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MIGRANT-SENSITIVE HEALTH SYSTEMS

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IOM International Organization for Migration
OIM Organisation internationale pour les migrations
OIM Organización Internacional para las Migraciones

Migrant-Sensitive Health Systems*

Overview

Health systems are often challenged to meet the needs of migrants. Accessibility to and appropriate utilization of health services are often compromised by a lack of familiarity with enrolment processes and entry points, financial and structural barriers to receiving care, and discouraging or discriminatory treatment by staff. If migrants can access health services, they may find it difficult to communicate symptoms or understand treatment instructions due to language barriers, a situation frequently complicated by different cultural constructs of illness causation and management, or unfamiliarity with a formalized health system. A lack of appropriate training for health professionals means they may not be prepared to identify and manage the variety of health issues presented by migrants, including communicable diseases, inherited conditions, chronic diseases, nutritional deficiencies, and the effects of displacement, trauma, torture, or sexual abuse.[1]

Migrant sensitive health systems and programmes aim to consciously and systematically incorporate the needs of migrants into all aspects of health services financing, policy, planning, implementation, and evaluation. Globally, there is a broad range of models for this approach, from single-site interventions to comprehensive national policies. This chapter will outline some of the key elements of migrant sensitive health strategies, and offer examples of programmes and policies from many countries.

The concept of migrant sensitive health services is underpinned by broader efforts to understand and effectively respond to the needs of migrant, minority, and indigenous communities worldwide. Starting from research and practice based in the academic disciplines of medical anthropology and immigrant/tropical medicine, front-line health care providers and advocates for these populations have evolved models of care that better respond to the linguistic, cultural, social, religious, and health status differences that affect their ability to use mainstream health care systems. These efforts, and the theoretical concepts that accompany them, have been variously described under the labels of multicultural health, cultural competence, migrant-friendly, race equality, diversity-sensitivity, and health disparities reduction. Many of the factors influencing migrants' health status and utilization of health services have to do with their social circumstances, so that the discourse on multicultural health links up with that on the social determinants of health.

When health systems choose to respond to needs of migrants, they do so for a variety of reasons. On a practical level, front-line staff may recognize the pressures caused by changing demographics and begin to develop tailored programmatic responses that will make it easier for them to do their jobs. Migrant-serving community organizations often advocate for these changes, and can be supportive partners in illuminating migrant needs and offering expertise and complementary services. Given the particular health issues faced by migrants, including many communicable diseases, it is good public health practice to facilitate their access to information, facilities, and services. Human rights advocates recognize that undocumented migrants are in a particularly vulnerable position, due to perceived or actual discriminatory practices, fears related to interactions with authorities, and legal and financial barriers that impede their access to health care.

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In some countries, policy frameworks both shape and respond to the realities posed by migrants at the health service delivery level. These policies are frequently motivated by persistent advocacy from migrant, minority or human rights organizations, and by findings from research and demonstration programmes that provide an outcomes-driven rationale for action. Going beyond basic articulations of rights to care, these documents often specify in detail how a health system should adapt its policies and service delivery to the needs of migrants. Among these are *The Amsterdam Declaration: Towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe*;[2] the United Kingdom Race Relations Act and subsequent National Health Service implementation frameworks;[3] frameworks developed under the auspices of the Portugal Presidency of the Council of the European Union and the Council of Europe; and State and Federal laws, and health facility accreditation standards in the United States.[4,5]

Policy and practice have a synergistic relationship – sometimes practice is ahead of policy statements, and sometimes it is the reverse. In South Africa, for example, a recent examination of health access for migrants in the context of the 2008 xenophobia riots noted that an explicit right to health services exists for migrants, but there is widespread discrimination, delay, denial or inappropriate charges by health staff when migrants seek them.[6] Conversely, states may have a system of good practices related to service delivery for some migrants and at the same time have legal restrictions or harmful practices related to the care of asylum seekers and the undocumented, or those in detention or awaiting deportation.[7, 8]

Types of Services that Comprise Migrant-Sensitive Health Service Delivery

Taking into consideration the unique needs and conditions presented by migrants in need of health services, a wide variety of programmes and interventions have been developed to help migrants access health services and to promote adaptations to migrant needs by mainstream health systems. These services (and the policy frameworks that support them) predominate in countries that have had historically high rates of immigration, such as Canada, Australia, New Zealand, the United States and the United Kingdom. However, a variety of innovative activities are also emerging from countries with more recent experience of large migrant populations. An excellent overview of this work in Europe is contained in the report on *Health and migration in the European Union*.[9,10] The following is a brief overview of different types of migrant sensitive health services, with a few examples to illustrate each.

Language Services

Provision of interpretation services and language-appropriate written materials is often the first and most critical intervention implemented to improve the migrants' experience in the health care system. Research shows that language barriers have a negative effect on access to care and prevention services, adherence to treatment plans, timely follow-up, and appropriate use of emergency departments. Misunderstandings of symptoms or mistranslations have resulted in delayed care, clinically significant medical errors, and death.[11,12] From a clinical ethics and human rights perspective, accurate communication is essential to obtain consent for health interventions and treatment and to guarantee confidentiality and privacy about health information. In response to demonstrated needs and legal and accreditation requirements, ever-increasing numbers of United States hospitals and health systems use specially-trained medical interpreters in programmes with budgets that can reach beyond US$1 million per year. In the United Kingdom, many local health trusts have interpreter and translation programmes, and other localities around the world also use interpreter services organized by non-governmental organizations (NGOs) or private companies.

Culturally Informed Care Delivery

Culturally informed health care delivery – also called culturally competent[13] or culturally sensitive care[14] – refers to the ability of a health care practitioner to acknowledge their own cultural backgrounds, biases, and professional cultural norms and to incorporate relevant knowledge and interpersonal skills related to the care of patients from different cultural backgrounds. In the case of migrant populations, this would also encompass being familiar with the health and social issues related to the experience of individual migrant groups. There are cultural, religious, social, and gender factors that come into play in the negotiation and implementation of treatment plans for a variety of general health issues, such as reproductive and child health, chronic disease management, aging and end-of life care; as well as specific issues that may affect migrant populations such as consanguineous marriages, female genital mutilation, and the effects of torture and trauma. In France, for example, the Government supported a multi-sectoral strategy to raise awareness about and reduce the prevalence of female genital mutilation among girls living in France.[15] Among the key points related to culturally informed care that emerged was that how a health professional raises the topic with a girl or her family is critical in facilitating a productive conversation. Similar efforts have been undertaken in Italy and Switzerland, and by several international organizations.[16]

Mental health issues among migrant populations, and unaddressed trauma, torture and integration issues, can have especially paralysing consequences on migrants trying to make a new life. Linguistic and cultural issues are particularly delicate in the context of mental health services. This is often complicated by the cultural differences in how mental health issues are perceived: in many countries, there are few formalized mental health services and those that exist are associated with the most serious disorders and a high level of societal stigma. 'Traditional' immigration countries have developed models of specialized expertise in dealing with the mental health concerns of migrants, and mental health systems have attempted to be more proactive in developing a cadre of mental health professionals who come from needed linguistic and cultural backgrounds. The State of New South Wales in Australia has recently issued the Multicultural Mental Health Plan 2008-2012, a strategic state-wide policy and service delivery framework for improving the mental health of people from culturally and linguistically diverse (CALD) backgrounds. The key actions outlined in the Plan are underpinned by several existing programmes, including the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, the Transcultural Rural Remote Outreach Project and the CALD Children and Families Mental Health Project.[17] In New Zealand, some specialized mental health services have been established, for example the "Refugees as Survivors" (RAS) centres, and "transcultural" teams that have clinicians partnering with ethnic peer support workers.[18, 19]

Culturally Tailored Health Promotion, Disease Prevention, and Disease Support Programmes

The concept of culturally informed care can be extended to population-based health programmes. A wide body of research demonstrates the efficacy of health promotion, disease prevention and disease support interventions that are designed with the linguistic, cultural, and educational characteristics of the target population in mind. The most successful programmes are often aimed at specific groups in a particular locale, and ensure participation of the target population in the intervention's design, implementation, and evaluation. The Innvadiab project, hoping to reduce the development of type 2 diabetes among Pakistani women living in Oslo, Norway, demonstrated that culturally adapted education has the potential to change Norwegian-Pakistani women's intentions and behaviour related to health diets.[20] *Promotores de salud* (community health workers) and primary care professionals often lead face-to-face health education campaigns among seasonal migrant workers in the Americas.[21] There are similar examples in many other countries, although like many interventions focused on migrants, these

efforts are often short-term demonstration projects that falter after the initial funding period if they are not incorporated into regular public health service operations.

Institutional and Community-Based Cultural Support Staff

A very effective model of care that directly addresses the linguistic and cultural issues posed by migrant populations is the use of cultural support staff, working both inside health organizations and in the community. They are variously called intercultural mediators, community health workers, or patient navigators, and are used in many countries and in a variety of contexts. Ideally drawn directly from migrant communities themselves, these cultural support staff can play a wide range of roles, such as interpreter, patient advocate, and health educator – and offer the added bonus of facilitating social integration for both the mediators and those they serve. In Hamburg, Germany, teams of intercultural mediators planned and conducted health events and community learning sessions, including an introduction to the German health care system. It is similar to programmes in 21 other German municipalities, funded by national umbrella of health insurers[22.] A programme in Belgium places 80 mediators in 62 hospitals around Brussels, where they provide interpretation services and patient support.[23, 24]

Organization- and System-Level Frameworks for Migrant Sensitive Services

There are many systems of care specifically organized to address the needs of migrants – some government sponsored, and many supported by civil society organizations. For refugees, starting at the pre-resettlement stage in-country, there are health programmes that provide health care services for short and long-term periods. Some health care systems and NGOs say that their ability to deliver appropriate health services in the destination country would be greatly facilitated by better communication of patient-specific health information from the sending countries. Upon arrival, there may be a short transition period of government-sponsored screening and other health services for asylum seekers and regular migrants, but after this point they must successfully navigate the regular health system (if they are eligible), or depend on free-standing migrant health programmes (often run by NGOs on limited budgets). It is important to recognize that in some countries asylum seekers and those with refugee status are a specialized and sometimes more privileged group than migrants overall, especially undocumented migrants (including failed asylum seekers).

Primary Health Care: Barrier or Gateway for Migrants?

Recent activity on strengthening primary health care within health care systems[25] has relevance to improving health services for migrants. Addressing health inequalities by moving towards universal coverage and putting people at the centre of service delivery are two goals that speak directly to some of the access limitations experienced by migrants. Primary care services should be the primary entry point for most, if not all, health care services, and eligibility and financing systems should account for migrants.

But too often primary care providers are not friendly to or actively discourage migrants from seeking services. Health care providers are often unfamiliar with the epidemiological profiles of migrant groups and feel unprepared to manage the complex psycho-social issues that affect migrants. Migrants may be referred away by primary care providers to NGOs or private providers, even when migrants are entitled to access public services. While migrants may sometimes prefer to access community services from organizations they trust, this practice can compromise continuity and quality of care, puts an unfair burden on NGOs who are often not reimbursed for the health services they provide, and allows government agencies to side-step care obligations. Al-

though the situation varies from country to country, migrants often experience financial barriers in seeking primary care, where they may be required to pay user fees or full cost of services, as differentiated from other residents. These barriers are almost always more pronounced for irregular migrants.[26]

Whether caused by social, structural or financial barriers, it is clear from a variety of studies that migrants do not use health care in a way that allows them to maintain optimum health status. A study of the health status and social situations of newborn children in two Portuguese communities with large migrant populations shows higher levels of morbidity for both mothers and babies, along with higher use of emergency rooms instead of local primary care services.[27] This suggest a strong need for education and outreach to migrant women about timely and appropriate use of different health services.

One response to these challenges is the concept of a dedicated primary care service for asylum seekers in Leicester, United Kingdom. Designed to address the difficulty of mainstreaming asylum seekers into regular health system, this programme allows for a gradual adaptation while delivering services particularly needed by migrants in one place. These include screening, mental health assessments, reproductive health services, a health visitor programme for child health, health promotion, and language support.[28]

Improving the Overall Capacity of the Health System to Respond to Migrants: Practice and Policy

Specialized expertise in dealing with complex needs of migrants is essential, but no substitute for improving the overall accessibility of mainstream health services. There are many examples of locality-specific attempts to bring more coherence and a systematic approach to migrant sensitive health services. In Spain, the Migrant-Friendly Health Centres programme was undertaken by an NGO in partnership with five hospitals and 33 primary health centres in the Catalonia public health system. The focus was on offering intercultural mediation services and making intercultural adaptations to the facilities' services, products and routines.[29] Similar efforts in Norway, through their migrant friendly hospital network, have addressed language accommodations, training for staff, and multi-faith religious accommodations in hospitals. Another effort resulted in an increased local authority subsidy for general practitioners in a municipality with 70% refugees and immigrants.[30]

The key to long-term improvements in the delivery of care to migrants lies in formal systems of migrant sensitive services and policies in mainstream health organizations, as opposed to ad hoc, short term individual projects. These strategies must engage health staff from all disciplines and areas of responsibility, and address all levels of health planning, service delivery, management, and governance. For example, as an outgrowth of the United Kingdom Race Relations Act requirements, the 22 Health Boards of Scotland now have an audit framework to support progress on race equality outcomes for service users, communities and staff. The framework addresses a range of highly specific targets and success indicators in the areas of organizational readiness, demographic investigations, access and service delivery, human resources and community development and involvement. The strategy specifically defines Black and Minority Ethnic as including asylum seekers, transitional populations (students, seasonal workers, gypsies/Travellers) and tourists.[31, 32]

In Thailand, the multi-partner Migrant Health Project emphasized four key organizational strategies to improving services for migrants: building the capacity of health service providers and migrant communities to identify the health needs of migrant and provide migrant friendly services, developing a health information system, identifying possible financing options to run sustainable and equitable services for migrants, and documenting models that could be replicated in similar settings.[33]

The Australian State of New South Wales has had a long-standing commitment to address the needs of culturally and linguistically diverse populations, including refugees, through policy statements and funding for migrant sensitive services at the state health department level. A recent strategic planning document speaks to promoting the "effective use of the health care interpreter service by all clinical staff and assist multicultural health state-wide services to extend their coverage in line with the settlement patterns of new arrivals and refugees".[34]

In 2000, the United States Department of Health and Human Services issued national standards for culturally and linguistically appropriate health services (CLAS), addressing health care organization practices related to staff-patient interactions, staff development, community involvement, data collection, and administration.[35,36] With the exception of previously mandated language access provisions, the standards did not have the force of law. But they did become a benchmark for a wave of voluntary efforts by health care providers, and provided the impetus for subsequent state laws[37] and accreditation standards for hospitals[38] and health plans.[39]

Research and Data Collection to Monitor and Plan for Migrant Needs

A critical component of designing and implementing migrant sensitive health systems is having the data to monitor migrant health needs, service utilization and ongoing health status. What data to collect is a complex and often controversial topic – for example, country of origin, period of residence, race, ethnicity, preferred language – and legal and operational barriers exist in many countries. Nevertheless, many countries and health care systems are experimenting with ways to collect and use this data for the purposes of planning and tracking. The Valencia Health Agency in Spain has a population information system that allows the collection and matching of data about nationality, residence, insurance status, and various health indicators to permit analysis in relation to each distinct cultural or national group, with the aim of recognizing any public health issues deriving from a particular group and addressing their repercussions for the service delivery system.[40] In the United States, the Institutes of Medicine have recently called for standardization of how data related to patient race, ethnicity and preferred language are collected, with the intent of using this information to design interventions aimed at the reduction of health disparities among different population groups.[41]

There is a great need for additional research on migrant health status and needs, and on the effectiveness of interventions aimed at them.[42] In additional to traditional study approaches, community-based participatory action research (CBPR) focuses on topics of importance to communities with the aim of combining knowledge and action for social change to facilitate integration, improve community health and eliminate health disparities. In Toronto, Canada, the Access Alliance Multicultural CHC sponsored a study examining the mental health of newcomer female youth and found that participants gained a sense of empowerment from having "a forum in which their voices are acknowledged and heard".[43]

Preparing the Health Workforce to Address Migrant Issues

Migrant sensitive service programmes have no chance of success if the clinical, service delivery, and administrative staff of health care systems do not understand the unique health and social needs of migrants, have the knowledge and skills to deal with them, and support the value of these interventions. In order to properly respond to both migrant individuals and communities, clinicians and public health planners need to be aware of the unique epidemiological profiles of migrant groups' countries of origin, how migrant health status can change (often for the worse) after many years of acculturation, and how both these factors are affected by social, educational, and economic status. Specific training, both during the course of undergraduate health professions education as well as in post-degree continuing education, is emerging as a critical component of clinical training to ensure that migrant needs are adequately met.

In addition to the clinical and epidemiological content related to diagnosing and managing prevalent illnesses affecting migrant streams, training on how to respond effectively to sociocultural issues is essential Often labelled cultural competence training, courses range widely in both length and content, and are still mostly optional. Responding to the large numbers of foreign nationals working in Qatar, the Weill Cornell Medical College, with the Hamad Medical Corporation, has implemented a cultural competence training programme for medical students to prepare them to work with diverse populations and to support the effective use of its medical interpretation programme.[44] In other areas, cultural competence training or standards are being required. In New Zealand, the Health Professional Competency Assurance Act of 2003 requires that professional registration bodies set standards of cultural competency, clinical competency and ethical standards and to ensure that practitioners meet those standards.[45] United States medical students are required to demonstrate an understanding of the health concerns, beliefs and communication needs of diverse populations, and six states have mandated cultural competence continuing education for physicians.[46, 47]

It is equally important for health care systems administrative staff to receive training on non-discrimination and the rights of migrants seeking care. As shown in the South Africa example above, reception staff in a health care organization are often the first point of contact and they can create substantial barriers to accessing services if they purposefully discourage or discriminate against migrant patients, or inadvertently do so because they can't communicate across language differences. The need for education about the needs of migrants is especially important for health care managers, because they influence policies and budgets for health care facilities, and set the tone and standard of behaviour for all staff.

In a corollary development, attractive opportunities are emerging to draw on the linguistic and cultural knowledge of immigrants themselves to enhance the ability of health systems to deliver migrant sensitive care (not withstanding the complicated issues of deliberately recruiting health service workers from countries where there are professional shortages). By supporting the requalification of migrant health professionals in destination countries, these efforts also speed up the integration and social adjustment of migrants in their host countries. In Portugal, with funding from a national foundation, Jesuit Refugee Services assisted immigrant physicians and nurses by facilitating their professional integration through many complicated stages of administrative procedure and academic requalification.[48] A similar effort in the United States, the multi-state Welcome Back programme, has helped more than 2000 migrant health professionals move towards requalification or employment in the health sector.[49]

When professional requalification is not possible (or during the requalification process), many programmes have also taken advantage of the linguistic, cultural and clinical knowledge possessed by migrant health professionals by employing them as intercultural mediators, health educators, and medical interpreters or translators. With or without health care credentials, trained migrant community members are ideal facilitators and intermediaries between migrants and health care programmes and services.

Issues that Need Attention and Topics for an Operational Action Framework

The last few years have seen a significant upsurge in attention to the health needs of migrants. Documentation of good practices, policy frameworks, research findings, and the effects of health inequalities have increased both in depth and breadth. In some countries, the dialogue about these issues has evolved over time and is 'maturing'; in other regions the parameters of discussion are just being set. In a global context, we can say that migrant health as a commonly accepted concern is still emerging. There are many opportunities to advance the agenda.

One significant gap in most countries is the lack of coordinated action to comprehensively address migrants needs within the context of existing health programmes. This includes removing legal and financial barriers to the system, acknowledging that the special needs of some migrants may require additional resources to address, and making an explicit commitment to adjustments within the system that will improve delivery of care. In place of the scattershot approach to funding one-time demonstrations or short-term projects, consistent funding for migrant sensitive services must be put in place, and the results of successful demonstrations must be integrated into regular service delivery systems.

These is a great need for comprehensive and accurate information about migrant health characteristics and for a higher level of awareness about how to address them. Advocates for migrant health services have done an excellent job of documenting needs and potential interventions, but the mainstream health care providers and policymakers are still largely uninformed. This information should be integrated into health worker education and made a part of professional societies' meetings and agendas. Coordinated systems for collecting and analysing data related to migrants and their health needs and status are still mostly lacking, and a prerequisite for effective planning and evaluation of the quality of care.

Similarly, many recommendations and action frameworks on migrant health have been discussed and promoted in particular regions, but still wait to be implemented. For other regions, the dialogue must be broadened or initiated. In all areas, lasting change will only come from engaging political and other sectoral stakeholders beyond health, supported by information about the policy advocacy and implementation strategies that have worked in countries with successful programmes. It will be difficult in many cases to separate discussions about increasing access to health care systems and insurance from the highly polarized debates about the terms of residence for migrants and their access to social benefits in destination countries. There must be a frank discussion about the broader societal costs of poor migrant health.

From the health implementation perspective, it is also critical to identify and package key elements of migrant sensitive health systems for inclusion in other important health agendas, including primary health care reform, initiatives related to major disease programmes (e.g., HIV, TB, malaria, non communicable diseases), population-specific programmes (maternal and child health, aging), and quality improvement programmes, including patient-centred care and patient safety. Global networks and regional/professional communities of practice can be used to document and share best practices.

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