MEETING THE HEALTH LITERACY NEEDS OF IMMIGRANT POPULATIONS
health literacy
CHE model
•information
communication
health policy
•empowerment
wellness
•prevention
migrants
•integration
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health promotion
MEET - Meeting the health literacy needs of immigrant populations
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Partnership group of the project is composed by:

**Oxfam Italia** (Italy) as a lead partner, with its huge experience in managing European projects, is in charge for overall implementation of the project and for the Dissemination Strategy thanks to its capacity to reach multiple stakeholders and target groups identified.

**Istituto Superiore di Sanità - ISS** (Italy), with its large experience in research activities in charge for conducting of Need Analysis.

**Research Innovation and Transformation - RITA** (U.K.), in charge for formulating a pilot (core) training programme for implementing the CHE model and support partner organisations in developing specific training programmes for testing the model in their target health topics.

**Centre for the Advancement of Research and Development in Educational Technology - CARDET** (Cyprus) is in charge for the implementation of the web portal and the e-learning platform and developing the project exploitation strategy.

**Verein Multikulturell** (Austria) is in charge for the implementation phase of training courses and tools adapted and developed during the project.

**Polibienestar - University of Valencia** (Spain): is in charge for the Post-Implementation Phase, assessing the results of the implementation of training courses and improving and adapting of the training courses and pedagogical materials.

The specific objectives of MEET project are:

- Develop and apply the “Community-based Health Educator – CHE” model based on confidence-building relationship, an outreach method aiming to engage “hard-to-reach” communities such as immigrants;
- Enhance the cultural and interpersonal competences of health and social service providers to develop health literacy skills and deliver a more effective service to immigrant users;
- Strengthen health literacy skills among immigrant people by promoting information, guidance and access to health care services and expand cross-sectoral coordination in designing and developing training programs for health professionals, in particular between health, education and social service sectors.
EXECUTIVE SUMMARY - Health Inequalities in Europe and potential of CHE model

Over the last two decades, internal and external migration has accelerated demographic change in many European countries. In Europe, the access to social and health services has began to be considered a primary indicator of the level of migrants’ integration. Having access to high quality healthcare is indispensable for all people to grow and live in a healthy condition that enables them to contribute to society. Investing in health for all and bridging inequalities in the access to healthcare is key to make it possible for migrant people to contribute to their own integration and social cohesion.

The project MEET aims to strengthen the recognition of diversity and multiculturalism and include migration-related competences in the health care services by adapting and developing a community health education model (CHE) and a professional development programme for social and health service providers.

Health Inequalities among migrant people
In Italy, Austria, Cyprus and Spain the health care providers underlined the need to work in close contact with the communities of migrants, in terms of reorientation of the services, cultural competences, information strategies and on how to reach vulnerable groups.

The needs raised by health care providers were:

- Access to information for health care providers
- Support for communication between health care providers
- Continuity of care, patient pathway structures and processes of care
- Interest in the CHE model

When it comes to researching among migrant groups in Italy, Spain, Cyprus and Austria detected a huge information gap concerning health protection and especially preventive health care.
Barriers to access local institutions are:

The “Community Health Educator” (CHE) as empowering health promotion model

The Community Health Educator Model was first introduced in the UK after the completion of the project, *Communicating Breast Screening Messages to Minority Women - Constructing a Community Health Education Model*, in 1993. The CHE model, which has been developed to address the inequality of migrants and minority ethnic (MME) groups in accessing cancer screening services in the UK, emphasises precisely the critical aspect of health education i.e. ‘critical consciousness’ advocated by the work of Paulo Freire (Freire, 1970).

Involving bi-/multi-lingual lay members of the MME communities to participate in health promotion activities challenges traditional didactic health education practice, as it transforms the form, content and mode of delivery of health promotion programmes in public health. Through the CHE programme, CHEs, interpreters, cultural mediators and volunteers in the communities can act as advisors, providing information on the cultural beliefs of their respective communities, as collaborators in the planning, design and production of health literacy curriculum and materials, and as out-reach to vulnerable members of communities (Chiu, 2003).

There are considerable benefits of involving the communities in health promotion initiatives using the CHE model. These benefits are:
- The community development potential: building the capacity of the lay people as CHEs who then can resource and support community members to develop their own capacity to tackle health issues is an essential part of the community development approach. The CHEs who participated in the above-mentioned research projects often reported success in raising awareness of a particular health issue and bringing about behavioral change among members of their...
community (Chiu, 2008).
- The organizational development potential: the presence of the CHEs recruited from the communities will have an effect on the attitude, knowledge and behavior of health professionals. The organization will not only be able to develop more appropriate, linguistically- and culturally-sensitive services, thus improving their quality and acceptability of services, but also to improve their general accessibility (Chiu, 2001a).
- The personal development potential: personal development is essential for CHEs to be successful brokers between their communities and health agencies. Some of the CHEs who have developed their community leadership skills have not only reported that their confidence in their role day-to-day lives (Chiu, 2001b).

It is important to note that the use of the CHE model is by no means confined to minority communities. The model is relevant to many, particularly disadvantaged, communities and should be considered to be adopted, no matter the ethnic group.
The application of the CHE model developed in the MEET project

In accordance with the CHE model framework, MEET project proposes actions aimed at reducing inequities including targeted health promotion and best practice exchange. The MEET project operates in 5 EU countries to set up a multidisciplinary-task-force model to tackle inequalities in the social and health care access of migrant citizens in different contexts. By working together, the partner organizations explored and identified differences, validated similarities, moved towards models, practices and policies, and became ‘European’.

The framework for developing programme using the CHE model normally has a three-staged cycle which consists of:
Stage 1: Identification of needs
Stage 2: Construction of health promotion/literacy programme
Stage 3: Implementation and Evaluation

Three-staged cycle and Meet main outputs

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Stage 1 Identification of the needs

The main output of this stage is the General and National Need Analysis conducted through qualitative (focus group) and quantitative (data analysis) methods. The general aim of the need analysis stage was to collect and analyze information and data of the national contexts in which the transfer of innovation will occur, which will serve afterwards as the basis for Stage 2.

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Stage 2 Construction of health promotion/literacy programme

In this stage, the MEET project required partners to work - from different starting-points on health promotion and different immigration contexts. The project consortium produced the following main outputs:

- **Community Health Educator Curriculum** is based on the results and the needs of the target group identified. It was the curricula for the training course developed in each country.
- **Support Handbook** is a supplement to the trainees during the training course or as a self-teaching method. The handbook contains the same elements as the training course, but be described in such details that trainees can use it without the training course.
- **Guideline Handbook** is a manual for the training course that provides the needed support to trainers. This tool describes the training course from a trainer’s point of view.
- **Pilot course implementation** in Italy, Cyprus, Spain and Austria. The training course was targeted to representative of migrant-oriented associations, cultural and linguistic mediators, community leaders and migrant adults.

All of these products are available on the **project website** and on the **project e-learning platform** in all implementing partner languages: http://migranthealth.eu/index.php/IT/

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Stage 3 Implementation and Evaluation

The implementation stage provides the health promotion/literacy programme a systematic planned period of implementation. This stage in the MEET project corresponds with the policy paper "Health Inequalities in Europe and potential of CHE model ". The project MEET aims to strengthen the recognition of diversity and multiculturalism and include migration-related competences in the health care services by adapting and developing a community health education model and a professional development programme for social and health service providers.
Recommendations

This increased diversity calls for a more migrant-sensitive workforce. Migrant-sensitive training approaches are fundamental for the health practice because they increase the access of all populations to health care and improve the quality and effectiveness of services. These improvements, in turn, reduce health inequalities in society and promote health for all. Furthermore, since both service users and providers are facing many problems related to this, new challenges for professionals, for management, for quality assurance and improvement in health services are posed and needed.

The purpose of the policy paper is to apply the CHE model, which is based on confidence-building relationship between health care systems and community of migrants, a method aiming to engage and empower “hard-to-reach” communities.

The health information system must be improved so it effectively deals with migration by internationally co-operating with the country of origin and the country of destination through the creation of a migrant-friendly health information system for all European partners. This improved health system must include an easily accessible service that reduces the fear of meeting the authorities and effectively tackles migrants’ health needs. Using a coherent policy approach will help reduce social exclusion and address inequalities in the general health system. The activities to apply the CHE model should take into account the following recommendations:

- **Involving** the political representatives in order to increase the sustainability of the CHE Model in the future and to incorporate the tools of CHE Model.
- **Involving** migrant communities in the definition of their health literacy needs to guarantee the correct detection of their needs and the successful impact of the preventive and/or promotion health programmes among them (customised programmes).
- **Making** ‘health literacy to migrants’ part of quality management in institutions such as schools, hospitals, universities and social work agencies.
- **Implementing** the awareness of CHE model to all relevant agencies and health professionals. Ensuring that professionals become aware of the core curriculum and system of the CHE is one way of establishing accurate information is being transferred. This could also be done by drawing on, and disseminating information on previous and current CHE projects so as to demonstrate the overall applicability, process and outcome.
- **Implementing** the use of technology to promote CHE awareness,
as well as satisfy health literacy needs of migrants providing and establishing technological tools (e.g. touch-screens) at places of interest that inform migrants about CHE, and about health issues that could be relevant to them.

• **Implementing** the creation of a “European network” between organizations and professional people, physicians, international organizations, social and health workers, human rights organizations and organizations of migrants to increase their cultural competence and for CHEs to be updated about the news that can affect their own community.

• **Facilitating** and supporting exchanges of good practices. European organizations should engage in developing a health literacy network for professionals working in research, policy and practice. Exchanging information on best practices can help everyone progress faster and ensure health literacy inequalities are dealt with at a Pan-European level.
HEALTH INEQUALITIES IN EUROPE AND POTENTIAL OF CHE MODEL

1. Health Inequalities and Health Promotion

1.1 The most relevant international recommendations on Health integration

The Resolutions of Ottawa Charter at the First International Conference on Health Promotion in 1986 and, in particular, the resolution on public policy for health, and the Recommendations of the Adelaide at the Second International Conference on Health Promotion in 1988, are the reference documents specific to the promotion of health where the need to reinforce the collective action for health is reported. The Charter of Ottawa highlights the importance of a concrete and effective class action to define priorities for health, take decisions, plan and put in place strategies for a higher health level.

In 1998, the “Health for all” policy framework of the World Health Organisation (WHO) was launched and the challenge of health inequalities was discussed and addressed at global and European level by WHO and European Commission (EC).

The European Union (EU) launched a second Program for action on Health in 2007 with the following objectives:

- To promote health by reducing health inequalities;
- To improve citizens’ health security;
- To create and disseminate information and knowledge on health.

The EU Spanish Presidency which took place between January-June 2010 addressed the issue of health inequalities and the monitoring of social determinants of health in the EU.

Through the adoption of the conclusions included in the report “Equity and Health in all policies: solidarity in health” by the EPSCO Council (Employment, Social Policy, Health and Consumer Affairs), the EU encouraged all Member States to acknowledge the impact of social determinants of health in the development of illnesses and the implications of this impact for the Social and Health Systems of each country.

Inequalities stem from a non-homogeneous distribution of social determinants of health, such as employment, income, education and access to prevention, information, care and treatments. There is an international “gradient” of inequalities among countries.

The issues that can be investigated for the purpose of defining the health profile of a community are diverse and often related to each other, ranging from the social and cultural context in a given population, the provision of health care and social services, the economy, the investigation on the life style, the morbidity and mortality.
The monitoring of inequalities in health is realised also through the European Observatory on Health Systems and Policies where it emerges that there is an expansion of inequalities in health among countries that are linked to social, economic and environmental problems.

The WHO has recently revised the approach of the Primary Health Care as a possible platform, already promoted in 1978, and reiterated the key concepts of equity, participation of the communities and use of advanced technologies, which refer to the “complexity” of the current social and cultural system. The concept of health is located at the base of an intervention model that meets the definition of health according to the WHO [Alma High 1978], i.e. health intended as a state of complete physical, mental and social wellbeing and not merely the absence of the state of disease or illness.

In order to be effective, any program of intervention must be able to acquire the right information on the state/profile of health of the target population that wants to reach; this is possible using data that synthesize the main aspects of health and/or the processes in place to promote and ensure the health itself, or of the “indicators” that will express -in a synthetic manner - the value or the measure of an intervention model.

The 68th World Health Assembly has acknowledged the role of the “universal health coverage” in improving equity in health and a clear perception of health. It has also underlined that it is fundamental to invest in research and that transferring results to Public Health can act as a flywheel on the socio-economic progress.

Over the last two decades, internal and external migration has accelerated demographic change in many European countries. The demographic profiles and social and economic status of migrants are varied and complex [Migration Policy Institute, 2006]. In the academic discourse, the term “migrants and minority ethnic” (MME) groups has come to include both newcomers and relatively settled migrant populations in Europe. New migrants are often at risk of poor health due to their unfamiliarity with the health systems and/or because of language and cultural differences between themselves and their adopted country. In Europe, the access to social and health services has begun to be considered a primary indicator of the level of migrant integration. Having access to high quality healthcare is indispensable for all people to grow and live in a healthy condition that enables them to contribute to society. Investing in health for all and bridging inequalities in the access to healthcare is the key to enable migrant people to contribute to their own integration and social cohesion.

This increased diversity calls for a more migrant-sensitive workforce. Migrant-sensitive training approaches are fundamental for the health practice because they increase the access of all populations to health care and improve the quality and effectiveness of services. These improvements, in turn, reduce health inequalities in the society and promote health for all. Furthermore, both

2. Health Inequalities among migrant people
service users and providers are facing many problems related to this. All this poses new challenges for professionals, for management, for quality assurance and improvement in health services. Registering lower levels of health literacy among migrants is also relevant, especially as it concerns the appropriate use of health care systems present in the hosting territories. The term “health literacy” describes the ability to obtain, understand and use health information: migrants in Europe often have a lack of information about available hospital and ambulatory care services or about general public health procedures. Health literacy is a strong predictor of health status and an important means of promoting and maintaining health for all populations. Today, definitions of health literacy are broad in scope, holding more potential for policy innovation and implementation.

3.1 What is a CHE model?

The CHE model which has been developed to address inequalities of access by Migrant and Minority Ethnic groups to cancer screening services in the UK emphasises precisely the critical aspect of health education i.e. ‘critical consciousness’ advocated by the work of Paulo Freire (Freire, 1970). Involving bi-/multi-lingual lay members of the migrants and minority ethnic communities to participate in health promotion activities challenges traditional didactic health education practice as it transforms the form, content and mode of delivery of health promotion programmes in public health. CHEs, interpreters, cultural mediators and volunteers in the communities through the CHE programme can act as advisors, providing information on the cultural beliefs of their respective communities, as collaborators in the planning, design and production of health literacy curriculum and materials, and as out-reach to vulnerable members of communities (Chiu, 2003). They form a critical link to community capacity building (Eng et al., 1997). There is a growing body of evidence to suggest that they are effective in reducing inequalities through empowerment and promoting the utilisation of preventive services (Travers, 1997; Lewin et al., 2006).

3.2 The development of the Community Health Educator model

As mentioned, the CHE Model was first introduced in the UK after the completion of the project “Communicating Breast Screening Messages to Minority Women - Constructing a Community Health Education Model” in 1993. Throughout the 90’s and 00’s, the CHE model was adopted widely across the U.K. through action research and practice. The model received the Department of Health, Ethnicity Unit’s Beacon Award in 2001, with funding to support knowledge transfer. The model was constructed and developed based on a series of successful participatory action research projects funded by the National Health Services Cancer Screening Programme between 1990 and 2012.
3.3 The principles and values of the CHE model

The theory and practice associated with the CHE model draws directly on the teaching of the radical Brazilian educationist Paulo Freire (Freire, 1970). Empowerment and participation are the twin foundational values that have underpinned the research through which the CHE model has been developed, and that underpin the model itself. These values are also at the heart of the new health promotion movement (Robertson & Minkler, 1994). The empowerment principle within the new health promotion movement acknowledges the need to fully engage people in making their own choices about health as well as to recognise the need to tackle the wider social political and economic determinants of health. Therefore, empowerment in this context emphasises the building of capacity for individual and community decision making and organisation through non-traditional methods. Conscious awareness-raising through critical pedagogy is central to the work of a CHE. The term CHE therefore does not denote the paternalistic and didactic approach often found in traditional learning (Chiu, 2003). CHEs are members of the community who are trusted by community members, and they take on the role of conscious awareness-raising through facilitating discussion and critical questioning around issues that concern the community.

3.4 The Community, Organisation, Personal development potential of the CHE model

There are considerable benefits of involving the communities in health promotion initiatives using the CHE model. These benefits are:

3.4.1 The community development potential

Building the capacity of the lay people as CHEs who then can resource and support community members to develop their own capacity to tackle health issues is essentially part of the community development approach. The CHEs who participated in the research projects mentioned above often reported success in raising awareness of a particular health issue and bringing about behavioural change among members of their community (Chiu, 2008).
3.4.2 The organisational development potential

The presence of the CHEs recruited from the communities will have an effect on the attitude, knowledge and behaviour of health professionals. The organisation will not only be able to develop more appropriate, linguistically- and culturally-sensitive services, thus improving their quality and acceptability of services, but also to improve their general accessibility (Chiu, 2001a).

3.4.3 The personal development potential

Personal development is essential for CHEs to be successful brokers between their communities and health agencies. Some of the CHEs who have developed their community leadership skills have not only reported that their confidence in their role day-to-day lives (Chiu, 2001b).

It is important to note that the use of the CHE model is by no means confined to minority communities. They are relevant to many, particularly disadvantaged, communities and should be considered whatever the ethnic group.

3.5 The structure, components of the CHE model

The explicit aim of the MEET project is to adopt the CHE model for promoting health literacy.

The integration of the concept of health literacy and the CHE intervention practice is needed to make further progress in responding to diversity and health inequalities. The expanded concept of health literacy reflects the potential to offer innovative health education and communication activities through the CHE model. Within this model, developing critical health literacy in communities means to:

- develop CHEs’ capacity to understand health conditions (functional health literacy);
- support cross-cultural clinical consultations or effective use of health services (interactive health literacy); and
- develop their capacity for social and political action (critical health literacy).

The following figure illustrate the between the CHE model and health literacy (Fig.1).
In order to tackle inequality of access to health services, the CHE model recognises that barriers exist between communities and services. It therefore incorporates a component of professional development whereby health professionals involved with the CHE model will also undergo a training programme that helps them to understand the model and its practice. This component facilitates the building of partnerships between professionals and CHEs. Members of the targeted communities and health professionals should be systematically involved in all aspects of planning, implementation and evaluation of health promotion programmes.

Full Content Adaptation Report developed by RITA, UK
4. The application of the CHE model developed in the MEET project

4.1 The three stages

To adopt the CHE model successfully, a systematic and planned approach towards collaborative working with multi-agencies, migrants and minority ethnic community organisations is key. Based on the above principles and values, CHEs would best be recruited from the neighbourhood through target community organisations. An intensive period of training should be provided so that CHEs can support their communities to fully participate in the design, implementation and evaluation of the health promotion/literacy programme. The framework for developing programme using the CHE model normally has a three-staged cycle which consists of (1) Identification of needs, (2) Development health promotion/literacy programme, and (3) Implementation and evaluation (Chiu, 2003). Below is a schematic representation of the three-staged cycle (Fig. 2).

Fig. 2. Schematic representation of the three-staged cycle for developing the CHE Model.

4.1.1 Stage 1- Identification of needs

Local knowledge and conditions of the health promotion/literacy programme is paramount. This stage is about gathering information and identifying resources, preparing the target communities, and negotiating with stakeholders. Building relationships between the communities, hosting organisation and related statutory agencies also happens mostly at this stage. Health need analysis and other contextual information gleaned at this stage can be used to focus health promotion/literacy programme, formulate training strategies, and agree evaluation strategy and success indicators, in accordance with resources and budget available.

Steps need to be taken to build good working relationship with stakeholders and target communities [Please see Content Adaptation Report for details]. A systematic communication plan is necessary to provide opportunity to grasp stakeholders’ opinions and to influence the direction of the development of the programme plan.
Stage 1 – Identification of the needs

The main output of this stage is the General and National Need Analysis conducted through qualitative (focus group) and quantitative (data analysis) methods. The general aim of the need analysis stage was to collect and analyze information and data of the national contexts in which the transfer of innovation will occur, which will serve afterwards as the basis for Stage 2.

- General Need Analysis Report

Stage 2 - Construction of health promotion/literacy programme

In this stage, the MEET project required partners to work from different starting-points on health promotion and different immigration contexts – on the introduction of the Community Health Educator Model, awarded in 2000 by the British Ministry of Health and adopted by many health districts in the UK. The project consortium produced the following main outputs:

- **Community Health Educator Curriculum** is based on the results and the needs of the target group identified. It was the curricula for the training course developed in each country.
- **Support Handbook** is a supplement to the trainees during the training course or as a self-teaching method. The handbook contains the same elements as the training course, but described in such details that trainees can use it without the training course.
- **Guideline Handbook** is a manual for the training course that provides the needed support to trainers. This tool describes the training course from a trainer’s point of view.
- **Pilot course implementation** in Italy, Cyprus, Spain and Austria. The training course was targeted to representative of migrant-oriented associations, cultural and linguistic mediators, community leaders and migrant adults.

All of these products are available on the project website and on the project e-learning platform in all implementing partner languages: http://migranthealth.eu/index.php/IT/

4.1.2 Stage 2 - Developing Health Intervention

Based on the information and analyses on Stage 1, a health promotion/literacy programme can then be constructed by involving CHEs and all stakeholders. In this stage, CHEs can identify their own knowledge and training needs. It provides also an opportunity for other relevant health practitioners to be involved in the training programme.

The recruitment of CHEs is also an important part at this stage. CHEs' social networks and their understanding of their neighbourhood is crucial for the success of the Model (Chiu & West, 2007), as they will have direct access to members of the target community and are readily recognised and accepted by them.

The experience of Consortium partners on the MEET project is informative in this respect, you can consult some of the recruitment strategies used by them in the Guideline Handbook.

In general, the training programme consists of three parts: (1) Core information; (2) Effective CHE; and (3) Understanding community that will respectively address functional, interactive and critical literacy.
4.1.3 Stage 3 - Implementation and Evaluation

The implementation stage provides the health promotion/literacy programme a systematic planned period of implementation. At this stage, the day-to-day management activities of the CHE model will be intensified. Health co-ordinators will need effective leadership and change management skills to support the CHEs during this period, and good facilitation skills to maintain good working partnership with all stakeholders.

Evaluation is important for knowing whether the programme is working. While most health interventions tend to use traditional methods e.g. randomised field trials, or pre-and-post comparison; the evaluation of the health promotion/literacy programme based on the CHE model will best be done in a participatory manner, so that all participants can play a part in collecting the evidence of success and identifying areas for improvement, as well as the unmet needs of the communities. Tradition evaluation can provide a clear picture of whether money has been well spent, and the extent to which objectives of programme have been met. However, evaluating the CHE service needs to take account of the values and practice that underpins the model developed out of the empowerment and participatory principles of the CHE model. Although participatory evaluation is different from traditional evaluation, its application to the CHE service is not by any means less robust or credible. To develop a participatory evaluation strategy requires co-ordinators to develop a clear rationale that underpins the means and ends of the service and to recognise that the purpose of the evaluation is bound up in the broad values and goals of the service and the level of its practice. Combining these evaluation methods flexibly would provide a positive environment for learning. Details of the differences in principles, purposes, and methods between traditional and participation evaluation and associated strategies can also be found in the Content Adaptation Report.

Stage 3 – Implementation and Evaluation

The implementation stage provides the health promotion/literacy programme a systematic planned period of implementation. This stage in the MEET project corresponds with the policy paper “Health Inequalities in Europe and potential of CHE model”.

The project MEET aims to strengthen the recognition of diversity and multiculturalism and include migration-related competences in the health care services by adapting and developing a community health education model and a professional development programme for social and health service providers.

**NOW the purpose of policy paper** is to apply the CHE model based on confidence-building relationship between health care systems and community of migrants, a method aiming to engage and empower “hard-to-reach” communities!
4.2 Implementing a Community Health Educator Service

The explicit aim of the MEET project was to adopt the CHE model for promoting health literacy. “Each partner focuses on a specific health condition area and targeted migrants and minority ethnic groups based on partners’ Needs Analysis. A clear intervention design would help focus evaluation and lead to a more systematic way to understand What Works!” (For more information you can consult the Full Content Adaptation Developed by RITA).

The main need underlined by health professionals emerged was to work in close contact with the communities of migrants, in terms of reorientation of the services, cultural competence, information strategies and how to reach vulnerable groups.

The needs raised by health care providers were represented in the figure below (Fig 3):

![Figure 3: Needs raised by health care providers in the MEET project](image-url)
Research among migrant groups diagnosed a huge information gap concerning health protection and especially preventive health care. The information on medical facilities and services often do not reach the migrant population to a sufficient extent. **Barriers** to access local institutions are illustrated in the Figure 4.

![Figure 4: Barriers for migrants to access local institutions](image)

The CHE Model will be developed according to the services, health benefits, and infrastructures of the Health System. When establishing the service, the right people involved in the process ensure that, on one hand, there is sufficient knowledge of the system and its environment to make informed decisions about the development of the service and, on the other hand, sufficiently powerful membership to enable the adoption and implementation of the service. Stakeholder analysis should consider persons, roles and interests, both internal and external to the organisation, and who can enable or prevent active adoption of the service.

An assessment phase to the CHE service/project will be developed in order to evaluate the effectiveness of the CHE in each context with a participatory approach involving all the stakeholders and communities participating in the implementation phase. **Key stakeholders and communities** must be prepared to commit the time and energy necessary to play an integral role in the evaluation. They are expected to: (1) reflect on the issues, developments and results, and (2) bring their individual/organisation’s insights into local realities, knowledge, and expertise to advance improvements.

Finally, an evaluation process of the intervention programme (CHE service/project) should take into account the different phases of the project development...
for the application of the CHE model. The structure/health service will have to contextualise the model, taking into account the results of the analysis of the existing national and/or local health strategies and the experiences of the needs and strategies suggested by the Community to achieve through the intervention. The responsibility of health promotion in health services is shared among individuals, community groups, health professionals, institutions that provide the health services. The role of the health sector must increasingly move in the health promotion direction, beyond its responsibility for providing clinical and curative services. Reorienting health services also requires a stronger attention to health research as well as changes in education and professional training. For these reasons the presentation of the results of the assessment process and their dissemination to be held in the facility that has run the project is essential and the participation of some representatives of the involved communities should be considered. It should be appropriate that the discussion provides the involvement of all participants in the project. The CHEs should have the opportunity to present positive and/or negative data collected during the project and above all must be able to communicate the information gathered from their communities.

4.3 The experience of the Community Health Workers in South Africa: lessons learnt for the health challenges in Europe.

Over the last decade in South Africa, a rapid growth in programme activities and budgetary allocations for the comprehensive response to HIV/AIDS has been responsible for the emergence of a large lay health worker infrastructure. It began in the mid-1990s, after the end of the apartheid regime, with state support for non-governmental organisations (NGOs) employing home and community-based carers, and the training of lay counsellors to promote voluntary HIV testing and of DOTS supporters for the parallel epidemic of TB. Lay workers have been described as "an indispensible extension of the reach and strength of professional involvement in ART services" (Steyn et al. 2006). By 2004, there were an estimated 40 000 such lay workers in South Africa, nearly equal to the number of professional nurses (43 660) working in the public sector. In that year, the government introduced the umbrella term 'Community Health Worker' for these and all other community workers in the health sector, and adopted a policy framework for their training and remuneration. While this framework is oriented to the notion of a generalist CHW, a wide array of more limited purpose HIV/TB workers currently constitute the majority of CHWs in South Africa and are driving developments in what has become a de facto national CHW programme. Expansion and regulation of the CHW infrastructure now features in both the

National Strategic Plan for HIV/AIDS and medium-term human resource plans for the health sector.

In the framework of an EU funded project, Oxfam Italia, in partnership with the Global Health Center of the Region of Tuscany and a South African NGO [Small Projects Foundation], have been working for more than three years in South Africa to strengthen the CHWs role in one of the most poor, rural and marginalised regions of the country (Or Tambo District Municipality in the Eastern Cape Province). In this kind of socio-economic context, the CHWs, in charge of performing duties related to basic healthcare provision within their communities and as counsellors at the clinics, play a key role since they act as a bridge between the community and the formal health services in all aspects of health development, providing an opportunity to increase both the effectiveness of curative and preventive services and, more importantly, community management and ownership of health-related interventions. International cooperation actors and programmes have recognised the valuable contribution of CHWs can provide in their interventions, especially in defining initiatives aimed at strengthening local healthcare systems.

Main weakness factors were nonetheless identified as: the general voluntary and precarious nature of their work, insufficient training, need for accredited training leading to a recognised qualification, lack of a career path for CHW’s, lack of clear management, support and reporting systems for them, low pay, and not sufficiently valued and supported.

A component of CHWs training and deployment was hence included within the project, assuming that sound improvements in the healthcare facilities’ performances could be produced by having CHWs assisting health staff in performing their duties, providing patient follow-up and care in communities, and conducting communities’ mobilization actions. Women, girls and children affected or exposed to HIV would also be more easily reached, educated and informed about HIV and PMTCT issues, sexual and reproductive health rights and sexually transmitted diseases thanks to CHWs engagement. This assumption proved to be correct, producing noteworthy results in all involved areas and decisively acknowledging CHWs’s centrality in promoting virtuous dynamics and experiences. The enhancement and formal recognition of their role and competences prompted health staff and local beneficiaries to valorise their work and boost their motivation and commitment. Arising from the project in South Africa, the following major changes have now been proven and are being replicated into 45 new clinics in OR Tambo District: 1) many of the CHW’s have been appointed by the SA Government as part of Ward Based Outreach Teams, 2) accredited training was provided to CHW’s in Counselling, HCT, PMTCT and can lead to a national qualification in Ancillary Health Care, 3) CHW’s are now recognised as a new category of worker under the SA Government Community Work Programme and 400 CHW’s are now being appointed, trained, paid and are working in each village in three of the 4 sub-districts of OR Tambo District. They are appointed and employed by the SA Government for the medium to long term. At the global level, the theme of inequality has been addressed by the WHO
and the European Commission with the aim of improving the health and safety of citizens, promote health, reducing health disparities, generating and disseminating health information and knowledge. In 2010, the EU has urged all Member States to recognise the impact of social determinants of health in the formation of the state of health and the implications of the impact of these for their health systems. We can say that, even in the presence of health-care systems marked by the guarantee of service and care, there is a constant inequality in the access to health care and, often, the health inequality happens when accessing the health services.

Guaranteeing equal health rights between migrants and native people is a complex objective that requires the contribution of all the stakeholders involved in order to give a holistic response based on a real diagnosis of the situation and should be agreed under the consensus of the actors (health professionals, migrant communities, social workers, migrant associations, etc.), as the CHE model promotes. High levels of bureaucracy, language barriers and cultural differences stop migrant from accessing preventive and promotion health programmes; these can be overcome thanks to the synergism between health professionals and CHEs.

CHEs help migrants to understand the national health systems of the country where they live and to face their particular health problems. In this sense, they can contribute to alleviate the misuse and abuse of urgency services and to encourage an active participation in health promotion and preventive programmes.

The CHE model is an important factor to promote different health topics [i.e. Sexual Health Promotion (HIV and STI prevention, VIP), Mother and Child Health Care, Mental Health, and Healthy lifestyles] directly in their communities.

The health information system must be improved so it that effectively deals with migration by internationally co-operating with the country of origin and the country of destination through the creation of a migrant-friendly health information system for all European partners. This improved health system must include a migrant-friendly, easily accessible service that reduces the fear of meeting the authorities and effectively tackles migrants’ health needs. Using a coherent policy approach will help reduce social exclusion and address inequalities in the general health system.

The activities to apply the CHE model should take into account the following recommendations:

- Involving the political representatives in order to increase the sustainability of the CHE Model in the future and to incorporate the tools of CHE Model.
- Including migrant communities in the definition of their health literacy needs to guarantee the correct detection of their needs and the successful impact of the preventive and/or promotion health programmes among them (customised programmes).
- Making ‘health literacy to migrants’ part of quality management in
institutions such as schools, hospitals, universities and social work agencies through specific training as the developed under the MEET project.

• Implementing the awareness of CHE model to all relevant agencies and health and social professionals. Ensuring that professionals become aware of the core curriculum and system of the CHE is one way of establishing accurate information is being transferred. This could also be done by drawing on, and disseminating information on previous and current CHE projects so as to demonstrate the overall applicability, process and outcome.

• Implementing the use of technology to promote CHE awareness, as well as satisfy health literacy needs of migrants providing and establishing technological tools [e.g. touch-screens] at places of interest that inform migrants about CHE, and about health issues that could be relevant to them.

• Implementing the creation of a “European network” between organisations and professional people, physicians, international organisations, social and health workers, human rights organisations and organisations of migrants to increase their cultural competence and for CHEs to be updated about the news that can affect their own community.

• Facilitating and supporting exchanges of good practices. European organisations should engage in developing a health literacy network for professionals working in research, policy and practice. Exchanging information on best practices can help everyone progress faster and ensure health literacy inequalities are dealt with at a Pan-European level.

It is also useful to remind that CHE model is created according to the intervention strategy that must be adopted and that the model in itself recognizes and tests the power and the efficacy of the intervention and indicates possible limitations or critical points, regarding its applicability to the target community. In conclusion, CHE can integrate and guide the intervention model and select professional and civil society figures able to support in conducting a CHE project/service.

The CHE model has to be embed in the European system to facilitate the model and satisfy the health literacy needs of migrants in all European countries.

There is a need of CHEs accreditation in order to make this figure a recognised profile inside the health and social European systems. Including this model inside the related degree programmes, promoting it as a recycling course among health professionals, and organising a summer school for CHEs are potential ways to promote the accreditation training for CHEs. Thus, sustainability of the model deals directly with the European recognition of the model and its promotion.
for local, regional and national health authorities. Migrant associations too have a role in their promotion among the migrant communities they give support.

6. Main references

Deliverable 2.3: General Need Analysis Report; MEET - Meeting the health literacy needs of immigrant populations - Project n°540139-LLP-1-2013-1-IT-GRUNDTVIG-GMP

MEET, Content adaptation report, RITA, UK Content Adaptation Report developed by RITA, UK; MEET - Meeting the health literacy needs of immigrant populations - Project n°540139-LLP-1-2013-1-IT-GRUNDTVIG-GMP

Modules 1, 2, 3 and 4 of the learning platform - Web: http://migranthealth.eu/index.php/en/
In the MEET project, the aim of the General Need Analysis stage was to collect and analyse information and data of the national contexts in which the innovation transfer would/will occur. Each partner carried out its national research to develop a National Need Analysis report and analysis framework shown below to ensure the project with the implementation of a best practice approach in curriculum development, addressing identified gaps in social and health care provision and the specific learning needs of all target group.

1. Austria

Health care system

The Austrian healthcare system, as a public service, guarantees care for ill people as well as prevention services for healthy people. Nevertheless, the greater part of the budget is spent for care services. The system’s legal status, financing, organisation and quality management are ensured by the state, the federal subjects, municipalities, social insurance services and legal representatives [e.g. chambers], services are provided by public as well as private institutions. It is financed mostly by public means [social insurance fees and taxes] as well as private contributions, e.g. recipe fees, daily rates for hospital stays or private insurance fees. Social insurance is financed by contributions of employees as well as employers. A very important aspect of the Austrian healthcare system is the equal access to services for everybody regardless of age, domicile, origin or social status of the person, as well as of the kind and amount of services. The Austrian Social System is a central pillar of the Austrian healthcare system. Therefore about 98 % of people living in Austria are covered by this compulsory insurance system. Complementary about one third of the people have a private insurance.

Migration & Health Care

Overall Migration Demographics
17% of the total Austrian population are foreign citizens. 52% of the total immigrants are people from EU countries, such as Germany, Romania, Hungary and Slovakia. People from Former Yugoslavia, Turkey and people from other South- and East-European states are migrating less often, since in 2006 a new term of law came into force. Nevertheless, the data show, that again, more people from non-EU countries are staying in or moving to Austria, then leaving the country.

Health Topic chosen
Mental health
Socially marginalised groups tend to have higher rates of mental disorders than the general population and can be difficult to engage in health care. Providing mental health care for these groups represents a particular challenge, and evidence on good practice is required.

Gaps in health service delivery to migrants
Marginalised groups can face significant administrative and financial obstacles in accessing health services and be neglected in the distribution of health resources. Services providing mental health care can struggle to reach people with mental disorders in these groups and engage them in care.

Researches among migrant groups diagnose a large information gap concerning the health protection and especially preventive health care. The information on medical facilities and services often do not reach the migrant population in sufficient extent and the low confidence in one’s own actions keeps migrants from taking the preventive health care into your own hands.

Barriers to access local institutions are mostly:
• Lack of information
• Lack of language skills
• Lack of trust /fears
• Socio-economic factors within the families

Source: the Austrian National Need Analysis report (Agaidyan et al., 2014)
2. Cyprus

Health care system

<table>
<thead>
<tr>
<th>Health Care System(s) in Cyprus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health Care Sector</strong></td>
</tr>
<tr>
<td>Organised three-tiered system</td>
</tr>
<tr>
<td>Primary care</td>
</tr>
<tr>
<td>Health centers</td>
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<tr>
<td>Outpatient centers</td>
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<tr>
<td>[hospital based]</td>
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<tr>
<td>Secondary care</td>
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<tr>
<td>Hospital based</td>
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<tr>
<td>Tertiary care</td>
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<tr>
<td>Hospital/specialised center based</td>
</tr>
<tr>
<td>Distinct population group coverage criteria</td>
</tr>
<tr>
<td><strong>Private Health Care Sector</strong></td>
</tr>
<tr>
<td>Privately-run hospitals</td>
</tr>
<tr>
<td>Privately-run clinics</td>
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<tr>
<td>Individual doctors in private practice</td>
</tr>
<tr>
<td>Fee-for service</td>
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<tr>
<td>Private health care insurance coverage</td>
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<tr>
<td>Insurance coverage linked to employer</td>
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</tbody>
</table>

Migration & health care

Overall migration demographics
- Foreign citizens in Cyprus comprise 20% of the population.
- The main countries of origin for migrants in Cyprus are: Greece, the UK, Bulgaria, Romania, Philippines, Russia, Sri Lanka, Vietnam, Syria, and India.
- There are more women than men especially for Asian countries such as the Philippines and Vietnam where more than 90% of migrants from these countries are female.

Health Topic chosen

Mother and Child Health Care
Topic chosen based on the high level of contact of this group with mother and child health care services and the reported problems encountered by healthcare professionals when dealing with migrants in this context.

Gaps in health service delivery to migrants

- **Accessibility**
  - health care costs
  - language barriers causing poor intercultural communication
  - inefficient access to information
- **Acceptability & quality of care**
  - institutional racism
  - bureaucracy and waiting lists

Source: the Cypriot National Need Analysis report (Pithara et al., 2014)
3. Italy

Health care system

In Italy, the National Health Plan identifies health interventions and guidelines that are targeted to ensure primary health care, hospital support services, emergency, prevention, care and treatment of HIV/AIDS, mental health, women’s health and health services for those people who are not registered in the PHS, at the central level. Regions have exclusive jurisdiction for public services organisation.

The Legislative Decree 286/98, article 35, paragraph 3, determined that foreign citizens on Italian territory, still not complying with the rules on entry and residence, have the right to out-patient and in-patient care, either urgent or, in any case, essential at the public accredited centers, particularly for prophylaxis, diagnosis and treatment of infectious diseases.

Migration & health care

Overall migration demographics

According to Istat [Istituto Italiano di Statistica], on the 1st of January 2015, foreign people resident in Italy were 5,014,437. The most represented community of immigrants in Italy is the Romanian (1,131,839) together with migrants from East Europe. The big emigration flows from Italy abroad have involved many Italian regions, but in particular, the Southern regions. Last but not least, the new immigration flows, although present as a phenomenon in all the Italian regions, is more concentrated in the North of the country. This depends on both the characteristics of the migration phenomenon and the features of the territory, mainly the labor market access.

Health Topic chosen

Sexual Health Promotion (HIV and STI prevention, VIP)

The early identification of HIV infection and the evaluation of recent infections can allow an early treatment of the infection, in particular in pregnant women to effectively prevent vertical transmission of infection. The social and economic conditions, the different cultural approaches to infectious diseases and the difficulties to access to HIV treatment are all factors that tend to isolate further the migrant with HIV infection. This is particularly important when we consider that the proportion of foreign patients with AIDS who are diagnosed HIV infected is particularly high (25.9%). In addition, the identification of the different HIV subtypes circulating within the population of migrants can allow adoption of specific treatment strategies limiting the spreading of HIV variants with drug-resistance mutations.

At national level, the analysis of the characteristics of women who performed the abortion, referring to the final data for 2012, confirms that the number of operations carried out by women with non-Italian citizenship has been increasing over the years, reaching, in 2012, 34% of all abortions, while in 2008 the percentage was 33% and 7% in 1995. We see a slight increase in recent years for the delicate issue of repeated abortions, due to the increasing contribution of foreign women which percentages of previous abortions are significantly higher than those of the Italian women: 37.7% compared to 20.8%, respectively [Ministry of Health, 2014].

Gaps in health service delivery to migrants

- The language and communication differences
- The absence of the cultural-linguistic mediator
- The lack of clear information on medical examinations to be carried out
- Relational difficulties of operators and insufficient training programs

Source: the Italian National Need Analysis report [Ensoli et al., 2014]
4. Spain

Health care system

The Spanish National Health System (SNHS):
- It is configured as a coordinate health system of services between different levels of Public Administrations; the Central Government has the responsibility of establishing the rules about the minimum conditions and requirements, as well as the means to facilitate the exchange of information; the Autonomous Communities, according to their Statute of Autonomy, have assumed the health responsibilities. For this reason, each Community has its own healthcare services [Observatory of Health, 2011].
- It has two level of intervention: Primary Care and Specialised Care.
- The resources are distributed according to a demo-geographical area called Health Area, which has a General Hospital as a referent for Specialised Care.
- Insured citizens in Spain can access the healthcare services with the Individual Health Card.
- The unregistered foreign residents or not authorised in Spain can only receive health in the following situations: emergencies with serious illnesses or accidents, care for pregnant women (prenatal and postnatal), and minors under 18 years old. Regarding this fact, the European Committee of Social Rights [2014] has warned Spain about the decline of the healthcare right after the last legislative amendments because this right must be guaranteed regardless the legal status [European Committee of Social Rights, 2014]. Indeed, some Autonomous Communities have adopted measures to provide health assistance for unregistered migrants.

Migration & health care

Overall Migration Demographics
- The migrant trend has been interrupted due to the crisis effects in the Spanish economy in the last years.
- Migrant people from East European countries are the main nationalities of migrant people from EU [48.73% of the migrant population]. Their nationalities are: Romanian, English, and Italian.
- The great bulk of the immigrant population is made of an economically active population. Regarding gender, the immigrant population is balanced [SNSI, 2014].
- The last legislative amendment undertaken by the Royal Decree 16/2012 on the urgent measures to ensure the sustainability of the SNHS constrains seriously the health rights of migrants in Spain.

Target group of the MEET project in Spain: Bulgarian immigrants
- High level of education and easier labour inclusion due to their “brand image” [Viruela, 2009].
- The inclusion of this group in the health field is still a challenge for the SNHS: difficulties such as the different culture and health habits, the language barriers, and their living conditions.

Health Topic chosen

The topic selected from the literature review and the focus groups carried out with migrants and health professionals in the Spanish national need analysis was healthy lifestyles in order to reduce the consumption of alcohol and tobacco of Bulgarian people and to promote among them preventive programmes.

Gaps in health service delivery to migrants

Insufficient investment in multicultural skills; training courses addressed to the health professionals has been detected. Professionals have shown an interest in CHE Model due to the importance of cultural mediation services in the field of health beyond the mere translations in order to understand the “meaning of culture”.

Source: the Spanish National Need Analysis report [Garcés et al., 2014]
Curriculum and training

The CHE model is a complex and dynamic intervention model and understanding the different levels of the model is essential to adopt and deliver the Curriculum and the training programme. During the training, the development of the CHE model and the range of resources associated with it must be clearly be explained. These have all been tested across many projects in the U.K. throughout the last two decades.

A CHE training programme does not operate in a social and political vacuum: adapting these resources and using them appropriately in a training programme requires an understanding of the structure and components of the CHE model. Therefore, it is important to understand how the infrastructure and the context of a country will form the foundation for adopting the model and formulating a CHE training programme.

The aim of the need analysis stage was to collect and analyse information and data of the national contexts in which the transfer of innovation (CHE model) will occur, which will serve afterwards as the basis for the content adaptation and for the conception of the training content and support materials (CHE curriculum, support handbook and guideline handbook) for the pilot training courses.

Each partner carried out national research to develop a National Need Analysis report and analysis framework to ensure that the project implements a best practice approach in curriculum development by addressing identified gaps in social and health care provision and the specific learning needs of all target groups.
## 1. Curriculum and training in Austria

<table>
<thead>
<tr>
<th>Training</th>
<th>Curriculum</th>
<th>Strengths</th>
<th>Weaknesses/challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training with CHEs</strong></td>
<td>• Introduction of participants and expectations of seminar and project</td>
<td>Inform migrants about the CHE model</td>
<td>• The use of the e-learning platform did not work as the target group does not have any access to computers and internet</td>
</tr>
<tr>
<td></td>
<td>• Introduction to seminar objectives and CHE Model</td>
<td>• Increase awareness of CHE model and use in own community</td>
<td>• It was not always easy to explain the contents to migrant participants, because there have been some language barriers.</td>
</tr>
<tr>
<td></td>
<td>• (Role of community health educator)</td>
<td>• Exchange with other participants on CHE model and Mental health</td>
<td>• Some questionnaires are too long and complicated for participants to fill out</td>
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<tr>
<td></td>
<td>• Terminology, definitions of mental diseases</td>
<td>• Exercises created a good atmosphere to work together</td>
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<tr>
<td></td>
<td>• How to promote mental health (an overview of Austrian Need Analysis Report - MEET Project)</td>
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<tr>
<td></td>
<td>• Information about mental health services and psychotherapy</td>
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<td></td>
<td>• Meaning of health</td>
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<td></td>
<td>• Understanding of health beliefs in own community</td>
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<td></td>
<td>• Oppression, Power, Exploring self-image, Self awareness, Group work vs. one-to-one work</td>
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<tr>
<td></td>
<td>• Communication barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Exercises, Discussion, Questions, Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Training with Health Professionals</strong></td>
<td>• Introduction of participants and expectations of seminar and project</td>
<td>• Inform Health Professionals about the CHE model</td>
<td>• It was not easy to find a date convenient for all for the trainings</td>
</tr>
<tr>
<td></td>
<td>• Introduction to seminar objectives and CHE Model</td>
<td>• Increase awareness of CHE model and use in daily work</td>
<td>• Use of the e-learning platform did not work well, as it was time consuming for them to spend even more time on the project in their free time</td>
</tr>
<tr>
<td></td>
<td>• (Role of community health educator)</td>
<td>• Exchange with other participants on CHE model and Mental health in daily work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How to promote mental health (an overview of Austrian Needs Analysis Report - MEET Project)</td>
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<tr>
<td></td>
<td>• Exchange on Mental health and migrants</td>
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<tr>
<td></td>
<td>• Inter-cultural communication/ Communication barriers</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Working with disadvantaged groups</td>
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</tbody>
</table>

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This project has been funded with support from the European Commission. This publication (communication) reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein. LLP / Grundtvig Programme / Project number: 540139-LLP-1-2013-1-IT-GRUNDTVIG-005
## 2. Curriculum and training in Cyprus

<table>
<thead>
<tr>
<th>Training</th>
<th>Curriculum</th>
<th>Strengths</th>
<th>Weaknesses/challenges</th>
</tr>
</thead>
</table>
| **2-day workshop with health professionals and trainers** | - Introduction of the Community Health Education [CHE]  
- Results from the Needs Analysis  
- The national health plan in Cyprus  
- Mother and Child Health Care services in Cyprus  
- Group activities and reflections  
- Planning a CHE service  
- Community Health Educator Core Curriculum  
- Working with health professionals and communities  
- Evaluating the effectiveness of a CHE service project  
- Mother and Child Health Care-Delivering the Pregnancy unit  
- Future planning of a CHE service  
- Critical reflections and concluding remarks | - Learned how to be an active community member/educator  
- Learning how to apply the model in field of work  
- Increasing awareness of CHE model  
- Familiarisation with online platform | - Length: Even though the material did need time to be understood, maybe it would be better to include more of the 2nd day topics to the 1st day |
| **1-day workshop with trainees in social work** | - Introduction of the Community Health Education  
- Planning a CHE service  
- Community Health Educator core curriculum  
- Mother and Child Health Care-Delivering the Pregnancy unit  
- Critical reflections | - Expanding CHE model by increasing awareness within educational institution  
- Familiarisation with online platform | - This was a short workshop that did not allow for detailed expansion and in-depth understanding of CHE curriculum regarding applications in different communities |
| **Workshop with migrants** | - Purpose of MEET project  
- What is a CHE model [principles and values]  
- Community Health Educator [Codes of Practice]  
- Community Health Educator [thoughts and feelings]  
- Health and Literacy needs for migrants in Cyprus  
- Mother and Child Health Care in Cyprus- Pregnancy | - Informing migrants [project’s target group] directly about the CHE model  
- Increased their possibility of involvement  
- Migrant women showed a great deal of interest in the section on ‘pregnancy’ demonstrating CHE’s usefulness  
- Increased capacity of reducing health inequalities with this first step to expanding their health literacy | - Due to lack of computers there was no possibility of familiarisation with the online platform |
## 3. Curriculum and training in Italy

<table>
<thead>
<tr>
<th>Training</th>
<th>Curriculum</th>
<th>Strengths</th>
<th>Weaknesses/challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tot 32 h:</td>
<td></td>
<td></td>
<td>• The limited amount of time provided for the training course did not leave any spare moment to actually work on the platform</td>
</tr>
<tr>
<td>Tot CHEs: 17 h</td>
<td></td>
<td></td>
<td>• The possibility to do more exercises</td>
</tr>
<tr>
<td>Tot HPs: 15 h</td>
<td></td>
<td></td>
<td>• Continuity [need to do other similar courses]</td>
</tr>
<tr>
<td>Day 1 (6 h)</td>
<td>Sexual health and HIV prevention; Introduction to the CHE Model and seminar objectives; How to promote health (an overview of Italian Need Analysis Report - MEET Project); Terminology; HIV and VIP; The national health plan and health laws; Ethnic differences and inequality in health services access; Women’s information &amp; support needs</td>
<td>• Increased competences in relation to HIV/AIDS infection and VIP; Inform HPs about the CHE model; Increased awareness of CHE model among migrants and related associations; Health professionals learned how to promote the model in their field of work; The interactive structure of the training</td>
<td></td>
</tr>
<tr>
<td>Training with CHEs and Health Professionals (HPs)</td>
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<tr>
<td>Day 2 (8 h)</td>
<td>Developing Ourselves; Negotiation; Power; Oppression; Community Education; Our Perceptions; Working with disadvantaged groups; Theoretical perspectives; Critical learning; Ourselves and ‘others’; Self awareness; Body image/awareness [a variety of creative and thought-provoking individual &amp; group exercises]; “Us &amp; Them” - The Influences of Language &amp; Culture; Inter-cultural communication; Relationships &amp; trust; Language &amp; interpretation; Working with CHEs</td>
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<tr>
<td>Training with CHEs</td>
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<tr>
<td>Day 3 (8 h)</td>
<td>Skills Day; Organisation &amp; delivery; Stress management; Time management; Trust, Language and Communication; Interpreting issues; Working with Health Professional; How to use our network to reach members of Ethnic communities; Planning the future and Evaluation; What to do? What kind of action do we plan? Construction of a shared plan of action between HPs and CHEs (working groups); How to evaluate our work; Implementing professional training and update courses of health workers, targeted to increase their knowledge on specific health needs of migrants in order to provide “culturally-competent” services</td>
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<tr>
<td>Training with CHEs</td>
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<tr>
<td>Training with Health Professionals (HPs)</td>
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</tbody>
</table>
### 4. Curriculum and training in Spain

<table>
<thead>
<tr>
<th>Training</th>
<th>Topics</th>
<th>Strengths</th>
<th>Weaknesses/challenges</th>
</tr>
</thead>
</table>
| **CHEs (two days per week with a total of 18 hours)** | • Purpose of MEET project  
• What is a CHE model (principles and values)  
• CHE (Service, implementation and curriculum)  
• Health and Literacy needs for migrants in Spain  
• Our perceptions: social role of alcohol and tobacco  
• Other ways of leisure  
• Understanding risk of alcohol and tobacco (individual, family, group)  
• Understanding benefits of health promotion and preventing programmes  
• Knowing the Spanish health system  
• Discovering the local health resources  
• Which leisure resources do you know in your city?  
• Discovering new local leisure resources | • Positive attitude of migrant people and a sense of self-empowerment as CHEs  
• Because their high cultural level, the trainer was able to go in-depth to the contents and materials  
• The participative methodology helped to understand the model  
• Participants learned how to be a CHE and how to apply the model in their community with a concrete health topic  
• Increased awareness of CHE model among migrants and related associations  
• Increased capacity of reducing health inequalities with this first step to expanding their health literacy | • They demanded a long course in order to go more into detail about the content  
• They were not able to access the e-learning platform because they do not have access to computers and the venue of the training couldn’t provide these facilities  
• Language barriers trainer – trainees |
| **Health professionals (one session of two hours)** | • Introduction of the CHE  
• Results from the Spanish National Needs Analysis  
• Dealing with the alcohol and tobacco context of migrant people: Experiences & protocol of action  
• Communication  
• How to promote cultural change? | • Interest on the CHE model and the MEET project  
• Increased awareness of the CHE within educational institutions  
• Increased the knowledge about the CHE and their interaction with CHEs  
• Health professionals learned how to promote the model in their field of work | • Difficulties for engaging them as the model is not well-known in Spain |
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