



MIGHEALTHNET
**Information Network on Good Practice in Health Care for Migrants
and Minorities in Europe**

Portuguese State of the Art Report

Maria Lucinda Fonseca
Sandra Silva
Alina Esteves
Jennifer McGarrigle

Departamento de Geografia / Centro de Estudos Geográficos
University of Lisbon
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Authors

Maria Lucinda Fonseca | Sandra Silva | Alina Esteves | Jennifer McGarrigle

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Preface

In order to successfully address the health related needs of immigrants and ethnic minorities and to safeguard public health in an increasing multicultural European population, it is essential to promote good practices and the exchange of information and expertise, both between and within countries. It is in this context that the network MIGHEALTHNET- Information Network on Good practice in Health Care for Migrants and Minorities in Europe was created.

The MIGHEALTHNET network aspires to respond to the scarcity of settings, at the European level, by providing a communication platform and a tool facilitating the transfer of knowledge and competences in the field of immigrant and ethnic minorities health to health professionals, policy decision makers, researchers, educators, representatives of immigrants and ethnic minorities, through the development of wikis – a virtual network of expertise and specialised institutions - which they can draw upon to implement and develop good practices.

This project was run under the DG SANCO 2003-2008 Public Health Programme but its conception is essentially the result of the work developed by a small group of researchers headed by David Ingleby, in the scope of the B5 research cluster – Social Integration and Mobility: Education, Housing and Health of the European Network of Excellence IMISCOE – International Migration, Integration and Social Cohesion (<http://www.imiscoe.org/>).

MIGHEALTHNET consortium includes academic and health institutions of 12 European countries, counting also with the collaboration of associated agencies of universities, NGOs and public departments of five other countries (http://mighealth.net/index.php/Main_Page).

The Project was co-funded by the involved institutions and the European Commission (DG for Health and Consumer Affairs) and received a grant from Stavros S. Niarchos Foundation. The Medical School of Athens was in charge of the general coordination and David Ingleby (University of Utrecht) was the scientific coordinator. In Portugal, the project was implemented in the Department of Geography and in the Centre for Geographical Studies of the University of Lisbon by a team coordinated by Maria Lucinda Fonseca (<http://www.ceg.ul.pt/mcm/>).

The wikis were built in 17 European countries (Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Greece, Hungary, Lithuania, The Netherlands, Norway, Poland, Portugal, Romania, Sweden, Switzerland, Turkey and the United Kingdom).

The Portuguese wiki is available at www.mighealth.net/pt. This report reflects the contents of the wiki, presenting a synthesis of the state of the art on immigration and health in Portugal.

The report follows the structure initially defined for the wiki – Interactive Database. Firstly, there is a contextualization of the immigrant population and ethnic minorities in Portugal, as well as of the immigration and integration policies. Then, follows an analysis of the state of health of migrants and ethnic minorities and a short characterization of the National Health Service, stressing the rights and conditions of access of immigrants and ethnic minorities to health care. Finally, some examples of good practices and measures to promote change and improvement in the quality of health services provided in Portugal are presented.

1. Background information

a. Notes on the concepts and sources of information used

In Portugal, the main agencies that collect and deal with statistical information on international migration are Statistics Portugal (*Instituto Nacional de Estatística - INE*) through the *Population and Housing Census* and the *Demographic Statistics*, and also the Aliens and Borders Service (*Serviço de Estrangeiros e Fronteiras - SEF*). The collection of data by these two agencies follows international procedures and recommendations. The statistical data available date back several decades and is in general available to the public, either to consult in printed copy or on the websites of the respective institutions; however, some of the more detailed data have to be purchased. Moreover, other public agencies under the tutelage of the Ministries of Labour, Education, Health, Foreign Affairs, Internal Affairs and Justice also produce relevant statistical information on international migration. However, the registries available in these institutions are very selective and specific to the domains of these agencies. Data collection procedures are quite diverse, making it difficult to compare data from different national sources with international data. The publications produced by these institutions can be accessed in their respective libraries or purchased. There are also relevant data available obtained through surveys conducted in nation-wide research projects (Fonseca et al., 2008).

Among the various sources of statistical information available in Portugal, the key variable which defines the immigrant population is nationality. Thus, in this report when we make reference to immigrants we mean the population residing in Portugal who does not have Portuguese nationality, except if mentioned otherwise.

The Population Census and Employment Surveys also include some information on country of birth. However, the use of this criterion presents some challenges because, on the one hand it is not used by the Aliens and Borders Service, and on the other hand it does not permit the distinction between the people from Portuguese origin born in the former Portuguese African colonies, namely Mozambique and Angola, who came to Portugal soon after the independence of these territories, from the immigrants of African ethnic origin.

b. MEM populations

For centuries Portugal was manifestly a country of emigration, seeing much of its population leave for the five continents. Since the 1960s, with particular emphasis from 1974 onwards, Portugal began to receive migrants from the African Portuguese-Speaking Countries (PALOP), in particular Cape Verde. Throughout the 1980s, in particular since Portugal's entry into the European Community, immigration intensified and widened to include labour migrants from Brazil, and other Portuguese speaking African countries, besides Cape Verde, with the arrival of migrants from Angola and Guiné-Bissau. The 1990s were characterized by the consolidation and growth of the immigrant population residing in Portugal, principally from PALOP countries and Brazil, and the emergence of a new migratory wave from Eastern European and former USSR countries. Immigrants originating from Asia are significantly fewer in number, however, important to note due to the recent growth of Chinese, Pakistanis, Indians and Bangladeshis. A lesser number of people arriving from a series of African countries are also worth mentioning. Thus, at the beginning of the 21st century, due to the social, economic and political environments which

facilitated and promoted the arrival of these migratory flows, Portugal can be considered as not only a country of emigration but also of immigration (Fonseca, 2008).

In 2007, according to preliminary figures from the Ministry of Internal Affairs (MAI), there were 435,736 documented foreign citizens¹ living in Portugal, which represents 4.1% of the total population living in the country². These numbers confirm a sustained growth of immigration since 2003, except in 2005 when there was a slight decrease. A finer grained analysis by nationality shows that Brazilians and Cape Verdeans are the largest immigrant groups, each representing 15% of the documented foreign population in Portugal. The Ukrainians (9%), followed by the Angolans (8%) and those originating from Guinea-Bissau (5%) are also numerous, corresponding respectively, to the third, fourth and fifth positions on the list of the main sending countries.

It is also worth mentioning for the first time that Brazilians are the largest community in Portugal relegating Cape Verdeans to second place. This situation was foreseeable due to the growing number of Brazilian citizens arriving in Portugal and the sustained growth of the Cape Verdeans³.

Another characteristic of contemporary immigration to Portugal is the presence, in high numbers, of undocumented migrants. As in Spain, Italy or Greece, irregularity, at least for a period of time⁴, constitutes part of the migratory histories of a large part of the immigrants and their descendents living in Portugal. It is difficult to quantify the number of undocumented foreigners living in Portugal at the present time. However, according to the estimates of various institutions it would appear that tens of thousands of immigrants are in irregular situations, principally Brazilians (Fonseca and Goracci, 2007).

The distribution of the resident foreign population in Portugal reveals a very asymmetric pattern of settlement. They are concentrated mainly on the coast, especially in the districts of Lisbon, Faro, Setúbal and Porto. This is the main trend, even if since 2000 a new pattern of spatial distribution has emerged, with the immigrant population settling in rural areas or in the outskirts of large cities (Fonseca and Malheiros, 2003; Baganha and Fonseca, 2004; Fonseca, 2008). Several research studies also refer to the fact that third country nationals experience worse living conditions and are more likely to reside in overcrowded dwellings, in shacks or in other dwellings lacking amenities and thus in general experience a higher risk of poverty and social exclusion (Malheiros and Mendes, 2007; Fonseca et al., 2002).

In the short history of immigration to Portugal, male immigration has always presented higher indexes than female immigration, although in recent years this tendency has been mitigated through family reunification. Thus, in 2007, out of the 435,736 immigrants legally residing in Portugal, 55% (240,096) were men and 45% (195,640) women.

1 Foreign citizens in Portugal include immigrants with long regular stay in the country, thus, foreigners with a residence permit, permanence permit or of a long term visa.

2 According to the Activity Report from the Aliens and Borders Service (SEF), the foreign population legally present in Portugal increased by 3.7% in comparison to 2006.

3 Cape Verdean immigration is residual, occurring mostly under family reunification and study motives whereas the Brazilian arrivals are essentially labour migration flows. Among these, there are already signs of family reunion entries.

4 Since the 90s there were 5 regularization campaigns in Portugal: This included two 'extraordinary' regularisation campaigns in 1992/1993 and 1996; regularisation campaign based on employment that took place between January and November 2001; and two other regularisation campaigns, one in 2003 based on a special agreement signed between Portugal and Brazil that allowed the regularisation of irregular Brazilian workers settled in Portugal and another one from April to mid-June 2004.

Most of the foreign groups display a classical structure, dominated by young people of working age. The population aged 20 to 39 years and 40 to 64 years corresponds, respectively, to 50% and 25% of documented migrants. The proportion of 0-19 years old (25%) is also significant, due to the importance of family migration. However, the percentage of elderly persons (65 years and over) is much less than that of the autochthonous population, accounting for only 4% of documented foreign citizens.

As a consequence of the slow down in the Portuguese economy and the increase in unemployment since 2002, immigrants have had increasing difficulties in finding employment. Subsequently, between 2001 and 2006, unemployment among immigrants increased from 8012 to 21673, especially among Brazilians and Ukrainians. In 2006, the unemployment rate for the male population born in Portugal reached 6.9%, the equivalent value for foreign born males was 8.2%. The unemployment rate among women was higher, namely 9.3% for Portuguese born females and 11.4% for foreign born females (OECD, 2008).

According to calculations by Peixoto (2008: 27), in 2006, foreign workers represented approximately 6% of the national active population. In terms of their professional situation, according to information presented by the Ministry for Work and Social Solidarity, in October 2005, from the 153,977 foreigners, working in private companies⁵ with employment contracts, 96.9% were employees and only 3 % were employers or self-employed. Most employers were nationals of European Union countries, while the employees were mostly from “Other European countries”, PALOP countries and Brazil (MTSS, 2005: 24). In 2005, foreign employees corresponded to 5.2% of the total number of workers (11,403 more people than in 2004) with a predominance of male workers (62.3%). In terms of nationalities, most of them came from “Other European countries” with a significant bulk of nationals from Moldova, Romania, Russia and Ukraine (35.3%). The workers from PALOP and Brazil were also significant representing 28.4% and 20.3%, respectively.

When comparing employees according to the major labour groups, the differences between Portuguese and foreigners are worth noting. In 2005, almost 50% of non-Portuguese employees were semi-skilled and unskilled workers, whereas the corresponding figure for Portuguese employees was 30% (MTSS, 2005: 17). Low skilled professions (labourers, craftsmen and similar workers, operators of machinery and assembly line workers, and unskilled workers), are those with the highest number of immigrant workers followed by service and retail workers (MTSS, 2005: 22). However, it should be noted that this data does not include domestic employees, temporary workers and those in irregular situations. Thus, the number of foreigners is significantly under-represented and the professional structure somewhat distorted, especially in the case of female employment.

Foreign employees, registered in the employment records of the Ministry of Work and Social Solidarity, have educational levels similar to the average of Portuguese employees. Still, the percentage of those who have higher education is slightly below the overall average (7.5% and 11.3% respectively), and the proportion of those who have educational qualifications equivalent to the 2nd cycle of basic education is slightly higher than that of the total number of employees (50.9% and 48.3% respectively) (MTSS, 2005: 17).

⁵ Also, including workers in the civil services and public institutions according to the legislation for individual work contracts.

c. Political context

As far as the rights of immigrants are concerned, Portuguese law can be considered as being extremely positive. In the 13th and 15th articles of the Portuguese Constitution the principle of equality among citizens is enshrined. Portuguese and legal foreign residents are considered equal and have similar rights – civil, social and economic – except for the right to political participation⁶. Moreover, Law no. 134/99 (28 August) forbids discrimination based on race, nationality or ethnicity. Portugal is also a signatory to the main international instruments in terms of human rights and the protection of migrant workers.

In the specific case of the political citizenship, Law no. 50/96 (4 September) stipulates that EU nationals, PALOP citizens residing for more than two years in Portugal and other foreigners residing for more than three years can vote in local elections. This Law also establishes that PALOP nationals can be elected for positions in local authorities if they have been legally residing in Portugal for four years or for five years in the case of other nationalities. Despite this, it is worth noting that the right to vote and the right to be elected are based in the existence of reciprocity conditions (Baganha and Marques, 2001: 31-35; Fonseca, 2005).

In recent years Portugal has drawn up an integrated legal framework, conducive to the reception and integration of immigrants into Portuguese society, in all its aspects. Examples of this qualitative leap are: the new law on Nationality (Law No. 2 / 2006 of April 17); the Legal Regime of entry, residence, exit and expulsion of foreign nationals, known as the new immigration law (Law No. 23/2007, of July 4); and the Plan for the Integration of Immigrants (Council of Ministers Resolution No. 63-A/2007 of May 3). These legislative instruments aimed to «*structure current national immigration policies into four main areas: the regulation of migration flows; the promotion of legal immigration; the fight against illegal immigration; and the integration of immigrants*» (SEF, 2007: 5).

The new *Nationality Law* (Law nº 2/2006 of 17th April - regulated through Decree-law n.º 237-A/2006, 14th December) made significant amendments to the previous nationality law (Law no. 37/81 of 3 October 1981) in terms of acquisition of Portuguese nationality. Among the most important changes there was a reinforcement of the “*ius soli*” principle facilitating the access of immigrants’ children born in Portugal to Portuguese citizenship⁷. According to the new law, Portuguese citizenship can be accessed by way of two processes: nationality of origin or by way of acquisition (by the effect of will, by adoption or by naturalisation). In the domain of the acquisition of nationality, the requirements for naturalization were made easier and a new concept of legal residence for the attribution or acquisition of nationality was introduced. Proof of legal residence can be made using any permit or valid visa (residence permit, permanence permit, work visa, study visa, temporary stay visa or extension of permanence permit) as long as the length of residence is fulfilled. In the process of naturalisation of a legal foreigner residing in Portugal, the differentiated treatment among different groups of foreigners has been eliminated and a minimum of six years of legal residence has been adopted as the requirement for all foreigners. The

⁶ The guarantee of civic rights is universal, but despite being dissociated from nationality, social and economic rights are closed linked to residence status and the economic incorporation of immigrants.

⁷ According to Carrilho and Patrício (2006) the rate of babies born to migrant mothers increased three times among the total births in Portugal between 1995 and 2004. In 2004, they represented 7.8% of the total number of births in the country. If these children, with one or more migrant parents obtain Portuguese nationality they become invisible in most statistics. For more information on the demographic impact of migrants in Portugal see Rosa, Seabra and Santos (2004).

new law also equivalized common-law marriage to marriage for the purpose of obtaining nationality⁸.

According to the new nationality law, Portuguese nationality is granted to the descendants of immigrants already born in Portugal, if at least one of the parents was born in Portugal and lived in the country, independently of the legal document held at the time the child was born; descendants of foreign citizens born in Portugal, providing the parents are not serving their country of origin, declare the intent to obtain Portuguese nationality and at the moment of birth at least one of the parents has been legally living in Portugal for at least five years. A subjective right to naturalisation was also consecrated in the new law to minors descendent of foreign citizens but born in Portugal, if at the moment of applying for nationality one of their parents had resided legally in Portugal for five years (independent of the residence title they held) or if the minor had concluded the first cycle of basic education in Portugal. The new nationality law also benefits the second generation of Portuguese emigrants rendering access to the Portuguese nationality more easily, providing they are able to prove they are second degree Portuguese ascendants (Law no. 237-A/2006 of 14th December).

In all of these situations language requirements are applicable (Law no. 1403-A/2006 of 15th December), it is also mandatory that applicants have not been convicted under Portuguese Law to three or more years in prison. The acquisition of Portuguese nationality only implies the loss of nationality of origin if the law of the country of origin determines it.

Finally, the Aliens and Borders Service no longer accepts requests for the acquisition of nationality by way of naturalisation, this is now a competence of the individual Civil Registry Conservatories and of the Conservatory of Central Registries, where all requests are centralised.

The “new immigration law” (No. 23/2007 of 4th July 2007, regulated by the Decree no. 84/2007, 5th November) introduced significant changes in the conditions for entry, stay, departure and expulsion of foreigners from national territory, as well as in the long-term resident status. Some of the alterations improved quite considerably the conditions of incorporation of immigrants into Portuguese society by simplifying the requirements for family reunification and establishing a regime of exception for immigrants showing strong links with Portugal to obtain residence permits. These immigrants are minors who were born and have always resided in Portugal and also attended pre-primary education, the first stage of basic education, secondary education or professional education in Portugal, and, also, individuals of age born in Portugal who have not left the country or who have lived in Portugal from the age of 10. Law no. 23/2007 also established a single title that allows entry into Portugal for residence reasons⁹, introduced a specific regime for temporary immigration and simplified the admission of researchers, academics and highly skilled foreigners. Moreover, it also established a special regime conceding residence permits to victims of human trafficking and illegal migration.

In terms of public attitudes and discrimination towards immigrants and minority ethnic groups, the report “Majority Attitudes towards Migrants and Minorities: Key findings from the Eurobarometer

⁸ In 2007 and 2008, the Aliens and Borders Service issued 6.684 and 8.053 certificates for the acquisition of nationality, respectively. The same institution issued 2.068 certificates for naturalization of minors in 2007 and 2.756 in 2008. For naturalization of adults the Aliens and Borders Service issued 8.733 certificates in 2007 and 30.090 in 2008. In those years the Aliens and Borders Service also issued 3.178 and 5.158 advisor letters for requests of acquisition of nationality by effect of will or adoption, respectively. Migrants who obtain Portuguese nationality become invisible in most statistics.

⁹ There was thus the introduction of a new concept of legal residence in Portuguese territory, whereby residing legally in Portugal was defined as not only the holders of residence permits, but also the holders of any valid title.

and the European Social Survey” (EUMC, 2005), Portugal is ranked fourth in the EU as showing more resistance to immigration. The research also showed that one in every six Portuguese citizens had reservations when asked about the entry of immigrants into the country and 62.5% of those interviewed were against the entry of more foreigners. These results do not differ significantly from the European average and are directly related to low-skilled respondents, living in rural areas and earning low wages, factors that have to be taken into account when analysing the results. On the other hand, the survey was conducted soon after an extraordinary regularization campaign of undocumented immigrants in Portugal, which may have increased the perception of their presence in the country.

Despite the results obtained in the survey, the position of Portuguese people towards immigrants and cultural diversity is on average more positive than in other European countries due perhaps to the long emigratory experience of the country. For example, in an analytical report on discrimination in EU countries published by Eurobarometer in February 2008, Portugal is one of the countries where citizens are more aware of equality of opportunities and believe there is a greater need for legal support against discrimination and where discrimination is lower, particularly in the health sector (Eurobarometer, 2008). There is further evidence of the contradictory attitudes of Portuguese citizens towards immigration in general in research conducted at the national level by Vala (1999a), Vala, Brito and Lopes (1999b) and also by Lages and Policarpo (2003) and Lages et al. (2006) on the images and reciprocal attitudes between Portuguese and foreign citizens. These studies provide a picture of the perception of ethnic and cultural differences, namely in terms of prejudice and discrimination on the part of the Portuguese population towards immigrants and vice-versa, and also among immigrants of different nationalities. The majority of Portuguese people recognise the relevance of immigrants for the country’s economy, the fulfilment of jobs the Portuguese workers no longer wish to do and defend the rights of immigrants (as long as they have not committed criminal offences). However, on the other hand, most of the interviewees, as reported by Lages et al. (2006:358) think that the number of immigrants in Portugal should be smaller.

The Portuguese State has been active in fighting discrimination based on race, colour, nationality or ethnic origin, disability, age, sexual orientation, religion or belief, language, education, social or economic backgrounds and several laws have been enacted with this purpose, besides the Portuguese Constitution (articles no. 13, 15 and 26), the Law no. 134/99 of 28th August and the Decree Law no. 111/2000 of 4th of July.

Portugal has also adopted the European rules on anti-discrimination. The transposition of European legislation approved in 2000 can be found in the Portuguese Law no.18/2004 of 11th May which transposes the EU directive 2000/43/CE, enacted by the Council on 29th June, on the principle of equality of treatment among people, irrespective of race or ethnic origin. It is applicable in the areas of employment, social security and benefits (such as the entitlement to free medicine, joining trade unions or having access to professional training and orientation), but also to healthcare and goods and services available to the general public, including housing. The Council directive 2000/78/CE of 27th November established a general framework for equal treatment in employment and occupation and together with the Labour Law and Law no. 35/4004 of 29th July unified a general ban on discrimination.

Also worth mentioning is the establishment of the High Commissariat for Immigration and Ethnic Minorities, presently known as the High Commissariat for Immigration and Intercultural Dialogue (ACIDI, I.P.), through the Decree Law no. 251/2002 of 22nd of November, the Commission for Equality and Against Racial Discrimination (CICDR), through the Law no. 134/99 of 28th of August

and the Commission of Religious Freedom (CLR), through the Law no. 16/2001 of 22nd of June (law on religious freedom).

On the subject of integration of note is the Plan for the Integration of Immigrants (PII), established by resolution of the Council of Ministers (No 63-A/2007 May 3), involving 13 ministries, which work together to operationalise 122 measures with 295 goals to be implemented between 2007 and 2009 (ACIDI, 2007). These goals are distributed across 9 areas of intervention (Labour, Employment and Vocational Training, Housing, Health, Education, Solidarity and Social Security, Language and Culture, Justice, Information Society and Sports) and 11 areas of cross intervention (Hosting; Descendants of Immigrants, Family Reunification; Racism and Discrimination; Religious Freedom; Immigrant Associations; Media; Relations with Countries of Origin, Access to Citizenship and Political Rights, Gender Issues and Trafficking of Human Beings).

The Plan for the Integration of Immigrants was developed in response to the recommendations of the European Commission, from 2000 to 2001, for the implementation of immigration policies that take into account not only the economic and social aspects of integration but also the issues concerning cultural and religious diversity, citizenship, participation and political rights¹⁰. It is based on basic principle No. 10 of the Common Basic Principles for Integration, which places inclusion and measures of integration in all policy areas and levels of government and public services at the heart of the formulation and implementation of public policies¹¹ (ACIDI, 2008: 5).

In reference to the period of May 2007 to May 2008, the annual report of the PII stated the achievement of an execution rate of more than 80% of the targets defined up to 2009 and in four areas of intervention the rate reached 100%.

Beyond all that has been mentioned hitherto, in order to protect their rights and interests, immigrants living in Portugal have organized themselves into associations. There is now almost one hundred Associations of Immigrants recognized by ACIDI. These Associations of Immigrants represent citizens of various countries, including: Brazil, Angola, Mozambique, Guinea-Bissau, Guinea-Conakry, Cape Verde, São-Tomé and Príncipe, Ukraine, Moldova, Romania, Russia, China and the Philippines, among others.

In short, the integration of immigrants into Portuguese society has become of growing importance in recent years, constituting a political priority today. Although national approaches are marked by peculiarities inherent to its own particular context, Portugal has tried to harmonize its national policies on immigration and integration with the EU directives and has actually made an effort to promote and facilitate the reception and integration of immigrants. That effort is reflected for instance in the Migration Integration Policy Index (MIPEX)¹² published in 2007, which puts Portugal in second place in the classification of government measures to integrate migrants in 25 European States and Canada, Norway and Switzerland. According to this report, “Portugal has created a legal framework composed of friendly policies and best practices for integrating immigrants, especially, among these,

¹⁰ Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on immigration, integration and employment (COM/2003/0336 final).

¹¹ Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on a common agenda for an integration framework for the integration of third-country nationals in the European Union (COM/2005/289 final).

¹² The MIPEX includes 140 indicators across five areas considered essential for the integration of immigrants: access to the labour market, family reunion, political participation, access to nationality and measures to fight racism and discrimination.

policies regarding access to the labour market, family reunification and anti-discrimination (Niessen, Huddleston, Citron, 2007: 146-151). However, as mentioned by Fonseca and Goracci (2007), despite the recent legal changes that improve the overall situation of immigrants in Portugal, namely the nationality law, some areas still show less favourable indexes. These are for example, electoral rights, security of the nationality status and long term resident status as well as the requirements for family reunification.

2. State of health

a. Sources of information

There are very few institutions that collect data on immigration and health in Portugal. Besides Statistics Portugal (INE), who provide some indicators extracted from the Population and Housing Census conducted every 10 years and the yearly Survey on Income and Living Conditions (EU-SILC), there is the Authority on Working Conditions who publishes data on fatal work accidents by nationality and activity sector in their annual reports. Another important source of information is the National Health Interview Survey implemented by the National Institute of Health Dr. Ricardo Jorge; however, nationality was only included in the last wave (2005/2006) (Cf. Dias et al., 2008a). This survey provides very useful information on the state of health of the immigrant and Portuguese populations (for example, perceived and real state of health, challenges faced by patients in accessing health services and medical care, etc.), on a very useful comparative basis. The Institute of Registries and Notaries also hold some data by nationality, namely on births and deaths. As previously mentioned, besides these institutions, there are a wide range of health care agencies that have statistical data or information on the nationality of patients but which are not available to the general public. This information was collected for administrative purposes and is not statistically treated. Some of the health care services holding this information are those providing maternal and child health care, health centres and hospitals, mental health care services, contagious diseases health services and public health services, among others.

b. State of the art

Little in the way of research has been conducted in Portugal on health and immigration and there is a considerable lack of research on the access of immigrants to healthcare. Moreover, there is a considerable lack of research on epidemiological data regarding MEMs. Not only is the information available on existing research and results limited, but it is also dispersed amongst different institutions and scientific areas.

Related to the scarcity of information there is also the issue of inconsistency of data collection procedures in this area and its lack of systematization. Researchers working in the domain of health or those interested in conducting research on health and immigration recognise the challenges and stress the urgency in finding solutions.

Some efforts are already being made in order to remedy the existing failure to disseminate information already available and inform the public on the need for more research in this area. In this

vein, in 2007, the Observatory of Immigration published a special issue of the journal *Migrações* on “Immigration and Health” and edited several recent Master’s dissertations dedicated to same area (Sousa, 2006; Monteiro, 2007; Manuel, 2007; Lopes, 2007). Similarly, the international conference “Health and Migration in the EU: Better health for all in an inclusive society”, in the ambit of the Portuguese Presidency of the EU, as well as the publication of a series of studies sponsored by the Government of Portugal (ACS, 2008; Portugal, 2007; Fernandes, 2007; Barros and Simões, 2007; George, 2007) served to place the health related issues of immigrants on the political agenda of the EU as well as other international institutions.

Despite being quite limited, the research developed in this domain has led to a growing interest among researchers and health professionals with diverse disciplinary backgrounds. The research already done focuses on diverse issues, while the following themes have been privileged:

- Access of immigrants to particular forms of healthcare, namely: the primary prevention of HIV (Santana and Nogueira, 2005a, 2005b; Távora-Tavira et al., 2007; Nossa, 2000; 2002; Faria and Ferreira, 2002; Matos, Gonçalves and Gaspar, 2005; Dias et al., 2002, 2004; Williamson et al., 2008);
- Maternal and child healthcare (Machado et al., 2006; Calado et al., 1997; Manuel, 2007; Monteiro, 2007);
- Sexual and reproductive health (Alarcão et al., 2008a; Harding et al., 2006a, 2006b; Lopes, 2007);
- Mental health (Rosa, 2007; Pussetti, 2006; Dias, 2005; Lechner, 2005a; Costa and Mota, 2000).

There are also other studies that analyse the issue of access and use of healthcare on the part of immigrants that focus on more generic aspects such as the constraints faced by users and the quality of the services or the responses to tensions in the relation between immigrants and the health services (Leandro et al., 2002; Gonçalves et al., 2003; Andrade, I., 2006; Godinho et al., 2007; Dias and Gonçalves, 2007; Dias, Severo and Barros, 2008).

Besides these issues, there are also studies that address themes related to: a) The social representations of health (Bäckström, 2006); b) The life styles of Cape Verdean teenagers (Gonçalves et al., 2005; Gaspar et al., 2005); c) Health problems with major incidence among immigrant communities, such as mental illness and heart diseases, diabetes or oral health (Monteiro, 2008, 2006; Harding et al., 2008; Dias, Matos and Gonçalves, 2002; Dias et al., 2004; Lechner, 2005a, 2005b, 2007; Abukumail et al., 2007; Carreira et al., 2007; Nicola and Carreira, 2007; Ferrinho, 2003).

It is also worth mentioning that the research on the relation between different aspects of health and the social conditions of the foreign population have also gathered relevance in the work developed by some researchers, namely Santana (2002, 2004, 2005 and 2007).

In most cases, these studies were developed by researchers working in the area of medical sciences or public health, namely the Institute of Hygiene and Tropical Medicine at the New University of Lisbon. Despite this, Machado (2007) highlights that recently, smaller nuclei from other research institutions in the fields of medicine, sociology, anthropology and geography have begun to develop research around these issues. Among the centres, the Institute of Preventive Medicine (Faculty of

Medicine of the University of Lisbon), the Centre for Anthropological Studies and the Centre for African Studies (ISCTE), the Institute of Social Sciences (University of Lisbon), Centre for Geographical Studies (University of Coimbra) and the research unit MIGRARE – Migration, Spaces and Societies (Centre for Geographical Studies of the University of Lisbon) are included. The Open University has also encouraged post-graduate students to conduct their dissertations in the area of migration and health.

c. State of health of MEMs

As stated above, there has been little research conducted on the epidemiologic characteristics between different migrant groups. Moreover, existing information is often not published or even inaccessible. However, there are already some data, even though scarce, on the state of health of immigrant communities in Portugal and on the most common problems afflicting them.

According to the Fourth National Health Interview Survey¹³, immigrants present a more favourable self-reported state of health in comparison to Portuguese citizens (62.8% classify their state of health as good or very good), show lower propensity to short term physical disability and experience a lower prevalence of chronic diseases (except for asthma). On the other hand, according to health professionals, recently arrived immigrants tend to experience health problems and they need very similar healthcare to that of the native population. However, immigrants seem to be more susceptible to certain health problems and risk behaviour, namely malnutrition, high risk and/or early pregnancies, depression and other psychological illnesses, alcoholism, domestic violence, risky sexual behaviour resulting in infectious diseases (HIV-AIDS, tuberculosis, hepatitis, etc.), work accidents, intra-ethnic community violence, etc. (Carballo, 2007a; Ingleby et al., 2005; Fonseca et al., 2005). The particularities of the physical and mental health of immigrants residing in Portugal when compared to the autochthonous population deserve a detailed analysis. Thus, a short synthesis of the conclusions of several studies in different health domains is presented here.

Maternal and Child Health

Recent research conducted by Harding et al. (2006a, cited by Machado et al, 2006) analysing all births registered in Portugal between 1995 and 2002 shows the differences in child-bearing ages between Portuguese women and African immigrants. The former group is characterised by a decrease in the number of births before the age of twenty, whereas the latter shows an increase in the number of births among very young women. The research also highlights a higher frequency of low weight premature births from African mothers when compared to Portuguese mothers. In terms of birth weight among live births, the evolution of the records shows a decreasing trend in both groups. On the other hand, the authors concluded that despite variations in the average weight of children of both groups, they are less relevant than in other countries: for example, in the case of the UK, the weight of newborns born to immigrant mothers is significantly lower than that of newborns born to British

13 The National Health Interview Survey (NHIS) is an instrument of assessment and observation of health, collecting population based data and generating estimations on the state of health and illness of the Portuguese population and respective determinants. It also has a longitudinal perspective analysing data through out the years. Four NHIS have already been conducted (1987, 1995/1996, 1998/1999 and 2005/2006) using probabilistic samples representative of the population living in the mainland (1st, 2nd and 3rd) and in the Autonomic Regions of Azores and Madeira (4th). The question of migrants was only included in the first and last National Health Interview Survey.

mothers. The authors admit that these discrepancies may be more often than not due to environmental factors than to genetic causes.

In order to have a better understanding of this issue, Harding et al. (2006b) analysed the variation of the weight at birth of children from immigrant parents born in Fernando da Fonseca Hospital with complete gestation time. It was possible to conclude that, besides biological causes, the behaviour of mothers, such as smoking, can be seen in significant differences of the average weight of newborns. Moreover, it was also observed that there is no major statistical deviation on the average weight at birth of newborns from African immigrants born in Portugal with that of the children of Portuguese descent. The differences are smaller when the parity of the mother's age and the gestation time of both groups are taken into consideration.

Research conducted by Machado et al. (2006), which received the 2006 BIAL Medical Clinic Award, represents a major contribution to the analysis of the relation between economic and social conditions of immigrant and autochthonous families residing in the municipalities of Amadora and Sintra and also to the understanding of the use of health services in the first months of newborns. The target population of this research included live births in the Fernando da Fonseca Hospital between 1st December 2005 and 31st May 2006 of which 43% were children of a foreign father or foreign mother¹⁴. One of the conclusions of this research is that the greater economic deprivation and social marginality of immigrant families is visible in worse maternal and child health conditions. The descents of immigrants have higher foetal and neo-natal mortality and mothers suffer from more pathologies during pregnancy, namely infectious diseases. This last fact can be justified by their later attendance of pre-natal medical care.

The same research concluded that immigrant families look more often for healthcare in hospitals rather than in health centres. The main reasons justifying this attitude is the absence of an assigned family doctor in the health centre, the perception of how serious the illness might be, being attended without rigid time schedules, ease to hide undocumented situations and family de-structuring or serious social problems.

Sexual and Reproductive Health

In terms of sexual and reproductive health, a survey on the assessment of the use of contraceptive methods by Brazilian and African immigrant women residing in Portugal was conducted in 2007¹⁵. This research (Alarcão et al., 2008a) showed that approximately 89% of the 876 surveyed women used contraceptive methods (in the Fourth National Health Interview Survey the proportion was 87%), such as the pill (57%), condoms (17%), tubal sterilization (16%) and intrauterine devices (6%), among others. A correlation between birth control and the place of birth of these women was identified showing that Brazilian immigrants and the women born in Portugal were more likely to use birth control (93%) in comparison to African women (87%). The birth control method used by the women is also associated to their place of birth: women born in Portugal use condoms more often (33%) than Africans (15%)

14 Most of the foreign parents are nationals from the Portuguese-Speaking African countries.

15 "The access of African and Brazilian immigrant communities to health care in Portugal", co-ordinated by Dr. Rui Portugal. The sample included 876 women aged between 15 and 55 of which 65% were African and 35% Brazilian immigrants. Among the African immigrants, 54% were from African descent and 11% had Portuguese nationality belonging to the African immigrant community.

or Brazilians (15%). In turn, 21% of Brazilian women and 16% of Africans had been sterilized, whereas this method was only used by 4% of the Portuguese; the intrauterine device was more often used by African women (9%) than by Portuguese (4%) or Brazilian women (4%). Other relevant results of the survey were that the pill was the contraceptive method more often used independently of the woman's nationality and that immigrant women use the condom less often than the Portuguese population. Immigrant women show a higher degree of surveillance of their gynaecological health with 58% of Brazilians, 52% of Africans and 40% of Portuguese stating that they have regular gynaecological check-ups. The research did not find significant correlations between the use of contraceptive methods and length of residence in Portugal.

Also on the subject of reproductive and sexual health, several studies (Dias, Matos and Gonçalves, 2002; Bäckström, 2006; Lopes, 2007) show that there is a major lack of knowledge on the part of immigrant communities on contraceptive methods available. But above all, many of the choices made and risk behaviour result from social constraints (be they familial, medical or among peers), beliefs or cultural values found both in the sending and receiving societies, and also from personal conflicts. For example, research conducted by Manuel (2007) on the representations and practices of family planning among Timorese immigrants in Portugal concludes that their immigration to Portugal and their contact with a different social, cultural and economic context had consequences on the representations and practices of Timorese women in terms of family planning and in their reproductive behaviour. In general, after coming to Portugal these women had to adapt their sexual behaviour and their expectations about child-bearing to the new context, having acquired a wider knowledge on other contraceptive methods and accessed more easily and frequently information on family planning. In this case, the woman's decision about contraception and the contraception method used was influenced by a vast set of situations, such as her age, the nature of the relationship with her partner, previous experiences, number of children or the degree of influence that these decisions would bear on her self-image, sexual expression and life style.

Chronic Diseases

Chronic diseases such as heart and respiratory diseases and diabetes are major pathologies among immigrants. According to data from the Fourth National Health Interview Survey, among the more frequent chronic diseases affecting immigrant communities are high blood pressure (13.1% for immigrants and 18.6% for Portuguese) and diabetes (2.8% and 6.1%, respectively).

The International Centre for Migration and Health¹⁶ began a research project on migration and diabetes in 2006, which is being implemented in several European countries including Portugal (the others are Germany, Austria, Canada, Spain, Greece, Ireland, Italy, Norway, Sweden, Switzerland and the United Kingdom). In the case of Portugal, the research is being developed by the Institute of Preventive Medicine in cooperation with the Association for the Protection of Portuguese Diabetics¹⁷. According to their preliminary results presented to the general public on 29th September 2007, the immigrant

¹⁶ The International Centre for Migration and Health is a non-profit institution based in Switzerland and founded in 1995 with the purpose of conducting research and training and promoting the implementation of policies in all areas related to migration and health. For further information on this centre see www.icmh.ch.

¹⁷ The interviews were conducted between July 2007 and March 2008 among immigrants from former Portuguese African Colonies. The sample was randomly selected and composed of migrant and non-migrant people living in the *distritos* of Lisbon and Setúbal, aged between 35 and 59 years.

groups more representative of the target population include citizens from Angola, Cape Verde, Saint Tomé and Príncipe, Mozambique and Guinea-Bissau. From this initial analysis, it is worth stressing the high proportion of women with diabetes (63% compared to 37% of men), the fact that 50% of diabetics are aged between 50 and 59 years and that the secondary level of education among this population is high (Costa et al., 2008; Costa, 2007). According to the same research, most immigrants thought they were well informed about diabetes when the diagnosis was made (56%) and that at the moment of the survey their diabetes was under control (72%). The results obtained also showed that the diagnosis of diabetes introduced slightly more changes in the life of diabetic immigrants in comparison to the life of diabetic natives. Whereas half of the immigrants stated that their daily life was harder than before the diagnosis, 53% of the non-immigrant population said that it was similar. There were also differences between the two population groups in their ability to control the disease with immigrants revealing more difficulty in the verification and correction of very high levels of sugar in comparison to the autochthonous population (approximately 40% and 20%, respectively) (Costa et al., 2008).

In the ambit of the research project entitled “The access of the African and Brazilian immigrant communities to health care in Portugal” a study on high blood pressure among these populations was conducted (Alarcão et al. 2008b)¹⁸. The results show a 45.4% prevalence rate of patients suffering from high blood pressure. This rate is higher among men (55.1%) than women (39.2%) and also higher among PALOP immigrants (52.2%) compared to Brazilians (24.3%). 42% of patients suffering from high blood pressure were conscious of their health problem, mainly African immigrants (43%), whereas the equivalent figure for Brazilians was only one third. A little less than half of the patients were medicated (47%), the proportion being higher among Africans (50%) than Brazilians (33%). The research also found a positive correlation between the number of high blood pressure African patients, age (older) and sex (stronger among men).

Infectious Diseases

According to data from the European Centre for Disease Prevention and Control¹⁹ (2008), Portugal has the highest rate of HIV/AIDS in Europe, although the number of diagnosed cases by HIV infection lowered almost 70% between 2000 and 2007. As far as the immigrant population is concerned, according to several annual reports from Euro/HIV (2006, 2007, 2008), Portugal is part of a group of Western European countries where HIV/AIDS infection among foreign residents has a smaller weight in the total number of identified cases. According to Faria and Ferreira (2002), foreign individuals represented 10% of the total number of reported cases of HIV/AIDS infection in Portugal between 1983 and 2002. African immigrants represented 84% of reported cases and among these only 8% were not PALOP citizens.

¹⁸ This study is based on a sub-sample composed of 317 individuals - 77% from PALOP countries and 23% from Brazil. 61% of the individuals are women.

¹⁹ The European Centre for Disease Prevention and Control was founded in 2005 with the goal of strengthening European defences towards transmittable diseases. It is based in Stockholm, Sweden and for further information see <http://ecdc.europa.eu/en/>.

Moreover, an international research project²⁰ on the transmission of HIV also conducted in Portugal and involving the population born in Europe (77%), Africa (18%), South America (3%) and Asia (1%), concluded that 75% of the new AIDS cases identified in Portugal are from people born in Portugal. In second place are African immigrants, in third nationals from South America and in fourth immigrants from Asia. It also concluded that among the infected immigrants coming from Africa and Eastern Europe, 40% contracted the disease in Portugal because they had sub-types of HIV non-existent in their countries of origin. Among the main conclusions of the research, the more relevant outcomes, due to the need of urgent political and social intervention, are related to the fact that patients infected with HIV following medical treatment continued to display risky sexual behaviour such as unprotected intercourse, and thus easily infected their partners. Also, individuals infected with resistant HIV strains but unaware of their situation (20% of the cases were already detected in the B and C stage of the disease) are able to transmit the resistant strain to others, causing a serious public health problem where the infection is not detected in its asymptomatic stage (Palma et al., 2007; 2005).

Despite the concordance of the results of the two previously mentioned sources, it must be stressed that the proportion of immigrants infected with the HIV/AIDS virus is, in both studies, much larger than the proportion of foreigners living in Portugal. However, this fact does not allow us to conclude that immigrants show a higher risk of infection as the prevalence rates among natives and immigrants for sample sub-groups with the same economic and social background remain unknown.

In an epidemiological study on sexually transmitted infections, with a sample of 220 African immigrants recently arrived in Portugal and sexually active, Távora-Tavira et al. (2007) obtained the following results in relation to the prevalence of sexually transmitted diseases: gonorrhoea (1.8%), syphilis (4.1%), hepatitis B (7.3%) and HIV (7.3%); there was not a single case of genital Chlamydia.

In research conducted on the knowledge and attitudes towards HIV among immigrants residing in a neighbourhood in the Lisbon region²¹, Dias, Matos and Gonçalves (2002) concluded that there are gender differences among the African population. The researchers noted that men, both young and adults, have little knowledge on the modes of transmission of the virus and on the means of prevention, do not have any perception of the risk of infection, even underrate it, and showed no concern about the problem. Thus, they often had misinformed ideas about the disease and displayed very risky behaviour with regards the infection and transmission of the disease. The women, on the other hand, were better informed, more conscious and concerned about AIDS and the risk of contracting the virus. They adopted a more critical attitude towards some of the misconceptions about the disease and tended to assume more preventive behaviours, even while the risk of infection is associated to the males' behaviour there was little they could do about it. The women interviewed also drew attention to the lack of information on the disease in their community and the discrimination associated with AIDS.

It is also worth mentioning that although youngsters, both men and women, have a higher conscience of what AIDS is and its risk of infection, they do not behave in accordance with their

²⁰ The SPREAD project (Strategy to Control Spread of HIV Drug Resistance) is a multinational multicentre surveillance protocol involving 16 European countries, which aimed to determine the prevalence of transmission of resistant HIV strains within different risk groups and to identify potential risk factors increasing the risk of transmission. The project lasted for three years and was co-ordinated by Professor Prof. Charles Boucher (Utrecht University, The Netherlands) and by Dr. Ricardo Camacho (Virology Lab from Egas Moniz Hospital, Portugal). In Portugal, the research was conducted during 2003 and the results were extracted from a national sample of 180 patients recently diagnosed with HIV.

²¹ The research included 66 subjects older than 15 years and almost all of them came from Angola, São Tomé and Príncipe, Guinea-Bissau and Cape Verde.

knowledge, starting their sexual lives very early and often without any kind of protection. In fact, in the community condom use was found to be very low. The reasons for this ranged from cultural and ideological barriers to its cost and difficulty to obtain. Among the community members, the use of the condom was more often associated with contraception rather than the HIV virus, and to various perceptions related with infidelity, single sexual encounters, lack of trust, intimacy and commitment in a relationship, etc.

The increase of new cases by HIV infection among women is a subject of concern among health institutions in Portugal, mainly because most of the infected women are in their fertile years and the consequences are visible at multiple levels, such as reproductive ability and in the vertical transmission to descents. In Portugal, the virus is diagnosed when women do the series of tests usually recommended during pregnancy. Among these cases, women do not show any symptoms and this diagnosis may cause other serious problems, not only psychological, but also cultural and social related to pregnancy and birth. Social exclusion and poverty worsen the situation of women with HIV in these circumstances. In research conducted in 2007 on pregnancy and seropositivity among immigrant women in the Lisbon region, the authors concluded that all women experience major psychological and social vulnerability when diagnosed with HIV during pregnancy. These situations of vulnerability increase remarkably when seropositivity during pregnancy is diagnosed in immigrant women (Lopes, 2007). Indeed, the lack of family ties and economic resources, isolation and marginalization, the barriers to access information and health care services are factors that turn immigrant communities particularly vulnerable to this infection. To these one must often add linguistic and cultural barriers. According to data from the Epidemiological Vigilance Centre for Transmissible Diseases from the National Institute of Health (CVEDT), the number of registered pregnant women with HIV has been increasing since 2001, jumping from 161 cases in 2000 to 371 cases between 2001 and 2004. Of the total number of HIV infected women, 44.9% are black and 45.9% are white. In 2004, among the 66 pregnant women diagnosed with HIV, 35 were born in Portugal, 30 were born in Africa and 1 was born in Eastern Europe (CVEDT, 2005, cited in Lopes, 2007: 98).

In the case of tuberculosis, it is known that in Portugal the incidence of the disease among immigrants is higher compared to the general population and there have been a growing number of new cases. It also generally acknowledged that immigrants are exposed to higher risk because they mostly come from countries showing high prevalence rates of the infection and many of them live in poor economic and social conditions. According to data presented in a paper published by the Portuguese Journal of Pulmonology, in 2003, the incidence of tuberculosis per 100 thousand inhabitants was 41 in the general population and 149 among the immigrant population, thus 3.6 times higher, with a total number of 324 cases. Geographically this situation had more expression in Lisbon (21%) and Setúbal (20%), with almost all of the patients coming from PALOP countries, particularly from Angola (3.5%) and Cape Verde (2.6%). However, there is also a considerable number of people infected with the disease coming from Guinea-Bissau, Saint Tomé and Prince and Mozambique. Most of these patients are men who have been residing in Portugal for more than 5 years (Rifes and Villar, 2003). Tuberculosis is also closely associated with HIV, being one of the more common opportunistic diseases.

According to data from the National Programme for the Fight Against Tuberculosis (2005), in an analysis of the newly infected cases from the 2002 cohort, the proportion of immigrants who had been cured was 78%, a much higher percentage when compared to other risk groups such as drug addicts and/or those infected with HIV (56%) and homeless people (46%). According to information

supplied by health professionals and NGOs, there has been a positive evolution in Portugal in recent years in terms of access to information, means of prevention and tests on the part of immigrants, as well as access to treatment. The main problem identified was fear on the part of immigrants in using the services and treatments available, due to the stereotypes and stigma associated with this particular infection. Immigrants often failed to do tests and only consulted the health services when the disease reached a serious stage. Often, when they were informed of their health problem they missed medical consultations and/or the treatments.

Mental Health

Before, during and after the migratory process, immigrants often experience different kinds of psychological pressures, well identified in the international literature and related to the break in family, social and cultural ties and difficulties of adapting to the host country. This situation can cause stress related problems, anxiety and depression that may last for years and which has the tendency to become more serious if not correctly diagnosed and treated.

Mental health is one of the higher risk health issues among immigrants. However, in Portugal little is known about this problem, in fact, it was only in the Fourth National Health Interview Survey (2005-2006) that statistical data on the situation of mental health among immigrant populations was collected for the first time (this was not representative of the different immigrant communities living in Portugal)²². In this survey, approximately one third of the population revealed probable psychological problems (22.2% of the immigrant interviewees and 27.1% of the Portuguese)²³. In a study by Godinho et al. (2008), of the 2,485²⁴ immigrants surveyed, 31% suffered from psychological problems, with female respondents being affected more by this problem. When comparing African and Brazilian nationals, the latter show a higher propensity to suffer from psychological problems. The same study also concluded that among the risk factors one can find the age of the immigrant when arriving to Portugal (the older the higher the risk), the legal status (with a higher risk related to illegal immigration or holding a more precarious permit) and the length of residence in Portugal (as the length increases, the risk decreases).

Depression linked to the consumption of alcohol is usually associated to Eastern European immigrants. Despite the absence of systematic data proving this relation, the idea is based on the experience of health professionals. Although the aforementioned survey shows that 46.1% of the total number of immigrants and 48.4% of the total number of Portuguese consumes alcohol, at weekends alcohol consumption is more frequent among foreigners than Portuguese citizens.

From 2004 to 2007, the Hospital Miguel Bombarda, in Lisbon, provided a specialised service for migrants, ethnic minorities and refugees. Due to the restructuring of National Health Service mental health services the service was discontinued. The team providing the service was comprised of multidisciplinary specialists with clinical experience in transcultural mental health, they offered not

22 The research done in Portugal on mental health is mostly about situations of manifested distress, unhappiness, anxiety, restlessness, fatigue, irritability, stress, etc. The survey (Lechner, 2005a) focuses on "health diseases", as being health conditions diagnosed by a psychologist or psychiatrist (e.g. depression, dementia, schizophrenia, behavioural syndromes, etc).

23 The Fourth National Health Interview Survey used the Mental Health Inventory (MHI) instrument that provides an assessment of several domains of mental health including anxiety, depression, behavioural control, positive affect, and general distress.

24 69% were from the PALOP countries, 31% from Brazil and 58% were women.

only psychological and psychiatric consultations, but also psycho-pedagogic counselling and nursing care. During the few years in which it operated the service attended 520 people (clinical procedures) and gave 59 consultations. The majority of the patients were between 25 and 55 years old and came from PALOP countries, Ukraine, Moldavia, Brazil, Italy, Great-Britain, China and Bangladesh. The main psychosocial problems for which migrants sought help were related to the difficulties of adapting to a new country and a new culture. All of the patients displayed psychological problems and signs of mental illness related with the fear and anxiety associated with the process of integration into a new society. Some also displayed psychopathologies.

Finally, an ongoing research project coordinated by Chiara Pussetti (2006) from CEAS/ISCTE, on Public Health Policies and Health Practices, is studying the symptoms and healing strategies of migrants in the Greater Lisbon Area, and is likely to make an important contribution to this field.

Work Accidents

There are sectors of the labour market that owing to the nature of their functions are more risky and conducive to accidents. Most of the immigrant labour force is working in activity sectors with such risks, such as civil construction. In fact, immigrant workers are among the more vulnerable groups.

This situation is due to specific characteristics related to their status as immigrants, such as economic need, the fear of drawing attention to themselves, of losing their job or of being deported, but is also a result of language barriers that hamper communication and access to information on potential risks. Moreover, a lack of knowledge on the labour laws of the host country and consequently their rights and duties, namely in the areas of health and safety in the work place further aggravate this situation. Beyond these specific characteristics, the precarious nature of the actual job and the tasks it necessitates and high rates of labour mobility make awareness of professional risks more difficult, as well as the acquisition of safe habits and practices (Cardoso, 2008:203).

According to data from the Authority for Work Conditions, there was a slight reduction in the number of fatal work accidents between 2004 and 2008 (from 197 in the first year to 114 in the last). Of those, 45 occurred in civil construction companies, a sector in which more than 50% of fatal work accidents occur. The most frequent accidents involve Ukrainians, Angolans and Romanians.

d. Actions taken to tackle health disparities

There has been an effort on the part of the institutions responsible for providing health care services to tackle the disparities found in the conditions of health and access to medical care among needy populations, which include immigrants. These initiatives have been developed by the Ministry of Health, some NGOs (for example, *Médecins du Monde*, Association of Young Promoters of Healthy Amadora – AJPAS, Association of United Cape Verdeans) and private social solidarity institutions (for example, the Holy House of Mercy of Lisbon – SCML). Several partnerships have also been established (public-private, between associations, public and private agencies and EU programmes, etc.) that have been essential in disseminating information on the conditions of access to medical services and the prevention and treatment of diseases such as HIV/AIDS, tuberculosis and sexually transmitted diseases. Their role has also been important in strengthening relations between the population and health care services.

Among community public health interventions, the more relevant ones include the introduction of mobile health units in needy areas so that medical care can reach out to the population who for some reason (economic, behavioural, bureaucracy, legal, etc.) have been excluded from accessing health services. This kind of initiative has been adopted by diverse organizations, either individually (for example by the General Directorate of Health / Regional Health Administration, Holy House of Mercy of Lisbon or the association PROSAUDESC – Association for the Promotion of Health, Environment and Social and Cultural Development²⁵;) or in partnership (Médicos do Mundo Portugal - MdM-P in partnership with PROSAUDESC²⁶; Association of United Cape Verdeans, Programa Escolhas and Amadora Health Centre).

Some associations have community intervention projects whose goal is to provide targeted medical and social support to needy populations and to immigrants in particular. Among these interventions, the project promoted by the Association of Young Promoters of Healthy Amadora – AJPAS can be pointed out as a good practise. It has a multidisciplinary team that provides home help to HIV positive patients and to people with AIDS, to bed-ridden people, or those in the post-surgery stage, or in the terminal stage of an illness, etc. and also offers free medical consultations in post-labour periods through the Immigrant Support Service (SAI) in a peripheral area of Lisbon (Amadora municipality), where many immigrants and ethnic minorities of African descent reside.

This association has also developed activities, as partners, in the scope of European projects. Among these, the “European Partnership Project among African Communities and Health Actors for the Prevention of HIV/AIDS”²⁷ is distinct. Based on this research project, the AJPAS produced a kit for the prevention of HIV/AIDS, with the objective of deconstructing beliefs, taboos and myths found in the African community. It includes a video, a brochure and a user’s manual in Portuguese with subtitles in English, French and Spanish (AJPAS, 2004)

The “Guide for Immigrant Health” and “The Health Passport of Immigrants” are two initiatives that target the immigrant population with the goal of raising awareness of the conventional health services available and the institutions responsible for providing these services. These have been developed through partnerships between the Lisbon council, immigrant associations, the Holy House of Mercy of Lisbon – SCML, and the High Commissariat for Immigration and Intercultural Dialogue – ACIDI. Other initiatives include, for example: home help given to seropositive women by the “Step by Step” Association; multidisciplinary services that offers consultations to people at risk in the Alfredo da Costa Maternity Hospital; the aforementioned Migrant Consultation developed between 2004 and 2007 by the Portuguese Association of Psychology and Transcultural Psychiatry and the Miguel Bombarda Hospital (recently closed due to financial constraints by the Ministry of Health); the publication, by ACIDI, of a brochure in Portuguese, Russian and English on the health services available in Portugal and on health related questions; the distribution of brochures about HIV/AIDS by the National Commission of the Fight Against AIDS among the main immigrant communities residing in Portugal in their respective

25 It has a mobile unit that reaches out to immigrant communities living in the Terraços da Ponte and Ameixoeira neighbourhoods. The project “Propinquity Health” is an initiative that began in 2008 with the goal of giving information, sponsor alerting activities, to assess vital signs and to refer patients to the right services.

26 Medical consultations for immigrants and referral consultations.

27 The project was developed between January 1999 and December 2003 and its main goal was to prevent HIV/AIDS among Sub-Saharan African communities residing in Europe. The Project was implemented in seven countries: Spain, France, the United Kingdom, The Netherlands, Sweden, Belgium and Portugal.

mother tongue; and also the distribution of flyers providing information on the conditions of access of immigrants to the National Health Service by PROSAUDESC, in the scope of the research project “Healthy Information”.

Another initiative worth mentioning is the establishment of the Support Programme for Foreign Patients (PADE), which is the result of a protocol signed between ACIDI and the Institute of Social Security. This programme’s goal is to provide support to foreign citizens and to those accompanying them who need medical treatment in Portugal. Need is attested by a set of medical doctors and subsequently involves intervention in the domain of health and/or help if patients are extremely poor and struggling with problems related to housing, food, psychological or social support. The PADE includes a Network of Houses to host patients and companions allowing for the monitoring of the patient during three distinct stages: the process in the country or origin, the process of becoming a permanent resident in Portugal and the end of the treatment²⁸.

These initiatives are mainly focused in large urban areas, in areas whose populations are socially and economically in need and may be exclusively targeted, or not, to immigrant communities or certain groups (for example, young people, pregnant women, ageing population, etc.). Many other initiatives with a wider scope are being implemented in order to reduce disparities in the access of the population to health care and also in their state of health. These initiatives target the entire population and not only the immigrant population. There is a clear need for initiatives aimed at increasing awareness among health professionals and the population in general of the situation of immigrants in Portugal, in terms of their integration in the National Health Service. There are several studies presently being conducted on the state of health of immigrants living in Portugal, which will soon present conclusions. These results may contribute to increasing our knowledge of the situation and to the subsequent development of health policies and strategies directed towards immigrants to reduce some of the disadvantages they face in accessing health care services.

One of these projects, called “Access to Health Care Services and the State of Health of African and Brazilian Immigrant Communities in Portugal” deserves particular attention for its pioneering character. For the first time in Portugal, a health survey is being conducted with the goal of analysing the state of health and equity in the access to health services of the immigrant population. This research is co-ordinated by Rui Portugal and Mário Carreira, both from the Institute of Preventive Medicine at the University of Lisbon, and focuses on the access of Brazilian and African immigrants to, and their experience of, the health services. The study is based on a survey of a representative sample of both groups, which will be compared to the Fourth National Health Interview Survey. Some preliminary results from this project have been presented in national and international workshops and conferences (Godinho et al., 2007; Abukumail et al., 2007).

28 The end of health treatment implies the supervised return of the patient to his/her home country and his / her reintegration or integration in Portugal in the case of being the bearer of a Residence Permit, according to the definitions established by 1g) of article no. 122 of the Law no. 23/2007, 4th of July.

3. Health system and entitlement to care

a. The health system

Through out the years the health services in Portugal have been significantly restructured according to the different political, economic and social processes that the country has gone through: political and social democratisation, joining the EEC, entry into the European Economic and Monetary Union. Knowing the evolution of the Portuguese Health System provides not only a better understanding of its present configuration, but also enables the identification of its limitations, obstacles and possibilities for change.

As referred to in the *2001 Spring Report of the Portuguese Observatory of the Health Systems (OPPS: 2001)*, until 1971 the health services were simultaneously provided by several public and private institutions, such as the Holy Houses of Mercy (social solidarity institutions) that managed most of the hospitals and other health services available across the country. There were also the ‘Social-Medical Services’ for the beneficiaries of the ‘Federation of the Provident Funds’ and the Public Health Services which essentially provided health protection such as vaccination, maternal and child health, environmental sanitation, etc. To these, one must add general and specialised state hospitals, mainly located in large urban centres and the private services, which targeted the most privileged social groups of the population. According to the same source, it is also worth stressing that Portugal did not have a social protection regime, the ‘Social-Medical Services’ financed by compulsory payments from employees and employers corresponded to a health protection system that was closest in nature to the social security regimes of more developed European countries. However, to the contrary of that which occurred in these European nations, the Provident Funds had their own ambulatory medical services (OPSS, 2001: 37).

The first major reform of the Portuguese health system (known as the “Gonçalves Ferreira reform”) dates back to 1971 and it can be considered as the first attempt to establish a National Health Service (NHS), as it recognised the State’s responsibility in providing universal rights to health care to all Portuguese citizens. The evolution of Portugal in political and social terms between 1974 and 1979 introduced profound changes in health policies, culminating in the establishment of the National Health Service through Law no. 56/79, 15th September. Albeit this was only implemented in the mid nineties with the elaboration of the Health Basic Law (Law no. 48/90, 24th August) and the implementation of the NHS Status (Decree- law no. 11/93, 15th January).

Presently, the Health Services in Portugal are comprised of three co-existing systems:

- the National Health Services, composed of all public entities providing healthcare, particularly hospitals and health centres;
- private health insurance schemes;
- cpublic and private health sub-systems that include several professional sectors which function autonomously or through agreements with the NHS (namely the Health Assistance for Civil Servants, the National Trade Union of Bank Workers, the Trade Union of Northern, Southern and Islander Bank Workers, the Postal Service, the telecommunications corporation Portugal Telecom, the Social Services of the Armed Forces, etc.).

Thus, the Health Services in Portugal are not limited to the NHS, and there are other private and public entities independent of the Ministry of Health that work in accordance with the NHS to develop simultaneous or individual activities in the areas of health promotion, prevention, diagnosis, vigilance and care. However, it is the State's responsibility to provide healthcare ensuring the right to individual and public health protection, as well as equality of access and use among all citizens, independently of their social, economic, geographical and legal situations.

The NHS enjoys administrative and financial autonomy and is decentralized in its organization functioning under the tutelage of the Ministry of Health. The NHS includes all official institutions providing healthcare under the Ministry of Health (hospitals, irrespective of their designation, local health units, groups of health centres, etc.) and is comprised of central, regional and local resources. The NHS includes all healthcare services integrated in three networks: the network of primary healthcare services (promotion and vigilance of health, prevention of illness) set up by the Decree-law no. 413/71, 27th September; the network of differentiated healthcare (diagnosis and treatment of patients through the services provided by general and specialised hospitals; post-graduate training of doctors and nurses) established by the Decree-law no. 48.357/68, 27th April; and the network of continued healthcare (five types of medical and social rehabilitation ranging from hospital internment to healthcare at the patient's home) set up by Decree-Law no. 281/2003, 8th November.

According to Cláudia Chaves (2006: 108) primary healthcare is *"the first element of a permanent healthcare process"* and is the core of the country's health system, reflecting its degree of social and economic development. Due to their focus on primary healthcare and proximity to the citizens, health centres and general practitioners/family physicians often embody the experience people have of health services²⁹. Thus, it makes sense to understand how these services are organized and their features.

According to Branco and Ramos (2001), health centres in Portugal have gone through different changes and three generations of health centres can be identified: the first generation dates back to 1971 when healthcare provision was linked to the concept of public health; the second generation was when health centres were amalgamated with the different posts of medical and social services (1983); and the third generation corresponds to more decentralized, hierarchical and autonomous services from an administrative and financial point of view (1999).

In recent years, due to the state's inability to provide an efficient response to the population's needs, primary healthcare has been the target of significant and controversial reform that began with the approval of Decree-law no. 60/2003, 1st April, repealing Decree-law no. 147/99, 10th May. The proposed changes include several areas, ranging from the reconfiguration of management models used in health centres (greater autonomy, implementation of family health units and local health units, establishment of permanent care service) to the restructuring of public health services and the creation of information and competence development systems, mainly of human resources. Besides these changes, the one that is probably the most contested is the establishment of a network of care where different healthcare providers co-exist, such as health centres, profit and non-profit private agencies providing primary healthcare to NHS beneficiaries, cooperatives and other liberal regime professional agencies that signed contracts, conventions or cooperation agreements (Andrade, 2006:57).

²⁹ In theory, people have no direct access to secondary care and Health Centers and general practitioners are expected to act as gatekeepers. Yet, in practice, most people go directly to the emergency department in hospitals if they have any acute symptoms. A very large amount of attendees at hospital emergency units however do not need immediate care. (Freitas, 2003: 212).

Independently of their juridical nature, all services and structures of the NHS are universal, financed by tax payers' money (the public budget) and tend to be free of cost, despite the fact some users still pay a small fee (OPSS, 2001:60).

The establishment of the NHS has resulted in a reasonable healthcare coverage of the population over a relatively short period of time and also in the development of a professional career structure in the health sector. Despite these advances, the implementation of the NHS has displayed major structural and organisational weaknesses from the very beginning, namely:

- its financial basis which is rather volatile;
- a lack of innovation in the organization and management models of the services rendered;
- problems between the public financing of the NHS and private interests resulting from the lack of transparency between public and private interests from within the body of medical professionals (OPSS, 2001: 39).

The consequences of these constraints are visible in a system that poses huge difficulties of access for its potential beneficiaries, low efficiency and a low quality of services being offered to the public.

In order to solve these problems, and according to the 2002 Hospital Management Law (Law no. 27/2002, 8th November), in a context where the health system is becoming increasingly bipolar between a private sector (oriented towards better-off users) and a public sector (available to users who can not afford the private care services), private health insurance schemes have begun to develop in recent years in Portugal.

These schemes have grown exponentially and the users include not only Portuguese citizens, but also immigrants. Indeed, according to the results from the Fourth National Health Survey, immigrants who are well integrated into Portuguese society are covered to a higher degree by private health insurance schemes than Portuguese nationals - 12.2% and 10.5%, respectively (Dias, Paixão, Branco and Falcão, 2008a). 25% of the Portuguese population is covered by health subsystems, 10% by private health insurance and 7% by mutual funds (ACS, 2008: 7). In line with the reality in other European Union countries, the total expenditure on healthcare in Portugal as a proportion of the GDP has been increasing as a result of the aging population. For example, both in 2000 and in 2005, the NHS was responsible for approximately 72% of the total expenditure on healthcare. Private expenditure³⁰ covered the remaining 28% (OPSS, 2008:255).

As shown in this short analysis of the evolution and characteristics of the Portuguese NHS, it has several constraints in organisational, financial and management terms, resulting in negative repercussions in equality of access, quality and efficiency of the services rendered. In order to overcome these weaknesses several reforms have been implemented; however, without resulting in a visible improvement of the results. Therefore, there are growing expectations for the strategic plans and interventions presented in the 2004/2010 National Health Plan.

The continuing evolution of the health services and the constant reform of the NHS have to be considered as a continuous process of improvement with the objective of responding to the features

30 Direct payment by patients, premiums paid by private insurances and mutual institutions.

and needs of the population, as well as to the expectations of society. However, during this process the rights of the population and their immediate needs in terms of health cannot be forgotten, given it is the responsibility of the State to ensure the population is covered by the services and above all the quality of the care provided.

b. Entitlement of MEMs to healthcare

In Portugal foreign citizens have been guaranteed the right to be attended in a National Health Service health centre or hospital, regardless of their nationality, economic means or legal status³¹. Their conditions of access have been defined in Dispatch 25 360/2001, 16th November issued by the Ministry of Health. Documented foreign citizens must obtain a NHS user card from their local health centre, for which he/she must submit proof of legality of stay. Undocumented migrants can obtain a temporary user card, for which they need to submit a certificate issued by their local borough council confirming they reside there. Asylum seekers and refugees are granted medical assistance and when they have been granted a residence permit they have the same degree of access as Portuguese citizens³².

The cost of using the health service, or receiving medical treatment in health centres or hospitals, is the same for immigrants and their families as for Portuguese citizens, providing they make social security contributions³³. Those not making social security contributions pay more for medical care, in accordance with the official price charts³⁴. However, this is means tested as through the presentation of a social security certificate an individual's socio-economic status is considered. Some populations, like for instance, children between 0-12 years old, recipients of welfare provisions from the state, unemployed people registered to work at the job centre, sufferers of infectious diseases (such as HIV/AIDS, tuberculosis or sexual transmitted infections), pregnant woman, and recipients of family planning services are exempt from payment. It should be noted that the National Health Programmes that are being implemented, such as the National Programme of Immunization (free vaccines to children and young people) or the National Programme to Promote Oral Health (provision of dental check-ups for all pregnant women), give equal access to foreign citizens, regardless of their legal status (ACIDI, 2008: 34).

In the instance in which a person is refused treatment, they must report it to any body of the Ministry of Health, independently of the place it occurred, and/or to the High Commission for Immigration and Intercultural Dialogue (ACIDI, I.P.), as refusal to provide healthcare is punishable by law under Portuguese anti-discrimination legislation.

31 For further information on the impact of immigrants' healthcare needs in the State's Annual Budget, see D'Almeida and Silva, 2007.

32 Undocumented migrants, asylum seekers and refugees are not covered completely by the health system. They have entitlement and real access to primary healthcare and in the case of suffering from a contagious disease such as tuberculosis, HIV and STDs which might constitute public health risk. Except in these situations, these groups are asked to pay for all their healthcare assistance and treatments (exemptions are possible for people whose economic means do not permit).

33 In Portugal, the National Health Service is practically free of cost; users only pay a very small fee. For instance, the following amounts are charged to all patients of the National Health Service (both SNS and approved healthcare providers): consultations in health centres or approved healthcare providers – € 2,20; emergency consultations in health centres – € 3,70; consultation in a local hospital – € 3,00; consultation in a central hospital – € 4,50; basic emergency consultations in hospitals – € 8,40; general emergency consultations in hospitals – € 9,40; Home consultations - € 4,70.; hospitalization - € 5,20/day; surgery - € 5,20. Patients also have to make a full payment for healthcare, complementary diagnostics and therapies, as well as for medicines according to values approved by the legal charts. There are differences amongst medicine categories.

34 For more information on these out-of-pocket costs please refer to: Portaria n.34/2009 from 15th January; Decree-law n.º 173/2003 from 1 August; Decree-Law n.º 201/2007 from 24th May.

Health checks during childhood have an impact on both physical and mental development and on health conditions during the life of each individual; as such children are a group specifically targeted by health policy in Portugal. Access to regular medical appointments, compulsory immunization programmes, screening to detect possible diseases early and parental advice on child healthcare are essential health policy instruments that serve to reduce infant mortality rates and inequalities in access to health among the most deprived social groups.

Although Portuguese legislation guarantees the access of undocumented foreign citizens to the NHS, frequently these citizens only look for medical help in situations of emergency, due to their fear of being reported to the Aliens and Borders Authorities. Consequently, many children born in Portugal descendent from undocumented migrants are very much on the margins of healthcare needed for a healthy development.

In response to this problem, in 2004, Decree-law no. 67/2004, 25th March set up a national registry of irregular foreign minors so that health centres may develop the necessary efforts to accompany these children. Moreover, growing attention is being given to maternal and child health of migrant populations due to the increasing birth rate among foreign mothers in Portugal.

Between 1995 and 2007, the number of live births from foreign mothers living in Portugal tripled and in 2007 it represented 9.6% of the total number of live births. The proportion of live births with a foreign parent (either mother or father) reached 11.8% (Fonseca, 2008; INE, 2008).

As a complement to the aforementioned legislation and with the goal of promoting awareness among NHS professionals and users, the General Direction of Health regularly emits circulars and flyers such as: Information Circular no. 14/DSPCS, 2nd May, on the access of foreign citizens without permanence or residence permits or work visas to the NHS; Information Circular no. 48/DSPCS, 30th October, on the healthcare to foreign citizens residing in Portugal; and Information Circular no. 65/DSPCS, 26th November on the access of immigrant minors to healthcare. These are official documents that function as regulations and guidelines for fair practices in the health services.

4. Accessibility of care

Any discussion regarding the access of immigrants and their off-spring to health care services can neither be separated from the debate on the integration of these people into the hosting society, nor from the political context of the country, in particular from social policies (Ingleby et al., 2005). Health, immigration and integration policies seem to be crucial to immigrants' physical and psychological well-being, and also to the promotion of effective public services in terms of access and use on the part of immigrant patients.

Despite significant legislative advances since 2001 in Portugal on the entitlement of immigrants to healthcare, which guaranteed their access to the National Health Service, problems of access still exist relating to both structural/institutional barriers and with difficulties the migrants themselves may face due to personal constraints (Fonseca et al. 2007). In practice, access to healthcare is largely variable within the immigrant population in Portugal and depends to some extent on the legal status, length of stay in Portugal and on the immigrant's nationality (Freitas, 2003; Gonçalves et al., 2003; Fonseca et al., 2005).

Considering the legal status, undocumented immigrants show greater difficulties in terms of access and use of the National Health Service in Portugal, despite the fact that they enjoy a greater degree of entitlement to health care than in almost any other EU country. The constraints in the access of immigrants to the health services are related to a mistrust of the services and the professionals working there. In practise, this lack of trust is visible in a more frequent use of hospital emergency services on the part of irregular immigrants in comparison to the use of other services, albeit only in extreme situations. Documented immigrants have similar rights of entitlement to health services as Portuguese citizens as the National Health Service is based on the taxes paid to social security. Legal foreign citizens who pay taxes and social security contributions are entitled to more benefits (smaller fees, financial help to buy medicine or to pay for consultations and exams) than undocumented ones (Freitas, 2003; Fonseca et al., 2005).

Considering the length of stay of immigrants in Portugal and their access and use of health services, one may conclude there is a positive association in which the migrant population residing for longer periods show higher rates of enrolment in health centres and also use hospitals more often. The opposite is true for recently arrived immigrants, which can most likely be explained by a lack of knowledge of their rights and the services available, their lack of trust in an unknown system, language barriers and the good health conditions they generally have. Despite this, several research studies conclude that regardless of length of stay in the host country, immigrants do not regularly use health centres and hospitals; rather they do so mainly in emergency situations (Gonçalves et al., 2003; Dias, Matos and Gonçalves, 2002; Dias, Severo and Barros, 2008; Ingleby et al., 2005).

The access and use of health services by immigrants from different nationalities living in Portugal varies quite considerably. When considering one of the main aspects constraining access and use of these services in Portugal, namely language, Brazilian and PALOP nationals will have fewer problems in comparison to Asians, Eastern Europeans or immigrants coming from other parts of the world where Portuguese is not spoken. Another obstacle highlighted as inhibiting the access and use of health services in general are the specific cultural factors of the immigrant population, alongside individual factors (Ingleby et al, 2005). Some research studies point towards differences that may exist among communities in the perception of the actual need to have access to health services and take medicine or regarding the use of alternative methods and medicine (Gonçalves et al. 2003; Sousa, 2006; Manuel, 2007; Monteiro, 2007).

These are not the only conditioning factors in the access and use of health services on the part of immigrants. Other barriers like the internal organization of health services may lead immigrants to use them more or less, or one service may be preferred to the detriment of another. Thus, frequently, the immigrant population chooses hospital services, the emergency services in particular, instead of the local health centre. There are several reasons for this: in the case of undocumented migrants, this option is clearly related to bureaucratic and legal³⁵ issues as well as to the desire to remain anonymous, often pseudonyms and false addresses are used (Fonseca et al., 2005). In the case of documented immigrants, the quality and the timeliness of the services seem to be motive enough to prefer hospital services. In fact, emergency services by nature, where an absolute provision of health care prevails, allow for a higher degree of anonymity, speed in attendance and quality, relegating bureaucratic issues,

35 Presently, the Holy House of Mercy of Lisbon, a social solidarity institution, also attends undocumented immigrants through Mobile Units and Proximity Health Units.

analysis of living conditions and assessment of risky behaviours to second place. In health centres, more commonly an attitude of control on the part of health professionals prevails. Besides this, several research studies show that economic conditions are a clear obstacle in the access and use of health services by immigrants. The cost of services, medicine and the use of private services are in most cases very high considering the relative incomes of immigrants, putting their state of health in question.

Finally, the barriers inhibiting access to the National Health Service and to the use of health services are very often the result of lack of information on the part of health professionals, especially among administrative personnel, as well as a consequence of multiple and different interpretations of the law on the part of service providers. Despite the fact that access to the National Health Service in Portugal is universal in legal terms, evidence suggests that a lack of awareness of entitlement rights and sometimes even discriminatory attitudes on the part of health professionals continue to act as a barrier. In a research conducted by Fonseca et al. (2005) it is shown that undocumented immigrants are sometimes denied access to care in health centres due to the lack of documentation or financial constraints that prevent them from paying for consultations and the treatments³⁶. When confronted with these situations, health professionals tend to adopt one of three attitudes: not charging any fee for the service, postpone the payment or send the patient away without being treated. The same study also found that some health professionals are unaware of the free health services available to immigrants such as child care and immunisations.

On the other hand, health professionals identified several problems in immigrants' access to the National Health Service like the lack of ability on the part of the services to respond to demand and the absence of sensitivity and training of professionals to deal with the patients' cultural diversity. These obviously hamper the access and use of health services by immigrants. In order to inform and train professionals to deal with the increasing diversity of users, the General Directorate of Health, as previously mentioned, has been making a major effort to inform health services on the conditions of access for citizens to the National Health Service (Order No. 25360/2001), with the regular publication of circulars and newsletters (Information Circulars No. 14/DSPCS of 02/04/2002; No 48/DSPCS, of 30/10/2002; No 65/DSPCS of 26/11/2004). Additionally, there has also been a development of post-graduate programmes on migration and health which specifically target health professionals (see section 6)

The difficulties experienced by immigrants in accessing health care can also be seen in the high proportion of those not benefiting from any financial help from the State for consultations and prescription medicine. The results of a survey implemented to a representative sample of immigrants aged 18 or older, coming from PALOP countries, Brazil and Eastern Europe between December 2004 and January 2005 (Fonseca et al., 2005), in a project on family reunification and immigration, showed that 80% of the interviewees had never received any financial support for medical assistance. Data from the same study indicates that despite the low level of access to these social benefits common among all immigrant groups, the communities from PALOP countries have a slight advantage over Brazilians and Eastern Europeans. The proportion of beneficiaries was 22.6%, 15.9% and 18.4%, respectively (Fonseca et al., 2007).

36 According to Portaria n.34/2009, 15th January the following amounts are charged to undocumented migrants: consultations in health centers – € 32,20; consultation in hospitals – € 51,00; general emergency consultations in hospitals – € 147,00; emergency surgery in hospital – € 108, 00. Patients also have to make the full payment for healthcare, complementary diagnostics and therapies, as well as for medicines according to values approved by the legal charts.

Health Practices

Portuguese health professionals have already been alerted to the fact that the behaviour and health practices among different communities and their use of health services have a strong impact on their state of health. Moreover, the use of health services primarily only in emergency situations brings about serious risks and consequences to the health of immigrants.

There are very few studies on the differences of access to health care services among immigrant groups residing in Portugal. However, the limited information available on the use of services indicates differences between immigrant communities. Generally speaking, Brazilian women use routine consultations more often than women from any other community, whereas PALOP immigrants use both preventive and curative health services less, a situation that may be related to the difficulties and awareness of the importance of using health services. There are also signs that in the case of illness, Eastern European immigrants often resort to pharmacies for advice as it is a practice used in their home countries. Brazilians have a higher incidence of private health insurance and use private doctors more often. These differences may be due to the fact that in their country of origin they already have health insurance and/or face many difficulties in gaining access to public health services (e.g. extremely long waiting lists, lack of medicines, geographical constraints) and, in practice, for those who can afford it, private care (accessible through private insurance) is the best available alternative. Brazilian users in Portugal may share the idea that public care is unable to meet their needs and therefore resort to private insurance schemes. Another reason may be related to their working situation as Brazilians may be more likely to have a more stable job where the employer provides health insurance. Finally, immigrants from PALOP countries use health centres and hospitals more often in comparison to other communities because their length of stay in Portugal is on average longer, and thus, they know how to access the services. Moreover, some of these immigrants come to Portugal under cooperation agreements in the area of health between Portugal and PALOP countries (Calado et al., 1997; Bentes et al., 2004; Gonçalves et al., 2003; Fonseca et al., 2005).

In terms of the health practices of immigrants, maternal and child health consultations are used as an “entrance” to access other types of health and medical services because they are free of charge.

In Portugal there are disparities in the state of health of different immigrant groups resulting from their medical practices and use of health care services. This means that the weaker or better state of health of certain migrant groups is a direct result of their use (or lack of use) of care and health practices. PALOP nationals, for example, use curative and preventive services, including sexual and reproductive health services, less often than other groups (Bentes et al., 2004; Calado et al., 1997; França, 1992). This behaviour has obvious consequences on their state of health. In a study conducted by Machado et al. (2006), for instance, the authors conclude that the migrant population studied show worse health indexes than the rest of the population: higher foetal and neonatal mortality, as well as more diseases during pregnancy, especially infectious diseases. This situation is confirmed by other studies with African and Asian migrant groups (Lopes, 2007; Manuel, 2007; Monteiro, 2007) and is explained by the late or inexistent pregnancy check ups that delay any diagnosis of particular diseases the mother may have, the social condition of the families, as well as cultural aspects beyond the pregnancy. The use of hospitals or health centres also varies, as we will see later, according to nationality, length of stay in Portugal and legal status (Gonçalves et al., 2003). Data on the use of continued medical care on the part of these populations is almost non-existent.

Cultural and identity issues play a central role in the state of health of immigrants and in their use of health services. The use of traditional/popular medicine and the consultation of healers, friends and relatives is also a recurring practice among some segments of the resident population, mainly among some immigrant groups like Africans and Eastern Europeans (Gonçalves et al., 2003; Sousa, 2006; Manuel, 2007; Monteiro, 2007). The reasons highlighted explaining this behaviour include, a lack of trust in the National Health Service, the fear of being arrested or deported when they are undocumented, under-evaluation of health problems, trying to escape the stigma and stereotyping associated to some health problems (for example, HIV/AIDS, mental illnesses), lack of knowledge about free services (for example maternal and child consultations, family planning).

Some authors (Santana, 2004, 2005; Carballo, 2007b) also point out that the state of health of immigrants and of their descents and the correct diagnosis of their potential medical problems heavily depends on the immigrants' pre and post migratory experiences in terms of living and working conditions (for example, scarce economic resources, bad housing conditions), their social and cultural background and their relation with the health care services before and after migrating. Moreover, the lack of information, the difficulty of access to the health services, mainly among undocumented immigrants, and the linguistic barriers that hamper communication with health professionals also contribute to their high degree of vulnerability as far as health is concerned.

5. Quality of care

The factors affecting the quality of health care services are diverse and well documented in the literature as previously mentioned in this report.

From our experience during the implementation of this and other projects in the area of immigration and health, the main conclusions that can be drawn on the most important factors affecting the quality of the services and health care, from various meetings held with immigrants, health professionals and immigrant associations, point towards the following aspects: a) the lack of awareness of cultural issues and traditions brought from the sending countries; b) difficulties of communication due to language barriers; c) the lack of knowledge on the part of immigrants of health services and conditions of access; d) the absence or incipency of the information provided by health care providers on the rights, duties and services available to these communities; e) immigrants lack of use of the health services due to fear and lack of trust in the services; and f) a wide range of specific difficulties among foreign patients benefiting from the National Health Service and coming to Portugal under the Health Cooperation Protocols signed between Portugal and the PALOP countries.

Due to the fact that language is one of the most important and relevant issues identified influencing the quality of services and care provided, there is a Telephone Translation Service and a set of cultural mediators who are available to communicate between migrants and service providers. Unfortunately, in the case of health the existence of this kind of service has failed to bring desirable results in the majority of cases due to the sensitivity of the information involved/required to be translated (bureaucratic issues are an exception). On the other hand, we discovered through another research project in process that health institutions are not aware of the existence of this service.

Portuguese researchers have already developed studies on the opinion of immigrants on the quality of health care services, giving particular attention to the National Health Service.

A study by Gonçalves et al. (2003) on the access to health care by African immigrant communities concludes that most of the interviewees consider hospitals to have a better quality of treatment in comparison to the services provided by health centres. This is related with a greater flexibility in terms of schedules, a larger number of health professionals and better administrative services.

Despite this, 69% of the interviewees who expressed their degree of satisfaction with the care provided by the health centres were satisfied and the vast majority stated that they had never experienced any kind of problem; on the other hand 24% were not satisfied. The reasons for this dissatisfaction have to do with low quality services (44%), long waiting times (38%) and the fact they were unable to schedule an appointment (22%). Opening hours, the lack of doctors, the attitude of professionals and the physical conditions of the health centre were also pointed as being problematic.

Some of these conclusions are also reiterated by Sousa (2006) and Andrade (2006). In Sousa's research on the relationship between Ukrainian immigrants living in Portugal and health care, the interviewees referred to the bad quality of the services and therapies as being the most serious problems. They also admitted frequenting the hospital more often than health centres, but only in very serious health situations (86.4% of the interviewees). Focusing on the geography of health, urbanization processes in the Metropolitan Area of Lisbon and the African immigrant population, the study conducted by Andrade includes a chapter dedicated to the satisfaction of African immigrants with health care provided by the National Health Service. The study concludes that 69.7% of the interviewees are satisfied with general health care, whereas 30.3% are unsatisfied. More positively, African immigrants highlighted the professionalism and competence of health professionals (39%) and the presence of good quality and substantiality diversified health care (12%). Among the negative issues, the interviewees stressed the waiting time to schedule a medical appointment or minor surgery, medical services and medical appointments (family doctors, emergency appointments, etc.) – 31.3% and also medical negligence and lack of sensitivity and clarity on the part of health professionals (15.3%). Finally, the surveyed population considered that human resources were generally insufficient (11.3%).

It must also be pointed out that in some cases the assessment made about the services provided by the National Health Service varied according to gender, age and personal experience. Length of residence in Portugal, experiences with the health services in their country of origin and some cultural and individual issues largely determined the position and opinion of respondents. Lastly, it is important to clarify that many of the problems and experiences identified by the immigrant communities as far as the National Health Service is concerned are shared by the Portuguese population, namely waiting times, the difficulties to schedule medical appointments, the hours during which the services operate and the shortage of general practitioners/family physicians.

6. Measures to achieve change

International migration is a central issue on the policy agenda of many countries and the relationship between migration and health has achieved growing relevance both for politicians and researchers.

A survey on “best practices” in the integration of immigrants conducted by IOM found that 60% of the 55 initiatives who responded and had the goal of promoting the integration of immigrants in

the area of health are financed by the third sector (NGO, private social solidarity institutions, religious associations and entities) and 64% are reliant on public funding (from the State, Local councils and the EU). The same study also found that the State is the sole financing entity of approximately one third of the initiatives, as well as a further 26% in partnership with other entities (Fonseca and Goracci, 2007: 145-146). In the ensuing subsections we present different initiatives whose objectives are the promotion of migrant health in Portugal. We also make some suggestions for future research.

1) State-sponsored initiatives

The Portuguese Presidency of the EU, in the second semester of 2007, placed the issue of health and international migration on the agenda as a dominant subject in the general area of health. Some of the initiatives undertaken include, as already mentioned, the European Conference “Health and Migration in the EU - better health for all in an inclusive society” (26 - 27 September 2007) and a meeting of national coordinators for AIDS, from 53 countries, on “HIV and Migration” (12-13 October 2007), both held in Lisbon. It was indeed necessary to promote debate at this level on the issue and thus this was a notable step forward, which resulted in conclusions and recommendations that represent a challenge for policy makers, associations and civil society. Moreover, these initiatives have introduced issues of international migration, public health and the National Health Service to public debate and have served to promote interest in the area and led to the development of qualitative and quantitative research in this area.

Despite the limited character of the information available, in practice it can be said that several measures have been adopted in order to implement mechanisms of change. For example, in the process of drafting the Plan for the Integration of Immigrants (PII) 2007-2009, a number of obstacles inhibiting the access of immigrants to the NHS and the quality of treatment offered were identified. To try to remedy these shortcomings, the Plan for the Integration of Immigrants introduced 10 measures in this area, including: a) the promotion and implementation of training, education and communication programmes to combat the lack of information that immigrants have on health services (encouraging the use of NHS) and to inform health professionals and other public bodies of the legal rights immigrants have and the subsequent administrative procedures (to establish administrative, intercultural and language skills) (measures 22, 23, 24, 26 and 30 of the Plan); b) the promotion of partnerships between local and international organizations, public and private institutions, other groups and stakeholders on issues relating to immigrants, in order to improve the quality of services provided by the NHS and facilitate change in the organisational culture of institutions (measures 25, 27, 28 and 29 of the Plan). These measures were and continue to be implemented with the support of a multidisciplinary group - “Health & Migrants” - established for this specific purpose and coordinated by the General Directorate of Health. According to the annual execution report of the Plan for the Integration of Immigrants, the evaluation of the outcomes of some of these goals has proved difficult due to a lack of statistical information (ACIDI, 2008: 37).

Regarding the dissemination of information on the rights of immigrants in the domain of health, the new Health Office of the National Centre for the Support of Immigrants, established in 2004, must be given attention. This office develops its activities in conjunction with two socio-cultural mediators, who, due to their immigrant background, are considered to be close to the immigrant population and aware of the challenges they face. The Health Office team concentrates on the resolution of problems related to the access of immigrants (either in regular or irregular situations) and patients from PALOP

countries coming to Portugal under Cooperation Agreements to receive health care. Most of the work developed by the office is based on dialogue with other health related institutions. It has a very important role in the diffusion of information among immigrants on their rights and duties in terms of health and also among the administrative staff of the National Health Service on the right application of Portuguese legislation.

Communication is crucial for the integration of immigrants, thus on this premise ACIDI established STT – Telephone Translation Service, in 2006. STT targets immigrants who do not speak Portuguese as well as Portuguese people who need to communicate with them. All public and private institutions can use this service. The 37 participating translators/mediators speak one or more languages and also provide access to information made available by the SOS Immigration Phonenumber and other bodies under ACIDI, I.P. Besides this, since 2000, there have been many initiatives taken at the central level specifically targeting primarily recently arrived immigrants. These measures are mostly related with integration policies and emphasise access and the promotion of health.

2) Initiatives by civil society and NGOs

Complementary to the Government’s legislative efforts in terms of health and immigration visible in the Plan for the Integration of Immigrants, there has been remarkable participation on the part of the third sector (NGOs, Religious Associations and Organizations) and private institutions (social solidarity institutions, corporations, hospitals, etc.) as facilitators of the integration of immigrants in terms of health.

In 2007, the High Commissariat for Immigration and Intercultural Dialogue (ACIDI) in partnership with the International Organization for Migration (IOM) and the Luso-American Foundation (FLAD) made a list of the initiatives promoting the integration of immigrants in Portugal³⁷ (Fonseca and Goracci, 2007). Although it is not an exhaustive inventory as it only includes the initiatives who responded to the questionnaire, this research provides a good picture of the kind of initiatives implemented by the public, private and third sectors. The 55 initiatives identified, (20 of whom work primarily in the area of health and the remaining 35 work across other domains as well as health) related to the integration of immigrants in the area of health, are very diverse and include the dissemination of information, changes in the procedures adapted by health care institutions with the goal of satisfying the specific needs of migrants, improvement in the conditions of access to health services and help in validating health professional degrees held by immigrants (Fonseca and Goracci, 2007: 149).

Despite the notable progress in legislative terms regarding the regulation of the access of immigrants to health care in Portugal, and given the scarcity of information, it is difficult to estimate the daily realities faced by immigrants and their off-spring in terms of access, the state of their health and the quality and suitability of health care rendered to them. In Portugal, there are no national multicultural health programmes exclusively targeting immigrants and minority ethnic groups. These populations use the services available to all citizens (this in itself is often considered a “best practice” contribution toward the integration of immigrants in Portuguese society). The initiatives exclusively oriented towards immigrants and ethnic minorities are usually sponsored by NGOs and target local areas. For example, the mental health consultations launched by the Miguel Bombarda Hospital in

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37 The inventory of initiatives took six months and was carried out using a questionnaire that was widely distributed and posted on ACIDI's website, on radio stations and in daily and weekly national and regional newspapers. The participation of voluntary organizations, of the private sector and public agencies in multiple activity sectors was also requested.

partnership with several immigrants' associations and with the Clinical Unit of the Institute of Hygiene and Tropical Medicine, were only implemented in Lisbon. However, the publication and distribution of brochures and flyers in immigrant's own languages, which provided information on the health services and health issues, promoted by ACIDI, I.P. and the National Commission Against AIDS, was a nationwide initiative.

Another initiative worth mentioning is the "Health Guide for Immigrants" sponsored by the Holy House of Mercy of Lisbon (the first being in 2008 and a second in 2009). The goal is to publicise health resources available among immigrants and their descents, this emphasises both the Holy House of Mercy's health related resources as well as public health services. This project was developed in partnership with several local institutions, government agencies and the voluntary sector (ACIDI, I.P., Council Parishes, Immigrant Associations, parishes, etc.). One of the main instruments of this project is the Health Passport, a document not only supplying useful information, but which can be used as an accompanying document when the immigrant is accessing the different agencies providing health care or support.

3) Validation of migrants' professional diplomas

As far as the recognition of professional skills is concerned, two projects are worth mentioning, one for medical doctors and the other for nurses. The first project began in 2002 as a result of a partnership between the Calouste Gulbenkian Foundation and the Jesuit Refugee Service. Two years later, this partnership was enlarged to the Francisco Gentil Higher Education Nursing School and to the Fernando da Fonseca Hospital (Amadora-Sintra) with the goal of developing the project "Recognition of Skills and Support of the Professional Integration of Immigrant Nurses". As a result of these projects, 107 immigrant medical doctors and 45 nurses obtained the equivalency of their academic diplomas and permission to work as health professionals in Portugal.

Some research has also been conducted in Portugal on healthcare professionals with immigrant backgrounds (Ribeiro, 2008a, 2008b; Machado, 2000; Baganha e Ribeiro, 2007; Silva e Fernandes, 2007; Baganha, Ribeiro e Pires, 2002).

4) Education and training

As we mentioned above, there have been some efforts to foster capacity-building and to widen professionals' access to training programmes in the field of migrant health. Among these efforts are: 1) the development of post-graduate programmes such as the Masters on Cultural Psychiatry at the Faculty of Medicine at the University of Coimbra, the Masters on Intercultural Relations at the Open University, in Lisbon and the Masters on the Sociology of Health and Illness at ISCTE; and the course 'Health, gender and immigration' provided within the post-graduate programme 'Law of Gender Equality' at the Faculty of Law at the University of Coimbra; 2) the promotion of seminars focused on research, service delivery and intervention in the field of migrant health promoted by the GIS Association/ Group of Immigration and Health (see GIS, 2009); 3) the promotion of 'open meetings' concerning theoretical approaches and therapeutic and clinical experiences in the field of migrant health by the Transcultural Psychiatry Centre of the Miguel Bombarda Hospital, Lisbon; 4) the elaboration of protocols between the Portuguese Association of Transcultural Psychology and Psychiatry and educational institutions for the development of advanced training in transcultural mental health.

5) Suggestions for future research

Remarkable progress has been made in the area of migrant health research in Portugal in the last decade, attested to by the bulk of studies conducted in the 2000s. Nevertheless, the literature review and the information gathered in two workshops³⁸, in which researchers, representatives from associations of immigrants, health services and NGOs participated, support the need for more research and, mainly, the need to systematise and disseminate relevant information in order to characterise the state of health and the health practices of the different groups of immigrants and their descents, as well as their conditions of access to the National Health Service. Migrant health in Portugal could benefit from future research in the following area:

- social determinants of health among migrants;
- epidemiological studies, including both first and second generation migrants;
- the role of civil society and NGOs, and user-led initiatives in bridging the gap between existing formal care and the care migrants identify as necessary;
- migrants' perceptions of health care and health care professionals and the impact this has on migrants' access and use of care;
- challenges and solutions identified by professionals when delivering care to migrants (with a focus on the quality of care and issues pertaining to discrimination and racism);
- migrants' alternative pathways to care (e.g. traditional healers, use of transnational medicines and transnational care) and 'meeting points' between formal and informal care;
- the appropriateness and effectiveness of formal and informal interpreter services in facilitating communication between health professionals and non-Portuguese speaking migrants; etc.

7. Final Considerations

As referred to by Fonseca, Esteves, McGarrigle and Silva (2007), health conditions and practices cannot be dissociated from immigrants' socio-economic background and their legal status. Therefore, these populations show specific vulnerabilities associated with their immigrant background, namely stress resulting from social isolation, language difficulties and a lack of knowledge of the host society's norms, stigmatization and discriminatory attitudes on the part of some health professionals and also additional disadvantages due to his/her legal situation, precarious labour market positions, poorer housing conditions and limited access to social protection mechanisms. On the other hand, cultural differences also have a role to play and can be seen in alternative individual health practices and in the self-representation of immigrants' state of health. Expectations of health care and the "clinicalisation" of particular illnesses or conditions may differ across cultural and social backgrounds and depend on past experiences in the country of origin. Thus if the results of studies are to be interpreted accurately and our knowledge of inequalities of access to medical assistance of particular groups enhanced it is essential to define key concepts and adopt more adequate indicators to monitor this phenomenon (Fonseca, Esteves, McGarrigle and Silva, 2007).

The relevance of the social, economic and legal status of immigrants and their off-spring on their health highlights the fact that the promotion of health cannot be limited to public intervention

³⁸ See annex 1.

in this specific domain. To the contrary, the promotion of health must be complemented by integrated actions to promote equal opportunities among immigrants and the native population in the access to a healthy life.

In Portugal integration policy emerged very late, only really developing in the mid nineties when the poverty and social marginality of 'first wave' immigrants, mainly PALOP nationals, started to become visible in some of Lisbon's neighbourhood and in other municipalities of the Metropolitan Area. From this time forth, there have been successive legislative changes and policy responses to promote the integration of immigrants to the point where Portugal has reached second position in the MIPEX- Index of Integration Policies (Niessen, Huddleston, Citron, 2007: 146-151). Whilst far from representing the ideal situation, the measures presented in the Plan for the Integration of Immigrants and the development of integrated actions involving the participation of the public and private sectors and NGOs, reveal the political relevance given to this issue and the will to respond positively to some of the problems identified.

To conclude, it must be stressed that integration is a process and not an end, involving the interaction between immigrants and the autochthonous population and the adaptation of social institutions to the social and cultural diversity of the new residents (Penninx, 2003; Papademetriou, 2003). Thus, the reduction of differences in opportunities between immigrants and natives in the area of health is not only a responsibility of central or local government, but necessitates the involvement and the cooperation, both horizontal and vertical, of diverse institutions. Therefore, as the European Commission recommends in the Common Agenda for Integration, it is important that Member States develop instruments of coordination and cooperation among different public and private institutions and civil society at national, regional and local levels. Moreover, they should give incentives to encourage the establishment of monitoring and assessment mechanisms that work to systematically and continuously improve decision making and policy implementation processes based on best practices and the identification of norms, instruments and processes that can be improved (Fonseca and Goracci, 2007).

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ACCRONYMS

ACIDI – Alto Comissariado para a Imigração e o Diálogo Intercultural / High Commissariat for Immigration and Intercultural Dialogue
 ACS – Alto Comissariado da Saúde / High Commissariat for Health
 AJPAS – Associação de Jovens Promotores da Amadora Saudável / Association of Young Promoters of Healthy Amadora
 ARS – Administração Regional de Saúde / Regional Health Administration
 CNLCS – Comissão Nacional de Luta Contra a SIDA / National Commission of Fight Against AIDS
 DRS – Direcção Regional de Saúde / Regional Directorate of Health
 INE – Instituto Nacional de Estatística / Statistics Portugal
 MdM-P – Médicos do Mundo Portugal / Médecins du Monde Portugal (Doctors of the World)
 MTSS – Ministério do Trabalho e da Solidariedade Social / Ministry of Labour and Social Solidarity
 OECD – Organisation for Economic Co-operation and Development
 OPSS – Observatório Português dos Sistemas de Saúde / Portuguese Observatory of the Health Systems
 PADE – Programa de Apoio a Doentes Estrangeiros / Support Programme to Foreign Patients
 PALOP – Países Africanos de Língua Oficial Portuguesa / Portuguese-Speaking African Countries
 PROSAUDESC – Associação Promotora de Saúde, Ambiente e Desenvolvimento Sócio-Cultural / Association for the Promotion of Health, Environment and Social and Cultural Development
 SEF – Serviço de Estrangeiros e Fronteiras / Aliens and Borders Office
 SNS – Serviço Nacional de Saúde / National Health Service
 SOAR – State of the Art Report
 TOC – Trabalhadores por Conta de Outrem / Employees

ANNEX I

WORKSHOP

“Health and Immigration: relations between users and services of the NHS”, held in the ACIDI I.P. premises in Lisbon, on 17th September 2008

NATIONAL MEETING

“Health and Integration of Immigrants in Portugal: Problematic areas, Critical factors, Good practices and Recommendations”, held on 10th December 2008 at Faculty of Letters, University of Lisbon.

List of Participants

Name	Institution
Alexandra Dias	Hospital Fernando da Fonseca, Departamento de Pediatria
Alina Esteves	Centro de Estudos Geográficos da Universidade de Lisboa
Ana Gama	Unidade de Saúde e Desenvolvimento – Instituto de Higiene e Medicina Tropical
António Carlos da Silva	Associação de Jovens Promotores da Amadora Saudável
António Veiga	Associação Guineense de Solidariedade Social
Camila Lamarão	Associação Solidariedade Imigrante
Cristina Santinho	Grupo Imigração e Saúde
Dora Sampaio	Centro de Estudos Geográficos da Universidade de Lisboa
Elsa Lechner	CEAS – Centro de Estudos de Antropologia Social (Núcleo de Antropologia da Saúde) - ISCTE
Fátima Xarepe	Maternidade Alfredo da Costa
Glória Toletti	Associação Portuguesa de Psicologia e Psiquiatria Transcultural
Graça Costa	Direcção Saúde da Santa Casa da Misericórdia
Inês Silva Dias	Associação Portuguesa de Psicologia e Psiquiatria Transcultural
Ivete Monteiro	CEMRI – Universidade Aberta
Jennifer McGarrigle	Centro de Estudos Geográficos da Universidade de Lisboa

Joana Sousa Ribeiro	CES – Coimbra
Lídia Correia	CEMRI – Universidade Aberta
Lyria Maria dos Reis	Universidade Aberta
Maria Lucinda Fonseca	Centro de Estudos Geográficos da Universidade de Lisboa
Mário Rui	Direcção Saúde da Santa Casa da Misericórdia
Patrícia Baltazar	Universidade de Évora
Raísa Machidonchi	Centro Cultural Moldavo
Raul Fernandes	Ordem dos Enfermeiros
Sandra Silva	Centro de Estudos Geográficos da Universidade de Lisboa
