Anno XLVII *Economia & Lavoro* *Dialogo 2 pp. 91-101*

UNIVERSAL PROVISION BUT PRACTICAL CHALLENGES IN ACCESS: THE UK CASE

by Nicola Bowtell, Gemma Al-Jassar, Christina Gray, Katie Kelsey, Julia Verne

The UK has a 2000 year history of migration, and Black and Minority Ethnic (BME) groups now make up nearly one fifth of the population in England and Wales, of which over 5 million are women. Inequalities in the health experience of some UK residents, including BME women, has been recognised since 1980, and has led to a sustained commitment over 30 years, to improve service access and health outcomes for everybody. However, despite these policy initiatives, observations reveal there are still inequalities in access and outcomes for some BME women, for example; reproductive health, screening, mental health, and end of life care. Through a literature review and interviews with experts, migrant women and policy makers, this paper aims at exploring the health status of BME women, some of the main barriers to their access to care, and current UK policy initiatives designed to reduce these barriers. The research demonstrates that the development of specialist community based culturally sensitive services alongside the training of health care professionals can help to reduce these inequalities.

Il Regno Unito ha 2000 anni di storia di migrazione, e i neri e le minoranze etniche ora costituiscono quasi un quinto della popolazione in Inghilterra e Galles, di cui oltre 5 milioni sono donne. Le disuguaglianze nella salute sperimentate da alcuni residenti del Regno Unito, tra cui donne migranti, sono state riconosciute dalle autorità pubbliche sin dagli anni Ottanta, con un impegno costante da oltre 30 anni volto a migliorare l'accesso ai servizi per tutti. Tuttavia, nonostante queste iniziative politiche, nel Regno Unito persistono ancora disparità nelle condizioni di salute e nell'accesso ai servizi per le donne nere e appartenenti a minoranze etniche, ad esempio, nella salute riproduttiva, nello screening, la salute mentale e le cure di fine vita. Attraverso una revisione della letteratura e interviste con esperti, donne migranti e politici, questo lavoro si propone di esplorare lo stato di salute delle donne BME (Black and Minority Ethnic Women), alcuni dei principali ostacoli al loro accesso alle cure, e le iniziative di policy destinate ad alleviare queste barriere. La ricerca dimostra che la promozione di servizi di cura culturalmente attenti alle diversità, accanto a una adeguata formazione degli operatori sanitari, possono aiutare a ridurre queste disuguaglianze.

This paper summarises a project conducted in the UK to examine the health of migrant women and the way in which the health services meet their needs. The information presented derives from a literature review and the results of interviews with experts, migrant women and representatives of migrant women and presentations and discussion held at

---

Nicola Bowtell, Public Health England.
Gemma Al-Jassar, Public Health England.
Christina Gray, Bristol City Council.
Katie Kelsey, University of Exeter and consultant at NIACE (National Institute for Adult Continuing Education).
Julia Verne, Public Health England.

two conferences. In particular, the paper looks at: recent data on migration; the health status of ethnic minority women; the factors influencing their health; policy responses to the challenges; health service provision and factors affecting their access to it. We conclude with some recommendations. The UK has a 2,000 year history of migration. Our study focussed on women who migrated to the UK since the second world-war, the eldest of whom will be in their nineties. Migrants have arrived in successive waves for political and economic reasons some seeking political asylum and others a better economic future. The migrant groups include: middle Europeans (who migrated during or after the second world war), Irish from the Republic of Ireland and people from the former colonies of the British Empire such as India, Bangladesh, Pakistan, the Caribbean, South Africa, Uganda, Kenya, and Hong Kong. In recent years, migrants have arrived from Somalia etc. and from the EU 8 countries especially Poland.

1. Ethnic minority populations

In 2011, Black and Minority Ethnic (BME) groups made up 19.5% (10,941,226) of the population in England and Wales, of which 5,535,657 were women. The majority of the usual resident population in the England and Wales, 48.2 million people (86.0% of the population), reported their ethnic group as White in the 2011 Census. Within this group, White British was the largest with 45.1 million (80.5%), followed by Any Other White with 2.5 million people (4.4%). Indian was the next largest ethnic group with 1.4 million people (2.5%) followed by Pakistani (2.0%). The remaining ethnic groups each accounted for up to 2% of the population.

There have been a number of recent changes in ethnic diversity in England and Wales. The "Any Other White" category has had the largest increase across the ethnic groups, with an increase of 1.1 million (1.8 percentage points) between the 2001 and 2011 Censuses. This includes people with Poland as a country of birth, who were the second largest group of non-UK born residents in 2011 and increased by 0.5 million (a nine-fold increase) between 2001 and 2011. The Asian/Asian British ethnic group categories had some of the largest increases between the 2001 and 2011 Censuses. People identifying as Pakistani and Indian each increased by around 0.4 million (0.5 percentage points and 0.6 percentage points respectively). The remaining ethnic groups each showed small increases of up to 1%. Asylum applications during the last decade were at their lowest in 2010 (17,790) following a peak in 2002 (84,130) (Home Office, 2011).

It is not only inward migration which is affecting the ethnic composition of the UK, fertility rates in migrant groups and ageing of migrants in the UK contribute to a constantly changing demographic picture. The high fertility rate in some of the new migrant populations is driving up the absolute fertility rate and the proportion of births to non UK born mothers has been steadily rising in England in the last decade. The number of live births to mothers born outside the UK has increased steadily in the last decade (2000-10) - 97,895 (16.5%) to 181,827 (25.1%), reaching 25% of all births recorded in 2010. The UK is also experiencing a rapid growth amongst its older migrants. Recent work undertaken by the Runnymede and the Centre for policy on ageing (2010) shows that there will be a substantial increase in the number of older people from ethnic minorities. The number of people from ethnic minority groups aged 50 and over is projected to increase from 1.3 million in 2001 and 1.7 million in 2007 to 2.4 million by

2016, 3.8 million by 2026 and 7.4 million by 2051. This is mostly driven by migrants already in the UK who are ageing.

2. THE HEALTH OF MIGRANT WOMEN

In the UK the relationship between ethnicity and health is extremely complex (Karlsen, Nazroo, 2002). Three dimensions – gender, ethnicity and social class – form the basis of social inequalities in health. These dimensions are closely interrelated and are associated with specific risks to health and differential vulnerability during the population's lifetime, before and after migration. The ways in which these interact depend on the empowerment of individuals, organisations and communities. Important determinants of the health of migrant women include: the reasons for migration, the health status of the population prior to migration, their socioeconomic status post migration, and other cultural factors. The ability to communicate and understand how health and other services can be accessed are key determinants to the effectiveness of preventative and health services.

The health of migrants is not necessarily worse than that of their new nation. A small proportion of migrants, usually well-educated migrate to improve their economic or social status. They may have better health than the average for the host nation. This is known as the "healthy migrant effect". This is reinforced in controlled migrations where good health is required to pass comprehensive medical screening before entry. However, it has been observed that sometime after migration, immigrants' and nationals' health patterns converge. This convergence pattern seems to vary across migrant populations and there are variations in health across different BME groups, with asylum seekers at the worse end of the spectrum and those on work visas tending to be at the better end of the health spectrum.

2.1. Risk factors for poor health

Data on wider determinants of health for BME groups in the UK highlight the heterogeneity across BME communities In terms of life-style and other socioeconomic risk factors. In general, women from BME groups are less likely to smoke and drink alcohol than white British women and this has a protective effect on health. However, they are more at risk than their White British counterparts from poor working and housing conditions with some, in particular asylum seekers and undocumented workers experiencing destitution.

We have focused on the working and housing conditions in this paper to highlight some of these issues. There are differences in employment rates and working conditions depending on the type of migrant. A number of studies have explored the working conditions of migrants. These show the exploitative working conditions suffered by many, with undocumented workers at the "sharp end" (McKay *et al.*, 2006). Undocumented migrant workers are often exploited and work in unregulated or sub-standard conditions which have their own health risks (Kelly *et al.*, 2005).

The restricted rights of migrant workers to welfare benefits have meant many have become reliant on the private rented sector for a place to live. Poor living conditions, overcrowding, lack of privacy and concerns about safety and security are everyday experiences for migrants. The problem for refused asylum seekers is much worse and can be described as complete destitution. Research has found that destitution occurs at many points within the asylum process (Smart, 2009). Refused asylum seekers often describe having to leave accommodation early in the morning, unable to return into late at night, to avoid being found on the premises by the accommodation provider. Experiences of sleeping rough were also commonly recounted (Crawley *et al.*, 2011). A recent study undertaken by the Asylum Support Partnership found that nearly half of the destitute asylum seekers visiting voluntary sector agencies had been destitute for more than 6 months, and a third for more than two years (Smart, 2009).

2.2. Health Status

In the past two decades, a high proportion of the migrants to the UK have been young adults and both families from North Africa and the EU-8 countries have had high fertility rates. So much of the research on migrant women's health has focussed on reproductive health. An analysis of migrant mothers showed that 7.1% of mothers born outside the UK giving birth in the UK had no antenatal care, compared to 2.4% of mothers born in the UK (Health Protection Agency, 2011). Black African women have a maternal mortality rate six times that of white women (Lewis, 2007). In addition there are high levels of gynaecological problems especially amongst trafficked women, and high prevalence of female genital mutilation (FGM) among asylum seekers (Aspinall, Watters, 2010).

Recent evidence on access to sexual and reproductive health services highlights the continued inequalities faced by some BME women. The National Health Service's (NHS) commitment to equality in maternity services has been reflected in a wealth of policy initiatives striving to redress these inequalities in experiences and outcomes (Bharj, Salway, 2008).

Ethnic minority women and migrants have also high prevalence rates of mental illnesses. The risk factors are related to pre-migration trauma, the stresses of being a migrant (including "acculturation stress") and the socio-economic conditions in which migrants live in the host country seem to play a role, as well as underlying risk and predisposition to disease. Studies have highlighted higher rates of depression and anxiety among asylum seekers and refugees compared to the national population or other migrant categories (Raphaely, O'Moore, 2010). Other research has found higher levels of anxiety and depression among Gypsies and Travellers, and found these disorders particularly high among female Gypsies and Travellers. A study by McCrone and colleagues (2005) highlights the high prevalence of mental illness among Somalis living in London, with issues ranging from stress and anxiety to suicide. The same study reported that although this community had a high level of needs, the numbers accessing services were low. A recent study reported migrant workers experiencing mental health issues with insecure, low paid work. Consequently migrant workers reported suffering from exhaustion, fever, headaches, sleeping problems, raised blood pressure, anxiety, and depression (Weishaar, 2008).

Some BME groups are prone to specific conditions, for example diabetes and heart disease are especially prevalent in south-east Asians. In England cancer incidence varies by ethnicity too. A recent research found that BME groups investigated were at lower risk of developing cancer than the White ethnic group. However, differences were found for some specific cancer sites. Women from the Asian ethnic group had significantly higher rates for liver, mouth and cervical cancer (over 65s only). Females over 65 years from the black ethnic group had higher rates of cancers of the stomach, liver, cervix and myeloma.

Migration research and policy in the UK has tended to focus on "young" labour migrants, and less attention has been paid to people who migrate in later life or to migrants who have aged in place. The under-investigation of older migrants in the United Kingdom and in other countries can in part be attributed to the low representation of older people in most of the UKs BME population (Nazroo *et al.*, 2004). However, as earlier migrant generations reach old age, the UK is experiencing a rapid growth of the number of BME elders. Census Data shows the rate of life limiting long standing illness is about 50% higher for Pakistani and Bangladeshi and Bangladeshi women than for the White population. The age at migration and the associated duration of residence also impact on the lives of older migrants, with clear differences between those who migrate when young and 'age in place' and those who migrate after retirement (Dwyer, Papadimitriou, 2006). Less is known about the specific health care needs of those migrating in old age. However, one of the few studies noted that older refugee women aged faster due to experiences and high stress, specifically causing high blood pressure and strokes (Ditscheid, 2004).

3. The British Health Service: is there equity in access for ethnic minority women?

3.1. UK policy to tackle health inequalities

Inequalities in the health experience of UK residents including for ethnic minority women have been recognised since the 1980 Black Report. This had led to three decades of research and policy development in the UK attempting to reduce these inequalities. The 1998 Acheson Report noted the persistence of these inequalities and concluded that the solution did not lie with the health sector alone. It recommended action to tackle the root causes of health inequalities including education, employment, housing and the environment. The government of the time responded by developing a national health inequalities strategy, with aimed: to reducing inequalities in infant mortality and life expectancy at birth and to support a long-term sustainable reduction in health inequalities. Other initiatives introduced include Delivering Race Equality in Mental Health, Race for Health and the No Patient Left Behind policy. In addition, added impetus for taking action to reduce gender inequalities has come from the Equality Act 2006. This legislation requires all public bodies not only to ensure that services do not discriminate between men and women but also actively to promote equality of opportunity for both sexes.

In 2010, the state of inequalities in health in England was reviewed again and vast inequalities were found to persist. Despite having a universalistic healthcare system, data and research undertaken over the past decades have shown persistent inequalities of access and health outcomes for BME women.

3.2. The legal framework

The National Health Service (NHS) was established in 1948 and largely provides healthcare free at the point of use. Primary care is the first point of contact for most people receiving NHS care. This is usually delivered by a general practitioner (GP). Secondary care is hospital based care and can either be planned specialist medical care or surgery usually following referral from a GP. Secondary care can also involve emergency hospital care. There are certain types of service in the NHS that are currently free of charge – "free to all" – irrespective of country of normal residence such as emergency treatment at any Accident and Emergency (A&E) department; family planning services; treatment for communicable diseases and for sexually transmitted infections (including HIV); and some mental health conditions.

Entitlement to free NHS hospital treatment is based on “ordinary residence” in the UK, not nationality. Ordinary residence means, broadly, living in the UK on a lawful and properly settled basis. Being registered with or referred by a GP, or payment of UK taxes or national insurance does not override this “ordinary resident” status. Asylum seekers in England who have not had their claim refused (including those who had an appeal outstanding) are entitled to free secondary health care. Those who have had their claim refused but are receiving specific support from the UK Border government suggest implementing a revised definition of qualifying residency, with current residence with indefinite leave to remain for non-European Economic Area (EEA) migrants a necessity for entitlement.

3.3. Access in practice

There has been widespread concern that some of the UK’s health services fail to adequately meet the needs of our BME populations. However, assessing whether the uptake of services across ethnic groups is inequitable is difficult (Aspinall, Jacobson, 2004) and the evidence in this field is limited. Studies exploring service use of primary and secondary care must take into account service need before conclusions on take-up can be concluded. Assessing the appropriateness or effectiveness of these services is even more complex and will often need to take account of potential ethnic variation in preferences and incorporate patient-defined outcomes (Astin, Atkin, 2010).

When looking at access to primary health care services for all ethnic minority (recent and established migrant groups), analysis has shown that people from BME groups are more likely than the White British population to see their general practitioners (GP), but less likely to access more specialist services. Nazroo and colleagues (2009) found that Black Caribbean, Indian, Pakistani and Bangladeshi respondents were more likely to have visited their GP.

In contrast, there is evidence that Gypsies and Travellers and also asylum seekers and refugees have poorer access to general practitioners (GPs) and other primary care services. Parry and Van Cleemput (2004) reported severe difficulties in registering with a GP among Gypsies and Travellers. They found that 16% of their respondents were not registered with a GP either where they were living or elsewhere, and the proportion was as high as 38% for those living in trailers or empty land and 37% for those who travel all year round.

When looking at access to secondary health care and screening programmes, we also see inequalities of access. Although the NHS Breast Screening Programme does not collect data on the ethnicity of women, a number of studies undertaken in England have identified variability in screening uptake by BME communities (Scanlon, Wood, 2005; Webb *et al.*, 2004), with the lowest levels amongst asylum seekers and refugees (Aspinall, Watters, 2010). Pfeffer (2004) identified that ethnic identity, social norms, religious faith and sex of the healthcare worker influenced screening rates. Thomas and colleagues (2005) found BME women lacked knowledge about cancer, all cancers were feared, and did not attend screening because they feared the revelation of fatal disease.

There is evidence that BME patients may be less likely to be referred for specialist or follow-up services. Nazroo and colleagues (2009) found significantly lower levels of hospital utilisation among Indian, Pakistan, Bangladeshi and Chinese respondents. Aspinall and Watters (2010) go further concluding that there are persistent concerns that a lack of clarity on the ground is leading to the withholding of essential care in a minority of cases.

Research has highlighted inequalities also in access to palliative care services for BME groups. Recent research has shown that GPs and hospital consultants are less likely to refer people of BME backgrounds to hospice inpatient and day-patient care. Referrals depended on both the potential service user and the health professional being knowledgeable about the nature and availability of services, and their potential to meet individual needs. A common theme in the literature on palliative care services is that health professionals require education in cultural sensitivity and the development of cultural competence.

Older refugees, and especially older women refugees, faced particular problems in accessing health services. They may be resistant to approaching public authorities due to their experiences in exile, or of discrimination in their country of settlement (Saunders, 2004). They may also feel insecure due to loss of social status, difficulty in contributing financially and lacking social networks. This can lead to dependence on younger generations and, in extreme cases, to violence against older refugees, triggered by dependency and isolation and mostly affecting women (Saunders, 2004). For older family joiners, in the early years at least, access to welfare services is shaped by their right to reside being subject to continuing family support and 'no recourse' to public welfare (Seddon *et al.*, 2002).

There are several possible reasons behind the lower access of migrants to health services. The socio-economic status of the women has been shown to be an important predictor of access to antenatal care. Regression analysis showed the strongest predictors of no antenatal care were not whether born in the UK or ethnic group, or for migrants, length of residence in the UK, but socio demographic factors such as younger age, lower educational levels and occupational class and living in a ward where at least 30% of the population were from BME groups, (Jayaweera, Quigley, 2010).

The quantity and quality of information provided to some BME women is another barrier highlighted in the literature. A survey of mothers giving birth over a two week period in England revealed that compared to White women born in the UK, BME women born outside the UK booked for antenatal care later, had poorer information provision and were less likely to be treated with respect by staff (Redshaw, Heikkila, 2010).

Inequalities in access to services can also be due to "cultural mismatch" – perception that they may not be understood because of language barriers, cultural and lifestyle differences, and finally definitions of illnesses and of what is "appropriate" care. For example, in a study looking at differential access to hospital and follow-up treatments for Cardiovascular Disease, Sekhri and colleagues (2008) concluded that at an early stage after presentation with suspected angina, coronary angiography is underused in South Asians (as well as in older people, women and people from deprived areas). Uptake of cardiac rehabilitation is also lower among minority ethnic groups, women and those from lower socioeconomic groups (Bethell *et al.*, 2009). People who do not speak English face particular barriers and there is limited provision of culturally appropriate cardiac rehabilitation services (Astin, Atkin, 2010).

4. BARRIERS AND POLICY RESPONSES

There is a growing body of research evidence relating to access to and use of health care among migrants in the UK. Issues identified include: inadequate information, particularly for new migrants unfamiliar with health care systems in the UK, insufficient support in interpreting and translating for people, lack of access to reliable transport especially for recent migrants, confusion around entitlement to certain services particularly among migrants with insecure immigration status, and cultural insensitivity of some health care providers (Phillimore, Goodson, 2010). Some of these barriers, in particular language and transport, appear to cut across length of residence, affecting longer established migrants as well.

4.1. Language barriers

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 (Mir, 2008). Language barriers can lead to poor provider patient communication. Inadequate access to interpreting services and translated information is a widespread problem for many BME women, particularly those who are recent migrants and older people (Aspinall, Watters, 2010; Allmark *et al.*, 2010). As just mentioned, a population based survey of mothers revealed that compared to white women born in the UK, women born outside the UK had poorer information provision and were less likely to be treated with respect by staff (Redshaw, Heikkila, 2010).

Language barriers are a difficulty faced by health professionals interacting with ethnic minority individuals. GPs report increased pressure of work resulting from patients who cannot speak English and who may manifest multiple problems, with health only presenting part of the broader social problems, as social aspects of an individual's life could be contributing to health related issues.

The acquisition of language is an important skill that can empower BME women. The Gurkha Resettlement Education and Training Project in the UK is an example of good practice in this field. This project aims to develop and deliver excellent language education to Gurkha spouses and their families. Not only to those who used the service improve their language skills, they also improved their awareness of services, and how to access them.

4.2. Cultural influences on health

Culture and belief systems affect health through health-related behaviours (for example, smoking, drinking alcohol, diet, exercise, sexual behaviour, concepts of health, images of the body, etc.) Unsurprisingly, these behaviours vary across ethnic groups with different ethnic groups exhibiting different behaviours which contribute to increased health risks. Reported health behaviours of migrants on arrival may change over time. Cultural and belief systems not only affect life-style but also the way in which women are treated within their cultures with respect to illness and how they interact with health services. Because of different gender cultures, the provision of same sex providers and single-sex facilities are indicated as essential for women from some BME groups. Pfeffer (2004) identified that ethnicity, social norms, religion and the sex of the healthcare professional influenced cancer screening rates. Mir and Sheikh (2010) found evidence of Pakistani women suffering humiliation when being forced to accept care from male health professionals as well as opting not to take up recommended exercise programmes when those on offer were of mixed sex.

Different gender cultures and social perception on legitimacy of traditional gender roles and power within marriages affect the way women from ethnic minorities report issues such as domestic violence. Concerns about family and community "honour" can also deter victims from reporting abuse. Furthermore, there appears to be low recognition of the needs of BME women experiencing domestic violence when developing services (Gill, Banga, 2008). Victims of domestic violence and in particular, those who do not have "Indefinite Leave to Remain", or those whose immigration status is linked to an abusive partner find it particularly difficult to access support.

4.3. The role of health care professionals

There are a range of institutional (public) services made available to support the health of ethnic minority individuals at national, regional and local level. However there is an issue in making these services known to individuals from BME groups and further issues in individuals feeling able to access them effectively. Health care professionals (HCP's) are individuals who provide such information.

HCP's experience a number of difficulties when dealing with individuals from ethnic minorities. Evidence suggests that HCP's do not have an understanding of whether ethnic minorities are entitled to accessing primary and secondary health services, which are dependent on their immigration status. They also might not have an understanding of ethnic minorities' specific cultures, including expectations and attitudes on "proper" gender roles and "proper" standards and types of care (Johnson, 2003).

A common theme in the research evidence is that ethnic minorities can feel unwelcome and isolated from services and that some providers are dismissive and disrespectful in general terms (Worth *et al.*, 2009). Providers have been found to hold preconceptions and negative stereotypes about the characteristics and preferences of particular minority ethnic and religious groups, as well as racism, in some cases leading to the withholding of particular interventions or treatments (Davies *et al.*, 2009).

Due to a lack of relationship occurring between health professionals and ethnic minority individuals, Johnson (2007) has argued that suspicion of authority figures may lead to resistance to registration, concealment of information and avoidance of services intended to be health promoting, such as screening and immunisation. This can affect practices' ability to meet targets and can mean some practices are unwilling to accept migrants as patients.

There is evidence to suggest that the failure of services and individual practitioners to understand and accommodate patient's cultural and religious beliefs, preferences and behaviours does, in some cases, lead to sub-optimal care and may exacerbate levels of ill-health. HCP's may require education with regards to the culture of individuals from ethnic minorities, including gender cultures. Health professionals will then be more able to provide the information and services that such individuals need.

5. Examples of good practice

A number of peer led health education programmes have developed in England and the rest of the UK to try and overcome some of the barriers to accessing health services amongst BME women. Health Champions project in Plymouth is one of these projects, working with women from a wide range of BME groups. Many of these women had been previously isolated, and some had experienced domestic violence, and psychological bullying. There were three key outputs for this project. Firstly, a community health radio programme was delivered in several languages including, Romanian, Chinese, French, Farsi, Arabic and Kurdish. Secondly, a breast screening awareness and self-examination DVD was developed in five languages (English, Farsi, Kurdish, Arabic, and Mandarin). Finally, they trained two Community Health Champions teams. The role of the health trainer is integral to the success of this project. Their remit is to provide personalized one-to-one support, encouragement and motivation to individuals to make and sustain positive lifestyle choices.

Another area where policy is developing in the UK is in the provision of specialist health and social care services for older ethnic minority women. The literature points to cultural barriers being central to access issues for elderly BME women. Many families feel uncomfortable about having a family member being looked after by professionals rather than by people who know them (Bell, Casebourne, 2008). Furthermore, communities feel that the care provided will not be culturally appropriate (Craig *et al.*, 2007). This belief can be reinforced by a lack of good information about available services (Blood, Bamford, 2010).

Research exploring the needs of older migrant women and appropriate policy responses point towards the need to enable roles of informal community and faith networks, since older BME women prefer assistance from women within their own cultural community (Cook *et al.*, 2010). One example is the Black Carers Project in Bristol. This project aims to relieve the mental and physical distress amongst the black carers of people who are in need of care and are resident in Bristol by providing: information, advice, training, outreach and development services; a forum which brings together carers in order to determine their needs; and advocacy for services relevant to the needs of ethnic minority carers. The work offered by Bristol Black Carers is wide and varied. It can be simply dealing with a telephone enquiry to provide the name of a contact or organisation for a carer to approach directly. At the other end of the spectrum they can receive referrals for clients with complex and multiple problems. These involve undertaking a needs assessment followed by appropriate referrals. This could be practical help to find a career with equipment to help them in their caring duties or an adaptation to their home, or it could be help in accessing respite care or assistance with ensuring they receive all the relevant financial benefits to which they are entitled. This is particularly important for those carers who do not understand or speak English well. One of the important aspects of the service is its ability to deliver services that are culturally sensitive to the client group. Bristol Black Carers maintain on-going support and make follow-up visits to carers.

The service offers support for all black and ethnic minority carers and those engaged with the service come from a large range of ethnic backgrounds. The majority come from Somali, Afro-Caribbean, Black African and South East Asian origins. Currently Bristol Black Carers have around 400 carers on their database who have accessed support.

6. CONCLUSIONS

Many women from Black and Minority Ethnic groups face challenges to achieving the same health status as White British women. Three decades of research and policies have led to a greater understanding of the diverse needs of BME women and to improvements in the way health services are provided. However, health services still do not adequately meet the needs of individuals from some BME groups (Akin, Chattoo, 2007). Changes made to asylum welfare support, may have compounded these issues (Bloch, Schuster, 2005).

Whilst many barriers discussed in this paper are common to both men and women from ethnic minority groups, they can often impact to a greater extent on women because of cultural norms. Over the last few decades many community groups, charities and social enterprises have been set up to provide support to refugee, migrant and ethnic minority women, however there are still many communities where this service provision is patchy, and this is especially true of less diverse and rural communities. Furthermore, many of these services receive grant funding and providers have found it difficult to sustain them, when funding has been reduced. Research conducted by the Women's Resource Centre (2007), and findings from the Thirty-Second Report of the Working Group with the voluntary Sector (2006), found that London-based ethnic minority women's organisations have experienced long-term instability.

Despite there being many initiatives in place to tackle health inequalities, interventions still need to develop to encompass theory-based strategies to change health behaviours (Aboud, 2009). There is some consensus that it is important to address deep-rooted influences on health behaviour in "at risk groups", including cultural influences and structural factors. They have distinguished between interventions adapted at a "surface structure" and those adapted at a "deep structure". The former match interventions to observable characteristics such as people and language, while the latter engage with cultural, social, environmental and psychological forces. Whilst the former will increase the "receptivity" of health-related messages, it is only the latter which will impact on behaviour change.

In particular interventions still need to better address the lower levels of awareness and poor access to health promoting information among minority ethnic groups. While this in part relates to language barriers, obstacles to gaining access to the necessary information to make informed decisions do not appear to be confined to non-English speakers (Allmark *et al.*, 2010; Hawthorne *et al.*, 2008; Waller *et al.*, 2009; Chauhan *et al.*, 2010). As one of the good practice selected – The Health Champions – has demonstrated, clearly there are multiple routes through which individuals can access health-related information, and preferences for particular modes of communication will vary between groups. A peer led health education for migrants and a training for health care professionals in order to "deconstruct" preconceptions and stereotypes and to increase the understanding of ethnic minority women's cultures and habits are crucial to improve service access and health outcomes.

REFERENCES

ABOUD F. (2009), *Editorial Virtual Special Issue: Health Behaviour Change*, "Social Science & Medicine", http://www. elsevier.com/social-sciences/editorial-virtual-special-issue-health-behaviour-change

ADANU R. M., JOHNSON T. R. (2009), *Migration and Women's Health*, "International Journal of Gynaecology and Obstetrics", 106, pp. 179-81.

ALLMARK P., BRITAIN G. (2010), *Ethnic Minority Customers of the Pension, Disability and Carers Service: An Evidence Synthesis*, Leeds, Department of Work and Pensions.

APRE – AGENZIA PER LA PROMOZIONE DELLA RICERCA EUROPEA (2011), *Worskshop Migrazione e Genere. Esperienze e conoscenze a confronto*, disponibile all'indirizzo http://www.unisi.it/dl2/20110218110059832/genderemigrazioni.pdf.

ASPINALL P. J., JACOBSEN B. (2004), *Ethnic Disparities in Health and Health Care: A Focused Review of the Evidence and Selected Examples of Good Practice: Executive Summary*, London, London Health Observatory.

ASPINALL P. J., WATTERS C. (2010), *Refugees and Asylum Seekers: A Review from an Equality and Human Rights Perspective*, Equality and Human Rights Commission. Research Report, n. 52.

ASTIN F., ATKIN K. (2010), *Ethnicity and Coronary Heart Disease: Making Sense of Risk and Improving Care*, London, Race Equality Foundation. Better health briefing paper, n. 16.

ATKIN K., CHATTOO S. (2007), *The Dilemmas of Providing Welfare is an Ethnically Diverse State: Seeking Reconciliation in the Role of a "Reflexive Practitioner"*, "Policy & Politics", 35, 3, pp. 377-93.

BALAAM M.-C., AKERJORDET K., LYBERG A., KAISER B., SCHOENING E., FREDRIKSEN A.-M., ENSEL A., GOUNI O., SEVERINSSON E. (2013), *A Qualitative Review of Migrant Women's Perceptions of their Needs and Experiences Related to Pregnancy and Childbirth*, "Journal of Advanced Nursing", 69, 9, pp. 1919-30.

BARALDI C., BARBIERI V., GIARELLI G. (a cura di) (2008), *Immigrazione, mediazione culturale e salute*, Franco Angeli, Milano.

BARBAGLI – MINISTERO DELL'INTERNO (2007), *Primo rapporto sugli immigrati in Italia*, disponibile all'indirizzo http://www.interno.it/mininterno/export/sites/default/it/assets/files/15/0673_Rapporto_immigrazione_BARBAGLI.pdf, p. 101-6.

BARTOLI C. (2012), *Razzisti per Legge. L'Italia che discrimina*, Laterza, Roma-Bari.

BELL L., CASEBOURNE J. (2008), *Increasing Employment for Ethnic Minorities: A Summary of Findings*, National Audit Office, London.

BETHEL H., LEWIN R., DALAL H. (2009), *Cardiac Rehabilitation in the United Kingdom*, "Heart", 95, 4, p. 271.

BHARJ K. K., SALWAY S. M. (2008), *addressing Ethnic Inequalities in Maternity Service Experiences and Outcomes: Responding to Women's Needs and Preferences*, Better Healt Briefing 11. A Race Equality Foundation Briefing Paper, Race Equality Foundation, London.

BISCHOFF A. (2003), *Caring for Migrant and Minority Patients in European Hospitals. A Review of Effective Interventions*, A study commissioned by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine, MFH – Migrant Friendly Hospitals, a European initiative to promote health and health literacy for migrants and ethnic minorities, Wien.

BLANGIARDO G. C. (2009), *La presenza straniera in Italia*, in *XV e XVI Rapporto sulle migrazioni, 2009 e 2010*, ISMU, Milano, disponibile all'indirizzo http://www.ismu.org/?page=490#.

BLOCH A., SCHUSTER L. (2005), *Asylum Policy under New Labour*, "Benefits", 13, 2, pp. 115-8.

BLOOD L., BAMFORD S.-M. (2010), *Equality and Diversity and Older People with High Support Needs*, UK International Longevity Centre,London.

BOLDRINI R., DI CESARE M. (2011), *Certificati di assistenza al parto (CEDAP). Analisi dell'evento nascita*, Anno 2008, Ministero della Salute.

BOLLINI P., PAMPALLONA S., WANNER P., KUPELNICK B. (2009), *Pregnancy Outcome of Migrant Women and Integration Policy: A Systematic Review of the International Literature*, "Social Science & Medicine", 68, pp. 452-61.

BONIZZONI P. (2009), *Famiglie globali. Le frontiere della maternità*, UTET, Torino.

CAPONIO T., COLOMBO A. (2011), *Migrazione, separazione coniugale e ruoli di genere: il caso delle lavoratrici domestiche in Italia*, "Polis", 3, pp. 419-48.

CARCHEDI F., TOLA V. (a cura di) (2008), *All'aperto e al chiuso: prostituzione e tratta. I nuovi dati del fenomeno, i servizi sociali, le normative di riferimento*, Roma, EDIESSE.

CARITAS-MIGRANTES (2011), *Dossier Statistico Immigrazione 2011, 21° Rapporto*, Caritas-Migrantes, Roma.

CARLETTI P. (a cura di) (2009), *La salute della popolazione immigrate: metodologia di analisi*, Ancona, Osservatorio Diseguaglianze Regione Marche, disponibile all'indirizzo http://www.ars.marche.it/osservatorio_dis/doc/pubb_SaluteImmigrati2009.pdf.

CEEN (2006), *Assessment of the Health* Status *of Roma and the Related Health Care Need*, CEEN Economic Project & Policy, Consulting GmbH.

CHAUHAN U., BAKER D., LESTER H., EDWARDS R. (2010), *Exploring Uptake of Cardiac Rehabilitation in a Minority Ethnic Population in England: A Qualitative Study*, "European Journal of Cardiovascular Nursing", 9, 1, pp. 68-74.

COOK J., MALTBY T., WARREN L. (2010), *A Participatory Approach to Older Women's Quality of Life*, in A. Walker, C. Hagan Hennessy (eds.), *Growing Older: Quality of Life in Old Age*, Open University Press, Maidenhead, pp. 149-66.

CORETTA P. (2011), *Institutional Racism and Ethnic Inequalities: An Expanded Multilevel Framework*, "Journal of Social Policy", 40, pp. 173-92.

COUNCIL OF EUROPE (2012), *Human Rights of Roma and Travellers in Europe*, Council of Europe Publications, Strasbourg.

COUNCIL OF EUROPE – EUMC (2003), *Breaking the Barriers: Romani Women and Access to Public Health Care*, available at http://fra.europa.eu/fraWebsite/attachments/ROMA-HC-EN.pdf.

CRAIG G., GAUS A., WILKINSON M., SKRIVANKOVA K., MCQUADE A. (2007), *Contemporary Slavery in the UK: Overview and Key Issues*, The Joseph Rowntree Foundation, York.

CRAWLEY H., HEMMINGS J., PRICE N. (2011), *Coping with Destitution: Survival and Livelihood Strategies of Refused Asylum Seekers Living in the* UK, Oxfam, London.

DAVIES M., ELWYN G., PAPADOPOULOS I., FLEMING L., WILLIAMS G. (2009), *Can Promoting Patient Decision Making be Exclusionary? Moral Expectations and Cultural Differences in the Narratives of* UK *Maternity Clinicians*, "Communication & Medicine", 6, 1, pp. 39-48.

DEV A., ZHURI G., PANA B., TRIPHATI V. (2004), *Tuberculusis Partnership Project-Romania. Doctors at the World_*USA, http://pdf.usaid.gov/pdf_docs/pdaca983.pdf.

DIREZIONE GENERALE DIRITTO ALLA SALUTE E POLITICHE DI SOLIDARIETÀ (2012), *Coordinamento Interregionale in Sanità. Tavolo interregionale "Immigrati e Servizi Sanitari"*, Ancona, Osservatorio sulle Disuguaglianze nella Salute. Indicazioni per la corretta applicazione della normativa per l'assistenza sanitaria alla popolazione straniera da parte delle Regioni e Province Autonome italiane. Giugno 2011, disponibile all'indirizzo http://www.immigrazioneoggi.it/rubriche/salute/docs/sanita_regioni_autonome.pdf.

DITSCHEID C. (2004), *Older Refugee Women*, "Refugee Women's News", 26, January and February.

DWYER P., PAPADIMITRIOU D. (2006), *The Social Security Rights of Older International Migrants in the European Union*, "Journal of Ethnic and Migration Studies", 32, 8, pp. 1301-19.

ECLEMEA I. (2010), *Management Financiar în sănătate – secţiune de formare realizată în cadrul proiectului Competenţe în administrare şi gestiune pentru sectorul de sănătate publica.*

EGGSI (2010), *Ethnic Minority and Roma Women in Europe: A case for gender equality?* available at http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=492&type=2&furtherPubs=no.

EKBLAD S., LINDENCRONA F., SHAHNAVAZ S. (2009), *Promoting Mental Health and Preventing Mental Disorder among Refugees in Western Countries*, "International Journal of Mental Health Promotion", 11, pp. 33-44.

EKÉUS C., CNATTINGIUS S., ESSÉN B., HJERN A. (2011), *Stillbirth among Foreign-born Women in Sweden*, "European Journal of Public Health", 21, pp. 788-92.

ERIKSSON C., JÄRLIDEN E., LARSSON A., SANDBERG S. (2010), *Partnerskap för hållbar välfärdsutveckling – Utveckling och forskning under sex år i fyra städer (Partnership for Sustainable Welfare Development – Research and Development for Six Years in four Cities)*, "Studier i folkhälsovetenskap", 2, Örebro universitet.

ESSCHER A., HAGLUND B., HÖGBERG U., ESSÉN B. (2013), *Excess Mortality in Women of Reproductive Age from Low-income Countries: A Swedish National Register Study*, "European Journal of Public Health", 23, 2, pp. 274-9.

ESSEN B., BÖDKER B., SJÖBERG N. O., LANGHOFF-ROOS J., GREISEN G., GUDMUNDSSON S., OSTERGREN P. O. (2002), *Are Some Perinatal Deaths in Immigrant Groups Linked to Suboptimal Perinatal Care Services?*, "BJOG", 109, pp. 677-82.

ESSEN B., BÖDKER B., SJÖBERG N. O., GUDMUNDSSON S., OSTERGREN P. O., LANGHOFF-ROOS J. (2002), *Is there an Association between Female Circumcision and Perinatal Death?*, "Bulletin of World Health Organisation", 80, 8, pp. 629-32.

EUROPEAN COMMISSION (2007a), *Opinion on the Gender Dimension of the Inclusion of the Ethnic Minorities*, DG Employment, Social Affairs and Equal Opportunities, Advisory Committee on Equal Opportunities for women and men, Luxembourg.

ID. (2007b), *Ethnic Minorities in the Labour Market: An Urgent Call for Better Social Inclusion*, December, Luxembourg.

EUROPEAN WOMEN'S LOBBY POSITION PAPER (2012), *Tackling Multiple Discrimination of Romani and Traveller Women – A Crucial Factor for the Successful Implementation of the National Roma Integration Strategies*, available at http://www.womenlobby.org/spip.php?article4454&lang=en.

FEDYUK O. (2012), *Images of Transnational Motherhood: The Role of Photographs in Measuring Time and Maintaining Connections between Ukraine and Italy*, "Journal of Ethnic and Migration Studies", February, pp. 279-300.

FLECK G., RUGHINIȘ C. (eds.) (2008), *Vino mai aproape – incluziunea și excluziunea romilor în societatea româneasca de azi*, Human Dynamics, http://www.academia.edu/285917/Vino_Mai_Aproape_Incluziunea_si_Excluziunea_Romilorì_in_Societatea_Româneasca_De_Azi

FRA – EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS (2013), *Inequalities and Multiple Discrimination in Access to and Quality of Health Care*, available at http://fra.europa.eu/sites/default/files/inequalities-discrimination-healthcare_en.pdf.

FRA – EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, UNDP – UNITED NATIONS DEVELOPMENT PROGRAMME (2012), *The Situation of Roma in 11 EU Member States: Survey Results at a Glance*, available at http://fra.europa.eu/sites/default/files/fra_uploads/2099-FRA-2012-Roma-at-a-glance_EN.pdf.

GERACI S., BONCIANI M., MARTINELLI B. (2010), *La tutela della salute degli immigrati*, Roma, Caritas, disponibile all'indirizzo http://www.stranieriinitalia.it/briguglio/immigrazione-e-asilo/2010/luglio/rapp-caritas-salute-2010-1.pdf.

GILL A., BANGA B. (2008), *The Reality and Impact of Domestic Violence, Crime and Victims Act 2004 on BMER Women Experiencing Gender-based Violence. Safe*, "Journal of Domestic Abuse", 25, Spring.

GLICK SCHILLER N., BASH L., SZANTON-BLANC C. (1992), *Towards a Transnational Perspective on Migration*, New York, New York Academy of Sciences.

GOVERNMENT OF ROMANIA (2001), *Governmental Strategy for Improve the Rome Condition*, printed in the official gazette no. 252, May 16.

ID. (2005a), *Joint Memorandum on Social Inclusion of Romania*, Brussels.

ID. (2005b), *2007-2013 National Development Plan*, available at http://erawatch.jrc.ec.europa.eu/erawatch/opencms/information/country_pages/ro/policydocument/policydoc_0009, Brussels.

ID. (2012), *Strategy of the Government of Romania for the Inclusion at the Romanian Citizens belonging to Roma Minority for the Period 2012-2020*, http://ec.europe.eu/justice/discrimination/files/rome_romania_strategy_en.pdf, Brussels.

GRIGORAȘ V., RUGHINIȘ C., VOICU M., VOICU O. (2007), *Barometrul Incluziunii Romilor Roma Inclusion Barometer*, Open Society Foundation, Bucharest.

HAWTHORNE K., ROBLES Y., CANNINGS-JOHN R., EDWARDS E. G. K. (2008), *Culturally Appropriate Health Education for Type 2 Diabetes Mellitus in Ethnic Minority Groups*, "Cochrane database of systematic reviews", 3.

HEALTH PROTECTION AGENCY (2011), available at http://www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1317131998682

HEDLUND E., LANGE A., HAMMAR N. (2007), *Acute Myocardial Infarction Incidence in Immigrants to Sweden. Country of Birth, Time since Immigration, and Time Trends over 20 Years*, "European Journal Epidemiology", 22, pp. 493-503.

HJERN A., HAGLUND B., PERSSON G., ROSÉN M. (2001), *Is there Equity in Access to Health Services for Ethnic Minorities in Sweden?*, "European Journal of Public Health", 11, 2, pp. 147-52.

HOME OFFICE (2011), *Control of Immigration: Quarterly Statistical Summary*, United Kingdom, Quarter 4 (October-December), Home Office, February.

HONDAGNEU-SOTELO P., AVILA E. (1997), *I'm Here, but I'm There: The Meaning of Latina Transnational Motherhood*, "Gender & Society", 11, pp. 548-71.

INGLEBY D., CHIMIENTI M., ORMOND M., DE FREITAS C. (2005), *The Role of Health in Integration*, in M. L. Fonseca, J. Malheiros (eds.), *Social Integration and Mobility: Education, Housing and Health*, IMISCOE Cluster B5 State of the art report, Estudos para o Planeamento Regional e Urbano n. 67, Centro de Estudos Geográficos, Lisbon, pp. 88-119.

ISTAT – ISTITUTO NAZIONALE DI STATISTICA (2002), *Flussi migratori e popolazione straniera, Anni 1990-1998*, ISTAT, Roma.

ID. (2010), *La popolazione straniera residente in Italia al 1 gennaio 2010*, disponibile all'indirizzo http://www.istat.it/salastampa/comunicati/non_calendario/20101012_00/testointegrale20101012.pdf.

ID. (2011), *La popolazione straniera residente in Italia: 1 gennaio 2011*, disponibile all'indirizzo http://www.istat.it/it/archivio/39726.

JAROKA L. (2013a), *Working Document on Gender Aspects of the European Framework of National Roma Inclusions Strategies Committee on Women's Rights and Gender Equality*, Committe on Women's Rights and Gender Equality, European Parliament, Brussels, http://www.europarl_europa.eu/sides/getDoc.do?pubRef=_%2FEP%2FNONSGML%2BCOMPARL%2BPE-516.873%2B01%2BDOC%2BPDF%2BV0%2F%2FEN

ID. (2013b), *Draft Report on Gender Aspects of the European Framework of National Roma Inclusion Strategies (2013/2066 [INI])*, Committee on Women's Rights and Gender Equality, European Parliament, http://www.europarl_europa.eu/sides/getDoc.do?pubRef=_%2F%FEP%2F%2FNONSGML%2BCOMPARL%2BPE-516.873%2B01%2BDOC%BPDF%2BVO%2F%2FEN

JAYAWEERA H., QUIGLEY M. A. (2010), *Health Status, Health Behaviour and Healthcare Use Among Migrants in the UK: Evidence from Mothers in the Millennium Cohort Study*, "Social Science & Medicine", 71, pp. 1002-10.

JIMÉNEZ-RUBIO D., HERNÁNDEZ-QUEVEDO C. (2011), *Inequalities in the Use of Health Services between Immigrants and the Native Population in Spain: What is Driving the Differences?*, "The European Journal Health Economics", February, 12, 1, pp. 17-28.

JOHNSON M. R. D. (2003), *Asylum Seekers in Dispersal*, Healthcare issues, Home Office online Report 13/03, Home Office, London.

ID. (2007), *Researching the Health of Ethnic Minority Groups*, "Researching health: Qualitative, quantitative and mixed methods".

KARLSEN S., NAZROO J. Y. (2002), *Agency and Structure: The Impact of Ethnic Identity and Racism on the Health of Ethnic Minority People*, "Sociology of Health and Illness", 24, pp. 1-20.

KELLY R., MORRELL G., SRISKANDARAJAH D. (2005), *Migration and Health in the UK*, an IPPR FactFile.

KOFMAN E. (2004), *Family-Related Migration: A Critical Review of European Studies*, "Journal of Ethnic and Migration Studies", 30, pp. 243-62.

KOFMAN E., RAGHURMA P. (2012), *Genere, migrazione e lavoro di cura nel Sud globale*, in F. Piperno, M. Tognetti Bordogna (a cura di), *Welfare transnazionale. La frontiera esterna delle politiche sociali*, EDIESSE, Roma.

LAURIA L., ANDREOZZI S. (a cura di) (2009), *Percorsi nascita e Immigrazione in Italia. Le indagini del 2009*, ISTISAN, Roma.

LEWIS G. (2007), *The Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer-2003-2005*, CEMACH, London.

MAHLER S. J. (2001), *Transnational Relationships: The Struggle to Communicate across Borders*, "Identities: Global Studies in Culture and Power", 7, pp. 83-619.

MALMUSI D., BORRELL C., BENACH J. (2010), *Migration-related Health Inequalities: Showing the Complex Interactions between Gender, Social Class and Place of Origin*, "Social Science & Medicine", 71, 9, pp. 1610-9.

MANFELLOTTO D. (2002), *Case Study 5: From Misinformation and Ignorance to Recognition and Care: Immigrants and Homeless in Rome, Italy*, in WHO – World Health Organisation, *Health Systems Confront Poverty*, World Health Organisation Regional Office for Europe, Geneva, pp. 69-78.

MCCRONE P. *et al* (2005), *Mental Health Needs, Service Use and Costs among Somali Refugees in the UK*, "Acta Psychiatrica Scandinavica", 111, pp. 351-7.

MCKAY S., CRAW M., CHOPRA D. (2006) *Migrant Workers in England and Wales: An Assessment of Migrant Workers Health and Safety Risks*, Health & Safety Executive, London.

MENJIVAR C. (2006), *Family Reorganization in a Context of Legal Uncertainty: Guatemalan and Salvadoran Immigrants in the United States*, "International Journal of Sociology of the Family", 32, pp. 223-45.

MIR G. (2008), *Effective Communication with Service Users*, "Ethnicity and Inequalities in Health and Social Care", 1, 1, pp. 71-8.

MIR G., SHEIKH A. (2010), *Fasting and Prayer don't Concern the Doctors... They don't even Know what it is': Communication, Decision Making and Perceived Social Relations of Pakistani Muslim Patients with Long-term Illnesses*, "Ethnicity & Health", advance access.

MLADOVSKY P. (2009), *A Framework for Analysing Migrant Health Policies in Europe*, "Health Policy", V, 93, 1, 55-63.

MOISĂ F., ROSTAS I. A., TARNOVSCHI D., STOIAN I., RĂDULESCU D., ANDERSEN T. S. (2013), *Civil Society Monitoring on the Implementation of the National Roma Integration Strategy and Decade Action Plan in 2012 in Romania*, available at http://www.romadecade.org/cms/upload/file/9270_file24_ro_civil-society-monitoring-report_en.pdf.

NAZROO J. Y., BAJEKAL M., BLANE D., GREWAL I. (2004), *Ethnic Inequalities*, in A. Walker, C. Hagan Hennessy (eds.), *Growing Older: Quality of Life in Old Age*, Open University Press, Maidenhead.

NAZROO J. Y., FALASCHETTI E., PIERCE M. PRIMATESTA P. (2009), *Ethnic Inequalities in Access to and Outcomes of Healthcare: Analysis of the Health Survey for England*, "Journal of Epidemiology and Community Health", 63, pp. 1022-7.

NILSSON L. (2013), *Samverkan och medborgardialog för en bättre hälsa – en satsning på bostadsområdet Varberga i Örebro kommun (Collaboration and Dialogue with Citizens for better Health – An Effort in the District Varberga in Örebro)*, Samhällsmedicinska enheten, Örebro läns landsting, Örebro.

OPEN SOCIETY FOUNDATION (2006), *Broadening the Agenda. The* Status *of Roma Women in Romania*, Open Society European Policy, Brussels.

OPEN SOCEITY INSTITUTE (2005), *Mediating Romani Health: Policy and Program Opportunities*, New York, Open Society Institute, available at http://www.opensocietyfoundations.org/sites/default/files/roma_health_mediators.pdf.

PARREÑAS R. (2001), *Servants of Globalization: Women, Migration and Domestic Work*, , Stanford University Press, Stanford (CA).

PARRY G., VAN CLEEMPUT P. (2004) *The Health Status of Gypsies and Travellers in England*, The University of Sheffield, Sheffield.

PASINI N. (2011), *Cittadinanza sanitaria in prospettiva comparata e multilivello*, Franco Angeli, Milano.

PFEFFER N. (2004), *Screening for Breast Cancer: Candidacy and Compliance*, "Social Science & Medicine" 58, 151-60.

PHILLIMORE J., GOODSON L. (2010), *Failing to Adapt: Institutional Barriers to ECOs Engagement in Transformation of Social Welfare*, "Social Policy & Society", 9, 181-92.

PIPERNO F., TOGNETTI BORDOGNA M. (a cura di) (2012), *Welfare transnazionale. La frontiera esterna delle politiche sociali*, EDIESSE, Roma.

PRIBILSKY J. (2004), *Aprendemos a convivir: Conjugal Relations, Co-Parenting and Family Life among Ecuadorian Trasnational Migrants in New York City and the Ecuadorian Andes*, "Global Networks: A Journal of Transnational Affairs", 4, pp. 313-34.

RADULESCU G. (2009), *Between Design and Failure*, available on the website http://georgeradulescu.blogspot.com.

RAPHAELY N., O'MOORE E. (2010), *Understanding the Health Needs of Migrants in the South East Region*, London, Health Protection Agency and Department of Health.

REDSHAW M., HEIKKILA K. (2010), *Delivered with Care: A National Survey of Women's Experience of Maternity Care*, National Perinatal Epidemiology Unit, University of Oxford, available at https://www.npeu.ox.ac.uk/files/downloads/reports/Maternity-Survey-Repor.

RINGOLD D., ORENSTEIN M. A., WILKENS E. (2003), *Roma in an Expanding Europe*, Breaking the Poverty Cycle-World Bank, Washington DC.

RUNNYMEDE, THE CENTRE FOR POLICY ON AGEING (2010), *The Future Ageing of the Ethnic Minority Population of England and Wales*, Older BME people and financial inclusion support, London.

SALANAVE B., BOUVIER-COLLE M. H. (1996), *The Likely Increase in Maternal Mortality Rates in the United Kingdom and in France until 2005*, "Paediatric Perinatal Epidemiology", 10, pp. 418-22.

SASTIPEN – CENTRUL ROMILOR PENTRU POLITICI DE SĂNĂTATE (2010), *Accesul romilor la serviciile de sănătate publică- studiu realizat în cadrul proiectului*, Evaluarea accesului romilor la serviciile de sănătate publică", finanţat de Guvernele Islandei, Principatului Liechtenstein şi Norvegiei prin Mecanismul Financiar al Spatiului Economic European, disponibil pe www.sastipen.ro/publicatii.

SAUNDERS E. (2004), *Elder Abuse*, "Refugee Women's News", issue 26, January & February 2004, http.//refugeewomen.org.UK/PDF/Elder_abuse_26.pdf.

SCANLON K., WOOD A. (2005), *Breast Cancer Awareness in Britain: Are the Differences Based on Ethnicity*? "Diversity in Health & Social Care", 2, pp. 211-21.

SEDDON D., FITZPATRICK P., CHATWIN M. (2002), *Migration and Social Security Handbook*, London, Child Poverty Action Group.

SEKHRI N., TIMMIS A., CHEN R., JUNGHANS C., WALSH N., ZAMAN J., ELDRIDGE S., HEMINGWAY H., FEDER G. (2008), *Inequality of Access to Investigation and Effect on Clinical Outcomes. Prognostic Study of Coronary Angiography for Suspected Stable Angina Pectoris*, "British Medical Journal", 336, pp. 1058-61.

SIMONAZZI A. (2008), *Care Regimes and National Employment Models*, "Cambridge Journal of Economics", 33, pp. 211-32.

SMART K. (2009), *The Second Destitution Tally*, Asylum Support Partnership, London.

SOSTA E., TOMASONI L. R., FRUSCA T., TRIGLIA M., PIRALI F., EL HAMAL I., CASTELLI F. (2008), *Preterm Delivery Risk in Migrants in Italy: An Observational Prospective Study*, "Journal of Travel Medicine", 15, pp. 243-7.

SPADEA T., FOSSARELLO L., MONDO L., COSTA G. (2013), *Le condizioni di salute*, in C. Saraceno, N. Sartor, G. Sciortino, *Stranieri e disuguali. Le disuguaglianze nei diritti e nelle condizioni di vita degli immigrati*, il Mulino, Bologna.

STAFF WORKING DOCUMENT (2012), *Commission Staff Working Document Accompanying the Document Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions National Roma Integration Strategies: A First Step in the Implementation of the EU Framework [COM (2012) 226 final]*, available at http://ec.europa.eu/justice/discrimination/files/swd2012_133_en.pdf.

STOIAN I. (2010), *Decadewatch Romania Report*, Mid Term evaluation of the decade of Roma inclusion, available at http://www.acrr.ro/download/DecadeWatchRomaniaReport_2010_EN.pdf.

STRONKS K., UNIKEN VENEMA P., DAHHAN N., GUNNING-SCHEPERS L. (1999), '*Allochtoon, dus ongezond? Mogelijke verklaringen voor de samenhang tussen etniciteit en gezondheid geïntegreerd in een conceptueel model*, "TSG", 77, pp. 33-40.

SUNDQUIST J. (1995), *Ethnicity, Social Class and Health: A Population-based Study on the Influence of Social Factors on Self-reported Illness in 223 Latin American Refugees, 333 Finnish and 126 South European Labour Migrants and 841 Swedish Controls*, "Social Science & Medicine", 40, pp. 777-87.

SUNDQUIST J., BAYARD-BURFIELD L., JOHANSSON L. M., JOHANSSON S. E. (2000), *Impact of Ethnicity, Violence and Acculturation on Displaced Migrants: Psychological Distress and Psychosomatic Complaints among Refugees in Sweden*, "The Journal of Nervous and Mental Disease", 188, pp. 357-65.

SUNDQUIST J., JOHANSSON S. E. (1997), *Long-term Illness among Indigenous and Foreign-born People in Sweden*. "Social Science & Medicine", 44, pp. 189-98.

THOMAS V. N., SALEEM T., ABRAHAM R. (2005), *Barriers to Effective Uptake of Cancer Screening among Black and Minority Ethnic Groups*, "International Journal of Palliative Nursing", 11, pp. 562-71.

TOGNETTI BORDOGNA M. (2012), *Donne e percorsi migratori. Per una sociologia delle migrazioni*, Franco Angeli, Milano.

UNDP – UNITED NATIONS DEVELOPMENT PROGRAMME (2002), *Avoiding the Dependency Trap*, A Regional Human Development Report, The Roma in Central and Eastern Europe, Bratislava.

UNICEF, MINISTERUL SĂNĂTĂȚII PUBLICE (2006), *Evaluarea programului de asistență medicală comunitară*, Alpha, Buzău, http://unicef.ro/content/report-final-24-4-aprilie-2007-pdf.

VAN ROOSMALEN J., SCHUITEMAKER N. W., BRAND R., VAN DONGEN P. W., BENNEBROEK GRAVENHORST J. (2002), *Substandard Care in Immigrant versus Indigenous Maternal Deaths in The Netherlands*, "BJOG", 109, 2, February 2002, pp. 212-3.

VASILEVA K., (2011), *Population and Social Conditions. Eurostat Statistics in Focus 34/2011*, available at http://epp.eurostat.ec.europa.eu/cache/ity_offpub/ks-sf-11-034/en/ks-sf-11-034-en.pdf.

VIANELLO F. A. (2009), *Migrando sole: legami transnazionali tra Ucraina e Italia*, Franco Angeli, Milano.

VISSANDJEE B., HYMAN I., SPITZER D. L., APALE A., KAMRUN N. (2007), *Integration, Clarification, Substantiation: Sex, Gender, Ethnicity and Migration as Social Determinants of Women's Health.*, "Journal of International Women's Studies", 8, 4, pp. 32-48.

VLĂDESCU C., SCĂNTEE G., OLSAVSKY V. (2008), *Health System in Transition*, "Romania Health System Review", 10, 3, http://www.euro.who.int/_dota/assets/pdf_file/0008/95165/E91689.pdf.

WALLBY T., HJERN A. (2011), *Child Health Care Uptake among Low-income and Immigrant Families in a Sweden Count*, "Acta Paediatrica", 100, pp. 1495-1503.

WALLER J., ROBB K., STUBBINGS S., RAMIREZ A., MACLEOD U., AUSTOKER J., HIOM S., WARDLE J. (2009), *Awareness of Cancer Symptoms and Help Seeking among Ethnic Minority Groups in England*, "British Journal of Cancer", 101, 24-30.

WEBB R., RICHARDSON J., PICKLES A. (2004), *A Population Based Study of Primary Care Predictors of Non-attendance for Cervical Screening*, "Journal of Medical Screening", 11, pp. 135-40.

WEISHAAR H. B. (2008), *Consequences of International Migration: A Qualitative Study on Stress among Polish Migrant Workers in Scotland*, "Public Health", 122, pp. 1250-6.

WESTERLING R., ROSÉN M. (2002), *"Avoidable" Mortality among Immigrants in Sweden*, "European Journal of Public Health", 12, pp. 79-286.

WESTMAN J., JOHANSSON L. M., SUNDQUIST K. (2006), *Country of Birth and Hospital Admission Rates for Mental Disorders: A Cohort Study of 4.5 Million Men and Women in Sweden*, "European Psychiatry", 21, pp. 307-14.

WIKING E., JOHANSSON S. E., SUNDQUIST J. (2004), *Ethnicity, Acculturation, and Self-reported Health. A Population Based Study among Immigrants from Poland, Turkey, and Iran in Sweden*, "Journal of Epidemiology & Community Health", 58, pp. 574-82.

WILLIAMS D. R. (2002), *Racial/Ethnic in Women's Health: The Social Embeddedness of Health*, "American Journal of Public Health", 92, 4, pp. 588-97.

WOMEN'S RESOURCE CENTRE (2007), *Report for London Councils: Funding of London Women's Refuges*, Women's Resource Centre, London.

WORKING GROUP WITH THE VOLUNTARY SECTOR (2006), *Thirty-Second Report of the Working Group with the Voluntary Sector Government Office*, House of Commons Committee of Public Accounts, London.

WORTH A., IRSHAD T., BHOPAL R., BROWN D., LAWTON J., GRANT E., MURRAY S., KENDALL M., ADAM J., GARDEE R., SHEIKH A. (2009), *Vulnerability and Access to Care for South Asian Sikh and Muslim Patients with Life Limiting Illness in Scotland: Prospective Longitudinal Qualitative Study*, "British Medical Journal", 388, p. 183.

ZANCONATO G., IACOVELLA C., PARAZZINI F., BERGAMINI V., FRANCHI M. (2011), *Pregnancy Outcome of Migrant Women Delivering in a Public Institution in Northern Italy*, "Gynecologic and Obstetetric Investigation", 72, pp. 157-62.

ZLOTNIK H. (1995), *Migration and the Family: The Female Perspective*, "Asian and Pacific Migration Journal", 4, pp. 253-71.

ZONTINI E. (2010), *Transnational Families, Migration, and Gender: Moroccan and Filipino Women in Bologna and Barcelona*, Berghahn, New York.