Healthy Inclusion

Perspectives of Providers on Participation of Migrants in Health Promotion in Estonia

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1. Introduction

This chapter introduces the project Healthy Inclusion: Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Interventions and Services and provides an overview of methods used and general situation concerning topics 'health promotion' and 'migrants' in Estonia.

1.1 General introduction of the project

"Healthy Inclusion: Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Interventions and Services" is an international project carried out within Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, Public Health (EAHC). It is an international plan involving 8 partners: *Forschungsinstitut des Roten Kreuzes* (Coordinator, Austria), *Studio Come S.r.l.* (Italy) *mhtconsult ApS* (Denmark), *Trnava University, Faculty of Health Care and Social Work* (Slovakia), *Stichting dr. Hilda Verwey-Jonker Instituut* (The Netherlands), *Institut für Soziale Infrastruktur* (Germany), *National Institute of Public Heath* (Czech Republic), *University of Tartu, Department of Public Health* (Estonia).The project commenced in July 2008 and will be finalized in May 2010.

Migration is a central topic in contemporary societies. Migrants belong to the most vulnerable groups and therefore require special consideration in public health strategies. The health status of migrants is often less favourable than that of a general population due to their overexposure to risks, more health damaging behaviour and restricted access to health care services. Project "Healthy Inclusion" uses the following definition of migrants: "Persons who have been born in another country, who have lived in the host country for at least five years and who have the intention of staying permanently, who have a legal (residential) status and who (as a group) have a disadvantaged (socio-economic or social cultural) position in the host country".

Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over their health.

The general objective of the “Healthy inclusion” project is to contribute to the increase of participation of migrants in health promotion interventions. Healthy Inclusion aims at being instrumental in reducing health inequalities for migrants and in developing policies and innovative approaches to address migrant health issues. The project provides knowledge about barriers to migrant access to health promotion interventions and possible strategies to amend these circumstances in a form of practical recommendations for integrating socio-cultural standards in municipal health promotion interventions.

To achieve the purpose of the project, more precise objectives are defined:

- Obtain the perspectives of health promotion providers on hindering and conducive factors for participation of migrants in health promotion interventions by exploring examples of positive experiences.
- Obtain the perspectives on access to health promotion services from migrants who have access, in terms of which interventions are inviting for them and why, and what are the hindering and conducive factors to participation.
- Obtain the perspectives on access to health promotion services from migrants who have no access.
- Development of recommendations for health promotion providers on how to integrate migrants into health promotion so that their inclusion in health promotion interventions would be self-evident.
- Provide feedback to service providers.

The project makes use of qualitative methods. Objectives of the project are attained through:

- A literature review of available national literature on topics of migration and health promotion in each participating country
- Semi-structured interviews with providers of health promotion interventions
- Semi-structured interviews with migrants who do and who do not have access to health promotion interventions
- Delphi- rounds including various experts from relevant fields to achieve consensus on recommendations.

This national report presents Estonian research results from work package 4 of the Healthy Inclusion project (literature analysis and qualitative analysis of interviews with representatives of health promotion interventions).

1.2. Method

Literature analysis

Literature analysis based on available Internet-sources was carried out to get an insight into policies and practices of health promotion and migration in Estonia. The search terms “migrants”, “health promotion”, “health promotion in Estonia”, “migrants and health promotion” were used in the Internet search engines, in various national and international databases (i.e. Library of University of Tartu) and other relevant web pages. The information was collected from institutional policy documents, ministries concerned with health promotion and migration; legislative texts; scientific articles; scientific survey reports; health promotion publications; media coverage on health promotion and migrants.

Literature analysis included 28 sources which contained information on topics of migration and health promotion in Estonia. It is worth mentioning that national literature with focus on migrants’ participation in health promotion or even migrants’ health in general is rather rare.

Questionnaire survey

Questionnaire survey is not an official part of project's methodology. Because Estonia joined Healthy Inclusion project in February 2009, almost 8 months after it was commenced, our duties in the specific work package (No. 4, interviews with representatives of health promotion providers) were reduced. The main reasons for including this additional data collection and analysis tasks were to compensate the data from insufficient amount of provider interviews and to get a more all-encompassing picture on health promotion interventions, their main target groups etc. The internet-based questionnaire included 17 structured and open-ended questions based on organization and intervention background questions provided in document "Interview guide – Providers"; also a question "Would you like to participate in a longer interview on these topics (health promotion and migrants)" was included to find the respondents for interview phase.

The initial sample included 56 providers whose contacts were found from internet web pages or using data from literature analysis. The sample is not meant to be representative by any criteria, so no direct generalisations can be made. Instead we tried to include many different kinds of organizations, interventions and target groups to explore the field of health promotional activities in Estonia.

Questionnaire was active between 30.04- 25.05.2009. We got a total of 34 answers and this data was used in chapter 1.3 *Health promotion in Estonia*.

Interview analysis

The selection of respondents for qualitative interviews was based on the questionnaire survey while also taking into account the inclusion criteria of health promotion providers:

- General local health promotion providers, i.e. for the whole population, not only or not specifically targeted to migrants in general or specific migrant groups.
- Offering health promotion interventions. Health promotion is directed to the promotion of health: improving lifestyle, living conditions, physical and social environment, quality of life. It is not directed or directly directed to prevention of disease (risk factors and symptoms). Important strategies are participation and empowerment.

- Health promotion interventions in which migrants participate (examples of positive experiences and good practices but also examples of negative experiences). We suggest also including interventions specifically developed for migrants as examples. Specific interventions are a mean to improve access for migrants. Focus should be put not only on hindering and conducive factors but also on solutions (strategies).
- Interviewees must have (hands-on) experience with health promotion interventions and/or a sufficient overview of activities and policies of their own organization.

Two focus groups inside the project research team were held to specify these selection criteria and adjust these to local circumstances. The main conclusions were:

- Included health promotional interventions should aim at important public health issues (risk behaviour, substance abuse etc)
- Interviewed providers should represent the different fields, topics and structures inside health promotion settings.

A total of 6 semi-structured qualitative interviews were conducted[1]; respondents were interviewed between June and July 2009. The duration of interviews varied between 40 minutes to 90 minutes. All interviews were recorded and transcribed[2]. Thematic analysis was performed using qualitative analysis software Atlas.ti.

1.3. Health promotion in Estonia

The National Health policy until 2010 (*Eesti tervisepoliitika aastani 2010*) statesthat ”Health is the most important personal and national resource and the best health possible belongs to everyone’s basic rights. Everyone should have an opportunity to make healthy decisions which are a prerequisite for society’s prosperous social and economic development”. The overall objective of the health policy (*Rahvastiku tervise arengukava 2008-2020*) in Estonia is to create opportunities and conditions in order to achieve a healthy life with an average

[1] Reduced number of interviews because Estonia joined Healthy Inclusion project as a partner in February 2009, more than 7 months after it was commenced

[2] Analysis was conducted in Estonian; interviews with Russian speaking respondents were transcribed in Russian and then translated into Estonian.

of 60 for men and 70 years of age for women and to increase average life expectancy for men up to 73 and for women 80 years of age by 2015.

In order to achieve these public health milestones, the importance and role of health promotion is widely recognized both by policy makers and health professionals. The aim of the national health promotional structure is to develop priority fields in health promotion both on local and governmental levels; commencing, coordinating and evaluating of these programmes and creating health promotion networks and developing inter-sectored collaboration. These tasks are fulfilled by the National Institute for Health Development (NIHD) which is administered by the Ministry of Social Affairs and by Estonian Health Insurance Fund (EHIF).The main health promotional subject field of NIHD includes:

- Promoting the health of children
- Prevention of cardio-vascular diseases
- Prevention of neoplasm
- Reducing alcohol consumption and its negative effects on population's health
- Prevention of HIV/Aids
- Prevention of tuberculosis
- Developing health promotional networks
- Regional development

NIHD administers and coordinates the work of health promoting networks. These include "health promoting schools", "health promoting kindergartens", "health promoting hospitals", "health promoting cities" and "health promoting workplaces".

The programmes funded and coordinated by EHIF are part of Estonian Public Health strategy. EHIF also supports various health promotional campaigns and projects which are targeted to health of children and adolescents and improving health awareness and life-style of adults while supporting the improvement of overall healthy environment. The long-term priorities of these health promotional and disease prevention projects are:

- prevention and early detection of cardio-vascular diseases
- early detection of malignant neoplasm
- prevention of injuries and poisonings

- prevention of alcohol-related health damage
- activities oriented to healthy development of children

Health-promoting activities and strategies on the regional level are organized by the Health councils and Health rooms. These health-promotional structures were formed in 2005. Health councils include representatives of regional and local governments and members of sub-committees (injury and drug prevention etc.) and health professionals. Health councils (a total of 16) are funded from the governmental budget through NIHD. The mission of regional Health council is to secure the implementation of national health programs and strategies and to develop a regional action plan.

Health rooms are non-medical, methodical offices for regional health promotion specialists. The main tasks of regional health promotion specialists include coordinating and implementing national health strategies in cooperation with local governments and different networks. Health rooms are functioning in each county and in three biggest cities (a total of 19).

Non-governmental organizations are important stakeholders of health promotion (in local level). These include both profit oriented and non-profit organizations. Many national health promotion programmes (i.e. EHIF projects) are organized under public procurement rules, so the interventions where NGO-s participate are often closely related to national health policy priorities. NGOs are also involved as service providers in local level with collaboration of local government, regional health councils etc. Health promotional initiatives are very often related with prevention activities (i.e. psychological counselling and rehabilitation for drug addicts, psychological counselling on topics of sexual and reproductive health, healthcare service in schools etc.). Therefore the role of NGO-s in health promotional activities can not be underestimated.

Health promotion interventions are available to ethnic minorities – initiatives and services are often (considering ethnic composition of different regions) available both in Russian and Estonian. Majority of the publications and campaign materials (leaflets, posters, web-based materials) are also bilingual. Health promotional networks (schools, workplaces, kindergartens) include also both Russian and Estonian speaking individuals/organisations with work language.

Based on the literature review we found no information about health promotion initiatives targeted to migrants exclusively.

1.4. Migrants in Estonia

Nowadays, Estonia is a multiethnic country with inhabitants from over 100 ethnic groups. In January 1st 2007 the total population of Estonia was 1 342 409 from which 921 062 (68. 6%) were Estonians and 421 347 (31. 4%) people from other nationalities[3] . Ethnic composition of Estonia has strongly transformed by the historic events of the 20th century. Before World War II, ethnic Estonians constituted 88% of the population. After annexation by the Soviet Union in June 1940 and occupation in 1944, rapid inflow of foreign born migrants began, peaking 1960-1980s. 1989 census showed the decrease of ethnic Estonians to 61.5% of total population. The beginning on 1990s showed a rapid increase in emigration which declined by the end of 1990s (Tiit 2004). Although immigration has increased since 2004 when Estonia joined the European Union, the overall migration balance is still negative (emigration surpasses immigration).

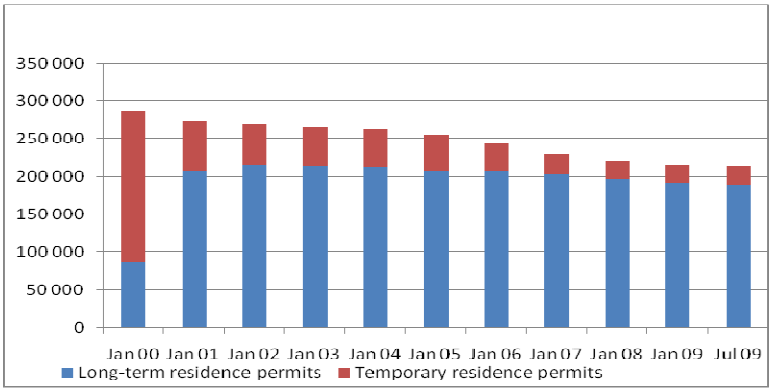
Due to a low reliability of resident data and to absence of mandatory residence registration requirement until 2005, the Statistics Estonia did not include migration events in the population estimation in 2000-2008. In 2009 first data over 8 years taking account of migration events was published revealing that migration events have decreased the total population (in period 01.01.2000-01.01.2008) by 16 000 people[4]. In the period 2000–2007 the total number of immigrants was 10 326. The mean age of immigrants was 35 years. 43% had Estonian citizenship, 15 % had Russian and 5% Ukrainian citizenship. Main countries of origin were Finland (re-immigration of Estonians) and Russia but also Ukraine, Germany, Sweden, Latvia and Great Britain. Main reasons for this increased immigration were improved economical situation and membership of the EU.

[3] Biggest groups are 344 280 Russians, 28 158 Ukrainians, 16 133 Byelorussians, 11 035 Finnish and 21741 other ethnicities.
[4] Migration data from other countries indicates that these migration estimates might be underestimated (Ainsaar, Maripuu, Eesti rahvastik 2007-2020)

Migration is strongly influenced by regulations of country's migration policy which in the case of Estonia has been conservative due to already high proportion of foreign born people. From the beginning of 1990s Estonia has implemented yearly immigration quota which in 2008 was increased from 0.05% to 0.1% of permanent population. The immigration quota does not apply on citizens of the EU and OSCE member states, Estonian citizens and their family members, refugees and citizens of the USA and Japan. The immigration is regulated by the Citizen of European Union Act, Law on Aliens and Law on Citizenship and Act on Granting International Protection to Aliens.

The Citizenship and Migration Board of Estonia (CMB) is responsible for the receipt and processing of applications for acquiring and restoring Estonian citizenship, acquiring residence permits and processing asylum applications. According to CMB 216 345 valid residence permits were issued as of January 2009 (see table 1 & 2 for details). The main reasons for immigration were related to family migration (1572 people in 2007). Also people who got their residence permit according to international treaties and work related migration were important reasons for approving applications of residence. The biggest group attaining residence permit was of Russian origin.

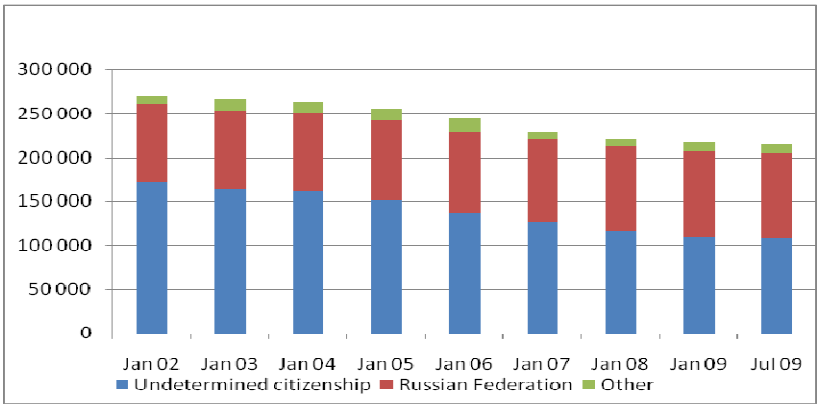
Table1. Number of valid residence permits by type



Source: Citizenship and migration board,

Available online: http://www.mig.ee/index.php/mg/eng/statistics

Table2. Valid residence permits by citizenship



Source: Citizenship and migration board,
Available online: http://www.mig.ee/index.php/mg/eng/statistics

Actual number of immigrants may vary because it is difficult to estimate the amount of illegal immigrants. According to CMB, in 2005 there were 2618 misdemeanour procedures associated with illegal stay and 428 cases related to illegal employment. Asylum seekers represent only a marginal part of total immigration, from 1997-2009 there has been 140 applications for asylum from which only 11 were granted and 12 were granted a subsidiary protection.

The main problems of immigrants are related to aspects of language and citizenship, unemployment and other unfavourable socio-economic conditions which might be related to their legal status, cultural differences and other migration related factors. Because the vast majority of foreign born migrants in Estonia originate from areas of former Soviet Union the international policy is oriented towards this subgroup. Integration strategy 2008-2013 has set a number of milestones to improve command of Estonian language among ethnic minorities, support their participation in the public sphere, increase social contacts among different ethnic groups, reduce the number of people with undetermined citizenship and reduce overall inequalities in wages and employment levels. Also increasing social trust between ethnic groups is an important goal.

A recent study on attitudes of ethnic minority[5] indicated that the majority of non-Estonians are generally satisfied with their life and believe that life will get better in the near future. Non-Estonians with Estonian citizenship are overall more optimistic than those with Rus-

[5] Mitte-eestlaste perspektiivid... (Perspectives of non-estonians)

sian or undetermined citizenship. Non-Estonians with Estonian citizenship have also better command in Estonian and they associate their identities more with Estonia and Europe. Generally, surveyed non-Estonians think that in order to become successful it is important to have proficiency in three languages – English, Russian and Estonian.

Generally very little is known about the health of the migrants. As terms 'migrant' and 'ethnicity' (or nationality) differ significantly, the results from national health surveys can not be generalized to migrant population. Various studies have indicated the overall health status of non-Estonian minority being worse than that of native Estonians. Ethnic differences are present in mortality; also non-Estonians have lower life expectancy at birth which is related to higher incidence of risk behaviour and substance abuse etc. Psychological aspects of economical and social uncertainty and insecurity of immigrant status might be one of the prerequisites of higher suicide rates among ethnic minority groups.

Access to healthcare services and health insurance is related with person's legal status. Health insurance applies for people who are permanent residents of Estonia or people living in Estonia on the basis of a temporary residence permit for whom a payer of social tax is required to pay social tax or who pays social tax for himself or herself. According to the constitutional law, emergency medical care will be provided to everyone despite their nationality, citizenship, or presence of health insurance.

1.5. Health promotion providers and interventions

A total number of 6 interviews with health promotion providers were carried out.

A relatively small number of interviews planned to be carried out within the Healthy Inclusion project which implied that the selection of providers should be made with high attention on inclusion criteria and on various aspects of the local health promotion setting and its main hotspots. The interviewed providers represent different types of organizations and their interventions are related to different fields and topics inside the public health field.

Organization: Selected service providers represented the national public health research centre (1), regional level health promotion coordination centre (1), a limited-liability com-

pany providing health care services (1) and non-governmental organizations providing health care and education (1), anti-alcohol campaigns and rising of awareness (1) and psychological counselling and therapy (1).

Funding: National and regional level service providers are funded by the government or local government budgets. Financing of NGO-s is more complex: those providing specific healthcare services (i.e. psychological counselling or replacement therapy for drug addicts) get funding either from the state or the local government budget. Majority of resources come from different international and national funds and are project-based.

Location and setting of intervention: Included organizations and their interventions were local except in the case of National Public Health Research Centre which is responsible for coordinating and planning of nationwide initiatives. Three interviews were conducted in Tartu (Southern-Estonia, 2nd biggest city in Estonia), one in Tallinn (the capital) and two in North-Eastern Estonia, a region with specific issues of drug-abuse and high HIV prevalence in big Russian-speaking communities. Settings depend on the type of interventions, target group and methods used. Although no direct generalizations can be made on the settings of interventions because health promotion is highly differentiated field, many NGOs providing health promotion initiatives contact their target groups through schools, workplaces, community centres etc. Also, Internet is used as interactive platform for health promotion interventions.

Migrants as participants: Migrants are not considered as a target group differing from overall population. All interventions are aimed at general population (except in the case of intervention providing rehabilitation treatment for drug addicts) while considering the ethnic composition of the area where interventions are provided.

Important types of interventions: Most interventions provided by the interviewed respondents include seminars and workshops about health education, psychological counselling, rehabilitation of drug addicts and various information events with the focus on different aspects of health and health behaviour.

2. Participation of migrants in health promotion interventions (provider/intervention level)

2.1. Types of interventions

From our questionnaire survey's[6] responses (n= 34) 11 represented public and 22 non-governmental non-profit organizations, one was a limited liability company. Most interventions were related to sports and action programmes, health education and various aspects of social health. The interventions were directed mostly at children (mentioned by almost 60%) and to whole population (38%). Interventions targeted at socially marginalized and disadvantaged people and people with disability/chronic disease were less common. Seminars and lectures were often used methods; „street work" and internet based services were more seldom. Frequency of interventions varied, in the case of sports associations, activities were conducted regularly (from every day to 2-4 times a week); project based interventions (i.e. health education programmes in the form of seminars and lectures) were also conducted perennially but were provided less often. The number of participants is related to the specific intervention, provider and target group. For example one provider of school healthcare reported its target group as big as 20.000 pupils while most of other providers in the field of health-education reported the number of participants to be from 20-150 per event. These numbers vary greatly because evaluations are often based on subjective estimations and no statistical account has been held.

2.2. Concepts of Health Promotion

According to the survey data answers on awareness of theoretical foundations and concepts of health promotion differentiated between public/health education providers and more action-oriented interventions. Organization providing health education and those of public service had more elaborated and complex understanding of theoretical foundations of health promotion (reporting "holistic", "social epidemiology", "regional development",

[6] The sample of this questionnaire survey is not representative to Estonian health promotion service-providers nor does it accurately describe the organisational structure and interventions used by the practitioners. No studies matching these criteria were present at the time of writing the report in this field . Therefore these results may only be interpreted with caution to underline some of the possible trends in the health promotional settings in Estonia. This survey was conducted to compensate the data obtained from literature review and qualitative interviews.

”health belief model”, ”empowering approach” etc) while intervention providers related to physical activities reported often ”sports theory”, ”supporting sporty lifestyle”. The answers to the question concerned about organizational problems related to health promotion initiatives brought up financial problems as a main difficulty. Other concerns were related to missing evaluation or lack of qualified staff/volunteers. Interventions and measures used in health promotion were generally seen as moderately effective. Main criticism was addressed to disjointedness of project-based interventions which was related to unstable funding and lack of central coordination. The overall concerns related to health promotion interventions:

”There are too few efficient health promotional interventions and there is no systematic approach to health promotion. Actions are divided between many several stakeholders whose cooperation is minimal.” NGO providing health education

”Actions should be systematically planned at every level; they should be more self-sufficient and continuous. Evaluation of efficiency should be inseparable part of (health promotional) actions”. NGO

Proposals and recommendations to improve planning, coordination and conduction included the need for better collaboration and more stable funding:

”Project-based funding should be no more than 50%. The rest should be provided by the governmental funding”. NGO, HIV prevention

„…to avoid one-time projects, to energize collaboration between organizations who are pursuing the same goals“. NGO, health education

The continuity and collaboration inside the sector were seen as the main keywords for better and more effective health promotion. The need for improved networking between various professionals, organizations and structures both in coordinating and commencement phases was the main proposal of questioned health promotion providers.

2.3. Actual participation of migrants in the interventions

Intervention level: The majority of health promotion providers do not consider migrants as a special target group. It is perceived that migrants do not need special attention or special policy to improve their participation in health promotion intervention. Although respondents mentioned some cultural differences between Russian-speaking minority and Estonians, these differences are not major. Ability to speak native language is a sign of a person's integration into the society. The main attitude is that once a person can speak Estonian, he or she can participate in health promoting interventions:

"I cannot really say that we see these as different things when an employer has employed this migrant, then after all he/she can automatically use all the possibilities of that work environment, it is in a form of massage as a health service that many companies offer, or some kind of rehabilitation arena, or then the good furniture or good computers or the opportunity to eat healthy food. So I can't see the distinctiveness in it." R5Q01

Even such a small sample of providers revealed different action patterns in a situation where migrants are not seen as a special target group. One of the approaches is based on the responsibility of a person. The person should make effort himself to participate in the intervention. In the case of different ethnic groups such an effort is usually language competence. Everyone is accepted as a client once he understands language and can take part in the intervention:

"In principle, nevertheless, they still could if they wanted themselves." R3Q01

„There is the language acquirement demand and therefore there should not be any complications/obstacles to the access of migrants" R2Q01

Another approach we found accepts a person the way he or she is and guarantees unconditional participation in the interventions. It is acknowledged that due to different socio-economic factors migrants have disadvantaged position in the society. First of all, this serves the interest of the society as a whole to provide support to these people and to include them in health promotion activities. In these cases the provider finds the way to communicate with a person in his or her native language so it should not be an obstacle to

participate in the intervention. We found such an approach working, for example in the case of an NGO providing psychological counselling/care:

„Yes, all on equal terms. We believe it is sufficient if the person is registered in the city of Tartu. And if, for example, was a student in crisis... he still gets help regardless of what language he speaks, even in Finnish. R6Q01

In general, on the practical level health promotion organisations in Estonia take the existence of two communities into account. Even if there is no active policy or regular actions aimed to improve participation of migrants in the interventions, in every particular case when migrant seeks help or would like to use services of the provider, a solution will be found.

For one of the interviewed service providers mainly Russian-speaking people are the target group. This is the case of an NGO providing substitution treatment (methadone) for drug addicts. In general, risk behaviour and problem such as drug abuse and HIV are associated with migrant population. High level of unemployment, widely spread drug abuse and high level of HIV among the population are problems of north-east region where proportion of Russian speaking population exceeds 90%.

„In general, in those regions that I know they are exactly involved in areas such as AIDS and drug addiction where they are dealing with this area of health promotion.“ R4Q01

This fact that drug-related problems are associated first of all with migrant population resulted in the situation were rehabilitation care is mainly provided in Russian and concentrated in regions were proportion of Russian-speaking population is high. However, in some other regions that are not considered problematic, rehabilitation services for drug addicts are not provided at all. Drug addicts from these regions who need rehabilitation are sent to North-East Estonia where services are mainly provided in Russian language. This situation may result in high drop-out rate of native people and could be seen as discriminating against this group.

"And Estonian speakers, they do not drop out... or at all do not take part in groups... in the field of drugs...at the Youth Centre... well, they live there, the youngsters are 13 to 18 years old, then the situation changes, there are a few Estonian speakers altogether. Although I had to work with Estonian groups, i.e. if there sits 15 people, then there might have been Estonian speakers too, up to 80% and some Russians. And all of this proves that our region is covered but there it is not at all, there is Tallinn. Tartu. Pärnu..." R1Q01

2.4. Hindering or conducive factors on the intervention level

On the intervention level the main hindering factor reported by the providers was the existence of two **different informational spaces.** One of the factors mentioned by the providers is the separation of Estonian and Russian speaking communities. This is especially true when we look at the informational spaces each community lives in. Russian speaking community often watches Russian TV channels, reads Russian newspapers, receive education in Russian and in every day life they mostly communicate with compatriots. The result of such separation is that the Russian speaking minority can not reach information (or information can not reach them) about available health promotion interventions. These different informational spaces can have an effect on attitudes towards health behaviour and health promotion.

„That it is not speaking the language or the unwillingness to obtain the information in another language], it certainly is like an obstacle, you will not get all the information that might be very useful or valuable for you." R5Q02

"This modern information that develops Estonian youth, perhaps does not reach the Russian youth as quickly, this might be the problem. Also the people that work with Russian youth, the medical personnel, school nurses, they still get their education in Russian too and they speak-socialize in Russian so they too will not get this new, up to date information. To a large extent, it is the language that holds back migrants." R4Q02

It is believed that temperament and behaviour of the Russian speaking minority differs from the general population. Some providers consider this as an important factor which is influencing health behaviour and participation in health promotion interventions. In several interviews health behaviour of Estonians and Russians were contrasted.

"The Russians are in this sense (sex education) very accurate and controlled, they come to study the contraceptives when there is an opportunity and when they get it (the information) in their own language, it is very easy for them to hear." R4Q03

„Lets say among my acquaintances, the people that I have worked with, Estonian elderly are more interested in health than Russian elderly." R4Q04

There is also an understanding that attitudes and behaviour are not so much related to the ethnicity as to the personality, social status of a person and other related factors.

It is not about the nationality, it depends on the personality and some values and attitudes and well, I think that it is not about the nationality. R5Q03

Conducive factors

The separation of two communities and lack of sufficient knowledge of Estonian language are the main barriers to participation of migrants on the level of intervention. From our interviews we learned that conducive factors are mostly related to diminishing this gap between communities. Among those mentioned the most often was the ability of providers to speak Russian language. During soviet period Russian was the official language and therefore compulsory to learn in Estonian schools; for that reason older generation can speak Russian quite fluently. Our respondents told us that the usual practice is that when one of the staff members cannot speak Russian they often turn to their older colleagues or to some Russian native speakers for help.

Employment of native speakers is another conducive factor. To improve the participation of Russian speaks, staff members with similar backgrounds are employed by the providers. In some cases when specific target group is consisting mostly of Russian-speakers e. g. all members of staff in an organisation interviewed for this project offering substitution treatment in North-East Estonia are Russian speakers . From the point of view of a client it is a very beneficial situation. However, such provider organisations are in worse position when applying for grants to financially support their activities. Their knowledge of Estonian lan-

guage is not good enough to compete with native speakers. Regarding provider organisations where working language is Russian, one issue should be mentioned here, although it is more related to the policy level rather than to the intervention level. Situation when not only migrants but also providers cannot participate equally in the health promotion activities in the country due to insufficient command of Estonian language is taken into account by organisations providing training for providers. Information and sometimes trainings and lectures for staff are delivered in Russian language.

In general, it is common practice for providers to translate information about the interventions to Russian and other (English, Finnish) languages. The information translated includes announcements put on the mailing lists, web sites, leaflets and booklets.

From the interviews we can conclude the importance of one more factor: provider's cooperation with educational institutions. Providers stress the socialising and integrating role of educational institutions. On one hand, schools can incorporate knowledge on health promotion into their educational programs. On the other hand giving special lectures or seminars at schools gives providers good opportunities to reach their target populations directly. Providers reported that students evaluated such meetings with health promotion specialists as very beneficial.

Life conditions of migrants that could be hindering or conducive

Ethnicity and religion. Factors related to ethnicity and insufficient knowledge of Estonian language was already discussed above as the main factors hindering access of migrants to health promotion. Religion does not play an important role in everyday life of both communities and was not discussed in the interviews as a relevant issue at all.

Age. Providers did not report many differences between young people of different ethnic backgrounds. However, one interview realized differences in health attitudes of older generation that have been mentioned: it was said that Estonian seniors care more about their health that Russians.

Socio-economic status. An important hindering factor for migrant population is their lower socio-economic status. Our respondents reported lower socio-economic status of migrants as a risk factor for unhealthy life styles. For example, providers' experience shows high proportion of drug addicts with problematic family background.

"...As a rule, young drug users come from an asocial family. Not in 100%of the cases but still 60-70% of the time. That is if they grew up without parents, with a single mother, with a grandmother." R1Q02

Due to insufficient language skills migrants have limited access to skilled work and education. This results in lower socio-economic status. In the current economical situation when unemployment is growing, migrants have a higher risk of loose their job. Even when person has a job there is often perception that he or she will be first to become fired due to their ethnic background. Such perception causes permanent psychological stress and brings down the quality of life.

„However, my empirical observations of the representatives of other nationalities show that now when unemployment is also growing and ordinary people too cannot find work, for these ethnic people finding work is even more difficult. /.../ another thing is also language skills and some institutions, in principle ...they do not employ people from another nationality, he does not have to be Russian, if he does not speak Estonian fully then he is not employed /.../" R4Q05

Some health promotion initiatives such as for example network for healthy work environment are available for people working at firms or organizations belonging to the mentioned network. As a rule, those are more advanced businesses with sufficient income and higher salaries for employees. However, not many migrants are employed by organizations of that kind which limits migrants' access to such interventions.

3. Policies of organisations to improve participation of migrants (organisational level)

3.1. Organizational policies

Based on of our interviews we can distinguish between three patterns in organisational policies to include migrants in health promotion interventions. **First** of all, migrants who are integrated into Estonian society (speak the language, attend a school or a university, have a job) can participate and do participate in the health promoting interventions. This includes interventions such as promotion of healthy work space, lectures, seminars, and other kinds of information about healthy life styles, health risks etc (or in other words, what we could call proactive interventions). As a rule, in these programs migrants are not seen as a special target group but in some cases (e.g. when Russian speakers constitute majority of the population in that region like in North-East Estonia), information about interventions is distributed in Russian language also. Participation in these interventions requires an active attitude of the migrant – he or she should seek for the interventions available and make an effort to reach it. It is perceived that except their ethnic background and language competence these migrants do not differ from the general population.

„I would not say that they are different, for me, they are all representatives of a particular company or agency that their work environment has chosen them to his organization to represent them in this network and they participate in our training, they all get the information through me, they have the opportunity to use our web-materials, so I do not see any differences.“ R5Q04

An example of the second pattern of migrants' inclusion is psychological care/consulting provided by the Tartu Counselling and Crisis Help Centre. This approach also stresses the equal treatment of all people. However, it is recognised that due to their situation migrants are in a disadvantaged position and necessary steps are made to provide services in languages spoken by migrants.

„There is an attitude that when the environment is good and a person just needs to gather information then he is himself adoptable. This is just the group [migrants] that need socially more active environment that would create opportunities." R6Q02

As it was reported in the interview the background of migrants who turn up for help is often somewhat different from those recognised in the first pattern. These are people who have been living in Estonia for 15-20 years or even longer but still cannot speak the local language, cannot accept their minority status and are not accepted in the society. On one hand these people have legal status, have access to medical services. On the other hand their situation results in higher probability of unemployment, lower social status and limited participation in the life of the community. This in turn results in psychological tensions and stress.

Another group of migrants discussed in the interview with the representative of the Counselling Centre are newly arrived immigrants. These are people who came to Estonia after 1991. Although ethnic background and spoken language of both subgroups is similar, this second group is more loyal to Estonian state and society in their attitudes, tolerance and readiness for integration. However, this group has problems as well with integration to Estonian society and adaptation with their new living environment causes stress.

Information about availability of psychological counselling is distributed in two languages: Estonian and Russian, website of the Counselling Centre is also available in English. Leaflets are distributed in libraries, hospitals, day care centres. Sometimes general practitioners will send their patients to the Counselling Centre.

The **third** pattern of intervention in which migrants participate are services targeted at the special groups with risk behaviour – drug addicts, HIV positive people, ex-prisoners or prostitutes. For this project we interviewed an NGO "Corrigo" who provides substitution treatment for drug addicts and rehabilitation for juveniles with drug problems. Nearly all clients as well as personnel of this NGO are Russian speaking population living in North-East Estonia.

"There are Estonians, too... /.../ not as much... 5% I think... We have not checked the national background so directly but not as many as Russians but Russian speakers come here. And Estonian speakers, it is not that they drop out... they do not attend at all" R1Q03

Many migrants are second or even third generation. However, they still cannot speak Estonian language. Due to their addiction their health status is very low: many of them are HIV positive, have hepatitis B or/and C, have other health problems.

"They work; more than half of them work. But mostly, however ...somehow unofficially...temporarily... Unofficially because they have debts...and they can not work legally. Debts as much as 100 000...mostly on constructions...cargo transport, work on road-constructions, very many of them work on road-making." R1Q04

In case of substitution treatment program the information about intervention is spread through different channels, including GPs, experts for infections, probation officers, social workers, various NGOs and social networks of the target population.

3.2. Hindering or conducive factors on the organisational level

It was already mentioned in the previous section; probably the most important factor to include for most disadvantaged groups of migrants is provision of services in their native language. Our analysis demonstrated that employment of personnel with similar backgrounds helps very much in this respect. Similar cultural background guarantees higher level of trust between the provider and the client. In the employment of migrants it is important to demonstrate that migrants are recognised as equal partners in health promotion.

The interviews revealed the existence of several policies that help to improve participation of migrants in health promotion activities. We mentioned the employment of migrants as staff members in health providing organisations as a conducive factor. This overall positive tendency has its own risks. There are cases when the whole staff of health providing organisations consists of Russian-speakers only. Insufficient knowledge of Estonian language could be a hindering factor for including such organisations in the total network of health promotion institutions. Such organisations may find themselves in the knowledge

vacuum. Our research shows that some steps are done to overcome this threat. For such organisations health promotion related information and trainings are available in their native language.

"Information Day was arranged so that there was an organized translation so that language was not an obstacle. Materials were both in Estonian and Russian and presentations had translation." R5Q07

Our respondents found different kind of relationships/networks on different levels very useful. For example, they mentioned partnerships with health care departments and/or social welfare/care departments as being very supportive in their everyday work. Respondents also mentioned their personal networks to be an important resource. One more kind of networks mentioned in the interviews were professional networks that include other health promotion providers working in the same field – e.g. network of youth counselling organisations or health promoting workspaces - to mention just a few.

"Planned Parenthood Association has gathered all these youth counselling cabinets and services under its wing and its staff is continually being developed through training so that there are gynaecologists as midwives who provide professional information. There is also information about it also in schools." R4Q10

Among hindering factors which are influencing organisations there is situation where funding they receive, as a rule, is project-based. This creates a situation where the very existence of organisation every year is not assured.

"But this is not consistent because project ends and this is over also, so still those national programs and projects should change but what is important in programs and national funding is that it should be more effective, that it would not just be spending the money on something but there should be an outcome, too /.../ Health is the place where it pays off to invest in it. And this should be done skilfully and effectively." R4Q06

4. Governmental policies to improve participation of migrants (institutional level)

4.1. Governmental policies

Interviewed providers did not report any specific government policies aimed at improving participation of migrants in health promotion interventions. Increasing overall impact and scope of health promotion interventions targeted to migrant-population is not mentioned as a goal in the population's health policy documents and therefore this field of action is rather poorly coordinated. Majority of interviewed respondents reported that they had previously had little or no contact with specific institutional level policies and that inclusion of migrant population in health promotion interventions is seen as a matter of responsibility and adeptness of providers themselves.

> *"I would not say that there is some kind of policy. It is more like health promoter's own business how she gets to the migrants." R3Q02*

> *"No, there is not, not even for once I have heard that there would be some kind of inclusion of migrants. That is why it was interesting for me to read it, got it yesterday and it is quite an interesting issue and very interesting." R4Q07*

One of the most influential policy documents regarding inclusion of migrant population is Estonian Integration Strategy 2008-2013. It addresses topics of health and health promotion only briefly stating that equal opportunities for health promotion are among important prerequisites required for an effective and successful integration process. Nevertheless, the Action Plan of Integration Strategy 2008-2013 does not include specific measures and actions directed at the inclusion of migrant population in health promotion interventions. Other relevant policy documents (i.e. the Population Health Development Plan 2009-2020) are regulating issues of migrants' health in national level only indirectly through frameworks of education, social policy etc.

Although various policy documents on national level are influencing health promotion interventions and the selection and inclusion of target groups, the perceived impact of these

government policies on everyday work in the field of health promotion is, according to the interviewed providers, rather meagre.

One important aspect regarding government policies was in the interviews often referred to as the “broadness” of health promotion. Health promotion covers many different fields of health, encompasses different target groups and methods of intervention. Although respondents claimed that general institutional policies are lacking, many different professional guidelines and policy documents are applicable when tackling specific health issues, i.e. prevention of HIV/AIDS, cardiovascular diseases and injuries which are currently important topics in the health promotion in Estonia.

”This health promotion is such an extensive topic but at the end it is assigned to preventing drug abuse, HIV and AIDS, these are the issues that are in focus, their communities... R3Q03

4.2. Hindering or conducive factors on the institutional level

Majority of hindering and conducive factors on the institutional level perceived by the interviewed providers are related to categories of accessibility, integration and continuity of interventions. Lack of resources in general is seen as a major hindering factor for further inclusion of migrant population. Although majority of interventions are free of charge for the participants, the limited resources of government funds prevent further campaigns and programmes targeted at migrant population.

If there were resources, I believe that it would be easier, too. If there are resources and funds in some form also in the national level to make some sort of separate campaigns for them (migrants) ... in their own language and directed at them. R3Q04

The problem with continuity of interventions in project based funding schemes is common. Besides inconsistent provision of health promotional interventions, it also has negative effect on development of healthcare system as a whole. Clearly more coordination from institutional level and continuity of national programmes are needed.

" I see this as a very serious risk that if the continuity is interrupted, it is definitely a major obstacle to health promotion and to the development of the system as a whole including the part related to migrants. R5Q05

"But it is not consistent because project ends and it is over." R4Q09

To be efficient and effective health promotion interventions need constant analysis of feedback and if required, re-orientation of priorities and practices to meet the needs of its target groups. Current state of national level monitoring and evaluation of health promotion programmes is generally seen satisfactory and can be interpreted as a conducive factor. Nevertheless, this applies only to national programmes; evaluation practices in many grassroot initiatives provided by the NGOs are often insufficient.

Monitoring and evaluation certainly favours feedback collection and analysis allows drawing conclusions of effectiveness so far and then we have more to go on with. R5Q06

Overall priorities of the government, particularly in the healthcare system, have considerable effect on effectiveness of health promotion interventions. Prevention measures are important to secure health of the population but the focus of health policies on health promoting activities is vague according to interviewed providers. More attention to health promoting initiatives from institutional level would save resources in a long run and improve the health status of all population groups, including migrants.

Everything is still stuck with the money, priorities, what are the priorities in the society. Is it important for our country or not. Do we want them to be healthy, do we use the money that the state has given us effectively so that we do not have to spend it on people with diseases later on, when a person is sick then there is no difference whether he is a migrant or not, he has to be treated anyway. R4Q08

Although there is no distinction between migrant population and general population in provision of health care – all people are according to the law treated on equal basis - improved and more focused attention to migrant population in health promotion interventions would be needed.

5. Conclusions

A total number of 6 interviews with health promotion providers were carried out. Small sample size was caused by the fact that we joined the Healthy Inclusion project in February 2009, almost 8 months after the project was originally commenced. Relatively small number of interviews implied that selection of providers should be made with more attention to inclusion criteria and on various aspects of the local health promotion setting and its main hotspots.

This chapter summarizes the findings of health promotion service provider interviews focusing on good strategies and hindering factors in inclusion of migrant population in interventional, organizational and institutional levels

5.1. Provider/intervention level

On the intervention level the main distinguishing factor between general population and migrants was related to separation of Estonian and Russian speaking communities and the existence of two different informational spaces**.** These different informational spaces can have an effect on attitudes towards health behaviour and health promotion as Russian speaking minority could possibly not reach the information (or information can not reach them) about available health promotion interventions. Although majority of health promoting initiatives (with campaign materials also available in Russian) are designed to reach both ethnic groups, the reception differs by interventions offered.

Some providers considered cultural and behavioural differences as an important factor influencing health behaviour and participation in health promotion interventions. In several interviews health behaviour of Estonians and Russians were contrasted but the majority of interviewed providers agreed that attitudes and behaviours are not so much related to ethnicity as to personality, socio-economic status, motivation and other personal traits.

The separation of two communities and lack of sufficient knowledge of Estonian language are the main barriers to participation of migrants on the level of intervention. Conducive factors are mostly related to the capability of integrating these two communities. Providers' proficiency in Russian or staff members with similar ethnic background as the target group is, from the clients' point of view, very beneficial. In general, it is common practice for providers to translate information about the interventions into Russian and other (English, Finnish) languages. The information translated includes announcements put on the mailing lists, web sites, leaflets and booklets.

Health promotion interventions are often targeted at adolescents and carried out by the providers in cooperation with the educational institutions. Providers stress the socialising and integrating role of educational institutions. Schools can incorporate knowledge about health promotion into the educational programs. Special lectures or seminars in schools give providers good opportunities to reach their target populations directly. Providers reported that students evaluated such meetings with health promotion specialists as very beneficial.

Life conditions of migrants and their cultural background might be considered in some cases as hindering factors. Migrants with lower socio-economic status and lower educational level are a target group which is hard to reach and often very problematic. It is also related to employment and insufficient knowledge of Estonian language. Lower socio-economic status of migrants is a considerable risk factor for unhealthy life styles.

5.2. Organisational level

Three patterns of different organisational policies to include migrants in health promotion interventions can be addressed:

- **General approach:** Interventions for general population but also for migrants who are integrated into Estonian society and do participate in the health promotion initiatives. Interventions such as promotion of healthy work space, lectures, seminars, and other kinds of information about healthy life styles, health risks, etc (or in other words, what

we could call proactive interventions). As a rule, in these programs migrants are not seen as a special target group; nevertheless, in some cases information about interventions is distributed in Russian language also. Participation in these interventions requires an active attitude of the migrant – he or she should seek for the interventions available and make an effort to reach it. It is perceived that except their ethnic background and language competence these migrants do not differ from the general population.

- **General interventions with special attention to ethnic minorities:** On the basis of equal treatment of all people it is recognised that due to their situation migrants are in a disadvantaged position and needful steps are necessary to be made to provide services in languages spoken by the migrants. In the case of psychological care/consulting provided by the Tartu Counselling and Crisis Help Centre, information about availability of psychological counselling is distributed in two languages: Estonian and Russian and on the website it is also available in English. Leaflets are distributed in libraries, hospitals, day care centres.

- **Interventions targeted at special risk groups**: Migrants as a subpopulation with higher risk level are often involved as a target group of these interventions. For example interviewed NGO “Corrigo” provides substitution treatment for drug addicts and rehabilitation for juveniles with drug problems. Nearly all clients as well as personnel of this NGO are Russian speaking population living in North-East Estonia. In case of substitution treatment program the information about intervention is spread through different channels including GPs, disease carriers, probation officers, social workers, various NGOs and social networks of the target population.

5.3. Institutional level

There are no specific government policies which tend to improve the participation of migrants in health promotion interventions. The majority of interviewed respondents reported that they previously had had little or no contact with specific institutional level policies and inclusion of migrant population in health promotion interventions is seen as a matter of re-

sponsibility and adeptness of providers themselves. Although various policy documents spread on national level are influencing health promotion interventions and selection and inclusion of its target groups, the perceived impact of these government policies, according to the interviewed providers, on their everyday work in the field of health promotion is rather meagre. Although respondents claimed that general institutional policies are lacking, many different professional guidelines and policy documents are applicable when tackling specific health issues, i.e. prevention of HIV/AIDS, cardiovascular diseases and injuries which are currently important topics in health promotion in Estonia.

Major hindering and conducive factors on the institutional level perceived by the interviewed providers are related to categories of accessibility, integration and continuity of interventions. Also lack of resources in general is seen as a major hindering factor for further inclusion of migrant population. Although most of the interventions are free of charge for the participants, the limited resources of government funds prevent further campaigns and programmes targeted at migrant population. The problem with continuity of interventions in project based funding schemes is common. There is also a need for constant analysis of feedback and if required, re-orientation of priorities and practices to meet the needs of the target groups. Current state of national level monitoring and evaluation of health promotion programmes is generally seen satisfactory and can be interpreted as a conducive factor. Nevertheless, this applies only to national programmes; evaluation practices in many grass-root initiatives provided by the NGOs are often insufficient. Although there is no distinction between migrant population and general population in provision of health care – all people are according to the law treated on equal basis - improved and more focused attention to migrant population in health promotion interventions would be needed.

6. Summary

"Healthy Inclusion" is an international project carried out within the Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, Public Health (EAHC).

The general objective of the "Healthy inclusion" project is to contribute to the increase of participation of migrants in health promotion interventions. The project provides knowledge about barriers to migrant access to health promotion interventions and possible strategies to amend these circumstances in a form of practical recommendations for integrating socio-cultural standards in municipal health promotion interventions.

This report provides the perspectives of health promotion service providers. Objectives of the providers report were attained through literature review of available national literature on topics of migration and health promotion in each participating country and semi-structured interviews with providers of health promotion interventions. An additional internet-based questionnaire on organization and interventions used among health promotion service providers was carried out. A total of 6 semi-structured qualitative interviews were conducted[7].

On the intervention level the main findings were related to different informational and communicational spaces between different ethnic groups. Language barriers and personality traits as motivation have hindering effect on overall participation in health promotion initiatives. Although the majority of health promotion initiatives (with the campaign materials also available in Russian) are designed to reach both ethnic groups, the reception differs from interventions offered. Unfavourable socio-economic circumstances have also a negative effect on migrants' overall health status: this leads to an increasing need for special interventions targeted at specific health risks (i.e. for groups of intravenous drug abusers, HIV positive etc.)

[7] Reduced WP4 because Estonian partner joined Healthy Inclusion project in February 2009, 7 months after it was commenced

The separation of two communities and lack of sufficient knowledge of Estonian language are the main barriers to participation of migrants on the level of intervention. Organisational policies differ depending on the target group. Most of the interventions are intended for general population and are not targeted at ethnic minorities/ migrants although information is often offered also in Russian language. These interventions could be labelled as proactive. Other types of organisational policies include interventions with special attention to ethnic minority and interventions targeted at special risk groups (i.e. substitution treatment for drug addicts, rehabilitation and counselling of juveniles with drug problems)

There appears to be no specific government policy aimed at improving the participation of migrants in health promotion interventions in Estonia. Although various policy documents available on national level are influencing health promotion interventions and selection and inclusion of target groups the perceived impact of these government policies on everyday work in the field of health promotion is according to interviewed providers rather meagre. The main hindering and conducive factors on the institutional level perceived by the interviewed providers are related to categories of accessibility, integration and continuity of interventions. Also lack of resources in general is seen as a major hindering factor for further inclusion of migrant population. Based on the research, we can conclude that more active and profound focus on migrant population in health promotion interventions would be needed.

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Appendix

An overview of the characteristics of the organisations and intervention(s)

Table 1. Organisations

Number	Type of organization	Main financial resources	Groups/populations	Settings
1.	2	5	4,5,9	5
2.	8	3	7,8, 9	1,2,5
3.	2	5	1,2,4,5,6,7,8	1,4,6
4.	4	5	5,6,7,	4,6
5.	2	5	8	6
6.	2	5	1,2,5, 7	5

Type of organization:
1. Community centre or an association; 2. Health care centre; 3. (Adult) educational centre; 4. (Local) project; 5. Doctor; 6. Church related organisation; 7. Sports association; 8. Other

Main financial resources:
1. services; 2. donations; 3. membership fee; 4. payments of courses; 5. others

Groups/populations:
1. women; 2. men; 3. migrants (special groups?),; 4. disabled people or people with a chronic disease; 5. socially disadvantaged people; 6. older people; 7. children; 8. employees; 9. other

Settings:
1. School; 2. Neighbourhood; 3. Sports club; 4. Community centre; 5. Health (care) centre; 6. other

Table 2. Interventions

Number	Type of intervention	Target group	Form	Frequency	Number of participants	Approach
1.	counselling and information, substitution therapy	Drug abusers need of therapy and counselling	Substitution treatment, counselling	Regularly, every day	300-450	CARe method
2.	health education	General population, focus on adolescents	Seminars, courses	Irregularly	Depends from intervention offered, usually 20-50 at a time	Promotion of healthy lifestyles
3.	health education	General population of a county	Seminars, Information events	irregularly	100-300	Health oriented
4.	health education; social health	Adolescents and elderly people	Seminars, consultancy	irregularly	Not known	Holistic
5.	health education	Employees and employers	Seminars, Information events	regularly	Employees of nearly 100 companies, firms etc.	Healthy workspaces
6.	psychological counselling	General population	consultancy	regularly	200-300	Health oriented