





# Maternal and Child Healthcare for Immigrant Populations

International Organization for Migration (IOM)

## Background Paper

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## Executive Summary

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

In the European Union, recent migration trends and phenomena such as the increasing feminization of migration, alongside with family reunification policies developed by some Member States, raise new concerns about the capacity of social and health policies to deal with newcomers' groups.

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

Within many groups, such as failed asylum seekers, trafficked people and undocumented migrants, women and children are recognized as being particularly vulnerable to health problems and often having reduced access to prevention and healthcare. Not only is maternal and child health therefore a priority, but also motherhood and childhood constitute a unique period in which to reach families, identify health problems and make a substantial intervention on health promotion and disease prevention.

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

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

Some initiatives that could be considered as good practice in this area are presented in this paper; namely in Portugal (health mobile units), Spain (maternal-child health prevention and promotion programmes and related specialised services, two case studies), and Cyprus (health visitor).

Formulating recommendations requires increased focus on access to healthcare systems, to prenatal and postnatal care, family planning and screening for HIV in conjunction with the development of innovative concepts for the planning of health promotion interventions which respond in an effective way to families', women's and children's health needs and specifically address migrant groups.



## 2. Relevant Facts, Figures and Trends in Maternal and Child Health in Migrant Populations

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

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

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

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

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

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

### 1. Maternal and newborn health

In host countries, migrant women often face difficulties during pregnancy and childbirth. In Portugal, a study on maternal health in 1964 newborns demonstrated a higher maternal morbidity among immi-





grants compared to the Portuguese population (Machado et al., 2006).

In maternal health the healthy migrant effect has shown in some indicators like mortality (Muening & Fahs, 2002; Noh & Kaspar, 2003). However, empirical evidence shows higher levels of maternal mortality in migrant segments of populations compared to residents both in developed and developing countries (Bartlett et al., 2002; Razum, Jahn, Blettner & Reitmaier, 1999). Also, in several studies the perinatal, neonatal and child mortality rates have been consistently higher in foreign-born groups than in the national populations (Carballo & Nerukar, 2001; Schulpen, 1996).

A Belgian study on maternal mortality appears to confirm the hypothesis that increasing maternal age is an emerging demographic risk factor for maternal mortality, though the latter effect was also partly due to the high proportion of immigrant women with continued child-bearing into their later reproductive years (Temmerman et al., 2004).

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

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

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

With regards to miscarriage and prematurity indicators, migrant wom-

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

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

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

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

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

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

inter-institutional coordination together with the community is one way to find better and more efficient understanding when providing health and social services to migrants.

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

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

## 2. Family planning and contraception

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

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

particularly among migrant women (APF, 2006; Wall, Nunes & Matias, 2005; Woollett et al., 1998).

## 3. HIV/AIDS

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

In Spain, a study in women of childbearing age showed that 51% of the immigrant women were seropositive while seroprevalence in Spain-born women was 16% (Alvarez, Serrano, Parrado, Ortuño & Sánchez, 2008).

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

## 4. Access to maternal care services

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



care (Rudman, El-Khoury & Walsenstrom, 2008).

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

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

Other frequent obstacles to health care that have been observed include poor language skills leading to poor communication between migrants and health care providers. Several studies show that poor communication between migrants and health-care providers coupled with insufficient use of trained interpreters and with the personnel's lack of knowledge about cultural background often result in mutual misunderstandings. In Scandinavian countries these factors have been described as key causes of poor and delayed gynaecological care and increased risk of delayed or missing obstetrical care (Carballo et al., 2004; Jeppesen, 1993). Also social isolation and racism are recognized as factors affecting the use of health care services (Smaje & Grand, 1997; Ascoly et al., 2001).

On the other hand, health care seeking behaviour appears to be influenced by the cultural background and personal experience. Cultures characterized by strict gender roles may believe that it is inappropriate to discuss pregnancy and childbirth in mixed company, and as a result, medical consultations with male doctors or male interpreters can become problematic (Ascoly et al., 2001). Researchers mention that traditional beliefs and the inclination to seek non-conventional medical care in the first place are influencing factors in the delayed

health care seeking behaviour of Turkish women in Germany (David et al., 2000).

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

## 5. Child and adolescent health

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

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

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

## 2. European Union or Member States Policies, Programmes or Priorities in Migration and Health with Relevance for Maternal and Child Health

### 1. Maternal and child health of migrants: the European view and experience

In the European Union, maternal and child health entitlements and benefits, as well as other aspects of socioeconomic integration policies that migrants and refugees may benefit from, are decided at national level, by each Member State. This is due to the sovereignty that Member States maintain on the organization and financing of social systems and policies and in their unwillingness to cede control of social spending and specifically social security administration. The explaining factors behind this state of affairs will not constitute the object of this section. Instead, the recognition of social policies heterogeneity in the European Union, or as Warnes (2002) clearly summarizes “*The EU territory is not yet a seamless health-care entitlement domain*”, works as a starting premise for the following developments.<sup>1</sup>

In this specific domain –health policy for migrants– the role of the European Commission has been until now fairly small, and mainly of programmatic nature. A quite recent report that maps the European Commission's policies related to migration concludes that “*migration does not feature highly in strategic policy documents on health*” (Kate, Niessen, 2008). In the analysed material, the references to migrant's health are scarce or even nonexistent and do not report any specific concern with maternal and child health. The European Commission strategic plans, policies and programmes only cover this topic indirectly when, for example, migrants are prioritised as an important target group for the prevention of communicable diseases –which includes, for example, HIV mother-to-child transmission– or as a special vulnerable group in the access to health care, which, for example, includes access to antenatal care for migrant women.

In this context, the Portuguese Presidency of the European Union in 2007 had a pioneer initiative by choosing migrants' health as one of its core topics (Fernandes; Pereira-Miguel, 2009). The main reasons that supported this political decision were the recognition of the demographic challenge that Europe actually faces regarding population ageing and the importance that immigration may have on it; the importance of health and health care in the social and economic integration of migrants and; the special vulnerability that the reality of migration embodies. Above all, the universal value of human rights was the pillar on which the Portuguese Presidency founded the decision to put migrants' health on the European political agenda. With this initiative, the Portuguese Presidency placed the right to health in the exact position it should be interpreted and judged; a fundamental human right. In fact, and according to the Universal Declaration of Hu-

man Rights: “*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including (...) medical care*” (Art. 25, no. 1). The Charter of Fundamental Rights of the European Union states that “*A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*” (Art. 35). At the light of the same set of principles and values, pregnant women, mothers and their children are considered priority groups in the access to health. The Universal Declaration of Human Rights states that “*Motherhood and childhood are entitled to special care and assistance*” (Art. 25, no. 2). Also, the Convention on the Rights of the Child clearly states that “*States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services*” (Art. 24, no. 1). It also states that States Party should “*ensure appropriate pre-natal and post-natal health care for mothers*” (Art. 24, no. 2,d). Maternal and child health have a special place at human rights history. The recent resolution of the United Nations Human Rights Council of June 2009, based on all the international conventions, treaties and resolutions<sup>2</sup> that aim at protecting maternal and child health, requests all States to “*renew their political commitment to eliminating preventable maternal mortality and morbidity*” and encourages States to “*give increased attention and resources to preventable maternal mortality and morbidity*”. Also, the 61st resolution of the World Health Assembly, totally dedicated to migrants' health, identifies the needs of migrants that experience increased health risks (e.g. women and children) as priority groups. Although migrants' health has not been until now a priority for the European Commission, it is the focus of a large social movement performed by national and international non-governmental organisations and the scientific community. Within this collective effort, maternal and child health are central topics, not only because of the human rights frame, but also because reproductive health among migrants is classified as “*one of the most important, and still unmet, public health challenges*” of present days (Carballo; Divino; Damir, 1998).

Within the European Union borders, each Member State is responsible for guaranteeing migrants' health rights, more so to undocumented ones. This state of affairs is expressed in many institutional and legal documents, such as the 61st resolution of the World Health Assembly that urges its Member States to promote an equitable access to health care for migrants, nonetheless conditioned to “*national laws and practice*”. Also, the European Pact on Immigration and Asylum, adopted during the French Presidency of the European Union in 2008, clearly situates the social measures of integration at a national level, while it calls for a European global and concerted strategy on immigration policy. As a consequence, the discussion and the action that





takes place to influence public policy on health matters should happen mainly at a national level, since the decision-making exclusively lies with national governments. Nonetheless, the global character of migration, the human rights issues it raises, and the inevitable impact it has on Europe's economic development and social cohesion will certainly lead to a gradual European consensus on the social integration of migrants.

## 2. Maternal and child health of migrants: Member-States public policy

The decisions that each EU Member State takes in relation to maternal and child health rights of migrants, as well as to other social rights, is determined by many factors: demographic weight of emigration in the country, specially of undocumented migrants; previous historical background on migrants' policies (e.g. restrictive nature or more accepting one); social and cultural significance of migration (e.g. countries that historically faced strong emigration flows tend to present higher acceptance of immigration and their impacts); the social and economic situation of the country (e.g. periods of economic recession or growth); the on-going public administration reforms (ex. cuts on public spending). Also, the international agreements, conventions or treaties that each Member State is committed to are part of the framework that influences and many times determines the social policy formulation. As a consequence, the comparative analysis of migration policies needs to be done at the light of the implementation context because every political solution is intended to solve specific circumstances.<sup>3</sup>

The evidence gathered on maternal and child health clearly demonstrates that there are health inequalities between migrant women, their children and the national population. Inequalities have mainly been studied in health status and less in access to health care and prevention (Mladovsky, 2009). Despite the research done, it is consensual that the health situation of migrant populations is poorly known (Carballo; Divino; Damir, 1998; Fernandes; Pereira-Miguel, 2009; Mladovsky, 2009). For that reason, EU Member-States play an important role actively improving data collection on migrant health so that the public debate and policy-making can be better formulated. Until now, the lack of attention towards migrants' health may, after all, be a consequence of the predominant focus of the National Health Systems on other aspects, rather than on health equity (Horton, 2008).

Maternal and child health policies and programmes have a strong and vast implementation in the European health services, being widely recognized as a key investment for a country social and economic development. For that reason and in this specific domain, availability has not been such a strong topic as accessibility, once the existing health services are believed to have the capacity to offer the services needed

to migrant women and their children. The determinants that influence accessibility can be analysed from two different, although complementary, perspectives: demand and supply-side (Romero-Ortuño, 2004). The demand-side perspective looks at the characteristics that, being present in the population group, influence their interaction with the health services. The supply-side factors focus on the policies and organizational aspects of the health agencies that may play a role in the way people access the services.

Based on the experience of four countries from the European Union,<sup>4</sup> Mladovsky (2009) developed a framework aimed at analysing health policy that targets migrants. The framework orients analysis towards five main topics: data collection; population groups targeted; health issues targeted; part of the health system targeted and; implementation of policies. Just by themselves, every topic offers a high level of complexity; either we select the demand or the supply-side perspective, or both. The interface between migrants and the health systems is, in fact, a complex and challenging issue that demands for large-scale information, but also for knowledge and information that describes and analyses the specificities of groups and contexts.

The main focus of this section is on the supply-side factors that affect the access to health care for undocumented migrant women and their children. Migrants that are in a legal situation do face access problems, and this should be the object of political concern and investment, however it is the group of undocumented migrants who are in the worst position when dealing with the publicly funded social systems. In reality, the European publicly funded health systems are organised around citizenship and therefore undocumented migrants do not enjoy any entitlement to it. The emergent reality of undocumented migration in Europe has been confronting each Member State with the need to give an answer to the health needs and problems of this group. Undocumented migrants' access to health care is a topic that does not have unanimity in society. There is a huge diversity of expressed opinions and beliefs around the issue. Moreover, the scarce data on migrants' health does not help the public debate.

From the health provider perspective, accessibility problems may result from: the nature of entitlements granted to undocumented immigrants; the responsibility for service costs; amount and complexity level of the administrative procedures and the legal consequences derived from applying for publicly funded health services. In some Member States, the entitlement to health care of undocumented migrants is preconditioned to the occurrence of special circumstances, that is to say that access to health public services is denied, unless the case meets special criteria. This is the case of the United Kingdom and Germany, for example, where undocumented migrant women may access health care under the condition of "*Immediately necessary treatment*" or "*Accident & Emergency treatment*", respectively. The exceptions are intended to protect and value humanitarian principles

and values, however the use of loose criteria to regulate such important rights has been pointed out as an amplifying factor for health inequity, once access and other benefits totally rely on the interpretation that the health staff (medical or not) make of the regulations and on the diagnosis they made of the concrete situation (Romero-Ortuño, 2004). These are undesirable effects of policy implementation that the public systems are actually facing.

In England, a local project that aims at promoting health care access for vulnerable populations reports manifest difficulties of undocumented migrant women in accessing antenatal care (Médecins du Monde, 2007). The pregnant women assisted by the project services presented poor indicators of early and regular access to antenatal care, which is fundamental for a healthy delivery. They also present problems in the access to secondary care, namely pregnancy terminations. Essentially, in these situations their entitlement to health care is not accepted or recognised by the health services, which in practice demand either a proof of entitlement or the ability to pay the service costs. These women's experiences through the health services clearly demonstrate that more often than it is desirable legal exceptions are not applied, which severely compromises the humanitarian values for which they were created.

Other Member States decided at a point in time to guarantee undocumented migrants a universal access to the publicly funded health care. An example of this is the Spanish National Health System which grants full access to migrant pregnant women regardless of their legal status (Bosch, 1999). This decision, dated from 1999, was based on a decision of the Madrid's Superior Court of Justice of the same year on the case of three undocumented migrant women who had been denied public health care during pregnancy. The Court determined that these women were entitled to the health care they needed and based this decision on the United Nations Convention of Children's Rights<sup>5</sup> stating that "*member states shall take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers*" (Art. 24). According to the Court, the Spanish National Health Service had to act in accordance with this international convention,<sup>6</sup> which the National Service did, extending health care to undocumented migrant women during pregnancy, delivery and puerperal stages, free of charge.

In 2001, Portugal also clarified the health rights and obligations of immigrants, which included maternal and child health. It guarantees for all immigrants who are legally resident in the country complete and equal access to the National Health Service and for those who do not have a resident authorization a special access system. In these last cases, immigrants' access is conditioned to the documental proof that they have been in the country for more than ninety days (High Com-

missariat for Immigration and Intercultural Dialogue, ACIDI, 2009). In this situation, access to the National Health Service implies the payment of services, in accordance with the scale of charges in force, with some exceptions justified by public health interests. Maternal and child health and family planning are one of them, provided they concern matters related to primary, secondary and tertiary prevention.

Another important issue is the type of connection established between health public services and migration control measures. Despite the fact that in some EU countries undocumented migrants may have access to health care when certain circumstances are met, the legal consequences of that access may vary. In Germany, public officers and civil servants from public administration bodies used to be obliged to report undocumented migrants met during the course of their work. This is a highly sensitive issue, not only because it creates a conflict with public health interests, but also because it has the potential to transform the right to health into an instrument of migration control (Horton, 2008).

This aspect was also developed at the European Conference on Migrant Health, held by the Portuguese Presidency of the EU in 2007. On top of the political awareness that the Conference brought about, it produced some important recommendations on maternal and child health. Apart from the types of health care that are prioritized (e.g. antenatal and postnatal care) it defended that the right to health of migrant women and their children should be totally independent from their legal status, that is to say that health should be regarded as a fundamental human right, rather than a social entitlement subject by nature to restrictions. The recommendations also indicated that when the national law or regulations do not grant the same rights to migrants than to national citizens, special regimes ought to be created to guarantee the necessary protection. Clearly, the conference recommendations on this topic stand for public health values to prevail over socioeconomic and security matters (e.g. migration control).

EU Member States are responsible for guaranteeing migrants' health rights, even more so to undocumented ones: creating and promoting the most dignifying ways of access to health prevention and care, as well as assuring compliance with the law by every official agency are two fundamental areas of public action in this domain. Maternal and child health policies and practices in Europe that act upon access and quality of health prevention and care for migrants, specially undocumented ones, ought to be formulated and evaluated at the light of the European common principles and values, explicitly the ones that regard health as a fundamental human right and mother and child as special and vulnerable groups.



### 3. Practice on Maternal and Child Healthcare for Migrants

#### 1. General aspects of good practices

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

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

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

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

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

They are:

1. *Mainstreaming*: this vision, which promotes the consideration of race/ethnicity/origin in the organization and provision of services, contrasts with the notion of special provision as not integrated into the general system in funding, planning and service development. Thus even if in some cases special provision/services are flexible and innovative to tackle specific needs (local level), in the long run and at a national level, a mainstream approach enables multi-agency work and a holistic approach to health while enhancing funding provision due to the commitment of the senior level.
2. *Assessing needs of local populations*: it is as important to know more about the local populations and their needs as to get them involved in the planning as a way to ascertain which the unmet needs are. This process should be on-going and enable the provision of more effective services. These could be achieved by different means: talking to individuals and families, visiting local communities, holding public local meetings, talking to local workers to map new needs, among others.
3. *Community consultation and partnerships*: for services to be appropriate, they need to be based on community needs, thus it is convenient to develop links and partnerships with local communities and the voluntary sector that have been working on relevant issues and have experience on the matter which can be used as an input for services planning and development.
4. *Capacity building*: as much as links and partnerships between the national health sector and local communities are important, it is also pertinent to build the capacity of those local communities and partners who belong to more excluded sectors (minorities/migrant communities) as a way for them to improve their skills and social capital which enhance their contribution as interlocutors and as a way to obtain gains from the partnerships.
5. *Training*: activities such as training and raising cultural awareness for the staff involved in health provision (medical and non-medical) are fundamental to provide workers with the specific skills and information they need to work more effectively serv-

ing minorities and migrant communities. Training should include cultural competences skills as well as anti-discriminatory attitudes and policies, addressing direct and indirect discrimination and institutional racism.

6. *Monitoring*: including services planning and provision and employment is fundamental to ensure that there are no unintentional barriers when accessing health services due to a person's background.
7. *Service delivery*: health services policies indicate how services are organized and how staff works, and often the existing policies do not consider the needs of certain populations, often, unintentionally. So for service delivery to be appropriate, consultation and dialogue with the communities should be fluent to avoid inadequate practices in terms of dietary needs, religious needs, language and communication needs, and others such as registration, medical records and appointment needs as well as hospital care needs (i.e. naming system, type of questioning for medical records, adequate resources such as gowns, same sex health professionals, etc.). These needs require the training of administrative staff and the flexibility of material and personal resources.
8. *Employment issues*: even if some countries have affirmative or positive employment policies, others do not. However, it is desirable to have a diverse workforce which incorporates workers from different backgrounds who offer simultaneously inside knowledge and sensibility to the general workforce at the same time.
9. *Maternity and child care provision*: due to the importance of this special time in the lives of mothers/children, pregnancy and childbirth, and the physical and psychological vulnerability of the mother, specific precautions should be taken by health providers. On the one hand, pregnancy may be the situation when the mother first contacts health systems, thus this opportunity should be highly valued. On the other hand, there are many parental approaches, practices and priorities in child rearing which are different from those of the health practitioner, but equally valuable, which require a closer examination. Some examples of good practice should/could include:<sup>7</sup>
  - Sensitivity in teaching hospitals, for example, making it possible for female patients to request that only female medical students be allowed to observe an examination.
  - Prenatal classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is different from the national tongue. This might include a few intensive lessons to teach them the basic language skills they will need during their stay in hospital.

- Sheets and pamphlets with basic information and instructions on health related issues should be translated and circulated to outreach the population.
- Health education programmes that highlight the importance of both prenatal and post-natal care.
- Training for staff in using culturally unbiased developmental tests which take into account environmental differences of children from different social groups.
- Support to meet the particular needs of mothers and children from minorities, ethnic and immigrant groups, i.e. bilingual mother and toddler groups, appropriate child minding provision, play groups, day nurseries and support groups for women of different communities where they can relax and speak their own language, if possible or feasible.
- Active recruitment of minority health workers who share the cultures, values and backgrounds of minority, ethnic or immigrant groups, or if not possible, training of other health professionals.
- Training in relevant cultural and religious needs for those health workers (namely ante-natal midwives, doctors, nurses) who will be dealing with minority, ethnic or immigrant mothers.

Overall, good practices in the field of the migrants' health and ethnic minorities should aim at reducing health inequalities in a culturally appropriate way to maximise health outputs. In order to determine whether a practice is a good practice, it is necessary to clearly define at least two aspects: values and a common basis or matrix for comparison. As exposed, values that feed our criteria for good practices are reducing health inequalities and outreaching the migrant or difficult to reach population while attaining cultural suitability and the empowerment of the target population.

## 2. Good practice 'check list'

The basic elements of practices to consider when assessing good practices, based on the work carried out for the Good Practice Report compiled for the Portuguese 2007 EU Presidency Health Programme, are presented below (more detailed information can be found in Padilla et al., 2009).

1. Target population and health needs addressed by the practice in question.
2. Goals and objectives of the practice in terms of the public health problem.





3. Field on which the practice seeks to focus (i.e. prevention, promotion, treatment, etc.).
4. Scope: level of centralization, decentralization, etc. that is appropriate (i.e. national, regional, local, etc.).
5. Provider: whether the provider is a public, private or non-governmental institution, or if it is a partnership of several bodies.
6. Resources: main financial aspects of the practice (i.e. sources of funding, etc.).
7. Management: how decisions are made and how they are implemented. Are interested stakeholders taken into account?
8. Indicators: ways to measure and control the effect of the practice (if possible, assessing the before and after situations).
9. Conclusions/results and potential implications for public health practice and policy.
10. Future steps that may be taken to extend or further improve the model.
11. Possibility to adapt the model/practice elsewhere.
12. Contact information.

### 3. Venda Nova (Portugal): A holistic approach to inclusion

#### Target population and health and social needs

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

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

Regarding the social needs, we observed problems with education (high drop-out rates from school and low literacy among adults); unemployment and precarious jobs. There are also extremely degrading

housing conditions, in urban slums, even if some of the neighbourhoods are re-housing facilities.

#### Goals and Objectives

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

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

This intervention project intends:

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

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

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

#### Field

The mobile health unit is used to provide health and nursing care and to make referrals to the health centre and other institutions, where provisions, care and treatment continue.

Families at risk continue to be supported by the team in the community.

Besides this specific intervention, the team also promotes, jointly with community members, health education and health promotion activities and collective events like:

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

### Scope

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

### Provider and Resources

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

### Management

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

The partnership and collaboration include community groups, social institutions, city halls, schools, NGOs and child care centres.

### Indicators

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

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

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

## 4. Other good practices on maternal and child healthcare

### 1) Spain (Lleida)

Municipal resources for maternal and child health: Maternal-child Programme (PMI) and Maternal-child Service (SMI)

- *Target population and health needs*

The PMI and the SMI are socio-health resources of the Municipality of Lleida for at-risk families (either social or health risks), with children between the ages of 0 to 3, that need support in child rearing and education.

The PMI was created in 1987 to do the follow-up of newborns of mothers with low health coverage (previous to universal coverage in 1991), usually living in the impoverished neighbourhoods with common family, social and health problems and with low rents. Currently, everyone can access the programme. The programme starts the follow-up in the hospital to then be followed with the PMI, with weekly appointments during the first year and monthly appointments later on. The family is discharged at the end of the third year after an assessment and a family visit at their home. If needed, other social services are called.

The SMI is a type of informal education for families with children under the age of three, with difficulties or limited skills to provide education for their children. The team includes teachers, psychologists and social workers. Many of the families of the SMI are also clients of the PMI, so the target population is similar. The families could be immigrant or national families.

Additionally to families at social and health risks, other target populations include teenage mothers, single-parent homes, socially isolated families, families at risk of breaking out and families that need help with their children to go to work.

- *Goals and Objectives*

- To prevent, identify and do the follow-up of all socio-sanitary risk situations in children aged 0-3.
- To provide health education to parents of children aged 0-3.
- To improve affective relationships within the families and the children, optimising mother-child links.
- To offer families a no-formal educational space where to discuss all issues and topics of their interest about childbearing and child-rearing.
- To provide food for children.
- To provide families with more information about other socio-educational and health resources and services available in the city.



- *Field*

The PMI and SMI provide health promotion, prevention and curative care, including also health education. In addition, PMI also may include other complementary services such as other social services, services for drug-addiction, all basic health and sanitary services, family planning, a home for women and children who are victims of abuse and violence.

- *Scope*

PMI and SMI are implemented at the municipal or city level.

- *Provider*

Municipality of Lleida (Catalonia, Spain).

- *Resources*

Public funding of the municipality with partnerships with Caritas and other civil society institutions.

- *Management*

N/A

- *Indicators*

N/A

- *Conclusions/Results*

The resources made available by the Municipality of Lleida through the mother-child programme and services seem to respond to the community needs of host, minority and migrant families' needs in terms of social and health needs. Health is not only perceived as the lack of illness but is rather seen as a comprehensive state of mind and wellbeing with is reflected in the type of services provided and with a long-term concern.

## 2) Spain (Barcelona)

Prevention and promotion of the maternal-child health for immigrant mothers with children under the age of three.

- *Target population and health needs*

The collaboration between the Asociación Salud y Familia (ASF) and the Clinical Hospital of Barcelona (HCB) started in 2006 with a programme of intercultural mediation for mothers of Chinese and

Maghreb origin to improve communication and quality of services to these mothers. Previous work had public health specialists to realise the special needs of immigrant mothers as a group that would benefit from specific actions and intervention in health promotion and disease prevention, specially to reduce different barriers to access health services. Many of the existing barriers were communication related and led to low-quality services, therefore the selected ethnic groups for the project were Chinese, Moroccans and Latin-Americans, with a control group of national mothers.

- *Goals and Objectives*

- To become familiar with the perceptions of immigrant mothers about the health services received during pregnancy and childbirth.
- Identify specific barriers that prevent access and utilisation of health services during the pregnancy and childbirth, including exogenous and endogenous barriers to the sanitary system.
- To contrast the perception of immigrant mothers with the perception of the health personnel in relation to services given during pregnancy and childbirth.
- To design together with the health personnel an agenda for changes to be implemented to adapt the maternal services to the needs and demands of the new immigrant populations.
- To disseminate the results about the disparities, demands and sanitary needs of immigrant mothers, especially to health professionals that are responsible for the maternal health of immigrants.

- *Field*

The programme was a qualitative research project that used focus group as the main technique. Focus groups were led by specialists and intercultural mediators, in 2008. The aim was to identify similarities and differences in the perception of maternal health services among immigrant mothers of different ethnic origin and national mothers, to improve health services and health promotion.

- *Scope*

The programme on prevention and promotion of the maternal-child health for immigrant mothers was conducted at the city level (Barcelona).

- *Provider*

Partnerships between the Asociación Salud y Familia and the Clinical Hospital of Barcelona, with the support of the Clinical Institute of Gynaecology, Obstetrician and Neonatologist of Barcelona.

- *Resources*

Funding was provided by the social programme (Obra Social) of Caja Madrid (mutual bank), which is the foundation of Caja Madrid funding social projects nationwide.

- *Management*

N/A

- *Indicators*

N/A

- *Conclusions/Results*

The results indicate that there is a clear contrast between the perceptions and expectations of mothers about the public health system, depending on the culture of the country of origin, although some similarities were identified in relation to common experiences in the utilisation of health services and the attention received. The information on the perception was shared with the health professionals of the Maternal-Fetal and Neonatologist services of the Clinical Hospital of Barcelona and the evaluators of the ASF. The changes proposed were:

- i. Intercultural attention and information in the final period of pregnancy before entering the hospital, through a group including intercultural mediators and mothers of the same ethnic origin. The information provided in the group will include information about the programme 'Mothers between two cultures' and family planning information among other.
- ii. Target services for immigrant mothers during delivery and when in the hospital (information about family planning, individual assistance, useful information for after leaving the hospital on changes and adaptation to the new life with the baby, and post-partum information).
- iii. Special programme for mothers with newborns with special needs;
- iv. To improve the intercultural skills of health professionals and other professionals that deal with immigrant mothers and families;
- v. To produce informational and educational material inter-culturally adapted.

### 3) Cyprus

Maternal and child health on immigrant families: Health visitor

- *Target population and health needs*

The health visitor programme aims at providing health care to mothers (or expecting mothers), infant or child, and generally to the whole family in order to preserve and promote health and to prevent illness.

- *Goals and Objectives*

Health visitors of the Ministry of Health, Cyprus, are working with immigrant families and specifically with mothers of young babies, advising on areas such as feeding, safety, physical and emotional development and other aspects of health and childcare through maternity and child health care clinics. More specifically:

- i. Mothers with children attend a clinic several times during children's first year of life, gradually reducing the visits to one appointment every six months and then once a year.
- ii. The Health Visitor meets the parents and their children at the clinics or even at their homes.
- iii. The Health Visitor assesses the child's normal growth by measuring their weight, height and head circumference. Measurements are always marked on percentile charts to give an indication of how a child compares at one particular time with other children of the same age. Also to give a longitudinal representation of the child's growth.
- iv. The Health Visitor monitors the child's physical, mental and social development and refers them if need be for further investigation and treatment to other professionals (specialists).
- v. At the clinic the child also receives all routine vaccinations according to the Cyprus Ministry of Health vaccination schedule.
- vi. Offering support to the parents as regards to child raising is one of the most important tasks of the clinic.
- vii. Counselling the families is also another task of the health visitors at the clinics, e.g. on nutrition, breast-feeding, family planning, normal growth and development of children, etc.
- viii. At the clinic children can have a Vision Acuity Test at the age of 3-4 years and a Hearing Test at the age of 8-9 months and 4 ½ years old.
- ix. There is also a centre for reception of asylum seekers, in a specific area of the island where all infants are receiving health care services.



- Field

Health visitors provide health promotion and preventive interventions, making referrals to the health clinic for curative care when necessary or when specific screening tests need to be conducted (visual and audio tests).

- Scope

Nationwide.

- Provider

The Ministry of Health of Cyprus through its nationwide health system (clinic, visitors, etc.).

- Resources

Public funding of the Ministry of Health.

- Management

N/A

- Indicators

N/A

- Conclusions/Results

This programme seems adequate to outreach immigrant families to improve their health, providing promotion, prevention and interventions at different stages (pregnancy, infancy and childhood). It also seems to be a transferable practice to be applied in other contexts, depending on issues such as organization of the health ministry at the national and local level.

Other best practices in EU Member States have been identified as follows: the Netherlands (avoiding HIV vertical transmission), Austria and Italy (pre-natal courses for migrant women or women from minority groups), Sweden (regional medical programme for asylum-seekers' children with severe withdrawal behaviour) and Germany (health promotion for migrant women; 'Eating with Joy').

## 5. Conclusions

The progressive ageing of the European population will only be addressed by the entry of immigrant populations. Considering the importance of the construction of a collective European future, it is essential to create the right environment for mothers, children and the entire migrant populations in order for them to improve their integration to host societies by accessing quality health care.

Any reform concerning migrants' health must be clear about the inspiring principles and values of the EU. Practical solutions may differ depending whether health is considered as a human right or as a social protection entitlement. A coherent and sensitive policy framework based on a holistic approach needs to be developed in order to provide health care to mothers and children.

### General Recommendations

- Presently, advocacy and other actions to influence public policy on these matters should happen mainly at the national level, since the decisions heavily depend on national governments.
- Strong alliances and partnerships need to be built between actors from the public, private and the third sector, in order to effectively influence policy formulation and implementation.
- Law compliance is an important issue as many times the law is not fully respected, leading to the inherent violation of migrants' rights and entitlements to health. Governments and civil society need to pay more attention to the rights of all vulnerable populations, with special focus on the family.
- The access of undocumented migrants to publicly funded health care is a sensitive political and social issue, but it is also an issue of public health. Public policy evaluation is essential to ensure that the effects of public interventions are properly known and political discourse and decision-making are based on empiric research rather than on mere opinions and assumptions.
- Key-actors (i.e. doctors, nurses, psychologists, social workers, nutritionists etc.) play an important role influencing the results of the social and political debate through their daily practices. Their practice and attitudes may be important factors for a wider social acceptance of migrants' access to health services.

- As interventions at the very local level have been proven effective, partnerships between local authorities and local organizations from civil society should be favoured. Partnerships between public agencies and civil society are important as a way to come up with projects that are sustainable in the long-term, rather than projects with short-term funding that usually end when funding ends.

### Specific Recommendations

- It is essential to ensure supportive environments for the social integration of women and children living in marginal situations or in insecure conditions.
- Health services for mothers and children should be seen from a holistic and integral perspective, as health is a dimension influencing people's lives as a whole.
- It is important to design interventions that reach difficult-to-reach populations such as migrant women and children.
- It is necessary to work together with the migrant and minority communities in order to better assess their needs, and improve knowledge and information on these groups.
- Recognising the importance of local interventions and proximity, programmes and solutions based on community health are desirable.
- As cultural competence is one fundamental aspect of healthcare for immigrant mothers and children, adequate training for health professionals should be offered in hospitals, clinics, health centres and to all professionals working with immigrants (doctors, nurses, etc. as well as administrative staff).
- Cultural competence should be provided by intercultural and interdisciplinary teams which also include immigrants, as a path for achieving empowerment, commitment and involvement.
- The provision of facilitating services such as translation and translated material in the most common languages of the immigrant population, as a better way to reach them and to provide better services, is desirable. Cultural mediation may also be resourceful and convenient.



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## References

- Abraído-Lanza, A. F., Dohrenwend, B. P., Ng-Mak, D. S. & Turner, J. B. (1999). The Latino mortality paradox: a test of the 'salmon bias' and healthy migrant hypotheses. *American Journal of Public Health*, 89 (10): 1543–1548.
- ACIDI (2009). Immigration in Portugal. Useful information, 2009. Alto Comissariado para a Imigração e o Diálogo Intercultural (ACIDI, High Commissariat for Immigration and Intercultural Dialogue, Portugal).
- Alderliesten, M., Vrijkotte, T., Van Der Wal, M. & Bonsel, G. (2007). Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. *British Journal of Obstetrics and Gynaecology*, 114: 1232–1239.
- Alvarez, J., Serrano, M., Parrado, L., Ortuño, S. & Sánchez, M. (2008). Prevalence and incidence in Albacete, Spain, of *Toxoplasma gondii* infection in women of childbearing age: differences between immigrant and non-immigrant (2001–2007). *Spanish Journal of Public Health (Revista Española de Salud Pública)*, 82 (3): 333–342.
- American Academy of Pediatrics/Committee on Community Health Services (1995). Health care for children of farmworker families. *Pediatrics*, 95: 952–953.
- Ascoly, N., Van Halsema, I. & Keyzers, L. (2001). Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 14 (4): 371–93.
- Association for Family Planning (Associação para o Planeamento da Família, APF) (2006). Migrações Internacionais: Género e Saúde Sexual e Reprodutiva. Available from: <http://www.duplaoportunidade.org/IMG/pdf/Migracoes.pdf>
- Bandyopadhyay, M. & Thomas, J. (2002). Critical determinants of women migrant worker's vulnerability to HIV infection in Hong Kong. *Abstract n° E11646, International Conference on AIDS*, 14.
- Bartlett, L. A., Jamieson, D. J., Kahn, T., Sultana, M., Wilson, H. G. & Duerr, A. (2002). Maternal mortality among Afghan refugees in Pakistan, 1999–2000. *Lancet*, 359: 643–649.
- Bollini, P. & Siem, H. (1995). No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000. *Social Science and Medicine*, 41 (6): 819–828.
- Bosch, Xavier (1999). Pregnant illegal immigrants get free health care. *The Lancet*, Vol. 354, pp. 1368.
- Bragg, R. (2008). Maternal deaths and vulnerable migrants. *The Lancet*, 371: 879–880.
- Brockhoff, M. (1995). Child survival in big cities: the disadvantages of migrants. *Social Science and Medicine*, 40 (10): 1371–1383.
- Carballo, M. & Nerukar, A. (2001). Migration, refugees, and health risks. *Emerging Infectious Diseases*, 7 (3 Suppl.): 556–560.
- Carballo, M. (2006). Female migrants, reproductive health, HIV/AIDS and the rights of women. In UNFPA/IOM, *Female migrants: Bridging the gaps throughout the life cycle*. New York: UNFPA.
- Carballo, M., Grocutt, M. & Hadzihanovic, A. (1996). Women and migration: A public health issue. *World Health Stat Q*, 49 (2): 158–164.
- Carballo, M., Katic, B., Miller, R., Gebre-Mehdin, J. & Van Halem, J. (2004). Migration and Reproductive Health in Western Europe.
- Carballo, Manuel; Divino, Jose Julio; Zeric, Damir (1998). Migration and health in the European Union. *Tropical Medicine and International Health*, 3: 12, pp. 936 – 944.
- Carta, M., Bernal, M., Hardoy, M., Haro-Abad, J. & "Report on the Mental Health in Europe" working group (2005). Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). *Clinical Practice and Epidemiology in Mental Health*, 1: 13. Available from: <http://www.cpementalhealth.com/content/1/1/13>
- CEMACH (2007). *Saving mother's lives: Reviewing maternal deaths to make motherhood safer 2003–2005*. London: CEMACH Programme (Centre for Maternal and Child Enquiries, CMACE, London).
- Council of the European Union (CEU) (2008) *European Pact on Immigration and Asylum*.
- Chemtob, D., Leventhal, A. & Weiler-Ravell, D. (2003). Screening and management of tuberculosis in immigrants: The challenge beyond professional competence. *International Journal of Tuberculosis and Lung Disease*, 7: 959–966.
- Coker, R. (2003). *Migration, Public Health and compulsory screening for TB and HIV - Asylum and Migration Working Paper 1*. London: IPPR.
- Collins, T. (2003). Globalization, global health, and access to healthcare. *International Journal of Health Planning and Management*, 18: 97–104.
- David, M., Borde, T. & Kentenich, H. (2000). Knowledge among German and Turkish women about specifically female bodily functions, contraception, preventative medical examinations and menopause. *Ethnicity and Health*, 5 (2): 101–112.
- Del Amo, J., Broring, G., Hamers, F., Infuso, A. & Fenton, K. (2004). Monitoring HIV/AIDS in Europe's migrant communities and ethnic minorities. *AIDS*, 18: 1–7.





Department of Health, Social Services and Public Safety & Equality Commission for Northern Ireland (2002). "Racial Equality in Health: Good Practice Guide. Consultation Document". Online:

<http://www.equalityni.org/archive/pdf/RaceHealth.pdf#search=%22racial%20equality%20in%20health%20good%20practice%20guide%20consultation%20document%22>

Dias, S. & Quintal, F. (2008). Cultural Dynamics in Mental and Reproductive Health of Immigrant Women in Portugal. *European Journal of Public Health*, 18 (Suppl. 1): 48.

Dias, S., Severo, M. & Barros, H. (2008). Determinants of health care utilization by immigrants in Portugal. *BMC Health Services Research*, 8: 207.

EPI-VIH Study Group (2002). HIV infection among people of foreign origin voluntarily tested in Spain: A comparison with national subjects. *Sexually Transmitted Infections*, 78: 250-254.

Ergenekon-Ozelci, P., Elmaci, N., Ertem, M. & Saka, G. (2006). Breastfeeding beliefs and practices among migrant mothers in slums of Diyarbakir, Turkey, 2001. *European Journal of Public Health*, 16: 143-148.

Essen, B. et al. (2002). Are some perinatal deaths in immigrants groups linked to suboptimal perinatal care services? *British Journal of Obstetrics and Gynaecology*, 109 (6): 677-682.

Fakoya, I., Reynolds, R., Casweel, G. & Shiripinda, I. (2008). Barriers to HIV testing for migrant black Africans in Western Europe. *HIV Medicine*, 2: 23-25.

Fennelly, K. (2004). *Listening to the Experts: Provider Recommendations on the Health Needs of Immigrants and Refugees*. Malmö: Malmö University.

Fernandes, A., Pereira-Miguel, J. (2009). Health and Migration in the European Union: Better Health for All in an Inclusive Society. Lisbon: Instituto Nacional de Saúde Doutor Ricardo Jorge.

Giacchino, R. et al. (2001). Hepatitis B virus infection in native versus immigrant or adopted children in Italy following the compulsory vaccination. *Infection*, 29: 188-191

Gissler, M., Pakkanen, M. & Olausson, P. (2003). Fertility and perinatal health among Finnish immigrants in Sweden. *Social Science and Medicine*, 57 (8): 1443-1454.

Guchteneire & Saori. (2006) Foreword to the report by Thanh-Dam Troung, *Poverty, Gender and Human Trafficking in Sub-Saharan Africa: Rethinking Best Practices in Migration Management*. Paris: UNESCO.

Gwyneth, L. et al. (2001). *Why mothers die 1997-1999: The fifth Report of the UK confidential inquiries into maternal deaths*. London: Royal College of Obstetricians and Gynaecologists.

Harawa, N., Bingham, T., Cochran, S., Greenland, S. & Cunningham, W. (2002). HIV prevalence among foreign-born and US-born clients of public STD clinics. *American Journal of Public Health*, 92 (12): 1958-1963.

Harding, S., Boroujerdi, M., Santana, P. & Cruickshank, J. K. (2006). Decline in, and lack of difference between, average birth weights among African and Portuguese babies in Portugal. *International Journal of Epidemiology*, 35: 270-276.

Hjern, A. & Grindeford, M. (2000). Dental health and access to dental care for ethnic minorities in Sweden. *Ethnicity and Health*, 5: 23-32.

Hjern, A., Angel, B. & Jeppson, O. (1998). Political violence, family stress and mental health of refugee children in exile. *Scandinavian Journal of Social Medicine*, 26: 18-25.

Hjern, A., Ringback-Weitof, G. & Andersson, R. (2001). Socio-demographic risk factors for home-type injuries in Swedish infants and toddlers. *Acta Paediatrica*, 90: 61-68.

Horton, Richard (2008). What does a National Health Service mean in the 21st century? *The Lancet*. Vol. 371, pp. 2213 - 2218.

Hulewat, P. (1996). Resettlement: a cultural and psychological crisis. *Social Work*, 41: 129-135.

Irfaeia, M. Maxwell, A. And Krämer, A. (2008) "Assessing Psychological Stress among Arab Migrant Women in the City of Cologne/Germany Using the Community Oriented Primary Care (COPC) Approach", *Journal of Immigrant and Minority Health*, Volume 10, Number 4, pp 337-344

International Metropolis Conference (11th), *Women and Migration*, Pre-Conference Workshop, Lisbon, Portugal, October 2, 2006

International Organization for Migration (IOM) (2000) *Report on the International Workshop "Best Practices concerning Migrant Workers and their Families"*, Santiago de Chile, 19-20 June 2000. From <http://www.iom.int/>

IOM (2004). *Migration Health Report*. <http://www.iom.int/iomwebsite/Publication/ServletSearchPublication?event=detail&id04494>

IOM (2005). *World Migration 2005: Costs and Benefits of International Migration*.

Iseman, M. & Starke, J. (1995). Immigrants and tuberculosis control. *New England Journal of Medicine*, 332: 1094-1095.

Jansà, Josep M. & García de Olalla, Patricia (2004) *Gac Sanit* 2004; 18(Suppl.):207-13.

Janessens, K., Bosmans, M. & Temmerman, M. (2005). *Sexual and Reproductive Health and Rights of Refugee Women in Europe*. Ghent: International Centre for Reproductive Health (ICRH).

Jasseron, C. et al. (2008). Prevention of mother-to-child HIV transmission: similar access for sub-Saharan African immigrants and for French women? *AIDS*, 22 (12): 1503-1511.

Jeppesen, E. (1993). [Obstetric health care offered to Turkish immigrant women - a quality assessment]. *Ugeskr Laeger*, 155 (47): 3849-3854.

- Lisbon Conference Proceedings (2008). *Health and Migration in European Union. Better Health for all in a inclusive society*. Lisbon: INSA, Ministry of Health.
- Kandula, N. et al. (2004). Assuring the health of immigrants: what the leading health indicators tell us. *Annual Review of Public Health*, 25: 357–376.
- Kataoka, S., Zhang, L. & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159: 1548–1555.
- Kate, Mary-Anne, Niessen, Jan (2008). Guide to Locating Migration Policies in the European Commission. 2nd Edition, Published by EPIM and MPG
- Kennedy, P. & Murphy-Lawless, J. (2003). The maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review*, 73: 39–53.
- Nazilla Khanlou, N. and Crawford, C. (2006) “Post-Migratory Experiences of Newcomer Female Youth: Self-Esteem and Identity Development”, *Journal of Immigrant and Minority Health*, Vol. 8, No. 1, pp. 45–56.
- Kiwanuka-Mukiibi, Paul, Yann Derriennic, and Gloria Karungi. June 2005. *The Good Practice Model: Community Participation in Luweero District, Uganda*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.
- Kornosky, J., Peck, J., Sweeney, A., Adelson, P. & Schantz, S. (2007). Reproductive characteristics of Soththeast Asian immigrants before and after migration. *Journal of Immigrant and Minority Health*, 10: 135–143.
- Machado, M.C., Santana, P., Carreiro, M. H., Nogueira, H., Barroso, M. R. & Dias, A. (2006). *Iguais ou diferentes? Cuidados de Saúde materno-infantil a uma população de imigrantes*. Lisboa: Laboratórios Bial.
- McDonald, J. A., Suellentrop, K., Paulozzi, I. J. & Morrow, B. (2008). Reproductive health of the rapidly growing Hispanic population: data from the Pregnancy Risk Assessment Monitoring System, 2002. *Maternal Child Health Journal*, 12: 342–356.
- McGinn, T. (2000). Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 26 (4): 174–180.
- McKay, L., Macintyre, S. & Ellaway, A. (2003). *Migration and Health: A Review of the International Literature*. Glasgow: Medical Research Council – Social and Public Health Sciences Unit.
- McKenna, M., McCray, E. & Onorato, I. (1995). The epidemiology of tuberculosis among foreign-born persons in the United States, 1986 to 1993. *New England Journal of Medicine*, 332: 1071–1076.
- Médecins du monde UK (2007). Project London – Improving Access to Health-care for the Community’s Most Vulnerable. Report and Recommendations.
- Merten, S., Wyss, C. & Ackermann-Liebrich, U. (2007). Caesarean sections and breastfeeding initiation among migrants in Switzerland. *International Journal of Public Health*, 52: 210–222.
- Miller, L., Kiernan, M., Mathers, M. & Kleinn-Gitelmann, M. (1995). Developmental and nutritional status of internationally adopted children. *Archives of Pediatrics and Adolescent Medicine*, 149: 40–44.
- Mladovsky, Philipa (2009). A framework for analyzing migrant health policy in Europe. *Health Policy*, 93, pp.55–63.
- Montgomery, E. (1998). Refugee children from the Middle East. *Scandinavian Journal of Social Medicine*, 54: 1–152.
- Mosher, W. D., Martinez, G. M., Chandra, A., Abma, J. C. & Willson, S. J. (2004). Use of contraception and use of family planning services in the United States: 1982–2002. *Advance Data*, 350: 1–36.
- Muening, P. & Fahs, M. (2002). Health status and hospital utilization among immigrants to New York City”. *Preventive Medicine*, 35: 225–232.
- Neault, N. B. et al. (2007). Breastfeeding and health outcomes among citizen infants of immigrant mothers. *Journal of the American Dietetic Association*, 107 (12): 2077–2086.
- Newacheck, P.W., Hughes, D.C., Hung, Y.Y., Wong, S. & Stoddard, J.J. (2000). The unmet health needs of America’s children. *Pediatrics*, 105: 989–997.
- Noh, S. & Kaspar, V. (2003). *Diversity and Immigrant Health*. Toronto: University of Toronto.
- Ny, P., Dykes, A. K., Molin, J. & Dejin-Karlsson, E. (2007). Utilisation of antenatal care by country of birth in a multi-ethnic population: a four-year community-based study in Malmo, Sweden. *Acta Obstetrica et Gynecologica Scandinavica*, 86 (7): 805–813.
- O’Donnell, C.A., Higgins, M., Chauhan, R. & Mullen, K. (2007). “They think we’re OK and we know we’re not”. A qualitative study of asylum seekers’ access, knowledge and views to health care in the UK. *BMC Health Services Research*, 7: 75.
- Padilla, B., Portugal, R., Ingleby, D., de Freitas, C. and Lebas, J. (2009) “Good Practices on Health and Migration in the European Union” in Fernandes, A. and Pereira Miguel, J. (Eds) *Health and Migration in the European Union: Better Health for All in an Inclusive Society*. Lisbon: Instituto Nacional de Saúde Doutor Ricardo Jorge.
- Panagopoulos, P. et al. (2005). Delivery and immigration: the experience of a Greek Hospital. *Clinical & Experimental Obstetrics & Gynecology*, 32 (1): 55–57.
- Pedersen, P., Michaelsen, K.F. & Mølgaard, C. (2003). Children with nutritional rickets referred to hospitals in Copenhagen during a 10-year period. *Acta Paediatrica*, 92: 87–90.
- Platform for International Cooperation on Undocumented Migrants (PICUM) (2007). *Access to Health Care for Undocumented Migrants in Europe*. Brussels: PICUM.
- Puiggròs, M., Voltà, C., Eserverri, I., Colomer, J. & Barnusell, J. (2008). Immigrant pregnancy and neonatal morbidity. *Anales de Pediatría (Barcelona)*, 68 (6): 596–601.



- Putter, J. (Ed.) (1998). *AIDS & STDs and Migrantes, Ethnic Minorities and other Mobile Groups: The State of Affairs in Europe*. Woerden: European Project AIDS & Mobility.
- Razum, O., Jahn, A., Blettner, M. & Reitmaier, P. (1999). Trends in maternal mortality ratio among women of German and non-German nationality in West Germany 1980–1996. *International Journal of Epidemiology*, 28: 919–924.
- Razum, O., Zeeb, H. & Rohmann, S. (2000). The “Healthy Migrant Effect” – Not merely a fallacy of inaccurate denominator figures. *International Journal of Epidemiology*, 21: 199–200.
- Rees, G. A., Doyle, W., Srivastava, A., Brooke, Z. M., Crawford, M. A. & Costelloe, K. L. (2005). The nutrient intakes of mothers of low birth weight babies – a comparison of ethnic groups in East London, UK. *Maternal and Child Nutrition*, 1 (2): 91–99.
- Romanus, V. (1995). Mycobacterial infections in Sweden. *Scandinavian Journal of Infectious Diseases*, 98: 15–16.
- Romero-Ortuño, Román (2004). Access to health care for illegal immigrants in the EU: should we be concerned? *European Journal of Health Law* 11: 245–272. <http://www.equalityni.org/archive/pdf/RaceHealth.pdf#search=%22racial%20equality%20in%20health%20good%20practice%20guide%20consultation%20document%22>
- Rudman, A., El-Khoury, B. & Walsenstrom, U. (2008). Evaluating multi-dimensional aspects of postnatal hospital care. *Midwifery*, 24 (4): 425–441.
- Sanchez Becerra, I. [Coordination of Social and Health Care: Indispensable Condition for Interventions for the Migrant Population] Coordinación Socio-sanitaria: Premisa Ineludible para la Intervención con Población Inmigrante. [4th Forum of Primary Care Pediatrics of Extremadura, Spain] IV Foro de Pediatría de Atención Primaria de Extremadura.
- Saracino, A. et al. (2005). Access to HAART in HIV-Infected immigrants: A retrospective multicenter Italian study. *AIDS Patient Care and STDs*, 19 (9): 599–606.
- Schulpen, T. W. (1996). Migration and child health: the Dutch experience. *European Journal of Pediatrics*, 155 (5): 351–356.
- Shedlin, M. & Shulman, L. (2004). Qualitative needs assessment of HIV services among Dominican, Mexican and Central American immigrant populations living in the New York City area. *AIDS Care*, 16: 434–445.
- Singh, G. K., Kogan, M. D. & Dee, D. L. (2007). Nativity/immigrant status, race/ethnicity, and socioeconomic determinants of breastfeeding initiation and duration in the United States, 2003. *Pediatrics*, 119 (Suppl1), S38–46.
- Smaje, C. & Grand, J.L. (1997). Ethnicity, equity and the use of health services in the British NHS. *Social Science Medicine*. 45 (3): 485–496.
- Solorio, M., Currier, J. & Cunningham, W. (2004). HIV health care services for Mexican migrants. *Journal of Acquired Immune Deficiency Syndromes*, 37: S240–S51.
- Sosta, E. et al. (2008). Preterm delivery risk in migrants in Italy: and observational prospective study. *Journal of Travel Medicine*, 15 (4): 243–247.
- Sword, W., Watt, S. & Krueger, P. (2006). Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 35 (6): 717–727.
- Temmerman, M., Verstraelen, H., Martens, G. & Bekaert, A. (2004). Delayed childbearing and maternal mortality. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 114 (1): 19–22.
- Thorpe, S. (2003). Born Equal. *Health development Today*, 18: 21–23.
- Tong, C., Chen, J. & Cheng, L. (1999). Survey on causes of induced abortion in Shanghai. *Shanghai Medical Journal*, 22 (6): 345–353.
- Troe, E. J., Kunst, A. E., Bos, V., Deerenberg, I. M., Joung, I. M. & Mackenbach, J. P. (2007). The effect of age at immigration and generational status of the mother on infant mortality in ethnic minority populations in The Netherlands. *European Journal of Public Health*, 17: 134–138.
- Truong, Thanh-Dam. 2006. *Poverty, Gender and Human Trafficking in Sub-Saharan Africa: Rethinking Best Practices in Migration Management*. Paris : UNESCO.
- UNAIDS (2004). *2004 Report on the Global AIDS epidemic: 4th Global Report*.
- UNAIDS/IOM (2001). *Migrants’ Right to Health*. Geneva: UNAIDS.
- UNFPA (2005). *A situação da população mundial 2005. A promessa de igualdade: Equidade em matéria de género, Saúde Reprodutiva e Objectivos de Desenvolvimento do Milénio*. Nova Iorque: Fundo das Nações Unidas para a População.
- Urquia, M. L., Frank, J. W., Glazier, R. H. & Moineddin, R. (2007). Birth outcomes by neighbourhood income and recent immigration in Toronto. *Health Rep*, 18 (4): 21–30.
- Vahratian, A., Buekens, P., Delvaux, T., Boutsens, M., Wang, Y. & Kupper, L. L. (2004). Birth weight differences among infants of North African immigrants and Belgians in Belgium. *European Journal of Public Health*, 14 (4): 381–383.
- Van Steenkiste, M., Becher, A., Banschbach, R., Gaa, S., Kreckel, S. & Pocanschi, C. (2004). [Prevalence of caries, fissure sealants and filling materials among German children and children of migrants] [Article in German]. *Gesundheitswesen*, 66 (11): 754–758.
- Vilarmau Vila, J. (2003) [For a multicultural and democratic healthcare. Challenges of social work for the New Millennium] “Para una sanidad intercultural y democrática. Retos del Trabajo Social para el nuevo milenio”. [Journal of the Social Services and Social Policy] *Revista Servicios Sociales y Política Social*.
- Verbruggen, Nele (Ed.). *Health Care for Undocumented Migrants*, [www.picum.org](http://www.picum.org).

Wall, K., Nunes, C. & Matias, A. (2005). *Immigrant women in Portugal: Migration trajectories, main problems and policies*. Lisbon: ICS.

Warnes, Anthony (2002). The challenge of intra-Union and in-migration to 'social Europe'. *Journal of Ethnic and Migration Studies*, 28: 1, pp. 135 – 152.

Waterstone, M., Bewley, S. & Wolfe, C. (2001). Incidence and predictors of severe obstetric morbidity: case-control study. *British Medical Journal*, 322 (7294): 1089-1093.

Weathers, A., Minkovitz, C., O'Campo, P. & Diener-West, M. (2004). Access to Care for Children of Migratory Agricultural Workers: Factors Associated With Unmet Need for Medical Care. *Pediatrics*, 113 (4): 276-282.

World Health Organization (WHO) (2003). Gender and HIV/AIDS. Available from: [http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/)

WHO (2005). World Health Report 2005: *So that all mothers and children count*.

WHO (2007). *Health of Migrants*.

Wolff, H. et al. (2008). Undocumented migrants lack access to pregnancy care and prevention. *BMC Public Health*, 8: 93.

Wolff, H., Stalder, H., Epiney, M., Walder, A., Irion, O. & Morabia, A. (2005). Health care and illegality: a survey of undocumented pregnant immigrants in Geneva. *Social Science Medicine*, 60 (9): 2149-2154.

Wong, W., Tambis, J., Hernandez, M., Chaw, J. & Klausner, J. (2003). Prevalence of sexually transmitted diseases among Latino immigrant day laborers in an urban setting-San Francisco. *Sexually Transmitted Diseases*, 30: 661-663.

Woollett, A., Marshall, H. & Stenner, P. (1998). Young women's accounts of sexual activity and sexual/reproductive health. *Journal of Health Psychology*, 3 (3): 369-381.

World Bank (2001). *Engendering development: Thought gender equality in rights, resources and voice*. New York: Oxford University Press/World Bank.

Yang, X. (2006). Gender, migration, risky sex, and HIV infection in China. *Studies in Family Planning*, 37 (4): 241-250.

Yeh, M., McCabe, K., Hough, R.L., Dupuis, D. & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research*, 5: 65-77.

Yu, S., Bellamy, H., Schwalberg, R.H. & Drum, A. (2001). Factors associated with use of preventive dental and health services among U.S. adolescents. *Journal of Adolescent Health*, 29: 395-405.

Zhao, D. et al (2002). Status and needs of sexual health among women migrant workers in Taiyuan. In E. Gao, C. Lou, X. Tu & S. Iqbal (Eds.), *Status, perspective and strategy of reproductive health among adolescents and unmarried youth* (pp. 231-243). Shanghai: The Second Military Medical University Press.

## Footnotes

- 1 The diversity of social protection instruments and policies over the European Union is quite high, but this is both true for intra-Union and outside-Union migrants.
- 2 The United Nations Millennium Goals adopted in the year 2000 place maternal health and child health as two of the eight main goals to be achieved worldwide.
- 3 The policy analysis conducted on this paper is based on a literature review. The examples given of European national policies only intend to illustrate the issues being discussed and not be representative of the whole European situation.
- 4 The four countries analysed were England, Italy, Netherlands and Sweden.
- 5 The Convention of Children's Rights had been ratified by Spain on 5 January 1991.
- 6 Until then, the Spanish National Health System would only recognise the right to care in "emergency cases".
- 7 Consultation document on Racial Equality in Health. Good Practice Guide. Website: [www.equalityni.org](http://www.equalityni.org)



## Appendix

### 2007 Lisbon Conference

#### Recommendations on Maternal and Child Care

(Source: *Health and Migration in the European Union. Better Health for All in an Inclusive Society*, Conference Proceedings, National Institute of Health, Ministry of Health, Lisbon, 2008)

##### Access to the Health Care System

Migrant mothers and their children must be granted equal access to the Health Care System, irrespective of their legal status.

This can be achieved through specific norms protecting illegal migrant women (especially pregnant ones) and their children from deportation.

In addition, programmes should be instituted to improve their education and to remove cultural barriers that may prevent their full integration and therefore their autonomous access to health care.

Services may be required to treat specific diseases from the area of origin of migrants and prevent the spread of such infections.

##### Access to Antenatal care

More specifically, migrant mothers must be given equal access to existing antenatal care services, to ensure that they have the same opportunities to deliver a healthy baby, while they too remain healthy.

Since often these women have higher rates of pregnancy-related problems (with the resulting increased vulnerability of their children, such as prematurity, pregnancy complications, etc.), specific programmes must be set in place to encourage pregnant women to avail themselves of existing facilities at the local level.

##### Access to Postnatal care

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

##### Access to Family-planning

Effective family planning services exist in all EU countries, but – by and large – migrant women of reproductive age do not avail themselves of these services to the same extent of country nationals. The ensuing high

rate of unwanted pregnancies and high frequency of voluntary pregnancy terminations, legal or illegal must be eliminated through specialised services capable of responding to the specific language and cultural needs of migrant couples.

##### Screening for HIV

There is a considerable variation in antenatal testing practice, local rate of sero-positivity, and perception of principal risk factors both between and within countries of the EU.

In order to give all pregnant women, whether residents or citizens of the EU, the same opportunities, the following specific recommendations are therefore to be enforced:

HIV testing according to the opting out principle should be included in the national antenatal screening programmes.

Specialized ante partum and postpartum care should be available to all (HIV-infected) women without discrimination on racial, lifestyle or other grounds.

Follow up by ethnic health advocates preferably within the frame of the GIPA (Greater Involvement of People living with AIDS/HIV) principle is recommended.

A partnership within the treatment centre between the medical services and the ethnic health advocate is the “best practice” for the support of HIV-infected pregnant women.

##### Full protection against traditional harmful practices

Although migrant women may be allowed to keep some of their traditional practices, these may never be against the law of the host country. Therefore, female genital mutilation cannot be accepted within the EU borders in any form or shape.

EU countries have a duty not only to legislate against such practices, but also to enforce them.

##### Protection against the risk of domestic violence

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

Effective prevention and repression of women's traffic

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

Services to ensure proper growth and education for migrant children.

Migrant children, even those present as illegal immigrants have a right to be educated. EU countries, within the legal framework to deal with illegal immigration, should design ways not to unfairly "penalise" illegally present children.

Full prevention and repression of child trade

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







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