AIBR
Revista de Antropología Iberoamericana
www.aibr.org
VOLUMEN 2
NÚMERO 3
Septiembre - Diciembre 2007
Pp. 489 - 517

Madrid: Antropólogos Iberoamericanos en Red.
ISSN: 1695-9752
E-ISSN: 1695-9752

Immigration, health and diversity management: Preliminary developments of a project in neighborhoods of Catalonia.

Dan Rodríguez-García
Universitat Autónoma de Barcelona

Teresa San Román
Universitat Autónoma de Barcelona

Received: 17.06.2007
Accepted: 24.08.2007

DOI: 10.11156/aibr.020306e

Translation: Ignacio González. *La versión original en español de este artículo está disponible en la página web de la revista*

SUMMARY:
This article presents an ongoing research project on immigration, health, and socio-cultural diversity, and offers preliminary information on the theoretical and socio-demographic context of this investigation. The objective of the project, funded by the Department of Health of the Autonomous Government of Catalonia, Spain, is to analyse the socioeconomic and cultural factors involved in health and the access to the formal health system of a few major migrant communities and ethnic minorities living in high-priority neighbourhoods in Catalonia. The results of this project, which will come fundamentally from ethnographic research, aim to give suggestions for improving health conditions for the population and to provide to those professionals working in the public health care system with some conceptual and practical tools for improving intercultural communication between themselves and their patients, as well as for detecting, preventing, and resolving problems in everyday practice.

KEY WORDS:
Immigration, Health, Socio-cultural diversity, Applied anthropology, Ethnography

ACKNOWLEDGEMENTS

We appreciate the cooperation of Miriam Torrens, Irina Casado, Hugo Valenzuela, Óscar López, Virginia Fons, Carmen Méndez, Meritxell Saez Sellarés and, in particular, that of Lucía Sanjuán.

The investigation (*Desigualtats socioeconòmiques i diferència cultural en l'àmbit de la Salut en barris d'actuació prioritària de Catalunya*, Project/Agreement of the research group at Autonomous University of Barcelona GRAFO and the Departament de Salut de la Generalitat de Catalunya) began to take shape in 2005, and was formally concluded in 2009; however work on different aspects carried on for about two years and, to some degree, is still underway.

DAN RODRÍGUEZ-GARCÍA
Lecturer in the Department of Social and Cultural Anthropology at the Autonomous University of Barcelona, (Spain) and Member of the Research Group on Fundamental and Applied Anthropology (GRAFO). Address: Departamento de Antropología Social y Cultural, Autonomous University of Barcelona, Facultad de Letras, Edificio B, 08193 Bellaterra (Barcelona), España. E-mail: dan.rodriguez@uab.es.

TERESA SAN ROMÁN
Senior Lecturer in the Department of Social and Cultural Anthropology at the Autonomous University of Barcelona, (Spain) and Director of the Research Group on Fundamental and Applied Anthropology (GRAFO). Address: Departamento de Antropología Social y Cultural, Autonomous University of Barcelona, Facultad de Letras, Edificio B, 08193 Bellaterra (Barcelona), España. E-mail: teresa.sanroman@uab.es.

1. Introduction:
the project's context, goals and methodology

One of the growing fields of research in anthropology is that which connects migrations and interculturality with the health sector in urban contexts. This article is a concise explanation of an ongoing research project in Catalonia (Spain) on health issues related to immigration and socio-cultural diversity, providing sociodemographic data, as well as context theory. The project is called "Socioeconomic inequalities and cultural divergence in the field of health within priority action neighbourhoods of Catalonia". It is part of an agreement between the Department of Health of the Generalitat de Catalunya (devolved government) and the GRAFO (Research Group on Fundamental and Guided Anthropology). It is made up of researchers and lecturers belonging to the UAB's (Autonomous University of Barcelona) Department of Social and Cultural Anthropology, and is directed by Dr. Teresa San Román. The project lasts two years (its final results will hopefully be available in 2008) and involves ethnographers working in different immigrant communities. It is also supported by UAB's Department of Social and Cultural Anthropology, in cooperation with medical centres and staff.

The project is a part of the *Salut als Barris* (Health in the Neighbourhoods) Program, conducted by the Department de Salut (Health Department); a program, which in turn, is part of the Generalitat's *Llei de Barris* (Neighbourhood Act), that presents a comprehensive action plan focused on high priority areas, in demand of urban, social and healthcare changes. The program's priorities are: 1) the analysis of social and cultural factors which may create inequalities regarding health; 2) cooperation with municipalities and certain medical and community centres to plan, act and evaluate, and 3) to promote community health and illness prevention.

The project's general goal is to disclose and analyze factors that have an impact on the healthcare of immigrants and ethnic minorities living in Catalan neighbourhoods in need of priority action (urgently wanting urban and socioeconomic transformation); to identify the diverse socioeconomic and cultural elements influencing these vulnerable segments of society –located in some of the Health Program's communities. We also wish to unveil factors affecting these people's health, their access to healthcare and their relationship with medical staff. At the same time, we intend to provide training for the medical personnel treating these groups, as well as informing the communities themselves, so they can

actively improve their own quality of life, on a mid or long-term basis. In this sense, ethnographic work, together with reflection and comparative analysis on medical practice, should augment our knowledge and help fulfil the project's ultimate goal, which is to improve healthcare and provide professionals with conceptual and practical tools to detect problems, prevent difficulties and solve potential conflicts; a way of bettering intercultural professional communication and establishing a sense of true communitarian participation. This objective shall be attained with interdisciplinary work by our research team and medical professionals (doctors, nurses, technicians, clerks, etc), especially those directly involved and motivated. Overall, we want our research results to help improve everyday medical practice with immigrants and ethnic minorities; to understand complex cultural, economic and political factors involved in these people's health, and help create a more efficient healthcare system, adjusted to current reality.

In particular, the project aims at developing ethnographic reports to better understand those minority groups and provide them with good medical care. It is a matter of knowing those situations and fundamental problems of a cultural, social, economic and legal type, affecting these communities and their access to medical services in Catalonia, apart from pointing out factors which are detrimental to these collectives' optimal adjustment in this respect. In order to do so, we must:

a. Understand fundamental cultural traits regarding representation, evaluation and behaviour related to the concept of person, body and psyche, the body's components and their interaction; their concept of life, death, and human reproduction, as well as their views on health and disease; what they understand by pain and its causes and the scale and importance with which it is valued; their concept of therapy, of therapists, and their ideal relations with them; their ideas and experiences regarding compatibility of different types of treatments and therapies, from biomedicine to traditional forms of healing or alternative medicine, as well as those models established by WHO in their countries of origin, being public or private; forms of access to these, the possible combination of their uses and different kinds of value and utility awarded to each of them; and to know and evaluate the existence and efficiency of potential support networks in health terms.

b. Comprehend economic, social and cultural situations which have been instrumental in their decision to carry out their migration;

commitments resulting in economic, social and emotional taxation; features of the migration and settlement process; their current situation; how they interact with their place of origin (with their particular ethnic group and with others); community, work and leisure relations with different social and ethnic segments of society, along with ideas and prejudice in that regard; how they experience racism, segregation and other forms of prejudice; until when they plan to stay/return and their assessment and attitudes regarding their origin and destiny. These are aspects which are somehow related to physical and mental health, to the sense of failure or fulfilment, to social integration skills and the use of services and communication abilities. To sum up, variables involved in socio-cultural integration which are crucial to understand how and why people think and behave in certain ways.

c. Assess medical professionals' previous knowledge concerning such issues and jointly identifying those sectors affected on different levels and in different ways; the features, problems and factors which are influential. That is, to understand the background, perception, concern and attitudes of those professionals who work with these minority groups.

d. Create guiding tools in this field for medical staff to consult, and others for patients themselves, as well as for people in their immediate environment. For example, to suggest categories, indicators as well as flexible and appropriate tools for problem detection; a cross-cultural guide for the medical staff, and another for patients. An initial verification of these tools should be done.

e. Carry out an information and awareness campaign aimed at those groups who are subject of research by an interdisciplinary team made up of medical staff as well as GRAFO members at UAB, and other active individuals belonging to civic entities within those neighbourhoods.

f. Provide the Administration with advice on how to deal with these minorities which are culturally diverse, marginalized or at risk of being treated thus. Rationally justified strategies (based on qualitative and quantitative research regarding health problems in their own particular context, empirically and theoretically assessed information) to be developed with the help of motivated health

professionals coming from different social stratums. We would thus establish reliable guidelines and identify counterproductive procedures.

g. Establish a small group of medical staff members with comprehension and cross-cultural communication skills, capable of using data collection techniques as well as to carry out qualitative analysis. Individuals who are acquainted with basic knowledge regarding these groups' culture and conditions, as well as the social, economic and cultural processes they are subject to. Training would be designed to promote dialogue as immediately associated to everyday practice and would contain reflections/thoughts regarding healthcare in specific social and cultural contexts.

h. Set out the foundations for minority groups and civic entities to participate in health programs and actions which may be carried out. Elements to serve as incentives for the awareness of health institutions and to help them deal with problems affecting these segments of society; ways of promoting understanding and cooperation between each other.

Our field of research are some of the neighbourhoods included in the aforementioned program (Neighbourhood Health Program), all of which are low income multiethnic communities, selected due to their ideal conditions for the study's purposes.

The chosen areas are immigrant communities with members from Morocco, Pakistan, Senegal, Gambia, and Equatorial Guinea, apart from Eastern European (mostly Romanian), Romanian and Catalan gypsies, as well as gypsies from other of the nation's regions. None of these groups can be labelled as wholly marginal or socially and economically precarious. The study is limited to those segments which are in a marginal situation or at risk of becoming such. It should be noted that our selection process has been done according to the following criteria: the needs proclaimed by health professionals; groups which are extensively found in priority neighbourhoods; and the existence of some ethnographer involved in the project with enough knowledge to carry out ethnographic research in these communities. According to these criteria certain, some groups were left out from the first study (for example, Latin Americans and Chinese). The chosen neighbourhoods are the following[1]:

1. The ethnographic information collected among groups of Senegalese and Gambian origin are part of previous studies done by Adriana Kaplan and T. San Román, members

Neighborhood	Municipality	Region	Group
Poble Sec	Barcelona	Barcelonès	Romanians and Pakistanls
Collblanc Torrassa	L'Hospitalet	Barcelonès	Romanian gypsies
Sant Roc	Badalona	Barcelonès	Romanian gypsies
Ca n'Anglada	Terrassa	Vallès Occidental	Gypsies and Pakistanis
Parc fluvial riu Ripoll	Sabadell	Vallès Occidental	Romanian gypsies
Can Folguera	Sta. Perpétua Mogoda	Vallès Occidental	Gypsies
Sant Cosme	El Prat de llobregat	Baix Llobregat	Gypsies
Barris Sud	Vic	Osona	Maghrebis
Barri de l'Erm	Manlleu	Osona	Maghrebis
Centre històric	Balaguer	Noguera	Romanians
Casc antic	Tortosa	Baix Ebre	Romanian gypsies
La Mariola	LLeida	Segrià	Gypsies
Nucli antic	Manresa	Bages	Gypsies

FIGURE 1. Group of selected neighbourhoods and collectives.
Source: Prepared by authors from data provided by the Census.

Social and cultural anthropology will provide a methodology for the project: ethnographic methods involving observation and participation, the establishment of a general holistic socio-cultural framework (in origin and destiny, through bibliographical analysis and fieldwork) and the design of specific techniques for collecting information firsthand; elements aimed at understanding health issues within the life and socio-cultural context of these people. It is a matter of converging available statistic data with empirical facts obtained directly from these collectives' reality, on different levels: medical, associations, families, informal encounters, etc. Relevant information to be obtained includes: ideas regarding the reproduction of human beings and the concept of person, the norms and relative uses of reproductive sexuality, ideas regarding mental and

of the research team.

physical illness, formal and informal healing methods, frequent illnesses among specific groups; patients' role during treatment, religious factors which influence the patient and his treatment, etc.

These qualitative techniques shall be flexible and adjusted to the groups' characteristics and situation. They are the following:

a. Direct and continuous observation during the whole project in those contexts of interest to attain a wide comprehension of the chosen groups and situations.

b. Interviews with experts (experienced individuals who deal with these groups' health issues).

c. In-depth interviews with a guide for observing the most interesting issues of our study; issues to be detected during fieldwork and in conversations with medical staff.

d. Focal groups, once we have understood the context, and the selection of participants seems clearly justified.

e. Construction of life history therapeutic itineraries, or starting out from the beginning of their migration, considering their use of public and private medicine, its different types of services and their eventual recourse to specialists on different types of expertise, traditional and alternative therapies, focusing on the form and reasons for choosing and combining these types of resources.

f. Actual and potential support networks for individuals involved in the study (as subjects), so these links and nodes may be utilized for health purposes, apart from their obvious relational functions.

g. Personalized monitoring of certain people with health problems in every context in which they participate (family, neighbourhood, work, health institutions, non-official "medical experts", places of worship or education, etc).

Although emphasis is placed on the qualitative aspect, the program's goals require the use of mixed methodologies, also incorporating quantitative analysis, whose practicality is greater during the final fieldwork stages. At this point, researchers are more familiar with the context and situations which help them establish better quantifiers, without losing sight of

meaning and context. The project is based on a preliminary study of the selected minorities and neighbourhoods, what provides an anthropological interpretation of the pertinent available documents (Neighbourhood Health Program information, as well as other sources belonging to the Generalitat, municipalities involved in the program and other centres, as well as documents regarding programs, projects, reports, etc.). It also includes isolated interviews with key informants (administration technicians, assistants and social workers, health technicians, mediators, local leaders and local health specialists). These activities should provide basic information for comprehensive guidance and direction of the project (data on immigration and minorities) and its specific habitat, in accordance with general social and urban conditions and elements of special interest for the project (for example, family regrouping guidelines, cycles and interaction guidelines in the context of immigration regarding very poor or marginalized gypsies, mobility patterns, etc.).

Concerning ethnography, the selection of neighbourhoods is done based on ethnographic demands of the collectives under scrutiny, focusing on those which may be most culturally and socially inaccessible. Ethnographers carry out fieldwork, without losing sight of particular and general contexts related to problems studied, the meanings and interaction between factors involved. Apart from these, from the start we count on the help of health professionals with sufficient knowledge of these contexts and anthropological and social research in general, so that their presence, as well as their daily problems in health institutions, shall be open to analysis; which will have an effect on their training in this area.

2. Theoretical and sociodemographic approaches

2.1 Health, Immigration and Cultural Diversity

As we will later see, Catalonia is one of the autonomous communities with the highest immigration rate within the State, a trend which probably won't wane in years to come. This is not a passing fancy, but a reality with structural effects (political, economic, demographic and socio-cultural) to be managed, being the most important driving force behind social change ~~-in~~ the short, mid and long-term.

Certainly, this new immigration, and the economic and socio-cultural diversity issues it brings forth, creates citizens' general demands which are to be met, and has become one crucial element which, jointly with ageing of the population and changes in salaried work and family roles, is basic for the new social healthcare scenario in Catalonia. This interac-

tion between groups of different origins doesn't only affect the economic and labour sector, but creates a new reality in the health sector, with the emergence of new and important challenges, requiring new strategies and proper management. Unlike other countries such as USA, Canada or England, better accustomed to international immigration, its repercussions on the Spanish healthcare sector have just started to be analyzed. In this context, it is more common to hear about: multiculturalism in the health sector; cross-cultural medicine and nursing; ethnonursing; medical pluralism; conciliatory or hybrid health system (*versus* biomedical or allopathic); holistic and conciliatory health perspective; complementary medicine; intercultural health mediation, etc.

Some of these new situations have to do with vulnerability regarding disease, especially infections; the difficulty of accessing normalized healthcare; immigrants' ignorance of how the host country's healthcare system works, what leads to an inappropriate use of available services, non conformity with timetables, generalized recourse to Emergency services, etc.; and the difficulty of monitoring treatments and participating in health education and promotion activities. On the one hand, medical professionals complain about immigrants' resistance to follow therapeutic recommendations regarding diagnosis and prevention routines to promote health; immigrants' indefinite complaints; occasional difficulties regarding medical examinations and further monitoring; the language hindrance (including illiteracy, at least concerning our alphabet); and, in general, the excessive work load for today's health teams as there is an increase in the volume and heterogeneity of patients. Often, people overlook the fact that many of these problems have to do, above all, with the need to implement the administration's resources and to improve management strategies before a sociodemographic situation which has radically changed in very little time. On the other hand, there are immigrants and members of minority ethnic groups who complain about medical staff not knowing anything in regard to their culture or socioeconomic context; that they don't receive enough time and attention; underlining the fact that there is a language barrier, which complicates their rapport with medical personnel, affecting their ability to follow treatment.

Above all, we need communication and information channels, for both parts —immigrants and medical staff —to understand each other; and, in general, between the administration and civil society. These communication difficulties and the services' lack of adjustment to social and cultural realities affect healthcare on different fronts: the quality of the "anamnesis" (information provided by the patient during a clinical interview, to complete his medical history); the delay in recognizing symptoms

and diagnosis; monitoring of each case and the failure of treatments due to comprehension problems; the abandonment of the treatment and visits, etc. In this sense, intercultural health mediation is one of the tools to be used for the improvement of healthcare among immigrants. We are not only talking about translating from one language to another, but of a combination of actions aimed at overcoming linguistic and socio-cultural barriers which affect the quality, efficiency and equity of healthcare, and its influence on these immigrants' medical condition; actions which should follow three guidelines: patient, health professional and translator —mediator. The mediator, therefore, is a bridge which improves communication and promotes constructive changes in relationships between people from diverse socio-cultural backgrounds, as a form of prevention and resolution of individual, family or community conflicts. Although nowadays there are different programs underway, there still aren't enough professionals to mediate in the health sector. There is also a lack of awareness on the importance of experts' support on intercultural issues associated to this sector. It will be necessary to invest in training for medical professionals regarding cross-cultural healthcare (knowledge on cultural diversity, etc) and translate health informative materials to different languages (something that has been properly carried out in countries such as Canada), as is established according to the Plan Director of the Inmigración en Salud de la Generalitat de Catalunya (Health Immigration Guiding Plan of the Generalitat of Catalonia).

Recent studies carried out in Catalonia regarding immigration and health (see thematic bibliography at the end of the article) have focused, on one hand, on the analysis of the system itself, of those limitations which obstruct efficient response to new realities, and of new services which are being implemented (reception, accommodation, sphere of mediation, etc.); and, on the other, on aspects regarding immigrant and minority patient care, which may be summed up as follows:

1. Sexual, reproductive and mother-to-child health (including aspects such as vaccine coverage, pregnancy, delivery and post-partum care, genital mutilation, international adoption, etc.)

2. Infectious, imported or acquired illness in the host society, as well as parasitic diseases (including illnesses such as malaria, tuberculosis, AIDS, etc.)

3. Mental health (including migratory grief, multiple stress and somatization disorders.)

To sum up, the particulars regarding immigrant health have to do with a combination of factors which include: a) peculiar characteristics associated to their place of origin (dietary habits, mother-to-child habits, cultural features, socioeconomic conditions, endemic illnesses, etc.); b) the migratory process, especially in the case of immigration arriving from poor countries and above all in refuge and asylum cases (physical and psychological exhaustion, stress, depression, deficient health conditions related to their place of origin, etc.); c) integration problems in host society (lack of employment and income, problems for accessing information, segregation, marginalization or territorial and social exclusion, etc.); d) health system's structural characteristics and the lack of adjustment to services provided.

In this context, it is fundamental to take the anthropological perspective into account, because it enables us, among other things, to understand socio-cultural differences related to how people view health and disease. Conceptions, attitudes, conducts and behaviours regarding health are social and cultural constructions. And this is connected to ideas regarding human beings' education, norms and uses associated to breeding and looking after individuals, social roles according to age and gender, the concept of illness, of what is right/wrong, healthy/unhealthy, etc. This implies not only having in mind the individual as an isolated element, but also the group or social and cultural community to which he is connected. Thus, it is very necessary to have firsthand ethnographic or "internal" knowledge of this reality and the socio-cultural features of these immigrant or ethnic minority groups. Thus, for example, among Asian immigrants health and disease are traditionally considered in a more holistic manner (balance between energies and humours, cold/heat, etc. where every aspect of life has an influence, such as diet, movement/repose, environment, or emotions) and are less focused on cause-effect associations and pharmacological quick effect treatments, typical of the hegemonic biomedical and more technical allopathic methods of Western culture. Also, in the Eastern tradition, there is no distinction between body and soul. In the case of Muslim regions, both Asian (for example in Pakistan), and African, (in Morocco or Senegal), the influence of Islam regarding health is also great, due to the lack of a strict dichotomy between body and soul, as well as the association between health and the holy (many times disease is attributed to divine punishment). At the same time, in the case of Pakistanis, as well as with sub-Saharan Africans, it is necessary to consider the trinomial association between sexuality, matrimony and progeny, which is the framework for gender relations, and

the marked division between gender and age roles[2]. Among sub-Saharan immigrants, for example, one must bear in mind reproduction management and their original domestic structures, the importance of family and social networks and the conception of man not as an isolated individual, but as part of a group (family, network of relatives and friends, etc.); as well as more general aspects related to interaction between persons and the world, as, for example, the lack of such a distinct differentiation between the world of the visible and the invisible as exists in Western societies, and the belief (experience) in invisible latent forces, which is at the foundation of their concept of reality; their views on health and illness should also be taken into account. Other specific characteristics might have to do with different food traditions, as is the case with very seasoned dishes or the general use of spices among different African or Asian populations. Sometimes, as in the case of Pakistanis, with high fat content dishes, food seems to entail coronary heart disease and diabetes.

However, we underline the fact that, even from the anthropological perspective, culture can not explain everything, for not every practice has in culture a cause *per se*. On the one hand, it is important to know that many of the health issues related to immigrant populations, and their attitudes towards health and the medical personnel, are very similar to those of local people. On the other, although immigrants are mostly young healthy individuals, they often live in socially and economic precarious circumstances (also bad working conditions) what makes them vulnerable to health problems derived from inequality in living conditions (housing, education, working place, irregular status, etc.). Therefore, socioeconomic factors (limited income, poverty, education, etc.) can be crucial. Many experts point out that in neighbourhoods with bad social and sanitary conditions, immigrants suffer the same health problems as the rest of the population, while, particular diseases, such as tropical pathologies, have no significant predominance. It is possible to avoid, therefore, culturalization or ethnification of social situations, in order not to confuse cultural difference with social inequality. Anyhow, we intend to analyze the association between different factors, which are not necessarily separate, but are frequently explained the one by the other.

It is also essential to understand that, in this section of healthcare, adequate integration of immigrant populations and ethnic minorities necessarily implies bidirectional adjustment; that is, both parts involved in

2. It is necessary to highlight the fact that although Islam regulates every aspect of the believer's life and stipulates the gender relation models, gender inequality is more a consequence of postcolonial patriarchal structures and politicization of religion than of religion itself, which can be interpreted to legitimize men's privileges and not women's.

the migration process –those who arrive and those who were already here –have to change things. Besides, it is important to know that many of the aspects which seem contradictory *a priori*, in realty are not, or shouldn't even be thus considered. For example, the traditional and biomedical models are not necessarily opposed –they may even be overlapped –, for they can be used for different things or in different stages of the process (remedy, prevention, treatment, etc.).

2.2 General context of immigration in Catalonia

The speed with which Spain has transitioned from an emigration to an immigration country is unprecedented in European demographic history, even worldwide. While in Northern European countries, such as England and France, change took place throughout several decades (between 1950s and 1970s), in Spain's case the socioeconomic landscape changed radically in over five years. In fact, Spain is the country within the European Union which has undergone the greatest uninterrupted immigration increase since 1997, receiving almost 45% of the immigrants arriving in the EU, as of 2006. What is more, in the last six years Spain has become the world's country with the highest migratory flows, only behind USA. Since the year 2000 immigration has crucially affected Spain's political agenda, making it clear that it is not a timely phenomenon or a technical or administrative matter, but a reality with structural consequences (political, economic, demographic, socio-cultural) which may be taken care of.

According to the municipal census of January 2006, Spain had 4,144,166 foreign-born registered residents (including those who didn't have a residence permit), which represent 9.3% of Spain's total population (44,708,964). According to the census' provisional information as of 1 January 2007, the number of foreigners had augmented up to 4,482,568 residents, almost 10% of the total population (without taking into account those who were born abroad but are Spanish nationals). Catalonia, as one of the State's autonomous communities which attracts most immigrants, had, as of 1 January 2006, 913,757 foreign registered residents, who represented 12.8% of Catalonia's total population (7,134,697). Provisional census data as of 1 January 2007 indicates that the number already reaches 966,004 people, which are 21.5% of the State's foreign-born residents, and 13.4% of Catalonia's total population. This makes Catalonia, not only an extraordinary region for immigration within the State, but also a host region of international importance. And,

in spite of concentrating this import of people in focal points (provinces and municipalities), the truth is that each day there are less communities in Catalonia, both urban and rural, which are not being affected by foreign immigration.

Immigration in Catalonia is influenced by international migratory flows, which are not only conditioned by globalization and the acceleration of mass mobility, but also by the great diversification of places of origin and types of migration. In this sense, although immigrants coming from the EU make up great part of the total, in the last few years a great diversification has taken place regarding countries of origin, offering a more heterogeneous range of nationalities involved in migration. If, until recently, the places of origin belonged to the EU and the Maghreb (in particular Morocco), currently nationalities as diverse as Ecuador, Romania, Pakistan, China or Gambia have an ever-increasing presence in Catalonia (see FIGURES 2 and 3). Thus, in Catalonia, and in Spain in general, we see a consolidation of the typical double migratory flow from "poor countries" to "rich countries"; a new diversity which affects every social segment (working, educational, medical, etc.).

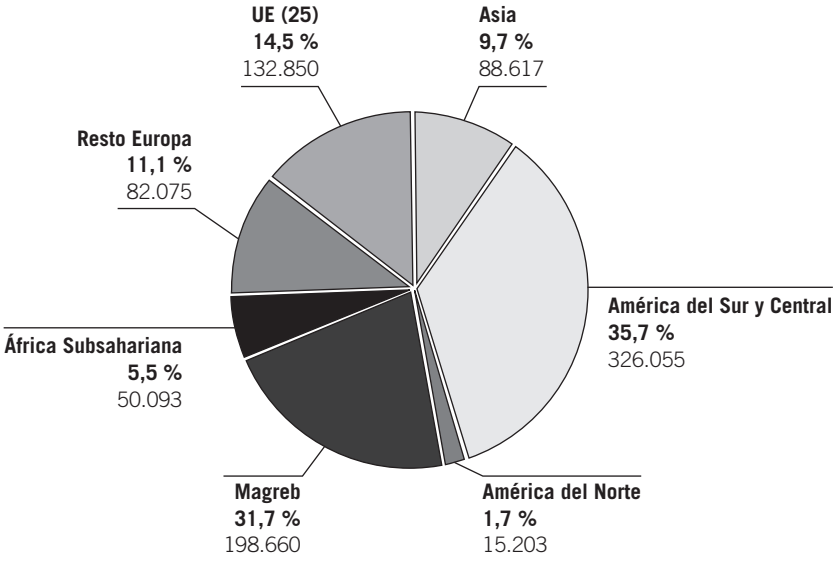

FIGURE 2. Foreign population in Catalonia depending on place of origin as of 1/1/2006. *Source*: Municipal Census 2006, INE. Prepared by authors.

Nationality	Total
Morocco	188.604
Ecuador	86.710
Romania	51.353
Colombia	43.228
Bolivia	35.387
Argentina	37.976
China	34.791
Italy	31.914
Peru	29.544
France	25.402
Pakistan	25.728
Germany	18.790
UK	16.458
Dominican Rep.	16.710
Gambia	14.329

FIGURE 3. Foreign population in Catalonia by nationality ranking as of 1/1/2006
Source: Municipal Census 2006, INE. Prepared by authors.

Finally, regarding immigration's impact on society, over 60% of the immigrants who arrive in Catalonia are young (between 19 and 44 years of age), something that, along with a higher birth rate than that of the native population (foreign mother's births make up 14% of the total), is having an important impact on lowering the age average among the population; something which is felt in every social sector, health included (see FIGURE 4.)

2.3 Sociodemographic approach to communities, neighbourhoods and groups under research

To start off, there are many limitations in accessing detailed and updated information related to the selected groups. Furthermore, these groups' statistical visibility is very limited: for example, Catalan gypsies who generations ago came from other State's regions are ethnic minorities but not foreigners or immigrants. Thus, they are not registered by nationality or place of origin in official records. Also, great part of the immigrant

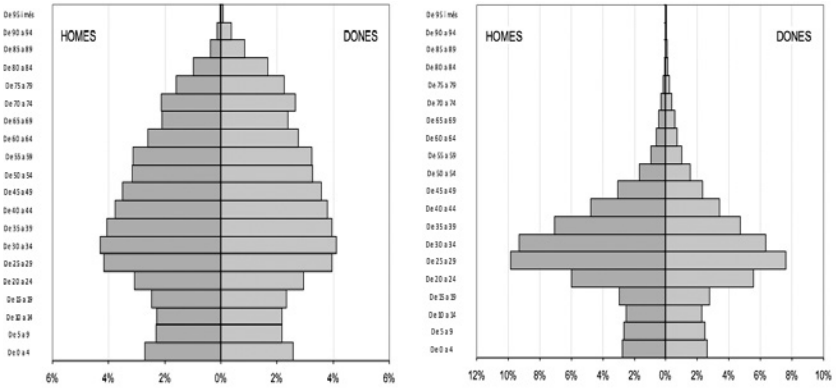

FIGURE 4. Population pyramids: Spanish nationality population (left) and foreign-born population (right) registered in Catalonia as of 1/1/2006.
Source: Secretaria per a la Immigració, Generalitat de Catalunya (non official data). Preparation: Domingo and Gil (2006).

population (especially those coming from Africa), are not statistically visible, due to them being illegal aliens.

Besides, there are great limitations to access published data on a "neighbourhood" level. Except in a few communities, such as Barcelona for example, neighbourhood community data is not published, and when available, it is commonly not updated. Often communities use different methods for registering their population, with territorial categories that not always coincide with those of neighbourhoods being researched. For example, categories such as "statistical section", "statistical area" or "district" are not equivalent nor are exactly made up of neighbourhoods, but by an aggregation of smaller units. On top of that we should add institutional protection of statistics and data, which often makes the reading of particular codes, when available, something to be done only indirectly.

Under these circumstances, what follows are just some approximate guidelines to approach these communities' sociodemographic reality; choosing examples when indirect data was available. Ethnographic work, now in progress, will be required to obtain detailed information on these groups and neighbourhoods.

Regarding the program's neighbourhoods and communities, in most cases we find a strong presence of foreign immigration. Although Barcelona is the city with most immigration in absolute terms, communities such as Hospitalet del Llobregat, Vic or Manlleu have much higher foreign population density (see FIGURE 5.)

Municipalities	Total Population	Total Foreign-born	%Foreign-born
BARCELONA	5.309.404	645.737	12,2
Barcelona	1.605.602	244.988	15,2
Hospitalet de Llobregat	248.150	41.712	16,8
Badalona	221.520	29.345	13,2
Terrassa	199.817	22.479	11,2
El Prat de Llobregat	63.069	4.868	7,7
Sta. Perpètua de Mogoda	21.644	1.384	6,4
Manresa	71.772	8.854	12,3
Vic	38.747	8.510	22,0
Manlleu	19.979	4.083	20,4
LLEIDA	407.496	52.633	13,0
Lleida	125.677	17.239	13,7
Balaguer	15.769	2.710	17,2
TARRAGONA	730.466	99.103	13,5
Tortosa	34.266	5.751	16,7

FIGURE 5. Catalonia's foreign population per province and municipality chosen as of 1/1/2006.

Source: Municipal Census 2006, INE. Prepared by authors.

Barcelona had, as of 1 January 2006, 244,988 foreign registered citizens, which make up about 15.2% of the total registered population (above the province's 12.2% and Catalonia's 12.8%). In spite of Ciutat Vella being the community with the highest foreign-born population, both in absolute and relative terms, there are other districts such as Nou Barris, San Martí or Sants-Montjuïc —where the neighbourhood of Poble Sec is located —in which foreign immigration has greatly increased lately (see Figure 6). In fact, according to Barcelona's City Council Statistics Department, districts with above average foreign-born populations are (in this order): Ciutat Vella (38.5%)[3], Sants-Montjuïc (17.8%) and Eixample (16.4%).

3. The Census Act enables the registration of people without a fixed address. In Barcelona

An increase in immigration is extending to all of the city's districts, a dispersion heightened by the town's urban saturation and the difficulty in accessing housing —which is of a transitory nature.

In the case of statistical areas (there are 38), Barcelona's section the with highest foreign-born population rate is the one made up of el Raval, Esquerra Eixample, Sants, Gracia and Sant Gervasi. The areas with the highest relative immigration rate (in relation to total population) are el Raval (where 47% of the registered population is foreign-born), Parc (35%), Gòtic (32%), Trinitat Vella (29%), Poble Sec (27%), Barceloneta (25%) and Ciutat Meridiana-Vallbona (24%). El Raval and Poble Sec, districts where the ethnographic research is being done, host great part of the city's foreign-born population (see FIGURE 6.)

FIGURE 6. Barcelona's territorial division into districts (left), and according to Large Statistical Area (right).

Source: Barcelona's City Council Statistics Department.

they are assigned - for purely administrative reasons - the municipal units' address of Ciutat Vella, which has an effect on the figure.

As we have seen, there are communities where foreign-born population density is much higher than in Barcelona. This is the case, for example, with Hospitalet de Llobregat, within the Barcelona province. At the start of 2006 Hospitalet had 41,712 foreign registered inhabitants, almost 17% of its total population. It is becoming, not only one of the communities with the highest rate of foreign-born population in Catalonia, but one of the locations with top foreign population density in Spain and Europe. Although the immigrant population has grown at an exponential rate in Catalonia, in Hospitalet de Llobregat this increase has gone even further, growing at an average of 400 new –non European Union –foreigners per week, especially in the neighbourhood of Collblanc-Torrassa, one of our project's research neighbourhoods. This swift change of scenario has overwhelmed social coverage structures. In the case of healthcare, there is a demand which exceeds medical professionals' availability.

This situation is similar in other municipalities of Barcelona, as for example Terrassa, where intense internal immigration, in particular from Andalusia, during the 1960s and 1970s has given way to an unprecedented increase in foreign-born immigration. In particular, the neighbourhood of Ca n'Anglada, chosen as one of the project's fieldwork communities, currently has 30% of foreign-born individuals among its citizens.

Also, the region of Osona –still within Barcelona –has become one of Catalonia's main poles of attraction for immigrants. Currently, 13% of its population is foreign-born, due to the region's recent economic growth, characterized by diversity of opportunity and the existence of sectors in expansion, among which, the meat industry, construction business and hotel industry stand out. These sectors (specially the meat industry) offer low qualified jobs, often in very tough conditions; positions which are frequently rejected by locals, thus attracting many immigrants. Vic and Manlleu are the region's main immigration areas, with people from more than 53 different countries, although Moroccan-born immigrants are a majority (see, Figure 5, above).

Outside the Barcelona province, we find communities with the same structural situation: in Tortosa (Tarragona), for example, where our ethnographic research is also being conducted –with Romanian gypsies –, there are immigrants from 91 different countries. Romania, with 1,147 individuals (644 men and 503 women), is the third, behind Morocco and Pakistan, according to provisional data for 2007.

Finally, different communities in the province of Girona have for years been major hotbeds for foreign-born immigration. In fact, Girona is the province with the highest rate of foreign-born population in Catalonia (17%, well above Catalonia's average). In this area, communities such as

	Total Foreign-Born	Pakistan	Romania	Morocco	Gambia	Senegal	Equatorial Guinea
Cataluña	**913.757**	**25.728**	**51.353**	**188.604**	**14.329**	**12.563**	**1.334**
Barcelona	645.737	23.470	20.364	118.795	5.648	6.643	1.035
Girona	116.284	344	6.878	31.144	7.418	2.122	53
Lleida	52.633	162	9.961	11.830	1.149	1.986	131
Tarragona	99.103	1.752	14.150	26.835	114	1.812	115

FIGURE 7. Foreign population per nationality in Catalonia and provinces as of 1/1/2006. *Source:* Municipal Census 2006, INE. Prepared by authors.

Salt, which attracted national immigration (from Andalusia) during the 1970s, has become one of the major host communities for foreign immigration, especially African, in particular Moroccan (45% of its foreign population) and Gambian (32%). As in cases abovementioned, foreign-born population density –currently of 32.2% –is outstanding.

Regarding the selected collectives, their features and distribution, we would like to point out that almost all of them have a strong presence in the territory, although some of these are specifically located in certain provinces, communities and neighbourhoods (see Figure 7.) Our ethnographic research is being done with this distribution in mind.

One of the most salient aspects regarding the sociodemographic profile of these collectives is that they are greatly heterogeneous, each with very different features, both due to their moment of arrival and migration project. Furthermore, their sociodemographic characteristics (age, distribution by gender, etc.) and cultural features (religion and belief system, ways of interpreting the person and the body, dietary habits, rituals and traditional medical practices, structure and family support, etc.) are very diverse. This heterogeneity must be taken into account when analysing healthcare processes prevalent in the host society.

Pakistanis, for example, are a group whose presence in Catalonia is relatively recent, with a distribution by gender which is mostly male (almost 90% are men), young (60% are adults from 25 – 39), most of them having primary school studies, and with high spatial concentration and segregation, unlike other collectives, such as Latin Americans. The majority of Pakistanis come from the Punjab region, and live in the municipality of Barcelona (14,251 individuals, as of 1 January 2006), between the districts of Ciutat Vella and Sants-Montuïc, especially in the neighbourhood (statistic area) of Poble Sec and el Raval. 40% have been in the city

for less than a year, and 45% from one to five years. Other socio-cultural features specific to Pakistani immigrants are, apart from the predominance of men and their Muslim religious creed, their working on particular economic sectors, very well defined initially: electronics and souvenir bazaars. These are group economic strategies —"ethnic businesses" —which, to a large extent, explain this group's residential concentration.

Moroccans, although sharing many traits with Pakistani, Senegalese and Gambian immigrants (Islam, dietary aspects, organization and procreation models, etc.), have had a much longer presence in Catalonia, and are much more dispersed throughout the territory —within Catalonia's four provinces as well as in each community. For example, in Barcelona, where there were 15,522 Moroccan registered immigrants as of 1 January 2006, not only did they have a strong presence in districts with more foreign-born population as Ciutat Vella (4,468), but also in districts such as Sants-Montjuïc (2,513, of which 1.153 lived in Poble Sec), Sant Martí (1,858), Nou Barris (1,347) and Sant Andreu (1,285). Moroccan immigration is also greatly present in the region of Osona, and in particular in the communities of Vic and Manlleu, which is where most of the region's immigration is located, and where ethnographic research is currently taking place. In Manlleu, for example, and in spite of the variety of immigration nationalities lately noticed, Moroccans are clearly the most abundant. As of 1 January 2006, there were 3,229 Moroccan registered nationals, which represent 80% of the total number of foreign-born immigrants (4,083 people, in absolute numbers). As with other groups, we also have to consider this group's internal heterogeneity. In Manlleu, unlike other communities, immigrants had rural backgrounds, coming from Nador (in the Rif mountains). These had very specific socio-cultural traits as, for example, Arab not being their native tongue, while using Amazigh idioms instead —the region's ethnic majority —, a tradition which is mainly kept in oral records. The settlement of a Moroccan colony of immigrants in Manlleu during the early 1990s —most of them men coming from the abovementioned North African region —galvanized migratory chains; establishing a unique immigrant community in the area. In the neighbourhood of Erm, where ethnographic research is being conducted with Moroccan nationals, live 42.5%ALLY of Manlleu's immigrants (1,830 people, in absolute numbers). In fact, 55.5% of this neighbourhood's population is foreign-born, exceeding native citizens' percentage. 51% of these come from Morocco (1,681 people, in absolute numbers.) Finally, this diversification of Moroccan immigrants manifests itself also in the labour sector, in various fields, and its ratio per gender is more balanced than that of Pakistanis and other groups such as Senegalese and Gambian

collectives; given the more prolonged stay of Moroccans in Catalonia. However, the percentage of men, especially adults, is higher than that of women.

Sub-Saharan communities tend to be more socially and demographically differentiated. Senegalese and Gambian residents represent 60% of Catalonia's total sub-Saharan population, although other nationalities, such as Equatorial Guinea —with strong historical (colonial) ties with Spain. People from Guinea have consistently migrated to Catalonia since the 1950s, especially after 1969 when there was a failed coup d'état to overthrow Macias' dictatorship. Guinean immigration is, therefore, the oldest form of migration coming from countries outside Europe. Many of these immigrants have little statistical visibility due to the fact that most of them are of Spanish nationality, while others are illegal aliens. This helps us analyze the migration process in very different periods of its history, where different facts have had an influenced (studies, political refuge, family visit, healthcare, work and improvement of life conditions, etc.), which have had different effects on social integration in Catalonia. At the beginning of the migration process these individuals were able to obtain Spanish nationalities, complete high level education studies, and make the transition to the country's labour market —especially as second and third sector professionals —, however, more recent migrations —especially, during the 1990s —have been mainly motivated by a search for economic resources; many of these immigrants living in Catalonia as illegal aliens. We may add that, unlike other African groups, where Muslim religion is normally prevalent, many Guineans are Christians; although in a widely diverse religious and ethnic context (Annoboneses, Bubi, Fang and Ndowé are the main ethnicities). Guineans have found their place within Barcelona's urban areas, and are generally different from other African immigrants in the sense that they belong to higher socioeconomic and educational echelons; furthermore, Spanish being their native tongue.

Since the 1970s, Senegalese and Gambian immigrants, and others from Nigeria, Sierra Leone, Zaire or Cameroon, have arrived in Catalonia. In the 1980s the first large migration wave took place; later, there was a second one, with very different characteristics (lower socioeconomic levels, illegal immigration, etc.). Despite an increase in family reunification and women's independent migration projects —prominent in the last few years —, most Senegalese and Gambian immigrants in Catalonia are Muslims and work in the construction, agriculture and service sectors. However, they also participate in the informal economy, with budding ethnic and transnational businesses.

In spite of the similarities, we must consider the heterogeneity of these groups, both before their arrival in Catalonia —more recent in the case of Senegalese individuals —, or due to their origin (rural or urban), their ethno-linguistic groups and territorial distribution: while Senegalese immigrants mainly live in the province of Barcelona, Gambians are located between Barcelona and Girona, where they are even more numerous. Their population distribution by gender —moreover, in the case of Gambians —is highly masculine, especially among adults.

Romanian immigrants' history in Spain is even more recent than Asians'[4]. In Spain they have gone from being 4,000 in the year 2000 to 400,000m in 2006 (524,995 as of 1 January 2007, according to the Census' provisional data). There are 51,353 Romanians living in Catalonia, being the third foreign nationality in Spanish immigration, only behind Morocco and Ecuador.

Unlike other immigrant groups, such as Pakistanis, Chinese, or even Moroccans, which commonly come from specifics regions, Romanians' places of origin are very diverse: both from rural or urban backgrounds; coming from central, southern, western and southeast provinces.

Nevertheless, there are communities where immigrants do have a common origin. Castelldefels, in the Barcelona province, has a significant Romanian community (1,153) which predominantly comes from the district of Alba, Transylvania, in Midwestern Romania. Romanians mostly live in the provinces of Barcelona and Tarragona, carrying out different types of jobs (temporary fruit-picking, construction, etc.). The male and female ratio is the most balanced within the program's groups; women's immigration, both related to dependent or independent migration projects is high. Here we must underline young women's immigration related to sexual and labour exploitation networks (prostitution), which has increased in recent years. Apart from their concentration in Barcelona and Tarragona, there are communities in other provinces like Lleida or Balaguer, where there are Romanians in relatively large numbers (2,404 and 829, respectively). Data for Barcelona as of 1 January 2006 shows they can be found in most districts. According to these statistics, there were 4,704 Romanian individuals living in Barcelona —in 1996 there were only 78. Romanians have a strong presence in most districts, especially in Ciutat Vella (820), Sants-Montjuïc (640, 138 in Poble Sec), Sant Martí (615), Nou Barris (567), Eixample (567) and Horta-Guinardó (507). Within the Barcelona province, they have a strong presence both in Hospitalet del Llobregat (839) and Badalona (1,136).

4. On Romanian immigrants in Spain, see Pajares, M (2007).

The gypsy collective is also greatly differentiated from other groups. In the case of Catalan gypsies and other internal migrants, these are not foreign-born immigrants, but an ethnic minority with its own cultural traits ('*rom*' culture), and which, in some cases, has been present in Catalonia for more than 500 years. Thus, their statistical visibility is very limited. In 2006 there were some 80,000 gypsies in Catalonia, which represents 1.2% of the total population and 12% of the State's gypsy population at large (60,000). Gypsies who have lived in Catalonia the longest, "Catalan gypsies", are to be found in central neighbourhoods within the cities they inhabit. However, those coming during the internal migrations of the 1950s and 1960s are located in districts which were built due to urban expansion policies —carried out in large cities and municipalities close to the province capital. Most of them live within the Barcelona province, in the districts of Sants-Montjüic (Bordeta-Hostafrancs in particular), Cera street and its proximities (between el Raval, in Ciutat Vella, and Sant Antoni, in Eixample), Gracia and Sant Martí; but there are also ample groups in Girona capital, Lleida, Tarragona and Reus.

Although, in recent decades there has been a significant improvement in their living conditions —due to their access to social protection services, public housing, healthcare and education services —great part of the gypsy community is still one of the region's most vulnerable groups, at risk of becoming socially and economically excluded in Catalonia; apart from becoming targets for discriminatory practices which hinder their access to goods and services in equal conditions to other Catalan citizens. There are sociodemographic characteristics, such as their birth rate above Catalonia's average —their very high illiteracy rate (60%), or housing difficulties (mobility due to eviction), which indicate specific problems regarding this group's healthcare use.

Finally, in regard to Romanian gypsies, though being a small group in absolute terms compared to other groups —there are from 2,000 to 3,000 individuals in Catalonia —they have very differentiated sociodemographic features, which require ethnographic research. Firstly, there are statistical visibility problems, because not all Romanian nationals are gypsies. In spite of these difficulties, we may point out that they are a growing collective, for among the 10 million gypsy individuals living in Europe, most of them are located in Eastern Europe (8 million), Romania being the country with most gypsy citizens —some 3 million, which make up over 9% of the total population. Unlike non-gypsy Romanian immigration, which comes from different areas, the majority of Romanian gypsies living in Catalonia come from a small number of places, in particular from lalomita County, within the historical region of Wallachia,

in Southeast Romania. Their communities of origin are mainly –nd-rei and Fete-ti. This is an impoverished area where most of the population works as agricultural or industrial labourers, in precarious conditions. This scenario of historical poverty and social exclusion is the main incentive for them migrating to Catalonia. There are other Romanian *rrom* groups in Catalonia coming from other regions, such as Timi-oara (province of Timi-, in Banat) and Murgeni (province of Vaslui, in Moldova). Concerning their location throughout the territory, the municipality where most Romanian gypsies live is Badalona, a city near Barcelona, especially in the neighborhood of Sant Roc –mainly immigrants from Ialomita –and also in the district of Fondo, in Santa Coloma de Gramanet, in the outskirts of Badalona –here there is a stronger presence of *rrom* from Murgeni. Also, in Tortosa (Tarragona), most of the *rrom* population is from Timi-oara. There is also a meaningful number in Barcelona's suburbs (Hospitatlet de Llobregat, mainly in Collblanc, Pubilla Casas and Tortosa), and in the districts of Horta-Guinardó, Sant Martí, Sant Andreu and Sants-Montjuïc. Our ethnographic research is being conducted in several of these communities.

As the other groups, Romanian gypsies, and the *rrom* in Eastern Europe, are a very heterogeneous group. They are often viewed as homogeneous due to the media's proneness to establish stereotypes, and also because they are commonly confused with other collectives –not every Eastern gypsy is Romanian, nor are they all in the same situation. There are many subgroups defined in terms of ethnicity, language and occupation. However, a common feature is that of their family organization, which corresponds to the patrilineal extended family, with different generations living within the same household and very well distinguishable gender roles. We would like to mention their recourse to mendacity and the substandard living conditions and sense of social of exclusion by which they are affected, especially in Barcelona's urban areas; something we have to consider when analyzing their access and use of healthcare services.

2.4 Preliminary conclusions.

In the present article we have exposed an ongoing research project which hopes to understand the conjunction of socioeconomic situations and cultural factors in regard to different socially and economically vulnerable segments of society: immigrants and ethnic minorities with a strong presence in high priority districts within the Neighbourhood Health

Program —set up by Catalonia's Health Department, and carried out by the GRAFO research team (UAB). It consists of analyzing health affecting factors, access to healthcare and relationships between these minorities and medical staff. While it is still too early to draw definite conclusions, we may point out some reiterations extracted from report analysis and preliminary information obtained to launch the project:

i. Immigration in the last few years has changed Catalonia's healthcare landscape in significant ways. In this context, health professionals demand more resources and training to deal with the situation.

j. There is a lack of resources and better coordination is required between the administration and social agents, as well as information, connection and dialogue channels.

k. Among immigrants there may be medical problems more closely related to sexual, reproductive, maternal and child health, as well as infectious and parasitic diseases [In some bibliographical sources there doesn't seem to be enough evidence on epidemiological data to sustain this statement. At times the results obtained from different studies are in contradiction; while many surveys are methodologically flawed. At times they are based on extremely marginalized populations, or only certain services are reflected. Other methodological features have to do with sociodemographic aspects. For example, the fact that immigrants make more use of gynaecological consultations and paediatricians than natives is explained by these people's profile: young individuals in childbearing age, versus a more ageing native population].

l. There are many difficulties for these groups to access healthcare and to receive appropriate monitoring as patients. We may point out several of them: not having a health card —due, in part, to residence registration problems; not knowing how the system works, or making inappropriate use of it; fear due to their situation as illegal aliens —lacking support networks; mobility and change of location issues; different uses and ways of understanding health —including a perception of health as something secondary, in contrast to labour and housing; communication problems —explanation and diagnosis —between medical staff and patient (language, illiteracy, difference in gender roles, prejudice, differences in conceptualization and interpretation or pure discrimination).

m. Socioeconomic exclusion and administrative irregularities are major factors affecting immigrant's rights when using healthcare.

The way in which this project has been conceived, its design and execution, is inscribed in the way in which GRAFO interprets the anthropological scientific method, and basic, fundamental, and applied anthropology[5]. In regard to the former, we understand the scientific method in anthropology as based on testing through comparative procedures; constant analysis of the research process and results; interaction between theory and practice; the need to transcend the limitations of the positivist (social determinism) and interpretative approach (focused on meaning; which ultimately leads to the negation of knowledge and its practical application to solve social issues, considering interpretation –approximation –as the ultimate form of understanding); and anthropology's capacity to attain rigorous knowledge, neither infallible nor permanent –at times better or worse –, but reaching explanations and predicting phenomena; a useful form knowledge which, as Lévi-Strauss put it, provides the least worst option of performance due to better understanding. In regard to the latter, and linked to the former, our foundation is methodologically rigorous; theoretically and ethically committed to employ anthropological and ethnographical knowledge for social purposes; underlining the need to fully understand socio-cultural frameworks and their context; offering a well grounded critical view of realities under analysis, which implies using the obtained knowledge to provide an agreement between differing interests and needs. In this particular project, based on ethnographical work, an initial theoretical and sociodemographic study has been started for the preparation of meticulous ethnographic guidelines with items designed according to the project's goals –previous to fieldwork. Ethnographic work is being conducted with a selection of appropriate groups and neighbourhoods (in this case, the most culturally and socially accessible) on which experienced ethnographers have already been working; thus, with the directing team's advice, we will be able to deal with the project's most interesting aspects in more precise ways, without losing sight of the context, the meanings and causal relations between diverse phenomena. The ethnographic stage will be followed by a comprehensive analysis of the information provided by different institutions and the administration's already existing reports, as well as by our fieldwork –a comprehensive and comparative analysis of conclusions obtained in different neighbourhoods. This final stage will provide a definite con-

5. See: San Román, T. (2006) and González Echevarria, A. (2003).

clusions report, divided into two parts: a comparative and ethnographic section, expected for July 2008, and a section providing suggestions and procedure plans, for November 2008. This stage includes the preparation of materials, guidelines, introduction of data programs and research categories, warnings, dialogues and training for medical staff, which, in the mid and long term, implies active participation of the minority groups involved. Thus, ethnographic work as well as reflection and comparative analysis on and through medical practice, should improve our knowledge and fulfil the project's ultimate goal, which is to improve healthcare and provide professionals with conceptual and practical tools to detect, prevent and solve conflicts, therefore bettering professional intercultural communication and encouraging actual community participation.

Overall, this is a project done by people who believe in Anthropology as a form of applicable knowledge, which serves social construction and transformation. In fact, this is, or should be, part of our discipline's ethical requirements and social responsibility.

References[6]

Domingo, A. y Gil, F. (2006). L'evolució recent de la població estrangera a Catalunya. En *l'Estat de la immigració a Catalunya. Anuari 2005*. Larios, M. J. y Nadal, M. (Dirs.). Barcelona: Fundació Jaume Bofill.

González Echevarria, A. (2003) *Crítica de la singularidad cultural*. Barcelona: Anthropos.

Pajares, M. (2007) *Inmigrantes del Este: Procesos migratorios de los rumanos*. Barcelona: Icaria.

San Román, T. (2006). ¿Acaso es evitable? El impacto de la Antropología en las relaciones e imágenes sociales, *Revista de Antropología Social*, 15: 373-411.

6. This article provides bibliography on health and immigration available for consultation in the following URL: http://www.aibr.org/antropologia/02v03/articulos/020303b.pdf