

Poverty and social exclusion in the WHO European Region: Health systems respond



EUROPE

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6. Germany: MiMi Project - With Migrants for Migrants

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Summary

In Germany, 18.6% of the people are immigrants. When compared with the host population, immigrants face higher risks of poverty and ill health. These risks stem from the immigration process, which can entail adverse living and working conditions, as well as social exclusion.

Recent policy initiatives in Germany have sought to improve the health and social inclusion of immigrant populations. The German National Framework for Prevention Strategies, the National Integration Plan, the Immigration Act of January 2005, and the German National Action Plan against Poverty and Social Exclusion support the integration of immigrants and the reduction of health inequities.

This case study focuses on an initiative that formed within this social and political context: the *With Migrants for Migrants – Intercultural Health in Germany* programme, henceforth referred to as MiMi. Developed at the Ethno-Medical Centre in Hanover, MiMi was launched, in cooperation with the Federal Association of Company Health Insurance Funds (BKK Bundesverband), in 2003 as a pilot programme in four cities. MiMi's goal is to recruit, train and support intercultural mediators and enable them to teach the German health system and related health topics to their respective immigrant communities. These mediators are well-integrated immigrants with a sense of civic commitment; they are 20–60 years of age, with legal residence in Germany. The majority of them (80%) are women. Programme participants for the community group sessions organized by mediators are usually immigrants with lower levels of social integration. During these events, information on health and health system access is delivered in diverse languages within a culturally specific context.

The programme applies the following mechanisms:

- standardized training of intercultural health mediators from immigrant communities;
- community group sessions to inform immigrants about health issues and access to the health system;
- a health guide to explain the health system (available in 15 languages), in addition to educational materials on specific health-related topics;
- a network of intersectoral partners and activities, including project conferences and training health professionals, to increase the capacity of partners to meet the needs of migrant communities; and
- a monitoring and evaluation system, to ensure sustainability and effectiveness.

Since the programme's inception, MiMi has expanded to 46 cities in 10 federal states. MiMi now cooperates with more than 100 partners across Germany. Municipal health services and social service providers are key partners. The programme has facilitated important links between immigrant communities and the health system, enabling increased comprehension of their respective needs.

As of December 2008, MiMi had trained 781 mediators from 65 different countries, involved over 17 700 immigrant attendees at community group sessions (reporting high satisfaction rates for usefulness of activities), and helped to diffuse health knowledge to more than 41 500 family members, according to a centralized data-pool at the Ethno-Medical Centre. The health system itself has also benefited from the programme. Service professionals have become more aware of (and attuned to) the needs of the immigrant population, which allows them to better address this population's needs in culturally appropriate ways.

Socioeconomic and policy context

In 2007, 15.3 million people with an immigrant background lived in Germany. About half of them are non-German citizens (7.3 million *Ausländer* or foreigners), while the other half (about 8 million) have become German citizens or are Germans living abroad. Immigrants account for 18.6% of the German population. Altogether, just under a third of all children younger than 5 years of age in Germany have an immigrant background. Turkish immigrants constitute the largest group of immigrants (1.8 million), followed by people from the former Yugoslavia, Italy and Greece (Federal Statistical Office of Germany, 2007, 2008).

The structure and process of immigration to Germany has been changing. In the 1960s and 1970s, so-called guest workers and their families constituted the immigrant population, while refugees and asylum seekers dominated the 1980s and 1990s. Since the 1990s, resettlers (Germans from the newly independent states (NIS)) constitute the third group that has increasingly migrated to Germany (Federal Statistical Office of Germany, 2008).

Overall, the percentage of immigrant women and children is growing, and the demographic structure comprises more and more elderly immigrants. Also, the number of illegal immigrants is increasing, which poses a challenge to German society and government. Overall, Germany has become a so-called migration country (Hornung, 2004).

In terms of their socioeconomic status, immigrants are generally disadvantaged. The chance of getting a well-paid job depends to a large extent on educational attainment. Although the prospects for education have improved for the second generation, it must be noted that children with an immigrant background still have a lower educational status. Also, the first generation of parents is still working under precarious circumstances – that is, they are working in manual, unskilled and semi-skilled jobs, with little social security and poor prospects of promotion. Moreover, immigrants run a higher risk of unemployment (Hradil, 2001).

With regard to inequities in the health status of immigrants, compared with the host population, we find the paradox of the healthy-migrant effect. This means that the health status of immigrants is good at the time of settlement, since they belong to a selected sample of healthy people. This advantage, however, diminishes with time. Socioeconomic disadvantage and insufficient access to the local health system worsens their health status, as compared with that of the host population. Interestingly, though, health inequities do not show a consistent pattern. Older guest workers, for instance, have a lower total mortality than their German peer group – for example, cardiovascular mortality is lower among Turkish men. Maternal death among immigrants, however, is 1.7 times higher than among of their German peer group (Razum, 2006).

Notwithstanding this inconsistent pattern, it is obvious that immigrants lack sufficient access to the German health system. They face a number of problems: insufficient information on existing structures and measures; poor communication between patients and professionals; and differing cultural concepts of health and disease. Together, these problems determine the perception, causation and presentation of symptoms. On the other hand, immigrants might possess a range of personal and social resources, such as transcultural competence, flexible coping strategies, perceptions of self-efficacy and control, and family networks (Hornung, 2004).

As a consequence, policies to improve the health status of immigrants include strategies to reduce stress and strengthen resources, both at an individual and structural level. Such strategies include (Hornung, 2004):

- trauma therapy;
- occupational health and safety;
- health promotion services that address the personal situation of immigrants without stigmatization;

- qualification of health professionals, to improve their intercultural competence;
- broadening health services transculturally, by incorporating and integrating professionals with immigrant backgrounds, introducing interpreter services, and linking health and psychosocial services;
- improving knowledge of health and personal responsibility in immigrant patients; and
- strengthening social networks and self-help groups in immigrant communities.

Since 1997, the Federal Commissioner for Migration Issues has coordinated the German cross-sectoral working group on migration and public health (Arbeitskreis Migration und öffentliche Gesundheit). The working group is a professional network of 41 members, each representing different authorities of the public health services. Their concern and aim is to improve public health services for immigrants.

The health-related measures mentioned above should be embedded in a general strategy to promote social inclusion of immigrants. This currently happens within the framework of the National Integration Plan. For the first time, all those dealing with integration in politics and in society work hand in hand: the federal government; federal states (Länder); local authorities; immigrants; institutions and organizations from science, media, culture, sports, trade and industry; trade unions; and religious groups. The most important aims of the National Integration Plan (Bundesregierung, 2007) are:

- improving integration measures, such as training;
- promoting the German language from the start of migration;
- ensuring good education and vocational training, to improve opportunities in the labour market;
- improving the life situation of women and girls, to achieve gender equality;
- supporting integration in the communities;
- recognizing cultural diversity;
- using sports for integration;
- using the various kinds of media available to support integration/social inclusion;
- strengthening integration through civic commitment and equal participation; and
- ensuring that the knowledge of immigrant populations is incorporated into the scientific and learning culture in Germany and that immigrants also are integrated into the scientific community.

■ Programme benefiting the target population ■

Overview of the With Migrants for Migrants programme

Language and cultural barriers, as well as adverse socioeconomic living conditions, make access to health services difficult for immigrants and their families. To address this situation, the With Migrants for Migrants – Intercultural Health in Germany programme (henceforth referred to as MiMi) aims to make the health system more accessible to immigrants, to increase their health literacy and to empower them through a participatory process. MiMi does this by recruiting, training and supporting intercultural mediators, to enable them to teach the German health system and related health topics to their migrant communities. It also builds the capacity of all partners involved in this process to improve migrant health.

Originally developed at the Ethno-Medical Centre (Ethno-Medizinisches Zentrum), with financial support from the BKK Bundesverband, MiMi was launched in 2003 as a pilot programme in four cities in the federal states of Lower Saxony and North Rhine-Westphalia. It has since expanded to 37 cities in Lower Saxony, Hessen, North Rhine-Westphalia, Brandenburg, Baden-Württemberg, Rhineland-Palatinate, Bavaria, Hamburg, Bremen and Schleswig-Holstein.

Each city's implementation phase lasts about 18 months. Implementation entails the use of the following core mechanisms: training of intercultural health mediators from immigrant communities; community group sessions – delivered by the trained mediators – to inform immigrants about health issues and health system access; a health guide to explain the health system and educational materials on specific health-related topics; a network of intersectoral partners and activities to increase the partners' capacity to meet the needs of immigrant communities, including project conferences and the training of health professionals; and a monitoring and evaluation system. The following subsections will elaborate on these mechanisms, providing relevant background and explaining how they evolve in each of the phases of implementation.

Pre-implementation: designing tools and methodologies for mediators

To reach its goal, the Ethno-Medical Centre considered that the mediators, once trained, would need tools, platforms, and approaches that helped reach the aim of improving immigrant access to the German health system. Thus, during the project formulation stage, it designed a methodology of interrelated and synergistic mechanisms. This methodology encompassed community group sessions, a health guide, and intersectoral collaboration, explained below.

Community group sessions are designed to address the following core topics:

- the German health system (as a mandatory topic for all information sessions)
- unhealthy eating habits and lack of physical activity
- smoking, alcohol and substance abuse/medication dependency
- mental health
- accidents/injuries and children's health
- health of the elderly.

In developing the programme methodology and curricula, MiMi determined that immigrants should be provided with language and culturally appropriate information in accessible locations. Sessions were to be held in easy-to-reach local arenas, such as municipal health service points, community centres, sports clubs, religious institutions, educational institutions (such as language schools) and private company offices.

The *Health guide* delivers complementary information (in the diverse native languages of immigrants in Germany) about: health insurance; issues related to visiting a doctor or dentist; issues related to the operations of pharmacies and hospitals; a description of the public health service; what to do in case of emergency; and useful contacts (BKK Bundesverband, 2008).

Under the topic of health insurance, the guide covers:

- German statutory health insurance, including its benefits, beneficiaries, private health insurance and the principle of free choice of insurance companies;
- additional payments, giving instances when personal contributions are necessary and when they are exempt; and
- the Asylum Seekers' Benefits Law (Asylbewerberleistungsgesetz), which covers benefits available to asylum seeker and refugees.

Under the topic of visits to a doctor or dentist, the guide covers:

- the issues of choosing a doctor, consultation and confidentiality;
- preparing for a doctor's appointment;
- information a doctor should deliver, regular medical check-ups for early diagnosis and recommended vaccinations;
- dental check-ups and the bonus booklet;
- dentures and dental treatment abroad; and
- the curative costing plan, personal contributions and private dental health insurance.

Under the topic of at the pharmacy and in the hospital, the guide covers:

- choice of hospital, contracts, referrals and discharge;

- information before operations, doctors' duties, what to bring for hospitalization and daily hospital routine; and
- tracking medical history and frequent examination requirements.

During the design phase, the network of partners was foreseen as a dynamic and essential component of the programme, as it enables intersectoral work to deliver the community sessions and design the health guide, while facilitating the reduction of ethnic discrimination in service delivery and making public health services more responsive to the needs of immigrant patients. The following four groups of professionals were identified as central to reach through the network:

1. health service employees not adequately prepared to work with the immigrant population;
2. integration officers unfamiliar with health provision matters that pertain to immigrants;
3. social and immigrant counselling services that maintain direct contact with the immigrants; and
4. immigrants who feel too inhibited to approach the health services and who are unaware of available health and social support.

Initial steps: from design to activating operations

This section covers forming and establishing partnerships, linking partnership resources to programme methodology and recruitment of intercultural mediators.

Forming and establishing partnerships

After developing the programme methodology and securing funding, MiMi set out to form partnerships with the local health and integration services. A first round of meetings took place with the heads of these services. The next step for MiMi was to recruit the cooperation of additional partners, such as local authorities, NGOs, insurance companies and educational institutions. Then, another round of meetings was set up to bring together: (a) the health services, (b) the integration offices and (c) the recently recruited partners.

This second round of meetings served two purposes. First, it allowed MiMi personnel to present partners with a unique opportunity to turn into practice the theory of engaging disadvantaged communities. Second, once partners committed to the programme, the meetings served as a forum to formulate and sign a contract that defined the role and responsibilities of each partner in the implementation process. For example, in one area, the health services would be responsible for providing training resources, and the integration office would be designated as the lead player in reaching the target population. All partners agreed to be part of the monitoring and evaluation process and to incorporate MiMi as the official programme name. This was to ensure standardization and maintenance of quality in the programme. Partners agreed to help identify opportunities for sustainable funding and agreed on the publication of programme materials and results. This contract would later develop and come to be known as the shared action plan.

The way in which partners are incorporated into the programme changed as the programme expanded. In the initial stages (2004–2005), MiMi looked for and contacted potential partner organizations. In the second phase of the programme, after the pilot phase, word of the programme became widespread. Then, potential partners and individuals who wanted to be involved with MiMi contacted headquarters directly. Word of mouth and television and newspaper coverage helped to promote the programme. Within the first year of the programme's launch, 96 newspaper articles were published on MiMi. This also helped to drive political support, as mayors of cities became aware of the benefits the programme offered.

In each of its sites, MiMi was invited to present the programme to local officials (such as mayors and city councillors), who then met with the local legislative body (parliament or other relevant body) to discuss and approve the programme's implementation. Parliament's approval is indispensable to the sustainability of the programme, as it allows the health and social services to take the vital next step, in their role as partners, of allocating part of their financial budget and human resources to the operation of MiMi.

Linking partnership resources to programme methodology

The role of each of the health system and other partners in the MiMi programme varies according to the programme area in which it is implemented and according to the availability of resources. Some partners are able to make monetary contributions,

while others offer the use of their existing physical infrastructure and human resources. Of all partners, 30% offer materials and rooms for both training and community group sessions.

In training courses for mediators, medical professionals provide technical and content-related training, so that mediators themselves can plan and conduct community group sessions on various health-related topics. Often, medical professionals set aside special so-called teaching hours during normal business hours to conduct additional training. In these sessions, medical professionals also help to facilitate the use of municipal health service points – that is, public health departments, medical specialists and advisory centres.

During community group sessions conducted by trained and certified mediators, doctors and nurses are present an average of 20% of the time to provide additional support, and they often remain connected to the immigrant community through the MiMi network. These medical professionals essentially become a steady source of health-related information, and mediators are encouraged to ask for their advice whenever needed.

For the health guide, 80 professionals from various organizations in different areas of implementation collaborated to determine the main health topics to be addressed. All partners – including the health and social services, insurance companies, and universities – contributed to the development of the guide and its publication process. Partners now use and help to distribute this guide among their clients.

Recruitment of intercultural mediators

After partners committed to the programme and established their roles within it, mediators were recruited. Advertising campaigns through newspapers, television and posters are among the methods used to recruit new mediators. These campaigns specify that the MiMi programme is looking for strong migrants and invite individuals to meetings about the programme. Word of mouth also helps to attract new mediators. Informative meetings then provide details about the MiMi programme and the role and responsibilities of intercultural mediators. When immigrants are interested in becoming mediators, they go through a formal application process.

A sufficiently high social index is the criteria used to select applicants to become mediators. This index is formed by evaluating the following criteria: educational attainment, level of social integration, language abilities, occupation, and the respect they enjoy among their communities. For example, to determine the level of an applicant's language abilities and ensure that he or she is endowed with the necessary skills to become a mediator, the applicant may be asked to translate a newspaper article from the German to his or her native language, and vice versa.

Building the programme and key operations

This section covers mediator training, medical professional training, co-ordination among partners and the improvement of financial sustainability.

Mediator training

Once the training mechanisms were established and the applicants selected, the recruits were ready to begin official mediator training. For a total of 50 hours, during evenings and on weekends, mediator recruits were trained on the following 17 health-related topics:

1. the German health system, including necessary vaccinations
2. risks of alcohol consumption
3. nutrition and exercise, such as risks of unhealthy eating habits and lack of physical activity
4. risks of smoking and how to quit
5. dealing with medication: when it is necessary and how to avoid addiction
6. pregnancy and family planning
7. children's health and preventing accidents
8. healthy teeth and oral hygiene
9. obesity
10. first aid for children
11. mental health: depression, anxiety and stress; recognizing a psychological illness; helpful services

12. care for the elderly
13. illness prevention services and early diagnosis examinations
14. breastfeeding
15. diabetes
16. the disease management programme
17. breast cancer: early diagnosis and therapies.

When recruits finish their training, they must pass a multiple-choice test on these topics to receive a certificate and become official intercultural mediators. MiMi mediators are paid €150 for each community group session they conduct, or €200 (€100 each) if two mediators opt to have a joint session. Sessions themselves usually last 3 hours, and preparation and post-session reports (to record information on demographics of attendees and questions asked) usually take another 6–9 hours.

Medical professional training

Additional research, observation and evaluation – through a joint effort of the Ethno-Medical Centre and the medical faculty at the Hannover Medical School – found that service professionals too required more formal assistance to learn how to better meet immigrant needs (see the section on “Monitoring and evaluation” for more details on the collaborative effort in evaluating programme efficiency and effectiveness). As a result of these efforts, the MiMi programme has recently begun to provide training courses for (health) service professionals, developed by the Ethno-Medical Centre. Though this was not part of the original MiMi programme and methodology, it has helped health professionals in more established implementation areas to better understand and work with immigrant clients.

Professional training has two levels. At the first level, health service managers undergo two days of training. This helps to ensure: (a) that they take on the responsibility of managing future staff training sessions and (b) that they have full knowledge of what their personnel will be learning. At the second level, training proceeds with personnel training which, depending on the size of the particular health service organization, can take up to a year. Each 2–3 hour session aims at promoting transcultural awareness and understanding. The entire training course includes:

- an overview of the immigration process and recent trends in immigration
- guidelines for effective communication and how to use interpreters
- advice on conflict management
- trading places and role playing.

Essentially, the course gives medical professionals historical background on migration, a theoretical understanding of transcultural patient–doctor relationships, and a practical toolkit to more effectively serve immigrant communities. The course focuses on overcoming barriers related to communication and cross-cultural understanding, which represent 90% of the access barriers facing migrants. The other 10% is comprised of German medical practitioners’ limited knowledge about some diseases that may be more prevalent in the immigrant’s country of origin, but which are less prevalent in Germany. Should a situation arise in which service staff is confronted with such an illness, this training also provides medical professionals with a network of other professionals they can contact. Finally, training courses have also resulted in the production of standard guidelines to help medical professionals work with immigrants.

Coordination among partners

The Ethno-Medical Centre, in cooperation with the BKK Bundesverband, conducts public relations activities through newsletters, various media and the MiMi project web site (MiMi, 2008), where multilingual MiMi guides and materials are available for download. These public relations activities ensure that both partners and the public are regularly informed about programme developments.

To facilitate cooperation among the growing number of partners, MiMi has developed a coordination scheme based on a contractual partnership between site-specific bodies, with central management from the Ethno-Medical Centre. The coordination scheme includes:

- meetings with representatives of the BKK Bundesverband (sponsors);
- meetings for project coordination;

- programme review conferences (MiMi Projektkonferenzen) every six months, which all partners attend; and
- ensuring operation of shared action plans and ongoing exchange through e-mail and telephone conversations among partners throughout implementation, to measure each partner's respective progress.

The biannual programme review conferences help facilitate the flow of information among policy-makers, mediators, and health and social workers. At the conferences, mediators meet policy-makers and partner agency representatives to suggest how to best advance the programme. Also at the conference, all partners exchange experiences and develop solutions to challenges.

Improving financial sustainability

The costs of operating the MiMi programme are mainly incurred through: recruitment campaigns, training and pay for mediators; staff salaries and daily operations; and programme evaluation. MiMi's funding and its distribution of funds have evolved with the expansion of the programme. During the first year of the programme, with four pilot cities, the BKK Bundesverband supported MiMi. After the first year, the Ethno-Medical Centre negotiated and allocated funds, according to the number of cities or regions and the phase in which the project was implemented (with cost reduction over time).

This finance model, however, became unsustainable as the programme expanded. The most recent funding model now incorporates three main funding sources, a step forward for MiMi in ensuring programme sustainability. The three funding sources of each project implementation are: (a) the city, (b) the county (such as the federal state of Lower Saxony) and (c) the insurance companies.

Monitoring and evaluation

This section covers questionnaires on training events and community health sessions, and the overall programme evaluation.

Questionnaires on training events and community health sessions

Evaluation of the MiMi programme is an ongoing process. After every training event or community group session, questionnaires are filled out to (better) monitor progress. During (or after) training events, the organizer of the event, trainees and trainers all fill out an evaluation form on the session's activities. A similar process occurs in community group sessions, but the participants currently also answer pre-session questions to note their preconceptions of health, their demographics and what they hope to learn. Some of the questions included are as follows.

- How did you hear about the MiMi programme and this information event?
- Whom do you usually contact when you are ill?
- Why did you decide to participate in this community group session?

Participant questionnaires are available in 15 different languages. Post-session questionnaires are six pages long and include such questions as the following.

- Did your opinion about this topic change?
- Did you learn anything new?
- Will you make use of this knowledge in the future?

In the first year of the programme, 70–80% of the questionnaires were completed. MiMi is now trying to improve the format of the post-session questionnaires (for more details, see "Changes and future steps" in the section on "Lessons learned").

Overall programme evaluation

A more systematic, overall programme evaluation is underway. This evaluation aims to expand the current concept of evaluating the health determinants of target populations and the capacities built during training and community group sessions – for example, health literacy, behaviour and attitudes. In addition, more innovative research approaches aim to qualitatively describe the use and benefits of MiMi to the actors involved through, for example, interviews and working groups with trainers, mediators, and participants. Also, research aims to determine the cost–effectiveness of the project in various settings. Partners at the Hannover Medical School, the Public Health Service, the Department of Social Psychiatry and the Ethno-Medical Centre are evaluating the

programme, and the evaluation is funded through research grants from the German government. Such cooperation allows MiMi to take advantage of the experiences these institutions have in research and evaluation of projects.

Annual evaluation reports covering state-wide programmes have been published since 2007. Preliminary quantitative findings from the monitoring process (see Table 6.1) have indicated that the programme has:

Table 6.1. Results of information campaign evaluations

Type of information		Year				
		2004	2005	2006	2007	2008
Immigrants accessed	Total per year	1 105	1 569	3 817	4 069	6 965
Gender ^a	Male	32.0	27.3	17.8	16.5	20.2
	Female	68.0	72.7	82.2	83.5	79.8
Age (in years) ^a	<20	9.6	5.8	3.9	3.0	4.8
	20–50	66.7	65.8	63.5	68.0	65.6
	>50	23.7	28.4	32.6	29.0	29.6
Origin ^a	No. of countries	34	64	92	79	98
	Europe	79.8	69.4	77.0	76.8	66.1
	Asia	18.9	18.4	15.2	18.3	29.1
	Africa	0.1	9.9	6.3	2.9	3.6
	North America	0.0	0.2	0.1	0.1	0.1
	Central America	0.6	0.4	0.2	0.4	0.2
	South America	0.6	1.8	1.2	1.5	0.9
German language skills – self concept	None	17.4	17.5	9.6	7.7	7.5
	Satisfactory	22.2	21.5	21.0	18.3	18.1
	Sufficient	29.2	28.2	34.0	30.2	32.5
	Good	17.0	20.0	21.2	26.3	25.2
	Very Good	14.3	12.8	14.2	17.5	16.8
Recruitment channels for campaign participants ^b	Personal invitation	78.1	73.9	64.5	54.1	55.9
	Brochures	4.5	10.3	5.7	6.9	5.9
	Posters	5.5	11.0	5.9	6.4	3.1
	Newspaper	4.2	3.8	3.3	5.7	2.0
	Phone	13.1	11.3	20.8	23.2	32.2
	Letter	9.0	8.4	15.4	14.5	10.8
	Home page	1.1	0.8	1.7	2.5	2.2
I have to review my attitude towards health ^a	Not true	5.5	3.1	4.4	2.9	2.8
	Not really true	8.9	7.9	4.8	4.5	6.1
	Neutral/ partly	30.3	23.5	28.1	26.4	28.2
	Quite true	25.8	27.8	28.2	33.2	33.9
	True	29.5	37.6	34.5	33.0	29.0
I will look after my health more in future ^a	Not true	2.1	2.3	1.9	1.3	1.3
	Not really true	3.2	5.0	2.7	2.4	2.8
	Neutral/ partly	22.0	13.6	17.0	15.7	16.3
	Quite true	31.5	35.0	33.8	37.4	37.9
	True	41.2	44.1	44.6	43.2	41.7
Did you learn anything new at the event? ^a	Nothing	1.1	2.7	2.2	1.1	1.4
	A little	6.3	5.6	7.1	6.0	5.3
	Partly	21.9	17.1	21.3	20.2	26.2
	A lot	49.0	48.4	57.8	56.2	52.7
	Everything	21.7	26.2	11.6	16.5	14.4

^aPercentage of participants.

^bPercentage of positive answers of participants; one participant can provide more than one answer.

- expanded, reaching a greater number of immigrant participants and spreading their newly found knowledge to family members;
- reached various immigrant communities, the programme having trained 781 mediators (originating from 65 countries) by December 2008; and
- empowered women, since the majority of intercultural mediators are women (80%).

In addition, there are also qualitative findings, which suggest the following.

- Current health systems do not necessarily need additional health services specifically created for immigrants; rather, most health needs can be addressed through: (a) supplementary services that help facilitate access to the health care system; and (b) increased capacity to meet increased demand. Examples of supplementary services and increased capacity include: the employment of more bilingual staff, including physicians; the creation of health information material available in different languages; and the increased availability of interpreters, all of which contributes to increasing immigrant access to health services.
- Guidelines are helpful for medical professionals who address in a culturally specific context such specific areas as drugs, HIV/AIDS, mental health and oral health. In the past few years, the use of such methods has increased participation of immigrants in drug rehabilitation centres in Hamburg from 3% to 20%.

Lessons learned

This section covers successes, challenges and areas of improvement, as well as changes and future steps.

Successes

Since its inception in 2004, the MiMi programme has had a number of successes. Evaluations indicate that the programme has facilitated the formation of important links between immigrant communities and the health system. Intercultural mediation coupled with (a) direct immigrant participation and (b) the involvement of local health and social services in accessible community settings have been critical in enabling these linkages. Health professionals have increasingly come to view the immigrant community as a vital partner in health promotion. Such links have fostered a mutual comprehension of respective needs and, through the engagement of social services, also enabled action on the socioeconomic determinants of health of the immigrant population.

The programme has mobilized not only its partners in a collaborative effort, but also political support. More local government authorities are making financial commitments to demonstrate their support. Moreover, the German Government Representative for Immigration, Refugees and Integration, Professor Dr Maria Böhmer, has acted as patron of MiMi. Such support was made possible by the key method of inviting policy-makers to share in the programme's experiences and achievements during press conferences.

Furthermore, MiMi has sought to promote intercultural collaboration at its headquarters. The personnel at the Ethno-Medical Centre are diverse, with 50% of programme staff being immigrants and the other half being native born. More recently, the programme improved gender balance in management by actively recruiting and hiring immigrant women for managerial positions. MiMi has found that its strongest teams have been multicultural, because they offer and discuss different viewpoints and because they address the most difficult cross-cultural issues.

Challenges and areas for improvement

MiMi faces continuous challenges and has found aspects of the programme that might be improved. First, though some local authorities have committed financially to the programme, local authorities in other areas still need to do so. Local governments need to take increased ownership of, and become more engaged in, the programme.

Second, in some communities, MiMi immigrant participants have become very active in requesting access to services. This has resulted in a backlash from some services, which complain that immigrants suddenly have too many needs and that the

health system does not have the capacity to serve them. For the majority of cases, the issue is not that immigrants have unique needs that the health system does not provide or that suddenly they have new needs; rather, the issue is that these needs have always existed and have now been brought to light. Essentially, after addressing the inequities present in immigrant access to health services, the capacity of the health and social services must be re-evaluated and increased where needed.

Third, MiMi has created a new evaluation standard in Germany. The cost-effectiveness of MiMi is monitored and evaluated using a method that is not only qualitative, but is also quantitative. This has created some tensions between MiMi and other interventions, which are now often asked to meet the same standard. MiMi believes that this dual approach is a step in the right direction and that it ultimately improves both the effectiveness and efficiency of interventions.

Fourth, due to the expansion and widespread media coverage of MiMi, some cities are attempting to duplicate the programme without the help, authorization or operational process and methodology of MiMi. This competition in recruiting intercultural mediators has reduced the supply of available and well-integrated immigrants to serve in the programme.

Fifth, two villages involved in the MiMi programme have been unsatisfied with the results. These villages found the programme did not adequately meet its aims. Further investigation revealed mistakes in the implementation and operation of the programme within these villages, such as the following.

- **Under-qualified intercultural mediators.** Training on health topics requires mediators to have a good grasp of the German language. Subsequently, the teaching of community group sessions requires mediators to have a good grasp of the respective language used by the particular immigrant community they address. Accepting immigrants who lack sufficient language abilities in both German and the immigrants' languages increases the risk of incorrect or incomplete information transfer.
- **Underpayment of intercultural mediators.** Mediators are a critical component of the programme's operation and should be treated as such. They require sufficient funds to deliver high-quality community group sessions, and underpaying them jeopardizes the quality of the programme and its endeavours. In addition, it may hinder the recruitment of the most integrated and talented immigrants for the job of mediator.

Finally, internal programme coordination might be enhanced through:

- decentralizing operation centres in each state, as the programme will soon include more than 30 cities and its programme operation is currently centrally coordinated at MiMi headquarters in the Ethno-Medical Centre;
- making a clearer division of tasks between partners and the organization that executes projects;
- holding more frequent regional conferences to exchange information and experiences between regional partners; and
- endowing mediators with more responsibility for decision-making, as they represent the core of the programme and may possess additional insights that can improve programme operations and methodology.

Changes and future steps

Continuous monitoring of the MiMi programme has helped catch mistakes early and discover areas for improvement, thus facilitating positive change. Some of these changes have already been made, and others are in progress.

To ensure the sustainability of the programme, requirements have changed for: (a) new partners wishing to join an existing implementation area and (b) new cities wishing to implement the programme. Each new MiMi partner must develop a concept for funding the project after initial funding from the BKK Bundesverband has ended, such as funding from charitable foundations or other health insurance funds. Also, each new implementation area must now have secured financial support for five years prior to programme initiation. The original requirement was two years.

In September 2007, the MiMi programme began the creation of a national network of mediators and a working group that consists of representative mediators from each city. Then, at a national convention, the delegates will elect one woman and one man to become the national spokespersons for the MiMi programme, to raise political support at the national level. The BKK Bundesverband provides funding for the national convention and the mediators' working group.

Changes have been made to the session questionnaires. MiMi is continuing to use pre- and post-session questionnaires. Previous post-session evaluation forms were lengthy, requiring about 30 minutes to complete. This usually resulted in

substandard response rates and incomplete or fewer completed questionnaires. As a result of this, the questionnaire was made more succinct (20% shorter) and less time-consuming to complete. Also, instead of *income, capacity to save* is now measured, leading to a higher rate of answers to this question. To enhance the overall programme evaluation, MiMi might aim to capture more demographic information, such as the status of migration (first-, second- or third-generation migrant), parents' country of birth and resident permit status.

Finally, the evaluation of MiMi demonstrates its capacity to serve immigrants best if used for: (a) health promotion and preventative care information sessions and (b) the reduction of communication and information barriers, to increase access to existing health services. To maintain this service capacity, the Ethno-Medical Centre has decided to keep this focus and limit its expansion to related activities. For example, when evaluations demonstrated the need for increased services for people with mental and physical disabilities, the Ethno-Medical Centre was able to outsource this need and form a new NGO dedicated to serving these people. This allows the Ethno-Medical Centre to maintain the quality of MiMi programme operations, while simultaneously addressing/respecting additional needs.

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