

Developing a Public Health Workforce to Address Migrant Health Needs in Europe

International Organization for Migration (IOM)

Background Paper

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Executive Summary

The size and diversity of contemporary migration flows have made migration an important public health topic. Migrants travel with their health profiles, risks and beliefs. Many migrant health needs result from the environment in the community of origin, type of migration, and socio-economic conditions and lifestyle in countries of origin and destination. Migrants often experience greater difficulty than host country populations in gaining access to appropriate health care. Access barriers can be legal, administrative, organisational or socio-economic, or result from migrants' own health beliefs, health seeking behaviour, and cultural and linguistic challenges. Such disparities may influence the health of migrants, as well as the health of the host communities.

Health workers face an increasing diversity in health perspectives, beliefs, culture and linguistic background of their patients, as well as a greater variety in epidemiology and disease profiles. The prevalent health care model, under which the workers deliver services, has, in many countries, failed to guarantee fair, equitable and culturally appropriate health care for everyone, including migrants. This old model must be adapted to the changing society and its needs. Transforming the old health care model will not succeed, however, without the development of a migrant-sensitive public health workforce. Health professionals in such a workforce appreciate and understand the determinants of migrant health. They are able to respond appropriately

to diverse cultural and linguistic backgrounds and different health perspectives and beliefs. They recognise the epidemiological considerations and disease symptoms associated with migration, and have the clinical competence to provide appropriate care. They are familiar with and have the capacity and willingness to respond to the administrative, legal and rights issues which impact on migrants' access to health services.

Key documents guiding health professional training in the European context give insufficient attention to the skills required for inclusion of socio-economic, ethical and cultural dimensions in the provision of health care. They also fail to adequately consider the specific competencies necessary to adapt health care to the increasing diversity in society. Existing training programmes in migrant health are too few, scattered and poorly evaluated, and those developing them lack avenues of information exchange.

Based on a literature review and survey in selected EU countries, this document provides recommendations for actions and strategy and policy changes by the European Union, Member States and training providers. The engagement of all these actors is needed to reorient the competencies of the public health workforce to the needs of modern Europe.

1. Introduction

Globalisation, economic disparities, political upheavals, wars, other threats to civil security and demographic changes have considerably increased and complicated migration trends in the last two decades.¹ Migrants are essential for Europe today, both because of its aging population and to respond to labour market needs. Migration is, however, bringing new challenges to Member States. EU governments are increasingly concerned about the management of the resulting diversity and reduction of social and health-related inequities.

The impact of migration on publicly funded health care systems is a related important challenge which EU governments are now facing. Today's health care systems are expected to serve individuals who come from a wide range of health environments and have different vulnerability levels. The prevalent health care model has failed in many countries to guarantee the delivery of fair, equitable and culturally appropriate health care for everyone, including migrants. An important and urgent task is to transform the model so that it is better adapted to the real needs of a culturally diverse society.² Such a transformation, however, cannot take place without health professionals who support the required changes and deliver culturally appropriate, equitable and competent care.

This paper aims to encourage debate and action on developing a migrant-sensitive public health workforce. Such a workforce has the necessary competences in epidemiology, clinical care and health administration to care for a diverse patient population, as well as the knowledge and attitudes to do so in a culturally appropriate manner. The paper was commissioned by the International Organization for Migration (IOM) and the World Health Organization (WHO), and initially prepared by the Andalusian School of Public Health (*Escuela Andaluza de Salud Pública*, EASP). It was elaborated within the framework of the AMAC project, "Assisting Migrants and Communities: Analysis of Social Determinants of Health and Inequalities", managed by IOM.³

The EASP team collected the information, on which this paper is based, through Internet and Medline searches and virtual interviews. The team, together with IOM and WHO officials, chose the countries—Malta, Poland, Portugal, United Kingdom, Spain and Sweden—to represent different European geographic regions and migration histories. Websites of official public organisations were searched for key documents on health professional training policies and practices regarding migration, health and culture in Europe. Medline searches identified scientific publications on the same topics. Qualitative interviews were conducted with key respondents (representatives of

health services, universities and continuing education centres) in six countries using the LimeSurvey software.¹

The paper provides a general overview of migration at the European level, followed by a review of the challenges and opportunities that the "age of migration" has brought for European health systems and health professionals.⁴ Determinants of migrant health and existing barriers to health care for migrants are discussed in this section. The paper argues that current public health challenges, brought about by increasing diversity, require both a new health care model and an appropriately trained public health workforce to implement and run it. Key documents guiding higher education in Europe and their implications for migrant health-relevant curricular content for doctors, nurses, psychologists and social workers are then analysed. Next, the results of the qualitative interviews are presented. They include the respondents' perceptions regarding key aspects of designing, implementing and evaluating training strategies for health professionals. Collected 'good practice' examples are included in an appendix. The paper concludes with recommendations to the European institutions, national governments and organisations responsible for health professional training.

The development of a migrant-sensitive public health workforce is an important and urgent task. It requires wide collaboration between policy makers, planners, service providers, educators and trainers. A workforce, trained to deliver competent care to a diverse population, contributes to improving the health of all people in Europe.

¹ The list of potential respondents was compiled from names provided by IOM and WHO, participants in relevant conferences, literature references, web searches and individuals whom the study team personally knew to be responsible for or involved in migrant health and training. Of the total of 172 individuals contacted, 41 filled in the web-based interview form. The following figures show, by country, the number of completed survey forms received and the number of individuals contacted: Malta (8 of 23), Poland (3 of 49), Portugal (1 of 10), Spain (18 of 31), Sweden (5 of 26) and UK (6 of 33).



2. Migration at the European Level

2.1. Definition of migration and migrant

In a demographic sense, global migration has been defined as a “process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants.”⁵

In a social sense, the concept of migration commonly includes the diversity of persons and groups who migrate to other countries of their own free will in order to improve their and their families’ social and material prospects.

We use the generic term, “migrant,” in this paper to refer to the diversity of persons who have migrated either from one EU country to another or from a country outside the EU to an EU country. It is important to recognise that all migrants are not the same. Migrant groups include migrant workers and their families, long-term and short-term immigrants, internal migrants, international students, internally displaced people, asylum seekers, refugees, returnees, irregular migrants and, and victims of human trafficking.⁶

Bearing in mind the wide range of social, cultural, ethnic, religious, age and sex differences between migrants is important. The specific needs of disadvantaged migrant populations are left unaddressed in social and health care policies and services targeting migrants if all individuals of different origin to the host country population are grouped under one generic concept of migrants and/or ethnic minorities.

2.2. History of migration in Europe

Current global migratory trends show acceleration both in the volume of migrants and the number of countries from and to which they move. Migration in general shows increasing diversity in migrants’ areas of origin, type of migration and reasons for migrating.⁷

European countries are experiencing an increase in migration for different reasons and causes. Migrants come both from other European Union countries and from outside the EU. These migratory movements cause social and demographic changes, which demand political solutions from the different Member States. Such solutions are crucially important for the host country, its health, social cohesion and economic development. They are also central to the provision of appropriate health and social care for migrant populations most in need.

European countries were primarily countries of emigration for more than two centuries. Immigration, however, is a relatively recent phenomenon in Europe. It became of special relevance for most countries only after the Second World War. The first migratory waves following World War II coincided with the development of European welfare states. They were internal to Europe and consisted mainly of Italians, Spaniards and Turks. Initially, immigrants were assumed to be temporary, not permanent, residents. This created an obstacle for establishing social policies that would be sensitive to the migrants’ social and health needs and help to integrate them into host countries. The lack of such policies resulted in ghettos of migrant populations and racist postures in the host country ones.

In the mid-sixties, western European countries closed their borders to economic and labour-related migration. The need to control or prevent the entry of migrants appeared in political discourse. It created a discriminatory institutional framework, which excluded migrants economically and socially. It was not until the mid-seventies that the idea of integrating migrants into the host societies began to be adopted. The first integration policies were established in the Netherlands, Sweden, Denmark and Finland.⁸

Migration in Europe has increased greatly in recent times. As already mentioned, it is essential to compensate for ageing populations and respond to labour market needs. Most migrants are young and the proportion of females has grown considerably. Various Member States of the European Union are now promoting policies for integration and social protection of non-EU migrants and the creation of a European citizenship. In September 2005, the European Commission presented a Common Programme for Integration – a framework for the integration of third country nationals in the Union.⁹

This programme proposed specific measures for establishing common basic principles in the EU and its Member States.¹⁰ These principles are:

- Integration as a two-way process;
- Respect for the basic values of the EU;
- Employment as an essential element of integration;
- Basic knowledge of the language and institutions of the receiving country;
- Education to prepare the descendents of migrants for active participation in the receiving society;
- Equitable access to public and private goods and services;
- Intercultural dialogue and knowledge of migrants’ cultures;
- Respect for the practice of diverse cultures and religions;
- Participation of migrants in democratic processes; and
- Inclusion of integration in all policies and at all levels of government.

Tensions between the social and economic aspects of European policies continue in spite of these efforts, and integration policies are no exception. Such tensions are seen in setting priorities for health and social care of migrants in different Member States. Economic growth, social development and a wide range of other complex factors affect this process. They include different governance, social and health care structures, relationships between the State and the civil society, and different migration histories.¹¹

The social and health policy priorities of European countries demand common specific objectives. They must be adapted to the local context, however, because migration varies from one country to another, as well as on a regional and local scale.

2.3. Social integration policies of selected countries

European societies are in a continuous process of transformation and social dynamics.¹² EU Member States, such as Sweden, which have a long tradition of developing integration policies have given priority to the fight against any form of discrimination. This is seen as an essential factor to ensure respect for the human rights of persons living in the country.¹³ The National Office for Integration in Sweden has carried out migration and refugee programmes since 1998. The Swedish government places particular importance on aspects of language learning, guidance courses concerning the social environment, training and guidance for employment.

In the United Kingdom, action over cultural diversity is promoted through a Permanent Secretariat, whose task is to assure fulfilment of integration commitments in each ministry.¹⁴ No specific government policy exists to promote intercultural dialogue. Instead, such a dialogue is included as an action principle in all policies.¹⁵ A new proposal for legislation on issues of equality aims to fight against all forms of discrimination.¹⁶ A global strategy is being followed to reduce social inequalities in health care. It is based on the best and most recent evidence available, and integrates cross-cutting cultural diversity.¹⁷

Countries with a shorter tradition of immigration, such as Spain, began to develop integration policies in the mid-nineties. The Secretary of State for Immigration and Emigration was created in 2004. In 2007, a Strategic Citizenship and Integration Plan 2007–2010 was passed.¹⁸ It is guided by the principles of equality of rights and opportunities, citizenship and intercultural competence, and includes health among its twelve areas of work. Most of the sectors concerned in integration policies (education, employment, housing, health, social services) are the responsibility of the Autonomous Communities and local bodies.¹⁹ This results from the high degree of political and administrative decentralisation that characterizes the Spanish state.

Malta is another country in which immigration is a recent phenomenon. Its integration policies are still at an early state of development. In the fight against poverty and social exclusion, Malta's challenges include dealing with migration, promoting equality and diversity, strengthening the legal and political frameworks for fighting discrimination, promoting the integration of nationals of other countries, and fighting racism.²⁰

Poland, also with a short history of immigration, assigns the responsibility for the integration policy to the Ministry of Work and Social Policies and the Interdepartmental Team for Migration.²¹ An evaluation report on its integration programme considers the latter to be ineffective. One reason for this is said to be the inadequate training of staff with regard to the migratory situation.²² Poland's Strategic Report on Protection and Social Inclusion 2008–2010 does acknowledge migrants to be a vulnerable group, who have difficulties in accessing public services.²³

In 2007, Portugal included migration and the health of migrants as one of the priority items on its political agenda. It established a new legal system for the arrival, stay, departure and expulsion of foreign citizens from Portuguese national territory. Several relevant EU Directives were incorporated into the legal system. Subsequently, the Migrant Integration Plan and the National Plan of Action for the European Year of Equal Opportunities for All were approved. The debate over the political participation of migrants was opened, and the High Commission for Immigration and Intercultural Dialogue (Alto Comissariado para la Imigração e Diálogo Intercultural, ACIDI, IP) was formalized.²⁴

The size of migratory flows, difficult conditions of integration and the geographical concentration of the migrant population have created a situation of vulnerability and social exclusion in Portugal. To reduce discrimination, the government of Portugal intends to reinforce the integration of migrants.²⁵ The Migrant Integration Plan was put into practice in May 2007. It includes the creation of integration support centres, telephone help lines in various languages, and language courses and training teams. In addition, training courses for public officials on issues of citizenship and intercultural relations have been developed under the auspices of the Presidency of the Council of Ministers.

Migratory policies, which have traditionally raised the rejection of migrants and xenophobia among the autochthonous population, are now increasingly concerned with the integration of migrants. Appropriate analyses and extensive public debates are still necessary in this area. The topics include aspects of redistributive justice and the maintenance and improvement of the health, quality of life and welfare of migrants in a diverse Europe.



3. Health and Migration in Europe

3.1. Public health and migration

The health and welfare of a country's population is, to a large extent, the result of the political actions of the government, social agents, the health system, and the training and professional competence of its public health workforce.²⁶ The main challenges identified in current public health policies in European countries are to (a) maintain and improve the population's level of health and welfare; (b) organise health services so that they deal with social, financial, demographic, ecological, technological and health changes; and (c) adequately train a public health workforce to respond in an effective and equitable manner to these challenges.²⁷

The size of and diversity of contemporary migration flows have made migration an important public health topic. Addressing the needs of individual migrants, as well as the public health needs of host communities, requires policies and practices that correspond to the emerging challenges facing migrant populations today. The approach needs to be comprehensive and cover the full spectrum of the health sector. Migration affects public health policy, legislation, regulation and standard development, as well as the education and training of the public health workforce.²⁸

As people move, temporarily, seasonally or permanently, they connect individual and environmental health factors between communities. Migrants travel with their health profiles, risks and beliefs. These reflect both their socio-economic and cultural background and the disease prevalence in their community of origin. Often such profiles and beliefs are different from those in the host communities. They can impact on the health status of the host communities and on related services, for example, when diseases are introduced through the arrival of migrants. On the other hand, disparities in profiles and beliefs may negatively influence the health of migrants, for instance when culturally appropriate services are lacking or diseases unknown to the migrants' place of origin are present in the transit or host community.²⁹

3.2. Determinants of migrant health

Migrants' health status is determined by many factors. While cultural and linguistic factors play a role, many migrant health needs result from other causes. These include the health environment in the community of origin, type of migration (e.g. forced or voluntary), and socio-economic conditions and lifestyle in countries of origin and destination. Public health workers may – or may not – be familiar with the impact of social and economic conditions on the health of migrants. The effect of the other determinants on health may also be unknown to or insufficiently perceived by them.³⁰

Migrant populations should not be treated as homogeneous collectives.

Instead, the characteristics of different migrant groups and their particular health determinants should be considered separately in planning and implementing health services and training health professionals. Most importantly, groups in a situation of greatest vulnerability should be distinguished from the rest and given particular emphasis.

3.2.1. Cultural and linguistic determinants

Cultural practices (including religious ones) and language problems can hamper communication with health providers and thus impede the delivery of appropriate health care. As discussed later in the paper, such difficulties are more likely to affect females and migrants from certain ethnic groups.

Many differences between migrant and host-country populations have been labelled as “cultural” characteristics of a certain group of migrants and/or ethnic minority. It is important to recognise that in fact, many such differences have a social, rather than cultural, origin.

3.2.2. Environmental and biological determinants

Health conditions and environment in the home community decide many baseline parameters for the health of migrants. Biological determinants include the predisposition of certain population groups to specific diseases that affect other population groups much less frequently or not at all. Sickle cell anaemia and thalassaemia are examples of such diseases, whose prevalence in certain groups of migrants is higher than in most host country populations in Europe. Certain infectious diseases, such as TB, AIDS and vaccine-preventable diseases can have a higher prevalence and incidence in those regions of the world where migrants to Europe mainly come from. Other conditions may be more prevalent in host communities, such as cardiovascular problems, and over time, migrants may acquire the health profile of the host community.³¹ Managing the exposure to and/or the importation of diseases is of increasing importance to public health in Europe.³² Exposure to illness, disease prevalence, and the capacity of the local health care system both in the home and in the host community all influence the health status of migrants, which can differ from that of the host population.³³ Such differences may be positive (e.g. body mass index) or negative (e.g. prevalence of infectious diseases).³⁴

3.2.3. Type of migration

Migration may be voluntary or involuntary and take place through legal or illegal routes. The conditions surrounding the migration process itself are important determinants of migrant health. This is particularly evident for migrants in an irregular situation (such as undocumented migrants and trafficked women) and in refugees and internally displaced persons (IDPs).

The movement of such migrant populations is frequently accompanied by exposure to violence and trauma, physical and environmental threats, and lack of access to basic health and social services. Such traumatic experiences can bring about a range of health problems, including mental health problems or stress-related illnesses. Women and girls are the most vulnerable groups in these populations.³⁵

3.2.4. Social determinants

Serious, avoidable and unfair social inequalities deteriorate the health of some population groups. The Black Report of the British Department of Health and Social Security (now Department of Health) showed, already in 1980, the importance of the relationship between social and health-related inequalities and the impact of social conditions on the health of migrants.³⁶ These findings were confirmed in the 1987 Whitehead Report³⁷ and the 1998 Acheson Report.³⁸

The 2008 report of the World Health Organization's Commission on Social Determinants of Public Health was another landmark document. It determined that health inequalities, both between and within countries, result from unsuccessful policies and inequities in living conditions, access to power and resources, and participation in society.³⁹ Such inequalities are particularly notable between migrants, many of whom come from poorer countries, and the host country population. Migrants often remain among the disadvantaged groups in their host communities and suffer disproportionately from poverty and marginalization.

3.3. Access barriers

Access to appropriate services and the way in which migrants' particular health needs are taken into account in health policies, health service organisation and the training of the public health workforce are additional influences on the health of migrant populations. Access to health care is a widely acknowledged universal human right. The EU health care strategy of October 2007 is intended to simplify procedures, increase quality and accessibility of cross-border health care and improve circulation of patients and professionals.⁴⁰ As a consequence, several changes have been introduced in different European health systems, covering the organisation, functioning and improvement of care to different groups of foreigners. Yet, non-EU migrants continue to experience greater difficulty in gaining access to appropriate health care.⁴¹ Barriers to access can be legal, administrative, organisational or socio-economic. They may result from migrants' own health beliefs and health seeking behaviour, or from cultural and linguistic challenges.

3.3.1. Legal, administrative, organisational or socio-economic barriers

Administrative and/or legal barriers may bar access to needed services. The regulations of different Member States vary regarding migrants' right to health services.⁴² The lack of appropriate documentation to establish

residence is an important barrier in some countries. Migrants may also be unaware of their right to health care. Migrants in an irregular situation, such as undocumented migrants, may fail to seek services for fear of deportation if health workers are obliged to report their registration at a health clinic or hospital to the authorities. Even where migrants have been granted the same rights as the host country population, health personnel may be unaware of such regulations.

A country's health care system may not offer the type of services that migrants need. The services may be too costly or organised and/or delivered in a way that causes migrants to feel excluded from the health service provision networks.⁴³

Socio-economic barriers include cost, marginalisation and discrimination. Cost of health services and of transport to the clinic or hospital may be more than some migrants are able to pay. Marginalisation and discrimination of certain groups, in turn, can make some migrants reluctant to see a health provider.

3.3.2. Health beliefs and health seeking behaviour

Different beliefs of illness causation and cure can hinder access to appropriate care. Migrants may delay seeking care, which can worsen the disease. They may fail to disclose which alternative or traditional medicines, commonly practiced at the home country, were used before seeking help, thus hindering communication between the health provider and the migrant.

Migrants' expectations of health care may also vary from those in the host country, resulting in misperception about the quality of care provided. For example, a trained midwife routinely attends to a normal delivery in the United Kingdom (UK), while an obstetrician does this in some other countries. A migrant from such a country may perceive a delivery by a midwife as inferior quality care, unless she is aware that this is normal practice in Britain and that British midwives are well trained.⁴⁴

3.3.3. Cultural and linguistic challenges

Cultural barriers include, for example, the unwillingness of female migrants from certain cultural groups (or the prohibition of their male relatives) to be examined by a male health provider. This is an obvious and serious barrier to access, unless the health service ensures the availability of a competent female provider.

The diversity of migrant groups has increased the linguistic challenge for health service provision. The European Commission report, "Quality and fairness of access to health services", specifically mentions linguistic differences as a serious difficulty in the interaction of certain migrants with health providers.⁴⁵ In some ethnic groups, inability to communicate in the local language is a particularly important access barrier to older migrant women.



4. Toward a Migrant-Sensitive Health Workforce

4.1. Need for a transformed health workforce

The day-to-day work of health professionals is changing in Europe. This is in part due to the increased population-diversity and the consequent diversity in patients' health perspectives, beliefs, culture and linguistic background. The greater variety in epidemiology and disease manifestation is also placing new demands on health professionals. Increasingly, health workers find themselves treating patients whose symptoms they may not know or understand well.

Delayed or inefficient care can result from ineffective communication between patient and care provider. Care may also be delayed or of poor quality if the provider lacks knowledge about the epidemiological profile of a migrant's home community.⁴⁶ If diseases remain undetected or are managed ineffectively, the health consequences can be serious both for the individual and for the community. Delayed care is associated with disease progression and a subsequent need for a health provider to undertake more extensive and costly treatment and intervention. A patient's limited access to preventive and health promotion services, in turn, increases risks and health care demands from conditions which the provider could have successfully mitigated earlier, often at reduced costs. Meanwhile, patients may lack awareness and understanding of and trust in the existing health care system. Such challenges further complicate a health provider's work in caring for a diverse patient population.

The provision of effective, efficient and quality care to the total population (including migrants) requires a redirection of the current health care model so that it best responds to the experiences, expectations and health needs of a diverse society. A migrant-sensitive public health workforce, which is essential for establishing and operating the new health care model, requires new competencies. Health professionals in such a workforce will appreciate and understand the determinants of migrant health. They will be able to respond appropriately to diverse cultural and linguistic backgrounds and diverse health perspectives and beliefs. They will recognise the epidemiological considerations and disease profiles associated with migration and have the clinical competence to provide appropriate care. Finally, they will be familiar with and have the capacity and willingness to respond to the administrative, legal and rights issues which impact on migrants' access to health services.

4.2. Required competencies of the health workforce

Most factors that influence the required competencies for a migrant-sensitive health workforce go beyond the limitations of linguistic communication between health workers and patients.⁴⁷ Instead, they are related to limitations in caring for persons who are socially and economically disadvantaged and carry different epidemiological profiles.⁴⁸ The main training needs to develop such competencies relate to the doctor-patient encounter, emerging diseases, health problems arising from living conditions, inequities in access and use of health services, and acquisition of intercultural skills.

Competences in areas, such as change management, social and cultural diversity and clinical and epidemiological aspects of diagnosis and care for migrants, are essential for public health purposes. They are required to manage the social and cultural diversity and reduce inequalities in the health-illness-care processes of migrants.⁴⁹ Three areas are of particular importance: (a) intercultural competence, (b) diagnosis and management of health conditions associated with migration and (c) administrative requirements governing migrants' access to health services and their right to health care.

The starting point in training for intercultural competence should be to consider both the culture of the health profession itself and the culture of patients.⁵⁰ If intercultural competence training does not go beyond simple knowledge and reproduction of stereotypes, it may only formalize and amplify differences.⁵¹ The western biomedical health model has created specific professional cultures, which differ from the diverse cultures of those attending health services. It is from these professional cultures that health professionals observe the cultural and social factors in migrant populations. Health professionals must learn to distinguish between two dimensions of sickness, namely 'disease' and 'illness.' Disease refers to the biological condition, whereas illness refers to the cultural dimension of suffering the disease.⁵² Illness thus refers to the subjective dimensions, the way in which the disease expresses itself.⁵³ A health professional, who cares for patients from diverse backgrounds, must understand and respond to both dimensions.

Health workers treating migrants must know the epidemiology of health conditions which are uncommon in the host country but more prevalent in countries of origin. They must anticipate and competently respond to potentially different disease processes and treatment effects among various ethnic and cultural groups.

Finally, health professionals must be able to advise their migrant patients regarding their right to health services. They also need to understand the administrative procedures, governing where and how these services are accessed in the local health system.

4.3. Efforts towards training the health workforce

It is widely acknowledged that training programmes for a public health workforce in general should be developed from a comprehensive, multidisciplinary perspective. The goal of training has been to equip public health staff with the appropriate skills and attitudes so that they can respond to health service demands and the needs of different groups in the society and act in the proper role of each specialty.⁵⁴ Health training has traditionally centred on diagnosis and treatment of prevalent illness, rather than maintenance of health or management of newly emerging conditions. More importance has been given to the scientific basis of medical practice than to the recognition of population health determinants or socio-economic and cultural dimensions in the health-illness-care process. Training has centred more on signs and symptoms of common illnesses, rather than on understanding the social and cultural context of patients, their possible migration background and related different health environment in their home community.

The arrival of migrants has posed new challenges for existing education and training programmes for health professionals. Training programmes on migrant health in Europe are still too few. The existing ones aim to promote understanding of the complexity of migratory movements and reduce inequalities in access to the health system. They also endeavour to sensitize the authorities to the special characteristics of caring for a multicultural citizenship.

Demand for training on intercultural issues has traditionally been linked to diplomacy and international relations. Such a demand is now emerging among public service professionals who need intercultural competence to tackle their daily work.⁵⁵ In some cases, the training in intercultural competence has been reduced to language communication skills only. In others, it has been more comprehensive, promoting the development of intercultural competence. The importance and value given to each of these aspects varies between Member States.

In Spain, plans of health, migration, coexistence and integration of migrants propose to increase linguistic and cultural understanding between professionals and patients and improve the requisite knowledge of health professionals.⁵⁶ To support this process, the Spanish Ministry of Health and Social Policies is promoting a strategy of training health professionals in intercultural competence and care of

migrant health. It is making available a set of resources, which can be used to respond to training interests and needs of different public institutions and scientific associations.⁵⁷

In the United Kingdom, the National Health Service (NHS) has established various training and sensitization strategies in response to health staff's lack of knowledge about religious beliefs and cultural practices of migrants. In addition, a strategy to contract health staff from ethnic minorities was adopted to improve communication and access of migrants to the health system. The UK has also promoted the use of a "liaison worker", who provides translation and cultural interpretation services, and can undertake health promotion and health care coordination.⁵⁸

The need for intercultural training has been identified in a number of European projects. The "Partners for Health" project, which included institutions from Italy, Belgium, the Netherlands, UK, Spain and Sweden, identified language difficulties as a hindrance to caring for migrants in all Member States and all levels of health care. This was due both because of the language itself and the medical terminology used. The project recommended promoting and facilitating the development of standards in intercultural competence training programmes for medical staff, and the inclusion of this subject in the university curricula of health staff and in training of administrative staff.⁵⁹ Some hospitals in the "Migrant-friendly hospitals" project started training health staff in equality and diversity.⁶⁰ The project included hospitals in Austria, Germany, Denmark, Greece, Finland, France, Ireland, Italy, the Netherlands, UK, Spain and Sweden. The "Cities for Local Integration Policies" (CLIP) project also emphasized the importance of promoting intercultural training. Such training aims to ensure that both the care-giving and management staff are aware of the specific needs, religious and cultural practices, and characteristics of migrant communities.⁶¹

Examples, such as the ones above, indicate the growing concern of European governments for improving health care to migrants. Development of comprehensive training strategies for health professionals that provide the necessary training in epidemiology, clinical care, health administration and migrants' rights to care, is still needed, however. Such training is essential in order to develop a public health workforce that will respond to migrants' health needs in a culturally sensitive manner, has the appropriate clinical competence, and knows how to guide their migrant patients to appropriate health services.⁶²



5. Policies and Practices of Health Professional Training in Europe

Four key documents are particularly important in guiding health professional training in the European context. They are the Bologna Declaration, the European Parliament and Council Directive 2005/36/EC, the Green Book Regarding European Health Staff, and the Common Emigration Policy for Europe.

5.1. Bologna Declaration and health professional training

The Bologna Declaration of 1999 was aimed at increasing employment in the EU and making the European Higher Education Area (EHEA) a magnet for students and teachers from other parts of the world. It established the EHEA and set up a framework for graduate and post-graduate training in Europe, including health professional training.⁶³ The basic principles of the Declaration are quality, mobility, diversity and competitiveness. The EHEA aims to establish the competencies (knowledge, skills and attitudes) required for performance of professional duties and respond to the work challenges of a globalised society.

The EHEA gives special attention to the mobility of health professionals and the acquisition of language skills required for such mobility. Insufficient attention, however, is given to skills required for inclusion of socio-economic, ethical and cultural dimensions in the provision of health care and for improving health of populations, migrant or otherwise. Communication skills, ethical commitment, acknowledgement of diversity and multiculturalism and knowledge of other cultures and customs are included as cross-cutting competencies in training health professionals. The approach to these skills, however, is very heterogeneous in the different courses. The section below provides a general description of some training modules, which are of particular relevance for developing required professional skills in the degree courses in medicine, nursing, psychology and social work.

5.1.1. Medical doctors

Some migration-relevant skills in medical doctor training programmes are general. They include respect for the autonomy of the patient and their beliefs and culture, acknowledgement of one's own limitations and the need to maintain and update professional competence (including professional values, attitudes, conduct and ethics), recognition of population health determinants (both genetic and those that depend on lifestyle, demographic, environmental, social, financial, psychological and cultural differences). Other competencies are cross-cutting, e.g. knowledge of a foreign language, capac-

ity to work in an international context, recognition of diversity, and knowledge of other cultures and customs. The importance given to training in these competencies, the weight given to each, and the way they are approached in the curriculum differ from one country to another. In Spain, for example, medical professionals, resident doctors and managers do not consider these competencies among the most important. Learning a foreign language is the sole exception. The position of these competencies in the medical curriculum is very marginal, both in terms of required credits and the space allocated during the years of study.

In the context of the EHEA, students and professional medical associations stress the need for basic common training content in all Member States in order to promote the mobility of health professionals. There appears to be little emphasis on promoting competencies which enable health professionals to deal with the social and cultural conditions in which people live and work.⁶⁴ In relating professional "mobility" with contact with "different cultures and societies," members of the International Federation of Medical Students' Associations (IFMSA) make reference to training needs to care for migrant populations.⁶⁵ They emphasise the need to achieve a "high standard of linguistic ability," because their professional practice involves contact with "patients." They do not clarify, however, whether they refer to EU citizens and/or citizens from other countries. The members recommend promoting language courses, establishing minimum language standards in universities, encouraging the learning of local languages (including medical vocabulary) and making medical dictionaries available on line. In practice, however, language competence is often limited to functional English.

5.1.2. Nurses

European regulations have established a profile for a nurse who is responsible for general care. Such a nurse receives training in health promotion, disease prevention, and comprehensive care for persons of all ages, in all situations, health and social care institutions and the community. Basic, common compulsory content of nursing curricula include the following: community nursing, nursing at different stages of the lifecycle, psychosocial nursing and mental health.⁶⁶ Training in competencies related to migration, health and culture may be included within these subject areas.

General competencies in nursing degree courses cover communicating effectively with patients, families and social groups (including those with communication difficulties), correctly representing the patients' viewpoint and acting to prevent abuse. Cross-cutting competencies

include the appreciation of diversity and knowledge of different cultures and customs. The challenge is to ensure that these competencies are included in professional practice in an effective manner.⁶⁷

In Spain, nurses can obtain a degree in social and cultural anthropology. This helps to improve the professionals' sensitivity to these issues. There is also evidence that most university schools of nursing have improved relevant curricular content.

5.1.3. Psychologists

The European scene is extremely varied and complex with regard to training for a degree in psychology.⁶⁸ All the major European universities provide training in psychology in faculties of philosophy and humanities or in medical faculties. The European Federation of Psychology Associations (EFPA) has carried out various initiatives in recent years aimed at educational convergence and professional mobility in Europe.

The goal of a psychology degree is "to train professionals with the scientific knowledge necessary to understand, interpret, analyse and explain human behaviour, and with the basic skills and abilities to assess and intervene at an individual and social level, throughout the lifecycle, with the aim of promoting and improving health and the quality of life." Common compulsory curricular content consists of social psychology and group psychology, lifecycle and educational psychology, psychology of personality and of human differences. Cross-cutting competencies include knowledge of a foreign language, capacity to work in an international context, recognition of diversity, knowledge of other cultures and customs, social commitment, sensitivity to personal, environmental and institutional injustice and concern for the development of persons, communities and peoples. In some countries, such as Spain, psychology professionals and employers consider these competencies less important than cognitive skills, team-work skills or the capacity to keep one's professional competencies up-to-date.

5.1.4. Social workers

A degree in social work aspires, at least on paper, to develop the necessary competencies for managing social and cultural diversity. This degree is in the process of being changed to adapt it to the requirements of European convergence. The different educational systems in European countries show a good deal of heterogeneity in social work training. They do, however, have a common aim, namely to train social workers who are capable of "promoting social change, solving problems in human relationships and strengthening and promoting the freedom of the population to increase its wellbeing."⁶⁹ Thus, a social worker should have the capacity to promote the inclusion of persons who are marginalized, socially excluded, dispossessed, vul-

nerable, and at risk. A social worker should also be able to address and challenge the barriers, inequalities and injustices, which exist in society. Globalization, social policies and migratory phenomena impact on the social, economic, technological and cultural context of social work.

Specific competencies for working with different populations have been defined for social workers. They include knowledge, skills and attitudes necessary to intercede with persons, families, groups, organisations and communities in order to achieve change and promote the development and improvement in people's living conditions. Cross-cutting competences are similar to those for medical doctors and psychologists, namely knowledge of a foreign language (which tends to be English exclusively), capacity to work in an international context, recognition of diversity and different cultures, and knowledge of other cultures and customs. Once again, social work teachers, professionals, graduates and students in Spain considered these competencies among the less important when prioritising competencies of a social worker.

5.1.5. Post-graduate training

There is an emerging offer of masters and doctoral degrees in Europe in areas such as public health, health promotion and medical anthropology. Universities and post-graduate training colleges, however, still have a long way to go before reaching European convergence within the framework of the EHEA.⁷⁰

5.2. European Parliament and Council Directive 2005/36/EC

The European Parliament and Council Directive 2005/36/EC of 7 September 2005 established an automatic recognition of qualifications in medicine, general care nursing, dentistry, veterinary surgery, midwifery and pharmacy.⁷¹ This is based on the coordination of minimum training content. The Directive establishes the basic training for each of these professions. Regarding the social and cultural context of the population for whom the health care is directed, the Directive establishes only that said training must assure "the acquisition of knowledge and competencies regarding the relationships between the state of health of human beings and their physical and social environment." No reference is made to the recognition of differences in the population or to the specific competencies necessary to adapt health care to this diversity.



5.3. Green Paper on the European Workforce for Health

The European Commission's 2008 Green Book on health staff does not list health care to migrants among the challenges faced by health staff today.⁷² The challenges mentioned focus on the aging and diversity of health staff, lack of attractiveness of health sector employment for new generations, and migration and unequal mobility of health professionals inside and outside the EU. The document also mentions the importance of permanent updating of professional qualifications (continuing education) and the need to increase language training in order to assist health staff in transferring.

5.4. Common Immigration Policy for Europe

The EC's Common Immigration Policy describes how the shortage and demand of medical and nursing staff in the developed world has caused an increase in the migration of professionals from less developed countries.⁷³ It recommends circular migration. This requires improving the health professionals' education and training so that their qualifications are suitable for the European labour markets. The challenge therefore is the ethical management of professional migration and its adaptation to the health systems of receiving countries, rather than acquiring the necessary competences for managing diversity in local health care contexts.

6. Survey Findings on Training a Migrant-Sensitive Public Health Workforce

The web-based survey covered key aspects of training to develop a migrant-sensitive public health workforce. They included identifying training needs and designing, planning and evaluating training programmes; defining who should receive the training; selecting the types of professionals to provide the training, and teaching methods. The 41 key respondents came from six selected countries: Malta, Poland, Portugal, UK, Spain and Sweden.⁷⁴ They worked for government institutions, universities and continuing education centres. The main findings are described below.

6.1. Organisations responsible for training

Government bodies, universities and continuing education centres were reported to be the main organisations responsible for planning and implementing training. Respondents in countries such as Malta, Portugal and Poland, whose migratory experience is recent, indicated the existence of occasional training initiatives in management of diversity. These have been supported by universities (University of Malta), health care institutions (Mater Dei Hospital, Central Clinical Hospital of Warsaw), non-profit organisations (MSF in Malta, IOM in Hungary, Poland, Slovakia and Romania) and voluntary organisations who work with asylum seekers and refugees needing medical care (Poland).

In Spain, many organisations and institutions promote diversity management training. They include health departments of the autonomous governments, provincial governments, local authorities, universities (graduate and post-graduate), specific post-graduate training centres (Carlos III Health Institute, Andalusian School of Public Health), professional associations (Spanish Society of Family and Community Medicine, semFYC), trade unions and health centres, as well as the Ministries of Health and Social Policy, and Labour and Migration. The initiatives are still fragmented and not very homogeneous.

In Sweden, universities and university colleges carry out training programmes for health professionals on issues related to migration, health and culture.

In the UK, the NHS, universities and diverse professional associations (such as the Royal College of Physicians) organise training in diversity management as a cross-cutting skill. All training centres of public organisations in Britain are obliged to fulfil the legal requirements for fighting discrimination and promoting equal opportunities. Consequently, diversity related content must be present in all professional

training. Sensitisation and training activities for health staff (e.g. nurses and midwives) are also carried out. Specific activities are arranged for health staff working with particular groups, such as asylum seekers and refugees.

6.2. Identification of training needs

The respondents identified the project, “Increasing Public Health Safety alongside the New Eastern European Border Line,” as a ‘good practice.’ This project is led by IOM and carried out in Poland, Slovakia and Hungary. The training needs of health staff were identified through individual and group interviews. The health professionals work with migrants in refugee and border guard centres in these countries and in Romania. The intercultural competency training strategy of the Spanish Ministry of Health and Social Policies provides another example of a ‘good practice.’ Training needs in this strategy were identified through group interviews of key respondents. They represented a diverse professional profile related to health care for migrants.⁷⁵

Nursing, primary care medical and social work staff were the main professional groups for whom training needs have been identified in training activities, organised by their own institutions. In Sweden, primary care and specialised nursing staff and midwives were the main groups. In the UK, they were nursing and medical staff and midwives. Doctors and nurses in hospitals and emergency services, psychologists, administrative staff and medical and nursing students are other professional groups, for whom training needs have been identified.

The training needs, which most respondents listed, include:

- Competences for managing cultural diversity;
- Communication skills;
- Mental health care;
- Epidemiology;
- Disease prevention;
- Legislation (right to health care); and
- Administrative issues (procedures and formalities for providing health care).

It should be noted that when discussing competencies for managing cultural diversity, the respondents used the terms ‘cultural,’ ‘transcultural’ and ‘intercultural’ competence interchangeably.

Other identified training needs related to sexual and reproductive health of migrant women; childhood, vulnerability and migration;



care of disability in migrant populations; health and human rights; mediation and resolution of disputes; work with community organisations; experiences and tools for improving health care for migrants; health literacy for migrants; language skills; and interdisciplinary work. The respondents reported a growing interest in training socio-cultural mediators and a need for these professionals in the health services.

6.3. Profiles of trainees

Migration and health-related training has been mainly aimed at primary care nursing staff, according to most respondents. A long background in the transcultural nursing model means that this type of training is traditionally assigned to these professionals. Primary care medical and social work staff and midwives are other professional groups receiving training. Some training efforts have included hospital and emergency service medical and nursing staff, psychologists and nursing assistants, medical students, psychiatrists, administrative staff, policy makers, and workers from non-governmental organisations working with migrants.

The respondents emphasised that teachers, politicians, the military, administrators, intercultural mediators, psychiatrists and nursing assistants also need training on intercultural issues.

6.4. Training content

Training content has varied depending on the professional profiles of those receiving training and the sectors at which the training was aimed (i.e. social, health and voluntary work). In the UK, for example, training content has included the right to health care; social assistance and social services; maternal and child health; mental health (asylum seekers and torture victims); and care of infections prevalent in certain migrant groups (e.g. HIV). Perception of health in other cultures, understanding health systems of other countries, sensitising people with regard to migration, equality and diversity, protection of migrant children, work with interpreters and interpretation of diversity at a local level have also formed part of training.

In Spain, training content has covered knowledge of other cultures, customs, religions and habits; communication skills; cultural, intercultural or transcultural competence (different depending on the context, health profession and country of migrants' origin); health care rights of migrants; social-health resources; and mediation of disputes. Training has also been provided on different perceptions of health and illness, mental illness associated with the migratory process, reproductive health, maternal and child health, tropical diseases and endemic pathologies in the countries of origin.

6.5. Types of professionals providing the training

Professional profiles of those responsible for the training are diverse. The most common groups are nursing, medical and social work professionals. In some countries, such as Spain, sociologists, anthropologists, political experts and cultural mediators have been included in the teaching staff. In Malta, cultural mediators provide this type of training. In the UK health professionals, who are directly involved in care provision to NHS users, are included as trainers.

6.6. Teaching methods

Theoretical classes and debates are traditionally used, although workshops, seminars and group work have been employed in some cases. In the UK and Spain, case studies and audiovisual material are common teaching methods. Little virtual training appears to be taking place in this area, although the respondents did suggest more innovative formats. These include case studies, work with real or virtual patients, role-play, field work, monitoring through discussion groups, creation and monitoring of plans of action, and round table discussions with intercultural mediators.

The most relevant methodologies for providing the training that were reported are:

- Audiovisual material;
- Migrants as trainers;
- Participation in group debates (local level);
- Fieldwork (through focus groups and practical case studies at a local level);
- Practical work in the field (making use of the diversity existing between the students themselves and the increasing interest in health and migration);
- Case studies (backed up by self-study material);
- Seminars and workshops on case studies and practical experience with real or virtual patients;
- Using role-play and simulation techniques;
- On-the-job training;
- Specific training of reference professionals in health centres;
- Round table discussions with intercultural mediators; and
- Exchange of experiences and cases attended.

The respondents suggested that persons with a wide experience of community work be included in the teaching staff. They also emphasised the importance of continuously evaluating the learning progress by using refresher sessions and discussion groups with other professionals. This was seen as important for planning subsequent steps in the training of each health professional.

6.7. Evaluation of training processes and results

Evaluation of the training process, results and impact on the knowledge, skills and attitudes of professionals was not common. The same was true of evaluation of training materials. The respondents were, however, able to identify various elements which help and hinder the implementation of training programmes.

Elements helping implementation include:

- Existing migration and health policies;
- Identification of training needs of professionals to carry out their professional activities;
- Interest of health professionals who are sensitised and/or trained in these subjects;
- Legislation and rules of operation of the health system (e.g. the NHS includes equality and diversity as key elements in training and health services);
- Facilities offered by a health organisation for training;
- Human factor (with regard to the person who leads the training process);
- Research related to this subject area at universities and training centres;
- Possibility to exchange experiences with other professionals; and
- Availability of networks of interdisciplinary collaborators.

Elements hindering the implementation of this type of training programmes are:

- Work load;
- Working hours;
- Shortage of funds;
- Low level of priority;
- Prejudices and lack of interest among professional groups;
- Lack of continuity in the courses;
- Scarcity of good scientific documentation;
- Unavailability of specialists to cover specific training needs;
- Lack of tangible tools to help professionals carry out their functions in this field; and
- Poor dissemination of information regarding training opportunities.

6.8. Intersectoral cooperation in training

The initiative for designing and implementing the training strategies normally comes from the health sector itself, according to the respondents. Occasionally, initiatives may come from other sectors, such as social services, governance or employment. Usually then, the initiating sector has the main control over matters of integration, social protection or migration. The voluntary sector and migrants' associations themselves also play an important role.

Forums and encounters, bringing together various actors, and the availability of financing for better coordination were mentioned as mechanisms toward improved intersectoral cooperation. Other elements, such as the country's size and relations with other actors from different disciplines and sectors, promote intersectoral collaboration. The respondents felt that coordination between different sectors produces better results, helps with the assignment of roles for each sector, promotes links with local communities, and improves communication. Lack of intersectoral cooperation, on the other hand, limits the scope of training programmes on these important subjects. Selected examples of existing training efforts for a migrant sensitive health workforce can be found in the Appendix.



7. Conclusions

Migration flows in Europe have increased in size and complexity. They respond to demographic changes and labour demands in Europe, political upheavals, and economic disparities between European countries and their neighbours. The consequent increased diversity in health determinants, vulnerability levels and needs among different members of society is challenging the capacity of health care delivery systems. This increased diversity calls for a more migrant-sensitive workforce.

Such a workforce:

- Has appropriate intercultural competence, language and communication skills;
- Knows how to manage change, cultural diversity and values;
- Is sufficiently knowledgeable of other cultures and customs to be able to develop professional practice with respect to the autonomy, beliefs and culture of the patient;
- Understands migrant health determinants and strives to contribute to reduce social and health care inequalities;
- Recognises the disease profile of migrants and its epidemiology;
- Manages competently the clinical manifestation of disease in different ethnic and population groups;
- Knows the rights of migrants to health services; and
- Is able to advise migrants on how to access and what to expect of health services.

Migrant-sensitive training approaches are good public health practice, because they increase access of all populations to health care and improve the quality and effectiveness of services. These improvements, in turn, reduce health inequalities in the society and promote health for all.

The following actions, strategies and policy changes are recommended for adoption and implementation by the European Union, governments, and institutions and organisations responsible for training health professionals.

Recommendations

7.1. EU and other European institutions

7.1.1. Promote the inclusion and harmonisation of migration health topics and intercultural competence in the training of all public health professionals, across all sections of graduate and post graduate medical curricula, in EU countries.

7.1.2. Support the creation of avenues for the exchange of training experiences, approaches and content between relevant actors and institutions of the different Member States. Support exchange visits of professionals and their participation in training activities in other Member States and countries of migrant origin.

7.1.3. Promote, fund and increase research into the effectiveness of training programmes at the European level. This should include evaluation of learning, as well as impact of training on the health of migrants. Develop evaluation systems to identify whether training programmes respond appropriately to migrant health needs. Include common objectives and indicators in the curricula of health professionals, both in undergraduate and postgraduate education and in continuing education, to make such evaluation possible.

7.2. EU Member States

7.2.1. Promote health professional training, including continuing education strategies, that strengthens the recognition of diversity and includes migration related competences and skills for all health professionals. Use incentives, such as accreditation, to encourage participation of training institutions.

7.2.2. Examine the main professional training strategies, the organisation of graduate, post-graduate and continuing education programmes and the manner in which the new competencies could best be incorporated into training in order to make appropriate changes in the training of public health professionals.

7.2.3. Ensure that the content of undergraduate, postgraduate and continuing education of health professionals supports the fight against social exclusion, discrimination and barriers to migrants' access to health care.

7.2.4. Take advantage of country-level activities towards a common compulsory curricular design, as stipulated in the Bologna Declara-

tion, to ensure that the required competencies for a migrant-sensitive public health workforce are incorporated. Different degree courses are at various stages of convergence with the EHEA, and provide different windows of opportunity for the inclusion of new curricular material.

7.3. Universities, education centres, professional associations and healthcare providers

7.3.1. Include curricular content on intercultural competency, communication skills, determinants of migrants' health, and public health issues associated with migration and population mobility in health professional training programmes at undergraduate, postgraduate and continuing education levels.

7.3.2. Design training programmes to be interdisciplinary, use participatory methodologies and facilitate theoretical-practical learning (e.g. role-play, learning communities, learning by doing, discussion groups and group dynamics).

7.3.3. Establish an on-line repository or library on training, including available tools and multimedia courses for self-training.

7.3.4. Involve migrants, in particular the many migrant health workers who reside and work in Europe, in the design, implementation and evaluation of training programmes.

7.3.5. Involve professional associations and other relevant actors in the design, implementation and evaluation of training programmes. Promote the exchange of experiences and good practices between members of the associations and between the associations themselves, aiming for an international network.

7.3.6. Expand intersectoral coordination in designing and developing training programmes for health professionals, in particular the coordination between health, education and social service sectors.

7.3.7. Encourage research and evaluation of effectiveness and impact of training programmes in migrant health.

7.3.8. Act as the leading actors of change in the healthcare setting supporting and encouraging individual professionals in their efforts to implement the new strategies.



Note about the Authors

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Dr Daniel López-Acuña, a Mexican national, graduated as an M.D. from the National University of Medicine and did both his Masters and Doctoral studies in Public Health at the Johns Hopkins University School of Hygiene and Public Health. In 1986, Dr López-Acuña joined the Pan American Health Organization, Regional Office for the Americas of the World Health Organization. Since then until 2005 he has executed several high-ranking functions, including that of Director of Program Management of the Pan American Health Organization. In 2005, he was appointed Director of Recovery and Transition Programmes, Health Action in Crises, at WHO Headquarters in Geneva. This Group is responsible for developing approaches and guidelines to support countries in transitional and recovery phases and strengthening institutional capacities in WHO for assisting countries in planning and implementing transitional and recovery action in post-crisis situations. It will be responsible for building partnerships and promoting inter-programmatic work to ensure an effective and concerted WHO response tailored to the needs of affected Member States.

Jacqueline Weekers has been working in the domain of Migrant Health for over 15 years. She is currently employed at the World Health Organization in Geneva, Switzerland as the senior Migrant Health Officer and works on the promotion of migrant health within the Organization and plans and oversees related activities. Until recently she was employed at the International Organization for Migration, where she had responsibilities ranging from development and management of migration health programmes globally, to advising governments and partners on policy and programme matters as the senior migration health policy advisor, aiming at approaches that address and manage the health of migrants and their hosting communities. Jacqueline Weekers is a Swiss and Dutch national and has an educational background in psychology and public health. Before joining the international community, she practiced as a psychologist in the USA and The Netherlands.

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Footnotes

- 1 World Migration Report 2008. International Organization for Migration (IOM), 02 December 2008.
- 2 López Acuña D, Pittman P, Gómez P, Machado de Souza H, López Fernández LA. La reorientación de los sistemas y servicios de salud con criterios de promoción de la salud: componente decisivo de las reformas del sector de la salud. Technical document prepared for the Fifth International Conference on Health Promotion, 5th to 9th June, Mexico, D.F, 2000.
- 3 Assisting Migrants and Communities: Analysis of Social Determinants of Health and Inequalities. International Organization for Migration, Brussels, 2008 [Accessed 12th June 2009] Available at: http://www.belgium.iom.int/page2.asp?Static_ID=10
- 4 Castles, S. and Miller, M. J. The Age of Migration: International Population Movements in the Modern World. Second Edition, London: Macmillan, 1998.
- 5 Glossary on Migration. International Organisation for Migration, Geneva. 2004.
- 6 Health of migrants. Report by the Secretariat. World Health Organization, Sixty-first World Health Assembly. Provisional agenda item 11.9. A61/12, Geneva. 7 April 2008.
- 7 World Migration Report 2008. International Organization for Migration (IOM), 02 December 2008.
- 8 Pajares M. La integración ciudadana. Una perspectiva para la inmigración. Barcelona: Icaria, 2005.
- 9 Communication from the Commission to the Council, to the European Parliament, to the European Economic and Social Committee and the Regions Committee, 1st September 2005. Common Integration Programme . Framework for the integration of third country nationals in the European Union COM(2005) 389 Final [Accessed 23rd June 2009] Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2005:0389:FIN:CS:PDF>
- 10 Communication from the Commission to the Council, to the European Parliament, to the European Economic and Social Committee and the Regions Committee. Third annual report on immigration and integration. COM(2007) 512 Final [Accessed 14th June 2009] Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0512:FIN:EN:PDF>
- 11 Entzinger H, Biezeveld R. Benchmarking in Immigrant Integration. European Research Centre on Migration and Ethnic Relations (ERCOMER). Report 2003 [Accessed 18th May 2009] Available at: http://ec.europa.eu/justice_home/doc_centre/immigration/studies/docs/epec_final_2005_en.pdf
- 12 Niessen J, Schibel Y. Manual on integration for heads of policy making and professionals. State Office for Justice, Liberty and Security. European Commission, 2007 [Accessed 11th May 2009] Available at: http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/2007/handbook_2007_en.pdf
- 13 Sweden's Strategy Report for Social Protection and Social Inclusion 2008-2010 [Accessed 5th May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf
- 14 Niessen J, Schibel Y. Manual on integration for heads of policy making and professionals. State Office for Justice, Liberty and Security. European Commission, 2007 [Accessed 11th May 2009] Available at: http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/2007/handbook_2007_en.pdf
- 15 Council of Europe. Intercultural Dialogue 2009 [Accessed 2nd June 2009] Available at: <http://www.interculturaldialogue.eu/web/intercultural-dialogue.php>
- 16 House of Commons. Equality Bill Committee. Resolution of the Programming Sub-Committee. 2009 [Accessed 14th June 2009], United Kingdom. Available at: <http://www.publications.parliament.uk/pa/cm200809/cmbills/085/amend/pbc0851905a.11-13.html>
- 17 UK National Report on Strategies for Social Protection and Social Inclusion [Accessed 4th May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/uk_en.pdf
- 18 Spanish Secretary of State for Immigration and Emigration. State Office of Integration of Immigrants. Strategic Citizenship and Integration Plan 2007-2010 [Accessed 23rd December 2008] Available at: <http://www.tt.mtas.es/periodico/inmigracion/200702/plan.pdf>
- 19 National Contact Point of the European Migration Network. Annual policy report, Spain 2007. [Accessed 8th June 2009] Available at: <http://emn.sarenet.es/Downloads/download.do?sessionId=67ED9C2FD8CF66E47B6F9019F21A88B5?fileID=670>
- 20 National Report on Strategies for Social Protection and Social Inclusion 2008-2010 Malta [Accessed 2nd May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/malta_en.pdf
- 21 Babis P. Integration of immigrants in Poland. Ministry of Labour and Social Policy 2008 [Accessed 4th May 2009] Available at: http://www.slovo21.cz/prilohy/PaulinBabis_Integration_of_immigrants_in_Poland-ost.pdf
- 22 Gmaj K. Do it yourself. Immigrants' integration to Polish society. Centrum Stosunków Międzynarodowych Center for International Relations 2007 [Accessed 12th May 2009] Available at: http://www.csm.org.pl/images/rte/File/EN/Publications/Reports%20&%20Analyses/2007/rap_i_an_0107a.pdf
- 23 National Strategy Report on Social Protection and Social Inclusion 2008-2010 Polonia. Ministry of Labour and Social Policy 2008 [Accessed 3rd May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/poland_en.pdf
- 24 Serviço de Estrangeiros e Fronteiras. European Migration network. Annual Policy Report Portugal 2007 [Accessed 12th June 2009] Available at: <http://emn.sarenet.es/Downloads/download.do?sessionId=A53BB56C42471C4D030147F4A29E5A9F?fileID=673>
- 25 National Strategy for Social Protection and Social Inclusion 2008-2010 Portugal. [Accessed 4 May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/portugal_en.pdf
- 26 Dubois CA, McKee M, Nolte E (eds). European Observatory on Health Systems and Policies Series. Human resources for health in Europe. Open University Press, 2006.
- 27 Green Book of the European Communities Commission, 10th December 2008, «regarding European Health Staff» [COM(2008) 725].



- 28 Health of migrants. Report by the Secretariat. World Health Organization, Sixty-first World Health Assembly. Provisional agenda item 11.9. A61/12, Geneva. 7 April 2008.
- 29 Migrant health for the benefit of all. The Eighty-Eight Session of the IOM Council, MC[INF]275. International Organization for Migration, Geneva, 8 November 2004.
- 30 Maffia C. Health in the age of migration: migration and health in the EU. *Community Practitioner*, Aug 2008; 81(8): 32-35.
- 31 Gushulak B, Pace P, Weekers J. Migration and health of migrants. In: Poverty and social exclusion in the European Region: Health systems respond. Follow-up to Resolution EUR/RC52/R7 on Poverty and Health [provisional title]. Copenhagen, WHO Regional Office for Europe, 2009.
- 32 Hargreaves S. Migration high on the agenda at the ESCAIDE 2008. *Lancet Infect Dis*, 2009; 9:11.
- 33 Gushulak BD, MacPherson DW. The basic principles of migration health: Population mobility and gaps in disease prevalence. *Emerging themes in epidemiology*. 2006; 3:3 doi:10.1186/1742-7622-3-3.
- 34 Agyemang C, Addo J, Bhopal R, de Graft Aikins A, Stronk K. Cardiovascular disease, diabetes and established risk factors among populations of sub-Saharan African descent in Europe: a literature review. *Globalization and Health* 2009, 5:7.
- 35 Gushulak BD, MacPherson DW. *Migration medicine and health: Principles and practice*. Hamilton, BC, Decker, 2006.
- 36 Department of Health and Social Security. *Inequalities in health: report of a research working group*. London: DHSS, 1980.
- 37 Whitehead M. *The Health Divide*. Pelican Books, London, 1987.
- 38 Acheson D. *Independent inquiry into inequalities in health*. Chaired by Sir Donald Acheson, London, The Station, 1998.
- 39 Commission on Social Determinants of Health. Secretariat's Report. World Health Organisation. EB124/9 124^a meeting of the Executive Council. 4th December 2008. [Accessed 20th May 2009] Available at: http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_9-sp.pdf
- 40 White Book of the European Communities Commission, 23rd October 2007, *Together for health: a strategic approach for the EU (2008-2013)* [COM (2007) 630 final].
- 41 Vulpiani, P; Comelles, JM; Van Dongen, E. *Health For All, All in Health. European Experiences on Health Care For Immigrants*. Roma: Ed. Freya Serna Cobo-Cidis/Alisey, 2000.
- 42 Gushulak B, Pace P, Weekers J. Migration and health of migrants. In: Poverty and social exclusion in the European Region: Health systems respond. Follow-up to Resolution EUR/RC52/R7 on Poverty and Health [provisional title]. Copenhagen, WHO Regional Office for Europe, 2009.
- 43 Lurbe I Puerto K. Los vacíos excluyentes en la atención sanitaria de los inmigrantes no comunitarios: ¿Se trata de racismo institucional? En: García Castaño FJ, Muriel López C. (eds.): III Congreso sobre la inmigración en España. Granada, Laboratorio de Estudios Interculturales, Universidad de Granada, 2002.
- 44 Personal communication with James Robinson, Equality and Health Improvement Facilitator, Lothian University Hospitals, Scotland. 27 March 2009.
- 45 Huber M, Stanciole A, Wahlbeck K, Tamsma N, Torres F, Jelfs E, Bremner J. Quality and fairness of access to health services. European Commission. Report 2008 [Accessed 12th May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/healthquest_en.pdf
- 46 Bisshoff A et al. Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. *Social Science & Medicine* 2003;57:503-512.
- 47 Partners for Health: a toolkit to identify and fight discrimination against migrants in health care 2008. European Commission. [Accessed 13th June 2009] Available at: <http://www.salutepertutti.org/>
- 48 Bernheim SM, Ross JS, Krumholz HM, Bradley EH. Influence of patients' socioeconomic status on clinical management decisions: A qualitative study. *Annals of Family Medicine*, 2008;6(1):53-59.
- 49 Seeleman C, Suurmond J, Stronks K. Cultural competence: A conceptual framework for teaching and learning. *Medical Education*, 2009;43(3):229-237.
- 50 Martínez Hernández Á. *Antropología y Salud Mental: dilemas y desafíos contemporáneos*. Colección Inmigración y Salud. Monografía 1: Salud Mental en la Inmigración. Escuela Andaluza de Salud Pública, 2008.
- 51 Teal CR, Street RL. Critical elements of culturally competent communication in the medical encounter: a review and model. *Social Science & Medicine* 2009;68:533-543.
- 52 Fabrega Jr., Horacio (1974). *Disease and Social Behavior*. Cambridge: M.I.T. Press.
- 53 Comelles JM, Martínez-Hernández A. *Enfermedad, Cultura y Sociedad. Un ensayo sobre las relaciones entre la antropología social y la medicina*. Madrid:Eudema, 1993.
- 54 Segal L, Bolton T. Issues facing the future health care workforce: the importance of demand modelling. *Aust New Zealand Health Policy*. 2009 May 7;6:12.
- 55 Ministry of Governance, State Office for the Coordination of Migratory Policies, Junta de Andalucía, Spain. *Requirements and Good Training Practices in Intercultural and Gender Issues in Public Administration*. 2008.
- 56 Pinzón S, Gijón MT, García Panal L. *Motivos de frecuentación y necesidades no cubiertas en población inmigrante en España. Convenio de colaboración entre el Instituto de Salud Carlos III y la Escuela Andaluza de Salud Pública*. Granada, 2009
- 57 López LA, González E. *Elaboración y validación de material pedagógico y de una estrategia de formación de formadores y formadores para la adquisición de habilidades y actitudes para la atención sensible y efectiva ante la diversidad, en el mundo profesional. Convenio de colaboración entre el Instituto de Salud Carlos III y la Escuela Andaluza de Salud Pública*. Granada, 2009
- 58 Huber M, Stanciole A, Wahlbeck K, Tamsma N, Torres F, Jelfs E, Bremner J. Quality and fairness of access to health services. European Commission. Report 2008 [Accessed 12th May 2009] Available at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/healthquest_en.pdf
- 59 Partners for Health: a toolkit to identify and fight discrimination against migrants in health care 2008. European Commission. [Accessed 13th June 2009] Available at: <http://www.salutepertutti.org/>
- 60 Khan D, Walker J, Horsefall A, Manning A. *Migrant-friendly Hospitals. Final Report MFH*. Bradford Teaching Hospitals NHS Foundation Trust

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Assisting Migrants and Communities (AMAC) Project

- 2005 [Accessed 2 mayo 2009] Available at: http://www.mfn-eu.net/public/files/experiences_results_tools/pilothospitals/UK_Bradford.pdf
- 61 Maurer E. Equality and diversity in local authority employment and service provision. Switzerland 2009 [Accessed 6th May 2009] Available at: https://wcd.coe.int/ViewDoc.jsp?id=1396665&Site=COE&BackColorIntranet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FD C864#P249_31613
- 62 Pereira Miguel J, Padilla B. Salud y migración en la unión europea: construyendo una visión compartida para la acción. Report 2007 [Accessed 16th May 2009] Available at: <http://www.portaldasaude.pt/NR/rdonlyres/3D05B05F-8C14-491E-99A4-8A6B03074660/0/HealthandMigrationintheEU2042007semimagens.pdf>
- 63 The European Higher Education Area. Joint declaration of the European ministers of education in Bologna on 19th June 1999. [Accessed 23rd June 2009] Available at: http://www.eees.es/pdf/Bolonia_ES.pdf
- 64 Statement on the Bologna process and medical education. Association for Medical Education in Europe (AMEE), World Federation for Medical Education (WFME), Association of Medical Schools in Europe (AMSE), World Health Organisation Europe (WHO-EU). Oslo 2005 [Accessed 25 June 2009] Available at: http://www.google.es/url?q=http://www.educacionmedica.net/pdf/documentos/bolonia/procesoBolonia.pdf&ei=dphESuWlJ9zKjAer841m&sa=X&oi=spellmeleon_result&resnum=1&ct=result&usq=AFQjCNHjNWSMI-oJ4n1svNOMf2tsltXXXA
- 65 Graduate student mobility in medical education in the European Area of Higher Education. International Federation of Medical Student's Associations. Berlin 2008. [Accessed 24 June 2009] Available at: <http://granada.ifmsa-spain.org/foro/index.php?action=dlattach;topic=211.0;attach=260>
- 66 White Book , Nursing Degree Qualification. Spanish Agency for Quality Assessment and Accreditation. 2004 [Accessed 10 July 2009] Available at: http://www.aneca.es/media/150360/libroblanco_jun05_enfermeria.pdf
- 67 Palomino Moral PA, Frías Osuna A, Grande Gascón ML, Hernández Padilla ML, Del Pino Casado R. El Espacio Europeo de Educación Superior y las competencias enfermeras. Index Enferm 2005; 14 (48-49): 50-3.
- 68 White Book, Psychology Degree. Spanish Agency of Quality Assessment and Accreditation. 2004 [Accessed 10th July 2009] Available at: http://www.upm.es/innovacion/cd/04_eees/libros_blanco/libroblanco_psicologia_borrador.pdf
- 69 White Book, Social Work Degree. Spanish Agency for Quality Assessment and Accreditation. 2004 [Accessed 10th July 2009] Available at: http://www.aneca.es/media/150376/libroblanco_trbjsocial_def.pdf
- 70 Tutosaus Gómez JD. European convergence in postgraduate education. Medical Education 2005; 8(3): 30-7
- 71 Official Diary of the European Union. Directive 2005/36/CE of the European Parliament and of the Council of 7th September 2005, regarding the acknowledgement of professional qualifications [Accessed 23rd June 2009]. Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:es:PDF>
- 72 Commission for the European Communities. Green Paper on the European Workforce for Health. Brussels COM(2008) 725. [Accessed 23rd June 2009] Available at: http://ec.europa.eu/health/ph_systems/docs/workforce_gp_es.pdf
- 73 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - A common immigration policy for Europe: Principles, actions and tools {SEC(2008) 2026} {SEC(2008) 2027} (presented by the Commission) [Accessed 18th August 2009] Available at: [http://eur-lex.europa.eu/Notice.do?val=473216:cs&lang=en&list=473216:cs,478659:cs,478654:cs,&pos=1&page=1&nbl=3&pgs=10&hwords=SEC%20\(2008\)%202026~](http://eur-lex.europa.eu/Notice.do?val=473216:cs&lang=en&list=473216:cs,478659:cs,478654:cs,&pos=1&page=1&nbl=3&pgs=10&hwords=SEC%20(2008)%202026~)
- 74 Pinzón S, Gijón MT, Kolehmainen-Aitken RL. Developing a public health work force for migrant populations' health in Europe. Resultados de la encuesta. Andalusian School of Public Health Granada 2009 [Accessed 25th June 2009] Available at: <http://si.easp.es/cuestionario/admin/admin.php?sid=67573>
- 75 Production and validation of teaching material and of a trainer training strategy for the acquisition of skills and attitudes for sensitive and effective attention to diversity in the professional world. Collaboration agreement ISCIII-Andalusian School of Public Health. Granada, 2008.



Appendix

Examples of training for a migrant-sensitive health workforce

The survey respondents were asked to provide 'good practice' examples of training in topics of relevance for developing migrant-sensitive health professionals. The EASP team provided additional examples. The number of Spanish examples in the final list reflects the EASP team's familiarity with training in Spain.

Some of the collected examples are described below.

Malta

1. Online cultural competence courses

The objectives of online cultural competence courses for health professionals are:

1. Promote cultural competence in organisations;
2. Discuss migration and its impact; and
3. Prevent disputes in dealing with staff of different cultures.

Health professionals, technicians and migrants themselves have been involved in designing and implementing the online courses. The courses consist of a series of exercises, readings, presentations and evaluations.

2. Diversity in health and social care

The objectives are to promote cultural competence within organisations, generate awareness of migration and its impact, and reduce conflict in dealing with people from different backgrounds. Training is targeted at health and social care professionals, military personnel, the police and teachers. Migrants and representatives of their organisations are included as trainers in the four-month course.

Spain

1. Improving intercultural competence in health services

The training was aimed at health and paramedic staff of primary care centres and hospitals in Catalonia. Its goals were to:

- Increase knowledge of the migratory phenomenon to understand its repercussions on health services;
- Offer space for reflection and practical learning as a group with professional experience of caring for migrants.

The seminar-workshop was conducted within the framework of the Network of Centres from the "Intercultural Mediation in Health Centres" programme.¹ The identified training needs included developing a broad view of the migratory phenomenon, acquiring the intercultural competence necessary to improve daily work with newly arrived persons, and taking an active part in the changes which the organisations have to undergo.

2. Intercultural mediation in health care

The training is targeted at intercultural mediators in primary health care centres in Catalonia.² It seeks to ensure that these mediators have the minimum qualifications and share a basic view of intercultural mediation in health care. Training covers medical anthropology, biomedicine, ethics, key medical issues, intercultural competence, intercultural mediation, professional identity, linguistic interpretation, intercultural communication, practice areas and ethics. The methodology is participatory with role-plays, exercises and supervision of the group.

3. Course on migration, health and gender

University students in social-health disciplines (medicine, nursing, social work, psychology, pedagogy, anthropology, etc.) in Andalusia are the target of this training.³ The goals are to:

- Analyse and understand the development of inequalities based on differences in sex, ethnicity and social position;
- Analyse and understand the influence of these inequalities on people's health, and consider the inclusion of migrant women in the Andalusian labour market and its repercussions on their health;
- Think critically about the current approach to health care delivery by the Andalusian health system, and the influence it might have on maintaining inequalities in health;
- Share experiences and knowledge to improve intercultural skills.

¹ The team of trainers included two doctors specialised in groups and health education, sociologist from the University of La Coruña, psychiatrist, Director of the Service of Psychopathological and Psychosocial Attention to Migrants and Refugees, doctor specialised in public health, lecturer from the University of Leeds (UK) and head of Cáritas/Migrantes in Italy.

² The training effort arises from an initiative of the Health Studies Institute (IES). The actors involved in its design and implementation are the Social Action of La Caixa and the Psychiatric Service of the Vall d'Hebron Hospital.

The course is held annually for two days and consists of two or three round tables and about 15 workshops on varying subjects. Topics covered include intercultural and gender competence of health professionals, health care to migrant women who exercise prostitution, and local action strategies for reducing inequalities.

4. Training of trainers

The training is supported by the Spanish Ministry of Health and Social Policies, and implemented by the Andalusian School of Public Health. It is directed at health professionals from all the Spanish Autonomous Communities through the training of trainers from health centres, professional associations and continuing education institutions.

The training needs of health professionals and the roles of different participants were identified in 2008. The roles are:

- Experts make up the Committee of Experts, which establishes the contents, materials, formats and teaching methods to be used in the training;
- Authors produce teaching materials (complete teaching blocks). They may or may not participate in the experts' meetings and in the Training of Trainers workshops;
- Training of Trainers workshop teachers are responsible for training the future trainers;
- Trainee professionals are the students, who attend the subsequent cascade training courses carried out by the institutions;
- Trainers are the students of the Training of Trainers workshops. They will also be the teachers who provide the cascade training; and
- Management Team is a technical team. It includes professionals who are experts on the subject matter or on professional training, teaching methods, management and production of teaching materials and management of virtual communities.

A set of resources, consisting of twelve teaching units, was produced to support the training. It includes class presentations with notes by the author on each session plan and teaching material, supporting reading material, audiovisual support material, a documentary, plans for group work, information about the authors, and communication resources.

The didactic units are:

1. Adaptation of services to interculturalism;
2. Mental health;
3. Sexual and reproductive health;
4. Interviews and communication with migrant populations;
5. Mediation and management of disputes;
6. Population health care needs and problems;

7. Accessibility to services;
8. Intercultural medicine;
9. Chronic diseases and determinants of health;
10. Imported diseases and emergency care;
11. Interculturalism in care; and
12. Skills and work in the field.

5. FORINTER project: Intercultural training

The FORINTER project is carried out by the General Directorate of Migration Policies and co-financed by the European Social Fund within the framework of the Operative Programme of Andalusia 2000–2006. Its goal is to introduce a cross-cutting intercultural perspective to various public policies. It supports designing, implementing and evaluating a training plan on intercultural issues. The training targets directors, managers and technical staff of public bodies whose professional work is related to the migratory phenomenon.

The FORINTER project carries out training activities in intercultural competence for civil servants in the eight provinces of Andalusia. In 2009, the activities include:

- Intercultural Training Courses (Almeria, Cordoba, Granada, Seville and Malaga);
- Training Course in Intercultural Mediation (Cordoba);
- Inter-culture and Social Intervention Courses (Almeria);
- 1st Africa Day (Seville);
- Inter-culture and Migrant Children and Young People Care (Cadiz and Jaen);
- Health Care to Migrants on an Intercultural Basis: Specialized Training Course (Huelva);
- Diversity Management: "culturally competent" professionals and centres, and
- Diversity Management in Planning (Seville).

Sweden

1. Training on values

The training targets social workers in Sweden. The goal is to sensitise students with regard to diversity and discrimination, and improve

^{III} The training programme is carried out under a Agreement of Collaboration between the Andalusian Regional Ministry of Health and the University of Seville. It has been held in Seville twice thus far (2008 and 2009). The following institutions participated in its design and implementation: University School of Health Sciences of the University of Seville; General Secretariat of Public Health and Participation of the Andalusian Regional Ministry of Health; Provincial Health Office of Seville; Andalusian Health Service (SAS); University Community Service (SACU); and Institute for Women of the Spanish Ministry of Equality.



their view of migration.^{iv} The training involves a card game in which some students are subject to discrimination in accordance to the rules of the game. The discussion at the end brings out issues related to discrimination. The students debate internal and external factors of discrimination and their different reactions to the situation.

2. Use of experts, politicians, professionals, and NGO and client organisation representatives in teaching sessions

The goal of including the above individuals in teaching sessions is to get relevant information from actual policy makers and practitioners regarding ongoing issues and debates. The trainees are students in social work, public health and other health professionals. The training consists of two to three hours of lecture and discussion, or a panel discussion.

United Kingdom

1. Knowledge and Skills Framework (KSF) of Agenda for Change

The training targets health professionals in the United Kingdom. Its goal is to promote equality and diversity through professional practice by training health professionals to:

- Act in ways that support equality and diversity;
- Support equality and diversity;
- Promote equality and diversity;
- Develop a culture, which promotes equality and diversity, moving from the promotion of equality and diversity to a leadership of an organisational culture that promotes equality and diversity.

Government health departments, health professionals and employee representatives are involved in the implementation. The training strategy is carried out within the framework of the NHS reform and in the context of the British government's new equality bill. Knowledge and skills which individual health providers require for their specific roles were determined and form part of the annual review and promotion processes.

2. Ethnicity Training Network

The goal of this course is to increase individual and organisational cultural competence through training that is based on an evidence based model of cultural competence in practice. The target group consists of health and social care professionals, trainers in cultural competence, service users and family carers.

The training programme is university based. It was initially funded by the Department of Health, and now receives funding from Care Services Improvement Partnership and course fees. The training consists of a range of courses. They are run for health and social care organisations (tailor made) and individuals (coaching and mentoring scheme), and include a Masters-level training programme. Teachers and tutors are trainers from the Ethnicity Training Network. The training strategy is established over two years, with ongoing implementation.

3. Developing and piloting a multidisciplinary programme for social care assessment, working with vulnerable women

This project was commissioned by the NHS West Midlands workforce deanery. Its goal is to develop a postgraduate programme in the Birmingham City University for specific cohorts of health visitors. The graduates will be able to identify and undertake social risk assessments, target resources and care appropriately to vulnerable women, and provide appropriate support to such women and their families. The planned training programme will last one year. It will be provided in 5 specific areas of the region with existing high levels of deprivation and perinatal mortality.

4. Refugee and asylum seeker health training

The goal of this 12-18 month training programme is to provide (1) an overview of the health needs of new arrivals (specifically asylum seekers and refugees) to health staff, and (2) specific health promotional sessions to asylum seekers, refugees, and unaccompanied asylum seeker children. The target groups are health professionals in Coventry (including health visitors, practice nurses, midwives, General Practitioners, public health staff and administrative staff) and refugees and asylum seekers. The specific training modules cover complex health needs and understanding of refugees' and asylum seekers' rights and entitlements.^v

^{iv} Training lasts from 2 to 3 hours, and is carried out with one teacher per 20 students during the first year of the social work degree course.

^v The session titles are: Refugee health, Mental health, Introduction to asylum, health and support, Parenting course, Female Genital Mutilation, HIV & sexual health, Sickle cell, Healthy living, Sexual health & risky behaviour, Men's health, Contraception, Report writing for asylum, and Public health and infectious diseases.



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