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In spite of its recent expansion, the amount of scientific literature on migration and health remains limited in Switzerland. Identifying lack of research is particularly important, since appropriate measures can only be implemented if they have scientific foundation and support. The aim of the present study is to identify priority areas and related issues of problem-oriented basic research that need to be addressed in Switzerland.

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Jenny Maggi, in collaboration with Sandro Cattacin

Research report
29 / 2003

**Needed Basic Research
in "Migration and Health"
2002-2006 in Switzerland**

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**Needed Basic Research in
„Migration and Health“ 2002-2006
in Switzerland**

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Introduction

The major challenge faced nowadays by the healthcare system in a pluralistic state like Switzerland, characterized by an important immigration history, is that the multicultural composition of the population asks for a health system that takes into account differences in needs, beliefs and practices concerning health and healthcare delivery. The Swiss Federal Office of Public Health (SFOPH) has become active at the beginning of the 1990s in the „Migration and Public Health“ sector with the targeted promotion of measures in selected groups of different national origins. The „Migration and Public Health Strategy, 2002-2006“¹ aims to reinforce these initiatives and to develop them in a systematic way. It pursues a dynamic and holistic approach of health encompassing the physical, mental and social well being (e.g. quality of life, social and economic security, good education, healthcare system accessibility, mobilisation of potentials), and is committed to the development of framework conditions for equal opportunities and integration (equal participation of migrants in social, political, economical life, mutual respect for differences).

In order to respond to a society and clientele whose nature and needs have changed as a result of migration, the strategy's main objective is the reorientation of the healthcare system towards the needs of a pluralistic and heterogeneous society. To improve access to the healthcare system and to provide specific services, research findings (Chimienti and Cattacin, 2001) and practical experience on which the strategy is based have permitted to define five fields of interventions (BAG, 2001). Priorities for the period 2002-2006 have been set in the following five areas: (1) *Education* (training in interpreting and intercultural mediation; advanced and continuing education of migrant issues for all healthcare professions); (2) *Public information, prevention and health promotion* (empowerment of the migrant population, raising the awareness of

¹ This strategy is a result of several experts' investigations (cf. Haour-Knipe and Fleury, 1996; Efonayi, Chimienti, Losa, Cattacin, 2001; Chimienti and Cattacin, 2001) and consultation processes, and has been developed in accordance with the WHO goal of „Health for All by the Year 2000“ by the Swiss Federal Office of Public Health, in cooperation with the Federal Office for Refugees, the Federal Aliens Office and the Federal Commission for Foreigners.

service organisations in the healthcare sector); (3) *Health care provision* (removing barriers to access; reference services; use of interpreters); (4) *Therapy for the traumatised asylum seekers* (specialised services; low-threshold services); and (5) *Research* (problem-oriented basic research; monitoring the health of the migrant population; evaluation of the measures).

As for research, Swiss and international scientific literature concerning the health of migrants is relatively recent (for a systematic review see Weiss, 2003). In Switzerland, during the last decade, an important amount of research in the field of migration and health has been developed, most probably because of the evolution of immigration (foreign workers have been gradually replaced by migrants with different demographic profile and national origins). Moreover, migration of asylum seekers and refugees with specific risk factors has increased. As a result, several studies in Switzerland have been focused on asylum seekers and refugees, for instance treatment of trauma (Wicker, 1993; Moser et al., 2001), consequences of torture and organised violence (Loutan and Subilia, 1995, Loutan et al., 1999; Gilgen et al. 2002), medical general assistance (Blöchliger et al., 1994), communication between physicians and patient in ambulatory health care (Blöchliger et al., 1997), in accident and emergency department (Blöchliger et al., 1998). Other research issues have concerned, for instance, doctor-patient interaction (Salis-Gross et al., 1997), interpreting and intercultural mediation (Weiss and Stuker, 1998; Singy et al., 2003), language barriers to healthcare (Bischoff, 2001; Bischoff et al., 2001), the establishment of transcultural competence in health institutions (Domenig, 2001), lifestyles and preventive behaviours among migrants (Wanner et al., 1998), migrants' utilisation of public psychiatric services (Testa-Mader et al., 2003), and transnational health strategies (Salis-Gross and Loncarevic, 1999).

In spite of its recent expansion, the amount of scientific literature on migration and health, as Chimienti et Cattacin (2001) have pointed out, remains limited in Switzerland. Identifying lack of research is particularly important, since appropriate measures can only be implemented if they have scientific foundation and support. The aim of the present study, which has been mandated by the SFOPH (Migration and Health service), is to identify priority areas and related issues of problem-oriented basic research that need to be addressed in Switzerland.

Method

In a first step, identification of *needed research* areas and related issues in Switzerland has been conducted by reviewing recent Swiss and international literature (published articles and books, 'grey literature') concerning the thematic under examination. Firstly, Databank from Medline, Aidsnet and from specific library archives (in particular FSM, Tropeninstituts, International Organization for Migration, RERO) has been investigated. Secondly, a series of pertinent scientific journals has been addressed (in particular, Ethnicity and Health, Journal of Immigrant Health, Social Science & Medicine, Medical Anthropology, Anthropology & Medicine, The European Journal of Public Health, Transcultural Psychiatry, International Journal of Social Psychiatry, Patient Education and Counselling, Health Policy, Women's Health Issues, Health and Place). Thirdly, an analysis of particularly relevant recent Swiss and international publications² has been conducted. Finally, Swiss Institutes of Social and Preventive Medicine, STI and University Hospitals has been asked for recent unpublished studies (or 'grey literature'). Identification of needed research has resulted from both authors' considerations regarding lack of research, and comparison between research issues conducted in Switzerland and in other countries. A first draft has been prepared at the end of this step,

² Chimienti, M.; Cattacin, S. en collaboration avec Efonayi-Mäder, D., Niederberger, M., Losa, S. (2001). « *Migration et santé* » : *priorités d'une stratégie d'intervention*. Neuchâtel : Forum suisse pour l'étude des migrations, Rapport de recherche du Forum suisse pour l'étude des migrations ; no 18. Gardemann, J., Muller, W. Remmers, A. (2000). *Migration und Gesundheit: Perspektiven für Gesundheitssysteme un öffentliches Gesundheitswesen*. Berichte & Materialien Band 17. Düsseldorf: Akademie für öffentliches Gesundheitswesen in Düsseldorf. IOM (2000). *Migration and Health. Migration Health in the year 2000 - Whither the future ?* Geneva : IOM. Loutan, L. (2001). The health of migrants and refugees. In: J.N. Zuckerman (Ed.), *Principles and practice of travel medicine*. Chichester : J. Wiley. Marschalck, P., Wiedl, K. H., Eds. (2001). *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch. Moser, C., Nyfeler, D., Verwey, M., Eds. (2001). *Traumatisierung von Flüchtlingen und Asyl Suchenden*. Zürich: Seismo. Murray-Garcia, J. L. (2002). *Multicultural health 2002: an annotated bibliography*. Woodlands Hills: The California Endowment. Nazroo, James Y. (2001). *Ethnicity, class and health*. London : Policy Studies Institute. Smedley, B.D., Stith, A.Y., Nelson, A. R., Eds. (2003). *Unequal treatment. Confronting racial and ethnic disparities in healthcare*. Washington, D.C. : The National Academies Press. Van Krieken, P. J. (2001). *Health, migration and return : A handbook for a multidisciplinary approach*. The Hague : T.M.C. Asser Press. Weiss, R. (2003). *Macht Migration krank? Zürich : Seismo. Wicker, H.-R., Fibbi, R., Haug, W. (2003). Les migrations et la Suisse. Zurich : Seismo.*

reporting four identified areas of needed research and a series of related issues (cf. Appendix 1).

In a second step, *priority research* areas and related issues have been identified by external expertises among the catalogue of needed research of the first draft. Ten experts in the field of migration and health, as well as five representatives of relevant institutions (cf. Appendix 2) have been contacted for comments to the first draft, detection of priority research among the selected needed research issues, and for possible identification of alternative priority research issues. As a result of external expertises, modifications have been introduced in the final paper³, and priority research issues in each thematic area have been established.

The paper will indicate⁴ both research issues that need to be investigated in the future and recommendations for priority research. Needed research has been divided into four broad thematic areas: (1) Health system; (2) Barriers and disparities in healthcare; (3) Life-world; (4) Monitoring. For each thematic area, specific research issues that need to be further developed will be presented. Priority research (resulting from external expertises) will be indicated in chapter ‘Recommendation for priority research’.

As for terminology⁵, the terms ‘migrants’ will be used in this text to indicate those people who have either come to Switzerland from another country (external migration), or have a direct migration background in their family (offspring of migrants), although this does not mean that they all have similar level of entitlements (e.g. legal status), length of stay (short-term or long-term migration), or health status.

³ In particular, as a result of external expertise, research issues or paradigm not previously mentioned have been introduced in the final text, and research issues considered as already investigated in Switzerland have been removed. Other modifications have concerned the introduction as well as terminology.

⁴ In this text, we will focus more on needed research issues rather than on a discussion of existing findings in Swiss and international literature.

⁵ There is no universally accepted terminology to describe migrants and their offspring. As Bollini and Siem (1995) has pointed out “According to historically and socially determined views on migration, the terms migrants, immigrants, ethnic minorities and ethnic communities may sound perfectly legitimated in one country and offensive or biased in another” (p. 819).

1. Understanding the reaction of the healthcare system to pluralistic societies

This thematic area is expected to highlight research issues that should better illustrate the ways in which the healthcare system react to the pluralistic composition of the Swiss society. Several research issues are linked to this thematic area, in particular doctor-patient relationship; interactions and communication between care providers (medical and non-medical professionals) and patients; patients’ and care providers’ decision-making and factors affecting the decision-making process; psychosocial issues and emerging interdisciplinary paradigm.

At this level, literature review show that it is essential to better acknowledge how ethnicity and social factors (e.g. gender, legal status, social class) influence patients’ interactions with the range of healthcare professionals (medical and non-medical profession) with whom they come into contact. A large amount of research, especially in US (cf. Murray-Garcia, 2002; Smedley et al., 2003), has been focused on the impact of ethnic concordance/discordance between physicians and minority patients on communication, decision-making and mutual perception, and the impact of these variables on health outcomes and satisfaction (Cooper-Patrick et al., 1999; Saha et al., 2000; Cooper and Roter, 2003). As in Switzerland ethnic providers remain a small fraction of the overall healthcare force, ethnic concordance/discordance research may not appear a priority. However, these studies highlight the importance of better documenting social and ethnic factors that affect communication, mutual perception as well as decision-making and service delivery. Further studies should focus on decision-making by patients and care providers, on the assessment of care management at different points along the continuum of care, and on the impact of patient-provider interactions on diagnosis and treatments (Smedley et al. 2003). For instance, additional research is needed on provider decision-making heuristics employed in diagnostic evaluation (Wennberg, 1999), and how patients’ ethnicity and other social factors such as gender, social class, legal status may influence these decisions. Experimental research has been conducted to assess the extent to which physicians’ treatment recommendations differ by patient ethnicity and gender (Schulmann et al., 1999). This research should be expanded to explore how social cognitive processes (e.g. bias, stereotypes, cf. Dovidio,

1999; Mackie, Devos and Smith, 2000; Operario and Fiske, 2001) may affect patients' and providers' conscious and unconscious perceptions of each other and influence the structure, processes, and outcomes of care (van Ryn and Burke, 2000; Balsa and McGuire, 2001). The attention should also be focused on the impact of ethnicity and social factors on the quality of patients' and providers' relationship, communication, and interaction (Krupat et al. 1999; Cooper-Patrick et al., 2000; Cooper and Roter, 2003), for instance in terms of symmetrical or asymmetrical relationship, empathy, mutual comprehension, treatment's observance, symptoms expression, mutual trust (cf. the reference to 'patient-centeredness' in medical communication research, Mead and Bower, 2000; Sullivan, 2003). To this respect, a better definition of communication and interaction quality's criteria is needed -matching both providers' and patients' perceptions and needs- also in order to identify to which extent particular characteristics of the interaction/communication process affect diagnosis, treatments and health outcomes. In addition, further research should better determine whether structural, institutional and organisational factors of healthcare settings affect the content of care and quality of communication for migrant patients (Weiss, 2003).

As Smedley and colleagues (2003) have pointed out, it is worth noting that within the vast majority of research that documents ethnic disparities in care, decision-making and communication processes have been focused on the role of the physician. This fails to consider that much of healthcare is provided by non-physician professionals (e.g. nurses, occupational and rehabilitation therapists, psychologists, social workers). The roles of other hospital and clinical staff (receptionists, community interpreters, intercultural mediators) are also central in contributing to the 'climate' in which care is delivered. These professionals play a significant role in conveying messages of respect and dignity and in influencing how patients feel about the healthcare setting (Habermann, 2000; Kingsley, 2001). Research is needed to assess how these individuals perceive, interact and communicate with migrants, and how patients respond to them.

Further research should also assess how educational programs can improve staffs' (physicians and non-physicians) attitudes, behaviours, and communication with migrants (e.g. transcultural communication, Luckman and Tindell Nobles, 1999; transcultural education, cf. Donini-Lenhoff and Hendrick, 2000; Nunez, 2000). The development of questionnaires or other forms of self-assessment to measure care providers' attitudes and stereotypes is also recommended (Paniagua et al., 2000). Research is critically needed in order to

study interactions, forms of communication and problems of contact between migrants and the range of healthcare professionals (Smedley et al., 2003). To this respect, it is also essential to better clarify legal, structural and financial possibilities of the healthcare system for the improvement of the communication process with migrants (Weiss, 2003). Further, strategies to increase migrants patients' ability to participate in treatment decisions and empower them as self-advocates within the healthcare system should be studied (Roter and al, 1998). It is important that such research are conducted in active collaboration with ethnic communities and representative associations, in order to match cultural knowledge and traditions that may serve as source of strength in the effort to empower migrant patients.

Another major challenge for the healthcare system is how to deal with mental suffering and psychosocial problems of migrants. First of all, lack of data concerning psychosocial health problems of migrants is observed (Chimienti and Cattacin, 2001). In fact, hospital discharge records and physicians reports do not generally yield data concerning migrants' specificities. The absence of these data does not permit to have a clear view of the most frequent psychosocial problems of migrant patients. Therefore, research is needed in order to set up statistical data concerning the most common psychosocial health problems of migrants that takes into account a pertinent range of variables differentiating these groups of patients (cf. Bischoff and Wanner, 2003). Representative surveys concerning the psychosocial health of different groups of migrants are also required. A lack of psychosocial and medical case-control studies on specific risks linked to migration for different groups of migrants is also noticed in the literature (Weiss, 2003). In addition, research that aims the verification of the impact on mental and psychosocial health of a series of variables linked to migration (e.g. language proficiency, legal status, integration, motivation of migration, expectancies and attitudes relatives to the host country, social policies) is required (Zenker, 2000).

Research is critically needed also for culturally sensitive diagnosis and treatments of psychosocial sufferings, and for the comprehension of their causal factors (etiology). Concerning diagnosis, a further development of innovative multidisciplinary lines of research is demanded in order to assess early diagnostic of psychosocial morbidities related to migration (Riecken, 2001). As for psychosocial treatment and assistance, it is important to better analyse the possibilities and difficulties of care giving to migrants in the realm of medical and hospital practices (Weiss, 2003). Innovative and

multidisciplinary models of psychosocial treatment and assistance should be further developed (Eberding and Schlippe, 2001; Faltermeier, 2001), matching migrants cultural needs and practices as well as their health perceptions (development of a culturally sensitive therapeutic concept). Concerning research aiming to study the etiology of psychosocial problems of migrants, it is necessary to take into account a large variety of variables linked to migration (e.g. language proficiency, legal status, origin, integration, motivation of migration, expectancies and attitudes relatives to the host country, social policies), and to differentiate migrants in distinct relevant demographic categories (e.g. origin, age, gender, social class). In addition, more attention is to be devoted in the future to the development of holistic approaches of diagnosis, etiology and treatment of psychosocial problems of migrants (Watters, 2001). An holistic approach suggests that rather than impose a dualism which seeks to define if the client has a physiological or a psychological problem, it may be more appropriate for clinicians to ask patients for their own view regarding the etiology of their conditions, and choice of treatment.

Emerging interdisciplinary perspectives (e.g. medical anthropology, cultural epidemiology, -integrating anthropology and epidemiology, cf. Weiss, 2001; transcultural psychiatry, a psychological approach of migration -situated at the frontier of psychology, intercultural psychology and health), taking into account the multicultural population composition, should be further developed. Analysis of their potential for interdisciplinary research and intervention in the domain of healthcare and health prevention (or promotion) is recommended, at both conceptual and methodological level (Weiss, 2003). Finally, meanings of healthcare systems' and practices' changes for professionals (e.g. the necessity of collaboration and coordination between medical and social sciences -derived from migration and the multicultural composition of modern societies) should be carefully studied in order to assess and manage potential professional identity crisis or conflicts (Rossi, 2002).

2. Understanding barriers and disparities in healthcare

Migrants have generally reduced access to healthcare in receiving societies for a number of political, administrative and cultural reasons that are not necessarily present for the native population, which vary in different societies and for different minority group. Language, different concepts of health and disease, or the presence of racism and xenophobia are examples of such selective barriers. Barriers to healthcare and under-utilisation of services by migrants is often observed by the literature, both in US and Europe⁶. The limited availability of interpreter or cultural mediation services in most host countries is believed to pose considerable linguistic and cultural barriers to appropriate medical services, particularly for the most disadvantaged segments of migrant groups (e.g. newcomers, women, elderly). Existing evidence reports that economic and administrative barriers to healthcare prevail in those countries that do not readily grant citizenship, and thus full social and political rights, to settled immigrants (Bollini, 1993). In addition, xenophobia and discrimination within the health services is often reported in the literature (Schulman, 1999; Smedley et al., 2003), both in employment of personnel from ethnic groups and in the delivery of services. Prejudice often assumes that the alien culture is inferior and somehow pathogenic, and patient's behaviour inappropriate (van Ryk and Burke, 2000). The presence of discrimination (and perceived discrimination) creates additional barriers in the utilisation of healthcare services. The level of entitlements for migrants in receiving societies (which is believed to vary according to their legal status in the host society, to social and political rights, and according to the degree of institutional and social discrimination against people of different ethnic backgrounds), is believed to affect both health outcome and access to healthcare (Bollini, 1997). Indeed, more data are needed to document the relationship between level of entitlements

⁶ In Switzerland, Wicker and colleagues (1999) reveal that among refugees and asylum seekers of Canton Bern an over-utilisation (in comparison to general population) in somatic medicine, and an under-utilisation of psychiatric services is observed. In Sweden, as reported by a study of Hjerm, Haglung et al. (2001), migrants (in particular victims of organised violence), use health services more than Swedish-born residents.

of migrants in the host country and access to healthcare, as well as health outcomes, in order to promote effective countermeasures.

The prevailing attitudes and politics toward immigration in receiving countries influence not only migrants' social status and entitlements in the society but also the response of the healthcare system to their specific needs. As Bollini and Siem (1995) have pointed out, two broad categories of reactions are observed in host countries: a 'passive' attitude, in which migrants are expected to make use of the existing health system with no major modification (also if actions are taken for cultural differences and linguistic barriers), and an 'active' attitude, in which the special health needs of migrant communities are acknowledged and actions are taken by the health authorities to ensure that linguistic and cultural barriers are minimized. Research evidence (Bollini, 1993) suggests that an 'active' attitude, in other words the adoption of specific health policies (and the creation of specific services) for migrants, could remove many economic, administrative and linguistic barriers to access to health care. This pluralistic (or multicultural) approach⁷ has been accompanied in some receiving countries (e.g. Australia, Canada) by the development and improvement of services for migrants, and increased recognition of the need for services to cater for the cultural diversity of the population.

Nevertheless, an overemphasis on culture at the expense of other social determinants of health and access to the health system such as socio-economic status, gender or the broad social policy context (Watters, 2001) is criticized in the literature (Ahmad, 1996; Eastmond, 1998; Dozon and Fassin, 2001). Focus on the idiosyncrasies of different cultures in a stereotypical way is believed to lead to situations where culture is seen as the cause of health disparities, which in turns results in a tendency to blame the victims. In addition, it is argued that variation within the cultures may be greater than variation between cultures. This literature should not be interpreted as minimising the importance of culture. Rather, it suggests that effective services will depend on taking into account the actual rather than perceived sources of diversity within and between communities. Specific health services should be developed on an analysis of community needs, rather than on the assumption of primary differences between

⁷ A debate between defenders and detractors of a pluralistic or multicultural approach exists in the literature (Schnapper, 2000; for an articulation cf. Kälin, 2003), also in Switzerland (e.g. defenders and critics of cultural mediation).

populations on the basis of culture. Research aiming the recognition and assessment of a diversity of needs within and between communities is expected to lead to a more evidence-based approach to specific services design, matching communities' needs, health perceptions, and current pattern of utilisation (Kelaher and Manderson, 2000). As Watters (2001) has suggested, the establishment of focus group may be a useful mean of prioritising proposals for the setting up of specific services relating to communities' health and social needs, countering the prevalence of stereotypical ways and assumptions regarding needs of particular migrant groups or communities.

The role of language as an important barrier to healthcare has been largely documented in the literature, both Swiss (Bischoff, Tonnerre et al., 1999; Toscani, Loutan and Stalder, 2000; Bischoff, Loutan and Stalder, 2001; Bischoff, 2001; Graz et al., 2002) and international (Morales et al., 1999; Pitkin and Baker, 2000; Bowen, 2001; Robinson and Gilmartin, 2002; Murray-Garcia, 2002). However, less research attention has been devoted to assessing intervention efforts than to understand the extent of barriers to healthcare. More research efforts should be focused on intervention strategies such as transcultural education and communication training for healthcare providers (Purnell and Paulanka, 1998; Canales, 2000; Robins, White et al., 2001; Smedley et al. 2003), community interpreting and intercultural mediation (Jacobs, Landeral et al. 2001; Nierkens, Krumeich et al., 2002; Singy, Weber and Guex, 2003). As Bischoff (2001) has pointed out, research is expected to assess not only the effectiveness of these interventions in reducing gaps in appropriate care delivery and healthcare access (as well as health outcomes), but also their cost-effectiveness and the extent to which these interventions result in organizational and institution-level changes to improve care for migrant patients. Qualitative research is also needed with input from medical anthropology and social sciences. In the area of communication, an adequate quantitative/qualitative mix is essential in obtaining reliable data. Moreover, patients' psychosocial aspects influencing understanding and communication should be more closely analysed, since they shape as well the translation of meaning.

Research is needed also to better clarify the concept of transcultural competence (Domenig, 2001; Donini-Lehnoff and Hedrick, 2000; Nunez, 2000; Carrillo et al., 2000) and its related elements, and to determine the content and forms of transcultural education for the entire range of health professionals (medical and social care providers, nurses, therapists, interpreters, cultural

mediators, and so on). Comparative studies on different existing models of transcultural or cultural competence (see also the concept of ‘cultural humility’ which is intended to replace ‘cultural competence’ in incorporating a lifelong commitment to self-evaluation, self-critique and non-paternalistic interaction instead of a finite body of knowledge, cf. Trevalon and Murray-Garcia, 1998) should also be conducted, in order to assess their impact on health outcome and access to health care (and on patients’ and care providers’ satisfaction).

The impact of economic and legal barriers to healthcare access (e.g. immigration law restrictions, legal status, insurance system) should also be further documented (Weiss, 2003). Moreover, it seems necessary to better understand the extent to which perceived discrimination and hostility experienced by migrants (both in society and in the healthcare system) has an influence on healthcare utilisation and access (Geiger, 2003). Identification of effective unequal treatment and discrimination in the healthcare system, in particular structural barriers to prevention and care is also considered an important research issue to analyse in further research (Weiss, 2003). Finally, it is worth noting that patient mistrust of care providers (or health treatments) may affect decision to seek care (Smedley et al., 2003). Investigations should therefore assess migrant patients’ attitudes toward healthcare providers and services, and examine the influence of such attitudes on healthcare system’s utilisation. For instance, according to patients of different cultures high reliance on technology to diagnose illness may be less positively perceived than other health assessment skills as touching the body (Van Dongen and Elema, 2001), pulse taking or discussion about the patient’s relationships and current circumstances (Sung, 1999). Further research should also assess appropriate means of addressing possible negative cultural beliefs about care seeking and mistrust of healthcare services, treatments and providers.

3. Understanding life-world of migrants

The delivery of health care in a pluralistic society demands a patient-centred care that takes into account different cultural attitudes, values, beliefs, practices and resources. For instance, culture may affect views about the causes and treatments of illness, when to seek treatment, whom to consult and what treatments are appropriate (Dilworth-Anderson and Gibson, 2000). Research aiming the comprehension of life-world of migrants -in other words their health strategies, resources, beliefs and requirements- is especially important for the health care system, to provide adequate prevention and management of health problems, and to better take into account autonomous capacities or health resources (Attia and Marburger, 2000).

The emergence of ‘transnational migrant communities’ within the advanced pluralistic democracies, that according to theorists of transnational migration (Gold, 2000; Levitt, 2001; Portes, 2001) are made possible because of advances in communication and transportation technologies (air travel, telephones, personal computers and other forms of modern telecommunication), implies the opportunity for migrants to maintain sustained contact with the country of origins (and other receiving countries). Transnational communities generally reflect the movement (psychic and physical) of migrants in and out the community, indicative of a general openness to the influence of both homeland and receiving nations’ cultures and social institutions (Kivisto, 2003). As a consequence, a recent trend of research, both in Switzerland (Salis-Gross and Loncarevic, 1999) and at the international level (DeAnne and Hilfinger, 2002), concerns the investigation of the transnational health seeking strategies (both supporting and professional relations) of particular groups of migrants. A strong transnational network at level of household production of health has been shown to exist, both at local or regional level and in other host countries and in the country of origin. Therefore, it is important to understand more the characteristics of such transnational health resources, practices and perspectives (e.g. moving back and forth across informal and formal health care systems, crossing multiple national, cultural and health care systems borders). Further documenting the transnational nature of personal, cultural and political perspective on health and health care and highlighting the layered complexities of migrants’ health practices and resources is essential for integrating and

supporting such health strategies. Therefore, additional research efforts should be focused on the analysis of the structure of transnational social networks with regard to coping with illness and maintaining health for different communities of migrants, using interdisciplinary approaches and incorporating qualitative narrative research. Such research should expand its methodology to collaboration with researchers in the countries of origin and in other receiving countries. Research concerning the characteristics of alternative health resources (for instance social networks, psychological, emotional and religious resources) of migrants appears also to be necessary, and should be taken into account during interaction between health professionals and migrants patients (Faltermaier, 2001).

Another body of literature at the international level concerns the influence of culture on health behaviour and health care utilisation patterns. Migrants may have their own cultural views of health care and health care practices based on past experience in their countries of origin. For instance, it has been shown in US that immigrant women from the former Soviet Union use massages, teas, and herbal remedies (practices based on those of their country of origin) instead of or prior to seeking health care services in the host country (Ivanov and Buck, 2002). Ideas about the maintenance of health and the treatment of illness may also depend on culture and can be maintained when people migrate. Migrants may prefer the system they are used to, which offers methods that they regard as tried and tested. Each system also influences the way people think about the body and its functions, and their beliefs about treatments and illness. The challenge to health care providers is therefore to identify both healthy and illness behaviour and perceptions for migrants of different cultures in order to improve the delivery of health care services. More research is needed with specific migrant populations to learn about their cultural patterns of health care utilisation, practices and beliefs. Further studies should be conducted also on the functions and resources of migrants' perception (and representations) of health and illness (Weiss, 2003; Muthny, 2001), also in order to reinforce their position within the health system and to orient health prevention and promotion following specific cultural health resources, beliefs and representations.

The reliance on medical systems other than allopathic medicine should also be better documented among migrants (Dein and Sembhi, 2001). Allopathic medicine is neither the primary or sole source of information on how to maintain health, nor the only system that migrant patients turn to when they are ill (Henley and Schott, 1999; Janes, 2002; Frank and Stollberg, 2002). Studying the

type, the extent and the context of use of traditional medical systems (and in particular patterns of parallel utilisation of allopathic medicine and traditional medicine) among migrants is important for a better understanding and valorisation of their health practices, but also for a more adequate delivery of healthcare.

Another line of research that has recently become a topic of concern and systematic studies is the relationship between migration and health risks related to the global process of migration –before migration (imported illness, imported protector or risky behaviour), during migration (smuggling, cf. Gushulak and MacPherson, 2000), after migration (new protector or risky behaviour) and possible return or strategy of re-emigration (van Krieken, 2001; Gushulak, 2001). Each step of the migration process points to potential health risks, both mental and physical. Further studies are indeed necessary in order to better analyse health risks associated with the global and dynamic process of migration (Chimienti and Cattacin, 2001), with breaks caused by migration and with particular kind of integration strategies (Riecken, 2001, Schmitz, 2001). The fact that several families and individuals who do migrate actually succeed in creating viable lifestyles for themselves implies that systematic investigation of protective factors facilitative of integration success (for instance success of the migratory project) is extremely important in order to build the necessary conditions of societal integration (Fisek, 2001). More studies are needed to further document the relationship between integration and health (both with respect to positive and negative health outcomes), its socio-cultural variations, causal factors and components (Lee et al., 2000; Schmitz, 2001; Riecken, 2001). In addition, the importance of taking into account the impact of the migration history on illness and health experience is mentioned (Sanella, 2002).

The importance of conducting research on the quality of life (and resources, social-networks) of migrants is also stressed, according to specificities linked to origin, age, social class, legal status and gender (Weiss, 2003). Finally, an important issue to further investigate for a better comprehension of migrants' life world is religious beliefs and practices and their relation to health (Mueller et al., 2001). Religion may provide essential meaning, spiritual support and moral guidance; it may influence practical aspects of daily life, and is indeed a mark of community membership. Research evidence (Mohd et al., 2002) shows for example the effectiveness of incorporating socio-cultural and religious aspects in the management of psychosocial problems among migrants with a strong religious background. More investigations should be conducted around

the relationship between religion and health. For instance, the interaction between particular kind of severe or chronic illness and religious or spiritual search for meaning should be better documented (Benoist and Massé, 2002). In the same vein, the impact of particular religious beliefs over attitudes concerning health and illness, choice of treatment, treatments' observance, reaction to illness (e.g. fatalism, coping) should receive more attention in future research (Henley and Schott, 1999). As the experience of migration or belonging to a religious minority can sometimes deepen religious faith and lead to rediscover the meaning and importance of religious roots, or lessen religious faith and practices, analysing the impact of such reactions on community identification, socialisation (both inside and outside the cultural community) and health outcomes can improve the understanding of migrants' life-world.

4. Monitoring

Lack of healthcare data that take into account the diversity of the migrant population is observed in Switzerland (like in other countries), as well as lack of monitoring concerning needs of specific groups of migrants (Chimienti and Cattacin, 2001). It is therefore extremely important to better consider in the future the diversity of the migrant population, and proceed to targeted analysis (Bischoff and Wanner, 2003). The collection and reporting of healthcare information by patient origin (and other relevant variables, e.g. demographic characteristics, length of stay, legal status) is an important step in monitoring health disparities and progress in eliminating these disparities. In addition, statistical routine concerning health status and level of mortality of the population should include resident migrants (Chimienti and Cattacin, 2001). The collection of data concerning treatment and assistance of migrants (not only in institutions of the public health system, but also among private doctors and institutions of the social system) is also required (Weiss, 2003). Such data is important to identify the most common health problems among migrants and to define priority interventions.

Regularly monitoring health needs (also concerning actions and information) of specific groups or communities of migrants is also crucial in order to improve both health prevention (and promotion) and quality of care. Monitoring the interventions in the health system is also assumed to be very important (Dreachslin, 1999; Shaw-Taylor, 2002). Efforts should be spend for example in monitoring the adequacy of the quality of care with respect to migrants' and communities' needs. Research is needed also for monitoring the quality of communication and interaction between care providers and migrant patients (Smedley, 2003), and for a better definition of such quality standards (matching both care providers and patients needs). As it is the most recognised and widely used measure of effectiveness of provider-patient communication and appears to be strongly correlated with quality of care (Donabedian, 1988), patients' satisfaction is extremely important to measure. Interventions aiming the improvement of the quality of communication (and interaction) should also be monitored, with respect to patients and providers satisfaction (Smedley, 2003). Moreover, monitoring of psychosocial treatment and assistance to migrants is

considered very important (Weiss, 2003), as well as the adequacy of different concepts of treatment and assistance according to the needs of migrant patients.

With the future systematic introduction of community interpretation and intercultural mediation in health care institutions with high attendance of migrant patients, the impact of community interpreters and intercultural mediators in the care provided has to be closely monitored. Several issues have been identified as needing further research in Switzerland (Bischoff, 2001). In particular, it is necessary to measure the impact of professional community interpreters and cultural mediators in terms of the quality of care. So far, mainly the negative impact of non-professional interpreters or mediators has been documented. Discourse analysis of professional interpreter-mediated patient-provider communication is also identified as necessary. It would be useful to provide evidence of what are the indicators of high quality interpretation and mediation, according to the health professional, the patient and the professional interpreter/mediator. This could contribute to the redefinition of quality health care community interpreting and intercultural mediation. Further monitoring the effect of language barriers is also believed to be essential, in particular concerning patient satisfaction, health care utilisation and observance, by comparing allophone patients with local language speakers, and by measuring the variables related to interpreting and cultural mediation (presence/absence of professional interpreter/mediator, type of professional, language concordance). Monitoring of interpreters' and cultural mediators' training programmes, their work in a medical setting, the handling of communication, negotiation, triadic relationship, and mediation aspects would be extremely important. Monitoring of health professionals' performances of communicating with migrant patients and measuring patients' satisfaction are very useful indicators of health care interpreting and cultural mediation.

As for epidemiological studies, need for an elaborated epidemiological research is often mentioned in the literature (Rieken, 2001; Aspinall, 2000), in order to determine prevalence and incidence of psychic and psychosocial problems among different groups of migrants, and to compare relative degrees of prevalence and incidence to those of the population in the countries of origin. Such epidemiological research should integrate the methods of cultural epidemiology (Weiss, 2001; Weiss, Cohen and Eisenberg, 2001), mixing quantitative and qualitative approaches, in order to provide cultural sensitive information about illness experience (patterns of distress), meaning (perceived causes), and associated behaviour (risk related and help seeking) to complement

epidemiological rates of mental and psychosocial disorders. Need is also expressed for a deeper epidemiological knowledge at the international level. As Chimienti and Cattacin (2001) have pointed out, further epidemiological studies are also required for the monitoring (and comprehension) of differences in health status between native and migrant populations (e.g. higher prenatal level of mortality among migrant women, health status of women of the new migration, health at work, health of elderly). Finally, qualitative data on specific groups with limited access to healthcare (e.g. illegal migrants) is considered to be extremely important.

Recommendations for priority research

In Switzerland, research on the thematic field of migration and health is quite recent and need therefore to be broadly developed. Special effort is to be devoted to interdisciplinary research paradigms and methods (using both quantitative and qualitative approaches), in order to further articulate medical and social sciences perspectives. The emergence of innovative interdisciplinary paradigm, for instance transcultural psychiatry, cultural epidemiology, medical anthropology, is particularly promising, and should be expanded in the future in order to better integrate transcultural research with migration and health research (cf. Weiss, 2003).

Our discussion of needed research has contributed to show that further research efforts should be focused on four thematic areas. As for the reaction of the healthcare system to pluralistic societies, it's essential to better understand how migrant patients' interact and communicate with the entire range of healthcare providers, and how ethnicity and other social factors influence the communication and the care delivery process. Research is required as well to increase knowledge on migrants' psychosocial problems, and to improve psychosocial treatment and assistance. A deeper understanding of barriers and disparities in healthcare is also important, as well as the assessment of interventions to reduce barriers. Further research is needed for a better comprehension of migrants' life-world, health strategies, resources, beliefs and requirements, both for valorisation of their autonomous capacities and to provide adequate management of their health problems. Finally, developing monitoring systems on migration and health is considered to be a priority. Monitoring efforts and epidemiological data should be developed according to international research, in order to favour international compatibility and comparability.

In the same vein, research on migration and health should be linked to an international perspective. Research design should comprehend, when possible, comparisons between different groups of migrants, between migrants and the Swiss population, and between Switzerland and other receiving countries. As basic research has to be problem-oriented, particular effort is to be devoted to research valorisation.

For each thematic area, the following issues have been identified by external expertise as priority research.

Recommendation 1: Conduct further research to understand the reaction of the healthcare system to pluralistic societies.

- Further understand how patients' ethnicity and social factors (e.g. gender, legal status, social class) influence diagnosis, treatment and health outcomes, as well as the quality of patient-provider interaction and communication. A better definition of communication and interaction quality's criteria is needed, also in order to identify which characteristics of interaction/communication affect diagnosis, treatment and health outcomes.
- Better determine structural, institutional and organisational factors of healthcare settings affecting the content and quality of communication and care.
- Study further strategies to increase migrants' (and communities', representative associations') ability to participate in decisions and empower them as self-advocates within the healthcare system.
- Assess the impact on psychosocial health of a series of variables linked to migration (e.g. language proficiency, legal status, origin, integration, motives of migration, expectancies and attitudes relatives to the host-country).
- Analyse the potentials and difficulties of psychosocial treatment and assistance to migrants in the realm of medical and hospital practices.
- Further develop innovative and multidisciplinary models of psychosocial treatment and assistance, matching migrants' cultural needs, beliefs, practices and health perceptions (development of a culturally adequate therapeutic concept).

Recommendation 2. Conduct further research in order to better understand barriers and disparities in healthcare.

- Further document the relationship between migrants' level of entitlements (e.g. legal status in the host society, insurance system, social and political rights, degree of institutional and social discrimination), access to health care and health outcomes.

- Better take into account actual rather than perceived sources of diversity within and between communities. Recognition and assessment of differences (e.g. focus group), is expected to lead to a more evidence-based approach to services design respectful of communities' perceptions and needs.
- Research is required to measure the cost-effectiveness of interventions to reduce barriers (e.g. community interpretation and intercultural mediation) and the extent to which these interventions result in organisational and institution-level changes to improve care for migrants patients.
- Clarify the concept of transcultural competence and its related elements, and define the content and forms of transcultural education for the entire range of health professionals. Comparative studies on different existing models of transcultural competence should also be conducted to assess their impact on access to healthcare, health outcomes and patients' and providers' satisfaction.
- Better understand the extent to which perceived discrimination and hostility (both in society and in the healthcare system) influence healthcare utilisation and access. Further identify effective unequal treatment and discrimination in the healthcare system (in particular structural barriers to prevention and care).

Recommendation 3. Conduct further research to understand life-world of migrants.

- Further analyse the structure of transnational social networks with regards to coping with illness and maintaining health for different communities of migrants (using interdisciplinary approaches and incorporating qualitative narrative research). Expand methodology to collaboration with researchers in countries of origin and in other receiving countries.
- Assess the characteristics of other kind of health resources (e.g. social networks, traditional health systems, religion, psychological and emotional resources), to be taken into account during interaction between health professionals and migrant patients.

- Study health risks in the life of migrants associated with breaks caused by migration and with particular kind of integrative strategies.
- Systematic investigation of protective factors facilitative of integrative success among migrants.
- Further document the relationship between integration and health (with respect to both positive and negative outcomes), its intercultural variations, causal factors and components.

Recommendation 4. Develop monitoring systems on migration and health.

- Statistical routines concerning health status and level of mortality of the population should include resident migrants. Collect and report healthcare information by patients' origin and other relevant variables (e.g. demographic characteristics, length of stay, legal status), in institutions of the public health system, among private doctors, and institutions of the social system.
- Monitoring the quality of communication between the entire range of care providers and migrant patients. Define standards of high quality communication (matching both patients' and providers' needs).
- Measure migrant patients' satisfaction with respect to the quality of care (e.g. communication, diagnosis, treatment, follow up).
- Monitoring of psychosocial treatment and assistance to migrants, and the adequacy of different concept of treatment and assistance according to the needs of migrants patients.
- Measure the impact of professional community interpreters and intercultural mediators in terms of the quality of care. Define standards of high quality community interpretation and intercultural mediation (according to health professionals, patients, and professional interpreters/mediators).
- Conduct an elaborated epidemiological research (with combination of quantitative and qualitative approaches, cf. cultural epidemiology) to determine prevalence and incidence of psychic and psychosocial problems among different groups of migrants, and for comparison with populations in the country of origin.

- Qualitative data on specific groups with limited access to healthcare (e.g. *sans papiers*) for monitoring their health status and health needs.

References

- Ahmad, W.I.U. (1996). The trouble with culture. In: D. Kelleher, S. Hillier (Eds.), *Researching cultural differences in health*. London: Routledge.
- Attia, I. and Marburger, H. (2000). *Alltag und Lebenswelten von Migrantenjugendlichen*. Frankfurt: IKO-Verlag für interkulturelle Kommunikation.
- Aspinall, P.J. (2000). The new 2001 census question set in cultural characteristics: Is it useful for the monitoring of the health status of people from ethnic groups in Britain? *Ethnicity and Health*, 1 (5), 33-40.
- Balsa, A. and McGuire, T.G. (2001). *Prejudice, uncertainty and stereotypes as sources of health care disparities*. Boston: Boston University.
- Benoist, J. and Massé, R., Eds. (2002). *Convocations thérapeutiques du sacré*. Paris: Karthala.
- Bernstein, J., Bernstein, E. et al. (2002). Trained medical interpreters in the emergency department: Effects on services, subsequent charges, and follow-up. *Journal of Immigrant Health*, 4 (4), 171-176.
- Bischoff, A. (2001). *Overcoming language barriers to health care in Switzerland*. Basel: Universität Basel.
- Bischoff, A., Loutan, L. and Stadler, H. (2001). Von einer Sprache zur anderen: Kommunikation mit fremdsprachigen Patienten in einer medizinischen Poliklinik. *Soziale Medizin*, 28(3), 32-37.
- Bischoff, A., Tonnerre, C., Loutan, L. and Stalder, H. (1999). Language difficulties in an outpatient clinic in Switzerland. *Sozial und Präventivmedizin*, 44(6), 283-287.
- Bischoff, A. and Wanner, P. (2003). *Ein Gesundheitsmonitoring von MigrantInnen. Sinnvoll? Machbar? Realistisch?* FSM: Forschungsbericht.
- Blöchiger, C., Junghanss, T., Weiss, R. et al. (1994). *Gesundheitsprobleme und allgemeinmedizinische Versorgung von Asylsuchenden und Flüchtlingen in der Schweiz aus hausärztlicher Sicht*. Basel: Schweizerisches Tropeninstitut.
- Blöchiger, C., Tanner, M., Hatz, C. and Junghanss, T. (1997). Asylum seekers and refugees in ambulatory healthcare: communication between physician and patient. *Schweiz Rundsch Med Prax*, 86(19), 800-810.

- Blöchiger, C., Junghanss, T., Weiss, R. et al. (1998). Asylsuchende und Flüchtlinge in der hausärztlichen Praxis: Probleme und Entwicklungsmöglichkeiten. *Sozial- und Präventivmedizin*, 43(1), 18-28.
- Bollini, P. (1993). Health policies for immigrant populations in the 1990's. A comparative study in seven receiving countries. *Innovation in Social Science Research*, 6, 101.
- Bollini, P. (1997). *Asylum seekers in Europe : Entitlements, health status, and human rights issues*. Geneva : [s.n.].
- Bollini, P. and Siem, H. (1995). No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000. *Social Science and medicine*, 41, 819-828.
- Bowen, S. (2001). *Language barriers in access to health care*. Winnipeg, Health Systems Division, Health Policy and Communication Branch, Health Canada.
- Canales, M. (2000). Othering: Toward an understanding of difference. *Advanced Nursing Science*, 22 (4), 16-31.
- Chimienti, M.; Cattacin, S., en collaboration avec Efonayi-Mäder, D., Niederberger, M., Losa, S. (2001). « Migration et santé » : priorités d'une stratégie d'intervention. Neuchâtel : FSM, Rapport de recherche du Forum suisse pour l'étude des migrations; no 18.
- Cooper, L.A. and Roter, D.L. (2003). Patient-provider communication: The effect of race and ethnicity on processes and outcomes of healthcare. In: Smedley, B.D., Stith, A.Y., Nelson, A. R., Eds., *Unequal treatment. Confronting racial and ethnic disparities in healthcare*. Washington, D.C.: The National Academies Press.
- Cooper-Patrick, L., Ford, D.E., Vu, H.T. et al. (2000). Patient-physician race concordance and communication in primary care. *Journal of General Internal Medicine*, 15, 583-589.
- Cooper-Patrick, L., Gallo, J.J. Gonzales, J.J. et al. (1999). Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association*, 282(6), 583-589.
- DeAnne K., Hilfinger M. (2002). Transnational health resources, practices, and perspectives: Brazilian immigrant women's narratives. *Journal of Immigrant Health* 4(4), 183-200.
- Dein, S. and Sembhi, S. (2001). The use of traditional healing in South Asian psychiatric patients in the UK: Interactions between professionals and folk psychiatrists. *Transcultural Psychiatry*, 38(2).
- Dilworth-Anderson, P., Gibson, B.E. (2002). The cultural influence of values, norms meanings and perceptions in understanding dementia in ethnic minorities. *Alzheimer Disease Association Disorders*, 16 (2), 56-63.
- Domenig, D. Ed. (2001). *Professionnelle Transkulturelle Pflege*. Bern: Huber.
- Donabedian, A. (1988). The quality of care: how can it be assessed? *JAMA*, 260(12), 1743-1748.
- Dovidio, J.F. (1999). Stereotyping. In R.A. Wilson, F.C. Keil (Eds.), *The MIT Encyclopaedia of the Cognitive Sciences*. Cambridge, MA: MIT Press.
- Donini-Lehnoff, F.G., Hedrick, H.L. (2000). Increasing awareness and implementation of cultural competence principles in health professional education. *Journal of Allied Health*, 29(4), 241-245.
- Dozon, J.P. and Fassin, D. (2001). Critique de la santé publique: une approche anthropologique. Paris: Balland.
- Dreachslin, J. (1999). Diversity leadership and organisational transformation: Performance and indicators for health service organizations. *Journal of Healthcare Management*, 44 (6), 427-439.
- Eberding, A., Schlippe, A. (2001). Konzepte des multikulturelle Beratung und Behandlung von Migranten. In: P. Marschalck, K. H. Wiedl (Eds.), *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch
- Eastmond, M. (1998). Nationalist discourses and the construction of difference: Bosnian Muslim refugees in Sweden. *Journal of Refugees Studies*, 11(2), 161-181.
- Efonayi, D., Chimienti, M., Losa, S. and Cattacin, S. (2001). *Evaluation du programme global "Migration et Santé" de l'Office Fédéral de la Santé Publique*. Rapport de recherche. Neuchâtel: FSM.
- Faltermeier, T. (2001). Migration und Gesundheit : Fragen und Konzepte aus einer salutogenetischen un gesundheitspsychologischen Perspektive. In : P. Marschalck, K. H. Wiedl (Eds.), *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch.
- Fisek, G.O. (2001). Cultural context. Migration and health risks-A multilevel analysis. In: P. Marschalck, K. H. Wiedl (Eds.), *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch.

- Frank, R. and Stollberg, G. (2002). Ayurvedic patients in Germany. *Anthropology and Medicine*, 9(3), 223-244.
- Geiger, H.J. (2003). Racial and ethnic disparities in diagnosis and treatment: A review of the evidence and a consideration of causes. In Smedley, B.D., Stith, A.Y., Nelson, A. R. (Eds.), *Unequal treatment. Confronting racial and ethnic disparities in healthcare*. Washington, D.C.: The National Academies Press.
- Gilgen, D., Salis-Gross, C., Maeusezahl et al. (2002). Impact of organized violence on illness experience of Turkish/Kurdish and Bosnian migrant patients in primary care. *J. Trav. Med.*, 9, 236-243.
- Gold, S. J. (2000). Transnational communities: Examining migration in a globally integrated world. In P.S. Aulakh and M.G. Schechter (Eds.), *Rethinking globalisation(s): From corporate transnationalism to local interventions*. New York: St Martin.
- Graz, B., Vader, J.P., Raynault, M.F. (2002). Réfugiés, migrants, barrière de la langue: opinion des praticiens sur les moyens d'aide à la traduction. *Santé Publique (Bucur)*, 14, 75-81.
- Gushulak, B.D. (2001). An overview of the health aspects of return in the immigration context. In Van Krieken, P. J. (Ed.). *Health, migration and return: A handbook for a multidisciplinary approach*. The Hague: T.M.C. Asser Press.
- Gushulak, B.D., MacPherson, D.W. (2000). Health issues associated with the smuggling and trafficking of migrants. *Journal of Immigrant Health*, 2(2), 67-78.
- Habermann, M. (2000). Der Beitrag der Pflege zur Verbesserung des gesundheitlichen Versorgung des Migranten und Migrantinnen in der Bundesrepublik Deutschland. In : J. Gardemann, W. Muller, A. Remmers (Eds.), *Migration und Gesundheit: Perspektiven für Gesundheitssysteme un öffentliches Gesundheitswesen*. Berichte & Materialien Band 17. Düsseldorf: Akademie für öffentliches Gesundheitswesen in Düsseldorf.
- Haour-Knipe, M. and Fleury, F. (1996). *Evaluation du programme de prévention contre le sida auprès des populations étrangères en Suisse: etude 1994-1995*. Lausanne: IUMSP.
- Henley, A. and Schott, J. (1999). *Culture, religion and patient care in a multi-ethnic society*. London: Age Concern England.

- Hjern, A., Haglund, B., Person, G. and Rosén, M. (2001). In there equity in access to health services for ethnic minorities in Sweden? *The European Journal of Public Health*, 11(2), 147-152.
- Ivanov, L. L., Buck, K. (2002). Health care utilisation patterns of russian-speaking immigrant women across age groups. *Journal of Immigrant Health*, 1 (Vol. 4), 17-27.
- Jacobs, E. Landeral, D. et al. (2001). Impact of interpreter services on delivery of healthcare to limited-English-proficient patients. *Journal of General Internal Medicine*, 16, 468-474.
- Janes, C.G. (2001). Buddhism, science and the market: The globalisation of Tibetan medicine. *Anthropology and Medicine*, 9(3), 267-289.
- Kelaher, M., Manderson, L. (2000). Migration and mainstreaming: Matching health services to immigrants' needs in Australia. *Health Policy*, 1 (54), 1-11.
- Kingsley, S. (2001). Creating the climate for diversity and race equality in health care. *Ethnicity and Health*, 3/4 (6), 255-264.
- Kivisto, P. (2003). Social spaces, transnational immigrant communities, and the politics of assimilation. *Ehnicities*, 3(1), 5-28.
- Krupat, E., Irish, J.T. et al. (1999). Patient assertiveness and physician decision-making among older breast cancer patients. *Social Science and Medicine*, 49, 449-457.
- Lee, S.-K., Sobal, J., Frongillo, E.A. (2000). Acculturation and health in Korean Americans. *Social Science and Medicine*, 7.
- Levitt, P. (2001). Transnational migration: Taking stock and future directions. *Global Networks*, 1 (3), 197-216.
- Loutan, L. and Subilia, L. (1995). Torture et violence organisée: leur conséquences sur les requérants d'asile et les réfugiés. *Médecine et Hygiène*, 49, 1942-1950.
- Loutan, L., Bollini, P., Pampallona, S. et al. (1999). Impact of trauma and torture on asylum seekers. *European Journal of Public Health*, 9, 245-247.
- Luckman, J., Tindell Nobles, S. (1999). *Transcultural communication in health care*. Paperback.
- Mackie, D.M., Devos, T., Smith, E.R. (2000). Intergroup emotions: Explaining offensive action tendencies in an intergroup context. *Journal of Personality and Social Psychology*, 79(4), 602-616.

- Mead, N., Bower, P. (2000). Measuring patient-centeredness: A comparison of three observation-based instruments. *Patient Education and Counseling*, 39, 71-80.
- Morales, L.S., Cunningham, W.E. et al. (1999). Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine*, 14(7), 409-417.
- Moser, C., Nyfeler, D., Verwey, M., Eds. (2001). *Traumatisierung von Flüchtlingen und Asyl Suchenden*. Zürich: Seismo.
- Mueller, P., Plevak, D. et al. (2001). Religious involvement, spirituality and medicine: Implication for clinical practices. *Mayo Clinical Proceedings*, 76, 1225-1235.
- Murray-Garcia, J. L., Garcia, J. et al. (2001). The service patterns of a racially, ethnically and linguistically diverse housestaff. *Academic Medicine*, 76, 1232-1240.
- Muthny, F.A. (2001). Laienkonzepte von Gesundheit und Krankheit in verschiedenen Kulturen. In: P. Marschalck, K. H. Wiedl (Eds.), *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch.
- Murray-Garcia, J. L. (2002). *Multicultural health 2002: an annotated bibliography*. Woodlands Hills: The California Endowment.
- Murray-Garcia, J., Selby, J. et al. (2000). Racial and ethnic differences in a patient survey: Patient values, ratings, and reports regarding physicians' primary care performance in a large health maintenance organization. *Medical Care*, 38, 1-11.
- Nierkens, V., Krumeich, A. et al. (2002). The future of intercultural mediation in Belgium. *Patient Education and Counseling*, 4 (46), 253-259.
- Nunez, A.E. (2000). Transforming cultural competence into cross-cultural efficacy in women's health education. *Academic Medicine*, 75, 1071-1080.
- Operario, D., Fiske, S.T. (2001). Stereotypes: Processes, Structures, Content, and Context. In R. Brown, S. Gaertner (Eds.), *Blackwell Handbook in Social Psychology (Vol.4)*. Cambridge, MA: Blackwell.
- Paniagua, F., O'Boyle, M. et al. (2000). Self-evaluation and unintended bias and prejudices. *Psychological Reports*, 87, 823-829.
- Pitkin, K., Baker, D.W. (2000). Limited English proficiency and Latinos' use of physicians services. *Medical Care Research and Review*, 57(1), 76-91.
- Portes, A. (2001). Introduction: The debates and significance of immigrant transnationalism. *Global Networks*, 1(3), 181-193.

- Razali, S.M., Aminah, K., Khan, U.A. (2002). Ethnic match in mental health services. Religious-cultural psychotherapy in the management of anxiety patients. *Transcultural Psychiatry*, 39(1).
- Riecken, A. (2001). Psychiatrische Erkrankungen im Migrations- und Integrationsprozess. In: P. Marschalck, K. H. Wiedl (Eds.), *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch.
- Robins, L. White, C. et al. (2001). Assessing medical students awareness of and sensitivity to diverse health beliefs using a standardized patient station. *Academic Medicine*, 76, 76-80.
- Robinson, M., Gilmartin, J. (2002). Barriers to communication between health practitioners and service users who are not fluent in English. *Nurse Education Today*, 22 (6), 457-465.
- Rossi, I. (2002). Réseaux de soins, réseaux de santé : culture prométhéenne ou liberté de l'impuissance. *Tsantsa : revue de la Société suisse d'ethnologie*, Vol. 7, 12-20. Bern: SSE.
- Roter, D.L., Rudd, R.E., Coming, J. (1998). Patient literacy. A barrier to quality of care. *Journal of General Internal Medicine*, 13(12) 850-851.
- Saha, S., Taggart, S. et al. (2000). Do patient choose physicians of their own race ? *Health affairs*, 19 (4), 76-83.
- Salis-Gross, C., Blöchiger, C., Moser, C. et al. (1997). *Die Arzt-Patienten-Interaction in der hausärztlichen Betreuung von Asylsuchenden und Flüchtlingen*. Basel/Bern: Schweizerisches Tropeninstitut Basel/Bundesamt für Gesundheit.
- Salis Gross, C. and Loncarevic, M. (1999). *Gesundheitsstrategien in den türkisch/kurdischen und bosnischen communities: Zusammenfassung der Ergebnisse aus des Haushaltbegleitung (community study)*. NFP 39, Schweizerisches Tropeninstitut Basel/Institut für Ethnologie des Universität Bern.
- Sannella, A. (2002). Le parcours psychosocial du migrant. *Migrations et Société*, 83 (Vol. 14), 17-25.
- Shaw-Taylor, Y. (2002). Culturally and linguistically appropriate health care for racial or ethnic minorities: Analysis of the US Office of Minority Health's recommended standards. *Health policy*, 62 (2), 211-221.
- Schmitz, P.G. (2001). Akkulturation und Gesundheit. In Marschalck, P., Wiedl, K. H. (Eds.). *Migration und Krankheit*. Osnabrück : Universitätsverlag Rasch.

- Schnapper, D. (2000). La relation à l'Autre et la gestion des diversités. In P. Centlivres, I. Girod (Eds.), *Les défis migratoires*. Zürich: Seismo.
- Schulman, K.A., Berlin, J.A., Harless, W. et al. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine*, 340(4), 279-283.
- Singy, P., Weber, O. and Guex, P. (2003). Les migrants face au système de soins: une expérience à Lausanne. In Wicker, H.-R., Fibbi, R., Haug, W. (Eds.). *Les migrations et la Suisse*. Zurich: Seismo.
- Smedley, B.D., Stith, A.Y., Nelson, A. R., Eds. (2003). *Unequal treatment. Confronting racial and ethnic disparities in healthcare*. Washington, D.C.: The National Academies Press.
- Sullivan, M. (2003). The new subjective medicine; taking the patient's point of view on health care and health. *Social Science and Medicine*, 56, 1595-1604.
- Sung, C. (1999). Asian patients' distrust of Western medical care: One perspective. *Sinai Journal of Medicine*, 66 (4), 259-261.
- Tervalon, M., Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117.
- Testa-Mader, A., Clerici, N. and Degrate, A. (2003). La population étrangère au Tessin: malaise psychique et utilisation des services psychiatriques publics. In Wicker, H.-R., Fibbi, R., Haug, W. (2003). *Les migrations et la Suisse*. Zurich : Seismo.
- Toscani, L., Loutan, L., Stalder, H. (2000). Accès aux soins : le patient d'une autre culture. *Médecine et hygiène*, 58, 2316, 1933-1937.
- Van Dongen, E. and Elema, R. (2001). The art of touching: The culture of body work in nursing. *Anthropology and Medicine*, 8(2-3), 149-162.
- Van Krieken, P. J. (2001). *Health, migration and return : A handbook for a multidisciplinary approach*. The Hague : T.M.C. Asser Press.
- Van Ryn, M., Burke, J. (2000). The effect of patient race and socio-economic status on physician's perception of patients. *Social Science and Medicine*, 50, 813-828.
- Wanner, P., Bouchardy, C., and Raymond, L. (1998). Comportements des étrangers résidants en Suisse en matière d'alimentation, de consommation d'alcool et de tabac et de prévention. *DEMOS-Bulletin d'information démographique*, 2, 22.
- Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science and Medicine*, 52, 1709-1718.
- Wennberg, J.E. (1999). Understanding geographic variations in the healthcare delivery. *New England Journal of Medicine*, 340(1), 32-39.
- Weiss, M.G. (2001). Cultural epidemiology: an introduction and overview. *Anthropology and Medicine*, 8(1), 5-29.
- Weiss, M.G., Cohen, A., Eisenberg, L. (2001). Mental health. In M.H. Merson, R.E. Black, A.J. Mills (Eds.), *International Public Health. Diseases, Programs, Systems and Policies*. Gaithersburg: Aspen Publishers. Weiss, R. (2003). *Macht Migration krank?* Zürich : Seismo.
- Weiss, R. (2003). *Macht Migration krank?* Zürich : Seismo.
- Weiss, R. and Stucker, R. (1998). *Interprétariat et médiation culturelle dans le système de soins*. Rapport de recherche No 11. Neuchâtel: FSM.
- Wicker, H.R. (1993). *Die Sprache extremer Gewalt. Studie zur Situation von gefolgerten Flüchtlingen in der Schweiz und zur Therapie von Folterfolgen*. Arbeitsblätter, Nr.6, Bern: Institut für Ethnologie.
- Wicker, H.R., Bielinski, D., Katona, B. (1999). *Die Gesundheitsversorgung von Asylsuchenden in Kanton Bern. Ein vorläufiger Bericht*. Bern: Institut für Ethnologie.
- Zenker, H.-J. (2000). Betrachtung der psychiatrischen/ psychotherapeutischen Versorgung in Bremen. In : J. Gardemann, W. Muller, A. Remmers (Eds.), *Migration und Gesundheit: Perspektiven für Gesundheitssysteme und öffentliches Gesundheitswesen*. Berichte & Materialien Band 17. Düsseldorf : Akademie für öffentliches Gesundheitswesen in Düsseldorf.

Appendix 1 - Needed research

1. Conduct further research to understand the reaction of the healthcare system to pluralistic societies.

Research is needed to illuminate how and why ethnicity influence patients' communication and interaction with the range of healthcare professionals (medical and non-medical professionals). Specifically, research is required to:

- Better illustrate key factors that affect communication, mutual perception, decision-making and service delivery. Further studies should focus on decision-making by patients and care providers, on the assessment of care management at different point along the continuum of care, and on the impact of patient-provider interactions on diagnosis and treatments.
- Further understand provider decision-making, heuristics employed in diagnostic evaluation, and how patients' ethnicity (and other social factors as gender, social class, legal status, and so on) influences these decisions.
- Explore how social cognitive processes (bias, stereotypes, prejudice) affect patients' and providers' perceptions of each other and influence the structure, processes and outcome of care.
- Focus on the impact of social factors (e.g. ethnicity, gender, legal status, social class) on the quality of patient and provider relationship, communication and interaction. A better definition of communication and interaction quality's criteria is needed, also in order to identify which characteristics of interaction/communication affect diagnosis, treatment and health outcomes.
- Better determine structural, institutional and organisational factors of healthcare settings affecting the content and quality of communication and care.
- Assess how educational programs can improve care providers communication (and attitudes, behaviours) with migrants.

- Conduct action-research to study interactions, patterns of communication and problems of contact between migrant patients and the range of healthcare professionals.
- Better clarify legal, structural and financial possibilities of the healthcare system for the improvement of communication process.
- Studying further strategies to increase migrant patients' ability to participate in decisions and empower them as self-advocates within the healthcare system.

Research is also required to increase knowledge on migrants' psychosocial problems, and to improve psychosocial treatment (and assistance) for migrants. In particular, research efforts should be focused on:

- Set up statistical data concerning the most common psychosocial health problems of different groups of migrants.
- Develop representative surveys on the psychosocial health of different groups of migrants.
- Verification of the impact on psychosocial health of a series of variables linked to short-term and long-term migration (e.g. language proficiency, legal status, ethnic origin, ethnic group identification, acculturation, motivation of migration, expectancies and attitudes relatives to the host-country).
- Further develop innovative and multidisciplinary lines of research to assess early diagnostic of psychosocial morbidity linked to short-term and long-term migration.
- Better analyse the potentials and difficulties of psychosocial treatment and assistance to migrants in the realm of medical and hospital practices.
- Further develop innovative and multidisciplinary models of psychosocial treatment and assistance, matching migrants' cultural needs, beliefs, practices and perceptions (development of a culturally adequate therapeutic concept).
- Better study the causal factors of psychosocial problems. For instance, taking into account a large variety of variables (e.g. primary socialisation, motivation of migration, length of stay, legal and socio-economic status in the host country), and differentiating migrants in distinct relevant categories.

As challenges derived from migration and the actual the multicultural composition of host societies have contributed to the emergence of

innovative and multidisciplinary perspectives of research and to changes in professional practices, research is needed to:

- Further develop and analyse the potential of emerging perspectives for interdisciplinary research and intervention in the domain of healthcare and prevention, both at conceptual and methodological level.
- Study significations and consequences of change in professional practices within the healthcare systems (e.g. collaboration and coordination between medical and social sciences).

2. Research is needed in order to better understand barriers and disparities in healthcare.

In particular, research is required for the following issues:

- Better document the relationship between level of entitlements (which vary according to legal status in the host society, social and political rights, degree of institutional and social discrimination) for migrants and access to health care.
- Better take into account actual rather than perceived sources of diversity within and between communities. Recognition and assessment of differences both between and within communities is expected to lead to a more evidence-based approach to culture specific services design respectful of communities' perceptions and needs.
- Efforts should be focused on interventions strategies to reduce barriers and disparities in healthcare such as cross-cultural education and communication training for healthcare providers, language interpretation and cultural mediation. Qualitative research is also needed with input from medical anthropology and social sciences: an adequate quantitative/qualitative mix is essential in obtaining reliable data.
- Patients' psychosocial aspects influencing understanding and communication should be more carefully analysed.
- Research is required also to measure the cost-effectiveness of interventions to reduce barriers, and the extent to which these interventions result in organisational and institution-level changes to improve care for migrant patients.

- It should be important to determine the contexts in which interpreters versus cultural mediators respond more to both care providers' and patients' needs.
- Better clarify the concept of cultural competence (and culturally competent care) and its related elements, and define the content and forms of cultural education for the entire range of health professionals. Comparative studies on different existing models of cultural competent care should also be conducted to assess their impact on access to healthcare, health outcomes and patients' and providers' satisfaction.
- Further document the impact of economic and legal barriers to healthcare access (e.g. immigration law restriction, legal status, insurance system).
- Better understand the extent to which perceived discrimination and hostility (both in society and in the healthcare system) influence healthcare utilisation and access. Further identify effective unequal treatment and discrimination in the healthcare system (in particular structural barriers to prevention and care).
- Investigations should assess migrant patients' attitudes toward healthcare providers and services, and examine the influence of such attitudes on healthcare systems' utilisation. Further research should assess means of addressing potential negative cultural beliefs among migrants about care seeking and potential mistrust of healthcare services, treatments and providers.

3. Conduct further research to understand life-world of migrants.

Research is needed to a better comprehension of migrants' life, health strategies, resources, beliefs and requirements, both for valorisation of their autonomous capacities and to provide adequate management of their health problems. In particular, additional research is required in the following issues:

- Further analyse the structure of transnational social networks with regards to coping with illness and maintaining health for different groups of migrants (using interdisciplinary approaches and incorporating qualitative narrative research).
- Assess the characteristics of other kind of health resources (e.g. social, psychological, emotional, religious), for different groups of migrants, to be

taken into account during interaction between health professionals and migrant patients.

- Analyse the unique cultural patterns of health care utilisation, health practices and beliefs of specific groups of migrants.
- Further study on the functions and resources of migrant popular health (e.g. collective representations of health and illness).
- Understand the extent, the context and type of auto-medication practices among specific groups of migrants.
- Better document the reliance on medical systems other than allopathic medicine among different groups of migrants (and patterns of parallel systems' utilisation).
- Further study health risks in the life of migrants associated with breaks caused by migration and with particular kind of adaptive strategies.
- Systematic investigation of protective factors facilitative of adaptive success among migrants.
- Further document the relationship between acculturation and health (with respect to both positive and negative outcomes), its intercultural variations, and the component of acculturation.
- Better assess the impact of the migration history on illness and health experience.
- Conduct research-intervention on the quality of life of migrants, according to specificities linked to origin, social class, legal status, age and gender.
- Better document the relationship between religion and health (e.g. the impact of religion practices and beliefs over attitudes concerning health and illness, choice of treatment or services, treatment's observance, reaction to illness, perceived religious discrimination on health outcomes).

4. Develop monitoring systems on migration and health.

Further monitoring efforts are demanded. In particular:

- Differentiate healthcare data according to the ethnic diversity of the population. Collection and reporting of healthcare information by patient

ethnicity and other relevant variables (e.g. demographic characteristics, length of stay, legal status).

- Statistical routines concerning health status and level of mortality of the population should include resident migrants.
- Collecting data on treatment and assistance of migrants in institutions of the public health system, among private doctors, and institutions of the social system.
- Regularly monitoring health needs (also according to actions and information) of specific groups of migrants.
- Monitoring the adequacy of the quality of care according to migrants' needs.
- Monitoring the quality of communication and interaction between the entire range of care providers and migrant patients. Define standards of high quality communication (matching both patients' and providers' needs).
- Measure migrant patients' satisfaction with respect to the quality of care (e.g. communication, diagnosis, treatment, follow up).
- Monitoring interventions aiming the improvement of communication and quality of care to migrant patients.
- Monitoring of psychosocial treatment and assistance to migrants, and the adequacy of different concept of treatment and assistance according to the needs of migrants patients.
- Measure the impact of professional interpreters and cultural mediators in terms of the quality of care.
- Discourse analysis of professional interpreter-mediated patient-provider communication.
- Define standards of high quality interpretation and meditation (according to health professionals, patients, and professional interpreters/mediators).
- Further monitoring the effect of language barriers, in particular concerning patients' satisfaction, healthcare utilisation and observance.
- Monitoring of interpreters' and cultural mediators' training programs.
- Monitoring health professionals' performances of communicating with migrant patients.

- Conduct systematic epidemiological research (with combination of quantitative and qualitative approaches) to determine prevalence and incidence of psychic and psychosocial problems among different groups of migrants, and for comparison with populations in the country of origin.
- Conduct further epidemiological studies for monitoring (and comprehension) of differences in health status between native and migrant populations.

Appendix 2 - Consulting

Experts

- Mary Hoaur-Knipe (IOM-Geneva)
- Hans-Rudolf Wicker (University of Bern)
- Corina Salis-Gross (University of Bern)
- Ambros Uchtenhagen (ISF-Zurich)
- Alexander Bischoff (IPW-University of Basle)
- Ilario Rossi (University of Lausanne)
- Christoph Hatz (STI-Basel)
- Paola Bollini (forMed, Evolène)
- Milena Chimienti (FSM-Neuchâtel)
- Igor Rothenbühler (FSM-Neuchâtel)

Organisations

- Swiss Red Cross (Rahel Stuker)
- SUVA (Ulrike Hoffmann Richter)
- BAG, Migration and Health Service (Rahel Gall Azmat)
- BSV (Ludwig Gärtner)
- IMES (Simone Gretler Heusser)

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Pierre Centlivres, Isabelle Girod (Sous la direction de) (1998). Les défis migratoires: Actes du colloque CLUSE "Les défis migratoires à l'aube du troisième millénaire".

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