen Portugal as their host country.

The two centers, created exclusively to immigrants, bring together under the same roof a number of services related to immigration. Following the philosophy of working with partners to develop good integration policies and outcomes in a shared responsibility, the centres involve:

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[1] The detailed activity report of ACIME is available in English at http://www.acime.gov.pt/docs/Publicacoes/RelatorioActividades_ING/activity_report_short.pdf

1. Ministries' Departments:
   - Service for Border Control, Internal Affairs Ministry
   - Labor Inspectorate
   - Social Security
   - Health
   - Justice
   - and Education

2. And offers specialized offices that provide specific support on:
   - legal advice
   - family reunion
   - housing
   - social emergencies (e.g. homeless, immigrant living in very poor conditions)
   - labor market insertion (both to dependent work and self-employment)
   - access to Portuguese nationality
   - Portuguese language courses
   - Fighting against racial discrimination
   - Integration for the Roman community
   - Technical support to Immigrant Associations

Therefore, the CNAIs have been designed and managed from the perspective of providing a quality service to the immigrant, within a friendly environment and operating from a platform where the immigrant is the centre of all activity.

This project proved to be innovative in terms of providing a joint answer to the user, since it is based on a general shared data management system used in attending the public (facilitating the digitalization of data and documents and communication between the different offices). To be enhanced the services are assured with the involvement of socio-cultural mediators, who belong to different immigrant communities living in Portugal. These stakeholders, representing immigrant associations themselves and working in partnership with public administration, have a key role in the process of contact with immigrants and problem resolution.

As a result, we believe that this project have been building in Portugal a partner relationship between public administration and civil society (including immigrant associations). And that this crucial partnership contributes to strength trust relations, the feeling of co-responsibility and participation of different partners and help in the creation of a new approach to EU deal with immigrants' integration.

One might argue that for real integration there should not be "preferential treatments" or should not be followed *one stop shops*' models. Yet, through analysing the legalization process of immigrant citizens, it was possible to verify the complexity and dysfunction caused by the interaction of various public Services, situated in different locations, with different modes of functioning and, at times, even incompatible hours of opening to the public. Immigrants frequently mentioned this dispersion and lack of integration of Services as a factor of serious inefficiency, a reason for giving up the processing of legalization and persistent blocking of their social integration.

Those problems are faced by immigrants not only in Portugal:

1. The management of immigrants' integration in European Union is one of the most challenging responsibilities that most Member States are facing today. Either older immigration countries or countries that are experiencing for the first time immigration flows are being confronted with the need to define a sustainable integration policy.

2. Within the relationship with immigrant communities, different Member States share several difficulties that often compromise a consistent integration of immigrants. To be more precise, among the problems more often refereed are:

- the range of institutions involved in the integration process,
- the deficient cooperation between governmental services and their disperse locations,
- the diversity of procedures,
- the complex bureaucracy
- and the communication difficulties as a result of cultural and linguistic diversity.

3. Aiming to confront these challenges and define proposals for concrete measures, the Commission, in the ***Common Agenda for Integration*** (COM 2005 389), defined as priorities the:

> *strengthening the capacity of public and private service providers to interact with third-country nationals via intercultural interpretation and translation, mentoring, intermediary services by immigrant communities, 'one-stop-shop' information points and the building sustainable organizational structures for integration and diversity management and developing modes of co-operation between stakeholders enabling officials to exchange information and pool resources* (cbp 6).

4. Accordingly, and being inspired by the Common Agenda for Integration, several Member States have been defining concrete integration programmes to immigrants that mainly assess the 'one-stop-shop' (OSS) model. **The two Portuguese *National Immigrant Support Centres* (CNAI) were recognized as an example of best practices in the *Handbook on Integration for policy-makers and practitioners*.**[2] The integration and cooperation of different public services, previously with different locations and schedules, and new services that intend to answer to concrete immigrants needs and were not, until than, offered to immigrants, became a fundamental answer to newcomers and permanent immigrants.

5. Within this innovative model **Socio-cultural mediators** have a fundamental role because they guarantee not only a cultural and linguistic proximity to each immigrant that seeks for answers at these centres, but also a fundamental proximity between public administration and immigrant citizens. Furthermore, the participation of civil society institutions, as a partner in the management of this project, can bring important outcomes since the development of immigrant integration policy became a shared responsibility.

Goals and Objectives

The National Immigrant Support Centres (CNAI), in a logic of one-stop-shop, bring together a number of public services related to immigrants (e.g. Service for

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[2] Available for download in:
http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/handbook_en.pdf

Border Control and Aliens, Social Security, the General Inspectorate of Labour, Ministries of Health, Education and Justice) and offer specific support offices that promote immigrants integration in Portugal (e.g. Entrepreneurship, Legal Advice, Family Reunification, Employment Support).

The CNAI aims to provide a step forward regarding the integration of Portugal's immigrant population by offering competent, efficient and humane assistance in order to respond to migrants' needs. Socio-cultural mediators, who originate from the different immigrant communities, play a key role in all CNAI' services. Accordingly, each CNAI provides a range of services all under one roof in a variety of languages (Portuguese, Cape Verdean and Guinean Creole, Romanian, Russian and English). Services include the provision of information and direct assistance regarding legalisation and visa issues, family reunification, the educational system, health care access and provision, professional and educational skill recognition, social security and welfare issues, labour concerns, legal aid and immigrant association support.

In the specific case of the Heath Support Office, a team with two socio-cultural mediators have been mainly answering to problems related to immigrants' access to the heath services in Portugal.

Model

Although it is possible to identify different policy regimes and variations in the answer given to immigrants' integration in European Union, common obstacles to the integration can be identified in the majority of Member States. Among those common obstacles more often refereed are:

(1) The range of institutions involved in the integration process,
(2) The deficient co-operation in the field of admission and integration between governmental services and between different integration stakeholders;
(3) Disperse locations of governmental services with whom immigrants have to contact to keep a legal stay in the country and to reach integration,
(4) The diversity of procedures among public services and the complex bureaucracy;
(5) Communication difficulties as a result of cultural and linguistic diversity,
(6) The lack of immigrant participation mechanisms in the integration policy making

Accordingly the lack of a consistent co-operation between public services, not to mention its spread locations, and the short of transparent integration policies, are crucial impediments to effective integration policies. Furthermore, the frequent communication difficulties between immigrants and public services and the absent accurate answer to the several problems related to immigrants' integration, define most the realities lived within EU. Those obstacles not only difficult immigrants legal stay in EU countries, but also impinge immigrants to European societies' margins.

Above this, immigrant communities are usually very distant from political decision on matters that directly determine their integration and their lives in EU. This common divorce between policy makers and immigrant populations stimulate the creation of unsuitable policies.

ACIDI answer to the integration obstacles that immigrants face in Portugal (or even in EU Member States in general) is mostly inspired in the recommendations of the Commission Common Agenda for Integration (COM 2005 389) and in the best practices collected in the Handbook on Integration for policy-makers and practitioners.

The exchange of experiences and know how of the partners involved in the Portuguese National Immigrant Support Centers (state services, immigrant associations, socio-cultural mediators and other integration stakeholders) permit to define a coherent and effective integration model.

Field or determinant and Scope

Although by law the immigrants (even the ones that have an illegal status) have the right to heath care in Portugal, several hospitals and health centres refuse to give them support. Accordingly the Heath Support Office of CNAI has a fundamental role of both informing immigrants about their rights and duties on the access to health services in Portugal and creating awareness of the heath services to immigrant rights defined by the law. This office does not provide heath care but mainly is defined as a provider of heath care rights for immigrants.

Provider

The Heath Support Office of CNAI results from a partnership of ACIDI with the Heath Ministry.

Resources

The Heath Support Office of CNAI functions with ACIDI Budget that came from the Portuguese State.

Management

The CNAI is managed by a director that responds to the High Commissioner for Immigration and Intercultural Dialogue. Socio-cultural mediators, who originate from the different immigrant communities, play a key role in all CNAI' services and are crucial stakeholders in any service provided.

Indicators

(1) *CNAI Evaluation*
Accomplished two years of activity, the Portuguese High Commissariat for Immigration and Ethnic Minorities requested to the International Organization for Migration (IOM)

an independent evaluation of the outcomes of this support centres. This evaluation is fundamental in order to improve the services provided to immigrants in Portugal. Among the most relevant conclusions of IOM report was the recommendation of the development of an international network to discuss and assess the One-Stop-Shop as a model for immigrants' integration and its feasible implementation in other EU Member States.

(2) *Informative Brochures*

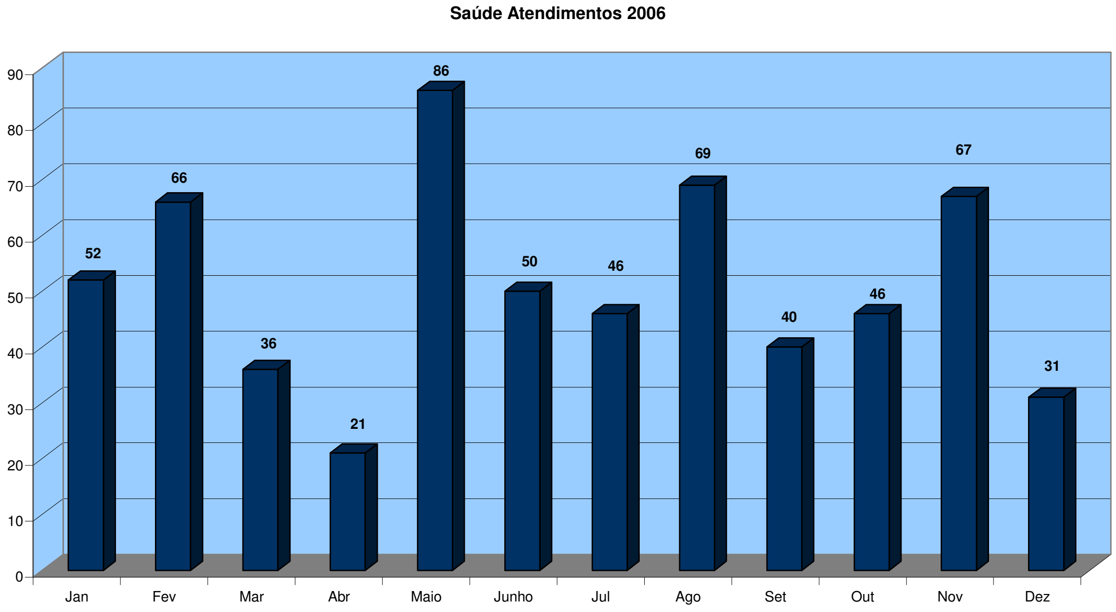
To support immigrants to understand the formalities that is behind the access to health services in Portugal, ACIDI has been promoting the publication of several informative brochures: (1) *Heath Guide for Immigrants* (also available in the internet[i]) and (2) a special chapter on heath services in a brochure with a framework on legislation and services that immigrants need to be aware of – Immigration in Portugal, see http://www.oi.acime.gov.pt/docs/rm/Brochuras/saude.pdf for more information.

In articulation with the General Health Direction from the Heath Minister, ACIDI also had promoted an informative campaign about tuberculoses. In that context several brochures in Portuguese and in Russian with relevant information about tuberculoses (e.g. symptoms) were distributed.

With a similar strategy, the ACIDI supported the National Commission that fights against HIV in the definition and publication of an informative brochure for immigrants about diseases sexual transmitted. As in the other case, the contents of the brochure were translated to Russian.

(3) *Users of the Health Support Office*

The Heath Support Office receives in average around 600 users per year (please see the graph below):



Results

CNAI is presented as an example of good practice in the Handbook on Integration for policy-makers and practitioners of the Directorate-General of Justice, Freedom and Security – European Commission (page 22).[3]

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- ACIME Activity Report (2005-2006) available at http://www.acime.gov.pt/docs/Publicacoes/Relatorio%20Actividades/RelatorioActividades2006.pdf

Lessons learned

The Heath Support Office is integrated in the Portuguese one-stop shop that promotes immigrants integration in Portugal in partnership with several State Services and Civil Society organizations (namely immigrant associations). CNAI and its support offices have been referred as an example of good practice that can be replicated in European Union. To improve in a permanent base the quality of all CNAI services, the institution have a regular and independent evaluation (made by IOM – Mission in Portugal).

As the other services, the Heath Support Office is managed by Socio-Cultural Mediators that provide cultural and linguistic support to immigrants, namely through the combination between information and specialised guidance.

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[3] Available for download in:
http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/handbook_en.pdf

ASSOCIAÇÃO PARA O PLANEAMENTO DA FAMÍLIA

FAMILY PLANNING ASSOCIATION ALGARVE

GOOD PRACTICE IN SEXUAL AND REPRODUCTIVE HEALTH

Introduction

Now a day, adolescent pregnancy, violence and gender-based discrimination and HIV infection represents in Portugal a significant problem, from what we only know a small and visible piece, like an iceberg. All of them are silenced problems, for a group of factors that contribute to get people more vulnerable each day. Portugal is one of European Countries affected with Sexual and Reproductive Health related problems, namely Youth Pregnancy and HIV/AIDS. This reality represents not only a health problem that requires specific intervention, with adapted strategies, but also a social and human rights fundamental problem, that generates discrimination, stigma, gender and social inequalities and social, familial and professional exclusion. It is also a fact Algarve is nowadays on fourth place on National ranking of HIV Infection and the use of efficient contraception is far from the desirable.

We believe that the adoption of risk behaviours on Sexual and Reproductive life results from the interception of psychological, social, cultural, financial and personal factors that determine perceptions, values, attitudes and consequently choices that can make persons vulnerable to sexual and reproductive health related problems and consequently contribute to an unhealthy Sexual and Reproductive life.

The lack of information and the ignorance about rights are, side by side with the difficulties to access sexual and reproductive health care and services, distorted perceptions about responsibility, respect, risk, affection, pleasure, and gender roles, among others, the responsible for this preoccupant situation. These factors justified for them selves the intervention on Sexual and Reproductive Health among the community, especially among those more affected and vulnerable for these issues.

The knowledge and recognition that some persons could be more vulnerable to these problems, gave us the obligation as a Health and Human Rights NGO to work in the field, trying to help and support people to get information, protection and resilience factors stronger, empowering men and women (youth and adults) on these important issues on Sexual and Reproductive Health, promoting social inclusion and accessibility to health services and care.

We advocate that only adapted**,** pro-active and comprehensives methodologies can create answers for population’s specific needs and lead us to our main objective.

Goals and objectives

APF mission is to help people to get responsible, informed and healthy decisions on their Sexual and Reproductive lives, promoting gender and social equality, equality of opportunities, the acceptance and respect of other's characteristics, options and orientations on Sexual and Reproductive matters, as issues of Human Rights. In this last 40 years, APF as worked on different contexts, having different priorities and objectives and also different targets. In Algarve we are developing a project that intends to work on these issues among migrants. Three years ago, we began our work with a different source of founding and goals focused on legislation, rights and accessibility related to gender equality and health care and services access improvement, especially among migrant women.

Objectives working with migrant community now day are:

- To contribute to a healthier and responsible Sexual and Reproductive life
- To improve the access to Family Planning care and services
- To contribute to reduce the numbers of HIV and other STI
- To contribute for an early detection and treatment of HIV and other STI
- Improve the access to health care and services
- To promote SRHR approach on public services that dealing with migrants

Model

Based on field work, APF intervention model it's not a closed model, for the contrary; it is always in construction and depends of the diversity of community needs and resources. The assessment of migrants' needs determine our first step. First of all we should listen what people had to say, understand their knowledge and misconceptions about own health and rights, about the others, about what they expect from us, understand more about their cultural issues, mediators of our relationships, acquisitions and decisions making. To achieve this information we adopted "focus group" methodology. Our second step was to make the initial contacts, with local authorities, associations, employers, and non-organized groups appealing to cultural mediators. With this approach methodology, we attempt to open doors and get inside the communities, with the guarantee of acceptance and trust. Cultural mediators have a huge importance in the work with populations with specific needs, spreading information, mediating contacts, introducing APF as trustful people, helping on the definition of appropriate strategies and working as peer educator.

After this first approach and work, intervention took place in the field through information and prevention activities with migrant women and appealing latter to an itinerant and equipped health facility, counting with a multidisciplinary team (Anthropologist, Psychologist, Nurse, Social Care Professionals), with specific knowledge in the area. Intervention is based on a group of principles that rules our attitudes. The availability, confidentiality, respect, acceptance and the importance given to people's problems are fundamental for success.

Intervention in sexual and reproductive health involve increasing information, clarifying misconceptions, social support, counselling, HIV testing, STI detection and treatment, and increasing the accessibility to Health care, to achieve peoples' empowerment on Sexual and Reproductive Rights**.**

Building solid and effective partnership networks is also a demand for success. It is important to create local and immediate responses for community needs but is so important than this, to promote conditions and skills to include migrant people in the National Health System, promoting the accessibility to care and services. In this level we have to enhance the cooperation of DGS (Health General Division – Ministry of Health) that through a protocol provided APF-Algarve with a Mobile Health Unit, an adapted vehicle in Sexual and Reproductive Health and ARS (Health Regional Administration) Algarve that represents a valuable partner with whom APF have been establishing procedures protocols to make our work possible.

Field or determinant

APF- Algarve field work comprises promotion of sexual and reproductive health and rights, prevention of sexual and reproductive health related problems like discrimination, violence, unwanted pregnancy**,** HIV testing, counselling, and the promotion of HIV treatment.

Scope

APF works on a national level with a regionalised structure. APF Algarve has a regional action scope. Anyway in specific intervention with migrant population, we privileged some locals that have been identified as relevant. In the first 2 years we started to work in Loulé. In "Amar, Amar, Há Ir e Voltar: Saúde Sexual e Reprodutiva para Todos" ("Sexual and Reproductive Health for All") we are working in Faro, Loulé and Albufeira, hoping to be able to expand our services to other locals further.

Provider

APF –Family Planning Association is a Portuguese Health NGO (since 1967), member affiliated of IPPF (International Planned Parenthood Federation).

Resources

In 2004, APF Algarve had two years project approved, named "Sexual and Reproductive Health and Ethnic Minorities" that obtain financial support in 100% of expenses from CIDM (Comissão para a Igualdade dos Direitos das Mulheres / National Commission for Women's Rights, currently named CIG – Comissão para a Cidadania e Igualdade de Género/ National Commission for Citizenship and Gender Equality)**,** with migrant women living in Loulé. In 2006, a new proposal was made to ADIS Program (HIV/AIDS National Programme), named "Sexual and Reproductive Health for All". The project has begun in April 2007, Year of Equality for All and the Portuguese Presidency of European Union and it's a milestone for APF and health partnership. This project represents an opportunity to continue working with migrants and is supported in

80% of the approved expenses for ADIS. Other 20% have to be supported by local municipalities, official entities and others organizations. APF still have the support from ARS Algarve and DGS.

Management

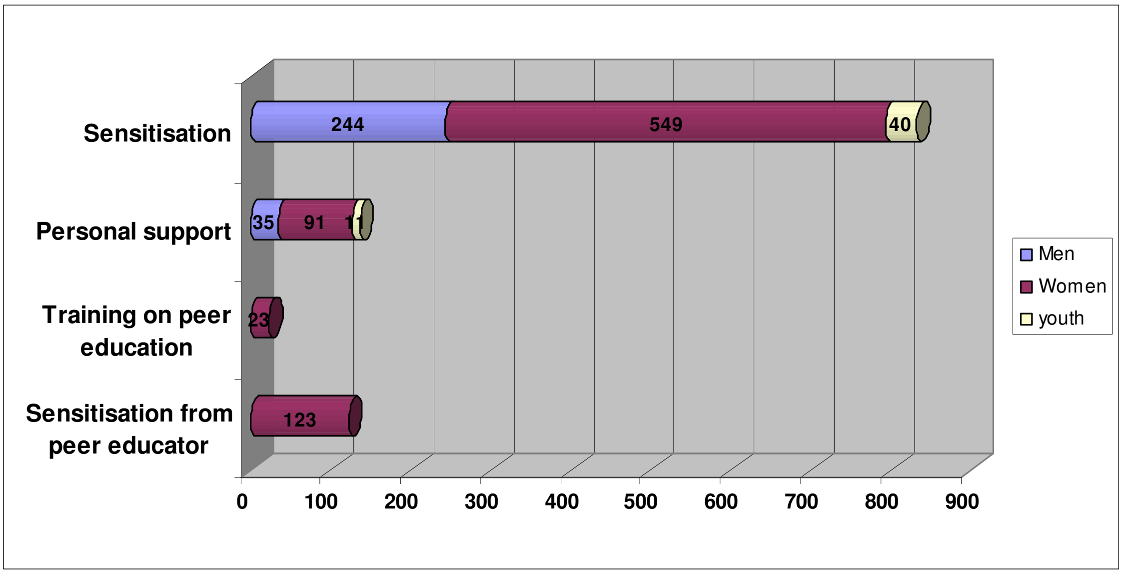
Coordination team takes decisions after the elements are consulted and after a previous analysis of the situation, in respect of APF principles and charter, and necessary networking with the project partners.

Indicators

We did not identify closed and numeric indicators for the previous project “Sexual and Reproductive Health and Ethnic Minorities” that could reflect results we expected. However current project, “Sexual and Reproductive Health for All” had the following:

- Number of users (men and women)
- Number of executed HIV tests
- Number of men and women that appeal to national health services through APF
- Knowledge on sexual and reproductive health and rights
- Adoption of healthy sexual behaviours
- Quality and adequacy of responses
- Satisfaction with the service

Results



Results from the project: “Sexual and reproductive health and Ethnic Minorities” (2004 -2006)

Conclusions

When the project “Sexual and Reproductive Health and Ethnic Minorities” was planed, numeric indicators weren’t defined; this factor could somehow represent a weakness in order to justified results and budget and had partially compromised final evaluation. That is the reason why significant results are qualitative rather then quantitative. However, the balance was very positive and goals were high achieved, information about Sexual and Reproductive Health and Rights was transmitted, effective contraceptives were provided and the empowerment was promoted, HIV tests were made, just as counselling on Sexual and Reproductive questions. Qualitative analyses revealed very positive implications on migrants’ sexual and reproductive life and on the access to health care on public health system.

The continuity of the project is a very important aspect that is up to us**,** local and national APF to do efforts to guarantee.

Future

“Sexual and Reproductive Health for All” is giving APF the opportunity to continue what was previously done; it’s an annual project with the possibility to be prorogued until 3 years, depending of the results. We are now planning the procedures with ARS Algarve and is APF intention to identify in the national health services, other governmental entities and NGOs, referenced professionals and specific procedures that be able to facilitate the access of migrant population and to guarantee their rights. We intend to work in co-operation with medical doctors to STI testing and evaluation, gynaecologic examination as well as the uterine cancer testing.

We are also establishing specific strategies to work with migrant sex workers, taking advantage from the APF Professional knowledge and experience in the work with sex workers, namely on APF North.

Lessons learned

As we said before, we’ve faced a lot of barriers that lead us to reflection and creative strategies to take them over. Working in the field, among people from different nationalities, languages, different motivations and interests and affected for different vulnerability factors, we have learned and integrate in our daily work some lessons that have represented an extraordinary personal and professional skills development to all the APF staff and volunteers involved.

First of all we assumed that working in the field is a question of professional and personal skills just as knowledge, perseverance, open mind, coherence and assertively respect.

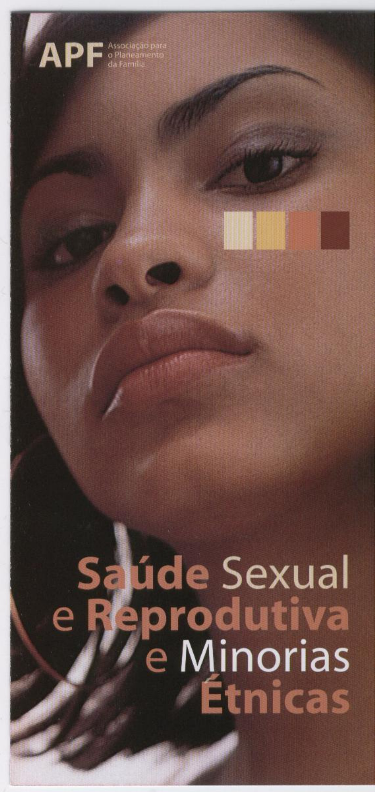
Approach can be a difficult and slow step. The acceptance of the community was the first barrier we have found, in part due to some resistant stereotypes in the relationship between the target and health providers. The unawareness, the mistrustfulness, the fear of being reported to the authorities, the different languages, different conceptions and ways of living due to cultural and social differences and the background, etc were some of the barriers we have found in the contact with migrant communities. The integration of cultural mediators in the team seemed to be a positive strategy to establish first contact, to create adapted strategies and materials, to involve other members of community in the project and work as peer-educator.

The second barrier was due to the motivation to get involved in this kind of action, related to the reasons to migrate. First motivation is always working, that is the reason to get away from their families and friends, work to get money and send back the origin country. It means that health and rights promotion activities are felt not as an advantage but as a waste of time and many, except on emergency situation. The factor we felt as a weakness earlier was rewarded with strength, the Mobile Health Unit is a valorous resource that gave APF and Health Services the chance to meet migrants and community on their own context, on facilitating circumstances, in appropriated places and timetables, without documents or fear of authorities.

On the other hand, especially with people from Eastern Europe we understood that we had to sensitise and work with men to reach women - that only felt comfortable to accept our support and services after their husband's approval. We adopted this strategy to be well succeeded among women and to be able to work with them their personal empowerment in Sexual and Reproductive Health and Rights. Anywhere we also understood that to develop a successful promotion of gender equalities we should necessarily work with men also.

Testimony/picture

"It is very good; it was very helpful for me and other women. I was very glad. We understood that is very good to have someone to talk, some place to go to speak about our difficulties and doubts on sexuality. We really need your support. Women have some difficulties to go to Public Health Services, to take contraceptives. For me, talking about condoms use to make me shy, looking at one was enough to make me blush. I couldn't think about using one. Today I am taking condoms with me, for me but also to my son. You help me a lot and a lot of people, our people. Now we feel comfortable to talk with you, to ask things about us, about our health. In the beginning was difficult for me and other people, to believe, because we were afraid, we didn't trust anybody but we saw this was good for us and we started to accept better, to talk about our lives, about health. Sometimes, appointments on Public Health Services take to long and women can't go because their work. It's also very important for men because is for them very complicated." *Mariana*



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MIGRATION AND HEALTH GROUP (GIS)

GRUPO IMIGRAÇÃO E SAÚDE (GIS)

Introduction

The GIS consists of a network founded in May 2006 with the objective of contributing towards the improvement of the health conditions of the immigrant population in Portugal. GIS works as an independent association, which aims at congregating academics, professionals as well as the civil society, namely immigrant associations operating in Portugal. This contribution is given through the constitution of a network of people and institutions, both private and public, who undertake research projects in this area or have professional activities directly connected to health issues concerning immigrants, who are encouraged to share and disseminate knowledge and information on the subject of migration and health.

Goals and objectives

The main objective of the GIS group is the sharing of knowledge and experiences concerning migrant health and well being in the Portuguese context. This concerns everyone interested in this topic, from academics and social scientists to health professionals and the migrants themselves.

The goal is that, by promoting the dialogue and the sharing of knowledge and information on positive and negative experiences, the phenomenon of migration and its relation to health issues may be better understood and handled both at the individual and institutional levels. One of the main objectives is to bridge and promote a strong relationship between academic/scholar knowledge/research and practical actions in the field of work with migrant communities, undertaken namely by health professionals and technicians. Its ultimate goal is therefore to make a difference and influence policy makers towards an improvement of the conditions – from understanding to effective material and human conditions-- migrants face where health is the issue.

Model

The group works on two levels, a internet service and periodical meetings and seminars. The GIS network is an official discussion list initiated by the GIS association. This group/network uses the internet structure to communicate with all its members and share a wide range of information concerning both Portugal and other countries as far as migration and migrant communities are concerned. The range of topics is wide, including information on funding for research projects concerning migrant communities, congresses and other meetings, information on specific subjects, academic or technical projects, reading lists and specific bibliography, information on legal matters, sharing of other types of information concerning migration . The discussion list is monitored on a daily basis; everyday day reception, filtering and forwarding of information to all the members takes place.

Besides the information and discussion made available through the net, this group also organizes periodical meetings and seminars, which function as presentation and discussion seminars; each month a few members of the group share with the others their experience/knowledge in working with migrant populations. Some of the themes discussed thus far in 2007 were: “Attitudes and representations of health by immigrants”, “Accessibility to health services by migrants”, “Data collecting for research projects”, “Problems in health work with migrants”, “Vulnerabilities and illness among migrant populations”, “Access to health services by undocumented migrants”, “Beliefs, taboos and myths on HIV/AIDS”, “Sexual illnesses, reproduction and gender issues”. There are also periodical coordination meetings.

Field or determinant

In order to cover all the various aspects that touch upon the issues of migration and health the group integrates several knowledge and professional areas, such as social and cultural anthropologists, sociologists, psychologists, human geographers, journalists, economists, lawyers, nurses, medical doctors, pharmacists, biologists, health technicians, directors and members of associations of migrants, technicians and officers from local municipalities, NGOs and NGO´s members, students, immigrants from a wide variety of countries.

Scope

The group involves both individuals and institutions; everyone that works or researches on health and migration issues is welcomed. Thus far, besides academics (mainly from the fields of the social sciences), health technicians and professionals, also research institutes and centres, universities, other public and private institutions, NGOs, directors and members of associations of migrants, technicians and officers from local municipalities, NGOs and NGO´s members, students, immigrants from a wide variety of countries and others are involved in GIS activities.

The members are spread throughout different organisms and institutions, located in different areas of Portugal. The functioning model, through the net structure and discussion list, encourages and promotes decentralization.

Provider

This is a public, open association; anyone interested on the thematic of migration and health is welcome. There are no costs associated. The only obligation to enrol is the completing of a personal file, which is then send to the coordination of the group, where a record of the members and their professional/research interests is kept.

Resources

There are, thus far, no financial resources available. The group works on a volunteer basis. All the five coordinators also work on a volunteering basis.

Management

The group is coordinated by five social scientists (four social and cultural anthropologists and one social psychologist). Individuals become part of the group by completing a personal record file, in which they specify their personal information and their work/research, as well as their interest in belonging to the group. One of the coordinators is in charge of coordinating the net- discussion list. Everyone may (and should) send information to be posted in the net. The guidelines for the activities of the group are decided in coordination meetings. Open meetings, allowing for the presence of everyone already belonging to the group as well as eventual interested potential members, intercalate with the coordination/direction ones.

Indicators

The effectiveness of the group and the interest it has risen can be measured in the number of members (over 100 in less than a year of existence), the feedback that exists within the group and the solicitations for public appearances of the coordinators in academic, professional and civil events.

Results

In less than a year the group, which started with five members, has over 100 enrolled members, without any publicity and counting only on the snowball effect. The frequency of solicitation for public appearance in events related to health and migration is also a reliable indicator of the success of the group. Between May 2006 and May 2007 the coordinators have participated, as members of the coordination of GIS, in more than 10 public events. Amongst these, some of the most important ones that took place in 2007 were the 11th International Metropolis Conference "Paths and Crossroads: Moving people, Changing Places", which took place in Lisbon in October 2006, the IEEI (Institute for International Strategic Studies) Conference "II National Debate: The Future of Europe. Europe and its Values" (March 2007) and the Socinova (UNL-FCSH) Conference, organised in partnership with Odivelas Local Municipality " Sub-Saharian Migrants in Europe" (May 2007)

Conclusions

By analysing the above mentioned results it seems that GIS meets the need for a systematization of knowledge and actions of individuals and groups directly involved in health and migration issues at a national level. The intense sharing of information through the net reveals the degree of consolidation of the group and the fact that it is already a reference in the field of migration and health in Portugal.

Future

The rapid growth of its members and of the solicitations that have been addressed to the group points towards a certain further growth of GIS. GIS has also applied to be involved directly in research projects concerning migration and health. We are also counting on the future use of the information provided by the group directly by immigrants themselves, thus becoming a stronger reference in the field of migration and health.

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Institutional references:

- ACIDI - Alto Comissariado para a Integração e Diálogo Intercultural (High Comissariat for Integration and Intercultural Dialogue)
- Médicos do Mundo (Doctors of the World)
- APF- Associação para o Planeamento da Família (Association for Family Planning)
- AJPAS- Associação de Jovens Promotores da Amadora Saudável (Association of Youth Promoting a Healthy Amadora)
- CEAS/ISCTE- Centro de Estudos de Antropologia Social/ Instituto Superior de Ciências do Trabalho e da Empresa (Centre for Social Anthropology/ISCTE)

Testimony

There is not a specific, individual testimony, but there are several migrant associations which are part of the group and acknowledge the advantages of this group as a vehicle for good practices—such is the case of PROSAUDESC, a migrant-associated NGO for health and community development

Lessons learned

From the experience of one year of work it is clear that funding is needed in order to carry on several projects that the group has. Funding is needed not only for organization but also for specific tasks, such as the publication of the papers presented at the groups seminars. The publication of such texts will represent a major asset to improve the visibility of the group and its activities and influence policy makers. Funding will also allow for specific (needed) research projects, such as in the field of HIV/AIDS prevention in migrant populations (since this research needs to be carried out in the diaspora but also in the original places the migrants come from), or the scope of the access of non-documented migrants to the national Portuguese health services.

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FUNDAÇÃO
CALOUSTE
GULBENKIAN

SPECIALISATION COURSE IN OBSTETRIC NURSING IN CAPE VERDE

School Year 2005/2006

Cape Verde

Introduction

Several reference documents from the Cape Verde Ministry of Health place as a priority the improved training of professionals in the area of nursing, especially the Diagnosis for the National Development Plan 2002-2005, which highlighted the significant deficit of staff in that area.

On the other hand, the Cape Verde report on the Millennium Development Goals points out the high child mortality rate of the country and the need for measures to help continue improving this rate. Among these is the training of human resources in the area of obstetrics.

Goals and objectives

The main goals of this Project - a joint initiative of the Cape Verde Ministry of Health and the Escola Superior de Saúde da Cruz Vermelha Portuguesa [4] are:

(i) to improve the knowledge and skills of nurses allocated to different health structures in the area of obstetric nursing;
(ii) to contribute to decrease morbidity and mortality through the strengthening of differentiated assistance in pregnancy, at birth and at the post-partum phase.

Model

The training lasted for one school year and was organised into 2 semesters with a total of 1,400 hours (540 hours of theory and 860 hours of practice). The distance method of learning – e-learning - was occasionally used for some parts of the theoretical

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[4] Portuguese Red Cross Higher School of Health

content/seminars allowing for the exchange of knowledge through new information technologies, through the use of the Internet.

The 26 professionals admitted to the course had a minimum of five years Professional experience in general nursing and were employed in the health structures which provided care in the area of obstetrics. This aspect contributed to the sustainability of the project as there were no problems concerning their integration in the health structures or securing their salaries.

The pedagogical team consisted of nursing teachers and professors from the *Escola de Enfermagem Hugo de Barros*[5] (Cape Verde), Escola Superior de Saúde da Cruz Vermelha Portuguesa (Portugal) and other professionals from the Baptista de Sousa Hospital (Mindelo) for specific points of the programme.

Area or Decisive Field

Promotion of mother-child health.

Scope

National

Organiser of the Course

Escola Superior de Saúde da Cruz Vermelha Portuguesa, private non-profit institution.

Resources

The Cape Verde Ministry of Health covered the salaries and expenses of the trainee professionals who travelled between the islands for professional purposes, the accommodation of teachers and professors who took part in the training and the space and logistic and administrative support for the theoretical and practical activities of the training action.

The Calouste Gulbenkian Foundation secured the payment of (i) study grants for the trainees, (ii) acquisition of didactic material and back-up equipment required for the course, (iii) travelling expenses, insurance and per diems for Portuguese teachers and professors from the PRCHSH and (iv) the organisation of e-learning.

Management

The experience of the *Escola Superior de Saúde da Cruz Vermelha Portuguesa* in Training in the area of mother-child health contributed to the success of the programme, not only in terms of its preparation but also of the results achieved.

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[5] Hugo de Barros Nursing School

Indicators

Upon the completion of this training course all trainees are able to undertake:

- Consultations of pregnant women including pre-natal exams;
- Nursing assistance during high-risk pregnancies;
- Surveillance and provision of care to normal and high-risk parturients;
- Normal childbirths and deliveries;
- Active participation in breech births;
- Assistance to surgical births: caesarean and forceps;
- Episiotomy, episiorraphy and perineorraphy procedures;
- Surveillance and provision of care to healthy and high-risk puerperal mothers and (pre- and post-term, low weight and sick) neonates;
- Provision of care to mothers with pathological, gynaecological situations;
- Surveillance and provision of child health care.

Results

(i) A specialist in obstetric nursing to provide services in each health centre;
(ii) Two specialists in obstetric nursing in the maternity service at each central hospital.

Families living in the countryside greatly benefited given that the few specialists who already existed worked in urban centres.

Conclusions

This specialisation course in obstetric nursing, taught in the trainees' country of origin, was important for the Cape Verde health sector on the one hand by helping suppress the manifest lack of these health professionals and on the other hand by helping to decrease mortality and morbidity through the reinforcement of differentiated assistance in pregnancy, at birth and during the post-partum phase. It should be also noted that as the training was provided in the social and geographical context in which the trainees would use their newly learned skills, it would be better adjusted to the true necessities of the country and would discourage the departure of these professionals to other parts.

Future

With the purpose of making full us of the training received, the specialist nurses can, through the constitution of a pool of trainers, cooperate in "on the job" training of their peers, thus contributing to the development of skills and competences of all those who carry out their professional activities in the area of maternal health and obstetrics. On the other hand, as a Cape Verde health education institution was involved in this training action conditions now exist whereby the future replication of this type of training and, in this case with the help of local trainers, is possible.

This type of intervention is included in the strategy defined by the Gulbenkian Development Aid Programme to support the enhancement of human resources in

Portuguese Speaking African Countries and East Timor in areas identified as decisive for their development. Support has therefore been privileged, in the area of health, to multi-annual projects dedicated to the institutional (pedagogic, scientific and administrative) enhancement of local training institutes for health professionals (normally of medium level) and that will help bring about a Portuguese speaking network and in due time encourage South-South actions of cooperation.

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COMMUNNITY INTERVENTION IN THE CASAL DA MIRA NEIGHBOURHOOD - AJPAS

Introduction

The municipality of Amadora was created on September 11th 1979, and from that date onwards, it stopped being a Parish of the Oeiras municipality (to which it belonged since 1916). It is located in the geographic area of the North Lisbon Metropolitan Area, with 23,77 square kilometres, and it is divided in 11 FREGUESIAS. It is the most densely populated city in the country, and its population ranges from 175.872 to 185.950, according to estimations from the National Institute on Statistics.

The Casal da Mira neighbourhood belongs to the Brandoa Parish and it's a housing project, made of 760 dwellings. The families living there are originally from the Azinhaga dos Besouros, Alegria and Novo neighbourhoods. The population is young, 50% is younger than 25 years old, and only 6% are older than 65. The data from the Technical Office of the Amadora Municipality indicate that the majority of this population is socially and economically disfavoured; many of the families depend on subsidies from the Government. This is a community where work is more relevant than education, with high rates of school dropout, teenage pregnancy, violence and other issues associated with social exclusion.

The neighbourhood has several structural problems, namely the insufficiency of public transportation, the absence of commercial facilities, the existence of only one pharmacy and the lack of infrastructures to support the young and elderly populations.

It was under this general framework and in a global intervention perspective that AJPAS began its community intervention in the Casal da Mira neighbourhood. To enable this work, and because AJPAS doesn't have facilities at the location, the intervention strategies are based on partnerships with the *Associação de Unidos de Cabo Verde* and the *Centro de Saúde da Venda Nova* (Venda Nova Health Centre), which have allowed for the use of the health mobile unit and its driver, technical support, vaccines and contraceptives.

Goals

1. Intervene, in the areas of maternal healthcare provision, family planning,
child health and immunization and health promotion, with the support of volunteers and technical officers of the *"Formar e Apoiar"* (Train and Support) Programme.; 2. Implement information/awareness campaigns, distribute culturally adapted information materials and condoms; 3. Create a sexual and reproductive health consultation targeted at young people, with individual and group appointments, also with the goal of building formal and informal groups, to interact with their peers and the general population; 4. Provide legal and social support; 5 – Promote educational activities targeted towards the neighbourhood children.

Targets: 1. Increase the access of the population to the health services; 2. Diagnose social problems and forward them to the competent authorities; 3. Create a youth group with the adequate tools to disseminate good practices in the health field; 4. Build a platform, supported by a network of partners; 5. Raise the rates of provision of maternal healthcare services, family planning and immunization to the levels established by the health authorities; 6. Build a group of young socio-cultural mediators to interact with their peers and with the general population; 7. Create a group of youngsters promoting health, in the field of HIV/aids; 8. Create a sexual and reproductive health consultation targeted at young people; 9. Promote the conditions to open a new teaching room for extra-curricular learning; 10. Increase the capacity of population to plan the activities to develop, specially the capacity of young people; 11. Increase the levels of knowledge of the target population, in order to capacitate them to find themselves the solution for their problems in the future.

Area or determinant: Prevention, promotion, maternal health, family planning, immunization, education, social, legal, immigration and social housing.

Scope

Local

Provider

AJPAS – Associação de Jovens Promotores da Amadora Saudável (Association of Youngsters Promoting a Healthy *Amadora*), Non Governmental Organization, with the status of *Instituição Particular de Solidariedade Social* (Private Institution of Social Solidarity), not for profit, founded on June 18th, 1993.

AJPAS has been recognized as *Instituição de Utilidade Pública* (Public Utility Institution), by the Municipality of *Amadora* on April 28th, 1999, published in the official journal of September 6th, 2000, and as an Immigrant's Association by the Portuguese High Commissariat for Immigrants and Ethnical Minorities, on January 10th, 2002.

With its seat in Amadora, AJPAS undertakes activities on the areas of Public Health and on the Social field.

Model

The model under use considers: 1. the establishment of the team in the previously defined territory; 2. in the recognized by the community of the intervention that had been done; 3. in the community capacitance; 4. In the existence of a multidisciplinary and articulated team that done a systemic board and not parcelled one, based in a team work; 5. the flexibility and the adaptation to the reality in all the Project levels; 6. the good relation with the colleagues, community and all the members of the team, that had made to pass the barriers pose during these 6 months. 7. There has been made a systematic evaluation by the teams, partners and the community, it has allowed to see the points, the great acceptability of the community strong, and also the weak points, the lack of physical space and some difficulties of joint with some institutional partners, due to lack of flexibility demonstrated in the question of a global intervention. The used methodologies are varied, playful, creative and participative.

Resources

To develop these activities, AJPAS has the financial support of the Ministry of Health, through the National Coordination for HIV/AIDS Infection, the Ministry of Foreign Affairs, of Cape Verde – Institute of the Communities, and of the Municipality of Amadora, through *PAMA - Programa de Apoio ao Movimento Associativo da Amadora* (Programme to Support the Amadora Associations). AJPAS counts with its human resources, its partners and the precious support of many volunteers who have been adhering to the project in a spontaneous and passionate fashion. The staff of the project is composed of 2 medical doctors, 4 nurses, 1 legal officer, 1 social worker, 1 psychologist, 1 human resources manager, 1 kindergarten teacher, 1 administrative assistant, 1 socio-cultural mediator, 2 drivers and 12 volunteers.

Management

Management is shared. There is a board, who discusses the activities, based on the defined goals and expected outcomes. AJPAS made an initial diagnosis of the situation to respond to the needs of the population. The population was consulted and is a part of the process, in every stage. An intervention platform was constructed, including: Ministry of Health, Lisbon Regional Authority – Venda Nova Health Centre. Ministry of Education, through the Lisbon Regional Authority, Amadora Municipality. Meetings with the Ministry for Labour and Social Affairs, through the Employment Institute and the Local Social Security Department and with the Intercultural School of Trades and Sports as well as with other relevant community partners have been scheduled.

Indicators

The indicators used are the process and results indicators already defined by the Ministry of Health for the mobile units. Together with the partners, we are currently defining new indicators that result from the evaluation of the first 6 months of intervention. Social indicators are being tested. We are using efficiency, efficacy and impact indicators.

Results

The results have surpassed expectations, because the number of the people requesting our support increases by the week. These data / information's are correctly documented in a data base made to this objective, based in the health *ex-Sub Region* data base that is posed in the mobility unities. By the moment is not possible present them statistic because they are in treatment process. The participation of the population to our work shows the way that a unknown team passed in 6 months to be the connection key with the society, and for many his only answer. In the vaccination area, mater health, and medical care we can say that the percent of the attendance is 100% of the population that came to us, in a term of 25 people for week. In the social area, must of the problems posed to our team, it was resolved yet with a multidisciplinary intervention and with the support of our colleagues. Other problems are almost resolved or in process of been resolved. With the children that have been done a job, also weekly, that have also the finality to be a healthy way of occupation of their free times, in a media of 15 – 20 children by week. About young people, we had been utilized many methodologies, same attended in the maternal health consultation and familiarly plan, an overage of 4 -6 for week, with the distribution of information, condoms and contraceptive methods. Others came to us in the information area about AIDS and other institutions with the objective to collect information's and condoms. In the first 6 months that were distributed 240 flyers and 1860 condoms. With the creation of the consultation of sexual and reproductive health in July 2007, already 11 young had been individually taken care of. For September, the beginning of the attendance in group is programmed (because the partner that yields the physical space was closed in the month of August). One more time it has to enhance the fact of all the work is done on Saturdays, in the Mobile Unit and/or the street next to the pharmacy, for, although some requests, the City council of Amadora does not yet to have yielded a space where the AJPAS can intervene next to the population, throughout the week and with better conditions of attendance.

Conclusions

The community intervention has to be based on the target community needs, on the mobilization of the partners and at the local level, on wins and losses, on the correct definition of our intervention area, on the solidarity of action, on the capacity building of the community, on the network and partnership work, on the team's cohesion and above all on the importance and value given to the interventions and on the way this type of work is accepted within the community.

It is a task with variable progress where the strategic vision and interactive planning are the basis of the results. A key conclusion that can be drawn is that any community intervention project must have the agreement of the policy makers, be integrated in health policies and in this case also in integration policies and be agreeable to the community and the partners, identifying the areas felt as more important by the community, working based on their expectations.

Future

The future depends on the results, on the sustainability, on the team's cohesion, on the capacity building of the community, so as to guarantee that after the ending of the project, there will be a local capacity to answer the new challenges that may arise.

It also depends on the evaluation that the financial institutions will make of the outcomes. Above all, the future will depend on the competences that both the team and the target community acquire throughout the process. The future also depends on the outcomes and on the possibility of replicating the model on other communities and this is entirely linked to the need to make the technical officers understand that they must come out of their offices and go to the communities, meeting their real needs, instead of applying methodologies disconnected with the reality, using tailor-made approaches instead of prêt-a-porter.

For additional information, contact:

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