Maternal and Child Healthcare for Immigrant Populations

International Organization for Migration (IOM)

Background Paper

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Abstract

Caring for migrants’ health is a matter of human rights and a fundamental way of tackling unacceptable inequalities in health and healthcare.

In the European Union, the recent migration trends and movements, such as the increasing feminization of migration, alongside with family reunification policies developed by some member states raise new concerns about the capacity of social policies to deal with this population group.

International organizations have reinforced that women are a critical foundation for the sustainable development of the society in which they are integrated (UNFPA, 2005). Efforts on education, maternal health and economic opportunities benefiting women and children have an immediate as well as long-term and intergenerational impact (World Bank, 2001). In addition, the WHO highlights the importance of maternal and child health improvement as an integrative aspect for the reduction of family and community poverty (OMS, 2005).

Within many groups, such as refused asylum seekers, trafficked people and undocumented migrants, women and children are recognized as being particularly vulnerable to health problems and having often reduced access to prevention and healthcare. Maternal and child health is therefore not only a health priority but moreover motherhood and childhood constitute an unique period to reach families, to identify health problems and to have a substantial intervention on health promotion and disease prevention.

Examples of prospective and retrospective research being carried out at a national or regional level are: maternal, perinatal and infant mortality and morbidity (Belgian, UK, Netherlands, Sweden, Spain, Greece, and Portugal), infections prevalence (Portugal, Spain), women and children access to healthcare services (Sweden, Portugal). Some of these studies also compare documented and undocumented immigrant families.

In some member states (Portugal, Spain), innovative legislation allows migrant families an universal access to the National Health System regardless of their legal status in the national territory or of their country of origin. Although there is a consensus that good practices should be jointly developed by the public, private and social sector, there is no general agreement on what good practices are or should be.

Some initiatives that could be considered as good practice in this area are being carried out by some members states, namely Portugal (Health Mobile Units), Check Republic (Research), Netherlands (Avoiding the HIV vertical transmission), Austria and Italy (Pre-natal courses for migrant women or from minority groups), Sweden (Regional Medical Programme for asylum-seeking children with severe withdrawal behaviour), Spain, (the Maternal-Child programme and the Maternal-Child service are socio-sanitary resources promoted by the Lleida Municipality for families at risk - with children aged 0-3 - that are in need of support on child rearing and education), Germany (Health promotion for migrant women; Eating with Joy), Italy and Cyprus (Maternal health and child of immigrant families).

Formulating recommendations will require increased focus on access to healthcare systems, to antenatal and postnatal care, family planning, and screening for HIV in conjunction with the development of innovative concepts for planning health promotion interventions that respond in an effective way to families, women and children health needs. We must also focus on developing recommendations for health promotion providers on how to better integrate migrant families in health promoting interventions.
Introduction

Migration, nowadays, represents a great opportunity for the European Union. It counteracts the demographic ageing and enhances its economic potential by meeting the needs of an increasingly demanding labour market and by contributing to socio-cultural enrichment. However, migration is also a challenge for the European Union: new needs emerge as the population becomes more heterogeneous and increasingly mobile, and societies have to adapt to the new context of coexistence of migrants and host populations.

If considering the particular issue of the health of migrants, we must to emphasize the salient role that health and health care play in the integration of the migrant population. As Ingleby (2008) wrote “access to good quality health care is thus an important aspect of the social inclusion or exclusion of migrants”. Caring for migrants’ health is first and foremost a matter of human rights and a matter of tackling unacceptable inequalities in health and health care. But not only: caring for the health of migrants is beneficial both for migrant and host populations. Indeed, the socio-economic promise of migration will not be realized if migrants live in unhealthy places, do not access health services and enjoy a worse health condition than host populations. Meanwhile, acknowledging the necessity to remove barriers in access to care can also represent an improvement for health systems which is beneficial to the whole population.

The participation on AMAC Project and this background paper on Maternal and Childhood Healthcare in Migrant’s Populations, is in the same spirit, and thus a follow up, of the European Conference “Health and Migration. Better Health for all in an inclusive society”, held in Lisbon and organised by the Ministry of Health during the Portuguese Presidency of the EU Council, in September of 2007. During that event, Woman and child healthcare had been one of the four thematic workshops organized around relevant issues that were considered priorities. The workshop discussions rendered a set of recommendations to be implemented at different levels within the European Union.

The final conclusions and recommendations of the Lisbon Conference emphasized the need for a specific and common policy for the management of health and health care for migrant and ethnic minority populations. A comprehensive perspective is needed to acknowledge the different situations around migration and the recognition of migrants’ fundamental rights. Portugal recognises the right of migrants to access the National Health System. The law ensures access to health care for all citizens regardless of their legal situation in the national territory. However, in practice, several obstacles and barriers are well-known (language and cultural miscommunication, lack of information, cultural incompetency, administrative resistance, etc.) that render a more difficult access.

The Conference created an initial spark to foster collaboration among EU Member States to further develop and support initiatives to improve practices and knowledge around issues of migrants’ health. Thus, on December 2007, the Employment, Social Policy, Health and Consumer Affairs Council of the EU decided to adopt the recommendations on the health of migrants, largely based on the Conference recommendations and conclusions. That document highlighted the importance of cross-sector action as well as Member States’ responsibilities. Consequently, the European institutions and Member States were invited to take action on the subject. The EPSCO Council Conclusions were also echoed at the World Health Organization. A resolution on the Health of Migrants was proposed by Portugal as an item of the 122nd Executive Board agenda, latter discussed at the 61st World Health Assembly, in May of 2008. Finally, an important resolution was
approved that also builds on the recommendations of the Lisbon conference which was all in all an achievement of the European Union.

Recently, the French Presidency approved a new political document, the “European Pact on Immigration and Asylum” (Sept. 2008), with a different spirit. It considers that “the European Union, however, does not have the resources to decently receive all the migrants hoping to find a better life here. Poorly managed immigration may disrupt the social cohesion of the countries of destination. The organisation of immigration must consequently take into account Europe's reception capacity in terms of labour market, housing, health, education and social services, and protect migrants against possible exploitation by criminal networks. The creation of a common area of free movement also brings Member States new challenges. The actions of one Member State may affect the interests of the others. Access to the territory of one Member State may be followed by access to the others. It is consequently imperative that each Member State considers others interests when designing and implementing its immigration, integration and asylum policies.”
Relevant Facts, Figures and Trends in Maternal and Child Health of Migrant’s Populations

As migration has turned into a new or permanent reality for most European countries, more research is being conducted in order to become more acquainted with the changes, its consequences and in order to produce better public policies. Even if with globalisation travelling has become more frequent and less dangerous, migration still entails stress and risks of different types. Even in the best conditions, the migration process involves a series of events that can place migrant’s health at risk. The process of migration involves uprooting, being separated from family and traditional values, and being placed in new social and cultural contexts where job and legal security may be minimal or unknown. Furthermore, the rise of inequalities across and within countries negatively affects access to health care (Collins, 2003).

Studies show that migrants and especially women suffer from several health problems including psychological and emotional distress that put their health and that of their families at risks. Irfaeya, Maxwell and Kramer (2008) in a recent article provided the most comprehensive study of psychological distress among (Arab) women living in Germany. According to them, higher stress scores were associated with older age, lower level of education, having more children, coming from a North African rather than Middle Eastern or European country, having lived in Germany for <15 years, having had a disease since migrating to Germany, being ill at the time of the study, and feeling negatively about being a migrant (2008: 337). If the general wellbeing of migrant women is compromised, other aspects of their health and that of their families may be also compromised, thus there is a need for holistic intervention that avoids the compartmentalisation of women’s health and instead uses when proper, a family approach.

Since the 1990s, there is a growing awareness that women who migrate are particularly vulnerable and that their reproductive health and especially maternal health remains often unnoticed and unaddressed. In 1996, the World Health Organization (WHO) emphasized the importance of giving greater priority to health monitoring of women in all migration-related situations (Carballo, Grocutt, & Hadzihasanovic, 1996). This becomes especially important when considering the increasing feminisation trend within migration flows. While maternal mortality and other indicators of reproductive ill-health are generally low in Western Europe, we know that the risks are significantly higher for migrant and refugee populations living in those countries than for the resident population (Carballo & Nerukar, 2001; CEMACH, 2007; Gissler, Pakkanen, & Olausson, 2003; Temmerman, Verstraelen, Martens, & Bekaert, 2004; Waterstone, Bewley, & Wolfe, 2001).

Studies point out that immigrant women are significantly more likely to have low family incomes, low social support and poor health status (Sword, Watt, & Krueger, 2006). Reproductive and maternal health appears to be affected by changes in social and economic environment, changes in sexual behaviour, social status and access to health care (Carballo & Nerukar, 2001). Women within many groups, like refused asylum seekers, trafficked women and undocumented migrants, are recognized as being particularly vulnerable to health problems and often have reduced access to prevention and health care (Bragg, 2008; Wolff et al., 2008).

In some cases migrants have not presented the worst health indicators if compared to national populations and sometimes appear to be healthier, which has been described as the healthy immigrant effect (Gissler et al., 2003; Kandula et al. 2004; McKay, Macintyre, & Ellaway, 2003; Abraído-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999; Razum, Zeeb, & Rohmann, 2000). People who migrate generally tend to be healthier; however immigrants have been recognized to be particularly vulnerable to ill-health. In the case of women and children this is particularly true,
especially regarding reproductive and maternal health, due to several risks which these groups are exposed in host countries (Kandula et al., 2004). In some countries, research suggests that “the high proportion of new born from foreign mothers, the mental needs, deficits in oral and dental health, and the increase of tuberculosis in migrants, together with limited vaccine coverage in children, define the main health needs of these populations” (Jardà and Garcia de Olalla 2004: 207).

International organizations have reinforced that women are an important foundation for the sustainable development of the society where they are inserted (UNFPA, 2005). According to the World Bank, efforts on education, maternal health and economic opportunities for women create immediate, long-term and intergenerational effects (World Bank, 2001). These three investment areas are recognized as decisive elements for the development of women human capital and, by extension, of their children and families. Also, the WHO highlights the relevance of maternal and child health improvement as an integrative aspect for reduction of family and community poverty (OMS, 2005).

1. **Maternal and newborn health**

In host countries, migrant women often face difficulties during pregnancy and childbirth. In Portugal, a study on maternal health in 1964 newborns demonstrated a higher maternal morbidity among immigrants compared to Portuguese population (Machado et al., 2006).

In maternal health the *healthy migrant* effect has been showed in some indicators like mortality (Muening & Fahs, 2002; Noh & Kaspar, 2003). However, empirical evidence shows higher levels of maternal mortality in migrant segments of populations compared to residents both in developed and developing countries (Bartlett et al., 2002; Razum, Jahn, Blettner & Reitmaier, 1999). Also, in several studies the perinatal, neonatal and child mortality rates have been consistently higher in foreign-born groups than in the national populations (Carballo & Nerukar, 2001; Schulpen, 1996). A Belgian study on maternal mortality appears to confirm the hypothesis that increasing maternal age is an emerging demographic risk factor for maternal mortality, though the latter effect was also partly due to the high proportion of immigrant women with continued childbearing into their later reproductive years (Temmerman et al., 2004).

A British study found that social exclusion and being non-white were some of the main predictors of severe maternal morbidity (Waterstone et al., 2001). Moreover, high child mortality among migrants has been clearly associated to concentration in low-quality housing and in part to fertility patterns at early ages of children and mother's educational attainment at later ages (Carballo & Nerukar, 2001).

Apart from socio-economic differences, high rates of perinatal and child mortality among migrants can be attributed to factors associated with the migration process, socio-cultural factors and different life style (Brockerhoff, 1995; Carballo & Nerukar, 2001; CEMACH, 2007; Essen et al., 2002; Machado et al., 2006; Schulpen, 1996). Data from Statistics Netherlands obtained from 1995 through 2000 for infants of mothers with Dutch, Turkish and Surinamese ethnicity showed that infant death from perinatal and congenital causes increased with lower age at immigration, and total and cause-specific infant mortality seem to differ according to generational status and age at immigration of the mother (Troë et al., 2007).

A study in Sweden analysed the association between suboptimal factors in perinatal care services and perinatal deaths. The most common factors that could increase mortality among migrants were
delay in seeking health care, mothers refusing caesarean sections, insufficient surveillance of intrauterine growth restriction, inadequate medication, misinterpretation of cardiotocography and interpersonal miscommunication. Comparing immigrant mothers from the Horn of Africa to Swedish mothers who delivered in Swedish hospitals in 1990-1996, the rate of suboptimal factors (in perinatal care services, categorized as maternal, medical care and communication) likely resulting in potentially avoidable perinatal death was significantly higher among African immigrants (Essen et al., 2002).

With regards to miscarriage and prematurely indicators, migrant women also appear to present worst health outcomes compared to nationals. A study in Sweden comparing fertility trends, parturient background and pregnancy outcomes among Finns and Swedes showed that Finns who had given birth in Sweden were older, had a higher parity and a higher prevalence of previous miscarriages than Swedes in Sweden or Finns in Finland (Gissler et al., 2003).

Multiparity appears to be more frequent among migrants than non-immigrant (Puiggròs et al., 2008; Panagopoulos et al., 2005; Vahratian et al., 2004). In Italy, parity and length of stay were important factors associated to preterm delivery (Sosta et al., 2008).

In some studies immigrant status of mothers was associated with lower risk of preterm delivery (Urquia et al., 2007; Vahratian et al., 2004; Wolff et al., 2008), however it was found opposite results showing that preterm delivery tend to be occurred more frequently in migrant women (Harding, Boroujerdi et al., 2006; Machado et al., 2006; Sosta et al., 2008).

A retrospective study in Greece investigated the differences regarding the mode of delivery between Greek and immigrant women (Panagopoulos et al., 2005). Results showed significant differences between the two groups: the percentage of multipara and indication to caesarean delivery was higher in the immigrants group compared to the nationals (Panagopoulos et al., 2005). In Switzerland, a study with 37 332 mother-child pairs from various nationalities who delivered in a hospital from 2000 to 2002 showed some inequalities in reproductive health outcomes. Migrant women presented higher rates of caesarean and an increased risk of being transferred to neonatal care units (Merten, Wyss, & Ackermann-Liebrich, 2007).

Migrant women appear to be more likely to have worst mental health indicators as postpartum depression than national women (Sword et al., 2006).

In Spain, a study analysed the characteristics of immigrants’ pregnancy and its neonatal morbidity indicating that, although the average gestational age was similar between immigrant and national groups, the average weight was significantly higher in immigrant women’s newborns (Puiggròs et al., 2008). Migration status of mothers has been associated with a higher risk of low birth weight of migrant newborns (Carballo & Nerukar, 2001; Mosher, Martinez, Chandra, Abma, & Willson, 2004; Urquia, Frank, Glazier, & Moineddin, 2007). Another study (Sanchez Becerra, 2005) indicates that due to migration, women find themselves in a strange environment that puts them in a condition of inferiority regarding motherhood, family nutrition, domestic habits and the care of the children. This situation is complex and has direct impact on their social and sanitary environments, making necessary and a priority to find adequate solutions to fill in the gaps. In this sense, Vilarmau Vila (2003) believes that inter-institutional coordination together with the community is one way to find better and more efficient understanding when providing health and social services to migrants.

The association between breastfeeding and improved health outcomes for infants, in particular of immigrant mothers has been broadly acknowledged (Neault et al., 2007). Some studies indicate that immigrant women present higher level of breastfeeding initiation and longer duration rates (Merten et al., 2007; Singh, Kogan, & Dee, 2007). Cultural beliefs have a significant influence on
breastfeeding practices (Ergenekon-Ozelci, Elmaci, Ertem, & Saka, 2006). In Turkey, a study with a qualitative and quantitative component intended to explore the breastfeeding beliefs and practices of mothers who were forced to migrate. In general, mothers had a positive attitude towards breastfeeding but colostrum was usually perceived negatively. Mothers with lower education generally believed that colostrum should not be fed to the infant and that a pregnant woman’s milk was unhealthy for the baby (Ergenekon-Ozelci et al., 2006).

A high prevalence of inadequate nutrition has been verified among migrant women who deliver low birth weight babies (Rees et al., 2005). A study from United Kingdom that compared the nutrient intakes of mothers of different ethnic origins showed a high prevalence of inadequate nutrition among those who delivered low birth weight babies. Folic acid and iron intakes were low in all ethnic groups, and the mean vitamin D and calcium intakes were significantly different between the ethnic groups (Rees et al., 2005).

2. Family planning and contraception

Several studies have suggested that migrants tend to underuse contraceptive methods and have lower control of pregnancy compared to non-immigrant populations, which consequently results in higher proportion of unintended pregnancies (Kornsoky, Peck, Sweeney, Adelson, & Schantz, 2007; Ny et al., 2007; Puiggròs, Voltà, Eseverri, Colomer & Barnusell, 2008; Troe et al., 2007; Wolff et al., 2005; Wolff et al., 2008). A study in Portugal aimed to analyse birth rates registered between 1995 and 2002 in Portuguese and African mothers indicated a decline of birth rates in Portuguese teenage mothers, however an increase of birth rates in African teenage mothers was observed (Harding, Boroujerdi, Santana & Cruickshank, 2006).

Several studies point out that migrants have lack of access to and knowledge on the available family planning services and have lack of information about the adequate contraception methods (Carballo, 2006; Dias & Quintal, 2008; Tong, Chen & Cheng, 1999; Zhao et al., 2002). Also, cultural factors like gender inequalities may be disabling of the use of contraceptive methods, particularly among migrant women (APF, 2006; Wall, Nunes & Matias, 2005; Woollett et al., 1998).

3. HIV/AIDS

The epidemiological data available indicate higher incidence rates of HIV infection among migrants, compared to national populations (Fennelly, 2004; IOM, 2005; Coker, 2003; Del Amo et al., 2004; EPI-VIH Study Group, 2002; Harawa et al., 2002; Putter, 1998; Saracino et al., 2005; Shedlin & Shulman, 2004; Solorio, Currier & Cunningham, 2004; UNAIDS, 2004; Wong, Tambis, Hernandez, Chaw & Klausner, 2003). Women appear to be at greater risk than men for HIV due to biological, social and cultural factors (WHO, 2003b; Putter, 1998; UNAIDS/IOM, 2001; UNAIDS, 2004; Bandyopadhyay & Thomas, 2002; Yang, 2006). Furthermore, immigration-related factors place migrant women at greater risk than other women for STIs, including HIV.

In Spain, a study in women of childbearing age showed that 51% of the immigrant women were seropositive while seroprevalence in Spain-born women was 16% (Alvarez, Serrano, Parrado, Ortuño & Sánchez, 2008).
Studies have indicated that often migrants have late HIV screening in pregnancy (Fakoya, Reynolds, Casweel, & Shiripinda, 2008; Jasseron et al., 2008). In order to investigate whether mother-to-child HIV transmission management and rate differed between African immigrants and French-born women, a study was carried out among human immunodeficiency virus type 1-infected women delivering between 1984 and 2007 in the multicenter French Perinatal Cohort. Results showed that among 9245 pregnancies (7090 women) the proportion of African mothers had increased. Also, African women presented a later access to care, discovered more often their HIV infection during pregnancy, started prenatal care in the third trimester and started antiretroviral therapy after 32 weeks of gestation (Jasseron et al., 2008).

4. Access to maternity care services

Women of socially disadvantaged groups, migrant and/or from ethnic minority’ groups have been recognized to be less likely to receive early prenatal care and the necessary care during pregnancy, childbirth and post-natal period (Alderliesten et al., 2007; CEMACH, 2007; Gwyneth et al., 2001; IOM, 2004a; Jasseron et al., 2008; Machado et al., 2006; McDonald, Suellenpont, Paulozzi, & Morrow, 2008; Ny, Dykes, Molin, & Dejin-Karlsson, 2007; Sosta et al., 2008; Thorp, 2003; Vahratian et al., 2004). Also, in a longitudinal population-based survey with 2338 women in Sweden showed that specific groups of women like migrants were dissatisfied with different assessments of postnatal care (Rudman, El-Khouri, & Walsenstrom, 2008).

Empirical evidence has pointed out that migrant groups face several barriers in accessing national maternal health services in Europe (Janssens, Bosmans & Temmerman, 2005). Maternity care is classed as immediately necessary care and so cannot be refused for reasons of inability to pay (Bragg, 2008). However, immigration status presents new challenges for maternity services in the receiving countries (CEMACH, 2007). For undocumented migrants, current regulations and legislations in EU member states do not guarantee access to health care and tend to become more restrictive (PICUM, 2007). Several studies have associated migrant status to pregnancy complications, perinatal and maternal mortality (Carballo & Nerukar, 2001). Lower entitlement to health care of immigrants in the receiving societies has been associated to higher rates of perinatal mortality and disability among migrant groups compared to the national population (Bollini & Siem, 1995). A Swiss study indicated that undocumented migrant women, compared to women who are legal residents in Geneva, have more unintended pregnancies, delayed prenatal care and use fewer preventive measures (Wolff et al., 2008).

Many authors report the disadvantaged socio-economic status as an important barrier to health care, like unemployment, difficulties in transport or inadequate housing. Health of migrants is constrained by the need to fulfil practical and social needs first, which may compromise their own health, including maternal health (Kennedy & Murphy-Lawless, 2003).

Other frequent obstacles to health care that have been observed include poor language skills leading to poor communication between migrants and health care providers. Several studies show that poor communication between migrants and health-care providers coupled with insufficient use of trained interpreters and with the personnel's lack of knowledge about cultural background often result in mutual misunderstandings. In Scandinavian countries these factors have been described as key causes of poor and delayed gynaecological care and increased risk of delayed or missing obstetrical care (Carballo et al., 2004; Jeppesen, 1993). Also social isolation and racism are recognized as factors affecting the use of health care services (Smaje & Grand, 1997; Ascoly et al., 2001).
On the other hand, health care seeking behaviour appears to be influenced by cultural background and personal experience. Cultures characterized by strict gender roles may believe that it is inappropriate to discuss pregnancy and childbirth in mixed company, and as a result, medical consultations with male doctors or male interpreters can become problematic (Ascoly et al., 2001). Researchers mention that traditional beliefs and the inclination to first seek non-conventional medical care are factors in the delayed health care seeking behaviour of Turkish women in Germany (David et al., 2000).

Migrants, particularly those who recently arrived in the country often lack knowledge about the national health system in general and the available maternal health services in particular (Dias, Severo & Barros, 2008; O’Donnell et al., 2007). Migrants themselves identify lack of information on maternal health and lack of awareness on sources of help and advice as an important barrier (McGinn, 2000).

5. **Child and adolescent health**

Within migrant population, children are at increased risk for health problems. Epidemiological data has indicated that migrant children are more vulnerable to respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, dental problems, pesticide exposure, infectious diseases, poor nutrition, anemia and short stature (American Academy of Pediatrics, 1995; Giacchino et al., 2001; Hjern & Grindefjord, 2000; Iseman & Starke, 1995; McKenna, McCray & Onorato, 1995; Miller et al., 1995; Pedersen et al., 2003; Romanus, 1995; Steenkiste et al., 2004). Also, during migration process migrant children tend to be more exposed to intentional and unintentional injuries, family violence and mental health problems (Carballo & Nerukar, 2001; Hjern, Angel & Jeppson, 1998; Montgomery, 1998; Hulewat, 1996; Carta et al., 2005; Hjern et al., 2001).

Studies have pointed out a higher prevalence of unmet health needs among migrant children often related to reduced use of health care services and delayed or inadequate preventive medical care (Chemtob et al., 2003; Newacheck et al., 2000; Yu, Bellamy, Schwalberg & Drum, 2001; Yeh et al., 2003; Kataoka, Zhang & Wells, 2002; Weathers, Minkovitz, O’Campo & Diener-West, 2004).

Several studies indicate that immigrant children and adolescents or of minority groups have worse health indicators than the national population. Some of the health problems identified among minorities adolescents are related to nutrition, obesity, domestic accidents, tobacco and drug use, sexual behaviour (less parental control, teenage pregnancy) among others (Kandula et al. 2004; Jansà and García de Olalla 2004; Khanlou and Crawford 2006). Some recommendations from the studies were the need to create in multi-cultural and post-migration societies, multi-sectoral and context-specific mental health promotion and other specific health related strategies and policies for youth.
European Union or Member States Policies, Programmes or Priorities in Migration and Health with Relevance for Maternal and Child Health

Within the European Union maternal and child health entitlements and benefits, as well as the remaining aspects of the socioeconomic integration policies that migrants may benefit from, are decided at national level, by each Member State. This is due to the absolute sovereignty that each Member State, within the European construction process, still maintains on the organization and financing of social systems and policies and their unwillingness to cede control of social spending and specifically social security administration. The explaining factors behind this state of affairs will not constitute the object of this section. Instead, the recognition of social policies heterogeneity in the European Union or as Warnes (2002) clearly summarizes “The EU territory is not yet a seamless health-care entitlement domain”, works as a starting premise for the following developments.

The decision that each Member State takes in relation to maternal and child health rights of migrants, as well as to other social rights, is determined by many factors: demographic weight of emigration in the country, specially of illegal migrants; previous historical background on migrant’s policies (e.g. restrictive nature or more accepting one); social and cultural significance of migration (e.g. countries that historically faced strong emigration flows tend to present higher acceptance of immigration and their impacts); the social and economic situation of the country (e.g. periods of economic recession or grow); the on-going public administration reforms (ex. cuts on public spending). Also, the international agreements, conventions or treaties that each Member State is committed to are part of the framework that influences and many times determines the social policies formulation. As a consequence, the comparative analysis of migration policies needs to be done at the light of each implementation contexts because every political solution is intended to solve specific circumstances. Another consequence that arises is that – for the present moment – any action taken to influence public policy on these matters should happen mainly at a national level, once the decision heavily relies at national governments. Subsequently, the role of the European Commission in this specific domain has been until now fairly small, and mainly of programmatic nature.

A quite recent report that maps the European Commission’s Policies related to migration concludes that “migration does not feature highly in strategic policy documents on health” (Kate, Niessen, 2008). In the analysed material, the references to migrant’s health are scarce or even nonexistent and do not express any specific concern with maternal and child health. The European Commission strategic plans, policies and programmes only cover this topic indirectly when, for example, migrants are prioritised as an important target group for the prevention of communicable diseases – which includes, for example, HIV mother-to-child transmission - or as a special vulnerable group in the access to health care – which, for example, includes access to antenatal care for migrant women. Although migrant’s health hasn’t been a priority for the European Commission activity, it is the focus of a large social movement performed by national and international non-governmental organisations, national governments and the scientific community, mainly because reproductive health among migrants is classified as “one of the most important, and still unmet, public health challenges” of present days (Carballo; Divino; Damir, 1998).

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1 The diversity of social protection instruments and policies over the European Union is quite high, but this is both true for intra-Union and out-Union migrants.
Maternal and child health policies and programmes have a strong and vast implementation in the European Health Services, being widely recognized as a key investment for a country social and economic development. For that reason and in this specific domain availability hasn’t been such a strong topic as accessibility, once the existing health services are believed to have the capacity to offer the services needed to migrant women and their children. The determinants that influence accessibility can be analysed from two different, although complementary, perspectives: demand and supply-side (Romero-Ortuño, 2004). The demand-side perspective looks at the characteristics that, being present in the population group, influence their interaction with the health services. The supply-side factors focus on the policies and organizational aspects of the health agencies that may play a role in the way people access the services. The main focus of this section is on the supply-side factors that affect the access to health care for illegal migrant women and their children.

Undocumented migrants face considerable accessibility problems to health systems. The European publicly funded social systems are organised around citizenship and therefore irregular migrants do not enjoy any entitlement to it. However, the emergent reality of irregular and undocumented migration in Europe has been confronting each Member State with the need to give an answer to the health needs and problems of this group. Public policy is a product of several social actors’ interaction, like governments, non-governmental organizations, professional groups or researchers. Undocumented migrants’ access to health care is a topic that does not gathers unanimity in society. There is a huge diversity of expressed opinions and beliefs and the scarce data on migrant’s health does not help to clarify positions. The lack of attention towards migrant’s health may, after all, be a consequence of the predominant focus of the National Health Services on other aspects, rather than on health equity (Horton, 2008). Public health is also affected by other areas of policy making (ex. border control), which increases the level of complexity of public decision.

From the health provider perspective, accessibility problems may result from: the nature of entitlements granted to undocumented immigrants; the responsibility for services costs; amount and complexity level of the administrative procedures and the legal consequences derived from applying for publicly funded health services.

In some Member States, the entitlement to health care of undocumented migrants is preconditioned to the occurrence of special circumstances, that is to say that access to health public services is denied, unless the case meets special criteria. This is the case of the United Kingdom and Germany, for example, where irregular migrant women may access health care under the condition of “Immediately necessary treatment” or “Accident & Emergency treatment”, respectively. The use of loose criteria to regulate such an important right has been pointed out as an amplifying factor for health inequity, once access and other benefits totally rely on the interpretation that the health staff (medical or not) give to the regulations and on the diagnosis they made of the concrete situation (Romero-Ortuño, 2004). These are undesirable effects of policy implementation that the systems are actually facing. In England, a local project that aims at promoting health care access for vulnerable populations report manifest difficulties of undocumented migrant women in accessing antenatal care (Médecins du Monde, 2007). The pregnant women assisted by the project services presented poor indicators of early and regular access to antenatal care, a fundamental key to a healthy delivery. They also present problems in the access to secondary care, namely pregnancy terminations. Essentially, in these situations their entitlement to health care is not accepted or recognised by the health services, that in practice demand whether an entitlement proof or the ability to pay the service’s costs. These women trajectories through the health services clearly demonstrate that more often than it is desirable legal exceptions are not applied, which severely compromises the humanitarian values for each they were created.

Presently, some European countries are taken public measures to reduce even further the access of undocumented migrants to health services (ex. England) which has originated a strong public
debate around the advantages and disadvantages of reducing the access of migrants to the publicly funded health care.

Other Member States decided at a point in time to guarantee to undocumented migrants a universal access to the publicly funded health care. An example of this is the Spanish National Health System that concedes full access to migrant pregnant women regardless of their legal status (Bosch, 1999). This decision, dated from 1999, was supported on a decision of the Madrid’s Superior Court of the same year on the case of three irregular migrant women who had been denied public health care during pregnancy. The Court determined that these women were entitled to the health care they needed and supported this decision on the United Nations Convention of Children’s Rights that says that “member states shall take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers” (Art. 24). According to the Court, the Spanish National Health Service had to act in accordance with this international convention, which the National Service did, extending health care to undocumented migrant women during pregnancy, delivery and puerperal stages, free of charge.

Another important issue is the type of connection establish between health public services and migration control measures. Despite the fact that in some EU countries undocumented migrants may have access to health care when certain circumstances are met, the legal consequences of that access may vary. In Germany, public officers and civil servants from public administration bodies are obliged to report undocumented migrants encountered during the course of their work. This is a highly sensitive issue, not only because it creates a conflict with public health interests, but also because it transforms the right to health into an instrument of migration control (Horton, 2008). This aspect was also developed at the European Conference on Migrant’s Health, held by the Portuguese Presidency of the EU Health Council in 2007, entitled “Health and Migration in the European Union: Better health for all in a inclusive society”. On top of the political visibility that the Conference added to the overall problem, it produced some important recommendations on maternal and child health. Apart from the types of health care that are prioritized (e.g. antenatal and postnatal care) it defended that the right to health of migrant women and their children should be totally independent from their legal status, that is to say that health should be regarded as a fundamental human right, rather than a social entitlement subjected to restrictions by nature. The recommendations proceed saying that when the national law or regulations do not concede the same rights as the national citizens, special regimes ought to be created to guarantee the necessary protection. Clearly, the conference recommendations on this topic stand for public health values in the existing conflict between them and the socioeconomic and safety affairs (e.g. migration control).

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2 The Convention of Children’s Rights had been ratified by Spain in 5 January 1991.

3 Until then, the Spanish National Health System would only recognise the right to care in “emergency cases”.
Practice on Maternal and Child Health for Migrants

1. General aspects for Good Practices or case studies

There is no agreement in the literature about what a good practice is or should be however there are some basic elements that can be considered basic and common to good practices in the field of migration and health. We opted for defining good practices as “activities that are innovative, can be shown positively to affect migrant rights, are sustainable, and are replicable” (IOM 2000). Nonetheless, from previous work on this field we know that fully meeting the criteria is very rare. Usually the most difficult aspects relate to being innovative (most solutions have been applied somewhere) or being sustainable (resources tend not only to be scarce but are usually time constrained).

In addition, previous research on assessing good practices in health systems have highlighted that good practices always imply active community participation and partnerships with stakeholders (Kiwanuka-Mukiibi et al. 2005), thus these principles should be included when assessing and selecting good practices. In this sense, practices to be understood as good, best or bad, need to be defined according to values, thus good practices are never value-free. Furthermore, from the political and policy perspectives, good practices have gained relevance because they offer concrete and credible solutions to real problems in society instead of theoretical models difficult to translate into action. As Guchteneire and Saori stated, good practices “provide a much-needed link between research and policy-making by inspiring decision-makers with successful initiatives and model projects that can make an innovative and sustainable contribution to actually solving problems in society”.

Given that we are considering good practices in the field of the health of migrants and ethnic minorities within the specific case of maternal and child health, it is important to address issues that involve health inequalities. Similarly to the case of good practices, there are also different approaches to health inequalities, but because our preoccupation pertains to health and migration, we should recognise the importance of dealing with health inequalities in the light of cultural competence. According to a manual developed in Northern Ireland, key aspects to address inequalities in health and achieving cultural competence are:

a. Recognising and valuing diversity.
b. Auditing systems and processes within an organisation.
c. Creating a more inclusive organisational culture.
d. Challenging individual attitudes and behaviour.

These aspects can be incorporated to good practice within the health sector, including women and child health. Several strategies to attain equalities in health among migrant population were identified in that report, and can be seen as principles that promote good practices. They are:

1. Mainstreaming: this vision which promotes the consideration of race/ethnicity/origin into the organization and service provision contrasts with the notion of special provision as not integrated into the general system in funding, planning and service development. Thus even if some cases special provision/services are flexible and innovative to tackle specific needs (local level), in the long run and national level, a mainstream approach enables multi-agency work and a holistic approach to health while enhance funding provision due to the commitment of the senior level.
2. **Assessing needs of local populations**: it is as important to know more about the local populations and their needs as well as to get them involved in the planning as a way to find out more the unmet needs. This process should be on-going and enables the provision of more effective. These could be achieved by different means: talking to individuals and families, visiting local communities, holding public local and consultation meetings, talking to local workers to map new needs, among others.

3. **Community consultation and partnerships**: for services to be appropriate, they need to be based on community needs, thus it is convenient to develop links and partnerships with local communities and the voluntary sector that have been working on relevant issues and have experience the matter that can be input for services planning and development.

4. **Capacity building**: as much as links and partnership between the national health sector and local communities are important, also it is pertinent to build the capacity of these local communities and partners who belong to the more excluded sectors (minorities/migrant communities) as a way for them to improve their skills and social capital that enhance even more their contribution as interlocutors and as a way to gain from the partnerships.

5. **Training**: activities such as training and arising cultural awareness for the staff (medical and non-medical) involved in health provision are fundamental to provide workers with specific skills and information they need to work more effectively serving minorities and migrant communities. Training should include cultural competences skills as well as anti-discriminatory attitudes and policies, addressing direct and indirect discrimination and institutional racism.

6. **Monitoring**: including services planning and provision and employment in fundamental to ensure that there are no unintentional barriers in accessing health services due to a person’s background.

7. **Service delivery**: health services policies indicate who services are organized and how the staff works, and often there are many ways that the existing policies do not consider the needs of certain populations, many times, unintentionally. So for service delivery should be appropriate, consultation and dialogue with the communities should be fluent to avoid inappropriate practices in terms of dietary needs, religious needs, language and communication needs, and other needs such as registration, medical records and appointments needs as well as hospital care needs (i.e. naming system, type of questioning for medical records, adequate resources such as gowns, same sex health professionals, etc. which require the training of administrative staff and the flexibility of material and personal resources).

8. **Employment issues**: even if some countries have affirmative or positive employment policies, others do not. However, it is desirable to have a diverse workforce that incorporate workers of different backgrounds who at the same time provide inside information and sensibility to the general workforce.

9. **Maternity and child care provision**: due to the importance of this specific time in the lives of mothers/children, pregnancy and childbirth, and the physical and psychological vulnerability of the mother, specific precautions should be taken by the organizations. On the one hand, pregnancy may be one situation when the mother first contact the NHS, thus this opportunity should be highly valued. On the other hand, there are many parental approaches, practices and priorities in child rearing which are different from those of the health practitioner, but equally
valuable, that requires a closer examination. Some examples of good practice should/could include:

- Sensitivity in teaching hospitals, for example, in making it possible for female patients to request that only female medical students be allowed to observe an examination.

- Ante-natal classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is different from the national tongue. This might include a few intensive lessons to teach them the basic language skills they will need during their stay in hospital.

- Sheets and pamphlets with basic information and instruction on health related issues should be translated and circulated to outreach the population.

- Health education programmes that highlight the importance of both ante-natal and post-natal care.

- Training for staff in using culturally unbiased developmental tests which take into account environmental differences for children from different social groups.

- Support to meet the particular needs of mothers and children from minorities, ethnic and immigrant groups, i.e. bilingual mother and toddler groups, appropriate child minding provision, play groups and day nurseries and support groups for women of different communities where they can relax and speak their own language, if possible or feasible.

- Active recruitment of minority health workers who share the cultures, values and backgrounds of minority, ethnic or immigrant groups, or if not possible, training of other health professionals.

- Training in relevant cultural and religious needs for those health workers (namely ante-natal midwives, doctors, nurses) who will be leading with minority, ethnic or immigrant mothers.

In sum, good practices in the field of the health of migrants and ethnic minorities should aim at reducing health inequalities in a cultural appropriate way to maximise health output. In order to determine whether a practice is a good practice, it is necessary to clearly define at least two aspects: values and a common basis or matrix for comparison. As exposed, values that feed our criteria for good practices are reducing health inequalities and outreaching the migrant or difficult to reach population while attaining cultural appropriateness and the empowerment of the target population. It follows the basic good practice features to consider when assessing the practices, based on the work carried out for the Good Practice Report compiled for the Portuguese Presidency of the EU Council.

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4 Consultation document on Racial Equality in Health. Good Practice Guide. Website: www.equalityni.org
2. Good Practice Features

1. Target population and health needs of the practice in question.

2. Goals and Objectives: result or goal of the practice in terms of the public health problem

3. Field or determinant: that the practice seek to focus (i.e. prevention, promotion, treatment, etc.)

4. Scope: level of centralization, decentralization, etc. that is appropriate (i.e. national, regional, local, etc.)

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

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

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

8. Indicators: indicate ways to measure or control the effect of the practice (if possible, state the before and after).

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

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

11. Possibility to be adopted somewhere else:

12. Contact information:
Venda Nova: A Holistic Approach to Inclusion

1) Target population and health and social needs

It is a community intervention project developed with populations living in impoverished neighbourhoods with low access to health services, who are mainly but not only migrants and ethnic minorities. The target population is a young population with low social-economic status, living in the outskirts of Lisbon. There are people from different origins, being the majority of them from African countries (Angola, S. Tomé, Cabo Verde, Guiné). They have a high rate of illiteracy and problems with housing, security and irregular residence in Portugal.

An initial diagnosis identified some special needs in children and maternal health, such as lack of regular check-ups and childhood vaccinations but also inadequate access to family planning, contraception and prevention of sexually transmitted infections.

Regarding the social needs, we observed problems with education (high drop-out rates from school and low literacy among adults); unemployment and precarious jobs. There are also extremely degrading housing conditions, in urban slums, even if some of the neighbourhoods are rehousing complexes.

2) Goals and Objectives

The guiding principles of the project are based on the World Health Organization recommendations:

To give high priority to the most disadvantaged sectors of society so that all have access to health care through community participation and inter-institutional collaboration. The field work and outreach is carried out in a geographic area of degraded houses and social neighbourhoods, with the help of a mobile unit.

This intervention project pretends:

- An increased community participation providing support in the contact with families for vaccination, health surveillance, contraception, making appointments with the health centre, home visits, and dissemination of information;
- A positive evolution of health and social status; and
- An involvement of the population to the project.

The project outreaches the population through various means of contact, namely their own initiative, community and neighbourhood leaders, the project team, the health centre, the obstetric hospital, schools, and other local institutions and groups.

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

The mobile health unit is used to provide health and nursing care and to make referrals to the health centre and other institutions, where provisions, care and treatment continue. Families at risk continue to be supported by the team in the community. Besides this specific intervention, the team also promotes, jointly with community members, health education and health promotion activities and collective events like:

- Child vaccinations campaigns;
- Health promotion activities with specific groups such as teenagers;
- Young mothers;
- Children;
- Parents and educators at school;

4) **Scope**

The Community Intervention Project is a local project (district level) with the support of the Directorate General of Health, implemented since 2001, by the Health Sub-Region of Lisbon, in Venda Nova Health Centre.

5) **Provider and Resources**

This project is supported by public funds (Venda Nova Health Centre’s budget) and works in partnership with other institutions and NGOs (local associations).

6) **Management**

A link between the Health Centre and the community has been established. This link has allowed a greater relationship between the partners, an increase in the community knowledge, as a consequence, a positive change in attitudes and behaviours.

The partnership and collaborations include Community Groups, Social Institutions, City Hall, Schools, NGO’s and child care centres.

7) **Indicators**

Evaluation topics are produced every year and evaluation is shared with the community and institutional partners. Some of the indicators are:

- Coverage rate of health surveillance (maternity health; infants health; vaccination program and family planning) regarding the number of people attended at home and in the mobile unit
- Effectiveness referral rate (maternity health; infants health; vaccination program and family planning) regarding the number of people attended at home and in the mobile unit
- Evaluation of the health promoting actions (mainly in reproductive health)
- Evaluation of the partnership work (developed actions, community participation level)

Some of the data, such as population numbers, are difficult to establish as we are dealing with a high rate of immigrants. The solution for this problem is to confront several institutional numbers. The main data to construct our indicators are:

- Number of community individuals (age and sex)
- Number of attended community individuals (age, sex and health situation)
- Number of attended families
- Number of home visits
- Number of negligence/violence identified situations
- Vaccinations (age, sex, vaccine type)
- Number of group health promoting actions (type of group, health related issues.)
Recommendations and Guidelines

- Any reform that concerns migrant’s health has to be clear about the inspiring principles and values. Solutions may differ depending if Health is considered a human right, or a social protection entitlement. A coherent and sensitive policy framework based on a holistic approach needs to be developed in order to provide health care to mothers and her children.

- Presently, advocacy actions and others to influence public policy on these matters should happen mainly at a national level, once the decisions heavily rely on national governments.

- Strong alliances need to be built between actors from the public, private and social sector, in order to effectively influence policy formulation and implementation.

- Law compliance is an issue once many times the law is not respected with the inherent violation of migrant’s rights and entitlements to health. Governments and civil society need to pay more attention to the rights of vulnerable populations.

- It is essential to ensure supportive environments for the social integration of women and children living in marginal situations or in insecure conditions.

- The access of undocumented migrants to publicly funded health care is a sensitive political and social issue. Public policy evaluation is essential to ensure that the effects of the public intervention are properly known so that political discourse and decision funded on opinions and assumptions can be avoided.

- Key-actors (i.e. doctors, nurses, etc.) play an important role influencing the results of the social and political debate through their daily practices. Their practice and attitudes may be important factors for a wider social acceptance of migrant’s access to the health services.
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Appendix

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<th>LISBON CONFERENCE RECOMMENDATIONS on woman and child care</th>
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**Access to the Health Care System**
Migrant mothers and their children must be granted equal access to the Health Care System, irrespective of their legal status.
This can be achieved through specific norms protecting illegal migrant women (especially pregnant ones) and their children from deportation.
In addition, programmes should be instituted to improve their education and to remove cultural barriers that may prevent their full integration and therefore their autonomous access to health care.
Services may be required to treat diseases specific of the area of origin of migrants and prevent the spread of such infections.

**Access to Antenatal care**
More specifically, migrant mothers must be given equal access to existing antenatal care services, to ensure that they have the same opportunities to deliver a healthy baby, while they too remain healthy.
Since often these women have higher rates of pregnancy-related problems (with the resulting increased vulnerability of their children, such as prematurity, pregnancy complications, etc.), at the local level, specific programmes must be set in place to encourage pregnant women to avail themselves of existing facilities.

**Access to Postnatal care**
Equal access must be guaranteed to migrant infants and mothers also during the post-partum period. This should include proper follow-up of the mother and vaccinations, and other specific interventions for the infant.

**Access to Family-planning**
Effective family planning services exist in all EU countries, but – by and large – migrant women of reproductive age do not avail themselves of these services to the same extent of country nationals. The ensuing high rate of unwanted pregnancies and high frequency of voluntary pregnancy terminations, legal or illegal must be eliminated through specialised service capable of responding to the specific language and cultural needs of migrant couples.

**Screening for HIV**
There is considerable variation in antenatal testing practice, local rate of sero-positivity, and perception of principal risk factors both between and within countries of the EU.
In order to give all pregnant women, whether residents or citizens of the EU, the same opportunities, the following specific recommendations are therefore to be enforced:
HIV testing according to the opting out principle should be included in the national antenatal screening programmes.
Specialized ante partum and postpartum care should be available to all (HIV-infected) women without discrimination on racial, lifestyle or other grounds.
Follow up by ethnic health advocates preferably within the frame of the GIPA (Greater Involvement of People living with AIDS/HIV) principle is recommended. A partnership within the treatment centre between the medical services and the ethnic health advocate is the “best practice” for the support of HIV-infected pregnant women.

Full protection against traditional harmful practices
Although migrant women may be allowed to keep some of their traditional practices, these may never be against the law of the host country. Therefore, female genital mutilation cannot be accepted within the EU borders in any form or shape. EU countries have a duty, not only to legislate against such practices, but also to enforce them.

Protection against the risk of domestic violence
The EU must act decisively to prevent all forms of violence perpetrated against migrant women. This includes husbands and relatives wishing to prevent women, especially the younger ones, them from reaching the freedom and decision-making power enjoyed by EU women.

Effective prevention and repression of women's trade
Women and children trade within EU borders and from outside the Community is a tragic reality. Member Governments must repress with vigour forced prostitution and child paedophilia, two evils that – in spite of all efforts seem to be growing in the Union. Rehabilitation and re-education of victims must be an integral part of this action.

Services to ensure proper growth and education for migrant children.
Migrant children, even those present as illegal immigrant have a right to be educated. EU countries, within the legal framework for dealing with illegal immigration, should design ways to unfairly “punish” illegally present children.

Full prevention and repression of child trade
The Union must act to protect migrant children, especially the so-called «unaccompanied foreign minors» who often are at high risk to fall victims (paedophilia and child pornography).