Studies of (in/ex)clusion of migrants and ethnic minorities in the health system

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Resumo

O presente trabalho reflecte sobre as experiências de (in/ex)clusão de migrantes e minorias étnicas no sistema de saúde, com especial enfoque sobre saúde mental e bem-estar psicológico. É defendido que, num contexto social cada vez mais diverso do ponto de vista cultural e étnico, os clínicos e outros profissionais de saúde devem ser competentes para prestar apoio a pessoas de diferentes origens, em conformidade com guidelines éticas internacionais (APA, 2003). Apresenta-se um modelo teórico de competências multiculturais (Sue et al., 1992; Arredondo et al., 1996), recentemente revisto para incluir competências para a diversidade individual e cultural (Daniel et al., 2004; La Roche e Christopher, 2010), como base para o desenvolvimento de programas de formação específicos dirigidos a profissionais, incluindo psicólogos, e de serviços culturalmente competentes. São ainda resumidamente apresentados alguns estudos empíricos e projectos a decorrer que desenvolvemos, ao nível nacional e Europeu.

Abstract

The present paper reflects on the experiences of (in/ex)clusion of migrants and ethnic minority persons in the health system, in particular in the domains of mental health and psychological well-being. It defends that, in a social context that is increasingly diverse from a cultural and ethnic perspective, clinicians and other health professionals have to be competent in providing care to people from different backgrounds, in line with ethical international guidelines (APA, 2003). A theoretical model of multicultural competencies (Sue et al., 1992; Arredondo et al., 1996) is presented, recently reviewed in order to include individual and cultural diversity competencies (Daniel et al., 2004; La Roche e Christopher, 2010), as a foundation for the development of specific training programs for professionals, including psychologists, and of culturally sensitive services. A few empirical studies and ongoing projects we have developed are briefly presented, both at a national and a European level.
1. Introduction

In an increasingly diverse world, clinicians need to be able to work with people who are culturally different from themselves (see American Psychological Association, APA, 2003). The importance of attending to cultural issues in psychotherapy and counseling has been increasingly recognized, along with the growing diversity of Western societies, which has consequently resulted in greater diversity of clients seeking help in mental health services.

Broadly defined, in this literature, culture has referred to people’s values and behaviors based on ethnic origin, race/colour, language, religion, age, gender, sexual orientation, gender identity, and (dis)ability (Sommers-Flanagan & Sommers-Flanagan, 2004). Recent studies have shown that all these differences influence the healthcare provider-receiver interaction (Ahmed, 2007). At the same time, various dimensions of culture also shape our health behaviors and health status. Two of the most important of these dimensions are socioeconomic status (i.e. poverty) and sex, which have been largely studied constructs in social health psychology (Gurung, 2006). Considerable literature in this area has also focused on the issues of ethnic diversity as related to immigrants and other ethnic minority groups (such as the Roma people and immigrant descendents). While our team has developed work in a number of areas and with distinct minority groups, the present chapter will also mainly address the (in/ex)clusion of migrants and ethnic minorities in the health system, with a special emphasis in psychological health and well-being.

2. Mental Health, Culture and Migration

The provision of health care for migrants and ethnic minorities has received greater attention in recent years, namely in Europe and North America. This attention developed as a result of several factors. On the one hand, research evidence has shown that migrants may be more liable to certain health problems than the majority population, given that they are often exposed to (more and graver) health risks (Gurung, 2006). Many risk factors are related to poverty and social exclusion, while others to acculturative stress and experiences of perceived discrimination and prejudice (Zane et al., 2004). In general, the problems of migrants often resemble those of long-established minorities such as the Roma people (Ingleby, 2010). In this regard, migrants and ethnic minorities are often referred to as “vulnerable groups”. While controversial (many argue that migrants and ethnic minorities have to be physically and psychologically “stronger than average” to cope with the social exclusion and other stresses which they are routinely exposed), this has oriented policy-makers, researchers and practitioners to focus on specific risk and protective factors of health and well-being associated with migration.

On the other hand, despite having more problems, migrants often make less use of mainstream health services (Ponterotto et al., 1995), and when they do, the treatments are often less effective (Alegría et al., 2009). Hence, researchers make reference to both “health
discrepancies” and “health care discrepancies”. Regarding the latter, disparities in access/barriers to health care and even experienced discrimination within the health system have been documented in the literature (e.g. IOM, 2009). The Annual Report of the International Migration Organization (IOM, 2009), “Developing a Public Health Workforce to Address Migrant Health Needs in Europe” revealed that most health systems of different countries do not ensure a fare, equal and culturally appropriate care for migrants and ethnic minorities. In fact, several research studies and official reports have demonstrated major disparities in the mental health treatment of minority groups, in particular racial and ethnic minorities (e.g. US Department of Health and Human Services, 2001; European Commission, 2004). Portugal is no exception (e.g. Moleiro et al., 2009). Furthermore, second generation migrants often report even poorer health and mental health outcomes than first generation migrants, often associated to increased perceptions of discrimination and acculturation stress (Alegria et al., 2009).

3. Individual and Cultural Diversity Competences for Clinicians

Given the aforementioned literature, greater attention has been paid to the development of individual and cultural diversity competencies among practitioners, in particular in counseling and clinical areas (Daniel et al., 2004; La Roche e Christopher, 2010). This development was seeded in multicultural counseling (Sue et al., 1992), proposed in the USA in the nineties.

Cultural competence has been seen as a process, orientation or approach (Pedersen, 1991; Sue, 1998). Understood as such, more than a technique or a specific set of topics to consider when working with diverse clients, it is a way of construing the helping relationship encounter inasmuch it involves the client, the helper, and context (Sue, 2003). This is a fluid and dynamic process, involving both participants in interaction.

Since its origin in the counseling psychology literature, multicultural counseling competence (Sue et al., 1992) has been defined three-dimensionally, as the (1) awareness, (2) knowledge, and (3) skills necessary to work effectively and ethically across cultural differences and diverse clients (Arredondo et al., 1996). The first dimension – awareness – refers to the way the helper's attitudes, beliefs, values, assumptions, and self-awareness affect how they interact with those clients who are culturally different from themselves. It involves the exploration of the self as a cultural being, and of one's own cultural and racial preconceptions. The second dimension – knowledge – relates to the informed understanding of cultures that are different from one's culture, including their histories, traditions, values, practices, and so forth. It also involves knowledge about such concepts and processes as cultural impacts on psychosocial development, acculturation models and acculturation stress, ethnic and racial identity development, cultural communication styles in the helping relationship, perceived discrimination as a risk factor for well-being, and culture-bound syndromes and culture-specific interventions. Finally, an important third dimension consists in the ability to engage in effective and meaningful interactions with diverse individuals, including the development of a
relationship, by integrating one's awareness and knowledge into practical skills in the helping relation, assessment and intervention (Arredondo et al., 1996). Hence, multicultural competence refers to the acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (Sue, 2001).

This model continues to be the foundation of the international literature on intercultural competencies, while it has been reviewed (Arredondo et al., 1996; Sue, 2001) and also adapted toward being more inclusive of other forms of diversity found in clients, such as age, gender, sexual orientation, gender identity, religion, language, and (dis)ability (e.g. Daniel et al., 2004; Israel e Selvidge, 2003).

More recently, some authors have approached individual and cultural diversity competencies from an organizational standpoint. Trujillo (2001) proposed an adaptation of the three-dimensional model to health services, in particular, mental health services and their teams (see Figure 1). At a societal level, it involves advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups (Sue, 2001), in other words, having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by clients, families and their communities (Trujillo, 2008).

| Figure 1 - Cultural Competence Continuum (adapted from Trujillo, 2008) |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Central Belief                 | Blindness       | Pre-Competence  | Competence      | Proficiency     |
| Attitude & Awareness           | There are no differences | Differences exist | Differences exist | Differences exist |
| Knowledge Base                 | Mainstream treatment is universal | Acceptance & curiosity | Expansion of cultural awareness | Seek to add to the knowledge base |
| Clinical Skills                | Mainstream treatments | Basic cultural knowledge | Adaptation to specific needs | Development of new knowledge with participative research |
| Staff                          | Majority group members | Efforts to train staff | Integrate bilingual & minority group members | Participate in development of culturally-sensitive policies |

The figure presents 4 levels or stages of development of service or organizational cultural competence – cultural blindness, pre-competence, competence, and proficiency. Even though the model was developed to characterize health and mental health services in particular, it can also be a heuristic model to analyze other services or institutions with intercultural work-related
tasks, such as schools, social services, community-based services, among others. In the model, the first stage is cultural blindness. This stage is characterized by the basic belief that "differences do not exist", that is, "we are all different but all alike". In these services, professionals work from a mainstream perspective and address the relationship, assessment and intervention as independent of cultural background. Accordingly, knowledge and skills are focused on mainstream theories and practices, which are the basis for the work with every client. In a second stage, of pre-competence, some cultural differences begin to be recognized, and therefore professionals are curious to learn and accept them as part of their work. Some basic knowledge about specific groups is sought and used, such as celebration of specific holidays, foods, and other cultural aspects. They also promote brief training workshops and seminars for staff. This stage can lead to yet another one – cultural competence -, in which teams are more and more involved in ongoing training, and attempt to assess and intervene in accordance to specific needs of minority groups. These teams usually integrate bilingual and/or minority group members as staff, or even mediators and interpreters. Finally, according to this model, cultural proficiency entails the motivation and contribution to the development of new knowledge, practices and policies which are sensitive to cultural diversity, and in collaboration with the communities themselves (for instance, through participatory research). These teams and services not only embody an attitude and practice of promotion of awareness, knowledge and skills in their work with migrants and ethnic minority clients, but also disseminate this knowledge and good practices beyond the scope of their institution.

4. The project “Mental Health, Diversity and Multiculturalism: Towards the integration of specific needs of minority groups and practitioner's multicultural competencies” *

The need for culturally responsive treatments has been increasingly acknowledged, even though there is still debate regarding its relevance and process. Nonetheless, it is undisputable that most medical and psychological treatments have been historically rooted in theories that are not sensitive to that diversity. As indicated by the APA (2003), psychology has been traditionally defined by and based upon Western, Eurocentric, and biological perspectives and assumptions; and these premises have not always considered the influence of racial/ethnic and cultural factors. The project “Mental Health, Diversity and Multiculturalism: Towards the integration of specific needs of minority groups and practitioner's multicultural competencies” (FCT PTDC/PSI/71893/2006) was developed in order to address the gap between the increasing recognition of specific needs of minority group clients in mental health and the lack of training in cultural competences provided to clinicians.

Recent official reports indicate that there was a 200% rise in the immigrant population since 1990’s (Machado et al., 2010) in Portugal, increasing the concerns for social integration and development of new approaches to migrant health, in particular mental health. Hence, in
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Portugal, it is more likely to find migrants and ethnic minority clients, from a variety of cultural backgrounds, among mental health users. However, there are still no professional or ethical guidelines regarding the required training of professionals (namely, psychologists, social workers, physicians, nurses, etc…) to work with such a diverse population.

Some international professional associations, however, such as the American Psychological Association (2003), have established guidelines to assist both professionals and training programs to develop individual and cultural diversity competencies, including work with migrants and ethnic minority clients. These guidelines (APA, 2003) highlight (a) the importance of providing psychologists with a framework and specific standards to integrate culture and diversity in education, training, research, professional practice and organizational change; and (b) present basic information, relevant terminology, current empirical research from psychology and related disciplines to support the proposed guidelines and underscore their importance. The commitment to cultural awareness and knowledge of the self – the clinician - and others – the clients - were translated in the first guideline, which states that “psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves” (p. 382). This recognition was further reinforced in a second guideline, by encouraging psychologists to recognize the importance of cultural sensitivity and responsiveness to, knowledge of, and understanding about ethnically and racially different individuals, and to apply culturally appropriate skills in clinical and other applied psychological practices. In terms of education and research, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education, whereas culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centred psychological research among persons from ethnic, linguistic, and racial minority backgrounds. Finally, the guidelines encourage psychologists to use organizational change processes to support culturally informed organizational (policy) development and practices. These efforts have been unparalleled by most European psychology associations.

Contrary to North-American counterparts, European professional associations have made little progress in establishing much needed guidelines and standards of care, practice and training (Moleiro et al., 2010), with the exception of the U.K. In Portugal, the project “Mental Health, Diversity and Multiculturalism” (also known as “Health in Diversity”) argues that the under-representation of minority group members in mental health services is due, in part, to the perceived obstacles and institutional barriers experienced by these individuals, which include the inadequate training of professionals to work with clients who are culturally different from themselves. The project proposed to explore the practices and experiences of mental health professionals (psychologists in particular) in their work with minority clients (ethnic or other), identifying the multicultural competencies needed to work with minority populations in Portugal and assessing the perceived competence of these professionals to work with clients different from themselves. Concurrently, the present project aimed to contribute to a deeper understanding of the mental health beliefs of minority group members, their concerns and
experienced obstacles in the access to resources, and their specific needs. To do so, we proposed to develop a series of qualitative studies, with individual interviews and focus group methodology.

Hence, the objectives of this project are two-fold. Firstly, it examines the multicultural competencies of psychologists working with migrants and ethnic minority group clients in Portugal, identifying these competencies, creating a specific instrument for their assessment, and surveying and exploring the way these competencies are put into practice. Secondly, the present study aims to explore the representations of mental health and illness held by migrants and ethnic minority groups in Portugal, identifying their main concerns associated with the use of mental health services, and characterizing their specific needs within the interactions with mental health professionals.

4.1. Focus Groups with Ethnic Minorities

In the context of this project, a qualitative study was conducted, involving 8 focus groups with migrants and ethnic minority members, in a total of 40 persons. Of those, 30 were women and 10 were men, with a mean age of 34 years old. The majority of participants (71%) were between 18 to 39 years old, and 8% were aged above 50 years old. The participants were mainly from African countries (a total of 68%), 20% from Brazil and 12% from European countries, including Easter Europe.

Focus groups were conducted based on a semi-structured protocol, developed according to the goals of the study and the relevant literature. Questions included the following topics: 1) access to the Portuguese health care system (physical and psychological); 2) psychologist qualities preferred in working with immigrant clients (i.e. “What do you think psychologists or mental health professionals should take into account and/or be aware of when working with immigrants or descendants of immigrants?” and 3) the perceptions of needed cultural competencies among mental health professionals (i.e. “We would like that, as a group, you could make a list of eight things that mental health professionals, including psychologists, should be aware when working with people from your background.”).

Qualitative content analysis of the perceptions of cultural competencies resulted in 57 units of analysis (mean per group of 7; 3-14). Of these, 15 referred to awareness, such as recognition of cultural differences (“Being attentive to the specificity of cultures”) and a non-discriminatory attitude (“Not judge the patient’s personal beliefs”). Knowledge was addressed in 25 units of analysis. These referred to issues such as specific cultural information (“Learn about the differences and particularities of the patients’ culture and habits”), as well as information regarding discrimination and racism (“They should know about exclusion and prejudice”). Finally, with regards to clinical skills, 17 units of analysis were coded, involving the adjustment of interventions by the mental health professionals in the relationship with the client (“Interpreting the patient’s complaints taking into account the cultural differences of the patient”).
but also the role of those professionals in the community, including as mediators and advocates ("Have a mediating role between immigrants and the general population").

Participants reported having mixed experiences in the health services, from positive experiences, in which professionals paid attention to cultural differences, to less positive experiences such as diverse cultural barriers, language difficulties, and disappointment. One participant reported the unmet needs of her mother: "My mom, since she came here, had and still has some serious integration problems, and has had depression; and all of the mental health professionals who worked with her - the only treatment they gave her - has always been based on drugs." In contrast, another participant stated: "And then I went to a [second] psychiatrist, … I found it amazing, she was the opposite of the first one… in addition to paying attention to my current situation, she was also concerned with my situation here as immigrant." Some participants mentioned the existence of other types of help-seeking behaviours and professionals, as traditional healers, within the immigrant population: "I think a person who, in his/her own country, chose to go to a traditional healer; won’t change to a psychologist here. I think they’ll probably look for the same kind of resources here..."

4.2. Religious Minorities: An exploratory pilot study

In a related study, we (Freire e Moleiro, 2010) aimed to explore the perceptions and experiences of members of religious minorities regarding:

(1) The perception of belonging to a religious minority group in Portugal;
(2) The perception and representations of mental health and psychological well-being;
(3) The access to the Portuguese health care system (physical and psychological);
(4) The perception of psychologist's multicultural competencies when working with religiously diverse clients.

In this exploratory pilot study, 10 individual interviews were conducted (to 5 female and 5 male participants). The interview inquired participants about 4 domains of their experiences: Section I – Identity and acculturation; Section II – Awareness of health and mental health; Section III – Specific meaning regarding psychological health and 4) Section IV – Experiences of access and services. Participants were individuals from a variety of religious backgrounds, in a minority in Portugal: Jehovah’s Witnesses, Evangelical, Seventh-day Adventist, Jesus Christ of Latter-day Saints, Islam, Buddhist, and Bahá’í Faith.

Content analysis of the interviews resulted in 5 domains, 19 categories and 23 subcategories. In-depth results are beyond the scope of this paper. However, regarding the (in/ex)clusion of religious minorities in the health system, our study found that there was a positive expectation about the health care professionals sensitivity, in particular psychologists ("(...) Psychology is an area that raises awareness of individual differences and racial issues, and I think that psychologists are more tolerant in general [than physicians and nurses]; Buddhist participant). Nonetheless, it was also stated that “[I think] psychologists would
get much better results in their clinical practice if they considered the spiritual dimension of human life. And many of them don’t” (Baha’i participant). Furthermore, the Evangelical participant added “Well, I also think that some minority groups still need to be studied further and an object of research by psychologists”. This statement accurately addresses the issue of (in)visibility of religion as an variable in the provision of culturally-sensitive services. In fact, some people still describe experiences of discrimination, which is consistent with other national and international findings (e.g. Miller & Thoresen, 2003; Plante, 2007). The results also highlighted a paradox: while participants expressed openness and positive representations regarding psychological support, most did not seek help and thought of it only after other forms of healing were tried (such as prayer, support from a religious leader, family, and the community). This has also been found by others (e.g. Merchant et al., 2008).

5. T-SHaRe Transcultural Skills for Health and Care (European study)**

The T-SHaRe Project (Transcultural Skills for Health and Care) is a European study, coordinated in Portugal by Chiara Pussetti (from CRIA – polo in ISCTE-IUL, Lisbon), with a multi-disciplinary team of anthropologists and psychologists. European partners include France, Norway, Slovenia and Italy, with the promoting centre in Napoli (Azienda Sanitaria Locale Napoli 2 Nord). The objectives of this project, which is still ongoing, are:

- The comparison among health and care systems in the countries involved;
- The analysis of different visions, approaches, knowledge, competences, and needs in the area of health and care of the main immigrant group cultures, with a special emphasis on women’s health and mental health;
- The exploration of the skills in the field of therapeutic mediation that health care professionals should develop from the immigrants’, cultural mediators’ and health care providers’ points of view;
- The design of innovative protocols for building and training inter-professional and intercultural team working in the healthcare services for migrant users, again with a focus on mental health and women health;
- The production of methodologies and tools addressed to healthcare cultural mediators;
- And, finally, testing and validating an innovative protocol for building and guiding inter-professional and intercultural team working in the healthcare services for migrant users.

At present, only the first two goals have been completed, while the third is at a concluding phase. The Portuguese team was responsible for the comparison among health and care systems among the five countries involved, including accessibility to health care. In sum, a few conclusions were drawn from these comparisons. Firstly, all the countries, with the exception of
France, appear to have services that are specifically focused toward immigrants. Secondly, some pro-active efforts to disseminate information on health care information for immigrants have been found in France, Portugal and Italy. Despite the existence of these pro-active policies of communication and dissemination of information on health services, the outcome of these policies appears to be quite ineffective in all the countries besides France, in the sense that, according to the researchers’ perceptions, within the public health system there is little knowledge on immigrants’ rights, needs and conditions in which health care may be obtained. Similarly, immigrants were perceived to also have little knowledge regarding their own rights in health care. Concerning issues related to linguistic accessibility, varying institutional and formal efforts in translating information regarding health issues seem to be available through diverse means: posters, leaflets, brochures, booklets, Internet – Homepages. Interpreters and translators within the health service are provided at a professional level in France, Italy, and Norway, even though the only country in which translators are officially recognized by the health system is Italy. In terms of procedural accessibility (the simplicity/complexity of documents, cards and forms needed to be able to receive services), most countries evaluated it negatively, i.e., as slightly to moderately complex. Finally, at the level of cultural competency (efforts made on behalf of the health services in understanding immigrants’ specific needs and social context), research teams in France, Norway and one of the Italian research partners considered that efforts are being undertaken, while researchers at the Frantz Fanon Association (Italy), in Portugal and Slovenia understand that there are only few to no efforts in this direction. With the exception of Slovenia, researchers in all the other countries report that some sort of cultural mediation activities exist, at least in some settings (e.g. in Portugal, health mediation occurs, for instance, in Amadora and Setúbal). However, the requirements involved in becoming a cultural mediator differ from one country to another and are strongly linked to the people who are able to conduct mediation. Overall, cultural competency of general health care services was assessed as weak by most countries (except France). This is consistent with the lack of knowledge on communication and culture of clinicians and other health care professionals, but also the difficulties professionals have in accessing interpreters, mediators and other communicative tools, and supervision.

6. Conclusions

The annual report of the International Organization for Migration (IOM, 2009) indicated that:

“The provision of effective, efficient and quality of care to the total population (including immigrants) requires a redirection of the current health care model so that it best responds to the experiences, expectations and health needs of a diverse society. A migrant-sensitive health workforce (...) requires new competencies” (p. 13).
This conclusion is consistent with the literature on the development of individual and cultural diversity competencies among health care professionals. This literature, in particular in the realm of counselling and psychotherapy (Daniel et al., 2004; Sue et al., 1992), has pointed toward the need to promote the systematic training of clinicians, such as psychologists and psychotherapists.

Recognizing both the ethical and practical importance of cultural diversity competence development, a number of approaches have been proposed to train professionals (D'Andrea et al., 1991). These training programs generally focus on one of two approaches (Rogers-Sirin, 2008). On the one hand, some programs emphasize experiential learning, through either real or simulated experiences. Some examples of experiential learning are role-plays, simulations, self-reflection exercises and process-oriented group discussions. On the other hand, training programs that emphasize didactic learning (i.e. promoting understanding of culture), through readings, lectures, guest speakers and videos. Supervised internships with diverse clients and supervisors have also been proposed (Yutrzenka, 1995). The specific needs of the professionals within the organization should be considered when choosing a didactic, experiential, or mixed approach (Rogers-Sirin, 2008).

Our team has developed two brief training programs (8 to 12 hours, and follow-up/supervision) in individual and cultural diversity competencies, so far – one directed at child and youth care professionals in a multicultural context (see Moleiro et al., 2010) and another with psychologists at a community-based clinic providing psychological services to Lesbian, Gay, Bisexual and Transgender persons (see Moleiro et al., submitted). Our findings indicate (1) that professionals may have a tendency to over-estimate their own competencies in self-report, which may result in low consistency between self-report and the demonstration of ability to translate individual and cultural issues into the strategies and relational aspects of care with specific cases; and (2) that relatively brief training programs may be effective in changing both awareness and actual ability to make use individual and cultural diversity issues in case conceptualization.

It is our understanding, as Ingleby’s (2010), that “…it’s not enough simply to provide more care – the kind of care that is given may have to be different. (…). [Culturally-sensitive care] begins when you realise that providing the same care may be providing inferior care – that one also has to take diversity into account.”

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References


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