The Health Dimension of Southeast Asian Migration to Europe

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1. BACKGROUND AND CONTEXT

1.1 Demographic Developments in Europe

- Fertility rates are declining and family sizes are shrinking
  - TFR is less than 2
  - Growth rate is slowing down (0.20% in 2005-2010 projected to -0.19% by 2050)
  - Ageing of the population is accelerating (life expectancy of 75.4 years in 2005-2010 will increase to 81.7 years by 2050)
  - As a region, Europe in 2010 had the highest percentage of population 65 years and over (16.2%)
  - Size of this group will double in 2050
1.2 Implications

- a shrinking workforce can reduce productivity
- rising proportion of elderly threatens solvency of pension and social insurance schemes
- as household size decreases, family’s ability to care for the elderly declines
- changing patterns of illnesses with predisposition to chronicity and disability will involve major shifts in health policy and programme priorities
1.3 Immigration was seen as a solution to the imminent problem.

Perceived Benefits

- Provides an opportunity for governments to rise to the challenges of the demographic phenomenon
- Counteracts ageing of the population
- Fosters economic growth by providing the labour force requirements for an industrializing economy
- Enhances socio-cultural enrichment in the region
2. ASIAN MIGRATION TO EUROPE

Figure 1. Percentage of Asian Migrants to Europe by Country of Origin, 2009

Source: IOM LINET elaboration of Eurostat data, 2011
Majority of migrants from Asia are concentrated in three countries – Italy, Germany and Spain – which together attract around 80 percent of the total. Eighty percent are of working ages (15-64 years old). The migrants present almost equal sex distribution, but a closer look by country of origin indicates high shares of females among those coming from Thailand, Indonesia and the Philippines.
Figure 2. Registered Chinese and Filipino Immigrants, Spain, 2000-2009

Source: Observatorio Permanente De La Inmigracion, 2010. Annuario Estadistico De Inmigracion 2010
Figure 3. Registered Chinese and Filipino Immigrants, Italy, 2005-2009

Note: Chinese citizens both from China and Hongkong
Source: Eurostat, 2010
3. ISSUES IN THE STUDY OF MIGRATION AND HEALTH

• Importance of data and research in the field of migration and health to develop evidence-based policies and programmes.

• Many data sources, national and regional, as well as published articles are available but they have not been compiled, consolidated, and systematically analyzed for meaningful policy and programme inputs.

• Interest in migrants’ health stems from the assumption that they come from countries with high rates of infectious and communicable diseases with potential transmission to the host population.

• In the country of destination, predisposing factors to illnesses are related to living and housing conditions, lifestyle and dietary changes and attitude to medical care.
• The health picture and epidemiological patterns brought by migration are directly related to two basic factors: the difference in morbidity situation between the places of origin and destination, and the demographic composition of the migrant population.

• Health status and outcomes are influenced by other factors such as:
  ▫ duration of stay in the host country;
  ▫ changes in social and economic situation;
  ▫ access to and acceptability of health services;
  ▫ degree of integration in mainstream society; and
  ▫ cultural practices at the preventive and curative levels.
4. THE RESEARCH

4.1 General and Specific Objectives

The general objective of the research was to arrive at meaningful recommendations for the incorporation of Asian (Filipino and Chinese) migrants’ health concerns in public health policies and programmes in Europe primarily Madrid and Milan.
The specific objectives were to:

1. draw the health picture of migrants in terms of morbidity patterns, predisposing factors, health-seeking behaviour, health services utilization pattern and attitude toward health services including providers;

2. assess the decentralized health policies in these areas and their implementation on the extent in which the expressed health needs of migrants are addressed. The perspectives of providers on the current health programmes and delivery of services were elicited;

3. identify the barriers and facilitating factors in access to and utilization of health services by migrants;
4. posit recommendations based on the health system analysis, the perspectives of migrants, health providers and key informants, and related literature for a viable inclusive health policy and programmes; and

5. determine the prospects of Southeast Asia and Europe cooperation in the planning and programming of migrants’ health in Europe and addressing emerging health problems in both regions.
4.2 Conceptual Framework and Analytical Plan

Figure 4. Conceptual Model of Research
Figure 5. Analytical Plan

EU Parliaments’ Position on Migrants’ Rights to Health

Series of Regional Consultations on Programmatic Concerns Regarding Migrants’ Health

Regional Prescriptions in Addressing Migrants’ Health (WHO/EC)

Translation within National and Decentralized Health Programmes

Operationalisation of Plans at Health Service Delivery Levels

Informants: Service Providers

Perceptions
- Problems Presented by Clients
- Communication and Interaction with Clients
- Concerns in Health Service Delivery

Informants: Clients (Migrants)

- Health Problems and Causation
- Home Management
- Current Health Services Utilisation Pattern
- Perception of Health Services Provision
- Problems in Access to and Utilisation of Services

Recommendations for Health System Responsiveness to Migrants’ Needs (Modifications in Policies, Programmes and Provisions)

Host Regional/Country Strategies and Priorities

Prospects for Asia-Europe Cooperation
- Programmatic (Sharing of information and technical know-how)
- Competence Building (technical and cultural)
- Research
Figure 6. Mortality Trends from Communicable Diseases, Malignant Neoplasm and Diseases of the Heart, Philippines, 1955-2005

Source: Department of Health-National Epidemiology Center (DOH-NEC), 2006. The 2006 Philippine Health Statistics
### Table 1. Ten Leading Causes of Morbidity, Number of Cases and Morbidity Rate, Philippines, 2008

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Number of cases</th>
<th>Morbidity rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute upper respiratory infection (cough, colds)</td>
<td>1,647,178</td>
<td>1840.6</td>
</tr>
<tr>
<td>2. Acute lower respiratory tract infection (pneumonia)</td>
<td>780,199</td>
<td>871.8</td>
</tr>
<tr>
<td>3. Bronchitis/Bronchiolitis</td>
<td>519,821</td>
<td>580.8</td>
</tr>
<tr>
<td>4. Hypertension</td>
<td>499,184</td>
<td>557.8</td>
</tr>
<tr>
<td>5. Acute watery diarrhoea</td>
<td>434,445</td>
<td>485.4</td>
</tr>
<tr>
<td>6. Influenza</td>
<td>362,304</td>
<td>404.8</td>
</tr>
<tr>
<td>7. TB, respiratory</td>
<td>96,497</td>
<td>107.8</td>
</tr>
<tr>
<td>8. Acute febrile illness</td>
<td>35,381</td>
<td>39.5</td>
</tr>
<tr>
<td>9. Diseases of the heart (myocardial infarction, angina pectoris)</td>
<td>32,541</td>
<td>36.4</td>
</tr>
<tr>
<td>10. Chickenpox</td>
<td>25,677</td>
<td>28.7</td>
</tr>
</tbody>
</table>

Figure 7. Prevalence and Incidence Rates of Tuberculosis (Per 100,000 population), Philippines, 2000 and 2009

Table 2. Two-week Morbidity Rate Per 1,000 Population by Major Disease, China, 2008

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease</th>
<th>Morbidity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypertension</td>
<td>31.4</td>
</tr>
<tr>
<td>2</td>
<td>Acute Upper Respiratory Infections (cold and coughs)</td>
<td>18.2</td>
</tr>
<tr>
<td>3</td>
<td>Acute Nasopharyngitis</td>
<td>15.4</td>
</tr>
<tr>
<td>4</td>
<td>Gastroenteritis</td>
<td>13.6</td>
</tr>
<tr>
<td>5</td>
<td>Rheumatoid Arthritis</td>
<td>7.6</td>
</tr>
<tr>
<td>6</td>
<td>Intervertebral Disc Disorders</td>
<td>6.8</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes Mellitus</td>
<td>6.0</td>
</tr>
<tr>
<td>8</td>
<td>Cerebrovascular Disease</td>
<td>5.8</td>
</tr>
<tr>
<td>9</td>
<td>Influenza</td>
<td>4.4</td>
</tr>
<tr>
<td>10</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>4.1</td>
</tr>
</tbody>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Diseases of the circulatory system (ischemic heart disease,</td>
<td>Neuropsychiatric conditions (unipolar depressive disorders,</td>
<td>Hypertension</td>
<td>Acute upper respiratory tract</td>
</tr>
<tr>
<td></td>
<td>cerebrovascular)</td>
<td>cerebrovascular)</td>
<td></td>
<td>infections (cough and colds)</td>
</tr>
<tr>
<td>2</td>
<td>Complications of pregnancy, childbirth and postpartum</td>
<td>Malignant neoplasms (lung, colon, and breast cancer)</td>
<td>Acute upper respiratory</td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>infections (colds and cough)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Diseases of the digestive system (liver diseases, enteritis</td>
<td>Cardiovascular diseases (ischaemic heart disease,</td>
<td>Acute nasopharyngitis</td>
<td>Bronchitis/Bronchiolitis</td>
</tr>
<tr>
<td></td>
<td>and colitis)</td>
<td>cerebrovascular disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Diseases of the respiratory system (pneumoconiosis causes</td>
<td>Sense organ diseases (degenerative hearing loss, eye problems)</td>
<td>Gastroenteritis</td>
<td>Hypertension</td>
</tr>
<tr>
<td></td>
<td>by external agents and acute respiratory infections like</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>bronchitis and bronchiolitis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Neoplasms (malignant)</td>
<td>Unintentional injuries (road traffic accidents, falls)</td>
<td>Rheumatoid arthritis</td>
<td>Acute watery diarrhoea</td>
</tr>
<tr>
<td>6</td>
<td>Injury and poisoning</td>
<td>Respiratory diseases (COPD, asthma)</td>
<td>Intervertebral disc disorders</td>
<td>Influenza</td>
</tr>
<tr>
<td>7</td>
<td>Diseases of the musculoskeletal system and connective tissues (arthropathies and related disorders)</td>
<td>Musculoskeletal diseases (rheumatoid arthritis, osteoarthritis)</td>
<td>Diabetes mellitus</td>
<td>TB respiratory</td>
</tr>
<tr>
<td>8</td>
<td>Diseases of the genitourinary (urinary calculus, nephritis)</td>
<td>Diabetes mellitus</td>
<td>Cerebrovascular disease</td>
<td>Acute febrile illness</td>
</tr>
<tr>
<td>9</td>
<td>Other ill-defined signs and symptoms</td>
<td>Digestive diseases (liver cirrhosis, peptic ulcer disease)</td>
<td>Influenza</td>
<td>Diseases of the heart (myocardial infarction, angina pectoris)</td>
</tr>
<tr>
<td>10</td>
<td>Other forms of heart disease (heart failure, conduction</td>
<td>Intentional/ Self-inflicted injuries</td>
<td>COPD</td>
<td>Chickenpox</td>
</tr>
</tbody>
</table>

Sources: Instituto Nacional de Estadística (INE), 2012. Hospital Morbidity Survey 2010
NBSC, 2011
Figure 8. Percentage of Population Using Traditional Medicine, Selected Countries, Western Pacific Region, 1990s

Western Pacific Region

With the adoption of Health for All and Primary Health Care Approach, WHO Regional Committee for the Western Pacific adopted a resolution on traditional medicine in September 2001. The Regional Strategy for Traditional Medicine (TM) in the Western Pacific puts it officially into the health service system.

There were seven objectives related to TM for the period 2001-2010:

• develop a national policy for traditional medicine;
• promote public awareness of and access to traditional medicine;
• establish appropriate standards for traditional medicine prescription;
• encourage and strengthen research into evidence-based practice of traditional medicine; and
• foster respect for the cultural integrity of traditional medicine.
China

- The Chinese health care system is officially committed to the provision of both Chinese and Western medicine.
- The integration of the two medical systems is written in the Chinese health policy. Traditional Chinese Medicine (TCM) and Western medicine are practiced alongside each other at all levels of care.
- Public and private national, provincial, regional, district, community, and military hospitals are involved in the delivery of Western and Chinese medicine.
Philippines

In 1997, the Traditional and Alternative Medicine Act created the Philippine Institute of Traditional and Alternative Health Care under the Department of Health. Its objectives were to:

a) encourage scientific research to develop traditional and alternative health care systems with direct impact on public health;

b) promote and advocate the use of traditional, alternative, preventive and curative health care modalities that have been proven safe, effective, cost effective and consistent with government standards on medical practice;
Summary of Recommendations of International Conferences on Migrants’ Health in Europe

A. Incorporation of Social Provisions in Service Delivery
   1. Increased accessibility to culturally sensitive health services
   2. Involvement of migrant communities in health promotion, programme planning and delivery
   3. Availability of high quality translation and interpretation services

B. Enhancement of Providers’ Competence
   1. Appropriate training of health professionals in dealing with migrants’ health issues
   2. Cultural and linguistic competence as well as communication skills and should be built into the curriculum of medical and nursing schools
3. Providers’ cultural and gender sensitivity to migrants’ health issues should be raised
4. Social and psychological support should be provided to clients

C. Monitoring and Surveillance

1. Routine surveillance on health of migrants (from clinic reports)
2. Evaluation of migrant oriented programmes for possible replication and sustainability
3. Development of regional and national assessment mechanism on migrants’ health and their access to services
4. Surveillance should be compatible with international requirements
D. Coordination and Cooperation between Sending and Receiving Countries

1. Shared sending-receiving country policies since migrants’ health is a joint responsibility
2. Promotion of bilateral and multilateral cooperation among sending and receiving countries in disease surveillance, monitoring and reporting
3. Strengthening health systems in developing countries to address potential threats to receiving countries as well as confront challenges of NCDs
4. Promotion of migrants’ health in the health agenda of international organizations
5. Exchange of information, education, and training materials, as well as good practices related to population’s health
6. Involvement of non-EU countries in EU funded projects (services, research, evaluation)
Issues

a) lack of adequate or published database that is regionally, nationally and sex disaggregated among migrants on illness patterns; health services utilization including clinic consultations, levels of satisfaction with services, expressed needs; and programmatic assessment on adequacy and appropriateness of clinic services;
b) inability of current health care systems to provide services that respond to specific needs of migrants due to the cultural divide, language problems and work load of providers among others; and

c) inadequate implementation, monitoring and evaluation of initiatives due to absence of standardized mechanisms for retrieval, appropriate indicators, and reporting systems.
5. MIGRANTS’ MORBIDITY PATTERNS, HEALTH-SEEKING BEHAVIOURS AND ATTITUDE TOWARD THE HEALTH SYSTEM

5.1 Health of Migrants in Spain (from Literature Review)

- Many of the industries have significant occupational hazards including exposure to chemicals; physical exertion from manual labour; heavy lifting; and mental health problems due to isolation and loneliness.
- Ischemic heart problems and cerebrovascular diseases show higher prevalence rates among migrants.
- Incidence of hypertension, obesity, diabetes, smoking, and alcoholism has been increasing among migrants.
• Cancer incidence rate may not be higher than the native populations but the illness tends to be diagnosed at a later stage among migrants.
• Preventive programs are important but few health promotion programs are adapted to migrants’ cultural and social backgrounds.
• Higher numbers of work-related problems and injuries are reported among migrant workers such as musculoskeletal disorders, chronic respiratory infections, and accidents.
Comprehension problems exacerbate their health risks (e.g. inability to read health warnings, misunderstanding of safety instructions, and lack of awareness of occupational risks).

Common mental health disorders are depression and anxiety which affect their functioning and are not reported since these may jeopardize their work prospects.
5.1.1 Infectious Diseases

- The concern that migrants bring infectious and communicable diseases to the majority of the population of the receiving countries has been raised in many regional dialogues.
- However, the risk of transmission of these illnesses from migrants to the receiving countries seems small. Twenty-two percent of new cases of TB in 2008 involved migrants, mostly from Asia or Africa.
- Tuberculosis is an important problem. Latent tuberculosis infection rates of 52 to 72 percent and active infection rates of 7.8 percent have been reported among migrants.
• It is the most relevant infectious disease in immigrants. Most cases are reactivated in the first five years after arrival. Thus, they have to be actively screened for both latent and active tuberculosis. (Department of Statistics of the City Council of Madrid in Lopez-Velez, et. al, 2003)

• Early treatment is necessary. It is delayed because many migrants tend to hide their condition and do not access the health care services until the illness worsens.
5.2 Factors Affecting Health Services’ Utilization

A. Health Beliefs and Health-seeking Behaviour

- The knowledge of migrants regarding the nature and causation of their problems as well as health management affect their health-seeking behaviour. Problems may be due to their inadequate “health literacy” related to causation, symptoms and management of illness.
• Another factor is the variance in the recognition of the health problem and its management between the migrants and health services providers. The resultant divergence leads to a mismatch in actual and expected treatment with the labelling by migrants of “providers’ incompetence”.

• For migrant groups with specific health beliefs and health-seeking behaviour, health promotion through education is needed. However, it would unlikely be taken seriously unless deemed acceptable.
B. Lack of Knowledge of the Health System

• Another barrier in accessing health services is lack of knowledge of the health system, the services it provides and the means of its access (e.g., obtaining a health card).
• Migrants bewail the tedious bureaucratic process to obtain a health card.
C. Communication Problems

- Language barrier is the most serious obstacle to quality health service provision.
- Colloquial knowledge of the Spanish language may not be sufficient to address their health needs. What the migrant conveys may not be well understood by the provider and vice versa.
• Cultural mediators need to translate not only the words (verbatim) but the meaning and the context of the statements to both the clients and the health providers.
• To do this, considerable knowledge of the patient’s socio-cultural and health context is necessary.
• Brochures, folders, and posters are distributed in migrants’ languages to reach potential users. However, their viability and effectiveness have not been assessed in terms of comprehension and behaviour modification.
D. Fear of Discrimination

• Some migrants are reluctant to utilize the health services due to fear of discrimination by the community and health services regarding illnesses including TB, HIV/AIDS and mental conditions.

• Mental problems such as depression and anxiety can be stigmatizing in migrant communities.

• Many migrant clients do not know that confidentiality of medical interactions is ensured by the law.
E. Employment Constraints

- Problems related to consultation arise when migrants encounter difficulties in taking time off work to visit provider during the clinic hours. This is particularly true for domestic and restaurant workers.
- The situation is aggravated by long waiting time in clinics.
- Residence and workplace in relation to the clinic may cause inconvenience since travel is time-consuming and consultation hours detract from their income generation which is based on hourly inputs (e.g. domestic work).
F. Socio-cultural Issues

• Differences in mindsets between providers and patients can cause problems when illness and its management are explained by providers from the biomedical perspective. The patient may regard this as incomprehensible. Besides, they have their own expectations in health service provision.

• Due to medical pluralism, the tendency to seek remedies from traditional systems delays timely consultation constraining appropriate diagnosis and management.

• Health practices adopted by migrants before they came are carried over to the destination country. Thus, public health consultations are made when these are not able to remedy the problem.
Sequelae of Employment

A. Health Effects

• Those whose responsibilities include cleaning (domestic workers) mentioned of products that they felt were hazardous (detergents, bleach).
• Acute physical reactions are mostly dermatologic and respiratory in nature such as eye and throat irritation, difficulty in breathing, suffocation, and burns.
• The physical nature of household work could be exhausting. Generalized musculoskeletal pain occurs from the work itself and the need to travel between houses if they work in more than one adds to the fatigue.
Those whose main tasks involve household work complained of physical strains associated with repetitive and speedy motions in scrubbing, ironing, and mopping; and back pain from pushing furniture and cleaning windows or doors.

Women whose work involve the care of persons with limited mobility including the elderly reported physical problems and potential injury in assisting the elderly to bathe, dress, and move about the house.
• Elderly care is an activity for which they have no formal training.
• Some of the women cleaners and carers were prescribed pain relievers but felt that these medicines were of limited efficacy.
• The amount of work and the time they have to complete the tasks are stressors. They are assigned more work than they are able to manage at a reasonable pace.
• Cooks and restaurant workers are in the same predicament as they work long hours in the kitchen cooking and carrying food to clients.
B. Psychosocial Effects

• Caregivers suffer from psychological and emotional demands by the elderly.
• They encounter problems in organizing their tasks because they are given multiple responsibilities. They have little control over their working time.
• Boredom is related to workplace isolation. They work alone, with few people to talk to or interact with.
5.3 Health Seeking Behavioural Patterns

Preference for Emergency Care

- *Patient pathways* provide the process in which patients can seek medical care. Often, they walk into hospital emergency wards or primary health care emergency centres due to less waiting time than the health centre.

- A review of data from Spanish National Health Surveys, and findings from various studies showed that immigrants visit general practitioners and specialists at a lesser frequency than the native-born population, and tend to stay in hospitals for less number of days.
• They use emergency services at a higher rate than the Spanish population. High emergency services utilization suggests that emergency room is used as a substitute for the primary health care clinic. This is possibly due to inability to take time off from work during the day to see a general practitioner, not considering that the health condition may be serious enough to see a general practitioner.
The exposure of immigrants to risky activities may also provide the explanation for the use of the emergency services. Emergency care is legally available to all immigrants regardless of registration in their municipality; whereas to access other avenues of care, registration with the municipality is required.
FINDINGS OF THE ASEF RESEARCH: ILLNESS PATTERNS, HEALTH SERVICES UTILIZATION AND BELIEF SYSTEMS
The Chinese and Filipino Experience

A. The Chinese

- Illnesses encountered in the previous year by the Chinese included respiratory tract infection, fever, diabetes, diarrhoea, kidney problems, pneumonia, and hypertension.

- Appropriate treatment according to the respondents’ problems was provided by the health care system. Most initially subscribe to the Chinese health system before approaching a health service delivery point in the city. They take Chinese medicines which are readily available or are brought from their home visits to China.
• They are basically aware of the causes, manifestations of illnesses mainly from the Chinese viewpoint.
• Herbals are taken and acupuncture is resorted to prior to seeking Western-based care.
• It seems that a Chinese therapeutic system is informally in place in the country (herbal outlets, healers, etc.) and it is substantively utilized.
• The key informants suggested the assessment of the current Chinese health system that serves as the basis for Chinese migrants’ health-seeking behaviour.
• On the utilization of government health services, the problems encountered were: long waiting time, bureaucracy, including tedious paperwork in getting a health card, and language (communication) barriers.

• However, they did not see problems in terms of technical competence of provider, adequacy of facilities and availability/affordability of western drugs.
<table>
<thead>
<tr>
<th>Diseases</th>
<th>Causes</th>
<th>Management</th>
</tr>
</thead>
</table>
| Wind-injury (common colds), Fever, Flu | • Climatic pathogenic changes such as strong exogenous wind, the Wind-Cold (causing nasal congestion and chills); Wind-Heat (causing fever and sore throat), and Summer Heat factors; dampness, and dryness  
  • Exposure to rain and cold  
  • Weakening of body resistance due to deficiency of Qi  
  • Differences in body’s constitution: for instance, Wind-Cold factor can cause illness to a person with Yang deficiency  
  • Transmission through contact or droplets | • Cong Chi Tang/Green Onion and Soybean Decoction; Jing Fang Bai Du  
  San/Schizonepeta-Saposhnikovia Detoxifying Powder (for wind-cold injury)  
  • Yin Qiao San/Lonicera and Forsythia Powder; Sang Ju Yin/Mulberry and Chrysathemum Drink (for wind-heat injury) | • Lung Meridian of Hand-Taiyin, the Large Intestine Meridian of Hand-Yangming and the Bladder Meridian of Foot-Taiyang (wind-cold injury)  
  • Small Intestine Meridian of Hand-Taiyang, the large Intestine Meridian of Hand-Yangming and the Sangjiao Meridian of hand Shaoyang (wind-heat injury) |

It will be noted that there is recognition of western sources of the problem e.g., contact or droplet infection, inappropriate diet, inhaled fumes, etc. These were validated with Chinese traditional practitioners.
<table>
<thead>
<tr>
<th>Diseases</th>
<th>Causes</th>
<th>Management</th>
</tr>
</thead>
</table>
| Cough | • Exogenous pathogenic source commonly Wind attack with Cold, Heat, and Dryness affecting the lungs  
• Internal injury due to overstimulation; intemperate diet with excessive spices, fats, alcohol, or smoking; fatigue; impaired function of the spleen causing turbid phlegm in the lungs  
• Contact or droplet transmission | • Loquat syrup (Pei Pa Koa)  
• San Ao Tang; Zhi Sou San/Cough Stopping Powder (exogenous cough due to wind-cold attack)  
• Sang Ju Yin (exogenous cough due to wind-heat attack)  
• Er Chen Tang (endogenous cough due to phlegm-dampness) | • Feishu or the Back-Shu acupoint of the lung (BL-13)  
• Hegu (LI-4) at the right hand  
• For copious sputum, Fenglong (ST-40), or the stomach meridian located at the leg  
• For throat itch, Tiantu (CV-22), located at the sterna notch  
• For chest tightness, Neiguan (PC-6), the heart meridian at the forearm, and Tanzhong (CV-17), found in the chest between the nipples |

B. The Filipinos

Table 5. Illness Experience, Causation, Manifestations and Management

<table>
<thead>
<tr>
<th>Illness</th>
<th>Causation</th>
<th>Manifestations/ Symptoms</th>
<th>Management</th>
<th>Home Management</th>
<th>Interval between onset of symptoms and consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infectious diseases</strong></td>
<td></td>
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</tr>
<tr>
<td>Cough, colds and flu</td>
<td>cold weather, cigarette smoking, extreme fatigue, weak immune system, transmission by other sick individuals, intake of cold foods (ice cream)</td>
<td>fever, headache, sneezing, weakness, body pains, vomiting, throat pain, difficulty of breathing</td>
<td>consultation in health center, medicine (aspirin) intake, rest, fluid and Vitamin C intake</td>
<td>self-medication</td>
<td>When problem worsens</td>
</tr>
<tr>
<td>Illness</td>
<td>Causation</td>
<td>Manifestations/ Symptoms</td>
<td>Management</td>
<td>Home Management</td>
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</tr>
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<td>-------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Infectious diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea/ Gastroenteritis</td>
<td>intake of spoiled and dirty food, overeating, hot weather, virus, poor diet intake, dirty hands, weak liver</td>
<td>stomachache, vomiting, frequent defecation with watery stools</td>
<td>soft diet, medications (antibiotics, intravenous fluids, herbal tea)</td>
<td>self-medication (<em>Diatabs</em> [Loperamide])</td>
<td>within the day if condition persists</td>
</tr>
<tr>
<td>Respiratory infections such as pneumonia and TB</td>
<td>exposure to colds and dust, unattended cough, pollution, person to person transmission</td>
<td>prolonged high fever, dry cough, laboured breathing, gum bleeding and blood in stools</td>
<td>medical attention, drug intake, rest</td>
<td>self-medication (Amoxicillin)</td>
<td>1 to 3 months</td>
</tr>
<tr>
<td>Illness</td>
<td>Causation</td>
<td>Manifestations/ Symptoms</td>
<td>Management</td>
<td>Home Management</td>
<td>Interval between onset of symptoms and consultation</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Chronic diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory diseases such as emphysema</td>
<td>dirty surroundings, cough, air pollution</td>
<td>recurring cough, chest pain, high fever</td>
<td>diet, rest, check-up, medicine intake</td>
<td>self-medication (Ventolin and Salbutamol inhalation)</td>
<td>1 week to 3 months</td>
</tr>
<tr>
<td>Arthritis/joint pain</td>
<td>standing at work, ageing, lifting heavy things or objects</td>
<td>joint and bone pain, weakness, muscle pain</td>
<td>medicine intake</td>
<td>self-medication (pain relievers), hot compress and massage with oil</td>
<td>1 week to 3 months, when consultation is necessary</td>
</tr>
<tr>
<td>Sensory problems (eye problems, headache)</td>
<td>stress</td>
<td>headache, dizziness</td>
<td>drug intake</td>
<td>self-medication (EyeMo eyedrops)</td>
<td>1 week</td>
</tr>
<tr>
<td>Diabetes</td>
<td>high sugar intake</td>
<td>hypoglycemia, frequent hunger, nausea, frequent urination, itchy sexual organs, weakness</td>
<td>drug intake, exercise, regular check-up, insulin</td>
<td>diet modification, avoidance of sweet and fatty foods intake of oral meds (Metformin)</td>
<td>1 week to 3 months</td>
</tr>
<tr>
<td>Cardiovascular and circulatory problems (high cholesterol, hypertension, stroke)</td>
<td>ageing, blood pressure, inherited, stress, improper diet, environment, lack of exercise</td>
<td>fainting, back neck pain, nausea frequent dizziness, vomiting, headache, numbness of body, chest pain</td>
<td>hospitalization, fluid intake, therapy, consultation, rest, medicine intake</td>
<td>dietary change intake of oral anticholesterol agent (e.g. Simvastatin) intake of oral atihypertensive agent (e.g. Metoprolol)</td>
<td>1 week to 3 months</td>
</tr>
</tbody>
</table>
Utilization of Health Services

• The health centre is commonly utilized but frequency of visits is relatively low. The crisis orientation of the migrants is clear in the sense that they visit the service delivery point when the illness becomes serious or when home or self management does not relieve the symptoms. Little time is devoted to illness prevention. Consultation is free and medicines are cheap. The service delivery point is accessible from their residence but long waiting time deters their income generation functions (hourly rates).
• Waiting time is long in service delivery points, ranging from 45 minutes to 2 hours. In the hospital, waiting time is between 1 to 2 hours.
• There were clients who expressed their displeasure in the seemingly “inadequate services” of provider emanating from their own expectations based on their Philippine experience.
• According to some respondents, providers in health centres and hospitals are too formal. They are serious and authoritative. “Information is seldom provided nor explanations given at length. No clear instructions were given regarding the illness management.”
• They decry their inability to understand the Spanish explanation and would like to consult English-speaking health care providers.
• Specific problems were expressed such as attitude of providers and “hearsays” based on experiences of friends with specific providers in terms of diagnosis and management raising the issue of competence. These “hearsays” reinforce their mistrust of the providers.
From the Filipino clients’ perspectives, the issues related to services provision are:

1. “Felt” discrimination by providers due to their perceived negative attitude toward Asian migrants.
2. Providers’ lack of knowledge of the migrants’ background that lead to misunderstanding of the clients’ health situation and problems.
3. Difficulty in communication with the provider regarding clinical history, symptoms and management.
4. Doubts regarding competence of care by providers on certain health problems given their expectations of diagnosis and management.
5. Poor interpersonal relations between providers and clients concluding that providers are serious and unfriendly.
An important concern raised by clients is the interpersonal relations in consultation.

- Based on their experience in the utilization of health centres and the interpersonal relations between clients and providers in the Philippines, Filipino clients bewail the lack of warmth and empathy of the Spanish health service providers. Their expectations in receiving services are:

  a) adequacy of information given to them on the nature of their illness based on their description of symptoms and the management given to them (why, mode of action of drugs); and

  b) positive providers’ attitude manifested by compassion, concern and respect.
The issue of deployment of cultural interpreters was raised to key informants. They shared that:

a) they are not cost-efficient given the many migrant groups with different dialects and languages requiring cultural interpreters;

b) their interpretation may be different from that of the clients considering that they are not familiar with medical terms and most of them have been long term residents of the country; and

c) the sustainability of such proposition is questionable based on the cost implications of such initiatives.

They feel that immigrants particularly the younger ones, should acquire language proficiency and eventually be integrated into the system through access to higher education (possibly to medical school) with better prospects of employment.
5.4 Barriers in Access to the Health System

There is evidence of barriers that block or make it difficult for the immigrant population to access health care and specialised services.

1. Required documents to register as a resident is one of the main reasons that limits access to health services. To obtain a resident’s certificate one needs identification and a document that verifies residence in the country. In many cases, this presents a problem to the migrants particularly the Chinese.
2. Due to lack of knowledge of the immigration law and fear about contacting the police and other institutions, they fail to obtain the certificate that grants them the right to full health care.

3. A lack of understanding of the health system and the care to which they are entitled means immigrants do not use services regularly. Primarily they use emergency care services for immediate response. A problem arising from reliance on the emergency service is that, although it resolves specific problems, there is no follow-up care given nor a holistic approach to care.

4. Health centre hours do not cater to the immigrant population’s employment schedules. Thus, they go for emergency services.
5. The relationship between immigrants and health services is characterised by a lack of mutual recognition and understanding caused by cultural divergence as evidenced by the complaints made by health care personnel (non compliance with treatment, incomplete or nebulous description of symptoms, lack of understanding of instructions) and the clients themselves.

6. This situation is worsened by communication difficulties due to lack of Spanish language fluency.

7. Lack of the knowledge of the confidentiality of consultation deterring clients with tuberculosis, mental problems and STDs from clinic visits.
Providers’ Perspectives

- The problems presented by Filipinos were respiratory (coughs, asthma, flu, pneumonia), gastrointestinal, as well as chronic (heart disease, hypertension, diabetes and arthritis).
- Common problems were backaches and fatigue arising from domestic work and restaurant employment. Patients seen by providers include children (less than 12 years); adolescents (12-20 years); and adults (more than 20 years).
• In the case of Chinese, problems are more serious such as kidney surgery, liver infection, pneumonia, and bronchitis.
• As in other patients, they evaluate and observe the patient, undertake the necessary diagnostic procedures, and provide the requisite management including prescription of medications and referrals.
• The providers felt that they are technically competent to deal with the presented problems. They have not confronted diseases which they were not prepared to treat.
From their perspectives, the following issues were drawn:

1. Heavy patient load averaging 30 to 40 clients a day. This constrains adequate interaction with clients due to the pressure of attending to all clients.

2. Communication with clients – The difference in language deters better understanding of the health problems presented by them. Cultural perceptions also create differential treatment expectations. Providers feel that the clients are nebulous in describing their illnesses including antecedents that prevent adequate diagnosis and management.
3. Lack of record completeness. Long working hours of clients (as domestic workers and restaurant servers) deter the up-to-date follow-up of consultations. Hence, they tend to go for emergency care with 24 hours services. Records become incomplete.

4. Low compliance to medications, referrals and follow-up. Once the pain subsides, the patients do not return for follow-up care deterring further assessment.

5. Lack of understanding of the Spanish health system and steps to access services.
Health Policies in Italy

**Esclusion phase:**
- Denied right
- Withheld right

**Access phase:**
- Recognized right

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Società Italiana di Medicina delle Migrazioni
Trend in health policies for foreigners

From formal rights:
Access to health care services
To true rights: to increasing awareness in accessing the services

Changing objectives in the Sanitary Regional Plans:
From emergency services to diversity in management services
The legal status of foreign people

- Regular stayers with residence permits
- Overstayers
- Undocumented migrants without any permits
Different level of assistance for

- Foreigners enrolled in to the National Health System

- Overstayers

- Undocumented migrants

STP
## Quantitative Findings

### Percentage Distribution of Respondents by Health Problems in their Place of Origin, Italy, 2011

<table>
<thead>
<tr>
<th>Health Problems</th>
<th>Chinese</th>
<th>Filipino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td>2.4</td>
<td>4.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Respiratory</td>
<td>63.8</td>
<td>57.6</td>
<td>60.7</td>
</tr>
<tr>
<td>Infective</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Dengue</td>
<td>0.0</td>
<td>3.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.0</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Metabolic</td>
<td>0.0</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Oncological</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Osteo-articular</td>
<td>0.0</td>
<td>1.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Allergic</td>
<td>3.1</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Respiratory and hypertension</td>
<td>0.8</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Cardiovascular and metabolic</td>
<td>0.0</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Respiratory and other</td>
<td>1.6</td>
<td>0.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>2.4</td>
<td>3.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Does not know</td>
<td>10.2</td>
<td>0.8</td>
<td>5.6</td>
</tr>
<tr>
<td>None</td>
<td>14.2</td>
<td>20.8</td>
<td>17.5</td>
</tr>
</tbody>
</table>
### Percentage Distribution of Respondents by Causes of Illness in Country of Origin, Italy, 2011

<table>
<thead>
<tr>
<th>Causes of Illness</th>
<th>Chinese</th>
<th>Filipino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>36.2</td>
<td>8.8</td>
<td>22.6</td>
</tr>
<tr>
<td>Diet</td>
<td>6.3</td>
<td>12.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Climate</td>
<td>40.2</td>
<td>53.6</td>
<td>46.8</td>
</tr>
<tr>
<td>Hygiene</td>
<td>2.4</td>
<td>4.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Immune system</td>
<td>7.9</td>
<td>6.4</td>
<td>7.1</td>
</tr>
</tbody>
</table>
## Percentage Distribution of Respondents by Illness Management in Country of Origin, Italy, 2011

<table>
<thead>
<tr>
<th>Illness Management</th>
<th>Chinese</th>
<th>Filipino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical products</td>
<td>35.2</td>
<td>65.7</td>
<td>50.0</td>
</tr>
<tr>
<td>Change in behaviour</td>
<td>2.9</td>
<td>9.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Family products</td>
<td>8.6</td>
<td>14.1</td>
<td>11.4</td>
</tr>
<tr>
<td>Traditional medicine</td>
<td>15.2</td>
<td>0.0</td>
<td>7.8</td>
</tr>
<tr>
<td>Family and pharmaceutical products</td>
<td>9.5</td>
<td>0.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Traditional and allopathic medicine</td>
<td>12.4</td>
<td>2.0</td>
<td>7.4</td>
</tr>
<tr>
<td>Others</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Does not know</td>
<td>8.6</td>
<td>1.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Does not say</td>
<td>1.0</td>
<td>4.0</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Percentage of Distribution of Respondents by Presence of Illness in the Last 12 Months, Italy, 2011
Percentage Distribution of Respondents by Types of Remedy Used, Italy, 2011

<table>
<thead>
<tr>
<th>Types of Remedy</th>
<th>Chinese</th>
<th>Filipino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>37.5</td>
<td>37.6</td>
<td>37.6</td>
</tr>
<tr>
<td>Traditional</td>
<td>8.9</td>
<td>7.1</td>
<td>7.8</td>
</tr>
<tr>
<td>Medicines</td>
<td>35.7</td>
<td>47.1</td>
<td>42.6</td>
</tr>
<tr>
<td>Traditional and medicines</td>
<td>16.1</td>
<td>8.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Does not know</td>
<td>1.8</td>
<td>0.0</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Percentage Distribution of Respondents by Utilisation of Health Services, Italy, 2011
Percentage Distribution of the Respondents by Knowledge of the Health Services, Italy, 2011

Knowledge of Health Services

- Social & Health Care
- General Practitioner
- Hospital
- Private Health
- Voluntary

Percentage

- Chinese
- Filipino
## Percentage Distribution of Chinese Respondents by Frequency of Use of Health Care Facilities, Italy, 2011

<table>
<thead>
<tr>
<th>Health Care Facilities</th>
<th>Never</th>
<th>Rarely</th>
<th>Often</th>
<th>Does not know/ No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social &amp; health care facilities</td>
<td>75.0</td>
<td>15.4</td>
<td>1.9</td>
<td>7.7</td>
</tr>
<tr>
<td>General practitioners</td>
<td>46.9</td>
<td>34.7</td>
<td>10.2</td>
<td>8.2</td>
</tr>
<tr>
<td>Hospital</td>
<td>35.3</td>
<td>51.0</td>
<td>7.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Private health</td>
<td>90.0</td>
<td>8.0</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Voluntary</td>
<td>96.2</td>
<td>3.8</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Percentage Distribution of Filipino Respondents by Frequency of Use of Health Care Facilities, Italy, 2011

<table>
<thead>
<tr>
<th>Health Care Facilities</th>
<th>Never</th>
<th>Rarely</th>
<th>Often</th>
<th>Does not know/ No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social &amp; health care facilities</td>
<td>47.4</td>
<td>23.7</td>
<td>5.3</td>
<td>23.7</td>
</tr>
<tr>
<td>General practitioners</td>
<td>13.2</td>
<td>57.9</td>
<td>21.1</td>
<td>7.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>18.4</td>
<td>57.9</td>
<td>7.9</td>
<td>15.8</td>
</tr>
<tr>
<td>Private health</td>
<td>50.0</td>
<td>18.4</td>
<td>0.0</td>
<td>31.6</td>
</tr>
<tr>
<td>Voluntary</td>
<td>84.2</td>
<td>5.3</td>
<td>7.9</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Percentage Distribution of Respondents by Possibility of Receiving Information in Specific Health Care Facilities, Italy, 2011

<table>
<thead>
<tr>
<th>Health Care Facilities</th>
<th>Chinese</th>
<th>Filipino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social &amp; health care facilities</td>
<td>41.7</td>
<td>82.4</td>
</tr>
<tr>
<td>General practitioners</td>
<td>33.3</td>
<td>90.6</td>
</tr>
<tr>
<td>Hospital</td>
<td>29.6</td>
<td>83.3</td>
</tr>
<tr>
<td>Private health</td>
<td>66.7</td>
<td>46.7</td>
</tr>
<tr>
<td>Voluntary</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Percentage Distribution of Respondents by Ability to Negotiate Therapy in Specific Health Care Facilities, Italy, 2011

<table>
<thead>
<tr>
<th>Health Care Facilities</th>
<th>Chinese</th>
<th>Filipino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social &amp; health care facilities</td>
<td>41.7</td>
<td>82.4</td>
</tr>
<tr>
<td>General practitioners</td>
<td>33.3</td>
<td>90.6</td>
</tr>
<tr>
<td>Hospital</td>
<td>29.6</td>
<td>83.3</td>
</tr>
<tr>
<td>Private health</td>
<td>66.7</td>
<td>46.7</td>
</tr>
<tr>
<td>Voluntary</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Percentage Distribution of Respondents Who Have Had Follow-up Examination in Specific Health Care Facilities, Italy, 2011

<table>
<thead>
<tr>
<th>Health Care Facilities</th>
<th>Chinese</th>
<th>Filipino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social &amp; health care facilities</td>
<td>66.7</td>
<td>88.2</td>
</tr>
<tr>
<td>General practitioners</td>
<td>31.8</td>
<td>71.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>32.1</td>
<td>34.5</td>
</tr>
<tr>
<td>Private health</td>
<td>75.0</td>
<td>26.7</td>
</tr>
<tr>
<td>Voluntary</td>
<td>100.0</td>
<td>80.0</td>
</tr>
</tbody>
</table>
Percentage Distribution of Chinese Respondents by Utilisation of Specific Sources of Information, Italy, 2011

Sources of Information

- TV
- Newspaper
- Pamphlet
- Internet
- Friends/Network
- Professional Health Care
- Alternative Health Care
- Public/Government Health Care
- Private Health Care

Percentage

- Yes
- No
- Does not know/ No response
Percentage Distribution of Filipino Respondents by Utilisation of Specific Sources of Information, Italy, 2011
Qualitative Findings

Chinese migrants behaviour:

- Reserve and control of emotions are cultural features.
- Direct questions are perceived as intrusive.
- Health workers are expected to give very concrete answers.
Health workers perceptions about Chinese users

Communication with them is very challenging, as they are:

• Autarchic, ermetic, and non emphatic, belonging to a distant cultural universe.
• They don’t answer questions and refuse to dialogue about global health conditions.
Characteristics of Chinese in Milan

- People from rural areas of China belong to older generations, non educated and are less socialized to Western medical system.
- People coming from rural areas of Zhejiang constitute the majority in Milan.
- They are strongly anchored to traditional beliefs and practices.
- They reveal reluctance to submit to practices that they do not understand
Health behaviours

• Depending on the symptoms and outcomes expected, individuals choose among Western, traditional, and syncretic therapies.
• Chinese medicine acts on the root of the problem, re-establishes equilibrium with slower effect and is used for less serious problems or ailments in their initial stages.
• Western medicine acts directly on the symptoms with immediate effect and is used for serious problems at an acute phase = emergency
• Imbalances are to be addressed with traditional medicine
Therapeutic syncretism

• It is a very widespread tendency in the Chinese community in Milan.
• It tends to alarm doctors who are worried about possible interference with drugs administered and for state of igiene of traditional remedies
Access to health services 1
Main obstacles

- Linguistic barrier: insurmountable if not for the presence of linguistico-cultural mediator (very much appreciated, but insufficiently widespread)
- This compromises the relationship between doctors and patients
- Chinese patients have recourse to: a) their children; and b) Chinese paid interpreters
Access to health services 2
Main obstacles

• Access to health services:
• Complicated bureaucratic procedures + poor knowledge of the apparatus
The “migratory trauma”

- CHANGING DIMENSION
  - Language
  - Space-time relation
  - Body representation
  - Crisis of the identity consciousness

Castiglioni M., 2001
The “migratory trauma”

The somatized malaise – the body as memory

“since I’m here, I can’t feel my body as I did. I don’t know what’s happening, I feel pain everywhere. I don’t know what’s good for me or not, I’m always tired. I can’t sleep…”

(Filipino patient)
The “migratory trauma”

Place of arrival

- Borders crossing and Cultural interpretation
- Loss of self-awareness and Homesickness
The “migratory trauma”

The social stigma of being an immigrant which brings a requirement of social citizenship
Metaphors on body, health, and illness

Redefining
- Communication strategies
- Multidisciplinary methodological instruments

Day-life medicalization
Conclusions

• For future research on the topic: it is convenient to separate the Filipinos and Chinese.
• Very different strategies for adapting to the host context.
• Health workers tend to describe them negatively.
Common traits

- Scarce use of the social and health services
- Capacity of not showing up with respect to the service, albeit in a very different manner
- Use of other types of medicines
- Use of health services
- Not coherent nor systematic
- Poor recourse to the family doctor, mostly for Chinese due to absence of reference point.
- Language barrier and bureaucratic complications.
- Incorrect use of health service, or when pathology is at advanced stage.
Adjustment strategies

- Use of alternative and clandestine medicine where there is no form of control.
- Return to the country of origin for preventive medicine and treatment.

Suggestions

- Outreach actions in the communities, for information on health system and on specific subjects.

- Very important: sex education for minors for prevention of unwanted pregnancies, abortion and sexually transmitted diseases.
6. CONCERNS, CHALLENGES AND RECOMMENDATIONS FOR THE INCORPORATION OF MIGRANTS’ ISSUES IN EUROPEAN HEALTH PROGRAMMES

The research addresses two basic questions:

1. What are the issues and challenges in the incorporation of Asian migrants’ health concerns in European health policies and programmes? and
2. What are the prospects for Asia-Europe cooperation in these areas?
Policy and Legal Framework

The Global Consultation on Migrant Health (2010) listed as priorities to address in this area the:

a) reflection in national law and practice the regional prescriptions drawn in the numerous conferences, consultations and dialogues and their translation into congruent service programmes that promote equal access to health services regardless of status

b) promotion of coherence in inter-sectoral policies that affect migrants’ access to health services
Issues arising from the above are:

a) the need for assessment of the extent in which national health policies are reflective of the regional prescriptions and how they have been translated into operational terms at the clinic level to encompass the migrants’ equity and rights to health, basically, the vertical congruence of policies and programmes; and

b) need for a systematic approach to the translation of policies into programmes (guidelines) taking into consideration the recommendations at different levels and the resources to be mobilized.
Health Services’ Delivery and Migrants’ Utilization of Services

Priority areas include:

a) increasing understanding of health and social issues related to migrants’ health services utilization

b) provision of health services that are culturally and linguistically appropriate within a comprehensive, coordinated and financially sustainable programme

c) capacity building of health services providers for the delivery of culturally and linguistically appropriate health services

d) enhancement of continuity and quality of care received by migrants through adequate standards of health service delivery and programme management

e) ensuring an adequate record keeping and development of database on health problems and services utilization by migrants
The lack of an operational framework that guides the incorporation of “culturally and linguistically appropriate health services in a comprehensive, coordinated and financially sustainable fashion is underscored” (specifically operational guidelines).

CONCERNS:

• How could this statement be translated into operational terms at the clinic and community levels?
• What mechanisms should be in place to ensure that the health programs are “culturally and linguistically” appropriate?
• What are the prerequisites for such an approach?
• What training would the work force need for this purpose? Who should provide the training?
• Given the multiplicity of cultural groups and their linguistic variability, how could this be realized within different health service delivery points?
• How could culturally and linguistically appropriate preventive and promotive services be planned and implemented at the community level? What are the prospects of migrants’ involvement in this sphere? What are the requisites for their participation?
• How can information and education programmes be transformed into this mode? How effective are current information programmes with translated leaflets and other materials in raising awareness of groups and transforming their health-seeking behaviour?

• How can this initiative be monitored and evaluated?

• To what extent can the best practices be documented for their replication potentials?

• What should be the indicators of best practices in terms of the integration of migrants’ concerns in health services delivery?
Within this purview, the research observed four areas that need to be considered in terms of programmatic translation: quality of care, consideration of medical pluralism, cultural competence of the providers, and integration of migrants into the Spanish mainstream.
6.1 Quality of Care

- Quality is an important element to consider in the context of health service delivery both for migrants and non-migrants.
- The current approach overlooked the interpersonal dimension of care and may have suggested that quality means technically competent providers and up-to-date clinic facilities.
- The salient elements of health care programmes that are of quality are: information given to clients; technical competence of providers, interpersonal relations between clients and providers, follow-up or continuity mechanisms; and appropriate constellation of services.
Toward a Set of Quality of Care Indicators

Within the above elements are the intrinsic factors that account for quality indicators in health care provision.

a) Acceptability and Appropriateness of Services
b) Accessibility of Programmes
c) Responsiveness or Patient-centredness of Providers
d) Capacity of the Health System and Providers to Deliver Needed Services (Technical Competence and Facilities)
6.2 Cultural Competence of Providers

A culturally competent health agency:

- recognises that its client base is diverse and includes people from a range of cultural and linguistic backgrounds;
- acknowledges from the policy to service delivery levels that cultural competency and diversity management are integral to core health programmes;
- recognises that cultural competence is as much about changing itself as about changing the culturally diverse clients;
forms partnerships with community groups, other health organisations, ethno-specific agencies and other sectors to make its policies and processes more culturally competent and acceptable;

facilitates close community involvement, through the development of partnerships with adults, young people and families in designing and implementing health promotion programmes;

recognises the benefits of diversity and dialogue across cultures and aims for a workforce that is aware of the cultural makeup of the population it serves. (Modified from Australian Health and Medical Research Council, 2005)
A culturally competent health provider:

- acquires cultural competency in medical and postgraduate training;
- is provided with cultural competency standards to guide the work;
- has information about specific migrant groups for self-reliance in working with migrants and their communities;
- ensures that skills rather than stereotypes are promoted, for an understanding that migrants are influenced by their cultural context and situation but these could be modified;
- supports incorporation of cultural competencies into the health professional practice;
• acknowledges the importance of linguistic and cultural comprehension for effective communication with migrants;
• is able to communicate effectively with migrant groups;
• recognises and respects migrants’ feelings and attitude;
• feels the need to involve the family and community in discussions about health-related issues; and
• understands how differences in culture, language and migration experience may impact on the way health promotion, prevention and services are developed.
6.3 Medical Pluralism

- An emerging area that is drawing the interest and concern of policymakers and programme planners is medical pluralism.
- Recent research on health services utilization reveals a thriving market of multiple health options.
- With the recognition that migrants adopt traditional systems of health practice, views on the acceptance of cultural pluralism in health care need to be extricated.
• This can also be seen as complementary health care signifying that it can work with Western biomedicine. There is recognition of this approach in many Asian countries (China and India) and has been adopted as a component of health programmes within the Asian region. For example, Chinese patients utilize their traditional medical system simultaneous or sequentially with Western medical practices.

• This does not imply a rejection of the biomedical system, but a mix of western and traditional health practices. Migrant populations with developed health systems in their home country tend to utilize multilevel, pluralistic healing systems.
• They are likely to seek out initially health facilities and practices that are familiar, appropriate, affordable, and effective to them.

• Rather than simply representing a “culturally appropriate” site of health care practice, traditional health care serves a purpose: “Without application forms to fill out, health card to show, or long-waiting time for consultations, they can seek immediate response to pressing physical concerns.”

• Medical pluralism would likely be the norm rather than the exception for some migrants in the future. This blending of systems in both the countries of origin and destination may be an acceptable option.
The popularity of complementary medicine raises a range of issues for practicing clinicians. Principles of biomedical ethics define obligations of the health care profession, but applying them in particular cases at the interface of complementary and biomedicine may be challenging.

Recognition of medical pluralism can help clinicians’ deliberations related to complementary medicine. A three-point practical approach to applying basic principles of ethics in the light of medical pluralism are: (1) inquiring about complementary medicine use and the scientific evidence related to it, (2) acknowledging and assessing the health beliefs and practices of patients, and (3) accommodating diverse healing practices.
6.4 Migrants’ Integration

• For the second-generation migrants to flourish in Spain, integration may provide an adequate frame of analysis.
• Access to educational opportunities will enable children to penetrate the professional market. School attendance at all levels is decisive for individual competitiveness in labour markets and for any efforts to gain access to relevant resources in the country.
• Since the education system is moulded by the national culture, there is no recourse for migrants but to learn the Spanish language.
• Access to employment, health services, and education is provided by the state.
• Migrant integration can occur in functional realms: enterprises, hospitals, schools, universities, and local administration.
• All migrants integrate when they take roles inside organisations and fulfil the social expectations linked with them.
• The family of migrants must be able to take over membership functions in the Spanish community.
• They are expected to orientate their modes of life to the conditions in host social systems and develop corresponding competence and attitude.
Support to the development of specific integration programmes for newly arrived immigrants include:

- acquisition of language skills emphasizing practical inter-cultural skills needed for effective adaptation
- commitment to fundamental European values by identifying the basic rights and obligations of newly arrived immigrants in the framework of specific national processes (e.g. integration commitments, welcoming programmes, national plans for citizenship and orientation courses)
• fostering diversity management in the workplace and rendering advancement opportunities for legally residing and working third-country nationals

• guarantee fundamental social rights and favour labour standards and social cohesion. Within this context, due attention should be paid to the participation of immigrant women in the labour market

• ensuring a non-discriminatory and effective access to health care, social protection, and social security schemes
Interest in this initiative stems from the series of European conferences. (Conference on Health and Migration in the EU, 2007; WHO-EURO Ministerial Conference on Health Systems, 2008; EU Level Consultation on Migration Health, 2009; etc.) These conferences discussed the health concerns of migrants; the need for responsive health policies; and the assessment of prospects for Asia-Europe Cooperation in health programming to better reflect their concerns.
a) Need to draw a clearer picture of the disease patterns of Asian migrants, their determinants, and potential threats to non-migrant populations as reflected in statistics and published literature. These could provide the basis for health policy priorities and programmes dealing with specific groups of migrants if presented in a succinct and systematic manner.

- Regional/National and sex disaggregated data are presently generated which could serve as the basis for planning and policymaking on migrants’ health. If compiled and analysed, these could be shared among countries within the region and between sending and receiving countries and regions;
b) Need to evaluate and share the information available on current health policies and programmes in European and Asian countries identifying good practices for cross-regional adaptation. Knowledge of existing health situation in the countries of origin could provide insights into problems that migrants could present in destination areas. Both countries could benefit from the data generation, policymaking, programming process and recommendations for the improvement of health care of their population;
c) Transfer of technology and knowledge in dealing with chronic/non-communicable diseases as Asian countries are at the threshold of their epidemiological transition;

d) Assessment of traditional medicine and potential for its adoption in receiving countries;

e) Joint research in the social and psychological dimensions of illness occurrence, health-seeking behaviours and the barriers and facilitating factors to migrants’ utilization of services; potential participation of migrants in health promotion activities. In this regard, existing literature must be compiled and consolidated both at the sending and receiving countries since health services utilisation is a function of the practices before migration.
Thank You!