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BETTER HEALTH FOR BETTER INTEGRATION:  
INEQUALITIES AND POLICY RESPONSES FOR ETHNIC  
MINORITY WOMEN IN FOUR COUNTRIES

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INTRODUCTION

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What is the health status of ethnic minority women in different countries? And what are their rights and actual behaviours in accessing care? Is there equity in access and in treatments for them? By drawing from a comparative research across Italy, Romania, Sweden and the United Kingdom, the different papers included in this special issue address these questions.

1. THE ISSUE: THE LINK BETWEEN HEALTH AND MIGRATION

With the constant flows of information, money, products, cultures and people European populations are becoming increasingly diverse. Social changes in European societies, such as the ageing population or enlargement of the European Union, also place migration and cultural diversity more at the centre of national and European political agenda.

Health and migration are closely linked for a variety of reasons and mechanisms (Stronks *et al.*, 1999; Ingleby *et al.*, 2005). Migrants have different experiences and lifestyles backgrounds that they bring with them in the host country as “footprints” of the socio-economic and cultural environments of their countries of origin. Migrants also have their own migration history which is peculiar depending on their age and starting health status, on the type of “welcoming” of the country they reach, on the reason for and status of migration (labour migrants, secondary migrants and second or third generation migrants, refugees and asylum seekers or undocumented migrants). Migration histories have in common a process of “matching effort”: “acculturation stress”, loss of familiar environment and social support systems which are difficult to recreate in the host country, and forms of discriminations which can negatively affect their health, weakening also the so called “healthy migrant effect” (Manfellotto, 2002; Westerling, Rosén, 2002). The living conditions in the host country also play a crucial role: poor living conditions, bad quality housing, and heavy jobs in unsafe environments. Long working days might sometimes be the root cause of particular health problems that apply to migrants in general or to specific groups.

Finally, policies matter. Even though migrants might have different health backgrounds and different health states, these differences are increased by the fact that their rights vary

according to their permit of stay which may have consequences for health: differences in possibilities to stay, access to work and access to health care. As widely recognised, the latter is crucial: migrants in a given receiving country are faced with specific institutions and structures, so that the satisfaction of their health needs depends on the health system of the host country, on the legal rights they are entitled to, on the actual access and the quality of care received (Ingleby *et al.*, 2005).

## 2. THE ATTENTION WITHIN EUROPE

For a long time the topic of migration and health has been seriously neglected. With the increasing size of ethnic minorities in European societies and the importance attached to their rights and to the process of integration, the past twenty years have seen a growing attention to migration issues, both in research and in health care practice. In particular, in the last decade health and migration has become a primary concern within EU institutions, as the number of documents produced and of projects financed highlight. For example, in 2007 the European Commission issued the *Communication on EU Health Strategy*, where, among its goals, it specifically addressed the problem of inequalities in health between and within the EU Member States. In June 2008, the European Council also tackled the problem, underlining the importance of closing the gap in health and in life expectancy between and within the Member States. Besides, in October 2009, the *Communication Solidarity in Health: reducing health inequalities in the EU* adopted by the Commission listed a number of factors which influence the persistence of these inequalities, mainly related to four categories: employment; income; length of education and ethnicity. Since 2000, several initiatives and projects on migrant health have been developed and financed, such as the Cost Action IS1103 on “*Adapting European Health Systems to Diversity*” (ADAPT), building on the achievements of Cost Action ISO603 on “*Health and Social Care for Migrants and Ethnic Minorities in Europe*” (HOME)<sup>1</sup>, or such as the “*Migrant Friendly hospitals*” (MFH), a European initiative to promote health and health literacy for migrants and ethnic minorities sponsored by the European Commission, DG Health and Consumer Protection (SANCO)<sup>2</sup>.

As Ingleby and colleagues underline (*ibid.*), despite the relevance that this issue has gained in the last decades, there is still a lack of research on the topic of migration and health and a lack of international and multidisciplinary cooperation to promote the sharing and exchange of knowledge and expertise on migrant health. Particularly lacking is research on the link between migration and health that uses a gender perspective and focuses on the specific situation of women. Indeed, comprehensive/gender disaggregated data concerning ethnic minorities is difficult to be found and quantification of the incidence of ethnic minority women is based on incomplete data and on estimations provided by single researches carried out on ethnic minorities and by NGOs active in this field (European Commission, 2007a, p. 7). Data collection is particularly relevant in the case of migrant women, as it is estimated that some 50% of migrants worldwide are women (European Commission, 2007b, p. 47).

<sup>1</sup> HOME-ADAPT are Europe-wide research networks, financed by COST (European cooperation in science and technology); see [www.cost.eu/domains\\_actions/isch/Actions/IS1103/](http://www.cost.eu/domains_actions/isch/Actions/IS1103/).

<sup>2</sup> See <http://www.mfh-eu.net/public/home.htm>.

### 3. THE RESEARCH

In this special issue we start to fill this gap in the literature on the link between migration and health<sup>3</sup>. Indeed, as the title suggests, we assess the health status and access to health services of ethnic minority women across four countries (Italy, Romania, Sweden and the United Kingdom). When defining ethnic minority women a distinction is made between established ethnic minority women and recent migrants including asylum seekers, refugees, trafficked women, undocumented migrants and Roma women. The comparative analysis across the four countries highlighted some interesting findings both in their respective migration histories and also their institutional frameworks. As summarised in the titles of each paper, in Italy ethnic minority women's health needs are met within a fragmented and subsidiary universalistic system, in the UK and Sweden rights are universal but with various challenges in actual access, and in Romania rights are still insurance based which strongly penalises who, for various reasons, has a weak attachment to the labour market, as Roma women.

This special issue focuses especially on policies. After providing an overview status and the determinants of health of ethnic minority women the research has indeed analysed the legislative frameworks and service configuration, highlighting good practices. To pursue this objective, the methodology adopted has been based on the concept of "mutual learning" and "active participation" in the process of policy design. On the basis of the analysis of their respective national/regional situations and through the learning process prompted by the exchange of best practices, the project's research partners have had the opportunity to identify and discuss weaknesses and strengths of the different policies and strategies that could be developed to tackle health inequalities. The research has been based on data collected through desk analysis (including secondary analysis, literature review, regulative framework and policy analysis) and field work (interviews with relevant stakeholders to select good national and regional practices and to collect specific documents and information at local level). The project has also organised a final seminar in each country with representation from the government as well as several local authorities to discuss research results and develop policy recommendations.

Focusing on ethnic minority women is relevant since all the existing evidence shows that ethnic minority women face higher risks of bad health conditions. The reasons are multiple and interrelated. Migrant women face specific gender needs related to maternal/reproductive health (including epidemiological elements linked to their reproductive system) and women's greater longevity, as well as facing additional cultural, linguistic, financial and administrative barriers in accessing services. Furthermore ethnic minority women are exposed to additional health risks due to working conditions related to their higher level of employment segregation in specific sectors, such as home assistance, their weaker protection from domestic violence and human trafficking and their exposure to gender practices that might lead to physical and mental damages such as genital mutilation (EGGSI, 2010). Cultural

<sup>3</sup> The research has been conducted within a project called "Better Health for Better Integration: building capacities to improve health equity for ethnic minorities women" (BHBI). This project, which was funded by the PROGRESS Programme of DG Employment, Social Affairs and Inclusion and coordinated by Fondazione Giacomo Brodolini, started in December 2010 and it ended in February 2013. Partners involved in the project came from four different countries: Italy, Romania, Sweden and the United Kingdom. More specifically the partners were: Fondazione Giacomo Brodolini (Italy-coordinator); South West Public Health Observatory (United Kingdom), National Institute of Adult Continuing Education (United Kingdom), Civil Society Development Foundation (Romania), Örebro County Council (Sweden). For a detailed description of the project see <http://www.bhbi.eu/>.

barriers are probably the most evident kind of barriers in accessing healthcare for women migrants and women belonging to ethnic minorities. Another major problem is present in those countries where even the formal access is limited because rights are related to the individual's legal and employment status and private health services are very expensive: as a result, a significant number of migrant women and women belonging to ethnic minority groups do not have proper health insurance and therefore medical support.

Adequate health care and health promotion, as well as equal access to health services, are therefore particularly important for migrant women and members of minority ethnic groups. Since the degree of centralisation and of homogeneity in the territory of welfare policies differ across countries, our research has covered both urban and rural contexts, taking into account that residents of rural areas might be characterised by different socio-economic conditions and might face additional obstacles in accessing services. The research has also taken into consideration a regional and national dimension: in Italy, Sweden and the UK, where the national health systems are characterised by relatively high decentralisation levels, the attention has been given also to a sub-national (regional) level, covering the regions of Marche (Italy), South West of England (UK) and Örebro (Sweden). In contrast in Romania the reform and administrative process to reorganise policies and services at the local level is still on-going, and it was therefore decided to carry out the study taking the whole national context into consideration.

In line with the conclusions issued by the World Health Organization in the framework of the promotion of primary care<sup>4</sup>, in each paper the attention has been addressed to four aspects: ethnic minority women's health; their rights and access to health care, looking both at the legal framework and at access in practice; the nature of "good practice", and measures taken to improve the quality of multicultural health care and thus to reduce health inequalities. Health inequalities can cover different health conditions and different ethnic minority groups. They can affect elderly women, Roma women, be generated by employment conditions, or be in the area of sexual and reproductive health. Without disregarding the first three areas, especially in those countries where they are most relevant, the papers in this special issue focus on the latter. In the past two decades, a high proportion of new migrants across Europe have been young adults and families and therefore understanding service access and health outcomes around reproductive health for these women is important.

#### 4. THE "KEY WORDS"

The words included in the title of this special issue are, as usual, not random.

First of all, the "*ethnic minority*" term is not used to define a legal category. Rather, given the lack of a mutually recognised definition of ethnic minorities at the EU level, is used as a wide and purely descriptive term which refers to people not belonging to the ethnic majority, as suggested by the High Level Advisory Group of Experts on the Social Integration of Ethnic Minorities and their Full Participation in the Labour Market (European Commission, 2007b, p. 28). This means that in addition to women belonging to established ethnic minorities (who may be of immigrant and non-immigrant origins, citizens or not),

<sup>4</sup> In line with the conclusions issued by the World Health Organization in the framework of primary care (2008), in [http://www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf).

the research has also covered recent migrants, asylum seekers and/or refugees, the Roma and stateless persons. Even if not all ethnic minorities are in a disadvantaged situation (some being well protected by the national legal frameworks), usually the women in these communities present a higher risk of health inequalities with respect to the women in the native population or the minority men.

Second, “*better health for better integration*” recall to the role that health has in integration. Health is an important aspect of integration in two senses. Migrants who are burdened or handicapped by health problems are hampered in the task of integration. Illness exacerbates marginalisation and marginalisation exacerbates illness, creating a downward spiral. At the same time, integration is a prerequisite for effective health care delivery, which is often impeded by inadequate access. Access to effective health care should be seen as no less important than housing and education for the wellbeing, and thus the integration, of migrants (Ingleby *et al.*, 2005).

However, the relation between health and integration is not as straightforward as it might appear. To be understood, it has to be connected to the issue of acculturation, as opposed to integration, and of *empowerment and equity*. Acculturation does not necessarily lead to better health: for instance, some forms of health-threatening behaviour, such as over-eating, smoking and alcohol abuse, are associated with a “Western” life-style. Moreover, since integration (as opposed to assimilation) is a two-way process, good communication and mutual understanding is essential for effective health. The development of this good relationship is not only the task of the migrant, but of health services that need to be patient-based, able to respond to diverse needs (cultural, linguistic, minority or migration-specific) and to provide care that is more culturally competent (Bishoff, 2003).

Yet, building integration implies a step forward towards *building capacities*, that is towards the empowerment perspective. Empowerment is similar to responsiveness but goes further in enabling migrant and minority patients and communities to participate fully in decision making. This participation not only contributes to increasing integration but also to producing better health outcomes, because it improves what has been recently called “health literacy”, the knowledge, the trust and the capacity to use the health system and to live a healthy lifestyle.

Finally, improving the quality of health care encompasses also in a crucial way the aim of “*equality*”. The health care system or institution is not providing quality of care if it is not doing it for all its patients. Quality in terms of equality is thus a key issue in migrant and minority health. It is also a political issue, to the extent that a national care health system is supposed to provide health care equally well to all its citizens, regardless of socio-economic conditions, gender, ethnicity or legal/illegal status.

## 5. RESULTS: COMMONALITIES AND DIFFERENCES ACROSS COUNTRIES

What are the main results of the research? What the commonalities and differences across countries?

Ethnic minority women in the four countries are diverse in terms of country of origin, age, socioeconomic status, employment, family situation, migration project, and social cohesion. Sweden, whose population is much smaller in size compared with the other countries examined, has a relatively high proportion of foreign born inhabitants. The UK has the second highest (17.1%), followed by Italy (8.8%). The UK has a long history of

migration, whereas in Italy migration is a more recent phenomenon, arising in the last two decades. The GDP per capita and the employment rates of the four countries also vary remarkably: they are particularly high in Sweden, and low in Romania. 40% of the Romanian population is at risk of poverty or social exclusion, explaining why Romania is a country of emigration. A significant part of its migratory outflow is towards Italy, where Romania represents the main country of origin for migrants. On the contrary, the social welfare system of Sweden reduces the risk of poverty and social exclusion, with the UK and Italy following. These countries are also characterised by remarkable internal inequalities in wealth distribution, with the sole exception of Sweden. The difference in total expenditure on health at purchasing power parity per capita is also extremely high, with a clear gap between Romania from one side and Italy, UK and Sweden on the other, as the latter spends almost five times more than the former.

Countries differ interestingly also in their regulatory framework. The United Kingdom, Italy and Sweden all have universal health systems in place, but there are some differences in the regulatory approach, creating potential grounds for actual inequalities. In the UK, despite a universalistic healthcare system, data and research undertaken over the past decades have shown persistent inequalities of access and health outcomes for ethnic minority communities. The UK government has responded by drafting legislation, and policy over the past 40 years to reduce these inequalities. In Italy, despite a national regulation formally granting full access to health care to the migrant population (undocumented migrants included) in reality regional administrations have activated a highly diversified set of policies and services, with a sharp impact on services accessibility and usability. Like the UK, Sweden has a social welfare system which emphasises equal access for all. However, even in Sweden barriers in actual access connected to “cultural mismatch” are evident. Romania, in contrast, adopts an employment-based system that is structurally discriminatory, particularly against the most vulnerable and poor at risk of social exclusion, like Romani women.

The public health care system plays an essential role in promoting and guiding the development of policies and services to tackle health inequalities. The effectiveness of its actions strongly depends on its capacity to develop a cooperative model involving various stakeholders. Our comparative analysis of the major actors involved in addressing ethnic minorities health needs reveals a highly diversified picture, with third sector actors playing a major role, often, when health needs are greater, levels of vulnerability and social exclusion higher, or institutional responses regionally fragmented, as in Italy. In Italy, the public sector has not traditionally worked with other organisations to provide integrated solutions, unlike in the UK and Sweden. In the United Kingdom, third sector organisations have a long history of working with statutory services, and inter-agency practice is more advanced with some organisations receiving funding from statutory bodies. However, recent financial cuts, might threaten the sustainability of this co-operative approach. In Romania, third sector organisations were established in the last two decades, after the end of the Communist regime, and are still developing their capacity and integration within mainstream service provision. In the majority of cases they seem to be the only active sector, in full autonomy and with a very weak connection with the public sphere. In Sweden, the public sector is seen as central within its legal framework, and third sector organisations still tend to play a more secondary role.

Research has demonstrated that differences in formal rights and service access can impact on women's health. Many ethnic minority women have worse health outcomes across

many health conditions, and the severity of these poorer outcomes does appear to differ across the four countries. Both physical and mental illnesses appear to be more widespread amongst the ethnic minority population, women included. In sexual/reproductive health, ethnic minority women seem more at risk of pre-term childbirth, abortion, child health conditions at child birth, maternal mortality. They also have higher levels of gynaecological problems especially amongst trafficked women, and high prevalence of female genital mutilations among asylum seekers. Moreover, everywhere migrants are more at risk of not seeking care or seeking it late. In Italy and the UK, for example, all pre-natal care indicators (examinations, ultrasounds exams, gestational age at first examination, antenatal courses, and obstetric visits) show poorer results for most ethnic minority women indicating that access to these services is more problematic. Yet, policies do matter and such inequalities result less pronounced in the universal Sweden, while maximum in the occupational welfare model in Romania. Policies do matter also in reducing intra-migrant inequalities. Undocumented migrants and asylum seekers are at the worse end of the health spectrum, being also at the worse end of the socio-economic spectrum. Yet, their disadvantage appears less pronounced where rights and actual access to care are more developed.

Within such given regulatory frameworks and amount of resources invested, policies also matters in the development of good practices to tackle barriers in access. The different programmes selected in each country as “good practices” point out the importance of the above discussed integration approach: positive health outcomes have been reached in those programmes that have adopted an empowerment perspective, working both on prevention and care, and both on health literacy of care workers and migrants, through a peer education-peer information system. Such empowerment implies a two-side dialogue, able to build reciprocal cultural understanding and thus to offer “cultural competent” care. The case studies presented in this issue confirm that many migrants are not accustomed to the ways of categorising problems in services and to presenting their difficulties in a way the service provider regards as “appropriate”. Moreover, because of religious beliefs and different gender and motherhood cultures, they might find the existing routines and settings unacceptable. Health care professionals might, on their part, not have an understanding of whether ethnic minorities are entitled to accessing primary and secondary health services. They also might hold preconceptions and negative stereotypes about the characteristics and preferences of particular minority ethnic and religious groups.

Language obviously is the first barriers to breakdown, through appropriate interpreter services. Indeed, a lack of effective communication can influence the health of individuals in many ways: due to real and perceived cultural barriers, lack of provider confidence, lack of patient empowerment and rushed consultations. As the good practices “Gurkha Resettlement Education and Training Project” in the UK or “Lo sapevi che...” in Italy highlight, the acquisition of language and of awareness of rights and services available are important skills that can empower ethnic minority women.

The acquisition of cultural knowledge alongside language can also be empowering for ethnic minority women. Culture and belief systems can affect health related behaviours and in turn health outcomes. They can also affect the way in which women are treated within their own cultural community, particularly with respect to illness and how they might access and use health services. In this reciprocal understanding the gender structures, identities and practices behind observed behaviours need to be further understood and contextualised when for example, information resources are provided or during practitioner interactions. Indeed, together with ethnicity and social class, gender form the basis

of social inequalities in health. Many women arrive in the host country already “marked” by practices such as genital mutilation or domestic violence. In the host country they then tend to be segregated because of gender structures within the labour market and the family. Moreover their access to services can be discouraged by poor information, and by culturally inappropriate models of care (for example, the provision of same sex health professionals or wards). As evident from the good practice “Health Champions project” selected in Plymouth in the UK or the “Health project in Örebro Mosque” in Sweden, a peer-led education approach is essential in order to reach a better “match” between migrant and health services, including “gender models match”. As the project on the “Impact of Multicultural Health Advisors” conducted in Sweden points out, to achieve this “better match” and thus to promote healthier lifestyle choices and a greater service access, it is important to deliver frequent and ongoing community based practice. Projects need to be sustainable and undertaken over a significant time if community trust is to be established and an improvement in both service access and outcomes are to be achieved.

Finally, the improvement of health outcomes for ethnic minority women requires large scale, sustained interagency co-operation across different policy areas. The “Dialogforum” promoted within the good practice “Healthy district project” in Sweden clearly emphasises this: actions have to tackle the root causes of health inequalities including education, employment, housing, environment, gender models. In summary, better health as a precondition and consequence of better integration can be achieved without lying on the health sector alone.

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