

**A PROPOSAL FOR THE ESTABLISHMENT OF THE
EUROPEAN SCIENTIFIC NETWORK ON HEALTH,
MIGRANTS AND POVERTY***

(*) Background paper prepared by the NIHMP (Rome) for the Conference on the "European Scientific Network on Health, Migrants and Poverty", Rome, 24-26 November 2008

*Istituto Nazionale per la
Salute, i Migranti e la Povertà
Roma, Italia*



*National Institute for
Health, Migrants and Poverty
Rome, Italy*



TABLE OF CONTENTS

1. INTRODUCTION	pag. 4
2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH	pag. 7
2.1. Mortality	
2.2. Morbidity	
2.3. Access to health services	
3. CURRENT INITIATIVES ON SOCIO-ECONOMIC DETERMINANTS AND HEALTH	pag. 12
3.1. Global level	
3.2. European level	
3.3. National level	
3.4. Local level	
4. OBJECTIVES OF THE EUROPEAN SCIENTIFIC NETWORK ON HEALTH, MIGRANTS AND POVERTY	pag. 17
4.1. Overall objective	
4.2. Specific objectives	
5. THE EUROPEAN CONFERENCE CONVENED AT THE NIHMP SEAT IN ROME IN NOVEMBER 2008	pag. 21
6. NEXT STEPS	pag. 22
7. REFERENCES	pag. 23
ANNEX 1. COMMUNITY PROJECTS ON MIGRATION	pag. 27

1. INTRODUCTION

In order to facilitate the exchange of viewpoints and the emergence of a consensus on future initiatives at the *ad hoc* Conference that will take place in Rome from 24 to 26 November 2008, the present paper describes the proposal of the National Institute for Health, Migrants and Poverty (NIHMP), Rome (Italy), for establishing the “**European Scientific Network on Health, Migrants and Poverty**” through a joint undertaking of interested institutions in EU Member States, possibly in the framework of the European Public Health Programme. The Network, in English and possibly other languages, aims at promoting the gathering, analysis and diffusion of:

- data on health of migrants and other socio-economically disadvantaged population groups in EU Member States;
- guidelines, tools and other products to support policy development and implementation as well as capacity building in support of the above-mentioned population groups.

The Network is also intended to provide the opportunity for the interested institutions in EU Member States to collaborate on a number of different relevant and innovative projects to further improve their ability to cope with the needs of these population groups.

The Conference, organized in Rome by the NIHMP from 24 to 26 November 2008 aims at:

- verifying the consensus on the usefulness of such a Network;
- discussing in details possible tasks and activities of such a Network;
- looking forward to establishing an alliance among different specialized institutions in EU Member Countries.

The motivation for such a proposal comes from the need for improving our ability to counteract the well known negative impact throughout Europe of unfavourable socio-economic factors on health of **highly disadvantaged population groups, including Roma and homeless persons**, resulting in earlier emergence of many diseases and reduced life expectancy (Schaaf, 2008). This initiative is also in response of the Commission Staff Working Document accompanying the Communication on Community Instruments and Policies for Roma inclusion (2008) that has strongly highlighted the health needs of socially excluded groups to be taken into consideration in the decision-making processes of the new Health Strategy “Together for Health: A Strategic Approach for the EU 2008-2013”, recently adopted by the European Commission.

Over the last years, several European Conferences on migrants and health (i.e. in Rotterdam, The Netherlands; Lisbon, Portugal; Milan, Italy and Malmo, Sweden) and particularly the Lis-

1. INTRODUCTION

bon Conference, have stressed the importance of such an initiative. Moreover, the Resolution adopted by the sixty-first World Health Assembly in 2008 on “Health of Migrants” has called upon Member States:

- to promote migrant-sensitive health policies;
- to promote equitable access to health promotion and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing the health of migrants;
- to assess and analyse trends in migrants’ health, disaggregating health information by relevant categories;
- to better identify the gaps in service delivery in order to improve the health of all populations, including migrants;
- to gather, document and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit and destination;
- to raise health service providers’ and professionals’ cultural and gender sensitivity to migrants’ health issues; and
- to train health professionals to deal with the health issues associated with population movements; and
- to promote bilateral and multilateral cooperation on migrants’ health among countries involved in the whole migratory process.

The present proposal of establishing the European Scientific Network represents also a follow-up of the Rome Ministerial Conference on “Health in All Policies” in 2007. Moreover, the current proposal intends to deal with migrants together with other socio-economically disadvantaged population groups in an integrated network and not isolate migrants from other population groups with similar problems. **The priority population groups for this initiative are the socially-excluded migrants, Roma, the homeless persons and other very poor and highly disadvantaged population groups¹.**

The present proposal aims at establishing and managing, through the cooperation among qualified Institutions in the EU Member States and other relevant partners, a Network to promote scientific enquiry and knowledge development by sharing information, data and experiences and, possibly, work together on different objectives, among which, in particular:

- Sharing best practices in all policies to promote health and integration of migrants and socio-economically disadvantaged population groups in different Member States;
- Developing a data base on specialised structures competent in different countries for providing health care and information to migrants and socio-economically disadvantaged population groups and on the presence of such groups in Europe and their characteristics and health status;
- Improving diagnostic and treatment protocols for specific diseases of migrants and socio-economically disadvantaged population groups;

¹ The prevalence of homelessness varies across countries. However, it appears to have increased in Europe since the 1980s, particularly among young people and women. There is clear evidence of the significantly poorer health status of homeless people when compared to the general population, including some communicable diseases. Homeless people tend to have problems obtaining adequate health care and may experience barriers to access, due to discrimination, appointment procedures, and financial constraints. Conditions requiring uninterrupted treatment such as TB and HIV are often inadequately controlled and difficult to manage without a stable residence. Nomadic and semi-nomadic populations like the Roma form another vulnerable and at-risk community for communicable diseases. The estimated population across the EU is 8-12 million, mainly concentrated in Central and Eastern Europe. Despite the small number of studies, it is estimated that the life expectancy of Roma is shorter on average by ten years than that of the rest of the population and that the child death rate is up to four times higher and also that their exposure to certain cardiovascular diseases is higher.

1. INTRODUCTION

- Developing tools and modules for (distance) training of different categories of professionals charged with care of migrants and socio-economically disadvantaged population groups;
- Mapping and widely diffusing of all EU Public Health Programmes, WHO initiatives, National and main local projects in the field of Migration and Health as well as in the field of socio-economically disadvantaged population groups and establishing a common data base of the “communication and information” materials concerning migrants and socio-economically disadvantaged population groups in different Member States;
- Validating research tools and advocacy instruments.

The present proposal aims at establishing an experimental and flexible Network pursuing the above-mentioned objectives for a period of three years. Practicable means for stabilizing the Network in case of success should be considered throughout the experimental phase.

Responsibilities for leading each one of the work packages that will be established to achieve the different above-mentioned objectives should be attributed on a voluntary basis to one or more interested institutions in Member States, whereas participation in each work package should be as large as possible involving as many institutions in different Member States as possible.

NIHMP in Rome is prepared, in collaboration with all other interested Member States institutions, to take all the necessary steps to plan and establish the telematic network possibly with at least one Reference Unit in each European country to cooperate in one or more specific objectives. NIHMP is prepared to manage the central data base and drive the governance mechanisms, by also providing needed methodological documents and technical assistance. The network architecture will base on standard Internet connections, with dedicated mailboxes in all partner countries, through which materials and information will be acquired and shared. Particular attention will be paid to avoiding any overlap with already on-going European projects and existing networks (for examples see Section 3.2.) and to establish clear links with them where appropriate.

Considerations should also be paid to the possibility of allowing access to the Network of Third Countries, particularly the ones of origin of migrants and of the transit ones.

2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH

People with low level of education, occupational class (particularly unemployed and underemployed), income level or other groups such as migrants, are characterized by a higher incidence and prevalence rates of many diseases as well as by lower treatment and cure rates, and access to health services.

Migrations to EU countries have been constantly increasing over the past 25 years. In the European Union, there are about 25 million migrants. Most of them originate from Mediterranean countries and former colonies of current EU Member States. During the past 20 years, Europe experienced very important annual increases of inward migration and, over the last 5 years, EU net migrant inflows reached an annual level of 2 million. Increased immigration flows are mainly due to strong and persisting push and pull factors related to globalisation and the North-South divide in terms of demographic trends and welfare standards². The EU is set to remain a popular destination for migrants over the coming decades. According to 2005 IOM's figures, European countries are becoming the new destinations for migrants and the medium variant of the United Nations population projections assumes that the general direction of these flows will remain the same over the next few decades, with an estimated growth in 2050 to 142 million persons. As many of them are of working age migrants, they tend to bring down the average age of the population. In relation to skill level, Europe attracts less high skilled immigrants and more low skilled immigrants compared to USA, Australia and Canada, while vacancies in highly skilled jobs are increasing. In relation to labour market participation, participation/employment rates of immigrants and their descendents remain low in many Member States. Illegal migration contributing to irregular work remains high. Almost in all Member States the integration of immigrants represents an important issue. Immigrants are among the most vulnerable groups. The fight against discrimination represents an important

² The 2008 Edition of the OECD International Migration Outlook shows an increase in migration flows to the OECD countries, notably due to family and employment reasons, while the number of asylum seekers continues to decline. Moreover, there are increasing inflows of international students. European migrants are far more common in Europe, but Asian migrants outside of Europe are also widely represented. For instance, China accounts for almost 11 % of the flows, whereas Poland and Romania account for less than 5% of the flows. Brazil, Chile, China, Estonia, India, Indonesia, Israel, Russia, Slovenia and South Africa currently account for a sixth of all immigration flows to the OECD. The foreign-born population have increased by about 18% since the year 2000. In most OECD countries, both immigrants, men and women, earn significantly less than their native born counterparts, and immigrants from non-OECD countries are at a particular disadvantage. The above-mentioned OECD Report provides, among others, a review of structural and institutional developments in migration policies.

2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH

dimension of this issue. Poverty and social uneasiness among non-EU immigrants are often so dramatic that they may give rise to outbreaks of disease (e.g. tuberculosis), assumed to have been eradicated in the EU.

Moreover, voluntary pregnancy termination shows that abortion rates are much higher for foreign than for European women. Female Genital Mutilation (FGM) is not only an important issue in Africa, the Middle-East and Asia where it has been traditionally practised, but, due to the arrival of immigrants, refugees and asylum seekers from these countries, FGM has become also an European concern. It is estimated that, in the European Union alone, as many as 500,000 girls and women are affected or threatened by the practice of FGM. The magnitude and seriousness of medical and social consequences of this practice in Europe and the human rights that might be violated by it, should not be underestimated. The health status of immigrants in Europe is likely to differ from that of the native European Union population. In fact, in spite of the “healthy migrant effect”, which explains an initially better health status in immigrants through selective migration of healthy people, health status in the immigrants' countries of origin is generally worse than in the hosting countries. Another factor influencing health is the lower socioeconomic status of immigrants, including lower availability of individual resources and specific deficits in health literacy, especially of those non regular.

Social epidemiological research has shown that the socio-economic determinants are indeed associated with health and life expectancy. Whether someone is imbedded into social structures and receives instrumental or emotional social support is significantly associated with mortality and morbidity. ‘Social isolation kills’ – that has been found in many studies (for overview see Berkman & Glass, 2000). Cultural and linguistic obstacles also play a major role in supporting social discrimination.

Inequality in health is not confined to the poorest members of the society, but there is a gradient of mortality and morbidity across the whole of the society depending on low education, low occupational standing and/or small income. Apart from age, sex and constitutional characteristics, health behaviour, social networks and living and working conditions strongly influence health. These health determinants are socially patterned with higher risks in people with lower socio-economic status.

Among the living and working conditions, access to food, drinking water, housing and health care services are an obvious prerequisite for health. The health burden of adverse job conditions has been discussed in terms of physical demands and psychosocial stress. Most health determinants are socially patterned: an inverse social gradient of adverse health behaviour is found across the life course as early as not being breast fed (Graham, 2000), physical inactivity (Lampert et al, 2007), obesity (Kurth & Schaffrath Rosario, 2007) and high TV consumption (Langnaese et al, 2002). Later on, smoking, physical inactivity and unfavourable nutrition is detected in adulthood (Mielck, 2000; Mackenbach, 2006). Moreover, the risk of being socially isolated, of having no confidant, of getting inadequate instrumental and emotional support is elevated in people with lower socio-economic status (Weyers, 2007).

With regard to living and working conditions it is obvious that healthy food and proper housing requires financial prosperity and individual/familial asset building. Educational assets are significantly associated with parental social status (OECD, 2001) and with immigration background (PISA 2008). The risk of unemployment (Reinberg A & Hummel M, 2005) and poor physical and psychosocial working conditions (Bosma et al, 1998) is more prevalent in lower

2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH

socio-economic groups. Last but not least, the access to the medical system is unevenly distributed across society especially regarding the use of preventive medicine which displays a strong social gradient (Janssen & et al, 2006).

The higher exposure of vulnerability towards these social risk factors in lower status groups across the life course leads to substantial inequalities in health and life expectancy in all Western societies. Often it is even transferred from one generation to the next (Power & Kuh, 2006) leading to persisting or even increasing social and health inequalities.

2.1. Mortality

An independent comprehensive expert Report on “Health inequalities”, commissioned by, and published under the auspices of the UK presidency of the EU in October 2005, and other documents clearly indicate that:

- in all countries with available data, rates of premature mortality are higher among those with lower levels of education, occupational class, or income;
- inequalities in mortality exist from the youngest to the oldest ages and in both genders, but tend to be smaller among women than among men; and
- inequalities in mortality can also be found for many specific causes of death, including cardiovascular disease, many cancers, and injury.

In all countries with available data, rates of premature mortality are higher among those with lower levels of education, occupational class, or income. Inequalities in mortality exist from the youngest to the oldest ages and in both genders, but tend to be smaller among women than among men. Moreover, inequalities in mortality can also be found for many specific causes of death, including cardiovascular disease, many cancers and injuries. The final report of the EUROTHINE project, published in 2007, showed that, in the EU, cardiovascular diseases are the main factors of inequalities, accounting for 33 and 50% of inequalities in mortality associated with educational class in men and women, respectively, and that injuries and cancers, particularly lung cancer, are more important factors of health inequalities in men than in women. Inequalities in mortality related to occupation follow a distribution similar to those due to education. These inequalities in mortality lead to substantial inequalities in life expectancy at birth (4 to 6 years among men, 2 to 4 years among women). In many Western European countries mortality differences between socio-economic groups have widened during the last three decades of the 20th century. This has continued into the 1990s, and has led to considerable increases of the relative excess risk of dying in the lowest socio-economic groups.

The explanation of this disturbing phenomenon is only partly known. One aspect which should certainly be taken into account, however, is that this widening of the relative gap in death rates is generally the result of a difference between socio-economic groups in the speed of mortality decline. While mortality declined in all socio-economic groups, the decline has been proportionally faster in the higher socio-economic groups than in the lower. The faster mortality declines in higher socio-economic groups were in their turn mostly due to faster mortality declines for cardiovascular diseases. In many Western European countries, the 1980s and 1990s have been decades with substantial improvements in cardiovascular disease mortality. These have been due to improvements in health-conducive behaviours (e.g. less smoking, modest improvements in diet and more physical exercise), and to the introduction of effective health care interventions (e.g. hypertension detection and treatment, surgical interventions and thrombolytic therapy). Apparently, while these improvements have to some extent been taken up by all socio-economic groups, the higher socio-economic groups have tended to benefit more.

2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH

The available evidence suggests that during the late 1980s, inequalities in mortality were in Eastern Europe at least as big, and perhaps even bigger than in Western Europe. For example, a study looking at differences in mortality by level of education in Finland, Norway, Italy, Hungary, the Czech Republic and Estonia in the late 1980s showed substantial inequalities in mortality in all countries, both among men and women. Among men, the excess mortality ranged between 50 and 78 per cent in the three Eastern European countries, as compared to between 25 and 41 per cent in the three Western European countries. Among women, however, relative inequalities in mortality were of similar magnitude in the Eastern as compared to the Western countries. Since the political transition, mortality rates have changed dramatically in many countries in Eastern Europe, sometimes for the better (e.g. in the Czech Republic) but often for the worse (e.g. in Hungary and Estonia), particularly among men. This is probably due to a combination of (interlinked) factors: a rise in economic insecurity and poverty; a breakdown of protective social, public health and health care institutions; and a rise in excessive drinking and other risk factors for premature mortality. The available evidence clearly shows that these changes in mortality have not been equally shared between socio-economic groups in the countries with available data, mortality rates have generally improved less, or deteriorated more, in the lower socio-economic groups. People with higher levels of education have been able to protect themselves better against increased health risks, and/or have been able to benefit more from new opportunities for health gains. An example is provided by Estonia where a considerable rise of inequalities in mortality has occurred. Evidence from some other Eastern European countries (Hungary) suggests a similar widening of the gap in death rates. The fact that this is not seen in some other countries (Czech Republic), however, suggests that a widening of the health gap in a period of important political and economic change is not unavoidable.

2.2. Morbidity

As it is the case with mortality, rates of morbidity are usually higher among those with a lower educational level, occupational class or income level:

- substantial inequalities are also found in the prevalence of most specific diseases (including mental illness) and most specific forms of disability;
- over the past decades, inequalities in morbidity by socio-economic position have been rather stable; and
- together with inequalities in mortality, inequalities in morbidity contribute to large inequalities in 'healthy life expectancy' (number of years lived in good health).

Inequalities are also evident in the prevalence of self-reported chronic conditions by level of education among people aged 25-79 years, in the 1990s, in eight European countries thus indicating that most chronic diseases have a higher prevalence in the lower educational groups.

Moreover, the European Commission has also released the Communication on "Unequal Welfare States, Distributive Consequences of Population Ageing in Six European Countries". DG Employment and Social Affairs, 2004. As retired people generally have lower incomes than employed workers, ageing will lead to a slight rise in income inequality in Europe in the next 20 years. Larger numbers of people with lower incomes will in turn lead to higher poverty rates.

2.3. Accessibility of health services

While health care systems have contributed to significant improvements in health across the EU, access to health care remains uneven across social groups. High risk populations in Europe, indicated by low level of education, occupational class, income level, or other groups

2. SOCIO-ECONOMIC DETERMINANTS OF HEALTH

such as migrants, differ in incidence and prevalence rates, treatment and cure rates, and access to health services (APPLICA, 2005).

A major challenge is allowing access for all to high quality care reflecting recent technological progress while ensuring sustainability. Hence, EU Member States are implementing policies to reduce these inequalities, e.g. by: addressing risk factors through health promotion; reducing the prevalence and incidence of certain diseases; and ensuring more effective prevention activities in various settings (at home, school, work). Also important are steps to: (i) increase population coverage; (ii) address financial barriers to care; (iii) emphasize promotion and prevention activities over curative care; and (iv) address cultural barriers to the use of services. The structural funds will be used to support reform and capacity building mainly, to improve access and to develop human resources. A combination of general policies and those tailored to lower socio-economic groups is needed. Virtually, all Member States have implemented universal or almost universal rights to care and have adapted services to reach those who have difficulty accessing conventional services due to physical or mental disability or to linguistic or cultural differences. However, limitations in available resources may make difficult a concrete achievement of such an objective. Moreover, only few Member States have begun to address health inequalities systematically and comprehensively by reducing social differences, preventing the ensuing health differences, or addressing the poor health that results. Finally, policies outside the health sector are also central to improving the health of the population and reducing the existing gaps in health care provision (Joint Report on Social Protection and Social Inclusion, 2008).

Although the above reported analyses deals with health inequities across the gradient and considers targeted measures for specific vulnerable groups within a system wide-approach, it is important to stress that it is the intention of the NIHMP with the present proposal to address the needs of **highly disadvantaged population groups in particular.**

3. CURRENT INITIATIVES

It should be stressed that the importance of socio-economic determinants in the E.U. in relation to health is well understood and many projects have been or are being initiated to improve the situation. On European, national and local level, there are promising strategies and projects to tackle health inequalities by recognizing social determinants of health. This evidence confronts policy makers with a challenge. Reducing health inequalities has become one of the main issues within the public health sector in Europe and its member countries. A mapping action in the frame of the European project “Closing the Gap: Strategies for Action to Tackle Health Inequalities in Europe” has been carried out from 2004 to 2007 in collaboration of 21 national health promotion and prevention organisations (www.health-inequalities.eu).

3.1. Global level

At this level, the work of the WHO Commission on Social Determinants of Health (CSDH) should be stressed. The Commission supports countries and global health partners to address the social factors leading to ill health and inequities. It draws the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries. The determinants include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems (http://www.who.int/social_determinants/en/).

Relevant in this context is also the WHO Resolution on “Health of Migrants” already referred to in Section 1.

3.2 European level

The European Health and Consumer Protection Directorate General (DG) has declared ‘Socio-economic determinants of health - health inequalities’ as an important strand in their past and current public health strategy (http://ec.europa.eu/health/ph_determinants/healthdeterminants_en.htm). The DG’s action to reduce health inequalities aims to improve everyone’s level of health closer to that of the most advantaged; to ensure that the health needs of the most disadvantaged are fully addressed; to help the health of people in countries and regions with lower levels of health to improve faster. At the EU level this involves many ongoing or recently concluded projects (Annex 1) and many policy areas including:

3. CURRENT INITIATIVES

- Economic, employment and social policy - through the Lisbon process to strengthen the European economy and at the same time ensure social protection and measures to improve social inclusion.
- Regional Policy - to support the economies and health infrastructure of countries and regions of the EU which are lagging behind or have special needs.
- Research - to identify the causes of socio-economic health inequalities and to develop and evaluate measures to combat them.

More specifically, the public health action programme 2003-2008 supported the development of strategies and measures on socio-economic health determinants and health inequalities using data from the Community health information system. Health inequalities also form an important dimension of the current Community Action Programme in Public Health 2007-2013. To achieve this, DG SANCO aims at encouraging and supporting the development of actions and networks for gathering, providing and exchanging information in order to assess and develop policies, strategies and measures, with the purpose of establishing effective interventions aimed at tackling determinants of health. Second, it aims to promote and stimulate Member States' efforts in this field, for example, by developing innovative projects which will stand as examples of effective practice. 'Closing the Gap' and the aforementioned 'EUROTHINE' projects are examples for this.

Similar considerations apply to migrants; several projects have been or are currently carried out with the support of the European Public Health Programme (http://ec.europa.eu/phea/calls/previous_projects_en.html#projects_list)

An example of a relevant project is the '**Health Status of Migrants within Europe: Development of Health Indicators**' (project acronym: **MEHO**), a 36-month, European Commission-funded project, the primary aim of which is the development of indicators for the monitoring of health status of ethnic minority groups in European countries (EU and EFTA countries)(more information can be found at http://www.meho.eu.com/Upload/071101_WP6 IEA2007MIGRANTHEALTH_WORKSHOP.pdf). Also the EC-funded project "**Assessing Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities**" (**AMAC**) is relevant in this context. Moreover, the **European Public Health Association** has a section on migrant health (http://www.eu-pha.org/html/menu5_7.html) with the following priorities:

- Build a network of health professionals on migration and health from a public health perspective.
- Increase the knowledge on differences in health problems, use and quality of health care services and on interventions to tackle these differences.
- Discuss conceptual and methodological issues regarding ethnic differences in health and health care
- Develop strategies to influence national and European policy makers and politicians to increase attention for ethnic health and health care differences.
- Initiate and further use of standard identification methods and data collection procedures.

The **MIGHEALTHNET** (Information network on good practice in health for migrants and minorities in Europe) project, aims to stimulate the exchange of knowledge on migrant and minority health through the development of interactive data bases in each of the participating countries. Involved institutes can be found at: <http://mighealth.net/index.php/Partnership>.

The main aim of **AIDS & Mobility Europe 2007-2010** project is to reduce HIV vulnerability of migrants and mobile populations in Europe, through the development, implementation and promotion of appropriate policies and measures.

3. CURRENT INITIATIVES

The **CORRELATION II** project is preparing to reconstitute the European network around the prevention of blood-borne infections among socio-economically marginalized youth (proposal positively reviewed for EU Public Health programme 2008-2013).

Within the LEONARDO framework, a project develops an online tool for educating professionals in psychiatry about health care for migrant youth (**EUROPEAN WEBPORTAL ON PSYCHO-SOCIO-MEDICAL KNOWLEDGE FOR MIGRANT YOUTH**). The web portal becomes available in five languages: Turkish, English, German, French and Dutch.

A list of Community projects on migration is attached as Annex 1.

An ambition of the “European Scientific Network on Health, Migrants and Poverty” is also to provide a tool to make optimal use of all the products of the above mentioned European projects.

3.3. National level

It is up to Member States to develop strategies to improve health of vulnerable groups within their societies. How the social determinants can be recognized explicitly in such a strategy has been shown by Sweden. The overall aim of Swedish public health policy established in 2003 is to create social conditions which ensure good health for the entire population. It was also established that improving the public health of those groups most vulnerable to ill-health is particularly vital. The most important aim of the bill is to make public health a fundamental part of social policy. Since public health concerns and is influenced by many different sectors of society, it is important to set objectives that can act as guiding principles for the work done within the various sectors. Where objectives had previously been based on diseases or health problems, health determinants were now chosen instead. Objectives are accessible for political decisions and can be influenced by certain types of societal measures. Thus, the Swedish public health policy is based on eleven objectives containing the most important determinants of public health (Agren, 2003): (i) participation and influence in society; (ii) economic and social security; (iii) secure and favourable conditions during childhood and adolescence; (iv) healthier working life; (v) healthy and safe environments and products; (vi) health and medical care that more actively promotes good health; (vii) effective protection against communicable diseases; (viii) safe sexuality and good reproductive health; (ix) increased physical activity; (x) good eating habits and safe food; (xi) reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

The first six objectives relate to what are normally considered to be structural factors, i.e. conditions in society and our surroundings that can be influenced primarily by moulding public opinion and by taking political decisions on different levels. The last five objectives concern lifestyles which an individual can influence him/herself, but where the social environment normally plays a very important part. Political responsibility for implementing the policy is divided among different sectors and different levels in society (municipalities, county councils and government authorities). The National Institute of Public Health has been assigned to formulate interim targets as and when necessary and develop indicators as to how well the objectives are being fulfilled (http://www.fhi.se/shop/material_pdf/newpublic0401.pdf).

Linking the different sectors involved in population health horizontally is the idea of ‘Health in all Policies’. Health in All Policies (HiAP) was the main health theme of the Finnish European Union (EU) Presidency in 2006 and was called the natural continuation of Finland’s long term horizontal health policy. While the health sector has gradually increased its cooperation with other government sectors, industry and nongovernmental organizations in the past four decades, other sectors have increasingly taken health and the well-being of citizens into ac-

3. CURRENT INITIATIVES

count in their policies. The key factor enabling such a development has been that health and well-being are shared values across societal sectors. Finland devoted a conference and reader to this topic to present how measures in sectors other than the health sector affect population health and how population health can be promoted by measures in other sectors (Stahl et al, 2006). Moreover, a significant step forward in this sector took place with the Declaration on HiAP, approved in Rome on 18 December 2007 during a Ministerial Conference called jointly by the Italian Ministry of Health, the European Commission and WHO/EURO.

3.4 Local level

The social determinants can be recognized and tackled also in local communities. All the following project examples are taken from the Good Practice database of the Closing the Gap project (www.health-inequalities.eu). Clearly “closing the gap” is a different objective than “ensuring good health for the entire population”; this is clearly highlighted in the English strategy that was developed since the independent Acheson inquiry, appointed in 1997, that reviewed the current state of health inequalities and identified the evidence base for future policy developments.

Work: ‘Environment Task Force’ is a Norwegian low barrier method to provide employment for vulnerable groups. All participants are people who have been outside the labour market for years and socially excluded. The majority suffer from a combination of mental health problems or drug abuse. The project is located in an area where one traditionally has found a very poor socio-economic situation over generations. Participants work daily and carry out social tasks such as keeping streets clean from rubbish, helping older people from Elderly Institutions, working with a skilled carpenter in preschools. The ultimate goal is that participants find regular work. Another goal is to reduce alcohol and drug abuse and to improve health through physical activity; the majority of tasks involve considerable physical activity outdoors. Further goals are better nutrition and to improve dental care. Rebuilding individual self-confidence is a key task in their process as well as to develop a social network based on shared work experience.

Education: The Dutch project ‘Supervision by the youth practitioner’ aims to reduce school non-attendance rates because of illness. Pupils who are not attending school because of self reported illness are transferred to the youth physician who tries to gain insight into the medical and social condition of the pupil. Depending on the real problems the youth physician starts medical treatment of links to existing social and psychological helping structures. The intervention contributes to reducing health inequalities by trying to prevent young people from dropping out of school and thus having no job opportunities.

Health care system: The German Federal Centre for Health Education (BZgA) has developed a project entitled ‘I go to the U! And You?’ in order to increase the use of early detection measures (U) in kindergarten children. Originally, these services aim to evaluate the physical and psychological development of children and to detect illness and handicaps, but they are not sufficiently used by socially disadvantaged families. The intervention project is carried out in socially disadvantaged areas and works on the basis of two principles: incentive and peer pressure. The kindergarten plays an important role. Parents are addressed through posters and flyers that raise awareness about the importance of early detection and the services available. All children who frequent U7, U8 and U9 receive a funny T-shirt. When all children in a kindergarten have got the shirt, a group photo is made and takes part in a competition. Recognizing the importance of social determinants to tackle health inequalities, the national

3. CURRENT INITIATIVES

health promotion and prevention organisations have joined in a new European project called 'Determine'. The European Commission funded project has started in 2007 and brings together a high level Consortium to apply evidence based approaches across policy sectors in the EU and its member states (www.health-inequalities.eu). Bodies from 26 countries will analyse and apply important knowledge on socio-economic determinants of health, introduce innovative pilot projects, and develop and implement awareness and capacity building programmes. The objective is to generate greater understanding and to change conceptions and approaches amongst policy makers and practitioners, so that other policy sectors take the issues of health and health equity into consideration when developing policy.

4. OBJECTIVES OF THE EUROPEAN SCIENTIFIC NETWORK ON HEALTH, MIGRANTS AND POVERTY

4.1. Overall objective

The overall objective of the present proposal is to develop a new e-tool (defined as the “European Scientific Network on Health, Migrants and Poverty”) to facilitate sharing of experiences, data and information among main institutions competent for Health, Migrants and Poverty in all the EU Member States (ideally at least one institution in each Member State) and to work together to develop new and more effective practical approaches to facilitate accessibility of the population groups more in needs (e.g. unemployed people, Roma and homeless persons) to relevant health services and to more effectively protect their health. Broad diffusion will be ensured to valuable options and solutions for the benefit of innovative public policy cycles. Involvement of technical and scientific advisors to policy makers in EU Member Countries is needed as well as participation of governmental representatives would be highly appreciated. Particular attention will be paid to avoiding any overlap with already on-going projects and existing networks (for examples see Section 3.2.) and to establish clear and effective links with them where appropriate. The aim of the present proposal is focussed on policies, strategies and interventions within the health system (and in partnership with other sectors) that, taking into account ethno-cultural differences and acutely adverse socio-economic conditions, addresses particularly groups such as socially-excluded migrants, Roma and the homeless.

An evaluation will be needed on possible language(s), other than English, which the Network will make use of.

NIHMP in Rome will take all the necessary steps to plan and establish the telematic network possibly with at least one Reference Unit in each European country to cooperate in one or more specific objectives (**Objective n.1**). NIHMP is prepared to manage the central data base and drive the governance mechanisms, by also providing needed methodological documents and technical assistance.

The network architecture will base on standard Internet connections, with dedicated mailboxes in all partner countries, through which materials and information will be acquired and shared. A Network home page will be established on the NIHMP’s official web site. A feasibility study for the telematic connection of all focal points in Europe with the NIHMP will be carried out to find viable technical solutions. Hardware and software specifications will be proposed to and endorsed through a consensus by all partners, according to their internal security policies. A central database in Rome will provide the Network with structured and on-de-

4. OBJECTIVES OF THE EUROPEAN SCIENTIFIC NETWORK ON HEALTH, MIGRANTS AND POVERTY

mand information about relevant health issues. Network functioning and information reporting will be assured by the NIHMP.

The main objectively identifiable indicator of the achievement of the general objective will consist of the production of a governance scheme for partnership and its experimental implementation for a period of three years; consideration will also be paid to the stabilization of the network after the expiring of the experimental period.

The main output will be the broad diffusion of structured information on health, migrants and poverty on a number of different health and healthcare approaches and the possible evaluation of their efficacy and effectiveness under different conditions as well as innovative helpful tools developed through the Network.

The main outcome will be the gain, in terms of soundness and consistency, in public health policies and interventions to meet the needs of migrants and socio-economically disadvantaged population groups in different EU Member States.

4.2. Specific objectives

With exception of the objective N.1 (Establishment of the Telematic Network) whose establishment is preliminary and development is simultaneous to all other objectives and will be led by NIHMP, all specific objectives are meant as intermediate achievements, even though each of them is to be approached separately and simultaneously. Moreover, it is expected that one or more institutions in EU Member Countries will take responsibility for leading one or more of the specific objectives listed below.

The following objectives have been formulated also with the aim to address main recommended action areas developed in several policy-relevant documents such as:

- Better health for all in an inclusive society: Health and Migration in the EU. Portuguese Presidency of the EU. Conference Conclusions and Recommendations: (<http://www.hmelisbon2007.com/pdf/Conclusions.pdf>);
- Good practices in migrant's Access to health care in the EU (<http://www.eu2007.min-saude.pt/PUE/pt/conteudos/Noticias/relatorio+1+-+S+M.htm>);
- Bratislava Declaration on health, human rights and migration - COE (http://ec.europa.eu/phea/documents/technical_meetings/People_on_the_Move.pdf);
- WHO Resolution WHA61.17 on the Health of Migrants. (http://www.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf); and
- COE Recommendation 1503 (2001) on health conditions of migrants and refugees in Europe (<http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta01/erec1503.htm>).

Objective N.2. Sharing best practices in all policies to promote health and integration of migrants and socio-economically disadvantaged population groups in different Member States

This objective aims at exchanging information to identify the approaches in all policies to promote health of migrants and socio-economically disadvantaged population groups, developed in different Member States and at sharing available information on their efficacy and effectiveness. Public policies are virtuous cycles initiated by Governmental bodies to tackle recognised needs on political agendas. The policy process includes a time to revise the results and evaluate whether new effective solutions are possible. It is, therefore, crucial to know the best practices around which to strengthen the value of the expected outcomes. The collection and se-

4. OBJECTIVES OF THE EUROPEAN SCIENTIFIC NETWORK ON HEALTH, MIGRANTS AND POVERTY

lection of health approaches in Europe to migrants' and socio-economically disadvantaged population groups should be carried out in close cooperation with the competent Governmental bodies in partner countries. Institutional cooperation is a key point of this objective. All the partners will be requested to provide data and information about their relevant public policies. A central data base containing all information will be made available for inquiry by Network partners and other stakeholders whenever they need it. A consensus is required on the inventory format to be used.

Objective N. 3. Developing a data base on specialised structures competent in different countries for providing health care and information to migrants and socio-economically disadvantaged population groups and on the presence of such groups in Europe and their characteristics and health status

This objective is essential to draw up the operational map for information sharing and collaborating on specific objectives. The structures which are involved in the partner countries in the relevant healthcare are strategic entities for a fully empowered information network. These structures represent the main source for health care practices and data which should be feeding the central data base. The identification of competent structures in Member Countries will also include data on structures, missions, particular expertises and responsible specialists.

Availability of comparable data on the presence and composition of migrants and socio-economically disadvantaged population groups is very important for the complete understanding of migration and other social development processes. This information is basic for developing preventive approaches to better protect the health status of these population groups. Integration policies can be better put in place if demographic and permanence information are effectively shared at policy making level.

Also on this issue, a consensus on the format to be used for acquiring relevant information is required with the cooperation of all partners. The achievement of this objective calls for a study to be planned and developed. Among others, European institutional organizations to be contacted as well as methodologies to report relevant data will have to be carefully considered. Moreover, the definition of a minimum data set on migrants' demographic and presence information will have to be achieved.

Objective N.4. Improving diagnostic and treatment protocols for specific diseases of migrants and socio-economically disadvantaged population groups

There are several different components in this objective. A first one is related to specific diseases of migrants which are generally poorly known in local health structure of many European Countries. In particular, the diagnosis of some migrant's diseases requires the participation of mediators to bridge the linguistic and cultural gaps and, therefore, may largely benefit from the availability of a harmonized software to acquire the social and health data of the patient and of guidelines and expert systems to facilitate the diagnosis. Moreover, there are many treatment protocols available for a number of diseases, but they often do not take into account ethnic differences in health and health care or the special needs of patients who may be difficult to trace back or to recall; neither do they provide clear indications on most cost-effective treatment approaches. Best available protocols on diagnosis and treatment of selected diseases will be collected, evaluated and, if necessary, modified in close cooperation with the participating health structures in the partner countries.

A main issue in this context is the definition of priorities and the establishment of a consensus work plan.

4. OBJECTIVES OF THE EUROPEAN SCIENTIFIC NETWORK ON HEALTH, MIGRANTS AND POVERTY

Objective N.5. Developing tools and modules for (distance) training of different categories of professionals charged with care of migrants and socio-economically disadvantaged population groups

How to best transfer the needed know-how and ability to professionals who are committed with migrant and socio-economically disadvantaged population groups is the main issue to be tackled in dealing with this objective. Most distance learning methods are nowadays sound and effective enough to represent a valuable tool for professional teaching and up-to-dating. E-learning platforms are the technological solutions to these needs and the objective will base upon their use and management. Available teaching contents and modules will be made easily accessible or produced *ad hoc* with the cooperation of the European Scientific Network's focal points.

Training material needs to be classified according common indexing terms. They need to be also adapted for the uploading to the central training platform. These phases will be developed as cooperative tasks.

Objective N.6. Mapping and widely diffusing of all EU Public Health Programmes, WHO initiatives, National and main local projects in the field of Migration and Health as well as in the field of socio-economically disadvantaged population groups and establishing a common data base of the “communication and information” materials concerning migrants and socio-economically disadvantaged population groups in different Member States.

Previous Sections 2 and 3 have clearly indicated that there are many different initiatives at global, international, intergovernmental, national and local levels to improve health of migrants and socio-economically disadvantaged population groups. Similar considerations apply to the very many materials produced in different Member States to inform migrants and socio-economically disadvantaged population groups of their rights or to empower them to better protect their health. In view of the difficulty of keeping track of these initiatives and products, the aim of this objective is to develop an effective system to facilitate accessibility to all those interested to results of the on-going programme and of available communication materials. An *ad hoc* work plan will be jointly developed by all the participating institutions on how to proceed.

Objective N.7. Validating research tools and policy and advocacy instruments.

This objective aims at identifying priority research projects and promoting cooperation of Institutions in European Member States to implement them. Moreover, in the framework of this objective, it would be important to identify new policies to address the main needs of migrants and socio-economically disadvantaged groups and to raise awareness of decision makers on their importance.

5. THE EUROPEAN CONFERENCE IN ROME

The European Conference, convened on 24-26 November 2008 at the NIHMP's Headquarter in Rome, will provide the opportunity for an extensive discussion of the present background paper to highlight the project proposed by the NIHMP to establish the "European Scientific Network on Health, Migrants and Poverty" as well as for checking interests of institutions and organizations in different Member States to participate in the Network. Designated participants by the competent Authorities of all interested Member States as well as invited speakers will take an active role in the Conference that will start on 24 November 2008 in Rome at h.1 p.m., will continue on the 25 November 2008 starting at 9.30 and closing at 6 p.m.. The Conference will be over on the 26 November 2008, at 1.30 p.m. A gala dinner will be offered on the evening of 25 November 2008.

As far as the organization of the Conference is concerned:

- The afternoon session on 24 November 2008 will be a scientific/technical Session entirely devoted to the opening Session, the presentation of this paper and an interview round on related activities in the EU Member States.
- The morning of day 25 November 2008, and probably the first part of the afternoon, will be devoted to several simultaneous working groups to discuss and agree on core activities of the Network.
- The late afternoon of day 25 November 2008 will be devoted to reporting back to plenary with the presentations by designated rapporteurs for each group.
- The morning of day 26 November 2008 will be utilized to close the technical part of the meeting and to summarise next steps. A consensus document will be presented and hopefully endorsed by the Conference. A series of high level speeches focusing on migrations, health and poverty with possible emphasis on migrants health issues in integration strategies will follow until the close of the meeting at 1.30 p.m.

6. NEXT STEPS

The main purpose of this paper is to facilitate the building up of a consensus with qualified Institutions in as many as possible, and preferably in all, EU Member States on the project to establish an European Scientific Network on “Health, Migrants and Poverty” and to have an *ad hoc* collaboration started up in 2009, preferably in the framework and with the support of the European Public Health Programme and with the participation of WHO.

To this end:

- The present Background Paper will be presented at the start of the Rome Conference, discussed by several working groups during the Rome Conference, amended according to the contributions received and, hopefully, approved by consensus by the Conference;
- The Background paper, duly integrated with the main lectures delivered at the Rome Conference and with the list of participants and their affiliations, will constitute the basis for the proposal to be presented in 2009 in reply to the call for contributions of the European Public Health Programme (if possible), as a joint undertaking of all interested institutions in Member States;
- A procedure to evaluate the achievements obtained and the quality of the work carried out will be also developed during the Conference;
- Immediately, after the conclusion of the Rome Conference, a Steering Group will be established by the NIHMP to work out by consensus the above-mentioned proposal early in 2009.

7. REFERENCES

- Agren G (2003). Sweden's new public health policy. National public health objectives *for Sweden*. Stockholm: Swedish National Institute of Public Health.
- Arber S, Thomas H (2001). From womens' health to a gender analysis of health. In W. C. Cockerham (Ed.), *The Blackwell Companion to Medical Sociology* (pp. 94-113). Oxford: Blackwell.
- Berkman L, Glass T (2000). Social integration, social networks, social support, and health. In L. Berkman & I. Kawachi (Eds.), *Social Epidemiology* (pp. 137-173). New York: Oxford University Press.
- Bobak M, Marmot M: East-West mortality divide and its potential explanations: proposed research agenda. *BMJ* 1996, 312:421-425.
- Bosma H, Peter R, Siegrist J, & Marmot M (1998). Two alternative job stress models and the risk of coronary heart disease. *American Journal of Public Health*, 88, 68-74.
- Commission Staff Working Document accompanying the Communication on Community Instruments and Policies for Roma inclusion (2008)
- Dahlgren G, & Whitehead M, (1991). *Policies and Strategies to Promote Equity in Health*. Stockholm: Institute for Future Studies.
- Dahlgren G, Whitehead M (2007). *European strategies for tackling social inequities in health: Levelling up Part 2*. Copenhagen: WHO Regional Office for Europe.
- Department of Economic and Social Affairs – World Economic and Social Survey 2004 and 2007. International Migration and Development in an Aging World.
- Dragano et al (2007). Neighbourhood socioeconomic status and cardiovascular risk factors: a multilevel analysis of nine cities in the Czech Republic and Germany. *BMC Public Health*, 7.
- Graham H (2000). Socio-economic change and inequalities in men and women's health in the UK. In Annandale E, Hunt K (Eds.), *Gender Inequalities in Health* (pp. 90-122). Buckingham: Open University Press.

7. REFERENCES

- Janssen C, et al (2006). Der Einfluss sozialer Ungleichheit auf die medizinische und gesundheitsbezogene Bevölkerung in Deutschland. In M.Richter & K. Hurrelmann (Eds.), *Gesundheitliche Ungleichheit* (pp. 139-153). Wiesbaden: VS Verlag.
- Huisman M, Kunst AE, Andersen O, Bopp M, Borgan JK, Borrell C, et al (2004). Socioeconomic inequalities in mortality among elderly people in 11 European populations. *Journal of Epidemiology and Community Health*, 58 (6):468-75.)
- Karasek R A, Theorell T (1990). *Healthy Work: Stress, Productivity, and the Reconstruction of Working Life*. New York: Basic Books.
- Kawachi I, Subramanian S V, & Almeida-Filho N, (2002). A glossary for health inequalities. *Journal of Epidemiology & Community Health*, 56, 647-52.
- Kuh D, & Ben Shlomo Y, (2004). *A life course approach to chronic disease epidemiology*. Oxford: Oxford University Press.
- Kurth B, & Schaffrath Rosario, A. (2007). Die Verbreitung von Übergewicht und Adipositas bei Kindern und Jugendlichen in Deutschland. Ergebnisse des bundesweiten Kinder- und Jugendgesundheits surveys (KiGGS). *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*, 736-743.
- International Migration Outlook OECD SOPEMI 2008 edition*
- Lampert T, Mensink G, Romahn, N, & Woll A, (2007). Körperlich-sportliche Aktivität von Kindern und Jugendlichen in Deutschland. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*, 50, 634-642.
- Langnaese, K, Mast M, & Müller K, (2002). Social class differences in overweight of prepubertal children in northwest. *International Journal of Obesity*, 26, 566-572.
- Law M, Wald N: Why heart disease mortality is low in France: the time lag Explanation. *BMJ* 1999, 318:1471-1476.
- Lechner I, Mielck A: [Decrease in the "healthy migrant effect": trends in the morbidity of foreign and German participants in the 1984-1992 Socioeconomic Panel]. *Gesundheitswesen* 1998, 60:715-720.
- Mackenbach, J. P. (2006). *Health Inequalities: Europe in Profile - an independent, expert report commissioned by the UK Presidency of the EU*. London: Department of Health.
- Mackenbach J P (2007). *Socio-economic inequalities in mortality and morbidity: a cross European perspective. Tackling Health Inequalities in Europe. An Integrated Approach. EU-ROTHINE Final Report. Chapter 2*. Rotterdam.
- Marmot M, Davey-Smith G, & Stansfeld M S (1991). Health inequalities among British civil servants: The Whitehall II study. *Lancet*, 387-93.
- Marmot M G, Shipley M J, & Rose G (1984). Inequalities in death-specific explanations of a general pattern? *Lancet*, 1, 1003-6.

7. REFERENCES

- Martikainen P, Valkonen T (1996). Excess mortality of unemployed men and women during a period of rapidly increasing unemployment. *Lancet*, 208-213.
- Men T, Brennan P, Boffetta P, Zaridze D: Russian mortality trends for 1991-2001: analysis by cause and region. *BMJ* 2003, 327:964.
- Münz R: Woher? Wohin? Europäische Integrationsmuster 1950 - 2000. *Migration in Europa* (Edited by: Bade KJ and Münz R). Hannover, Niedersächsische Landeszentrale für politische Bildung 2001, 21-40.
- Organisation for Economic Co-operation and Development (OECD) (2001): *Lernen für das Leben. Erste Ergebnisse der internationalen Schulleistungsstudie PISA 2000*. Paris: OECD.
- Power C & Kuh D (2006). Life course development of unequal health. In Siegrist J & M. Marmot (Eds.), *Social Inequalities in Health - New Evidence and Policy Implications* (pp. 27-54). Oxford: Oxford University Press.
- Power, C. & Kuh, D. (2003). Life course development of unequal health. Final congress of the ESF Programme on 'Social Variations in Health Expectancy', Dublin, October 2003. Ref Type: Hearing
- Razum O, Twardella D: Time travel with Oliver Twist--towards an explanation for a paradoxically low mortality among recent immigrants. *Trop Med Int Health* 2002, 7:4-10.
- Rose G: Incubation period of coronary heart disease. *Br Med J (Clin Res Ed)* 1982, 284:1600-1601.
- Reinberg A & Hummel M (2005). *Höhere Bildung schützt auch in der Krise vor Arbeitslosigkeit. IAB Kurzbericht, 9/05*.
- Ringbäck Weitoft G (2003). Mortality, severe morbidity, and injury in children living with single parents in Sweden: a population-based study. *Lancet*, 361, 289-295.
- Robert-Koch-Institut (2003). *Gesundheit alleinerziehender Mütter und Väter. GBE-Heft 14*. Berlin: RKI.
- Schaaf M. *Roma Health*. In: Resolution EUR/RC52/Rt case studies: how European health systems are addressing the health of socioeconomically disadvantaged groups. Copenhagen, WHO Regional Office for Europe, 2008 (forthcoming).
- Siegrist J, Theorell T (2006). Socioeconomic position and health: the role of work and employment. In Siegrist J & M. Marmot (Eds.), *Social Inequalities in Health - New Evidence and Policy Implications* (pp. 73-100). Oxford: Oxford University Press.
- Siegrist J (2005). *Medizinische Soziologie*. München: Urban und Fischer.
- Siegrist J (1996). *Soziale Krisen und Gesundheit*. Göttingen: Hogrefe.
- Siegrist J, Marmot M (2006). *Social Inequalities in Health: New Evidence and Policy Implications*. Oxford: Oxford University Press.

7. REFERENCES

Stahl T, Wismar M, Ollila E, Lathinen E, Leppo K (2006). *Health in alle Policies - prospects and potentials*. Finland: Health Department.

Suhrcke, M, McKee, M, Sauto Arce, R, Tsolova, S, Mortensen J (2005). *The Contribution of Health to the Economy in the European Union*. Brussels: European Commission.

van Rossum C T, van de M H, Witteman J C, Hofman A, Mackenbach J P, & Grobbee D E (2000). Prevalence, treatment, and control of hypertension by sociodemographic factors among the Dutch elderly. *Hypertensio*, 35, 814-821.

Weyers S (2007). *Social Inequalities, Social Relations and Health Behaviour. Results from a Medical Sociological Study in the Ruhr Area (in German)*. Münster: LitVerlag.

Whitehead M (1990). *The Concepts and Principles of Equity and Health* World Health Organisation Regional Office for Europe Copenhagen.

World Health Organization (1999). *Health 21. The health for all policy framework for the WHO European Region*. Copenhagen: World Health Organization, Regional Office for Europe.

WHO Health for All Mortality Database Copenhagen, WHO Regional Office for Europe 2004.

Yusuf S (2004). Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *Lancet*, 364, 937-52.

ANNEX 1

COMMUNITY PROJECTS ON MIGRATION*

* Source: <http://ec.europa.eu/eahc>

Projects 2005

Project number: 2005122

Acronym: MEHO

Strand: 1. Health information (HI 2005)

Title: Monitoring the Health Status of Migrants within Europe: development of indicators

Main partner name: IBMG/Erasmus MC

Address PO Box 1738

City 3000 DR Rotterdam

Country: THE NETHERLANDS

Tel + 31 10-4081372

Fax + 31 10-4089094

E-mail s.denktas@erasmusmc.nl

Web site <http://www.erasmusmc.nl>

Project Leader Name DENTKAS Semiha

Associated partner(s) name Country

University of Edinburgh The United Kingdom

European Public Health Association The Netherlands

Agenzia di Sanita Publica della Regione Lazio Italy

The Universität Bielefeld Germany

The University of Copenhagen Denmark

The University of Pavol Jozef Safarik Slovakia

The University of Hamburg Germany

Duration: 36 months

Funding Recommended 791.776

ABSTRACT:

1. General Objective

Main objective of the project is the development of indicators to monitor the health status of ethnic minorities by using existing health related databases and surveys. A European network of epidemiological observatories on minority's health will be established. This network will generate a European overview of comparable and exchangeable data on socio-demographic and health profile of ethnic minorities for selected health problems. Aim is to include as many countries as possible, depending on the availability of data.

3. Methods and means

The main methodology of this project is to analyse existing ethnic minority specific health data, to discuss problems of identification and comparability during workshops, to analyse health differences between ethnic minority and indigenous populations using epidemiological techniques, to develop and discuss potential indicators to assess ethnic specific health differences and to present and discuss results.

4. Expected outcome

Results to be achieved

- Development of a set of comparable health indicators for migrants based on existing data in EU (take a census of available information on ethnic minorities within health and sociodemographic databases in EU countries, identify criteria for a definition of “ethnic minority” which can be comparable among EU countries; define strategies of analysis and common indicators to assess the relative differences in health between ethnic minority and indigenous populations across EU countries).
- Generate a first overview of (available data sources on) mortality of ethnic or migrant minorities in Europe (identify and describe existing data bases with information on mortality according to ethnic or migrant status (first and second generation migrants, other ethnic minorities; assess the coverage, completeness and quality of these databases, and to identify data bases useful for studying mortality in relationship to ethnicity or migrant status; collect data and analyze levels of mortality (by age, sex and/or cause of death) in ethnic or migrant minorities compared to the majority populations).
- Identification, description and set up communication links between databases that can be used to shed light on ethnic variations in cardiovascular disease in minority ethnic populations in Europe, re-analyse and present data to allow comparisons between European countries, to contribute to the larger EU project and to improve public health through linking data to policy.
- Characterisation of major infectious disease burdens in migrants in Europe from surveillance data and their impact on Public Health; to identify systematic deficits of official surveillance and reporting systems for migrant groups with respect to important infectious diseases; to provide better instruments for an improved assessment of the migration status to address more effective public health.
- Self-perceived health and health care use, to provide a list of indicators and data on health care use and perceived health as combined effects of health care needs community and health system characteristics. The indicators and data regard health care use and perceived health of migrant groups within and across countries relative to health needs, socio-demographic and health system characteristics of the countries included.
- Cancer, to identify and compile the ways information on migrant status is collected in European cancer registries; to develop a uniform definition on migrant status; to develop indicators for cancer risk, access to prevention & care, and survival, of migrants; to thereby contribute to improving the reporting and analysis of cancer risk, as well as cancer prevention and care, for migrants in Europe.
- The health of Roma people in EU, define the most important criteria identifying Roma health; to set an existing databases with available information on Roma health issues in EU; collect and analyse data on the health of Roma in comparison with the indigenous population.

Projects 2006

Project No: 2006302

Title: Health and migrations in the European Union

Beneficiary

Instituto Nacional de Saúde Dr. Ricardo Jorge (National Institute of Health)

Av. Padre Cruz

P-1649-016 Lisbon

E-mail: jomiguel@mail.telepac.pt

margarida.bugalho@insa.minsaude.pt

Website: www.insarj.pt

Project leader: José Pereira Miguel

EC contribution: EUR 220 000

Duration: 12 months

ABSTRACT

1. General objectives

The project aims to:

- improve the knowledge about the health status of immigrants coming from third countries, and its health determinants considering: demographic dynamics of migratory processes and their impacts, the specific political and legal frameworks at the national and international levels;
- identify best practices about immigrants' access to healthcare (including health promotion, prevention and healthcare services);
- contribute to the definition of health policies and strategies that could be implemented both at the EU and Member State level, aiming at better migrants' integration.

2. Strategic relevance and contribution to the public health programme

The project will provide evidence and identify good national practices related to the integration of migrants with regard to healthcare.

3. Methods and means

The methodology used differs between the two reports. The first is a report elaborated by an editorial board and its purpose is to analyse migration's socio-epidemiological, demographic and political context, study migrants' health status in Europe and its determinants, and evaluate health policy responses across EU Members States.

The methodology for the second report will develop a conceptual model. The determinants of health thus identified will be the basis to identify good practices at country level. The selection of best practices will include practices from different countries and from the perspective of public and private health sectors. The third sector is about non-governmental organisations, such as Médecins du Monde, Médecins sans Frontiers, Caritas, Mikado, IMISCOE or Women's Lobby.

A European conference will be organised, based on the preparation of two reports, which will be used as preliminary works.

4. Expected outcomes

The main results of the project will be the organisation of the conference with elaboration of the proceedings and recommendations, which will be presented to the Council of Europe.

Two reports will be produced, which will be used as preliminary documents for the European Conference on Health and Migration taking place during the Portuguese Presidency of the EU.

A network in 'health and migration' will be set up from the beginning of the project in order to share information between EU Member States and other networks which are working the same issues.

Key words: Conferences, Health Care, Immigrants, Health Promotion, Health Status

Project No: 2006129

Title: Best practice in access, quality and appropriateness of health services for immigrants in Europe (EUGATE)

Beneficiary

Queen Mary and Westfield College

University of London

Unit for Social and Community Psychiatry (Academic Unit)

Newham Centre for Mental Health

Cherry Tree Way Glen Road

London E13 8SP

United Kingdom

Tel. (44-20) 75 40 67 55 ext. 2315

Fax (44-20) 75 40 29 76

Website: www.qmul.ac.uk

Project leader: Stefan Priebe

EC contribution: EUR 700 000

Duration: 36 months

Associated partners

- Ludwig Boltzmann Gesellschaft, Vienna, Austria
- Université Catholique de Louvain, Louvain-la-Neuve, Belgium
- Department of Health Services Research, Institute of Public Health, University of Copenhagen, Denmark
- National Research and Development Centre for Welfare and Health (Stakes), Helsinki, Finland
- Etablissement public de santé Maison Blanche, Paris, France
- Universitätsklinik Charité, Campus Mitte, Charité, Berlin, Germany
- National School of Public Health, Athens, Greece
- University of Debrecen, Medical and Health Science Centre, Debrecen, Hungary
- Agency for Public Health, Lazio Region, Lazio Rome, Italy
- Kaunas University of Medicine, Kaunas, Lithuania
- Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg Nivel, Utrecht, Netherlands
- Instytut Psychiatrii i Neurologii, Warsaw, Poland
- Universidade do Porto, Faculdade de Medicina, Porto, Portugal
- Agencia de Salut Publica de Barcelona, Barcelona, Spain
- Karolinska Institute, Stockholm, Sweden

ABSTRACT

1. General objectives

EUGATE aims to provide a European-wide definition of what is meant by 'migrant', explore legislation, policies and funding arrangements relating to migrants and minorities, investigate organisation and utilisation of services, describe evaluation and monitoring methods, and identify and compare models of best practice.

2. Strategic relevance and contribution to the public health programme

Meeting the health needs of migrants and minorities is a challenge for public health. Inequitable variation in the utilisation of healthcare services between migrants and minorities concerns both healthcare providers and policymakers in Europe. EUGATE will bring together a multidisciplinary consortium from 16 EU Member States to consolidate the currently fragmented knowledge in the field, and identify best practice in access, quality and appropriateness of health and social services for different immigrant populations.

3. Methods and means

Systematic sampling and analysis of documents (on legislation, policies, funding arrangements, evaluation and monitoring mechanisms) will ensure a comprehensive inventory. Collecting information on institutions providing healthcare to migrants in the fields of primary, emergency and chronic care will provide an overview of the situation in Europe. Qualitative interviews with staff (medical and nonmedical) to investigate organisation and utilisation of healthcare institutions will be carried out. The review and analysis of best practice models will allow the development of a toolkit to support best practice all over Europe.

4. Expected outcomes

The project is expected to provide:

- the first comparable definition and set of indicators for describing migrants, immigrants and minorities to be used in health services and in health services research;
- a compendium on legislation, policies, funding arrangements, organisation, utilisation, evaluation and monitoring; an inventory and synthesis of best practices for addressing better the needs of migrants, immigrants and minority populations.

The project can build capacity in public agencies, in the healthcare sector, in universities and among politicians and thereby improve the skills of the European workforce.

Key words: Migrants, legislation, benchmarking, health care sector, health care

Project No: 2006206

Title: Increasing public health safety alongside the new east European border line

Beneficiary

International Organization for Migration

Rue Montoyer 40

B-1000 Brussels

Tel. (32-2) 282 45 60

Fax (32-2) 230 07 63

E-mail: rpetrovabenedict@iom.int

Website: www.belgium.iom.int

Project leader: Roumyana Petrova Benedict

Associated partner

- University of Pécs, Hungary

EC contribution: EUR 501 737

Duration: 30 months

1. General objectives

This project will contribute to the increase in public health safety of all EU Member States and help provide appropriate healthcare to migrants entering the European Union border area as a fundamental human right. The project will target the eastern external border of the enlarged EU where the implementation of the Schengen criteria is an ongoing process (Hungary,

Poland and Slovakia). In support of the increased general security provided by Schengen II, the project aims to develop a public health and border management module (PHBMM) as well as a proposal for structural changes in the public health services of targeted border sectors.

2. Strategic relevance and contribution to the public health programme

The enlarged European Union faces increased and more complex migration flows. The registered 39 million migrants represent approximately 8 % of the total population of the European Union (EU), while the number of irregular migrants in the EU is difficult to estimate. At present, the EU does not have a harmonised migration health policy, and the current protocols of border management along the EU external borders do not address the human public health aspects (nor do the Schengen criteria). Providing appropriate healthcare services for migrants is an important humanitarian obligation, but also, with growing importance, a public health concern for countries of transit and destination alike. The availability of healthcare for migrants and the ability of border staff to deal with the health concerns of migrants is one of the best security measures against public health risks associated with migration. Moreover, such measures are vital to the effective management of national, regional and EU-wide public health matters. National borders (making up the external borders of the EU), as the first point of entry for migrants, are an important target for actions aiming to improve the public health impact of migration.

3. Methods and means

The project's pilot phase will be implemented in the eastern border of the enlarged EU (Hungary, Poland and Slovakia) where the implementation of the Schengen criteria is currently ongoing, and will also include the participation of Romania. The project will be developed in four phases:

- (1) extensive assessment of the current conditions of the current border management procedures and structures regarding human public health aspects as well as securing the transnational regional network within the pilot area;
- (2) training material development and testing at the regional level;
- (3) public health minimum standard-setting checklist and development of a proposal for structural changes; and
- (4) dissemination of the experiences gained with the pilot PHBMM through country-level consultations with relevant governmental bodies of EU Member States and an EU-level seminar.

4. Expected outcomes

An innovative, comprehensive model will be developed and used to analyse the migration-related public health hazards and the conditions and capacity of the border management structure to respond to and control these challenges.

A core public health and border management module (PHBMM) will also be developed. Following the regional testing of the training materials, the module could be easily adapted and implemented in other EU Member States. The module will consist of two elements: training materials and minimum standards for public health in border management. Finally, the project will increase the awareness of Member States' governments to the health impact of migration and will support the development of EU migration health policy through the EU-wide dissemination of its results.

Key words: Migrants, Security measures, health care, health policy, human rights, standards, safety

Project No: 2006347

Title: Assisting migrants and communities: analysis of social determinants of health and health inequalities (AMAC)

Beneficiary

International Organization for Migration

Rue Montoyer 40

B-1000 Brussels

Tel. (32-2) 282 45 88

Fax (32-2) 230 07 63

E-mail: rpetrovabenedict@iom.int

Website: www.iom.int

Project leader: Roumyana Petrova-Benedict

EC contribution: EUR 200 000

Duration: 18 months

ABSTRACT

1. General objectives

The strategic objective of the project is to improve the health of migrants and communities affected by migration and, therefore, to tackle existing health gaps. The project's goal is to enhance the understanding of the complex relationship between health and population mobility.

2. Strategic relevance and contribution to the public health programme

While migration itself is under normal circumstances not a risk for health, conditions surrounding the migration process, particularly the inequalities in access to health services and in social determinants of health, can increase vulnerability for ill-health. Moreover, migrants are at risk of not receiving the same level of healthcare in the diagnosis, treatment and preventive services that the average population receives in host communities. Healthcare services are not responsive enough to the specific needs of these groups. Building upon recent European initiatives addressing health and migration, the AMAC project aims to consolidate the results and promote multi-stakeholder engagement in the dialogue on health inequalities linked to migration.

3. Methods and means

The project will begin with a review of the policy environment in view of the migration health-related conferences and consultations of 2007 and in relation to ongoing European-level projects in migration health. Based on this review, the expert team will identify priority areas as the topics of three individual workshops and develop a plan to establish synergies between their respective ongoing projects. Team members will prepare background papers on key issues linked to the chosen priorities, which will be discussed at the workshops, along with identified best practices and policy recommendations. The workshop results will be presented at a final EU-level consultation with key stakeholders in the fields of health, social affairs and justice/interior with a view to developing action points for integrating the recommendations into related national and EU strategies.

4. Expected outcomes

The project will provide governments and the European Commission with guidance on how to best address existing inequalities in access to, as well as the quality and appropriateness of, health services and on how to positively influence the social determinants of the health of migrants.

Key words: Inequalities, Migrants, Health Care, Health Services, Conferences

Project No: 2006342

Title Health and the Roma community: analysis of the situation in Europe

Beneficiary

Fundacion Secretariado Gitano

Calle Ahijones S/N

E-28018 Madrid

Tel. (34-91) 422 09 60

Fax (34-91) 422 09 61

Website: www.gitanos.org

Project leader: Nuria Serrano

EC contribution: EUR 367 056

Duration: 24 months

Associated partners

- Network of Local Authorities Efxini Poli, Athens, Greece
- Rede Europeia Anti-Pobreza, Porto, Portugal
- Roma Centre for Social Intervention and Studies, Romani Criss, Bucharest, Romania
- Office of the Council for Roma Community Affairs, Prague, Czech Republic
- Initiative for Health Foundation, Sofia, Bulgaria
- Health of Romany People Foundation, Sliven, Bulgaria
- Partners for Democratic Change, Bratislava, Slovakia

ABSTRACT

1. General objectives

The project will:

- contribute to the reduction of health inequalities affecting the Roma community in Europe; obtain reliable and objective data about the social/health situation of the Roma population and the use made of healthcare resources available for the mainstream society;
- identify factors considered vital in improving the Roma situation and promote equity;
- promote synergies between public/private sphere (health centres, hospitals, social organisations, public administrations, etc.).

2. Strategic relevance and contribution to the public health programme

The Roma community comprises Europe's largest ethnic minority and is generally characterised by the situation of social exclusion it faces. Inequalities in terms of healthcare and access to health services are one of the main factors contributing to that social exclusion. Despite their glaring visibility, their health conditions are not backed by statistics or reliable, updated data.

3. Methods and means

The project will perform a survey to collect reliable and objective data in regard to the health situation of Roma and the use made of and access to healthcare resources. Training for interviewers/researchers/field workers will be organised in each country focused on methodology and questionnaire administration. A group of experts will be formed in each country on health and the Roma community to support the project activities at national and European levels. The team of project partners will use the results of these reports to draft a joint report describing the situation of inequality detected and will make recommendations of active measures designed to foster Roma community health throughout Europe. In each of the countries, priorities to work on will be set up in order to develop specific actions to improve the health situation of the Roma communities in these countries, developing some fact sheets to work on with the community itself.

4. Expected outcomes

- Diagnosis of the social/health situation of the Roma community in seven European countries (Spain, Portugal, Greece, the Czech Republic, Slovakia, Romania, and Bulgaria — all with a significant Roma population).
- Drafting of an action proposal and recommendations' document targeting different key players in the social/health domain (political decision-makers, healthcare administration technicians, healthcare personnel, social entities working in the sphere of health and the Roma community, etc.).
- Awareness-raising and dissemination actions.
- Setting up priorities of action in each of the countries, in order to improve the health situation of the national Roma communities.

Key words: Inequalities, Health Care, Social Work, Recommendations, health status

Project No: 2006333

Title: Healthcare in Nowhereland — Improving services for undocumented migrants in the EU

Beneficiary

Donau Universitat Krems (Danube University- DUK)

Universitat fur Weiterbildung Krems

Dr Karl Dorrek Strasse 30

3500 KREMS AT

Project leader: Ursula Karl- Trummer

EC contribution: EUR 499 999

Duration: 36 months

Associated partners

- Azienda Unità Sanitaria Locale di Reggio Emilia (AUSL), Reggio Emilia, Italy
- University of Brighton (IHDRC), Brighton, United Kingdom
- Malmö Institut for Studies of Migration, Diversity and Welfare (MIM), Malmö, Sweden
- Platform for International Cooperation on Undocumented Migrants (PICUM), Brussels, Belgium
- Centre for Research and Studies in Sociology (CIES), Lisbon, Portugal

ABSTRACT

1. General objectives

The project aims at improving the level of health protection for the people of Europe by addressing migrants' and immigrants' access, quality and appropriateness of health and social services as important wider determinants for health, focusing on healthcare services for undocumented migrants (UDMs) as an especially vulnerable group, an increasing public health risk and a group providing difficulties for healthcare providers and health policy.

2. Strategic relevance and contribution to the public health programme

Undocumented migrants (UDMs), estimated to cover up to 15 % of all migrants in the EU, are a relevant and complex challenge for European public health and healthcare. UDMs are vulnerable groups with high health risks also threatening public health (HIV, TBC, etc.). Service provision for UDMs is precarious due to, for example, late contact, language, no entitlement, uncertain legal/financial frameworks. Health policy has to deal with contradictory aims and criteria from public health, human rights, security and law enforcement policies.

3. Methods and means

The project uses different methods aiming to achieve the objectives at the levels of policy, providers, clients and for integration of the three perspectives:

- public health policies: secondary analysis of documents and scientific literature and expert interviews;
- providers: group discussion and consensus conferences of practice experts, scientific/evaluation experts, and migrant representatives/advocacy groups; assessment of practice models following a stakeholder approach using document analysis, questionnaires, interviews and site visits;
- UDMs: telephone interviews with advocacy groups, semi-structured interviews with UDMs including a short, structured questionnaire.

4. Expected outcomes

- Results will create a knowledge base for providing, exchanging and developing good practice and contribute to a more pragmatic perspective in a so far largely ideological based debate on UDMs in the EU. In addition and complementary to other EU initiatives, it will put a focus on this specific migrant group of UDMs that find themselves in a specific situation and that pose a specific challenge to EU policies and healthcare organisations.
- By setting up an international network of experts, country reports of 27 EU Member States will be produced, which will be complemented with the EU landscapes presenting the results of the policy documentation and the country reports.
- Database on contextualised practices of healthcare for UDMs, to be able to make the knowledge of the models of practice accessible.
- Models of good practice will be selected and assessed. As a result a compilation of success stories in relation to given legal frameworks and UDM needs will be published.
- The results of the in-depth interviews with the UDMs containing their perspectives will be published in a scientific article.
- Fact sheets, translated into six EU languages, will include EU landscapes, models of good practice and UDM views, thus offering the possibility of a broad dissemination.
- A book will be published which combines the results of the findings on policy, at the provider and client level.
- An assessment tool, a tool for assessing models of good practice will be developed. Existing indicators (ECHI, OECD quality indicators) will be taken into consideration.
- A manual for conduct of the assessment will be developed.

Key words: Migrants, Law Enforcement, Health Care, Quality Indicators; Health Personnel

Project No: 2006317

Title: Information network on good practice in healthcare for migrants and minorities

Beneficiary

National and Kapodistrian University of Athens

75, Mikras Asias str.

GR-11527 Athens

Tel. (30-21) 746 20 59

Fax (30-21) 746 20 58

E-mail: ikotsioni@med.uoa.gr

Website: http://mighealth.net/index.php/Main_Page

Project leader: Athena Linos

Associated partners

- Semmelweis University, College of Healthcare, Budapest, Hungary

- Bağkent University, Mighealthnet, Turkey
- Middlesex University Higher Education Corporation, Middlesex, United Kingdom
- Charles University Prague, 1. Lékarská Fakulta, Prague, Czech Republic
- University of Southern Denmark, Statens Institut for Folkesundhed, Copenhagen, Denmark
- Universität Bielefeld, Germany
- Utrecht University, Netherlands
- Ullevaal University Hospital, Nakmi, Norway
- Jagiellonian University Medical College, Kraków, Poland
- Universidade de Lisboa Faculdade de Letras, Portugal
- Queen Mary University of London, United Kingdom
- Internationell Migration och Etniska Relationer, Malmö, Sweden

EC contribution: EUR 383 886

Duration: 24 months

ABSTRACT

1. General objectives

The project will promote exchange of expertise, information and good practices on healthcare for migrants and minority populations. The project will act as a catalyst in the formation of scientific and professional communities in each country concerned with migrant and minority health.

2. Strategic relevance and contribution to the public health programme

The project will allow healthcare professionals, policymakers, health authorities, researchers, educators, and migrant and minority groups to exchange information and good practices on healthcare for migrants and minority groups.

3. Methods and means

Development of interactive websites (wikis) focused on the state of health of migrants and minorities and on the development of appropriate service provision for these groups. The wikis will contain information on the following topics: contextual data on migrant populations and immigration policies; research findings concerning migrants' state of health and its determinants; the health system and migrants' entitlement to healthcare; accessibility of healthcare; quality of care; 'good practices' developed to improve the matching of service provisions to the needs of migrants; policy measures undertaken to investigate and improve migrant health and resources.

4. Expected outcomes

The project will:

- set up interactive websites in 16 countries, in the local language, containing a library of relevant documents and information about individuals, organisations and resources dealing with migrant and minority health. The websites will be linked to each other and to the central English-language site;
- organise meetings, at national and European level, to bring together representatives of the migrant and minority health stakeholders;
- stimulate the formation of networks of individuals and organisations concerned with migrant and minority health.

Key words: Migrants, Minority Groups, Health Care, Health Resources, Quality of Health Care

Project No: 2006344

Title: European network for HIV/STI prevention and health promotion among migrant sex workers (TAMPEP)

Beneficiary

TAMPEP International Foundation

Obioplein 4

1094 RB Amsterdam

Netherlands

Tel. (31-20) 692 69 12

Fax (31-20) 608 00 83

Website: www.tampep.eu

Project leader: Licia Brussa

Associated partners

- LEFÖ Beratung, Bildung und Begleitung für Migrantinnen (LEFOE), Austria
- Espace P (Espace P), Belgium
- Őííääöëÿ „Çãðääå è ñîèàèí ðàçàèèèâ’/Health and Social Development Foundation (HESED), Bulgaria
- Rozkoř bez Rizika/Bliss without risk (R/R), Czech Republic
- National Board of Social Services (Servicestyrelsen), Denmark
- MTÜ AIDSi Tugikeskus/NGO AIDS-I Tugikeskus (MTU), Estonia
- Pro-tukipiste ry (PRO TUKIPISTE), Finland
- Association Autres Regards (Autres Regards), France
- Prévention, Action, Santé et Travail pour les Transgenres (PASTT), France
- Amnesty for Women Städtegruppe Hamburg e.V. (Amnesty for Women), Germany
- AIDS Coalition to Unleash Power/Drase Hellas (ACT UP), Greece
- Szex Edukáció Alapítvány /Sex Education Alapítvány (SEA), Hungary
- Comitato per I Diritti Civili Delle Prostitute ONLUS (CDCP ONLUS), Italy
- Latvijas Genders Problemu Centrs (S/O Genders), Latvia
- Lietuvos AIDS Centras (LAC), Lithuania
- Croix-Rouge luxembourgoise (Dropin Croix-Rouge), Luxembourg
- Pro Sentret Oslo Kommune (Prosentret), Norway
- Stowarzyszenia Na Rzecz Promocji Zdrowia i Prewencji Zagrożeń Spo³ecznych (TADA), Poland
- Administração Regional de Saude do Norte (ARS NORTE), Portugal
- Asociația Romana Anti Sida/Romanian Association against AIDS (ARAS), Romania
- Obcianske zdruzenie ODYSEUS (OZ ODYSEUS), Slovakia
- Center za Preventivo AIDSa in Ranljive Skupine/Centre for AIDS Prevention and Vulnerable Groups (CARS), Slovenia
- Colectivo en Defensa de los Derechos de las Prostitutas (HETAIRA), Spain
- Scottish Prostitutes Education Project (SCOT-PEP), United Kingdom

EC contribution: EUR 600.000

Duration: 36 months

ABSTRACT

1. General objectives

The main objective of TAMPEP is to reduce the HIV vulnerability of migrant and mobile sex workers through the development, exchange, promotion and implementation of appropriate policies and interventions across Europe.

2. Strategic relevance and contribution to the public health programme

It is internationally acknowledged that human rights form the basis of the response to HIV and sex work as stated in the 2005 UNAIDS policy position paper on 'Intensifying HIV prevention'. The TAMPEP project will contribute to the implementation of the action: '3.2.3. Integrative approaches on lifestyles and sexual and reproductive health: HIV/AIDS' of the public health programme work plan 2006.

3. Methods and means

The combination of community-based research, targeted intervention and advocacy alongside the principle of direct participation of sex workers in the design, development, execution and evaluation are the key elements of the methodology. The stages of the methodology combine: national and European mapping of prostitution, assessment of changes in sex workers' populations and situations and their needs; survey on legal framework and policy development; actual interventions; evaluation and adjustment of the interventions to environmental changes; creation of models of intervention and mtools, while adapting them to specific groups and settings in various member countries; implementation and assessment of effects of scaling up HIV/AIDS strategies within the European context with common indicators and survey methods at national, subregional and European levels.

4. Expected outcomes

- A pan-European response to legal, health and social care needs of (migrant and mobile) sex workers in a framework of cooperation between 26 partners.
- Strengthening the capacities of service providers and community-based organisations for effective interventions and strategies for HIV/STI prevention among (migrant and mobile) sex workers and their clients.
- Comprehensive and updated assessment of the prostitution scene through qualitative and quantitative data gathered across the network of 25 countries, a network which has the role of a European expertise centre within the enlarged Europe.
- Comprehensive and updated assessment of legal framework regarding migration, sex work, and HIV/STIs at national and European levels, focusing on legislation and policy that impact either positively or negatively on sex workers' ability to access information and services.
- Exchange of experiences and skills within the network and beyond through the production of a European good practice manual with examples of comprehensive intervention strategies adaptable to various settings and countries.
- Strengthening referral routes to health- and social care services for migrant sex workers through the development of a new Internet resource: a website with a directory of health and social care services accessible to migrant sex workers and information for various stakeholders.
- Exchange of skills and experience in relation to cross-border prostitution at bilateral and regional and European level, thereby enhancing the capacity of health and social care service providers to respond to the needs of sex workers in this particular environment.

Key words: Migrants, Prostitution, HIV, Life Style, Human Rights

Project 2007

Project number: 100890

Acronym: AVERROES

Strand: 3. Health determinants (HD 2007)

Priority area: 3.3 Public health actions to address wider determinants of health

Title: AVERROES Network - Improving access to health care for asylum seekers and undocumented migrants in the EU

Main partner name: MEDECINS DU MONDE

Migration Health Coordination Secrétariat International

Address 62 rue Marcadet

City 75018 Paris

Country: France

Tel +33 1 44 92 15 84 Tél +33 1 44 92 15 82

Fax +33 1 44 92 14 55

E-mail juliette.senecat@medecinsdumonde.net

Project Leader Name Juliette Sénecat

Associated partner(s) name Acronym City Country

Médecins du Monde Belgique - Dokters Van de Wereld België MDM BE Bruxelles Belgium

Médicos del Mundo MDM SP Madrid Spain

Duration: 36 months

EC contribution: 749.988,00

ABSTRACT:

1. General objectives

The project contributes to enhancing the EU general population's health, by improving asylum seekers' and undocumented migrants' access to health care. MDM seeks to improve knowledge on asylum seekers and undocumented migrants' access to health care in the EU. MDM also seeks to promote these populations' right to access healthcare on equal terms with nationals, and seriously ill foreigners' right to protection against deportation – when they do not have access to health care in their country of origin.

2. Strategic relevance and contribution to the public health programme

The AVERROES project seeks to improve wider determinants of health and contributed to reducing health inequalities, notably by: sharing good practices on awareness raising, including the development of networks; providing documentation and evaluation of good practices in tackling issues of access to health care and differences in outcomes of health care by social group; promoting innovative approaches to addressing migrants health issues. Therefore it contributed to all three priorities of the 2007 Work Plan.

3. Methods and means

To achieve its objectives, the project proposes to create an NGO network covering 19 EU member states, which will carry out research, field surveys, and awareness raising activities at national and EU levels. By doing this, the network intends to improve knowledge on the issue of migrants' access to healthcare, as well as to convince policy-makers of the necessity of a policy change in the EU, aimed at improving asylum seekers' and undocumented migrants' access to healthcare.

4. Expected outcomes

A European NGOs network (covering 19 EU member states) is set up. This network aims at improving foreigners' access to health care and seriously ill foreigners' protection against deportation in the EU.

The network produces a comparative study on the EU and member states' political trends and legislations on migrants' access to healthcare, and a survey on asylum seekers' and undocu-

mented migrants' effective access to health care. The project and the network benefit continuously from and experienced coordination team's support and monitoring. The surveys published by the network are strategically disseminated in 19 Member states and at EU level. The main European and national policy-makers concerned are sensitised to the Averroes project's core messages, through their participation to national and European events organised by the Averroes network. Health professionals and the public opinion are encouraged to support the project's messages and are sensitized, through the surveys and the other material available on the project's website, to the difficulties encountered by the asylum seekers and undocumented migrants in accessing health care and prevention. The project progress is monitored and its results are measured against the project's general and specific objectives, through an internal and an external evaluation process.

Project number: 100897

Acronym: A & M 2007-2010

Strand: 3. Health determinants (HD 2007)

Priority area: 3.5 Capacity building

Title: Aids and Mobility Europe 2007 - 2010

Main partner name: Ethno-Medizinisches Zentrum e.V. and TARGET GmbH

Address Königstrasse 6

City Hanover

Country: Germany

Tel 0049 511 16841020

Fax 0049 511 457215

E-mail <mailto:ethno@onlinehome.de>

Project Leader Name Wienold Matthias

Associated partner(s) name Acronym City Country

AIDS-Fondet AIDS-Fondet Copenhagen DE

AIDS-I Tugekeskus AISC Tallinn EE

European AIDS Treatment Group EATG Brussels BE

Kültekin Ögel Yeniden Sisli, Istanbul TU

Státní zdravotní ústav SZU Prague CZ

Terrence Higgins Trust THT London UK

National Institute for Health, NIHMP Rome IT

Migration and Poverty

Duration: 36 months

Funding Recommended 500,000.00

ABSTRACT:

1. General objectives

The main aim of AIDS & Mobility Europe is to reduce HIV vulnerability of migrant and mobile populations in Europe. For the purpose of this proposal, the definition of migrant is based on language barriers in access to health services as a result of belonging to a population minority (mostly ethnic group). Specifically the project will aim to develop an innovative health education model for migrants and ethnic minorities; to implement structured transcultural mediator training and to conduct educational group sessions on HIV/AIDS; to strengthen the existing network structures of HIV prevention among migrants; to evaluate performance and outcomes; to disseminate the results and communicate them widely; to design adequate strategies to assure continuity of the approach and to influence European and national policy making.

2. Strategic relevance and contribution to the public health programme

It is internationally acknowledged that migrants and mobile populations are a vulnerable group and that there is a need to develop innovative health education models for the prevention of HIV/AIDS.

The A&M project will contribute to the implementation of the action: '3.2.3. Integrative approaches on lifestyles and sexual and reproductive health: HIV/AIDS' of the public health programme work plan 2007.

3. Methods and means

The project objectives will be achieved through a set of learning activities carried out on the national/regional levels, with pan-European methodologies and guidance. The combination of community based research and advocacy will be based on the principles of participation of migrants and of empowerment. The stages of the methodology will combine consensus building on a holistic and multi-level intervention and the involvement of regional networks as platforms for transcultural AIDS mediator training. This includes transfer of management methods guided by the principles of empowerment and participation of migrants in an evidence based, transparent process. The development will be informed by systematic internal review and expert advice (Master Toolkit Advisory Group, Policy Development Task Force and External Evaluation). Evidence provided will be disseminated and will also be used to inform policy development (Policy Summit and Common Recommendations). Special emphasis will be given to exploring the potential for sustaining and further expanding the capacities built through the project.

4. Expected outcomes

AIDS & Mobility 2007-2010 will build capacity in HIV- prevention in Europe through a number of innovative activities, events and publications. They include: HIV- prevention in migrant populations will be improved through the use of transcultural mediator training among six partner organisations (in Denmark, Estonia, Germany, Italy, Turkey and the UK). Regional networks as platforms for transcultural mediator trainings and transcultural mediator campaigns designed to mainstream HIV-prevention for young migrants that will also empower migrants to become leaders in the field of HIV-prevention. Additional coaching by social entrepreneurs will facilitate the development of sustainable prevention efforts. Payment schemes for transcultural mediators and the involvement of mediators in research methodology, data gathering and reporting that will strengthen the role and status of transcultural mediators in migrant and ethnic groups as well as in the interface between these communities and local health systems. Community based research that will involve all partners in the gathering of information on health literacy, knowledge, attitudes and practices, relationships of migrant groups to health care services and ways in which all these can be improved.



GRAFICA:
Giuseppe Romamazzi

IMPAGINAZIONE E STAMPA:
Agenzia D