THE HEALTH DIMENSION OF SOUTHEAST ASIAN MIGRATION TO EUROPE

Abridged Report

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ASIA-EUROPE FOUNDATION

De La Salle University Publishing House

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Published by De La Salle University Publishing House for the Asia-Europe Foundation

Published and distributed by
De La Salle University Publishing House
2401 Taft Avenue, Manila, Philippines 1004
Tel. No: (632)524-4611 loc. 271
Telefax: (632) 523-4281
Email: dlsupublishinghouse@dlsu.edu.ph
Website: www.dlsu.edu.ph

The De La Salle University Publishing House is the publications office
of De La Salle University, Manila, Philippines.

Cataloguing-in-Publication Data

RA 553 .O872 2012

Osteria, Trinidad.
The health dimension of Southeast Asian migration to Europe: abridged report / Trinidad Osteria, Daniela Carrillo, Anna Vittoria Sarli. -- Manila: De La Salle University Publishing House, 2012.
60 p. ; 22 cm.

ISBN 978-971-555-550-0

1. Migrants--Health and hygiene--Southeast Asia.
2. Asians--Health status--Southeast Asia. 3. Healthcare services--Europe. 4. Public health--Europe. I. Carrillo, Daniela.
II. Sarli, Anna Vittoria. III. Title

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1. Background

On September 1, 2011, the research proposal submitted by the Yuchengco Center in the Philippines and Fondazione Iniziative E Studi Sulla Multietnicita (ISMU) in Italy was approved by the Asia-Europe Foundation. The aim was to undertake a study on the public health implications of Asian migration to Europe. This was conducted in Madrid, Spain and Milan, Italy among the Filipinos and Chinese, the two largest Asian migrant groups in these cities. Yuchengco Center was responsible for the Madrid component of the project and ISMU conducted the Milan study.

2. Objectives

The general objective of the research was to arrive at meaningful recommendations for the incorporation of Asian migrants' health concerns in European public health policies and programmes.

The specific objectives were to:

2.1 assess the European regional policies and their national implementation to determine the extent in which the perceived and expressed health needs of the migrants are being addressed;

2.2 draw the health picture of migrants in terms of morbidity patterns, predisposing factors, health seeking behaviour including health services utilisation pattern, and attitude toward health services and providers. The perspectives of providers on the current health programmes and needs of migrants were elicited;

2.3 identify the barriers and facilitating factors in access to and utilisation of health services by migrants;

2.4 posit issues and recommendations based on the health system analysis, related literature, and the perspectives of migrants and health providers for a viable health policy; and

2.5 determine the prospects of collaboration between Asia and Europe to improve the planning and programming of migrants' health in Europe and strengthen the health systems in sending countries.

3. Methodology

A multi-method approach was adopted including the survey of migrants; face-to-face interviews with providers and key informants; review of literature; and policy analysis.

To situate the research, a thorough analysis of morbidity and mortality in Southeast Asia, Philippines and China (sending areas), Europe, Spain and Italy (receiving areas) as well as their respective health systems' (regional and national) response to existing and emerging problems was undertaken. Commonalities and divergence were delineated. Published documents and articles were compiled and reviewed.

The socio-demographic characteristics and the disease and mortality patterns of Southeast Asia, China and the Philippines were described. Regional and national health policies were presented. Multiple factors (social, economic, environmental) influencing these health patterns were drawn. Policy and programmatic responses of the World Health Organization in the Western Pacific (WPRO) and Southeast Asia (SEARO) as well as the health systems of China and the Philippines were reviewed in terms of priorities and health promotion, prevention and management strategies. The inclusion of traditional medicine in health programmes both at the regional and national levels in Asia was noted as this has implications on migrants' health seeking behaviour in countries of destination. Gaps in regional and national policies and programmes were identified.

From European health statistics and related documents, diseases and mortality patterns as well as health policies and programmes were analysed for the region, Spain and Italy. The basic questions addressed were: What are the prevailing morbidity and mortality patterns in Southeast Asia, China and the Philippines? the European region, Spain and Italy? Are data dichotomised into migrant and native populations in the destination countries? What are the regional health (WHO, ECDC, EC) policies with respect to communicable and non-communicable diseases that have implications on migrants' health? How are they translated at the clinic level? What are the challenges and issues that policy makers and providers confront in developing and operationalising the policies? Are there specific policy and programmatic needs related to the health of migrants that have not been addressed? A notable finding of the research is the closure in the epidemiological gap between the sending and receiving countries with the former moving toward the non-communicable and chronic mould arising from the improvement in the populations' health status and increase in life expectation.

4. Research Findings

A. Spain

The leading causes of morbidity in Spain are basically non-communicable. Unipolar depressive disorders, ischemic heart diseases, alcohol intake disorders, cerebrovascular diseases and Alzheimer's including other dementias constituted the major illnesses. For the migrants, cerebrovascular diseases and respiratory illnesses were common.

4.1 Illness Patterns of Migrants in Spain

Infectious diseases detected in migrants in Spain can be categorised into three groups. These are 1) respiratory, urinary tract and skin infections, which are easy to diagnose and do not constitute a major public health risk; 2) communicable diseases, such as tuberculosis, viral hepatitis, STDs, or infection with HIV which are serious and must be detected in asymptomatic individuals; and 3) tropical diseases, such as malaria, filariasis, and infections with intestinal parasites requiring specialised centres for diagnosis and treatment. Tuberculosis is an important problem. Latent tuberculosis infection rates of 52 to 72 percent and active infection rates of 7.8 percent were reported in 2000-2002. The increasing drug resistance raises concerns among health authorities. Most cases among immigrants are reactivated in the first five years after arrival. Thus, they have to be actively screened for both latent and active tuberculosis. (Lopez-Velez, et. al, 2003)

As the case with many other health conditions seen in the immigrant community, patients with HIV/AIDS largely reflect the epidemiological and socio-demographic profile of their home countries. Transmission is generally hetero- and homosexual in contrast with drug use commonly seen in the Spanish population. It is not known if individuals were infected prior to migration or in Spain, although one study estimated that at least 25 percent of individuals were infected prior to coming to the country. (Barrasa, 2005 in Vaughan, 2010)

4.2 Factors Affecting Access to Health Services

4.2.1 Health Beliefs and Health-Seeking Behaviour

The views regarding the nature, causation and management of migrants' health problems vary. Inadequate "health literacy" of migrants as to causation, symptoms and management of the illnesses was reported. Another contributory factor is the difference in the perception of the health problem and its management between the migrants and providers. The

resultant divergence leads to a mismatch in management expectations leading to the labelling by migrants of providers' incompetence. For migrant groups with differing health beliefs and health-seeking behaviour, education seems to be a response. However, it would unlikely be taken seriously unless deemed acceptable. In addition to limited knowledge, other constraints are their lack of knowledge of the health system and the services it provides as well as their attitude towards providers. (Netto, et al, 2010)

4.2.2 Linguistic Barriers

Language barrier is the most serious obstacle to quality service provision for migrants. Familiarity with the Spanish language that enables a person to "get by" in daily situations may not be sufficient to meet the health needs during the clinic encounter. What the client conveys may not be understood by the provider. Likewise, the client may not comprehend the information and instructions given by the provider. Professional interpreters or cultural mediators need to translate not only the words but the meaning and context of the statements of both clients and health providers. To do this, considerable knowledge of the patient's socio-cultural base is required. The concept of "cultural mediators" was introduced in the United Kingdom, Netherlands, Belgium, France, Spain, and Italy. While they fulfil important roles in reducing the communication barriers and bridging the gaps between the migrants and the health system, there are issues to be resolved such as the responsibilities and liabilities of the mediators, their readiness to assume their roles, sustainability of financial support to them, and familiarity with the medical and health idioms. Brochures, folders, websites, and patient information are provided in languages that reach potential users. However, their comprehension, acceptability, and effectiveness have not been assessed. In some instances, clinics make interpretation facilities available to users who need them. These are expensive since the number of languages and dialects migrants speak may run into thousands not including the numerous service delivery points all over the country. (World Health Organization Regional Office for Europe, 2010)

4.2.3 Stigma and Anxiety

Some migrants are reluctant to utilise the health services due to the stigma associated with certain illnesses such as TB, HIV/AIDS and mental illness. Depression is considered a disgrace in many migrant communities.

Disclosing intimate details regarding one's illness to a health authority may be threatening. In addition, there are sensitive topics that are difficult to discuss such as their illegal status, loneliness, alcoholism, fears and sexuality. Many migrants do not know that confidentiality of medical encounters is protected by law.

4.2.4 Time Constraints

Problems arise when they could not take time off from work during the clinic's opening hours. This is compounded by the long waiting time in the clinic. The distance of the clinic from the residence of clients and their workplace render consultation inconvenient since travel is time-consuming and detracts from their income generation which is based on hourly inputs (8 Euros per hour for domestic and service work).

4.2.5 Socio-cultural Barriers

The difference in mindsets between providers and patients causes confusion when management is explained, since the patients may regard this as irrelevant based on their pre-migration orientation. Medical pluralism, the tendency to seek remedies from different medical systems simultaneously or sequentially without consideration of contraindications is an intervening factor particularly among the Chinese. Indigenous management inspires confidence and builds trust despite differences in definition of causation and management by these two systems. The misunderstanding may also be due to the health staff's lack of skills or understanding of migrants' needs. General practitioners have been reported to spend less, rather than more time, on consultations with non-western migrants. "Cultural sensitivity" could be emphasized in health workers through training.

4.2.6 Health Effects of Employment

Ahonen, et al. (2009) indicated that perceived risks and corresponding health impacts of work fall into two categories: exposure to the environmental hazards and psychosocial factors.

4.2.7 Environmental Hazards

Those whose responsibilities include cleaning mentioned two products that they felt hazardous: bleach and ammonia. Degreasing agents as well

as ''strong'' and ''toxic'' products are efficient, but dangerous to their health. They preferred less toxic products but their employers choose the former. Acute reactions were mainly dermatologic and respiratory. They described eye and throat irritation, difficulty in breathing and burns. The physical nature of household work is exhausting. Generalised musculoskeletal pain occurs from domestic chores. Physical strains are linked with repetitive and fast body motions in scrubbing, ironing, and mopping; and back pain from moving furniture, making beds, and cleaning windows or doors. Women whose work involves care of the elderly with limited mobility reported strain and injury in assisting them to bathe, dress, and move about the house. This involves supporting the weight of another person or moving that person from one place to another. These are tasks for which they have no formal training but with high risk of back injury. Several women hurt their backs while assisting individuals with limited mobility. Their work drained their energy, resulting in fatigue and weakness. Women cleaners and carers were prescribed analgesics for acute and chronic pain. These are perceived to be of limited efficacy, since their job continued to worsen their musculoskeletal problems. The amount of work and the time to complete this are stressors. They are usually given more work than they are able to finish. Hence, they had to act swiftly to accomplish the activities. If unable to finish on time, they feared being terminated by employers. Women, whose responsibilities were principally caring for an elderly, described the addition of cleaning or cooking chores to their principal function, which complicate the task. Cooks and restaurant workers are in the same predicament as they work for long hours. (ibid)

Men migrant workers are more represented in dangerous industries and hazardous jobs, occupations and tasks. They are often hired as construction labourers and factory workers with poverty wages at the same time experiencing abuse and exploitation at the workplace. Their problems include social exclusion, lack of health and safety training, fear of reprisals and linguistic and cultural barriers that jeopardise health care management, with difficulty in accessing care and compensation when injured. The employment conditions of most migrant workers are dangerous to their health.

The overall impact of immigration on health, however, is poorly understood and pathways in disease occurrence and health seeking

behaviour are poorly documented. Current limitations highlight the need for causative, intervention and policy research. (Benach, et. al, 2009)

4.2.8 Psychosocial Effects

Elderly caregivers suffered from the emotional demands of their wards. These emanated from personal relationships developed during long hours spent together, and the difficulty of observing them deteriorate and die. They had little control over their working time. At times, they would not take breaks from this caregiving for fear of being reprimanded by employers. Some even skip meals to finish their tasks. They are unable to take personal or sick time off. Oftentimes, they work alone, with few to talk to or interact. The informality of their work means a great deal of insecurity as their employment can be terminated at any time. Previously undocumented migrants felt that they owed their employers the ''favour'' of having given them work when they lacked the work permit. Informality and favours imply limited ability to negotiate against the addition of more tasks, more work, longer hours or more. (Ahonen, et al, loc cit).

4.3 Utilisation of Health Services

A valid health card is required to access the Spanish health care system which is obtained through registration with one's local municipality. Both legal and undocumented individuals are eligible to register and receive this card. As of December 31, 2009, nearly 4.8 million immigrants (over 80% of the total) had registered with their local governments and possessed the health card necessary to access health care. Only 3 percent of those who had been in Spain for less than five years and only 1 percent of those who had been in the country for more than five years did not have the card. Despite the perception that immigrants abuse free health care in Spain, they used health services less than the native population. A review of data from Spanish National Health Surveys, and findings from various studies showed that immigrants visited general practitioners and specialists at a lower frequency than the native-born population, and stayed in hospitals for less number of days (Regidor, et. al, 2009; Jiménez-Rubio and Hernández-Quevedo, 2010; Muñoz de Bustillo and Antón, 2009; Buron, et. al, 2008; Jiménez-Martín and Jorgensen, 2009; Gimeno Feliu and Lasheras Barrio, 2009; Díaz Olalla, 2008 in Vaughan, loc cit). They used emergency services at a higher rate than the Spanish population (López Nicolás, et. al, 2009 in Vaughan, ibid). High emergency services utilisation suggests that they may use this as a substitute for primary care. This is

possibly due to inability to take time off from work during the day to see a general practitioner, not considering a health condition serious enough to see a general practitioner, and being forced to visit the emergency room when it becomes serious. Since immigrants are relatively young and exposed to risky activities, this may also provide explanation to the large-scale use of emergency services. Also, this service 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. Immigrant patients consulting emergency clinics reported non-specific symptoms such as respiratory, non-specific abdominal pain and skin lesions (Junyent, et. al, 2006 in Vaughan, ibid). The relatively high frequency of use of gynaecology services is likely related to higher immigrant fertility rates and less use of primary care gynaecologists and antenatal care programmes. Immigrants access preventive services such as physical/wellness exams, cholesterol and blood pressure screening, cancer screening, tobacco cessation services, nutrition and diet counselling and childhood immunisations at a lower frequency than the native population (Vall-Llosera Casanovas, et. al, 2009; Regidor, et. al, 2009 in Vaughan, ibid). They also consume fewer pharmaceuticals. Long time input for work plays a major role in determining health care utilization. Immigrants living in Spain for less than five years access primary and emergency health care less frequently than the native Spanish population, while those living in Spain for more than five years, particularly women, use primary and emergency health care services at the same or at a greater frequency (Aerny Perreten, et. al, 2010 in Vaughan, ibid). Differences in utilization between male and female immigrants were documented. Variations in utilization patterns by region in Spain also exist (Jiménez-Rubio and Hernández-Quevedo, 2010; Regidor, et. al, 2009; Rodríguez Álvarez, et. al, 2008 in Vaughan, ibid).

4.4 Providers' Perspectives

There are problems related to health services utilisation expressed by the providers (Esteva, et. al, 2006). Major barriers are language and clients' culture. The suggested solution was the deployment of translators or cultural intermediaries. Clinically, doctors saw no differences in pathology between immigrants and the native population; and no greater psychiatric problems while some indicated that specific protocols are needed for their needs. To analyse these in the provision of healthcare to the immigrant population and provide suggestions for improvement of service delivery, healthcare managers and professionals from primary and

specialised care units were queried. Support in providing healthcare to the immigrants strongly emerged. Translated materials and information with a longer period of time allocated per patient are required to address barriers. Specific providers' training focusing on cultural aspects and modalities of client-patient interaction was expressed. (Vazquez Navarrete et al, 2009)

Identified barriers to the implementation of prescribed strategies are:

- inadequate professional training on service quality, cultural competence and patients' communication; and
- limited documentation and dissemination of best practices in health services provision for migrants. (Legido-Quigley, et. al, 2008)

4.5 Current Research Findings

The self-administered questionnaires yielded 10 Chinese and 20 Filipino respondents. The analysis is concerned more with depth than breadth, considering the objectives of the research. These were supplemented by in-depth dialogues with key informants. The presentation is more narrative and contextual in terms of the eventual goal of providing inputs into health policies and programmes on migrants.

4.6 The Chinese Perspective

4.6.1 Illness Experience

While morbidity experience in the year previous to the survey could not be recalled adequately, respondents discussed their bouts of illnesses (in the past 3 months) which could be categorised into mild respiratory infection (colds, cough and fever), diarrhoea, and musculoskeletal problems resulting from their tasks. However, reports were made of relatives in the city who suffered from kidney problems, hypertension and diabetes where external consultations were made after traditional management.

4.6.2 Illness Response

The respondents were guided by the traditional Chinese medical approach being adopted in Madrid. Traditional medicines and healers are available in the city. Besides, medicines and herbals are obtained from China during their frequent visits home to secure supplies and products for their businesses. These are shared with friends and relatives in the city.

There are acupuncturists they consult for specific health problems. The perceived causes and therapeutic management of specific illnesses are guided by the yin-yang system. The first line of approach is the Chinese system with its own diagnostic mechanism and management through herbal medicines and acupuncture. However, when symptoms persist, they seek external consultation preferably from Chinese younger relatives who obtained their medical degree in Spain or the health services available (public or private). For the common illnesses, fever, cough and colds, they take Chinese medicines. The review of the Chinese basis for health service provision revealed detailed information on causation, and management of particular conditions and symptoms. Besides, those who frequently return to China consult the traditional providers there and carry with them the prescribed medicines.

4.6.3 Attitudes Toward Health Service Providers

When the problems could not be managed by the traditional system, they visit the health services. The providers prescribe medicines. One respondent mentioned that the provider consulted the internet and asked colleagues in the clinic regarding the health problem and the proposed solution ("buscar informacion por internet y preguntar amigos medicos"). At times, they bring their children who can speak Spanish to serve as interpreters.

The deterrents to the efficient utilisation of services are:

- bureaucracy and tedious paperwork needed to obtain a health card;
- long waiting time despite the appointment date given; communication with providers due to their inability to express or narrate their health problems; at the same time, lack of understanding of the questions and instructions given by the provider; impersonal and formal attitude of providers; and
- mistrust of the technical capacity of the providers based on their expectations from their own experience in China.

4.6.4 Services Known

The respondents know all of the health service providers in the city – primary health care physicians, specialists, hospital and private practitioners and what they provide.

4.6.5 Services Utilised

The primary health care system was visited by the respondents and the frequency ranged from 1 to 5 times in the past year. Their suggestions for the improvement of services include:

1. Reduction of waiting period (eliminar el tiempo de espera)
2. More personalised approach by the providers in dealing with clients since the former are formal and authoritative
3. Appointment priority be given to those whose illnesses are grave or serious
4. Information be given in Chinese or use of Chinese interpreters
5. More attention and time given to diagnosis and instructions in Chinese language

Based on the above analyses, the Chinese seemed to have adopted a system of medical pluralism on a sequential order. They use the Chinese traditional medicine with its own definitions of illness based on manifestations and causation. However, when this fails, they seek external consultation in the public health system.

4.7 The Filipinos

Twenty Filipinos were interviewed to gain insights into their health concerns, services utilisation pattern, attitudes toward the health system and providers, as well as recommendations for encompassing migrants' health needs in policies and programmes.

4.7.1 Pre-Migration Illnesses

When queried on morbidity experience prior to migration, the recollection was nebulous. They talked of the usual fever, cough and colds which were relieved by medications purchased by the respondent and other household members in the Philippines. No report of serious illnesses was given.

4.7.2 Illness Experience in Spain

The following illnesses were reported (multiple responses):

1. Cough, colds and flu
2. Diarrhoea and gastrointestinal infections

3. Respiratory infections
4. Chronic respiratory infections
5. Arthritis
6. Eye problems and headaches
7. Cardiovascular and circulatory problems

These were attributed to change in weather conditions, particularly in winter, detergents and chemicals, physical exertion, dietary changes such as increased intake of meat, fat, sugar and salt, cigarette smoking, alcohol consumption and anxiety.

4.7.3 Causation, Manifestation, and Management of Illnesses

Inquiries were made on the specific illnesses in terms of their causation, symptoms, home management, external consultation and interval between onset and outside management.

The first line of response was self-medication and intake of tea. When respondents visit the Philippines, they purchase medicines that they are familiar with or prescribed by their Filipino physician from drugstores. Most of the Filipinos during their visit to the Philippines also consult private health care facilities and purchase medicines in bulk (for fever, diarrhoea, diabetes, heart diseases, etc.) to take back to Spain. These include Diatabs for diarrhoea, paracetamol for fever, Celebrex for pain relief, and Ventolin for asthma. They also asked compatriots who return to the Philippines to purchase these medicines for them. They resort to self-medication initially, seeking outside consultation after some time (days and months) when illness persists or becomes serious.

4.7.4 Awareness of Health Facilities

They recognised the primary health centres as the service points for health education, preventive care through immunisation and curative care. The hospitals are referral units for serious illnesses and surgery. Private clinics provide services but are deemed more expensive.

4.7.5 Utilisation of Health Services

The health centre is commonly utilised but frequency of visit is low and variable (monthly, every 2 months, once or twice a year). The crisis

orientation of the migrants is manifested in their visit to the health facility when the illness becomes serious or when home or self-management fails. Consultation is free and the service delivery point is accessible from their residence. Opening hours of clinics are 9 am to 8 pm; 8:30 am to 8:30 pm and 8:30 am to 9 pm. However, waiting time is long, ranging from 45 minutes to 2 hours. In the hospital, waiting time is between 1 to 2 hours. This is a deterrent since their income (mainly as domestic and restaurant workers) is based on hourly rates. There were clients who expressed their displeasure in the seemingly "inadequate services". According to some, providers in health centres and hospitals are formal. They are serious. Some raised questions regarding their competence. Tales of "incompetent practices" are shared. Information was seldom provided and explanations not given at length. No detail was given regarding illness management. They decried their inability to understand the Spanish explanation and would like to consult English-speaking health care providers. Medicines are free or cheap. Despite this, they opt to get their medications from home. They bewailed their inability to discuss their problem with the doctor. Thus, at the end of the consultation, there was the feeling that not much was gained despite the prescription of medication.

Specific problems were reported such as misdiagnosis based on hearsays related to mismanagement. These "hearsays" seemed to reinforce their mistrust of the providers. They also raised the prospect of bringing Filipino physicians and nurses to Madrid. Yet, they are aware of the strict accreditation requirements of the Spanish government for foreign health professionals. They mentioned that Latin American doctors (Ecuadorians and Peruvians) have been recruited in the health system.

From the clients' perspectives, the issues related to services provision are:

- Felt discrimination by providers due to their attitude and arrogance.
- Providers' misunderstanding of the clients' health situation.
- Long waiting time.
- Inconvenient clinic hours.
- Perceived lack of providers' competence.
- Language barriers.

Table 1. Filipinos' Illness Experience, Causation, Manifestations and Management

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

4.7.6 Normative Cultural Values Expected by Filipinos from Health Providers

The perceived arrogance and indifference of providers were linked to Filipinos' expectations regarding client-professional relationship. Normative cultural values are defined as the attitude and behaviours a particular group expects in interactions with providers. Five Filipino normative cultural values are expressed by clients as drawn from the key informants and the interviewees.

Simpatia (Compassion)

Simpatia means "compassion". This value is reflective of provider's concern toward the client's illness. The sympathetic facial expression of the physician in the midst of communication problems is important to the client. It is expected that he is polite, pleasant and agreeable. The relatively impersonal attitude of the physicians is viewed negatively. Lack of *simpatía* can potentially result in dissatisfaction with care, giving an embellished, inaccurate, or incomplete history, non-adherence to prescriptions, and non-return visit to the clinic. Resentment toward an emotionally detached provider may lead to withholding of illness details.

Personalidad (Personality)

Personalidad is the distinctive aura the provider exudes. In here, the patient sees the doctor as one who personifies authority, competence and knowledge and at the same time, compassion. Such attributes are demonstrated in the provider's self-confidence and grasp of the problem at the same time showing a tacit affinity with the client. Within the setting, the physician's personality could be manifested by eye contact, a smile, a firm handshake or a hand on the shoulder of the client.

Respeto (Respect)

Respeto literally means "respect." Health care providers are viewed as authority figures who must be given *respeto.* Patients also expect reciprocal *respeto* from the provider by not scolding them or showing dissatisfaction over their narration. Demonstrating *respeto* shows understanding of the patient. The "nod of the head" in response to a patient's complaint or grimace toward the patient's suffering may represent a socially required gesture of respect.

Familismo

Familismo is collective loyalty to the family in making decisions related to health. These are usually made by the family and not the individual alone. Treatment adherence or surgery is referred to the family. *Familismo* can result in delay or deferment of important medical decisions such as chemotherapy. Issues that can be affected by *familismo* are withholding of informed consent and medication. Clinicians demonstrate appropriate respect for *familismo* by providing ample time and opportunity for the family to discuss important medical decisions or meeting and discussing with them.

4.7.7 Interviews of Providers

Three public health providers were interviewed. Their tasks are to listen to patients, carry out diagnostic procedures, provide treatment and prescribe medications. Daily, about 30-40 patients are seen by them and Asians are a minority. The problems presented by Filipinos are respiratory (coughs, asthma, flu, pneumonia) as well as chronic (heart disease, hypertension, diabetes and arthritis), eye infections, backaches and fatigue. Their patients include children (less than 12 years); adolescents (12-20 years); and adults (more than 20 years). In the case of the Chinese, problems encountered by the providers are more serious such as the need for surgery, urinary tract infection, and pneumonia. The providers felt that they are medically competent to address the needs of all patients.

Regarding facilities, the current set-up is adequate. Basically, the problems are cultural and linguistic. They are linked to communication as they could not understand the symptoms as presented by the clients and did not know if clients understood what was explained to them. ("Se les debe informar de todo, el problema es la barrera de lenguaje. Muchas veces parece que te entienden pero la realidad ed que no.") Clients have to be informed fully but the problem is the language barrier. Many times, they show that they understand but in reality, they do not.

From the providers' perspectives, the following issues were drawn:

1. Heavy patient load averaging 30 to 40 clients a day. Such burden constrains adequate interaction with clients due to the pressure of serving all clients waiting in the clinic.
2. Communication with clients – The difference in language and culture deters a better understanding of the health problems presented. Varying

cultural perceptions also create differential treatment expectations. Providers feel that the clients are nebulous in describing their illnesses and their antecedents that prevent adequate diagnosis and management. They also doubt if the clients understood their prescriptions.

3. Lack of record completeness. Long working hours of clients (as domestic workers and restaurant servers) deter up-to-date follow-up consultations. They tend to seek emergency care which is provided 24 hours as they are not inclined to wait in the clinic. Records, then, become incomplete. This is compounded by the lack of understanding of the extent and gravity of their health problems.
4. Low compliance to medications and follow-up. Once the pain subsides, the patients do not return for follow-up care preventing long-term treatment in specific cases.
5. Lack of understanding of the Spanish health system, administrative steps and mistrust of foreign prescriptions.

4.7.8 Key Informants' Perceptions

Key informants (2 Filipinos and 1 Chinese-Filipino) who have lived in Madrid for more than two decades and have observed the shifts in Filipino and Chinese migration in the country were interviewed. From their view points:

1. The health system in Madrid is efficiently managed and operated. It has the appropriate facilities and trained manpower. However, the large and variable migrant population precludes adequate provision of services.
2. The first generation of Filipino migrants were professionals who undertook further studies in Spain or set up their businesses. Thus, they learned the language and communicated well with the local population. The present group of migrants are mainly service workers. They could not find time to learn the language or immerse in the Spanish culture. Thus, they find it difficult to communicate with health providers.
3. On the prospect of the second generation becoming part of the health system, the hesitation to shift to professional work among children is noted. One of the important aspirations expressed by the first group of migrants was for their children to attend university, learn Spanish, and undergo professional training. However, for the present group,

Filipinos would prefer to work because of the high income. Hourly rate is 8 Euros which is equivalent to Php 60. Thus, if one works for 8 hours, she/he gets 64 Euros or Php 3,840 daily. They accumulate savings. The level of education obtained by present migrants is high (some college). The long working hours of parents lead to the neglect of children who are more inclined to earn by working rather than to pursue a higher education. Besides, young people prefer going to UK or US for their further education or long-term stay. Among the Chinese, though, there is a substantial number of young people in the university or even medical school.

4. Despite the acquisition of Spanish citizenship of the Filipino migrants, they still gravitate toward the Filipino community – attending the same church, organising social activities, subscribing to Filipino soap operas on TV and circulating visits to the Philippines. If the intention is a long-term stay in Spain, their family should acquire language fluency, children should go to the university and assume membership roles in society.
5. The question of deployment of cultural interpreters was raised by key informants. They shared that:
    a) they may not be efficient given the many migrant groups with different dialects and languages requiring linguistic 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;
    c) the sustainability of such a proposition is questioned based on the cost implications of such initiatives; and
    d) it is not known if the translated pamphlets are read and understood given the multiethnicity of Chinese and Filipinos.

4.7.9 Barriers To Access of Health System from Clients' Perspective

There are constraints that make it difficult for the Chinese and Filipino migrants to access health care and specialised services:

1. Due to lack of knowledge of the immigration law and fear about contacting the police and other institutions, immigrants fail to obtain the necessary certificate that grants them the right to full health care. The reform

to the law concerning the rights and liberties of foreigners, although presented as a means of improving management via the simplification of administrative procedures, does not remove the fears of migrants. This modification, in conjunction with the law, which empowers the police to access the personal details of municipal residents, raises fear as manifested in the reticence to initiate steps to legalise their situation and gain access to health care, a reflection in the reluctance to obtain a health card.

2. The main problems the migrant population have in accessing the Spanish National Health System (NHS) services are linked to the administrative requisites. Immigrants registered as residents have access to all the services the NHS offers to Spanish citizens in exactly the same way. People who have not registered as residents have the right to emergency health care only. Nonetheless, in many cases, 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 services. Another problem arising from reliance on the emergency service is that, although it resolves specific problems, there is no follow-up of care.
3. Health centre hours do not cater to the immigrant population's employment, which has been identified as a barrier to access to services.
4. The relationship between immigrants and health services is characterised by lack of mutual recognition and understanding caused by cultural differences as evidenced by the complaints made by health care personnel in relation to immigrants (non compliance with prescriptions and treatment, narration of blurred symptoms, etc.) and vice versa.
5. These situations are worsened by communication difficulties between health care personnel and the immigrant population who speak a different language.
6. Difficulty in access to health services relates to work and the immigrant person's socio-economic context. For example, some consider sickness an obstacle to work. Fear of losing employment prevents people to seek health services.

In summary, the biggest public health problems facing immigrants (Filipino and Chinese) are those related to access to health resources and difficulties in communication, not only linguistic, but cultural.

4.7.10 Issues Emanating from the Research

1. Migrants have been viewed as transmitters of communicable diseases in the host country, reinforcing preconceived notions of that they are the sources of tropical infections. This predetermination has become an element of discourse in which immigrants have been blamed. However, recent epidemiological data from sending and receiving countries negate this assertion. This was validated in the health problems presented by the countries of origin in the study of their epidemiological situation.
2. Given that primary health centres are the entry point to the health system in Spain, problems in access by the immigrants could be attributed to concerns over doctor's consultation practices such as the questions asked, interpretation of illness and prescribed management. Missed appointments may be due partly to the lack of trust of clients in health care services; their misunderstanding of the instructions and prescriptions; communication problems (language barriers); or cultural differences in the perception of health and its management.
3. Integration is the process of adopting the cultural habits, values, and ideals of the host population through continued contact with the native population. This process has been linked to increased utilization of services and improved health status of migrants, where epidemiological evidence indicates an equal health profile for immigrants with the native population if they adapt to the country of destination. Given the circular movement of both the Chinese and Filipinos between the country of origin and destination, the question of transnationalism vs. integration is raised.
4. "Cultural competency" of health providers is a mechanism by which providers can adequately address the health needs of migrant populations through knowledge of illness. Efforts involve training on the characteristics of migrant populations with the goal of providing appropriate and acceptable services. Culturally sensitive programmes can positively affect health outcomes by considering or modifying their health beliefs and practices in therapy. Limited Spanish proficiency is associated with adverse consequences on health status, use of health services, and health outcomes. (Castañeda, 2010)
5. Medical Pluralism. A related area of concern in health care delivery is medical pluralism. Although "traditional" healing may seem to be a natural area for management, migrants often utilise services either exclusively or in highly complementary fashion. Patients consult

health providers simultaneously or sequentially in their search for optimal treatment. Even in cases where conflict with the biomedical model is evident, there seems to be a blending of approaches. Patients' noncompliance with treatments may be due to the viewpoint that medications (antibiotics) are "too strong" with many undesirable side effects. However, this may not lead to its rejection, but a blending with traditional health practices. Often, the lack of knowledge of health care options requires migrants to adopt multilevel, pluralistic healing systems. They are likely to seek out health facilities and practices that are familiar, acceptable, appropriate, affordable, and effective. Rather than simply representing a "culturally appropriate" site of health care practice, herbals serve a practical purpose: Without health cards to show or long waiting time for consultation, immigrants easily move into outlets providing immediate response to a pressing physical problem. These give them a "point of reference" for managing their health problems. Thus, medical pluralism is likely the norm rather than the exception. As the study of alternative and complementary medical practices expands, the concept of multilevel, pluralistic healing pursuits increasingly replaced notions of simple traditional/modern (biomedical) dichotomies. The prevalence of illness beliefs varies, depending on factors as ethnicity, origin, and levels of acculturation. (Tilburt and Miller, 2007)

6. Cultural mediators have been viewed from a dual lens. While clients extol their virtue in facilitating their interaction with the health providers, key informants expressed their concerns regarding the viability of their roles in the light of the increasing complexity of migration; the multiethnicity of migrants; their interpretation of migrant-providers interaction; dialogue; and the financial sustainability of their co-optation within the health system.

B. Italy

5.1 Introduction

Despite the sizeable publications concerning the integration of the Chinese and Filipino communities in Italy, literature focusing specifically on their health practices and needs is scant: only a few were identified concentrating mainly on the Chinese community and its relationship to health services (Geraci and Maisano, 2010; Cologna, 2005), reproductive health; motherhood and child care

practices (Dotti and Luci, 2008; Chinosi, 2004; Farina, 2003), and the linkage between working conditions and health (Wu and Zanin, 2009). With regard to the Filipino community in Italy, researches on their health are basically inexistent. In contrast, several studies on migrants' health are available, dealing with other ethnic communities using the health service.

Interest in this study lies on the health needs of these populations which though pressing, tend not to be addressed by Italian society and the national health system. Hence, they are met in ineffective ways. While making efforts to address the needs of those migrant users who are using the services, the Italian health system has not envisaged an effective and systematic strategy aimed at improving the knowledge and trust of the migrant population on the national health services.

The Italian health services guarantee access by all people living in the territory independent of characteristics and legal status. A large part of the treatment is provided at very low cost, if not free of charge. Legal immigrants, as Italian citizens, have the right to the utilization of the regional health services, through the general practitioner who responds to their health needs and assists them in accessing specialist outpatient and hospital services. GPs have limited consultation hours (5-6 hours a day) but long waiting time. There are other services such as paediatric care, preventive medicine, public hygiene as well as drug treatment in social and health care facilities which include psychological support, as well as advice on birth control. They provide free abortion (until the third month of pregnancy) and prenatal care at moderate cost, if not free of charge. In some centres, there are linguistic-cultural mediators who facilitate the interaction between physicians and patients.

This situation, however, is complicated by a bureaucracy that is difficult to understand, and long waiting time in clinics. It is also a problem for Italians, although the impact on foreigners is greater. The situation is exacerbated by linguistic difficulties during consultations, which can be insurmountable, aside from scheduling of appointments, which are always done over the phone, and for payment.

Some services (mostly maternity and childcare) have attempted to adapt to the users, but others have been slow to change and have not managed to respond adequately to the therapeutic requirements of immigrants. The lack of linguistic-cultural mediators impedes fluid relationship during consultation and obliges those who are not fluent with the Italian language to seek their own translators.

The Chinese and Filipino communities in Milan are analogous that make them distinguishable from the other immigrant groups in the territory. They both have a long length of stay, and, their sense of identity is strongly rooted in their country of

origin. Both groups have their own work niches, which allow for and facilitate the arrival of new migrants but at the same time blocking more emancipatory pursuits among the latter (Zanfrini and Sarli, 2009; OIM, 2008; Simmons and Garcia, 2008; Cominelli, 2004; Greco, 2004; Ceccagno, 2003; Cologna, 2003; Zanfrini, 1999; Farina et al., 1997; Lodigiani, 1995). The Chinese community in Milan is involved in commercial and catering activities (more than manufacturing), and even when the work involves direct contact with Italians, contact is limited. Likewise, Filipinos who work for most part in the house and for caregiving, live with Italians, but with distance, because of the reserve which the Filipino culture imposes and the detachment in working relationship which the Italians often impose.

This is, thus, a case of two populations locked within their intra-ethnic set up capable of satisfying their needs from their community, and strongly oriented towards returning to, or are closely linked to, their country of origin. This gives rise to situations, where despite the strong economic and time investment in the Italian territory (as shown by the acquisition of a house or entrepreneurial activities), there remains a strong tie to the country of origin. Even the second generation, with Italian laws, which grant citizenship on the basis of *jus soli*, could not solve the important issues for integration in Italy.

5.2 Results

5.2.1 Quantitative Analysis: Findings and Challenges

The common health problems encountered in the place of origin for both groups are of the respiratory tract, including allergies and asthma. Almost a fifth (17.5%) from both groups never had any illnesses in their country of origin, relatively higher for Filipinos (20.8% versus 14.2% in the Chinese). This can be explained by the young age at which migration started for the Chinese. As for infectious diseases, only 2 Filipinos suffered from hepatitis, and no sexually transmitted disease or tuberculosis was reported. Both Filipinos and, mostly, the Chinese did not speak readily about their own state of health, underreporting their problems and approaching them with embarrassment.

Climate was the most common reason for the illnesses by both groups (46.8%), followed by contact transmission for the Chinese (36.8%) and incorrect diet for the Filipinos (12.8%). The perception of cause is associated with a medical mind frame different from the Western system, which sees food as an important cause of ailments and key to physical wellbeing. Alcoholism, which affects many Filipinos, emerged as a problem. Alcohol abuse in the Filipino community was more prevalent among males.

Concerning the treatment carried out in the pre-migratory past, a difference in response between the two communities was noted. The Chinese made more use of traditional remedies known within the family (home management and traditional medicine) (27.6%). These are for the most part tisanes and herbal infusions either recommended by local herbalists or known in the family. There is an evident syncretic use of treatment systems – both Western and traditional – reported by almost 22 percent of the respondents. The sole use of Western pharmaceutical products, however, was recorded in only 35.2 percent of the Chinese, and 66.7 percent in Filipinos. The Filipino community, in contrast, is characterised by limited use of the traditional medicines – 14 percent of respondents used products known by the family – whereas 65 percent used pharmaceutical drugs and only 2 percent utilised a syncretic type of medicine (traditional and allophatic). In both communities, majority recovered from the health problem/s reported: 86.5 percent of the Chinese and 81.8 percent of the Filipinos.

As for the state of health in the 12 months preceding the survey, a higher percentage of Filipinos admitted having health problems. The reluctance on the part of Chinese migrants to report their state of health was noted. The causes of illness were varied. There are pathologies linked to stress, more present among the Chinese (8.3% versus 2.3% in Filipinos). In Italy, there appeared to be few cases of infectious diseases, and only one person, of Chinese origin, claimed to have a sexually transmitted infection. The qualitative analysis revealed a greater transmission level of infectious and venereal diseases. Stigma against those affected by sexually transmitted diseases was admitted in both communities.

The remedies in the 12 months preceding the survey indicate that the percentage of those who have not taken anything known in the family was the same between Chinese and Filipinos (37.6%). However, the percentage of those who made syncretic use of the traditional and modern systems differs: 16.1 percent among the Chinese as against a modest 8.2 percent in Filipinos. Both groups demonstrated considerable use of Western medicines, with a higher percentage among the Filipinos. Only in 10 cases from the Chinese community did there emerge the intake of medicines from China (1.2%), despite the fact that both Chinese and Filipino respondents reported, in the qualitative research, a wider use of medicines brought directly from the countries of origin or, as regards the Chinese, obtained in Italy, from those importing them illegally.

Concerning the use of the health services, 55 percent of Chinese and 58.5 percent of Filipinos turned to public health providers. The remainder did not do so due to the perceived non-gravity of the illness. The qualitative data reveal the difficulties experienced by the Filipinos and more of the Chinese in accessing and using the health services. The severity of a pathology as a justification for recourse to the health system is subjective. The idea that access to or use of the service involves effort and inconvenience could push the response to an exceedingly high level. Only 3.3 percent of Chinese claimed not to have consulted public health providers because of language problems. This should be studied in greater depth and put into perspective, in line with efforts to permit easier access to the national health services, which are increasingly adapting to the demands of the migrant population, not to mention the free or low cost services.

The degree of satisfaction with respect to the service received was of medium level (59% for the Chinese and 79% for the Filipinos). Only 18 percent of the Chinese and 11 percent of the Filipinos reported being very satisfied. Twelve percent of the Chinese and 8.5 percent of the Filipinos expressed a low degree of satisfaction. The qualitative analysis suggests that the level of satisfaction rises in some measure according to the profession of the interviewers who, as has been seen, were intercultural mediators.

Regarding the knowledge of the social and health services and the types of treatment they offer, there is a difference between the Chinese and Filipino respondents. In relation to knowledge the Chinese showed a lower level than the Filipinos. They have a stronger relationship with general practitioners and hospitals; whereas the *social and health care services*[1]and the *dedicated surgeries*[2] were less well known. The Filipinos knew more of the services, overestimating their information potential and their role in prevention. In contrast, the Chinese seemed to have no knowledge of the information, education and preventive activities promoted by the health services. Apart from the hospital, which was "rarely" used, other services were "never" used at all by most of the Chinese respondents, particularly the private (90%) and voluntary (96.2%) ones. About a tenth (10.2%) of respondents visited general practitioners often. These data are in line with what emerged

[1] Social and health care facilities are public centres distributed in the territory, dedicated to reproductive health of women. They offer medical and psychological services as well as advice on birth control techniques. They guarantee the right to abortion, which is free, and follow pregnancies with extremely reasonable fees. In some centres there are linguistic-cultural mediators who foster relations with users.

[2] Dedicated surgeries are centres that offer free health assistance to migrants not in possession of a regular residence permit. In the city of Milan only one is public, the rest being structures run and staffed by volunteers.

from the qualitative analysis. The Chinese used the public health services rarely, in most cases, availing principally the Emergency Department. For the Filipinos, the situation is different. More than half rarely visited general practitioners (57.9%) and hospitals (57.9%). Note, however, that they made decidedly greater use of the general practitioner than did the Chinese: general practitioners were visited by 21.1 percent of respondents.

There were more Filipinos among those who received information. Negotiations on therapy depend on the attitude of doctors and health workers who are not in a position to spend more time with patients. This difficulty was more strongly perceived among the migrant population, and among Chinese, although the difference from Filipinos was not noticeable.

The last concern is the mostly used information source. Among those of Chinese origin, 94.5 percent used the family and friendship network, followed by the alternative health care (37%) and the Internet, on websites in Chinese language. The professional health care and the Centres of Public Health registered little more than 20 percent positive replies. Pamphlets are read only by 9.1 percent of the respondents. Concerning the Filipino migrants the friendship network was the main source although the Internet played a similar role. Public care systems have an important role, along with the messages sent out via television and pamphlets.

5.2.2 Qualitative Analysis

The research findings distinguished the Chinese community and the Filipino population.

5.2.2.1 Chinese Migrants

Health providers describe the relationship with Chinese users as particularly challenging. Superficial communication does not encourage contact between the providers and clients and they are perceived distant from each other. Chinese patients are described as “closed”, “hermetic”, wary of forming an empathetic relationship with the provider and of providing details as to their health. Reserve and control of emotions are cultural features of the Chinese population. Direct questions, even in shedding light on their clinical condition, are seen as intrusive, and the provider is expected to give answers that are concrete, to the point, and directly aimed at solving the problem.

Providers and key informants concur in noting that the population from the rural areas of China constituting the majority of the Chinese residents in Milan (Farina *et al.*, 1997) display a lower degree of knowledge of the Western medical system than those from urban areas. Although the more urbanised regions of China possess *avant garde* health systems based on the coexistence of traditional and Western medical systems in the more remote areas, the health structures are less widespread, poorly equipped, and the population does not have the means to access them (Dotti and Luci, 2008). Hence, the frequent recourse to healers and to local, traditional therapeutic practices. This is reflected in migrants' relationship with the Italian health system, viewed as different from the population of rural origin. The latter, strongly anchored to traditional beliefs and practices, manifested reluctance to submit to management they do not understand.

5.2.2.1.1 Chinese and Western Medicine: Different and Complementary Therapeutic Sources

Therapeutic syncretism appears to be widespread among the Chinese in Milan. The individual can choose among traditional, Western or syncretic therapies, depending on the symptoms he has and the desired effect. Chinese medicine, based on a holistic approach, has a slower effect, since it acts on the root of the problem. It aims to restore health by acting on the equilibrium of the body. It is used for less serious health problems or ailments at their initial stages. Western medicine, however, acts directly on the symptoms and has an immediate effect, but causes imbalances addressed by traditional therapies. It is used in emergency situations, when the health problem is serious or at an acute phase.

5.2.2.1.2 Language Barrier

Obstacles in the access of Chinese migrants to the national health system were experienced. The first is linguistic: the competence of many Chinese in the Italian language is extremely limited, that in many cases, translation is indispensable. Even though linguistic-cultural mediation is available within the health service, it is present only in facilities devoted to maternal-child health. Elsewhere, the provider in case of necessity can use them, but this is inopportune

and ineffective. Moreover, since the utilisation of the mediation service requires resources, it is used only when necessary. To address the linguistic obstacles, many Chinese migrants rely on their children, who are more fluent in the Italian language due to their Italian education. In many cases, patients rely on the support of other members of the community with better command of Italian to act as paid interpreters.

5.2.2.1.3 Bureaucratic Apparatus

Linguistic difficulties contribute to the aggravation of another problem, the lack of knowledge of health services and the bureaucratic procedures required for their use. Hence, many Chinese migrants do not use the services, or abandon the course of treatment started. The role of providers should not be limited to information, but ensuring that they are understood. Few doctors, because of linguistic problems and lack of time, make time for this. Consultations are short, not leaving enough time to listen to patients and reply to their questions, even less so when lengthier explanations are needed. Treatment procedures become orders, given out without leaving time for negotiation or for the patient to understand the prescription. The risk is that users will be lost in a situation where they do not ask for explanations and default with extremely negative effects on their health.

Many documented Chinese migrants, despite having the right to services, do not follow the procedures to obtain a medical card, an essential document for medical coverage. The bureaucratic procedure, complicated by lack of knowledge of the system and the language barrier, become time-demanding. Work and the unavailability of time (the continuity of employment is essential, not only for sustenance but for the renewal of their residence permit) may stand in the way of completing the procedures. It becomes serious in the case where there is no residence permit. Even if this risk does not exist, among undocumented migrants, the fear is that going to a public institution means running the risk of being reported. This leads to health neglect. This lack of information is combined with diffidence in the face of bureaucracy. The climate of suspicion becomes an ideal breeding ground for prejudice and mystification. There is the risk of creating a vicious circle of transforming diffidence into fear. Adding

to this is the long waiting period in clinics. The Chinese, for both cultural reasons and the mentioned difficulties, turn to the health system only in cases of emergency. This is interpreted as neglect compared to the Chinese health system, which is extremely rapid.

5.2.2.1.4 Access to the Health System and the General Practitioner's Role

The service mostly utilised is the emergency department, which permits immediate access, without the bureaucracy and long wait. This is the only point of access for the numerous undocumented Chinese migrants who do not possess a medical card, although it is also widely used, often improperly, by migrants whose papers are in order. Few of those having the right to do so go to their family doctor, their relationship with whom may be marred by the language barrier. Policy makers indicate that there is no evidence for necessity for strategies to adapt to the needs of the migrant users. This need is not felt with urgency by family doctors, whose task is supported by the need to set up mediation services or *ad hoc* training courses. It is likely that the problem of the management of migrant patients is not perceived or reported by family doctors because of the infrequent use of the service on the part of those migrants who, like many Chinese, have serious difficulties in integration. The poor recourse to the family doctor is accounted by lack of knowledge of the national health system. The family doctor is linked to bureaucracy, perceived as poorly related to the health and looked upon with suspicion. The obstacles in accessing the national health system prompt the Chinese migrants, independently of their documented status, to make use of alternative treatment within their community.

5.2.2.1.5 Chinese Therapeutic System in Milan

This system essentially revolves around the "Chinese herbalists' shops": small shops selling mainly traditional remedies and often Western medicines, illegally imported from China. Chinese migrants obtain their supply of medicines from these shops, in the context of self-medication based on subjective interpretation of the elementary principles of Chinese medicine. These are practices aimed at solving pathologies of few consequences, such as colds and flu. When the

problem becomes serious, many opt to go to the national health system, which they access via the emergency department. However, given the low level of accessibility of the Italian health service, some migrants turn to medicines imported from China (traditional or Western) for chronic illnesses. Besides, the recourse to the Western pharmacopoeia from China, equipped with therapeutic indications in Chinese and accessible without a medical prescription, serves as buffer against acute problems, in rather a questionable way from the allopathic system viewpoint. The tendency towards a relaxed use of antibiotics, at times even administering them intravenously using equipment available at the herbalists' shops, is noted. This facilitates a rapid return to work. Side by side with the sale of medicines, some of these herbalists' shops, as well as ethnic private clinics, provide, illegally, a range of medical services to which the Chinese migrants turn because of the inaccessibility of the national health system and their diffidence towards it, above all by undocumented migrants. In addition to injections, drips and dental treatment, sometimes surgery is performed, such as abortion. These are disquieting, calling for urgency to set up services and information campaigns to promote access on the part of Chinese migrants to the national health system. Chinese migrants who run the herbalists' shops do not possess any professional medical qualification recognised by the Italian system, although in some cases they may have undergone some medical training in China. Hence their profession is not subjected to any kind of check and they ply their trade illegally. Chinese medicine is not recognized in Italy, and the same for qualifications obtained in China by doctors and pharmacists trained in the Western system. In Milan, there exists a limited number of Chinese doctors who, having obtained a degree in medicine in Italy, practise their profession legally utilising traditional practices of massage, acupuncture and phyto-therapy. It is not known whether, in addition to these officially recognised professionals, there are others equally competent but with no valid qualifications. In the absence of checks, the treatment system within the Chinese community harbours widespread abuse and fraud. Given the low level of accessibility of the national health system and the inadequacy of the community alternative, many Chinese migrants, in cases of serious pathologies, choose to go to their homeland for treatment.

5.2.2.1.6 Critical Health Issues Emerging from the Research

Concerning mother and childcare, breast feeding is not often practised by Chinese migrant women, and this is addressed by information provided within out-patient departments in supporting migrants' childcare. This is linked to the migrant's employment and not the culture of origin. The mother's need to start working soon after childbirth renders breast feeding irrelevant. For work reasons, babies are sent back to China at infancy, where they will be tended by grandparents or other members of the extended family. Since this detachment is necessary, Chinese mothers start bottle feeding. Providers consider this negatively, mostly through information and dialogue in out-patient departments specific for migrants. The practice of sending babies back to China might cause identity and adjustment problems, as usually happens when they return to Italy to start school. Such an early mother and child separation may be traumatic.

Health providers and key informants highlight the frequency of voluntary interruptions of pregnancy among Chinese women. This is considered a normal method of birth control and with no moral negative implications. This is linked to the policy in China, whose population control is not influenced by religious beliefs and where strict policies for population control have been implemented. Knowledge of the negative health consequences of repeated induced abortions is not widespread among the migrants, nor is information on the three-month deadline imposed by Italian law for voluntary pregnancy termination. For this reason, some women ask for this operation after three months of pregnancy, and the negative answer of the health service is not easy to understand. This operation is practised illegally in clandestine clinics within the community. Although they may express approval for the attention paid by the maternity and childhood services to the needs of the migrants, the key informants point to serious deficiencies in the other health sectors, in terms of linguistic-cultural mediation. In particular, the urology and dermatology departments. Urological health care involves delicate problems with various implications at the cultural and psychological level, with treatment requiring free-flowing communication and dialogue. The same goes for dermatology, which treats sexually

transmissible diseases. The latter seems to be widespread within the Chinese community, but highly stigmatized. This implies limited access to health services and low levels of information, leading to serious difficulties in controlling, preventing and treating these pathologies. A large number of documented and undocumented migrant women who access the service because of their pregnancy are found to be suffering from sexually transmissible diseases. Some policy makers, and in particular members of associations, highlight the fact that, for preventing the transmission of infectious diseases, access by undocumented migrants should be given, mostly through information about the possibility for them to be treated without legal problems, and by implementing policies that safeguard their health. Outreach initiatives can be promoted through information about existing services. Information concerning treatment should be improved to change the perception that people often have of infectious diseases, which are considered incurable and regarded with passivity in terms of medication. Consideration should be made for protracted treatments and the difficulty of following them. Some communication strategies should be implemented to simplify the exchange of information (Simich, 2009). Hepatitis B is widespread in the Chinese community of Milan, as China is a highly endemic country. Experts suspect that the HBV level of transmission in the ethnic community is underestimated and access, although high, is inadequate. In contrast with other sexually transmissible diseases, hepatitis B is not considered shameful due to the information campaigns about this pathology in China. Though information about modes of transmission and prevention is not widespread and should be improved, as well as services provided by the national health system. The extremely hardworking life of these migrants is the main reason for the frequent and serious problems in the orthopaedic field, which can only be temporarily relieved through anti-inflammatory drugs, but not treated, as the cause, work, cannot be removed. The working conditions are exhausting for newly arrived migrants who have to pay the debts for emigrating, and often live in slavery conditions. These are the main reasons for their need for psychiatric services. Some health workers reported that Chinese migrants cannot understand and refuse to consult a psychotherapist. This depends on their cultural point of view, which does not see

the separation between psyche and body (Dotti and Luci, 2008); Nevertheless, Liu et al. (2011) reported that the Chinese living in the Netherlands do not stigmatize mental problems. On the contrary, they use "pluralistic approach" that views Western medicine as alternative remedies to traditional medicine. Some providers point out that, in Italy, the number of Chinese requesting psychological support is increasing, although there is not an appropriate response from the social and health personnel. In fact, the psychological services for migrants are not widespread.

5.2.2.2 The Filipino Community

5.2.2.2.1 Discrepancy in Mutual Perceptions

Filipino users are more integrated and socialized to the national health system, more inclined towards sympathetic communication, and more familiar with the Italian language. Moreover, their competence in English helps in overcoming difficulties with communication; their deferential, accommodating and smiling attitude, even in the face of serious health problems, are the main features observed by health workers. The sentence "*they don't create problems*" is recurrent. Discontent and mistrust towards the national health system is widespread in the Filipino community which takes the form of sarcastic remarks and jokes. The technical competence of health providers is questioned, as well as their rather unsympathetic and uncaring attitude. Some discriminatory behaviours are denounced and the incompetence in managing intercultural and inter-linguistic communication has been reported. In particular, scarce attention towards Filipino peculiar cultural and linguistic needs is given. Health workers reflect on the silent, invisible nature of the Filipino presence, confirming what emerges from the literature on the Filipino integration model in Italy (Lodigiani, 1995; Cominelli, 2004; Zanfrini and Sarli, 2009). At first glance, this group seems to be perfectly integrated into Italian society, but, through deeper interaction, a more problematic reality emerges. In fact, their competence in Italian language is limited. This sheds light on the false appearance of ease and confidence of Filipino migrants within Italian society, specifically the health system. Going deeper into the relationship between health workers and Filipino users, several

criticisms are posited, which are masked by reciprocal adjustment strategies based on limited interaction. The Filipinos can maintain their non-problematic nature as long as interaction does not go beyond superficial contacts. Providers shed light on an interesting "camouflage process" that Filipino migrants demonstrate because of the hybrid nature of their cultural features. The different phases of colonial and cultural dominion that characterized the history of the Philippines, as well as the different immigration flows, which varied ethnic composition of this population in the destination, render these migrants difficult to recognize as having common peculiar cultural features. Some health workers had difficulties in reporting the health specificities of Filipino migrants, as it was impossible for them to focus on this typology of users. They tend to group them with Latino-Americans, because of their Spanish-sounding names, or describe them as very "Westernised", because of their competence in English language and certain affinities with American culture. This apparent "westernisation" is predominant in characterising health providers' perceptions, which efface cultural diversity and emphasise similarities. This is mirrored in their behaviours, which underestimate the danger of incomprehension linked to cultural differences. For all these reasons, the communication between health workers and Filipino users is superficial, ineffective and unsatisfactory for these migrants. This is sufficient to compromise their trust in the technical capacities of the health system. Another reason for the mistrust is the culturally determined tendency not to value public service. This is probably linked to the situation in the Philippines, where private health practice is more reliable and well equipped than public ones. Notwithstanding free access to the national health services, some Filipino migrants recourse to private medicine.

5.2.2.2.2 National Health System: Use and Access

Filipino migrants have an adequate knowledge of the national health system services. This emanates from the workplace, as Italian families employ many of them as domestic workers. Another source is the intra-ethnic network, in some cases, through people coming from the same country. Filipino migrants can easily access the Italian health service. Nevertheless, the lack of fluency in the Italian language and the superficiality of the consultations prevent them

to give a complete and satisfactory description of the symptoms. This results in anxiety and the impression that they are not fully listening, a source of frustration. Due to these negative feelings, they have difficulties identifying a trustworthy professional to guide them through a targeted diagnostic and therapeutic path. They tend to start a "pilgrimage" to the health services, which precludes an effective management of the problem. In the presence of a cultural and linguistic mediator, this situation tends to be solved, as this person becomes the reference point. In contrast, general practitioners provide guidance and are perceived to follow a bureaucratic procedure for accessing the public health system. The linguistic barrier is the problematic aspect of the relationship with general practitioners. This is overcome through the help of a person coming from the same country who is more familiar with the Italian language. Nevertheless, it is difficult to combine the appointment scheduled by the general practitioner with the work schedules of both the patient and his/her interpreter. Secondly, Filipino migrants have difficulties with long waiting time in the clinic. Aware of their poor fluency in the Italian language, they fear that the seriousness of their health problem may not be effectively conveyed during the phone contact with the doctor. They often recourse to the emergency department, which permits immediate access but does not create any relationship between doctor and patient.

Besides, this is the only point of access for the few undocumented Filipino migrants, who do not possess a medical card. Actually, recourse to the structures based on voluntary work is possible, offering free care to undocumented migrants in the territory. Sometimes, direct contact with the second level medicine provided by hospitals is possible. Nevertheless, they use this least frequently. It seems likely that the lack of direct contact with the local Italians and with other migrant communities prevent them from frequent use of the services.

5.2.2.2.3 Back to the Philippines

Given the low level of trust in the national health system and the difficulty of interaction with the providers, many Filipino migrants prefer to address their health problems back home, during their periodic visits. The advantage is they have more free time unlike

in Italy, where their jobs make it difficult to deal with their health needs. Besides, a strong family network in the Philippines lightens their condition. In the case of hospitalisation, the relatives and friends are seen as a fundamental element in the healing process. However, in Italy this collective behaviour is frowned upon by personnel as against the institutional rules. There is widespread use of allopathic medicines brought back from the Philippines, although the existence of an illegal trade was not observed.

5.2.2.2.4 Traditional Remedies

Traditional medicine does not play an important role in the health behaviours of Filipino migrants residing in Milan. Contacts were made with this therapeutic system in their pre-migratory past but not in Milan. Traditional medicine is considered by migrants as superstitious or outdated. Massage is considered effective.

In the Filipino community, there is no parallel intra-community therapeutic system, as in the Chinese. Notwithstanding difficulties of interaction and a high level of mistrust, migrants access the national health system and have a higher level of knowledge compared to Chinese. In Italy, there are very few Filipino migrants trained as doctors in the Philippines, as it is more convenient for these professionals to emigrate where their professional qualifications are recognised by national institutions. In contrast, quite a significant number of Filipino dentists practice their profession illegally.

5.2.2.2.5 Critical Health Issues Emerging from the Research

An important problem that arises is the difficulty in maintaining the traditional diet. As the market for Filipino products is not extensive in Italy, traditional eating habits are discontinued, which create imbalance. Economic reasons contribute to this situation, as some elements of Filipino food are expensive in Italy. This may account for the considerable number of cases of diabetes during pregnancy. A strong need for nutrition education is recommended. Information on this is lacking and prevention through sound life styles is not practised. Frequent abuse of alcohol among Filipino men is reported.

While breast feeding is more frequent compared to the Chinese community, similar problems linked to their time demanding jobs prod the women to send babies to the Philippines. The separation

between the mother and the child, as well as family reunification after some time, often have negative psychological ramifications both for the mother and the child.

Providers have problems dealing with the reproductive health of teenagers. The dialogue between generations is limited on this topic. Teenagers do not usually attend health and social facilities until their marriage, and have little information about sexual behaviour from their parents or relatives. This implies a number of teenage pregnancies, which are often interrupted through induced medical abortions. The emergency department represents the first contact between these girls and competent health providers. Health workers suspect an underground of illegal and dangerous practices. Sometimes these are linked to the time limit imposed by the Italian law for voluntary interruption of pregnancy which is not known. The need for information campaigns addressed to the Filipino community is underlined.

An emerging problem is related to mental health. Although the need for assistance is not widespread, it is evident that consultation with professionals is increasing. Physical health is sometimes compromised by psychological health problems, put at risk by migration problems associated with exhausting jobs. In particular, some Filipinos, mostly women, suffer from depression due to their employment as carers. This job involves assistance, day and night, to a non-self-sufficient person (disabled or elderly), in cohabitation with the assisted person. This implies a high degree of isolation and stress. For work reasons, some Filipino mothers cannot live close to their children and this represents another source of depression. As a consequence, the health providers are aware of the somatisation of the psychological problems, but the problem is that Filipinos find it hard to accept the psychological nature of their illness. However, it is not infrequent for them to accept psychological support, mostly through intervention of a health provider.

5.3 Discussion and Conclusions

The commonalities between the Filipinos and Chinese are the minimal use of social and health services available in the territory (Wu and Zanin, 2009; Cologna, 2005; Farina, 2003); the tendency of "not showing up" for follow ups, albeit in a

decidedly different manner between Filipinos and Chinese; and the use of other types of medicine, Western and traditional.

The poor recourse to the general practitioner, for both groups but more so for the Chinese, prevents them from having a reference point to the health procedures to be adopted and the ways they can avail of the health system. Moreover, the language problem can become insurmountable in illness (Wu and Zanin, 2009; Cologna, 2005; Farina, 2003). To this is added the complexities of the bureaucratic procedures which are difficult to understand rendering almost useless the services offered. The incapability of GPs to give complete service to their foreign patients and the necessity for the latter to use members of their family or community as interpreters not only make it difficult for them to find suitable schedules for visiting the surgery but undermines the degree of confidence between doctor and patient. This is starker when the issues to be dealt with are personal and the interpreters are the patients' children.

Although over the years the health structures have made use of intercultural interventions, the providers themselves are not equipped with the means to interact in a structured manner with immigrant users. Not only is there a lack of linguistic-cultural mediators, but also non-Italian medical and paramedical staff. There appears to be no easy solution to this because of the unwillingness of the Italian state to recognise the diplomas of professional migrants, which strongly affects providers' selection by the migrant population. The education of the second generation in Italian schools has not appeared to be a solution. ORIM (Regional Observatory for Integration and Multi-ethnicity) showed a high drop-out level from high schools among second generation Chinese and Filipinos, partly on account of the linguistic difficulties encountered in school by those arriving after the age of 10. Besides, the lower prospects of young people entering the Italian job market discourage them from completing their studies, and sometimes drives them to a "second" migration to countries with more opportunities. The last happens more among young Filipinos (Zanfrini and Asis, 2006).

A dichotomy with respect to the two groups from the providers' perspective was seen. The Filipinos were described as more integrated, with whom it is easy to talk to compared to the Chinese, who are more introverted and difficult to relate to. For the Filipinos, the health structures offer services that are not thorough and above all, poor in terms of communication with users. Moreover, the presumed competence in English as a means of communication leads to an overestimation of their Italian competence. The Filipinos, like other groups of migrants but to a lesser

extent the Chinese, go from one doctor to another; from one surgery to another; simply because they are not assigned to one of them. On the other hand, when the relations are positive and the communication fluent, the course of treatment is carried out successfully.

To this must be added the lukewarm faith of Filipinos in a public health service that they consider, *a priori*, to be of poor quality. Prejudice affects the services. In fact, although health workers consider the level of communication as satisfactory and their capability to respond to health demands is sufficient, the Filipinos seem to lack trust not only in their capacity for listening to them and understanding their problems but in the quality of the services provided.

Moreover, a situation emerges in which the linguistic-cultural mediator is able to supply a solution, which is more specific than systematic. Where mediators carry out their role with competence and empathy, the situation is better and the use of the service is better and more flexible. However, this does not apply to every case indicating that merely overcoming the linguistic barrier does not lead to greater trust in the health system.

Regarding the Chinese, there is a need for health literacy. Simik (2009) reports that projects using qualitative methodologies, participatory and collective engagement practices have been found to be most successful in this field. In Rome, as in Turin or Prato, experiments involving key figures in Chinese communities succeeded in reducing mistrust. At the same time, training of providers will enable them to re-evaluate their attitudes.

There should be reforms not only in the modalities of providing and publicising the services but in increasing trust in them. With the exception of the attention shown by some services in various Italian territories, such as Prato, with a high concentration of Chinese, the approach towards the immigrant population is still viewed as holistic. Since Italy hosts foreigners coming from at least 194 countries, the recurrent issue is that the health services cannot respond to their variety of needs, prompting personnel to adopt strategies of listening and adopting non-discriminatory attitudes. The problems include providers' experience gained over the years, opening hours, language comprehension, the capacity for listening of health workers and the complexity of the bureaucracy. Lack of faith in the health structures has never been tackled, nor has it ever been taken into consideration. Attention has been paid to the needs of those who seek treatment, but the voice of those who do not find their way into the care system has remained unlistened to (Ingleby, et al., 2005).

A rethinking should be made on how to improve the services and make them more user friendly, to attract the foreign users with no inclination to use the health services. Some innovations highlight the importance of effectively meeting the health needs of migrant women, taking into account their vulnerability (Wu and Zanin, 2009), as well as migrant men, mostly Chinese, whose difficulties in addressing the health system are linked to linguistic and cultural barriers, ignored and neglected in favour of their female counterpart. The maternity and childhood sectors warrant special attention. Although these services have been effective in facilitating access, educating the population on the use of the services and bringing personnel closer to users, the Chinese and Filipino communities, like other immigrant groups, present specific health problems for which there have been no specific actions.

Of particular note is the frequency of pregnancies in very young women and unwanted pregnancies ending in abortion. There is the problem of sex education for minors, which affects the autochthonous population as much as migrants. Sexually transmitted diseases constitute a taboo among the Chinese, resulting in serious cases increasing the risk of infection. Despite the health services, even for routine examinations, women prefer to wait until they go back to their home country. In the field of reproductive health, as well as for other health aspects, treatment strategies are adopted that are based on transnational practices leading to limited contact with the health system of the receiving country.

The Chinese make wide use of traditional medicine, practised by therapists whose competence is not supported by certification in Italy. Even more serious, however, is the use of a form of medicine that answers to the need within the community but which is not subjected to any form of control. Hence, over the years, surgeries of various kinds have sprung for specialisations as dentistry and gynaecology, where abortions are carried out (Irer-Piemonte, 2010). There also flourishes the illegal trading in medicines coming from the country of origin. This is true above all for China but to a lesser extent for the Filipinos. Health needs, not being addressed by the national health system, are being met by an autochthonous system offering ways of treatment that in many aspects do not appear to differ much from the national available services. In effect, the use of intravenous antibiotics in a clandestine surgery does not respond to the need for alternative therapies or to the desire for closer attention but reflects merely the desirability for a speedier intervention and the total lack of faith in the treatment system available in Italy.

Within this framework, instead of simply banning Chinese clinics in Italy, which usually manage to meet the health needs of Chinese migrants, but rarely can

address them effectively and in a safe manner, it would seem advisable to regulate and restructure these centres, by promoting collaborations between Italian and Chinese practitioners and health providers (Wu and Zanin, 2009). In the same perspective, a tighter collaboration between the health systems of the migrants' receiving and sending countries should be enhanced, through workshops, conferences, and health workers exchanges, aiming at drawing the contribution that countries of origin can provide for a better integration of their emigrants in their residence context (Kirishi, 2008).

This could contribute to the transformation of a system that has not yet succeeded in opening up to the immigrant population, with the consequence, particularly in the Chinese and the Filipinos, of scepticism toward the Italian health system that leads not only to the use of medicine that is not subject to any kind of control but also to the return to the country of origin both for preventive care and treatment. Here is a sort of health transnationalism which is the recourse to strategies of transnational nature to overcome the barriers to health services existing within the framework of a single national context. Unluckily, these strategies do not appear to be effective, as they do not address the daily dimension of one's health needs in terms of information, prevention and care. An important mechanism for identifying and filling the gap existing between the Italian health system and some migrant population users should be made.

6. Concerns and Challenges in the Incorporation of Southeast Asian Migrants' Issues into European Health Policies and Programmes

The two basic questions in this research are:

- What are the issues and challenges in the incorporation of Asian migrants' health concerns in European health policies and programmes; and
- What are the prospects for Asia-Europe cooperation in this area?

A major step is the translation of regional prescriptions from the numerous conferences, consultations and dialogues into national programmes that guide health services provision.

6.1 Challenges in Translation of Regional Recommendations into National Plans

a. 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 migrants' equity and rights to health. Basically, the congruence of policies and programmes is to be ensured; and

b. systematic approach to the translation of policies into programmes (guidelines, trainings) taking into consideration the regional recommendations in clinic operations, services provision, monitoring and evaluation of outcomes as related to migrants.

Health Services' Delivery and Migrants' Utilisation of Services

Priority areas are:

a. Understanding health and social issues related to migrants' health services;
b. Provision of health services that are culturally and linguistically appropriate within a comprehensive, coordinated and financially sustainable frame;
c. Capacity building of providers for the delivery of culturally and linguistically appropriate health services;
d. Enhancement of continuity and quality of care through adequate toolkits and standards in programme management; and
e. Ensuring systematic record keeping and development of database on health problems and services utilisation by migrants.

With the above suggestions, questions are:

- How could the regional prescriptions be translated into clinic terms?
- What training would the workforce need for the aforementioned purposes? Who should provide the training? What should be the contents of the training programme?
- Given the multiplicity of migrants' cultural groups and their linguistic variability, how could equity in access to services be realised within different health service delivery points?
- How could culturally and linguistically appropriate preventive, promotive and curative services be planned and implemented at the clinic and community levels? What are the prospects of migrants' involvement in these spheres? What are the requisites for their participation? How can they be technically co-opted?
- How can information and education programmes become culturally and linguistically sensitive? How effective are current information programmes with translated leaflets and other materials in raising health awareness of migrants and transforming their health-seeking behaviour?
- How viable and sustainable is cultural mediation in the patient-provider interaction to enhance the quality of service provision?

- How can programme operations and information/education programmes on migrants' health be monitored and evaluated?
- To what extent can best practices be documented for their replication and sustainability?
- What should be the indicators of best practices in terms of the integration of migrants' concerns in health services delivery? How could innovation, health impact, replication and sustainability be assessed?

6.2 Challenges from the Research

Four major issues and concerns emerged, from the study, which can influence the adequate utilisation of services by migrants. Recommendations could then be extrapolated from these:

- Quality of health services delivery
- Medical pluralism
- Cultural and linguistic competence of providers
- Transnationalism versus integration of migrants into the Spanish/Italian mainstream

6.2.1 Quality of Care

Most clients deplored the quality of service provision basically in terms of lack of good interpersonal relations and information and mistrust of providers.

Quality is an important element in health service delivery. Literature discussed quality largely in terms of clinic operations. This approach overlooked the interpersonal dimension of care and suggested that quality meant technically competent providers and up-to-date clinic facilities. The components of quality health care programmes are: information given to clients; technical competence of providers, interpersonal relations between clients and providers, follow-up or continuity mechanisms; and appropriate constellation of service for referrals. (Bruce, 1990)

6.2.2 Medical Pluralism

An emerging area that is of interest and concern among policymakers and programme planners is medical pluralism. The research on health services utilisation reveals a wide range of options. With the recognition that migrants

adopt traditional systems of health practice, views on the acceptance of cultural pluralism in health care are shaped by a number of factors. The understanding of illness and its management influences cultural pluralism in migrant groups as distinct from the biomedical perspectives. This can also be viewed as complementary health care signifying that it can work with biomedicine. This approach is recognised in many Asian countries (e.g. China, India and the Philippines) and has been adopted as a component of public health programmes within the Asian region. For example, Chinese patients utilise their traditional medical system, simultaneously or sequentially with Western medical practices. This does not imply a rejection of the biomedical system, but a blend of Western and traditional health practices. Migrant populations with developed health systems in their home country utilise multilevel, pluralistic healing systems. They are likely to initially seek out health facilities and practices that are familiar, appropriate, affordable, and effective to them. Herbals are familiar to populations. 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 find immediate response to pressing physical concerns." Medical pluralism may 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 among 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 assist in clinicians' deliberations related to complementary medicine. A three-point practical approach or recommendation in applying basic principles of ethics in the light of medical pluralism are: (1) inquiring about complementary medicine and the scientific evidence related to it, (2) acknowledging the health beliefs and practices of patients, and (3) accommodating diverse healing practices. As such, recognition of medical pluralism encourages pragmatic willingness to examine the personal and cultural meanings associated with its use, the biases and assumptions of biomedicine, as well as the risk-benefit ratio of these practices. In this way, recognition of medical pluralism can help clinicians and policy makers enhance patient care in a manner consistent with basic public health principles.

6.2.3 Cultural Competence of the Providers

6.2.3.1 A Culturally Competent Health Provider:

- acquires cultural competency during medical and postgraduate training;
- is provided with cultural competency standards to guide the work;
- has information about specific migrant groups;
- ensures that skills rather than stereotypes are promoted, with an understanding that migrants are influenced by their cultural context and situation which could be modified;
- 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.

6.2.4 Transnationalism vs. Integration of Migrants

Given the medical syncretism adopted by the Filipinos and Chinese, the divide between transnationalism and integration is posited.

6.2.4.1 Transnationalism

Transnationalism is defined as the processes by which immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement. It emphasizes that many immigrants build relations that cross geographic, cultural, and political borders. An essential element is the multiplicity of involvements that transmigrants sustain in both home and host societies. (Portes, 1997) This becomes an impediment in transcending the cultural-linguistic divide in health service utilisation in the host country. Migrants return to

their home country for health care and procurement of medicines. Transnationalism challenges the previously held view of migrants as either maintaining shallow allegiances with the place of destination and strong connections with the place of origin if the intention is to return to the latter after an economically-oriented sojourn to the former, or undergoing the incremental processes of adaptation, integration, acculturation, and gradual weakening of ties with the home country if their long-term future is seen as lying in the place of destination. Analyses of transnational migration challenge the 'either-or' categorization of local (un)rootedness, and emphasise situation of simultaneity: social practices and multi-stranded social relations which are simultaneously 'here' and 'there' – both oriented to the destination(s) and the 'home.' (Yeoh, Willis and Fakhri, 2003) In such circumstances, the rigid boundaries and structures that separate origin and destination recede with the emergence of transnational social (and economic, political and cultural) moulds. (ibid) People live dual lives or more accurately single lives in dual or multiple contexts in which they build and sustain livelihoods, and maintain social roles, functions and attachments which crosscut national divides: "living a substantial part of their emotional, social and economic lives in their place of origin while working, living and settling elsewhere." Such movement does not consist of a single type of migration, but incorporates a wide variety of movements with their transnational connectivity and simultaneity. (Kelly, 2003)

Globalisation has been valued for its role in facilitating transnationalism. There has been an observed technical (and financial) feasibility of individuals to live and work in one place (destination) while retaining a role, stake and involvement elsewhere (place of origin). Space-time shrinking technologies – cheap flights, e-mail, cheap telephone calls, bank transfers, etc – have made it easier and affordable for transmigrants to keep in regular physical or electronic contact with family members or business associates back home, allowing them to maintain an involvement and influence in household decision-making including the transnational rearing of children and relatives, (ibid) as well as involvement in community decision-making and politics, business activities and local socio-cultural events.

6.2.4.2 Integration

For the second-generation migrants to flourish in Spain and Italy, integration seems to be the most logical approach in the future. Esser (2001) claims that integration not only matters but there is, in fact, no alternative to it within the long-term migration scenario. School attendance at all levels is decisive for individual competitiveness in labour markets and to access 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 or Italian language. Access to employment, health services, and education is provided by the state. Migrant integration can occur in functional realms: businesses, hospitals, clinics, universities, and local administration. Every migrant who intends to avail of these provisions must fulfil the preconditions of integration. He must, therefore, have some knowledge of what it means to work or behave as a worker, a patient or a student in the host country. All migrants integrate when they take roles inside organisations and fulfil the social expectations linked with these roles. It is difficult to understand how they succeed in acting inside a variety of organisations if they do not meet the expectations of these roles. The family of migrants must be responsible, competent and disciplined to take over membership functions in the Spanish or Italian community. They are expected to orientate their modes of life to the conditions in host social systems and develop corresponding competence and attitude. (Bommes, 2009) Four dimensions of integration are distinguished at the individual level – cognitive, structural, social and identificational. Cognitive integration refers to the adaption of processes necessary to fulfil conditions of inclusion in social systems. Individuals learn the language, skills, behavioural and situational norms of the receiving country. Structural integration refers to the process of taking membership roles in organisations, and realising income gains through occupational positions and formal education. This refers to the migrants' participation in social systems for better income, education and health. Social integration refers to migrants' social relations like friendships, intermarriage, membership in associations and networks. Identificational integration refers to the claims of belonging and identity with the host country made by migrants themselves. (Esser, 1980)

6.2.4.3 Integration as a Social Model for Migration

Three major dimensions of the integration process are: socio-economic, legal-political and cultural. Any policy that promotes integration should take into account each of these three, individually and their complex interrelationship. In reality, many policies that promote integration and improve migrant relations overlook this complexity. It assumes a significant degree of cultural adaptation of most immigrants to their new environment. Those who are successful may have opportunities. Those who are not risk becoming marginalised. However, limiting the debate on integration to the multiculturalism and integration divide overemphasises the relevance of the cultural dimension at the expense of legal and socio-economic aspects. A secure legal position and a satisfactory degree of institutional incorporation no longer seem to be the only conditions for successful integration. Familiarity with the mainstream language and culture of the country is a major determinant for successful integration. The need for acculturation emerges as an additional prerequisite for successful integration. (Entzinger and Biezeveld, 2003) This new trend in thinking on integration is captured in the European Commission's *Communication on Immigration, Integration and Employment (2003)*: "Integration should be understood as a two-way process based on mutual rights and corresponding obligations of legally resident third country nationals and the host society which provides for full participation of the immigrant. This implies that on the one hand it is the responsibility of the host society to ensure that the formal rights of immigrants are in place in such a way that the individual has the possibility of participating in economic, social, cultural and civil life and on the other, that immigrants respect the fundamental norms and values of the host society and participate actively in the integration process, without having to relinquish their own identity." (European Commission, 2003: 17-18).

6.3 Prospects for Asia-Europe Cooperation

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 incorporating these concerns; and the assessment of prospects for Asia-Europe Cooperation in health programming to better reflect their situation.

1. Sharing of policies and programmes related to the prevention and management of communicable and non-communicable disease.
2. Exchange of epidemiological data disaggregated by sex and age or knowledge transfer in terms of classification and categorisation of illnesses, information retrieval, processing, analysis and presentation for evidence-based policy making and programming (by nationality and demographic characteristics of migrants). (epidemiological reporting)
3. Strengthening of health systems in sending and receiving countries based on emerging health issues.
4. Bilateral and multilateral cooperation in assessment of health status and access to health care as well as indicators' identification and retrieval.
5. Exchange of information, education, and training programmes and best practices related to health in both regions using mutually agreed upon indicators.
6. Collaborative research programmes in the assessment of socio-cultural determinants of health practices of migrants, interventions to improve their utilisation of services and the efficacy and safety of traditional/alternative medicines.
7. Assessment of the prospects of adoption of traditional medicine within the public health system in receiving countries.
8. Development of data bank with common indicators for use by receiving and sending countries.

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