SWISS FORUM FOR MIGRATION AND POPULATION STUDIES

"Migration and Health": a basic document on the issues

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Introduction

Switzerland has a long tradition of linguistic and cultural diversity. Recently however, like the rest of the industrialized world, it has experienced profound socio-cultural changes which are reflected amongst other things in the plurality of lifestyles and ways of life, languages and value systems. Migration*[1] is an important factor, though not the only one, in this process which cuts across all spheres of society and confronts us with new challenges.

Whereas most European countries speak in terms of migrant population[2], Anglo-Saxon countries tend to talk of “ethnic” or “racial” minorities. In this case, the migration categories can correspond to membership of an ethnic minority, a particular racial category and/or a different nationality. It is sometimes also associated with the difficult socio-economic conditions in which some migrant groups find themselves. Because of this, these groups are often regarded as socially or socio-occupationally disadvantaged segments of the receiving society. At the same time, some minorities who are not descendents of migration sometimes face difficulties similar to those experienced by migrants (for example problematic access to an unfamiliar health system or language difficulties). The generic term “migrant” used throughout this document is therefore to be understood in the widest sense as referring also to other minority situations defined by ethnicity, religion, language or nationality, etc.

Moreover, in increasingly plural societies, health institutions often have to cope with clients with very different backgrounds, ways of life and systems of reference. These institutions are therefore called upon to be more open to an increasingly diverse population (migrants, for example). They also need to develop transcultural* structures to enable them to respond adequately to specific individual needs.

The purpose of this document is to offer frame of reference supplying information and tools for people wanting to submit a request for funds. This document should enable them to answer the key questions arising in the context of their project. Its aim is to make project leaders aware of the need to take the situation of migrants into account so they can adapt their efforts for health promotion as much as possible to that reality. Obviously, this frame of

[1] For the definition of terms marked *, see the glossary.

[2] By analogy, the « migrant population » includes all persons born abroad and their descendants, regardless of nationality.

reference cannot offer a ready-made solution for every situation and certainly cannot replace the imagination and initiative that goes in to every project.

The document has three chapters. The first situates the phenomenon of migration in the Swiss context, from the socio-demographic point of view. The second looks at the relationship between migration and health. The third chapter outlines a series of aspects related to migration that need to be taken into account when planning and implementing projects in the field of health care. An appendix includes a series of tables containing information on the specific needs of the migrant population as described in scientific literature, health promotion and prevention and the most disadvantaged target groups. These tables are based on the analysis of a number of scientific studies carried out in Switzerland on “migration and health”.

In the interest of readability we have chosen to place the references thematically at the end of the document rather than including them in the body of the text. You will also find a list of links and useful addresses, as well as a glossary of some of the terms commonly used in the field of migration and health.

1 Migration: a socio-demographic reality in Swiss society

A quick look at the demographic history of Switzerland since the end of the 19th century shows that migration has been a major component: even though the increase in the foreign population was not linear, Switzerland had become a country of immigration by the beginning of the 20th century. According to the figures of the Federal Statistical Office for 2005, almost one quarter of the population (22.6%) was born abroad. If their children and grand-children are added, this actually amounts to some 2 million people. Residents of foreign nationality represented 20.6% of the population in Switzerland. This puts Switzerland in third place among the countries of the European Union (EU-25), behind Luxembourg and Lichtenstein.

1.1 Characteristics of the migrant population: a high degree of diversity

The migrant population* has become increasingly heterogeneous in terms of national origins and socio-occupational characteristics.

Diversification of countries of origin…

For the past two decades we have noted a slower growth rate in the foreign population, with a sharp increase in the diversity of the countries of origin from which the migrants come.

However, the majority of the foreign population resident * in Switzerland in 2005 (58.5%, i.e. 883, 988 persons) come from EU-25. Since the agreement on the free movement of persons between Switzerland and the EU came into force (2004), the proportion of migrants coming from the EU has been increasing.

The table below shows the main countries of origin of the migrant population in Switzerland.

Table 1 : Main countries of origin of the permanent resident foreign population 2005

Country	Number	%
1. Italy	296 392	19.6%
2. Serbia-and-Montenegro	196 179	13.0%
3. Portugal	167 269	11.1%
4. Germany	157 580	10.4%
5. Turkey	75 448	5.0%
6. Spain	71 376	4.7%

Source: Federal Office of Migrations

Socio-occupational heterogeneity…

Persons with a migration background are represented in all social and occupational categories. Whereas in the past, the active migrant population was largely made up of people with a low level of skills, the present situation may be described as one of growing polarization, with highly qualified persons on one side and low skills on the other.

Their situation with regard to admittance (asylum seeker, temporary or permanent residence permit, etc.) is as varied as their reasons for migrating (economic migration, family reunification, forced migration, etc.).

Linguistic diversity…

Migration has added to Switzerland's linguistic diversity. In the space of 40 years, the proportion of non-national languages used as a first language has gone from 1.4% in 1960 to 9% in 2000. In other words, migrants' languages are occupying an ever-larger space on the country's linguistic scene.

This linguistic diversity means that, in order to better respond to needs, health promotion and prevention programmes have to take account of the different ways of thinking, reasoning and acting inherent in the different languages. Using the languages spoken by migrants can help the transfer of knowledge

and contribute to understanding, negotiating and solving a problem or reaching a decision. Adapting to this linguistic diversity (information in the relevant languages, use of interpreters, etc.) is thus also a challenge for health promotion and prevention.

Table 2 : Main non-national languages in Switzerland (first languages)

Languages	Number	Percentage
1. Serbo-Croat	103 350	1.4%
2. Albanian	94 350	1.3%
3. Portuguese	89 527	1.2%
4. Spanish	77 506	1.1%
5. English	73 425	1.0%
6. Turkish	44 523	0.6%

Source: Federal Statistical Office

Religious diversity…

With 4.3%, Islam became the third religious group in Switzerland in 2000, behind the Roman Catholics (41.8%) and the Protestants (35.3%). Beyond this numerical fact, this development obviously expands the belief and value systems in our society, as well as the religious references and codes of representation. But within a specific religious group, differences also exist due to ethnic diversity. It might be thought, for instance, that Muslims form a united group, where in fact this group covers a wide variety of nationalities and ethnic origins : 56.4% of Muslims in Switzerland come from the former Yugoslavia, 20% from Turkey, 6% from Africa (of which 3.4% come from Maghreb countries). It should not be forgotten that religious allegiance is subject to interpretation and that religious factors can sometimes be both a help and a hindrance to health and well-being.

Gender diversity…

In contrast to the past, migration by women – whether for family reunification or an independent journey – began to develop from the 1970s. The composition by sex of the resident population of foreign nationality confirms a degree of feminization of migration: the difference between the number of men and women in the foreign population as a whole is now only 8 points (54% men as against 46% women in 2004).

As to integration of men and women in the labour market, a clear difference between the sexes exists. The women are mainly concentrated in the service sector (domestic work, nursing, catering and hotel industry, etc.), whereas the men are over-represented in construction and industry.

From a gender perspective, migratory flows are generally speaking sex-specific in character, meaning that men and women decide to emigrate for different reasons. Furthermore, the experiences encountered by male and

female migrants are determined by their gender. Most of the differences are a result of the roles, behaviours and relationships attributed to or expected of a man or a woman by society, both in the country of origin and the receiving country.

It is also important to emphasize that the specific conditions encountered by female migrants (for example, symbolic representations or discrimination on grounds of gender) may potentially or actually contribute to the socio-economic marginalization of many female migrants. This marginalization has a negative effect on their health. But there are also situations which particularly affect male migrants; some find themselves doing under qualified work, representing a loss of status, which affects their behaviour and state of health.

2 Migration and health: a complex relationship

Traditionally, the relation between migration and health was considered part of the migrants' "pathological baggage", reflecting the state of health of the individuals concerned. This approach contained a series of negative elements that translated the health situation of the migrants: diseases imported from the context of origin (mainly infectious diseases), pathologies caused by having to adapt to the receiving society, psychological disorders, etc. Moreover, it tended to view the migrants' state of health in terms of the potential risks to public health.[3]

Nowadays, it is acknowledged to be difficult to *a priori* draw a direct causal relation between migration and specific pathologies. Nor can we ignore the often negative effects on migrants' health of the living and working conditions and the administrative procedures in the receiving country.[4] Consequently, being a migrant is not considered as a health risk factor *per se*. Recent work has stressed the *complexity* of the link, resulting from the combination of a wide variety of elements of genetic, social, economic, political and administrative nature, and factors relating to life-styles.

[3] In contrast to this approach, certain studies consider the relation between migration and health as positive, in that the people most likely to leave their country are generally those in good health (healthy migrant effect).

[4] This is what is described in scientific literature as the « exhausted migrant effect ».

2.1 The health status of migrants : a problem of social inequalities in health

It is generally acknowledged that the factors that determine health are not confined to the field of health as such: environmental and socio-economic conditions, customs and even politics in the widest sense create the basic framework of conditions for health.

The experience of migration, which is one of the most significant in the life of an individual or his/her family, and the context of migration, determine the migrants' socio-economic conditions and influence their state of health. Part of the migrant population can be found in the lower layers of the social hierarchy, doing jobs that expose them to occupational risks, notably accidents on the job.

Migrants are also more often affected by periods of unemployment in times of an unfavourable economic situation than the indigenous population. Because their wages are low in comparison to the standard of living, a large number of active migrants are also more concerned by the phenomenon known as the "working poor" than the rest of the population. Sometimes, admission status gives rise to an uncertain situation which has an adverse affect on health, particularly mental health.

As to the state of health and the health behaviour of migrants, a few general remarks can be made, even though the state of research in Switzerland leaves much to be desired. Many of the findings are incomplete, even contradictory. This is why, in 2004, the Federal Office of Public Health (OFSP) and the Federal Office of Migration (OFM) set up a programme *to monitor the health of the Swiss migrant population* (hereinafter GMM). The GMM has shown that, on average, migrants view their state of health as worse than the Swiss. This subjective assessment, i.e. based on the migrants' own estimation, is confirmed by a number of studies previously carried out in Switzerland. These showed that, as a general rule, migrant communities present unfavourable levels of health compared to the Swiss.

Generally speaking, the health of migrants is characterized, amongst other things, by:

- pathologies imported from their country of origin, mainly infectious diseases;
- for asylum seekers or refugees: psycho-social disorders connected with the causes or conditions of migration;
- slowly deteriorating health because of difficult jobs and often precarious living conditions in Switzerland;
- in some cases, poor reproductive health, resulting in dangerous pregnancies and a higher proportion of premature births;

- comparatively higher death rates than Swiss for certain causes of death, such as stomach cancer in persons of South European origin.

As far as the **health habits** of migrants are concerned, high-risk behaviours and bad access to health care services are the main problems:

High-risk behaviours: According to the findings of the GMM, the behaviour of different migrant groups places them at a relatively greater risk for tobacco consumption, little physical exercise and having to diet often; some groups also show a greater tendency to be over-weight. It has been noted that in all migrant groups, men smoke more than women. Certain groups of migrants on a whole, such as people from Turkey, also show a much higher rate of smokers than the Swiss population. However, with the exception of people from Austria, France and Germany, female migrants exercise less than the Swiss population.

This situation underlines the importance of diffusing information on the subject of health and ensuring its reception. According to the scientific literature, the way such information is received is influenced by a number of factors such as health literacy*, social capital, socio-economic situation, etc. Persons with a low level of health literacy have difficulty understanding written and oral information given by health specialists and following their recommendations, nor are they able to look critically at information relating to health. This being so, any interventions aiming to promote health and preventive care have to take the role of health literacy in the health behaviour of migrants into account.

Access to health care services: Scientific literature shows that recourse to health care services and health behaviours – whether protective or high-risk – are not simply a matter of individual choice. They are influenced by a series of factors which, although to a lesser degree, also concern the native population. Discrimination, language difficulties, differing concepts of health and illness, lack of knowledge and information about the health system and healthcare institutions in Switzerland for instance, are negative factors which lead to an underuse or inappropriate use, of the health services by the migrant population.

It follows from this that projects and programmes aiming to reduce inequalities * in the field of health also have to take the migrant population into account. It seems obvious that, apart from the health deficit noted in certain migrant groups, the aspect of health promotion and prevention also has to take account of the diversity that exists among the migrants in terms of ways of life, representational codes, value systems, etc. These aspects affect health-related behaviour, the perception of messages about prevention and the possibility to reach migrants or other minorities.

2.2 Health disparities among migrant groups

Differences in health are sometimes much more pronounced among certain groups or sub-groups of migrants than between the migrant community as a whole and the Swiss population.

According to the GMM survey, while 3% of the Swiss consider their state of health as “poor” or “very poor”, this percentage rises to 5% among Tamils, 7% among Italians, 9% among the Portuguese, 11% among migrants from the former Yugoslavia and 16% among migrants coming from Turkey.

Although nationality seems to be an important factor in explaining health disparities between different groups of migrants, other factors that influence health, notably age, gender, reason for migration, admission status, should not be overlooked.

Let’s view, for example, the age factor; 5% of Swiss aged between 51 and 62 consider their state of health to be “poor” or “very poor”. This percentage rises to 14% for Italian migrants of the same age, and between 30 and 40% for migrants coming from the former Yugoslavia, Portugal and Turkey. The gender gap varies from one nationality to the other. 83% of Italian male migrants, but only 74% of Italian female migrants consider their health to be “good” or “very good”. This difference between men and women rises to as much as 27 points among women of Turkish origin and 15 points among Tamil women.

The GMM shows that state of health is also influenced by the type of migration: asylum seekers, both men and women, feel themselves to be in worse health compared to economic migrants belonging to their community.

Professional activity also influences health condition, as is demonstrated by the differences in health conditions between migrants in a marginal situation (migrants with a precarious residence status, in this case persons with provisional admittance and (undocumented) migrants in an irregular situation): those who have a job consider themselves to be in good health compared to those who have no work. This underscores the positive effect of personal resources on people’s subjective assessment of their state of health.

It would be redundant to show a list of health disparities between different sub-groups of migrants, but it is important to note the existence of the *cumulative*

effects of certain factors[5]. In fact, in a migration context, these cumulative effects can lead to greater vulnerability and lack of resources: "being a migrant" does not necessarily imply being in a "bad" state of health. However, the fact of being, say, a female migrant with an unstable residence status (F permit or asylum seeker status) and young dependent children, but without a job and not speaking the local language, creates additional risks that are liable to deepen the existing health disparities.

Because of their often difficult socio-economic situation, there is a tendency to lump all migrants together in a category of the disadvantaged. As mentioned, the fact of belonging to the migrant population does not automatically mean being disadvantaged. It is therefore important not to generalize and to establish more differentiated categories. Even though the variables of ethnic origin and migrant status do seem to be the most important variables, greater attention should be paid to the migrant sub-groups which are potentially at greatest risk.

Taking account of the *cumulative effects* of the different high-risk situations may help to determine the most disadvantaged groups within the migrant population more effectively. However, it must be set in a wider perspective that allows other factors to be taken into account, such as life-styles or value systems, which can be both a resource and a risk.

3 Health promotion sensitive to the realities of the migrants' situation

The complex relation between "migration and health" (cf chapter 2) can only be understood if it is embedded in an overall awareness of the health inequalities existing in our society. The phenomenon of migration is one cause of this amongst others, and no doubt an important one, which can give rise to inequalities in health. This is why the strategies adopted in several developed countries, in an attempt to reduce health inequalities, emphasize the importance of the "migration" dimension in all efforts for health promotion and prevention.

[5] In a migration context, factors like an administratively precarious status, insufficient knowledge of the language of the receiving community, lack of social resources and information about the health system, discrimination and stigmatization, etc. can often lead to hazardous situations for migrants.

3.1 Why it is important to adopt an approach aimed at reducing health inequalities

Reducing the health disparities between different social groups, and improving the state of health of the most disadvantaged, are the main objectives of health care strategies in general, and health promotion and prevention in particular. A series of diverse arguments, incorporating all groups concerned by health inequalities, whatever the determining factor (gender, nationality, age, migration, socio-economic situation, etc.), support these aims. These arguments are used to justify all actions and measures intended for groups affected by *avoidable and unfair* inequalities in health.

Arguments of normative nature

Argument based on equity: Health disparities are ethically undesirable and unacceptable in that they are *avoidable and unfair*. Health inequalities become unjust if a person's poor state of health is due to the socio-economic factors (unequal opportunities in education, employment or access to the health system, for example). This argument approaches the notion of equity in the field of health. It sees health care as a resource to be shared and argues that according equal resources to everyone is the best possible distribution of resources when it comes to establishing social justice.

Principle of equality and non-discrimination: In relation to health, the principle of equality and non-discrimination* may be seen as a means to implement the principle of equity in health. In liberal, democratic societies, actions are often justified by reference to the principles of *equality* and *non-discrimination.* They are both the philosophical source and the instrument of the principle of the rule of law recognized in the constitutions of all democratic countries. In Switzerland, Article 8 of the Federal Constitution deals with the principle of equality and Article 261 b of the Penal Code forbids discrimination.

Argument based on the principle of human rights: The right to health has been laid down in numerous, legally binding international and regional treaties on human rights, such as the Constitution of the World Health Organization (WHO) and the *Universal Declaration of Human Rights.* It should be noted that the Ottawa Charter refers to the principle of the right to health and states the importance of implementing this in the field of health promotion.

Generally speaking, the *right to health* means that every person should be able to enjoy a mode of existence that allows him or her to have a healthy life, with access to preventive care and appropriate curative treatment when necessary. This being so, for an individual, the right to health is considered an integral

part of the other rights, notably the right to have a decent standard of living and education and to take part in the life of society.

Arguments of societal nature

Inequalities in health are damaging to all members of a society. Scientific research has noted that there is a correlation between the good health of the individuals in a society and social cohesion. Also, healthier, egalitarian societies demonstrate a stronger degree of social cohesion. It seems that the latter enhances people's sense of belonging to the same community and having to face the same challenges.

It has also been recognized that reducing health inequities by improving the state of health of disadvantage groups, helps to improve the average health of the population as a whole and thus improves public health.

Reducing health disparities could thus be expected to have a positive impact on social cohesion. For a migrant, health is also a crucial element in his or her integration. Logically, persons in good health have more energy to draw on to help them integrate in the receiving society, than those in worse or bad health. In the context of migration, it may be said that anything that promotes health also promotes the social integration of migrants.

Arguments of economic nature

It has been shown that actions aimed at improving the health of disadvantaged groups lead to a reduction in public spending on health. Moreover, good health is also a factor of production. This is particularly true for workers in the less advantaged segments of society. For these people, their physical condition is an essential tool for labour and economic development, and hence is part of the social capital of a society.

3.2 Taking the "migration" dimension into account in projects

The context of migration, the socio-economic situation of migrants, their sometimes different perceptions of health and their value and reference systems can give rise to specific needs in the field of health promotion. Because of this, it is important to take the "migration" dimension into account in health promotion projects. We will illustrate how this can be done by following the different stages of a project and drawing on practical experiences in the field of health promotion and prevention. These are taken from project descriptions or evaluation reports, or from examples mentioned in the different discussion groups examining the topic "health and migration". Some are

examples of positive action, others reflect a concrete problem encountered in a project, yet others show a high degree of awareness of the "migration" aspect.

Conceptual phase

Reducing health inequalities and applying the principles of equal opportunity* and of non-discrimination in health promotion are fundamental philosophical principles in any project that sets out to incorporate the dimension of migration. These are the principles that should guide the preliminary thinking in any project likely to include migrants among their beneficiaries. Depending on the situation and the experience available, it is important to opt for an approach that will allow a particular project to be adapted to the needs of the migrant population or, in some cases, to target the project specifically at this category of beneficiaries. The example given below illustrates both these approaches, and describes a situation where the services offered by an association were extended (i.e. opened up) by the introduction of a project specifically for migrants.

> **Example 1**: The association "Ostschweizerischer Verein für das Kind"[6] (OVK) in St Gallen decided to open its child development and nutrition advisory services to parents from the migrant community. It justified this step by reference to the Ottawa Charter, which stipulates that health promotion projects should offer the same resources and opportunities to all individuals (principle of equality). A pilot project (MigesBalù) [7] aiming at migrant families of different nationalities was set up to put this idea into practice.

Planning phase

Studying the starting situation: It is important to adopt an analytical approach that takes account of the various factors that determine the diversity of the beneficiaries and the types of interaction to be considered. Yet, it is not always easy to assemble the necessary information on the subject from the available literature or statistics on health or epidemiology. Often, few if any differentiated data based on migration status or length of stay are available and nationality alone is not enough to define the problems adequately.

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[6] The « Ostschweizerischer Verein für das Kind » is a nonprofitmaking association working in the region of St Gallen and Rorschach. It advises the parents of children from 0-6 years of age in matters such as breast-feeding, nutrition, education, etc. (www.ovk.ch).

[7] Acknowledged in various circles as one that demonstrates best practice, the MigesBalù project is an outstanding example of how to incorporate the "migration" dimension in health promotion (for more details see www.ovk.ch/de/main.projekt.php).

Example 2: OVK noted that migrant families did not make enough use of its advisory services, even though their children (aged 0-6) were concerned by the problems of nutrition and lack of physical activity. The association also noted that, for various reasons (night working, fatigue, language difficulties, feeling of being rejected by the receiving society), migrant families often keep their children at home while they are small. Because of this, these children run about much less than children of local families and spend too much time in front of the television. As a result, the children of migrant families are exposed to health risks.

Determining needs: It is possible that the needs identified for the project will occur in a different form particular to the migrants. These specific needs therefore have to be determined and there are two possible ways of doing so. The first is an "objective" approach which refers to the results of scientific studies, assuming that the subject in question has been studied from the point of view of diversity* or of migration. The second approach is more "subjective" and is based on the needs expressed (or felt) by for example health institutions, the migrant community, health professionals, experts or key-persons. These two approaches are obviously not mutually exclusive and a combination of the two is often useful.[8]

Example 3: A project submitted to Radix based on accounts given by migrants in touch with the Swiss health system showed that the migrant population's use of the health services is limited, for various reasons (e.g. the health systems in their country of origin function differently). The project has identified a specific need for migrants to be given information on the health system and how it functions, and the obstacles they may encounter in gaining access to care.

Identifying target groups: Thought should be given to the choice of target groups in light of the need identified. It should be remembered that migrants represent a very heterogeneous group and it is important to look both at the socio-economic dimensions (such as education and income), and other aspects which may be decisive (such as origin, gender, migration status and language knowledge), in determining the most disadvantaged sub-groups within the migrant community. It is also important to bear in mind the *cumulative effects* of certain factors (cf. section 2). This means that within a group perceived *a priori* as an entity, the sub-groups may have different needs or resources. Migrants from sub-Saharan Africa may serve as an example here; they tend to be regarded as a "homogeneous group", whereas in fact, the only thing they have in common, given their different languages and ways of life, is the colour of their skin and the stereotypes of which they are the object.

[8] For more details concerning the terms « objective need » and « felt need », cf www.quint-essenz.ch/fr/resources/glossary.

Example 4: The procedure for identifying migrant target groups outlined hereafter shows how important it is to use a differentiated approach, appropriate to the particular characteristics of the object and context of each project. "…We wanted to identify the migrant group that could be considered as a "high risk group" in terms of AIDS prevention. We began by consulting the literature and found that migrants with an unstable residence status and those descending from regions showing a high rate of HIV infection are the ones most at risk in the migrant community. Then, in order to target the most disadvantaged groups more effectively, we turned to experts and professionals in the field. The outcome of these two procedures was that we included in our target group "sex workers" and migrants from sub-Saharan Africa with an unstable admission status…" (a participant in one of the discussion groups on "migration and health).

Based on the observations made during the different stages discussed above, it is possible to envisage either projects intended exclusively for migrants, or projects addressing a wide, mixed audience. In the latter case, it is important to make sure that the dimension of "migration" is also included in the different stages of these projects. In a field where there is a lack of knowledge and experience, it may be wise to adopt the specific approach and target the migration context in a first instance, even if it is later decided to use the lessons learned in a wider, more "general" setting.

Implementation phase

Reaching the target group: Once the target population has been identified, the challenge is how to reach them. It is probable that the migrants included in the target group for the project will be harder to reach than the native population. In general, it is important to take the different value and representation systems of the target or beneficiary group into account at all the stages of development of any project. These dimensions become particularly important at the implementation stage, especially when the respondents are contacted. The determining elements of social interaction namely, vary greatly according to socio-cultural origin.

It should neither be forgotten that migrants are highly mobile within Switzerland, not in the least due to social ties. Gaining access to a particular group of migrants (for example undocumented migrants) may prove especially difficult because of their irregular entry, which forces them to stay out of public view.

Beside the factors which influence the accessibility of migrants, it is also important to bear the importance of other factors in mind, such as the setting and social networks, the means of making contacts and the choice of intermediaries. Here again, not only socio-cultural and traditional factors are to be considered, but also aspects such as the "rhythm" of the migrants' working life (working hours) and the nature of the persons chosen as intermediaries (do they for example inspire confidence in the community).

An important first step is therefore to contact the migrant networks (key persons, cultural mediators*, migrant associations, etc.) which can not only build a direct bridge between the project and the persons, but can also lead the way in contacting the target population.

Example 5: Project aimed at preventing dependencies wanted to include the parents of young Albanians in the target group and contacted an Albanian female teacher to carry out a small survey among the parents to find out more about their needs and wishes. An information evening on dependencies was organized for this purpose. However, nobody came to this evening, because the teacher, who was to act as a key person, was perceived by the Albanian community as being a representative of the "left" and someone who does not inspire confidence. After this unsuccessful information evening, the project leaders decided to visit the special classes for migrants' children to try to make direct contact with the Albanian parents. This example shows that a key-person does not necessarily guarantee success and that care is needed in the process of finding the right intermediary.

Example 6: The MigesBalù project used a special, diversified strategy to reach mothers of Albanian origin. Knowing that, in the traditional relations between the sexes in the Albanian community, the husband, as the head of the family, takes the decisions, the project decided to establish contact with the men first, with the help of male intercultural interpreters. The aim was they would allow their wives to use the services offered by the project.[9] The project was also presented in different migrants' associations.

Example 7: "We organized an information session for migrant families in a classroom at the school, but it was no success, because very few people attended. When we organized another similar session in the Turkish mosque, we were surprised by the high number of participants…" (a participant in a discussion group on participation in relation to migration and health).

Participation and optimal use of resources

Participation: Participation is an essential element in the approach to health promotion proposed by the WHO. The notion of participation as such comes from other fields, but it has become a key concept in health promotion.

Moreover, the successful implementation of a project depends on its management philosophy. If the project is aimed at the migrant population or includes migrants in its target group, migrants should also be involved in the implementation of the project (both at leadership and staff level), in the identification of problems and needs and in the execution and evaluation of the

[9] We must beware of the risk of generalization and schematization, regarding migrant communities. This method of establishing contact should not be applied at random, neither to all migrant communities, nor to the Albanian community as a whole. It would be wiser to adapt contacting methods to each individual context. Moreover, it is also important to create a space especially for dialogue with women migrants.

actions. Generally speaking, active participation by migrants is possible and desirable at every stage of a project, and most particularly the implementation stage.

> **Example 8**: "In our project, participation of migrants has been achieved: we have one migrant woman who carries joint responsibility for the project. She has been involved from the start. We systematically work with interpreters, intercultural mediators and migrants' associations in order to contact our target group. When it comes to implementing certain modules of our project, professionals of migrant origin regularly intervene and they are also involved in our advisory services for migrant groups" (a project leader).

Some advantages of including migrants in the management of projects

- It increases social support for and acceptance of the project and its interventions among the migrant population;
- It encourages cooperation with migrants instead of treating them as beneficiaries/addressees;
- It helps to get closer to the potential target population;
- It has a positive influence on the motivation of the migrants involved.

Optimal use of resources: Thought also has to be given on how to draw on the resources available among the migrants in the implementation of the project. Migrants possess the human capital they have acquired in the course of their education and working life, during and prior to migration, as well as the informal resources[10] they have built up during their lives (experiences of migration, knowledge of the language of origin, skills and expertise, etc.). Using these skills can be a great help both for project leaders and for the migrants involved.

The benefits of using migrants' resources

- It strengthens the ability to take control of their health and the factors that determine it (empowerment*);
- It makes human resources available (cross-cultural knowledge, language skills, know-how and experience of migration);
- It draws on the migrants' social resources (community networks, social ties, etc.) and so strengthens their ability to improve their health situation more than they could do by their own individual effort;

[10] A distinction is generally drawn between formal and informal resources. The former refer to resources in the form of formal competencies recognized by a diploma or a certificate (school certificates, university degrees, professional qualifications, etc.) while the latter are all the resources not validated by a diploma or certificate that an individual may possess, such as social skills, life experience, expertise, cultural codes, belief and value systems, etc. It should be noted that, in Switzerland, qualifications gained in certain countries of origin are not recognized, so that some migrants may also possess formal resources that could benefit the project, even if these have been ignored.

- It could contribute to reduce the costs of human resources.

Working methods and tools

The success of a project also depends on the method of implementation or diffusion of knowledge and on the working tools used, because these are what make an action or intervention effective.

Example 9: A project which decided to use modern communications technology to get its message over to families, produced a CD-ROM in the local language. This method was not successful with families having a migration background. It failed to take account of language knowledge and the fact that some families are not sufficiently familiar with the local language to understand the information on the CD-ROM. The project also starts with the assumption that the use of multimedia communication is as widespread among migrant families as among the native population, which is not the case. The weakness of this method lies in its generalizing approach, which does not take account of the characteristics of the migrant community which is part of its target population. The project should have produced CD-ROMs in the mother tongues of the migrants group it aimed to reach and found other tools or channels to put over its information (associations, weddings, community evenings, etc.).

Example 10: "All the parents in the target group in the maternity services in the region received a leaflet about our advisory services in their mother tongue. We have also adapted the opening hours of our advice office to meet the needs of migrant parents" (extract from the evaluation report on the MigesBalù project).

Some suggestions concerning working methods and tools

- The working methods and tools (individual conversations, meetings with target groups, individual approach, thematic workshops, role play, etc.) should take account of the widely varying characteristics of the participating migrants as much as possible (level of education, language knowledge, lifestyles, etc.);
- In the case of a mixed target group (local and migrant population), it is important to make sure that the method chosen is also effective for the migrant participants;
- In some cases, it may be necessary to apply a different methods, adapted to the specificities of the migrants;
- Working material (documentation, language, images, etc.) must be adapted to the migrants' needs;
- One should ensure that the instruments for internal and external evaluation allow for the specificities of the migrant target group (specific needs, diversity of value systems and perceptions of health, etc.).

Obviously, these different phases make more sense if they are linked to the process of formulating the objective of a project. The table below sets these stages alongside the objectives that a project must set for itself if it is to be sensitive to the situation of the migrants, reflecting their socio-economic and "cultural" characteristics in terms of diversity of ways of life and value systems.

Table 3: The different phases and objectives of the project in parallel

Phases	Objectives
Conceptual phase	• Help to reduce health inequalities in the migration context ; • Aim for equal opportunities for the migrant and the native population.
Planning phase	• Take account of the fact that migrants are affected by a number of inequalities that can be reduced (*starting situation*); • Consider the fact that different categories of migrants may have specific needs, for example with regard to access to health promotion programmes (*determining needs)*; • Ensure that the most disadvantaged groups of migrants are included in the project target group and that the *cumulative effects* of the different factors are taken into account in determining the target groups (*identifying the target group*).
Implementation phase	• Remember the importance of the migrant network in getting close to the migrants (*reaching the target group*).
Participation and best use of resources	• Ensure that migrants are appropriately involved in all stages of the project; ; • Take account of the (human/social) resources of the migrants that can be an asset to the success of the project.
Method and working tools	• Ensure that method and working tools take the realities of the migrants' situation into account and respond to their needs.

3.3 An example of project practice sensitive to the realities of migration

The inclusion of the "migration" dimension calls for a systematic approach if one is to tackle the challenges this poses for projects. Below, in the form of questions, we list some of the aspects that might help you to make your project sensitive to the realities of migrants' lives. Here again, we follow the procedure used in the previous section, we mention the challenges to go with each phase of a project. Obviously, these are general questions and not ready-made solutions for all projects. It is important to take account of the particular situation of every project and its specific problems.

Table 4: Test questions for taking the migrants' situation into account

Phases	Challenges
Conceptual phase	
	• How does your project contribute to reducing the health inequalities linked to migration? • What elements of your project show that its philosophy is to achieve equity for migrants in the field of health promotion?
Planning phase	
Studying the starting situation and objective needs	• What are the indications of health differences between the migrant population and the reference group (e.g. Swiss population)?

	• What are the reasons for these differences? Are they due solely to the migration context (for example problems of access to the health system) or could other factors also play a role (e.g. biological)? • Have the results of studies, dealing with inequalities linked to the migration context, been considered?
Determining the subjective needs	• How do the subjective needs of the migrant group differ from those of the Swiss population? • If you have opted for a "subjective" approach to determine the needs, have you taken into account the points of view of key-persons, cultural mediators, migrant community representatives, and health professionals? • What have you done to allow for the fact that different categories of migrants may have different needs? • What particular characteristics explain the specific needs of the migrants?
Identifying the target group	• Does your project's target group represent the most disadvantaged section of the migrant population? • What indicators are used in your project to identify the most disadvantaged target group? • Is your target group affected by the *cumulative effects* of various factors on health (e.g. gender, migratory status, language knowledge)?
Implementation Phase	
Access to target group	• Can the migrant target group be considered as a group that is *difficult to reach*? • Have you made contact with migrant networks in order to reach this group?
Participation and best use of resources	*Participation :* • How much importance to you attach to involving the migrants in the running and setting up of the project? • In what way do migrants participate? What are the selection criteria? • Are the commitment and working conditions of the mediators (remuneration, for example) comparable to those of the project staff? • Do migrants participate at all phases of the project? If not, are the reasons for exclusion valid and acceptable? *Making optimal use of resources :* • What resources have you recorded among the migrants in your project? (collaborators and participants) • How do you plan to use them in your project? • Have you considered the problems attached to using the migrants' resources (e.g. the nature of the resources, additional work-load for the migrant collaborators if called on unexpectedly, etc.)?
Working methods and tools	• Do the needs of the migrants call for a different method? • How do the methods chosen for the target group as a whole make allowance for the specificities of the migrants?

- Does the budget include the cost of translation of documents, intercultural interpreters, etc.?
- Has the material and information been adapted to the needs of migrants?
- Do your instruments of evaluation take the specificities of the migrant groups into account?
- Have the methods used proved equally effective for the migrant target group as for the native group?

4 Conclusion

Basing ourselves on scientific findings and observations, we have argued the importance of taking the dimension of "migration" into account in health promotion projects and outlined certain practical procedures and lines to follow, without any claim to be exhaustive. Creativity and flexibility are therefore called upon, when applying this advice and adapting it to the specific features of a given context.

In general terms, we have shown that, in the context of migration, three types of factors can influence the health of migrant populations: socio-economic factors, "culture"* in terms of values and systems of reference, and the migration experience. While part of the migrant population constitutes a disadvantaged segment of the population because of its difficult living and working conditions, the migrant population as a whole is characterized by wide linguistic diversity and highly plural lifestyles and value and reference systems. They thus have very diverse perceptions of health and well-being. The experience of migration (reasons for migration, flight, difficulties in integrating, uncertainties about the future, the experience of exile, etc.) leaves a decisive mark on the lives of migrants, particularly on the lives of asylum seekers or refugees, and their families,.

Clearly, these are not the only factors, and other aspects such as age and gender also influence the health of migrants. From the point of view of health promotion, therefore, these factors are complementary and they all have to be taken into account at every stage.

Lastly, we would like to mention the importance for institutions, organizations, associations and projects, to be open to the migrant population. Meeting the specific needs of this population with regard to health promotion and prevention will require an effort of on the part of institutions, to adapt their methods and perceptions, to take account of the changing and variable context of the individuals involved. Such an approach could help the actors in the field of health promotion and prevention to reach their target populations and cope with their diversity, whether or not they have a migration background.

References

Migration and integration

Bovay, Claude (2005). *Le paysage religieux en Suisse*. Neuchâtel: Office fédéral de la statistique.

Lüdi, Georges and Iwar Werlen (2005). *Le paysage linguistique en Suisse.* Neuchâtel: Office fédéral de la statistique.

Mahnig, Hans (ed.) (2005). *Histoire de la politique de migration, d'asile et d'intégration en Suisse depuis 1948*. Zürich: Seismo.

Federal Statistical Office (FSO) (2005). *La population étrangère en Suisse*. Neuchâtel: Federal Statistical Office.

Federal Office for Migration (FOM) (2006). *Statistique des étrangers et de l'asile*. Bern : Federal Office for Migration.

Wicker, Hans-Rudolf, Rosita Fibbi and Werner Haug (éd.) (2003). *Les migrations et la Suisse : résultats du Programme national de recherche "Migrations et relations interculturelles"*. Zurich: Seismo.

Migration and health

Achermann, Christin et Chimienti Milena, in collaboration with Fabienne Stants (2006). *Migration, Prekarität und Gesundheit*. Neuchâtel: SFM.

Efionayi-Mäder D and Chimienti M (2003). „Migration und Gesundheit: eine sozialpolitische Orientierung". *Sozialalmanach 5*: 155-172.

Gentilini, M., G. Brücker and M. de Montvalon (1986). *La santé des migrants*. Paris: La Documentation française.

Kaya, Bülent, Martina Kamm and Alexis Gabadinho (2007). *Ressources du personnel migrant : quelle importance dans le domaine de la santé?* Neuchâtel: SFM.

Loutan L (2001). "The health of migrants and refugees". In: *Principles and practice of travel medicine*– ed by Zuckerman JN and Chichester J W 467-475.

Federal Office of Public Health (FOPH) (2001). Migration and public health – The Confederation's strategic orientation, 2002–2006. Berne : Federal Office of Public Health.

Federal Office of Public Health (FOPH) (2006). *Recherche Migration et santé. Recueil d'articles sur la recherche actuelle dans le domaine "Migration et santé"*. Bern: Federal Office of Public Health.
(http://www.bag.admin.ch/suchen/index.html?keywords=Sammelband&lang=fr).

Weiss, Regula (2003). *Macht Migration krank? : eine transdisziplinäre Analyse der Gesundheit von Migrantinnen und Migranten*. Zürich: Seismo.

Health of migrants

Alexis Gabadinho, Wanner Phlippe and Janine Dahinden (2007). *La santé des populations migrantes en Suisse : une analyse des données du GMM*. Neuchâtel: Swiss Forum for Migration and Population Studies.

Bouchardy, Christine, Philippe Wanner and Luc Raymond (2001). *La mortalité des étrangers en 1989-92*. Neuchâtel: OFS.

Federal Statistical Office (FSO) (2000). *Schweizerische Gesundheitsbefragung. Gesundheit und Gesund-heitsverhalten in der Schweiz 1997*. Neuchâtel: Federal Statistical Office (FSO).

Gubéran, Etienne and Massimo Usel (2000). *Mortalité prématurée et invalidité selon la profession et la classe sociale à Genève ; suivi de, Ecarts de mortalité entre classes sociales dans les pays développés*. Geneva: Office cantonal de l'inspection et des relations du travail, OCIRT.

Loutan, Louis and Claire-Lise Chaignat (1994). "Afflux de réfugiés en Suisse : quels problèmes de santé ?" *Revue suisse de médecine militaire et de catastrophes*, 71(4): 105-109.

Rommel, Alexander, Caren Weilandt and Josef Eckert (2006). *Gesundheitsmonitoring der schweizerischen Migrationsbevölkerung*. Bonn: WIAD (Wissenschaftliches Institut der Ärzte Deutschlands).

Tonnerre, Claude, Alexander N. Bischoff and Louis Loutan (1997). "Interprétariat en milieu médical : enquête dans les services de médecine interne en Suisse." *Journal suisse de médecine*, 127(Suppl. 88): 44.

Wanner, Philippe, Bouchardy Christine and Raymond Luc (1998). "Comportement des étrangers résidant en Suisse en matière d'alimentation, de consommation d'alcool et de tabac et de prévention". *Démos*, (2) : 3-20.

Social inequities and health

Bisig, Brigitte and Felix Gutzwiller (ed.) (2004). *Gesundheitswesen Schweiz: Gibt es Unter- oder Überversorgung? - Band 1: Gesamtübersicht Die Bedeutung von Sozialschicht, Wohnregion, Nationalität, Geschlecht und Versicherungsstatus*. Zürich/Chur: Verlag Rüegger.

Guilley, Edith (2005). *Longévité et santé. In: Ages et générations. La vie après 50 ans en Suisse*. Neuchâtel : Office fédéral de la statistique, 55-71.

Kickbusch, Ilona (2006). *Die Gesundheitsgesellschaft. Megatrends und deren Konsequenzen für Politik und Gesellschaft*. Gamburg: Verlag für Gesundheitsförderung.

Künzler, Gabriela and Carlo Knöpfel (2002). *Les pauvres vivent moins longtemps: couche sociale, mortalité et politique de l'âge de la retraite en Suisse*. Lucerne : Caritas Lucerne.

Lehmann, Philippe, Catherine Mamboury and Christoph E Minder (1990). "Health and social inequities in Switzerland." *Social science and medicine*, 31(3): 369-386.

Schopper, Doris (2002). *Les inégalités sociales de santé : du constat à l'action.* Genève : Direction générale de la santé, République et canton de Genève.

Vranjes, Nenad, Brigitte E Bisig and Felix Gutzwiller (1996). *Gesundheit der Ausländer in der Schweiz*. Liebefeld: Facheinheit Sucht und Aids, Bundesamt für Gesundheit.

Equal opportunity and health

Kaya, Bülent, in collaboration with Denise Efionayi (2005). *Egalité des chances en matière de santé : State of the Art.* Neuchâtel: SFM.

World Health Organization (1986). *Ottawa Charter for Health Promotion.* Copenhagen: World Health Organization. Regional Office for Europe. (http://www.euro.who.int)

Saladin, Peter (ed.) (2006). *Diversité et égalité des chances. Les fondements d'une action efficace dans le microcosme des institutions de santé.* Berne : OFSP, in collaboration with H+ Les Hôpitaux de Suisse. Free, order by E-mail: martina.zweiacker@hplus.ch or to download:

http://www.bag.admin.ch/shop/00038/00209/index.html?lang=fr

Whitehead, Margaret (1991). *The concepts and principles of equity and health.* Copenhagen: World Health Organization. Regional Office for Europe.

Glossary

Transcultural skills

Transcultural skills stand for the ability to identify individual lifestyles and conceptions in particular situations and in different settings, and to understand and react appropriately in order to adapt to these situations. (Saladin 2006: 26).

Culture

Culture is the whole body of aptitudes acquired by individuals in the course of their lives, giving them the ability to create intersubjective concepts and act sensibly. Culture is thus an ongoing process which has to be analyzed, and not a state.

Different types of residence permit

The site www.bfm.admin.ch/Thèmes/Etrangers/Séjour/Genres gives a list of the different types of permit and their characteristics.

Discrimination

The outcome of actions, whether deliberate or unintentional, which leads to inequalities between social groups, resulting in the rejection of some of them. It can be the result of intolerance and racism.

Diversity

Diversity stands for personal and societal differences, particularly those engendered by origin, sex, language, aptitudes, age, lifestyle and social situation, which have an impact on the development of the individual in society. Managing diversity aims at a positive attitude towards these differences to obtain action that will be of use to the society and the company, its users and its staff. (Saladin 2006).

Equity

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no-one should be disadvantaged from achieving this potential, if it can be avoided.” (World Health Organization, Regional Office for Europe, Whitehead, 1991).

In French, the concept of “égalité des chances” (equal opportunities) is largely equivalent to the notion of “equity in health”, the term which is widely used in the English-speaking world.

In English (and by analogy in French) a distinction is made between equality (the opposite of inequality) and equity (the opposite of inequity). In the field of health, inequity refers to health inequalities which are considered to be “unfair

and avoidable", which relates to the sphere of morality and ethics (cf. equity in health).

In Switzerland the term most commonly used is equal opportunities.

Empowerment

Strengthening people's capacity to act on their own initiative, to have greater control over their decisions and actions, and so to determine their own living conditions in ways, appropriate to good health. (http://www.quint-essenz.ch).

Equity in health

Equity means fairness. Equity in health means that people's needs, and no other factors, guide the distribution of services, benefits etc.

Implies that ideally everyone should have the opportunity to attain his or her full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. "Equity policies are therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible."

(http://www.bdsp.tm.fr/Glossaire/Default.asp).

Foreigner

A person who does not hold the nationality of the country in which he or she lives. A legal term designating the difference between nationals and those who are not. All foreign nationals who also hold Swiss citizenship (dual citizenship) are recorded in census statistics as Swiss. On the other hand, stateless persons or those whose citizenship has not been established are considered as foreigners.

Risk group

A group of persons exposed to known risk factors on account of their biological, social or economic status, their behaviours or their environment and who are more predisposed to certain events, such as the occurrence of illness, than the rest of the population. (http://www.bdsp.tm.fr/Glossaire/Default.asp).

Health literacy

Health literacy is generally described as "the social and cultural skills, based on scientific knowledge, for a healthy lifestyle".

Health literacy is also understood as the capacity to take decisions in different areas of daily life that will have a positive influence on health. It includes the capacity to find information on health, to understand it and use it appropriately in practice.

(http://www.gesundheitsfoerderung.ch/de/about/news/news_detail.asp?offset=15&id=197, and Kickbusch 2006).

Health inequalities

Term used in some countries to indicate major, systematic but avoidable differences in health. As the term is ambiguous, in that it can be used to describe injustices or to describe difference in purely mathematical or statistical terms, WHO opted to use the term “inequity” instead of “inequality” in the European version of “Health for All”. Differences in socio-economic status, opportunities, etc. between two or several persons or groups in a society, the place in which they live, the community to which they belong, and illness itself, may all be a cause of inequality.

(http://www.bdsp.tm.fr/Glossaire/Default.asp).

Integration

Integration aims at establishing equal opportunities to access social and economic resources and at encouraging mutual understanding between Swiss citizens and foreign nationals. In particular, the aim is to facilitate coexistence based on common values and behaviours, to inform persons of foreign origin about the functioning of Swiss institutions, legal prescriptions and living conditions and to create general conditions which will help to improve equality of opportunity and involvement in the life of the society. (Federal Office for Migration).

Inequity in health

Differences in the area of health, which that are not only unacceptable and avoidable, but are also seen as inequitable and unfair. The term thus has a moral and ethical dimension. (http://www.bdsp.tm.fr/Glossaire/Default.asp).

Interpreter

Interpreters are language professionals with a perfect command of their first language as well as of one or several foreign languages. They are trained in interpretation techniques, to transfer the message orally from the original to the target language (http://www.inter-pret.ch).

Community interpreter

Community interpreters are specialized in interpreting in a three-way situation, using oral translation to facilitate mutual understanding between persons of different linguistic origins. When interpreting, they take account of the socio-cultural context of the speakers. (http://www.inter-pret.ch).

Cultural mediators

Cultural mediators inform migrants and professionals in the public services, in terms they can understand, about cultural differences, the specific rules by which the Swiss political and social system function, and the different ways of behaving. As they inform them, the mediators build bridges between the

migrant population and the educational establishments or advisory services and so help to ensure understanding between doctor and patient, lawyer and client, teacher and parents. (Saladin 2006).

Migrant

Individual, born abroad, who migrates from one country to another.

Migration

The crossing of administrative, political or geographical borders, by individuals or groups, for the purpose of settling temporarily or permanently in a place other than their place of origin. (International Organization for Migration).

Migrant population, population having a migration background

These notions cover all persons born abroad and children, of whom at least of the parents were born abroad.

Resident foreign population

All foreign citizens resident in Switzerland for at least one year holding one of the following permits:

- long-term settlement
- residence
- short-term residence, when the stay is equal to or more than 12 months.

This does not include the permanent resident foreign population, persons covered by asylum, diplomats and international officials and their families. (Federal Office for Migration).

Racism

Racism is an ideology that reduces human beings to their nationality, their ethnic origin, their religion on the basis of real or imagined characteristics of a physical or cultural nature and which considers “others” as morally and intellectually inferior. (Federal Commission against Racism).

Multipliers

The term “multiplier” refers to the people on whom the professional intercultural mediators can call to transmit information to groups or contexts to which these people have easy access. (Federal Office of Public Health, strategy on “Migration and Health”, 2002-2006).

List of useful links and addresses

Commission fédérale des Étrangers CFE

eka-cfe@bfm.admin.ch

www.eka-cfe.ch

Contact Netz

info@contactmail.ch

www.contactnetz.ch

Croix-Rouge Suisse

www.redcross.ch

Dictionnaire des termes courants en milieu hospitalier, Hôpital cantonal de Saint-Gall, Departement Pflege

Commande sous : www.pflegedienst-kssg.ch

Forum suisse pour l'étude des migrations et de la population

Institut auprès de l'Université de Neuchâtel

secretariat.sfm@unine.ch

www.migration-population.ch

Forum pour l’intégration des migrantes et des migrants

info@fimm.ch

www.fimm.ch

Guide de santé pour la Suisse

Nouveau : deuxième édition révisée !

Commande sous : http://www.migesplus.ch/publikationen-fr.php?thema=26&pub=6

H+ Les Hôpitaux de Suisse

Secrétariat central

geschaeftsstelle@hplus.ch

www.hplus.ch

Ihre Rechte bei der Ärztin, beim Arzt und im Spital

Editeur : Volkswirtschafts- und Sanitätsdirektion, Canton Bâle-Campagne

Commande sous : www.migesplus.ch

Info maternité

Editeur : Travail.Suisse

Commande sous : www.migesplus.ch

International Centre for Migration and Health, Genève

www.icmh.ch

INTERPRET

Association suisse pour l'interprétariat communautaire et la médiation culturelle

www.inter-pret.ch

Je vais à l'hôpital !

Editeur : Association suisse L'enfant et l'hôpital

Commande sous : www.migesplus.ch

Manuel « Diversité et égalité des chances » (Saladin 2006)

http://www.bag.admin.ch/shop/00038/00209/index.html?lang=fr

Office fédéral des migrations ODM

info@bfm.admin.ch

www.bfm.admin.ch

Office fédéral de la santé publique OFSP

Section d' Egalité des chances

info@bag.admin.ch

www.bag.admin.ch

Plate-forme d'information sur la santé à l'intention des migrants

www.migesplus.ch

Promotion Santé Suisse et Quint-essenz

http://www.promotionsante.ch

http://www.quint-essenz.ch

Radix

Promotion de la santé

info-zh@radix.ch

www.radix.ch

Société pour les minorités en Suisse

infogms@gra.ch

www.gms-minderheiten.ch

Vidéo « Trialog » sur l'interprétariat communautaire en milieu hospitalier (avec une brochure)

Editeur : Interpret. Association suisse pour l'interprétariat communautaire et la médiation culturelle

Commande sous : www.inter-pret.ch

Appendix

The following tables, which are based on a selective literature research regarding "migration and health", present information and recommendations on the specific needs of the migrant population and targeted groups regarding the health promotion and prevention. Readers wishing to deepen their knowledge of one of the presented themes can consult the references listed after each table.

Tab. 1: Angepasste Präventions-/Gesundheitsförderungsinterventionen in Bezug auf bestimmte Gesundheitsstörungen bzw. Risikoverhaltensweisen

HIV/Aids
(vgl. (BAG) 2004 ; vgl. Achermann et al. 2005 ; Chimienti 2005 ; Dubois-Arber et al. 2001)

Zielgruppen	***Empfohlene Massnahmen***
• Personen mit **prekärem Aufenthaltsstatus,** speziell HIV-Risikogruppen wie Sexworkers oder MigrantInnen aus Subsahara-Afrika bzw. aus anderen Regionen mit erhöhter HIV-Prävalenz • **Risikogruppen** wie Sexworkers oder MigrantInnen aus Subsahara-Afrika bzw. aus anderen Regionen mit erhöhter HIV-Prävalenz ungeachtet ihres Aufenthaltsstatus	• Angepasste Präventionsinformationen über Kanäle verbreiten, die an die Lebensstile und Treffpunkte der betroffenen Personen angepasst sind • Der Austausch unter Personen in ähnlichen Situationen sollte in vertrauensvoller Umgebung ermöglicht werden • Menschen, die zuwandern und/oder Asyl suchen, müssen umfassend über HIV informiert und mit den Schutzmöglichkeiten und dem medizinischen Angebot vertraut gemacht werden • Community-basierte Voluntary Counselling and Testing – Programme werden als effektiver eingeschätzt als top-down – Programme

Tuberkulose
(vgl. BAG 2003a ; vgl. BAG 2003b ; Loutan 2001a ; Manzano et Suter 2002 ; Zellweger 2003)

Zielgruppen	***Empfohlene Massnahmen***
• Alle **Einreisenden des Asylbereichs**, insbesondere **Kinder** • **Illegal Eingereiste** • **Risikogruppen** aus Ländern mit erhöhter TB-Prävalenz	• Fortführung des angeordneten TB-Screenings von Personen des Asylbereichs ist sinnvoll • Sensibilisierung des in der Grundversorgung tätigen Gesundheitspersonals • Überwachung von Kindern ab dem Zeitpunkt ihrer Einreise • U.U. Anordnung präventiver Chemotherapie

Krankheiten, denen durch Impfung vorgebeugt werden kann
(vgl. Genton et al. 2003 ; Manzano et Suter 2002)

Zielgruppen	*Empfohlene Massnahmen*
• Personen mit **prekärem Aufenthaltsstatus**, insbesondere **Kinder**	• Bisherige Praxis weiterführen (Impfungen in den Erstaufnahmezentren, später vom zuständigen Personal in den Kantonen durchgeführt) • Kinder: Bei fehlender Dokumentation sollten nicht systematisch alle Impfungen durchgeführt, sondern zuvor mittels Blutprobe kontrolliert werden, ob schon Immunität vorhanden

Krebs (Gebärmutter/Brust bzw. Prostata)
(vgl. Rommel et al. 2006)

Zielgruppen	*Empfohlene Massnahmen*
• **Tamilinnen** und **Frauen des Asylbereichs** • **Männer** aus dem **ehemaligen Jugoslawien** und aus **Sri Lanka**	• Die geringen Vorsorgequoten (Gebärmutterhalsabstrich/Brustuntersuchung bzw. Prostatauntersuchung) legen in Bezug auf diese Gruppen einen besonderen Bedarf an Informations- und Aufklärungsarbeit nahe

Gewalterfahrungen
(vgl. Verwey 2002)

Zielgruppen	*Empfohlene Massnahmen*
• **Gewaltflüchtlinge**	• Erfolgversprechende Projekte wie das Angebot 'Gesundheitswerkstätten' für bosnische Kriegsflüchtlinge weiterverfolgen

Psychische Gesundheit
(vgl. Achermann et al. 2005)

Zielgruppen	*Empfohlene Massnahmen*
• Personen mit **prekärem Aufenthaltsstatus**	• Angepasste Präventionsinformationen über Kanäle verbreiten, die an die Lebensstile und Treffpunkte der betroffenen Personen angepasst sind

FGM
(vgl. Hohlfeld et al. 2005 ; Thierfelder 2003 ; UNICEF 2002)

Zielgruppen	*Empfohlene Massnahmen*
• MigrantInnen-Gemeinschaften **aus Ländern, wo FGM traditionell praktiziert wird** (insbesondere MigrantInnen aus Äthiopien, Eritrea,	• Gesundheitspersonal befähigen, Präventionsaufgaben wahrzunehmen: FGM in der Ausbildung von GynäkologInnen und Hebammen thematisieren • Netzwerkbildung und Erfahrungsaustausch sollte gefördert werden, sowohl zwischen betroffenen

Somalia)	Migrantinnen wie auch unter dem Gesundheitspersonal • Auf grosse (Universitäts-/Kantons-) Kliniken fokussierte Massnahmen können den grössten Teil der Betroffenen erreichen • Zielgruppenspezifische Informations- und Ausbildungsarbeit • Aufklärungsarbeit in Gemeinschaften aus Ländern, in denen Mädchenbeschneidung traditionell praktiziert wird • Verstärkte Zusammenarbeit der verschiedenen Akteure

Sexuelle und reproduktive Gesundheit
(vgl. Achermann et al. 2005 ; Bollini et Wanner 2005 ; Bongaarts et Greenhalgh 1985 ; Lüthi 2002 ; Wanner et al. 2002 ; Wolff et al. 2005)

Zielgruppen	***Empfohlene Massnahmen***
• Migrantinnen mit **prekärem Aufenthaltsstatus** • **Türkinnen** • Migrantinnen **herkunfts-spezifisch**	• Für illegal anwesende Migrantinnen Möglichkeiten der Verhütungsberatung, der Vornahme der Röteln-Impfung sowie der Gebärmutterhalskrebs-Abklärung schaffen • Information via bevorzugte Kontaktwege/-orte der Migrantinnen in einer dem Kenntnisstand der Frauen angepassten Art und Weise (in Bezug auf Frauen türkischer Herkunft eher mündlich und visuell, praktische Anleitung in Gruppen) • Information insbesondere zu Verhütung und zu den Abläufen im schweizerischen Gesundheitswesen • Aufbau/Weiterführung von auf bestimmte Gruppen von Migrantinnen ausgerichteten Angeboten der Geburtsvorbereitung und Säuglingspflege

Nikotinkonsum
(vgl. Bodenmann 2003)

Zielgruppen	***Empfohlene Massnahmen***
• **Herkunftspezifische** Zielgruppen	• Beratung und Prävention, die auf Migrationserfahrung, Gegebenheiten im Herkunftsland und im Aufnahmeland sowie auf Sprachkompetenzen des zu Beratenden/der Risikogruppe Rücksicht nimmt

Ernährungsverhalten
(vgl. Kruseman et al. 2005)

Zielgruppen	*Empfohlene Massnahmen*
• **Afrikanische** MigrantInnen	• Interventionen, um die MigrantInnen mit den lokalen Nahrungsangeboten besser vertraut zu machen

Risikoverhalten allgemein
(vgl. Bodenmann et al. 2005)

Zielgruppen	*Empfohlene Massnahmen*
• **Herkunftsspezifische** Zielgruppen	• Im Rahmen jeglicher Ausbildung im Präventionsbereich sollte das Verständnis der Einschätzung und Wahrnehmung von Gesundheitsrisiken durch autochthone und Migrationsbevölkerung vermittelt werden; zudem sollten die Auszubildenden mit Instrumenten vertraut gemacht werden, welche eine verbesserte Kommunikation der Risiken ermöglichen

Tab. 2 : Allgemein gesundheitsfördernde/präventive Interventionen in Bezug auf bestimmte MigrantInnengruppen

Allgemeine Gesundheitsförderungs-/Präventionsmassnahmen
(vgl. Aspasie 2002 ; Bahnan Büechi et Sieber 2004 ; Hunkeler et Müller 2004 ; Keel 2001 ; Loncarevic et Selva 2001 ; Lüthi 2002)

Zielgruppen	*Empfohlene Massnahmen*
• Personen mit **prekärem Aufenthaltsstatus**, insbesondere **Frauen** und **Sexworkers** • **Türkinnen** • MigrantInnen **am Arbeitsplatz**	• Für Frauen und Sexworkers mit prekärem Aufenthaltsstatus Beratungsstellen schaffen, wo sie zu HIV und anderen Krankheiten informiert werden bzw. ihre Kenntnisse reaktivieren können • Verschiedene Integrationsmassnahmen; Möglichkeiten schaffen, damit sich Frauen mit prekärem Aufenthaltsstatus ein Solidaritätsnetz aufbauen können, z.B. indem in Durchgangszentren ein Bezugspersonensystem aufgebaut wird • Bezüglich Frauen türkischer Herkunft: Information über Gesundheit und Gesundheitsförderung allgemein sowie über das schweizerische Gesundheitssystem, über Möglichkeiten und Grenzen einer Selbstbehandlung via bevorzugte Kontaktwege/-orte der Migrantinnen verbreiten, und dies in einer dem Kenntnisstand der Frauen angepassten Art und Weise (eher mündlich und visuell, praktische

	Anleitung in Gruppen) • Informations- und Präventionsprogramme auf spezifische Arbeitssituationen und Sprachkenntnisse der ArbeiterInnen zuschneiden • Grundsensibilisierung mittels Aus- und Weiterbildung: Kurse für Gesundheitspersonal, 'Gesundheitswegweiser' und Gesundheitskurse für MigrantInnen

Tab. 3 : Bedürfnisse bestimmter Zielgruppen

Niederschwellige Angebote zur medizinischen Versorgung
(Achermann et al. 2005 ; Bahnan Büechi et Sieber 2004 ; Bärtschi et Lutz 2003 ; Loutan 2001a ; Médecins sans frontières (MSF) 2002) Asylsuchende: (Etlin et Perritaz 2004 ; Loutan 2001b ; Médecins sans frontières (MSF) 2002 ; Schäublin et al. 2003)

Zielgruppen	***Erkenntnisse/Empfehlungen***
• Personen **mit prekärem Aufenthaltstatus**	• Frauen haben spezifische Bedürfnisse • Nachfrage nach bestehenden angepassten Versorgungsleistungen übersteigt das Angebot (eruiert für Genf) • Anregungen seitens der NutzerInnen zur Verbesserung der bestehenden Angebote • Bedürfnis nach Klarheit bezüglich der Frage der Kostenübernahme

Betreuung von Migrantinnen während der peri- und postnatalen Phase
(Bongaarts et Greenhalgh 1985)

Zielgruppen	***Erkenntnisse/Empfehlungen***
• **Migrantinnen während der peri- und postnatalen Phase**	• Angepasste Informationen zu Verhütungsfragen • Mehr/angepasste Information zu den Abläufen im schweizerischen Gesundheitssystem • Adäquatere medizinischer Versorgung • Mehr Respekt, verbesserte Wahrung der Intimsphäre; psychosoziale Bedürfnisse

Betreuung älterer MigrantInnen
(Hungerbühler 2004)

Zielgruppen	***Erkenntnisse/Empfehlungen***
• **Ältere** Migrantinnen	• U.U. spezifische Bedürfnisse hinsichtlich der Betreuung in Alterseinrichtungen • Angepasste Informationen zu Spitex-Dienstleistungen • U.U. Zusicherung einer rituell korrekten Bestattung

References used in the tables

(BAG), Bundesamt für Gesundheit (2004). *Strategie Migration und Gesundheit: Analyse von MigrantInnennetzwerken. Entwurf Schlussbericht. Studie durchgeführt von INFRAS.* . Bern: Unveröffentliches internes Arbeitspapier.

Achermann, Christin, Milena Chimienti et Fabienne Stants (2005). *Migration, Prekarität und Gesundheit. Ressourcen und Risiken von vorläufig Aufgenommenen und Sans-Papiers in Genf und Zürich*. Neuchâtel: SFM.

Aspasie (2002). *Aspasie, 20 ans : rapport d'activités 2001*. Genève: Aspasie.

BAG (2003a). *Handbuch Tuberkulose*. Bern: Bundesamt für Gesundheit (BAG).

BAG (2003b). *Technische Weisung betreffend grenzsanitarische Untersuchungen und Massnahmen bei Personen des Asylbereiches*. Bern: Bundesamt für Gesundheit (BAG).

Bahnan Büechi, Rania et Christine Sieber (2004). "Frauen Sans-Papiers : Recht auf Gesundheit", dans Departement Migration, Schweizerisches Rotes Kreuz (SRK) (éd.), *Migration - eine Herausforderung für Gesundheit und Gesundheitswesen*. Zürich: Seismo, p. 139-149.

Bärtschi, Franziska et Monica Lutz (2003). *"[...] sie nehmen Risiko auf sich und hoffen, dass nichts passiert." : illegalisierte Migrantinnen und ihre Zugänge zu medizinischen Angeboten : theoretische und empirische Betrachtungen*. Bern: [s.n.].

Bodenmann, Patrick (2003). "La migration est-elle un facteur de risque du tabagisme ?" *Médecine et Hygiène*, (2452): 1870-1873.

Bodenmann, Patrick et al. (2005). *Perception du risque pour la santé liée à la consommation excessive d'alcool, au tabagisme et aux comportements sexuels à risque chez les migrants et les autochtones: necessité d'une prévention différente?* Lausanne: Policlinique médicale universitaire.

Bollini, Paola et Philippe Wanner (2005). *Santé reproductive des collectivités migrantes. Disparités de risques et possibilités d'intervention*: forMed/SFM.

Bongaarts, John et Susan Greenhalgh (1985). "An Alternative to the One-Child Policy in China." *Population and Development Review*, 11(4): 585-617.

Chimienti, Milena (2005). "Inclusion - exclusion : le VIH/sida face à d'autres maladies chroniques : (...)", dans *Solidarité et droits sociaux : réflexions partant de la question du VIH/sida Sandro Cattacin... [et al.] (Hg.). - Zürich : Schweizerische Gesellschaft für Gesundheitspolitik SGGP, cop. 2005. - P. 51-134*.

Dubois-Arber, Françoise et al. (2001). "HIV/AIDS-Prävention in der Schweiz : Bilanz und Ausblick." *Schweizerisches Medizin-Forum*, (24): 621-625.

Etlin, Melchior et Monique Perritaz (2004). "Centres de santé pour les requérants d'asile", dans Departement Migration, Schweizerisches Rotes Kreuz (SRK) (éd.), *Migration - eine Herausforderung für Gesundheit und Gesundheitswesen*. Zürich: Seismo, p. 150-156.

Genton, Blaise, Valérie D'Acremont et Daniel Desgrandchamps (2003). "Vaccination chez les migrants." *Médecine et Hygiène*, (2455): 2045-2048.

Hohlfeld, Patrick, Clara Thierfelder et Fabienne Jäger (2005). "Patientinnen mit genitaler Beschneidung : schweizerische Empfehlungen für Ärztinnen und Ärzte, Hebammen und Pflegefachkräfte." *Schweizerische Ärztezeitung*, 86(16): 951-960.

Hungerbühler, Hildegard (2004). "Altern in der Migration : Folgen der Lebens- und Arbeitsbiographie", dans Departement Migration, Schweizerisches Rotes Kreuz (SRK) (éd.), *Migration - eine Herausforderung für Gesundheit und Gesundheitswesen*. Zürich: Seismo, p. 221-242.

Hunkeler, Brigitte et Eva Müller (2004). *Aufenthaltsstatus und Gesundheit. Eine ressourcenorientierte qualitative Untersuchung zur Unsicherheit des Aufenthaltsstatus im Zusammenhang mit der psychosozialen Gesundheit bei Migrantinnen in der Stadt Zürich*. Psychologisches Institut, Sozial- und Gesundheitspsychologie. Zürich: Universität Zürich.

Keel, P. (2001). "Low Back Pain and Foreign Workers: Does Culture Play an Important Role?" dans Yilmaz, A. Tarik, Mitchell G. Weiss et Anita Riecher-Rössler (éd.), *Cultural Psychiatry: Euro-International Perspectives*. Basel Karger.

Kruseman, Maaike et al. (2005). "Post-migration dietary changes among African refugees in Geneva: a rapid assessment study to inform nutritional interventions." *Sozial- und Präventivmedizin = Médecine sociale et préventive*, (3 UR - http://www.springerlink.com/app/home/contribution.asp?wasp=158583983c1743f39ce75f2a90796a5a&referrer=parent&backto=issue,7,13;journal,1,20;linkingpublicationresults,1:109374,1): 161-165.

Loncarevic, Maja et Gabriella Selva (2001). *Vom interkulturellen Zusammenleben im Spital : ein Pilotprojekt des Schweizerischen Roten Kreuzes und des Kinderspitals Zürich*. Bern: Schweizerisches Rotes Kreuz, Departement Migration.

Loutan, Louis (2001a). "The health of migrants and refugees", dans *Principles and practice of travel medicine ed. by Jane N. Zuckerman. - Chichester : J. Wiley, 2001. - P. 467-475.*

Loutan, Louis (éd.) (2001b). *Policlinique de médecine : autoportraits : patients - soignants - citoyens, les chemins de la santé*. [Genève]: HUG, Hôpitaux universitaires de Genève.

Lüthi, Silvia (2002). *Wie sehen türkische Frauen das schweizerische Gesundheitssystem ?* [S.l.]: [s.n.].

Manzano, S. et S. Suter (2002). "La santé des enfants requérants d'asile à Genève." *Médecine et Hygiène*, (2379): 360-362.

Médecins sans frontières (MSF) (2002). *Accès aux soins des personnes en marge du système de santé : Genève-Lausanne*. Genève: Médecins sans frontières.

Rommel, Alexander, Caren Weilandt et Josef Eckert (2006). *Gesundheitsmonitoring der schweizerischen Migrationsbevölkerung*. Bonn: WIAD (Wissenschaftliches Institut der Ärzte Deutschlands).

Schäublin, Rodolphe, Alain Pécoud et Patrick Bodenmann (2003). "Prise en charge médico-sanitaire des requérants d'asile dans le canton de Vaud." *Médecine et Hygiène*, (2455): 2016-2018, 2021-2022.

Thierfelder, Clara (2003). *Female genital mutilation and the Swiss health care system*. Basel: Schweizerisches Tropeninstitut.

UNICEF (2002). *Trafficking in human beings in Southeastern Europe : current situation and responses to trafficking in human beings (...)*. Belgrade [etc.]: UNICEF, Area Office for the Balkans [etc.].

Verwey, Martine (2002). ""...das ist keine Gesundheit!" : psychosozial orientierte Gesundheitswerkstätten mit traumatisierten Flüchtlingen." *Bulletin Medicus Mundi Schweiz*, (86).

Wanner, Philippe et al. (2002). *Familien und Migration : Beiträge zur Lage der Migrationsfamilien und Empfehlungen der Eidgenössischen Koordinationskommission für Familienfragen*. Bern: BBL, Vertrieb Publikationen.

Wolff, Hans et al. (2005). "Health care and illegality : a survey of undocumented pregnant immigrants in Geneva." *Social science and medicine*, 60: 2149-2154.

Zellweger, Jean-Pierre (2003). "Tuberkulose bei Immigranten: Erkennung und Behandlung." *Schweizerisches Medizin-Forum*, (24 11): 556-558.