INTI PROGRAMME
European Fund for the Integration of
Third-Country Nationals Community Actions
Project: JLS/2008/EIFX/CA/1014

Healthy and Wealthy Together:
DEVELOPING COMMON EUROPEAN MODULES ON MIGRANTS HEALTH AND POVERTY

Second Transnational Peer Review Workshop Report
"Mental health and pre/post maternity services for migrants in Europe"

November 2010
Birmingham
England UK

« Project financed under the European Fund for Integration of Third-Country Nationals"

WS1: Developing good practices in addressing the mental health needs of migrants.

WS2: Developing good practices in addressing pre and postnatal maternity services for migrant women.

Jayne Thornhill & Dr P.A. Jones
Birmingham
England. UK

Healthy and Wealthy Together
Qec-ERAN conference
November 2010

Table of contents

Introduction

Healthy and Wealthy Together: developing common European modules on migrants' health and poverty

INTRODUCTION

- This project is financed by the **INTI** programme implemented by **Directorate General of Freedom, Security and Justice.**

- The overall goal of this project is to identify and develop good practice modules in addressing the issue of **poverty** and **health inequities** among legal migrants.

- INTI's purpose is to **facilitate the integration** of third country nationals into European societies, in accordance with the Common Basic Principles for immigrant integration policy in the European Union, by:
    - enhancing the **capacity of Member States** to develop, implement, monitor and evaluate all integration strategies, policies and measures
    - and **exchanging** information, best practice and co-operation in and between Member States.

OBJECTIVES

This project seeks to strengthen the implementation and awareness of the Common Basic Principles (CBP) at local level. The CBPs were adopted by the Justice and Home affairs council in November 2004 and incorporated into the European Commission communication on A Common Agenda for Integration in 2005. These 9 CBPs are primarily intended to assist member states in formulating integration policies for immigrants by offering a simple, non-binding guide against which they can judge their own policies.

The project has concrete objectives:

1. To promote mutual learning and exchange of best practices and measures to diffuse at European, national, regional and local levels in relation to migrants' poverty and health inequalities

2. To elaborate recommendations and operative conclusions targeted at European, national, regional and local stakeholders.

3. To support partners to develop local action plans

ACTIVITIES

Activity I: Establish Local Forum and Local Mapping

What is it?

Each partner has to establish A LOCAL COORDINATOR to coordinate the project on the local level.
In order to build a **local forum** to establish a thematic exchange network of public and private local actors working with or for migrants around the issue of health and poverty.

In order to bring to this project as much experience as possible it will involve partners who were or/and are experiencing important migration flows of third country nationals in their locations.

Each local Forum will undertake a **local mapping** in order to identify **three most relevant issues** in the field of Migrants health and poverty that have to dealt with their location.
This research will determinate the themes of European modules on which the Transnational Exchange Programme will be based on.

Who?
A Local forum should be composed a group Representatives from:

- Migrants associations
- Healthcare professional
- Local politicians
- 0ther involved stakeholders
-

This people will be involved in all the activities of the project in terms of good practices and experience sharing.

What is their role?

- Participate in the mapping exercise
- Participate in the Peer Reviews
- Present local practice
- Review the strategy and practice of the host locality

Activity II: Transnational Peer Reviews, Exchange & Development Workshops (3)

What is it?

Transnational Exchange Programme will be built upon the findings of partners' local mappings. It will consist of Three Transnational Workshops supported by external experts where good practices, experiences and policies will be exchanged between the representatives of Local Forums, and of an on-line interactive platform (blogs, chats,

individual profiles). The platform will serve as a tool for ongoing communication, ideas sharing and a continuously growing database.

.

Each peer review will focus on one of the 3 themes identified by the project

PRW1: "Sensitising professionals from health services providers to meet the needs of migrant groups"

Date: 10 to 11 June 2010
Place: Roquetas de Mar (Aguas Dulces), Almeria, Spain

PRW2: "Mental Health and pre/post maternity services for migrants in Europe

Date: 9 to 12 November 2010

Place: Birmingham, UK

PRW3: "Eu against poverty: focus on child and older retired migrants"

Date: 13 to 15 April 2011

Place: Amadora, Portugal

PARTNERS

LEAD Project:
Camara Municipal Amadora: PT
Supported by: **QeC-ERAN** BE

Exfini Poli EL
University of Birmingham UK
Municipality of Milan IT
Belfast Health and Social Care Tust UK
Municipality of Roquetas de Mar ES
Réseau Samdarra FR
Province of Piacenza IT

Project Coordinator:
Giulia Cantaluppi
g.cantaluppi@qec-eran.org

Project Assistant:
Nicolas Hauw
n.hauw@qec-eran.org

Project Website:
http://www.qec-eran.org/projects/inti_index.htm
http://project1.qec-eran.org/

WS1. Developing good practice in addressing the mental health needs of migrants

Topic in context

Background information

The achievement of good mental health levels is important for both the economic and social welfare of a society. However, the history of migration has always been replete with references to mental health issues and problems Data from EU countries gives clear evidence that contemporary migration is no exception to this and migrant populations have been found to disproportionately face serious mental health problems and psychosocial problems when compared to the host populations. Mental health approaches in European healthcare systems are often seen to be ineffective, and in some cases the reported rates of suicide and/or attempted suicide, as well as depression and psychoses, are higher than among non-migrants (Fernades & Pereira 2009).

Psychopathological specificities

Culture plays a major role in the expression and experience of mental health and ill health. Culture also affects the way people approach mental health services, how they use them, how and where they look for them and ultimately how they interact with mental health service providers. (IOM 2010)

Whether migration is planned or forced, some degree of stress is always involved. Migration means breaking family, friends, and established social networks, departing from traditional routines, value systems, and accepted ways of behaving and having to adapt to new social and psychological environments (Carballo & Nerukar 2001).

Psychosocial effects

Language barriers additionally play an important role in mental health, and barriers to good communication compound feelings of isolation and being unwanted. For many people, migration and resettlement results in social isolation and loneliness. This is especially so for people who have migrated alone. (Carballo & Nerukar 2001). Insecurities including legal status and transient living conditions, combined with unemployment and the non-recognition of qualifications alongside discrimination leads to feelings of a lack of self-esteem and a lack of self worth (ZEROUG-VIAL Halima 2010).

Good practice initiatives

The diagnosis and definition of mental health problems is a controversial area. Mental health organisations and health professionals use a variety of clinical and social models (IOM 2009). This category of people present a particular challenge to professionals because of the sheer scale of problems they face. The importance of social, political and economical factors needs to be taken into consideration. There is a danger in generalising and neglecting the uniqueness of the individual (ZEROUG-VIAL Halima 2010).

A holistic approach is required to address the determinants of migrants mental health problems, which 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

wellbeing. The case studies cited in the next section have been devised to counter the shortcomings in the mainstream service provision, and policies already in place that did not address the mental health needs of migrants. They are in essence innovations (Fernandes & Miguel 2007) that provide excellent examples of practical and creative solutions designed and implemented by NGO's, and/or statutory bodies. The examples include:

- France: Two case studies

a) A professional network to improve mental health services to migrants
b) Mediation through the picture: and experience of mediation by photography in the suburbs

- Italy: Mental and physiological problems of migrants connected with the process of family reunification

- Greece: IASIS day centre, boarding house, and professionals training programme

- Portugal and Latin America: Dentist for Good

- England: Culturally sensitive and professional counselling and support services

Developing good practice in mental health services: Case studies

Case study 1

Location: Lyon, France.

Organisation: Réseau Samdarra

Title of the project: Réseau Samdarra: a professional network to improve mental health care for migrants.

The main goal of the Samdarra network is to generate collective working time where professionals from different fields and localities can reflect on their service provision and help asylum seekers and refugees rebuild a future, where they feel integrated in society and are able put their past behind them.

The Network was established in November 2007 as a result of research into refugees and asylum seekers mental health needs and the identified difficulties faced by professionals: Isolation in their practice; a necessity to set up DIY solutions; a lack of institutional legitimacy to informal practices; and lack of opportunity for them to discuss issues.

Professionals in France recognise that migrants' mental health depends on several key factors interacting altogether. Most of these factors are social determinants, and

therefore the administrative, legal and economical situation, the migration routes and the enculturation process, all have an important influence in increasing or decreasing someone's risk of developing a mental health problem or illness.

Professionals working with asylum seekers and refugees encounter specific situations. Each professional working with asylum seekers or refugees is confronted with the asylum origin: the story that led people to flee their countries; and the traumatically content of this experience. Migrants are dealing with traumatic experiences and sometimes develop posttraumatic symptoms, which paradoxically may not be compatible with the obligation to tell what happened in their country of origin. Migrants' may require social, medical and psychological care with additional time to discuss their experiences, however, consultation time is not adequate, and procedures tend to be shorter and shorter.

These asylum situations depend on the legally strict ridged administrative procedures, led by social workers, which is generally not adequate to the migrants'' situation which is full of traumatic suffering. Professionals need an understanding of the repercussions to these different factors, and the impact that social care, legal and juridical systems, and services provided have on migrants' mental health and provide more appropriate services.

It is not advised for professionals facing these kind of situations, which are ethically complex and complicated, to stay isolated. Asylum seekers and refugees, as all people in a precarious situations, need to be taken care of by a group of professionals, who have the ability to help them learn how to rebuilt social links. The network facilitates interdisciplinary collaboration around migrants' mental health care.

The Network comprises:

- A salaried team : publicly funded to employ a full time co-ordinator, and a financial contribution towards a psychiatrist, psychologist and trainees from different social sciences fields. The team are responsible for fundraising, co-ordinating local projects and developing local partnerships.
- A technical committee: comprised of interdisciplinary groups and represenatitves from a variety of institutions that meet montly.
- A coordination committee: comprised of interdisciplinary groups and representatives from institutions involved in mental health issues for asylum seekers and refugees, meeting annually.
- Thematic working groups : Interdisciplinary working groups open to all interested proffessionals and voluntary agencies. Specific thematic issues for example, parenting in exile, or ethical issues that are developed collaboratively through projects linked to these themes.
- Local groups : Proffessional and voluntary agencies that strengthen partnerships between health and social care sectors, and develop solutions to adopting good practice.

The Samdarra network is creating pathways between the different fields involved, and generating collective working time where professionals from different fields and different territories share practices, and lead reflection about solutions in order to build a high quality service provision. Awareness raising and training of professionals in the needs of migrants is delivered through seminars and training. Understanding the repercussions of these different factors, the interventions of professionals involved in social and care

services, or legal and juridical systems, will impact on migrant's mental health through the services they provide.

http://www.samdarra.fr/

Case study 2

Location: Rhone Alpes, Lyon, France.

Organisation: Blandine Bruyere, psychologie teacher in the University of Lyon 11

Title of the project: Mediation through the picture: and experience of mediation by photography in the suburbs.

Rhone Alpes is a suburb in Lyon France that is comprised of 80% migrants, is an area stigmatised by both the media and politics since riots in 2005. The project was inspired by a therapeutic method in France used with patients in hospital called photo language – language through pictures that consists of several steps: questioning the image people think "others" have of their city; working on the image they have of themselves; and working on the image they wish to portray and make recognised.

The project approached the notion of 'otherness' in all its forms: which "others" are we talking about? Who are these "others", who are the "others" for the "others", and aimed to identify the similarities and differences, as minimal otherness or radical differences. Additionally, it aimed to put in parallel what a person sees, what a person shows, and what a person would like to show.

The University of Lyon engaged with local migrants that are engaged with FRANCO (friendship societies), through partnerships with social workers. Many of the migrants have lived in the same hostel for 30-40 years, and were being treated in a demeaning manner by the hostel management. Discussion with the hostel residents demonstrated their ambivalence about their link with the community, as migrants spoke about their difficulties, and their difficulties to escape or act differently from their situation. This raised a question regarding similarity or differences, it often being easier to think that others are radically different, but the reality demonstrates this is not true.

In social representations, immigrants are often seen as passive: taking benefit and advantage of social aid, and delinquents. This project aimed to enable the migrants to see things from a different viewpoint than their own, to try to identify themselves as 'others', and clarify their own way of looking at themselves.

Migrants engaged in the project were each given a digital camera and asked to take pictures of their City to illustrate the different ways people observe their city and their own way to see it – putting themselves in the eyes of others. Migrants were asked to try and put themselves in the shoes of a tourist, and finally a tourist guide. This allowed the migrants to look at their city through new eyes, and generated a new discovery that told a story through captions.

The tonality of the work demonstrated a change from the migrants feelings of anger at the start of the project, to the opening of the possibility to see their environment differently. It also confirmed to health professionals that individuality exists through a

group, and that it is by belonging to several groups that individuals get their own identity. The work has demonstrated that migrants try to repair their identity themselves in the way they try to build a new group around them, against the image of the community in which they initially grew up. It suggests that specific tools are needed for migrant communities in order for them to take out the 'otherness.' When working with migrants, health professionals need to consider emigration and accept that there is a part of all migrants that professionals cannot reach.

The benefit of the project for participants' mental health status has been difficult to measure, as there is not a scale available to measure the impact of the work. Participants were observed to take pleasure, were delighted to be working together, and the project has continued on a voluntary basis. The key learning is that the project has demonstrated to professionals that migrants can teach the ways in which professionals need work with them, and what migrants really need.

http://photolanguage.com

Case study 3

Location: Milan Italy.

Organisation: Municipality of Milan

Title of the project: Mental and physiological problems of migrants connected with the process of family reunification

Since 1970 Italy has been transformed from a country of emigration to a country of immigration. This is a recent phenomenon compared to other European countries for example, France, United Kingdom and Germany. Prior Government legislation relating to migrants prior to 1990 was inadequate and therefore between 1990 and 2000 the Government introduced a number of new laws to limit the number of immigrants coming into the Country. A control system – the Immigration Desk (S.U.I) – now ensures that migrants have all the required qualifications by law to live in Italy. The Milan Municipality interventions are compulsory and because of the large dimension of the phenomenon – in July 2010 sixteen percent of the city of Milan residents were migrants.

A one-stop centre for migrants in Milan has been set up in 2008 to give integrated support to migrants on legal, psychological, social and employment matters. The policy is to give a 360-degree response to migrants. The Centre is in contact with twin centres operating in Morocco, El Salvador and Ukraina, and also engages with migrants groups and associations. The centre receives more than seven thousand applications each year for one or more family members to be rejoined with migrants living in Italy. The centres work in cooperation with the Milan Municipality governance system on family reunifications. These regulations are complex and involve specialists working in different sectors: juridical; legal; and individual identity. For many families there are difficulties due to the length of time spent apart.

The El Salvador Case: Locations are Milan, San Salvador and Chalatenango, with partners based in Soleterre/San Salvador, Romero Community in Milan/Chalatenango,

with support from Consulate El Salvador in Milan and Italian Embassy in El Salvador. The Lombardia Region, Labour, Health and Social Policies Ministry provide funding. The programme engages with first-emigrating women and their families of origin. Approximately seventy percent of women from El Salvador are resident in Milan. Most cases involve at distance family conflict relationships and family cohesion mostly with minor sons. The project aims to lay the foundations for the ease of the arrival of families into the local area, as there are many problems with children relocating to Italy after spending a long time apart from a parent. Children are reported to endure this relocation, rather than actively seeking it.

The Ukraina Case: Locations are Milan and the region of L'viv, with partner organisation Zaporuka Foundation – a National Ukrainian Organisation - with support from the Regional Social Policy Department of L'viv. The Unicredit Foundation provides the funding. The programme engages with women, primarily aged over 40 years old in the region of Lomnardia, mostly employed as care assistants, and their families of origin, including schools and institutions. The project aims to address the "Italian Syndrome", experienced by families as a consequence of the isolation, working conditions, 'freezed' family at distance relationships, and the rejoining of adult children. More recently the project has engaged with minors that include nephews of reunited daughters, as a consequence of immigration amnesty in 2009.

Tools and Goals: Legal and/or psychological interviews and group meetings provide information and awareness on family rights, assistance to document preparation and orientation to territorial services. Interviews with psychologists and group meetings promote the planning of rejoining family, and accompanying sons and parents. A notebook of the family promotes a shared family project, between mothers and their sons, and the native family or other members of the family, in Italy and the Native Country. Family sessions are held to promote awareness of the migrant's family identity in Italy and in the Native Country. A multidisciplinary team including psychologists, and various agencies including trade unions and charitable agencies deal with legal and procedural aspects of reunion and is co-ordinated by the Milan Municipality.

Pilot Project: Transnational Communication with El Salvador.

A pilot project, located in the Centre of Milan that enables migrants in Italy to get in touch with their families in El Salvador through SKYPE. This is a group process to support the difficulties families face in transnational communication, in order to address the emotional and psychological feelings associated with the changes in family relationships and being parents at a distance. Ten families supported by a team including an Intercultural Mediator, Psychologist, and Educator meet monthly as a group and the programme is introduced across three phases:

- Phase 1. Group process: narration activity with families
- Phase 2. Individual SKYPE communication between the migrant and their family in the Native Country
- Phase 3. Writing up a family diary

Results: In El Salvador ten families have followed the programme of transnational communication during 2009-2010. Seven of these families are evaluating the reunification in Italy with 3 ongoing (2010). Three families decided not to reunify, but have improved their own at a distance relations (2010). Forty families cases have been supported in 2009-2010 in the post-reunification phase relating to: conflicts between couples in the reunification process; lonely mothers; and minor diseases.

In Ukraina fourteen women are involved in the first phase of the programme in preparation for the transactional website communication. Professionals are supporting a variety of family cases that include: divorce; reunion with adult children suffering with depression; and reunification with nieces.

Key Learning: Families at distance don't have a common family project: migrating members and left-behind and families are unable to develop a common project, because of the distance and the new family's condition. This is a reason why family relationships can be seriously affected during the rejoining process (ex. El Salvador) or in a protracted life at distance (cfr. Ukraina). The emigrating families have to be accompanied and supported in the process, by both the welcoming country and the native country. It is important that adults in charge of their children's (sons) education accompany them in order to promote a shared family project (economic and educational ones) and to prevent diseases.

Case study 4

Location: Greece

Organisation: IASIS a non-government organisation (NGO)

Title of the project: Training of mental health services personnel in diversity issues.

IASIS began its operation in 2005 providing therapeutic and counselling services of psychosocial support. IASIS aims to: operate on a prevention level towards psychiatric commitment by providing an alternative type of mental health care; improve the life quality of those receiving services by supporting their inclusion into the social procedures; train other mental health practitioners in the issues of psychiatric reform; and sensitise and inform the local community, to fight the mental health stigma.

Within this framework IASIS operates in two specialised centres:

IASIS Day Centre has operated since 2008 and is situated in the centre of Athens. It is an open structure that provides specialised socio-psychological services to adults who face mental health problems. The Centre delivers special seminars and training programs in an attempt to inform and sensitise the local society. The overall aim of the Centre is to act both on the level of psychosocial rehabilitation as well as on the level of prevention and informing concerning Mental Health. Beneficiaries of the day center services include: adult people of Attica who suffer of mental health disorders and or other disabilities even live with their families or in a psychiatric setting or community house; immigrants who needs empowerment and support; people interested in mental health issues (trainees, volunteers and others) and the whole community.
IASIS boarding house has operated since 2006 in the area of Saint Nicolas in Athens. It houses residents, individuals with psychological disorders and severe mental retardation. Its aim is to support the social rehabilitation of its residents. The residents of IASIS community house consist of 15 people aged between 25-70 with serious disabilities and/or psychiatric disorders who were living for long time in closed psychiatric hospitals or other institutions, excluded and isolated by the community and other social networks. The boarding house provides a warm and friendly environment that aims to

integrate residents back into society by helping them to develop their personals and social skills in life. In an effort to improve the quality of the services provided, the Centre operates in accordance with the quality model ISO 9001:2000.
IASIS interdisciplinary therapeutic team consists of: a coordinator, administrative personnel, psychologists, social workers, nurses, physiotherapist, work therapist, and specially trained escorts. The team also engage with other health professionals including: psychiatrists; pathologists; dentists; oncologists; cardiologists; legal experts and a security technician.

The treatment at the Day Centre for mental health issues include: psychiatric assessment and medication; individualized and or in groups psychological-therapeutical support to person and its family; occupational therapy and other creative activities; physical rehabilitation and educational services in health issues (nutrition, hygiene, safety etc), educational activities and other learning activities (computer, foreign languages, learning groups), and cultural events and recreational activities. The treatment is supported by a weekly programme delivered daily that aim to improve people's personal and social competencies in life, increasing the self- awareness and self-confidence; encourage self-expression and interaction with others and enable people with mental health problem and disabilities to be included within society.

To raise awareness and inform best practice in relation to mental health issues IASIS provides training and guidance to volunteers and trainees in terms of mental health issues; increases the awareness of the general public in terms of mental health issues by organising festivals, conferences, trainings, seminars; provides chances of training to its specialists by keeping them informed for issues related to mental health issues and rehabilitation; contacts and cooperated with agencies in the promotion of health; and conducts research and publications.

A train the trainers' programme has been introduced that resulted from a needs analysis indicating a lack of knowledge of the cultural background of migrants, and that the borders between psychological problems and cultural or post-traumatic shock were not always clear. The methodological framework includes experimental training over 6 days that include workshops, simulations and group exercises, simplified with a real-time supervisor. The modules key words include: empathy;
active listening; kknowledge of diversity; cultural approach and communication.

Results indicate that the programme is delivering an efficient psychological approach for immigrants; that professionals are making the correct diagnosis and decreasing mistakes.
http://wwwiaismed.eu

Case study 5

Location: Latin America and Portugal

Organisation: Turma do Bem

Title of the project: Turma do Bem (Dentist for Good)

The Dentist for Good project relies on the voluntary work of dentists who treat children and adolescents from low-income families, providing them with free dental treatment

until they turn eighteen. Patients are selected through a screening of children aged between 11 and 18 years and are enrolled in public schools, NGO's and institutions. The selection is made by applying the criteria developed by Economic Classification ABIPEME and the IHC index (ranks Complexity). Children with serious dental problems, the most need and closer to their first employment are given priority attention. As well as the physical health issues that serious dental problems present, it is more difficult for children with serious dental problems to find employment, and their mental health, self-esteem and confidence are all affected.

An equal rights policy is adopted, treatment on children is performed at the clinics of volunteer dentist, is curative, preventative and educational. The project has been successful in engaging volunteer dentists from all over the Country and all 26 states and Federal District, Latin America and Portugal. Volunteer dentists are supported by Regional coordinators that are dentists with responsibility for the implementation, dissemination and project development in their city.

Dentist for Good in Portugal: In Portugal 90% of the population has caries or other dental pathologies that are very severe. Sixty percent of young people under the age of 14 have never visited a dentist. At 12 years old children can have 50% of their teeth at risk. Amadora has a young population, comprised of a large immigrant population of 66%. Seventy six percent of the immigrant population is from Portuguese speaking African countries and live in poor neighbourhoods. There are no language difficulties but there are integration and cultural issues.

In November 2010 Portugal had 117 volunteer dentists and 82 beneficiaries, and the aim is to expand this volunteer network to deliver the service to more migrants living in Amadora.

The methodology covers four stages:

1. Screening: Screening takes place in schools, NGO;s and institutions. Screening is undertaken by a visual observation. The criteria is rigid, with the NGO's helping to select the children aged between 11-17 from the poorest families, and closest to their first employment.

2. Mobilise dentists: a variety of methods are adopted to mobilise dentists including mailing lists of children waiting for treatment, social networks including facebook and twitter.

3. Meeting with parents: Authorisation from parents is needed prior to treatment. The rights and duties of the families are explained, however, some parents are unable to read and write and project workers have to be very clear about their parental duties and responsibilities that include the need to accompany their children to the dentist and to ensure that children do not miss appointments. Failure to do will result in children not being entitled to the treatment.

4. Action. Children are forwarded for treatment at a dentist closest to where the family are living, to ensure that children are able to attend and be accompanied by their parents.

In Portugal the project employs a Manager and a Coordinator, and is financed through patronage to the sum of 100,000 Euros per year. In order to ensure sustainability the organisation requires additional patronage as the cost of each child's treatment offered voluntarily works out to 5,000 Euros per course of treatment.

Results of measured by: number of volunteer dentists; number of teenage children waiting for treatment; number of teenagers receiving treatment; and outcome results in self-esteem, school performance and employability. Satisfaction surveys demonstrate that children are very happy with the service provision.

Three key learning points have been identified: the project is being delivered across Brazil and Latin America, and can be replicated in many countries; there is no discrimination to migrant children; and the resource optimisation of the organisation.
The goal for 2011 is for 19,000 children from African countries of Portuguese speech to be treated, and that by 2015 forty five thousand children will have been treated and that 15,000 dentists will be volunteers.

http://turmadobem.org.br/br

Case study 6

Location: Birmingham. UK

Organisation: My Time Community Interest Company (CIC)

Title of the project: Culturally sensitive and professional counselling and support services

My Time delivers a range of services including family counselling service; intercultural counselling and psychological services; self-esteem and confidence building courses; and relationship counselling. The organisations approach and philosophy is based on the integration of Western and Eastern therapies particular cognitive humanistic, cognitive behavioral therapy (CBT), Morita therapy (Japanese Buddhist), African based therapy and Islamic psychology. The central belief within the My Time approach is that all human beings have the same basic ingredients of mind and body that we live within an environment (the world about us) and that we are psychically born into a family, culture or society that we inherit core beliefs and values.

An integrative approach is used, that is underpinned by Mindful Cognitive Behavioural Therapy (CBT,) and Person-Centred approaches combined with an understanding of cultural and faith needs. This is a Cognitive-Humanistic approach that centres on the specific needs of the client to find the best approach that enables the client to achieve their goals, and reduce depression and anxiety and other symptoms relating to their mental and physical well being. My Time puts strong emphasis on the combination of Mind, Body, Environment, Beliefs and Values, and believes that harmony between these five core aspects is essential to the development and growth of the individual.

My Time has spent many years supporting BME counsellors and psychologists in their training and development. The organisation has a skilled team of experienced culturally sensitive and multi-lingual counsellors that provide emotional support, talking therapies, crisis management, guidance, self-help and signposting. The organisation is a member of the BACP (British Association of Counselling & Psychotherapy) and in 2007 was awarded by the BACP for Innovation in providing culturally accessible counselling services. All counsellors are either BACP accredited or working towards accreditation.

Intercultural counselling and psychological services: A limited brief counselling service based on a culturally and faith sensitive approach, can be accessed by service users through other services that are internal to the organisation. One to one counselling is available in English, Albanian, Polish, Urdu, Arabic, Bengali, Hindi, Farsi and Punjabi languages.

Confidence and self esteem building courses: In partnership with a range of organisations, My Time designs, trains and delivers self-esteem programmes to individuals experiencing low self esteem, anxiety and depression in a safe and community-based environment. A range of creative media is used for example clay and photography, and participants engage with instructors and experts in a range of fields to enable them to make progress in creative activities and in other areas of their lives. The organisation helps participants to change their own negative views of themselves, and supports them in changing other people's views as they progress.

Family Counselling Services: In partnership with the Institute of Families and Parenting, a culturally sensitive Family Counselling service is offered to families experiencing mental health related issues. The service is available to families living across Birmingham and can only be accessed through specific referral routes. The project aims to support families with multiple and dysfunctional risk issues where fathers display negative behaviour/thoughts, and there are early signs of domestic violence or mental health problem

Horticultural and non-talking therapies: In 2008 My Time was part of the national Delivering Race Equality (DRE) Community Research Programme, and conducted a study entitled 'Sowing the Seeds of Hope', which explored the mental health needs of Asylum Seekers and Refugees and suggested alternative therapeutic approaches. As a result, in addition to the core services My Time now provides a horticultural therapeutic project for refugees and individuals experiencing long-term mental health issues including Post Traumatic Stress Disorder

http://www.mytime.org.uk

Migrant Mental Health Strategies in Europe. Dr P.A. Jones

Context

EU research rationale

Mental disorders represent five of the ten leading causes of disability world-wide yet only a small minority of those in need receive basic treatment. While mental disorders affect all groups in society, the poor, refugees and immigrants are disproportionately affected (Minas, 2002). Inevitably where 41% of countries have no mental health policy, 25% of countries have no mental health legislation, and 28% have no separate budget for mental health we know little about sections of populations with the greatest needs (ibid). However, increased population and mobility in Europe has brought health issues to the fore. In 2005, the World Health Organisation Regional Committee for Europe (WHO/Europe) set out to address strategy for mental well-being and to incorporate the rights of marginalised groups into mental health legislation. WHO/Europe (2005) acknowledged that stress-inducing societal changes lead to increased anxiety, depression, alcohol and substance misuse, violent and suicidal behaviours; making refugee and migrant populations especially at risk. Generally, there is extensive knowledge about mental health promotion, prevention, care and treatment that requires implementation but evidence-based research specifically about migrants[1,] mental health and accessibility of care is still in its infancy and often duplicated within the 27 European countries.

There has been a significant increase in reports concerning migrant and ethnic minority health since 2005, examined in a number of European countries simultaneously. The Assisting Migrants and Communities (AMAC) Project identified the Netherlands, Spain and the United Kingdom (UK) being included most frequently (Ingleby, 2009). Anomalies exist across European research in terms of categorising migrant status about whether ethnicity, cultural background or religion is the main variable. The UK tends to regard ethnicity as the most important indicator of health inequality (Winterton, 2005) while research in continental Europe is more likely to focus on migrant status. Categories devised decades previously tend to omit recently formed migrant groups.

There is a lack of consensus whether research done on particular migrant communities can create the basis for generalisation (Silveira & Allebeck, 2001). Two main types of research are carried out to establish migrants' state of health: Clinical studies relating to a particular diagnosis and treatment or population-based studies, which can be large or small scale, can both be problematic if not linked to information about ethnicity and migration (Palmer & Ward, 2007; Ingleby, 2009). In the UK there is strong evidence to suggest that mental distress for refugees and asylum seekers is not only linked to the circumstance of forced migration but also to experiences of difficult living conditions and low socio-economic situations (Crowley, 2003; Ward & Palmer, 2005; Phillimore *et al*., 2007; Knipscheer, *et al.,* 2009). Similarly there is a growing body of evidence in the UK to suggest that migrant workers struggle to cope with stress induced mental health problems (Holman & Shneider, 2007; Shneider & Holman, 2009), particularly those working in manual or low-skilled employment (Weishaar, 2008).

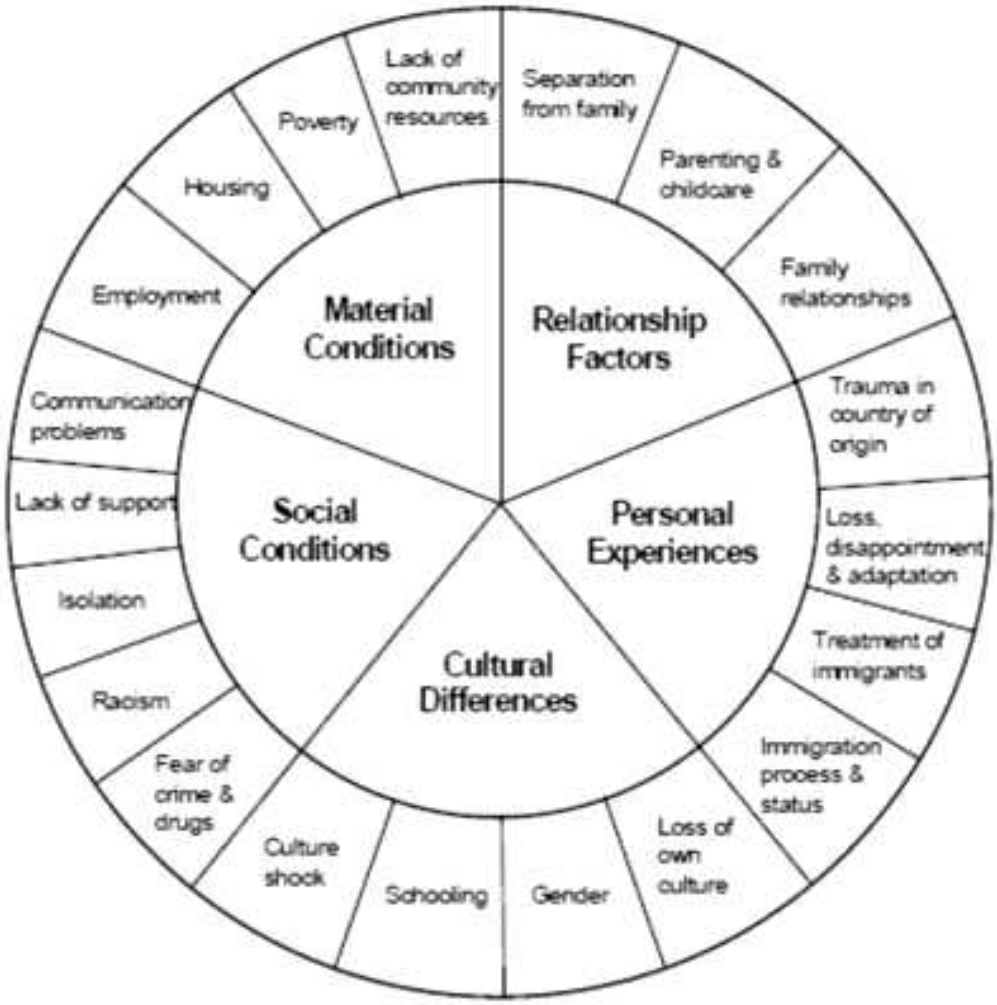
Key Stress Factors for Migrant Workers

• *communication difficulties* (many of those interviewed for the research arrive with very little English, which limited their opportunities for social interaction)
• *unfamiliarity with the new environment and culture*

[1] In this review, the term migrant includes economic migrant, asylum seeker, spousal migrant, irregular (sometimes referred to as undocumented) migrant and victim of trafficking

• *work-related stress* (including initial uncertainty about whether they can find employment, low wages and lack of overtime pay, poor working conditions, high workloads and long/unsociable hours leading to 'burn out', split shifts, night shifts, and working in positions for which they are considerably overqualified)
• *practical stress* (such as continued financial hardship, high living expenses and accommodation costs)
• *social stress* (e.g. loss of social contact and interaction)
Source: Collis, Stott & Ross (2010:54)

The above summary indicates that work-related stress is the more multi-dimension factor in mental health issues for migrant workers although the figure below demonstrates the complexity of material, relational, social, personal and cultural factors and sub-factors that could potentially impact on migrants' mental well-being.



Source: Collis, Stott & Ross (2010:55, adapted from WHO, 2002)

Strategies and initiatives to improve mental healthcare for migrants entail achieving change in both policy and practice and include lobbying, teaching and training as well as responding incidentally to perceived need. Research assessing good practice covers activities in both structural and incidental changes and from various perspectives e.g. accessibility, availability, acceptability and quality of services in the host environment.

Practitioners trained to enact strategies that overcome institutional discrimination means European states spending less on ensuring adequate healthcare to migrants (Bennegadi, 2009). Support to vulnerable groups can strengthen social cohesion. This literature review takes a human rights and social equity perspective to the issue of EU migrant mental healthcare.

Influenced by geo-political and socio-economic factors

WHO/Europe (2010:1) finds that mental illness accounts for almost 20% of the *"burden of disease"* in Europe and mental health problems affect 1 in 4 people at some point in their life. Nine of the ten countries in the world with the highest rate of suicide are in the European region. Community studies in EU countries in addition to Iceland, Norway and Switzerland show that risks of mental illness for women are significantly higher than for men (33.2% compared to 21.7%) except for substance use disorders. One of the most comprehensive studies of mental health disorders among migrant women (Arab) living in Cologne shows that higher stress levels were associated with older age, having more children, coming from a North African rather than middle Eastern or European background and having lower levels of educational attainment (Irfaeya, Maxwell and Kramer, 2008).

Epidemiological data from the Netherlands and Great Britain show schizophrenia admissions are up to 4 times higher for some migrant populations and in Sweden 2nd and 3rd generation migrants are more prone to psychiatric disorders than native residents (Schinina *et al*., no date). Mental health costs over £77 billion in England annually. Refugees and asylum seekers experience a higher incidence of mental distress than the wider population (Future Vision Coalition, 2009). For refugees and asylum seekers the most common diagnoses are trauma-related psychological distress, depression and anxiety (Crowley, 2003; Knipscheer, *et al.,* 2009). Socio-economic, cultural, experiential and environmental factors all play a part in defining the mental health of migrants who are more likely to suffer poverty and marginalisation but it is a mistake to base research on generalities. Cultural and religious practices, for instance abstinence from alcohol, may offer health advantages for migrants. Even within a single migrant group the differences in gender, ethnicity, religion, class and language can *"change the immigration experience"* (Patni, 2007:5).

Evidence that experiential factors surrounding economic/forced migration and asylum determination leading to anxiety, depression and other mental disorders have long been established (Carey-Wood, 1997) and affect migrants of different backgrounds, ages, gender and status. Migrant workers are at high risk of exploitation and often have little access to health and social services (Clapham & Robinson, 2009). A study of migrant domestic workers (MDWs) in private households demonstrated that MDWs frequently suffer from abuse (sexual, physical, and emotional), discrimination, low pay (or none), exceptionally long working hours, social isolation, and mental health problems arising from the extreme conditions of their employment (Kalayaan & Anderson, 2009).

Recent research on the emotional wellbeing and mental health of separated children in the UK mentions the *"extreme trauma, distress and accumulated loss of family members many young people had experienced"* before leaving their country of origin or during their journeys (Chase *et al.* 2008: 2). Zimmerman *et al.* (2006) highlighted the detrimental cumulative effect that continued violence experienced during the trafficking process had on the women's physical and mental health. More recent research establishing the specific health challenges that particularly involuntary or trafficked

migrants face throughout the migration and resettlement process, means that migration itself can be now be regarded as a social determinant of both mental and physical health (Davies *et al.,* 2009).

Symptoms of mental health problems

Symptoms of mental health problems include anxiety, stress, depression, panic attacks and agoraphobia. Poor sleep patterns are usually a common symptom but may not be immediately identified by sufferers as an indicator of poor mental wellbeing. Anxiety and nervousness may be linked to behaviour that has developed to avoid stimuli that remind sufferers of past experiences. Problems with memory and concentration may hinder learning and uncertainty about family members left behind exacerbates symptoms of depression and stress (Burnett & Peel, 2001).

Past experiences may include torture and organised violence that is still prevalent in many countries and has been endured, prior to flight, by some refugees in the UK. Survivors often do not volunteer their history due to feelings of shame, guilt and mistrust so building up trust in order to establish the physical and mental damage that face survivors is an initial difficulty for professionals. Many general practitioners are unaware of their patients' histories and are not educated to consider the possibilities of torture (Eisenman, Keller & Kim, 2000). Physical effects are sometimes clearly evident, such as fractures, soft tissue injuries and scars from burns and cuts. At other times physical symptoms are not necessarily immediately associated with torture such as post-concussion syndromes presenting with problems of memory loss, concentration and stress. Many female and some male asylum seekers have been victims of sexual violation and the dominant subsequent emotion is usually deep shame. Victims may not voice concerns about STDs so it is important to offer testing for HIV etc and where appropriate for pregnancy (Burnett & Peel, 2001a).

Conditions

Social isolation and societal change

Cultural support for mental health problems sometimes demonstrates an alternative value-set and outlook on mental illness that can involve religion, astrology, herbal remedies and extended family networks to support sufferers (Patni, 2007; Palmer, 2007). Challenor *et al.* (2005) highlighted the vital role Refugee Community Organisations (RCOs) play in relation to the mental health and well-being of refugees and refugee people seeking asylum. Anxiety, insomnia, depression and suicidal intent are all symptoms that can occur due to a multiplicity of factors including post-traumatic experience, concerns about political unrest in countries of origin, culture shock, discrimination and lengthy and uncertain determination procedures (Phillimore *et al*., 2007, Lewis, 2007). Lewis (2007), for instance, found that the most common reason for people becoming destitute in Leeds was while waiting for Section 4 Support[2]. Those RCOs that are able to provide advice, sympathy and understanding are vital in helping overcome isolation and depression (Challenor *et al*. 2005) and one study based on Birmingham New Communities Network of migrant and refugee community member organisations found that community support was 'critical' to recovery from mental health problems (Phillimore *et al*., 2009).

[2] Under Section 4 of the Immigration and Asylum Act 1999, the UK Border Agency may provide accommodation to failed asylum seekers who have a temporary barrier to leaving the UK and who would otherwise be destitute.

Domestic violence

In the UK domestic violence accounts for 16% of all violent crime with 77% of the victims being women (Nicholas *et al.* 2007). The cost of treating mental illness and distress as a consequence of domestic violence is an estimated £176,000,000 (Walby, 2004), a figure that excludes the cost of support given by the voluntary sector. Domestic violence is essentially private in nature and insufficient acknowledgement is given to the shame and isolation that plays a large part in perpetuating it. There is little doubt that geographical and social isolation exacerbate the situation for migrant women and present greater barriers in seeking out and receiving outside services and support (Collis, Stott & Ross, 2010). Isolation is compounded by the fact that many migrant women rely on partners and family for housing and income and for those who do not work outside the family home the support they might receive from financial independence, work colleagues and knowledge of legal and welfare rights is also missing (ibid). Of concern is the issue of women with no recourse to public funds for those A8 nationals who have not been able to meet requirements under the Worker Registration Scheme. These women have no support or access to practical assistance such as emergency housing.

Housing and environmental conditions

Pussetti's (2010) longitudinal work studying migrants in Portugal establishes the relationship between psychological vulnerability and social exclusion, discrimination and unstable housing and working conditions. In the UK, overcrowded living with family and friends, lack of training for staff in cultural awareness and lack of understanding of housing staff of the mental distress caused during transition period (Carter & El-Hassan, 2003; Goodson and Phillimore, 2008) contribute poor housing conditions. Collaboration between statutory and community sectors is a fundamental requirement for migrants and marginalised groups to access secure, adequate housing (Jones & Mullins, 2009). Local and national UK policy proves intransigent when priority housing is denied to single male and female refugees because they are not considered technically 'vulnerable' under homelessness regulations. This is in spite of the fact that many are traumatised; suffer mental illness and face language barriers as well as the handicap of not being familiar with the British system. Many studies note the link between mental ill health and poor housing conditions as well as inappropriate dispersal strategy and inadequate support networks that compound loneliness, social isolation, racism and discrimination characterizing the living environment for forced and economic migrants alike.

Mental health provision in country of origin

Bhugra and Jones (2001) suggest migrants' mental preparedness and health before they embark, such as psychological robustness; cultural identity and social support are important micro-factors when coping with a process that is inevitably stressful. They divide the migratory process into three stages, pre-migration, migration journey and post-migration when migrants deal with new social and cultural frameworks. Some studies of ethnically categorised mental health disorders have led to the assumptions that there is biological causation for prevalence of, for instance, schizophrenia among migrants compared to host White populations. Findings across ethnic and migrant populations are equivocal and more likely to be a result of populations expressing their distress in different ways. Bhugra and Jones (2001) conclude that it is much more likely that stress associated with migration will be different at each stage and compounded by life events, personal and relational factors. Categories of mental health conditions have massively increased in the West since the 1950s. It is understandable that migrants from

countries where provision is primitive may well avoid being diagnosed as having a 'mental health problem', perceiving it as *"extreme forms of insanity"* rather than a treatable disorder (Ingleby, 2009:13).

Key Issues

Communication and language

The mental health of forced and economic migrants, especially undocumented or refused asylum seekers and undocumented migrant workers presents particular challenges to service providers. Little English may be spoken, interpretation unavailable making the British mental health services difficult to understand, access or negotiate. Lack of communication and language are commonly cited as reasons for low user take up of mental health services (Palmer, 2007; Phillimore *et al.,* 2007; Fassaer *et al.,* 2009; Bennegadi, 2009) but communication issues are highly complex. In many cultures religion and spirituality plays a part in mental health and there is a lack of cultural awareness among health professionals (Crowley, 2003; Phillimore *et al.,* 2007). In the Netherlands where mainstream health services have been adapted to the needs of different ethnic groups, research found a low take up of services amongst first generation Moroccan migrants suffering from common mental disorders. This was explained by a lower perceived need for care of psychological distress influenced by ethnic background (Fassaer *et al.,* 2009).

Palmer's (2007) research found other considerations in addition to language barriers. His study of the Ethiopian community in London (coming from a background where English is neither the national nor established second language) revealed a further barrier in that Ethiopian respondents also stigmatised mental illness. In Ethiopian culture 'madness' was not recognised as a medical issue but a moral and spiritual one. Illness was considered to be punishment for sins and could be brought about by spiritual possession, a condition identified by symptoms often presented by depression and anxiety, such as headaches and lethargy. Palmer emphasised the importance of recognising mental disorder within the confines of an individual's cultural environment. Ethiopian society operates a hierarchy of authority dictating normative behaviour involving emotional constraint and a reluctance to ask questions.

Access, entitlement and availability

Entitlement to healthcare varies between countries depending on the category of migrant and the availability of resources. Moreover, whether socio-economic data is taken into account in diagnosis depends on a member country's approach to medicine. Lobbyist organisations such as 'Mind' (2009) and others emphasis disparity in UK policy where mental health policy recognises the vulnerability of migrants yet immigration policy can impact negatively on migrants' mental well-being (Lewis, 2007). Legal factors are a major determinant in the provision of mental healthcare for asylum seekers and refugees. A report funded by the European Refugee Fund examined legal and political factors affecting provision of health, welfare and legal advice in Rome, Berlin and London (Observatory, 2004). The report revealed that poor physical and mental health amongst forced and economic migrants, including the denial of the right to work for asylum seekers, results in poverty and destitution which are directly related to an individual's emotional and mental well-being.

Since migrants' entitlement to healthcare varies from one EU country to another it can be defined by three components: 'coverage' referring to the way in which expenses are

paid; 'health basket' referring to the range of services available and 'cost sharing' referring to financial contribution from the service user (Huber *et al*., 2008). Higher health spending goes hand in hand with the availability of diagnosis and treatment. Entitlement for failed asylum seekers is restricted in parts of the EU though Portugal has created an access system to disentangle universal health rights from migration control. Although local economies and systems differ, the field would benefit from greater cooperation at European level. Migrant take-up of healthcare including mental health services is hampered by practical, cultural, social and structural barriers such as institutional discrimination and in the case of undocumented migrants, fear of being reported to the authorities if they seek professional assistance. The Global Commission on International Migration estimated in 2005 there were between 4.5 and 8 million undocumented migrants living in the EU and in 2008 the EU recorded 238,000 new asylum applications, which indicates a sizeable and extremely population potentially needing healthcare services (Collantes, 2009).

Post traumatic stress disorder

Post traumatic stress disorder (PTSD) criteria can be evidenced using the Harvard Trauma Questionnaire notating 30 symptoms in total, 14 of which relate to previous traumatic events (Mollica *et al.* 1992). Adult refugees and asylum seekers living in Western countries experience a higher prevalence of mental health problems including PTSD and depression and anxiety than host populations (Toar, O'Brien & Fahey, 2009). Service providers and policy makers cannot assume that economic migrants have not been exposed to political violence or other sources of traumatic events before their migration (Knipscheer *et al.,* 2009). Studies suggest that post-migration factors such as social isolation, lack of work, cultural shock, language barriers, asylum procedure stress, fear of deportation and separation from children have been shown to be most prevalent in causing mental health problems (Blair, 2000, Hepinstall, Sethna & Taylor, 2004; Laban, *et al.,* 2005; Toar, O'Brien & Fahey, 2009).

Research into PTSD and acculturation of economic migrants found that respondents who held onto their traditions were less vulnerable to post traumatic stress (Knipscheer, *et al.,* 2009). Findings from a study of asylum seekers and refugees showed an association between PTSD and depression/anxiety due to residential status and lengthy asylum procedures, yet compared to refugees, a high percentage of those asylum seekers suffering psychiatric disorders did not use mental health services. It was not clear in this study whether this was due to communication and language barriers or because of cultural or personal reasons (Toar, O'Brien & Fahey, 2009). There is some evidence of an overlap between PTSD and maternal health. It has been suggested by several authors that PTSD can occur after a distressing labour or delivery and experiences of intense pain and fear can trigger the sensation of reliving a traumatic event (Saita, 2006). Female refugees are more likely to be affected by PTSD than male counterparts and contrary to expectations witnessing traumatic events are more significant in predicting symptoms of PTSD than experiencing them (Karunakara, *et al.,* 2004).

Access and entitlement to health care

One of the main restrictions to mental healthcare in the UK is that vulnerable individuals are unable to access services as a result of restrictions for refused asylum seekers (Mind, 2009). There are gaps in provision for refugees and asylum seekers to address intermediate mental healthcare needs, lack of specialist services e.g. to treat those who have experienced torture and limited expertise in working with refugee children where

psychological disturbance is three times the national average (Fazel & Stein, 2003). Registration with a GP – necessary for referral – is problematic for refugees and particularly for refused asylum seekers (Phillimore *et al*., 2007; Mind, 2009, Collantes, 2009). Studies show that the incidence of mental health problems among destitute asylum seekers is high (Dumper *et al.,* 2007). Language barriers are one of the main factors in the participation and integration process (Temple *et al.,* 2005) and have been identified as the largest obstruction to accessing health services (Palmer, 2009). The unavailability of interpreting services, lack of information, cultural perceptions regarding mental health disorders and misunderstanding of entitlements all exacerbate access to services.

Mind (2009) notes that pathways to secondary mental healthcare services are often too rigid and fail to take account of the needs of refugees and asylum seekers. Access for children and young people are particularly problematic. One study found that asylum seekers had more health problems that others in detention and the length of time spent in detention was significantly related to the development of new mental health problems (Green & Eagar, 2010). Since 2001, the British Government's increased use of detention centres for families with children has been condemned for breaking international standards on the rights of children. The detention experience, environment and lack of provision for children with special needs have prompted limited research into their mental well-being. A recent study of families in Yarlwood immigration detention centre (Lorek *et al.,* 2009) revealed that children had begun to display symptoms of depression, anxiety, sleep problems, somatic complaints and behavioural difficulties since being detained.

Approaches

Although medical approaches differ across EU countries, Ingleby (2009) emphasises the need to include socio-economic and contextual factors regarding the treatment of migrant communities. A 'bio-medical approach' is less interested in a patient's circumstances and cultural background, whereas a 'bio-psychosocial' or 'holistic' approach considers patients within their wider context. Yet questions that are relevant to all aspects of migrants' health concern the demographic, legal, political, experiential and historical factors that influence their living conditions. Many researchers associate migrant mental health issues with a lack of integration. A co-ordinated approach with PCTs and local health boards is lacking especially in meeting the needs of refugees and asylum seekers. Where voluntary sector provision is available it is largely under funded. There is insufficient collaboration with and between the voluntary sector and migrants and refugee community organisations (Mind, 2009).

Strategies

Who/Europe (2010) sets out four priorities for mental health:

- High quality information
- Service users' and carers' empowerment
- Development of community based practice
- Improving social care homes for children in Europe

Strategies to implement these priorities include:

- Urgent attention to be paid to language services provided at health settings (Palmer, *et al.,* 2009)
- Further research into the different meanings of mental health to different refugee populations and to their mental health needs (Palmer *et al.,* 2009)

- Exchanging ideas from research about mental well-being between EU states (Curtis & Hoyez, 2009)
- Increasing cultural competence and empowerment of practitioners (Bell *et al.,* 2008; Bennegadi, R. 2009)
- Active involvement of RCOs e.g. Work placements to be offered to community leaders and staff in the health sector. (Palmer *et al,.* 2009)
- The use of Community Development Workers to promote community practice (DH, 2006)

Good Practice Initiatives[3]

Good practice initiatives are not often evaluated especially regarding the effectiveness of different treatment methodologies for migrant patients (Ingleby, 2009). Creative evaluation strategies can be employed such as process evaluations (Fortier & Bishop, 2003) and community research (Temple & Moran, 2011).

Brussels: 'Medimmigrant' is a staged procedure that enables undocumented migrants and people with a precarious residence status to access urgent medical help

Finland: separate service units and healthcare professionals specialising in migrants' health needs are set up in larger municipalities. Interpreting and translation services are available for all migrants and are particularly recommended in the beginning of residence or when serious illness is involved.

France: elaborating an actions strategy using a model that shares diagnosis at various levels aimed at destroying the female genital mutilations in France by 2012. Involves three European countries – Norway, Sweden and UK

Germany: improving knowledge about sexual health, STDs and unwanted pregnancy to increase migrant women's autonomy and self-determination.

Greece: the administration of proper treatment for all migrants, including undocumented, for life threatening communicable diseases

Italy: facilitating access – migrant education about their rights and opportunities within the Italian socio-sanitary system. Adopting a transnational methodology by intervening and treating patients in Ethiopia.

Malta: screening process for irregular migrants

References

Bennegadi, R. (2009) *Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Competence and Empower Practitioners.* Teaching and Research Dept, Francoise Minkowska Centre, Paris: IOM

[3] All aspects of healthcare including mental health have been included in order to get an EU perspective on migrant access

Bhugra, D. & Jones, P. (2001) Migration and mental illness. *Advances in Psychiatric Treatment*, 7: 216-223

Blair, R. G. (2000) Risk factors association with PTSD and major depression among Cambodian refugees in Utah. *Health and Social Work*, 25:23-30

Burnett, A. & Peel, M. (2001) Asylum seekers and refugees in Britain: Blood pressure measuring devices: Recommendations of the European Society of Hypertension. *BMJ* Vol. 322: 544 No. 7285
http://www.bmj.com/content/322/7285/544.full?ijkey=11e55bad71e797aa52cede6e0f346e4fa4e17220&keytype2=tf_ipsecsha
[accessed 08.01.11]

Burnett, A. & Peel, M. (2001a) Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence. BMJ Vol. 322:606 No. 7286
http://www.bmj.com/content/322/7286/606.full?login_referer=http%3A%2F%2Fwww.bmj.com%2Fcontent%2F322%2F7286%2F606.extract%3Fsid%3D5645e946-0ac2-49bc-b337-b90a419c75cb
[accessed 08.01.11]

Carey-Wood J (1997) *Meeting Refugees' Needs in Britain: the Role of Refugee-specific Initiatives* (eds. Nee, C. & Marshall, T.) London: Home Office Research, Development and Statistics Directorate
Carter, M. and El-Hassan, A. A. (2003) *Between NASS and a hard place.* London: hact.

Challenor, F. Walters, G. and Dunstan, D. (eds.) (2005) *Need a hand? Report on the Review of Recent U.K. Volunteering Projects Relating to Asylum Seekers BVSC.* Undertaken for the Aspire DP: Birmingham

Chase, E., Knight, A. & Statham, J. (2008) Promoting the emotional wellbeing and mental health of unaccompanied young people in the UK. Thomas Coram Research Unit, Institute of Education: University of London

Clapham, A. & Robinson, M., (eds) (2009) *Realising the Right to Health*. (co-eds. Mahon, C. & Jerbi, S.) Zurich: Rueffer & Rub

Collantes, S. (2009) Access to Health Care for Undocumented Migrants and Asylum Seekers in 10 EU Countries: Law and Practice. Report based on the HUMA Network Project in the framework of the Public Health Programme 2003-2008.

Collis, A, Stott, N. & Ross, D. (2010) *Workers on the Move 3. European workers on the move and health in the UK: The evidence*. Norfolk: Keystone Development Trust

Crowley, P. (2003) *An Exploration of Mental Health needs of Asylum-seekers in Newcastle.* The Tyne, Wear and Northumberland Asylum-seeker Health Group

Curtis, S., & Hoyez A-C, 2009 Health, wellbeing and immigrant populations in France and Britain. *International Journal of Migration, Health and Social Care*, 5 (4): 4-19

Davies, A. A., Basten, A. & Frattini, C. (2009) *Migration: A Social Determinant of the Health of Migrants*. Geneva, Switzerland: IOM Migration Health Dept

(DH) Department of Health (2006) Mental Health Policy Implementation Guide: Community Development Workers for Black and Ethnic Minority Communities. Final Handbook: DH

Dumper, H., Malfait, R. & Scott-Flynn, N. (2007) *Mental Health Services in Birmingham*. A report to help inform the strategy of the Refugee Council in this area. Refugee Council

Eisenman, D. P., Keller, A. S. & Kim, G. (2000) Survivors of torture in a general medical setting: How often have patients been tortured and how often is it missed? *West J Med* 172 (5):301-304
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070871/
[accessed 08.01.11]

Fassaer, T., de Wit, M. A., S., Verhoeff, A. P. Tuinebreijer, W. C., Gorissen, W. H. M., Beekman, A. T. F. & Dekker, J. (2009) Uptake of health services for common mental disorders by first-generation Turkish and Moroccan migrants in the Netherlands, In *BMC, Public Health*, 9:307-316 (00554)

Fazel, M. & Stein, A. (2003) Mental health of refugee children: comparative study BMJ, 327:134 (7407)

Fortier, J. P. & Bishop, D. (2003) Setting the agenda for research on cultural competence in health care: final report. (Brach, C. ed) Rockville, MD: US Dept of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality

(The) Future Vision Coalition (2009) *A Future Vision for Mental Health*.
Goodson, L. and Phillimore, J. (2008) *Accommodate: report of accredited community research training***.** Birmingham: University of Birmingham

Green, J. P. & Eagar, K. (2010) The health of people in Australian immigration detention centres. *The Medical Journal of Australia*, Vol, 192 (2) 65-70

Hepinstall, E., Sentha, V. & Taylor, E. (2004) PTSD and depression in refugee children: associations with pre-migration trauma and post-migration stress. *European Child Adolescent Psychiatry*, 13: 373-380

Holman, D. and Schneider, C. with Anghel, R. and Collis, A. (2008) *Economic Migration in the East of England (Update 2007)*. Histon: East of England Development Agency

Huber, M., Stanciole, A., Bremner, J. & Wahlbeck, K. (2008) *Quality in and Equality of Access to Healthcare Services: HealthQUEST.* Brussels: DG Employment, Social Affairs and Equal Opportunities.

Ingleby, D. (2009) *European Research on Migration and Health*, University of Utrecht: IOM

Irfaeya, M., Maxwell, A. & Kramer, A. (2008) Assessing Psychological Stress among Arab Migrant Women in the City of Cologne/Germany Using the Community Oriented

Primary Care (COPC) Approach. *Journal of Immigrant and Minority Health,* Vol 10, 4:337-344 (04339)

Jones, P. A. & Mullins, D. (April, 2009) *Refugee community organisations: working in partnership to improve access to housing services*. A Race Equality Foundation Briefing Paper, part of the Better Housing Briefing series

Karunakara, U. K., Neuner, F., Schauer, M., Singh, K., Hill K., Elbert, T. & Burnha, G. (2004) Traumatic events and symptoms of post-traumatic stress disorder amongst Sudanese nationals, refugees and Ugandans in the West Nile. *African Health Sciences*, Vol.4 (2):83-93 (02401)

Knipscheer, J. W., Drogendijk, A., Gulsen, C. H. & Kleber, R. J. (2009) Differences and similarities in posttraumatic stress between economic migrants and forced migrants: Acculturation and mental health within a Turkish and Kurdish sample. *International Journal of Clinical and Health Psychology*, Vol. 9 (3):373-391

Laban, C.J., Gernaat, H. B., Komproe, I. H., Tweel, I. & De Jong, J. T. (2005) Post migration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Diseases* 193:825-832 (03007)

Lewis, H. (2007) *Destitution in Leeds: The experiences of people seeking asylum and supporting agencies.* York: Joseph Rowntree Foundation

Lorek, A., Ehntholt, K., Nesbitt, A. Wey, E., Githinji, C., Rossor, E. & Wickramasinghe, R. (2009) The mental and physical health difficulties of children held within a British immigration detention centre: A pilot study. *Child Abuse and Neglect*, 33 (9):573-585

Minas, H. (2002) Migration and Mental Health, editorial, *International Organisation for Migration Newsletter* 1: ISSN 1027-7625

Mind, (2009) *A civilised society: Mental health provision for refugees and asylum-seekers in England and Wales*. Mind with the support of Lloyds TSB Foundation

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S. & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disorders,* 180(2) :111-116

Nicholas, S., Kershaw, C. and Walker, A. (2007) *Crime in England and Wales 2006/07 (Home Office Statistical Bulletin)* [online]
http://www.homeoffice.gov.uk/rds/pdfs07/hosb1107.pdf
[accessed 02.12.10]

Observatory, (2004) *Europe Land of Asylum: reception and social inclusion of asylum seekers and refugees in three European capital cities.* Report in partnership with Berlin Senate, Comuni Rome and the Greater London Authority, funded by the European Refugee Fund

Palmer, D. (2007) An Exploration into the Impact of the Resettlement Experience, Traditional Health Beliefs and Customs on Mental Ill-Health and Suicide Rates in the

Ethiopian Community in London. *International Journal of Migration, Health and Social Care*, Vol.3(1):44-55

Palmer, D. & Ward, K. (2007) 'Lost' listening to the voices and mental health needs of forced migrants in London, *Medicine, Conflict and Survival* 43

Palmer, D., Alemu, E. & Hopwood, J. (2009) Bridging the gaps: refugee community organisations and the provision of mental health services in the London Borough of Camden, UK. *International Journal of Migration, Health and Social Care*, 4 (4):4-20

Palmer, D., Williams, L., White, S., Chenga, C., Calabria, V., Branch, D., Arundal, S., Storer, L., Ash, C., Bezuayehu, H. & Hatzidimitriadoe, E. (2009) No one knows like we do – the narratives of mental health service users trained as co-researchers. *Journal of Public Mental Health* 8(4)

Patni, R. (2007) Enabing Access to Welfare Services – the Place of Social Solidarity and Dialogue. *Social Work and Society*, Vol. 5 (1):1-16

Phillimore, J., Ergun, E., Goodson, L. & Hennessy, D. (2007) "*They do not understand the problem I have": refugee well-being and mental health.* York: JRF

Phillimore, J., Goodson, L., Hennessy, D. and Ergun, E. (2009) *Empowering Birmingham's migrant and refugee community organisations.* York: JRF

Portugal R., Padilla, B., Ingeby D., de Freitas C., Lebas J., & Miguel P. Good Practices on Health and Migration in the EU. Lisbon. 2007)

Pussetti, C. (2010) Identities in Crisis: Migrants, Emotions and Mental Health in Portugal. *Saude et Sociedade*, vol. 19 (1): 94-113

Saita, E. (co-ordinator) Cigoli, V., Gilli, G., Margolla, D. & Fenarolli, V. (2006) Post-traumatic stress disorder: childbirth. (Clinical Psychology Research Group)
http://vittoriocigoli.com/index.php?id=25
Accessed 31.10.10

Schneider, C. and Holman, D. (2009) *Longitudinal study of migrant workers in the East of England (Interim Report)*. Histon: East of England Development Agency

Shinina, G., Celmi, R., Kelly, E. & Zuodar, S. (no date) *Best Practices Promoting Migrants' Access to Mental Health Services in Europe.* Central Service for Mental health, Psychosocial Response and Cultural Integration: IOM

Silveira, E. & Allebeck, P. (2001) Migration, ageing and mental health: an ethnographic study on perceptions of life satisfaction, anxiety and depression in older Somali men in East London. International Journal of Social Welfare, Vol 10 (4):309-320

Temple, B. & Moran, R. (2011) Doing Research with Refugees: Issues and Guidelines. Bristol: Policy Press

Temple, B., Moran, R., with Fayas, N., Haboninana., McCabe, F., Mohamed, Z., Noori, A. and Rahman, N. (2005) *Learning to live together*. University of Salford: JRF

Toar, M., O'Brien, K., & Fahey, T. (2009) Comparison of self-reported health and healthcare utilization between asylum seekers and refugees: an observational study. *BMC Pubic Health*, 9: 214-224

Walby, S. (2004) *The Cost of Domestic Violence*. London: DTI available at: http://www.lancs.ac.uk/fass/sociology/papers/walby-costdomesticviolence.pdf

Ward, K. & Palmer, D. (2005) *Mapping the provision of mental health services for refugees and asylum seekers in London*. (ICAR) Kings College London

Weishaar, H.B. (2008) *Consequences of international migration: A qualitative study on stress among Polish migrant workers in Scotland*, *Public Health* 122:1250-1256

Winterton, R. (2005) *Minister of State for Health Services: Mental health inequalities and BME mental health.* Speech to an EU Presidency associated event, 7th November: Dept of Health UK
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4123562
[Accessed 17.10.10]

World Health Organisation (2005) *Regional Committee for Europe: Fifty-fifth session*, Bucharest, Romania, 12-15 September
WHO website (2010)
http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/mentalhealth
Accessed 17.10.10

Zimmerman, C., Hossain, M., Yun, K., Roche, B., Morison, L. & Watts, C. (2006). *Stolen smiles: a summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe*. London: London School of Hygiene and Tropical Medicine.

WS2: Developing good practice in addressing pre and postnatal maternity health services to migrant women

Topic in context

Background information

Problems associated with maternal and child health among migrants has long been a matter of concern in most EU countries (Birch et al 2007). Women's and family health should be central to professionals delivering health services, as the number of migrant women has increased over recent years. The inclusion of women is important because their health entails specific needs and also because in case of family migration, they tend to be responsible for the care of the children and the elderly (Ferandes & Miguel J 2009). Migrants' outcomes of pregnancy are known to be poor, and generally show significant disparities when compared with those of native populations. Studies indicate that migrant women are particularly vulnerable and that their reproductive health and especially maternal heath often remains un-addressed (Birch et al 2007).

Cultural beliefs

Cultural beliefs and reproductive practices are significantly different across national, ethnic and religious groups and can present both advantages and disadvantages to maternal and child health and well-being, and on access to and perceptions of maternal healthcare. Different cultural practices within families often seriously limit women's access to, and use of antenatal care and other services. Research in the UK identified that the autonomy of women to access maternal services is sometimes hampered by the need to seek permission from in-laws or the pressure to attend appointments with a male family escort (Phillimore e*t al.,* 2010). Conflicting pressures are bought to bear on women caught between traditional domestic values and practices, and those of the social environment they now find themselves working and living in, and that confront women with different psychological barriers (Carbello & Nerukar A 2001).

Risk factors

Migrant women make poor use of contraceptive services and generally have more difficult pregnancies than other women. They have more low birth weight babies and tend to deliver prematurely more often. Research has identified some of the issues, barriers and enablers to migrants accessing services, and the increased risk factors for infant mortality. These include: poverty; language needs; relocation and dispersal due to immigration or to avoid detection; difficulties and delays in accessing benefits and entitlements; housing access and quality; access to NHS and GP registration, local service provision issues; patient expectations, health beliefs, and behaviours (Kanneh 2009; Ipsos Mori 2008; Redshaw *et al.* 2006. Phillimore et al. 2010).

Several studies demonstrate that perinatel, neonatal, and child mortality rates are consistently higher in foreign-born groups than in the national populations (Carballo & Nerukar, 2001; Schulpen.1996; Machado et al., 2006; Phillimore et al. 2010). A range of risk factors impacting upon infant mortality rates has been identified that include: late access to services; lack of advice about support services available and healthy lifestyles; and lack of funds impacting upon maternal diet; and possibly intrauterine growth (Kanneh 2009; Ipsos Mori 2008; Redshaw *et al.* 2006). These risk factors are exacerbated by migrants housing conditions, which throughout Europe are often characterised by some of the worst conditions for maternal and child health (NGO Network 2007).

Good practice initiatives

Research on assessing good practices in health systems has highlighted that good practices always implies active participation by the community and partnerships with stakeholders (Kiwanuka-Mukibi et al. 2005). Some initiatives that may be considered as good practice, involving partnerships with a number of stakeholders and delivering pre and postnatal health services are cited in the following section. They are in essence innovations (Fernandes & Miguel 2007). They have been devised to counter the shortcomings in the mainstream service provision, and policies already in place that did not address the needs of migrant groups. The case studies provide excellent examples of practical and creative solutions designed and implemented by NGO's, and/or statutory bodies (Portugal et al 2007).

The following good practice examples include:

- Italy: pre/post maternity services
- England: two case studies are presented
    a) Supporting pregnant migrant women
    b) Pregnancy outreach services
- Greece: a health visitor programme
- Portugal: community intervention using a mobile health unit
- Romania: free access to healthcare for pregnant migrants

Developing good practice in pre and postnatal maternal services: case studies

Case study 1

Location: Piacenza Italy

Organisation: Portal Immigrati PC

Title of the project: Pre and post maternity services in the province of Piacenza. Italy.

The Italian health system guarantees health assistance to all (Italian and foreign citizens included) to ensure the universality and equity of access to health services according to the article 32 of the Constitution and Law No. 833/1978. For this reason, Local Healthcare Authority does not organise pre and post maternity services exclusively dedicated to migrant women, but provides the same access to health care facilities and specialist services as Italian women. However, according to the regional Law 5/2004, concerning the integration of migrants, in order to make the service easy and usable to all users, special attention has been paid to ensure that the access to services is more flexible.

The Province of Piacenza has implemented the project "Work and social integration of migrants in the province of Piacenza" whose main aim is to make migrants aware of the services offered by the public institutions and to give them tools to access to labour market. The project was funded by National Fund "Fondo Lire UNRRA" (*United Nations Relief and Rehabilitation Administration.* The project has developed "Portal ImmigratiPC" a portal for new citizens. The portal offers the following: easy access for migrants in order to enable awareness of what services are offered and how to deal with administrative procedures; e-learning courses in order to give migrants the tools make them able to integrate in social and labour framework; a specific section in the portal to prom tote training of foreign women in care professions giving them tools to access to the training courses; and the creation of a on-line system which allows exchange of information among stakeholders as police station, prefecture, union trades, in order to simplify the procedures concerning migrants.
As result of the Healthy and Wealthy together project a collaboration between Province of Piacenza and the local Healthcare Authority has been set up in order to enhance the health services to migrants that are provided especially around pre and post maternity services. The ImmigratiPC health section contains all the information concerning regulations and procedures for accessing health care services. This health section will now contain a subsection entitled 'services for women'. Within this section, women's health issues will be addressed that enable migrant women easily access the healthcare structures.

A particular focus will be given to pre and post maternity services, and space is set aside to address the needs of pregnant women specifically to the population in Piacenza. This space will have the objective of providing women with the all the information to be directed towards the pre and postnatal services that exist in the district. Multilingual leaflets and flyers indicating services with a focus on *why and when use them* are being developed.

Family Planning Clinics are services that promote sexual, reproductive and relational health of the individual, couple and family. Moreover, they ensure equity in migrants' access to this service regarding their reproductive choices and birth path. Midwives are providing a reception service to facilitate access to migrant women, using cultural mediators, if necessary. Specialised doctors and midwives provide pregnancy assistance to migrants.
Prenatal course: Research carried out by midwives has highlighted that rather than having a specific course migrant women prefer to take part in the Italian prenatal courses as this enables them to integrate themselves into local system. Prenatal courses are provided by midwives and take into account the specific needs of migrants for example, a more flexible timetable. A mediator attends to deal with linguistic and cultural needs. Postnatal courses follow the same structure.

A breastfeeding support service is provided to: facilitate relationship between mother and child; provide emotional support and promote breastfeeding and provide postnatal assistance to the mother and child during the first 3 months after the birth. After the fourth month the social service department of the municipality provides the service. Information about these service are given through flyers and leaflets at the time of hospital discharge.
The clinic provides specialised paediatric care to children without assistance. It also guarantees compulsory and recommended vaccinations (according regional laws).

For women without a regular residence permit in the periods of pregnancy, childbirth and postnatal period these services are provided:

- Examination for contagious diseases
- Screening tests and treatments for sexually transmitted diseases
- General medical examination for those without healthcare services card
- Direction to the healthcare services
- Cultural mediation service
- Administrative assistance in order to obtain STP code, a document necessary for accessing the above services

A reserved area for health professionals will allow the exchange of information between operators, examples of good practice, and information concerning training courses. Health professionals working in pre and post natal services will be trained in the use of the portal. The main aim is to foster a mutual understanding between the operators involved, an exchange of information and good practice in order to improve reception and health care procedures for women in the prenatal and postnatal period.

http://www.retepiacenza.it/immigrati/

Case study 2

Location: Birmingham UK

Organisation: Asirt

Title of the project: Working with newly arrived migrant women and families in Birmingham

Asirt is a small charitable organisation based in Birmingham England that provides advice and support to migrants within the region. Asirt works in partnership with other agencies to try and meet the complex needs of pregnant women and families from new migrant communities in Birmingham. Asirt is also engaged in training health workers, support workers and social workers on best practice in working with new migrant clients.

Birmingham has a long-standing tradition of immigration however, has seen significant increases in scale and diversity in the last ten years. Twenty one percent of the population was born outside the UK (2009). Between 2007 –2010 42,000 people from 186 different countries registered with GP services in Birmingham following arrival from abroad. Some GP practices report more than 2000 new migrant patients. Nearly 40% of al births in 2009 were to mothers born outside of the UK, and the Heart of Birmingham had the highest infant mortality rates in England. Reports show that mothers from new migrant communities are at higher risk.

Much of Asirts work with migrant pregnant women and new mothers is funded by the Heart of Birmingham Primary Care Trust to enable the organisation to administer essential safety-net provision to ensure that women and families have their basic needs met. Without this funding, the work of direct health service providers will struggle to improve health outcomes. Asirt often need to ensure that their clients basic needs are met in order to maximise health outcomes. The majority of clients are: refused asylum seekers; visa-overstayers or undocumented migrants; and not allowed to work; access welfare benefits; or access council housing and there are restrictions on health care entitlements depending on migrants individual status.

Asirts work with women and families helps to improve health outcomes by offering legal advice and representation in relation to immigration and support issues; ensuring access to accommodation and financial support; and telephone advice service for caseworkers, advice and support for workers across the West Midlands working with vulnerable women and families. Advice and specialist referrals on issues affecting the wellbeing of migrant women includes:

- Trafficking
- Female Genital Mutilation (FGM)
- Domestic violence
- Sexual violence
- Torture
- Forced marriageInformation is disseminated through a special website for women and families.

Asirt ensures that all families access health services, by assisting clients to register with a GP; referring pregnant women to appropriate support services including specialist FGM midwives, pregnancy outreach services and Children's Centres. Asirt also engage with other charitable organisations across Birmingham that are providing services to migrant families and pregnant women. Practical support is also offered to ensure that clients are able to meet their basic needs including: free cooked meals at weekly drop-ins; food parcels; essential baby supplies; and feminine hygiene products.
Partnership work with other agencies that support pregnant migrants includes Hope Projects, and the Bethel Health and Healing Project:

Hope Projects
Hope projects provide a safety net provision to help destitute asylum seekers and those barred from public funds through the provision of grants and emergency short term accommodation. Birmingham Law Centre, working in collaboration with a wide range of local agencies, manages the projects.

Heart of Birmingham teaching Primary Care Trust has provided funding to ensure that destitute pregnant women and new mothers are provided with a safety net of accommodation and financial support when they need it most. As well as providing emergency accommodation women are linked in with other charitable organisations that provide a range of support including food parcels, clothing and baby equipment. Referrals are also made to services that provide additional support through counselling, befriending and legal assistance.

Bethel Doula Project
The Bethel network is a registered charity that exists to promote the health and well-being of the people of Birmingham and its surrounding areas, and provides a range of support through counselling, a drop in centre and in the future plans a Health and

Healing Centre offering a variety of services. The aim is to establish a healing and healthy living centre in the heart of the community, in order to promote the health and wholeness of the people of Birmingham.

The network currently provides a range of activities through the premises provided by other charities in the area. Services include:

- counselling and prayer support
- open door drop-in
- community activities, especially those promoting healthy living

The Bethel Doula Project works with vulnerable new mothers, especially asylum seekers. 'Doula' refers to a helper who accompanies women around the birth of a child. The project arose out of a clear need discovered amongst pregnant women, most of whom were seeking asylum, and termed 'isolated' or vulnerable. A small team of committed volunteers grew in response, offering emotional and practical support to these special mums, which has continued and is increasing in demand every year. Referrals come from a wide range of sources, and at various stages of pregnancy.

A doula team is created for each mother, and offers assistance in getting ready for the new baby, and provides a person, free of any cost, to be with her at hospital during labour and the birth, if requested. Bethel also offer help at home and regular support, through visiting and phone calls, during the two weeks or so following the baby's birth: this could be shopping, cooking or helping with infant care.

The project is staffed almost entirely by volunteers, who are dedicated to support and meet families needs, often far beyond the first few weeks following the birth of the baby. The team offer practical and emotional support. Over time, the team encourage mums to connect into their wider community, through signposting and accompanying them to drop-ins, baby groups, etc.

Having a doula present at birth has been shown in research to give mums and babies a much better experience in labour, and increases success in breastfeeding.
The work is funded by Comic Relief for three years and also by other trusts, including William Cadbury Trust.

The organisation additionally offers counselling to individuals that have experienced trauma, such as domestic violence, accident, torture or victimisation. Each session usually lasts 50 minutes, and the first appointment includes an assessment of need. An agreement is made by the client to see their counsellor on a regular basis until they decide that their goals have been achieved. Services are available to people over 18 years of age, of any faith or none. No one is excluded from the service on the ability to pay. There is no discrimination on the grounds of race, gender, sexuality, disability, ability to pay or lifestyle. All Bethel Network counsellors are qualified and experienced - bound by a Code of Ethics and are subject to its complaints procedure. They receive professional supervision internally and independently.

www.asirt.org.uk
www.asirt.org.uk/women

Case study 3

Location: Birmingham UK

Organisation: Gateway Family Services Community Interest Company (CIC)

Title of the project: Pregnancy Outreach Service

Birmingham's infant mortality rate is significantly higher when compared to other areas of the Country. It is known that obesity; smoking and deprivation are some of the main causes. Breastfeeding rates in Birmingham and the region are lower than the national average, with ethnic minorities and people with lower levels of income being the most affected. In addition, unwanted teenage pregnancy affects many families. To address these trends Birmingham Health and Wellbeing Partnership on behalf of the NHS commissioned Gateway Family Services CIC to develop a new workforce to support pregnant women.

The total number of births in Birmingham wards with the highest mortality rates between July 09 – July 10 is shown in the following table.

Births by ethnicity in Birmingham	
Ethnic Origin	Total Births
Pakistani	38.6%
European	23.9%
African	10.6%
Other	8.6%
Bangladeshi	8.0%
Indian	5.3%
Afro-Caribbean	5.0%

Pregnancy Outreach Workers (POWs), have been recruited from the local population to reflect the needs of the communities that are most at risk of infant deaths. Bespoke and accredited training in breaking down barriers to enable engagement with service users effectively was developed. The POWs engage with predominantly migrant families living in the most deprived areas of Birmingham and deal with issues including teenage pregnancy, overcrowding, poor housing, obesity, smoking, breastfeeding initiation, and domestic abuse. The areas covered are where infants are more at risk, and the communities are the hardest to reach because of social, cultural and economic barriers.

The service primarily target women with low medical and high social risk, and whose needs are not entirely met by other statutory services. This enables them to tackle social issues that could put infants at risk of an early death. Currently (2010), 70% of clients are from an ethnic minority background. POWs work alongside other health and social care providers to support pregnant women and to reduce the factors that cause infant mortality. The organisation trains these paraprofessionals. The POWs have real life experience of issues that affect women living in these communities. Referrals to the service come from midwives that have identified that social risk is high, and that POWs support can make a real difference.

Whenever possible POWs assist teenage mothers to access the services that are specific to their needs, such as specialist teenage midwife, groups for teenage mothers, housing and benefit support in order to help issues of depression and isolation, which are common to this age group.

POWs are able to:

- Listen and provide practical support
- Motivate and encourage with lifestyle and behavioural change
- Offer practical help and support
- Deliver health promotion and information
- Liase with other voluntary sector agencies to provide support
- Support professionals to deliver care plans
- Follow up 'did not attend' (DNSs), appointments on request
- Run groups to support social inclusion
- Offer home based support

POWs are able to:

- Signpost to other agencies
- Accompany clients to appointments
- Advocate for clients
- Be lead professional on the Common Assessment Framework process
- Support women until two weeks after their birth
- Share information (with consent) with other agencies

POWs workers are trained to bridge the gap between their clients and other health professionals, and have the time needed to build trust with clients. The service breaks down barriers and supports equity of health service provision to the whole community, which are some of the main causes of deprivation. POWs speak a range of 18 languages and a translation service is available if necessary.

Findings indicate that the support needs of clients are more complex and long-standing than previously anticipated. Common issues include domestic abuse, drug and alcohol misuse, homelessness, child protection issues, poverty, overcrowding and inadequate housing. The particular needs or needs associated with women seeking asylum was also underestimated.

http://www.gatewayfs.org/how-we-help-you/leading-healthier-life/pregnacy-outreach-worker-service

Case study 4

Location: Greece

Organisation: The Ministry of Health Cyprus

Title of the project: The health visitor programme: Maternal and child health with immigrant families

The health visitor programme aims to provide health care to mothers and pregnant mothers, infants and children, and support the whole family to maintain health and prevent illness. The Ministry of Health publicly funds the programme.

Health visitors of the Ministry of Health, Cyprus, are working with migrant families and specifically targeting mothers of young babies, advising on areas including breastfeeding, safety, physical and emotional development and other aspects of health and childcare through maternity and child health clinics. While the service is provided nationwide, there is also a centre for the reception of asylum seekers, in Greece where all infants are receiving health care services.

Mothers with children attend a clinic several times during the child's first year of life, although arrangements can be made for the visits to take place at the family home. Offering support to parents in child raising is one of the most important tasks, as is advising families on nutrition, breastfeeding, family planning, and normal growth and development of children. The health visitor assessed the child's normal growth, and comparisons are made with other children of the same age. This also provides a longitudinal representation of the child's growth. Other specific screening including visual and audio tests are also undertaken at the clinic, as are all routine vaccinations according to the Cyprus Ministry of Health vaccination schedule. The child's physical, mental and social development is monitored, and referrals are made if necessary to other health professionals and specialist departments. Visits are gradually reduces to one appointment every six months and then once a year.

The programme is seen to be successful in outreaching migrant families, and providing support for them to improve their health through health promotion initiatives and interventions during pregnancy, infancy and childhood.

Case study 5

Location: Venda Nova. Portugal

Organisation: Venda Nova Health Centre, in partnership with other NGO's including community groups, schools and local institutions.

Title of the project: **Community Intervention Project: a holistic approach to inclusion**

The project is a community intervention programme using a mobile health unit to provide health and nursing care, and to refer families to the Venda Nova Health Centre, and other specialist services where care and treatment can continue. The service was developed following research that identified particular needs around the areas of maternal health and children.

The service is provided to populations living in impoverished neighbourhoods with low access to health care, who are mainly, but not exclusively, migrants and ethnic minorities, with low socio-economic status living on the outskirts of Lisbon. The majority of migrants are from African countries including Angola, S. Torné, Cabo Verde, Gulné. The population is predominantly young with 50% aged younger than 25 years old. The neighbourhood has several structural problems including a lack of public transport, the absence of commercial facilities, only one pharmacy and a general lack of infrastructure

to support the population. Data from the Technical Office of the Amadora Municipality indicates that the majority of the population are both socially and economically disadvantaged, with many of the families dependant on subsidies from the Government.

Outreach to this community has been enabled through a variety of means that involve a range of partners:

- Community and neighbourhood leaders
- The project team
- The health care centre
- The obstetric hospital
- Schools
- Local institutions and groups

The project is committed to the community, working with them and not only for them. The basic principles for intervention are participation, flexibility and integrated action.

In addition to specific interventions, the team also promotes in partnership with community members, health education and health promotion activities for example child vaccination campaigns, and young mothers.

Evaluation reports are produced annually and are shared with the community and institutional partners around a range of topics including: maternity health, infant health, vaccination, family planning and reproductive health. The indicators used are the process and results indicators already defined by the Ministry of Health for the mobile units. Partnership work is evaluated against implementing/developing actions, and community participation levels. A strong link is now established between the Health Centre and the community, and a stronger relationship now exists between the partners. As a consequence, there has been an increase in the community knowledge and a positive change in attitudes and behaviours. Results have surpassed expectations, and the number of people requesting support increases by the week.

The key learning from the project is that community integration projects must have the agreement of policy makers, be integrated in health policies and agreeable to both the community and the partners. It is important that services are developed around areas identified as important by the community itself, and based on community expectations.

Case study 6

Location: Romania

Organisation: National Health Insurances House

Title of the project: **Access to Healthcare Services for all Pregnant Migrant Women in Romania**

The aim of the programme is to protect the health of migrant mothers and their newborn children by ensuring access to healthcare, and the elimination of income, language and cultural barriers that limit migrant women to access to healthcare services. The service is publicly funded by the National unique health insurance fund, and the National Health Insurances House manages the services provided.

Migrant workers in Romania generally have low-income jobs and face many problems that are intensified by their vulnerable societal position. Difficulties are faced in obtaining medical assistance by many migrants who have 'temporary worker' positions, as there is no reciprocal agreement with the country of origin.

Examples of good practice for migrants supported by the National Unique Insurance fund are:

- Pregnant and postpartum migrant women who have no or below the minimum wage incomes, are beneficiaries of the National Unique National Insurance, without any payment required, in accordance with the Romanian health laws.

- In accordance with Romanian heath laws, pregnancy and postpartum monitoring for migrant women is provided even for those women that do not have insurance.

- Pregnant and postpartum migrant women are beneficiaries of free treatments and laboratory examinations, if necessary, even though they cannot pay for health insurance.

In addition to the legislation, a culturally sensitive approach towards migrant pregnant women is seen to be very important for the success of the programme. For example, in some cases pregnant women have been assigned a female gynaecologist. The intervention has influenced the general population and morbidity indicators. In the absence of this good practice it is believed the number of deaths among pregnant women and newborn babies would be even higher.

Email: itodea@ms.ro
Dr Iuliu Todea. Public Health Authority, Bucharest, Romania.

Migrant Maternal Health Strategies in Europe

Dr P. A. Jones

Context

EU research rationale

Across the EU population aging resulting from increased life expectancy and low birth rates is a well established fact (Commission of the European Communities (CEC), 2007; Commission for Rural Communities (CRC), 2007). In the UK for instance the estimated population aged 85 and over has increased by 6% in 2006 to 1.2 million. It is projected that by 2031 this number will more than double to 2.9 million, having major implications for future service provision (National Statistics, 2007). Non-nationals living in EU

Member States are largely younger than the national populations and on Jan 2009 numbered 31.9 million representing 6.4% of the total population. Seventy three per cent of non-nationals can be found in Germany, Spain, UK, France and Italy (Vasileva, 2010). In 2006 1 in 5 births in the UK were to women born outside of Britain (Taylor, & Newall, 2008) the highest percentages from mothers born in Pakistan and Poland (Table 1).
The highest fertility rate among the Government Office Regions of England in 2009 is the West Midlands with 2.06 children per woman (http://www.statistics.gov.uk/pdfdir/bdths0710.pdf). Since 1996 the World Health Organisation (WHO) emphasised the need to give great priority to monitoring the health of women in all migration-related situations (Carballo, Grocutt & Hadzihasanovic, 1996).

Table 1: Ten most common countries for non-UK born mothers 2009

Country	Percentage
Pakistan	2.6
Poland	2.6
India	1.8
Bangladesh	1.2
Nigeria	1.0
Somalia	0.8
Germany	0.7
South Africa	0.6
Ghana	0.5
China	0.5

Source: National Statistics Online
http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14408

As with research into migrants' mental health, comparisons between EU Member States about maternal health are complicated by the different use of classifications. With some recent research study exceptions, the UK tends to adopt ethnicity as a key variable while continental Europe generally categorises on the basis of migratory status. The need for more intelligent data sources across social and healthcare data bases to describe migrant populations experience, utilization and access to service has recently been highlighted (HPA, 2010). As examples show, geo-political, socio-economic, deprivation, cultural and migratory experiences as well as acculturation are chief determinants found across EU Member States.

Links with physical health and integration

Access to good quality healthcare is considered an important aspect of the social inclusion of migrants. Social integration is often a key factor in maintaining good physical health and well-being and beneficial to both migrant and host populations if the *"socio-economic promise of migration"* is to be realised (Machado, M.C. *et al.,* 2009:07). The Institute for Public Policy Research found that the per capita revenue to the Government generated by migrants in 2003/4 was higher (£7,203) than for UK born tax payers (£6,861) (IPPR, 2005). Recent family reunification policies developed by some EU Member States together with the increasing "*feminisation"* of migration have brought new concerns about the health care of migrant[4] women and children. The European

[4] [4] In this review, the term migrant includes economic migrant, asylum seeker, international student, spousal migrant, irregular (sometimes referred to as undocumented) migrant and victim of trafficking

Conference (2007), prioritised women and child healthcare as one of its key theme and sought to foster collaboration among EU Member States.

The White Paper, "*Together for Health: A Strategic Approach for the EU 2008-2013"* (2007) stressed the need for EU Member States to work together founded on values of universality and to integrate health into all the Commission's policies. Some Member States have welcomed this as an opportunity to intervene in health promotion and disease prevention for vulnerable migrant groups. Research has been carried out at national and regional level (Taylor & Newall, 2008; Phillimore *et al.,* forthcoming) on "*maternal, perinatal, and infant mortality"* in Belgium, Sweden, UK, Netherlands, Spain and Portugal (Machado *et al.,* 2009:06). Migrant women appear to have the worst mental health indicators for postpartum depression than national women (Sword *et al.* 2006).

Influenced by geo-political and socio-economic factors

Although global travel has become safer, migration entails different types of risks. The process of migration involves being separated from family, kin and traditions, coping with a new social system and cultural context. The rise of inequalities across and within countries negatively affects access to healthcare (Collins, 2003). Moreover, the size and nature of migrant populations is influenced by economic and geo-political events so that poverty, poor housing and overcrowding have significant impact on migrants' health. Maternal and child health services remain important needs for migrant populations (HPA, 2010). In Western Europe, maternal mortality and reproductive ill-health is generally low although risks are significantly higher for migrant and refugee populations living in these countries compared to the host populations (Modder, J. *et al.*, 2009; Taylor & Newall, 2008).

Migrant women are more likely to have low social status, low incomes and poor health status (Carballo & Kruger, 2006). A study from the UK comparing the diets of mothers of different ethnic origins showed a high level of inadequate nutrition amongst those with babies born with low birth weights (Rees *et al.,* 2005). Risks to the maternal and reproductive health of migrant women and children in host countries make these groups particularly vulnerable (Kandula, *et al.,* 2004). Risk factors for infant mortality include maternal obesity and malnutrition, poor maternal health, violence in pregnancy, late presentation for antenatal care, lack of access to diagnostic services for infectious diseases, maternal infections, and poor communication with local services due to language, cultural or behavioural differences and staff attitudes and lack of cultural awareness (HPA, 2006; Phillimore *et al.,* 2010). The most vulnerable migrant women include those found within failed asylum seekers populations, victims of traffickers and undocumented migrants (Bragg, 2008, Wolff, *et al.,* 2008; Taylor & Newall, 2008; HPA, 2010; Phillimore *et al.,* forthcoming). Wolff et al., (2008) conclude that undocumented migrants have more unintended pregnancy and delayed pre-natal care, are exposed to increased violence during pregnancy and use less birth control methods compared to legal residents.

Requiring a 'family' approach

If the general well-being of migrant women is compromised, then other aspects of their own and their families' health may be in jeopardy. There is a call for a holistic intervention into the wider health needs of migrant women and their families

acknowledging the link between physical, mental, maternal and reproductive health and family well-being (Machado, *et al.,* 2009). The World Health Organisation (2005:42) underlines the relevance of improvements in maternal and child health care as an integral aspect for the decrease of family and community poverty. The Report notes access to antenatal care is universal in "*high and middle-income countries"* except for migrants and other marginalised groups. Collaboration between statutory and non-statutory organisations is a prerequisite for holistic intervention yet two of the most comprehensive and recent studies of migrant health in the South East and West Midlands regions of the UK find a lack of consistency and co-ordinated action between such agencies throughout the regions (HPA, 2010; Phillimore *et al.,* forthcoming).

Conditions

Cultural and reproductive practices

Cultural beliefs and reproductive practices are significantly different across national, ethnic and religious groups and can present both advantages and disadvantages to maternal and child health and well-being. For example, some studies of migrant mothers indicate a higher level of breast-feeding initiation and longer duration rates improving health outcomes for infants (Merten *et al,* 2007; Singh, Kogan & Dee, 2007). A comparative study in Turkey revealed similar positive attitudes towards breastfeeding apart from negative beliefs about colostrum. Mothers with lower education generally believed that colostrum was unhealthy for babies (Ergenekon-Ozelci *et al.* 2006).

Cultural practices may also be a factor in preventing access to maternal and reproductive healthcare. Gender inequalities may prevent the use of contraceptive methods particularly among migrant women (APF, 2006). Research studies into a causal link between abortion and mental health are inconclusive but cultural and religious opposition to abortion has been recognised as an additional risk factor (Casey, 2010). Studies demonstrate the influence that cultural and reproductive practices can also have on access and perceptions of maternal healthcare. For example research in the South East region of the UK found Polish prejudice against midwife-led care and a widely expressed wish to return to Poland for delivery meant low levels of booking for antenatal care and difficulties arising in the case of antenatal emergencies (HPA, 2010). Consanguinity and sexually transmitted diseases such as HIV can complicate access and increase risk factors regarding mortality rates (Phillimore *et al*., forthcoming).

According to the World Health Organisation, female genital mutilation (FGM) affects 130 million women worldwide and every year another 2 million girls and young women are at risk of undergoing the practice (Dattijo, 2010). A typology of degrees of circumcision of the practice has been developed to classify the extent of excision of partial or total removal or infibulation of the clitoris, labia minora, labia majora, vaginal wall or cervix. Practices differ according to region and ethnic groups (Lundberg, 2008). The practice acts as a cultural barrier to migrant women accessing all aspects of maternal healthcare. One qualitative study of first generation Somali migrant women in Camden found barriers to the uptake of cervical screening included fatalistic religious attitudes towards cancer associated with 'God's will' as well as culturally specific barriers associated with embarrassment about FGM (Abdullahi *et al.,* 2009). Pregnancy, childbirth and postpartum issues are complicated by FGM because of the increased risk of mortality and morbidity (Rushwan, 2000). A Swedish study of migrant Eritrean women (Lundberg, 2008) developed 6 themes of experience relating to FGM:

- fear and anxiety
- extreme pain and long-term complications
- healthcare professionals knowledge of circumcision and healthcare
- support from family and friends
- de-infibulations
- decisions against circumcision of daughters

Violence in pregnancy has been linked to infant mortality and domestic violence is *"more acceptable"* in some cultures (HPA, 2010:203). The opportunity for mothers to reveal or seek help with abusive relationships within the process of accessing maternal services is often missed by staff's lack of cultural awareness or the barrier of language and confidential interpretation services (Phillimore *et al.,* 2010).

Autonomy of women

The autonomy of women to access maternal services is sometimes hampered by transport costs; other childcare consideration; the need to seek permission from in-laws; the pressure to attend appointments with a male family escort, exacerbated by excessive waiting time and the availability of family members (Phillimore, *et al.,* forthcoming). Cultural differences are often put forward as being responsible for a lack of autonomy of migrant women especially in issues of maternal healthcare but dependency is perhaps more complex. One qualitative study done in partnership by nine EU Member States revealed that the dependency ascribed to migrant women was largely a consequence of the process of family migration where a female migrant usually joins a husband who has migrated before her. Although not universally held throughout the study an argument was made for *"double discrimination"* of migrant women. Findings suggested that female dependency is based on three factors: financial situation, legal status and knowledge of the host country's language. Lack of income comes from migrant women being dissuaded from taking up paid employment by cultural patterns where women have traditionally stayed at home. However, in many EU countries a migrant woman joining a spouse on the basis of family reunion is not always entitled to take up employment at the beginning of her residency in the host country. Secondly, in the case of family reunion, women are legally subordinate to their husbands because their residence permit may become invalid if the marriage is dissolved. The third factor of lack of knowledge of the host country's language and systems creating language dependency is linked to reproductive health, a sphere in which a woman may need *"behind the back"* support and assistance with controversial issues such as birth control, abuse or sexually transmitted diseases (European Commission, 2008:59-60).

Transient housing conditions

In most Member States, despite many agencies, governmental and non-governmental being involved in organising and managing housing facilities and providing accommodation for asylum-seekers, refugees and migrants, the reality is lack of adequate housing except for that which is poor quality, overcrowded and expensive more often only available in neighbourhoods in deprived areas. In addition, vulnerable migrant groups such as new arrivals and undocumented migrants as well as asylum seekers and refugees in some cases end up in situations of destitution and homelessness (NGO Network, 2007). Research in the West Midlands shows that isolation presents a considerable barrier for migrant mothers in rural areas and the continuity of asylum seekers' maternal care is fractured because of frequent moves due to dispersal or detention (Taylor & Newall, 2008; Phillimore *et al.,* forthcoming). Increasingly culturally diverse migrants are moving to unprecedented areas of the UK

where hostility and lack of support are major issues. There are clear distinctions in housing situations for migrants of different groups. In the UK, most new migrants move into temporary, insecure accommodation; migrant workers depending on the private rented sector (in early stages of settlement migrant workers have no recourse to social housing) and asylum seekers reliant on supported accommodation then moved into social housing or the private rented sector, once granted leave to remain (Robinson, Reeve and Casey, 2007).

Migrant housing throughout Europe is characterised by some of the worst conditions for maternal and child health and well-being. For migrant workers, accommodation often consists of bed-sharing according to shift patterns and if it is provided by the employer, makes migrants particularly vulnerable (CRC, 2007). The mobility of migrant populations makes follow-up appointments particularly problematic e.g. neonatal audiology screening and development checks and late presentation for ante-natal care has also been highlighted (Collis, Stott & Ross, 2010). Seasonal patterns of many migrants' work makes transient living a way of life and access to healthcare including maternal healthcare very limited. Caravans, unlicensed caravan sites and converted farm buildings are used to house particularly migrant agricultural workers (CRC, 2007). Migrant children are twice as more likely to be living in rented over-crowded accommodation in the UK than their native-born counterparts with many ethnic minority families more likely to be spending a large share of their income on housing costs (Crawley, 2010).

There are additional reasons for the level of migrant residential mobility other than housing conditions as one recent Danish study of migrant spatial assimilation shows. While there is a tendency beyond that of necessity for new migrants and less integrated ethnic minorities to settle in multi-ethnic neighbourhood in the first instance because of a greater need for cultural and support networks: This is often a temporary measure as migrants use ethnic enclaves to become more settled and informed on their way into more integrated neighbourhoods (Finney & Simpson, 2009). Access and knowledge of entitlements as well as the lack of trained housing staff in cultural awareness and migrant needs (Carter & El-Hassan, 2003) also account for unnecessarily transient housing experiences for migrants.

Key Issues

Higher levels of maternal and infant mortality

Research and reports show that risks of maternal mortality are significantly higher for migrant and refugee populations living in Western Europe. A confidential enquiry into maternal and child health in the UK in 2007 found links between ethnicity, mortality and deprivation: The stillbirth rates for women of Black and Asian ethnicity were 2.7 times and 2.0 times higher, respectively, than those for women of White ethnicity. Neonatal mortality rates were 2.2 times higher for Black women and 2.0 times higher for Asian women compared to White women. While there was evidence of a decrease between 2005-2007 in the neonatal mortality rate for women of White ethnicity (from 2.7 to 2.3 per 1,000 maternities), the neonatal mortality rate for Asian and Black women remained at about the same level. Twenty eight per cent of women experiencing neonatal death were from non-White ethnic groups compared to 16% of the general maternity population. The enquiry found that ethnicity is often associated with levels of maternal social deprivation. In 2007 stillbirth and neonatal mortality rates for women in the most deprived population quintile were approximately two times higher than for women

resident in the least deprived areas (Modder, 2009). Taylor and Newall (2008) found that the highest infant mortality rates in the UK are to be found in the West Midlands.

The number of births to mothers born in EU countries other than the UK and Republic of Ireland increased by 87% between 2001 and 2006 to 27,000 representing almost 4% of all UK births in 2006 (National Statistics, 2007). Births to A8 mothers rose nearly 7-fold between 2004-2008 representing 3.2% of total births in the UK (Matheson, 2010). Compared to UK born women of the same age, 18% of women born overseas aged 30-34 stated that they intended to have four or more children. However, preliminary analysis in the UK comparing women born in Pakistan and Bangladesh with second and subsequent generation migrant women of Pakistani or Bangladeshi ethnic origin suggests that the fertility rate may be converging towards fertility levels observed for UK born women (Dunnell, 2010:19-20). Medical researchers in Norway found in a study of women undergoing termination in Oslo that rates were higher for labour migrants (7.3%) and refugees (10.8%) when compared to Norwegian women (6%). A difference in migrant women's socio-economic circumstances was one of the main reasons for the discrepancy (Vangen, Eskild & Forsen, 2008). The study reflected previous findings that reproductive patterns and cultural practices in the country of origin and years of residency in the host country have an influence on the fertility rate among migrants.

Access, entitlement and availability

Each EU Member State takes a different approach to maternal and child health rights of migrants as well as other social rights depending on previous history of migration, the social and economic situation of the country and public administration reform. The determinants that influence these elements can be considered as two complementary perspectives: demand and supply-side factors regarding immigration (Machado, 2009). Access, entitlement and availability are all related to supply-side conditions. Undocumented migrants face some of the greatest accessibility problems. For instance in the case of Germany undocumented migrant women may only access health care under *'immediately necessary treatment'* and similarly in the UK under *'Accident and Emergency treatment'*. German public officials as part of their role used to be obliged to report undocumented migrants (Machado, 2009:13-14). This creates conflict with public health interests because, it is argued, healthcare rights are transformed into an instrument of migration control (Horton, 2008). In Portugal a special access system has been available to irregular migrants since 2001 so that equal access to healthcare is available to all. At the European Conference on Migration Health held by the Portuguese Presidency of the EU in 2007 recommendations were made asserting the right to health of migrant women regardless of legal status.

Poor communication between migrants and healthcare providers has been frequently cited as a major obstacle to migrant access to health care (Machado, 2009). Communication, language barriers, lack of knowledge of entitlements and the purpose of gynecological procedures have been found to be the main obstacles to access and attendance for follow-up care (Taylor & Newall, 2008; Abdullahi *et al.,* 2009; HPA, 2010; Phillimore *et al.,* forthcoming). There is little knowledge of the specific problems of irregular or undocumented migrant women. One study was based on undocumented pregnant women attending free ante-natal care in Geneva. Most of the women were highly educated Latin-Americano women doing mostly domestic work. Of the 134 participants, 83% admitted that their pregnancy was unintended, mostly due to lack of contraception (Wolff *et al.,* 2005).

Strategies & Good Practice Initiatives

Generally, there is a need for a holistic intervention*, "a family approach",* to avoid compartmentalisation of migrant women's health and dealing with health inequalities in the light of cultural competence. It is important to base good practice on principles of:

- mainstreaming to enable multi-agency work
- assessing the needs of local populations within an on-going process
- capacity building particularly between the national health sector and local communities
- staff training and cultural awareness raising
- monitoring to identify unintentional barriers
- (Machado, 2009).

Data collection

Intelligent data sources have been cited as problematic when researching migrant women's maternal healthcare needs. Maternity data collected by the West Sussex Hospitals NHS Trust provided valuable information on maternal needs of migrant mothers and included:

- Mother's birthplace
- Gestation at initial assessment
- Method of delivery
- Birth weight in grams
- Admission to neonatal unit
- Feeding intention at delivery
- Current smoker at delivery
  (HPA, 2010;172)

Housing conditions

The Portuguese Refugee Council (PRC), with the help of EQUAL funding began construction of a new reception centre in Loures. It is integrated in a residential area and it will be, in part, a community centre. The services available (nursery, sports field, documentation centre) will both be delivered to asylum seekers and to the local community (NGO Network, 2008).

Access

The Maternal-Child Programme in Spain (Lleida) follows up for three years, newborns of mothers with low health coverage living in impoverished neighbourhoods. If needed, the clients can be referred to the Maternal-Child Service (SMI), a type of informal education for families with children less than 3 years of age. Families can be migrant or national. The resources made available by the Municipality of Lleida through these programmes consider 'health' as a comprehensive state of mind and well-being with long-term concern (Machado, 2009).

The health visitor programme in Cyprus aims to provide health care to migrant mothers, babies and families in a similar approach to promote health and prevent illness. Health visitors of the Ministry of Health in Cyprus are advising on areas such as feeding, safety, physical and emotional development as well as other aspects of health and childcare through maternity and child healthcare clinics (Machado, 2009).

Recent research in the UK (Collis, Stott & Ross, 2010) based on extensive work through Keystone/META (Mobile Europeans Taking Action) to better understand the needs of migrant workers arriving in the East of England found respondents spoke very positively about the quality of maternal and ante-natal care provided via a midwife service throughout the pregnancy and delivery compared to systems in their countries of origin where care was provided by doctors in a more formal and medicalised setting. In particular, the Polish and Lithuania systems were felt to have deteriorated rather than improved since the reforms of the late 1980s and early/mid 1990s.

References

Abdullahi, A., Copping, J., Kessel, A., Luck, M. & Bonell, C. (2009) Cervical cancer screening: Perceptions and barriers to uptake among Somali women in Camden. *Public Health,* 123:680-685

Association for Family Planning (Associacao para o Planeamento da Familia, APF) (2006)
http://www.duplaoprotunidade.org/IMG/pdf/Migracoes.pdf

Bragg, R. (2008) *Maternal deaths and vulnerable migrants*. The Lancet, 371:879-880

Carballo, M., Grocutt, M. & Hadzihasanovic, A. (1996) Women and migration: A public health issue. *World Health Statistics Quarterly*, 49 (2):158-164

Carballo. M, & Nerukar, A., (2001). Migration refugees and health risks. Emerging Infectious Diseases, 7 (3suppl) pp 556-560

Casey, P. R. (2010) Abortion among young women and subsequent life outcomes. *Best Practice and Research Clinical Obstetrics and Gynaecology*, Vol. 24(4):491-502

CEC (2007) *Europe's Demographic Future. Facts and Figures on Challenges and Opportunities*. Commission of the European Communities

CEC (2007) *White Paper - Together for Health: A Strategic Approach for the EU 2008-2013.* Brussels 23.10: Commission of the European Communities

Collins, T. (2003) Globalisation, global health, and access to healthcare*. International Journal of Health Planning and Management*. 18: 97-104

Collis, A, Stott, N. & Ross, D. (2010) *Workers on the Move 3. European workers on the move and health in the UK: The evidence*. Norfolk: Keystone Development Trust

Crawley, H. (2010) Moving Beyond Ethnicity: The Socio-Economic Status and Living Conditions of Immigrant Children in the UK. *Child Indicators Research* (1874-897x), Vol. 3(4) 547-570

CRC (Commission for Rural Communities) (2007) *A8 migrant workers in rural areas: Briefing Paper*

Dattijo, L. M. (2010) Awareness, perception and practice of female genital mutilation among expectant mothers in Jos University Teaching Hospital, north-central Nigeria. *Nigerian Journal of Medicine*, vol.19(3) 311-5

Dunnell, K. (2007) The *Changing Demographic Picture of the UK: National Statistician's Annual Article on the Population*. ONS

Ergenekon-Olzelci, P., Elmaci. N., Ertem, M. & Saka, G. (2006) Breastfeeding beliefs and practices in slums of Diyarbakir, Turkey, 2001. *European Journal of Public Health*, 16:143-148

European Commission (2008) *EUR 23610 – Immigrant women and their integration in aging societies, results from FEMAGE Project*. Luxembourg: Office for Official Publications of the European Communities

European Conference (2007) *"Health and migration. Better health for all in an inclusive society"* (27-28 Sept)

Ferandes A., Pereia Miguel J., 2009. Health and Migration in European Union: better heath for an all inclusive society. Insitituto Nacional de Saude Doutor Ricardo Jorge

Finney, N. and Simpson, L. (2009) *'Sleepwalking to segregation'? Challenging myths about race and migration.* Bristol: Policy Press

Horton, R. (2008) What does a National Health Service mean in the 21st century? *The Lancet*, Vol. 371:2213-2218

HPA (2010) *Understanding the health needs of migrants in the South-East region*. Health Protection Agency

Institute for Public Policy Research (2005) *Paying their way – the fiscal contribution of immigrants in the UK*

Jentsch B., Durham R., Hundley V., Hussein J., March 2007. International Journal of Consumer Studies. 31. Issue 2 pp 128-134

Kandula, N. R.. Kersey, M. & Lurie, N. (2004) *Assuring the health of immigrants: what the leading health indicators tell us.* Annual Review of Public Health, 25: 357-376

Kiwanuka-Mukibi, P., Derriennic Y., Karungi G., (2005). The Good Practice Model: Community Participation in Luweero District, Uganda. Bethesda, MD: The Partners for Health Refurmlus Project. ABT Associates Inc

Lundberg, P.C. (2008) Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden. *Midwifery,* Vol.24(2) 214-225

Machado, M.C., Fernandes, A., Padilla, B., Dias, S., Gomes, I., Dias, A. and Oliveira da Silva, M. (2009) *Maternal and Child Healthcare for Immigrant Populations*. Portugal:IOM

Matheson, J. (2010) *National Statistician's Annual Article on the Population; a Demographic Review*. ONS

Merten, S., Wyss, C. & Ackermann-Liebrich, U. (2007) Caesarean sections and breastfeeding initiatives among migrants in Switzerland. *International Journal of Public Health*, 52:210-222

Modder, J. (ed) (2009) *Confidential Enquiry into Maternal and Child Health: Perinatal Mortality 2007*. London: CEMACH

National Statistics (2007) *Both UK and foreign-born women contribute to rise in fertility.* News Release 11 December
http://www.statistics.gov.uk/pdfdir/fertility1207.pdf
accessed 22.10.10

NGO Network (of Integration Focal Points) (2007) Policy Briefing on Housing for Refugees and Migrants in Europe.
http://www.epim.info/docs/documents/ECRE%20Policy%20Briefing_Housing.pdf
accessed 27.10.10

Phillimore, J., Thornhill, J., Latif, Z., Uwimana, M. & Goodson, L. (2010) Delivering in an age of Superdiversity: a review of maternity services to migrant women in the West Midlands. Institute of Applied Social Studies: University of Birmingham

Rees, G. A. Doyle, W., Shrivastava, A., Brooke, Z. M. Crawford, M. A. and Costeloe, K. (2005) *The nutrient intakes of mothers of low birth weight babies – a comparison of ethnic groups in East London, UK*. Maternal and Child Nutrition, 1 (2):91-99

Robinson, D., Reeve, K. & Casey, R. (2007) *The housing pathways of new immigrants.* York: Joseph Rowntree Foundation

Rushwan, H. (2000) Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum periods. International Journal of Gynaecology and Obstetrics, 70:99-104

Singh, G. K., Kogan, M. D. & Dee, D. L. (2007) Nativity/immigrant status, race/ethnicity, and socio-economic determinants of breastfeeding initiation and duration in the United States, 2003. *Paediatrics*, 119 (Supll 1), 538-46

Sword, W. A., Watts, M. S. & Krueger, P., D. (2006) Postpartum health, service needs and access to care experiences of immigrant and Canadian born women. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*, 35 (6):717-727

Taylor, B. & Newall, D. (2008) *Maternity, mortality and migration: the impact of new communities.* West Midlands Migration Partnership and Heart of Birmingham PCT

Vangen, S., Eskild, A. & Forsen, L. (2008) Termination of pregnancy according to immigration status: a population-based registry linkage study. *BJOG: An International Journal of Obstetrics and Gynaecology*, 115: 1309-1315

Vasileva, K. (2010) *Populations and social conditions. Eurostat, Statistics in Focus 45/2010*: European Union

Wolff, H., Stadler, H., Epiney, M., Walder, A., Irion, O. & Morabia A. (2005) Healthcare and Illegality: A survey of undocumented pregnant migrants in Geneva. *Social Science and Medicine*, 60 (9): 2149-2154

Wolff, H., Epiney, M., Lourenco, A. P., Constanza, M. C., Delieutraz-Marchand, J., Andreoli, N., Dubuisson, J-B., Gaspoz, J. M. & Irion, O. (2008) *Undocumented migrants lack of access to pregnancy care and prevention.* BMC Public Health, 8:93

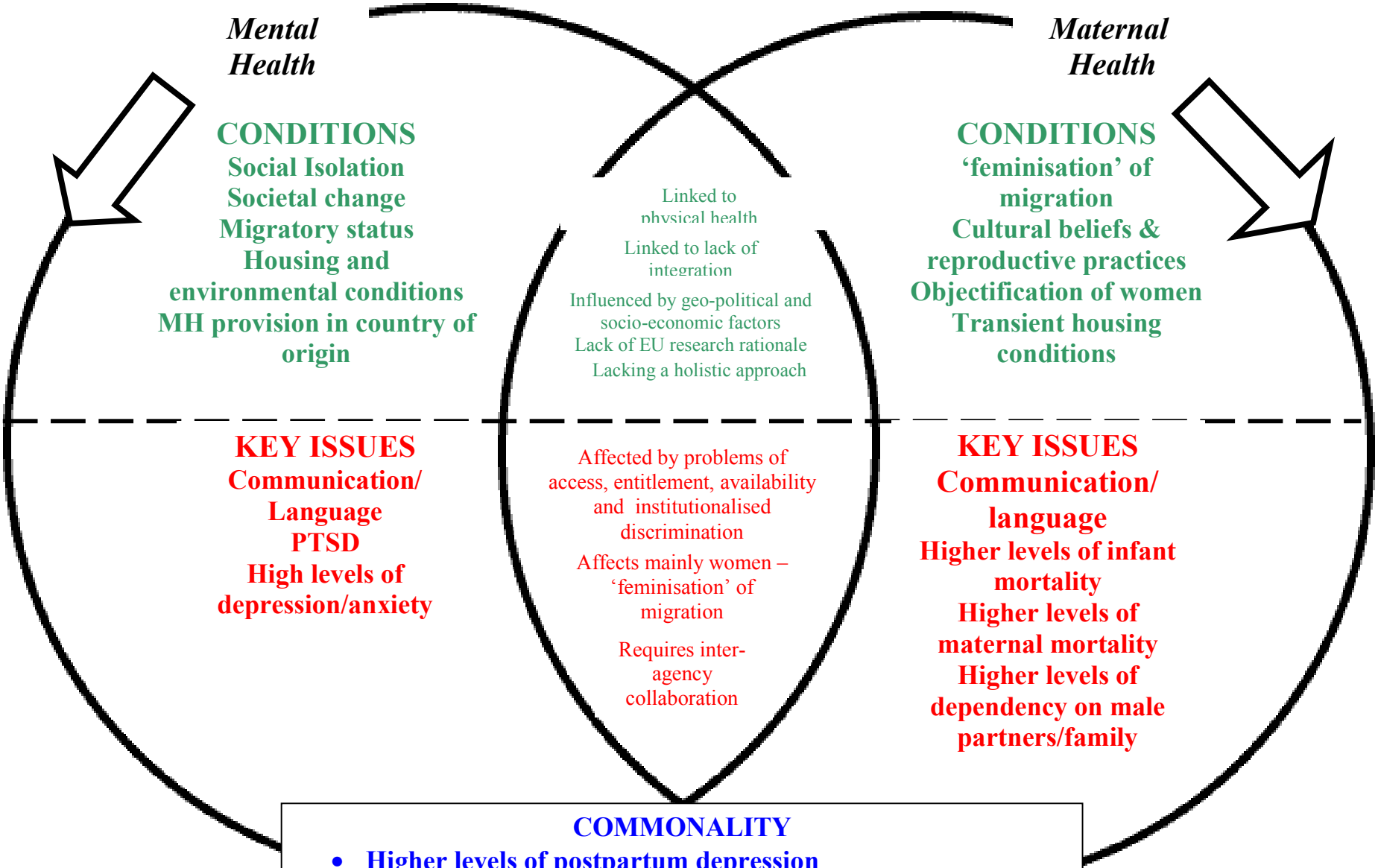
World Health Organisation (2005) *World Health Report 2005: make every mother and child count.*
http://www.who.int/whr/2005/whr2005_en.pdf
accessed 26.10.10

Overlapping issues
Dr. P.A. Jones

The underlying remit of the mental health and maternal health literature reviews was to identify links between issues of mental and maternal health for migrant women. Four interesting areas of common concern have evolved:

1. There are higher instances of postpartum depression in migrant new mothers than in populations as a whole due to geo-political and socio-economic factors surrounding the migration experience. This was an anticipated area of overlap and is widely evidenced.
2. There are possible links between abortion and mental health due to socio-economic constraints and circumstances that leave particularly migrant women workers in a no-choice situation that can cause feelings of ambivalence and guilt.
3. The link between PTSD and childbirth was raised as an issue by the Clinical Psychology Research Group based in Milan and headed by Vittorio Cigolli, where the experience of intense pain is believed to act as a significant stressor and trigger sensation of reliving traumatic events.
4. A linear connection can be made between migrant, undocumented and trafficked women's sometimes social and economic isolation, creating the restricted conditions where domestic violence can more easily occur; and the links between violence during pregnancy causing detriment and increased infant mortality.

The above issues are illustrated in the diagram on the following page.



COMMONALITY

- **Higher levels of postpartum depression**
- **Possible link between abortion and mental health**
- **PTSD following childbirth – recalling great pain**
- **Consequence of domestic violence/sexual violation**

Checklist of Good Practice

While research on assessing good practice always implies active participation with partnerships and stakeholders (Klwanuka-Mukini et al. 2005), there is no agreement in the literature about what constitutes good practice, and there are variables when good practice is evaluated from different professionals perspectives (IOM 2010). There is a real need for guidance, and an accredited criterion of what constitutes good practice that professionals are able to access (Watson J 2011). Priebe S., & Sandhu S. (2010) in consultation with partners from across the EU identified have seven components of good practice when developing services for migrants.

General aspects of good practice

- Organisational flexibility with sufficient time and resources including longer consultation time and better resources

- Good interpreting services including same language therapist, bi-cultural workers as interpreters and professional interpreting services

- Working with families and social services including collaboration with religious, and community groups and organisations.

- Cultural awareness of staff including promotion of cultural awareness through education or training of staff, and having multicultural staff to support the wider acquisition of acceptance and understanding of different cultures.

- Education programmes and information material for immigrants including programmes and translated material on health and the health care systems.

- Consistency in health workers to build a positive and stable relationship with staff and to improve staff-patient relationships.

- Staff training in service policy and migrants entitlements, supported by clear guidelines on care entitlement of different groups of immigrants.

Elements for better practice should involve:

- Sufficient resources: More practitioner time and good interpreting services is a challenge for commissioners and funding agencies, and likely to be influenced by political priorities.

- Collaborative partnerships with healthcare providers and other agencies: This is not always dependant on the provision of more resources and may partly be achieved through appropriate policies and protocols, with other services and organisations, in and outside of health care. #

- Positive attitudes: The most challenging aspect is likely to be staff and immigrants attitudes, which may be linked to personal experiences as much as the wider societal context.

WS1. Good practice checklist for developing mental health services

There is a lack of research into good practice in mental heath provision to migrants both nationally and internationally, and countries across Europe are grappling with similar problems. Initiatives in mental health are often developed in an add hoc manner, and the current state of cross-cultural training in the EU is difficult to access (Watters 2007)

Good practice checklist for developing mental health services:

- Migrants are not a homogenous group, but are affected by diverse experiences in their home and host countries. Professionals should bear this in mind when diagnosing mental health problems
- The patient may be extremely anxious about the security of personal information
- Issues of trust may be problematic
- It is usually unwise to put patients from the same country in the same therapeutic group

Good practice when a language and culture is not shared:

- Clarify objectives and review the meeting if using interpreters after the session
- Interpreters should be matched on age, gender and religious issues, with the same interpreter used at each meeting
- More time should be allocated when using interpreters
- Avoidance of specialist terminology
- Use trained and experienced interpreters wherever possible and respect their contribution and different training
- Remember that people from different cultures may put different interpretations on events or feelings
- Health beliefs about many aspects of psychiatry may be different across cultures
- Words may not translate easily across languages
- Provision of access to appropriate cross-cultural heath services
- Mental health assessment should be undertaken in migrants primary language, as emotions play a heavy role in the individuals level of functioning
- Training of healthcare professionals and the overall improvement of mental health care practice for migrant populations

- Promotion and support for the exchange and coordination of training strategies between EU countries

WS2. Good practice checklist for developing pre and postnatal maternal health care

For many migrants pregnancy may be the first time that they have contact with health services, and as such this presents an opportunity that service providers should value. During the time of pregnancy and the postnatal period, specific precautions should be taken by service providers to protect the physical and psychological vulnerability of the mother.

"All professionals who come into contact with pregnant migrant women need to be skilled in understanding and identifying the wide range of social risk factors that may leave these women vulnerable. Professionals need to have the available knowledge and resources to enable them to take action to help mitigate these risk factors and reduce the risk to mother and baby. Awareness of, and sensitivity to, cultural differences, are key elements in the provision of appropriate maternity care for women from migrant groups" (Phillimore et al 2010 p77).

Good practice checklist for developing maternal health services:

- Health and social care professionals should receive training in identifying vulnerable women

- social risk factors should be explored that may impact on the pregnancy and health of the child

- Affective and integrated referral process need to be developed that ensure rapid access to the required support when risk factors are identified

- Sensitivity in hospitals, for example, making it possible for female patients to request that only female practitioners participate in examinations

- Training in relevant cultural and religious needs for antenatal midwives, doctors, nurses and other health professionals that engage with migrant mothers

- Training for staff using culturally unbiased antenatal developmental tests, that take into account the differences of babies and children from different ethnic groups

- Perinatel classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is different from the National tongue. This might include lessons in basic language skills needed during the stay in hospital

- Translated sheets and pamphlets with basic information and instructions circulated through community groups and Third Sector organisations to reach the migrant population

- Health education programmes that highlight the importance of both prenatal and postnatal care

- Provision of bi-lingual antenatal and postnatal support groups for mothers of different ethnicities, where they can relax, speak their own language, and share experiences

In England, a toolkit for improving local service provision and migrant friendly maternity services gives examples of good practice initiatives that can be replicated by EU Member States. The resources in the toolkit aim to put migrant women at the heart of their maternity care and ensure they are able to access the required support to give them and their baby a healthy start in life (Sharpe H. 2010).

The toolkit highlights four key areas, which should be considered as part of a review of local maternity services including:

- Access to clear information for both the woman and those organising maternity care, ensuring adequate interpretation services are available to improve communications.

- Ease of access to heath care services for migrant women regardless of immigration status

- The attitudes and cultural awareness of health care staff to ensure women feel welcomed and supported by maternity services

- The availability of additional support for women who require it, including those with no recourse to public finds, and victims of FGM and domestic abuse.

References

Watson J., Structural funds and health gains. Online conference 26.1.2011

Watters C. (2007). Description of a study of good practice in the mental health and social care of Asylum seekers and refugees. European Centre for the Study of Migration and Social Care. University of Cantebury. England.

WHO. Health of Migrants – the way forward. Report of a global consultation. Madrid. Spain. March 2010.

Phillimore J., Thornhill J., Latif Z., Uwimana M., Goodson L (2010), Delivering in an age of Super-diversity. West Midlands Strategic Migration Partnership. Department of Health.

Priebe S., and Sandhu S. Best Practice in Health Services for Immigrants in Europe. http://wwweugate.org.uk

Racial Equality in Health. Good Practice Guide. www.equalityni.org

Sharpe H. (2010) Migrant Friendly Maternity Services: Toolkit for improving local service provision. Department of Health. West Midland Strategic Migration Partnership

Tribe R., (2002) The mental health of Refugees and Asylum Seekers: *Advances in Psychiatric Treatment*, Vol 8 pp 240-248

Burnett A & Peel M. Health Needs of Asylum Seekers and Refugees. *British Medical Journal* 322, pp. 544-547, 2001

Further reading

WS1 Mental health services

Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Competence and Empower Practitioners. IOM 2010.
Abstract
This paper aims to highlight the common denominator of cultural training demands and responses of mental health professionals, regardless of the healthcare system, the European country or the migrant community concerned, as well as the basic element to efficiently implement cultural competency within the mental healthcare setting.
http://www.migrant-health-europe.org/files/Mental%20Health%20Practice_Background%20Paper(1).pdf

Refugees, Acculturation Strategies, Stress and Integration. Phillimore J. *Journal of Social Policy*, 09 Dec 2010
Abstract
This paper turns to cross-cultural psychology's discussion of acculturation processes and, in particular, Berry's acculturation strategies (Berry, 1997) to look at the different factors that influence acculturation and how these factors impact upon the ability of individual refugees to integrate. Using qualitative data collected from 138 interviews with refugees living in Birmingham, England, the paper shows how a range of group and individual factors, relating to their experiences both in refugees' home and host countries, influences the acculturation strategies adopted by different refugees. It shows that in the current policy environment many refugees lack choice about acculturation strategy, are vulnerable to psychosocial stress and struggle to integrate.
http://journals.cambridge.org/action/displayAbstract?aid=793854

PUSSETTI, Chiara. Identities in crisis: migrants, emotions and mental health in Portugal. *Saude soc.* [online]. 2010, vol.19, n.1, pp. 94-113. ISSN 0104-1290. doi: 10.1590/S0104-12902010000100008
Abstract:
Based upon four years of fieldwork in a Portuguese mental health service for migrants, this paper critically discusses the nature of migratory experience as a risk factor and mental pathology.
http://www.scielo.br/scielo.php?pid=S0104-12902010000100008&script=sci_abstract

Best Practice Promoting Migrants Access to Mental Health Services in Europe. Schimina G., Celmi., Kelly E., Zoudar S. (no date). Central Service for Mental Health, Psycholosocial Response, and Cultural Integration. IOM
Abstract
This PowerPoint presentation investigates the accessibility of mental health care services by migrants in four European Countries: France; Germany; Italy and Switzerland; considers migration as a factor for mental health; and cites good practice case studies in mental health service provision in these countries.

http://www.ghf10.org/ghf10/files/presentations/ps21_schinina_guglielmo.pdf

Mental health, health care utilisation of migrants in Europe.
Lindert J., Schouler-Ocak M., Heinz A., Priebe S. Journal of European Psychology. Jan 2008. 23. Suppl 1:14-20
Abstract:
This paper gives an overview on the prevalence of mental disorders; suicide; alcohol and drug use; access to mental health and psychosocial care facilities of migrants in the European region and the utilisation of health and psychosocial institutions of these migrants.
http://www.ncbi.nlm.nih.gov/pubmed/18371575

Planting the Seeds of Hope: The Psychological and Mental Health Needs of Male and Female asylum seekers and refugees in the West Midlands.
Lilley M., Maqbool H., Hickson F., Bashir R., Guddam N., Rahimi AR., ehman M., Jabbar H, Turkai Y, Kunaka S. (2008)

Abstract:
This community led research report explores the mental health needs of asylum seekers systematically assessing their mental health needs and access to services, as well as highlighting the gender differences both in terms of issues, access to services, how the services could be improved and the emotional support they either had or needed. This research attempts to face up to their issues objectively and concentrated on the mental health issues of a core group of West Midlands residents in transience.
http://www.wmrdc.org.uk/silo/files/mental-health-needs-of-asylum-seekers.doc

WS2: Pre and postnatal maternal health services

Maternal deaths and vulnerable migrants. Bragg. R.
Abstract:
Women not considered to be 'ordinary residents' in the UK may be asked to pay for antenatal, birth and postnatal care. These women include refused (failed) asylum seekers, trafficked women and undocumented migrants. Charging practices negatively impact on these vulnerable women's engagement with maternity services. This report recommends a number of practical strategies that can be adopted to promote access to maternity care for this group of women.
http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/phapresentation2009.pdf

Cultural beliefs that may discourage breastfeeding among Lebanese women: a qualitative analysis. Osman H., Lama el Z., Livia W.

Abstract:
This study is part of a larger study that aimed to determine the utilization patterns of a hotline for postpartum support. The "Hotline Utilization Study" was conducted in preparation for a trial on reducing stress during the transition to motherhood (main results paper in preparation). The hotline was a mobile telephone that was answered by a midwife who was trained to respond to the questions and concerns of mothers regarding self-care, infant care, and parenting issues. There are a number of cultural beliefs that could potentially discourage breastfeeding among Lebanese women.

Understanding and addressing local beliefs and customs can help clinicians to provide more culturally appropriate counselling about breastfeeding.

http://www.internationalbreastfeedingjournal.com/content/4/1/12

Maternal and Childcare Healthcare for Immigrant Populations. International Organisation for Migration. 2010 (IOM)

Abstract:
This paper considers the facts, figures and trends in maternal and child health populations across the EU. Some initiatives that could be considered as good practice in this area are presented; namely Portugal (mobile health units), Spain (maternal-childhealth prevention and promotion programmes and related specialist services, two case studies), and Cyprus (health visitor programme).
http://www.migrant-health-europe.org/files/Maternal%20and%20Child%20Care_Background%20Paper(1).pdf

Delivering in an age of super-diversity: West Midlands review of maternity services for migrant women. (2010). Phillimore J., Thornhill J., Latif Z., Uwimana M., and Goodson L.

Abstract:
This research report focuses on the experiences of migrant women who had entered the UK within the last five years and accessed maternity services in the West Midlands Region. The report identifies: the views and experiences migrant women have about maternity services; the barriers and enablers that influence the engagement of migrant women with general practice; maternal and postnatal services; the ways in which migrant women access health and social care services; and the differing health beliefs of migrant women from different countries and their expectations of maternity services. The report makes a number of recommendations that service providers need to consider.
http://www.wmlga.gov.uk/media/upload/Library/Migration%20Documents/Publications/Delivering%20in%20an%20Age%20of%20Super-diversity%20v5.pdf

Migrant friendly maternity services: Toolkit for improving local service provision. Sharpe H. 2010. West Midlands Strategic Migration Partnership. Department of Health UK

Abstract:
This document has been developed as a toolkit to enable maternity services to take forward the recommendations from the Delivering in an age of Super-diversity report above, and ensure that local maternity services are migrant friendly. The document includes a number of good practice case studies that are addressing the needs of this vulnerable group of women pre and postnatal.
http://www.wmlga.gov.uk/media/upload/Library/Migration%20Documents/Publications/Toolkit%20for%20improving%20maternity%20services%20for%20migrant%20women%20v4.pdf

Maternity, mortality and migration: the impact of new communities. Taylor, B. & Newall, D. (2008) West Midlands Migration Partnership and Heart of Birmingham PCT

Abstract:
This report highlights the financial social and structural difficulties and challenged faced by migrant women giving birth in Birmingham UK, and the complex situations pregnant women may find themselves in. In particular the report highlights the plight

of women with no recourse to public funds and the resulting destitution faced. http://www.bhwp.nhs.uk/Files/Content/L/194/Maternity,%20mortality%20and%20migration_the%20impact%20of%20new%20communities%20-%20Jan08.pdf

Health care and illegality: a survey of undocumented pregnant immigrants in Geneva. Wolff H, Stalder H, Epiney M, Walder A, Irion O, Morabia Soc Sci Med 2005. 60:2149-2154

Abstract:

The objective of the study was to compare the use of preventive measures and pregnancy care of undocumented pregnant migrants with those of women from the general population of Geneva, Switzerland. The findings from the study underscores the need for better access to prenatal care and routine screening for violence exposure during pregnancy for undocumented migrants. Furthermore, health care systems should provide language- and culturally-appropriate education on contraception, family planning and cervical cancer screening.
http://biomedcentral.com/1471-2478/8/93

Make Every Mother and Child Count. The World Health Report 2005

Abstract:

The World Health Report 2005 – Make Every Mother and Child Count, says that this year almost 11 million children under five years of age will die from causes that are largely preventable. Among them are 4 million babies who will not survive the first month of life. At the same time, more than half a million women will die in pregnancy, childbirth or soon after. The report says that reducing this toll in line with the Millennium Development Goals depends largely on every mother and every child having the right to access to health care from pregnancy through childbirth, the neonatal period and childhood.
http://www.who.int/whr/2005/en/index.html

Health and Migration in the European Union: Better health for all in an inclusive Society. Fernandes A., & Pereira Miguel J. 2007

Abstract:

This report includes a number of best practice case studies from EU member states including services developed for migrant women and pregnancy services. The report also makes many references to the mental health needs of migrants and the issues practitioners face.
http://www.eifzvip.cz/dokumenty/elektronicka_knihovna/Health_Migration_EU2.pdf

Data and Information on Women's Health in the European Union. 2009. Faculty of Medicine Carl Gustav Carus. Dresden. Germany

Abstract

This report presents an overview of the state of women's health in the European Union. The report focuses on women aged 15 years and older in the 27 EU member states as well as the EEA countries Norway, Iceland, and Liechtenstein and occasionally Switzerland. The report includes sections on sexual and reproductive health; fertility; pregnancy outcome; maternal mortality; depression and mental health.
http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf

Good Practice

The health of migrants – the way forward. Report of a global consultation Madrid. Spain. 3-5 March 2010 World Health Organisation.

Abstract

This consultation report offers a summary of the issues discussed and an outline for an operational framework to guide action by key stakeholders. Part 2 is of particular interest suggesting key priorities and corresponding actions in four thematic areas: monitoring migrant health; policy and legal frameworks; migrant sensitive health systems; and partnerships, networks and multicultural frameworks.

http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf

Good Practice in Health and Migration in the EU: better heath for all in an inclusive society. 2007 Portugal.

Abstract

This conference report discussed the issue of health and migration with reference to some of the interventions that EU member states have found to be effective. The report includes practical and creative solutions that have been designed 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.

http://www.episouth.org/doc/r_documents/Good_practices_on_Health_and_Migration_in_the_EU.pdf

Racial Equality in Health and Social Care: A good practice guide. Department of Health, Social Services and Public Safety. Equality Commission for Northern Ireland

Abstract

This Racial Equality Good Practice Guide has been produced by the Equality Commission for Northern Ireland, in partnership with the Department of Health, Social Services and Public Safety. It's aim is to help ensure that the services provided by the Health and Personal Social Services (HPSS), meet the needs of all sections of the community, including people from black and minority ethnic backgrounds and traveller backgrounds.

http://www.equalityni.org/archive/pdf/raceeghealthWS.pdf

Best Practice in Health Services for Immigrants in Europe. EUGATE 2010

Abstract:

A study was conducted in 16 EU countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Portugal, Spain, Sweden and the United Kingdom to identify good practice in the delivery of health care to immigrants. The project reviewed existing legislation and policies, obtained the views of experts and health professionals in different types of health services. The summary of common findings with recommendations for better practice is reported in a number of languages.

http://www.eugate.org.uk/outcomes/index.html

Useful websites

International Organisation for Migration http://www.iom.int

Best Practice for immigrants in Europe (EUGATE) http://www.eugate.org.uk/

European Institute of women's health (Eurohealth) http://www.eurohealth.ie/

European Observatory on health systems and policies
http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth

Racial Equality in health and social care Northern Ireland www.equalityni.org

EU level consultation on migrant health http://www.migrant-health-europe.org/

The portal of the Province of Piacenza dedicated to immigrant citizens
http://www.retepiacenza.it/immigrati/default.asp?IDlan=2

HARP Mental health and wellbeing resource http://www.mentalhealth.harpweb.org/

PROMO Best Practice in promoting mental health in socially marginalised people in Europe http://www.promostudy.org/

A platform for European engagement in global health www.globalhealtheurope.org