

MIGRATION, MARGINALISATION AND ACCESS TO HEALTH AND SOCIAL SERVICES
OVERCOMING BARRIERS





Colophon

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“The health gap across the EU between those in good health and those in ill health is widening. Good health still depends on where you live, what you do, how much you earn.

The poor, the socially excluded and minorities are particularly affected by ill health.”

David BYRNE

Former European Commissioner for Health and Consumer Protection

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Amsterdam, July 2007

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2

Executive summary



Correlation is a European-wide network concerned with social inclusion and health. Together with various network partners, Correlation compiled this reader on migration, marginalisation and access to health and social services.

The authors of the different sections in this publication are from a broad variety of professional and geographical backgrounds. They examine barriers to health and social services – and ways to overcome them – in their respective working environments. The diversity of contributions produces rich information and provides an overview of emerging issues and approaches related to migration in different European regions.

The first contribution looks into the concept, the value and the potential impact of transcultural competence, based on the experiences of the Swiss health system. The author argues that migrant-specific drug services are necessary, especially in the field of counselling and therapy. The article describes measures to develop a transcultural organisation and stresses the need for quality management.

The author of the second contribution focuses on *community-based work* in the area of migration and HIV and the importance of the empowerment of migrant communities. The role of communities for appropriate monitoring, communication, care, and policy in the field of HIV is stressed. Policy-makers need to create a framework and resources to enable communities to get involved, and existing services need to give community members the opportunity to develop their own programmes and interventions.

The third contribution describes the *community engagement model* developed by the Centre for Ethnicity and Health during their Community Engagement Programme conducted across England. This approach creates an environment in which communities (individuals and organisations) and agencies can work equitably together, and ensures that the research benefits the communities who are being studied. The implementation of the model has begun to dismantle barriers to health and social service access and increased the understanding of service planners, commissioners and providers about segments of the population they serve

In the fourth contribution, the authors look into access to health services from a *human rights perspective*. They stress the obligation of states to respect the right to health, to protect the realisation of this right and to fulfil it. The authors conclude that to attain the right to health for all, a rights-based approach must be used, along with pragmatism: NGOs delivering health care where states fail to do so is sometimes the best solution.

The authors of the fifth article examine *drug prevention and demand reduction* for asylum seekers, refugees and undocumented migrants. They report that information is often lacking about the extent and nature of substance use among these groups, and about their specific drug service needs. The article describes the SEARCH project, a European initiative to identify these needs in terms of drug prevention and demand reduction and to contribute to the development of culturally appropriate methods of meeting them.

The sixth contribution discusses the situation of *people without a residence permit* in Belgium and describes the project “Access to medical and psychosocial services for people without a residence permit in Antwerp”. This project made an inventory of the services in Antwerp that offer help to this group and identified their specific needs and barriers to service access.

The seventh article is based on the work of the European network Tampep and examines the issue of *sex work* from a female labour migration perspective, including the increasing diversity of sex work settings; the migration patterns of sex workers; the significant levels of drug use and dependency among sex workers, particularly those based outdoors; and criminal elements increasingly seeking to control sex work. The authors argue that repressive policies on both prostitution and migration undermine prostitutes’ ability to implement strategies of self-protection and self-determination. The article concludes with a holistic strategy to address these issues, based on ten basic principles.

In the eighth contribution, the authors describe the situation of migrant drug users in two *low threshold drug services* in Italy. Referring to the Italian National Health System, which allows access to health services free of charge, and to the Italian immigration law, which gives foreigners the right to receive treatments for medical emergencies, they assess the particular risks these drug users face. The article describes a pilot study investigating the accessibility of health services for this group and the efficacy of the treatment offered. The results were more positive than expected, although some unmet needs were also identified.

The final contribution looks at the situation of *mobile drug users* in Amsterdam, particularly those originating from Central and Eastern Europe. Data were gathered by AMOC, a community service that was considered as well-placed to conduct the research because of its trustful relationship with the target population. The authors conclude that their approach was useful for looking at the lifestyles and needs of mobile drug users, and that

the findings - including the mutual support that existed between members of the target population – can make a valuable contribution to the development of relevant services and interventions.





3

Introduction

Eberhard Schatz, Dagmar Domenig, Jane Fountain, Georg Bröring



This publication has been compiled within the framework of *Correlation*, a European Network on Social Inclusion and Health (www.correlation-net.org). This network focuses on the development and implementation of effective strategies to provide health and social services to socially marginalised and vulnerable populations. In general terms, the network supports the harm reduction approach as a humanistic, evidence-based and cost-effective strategy. One of the aims of the network is to contribute to a better understanding of the European dimension of marginalisation, health and social inclusion.¹

Correlation is coordinated by the Amsterdam-based organisation AMOC/DHV (www.amoc-dhv.org)² and receives funding from the European Commission (DG SANCO – www.ec.europa.eu/health) and the Dutch Ministry of Health (www.minvws.nl).

The *Correlation* approach is to get together experts from different professional backgrounds in order to discuss problems and solutions in the area of health and social inclusion, thereby crossing the borders of various fields of work and expertise. Correspondingly, the articles in this book provide a diverse range of information about the situation of marginalised groups with a migration history. However, the field is so vast and comprehensive that the editors do not claim that this book is exhaustive. It rather highlights selected issues and populations that need specific attention.

The contributions include discussions of the legal situation of migrants and the cultural competence of services, and examples of the daily experiences of organisations that provide services to individuals. The various contributions all emphasise the need to improve access to health and social care amongst disadvantaged groups. In this context,

1 Correlation builds upon the expertise of several former European networks and started its activities in May 2005. Members of the network comprise a wide range of agencies and organisations in Europe, from governmental health organisations, research institutes, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), service providers and grass root organisations. Thanks to funding by the Open Society Institute (OSI), Correlation is able to involve people from the former Soviet Union.

2 AMOC/DHV is an organisation founded in 1978 with a broad experience in the field of European projects. Since 1998, AMOC has organised projects, seminars and conferences, mainly supported by the European Commission

specific attention is paid to the situation of undocumented migrants³, as they often face the most severe exclusion and the largest obstacles to service access.

The reader of this book will be impressed by the variety of problems identified, concepts developed and suggestions for action to improve the situation of migrants in the health and social care sectors. There are several initiatives, networks and organisations that are very involved with migrants in a dedicated way: some have built up considerable knowledge, expertise, evidence and strategies over the last years and decades, and others focus on the practical side of the relevant work. Over recent years, recognition has grown that transcultural competence, the input of health and social professionals, and a community-based approach are key components for the development of successful concepts and strategies.

Many national health systems acknowledge the importance of including programmes for and with migrants in their health action plans, and the European Union has set up comprehensive programmes for social integration and equal opportunities. Nevertheless, there are still striking discrepancies between laws and regulations and the entitlement of migrants to access services on the one hand, and the reality of the accessibility of these services on the other. Many examples in this book highlight this gap between theoretical service delivery and real life. In particular, social groups that face double stigma (such as migrant drug users, migrant sex workers, or migrants living with HIV) are exposed to considerable health risks. Inadequate and culturally insensitive health and social services contribute to the vicious circle of marginalisation, which is fuelled by language barriers, a lack of transcultural competence and the absence of political interest and support. The latter is especially significant, as it is often necessary to act against mainstream public opinion in order to break the circle of marginalisation and to allocate sufficient financial and professional support for suitably-tailored service delivery.

Many groups and individuals in the European Union do not have access to basic health and social services. This threatens not only to their own health and well-being, but also

³ Migrants without a valid residence permit are often referred to in the media and public discussion as 'illegal' migrants or immigrants. However, the editors of this reader believe that a human being can never be illegal, and prefer to use the term 'undocumented' migrants, a term that is also used in official UN documents and other key publications.

public health in general. The reasons for their permanent or temporary social exclusion may vary: they may belong to a stigmatised group, such as some ethnic minorities or sex workers; they may be problematic substance users; they may exhibit risk behaviour, such as adolescents experimenting with party drugs; and they may not be protected by, for example, health insurance, social security benefits and the police. They cannot be identified nor categorised as one group, but they share a combination of characteristics that may lead to health problems and social exclusion, such as homelessness, criminal behaviour, low social economic status, legal problems, and involvement in sex work or drug use. Health problems can include infectious diseases, such as sexually transmitted infections, HIV, tuberculosis and hepatitis, but also problematic use of alcohol, tobacco and other drugs, and poor nutrition.

There are no simple and straightforward solutions for a breakthrough. Only the further development of successful concepts, engagement on-site and – most of all – the strengthening of the social and transcultural competence of health and social services and workers can ensure a step-by-step improvement of the situation. Collective efforts at the local, national and European levels are required, in order to facilitate a dialogue and to put pressure on decision-makers to provide a favourable political and financial context. This publication contributes to this process by highlighting the issues of migration, marginalisation and access to health and social services from various viewpoints:

Dagmar Domenig's article looks into the different ways that transcultural competence can be created and implemented, using the example of drug treatment services. Drug-using migrants, especially those without a legal residence permit, are underrepresented in these services and quite often turn away with their needs unmet, even where the service recognises the need to work in a transcultural way. Having defined 'transcultural competence', the article describes methods and criteria that an organisation has to fulfil to ensure lasting success in this area.

Georg Bröring's article emphasises the impact of self-help and community-based work when developing strategies and carrying out programmes to prevent HIV/AIDS amongst migrants. Based on examples and information collected by the European Network AIDS & Mobility (www.aidsmobility.org), he provides an overview of the importance and impact of the involvement of migrants in monitoring, communication, service provision and policy-making.

Jane Fountain, Kamlesh Patel and Jez Buffin describe the development of an integral community engagement model in which a community is trained and supported to conduct a needs assessment on a health or social issue, and local service providers are involved in order that the necessary changes to services are identified and implemented. This model is not only valuable in reducing the access barriers of minority ethnic populations to health and social support, but also leads to an improved understanding of the situation by service planners, commissioners and providers.

The right to help for undocumented migrants in connection with common human rights as set out in the UN Charter is described by Joost den Otter and Ancella Voets. Analysing legislation, the authors argue that there is a discrepancy between entitlement to services and humanitarian commitments on the one hand, and the reality of service delivery for undocumented migrants on the other.

The European 'SEARCH Project' deals with drug prevention amongst asylum seekers, refugees and undocumented migrants. Roland Lutz and Eberhard Schatz describe how the project gained an overview of drug problems amongst these target groups in the countries concerned, identified drug information needs, documented models of good practice and supported new developments. The article also contains some important results and recommendations from the project.

In her article, Cathy Mathei explains the situation of undocumented migrants in terms of health services, using the example of Antwerp, Belgium. On paper, this group has a right to help, but in reality there are barriers created by bureaucracy that greatly hinder the work of institutions trying to help them. The research results are used to make recommendations for improvement.

Based on the experiences of the European Network for migrant sex workers, Tampep (www.tampep.com), the article by Licia Brussa describes the mobility and migration of sex workers and the factors influencing this mobility. Information on vulnerability factors and service provision for sex workers is given, and the author details the challenges that must be overcome to improve the support for this target group.

Marco De Giorgi, Fabio Patruno, Miguel Lago and Davide Sprocatti carried out an investigation in Rome and Turin especially for this reader, examining access to health and support institutions for drug- and alcohol-using migrants in these cities. The article describes a study investigating this group's positive and negative experiences of these services.

Some drug users have migrated to Amsterdam from other countries in Europe because they prefer the more liberal climate in the Netherlands. Enzo Crolle and Eberhard Schatz describe the background and the situation of these people, the work of an institution specifically designed to meet their needs, and issues to consider when conducting research among them.

Following the themes of this reader, a literature search on aspects of migration in Europe was carried out by six separate libraries in spring 2007. The information retrieval process was coordinated by the National Documentation Centre on Drug Use (NDC) in Dublin. The searches retrieved 429 publications, including journal articles, reports, conference papers and dissertations: this demonstrates that the relevant published literature is very limited. The aim is to add to the collection, step-by-step. The database of these publications is available through the Correlation website.



4

Transcultural competence in the Swiss health care system

Dagmar Domenig



4.1 Introduction

Migrants with an addiction problem, as well as their families, are underrepresented as clients of existing services in the standard drug addiction programmes in Switzerland. For example, the proportion of migrants receiving counselling and psychotherapy is well below 10%, which does not correspond to the supposed proportion of approximately 20-30% of drug dependents with a migration background (see Domenig, 2001 b: 79). In particular, undocumented migrants hardly ever turn to existing counselling centres or to any drug service, out of fear of either being discovered to be undocumented or of being unable to pay. Even when migrants do visit a counselling centre, the specialists there often do not succeed in adequately addressing their migration-specific needs. As a result, migrants turn away in disappointment and discontinue using the facilities on offer. There are fewer problems of access with walk-in services, injecting rooms and the like, which probably meet the needs of migrants more adequately because of their informal approach (Domenig, 2001b: 79).

The necessity for migrant-specific services, especially in the field of counselling and therapy, or, in other words, to give drug services a transcultural character, is increasingly accepted, even if it is not clear yet clear to most institutions how they should implement this (see also Dahinden et al., 2004: 35). For what exactly does transcultural competence imply? What does migration-specific drug work look like in real life? What must an institution do to be transculturally competent? This chapter attempts to answer these questions.

4.2 The meaning of transcultural competence

Transcultural competence means the ability to notice and understand *individual life-worlds* in a specific situation and in various contexts, and to infer appropriate ways of action from this (Domenig, 2001b: 200, Domenig, 2001a). Every individual constructs their own, individual “Lebenswelt” or life-world (Schütz, 2003) based on personal attitudes and values, biographical experiences, external living conditions and socio-cultural backgrounds. Consequently, generalised ethno-specific “cultural recipes” offer hardly any help in bridging existing gulfs in real-life encounters with migrants. On the contrary, they tend to widen these, because of intruding prejudices that most often have hardly anything to do with migrants’ real life-worlds. Thus, wearing a headscarf is not proof of being an oppressed woman; showing emotions does not mean a man is weak; being a

Muslim does not always mean not drinking alcohol nor eating pork; and a sick person being helped by the whole family does not mean that the individual is not able to do this alone. Statements which “culturalise” migrants often hide racist attitudes as well, for if so-called differences are regarded negatively, and if a person, because of these supposed differences, is marginalised and put at a disadvantage, this is racism (see Memmi, 1999; Frederickson, 2003). The culturalisation of migrant groups is therefore not always based on transcultural incompetence because of a lack of background knowledge or a lack of social competence: it can also form the basis of racial discrimination.

However, not only have the life-worlds themselves been influenced by individual circumstances, the perception of what is “foreign” is also influenced by one’s own background. If what is “foreign” is construed as being separate from oneself, i.e. without questioning one’s own socio-cultural background, behaviour that is different from one’s own habits and daily activities often appears quite peculiar. Because of this view based on differences, similarities, and hence what could be common ground, are barely considered. Nevertheless, background knowledge about socio-culturally influenced behaviour and illness concepts can be helpful in transcultural encounters, as a form of orientation and support. However, this knowledge should always be reflected in relation to the actual situation. Specialists should therefore learn to listen to patients` or clients` stories, and with them explore to what degree their life-world influences their response to their illness or addiction. This is far more helpful than memorising lists about supposed cultural norms (Culley, 2001: 125). At the same time, it must be taken into consideration that the ethnic identities of migrants have often been influenced much more by inequalities, discrimination and the inability of institutions to deal with *diversity*, than by any exotic, socio-cultural practices.

4.3 Dealing with diversity

Inequalities, as well as the marginalisation of minorities, have increased in recent years, not only between, but also within countries. Next to a more powerful advocacy for health, based on the principles of human rights and solidarity, other measures should assist here (WHO, 2005). The European Parliament and the Council of the European Union for example, have designated 2007 as “European Year of Equal Opportunities for All” with the following objectives:

- Rights – Raising awareness on the right to equality and non-discrimination.
- Representation – Stimulating debate on ways to increase the participation in society.
- Recognition – Celebrating and accommodating diversity.
- Respect and tolerance – promoting a more cohesive society.

(EU, 2005).

“Diversity-competence means that organisations have the capacity to make themselves diverse in terms of who they are (workforce), what they do (services) and whom they serve (clients)” (DeCoito/Williams, 2004: 2/8). A diversity-competent organisation is therefore able to respond to the needs of many different groups in a way that is appropriate for these groups in socio-cultural terms. However, diversity must not be reduced to differences either. It should also focus on people’s individuality and consider differences not primarily as divisive, but also as opportunities to unite. In this sense, diversity competence cannot simply be limited to merely tolerating diversity, but must reflect on existing ways of thought and behaviour and change these where necessary (Stuber, 2004: 16, 19).

In recent years, the concept of diversity has made its way into the debate on migration and integration in Switzerland. Well into the 1990s, the segregation approach was pursued not only in Switzerland but also in other European countries such as Germany and the Netherlands, and often marginalised migrants in institutions that had been specially created for this purpose. This, however, has now been replaced by an integrative approach, in which migrants, like all other citizens of a state, should be taken care of by the mainstream care systems and treated according to their specific needs. However, the situation of undocumented migrants, to whom the state normally guarantees only the right to emergency aid, continues to remain unresolved. In many places, in order to close this gap in the health system, various niche schemes are being created to address the specific

need for the protection and anonymity of migrants. At the moment, the integration of these particularly vulnerable groups into the regular health care system is one of the greatest challenges to this system, especially when addiction problems are involved.

The main objective of any transcultural change must be the realisation of equal opportunities for *all*. On the one hand, this means creating high quality services for all clients or patients (equal health opportunities), and on the other, the integration and the promotion of specialists with a migration background (equal opportunities at work). Comprehensively addressing transcultural competence is a prerequisite of this (Domenig, 2007).

4.4 Measures to develop a transcultural organisation

The main principles of diversity and equal health opportunities, as well as non-discrimination, must be implemented in an all-embracing development of an organisation, which is not always easy to master. The following measures are recommended for the development of such a transcultural organisation, and should always be adjusted to the actual and situational demands of the health institution in question¹:

- ***Transcultural commitment at management level.*** The transcultural development of an organisation must be initiated by top-level management (*top-down* strategy). However, each organisational development must also include those affected by these changes and their *know-how*, if possible right from the start (*bottom-up* process).
- ***Migration-specific ACTUAL and NOMINAL analysis.*** On the basis of an analysis of the ACTUAL and/or the desired situation, the next step those at management level have to take is to lay down NOMINAL guidelines (objectives, measures, means) to realise the transcultural development of their organisation. These NOMINAL guidelines must be visible in the annual objectives of both the individual institutions and sectors, as well as in those in charge of dealing with migration.

1 The measures to be taken to develop a transcultural organisation are based on a catalogue of measures developed for the addiction sector, as part of the Migration and Drugs study carried out by the Institute for Social Anthropology at the University of Berne in 1999-2000, commissioned by the Federal Office of Public Health (Domenig et al., 2000 and Domenig, 2001b: 213, see also Domenig, 2007).

- **Migration specialists.** Transcultural competence is a task for and at all levels. Therefore, in addition to the firm establishment of this issue at management level, it requires a specialist responsible for transcultural *mainstreaming*, who is involved in all projects and processes with the objective of integrating the transcultural angle.
- **Resources for the transcultural development of an organisation.** The organisation and initiation of a migration-specific way of working, or the enhancement of transcultural competence, require sufficient financial and staffing resources, which must be planned in the budget. These resources are required not only for a person responsible for migration issues, but also for training health professionals, the implementation of an interpreting service, the translation of existing brochures into different languages, and so on.
- **Promoting specialists who have personally experienced migration.** Employing migrants in institutions greatly contributes to the enhancement of transcultural competence. This should be reason enough to appoint migrants in leading positions not despite, but because of their background. In addition to the promotion of migrants, measures should be taken to counter (racial) discrimination, so migrants can work in an environment in which they are recognised and respected instead of being discriminated against.
- **Creating an interpreting service.** In order to cater for all migrants, a professional interpreting service must be created, which will mean that three people are present during a consultation or conversation (the client, the interpreter and the specialist). Specialists working with interpreters should also be offered internal training, including courses dealing with situations that may arise during the interpreting process.
- **A migration-specific adaptation of organisational processes.** It is recommended that the organisational processes within institutions in relation to the aspect of migration are examined and that, based on the results, appropriate changes are made.
- **A migration-specific adaptation of documents.** Strategies, guiding principles, standards, concepts concerning treatment etc., must be adapted in a migration-specific way, in order to manifest the transcultural shift both externally and internally.

- ***Further training in transcultural competence.*** In order to create sufficient base support for the transcultural development of an organisation, further internal training of all staff is required, not only in order to sensitise them to migration-specific themes, but also to increase their transcultural competence.
- ***Transcultural group processes.*** For complex situations, there should be opportunities to discuss cases under the supervision of relevant specialists or those in charge of issues relating to migration. Such opportunities are necessary because in treating and giving therapies to migrants, extremely complex situations continue to evolve. In such cases, purely general measures are insufficient to guarantee a form of care that suits and is adjusted to the situation.
- ***Promoting health literacy among migrants.*** The competence of migrants must be stimulated, not only to enable them to negotiate the highly differentiated and hence complex health service system, but also to encourage them to take a proactive role in their treatment and therapy. All media should ensure that migrant-specific life-worlds and symbolic contexts of meaning are taken into consideration.
- ***Cooperation with migrant communities.*** Working together with the migrant population and integrating what they can offer guarantees that they are familiar with regular care programmes and that informational messages are understood. Having meetings and carrying out other activities together make this cooperation visible to all.
- ***Cooperation and networking in migration.*** When cooperation and networking between external departments, migration projects and experts is increased, resources can be combined, and synergies can be used by all.
- ***Cooperating with and promoting science and research.*** It is important that migrant-specific research about problems of access to the health care system, existing gaps in this system and the quality of treatment of migrants is not only promoted throughout the health care system, but that recommendations from the research are also implemented.

4.5 Change management

Experience gained from various transcultural processes that were initiated in the past shows that, in addition to establishing objectives, measures and means, the transcultural

development of an organisation also requires the knowledge of how to initiate and perpetuate processes of change in both institutions and the people working there (Hinz-Rommel, 2000: 155). Adjustments, modifications and innovations are always potentially threatening in terms of a possible loss of power, additional strain, new situations, etc. In processes of change, very specific interests of individuals or groups are affected as well, and therefore conflicts of interest are created that in turn create resistance against what is new. Processes of change in which management are involved are therefore frequently marked by a high degree of emotion. In order for innovation to succeed, the objective of acceptance must at least have the same priority as that of the best possible objective decision (Schwarz et al., 2002: 187).

Within the scope of a transcultural development of an organisation, the goal of achieving acceptance is even more important where it concerns the target group of migrants, who do not always experience an acceptance of their problems. What is more, migrants with an addiction problem are doubly stigmatised. There are many different ways to increase the acceptance of a transcultural shift in an institution, such as project groups, hearings, conferences, etc. The pursuit of a participation strategy is central here, which, from the very beginning, not only involves all those concerned (including the migrants) but also their interests and know-how (Schwarz et al., 2002: 188).

4.6 Quality management

The transcultural quality of an institution is higher when it is effectively targeted and efficiently (economically) meets and satisfactorily fulfils the needs and expectations of both patients / clients with a migration background and those of the specialists involved. A second prerequisite is that, at the same time, the necessity for transcultural competence is also accepted and supported by all the other groups or stakeholders involved, as well as by the public. The quality check consists of reviewing the existing migration-specific standards or objectives, the services actually rendered (*output*) as well as the effect actually achieved among the migrants involved (*outcome*).

A breakthrough in transcultural competence in the health sector can only be achieved if it is closely linked to the quality management of an institution. Only then is there a guarantee that all processes are not only transculturally orientated, but that this orientation is also constantly checked and its effect measured. This does not entail a form of quality

management that is specially aimed at migrants, but specific measures should be taken within the existing quality control systems in order that this target group of migrants is automatically included. The central idea should be to improve the quality of treatment of *all* patients, not just of specific groups (see also Bischoff, 2003: 121).

The precondition for quality management is that, using specific indicators, transcultural competence can also be measured. The Lewin Group (2002) has developed such indicators for the U.S. Department of Health and Human Services. This comprehensive system of indicators forms a suitable basis for an institution to introduce a quality control system that integrates transcultural competence adapted to local circumstances.

4.7 Outlook

The social integration of migrants with an addiction problem and/or the avoidance of the social disintegration of especially vulnerable groups – in particular undocumented migrants and/or migrants with an addiction problem – cannot be achieved by the health sector on its own. In this respect, institutions dealing with addiction are also influenced by socio-political realities that set limits to migration-specific work. Still, hope remains that, despite some difficult conditions, as many people as possible see an institutional and structural anchoring of transcultural competence in the health sector not only as a major challenge to guarantee equitable access, experience and outcome for all, but also as an opportunity to promote more humane treatment of all people, regardless of their status of residence.

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5

Empowerment in the field of migration

Georg Bröring



5.1 Introduction

From the very first beginning of the AIDS epidemic, self-help initiatives and community-based work have been crucial for the development and implementation of HIV prevention and care initiatives. Gay men in particular responded to the health-related and social challenges of the disease by informing their community and fighting for their rights. Drug users and sex workers followed soon after. While governmental and public health promotion agencies took care of informing the general population about AIDS, non-governmental organisations (NGOs) and community-based organisations (CBOs) focused on populations in the margins of society and groups that were particularly vulnerable to discrimination and exclusion¹.

Self-organisation in the area of migration and HIV followed a little later – at least in the European context. Comprehensive studies were conducted in the late 1980s and early '90s (Haour-Knipe 1991, Hendricks 1991), in which the specific needs of migrants and ethnic minorities were explored. The general consensus in these studies is that the specific expertise of communities – regarding the cultural, linguistic and social aspects of migration – needs to be central in the development of responses.

This article will focus on the roles that people from an ethnic minority background and migrant organisations play regarding the empowerment of communities, in order to improve access to services - from HIV prevention to care and support. The experiences and data presented here are based on the work of AIDS & Mobility Europe (A&M), a European networking project funded mainly by the European Commission (DG SANCO) and based at the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ). This network has been operating for almost 15 years and has gathered comprehensive knowledge of, and insight into various aspects of migration and HIV– from prevention to care, from policies to interventions. Information about A&M can be found on www.aidsmobility.org.

1 A typical example is the division of tasks between governmental and non-governmental organisations in Germany. Whilst the Federal Office for Health Promotion (BzgA) coordinates campaigns for the general public, non-governmental organisations, such as the Deutsche AIDS-Hilfe, are in charge of information interventions for specific populations, e.g. men who have sex with men, drug users, sex workers and migrant populations.

5.2 Monitoring

Community work is very important to gain insight into emerging trends and, in particular, to collect qualitative data. Challenges in the field of prevention and care, such as misconceptions about routes of transmission and the sharing of medication, can only be identified if health workers have close and trusting relationships with the populations they wish to target. These relationships can best be established in a setting of self-organisation, i.e. in which community members themselves play a central role. The European Migrants Meeting, organised in particular for CBOs by AIDS & Mobility Europe on a regular basis, is a very valuable forum to highlight emerging trends. At the last two meetings (Brussels 2002 and Lisbon 2005), community members provided and exchanged information to identify priorities for the future. For instance, attitudes towards HIV in religious communities or in a multicultural urban setting were discussed, and conclusions and recommendations should feed into training activities or other follow-up activities on these issues.

Another example are the reports of Sabanedasan and Edubio (NIGZ 2001) who looked into attitudes of migrant communities towards service providers in Finland and Germany. Due to their community involvement as former asylum seekers and members of the African community, they were able to overcome barriers of mistrust and accessed very valuable information on the specific needs of asylum seekers and African migrants.

Finally, the trend reports that were compiled by the A&M network members in 2005 (Haour-Knipe a.o., 2007) owe a great deal to the involvement of various migrant communities. In these reports, A&M partners were requested to highlight some relevant emerging trends with respect to HIV prevention, care and support in their respective countries. The outcomes - from concrete examples of efficient interventions to highlighting crucial gaps - may help to define priorities for future action.

5.3 Communication

Over the years, community-based organisations have played a crucial role for the formulation and dissemination of information about HIV and AIDS. It is common sense that the mere translation of mainstream HIV information is not appropriate if the messages for specific populations – be they migrants, gay men or drug users – are to be effective. Cultural, social, linguistic and sexual contexts need to be taken into account, and this can be best achieved by the communities themselves. An example is a video letter that was developed in the framework of a working group on gender issues, coordinated by

A&M. Here, young Africans in Belgium formulated messages and debated sexuality and preventive behaviour, and these messages were exchanged with African communities in other European countries (available through www.aidsmobility.org).

Community involvement is not only necessary to formulate HIV prevention and care messages, but also for the transfer of these messages. In general, a community has access to the communication channels that are most efficient. Here, one may think about community media, such as TV and radio channels, websites and chatrooms, or newspapers in community languages. Places and moments of direct encounter – such as the coffee houses of Turkish communities or church gatherings of African communities – can play a crucial role in communication about HIV. A concrete example here is the **Safe Sex Comedy Show**, which takes place in various locations in the Netherlands, and where migrant youth communicate prevention messages and create awareness and solidarity regarding community members affected by HIV (http://children.epha.org/IMG/ppt/9._Doing_it_safe_-_the_Netherlands.ppt).

5.4 Care

There are numerous examples of community care services for migrants that are working in a setting of self-organisation. These services have emerged particularly in urban areas with a high proportion of migrants and ethnic minorities. In Paris, for example, Ikambere – a community service for African women living with HIV – provides comprehensive support for this community (www.ikambere.com)². Comparable services exist in other cities. In Belgium, for instance, a European country where the migrant communities are particularly affected by HIV, special social events, such as dinner evenings, are organised by community-based associations such as Siréas (www.sireas.be). Common to most of these is that their services are not limited to HIV, but address broader issues, such as psychological support, legal advice or simply the provision of a socially comfortable environment. The three Bs – bed, bath and bread – may be many people's first concern when they first approach an association, before they think about AIDS. Often, a communal meal or handcraft work is the starting point to address more critical health- or HIV-related questions.

2 In the French context, this is quite remarkable, as – based on the paradigm of equity of citizens (égalité) – specific services based on ethnicity or aimed at specific ethnic communities are not common in France.

Two concrete examples of care that involves community members should be mentioned here. In Portugal, African women are trained to provide services to migrants living with HIV. Not only does this help those who receive the services, it also contributes to the skill-building of those who provide them (see Portuguese trend report in Haour-Knipe a.o., 2007). However, this approach needs considerable financial and human resources. Another example comes from the Netherlands, where, in the Academic Hospital, post-test counselling is offered by and for community members from African backgrounds. If someone tests positive, community members are available on site to provide initial counselling and advice, and referral to other appropriate services.

An important obstacle to care is reported repeatedly: the stigma within a community that leads to the exclusion of members living with HIV. Here again, self-organisation plays an important role to mobilise communities from within and create a safe environment, based on respect and solidarity.

5.5 Policy

For quite some time, there was an unfortunate separation of prevention, care and policy. Prevention was for communities, care was for medical doctors and policy was for (mainstream) politicians. Fortunately, more and more links between these areas are being established, and the awareness about the need for their integration is increasing³. There are, meanwhile, various examples where community-based organisations have succeeded in influencing the political arena. The UK-based African HIV Policy Network (www.ahpn.org), for instance, is specialised in providing consultation when policies are developed that affect Black and minority ethnic communities. In other countries, such as Belgium, migrant self-organisations are on health and HIV advisory boards, thereby putting the needs of these communities on the agenda. European-wide, the involvement of migrant communities is still far from satisfying, but there are at least a few examples that can be presented as good practice, and that could serve as models for other countries.

³ In September 2006, AIDS & Mobility Europe organised a conference dedicated to the issue: Bridging Policy and Action (NIGZ 2007). The report can be downloaded on www.aidsmobility.org.

At the European level, the Civil Society Forum – established by the European Commission (<http://europa.eu/scadplus/leg/en/lvb/r12545.htm>) – acknowledges the importance of community involvement, and in addition to other issues and target populations, migrants are on its agenda. Migrant issues have also been included in the priorities of the HIV programme of the European Centre for Disease Control ECDC (http://www.ecdc.eu.int/Health_topics/AIDS/Index.html), and here again, community involvement will be crucial to develop appropriate action.

5.6 Challenges

Even though this article refers to a variety of good practices of self-organisation and community involvement, there are still numerous obstacles to overcome. The current political climate in Europe is not very favourable for creating a supportive environment for migrant and ethnic minority communities. Xenophobia is reported to a greater or lesser extent from virtually all European countries. A strong emphasis is put on integration at all costs, leaving little space for multi-cultural approaches. This limits the self-expression of communities and may have counter-productive effects on finding solutions (in many fields, including health and HIV) that correspond to their needs.

Funding mechanisms are another obstacle. Very often, they are difficult to access by communities that are not familiar with complicated application procedures. For newcomers in the funding world especially, the barriers may be too high to overcome, particularly limiting small-scale initiatives, which are so important in developing innovative pilot activities. The area of migration and HIV is ever-changing, as new populations and issues enter the scene: community initiatives are essential to respond to these changes. Some flexibility is needed by funding agencies to enable self-help organisations to develop these initiatives. A good example of this comes from Spain, where, as part of the National Plan on AIDS, governmental organisations provided specific training for CBOs to develop applications for funding.

Another challenge is to address the lack of people with migrant or ethnic minority background at the executive levels of health promotion and AIDS organisations: more of these individuals at the decision-making level would definitely have an impact on the level of self-organisation, too.

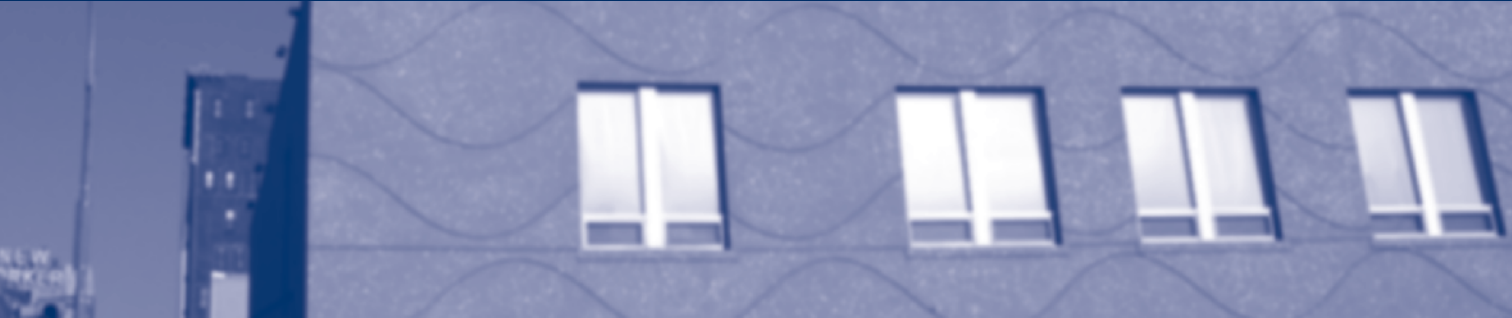
5.7 Conclusions and recommendations

After more than fifteen years of community-based work in the area of migration and HIV in Europe, the picture is still quite diverse. A lot has been achieved in the field of prevention, and many communities have overcome stigma and taboo in order to take HIV onto their agendas. At the same time, the situation is still very fragile. The public discourse and the current political climate show that migration issues remain sensitive, and a safe space for migrants in society can never be taken for granted. All members of society need to contribute to a framework that is stimulating and supportive for community involvement. Empowerment plays an important role in this respect, but empowerment needs to come from inside a community. Mainstream society – and the bigger and more powerful governmental and non-governmental organisations in particular – need to create a supportive environment, including training and funding, that makes this empowerment possible.

Resources need to be made available to share good practice concerning self-organisation and community involvement. Particularly in countries where NGO development is not (yet) well advanced, such as in some of the new member states of the European Union, efforts need to be made to increase awareness about the importance of community involvement, particularly when issues amongst migrant populations are to be addressed. The country reports that were written by A&M partners from the new member states (NIGZ, 2006) indicate that there is a clear need for improvement in this area. These efforts have to come from both governmental and civil society levels: the political level needs to create a framework and resources to enable communities to get involved, and existing NGOs need to put migration issues on their agendas and to give community members the opportunity to explore and develop their own programmes and interventions.

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NEW



6

Community engagement: the Centre for Ethnicity and Health model

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* The authors gratefully acknowledge the contributions to this paper from other members of CEH staff: Jon Bashford, Christine Brown, Kate Davies, and Robert McDonald.



6.1 Introduction

This paper briefly describes the community engagement model developed during the Community Engagement Programme conducted across England by the Centre for Ethnicity and Health (CEH)¹, Faculty of Health, University of Central Lancashire. This model radically challenges traditional research and consultation processes amongst socially excluded communities (variously described as community ‘representation,’ ‘involvement,’ ‘participation,’ ‘empowerment,’ and ‘development’). It provides a practical and robust means to ensure that health and social services are equitable, appropriate and responsive for all members of the population. Socially excluded communities are often described as being ‘hidden’ or ‘hard to reach’ by researchers and by health and social services. However, a basis of the CEH approach is that it is not the communities themselves that are hidden or hard-to-reach, but that those who usually conduct research have little success in accessing them and/or obtaining the desired information, and that there are barriers that hinder their access to health and social services.

Research amongst socially excluded communities does not usually involve the communities who are being researched, beyond using members as interviewees, or, at best, privileged access interviewers (for example, Blanken et al., 2000; Griffiths et al., 1993), and is usually conducted by a researcher from a university or other research institution who ‘parachutes’ into the community *‘thereby raising expectation that there will be some change, then disappears to produce a report and academic papers with no long-term impact’* (Fountain et al., 2004a p.66).

Some members of the population, particularly those from Black and minority ethnic communities,² face a series of barriers that prevent them accessing and benefiting from

1 The Centre for Ethnicity and Health can be contacted on CentreEthnicityHealth@uclan.ac.uk or via <http://www.uclan.ac.uk/facs/health/ethnicity>

2 The Centre for Ethnicity and Health is very conscious that various terms are used to refer to the many diverse communities throughout Europe, especially ‘migrants’ or ‘ethnic minorities.’ We prefer ‘Black and minority ethnic communities.’ This reflects that our concern is not only with those for whom ‘Black’ is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: ‘Black and minority ethnic’ also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be ‘Black,’ but who nevertheless constitute a distinct ethnic group.

health and social services. Black and minority ethnic communities are already socially excluded: failure to consider and meet their service needs exacerbates this situation. In terms of drug services, for instance, a study across the European Union (EU) (Fountain et al., 2004a,b) showed that there is considerable variation in services provided for these populations both within and between member states, but in the EU as a whole, drug policy and practice reflect the needs of the majority white population. Although there are indications that drug-using patterns amongst many Black and minority ethnic communities are not substantially different from those of socially-excluded white populations, it does not follow that existing drug services meet their needs. Service responses may have to be different in order that the barriers to drug service access - especially cultural and language barriers - can begin to be overcome.

The CEH Community Engagement Model (figure 1) addresses the issues outlined above in order that the health and social service needs of socially excluded groups can be better met by equitable access, experience, and outcome. Major aims of the CEH approach are to create an environment in which communities (individuals and organisations) and agencies can work equitably together to address an issue of mutual concern, and that the research benefits the communities who are being studied. Individuals from the target community are recruited and capacity built by an external facilitator's provision of regular support, appropriate resources and accredited training. These individuals are not necessarily those perceived as 'community leaders' nor as 'spokespersons' on the issue in question, but those who represent the diversity within a community and have access to its members. From the outset and throughout, there is explicit involvement in the engagement process of local agencies responsible for commissioning, planning and delivering services.

Centre for Ethnicity and Health Community Engagement Model



Figure 1. Centre for Ethnicity and Health Community Engagement Model

6.2 Implementation of the model

There are a number of key ingredients to ensure the successful completion of the process using the CEH Community Engagement Model: a facilitator, a host community organisation, a task and support in the form of training, a project support worker, funding, and a steering group.

6.2.1 Facilitator

The process of community engagement described here requires overall management, but by a body acting as a facilitator rather than an authoritarian controller, and concentrating on creating an environment where community organisations and agencies work together. After obtaining funding for a community engagement project, the role of the facilitator includes:

- advertising, recruiting, and selecting the community organisations to participate in the project, including advising and supporting potential applicants during this process;
- providing and managing the team of staff supporting the community organisations (project support workers and trainers, as described below, and dedicated administrative staff);
- encouraging inter- and intra-community participation and networking;
- facilitating the engagement between the statutory and community sectors;
- acting as arbiter and resolving conflicts within the engagement process; and
- advising, guiding and supporting the relevant service agencies to engage and to work with the community organisations and vice versa.

6.2.2 Host community organisation

In order that the community is at the heart of a community engagement project, it is essential to work through a host community organisation, which may be an existing organisation or one created for the project. The community organisation must have good links to the target community so that it is able to recruit members to participate in the work as community researchers and as research subjects. The organisation must be able to provide co-ordination and an infrastructure for the day-to-day activities that will be undertaken once the project is underway, such as somewhere to meet, access to

telephones and computers, and a financial system. The greatest proportion of funding for projects in the CEH Community Engagement Programme is distributed amongst the participating community organisations.

6.2.3 Task

The task that the community is to be engaged in must be meaningful, time-limited and manageable, and almost all the CEH community engagement projects to date have involved communities in undertaking a needs assessment on an issue that is significant to them and to local services. However, it must be stressed that although a research report from a community organisation is a significant outcome of a community engagement project, of equal importance is the process of building the skills and capacities of the community organisations, community members, and local service planners, commissioners and providers involved by:

- raising the awareness of community members of the issue in question and of the local services available, and raising the awareness of service planners, commissioners and providers of the community and their service needs;
- where it exists, reducing the community's stigma, fear, and denial of the issue (such as drug use and mental ill health);
- capacity building individuals and community organisations in order that they have an enhanced ability to articulate identified needs to service planners, commissioners and providers, thereby ensuring local ownership and clear plans to implement the research findings;
- enhancing the local workforce and planning agenda to ensure delivery and growth in the workforce, including the development of mentoring, accredited training, volunteer networks and employment;
- increasing the trust of the community in local service planners, commissioners and providers and vice versa; and
- involving local service planners, commissioners and providers in the process.

This process enables the development of services that are sensitive to, and meet, identified needs and sustains the engagement of the community and service planners, commissioners and providers; partnerships that have been established during the project; and the work that has been identified by the needs assessments.

6.2.4 Support

The support element of the CEH Community Engagement Model consists of training, project support workers, funding and a steering group. Support is crucial element in building the capacity of a group of people to conduct a piece of research, produce a report, and to ensure that the recommendations for service development are taken seriously. It should be emphasised that the majority of community organisations and community researchers who have participated in the CEH Community Engagement Programme have had little or no prior experience of conducting research, the issue they will be researching nor the local service provision to address it.

Training. When a community organisation is recruited to a CEH community engagement project, they are assisted by the facilitator to identify and recruit an individual from their community to act as a lead researcher / co-ordinator, and others to conduct the research. Training is provided for these community members to give them a basic knowledge of research methods and of the area they will be researching, including relevant national and local policies. Typical training programmes comprise five days on research methods and two days on the area of research, and take place in accredited workshops, giving participants the opportunity to complete an assignment to gain a nationally recognised university certificate.

Project support worker. As discussed by Fountain et al. (2004a), implementation of the CEH Community Engagement Model involves project support workers, who are required to offer a significant level of support to the communities, but to stop well short of doing the work that the communities are learning to do themselves. Most support workers employed on the CEH Community Engagement Programme are graduates, with previous experience in conducting research and of working with Black and minority ethnic communities. The majority are members of these communities themselves. The project support workers visit 'their' projects for at least half a day once a fortnight and are in telephone and/or email contact the rest of the time. They have a number of key responsibilities, including:

- assisting community organisations to recruit appropriate personnel to work on the project and to identify who they send to training workshops;
- attending training with these individuals and providing or organising further training sessions if requested;
- helping community organisations to develop their research project, including the

- methods to be used and the preparation of a submission to the CEH Community Engagement Programme Ethics Committee;
- advising on budget management;
 - acting as resource for information about the issue the research is addressing and about relevant agencies and organisations;
 - acting as a link between the often very small community organisations and very large local agencies;
 - making and maintaining links with local key stakeholders to ensure that projects are linked into local relevant service plans and agencies;
 - providing academic advice to those enrolling on the university certificate courses;
 - monitoring projects on an on-going basis and setting key tasks and milestones; and
 - assisting community organisations to disseminate and promote their projects' final reports.

Regular community organisation-support worker meetings are a crucial feature of the CEH Community Engagement Model, as they allow new skills and ideas introduced during the training workshops to be discussed, rehearsed, and digested effectively. Without regular meetings, community-based researchers risk becoming lost in a plethora of unfamiliar ideas.

Funding. The financial resources required for projects in the CEH Community Engagement Programme vary according to the number of community organisations who participate, as this also determines the number of CEH staff involved as managers, support workers, administration workers, and workshop leaders. The CEH has obtained some relatively large grants, including one for several million euro for *The Department of Health's Black and minority ethnic drug misuse needs assessment project* in which 179 community organisations participated. Much smaller projects, such as *A community engagement project to assess the sexual health needs of young people of South Asian heritage in Blackburn with Darwen* involved just one community organisation, and the total project funding was around 30,000 euro. Typically, however, community organisations receive around 20,000-30,000 euro each in a CEH community engagement project. The bulk of this is expected to be used to pay those who conduct the research amongst members of their community.

Steering group. A steering group is an essential requirement for each project in the CEH Community Engagement Programme, and comprises relevant local health and social service planners, commissioners and providers. This makes it clear with whom the community is engaging and maximises the likelihood that the community organisation's work will be sustained in the long term. The steering group role includes ensuring that the work the community organisation undertakes is compatible with local priorities and strategies; providing a mechanism for taking forward the research findings and recommendations; and harnessing the energies of those engaged in the project as they acquire skills and knowledge, by supporting them to take the next steps in terms of learning or career development.

6.3 Conclusion

Where all the above ingredients are present, the sustainability of the work using the CEH Community Engagement Model has greatly contributed to the engagement of local people in the planning and development of new services that address their needs. The themes that emerge from the community organisations' reports are often very powerful, particularly when combined with other reports from the same project. These data are key to commissioning and planning services for diverse communities previously thought of as 'hard to reach': although there may be statistics that show that there is under access, over access, or inequitable access to a range of health and social services, statistics cannot explain the underlying issues. Thus, the implementation of the model has not only begun to dismantle barriers to health and social service access by socially excluded populations, but has also increased the understanding of service planners, commissioners and providers about segments of the population they serve.

The Department of Health's Black and minority ethnic drug misuse needs assessment project is just one illustration of the model in practice. The project was conducted across England during 2000 – 2006, in three phases, and is the largest project in the CEH Community Engagement Programme to date. Phase one is reported in detail by Winters and Patel (2003) and Bashford et al. (2003).³ Achievements include:

- In phase one, 47 community organisations conducted interviews and/or focus groups with over 12,000 individuals, from 30 ethnic and national groups, who between them spoke 36 different languages and included informants with a range of religious faiths such as Islam, Christian, Rastafarian and Zoroastrian. Forty-five of the 47 community organisations were situated in the most deprived local authority districts in England. Over 2,000 of informants had used illicit drugs.
- In phase two, 475 community members from 90 community organisations attended workshops for training on drugs and on research methods. Of these, 177 enrolled for the University Certificate Community Research and Drugs or the University Certificate Community Research and 139 (79%) of them obtained one of these certificates.
- The role of local Drug Action Teams (DATs) is to co-ordinate the delivery of the national drugs strategy at local and community level, and to act as a focus for joint planning by local agencies, including health, social services, education and police. The participation of DATs was therefore a crucial element of this project. In phase three, an external evaluation (Baker et al., 2006) found that 88% of a sample of DATs reported a positive improvement in their relationship with the participating community organisations (the remainder already had a good relationship with them). For example (p.61):

“We had been trying to forge links with that community for a while. We will continue our links after this project. We are trying to get them into our formal planning and consultation structures, like the BME [Black and minority ethnic] Advisory Panel.”

“We are more aware of the wider issues as well as understanding substance misuse issues within the community. We have taken on board their recommendations and funded them, so they have more confidence in us, so the relationship keeps strengthening.”

³ See <http://www.uclan.ac.uk/facs/health/ethnicity> for details of a series of further publications from The National Treatment Agency for Substance Misuse on the results of this project, to be published in 2007-2008.

The application of the CEH Community Engagement Model has also assisted in organisational change processes for relevant agencies, including effective ethnic monitoring, workforce development, training and practice initiatives, and the development of a range of policies and practices that involve local communities from the outset. The process the model prescribes aims at more than community representation, involvement, participation, empowerment or development, although it will also achieve these. It is positive in its conception, and impacts and drives both communities and agencies to be proactive in their relationships. In this respect, the model conforms to the human rights legislation framework that is evolving across Europe.

In order that it operates as intended, the CEH has been developing and refining the model's theoretical and operational processes, incorporating the results of external evaluations. The model was first applied to drug use and Black and minority ethnic communities in 2000, but has since expanded into the domains of mental health, sexual health, regeneration, the criminal justice system, higher education and asylum. Although Black and minority ethnic communities remain a focus, other communities have been brought into the programme, including young people; people with disabilities; service user groups; victims of domestic violence; gay, lesbian and bisexual people; socially excluded white communities; and rural communities.

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7

The right to health

Joost den Otter, Ancella Voets



7.1 Introduction

There is at least one characteristic that all human beings have in common: the risk of getting ill. The way people deal with their illnesses varies considerably, but treatment in one country should, in essence, not differ from treatment in any other. Everyone knows when it is appropriate to visit a doctor in his or her own country. Differences in the way health care is organised become clear when people are not in their own country and are in need of medical help. In some countries, public health care is free of charge for everyone. However, in most countries people need either money or health insurance to cover the expenses. As these are often lacking for undocumented migrants, seeking medical assistance is often postponed until it is impossible to ignore the symptoms or complaints. This results in consulting a medical professional at too late a stage or in the wrong place (e.g. at the Accident and Emergency department of a hospital instead of a general practitioner). In addition, preventive medical care is also underused by undocumented migrants. Examples of this are vaccination programmes for certain infectious diseases (e.g. hepatitis B) for high risk groups, such as substance users and sex workers. For these groups, the stigma of drug use and sex work may also affect access to health care services when they are in need (e.g. they are vulnerable to contracting a contagious disease) and when they are also undocumented migrants, they face double barriers.

7.2 The right to the highest attainable standard of health

International agreements conceive the right to health as part of a wider social environment than simply the absence of disease. This extends not only to timely and appropriate health care but also the underlying determinants of health, such as safe working conditions and adequate food and shelter. The basis for an international legal framework of the right to health has been established through the Universal Declaration of Human Rights. This Declaration is not legally binding, but consists of a statement of principles that have been codified in several international instruments and treaties. The most relevant instrument on the right of everyone to the highest attainable standard of physical and mental health, for convenience often shortened to ‘the right to health’, is the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 (http://www.unhchr.ch/html/menu3/b/a_ceschr.htm). This right is inclusive and envisages health care to which people are entitled, rather than privileged, to access, and which is provided in a non-discriminatory manner, respecting diversity and difference. In this chapter, we will highlight Article 12 (the right to health) and Article 2 (obligations of the state).

ICESCR, Article 12

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.

The improvement of all aspects of environmental and industrial hygiene.

The prevention, treatment and control of epidemic, endemic, occupational and other diseases.

The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

7.3 Obligations of states

The right to health is often also enshrined in national constitutions and has generated significant jurisprudence. While the right to health includes the right to health care, it goes beyond health care and covers underlying determinants such as adequate access to health-related information. Like other human rights, it has a particular concern for disadvantaged, vulnerable people and those living on the fringes of society. The right requires an effective, inclusive health system of good quality. What ‘the right to health’ exactly means has been further specified in General Comment 14 (below). This comment asserts that all states have immediate obligations, including minimum core obligations. Core obligations are intended to ensure that people are provided with, at the very least, the minimum conditions under which they can live in dignity, enjoy the basic living conditions needed to support their health and be free from avoidable mortality. They serve, in other words, as a bottom line for responsibilities of states. Here, following the themes addressed by this reader, we confine ourselves to the issues relevant to undocumented migrant drug users and sex workers.

General comment 14 to Article 12, ICESCR

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds (see paras. 18 and 19);

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be

disproportionately burdened with health expenses as compared to richer households;

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;

Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

ICESCR article 2

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

In summary, the obligations of states are to respect the right to health, to protect the realisation of this right and to fulfil this right. To hold a state accountable, it is necessary that disaggregated data are available. These data can be used to influence national health policies. On the other hand, the same data could and should be used by collaborating non-governmental organisations (NGOs) to produce (shadow) reports to the appropriate reporting bodies in, for example, the Council of Europe or the United Nations.

7.4 Problematic access to health care

For socially excluded populations access to, in addition to the accessibility and acceptability of health care, is often problematic. Even when a state offers harm reduction, a mixture of preventive and curative health care, undocumented migrants are excluded from both local and national programmes. States often leave the responsibility of delivering health care for undocumented migrants to NGOs and those medical professionals who choose to take the risk of not being paid for the services they provide. Few undocumented migrants use regular health care facilities, and, to some extent, this is connected to their lack of knowledge: they simply do not know how health services in the country where they reside are organised. Furthermore, most undocumented migrants have a constant fear of being reported to the police, losing their job, and/or being detained or deported. This means they ignore their health needs until they become absolutely urgent. In the case of HIV/AIDS especially, this fear and ignorance may lead to unnecessary harm.

The accessibility (including economic affordability) of health care services is problematic for undocumented migrants in several European countries. In most of Europe, they access health care only in emergency situations, and most countries provide this. In some countries, essential care is also provided (i.e. care for diseases which are not an immediate health threat, but which may cause serious damage, such as diabetes and hypertension).

The acceptability of health care is another issue. Among other things, this encompasses respect for the culture of individuals. Although there have been enormous efforts to deliver culturally appropriate care in several European countries, only a few examples of good practice are widely-known.

7.5 Conclusion

To attain 'the right to health' for all, including undocumented migrants, (health) professionals working with this target group should use a 'rights-based approach'. However, to realise 'the highest attainable status of health', one has to be pragmatic too: NGOs delivering health care where states fail to do so is sometimes the best solution. Such NGOs should use their experiences and data to produce reports. A helpful tool for this is Judith Asher's (2004) 'The Right to Health: A Resource Manual for NGOs'. Both legal and health issues are well-elaborated and the work contains properly worked-out field studies that can be used as best practice on how to reach and influence local and (inter)national committees. The great challenge to do so requires a lot of time and effort and, in order to be successful, self-help organisations and NGOs need to cooperate and combine forces and expertise. We wish them success in doing so!

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<http://shr.aaas.org/manuals/rth.shtml>

Relevant additional resources

www.aidsmobility.org	Especially useful for issues on migrants and HIV/AIDS
www.bayefsky.com	All UN treaties including overviews by state
www.december18.net	Useful human rights portal in different EU languages
www.hhri.org	Health and human rights information (in English and Spanish)
www.mainline.org	NGO focussing on the health and quality of life of drug users
www.pharos.nl	NGO focussing on health care to refugees and asylum seekers.
www.picum.org	I-NGO focussing on undocumented migrants
www.who.int	World Health Organisation website



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8

Drug prevention for asylum seekers, refugees and undocumented migrants*

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8.1 Introduction

In different Member States of the European Union (EU), local, regional and national (health) authorities are faced with the a growing number of refugees, asylum seekers and undocumented migrants (i.e. immigrants without legal residence permits from various countries and ethnic backgrounds). Their stay in a particular Member State is sometimes limited to a few months, but a substantial number remain for years or permanently.

UNHCR (United Nations High Commission for Refugees) estimates that one in every 250 of those who leave their home country do so to find a safer existence elsewhere. It appears that many of these suffer from various health problems, including problematic substance use. However, apart from some explorative studies (e.g. Braam et. al 1999), there are few reliable data about the nature and extent of these problems. What little information there is rarely consists of more than hearsay - often based on dubious political interests - and some anecdotal evidence from health and social agencies.

Various European and national projects on the topic of migration and substance use have focused on different aspects of this issue, such as the mobility of substance users among EU Member States, and infectious diseases and substance use among migrant communities who are well-established in a country. New refugees, asylum seekers and undocumented migrants, however, differ substantially from the groups covered by these projects. Major differences are their diversity (different nationalities, languages, ethnic, religious and cultural backgrounds) and, in the case of asylum seekers and undocumented migrants, their legal immigration status. From the little we know, we can conclude that some were using substances before they came to Europe, while others became involved in substance use during their stay in refugee camps. Different factors contribute to making these groups especially vulnerable to substance use, including traumatic experiences in their home countries, psychosocial problems connected to difficulties adapting to their new environment (language problems, different norms and values, etc.), a lack of social and family contacts, their often uncertain future, and boredom due to forced unemployment and lack of other activities.

In different EU Member States, drug agencies have developed ad hoc approaches and information material in the fields of drug prevention and demand reduction. However, data are generally lacking on the extent and nature of substance use among asylum seekers, refugees and undocumented migrants, and their specific prevention and demand reduction needs.

8.2 Initial situation

The subject of addiction has been comprehensively and scientifically researched. This applies not only to substance and use risks, but also to care systems. However, very little reliable research data have been produced on the risk of addiction among migrants, and the data available on the health risks of refugees, asylum seekers and undocumented migrants are very poor. In many European regions, it has been observed, however, that there are major addiction problems within these groups. The experience of practitioners in drug prevention has shown that it is precisely in this area that there is a considerable need for research. The Coordination Office for Drug-related Issues at the LWL (Landschaftsverband Westfalen-Lippe) in Münster, Germany, has also consistently received reports that existing drug prevention programmes have proved to be unsuitable for refugees, asylum seekers and undocumented migrants. Preventive approaches have failed owing to a lack of knowledge about the target groups, the inability of drug workers to contact them and, last but not least, communication difficulties because of language.

The SEARCH project developed out of the motivation to produce basic findings on this problem area. Those taking part in the project were not pursuing any political objectives. Nevertheless, a correlation was seen between the individual behaviour of those affected and the conditions under which they live. Therefore, drug prevention can only be successful if it takes into account not just the individual requirements of those migrants in need of help, but also their living conditions. The conditions under which refugees, asylum seekers and undocumented migrants live can reduce the risk of addiction if targeted protection mechanisms are fostered. By promoting awareness, tolerance, communication and intercultural encounters, the intention was to influence these conditions. Efforts to change environmental conditions have a particular relevance for the health and social systems in almost all European countries, because refugees, asylum seekers and undocumented migrants are excluded from these systems. It therefore seemed necessary to address this issue at European level.

How many asylum seekers are actually accepted by an EU Member State varies considerably. Whereas Spain and Italy, for example, hardly accept any, the number of undocumented migrants there from North Africa appears very high, although their living situation is comparable with those of documented migrants in other countries.

8.3 The rationale for the SEARCH projects

The results of the SEARCH (2000 – 2002) and SEARCH II (2002 – 2004) projects were targeted at practitioners in drug prevention who deal with refugees, asylum seekers and undocumented migrants. At the European level, SEARCH and SEARCH II were concerned with raising awareness about problems and methods relating to this subject. The results of the projects were intended to have a promotional effect and through earlier and better recognition of health risks in the social groups concerned, the intention was to improve the planning of suitable measures. It was also intended to obtain information on good practice.

SEARCH was initially concerned with securing basic data on the prevalence of addiction in the target groups, and it was intended to develop methods for drug prevention based on the concept of intercultural competence. The purpose here was to equip refugees, asylum seekers and undocumented migrants with the necessary competence to be able to deal with the risks and dangers in what for them are alien cultures. In the final analysis, this means better protection from health risks.

Drug prevention work as envisaged by SEARCH and SEARCH II has practical consequences for local communities and local authorities, where most practitioners work. If suitable living conditions for the refugees, asylum seekers and undocumented migrants can be achieved successfully at the local level, then it might be possible to reduce the risk of addiction. The prerequisite for this, however, is that the local public institutions support drug prevention work.

8.4 The SEARCH projects

To address the issues outlined above, the SEARCH project, ‘Drug Prevention for Refugees and Asylum Seekers’, was funded by the drug prevention programme of DG Public Health and Consumer Protection in Luxembourg and co-ordinated by the LWL in Münster, Germany. The project’s aim was to contribute to the development of instruments in the field of drug prevention that can be used in other regions and Member States. The objectives were:

- To obtain a picture of the drug problem among refugees, asylum seekers and undocumented migrants in a number of EU Member States.

- To identify the drug information needs of these groups.
- To identify existing good practice.
- To initiate and support the development of new approaches and information material.
- To initiate and support the exchange of expertise.

The first phase of the project (SEARCH) focused on developing and piloting a method for the rapid collection of valid information on drug problems among the target population that can be used directly for drug prevention activities. The Rapid Assessment and Response (RAR) method, as developed by Stimson, Fitch and Rhodes (Stimson et al., 1998a) was used. Stimson et al. used this approach with success, notably in the prevention of infectious diseases among injecting drug users.

This phase of the project included the following activities:

- An inventory of existing interventions and information material in the regions of the partner projects in six European Member States.
- Developing an RAR model for refugees and substance use.
- Training and support in RAR methods.
- Realising RARs in the six Member States to cover topics such as the (legal and illegal) substances used, the routes of administration, use and problematic use, the context of substance use, the specific needs of refugees in terms of drug prevention, etc.
- Producing a manual on how to conduct an RAR on the issue of drug use among refugees, asylum seekers and undocumented migrants, to allow other organisations to use this approach.

The second phase, SEARCH II, consisted of the development of interventions in the six member States, based on the results of the surveys conducted in phase one. The results of this work were presented in a guide to drug prevention interventions for refugees and asylum seekers (Lutz, 2004a).

SEARCH II provided a smooth transition from SEARCH and supplemented the basic tasks with the following aspects:

- With the help of the RAR Monitoring Module, the changes in the target groups were recorded and interpreted (research aspect).
- The projects that had been started were further developed, consolidated and firmly established at a regional level on a sustainable basis (practice development).

- Six new European regions (countries) were added to further disseminate SEARCH throughout Europe (European dimension).
- The results of the projects in terms of procedural recommendations were published (guidelines) (Lutz, 2004b).

8.5 A selection of results from SEARCH and SEARCH II

When researching the health problems of migrants, a series of stress and risk factors lie behind general health risks, including that of addiction: intercultural communication, linguistic problems, living conditions, working conditions, lack of knowledge of care structures, family structures, the trauma of migration, and the prevalence of addiction.

8.5.1 Intercultural communication

Owing to the often short period of time in which they have been living in the country, their specific living situation and the reasons for their migration, our target groups in particular clearly have more communication difficulties with the people of the host country than, for example, the second or third generation of migrants who live there. In turn, the people from the host country have more difficulties in developing contact and in overcoming their reservations with the new arrivals. This situation, which must be overcome by both sides in order to achieve intercultural communication, requires the acquisition of intercultural competence. The experiences of both project phases concerning this central area are described in the 'Guidelines' (Lutz, 2004b).

8.5.2 Linguistic problems

Not being able to express oneself in the language of the host country means to be cut off from lively everyday communication and opportunities for contact, except with others who speak the same language. This encourages isolation and segregation, and even when the host country's language has been learned, considerable cultural differences are expressed in the content of the language (i.e. at semantic level), which can make it very difficult for migrants to understand health and medical issues. This understanding is, however, of essential importance for prevention activities. All our respondents confirmed that the inability to speak the language of the host country contributes to the isolation (and even to the 'ghettoisation') of asylum seekers, refugees and undocumented migrants. If addiction

prevention is to be successful, then it is essential that the risks and means of avoiding them are explained to them in their language and in terms of their cultural background.

8.5.3 Living conditions

Across Europe, many first generation immigrants (and frequently subsequent generations) live in disadvantaged areas in poor housing conditions. Often, their place of residence does not conform to the norms of the country of origin¹. This is particularly the case for asylum seekers, many of whom, in all European countries, live in restrictive and oppressive conditions such as prison-like immigration centres, and for undocumented migrants, many of whom are homeless. It was an extremely depressing experience for the SEARCH team to realise how unfit for human habitation much of their accommodation is.

8.5.4 Working conditions

Several studies in German-speaking countries (and we assume that this also applies to other European countries) indicate that immigrants generally have not just poorer working conditions than the rest of the population, but fewer possibilities of receiving training in the host country. Furthermore, the high technological demands of the host countries does not match their work experience in their home land, and places them at a disadvantage in terms of obtaining employment.

Other employment-related issues also affect the asylum seekers investigated by the SEARCH projects: state legislation dictates that most of them are not allowed to work, or only to a very limited extent, and many are therefore doomed to idleness and degraded to 'charity cases'. This promotes isolation, 'ghettoisation' and – according to our studies – has considerable impact on their self-esteem and motivation to deal actively and positively with their lives and health. Many never escape from this situation, not least because the financial means available to them are generally and structurally very restricted. This leads to the risk that they will commit acquisitive crimes, including selling drugs.

1 For Germany, compare MFJFG (Ed. 2000), Gesundheit von Zuwanderern in NRW, p.16 ff. Also see: Toni FALTERMAIER, Migration und Gesundheit, in: P. MARSCHALCK/K. H. WIEDL (2001), p. 93 ff.

8.5.5 Lack of knowledge of care structures

Migrants frequently live in considerable ignorance of the care structures within the social and health sectors of the host countries. When problems arise, they do not seek help, but discuss solutions within the family, who are often, however, overtaxed and react with helplessness. Whilst in the case of working migrants, this situation tends to improve over time, it applies to the SEARCH target groups to a considerable extent: they very often do not know how and where to receive help and sometimes access to this help is blocked by state legislation (there is no financing of certain health services for asylum seekers and refugees through the Asylum Seekers Benefits Act in Germany, for example²). A further important issue was identified in the various project locations: often, the people in our target groups come from areas of the world where violence, lack of rights, state despotism and political and religious persecution prevail. They do not understand the care systems in the western democratic world and mistrust institutions and their intentions. It is therefore important to identify culturally sensitive solutions to encourage access that take this into account.

8.5.6 Family structures

There is a tendency of migrants' (traditional) family structures to disintegrate and this plays a considerable role in their psychosocial stress. This disintegration can occur during migration itself, but also through the gradual adoption of the host country's cultural norms by some family members (generally the second generation), which can lead to internal family conflicts, increasing 'cultural antagonism' and the associated mental health problems³.

2 Compare critically with PRO ASYL (Hg.): G. CLASSEN, Menschenwürde mit Rabatt. Kommentar mit Dokumentation zum Asylbewerberleistungsgesetz (AsylbLG) und zum Flüchtlingssozialrecht, Berlin 2002.

3 'Imitating' the lifestyles of people in the host countries also plays a role: the habitual lifestyle and behaviour patterns in the culture of the country of origin may contrast considerably with those of the host country. For those who 'give up' their cultural identity, which may assist in protecting them from drug use, for a long time only have the possibility of 'simulating' a 'new' cultural identity. The use of alcohol, for example, becomes more risky the less this use was culturally acceptable in the country of origin.

These observations apply to immigrants in general but are even more dramatically experienced by the target groups we investigated as a result of further stress factors: often, family members were separated in the course of migration and, due to state restrictions in the reception countries, were unable to meet up again, or only to a limited extent. In such cases, the family cannot operate as a 'protective factor' - a shield against the dangers of the host country which are largely unknown, particularly to new migrants. The loss of the family leads to a loss of relationships and opportunities in life, and this is a risk factor not only for general health but also for substance use⁴.

8.5.7 The trauma of migration

The loss of the home, familiar surroundings, family, cultural certainty and confidence play a considerable role within every migration process. Foreign cultures can be experienced as something extremely incomprehensible, even threatening, while the loss of all that is familiar is mourned. The general process of 'uprooting' has begun to be taken seriously in all European countries, and no longer just responded to with the knee-jerk call for 'integration'. Integration presupposes openness, trust, confidence and respect on both sides. This must be first earned and the demand for integration must not be linked to the 'demand for cultural identity' or it will have the effect of creating fear and segregation, which in turn can lead to mental stress and other ill health.

This applies even more to the groups investigated by us. The reasons for leaving the home country are often dramatic and traumatising: persecution, fear, humiliation, torture and the threat of death play a role, but also squalor, poverty, impoverishment and hopelessness in the homeland. Such severe wounds heal slowly, and the insecure status as an asylum seeker or undocumented migrant, characterised by many new stresses and fear of the future, hinders the healing process. Our RAR found that trauma (and the associated post-traumatic stress syndrome) is a highly significant factor contributing to vulnerability to substance use and problematic use.

Overall, with the help of the RAR, we have acquired an impressive dataset on substance use and the associated risk factors among refugees, asylum seekers and undocumented

4 In some of our studies, we were able to establish a clearly higher vulnerability to the use of addictive substances for single men.

migrants, as well as appropriate means and methods for addiction prevention. Many of our initial assumptions had to be revised, but some were confirmed.

8.5.8 Prevalence of addiction

The actual prevalence of problematic substance use among the groups the SEARCH projects investigated is, in quantitative terms, very small. However, where addiction problems do occur, they tend to have a more detrimental effect when compared to a country's native population. In many countries, it was also noticeable that due to the national policies, it is almost impossible for asylum seekers and undocumented migrants to receive therapeutic treatment for addiction, because finance is not provided for it. However, this deficiency was not pursued any further in the project, especially since we had to restrict ourselves to looking at preventive activities. Nevertheless, we are mentioning this here to illustrate the effect of the health and social policies of the various European countries.

8.6 Recommendations for practical addiction care

Preventive care for refugees, asylum seekers and undocumented migrants at risk of addiction should focus on intercultural competence. Initiatives will be effective only if there is mutual understanding between those needing help from the one culture and the helpers from the other culture. That is one of the central findings of the SEARCH projects.

Initiatives should begin as soon as possible after migrants' arrival in the reception countries and be designed on a long-term basis. This particularly applies to behaviour-based approaches (addiction care distinguishes between behaviour and relation-based approaches). In SEARCH and SEARCH II, it became clear that approaches aimed purely at changing the behaviour of addicts or those at risk of addiction will remain largely ineffective.

There are six levels of action for practical addiction care work with refugees, asylum seekers and undocumented migrants: knowledge, access, action, sustainability, monitoring, and policy. These levels can only be seen as sequential to a limited extent.

8.6.1 Knowledge

Cultural knowledge is the first stage in effective addiction care. Not only is precise knowledge required of the culture from which clients and potential clients come, but also of the culture of the host country. Information must be collected on the ethnicity, religious views and values of the migrants, bearing in mind that their country of origin may not provide a reliable indication of their cultural roots. The results may identify behaviour patterns, viewpoints, norms and values that operate as protective factors and can be used as a basis for risk protection initiatives, including addiction, and they should be respected, promoted and shared with other service providers. The RAR method is very suitable for securing such information as well as for developing, implementing and evaluating suitable methods and approaches. A useful aid here are the grids that were used for the projects in SEARCH and SEARCH II (Verbraeck and Trautmann, 2002).

8.6.2 Access

Key informants (or key persons) are those who are in a position to gain the trust of the people being helped, and facilitate access to refugees, asylum seekers and undocumented migrants. Acting as cultural mediators, they imply a “we” feeling, whilst providing a connection to the culture of the host country. Ideally, the key persons should have shared some of the experiences of those needing care, such as ex-asylum seekers who have been granted refugee status. In addition to key informants, access to migrants could be via individuals working at health and social care facilities, but all key informants, cultural mediators and interpreters must acquire intercultural competence.

8.6.3 Action

The prevention methods used must take a sensitive and respectful approach based on the cultural background of the people requiring care: the cultural values and standard drug prevention initiatives in the reception countries should not be the only considerations. For example, with some migrant groups, it is possible to make effective use of drug risk- or fear-oriented education techniques that are deemed to be no longer valid in prevention initiatives aimed at native Europeans. Special attention needs to be paid to the double taboo associated with addiction problems: in many migrants' countries of origin, addiction

is not discussed, and in the host countries they fear that revealing they have an addiction problem could adversely affect their residential status. Refugees, asylum seekers and undocumented migrants should be involved in planning and conducting drug prevention programmes that address these issues.

Key persons who instil trust can be effective at persuading the target groups to make use of care programmes. It is much more likely that migrants will access these programmes if they are discussed on the personal rather than the professional level.

Specific drug prevention approaches for migrants must be firmly established in schools. This is dependent, of course, on migrants' children being allowed to attend school. Parents need drug and drug service education, too, particularly in terms of young people's vulnerability.

Drug prevention means integration work. Existing local community programmes should be involved. These could, for example, include computer and language courses or youth programmes. Integration does not mean forcing the migrants to adopt the host country's cultural norms: rather, it means encouraging participation.

8.6.4 Sustainability

Drug prevention projects should be incorporated into existing networks of organisations and institutions that work in the migration and health sectors. Assigning clearly defined institutional responsibility ensures the long-term establishment of addiction care activities. The knowledge and competence of the key persons should be linked in a 'competence pool', to facilitate future work via the care networks.

8.6.5 Monitoring

SEARCH's intention was to continuously control and evaluate the organisation, methods and impacts of drug prevention and addiction care activities. Changes in the number and composition of migrant populations must be continuously observed and care activities targeted accordingly. The RAR method proved appropriate for this task.

8.6.6 Policy

A political mandate is a desirable prerequisite for intercultural prevention and addiction care work. It ensures that the relevant projects and programmes are invested with the necessary personnel, expertise and materials.

The area of drug prevention particularly requires that governments make it possible and/or easier for refugees, asylum seekers and undocumented migrants to gain access to other health and care services. Discussion of these issues, however, was beyond the scope of the activities of SEARCH and SEARCH II. Nevertheless, effective drug prevention for refugees, asylum seekers and undocumented migrants should also strive to change the environmental conditions that can increase the risk of addiction. This can also only be ensured through political support.

8.6.7 The correct combination of methods

Every method chosen to address drug prevention for asylum seekers, refugees and undocumented migrants should be based on a comprehensive cultural analysis, including clarification of the cultural roots of the host country and of the migrants. As discussed above, for instance, seemingly 'outdated' methods can prove to be very useful, and many methods are particularly successful if they are taught by people who instil trust. The mixture of methods must include peer education and life skills training. These methodological approaches must be examined in terms of intercultural competence for their suitability for prevention work with the target groups and will require adaptation in many different ways.⁵

⁵ For more information, see www.projekt-search.de

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9

Access to health services for people without a residence permit in Belgium

Catharina Mathei



9.1 Introduction

In Belgium, people without a residence permit either used to have one but it has expired (for example students, asylum seekers, tourists) or they have never had one. In general, they have limited access to medical and/or psychosocial services, and existing facilities often fail to reach them.

It is impossible to be precise about the number of people without a residence permit in Belgium. Estimates lie between 100,000 and 150,000¹. They are not without rights, but these are very limited. In practice, they are entitled only to urgent medical care, and minors are also entitled to education. The word “urgent” suggests that help is provided only in urgent cases, but there is no statutory definition about the kind of care to which people without a residence permit are entitled: it is up to the medical practitioner to decide.

The difficulties of accessing health care experienced by people without a residence permit encompass many of this group's other problems. Language and communication difficulties are often an issue, as well as overwhelming administrative procedures, poor legal support and lack of finance. Furthermore, there is a clear lack of knowledge regarding their specific needs. The best sources of information on this subject are obviously the people themselves. However, past experience has shown that approaching and interviewing them is a very laborious and time-consuming process. Service providers working directly with people without a residence permit could serve as an alternative source of information. This is the approach taken in the project “Access to medical and psychosocial services for people without a residence permit in Antwerp, Belgium”².

The first step in this project involved taking an inventory of the services in Antwerp which offer direct help to those without a residence permit. The second step involved studying the annual reports of the various organisations and interviewing representatives from some of them. Besides collecting information about the services provided by these organisations and establishing a profile of them, an attempt was made to analyse the specific needs and problems experienced by people without a residence permit regarding access to help services in general and to medical care in particular.

1 The 1999 regularisation campaign regularised around 60,000 people. It was estimated that around half of those without a residence permit had submitted an application.

2 Mathei Catharina. Access to medical and psychosocial services for people without a residence permit in Antwerp, Belgium. 2006. Antwerp, Belgium.

9.2 Services for people without a residence permit

In Antwerp, eight organisations offering medical and/or psychosocial care to people without a residence permit were identified. Four of these (Protestants Sociaal Centrum, De Mutsaard, Artsen Zonder Grenzen and Bond Zonder Naam) specifically focus on refugees, asylum seekers and people without a residence permit. The other four offer care to specific populations : Free Clinic to drug users; Ch@pro to female sex workers; Boysproject to male sex workers; and Jongeren Advies Centrum Plus to young people. For each organisation, information was collected in the form of a recent annual report, except for De Mutsaard and Bond Zonder Naam. A representative from each organisation who would be willing to be interviewed was then sought, except from Jongeren Advies Centrum Plus (which felt they had nothing substantial to contribute because they do not see young people without a residence permit, although the door is always open to them. This organisation is therefore not discussed in this article).

9.2.1 Demographic characteristics³

The proportion of each organisation's clients without a residence permit varies considerably and is also determined by the specific services offered and the means of financing them. Artsen Zonder Grenzen, for example, specifically focuses on people with no health insurance and most of their patients do not have a residence permit. In Free Clinic, however, the proportion is lower because subsidies depend on whether patients have health insurance. Organisations which focus on the wider group of refugees (asylum seekers, temporary residence permit holders, people without legal residency etc.) see a high percentage of people without a residence permit. For the Protestants Sociaal Centrum, for example, 44% of the people who registered for assistance or support in 2004 were not legally resident in Belgium. Protestants Sociaal Centrum specifically focuses on people living in Antwerp-North, but other organisations (Artsen Zonder Grenzen, Free Clinic) also target people in Antwerp-North. This is probably related to the specific character of the communities there: there is a high level of impoverishment and concentration of social problems.

³ All organisations included in this report work with a wide range of nationalities: 50 in 2005 in the Free Clinic; 76 in 2004 in the Protestans Sociaal Centrum; 50 in 2004 in Ch@pro. Some organisations are more involved with specific nationalities. For example, the Boysproject (55%) and the PSC (26%), works with a fairly high proportion of people from Eastern European countries and Chapro is involved with a number of clients (34%) from Africa.

9.2.2 Socio-economic situation

People without a residence permit cannot depend on social insurance and benefits and/or a regular income, and survive by working for cash and from gifts and food packages. This explains the enormous success of initiatives such as the social grocer, where people can do their shopping at vastly reduced prices, and the distribution of free food packages, hot meals and clothes. There are a number of small-scale initiatives aimed at those whose immigration status puts them at financial, psychological and medical risk. These initiatives concentrate on exercising and developing migrants' talents and skills, and in some cases help them to earn a little money.

9.2.3 Access to medical care

For people without a residence permit in Belgium, access to health care is coordinated by Public Centres for Social Welfare (OCMWs). The OCMW in the place of residence pays the costs of urgent medical care and is refunded by the Ministry of Social Integration under four conditions:

- a duty doctor must sign a certificate of urgent medical care;
- the person must be illegally resident on Belgian territory;
- the person must have urgent needs; and
- the person must have an address in the OCMW district.

However, as a result of the many loopholes in the law and the considerable degree of autonomy of each OCMW, the interpretation and implementation of laws and regulations varies not only from town to town but also from borough to borough. The determining factors are diverse, and include the level of demand for medical services, whether total or partial payment of the medical costs is reimbursed, whether a subsequent visit from the doctor is required or only hospitalisation, and whether or not a medical card is used. As OCMWs have differing policies, access to health care for those without a residence permit thus remains arbitrary and some OCMWs are very restrictive in their interpretation of what constitutes urgent need. Normally, the OCMW will accept the costs of urgent medical care only after a social worker has assessed the needs of the patient during a house visit. If the social worker does not feel that the patient's needs are urgent, the OCMW will refuse to pay the medical costs.

Above all, the term "urgent" in the Royal Decree has caused some confusion about the scope of urgent medical care: this means that doctors and some OCMWs sign a certificate for it only in extreme cases. Although the text stipulates that: "Urgent medical care can refer to both preventive and curative care", some hospital doctors are prepared to put in stitches as part of urgent medical care, but feel that removing them is 'not urgent' and is therefore not covered by the decree. Antenatal care may also be refused because it is not regarded as 'urgent'.

The increasing numbers of applications for urgent medical care mean a higher workload for the OCMWs and their social services. The budget for urgent medical care has increased fivefold compared with the year 2000⁴, but the number of staff in the social services has not risen accordingly. At administrative level, the workload can affect the quality of the needs assessment and whether or not the costs will be accepted. Moreover, there are very few OCMWs where the social workers are specialised in the problems of urgent medical care and different social workers from the same OCMW assess needs differently. However, some OCMWs dealing with many applications for urgent medical care do have a specialised social worker. This facilitates the process considerably.

Some OCMWs (outside Antwerp) already work closely with doctors' conventions (a network of doctors). This system operates much faster and the doctor is guaranteed payment. Despite such schemes, it is still very complex for doctors to see patients without a residence permit. It demands strict compliance with administrative regulations and good knowledge of the system. In practice, doctors become demotivated. This negatively affects the medical care of people without documents: due to the administrative workload, delays often occur before patients are accepted, and this can have serious consequences for their health.

Chapro, Free Clinic and Artsen Zonder Grenzen offer medical care to people without a residence permit in Belgium. Chapro limits its services to treating sexually-related diseases. Free Clinic offers services to drug addicts, while Artsen Zonder Grenzen offers medical services to the wider group of asylum seekers, people without a residence permit or others with no access to standard health care. However, Free Clinic and Artsen Zonder Grenzen are increasingly unable to meet the demand for their services and are often forced

4 Source: Belga: 16/03/06: "Urgent medical care to illegal immigrants increased fivefold in four years".

to refuse patients. They also note that the doctors in their organisations make great efforts to refer patients without legal residence to more specialised medical care or to hospitals. Creating and maintaining a network is considered a partial response to this: personal contact with a doctor or other key person facilitates the referral process. In addition, both organisations can refer to specialists and laboratories which offer their services free.

In response to the complex administrative procedures facing people without a residence permit before they can receive medical care, some organisations are providing information to them and to care providers, including a brochure specifically for the city of Antwerp.

9.2.4 Access to psychosocial care

Living for long periods in a state of uncertainty about the future, particularly in a different culture, can cause psychological problems (the Odysseus syndrome⁵). According to our survey, however, access to psychological care in Antwerp is extremely limited for people without a residence permit, and the OCMW in the city refuses to accept the costs of standard psychological care for this group. This situation has led to Artsen Zonder Grenzen setting up its own psychological programme.

Most patients do not realise that psychological problems can be at the root of their physical health problems. They may view psychologists as being only for “mad people” and refuse to see one because they have more faith in a “normal” doctor. It is therefore essential that a psychologist works closely with the first doctor the patient sees, because a patient sometimes agrees to a psychological assessment out of respect for that doctor. The psychologist can then build up a relationship of trust to help the patient further.

The organisations’ patients who are migrants suffer mainly from chronic anxiety, depression or post-traumatic stress. The symptoms are closely related to their experiences in their land of origin (including war, torture, imprisonment and rape). This stress becomes exacerbated by their living conditions in Belgium, where they may be socially isolated, lonely, struggling for food and housing, afraid of the police, and facing an uncertain future. In such cases, the psychologist tries to work towards referring the patient within the existing network of mental health care services. The patient is given time to reflect on their problems, define

5 Artsen Zonder Grenzen. Toegang tot de Gezondheidszorgen in België. Activiteitenverslag 2003. Brussel:AZG.

what is wrong, and describe their needs and expectations. If they agree, a “therapeutic project” is set up, which will allow them to come to terms with the situation and tackle the problems.

9.3 Conclusion

On paper, people without a residence permit in Belgium certainly have access to standard medical care and, to a more limited extent, to psychosocial care. In practice, however, the obstacles are very high, particularly in the Antwerp region. The result of this situation is that the organisations involved in providing care services to people without a residence permit in Antwerp put a lot of effort into helping clients overcome these obstacles. Unfortunately, this takes up time that could have been spent in providing specific care services. Nevertheless, there are examples of good practice from OCMWs in Belgium that have tried hard to promote access in recent years.

Opportunities for patient referrals are very limited in Antwerp, partly due to a shortage of specialised services and partly due to the OCMW usually refusing funding. The services that are provided are facing increasing demands that they are unable to meet; problems that they feel unqualified to tackle; and communication problems related not only to language, but also to lack of trust.

With regard to language, Antwerp now has a municipal interpreting department and help centres are encouraged to use this service. The interpreting department pays two-thirds of the costs, while the department requesting the service pays the rest. Although this initiative is very much appreciated, it is currently not ideal. Firstly, the service is often conducted by telephone, which hinders communication, and secondly, it has to be requested in advance and an appointment has to be made. This makes it impossible to use the service in emergencies.

The study's interviewees proposed a number of recommendations to improve access to medical and psychosocial care for people without a residence permit. First, that the administrative procedures necessary in order to obtain to medical and psychosocial care should be simplified. At the same time, more effort should be made to inform these migrants about their rights and the administrative procedures. Second, that the activities of, and specific requirements for the different OCMWs should be harmonised. Other

suggestions concerned clarification of the concept of “urgent”; the abolition of restrictions on the provision of specific medical care, such as psychological help; the provision of medical insurance for people without a residence permit; and further evaluation of how the Royal Decree operates in practice.



10

Europe today: sex work from a female
labour migration perspective

Licia Brussa



10.1 Introduction

In recent years, the context of sex work has changed considerably. Europe has witnessed a rapid transformation in the sex industry and it continues to evolve with every change in legislation, public policy and law enforcement. We have witnessed an increasing diversity of sex work settings and geographic spread of sex work; a stratification of sex workers, with national sex workers forming the majority in Central and Eastern European countries and migrant sex workers forming the majority in North and Western European countries; significant levels of drug use and dependency, particularly among outdoor-based sex workers; and local and foreign criminal elements seeking to control sex work. These and other factors all contribute to varying degrees of vulnerability among sex workers.

Recommendations of the European Conference on Sex Work, Human Rights, Labour and Migration, Brussels, October 2005

- The EU [European Union] should integrate a human rights impact assessment in all anti-trafficking and migration policies and programmes in order to protect and promote the rights of migrant sex workers and trafficked persons.
- In order to protect their human rights, in particular the right to a legal remedy, the EU should provide migrant sex workers and trafficked persons with appropriate residency permits in order to ensure them effective access to justice.
- Migrant sex workers and trafficked persons, regardless of their immigration status, should have access to support services, including housing, education, vocational training, psychological and social counselling and legal assistance, in order to protect their human rights.

10.2 Factors Influencing migration

The composition of the migrant sex worker population is determined by a range of influences. First, there is the geographic vicinity of the departure and destination countries. One important factor in the shaping of migration patterns is the existing networks of sex workers, controllers and traffickers. This is linked to the concept of chain migration. There is also a range of push and pull factors that decide whether and where sex workers migrate.¹

Pull factors include migrating strategically in response to changing working conditions (for example from North to South Europe during the tourist season). Simple supply and demand of labour (in this case sex work) is another important factor in determining migration flows. If there is room for expansion in a certain prostitution scene, news will quickly spread and sex workers will migrate to meet the demand. This demand may be created by entrepreneurs who acquire places where prostitutes work, such as hotels, clubs and bars. High demand for sex work can also be a side-effect of the development of tourism in some countries and/or the presence of foreign entrepreneurs in regions of new economic development. Contrary to the popularly-feared scenario, large sporting events, such as the football World Cup or the Olympics, do not lead to an increase in sex workers in the location. Mobility also occurs because policy changes in a different country/region of country lead to more favourable or safer working conditions. Other factors include moving in search of higher earnings or of anonymity. Transnational mobility is also facilitated by informal networks existing within different communities, which support workers in search of new working places. Migrant and transient sex workers are likely to move between countries through established contacts via networks of their compatriots.

The various push factors include wanting to escape law enforcement, controllers and traffickers. TAMPEP has observed that sex workers' movements are increasingly influenced by actions undertaken by local authorities, such as when sex work tolerance zones are closed or sex workers are encouraged to leave a particular area. Such policy changes lead to new forms of sex work, territorial dispersion and increased vulnerability. Through communication among sex workers and 'intermediaries', information is shared

¹ TAMPEP Position Papers on Migration and Sex Work and on Trafficking can be found at www.tampep.eu

about where in Europe one can most easily enter into the sex industry at a given time, or which places in Europe provide better income and working conditions. In some cases, it is the controllers and traffickers who are entirely responsible for moving women into and between different countries. However, not all movements occur because the women are sold to pimps and traffickers or because they escape their controllers. The most important factor is the character and spirit of each woman who leaves her country in search of opportunities elsewhere. Her determination to overcome administrative, juridical or physical obstacles will shape her migration and settling-in process. Finally, migratory routes are always shaped, though not necessarily determined, by official entry requirements as well as police controls inside the destination country. The women determine their travel routes based on the information they get from their friends and colleagues about working conditions, their own experiences, agreements with intermediaries and/or the influence of those who control some forms of the sex industry.

Push and pull factors thus determine the organisation and structure of the sex industry and the degree of sex workers' vulnerability.

10.3 Migratory flows

Our European prostitution mapping carried out in 24 countries in 2005-2006² shows one very important trend: a rise of number of nationalities. In the early 1990s, there were around 10 nationalities working in the sex market. By 1998, the number of nationalities had climbed to 25. In 2006, sex workers of no less than 60 different nationalities were working throughout Europe. The countries with the highest diversity of nationalities were the UK with 56, Germany with 38 and Greece with 36. Overall, most of the sex workers who work in Europe are migrants:

- The old EU countries have an average of 68% migrants among their sex worker population. In some countries, the percentage is as high as 80%.
- The UK has the lowest percentage of migrants (37%), although London reported 76%.
- In the new EU countries, there is a much lower number of migrants working in the sex industry: an average of 23% of sex workers in Central European countries.

2 European Overview of HIV and Sex Work. TAMPEP7, February 2006

With 37%, the Czech Republic has the highest number of migrant sex workers in the region. Slovakia has the least, with 5%.

- The three Baltic States have an average of 12% migrants among their sex worker population. Romania has 5% and Bulgaria has 10%.

Moreover, the overall percentage of migrant sex workers has increased in all European countries:

- Around 70% of migrant sex workers in Europe come from another European country. Most are from Eastern Europe (45%). Nowadays, Russia and the Ukraine are most often mentioned, while in the 1990s, there was a high presence of Polish, Hungarian, Czech, and Slovakian women within the old EU countries. In 2006, the Baltic countries, Central Europe and the Balkans each accounted for around another 10% or so of migrant sex workers in Europe.
- Another significant group of the migrant sex workers in Europe originates from West Africa. Almost 15% come from countries such as Nigeria, Sierra Leone and Ghana. In Western Europe, there are also some sex workers from the Maghreb region as well as refugees from the Democratic Republic of Congo and Ethiopia.
- A smaller minority (9%) originates from Latin America. The remaining 5% is from Asia, primarily Thailand. In Europe, there is just a small presence of migrant sex workers from the Middle East, North America or Australasia. These tend to be individuals rather than members of a migratory group.

Sex workers are very mobile. Almost half of all sex workers are believed to have worked in more than one country. Most of the female migrant sex workers in the EU have worked in at least two EU countries and in three countries in their own geographical region (migration is often to neighbouring countries, then either moving on or going back and forth). Many sex workers not only experience high cross-border mobility, but they also move (or are moved) among various sex work locations within a country: at least half of the sex workers in a country will move around and work in several cities.

The different regions in Europe as destination countries of the migration flow experience rapid changes in the nationalities of sex workers:

- In Greece in the late 1990s, around 80% of migrant sex workers were women from Eastern European countries or the Balkans. Today, this has declined to 60% and 40% are from outside of Europe. A third of all migrant sex workers are from

an African country (Nigeria, Sierra Leone, Ethiopia) and the rest are either from Thailand or Latin America.

- In Italy we see a similar trend. The number of Eastern European or Balkan sex workers has dropped from 60% in 1997 to 34% in 2006. Again, a third of migrant sex workers are from Africa (mostly Nigeria) and 20% are from Latin America.
- In Germany, the number of Polish sex workers has slowly declined over the years, from 30% in 1997, to 23% in 1999, to less than 20% nowadays. However, there has been an increase in the recorded presence of various regional nationalities, such as women from Romania and the Balkan states.
- Another new trend is the rising number of women from China and Central Asia in Italy, France, Belgium and other old EU countries.
- Many of the women who work in Eastern European countries continue to migrate to other countries after having worked for some time and saved up enough money to finance additional travelling (e.g. to Austria, Germany or the Netherlands). For example, the number of Romanian and Bulgarian women in the Austrian sex industry is increasing and many women from Slovakia, Hungary and the Czech Republic migrate to Austria before they go anywhere else. Consequently, Austria shows the highest number of migrant sex workers (approx. 80%) whilst the percentage is lower in the rest of the East Region but steadily increasing (Czech Republic 37%, Hungary 15-20%, Poland 30%, Slovakia 5%).

EU enlargement in 2004 caused considerable changes in this respect. Migration flows from Central and Eastern Europe to Western Europe, and internal flows from Eastern Europe to Central Europe, have increased markedly. Today, women from countries in Central and Eastern Europe account for 30–40% of the total sex worker population in Western Europe.

The new EU countries in Central Europe play an interesting role in the European prostitution flow because they are at the same time source, transit and destination countries.³ For example, many Ukrainian, Russian, Belarusian and Moldovan women work in the sex

3 National sex workers are defined here as those who reside and work in the country they were born in, regardless of citizenship. Migrant sex workers work as sex workers in a country other than the one they were born in. Transient migrant sex workers also work in a foreign country, but have the intention of either returning to their home country or moving on to yet another country.

business in Poland, Hungary and the Czech Republic and after some time they either move to another EU country or stay in the region of Central Europe. Simultaneously, women from Central Europe and the Baltic countries and the Balkans leave their countries and look for work in Western Europe. From our assessments in the Central and Eastern European countries, we concluded that migration movements for the purpose of sex work within the former Soviet bloc are as high as those from that region to Western Europe.

It was expected that these patterns would change considerably with the accession of 10 Central and Eastern European countries to the EU, and, more recently, of Romania and Bulgaria. The data on sex workers' migratory behaviour seems to corroborate this thesis, particularly in Western and Central Europe. The new outer border of the EU is not directly experiencing an invasion of sex workers and traffickers: the routes are simply different. There is more cross-border mobility within the enlarged EU, particularly in the Central European region. This inflow of East sex workers to the West mirrors that of other sectors in the labour market: it was a labour mobility phenomenon and did not only involve sex workers. Notice should be taken of the lack of labour protection for the new EU country citizens living in the old EU states, whatever their work: they are all underprivileged in terms of access to legal protection.

10.4 Vulnerability factors

Unsafe sex in sex work settings is never context-free. Knowing how to use a condom correctly and protect oneself from HIV does not empower people to put that knowledge into practice, particularly in sex work settings. The degree of autonomy a sex worker has over the sexual services offered, and under what conditions, directly determines vulnerability to HIV infection. In favourable environments, a sex worker can have absolute control over the clients seen, safer sex and condom use, while in a less favourable environments the same sex worker would not be able to have that control, particularly if they were being controlled by a third party or in fear of being harassed by the police. It is not the actual selling of sexual services as such that determine the levels of risk, but the social determinants, working conditions and other contextual factors. In this respect, the legal, social and economical frameworks are particularly important.

Migrant sex workers are often disadvantaged by language: like many other migrants, they have had to pay significant amounts of money to migrate; many have limited control

and self-determination; and many are undocumented and have no legal status within the country in which they are working and are forced to work in 'hidden' sex work settings where they are susceptible to control by criminal elements.

Drug dependent sex workers' vulnerability is exacerbated by the double stigma and potential criminalisation as both a drug user and a sex worker, and those who inject face an additional risk of HIV infection if they use non-sterile injecting equipment. A sex worker from an ethnic minority that is socially excluded within a society faces additional vulnerabilities. Victims of trafficking and children who are sexually exploited and abused through prostitution are the most vulnerable: the gross violation of their human rights requires responses and solutions beyond the legislation, public policy and law enforcement around sex work. All of these factors undermine an individual's opportunities to implement self-protection strategies for health, well-being and autonomy.

The disproportionate levels of violence experienced by both indoor- and outdoor-based sex workers and the failure of the law to protect them from this has been identified across Europe as a major factor in increasing sex workers' vulnerability, particularly those who have no legal status or are directly criminalised. Other specific vulnerabilities of sex workers identified by European sex work projects include:

- Lack of ability to communicate in the local language, which results in isolation and lack of knowledge about legislation, rights, cultural norms, and health and social care services.
- Lack of access to a comprehensive range of health and social care services for undocumented and/or non-insured migrant sex workers.
- Migrant status, which for many brings with it a fear of 'authorities', and results in high levels of exploitation and violence. These include migrant sex workers becoming the target for gang robberies, violence from clients and exploitative working conditions by managers who assume they will not report such offences to the police and other authorities.
- Lack of equitable access to legal protection and to social support due to stigma and discrimination.

10.5 Providing services

The effectiveness of the efforts to provide services for sex workers requires comprehensive and multi-agency service provision. Strategies and policies need to be based on clear principles: equitable access to support and services, addressing the specific needs, with a person-centred approach and a simultaneous community development focus, and addressing all key actors in the sex work setting, including managers, clients and controllers. Our priorities include providing quality services with knowledge- and experience-based professional approaches and skills.

Outreach is essential to build trusting relationships, but street work and other outreach must be systematic, frequent and intensive. Initiatives should not be limited to distributing condoms, lubricants and information, but include social, legal and psychological assistance as well. Moreover, interaction with the police, the judiciary, the media, politicians and policy-makers should be considered. In this way, a broad platform and involvement of sectors other than the health care area can be attained, with the objective of creating and developing comprehensive health promotion and well-being strategies.

The social vulnerability of sex workers is one of the structural determinants of the risks to health and well-being and in particular to HIV and sexually transmitted infections (STIs.) The often unsafe and violent environment of the workplace and the poor living conditions of sex workers increases this vulnerability. The relationship between the health and social services responding to sex workers' needs should therefore be strengthened and improved.

In the civic area, existing sex work projects and services and community-based organisations may function as both advocates for the rights of sex workers and sources of information, and their expertise needs to be recognised. Depending on the needs of the country in question, such work might entail creating a national advocacy platform, collecting and disseminating evidence, providing expertise to ministries and local authorities, creating a protocol for best practice, and increasing public awareness through media work and campaigns. Most importantly, the protection of the individual human rights of sex workers need to be taken into consideration: they are frequently violated, and is vital to consider the role and impact of the efforts of sex work projects and services and of community-based organisations in the human rights framework.

10.6 New challenges

The context in which HIV/STI prevention services for sex workers have to operate is increasingly complicated: pronounced mobility and territorial diffusion, national diversity, social stratification and adverse working conditions. There is an urgent need to develop holistic approaches, broader possibilities for intervention, and different strategies of contact and engagement. Governmental involvement is also crucial, as this makes it possible to negotiate with those who determine the conditions under which sex workers work and service providers intervene. For example, sex workers' organisations and services should be able to negotiate with the police as soon as new regulations for street prostitution are adopted, because such rules can directly affect not only sex workers' working conditions, but also the ease with which they can be contacted on the street by services. The rapid and recent shift to indoor and underground forms of sex work, provoked by zero tolerance policies on street prostitution, requires an adequate assessment of the implications. Services must therefore find new methods of reaching the sex workers or contact will be limited, leaving a growing fraction of the target group excluded from any form of information and prevention services.⁴

However, if the goal is to promote a comprehensive new approach to sex work, we first have to clarify our vision of it. Traditional perspectives on sex work have perceived sex workers and their clients as objects rather than active subjects and excluded them from policy discussions and decisions. The marginalised and often illegal status of the sex industry has led to the social exclusion of sex workers. Certain frameworks make it difficult - if not impossible - to provide effective health and social care.

The social exclusion of sex workers exacerbates the situation of the industry's more vulnerable subpopulations, including minors, drug users, ethnic minorities, migrants and individuals controlled by pimps. They all face increased pressure from legislation, which often excludes them from the legal, social and health care services available to the general population. A prerequisite for the social inclusion of sex workers, especially the members of the vulnerable groups listed above, is the recognition and protection of their human and civil rights.

4 Methods and experiences in reaching (migrant) sex workers can be found on the TAMPEP website: www.tampep.eu

Taking into account the above facts and the new reality of sex work, we urgently need to develop holistic strategies on interventions covering different areas: HIV/STI prevention; health promotion; and legal, social and human rights protection. The NGOs active in this field should be empowered in their efforts to deliver special services for sex workers, supported in the development of multi-sectorial activities, and their voice strengthened in the identification of priorities for policy, strategies and intervention techniques. Moreover, the undeniable presence of migrant sex workers across Europe requires a transformation in the thinking around women's migration to include sex workers and consider them as part of the female migrant labour force. TAMPEP has established that policies prohibiting sex work and limiting possibilities for immigrants deeply undermine sex workers' chances to implement a strategy of self-protection (for their health and for their well-being) and self-determination that renders safer sex practices possible.

From the above, it is clear that migrant and national sex workers are highly vulnerable and that this vulnerability damages and risks their health and well-being. Another conclusion is that sex workers' control over their own health and the services they sell is directly related to the influence they exert over their living and working conditions, which in turn is determined by environmental factors.

Across the world, we are witnessing radical changes in the forms of sex work; the widespread mobility of its constituent population that continuously moves between and among several countries and regions; a constant turnover with the effect of a chain reaction; and struggles for the dominion of the sex market and lines of communication and transportation. In the light of all these factors, it is impossible to imagine that current economic, social and health interventions on behalf of sex work are rooted in or based on the local or domestic concerns of a single nation. The influence of these global factors must be taken into consideration in the development of policies that must be innovative, multidisciplinary and transnational in their scope, application and outlook.

10.7 Conclusions

The presence of migrant sex workers in Europe and in other regions of the world requires a rethinking of the issue of women's labour migration and the complex system of factors that provoke different forms and levels of vulnerability. Repressive policies on both prostitution and migration deeply undermine prostitutes' ability to implement strategies of self-protection and self-determination. These policies are also responsible for trafficking mechanisms. There is the need to promote a holistic strategy underpinned by principles of respect and inclusion of (migrant) sex workers, which should be based on 10 basic principles:

- To have a non-repressive approach to sex work and to sex workers.
- To include sex workers in the development, implementation, evaluation and decisions regarding activities and policies concerning sex work.
- To facilitate the access to appropriate social and health care services for both national and migrant sex workers, based on voluntary and anonymous offers, to reduce social and health inequalities.
- To have a multi-disciplinary approach to HIV and STI prevention, which addresses the needs identified by both national and migrant sex workers.
- To create a legal and a social framework for dealing with sex work based on the protection of sex workers' human, labour and civil rights.
- To guarantee *migrant* sex workers' human, labour and civil rights.
- To recognise the universal right to migrate.
- To facilitate the access and the integration of migrant sex workers into the labour market of the destination country.
- To create anti-trafficking policies that are based on the protection of women's human rights.
- To facilitate cooperation and networking on local, national and international levels.



11

Migrant drug users in two low threshold drug services in Italy

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11.1 Introduction

Migration from countries outside Europe to Italy is a relatively new phenomenon that started in the second half of the 1980s and has only recently become seen as a social problem because of the growing number of arrivals. These migrants usually remain in Italy for only a short time, particularly when they do not find a job and therefore do not become integrated into the local socio-economic context. In many cases, the first generation of migrants went back to their home countries, but others of the same nationality took their place¹. The new migrants are often younger and are having major integration problems, caused both by the higher number of arrivals and by legal restrictions.

In Italy, everyone who is registered with the National Health System receives most health care free of charge, however severe their illness. However, Article 13 of the immigration law gives foreigners who are in Italy temporarily the right to receive free treatments through the National Health Services for medical *emergencies* only. Thus, although the law offers the possibility of health care in an emergency to foreign people without a permit to stay, those addicted to drugs are especially at risk of experiencing prejudice and discrimination. This article describes a pilot study that was conducted to investigate the issues surrounding the accessibility of health services by drug dependent and/or alcoholic migrants and the efficacy of the treatment offered. The study also investigated the most common health-related problems and how satisfied migrants were with the support they received.

11.2 Methodology and objectives

The ASL 4 (National Health Service) in Turin and the Villa Maraini in Rome can be considered useful antennae for observing the situation of substance users in the National Health System. These services have acquired the trust of marginalised people – including migrants from countries outside Europe – over many years of experience in the field. The ASL 4 offers street services, day hospital treatment and care, and is very well-integrated with other structures in the area, working in strong collaboration with the agencies of the Social Private (NGOs) and in particular with Gruppo Abele, an organisation well-known for the assistance given to highly marginalised groups. The Villa Maraini Foundation in Rome

1 AA.VV, “Migranti – Rapporto 2006”, Intro pagg. 2 – 3 – Caritas, Roma 2007.

offer a support service to people who use drugs – together with the Italian Red Cross – made up of a network of low, medium and high threshold services.

Due to the trust drug users have in ASL 4 and the Villa Maraini, it was possible for the researchers to interview their service users with a migrant background about accessibility to treatment and therapy services. The study was carried out by structured interviews using a very simple questionnaire. The majority of the interviewees of ASL 4 in Turin were recruited in the Drop-in Centre of Gruppo Abele, where the main group of clients are problematic alcohol users, and in the bus of the Street Unit CanGo / ASL 4. The sample from the Villa Maraini were heroin users from the Drop-in Centre and those receiving methadone from the Medical Day Unit.

We should comment here that it has to be taken into consideration that interviewees may have wanted to please the interviewer by giving answers that were complementary to the general system of assistance and health care. It would be useful to follow this pilot study with more in-depth interviews of a qualitative kind, in order to better explore this issue.

11.3 Demographics

75 foreign people were interviewed (40 in Turin, 35 in Rome) of whom only one was female. This can be partially explained as follows:

- In Italy, the relation of male:female drug service clients is 5:1.
- Nearly all of the interviewees were originally from North Africa or Eastern Europe, migrant communities that are predominantly male.²
- Many female migrants who are problematic substance users are sex workers and also undocumented migrants and ‘slaves’, and are therefore unlikely to approach drug and alcohol services³.

2 C. Bonifazi, “L’immigrazione straniera in Italia”, pagg. 153 - 155 - il Molino, Bologna, 1998.

3 M. Da Prà/L. Grosso (a cura di) “Prostitute, prostitute, clienti: che fare. Il fenomeno della prostituzione e della tratta degli esseri umani” pagg. 16 – 20 - Edizioni Gruppo Abele , Torino, 2001.

The ages of the interviewees is shown in the table below: their average age was 38.

Age	Rome (N)	Turin (N)	Total (N)	%
18-22	3	5	8	11
23-30	2	15	17	23
31-39	13	11	24	32
Over 40	17	9	26	34

As shown above, the two groups differ regarding their age. The “Romans” are much older than those in Turin, where most are aged between 23 and 30.

The following data show when the interviewees arrived in Italy: the Rome group had been in the country longer than the Turin group.

Arrival in Italy	Rome (N)	Turin (N)	Total (N)	%
Before 1986	13	0	13	17
1987-1990	8	6	14	19
1991-2000	10	4	14	19
2006	0	6	6	8
Total	35	40	75	100

North Africa was the interviewees’ main region of origin (63%), followed by East Europe (25%), Central Africa (6%), Asia, and the United States of America. One interviewee described himself as stateless.

Only 16% had a regular permit to stay. 24% used to have one but it was not renewed, and the other 60% had no permit to stay.

For 47% of the interviewees, Italy was the first country of entry into the European Union. Substantial minorities had arrived from France, Spain and Germany, and the remainder from Holland, Belgium, Austria, Turkey, Hungary, Greece, the United Kingdom, Portugal, Luxemburg, Malta and Switzerland.⁴

⁴ On 1st of January 2007, Romania and Bulgaria became officially part of the E.U. This changes the configuration of the above data, given that a significant number of Romanian migrants are to be found across Italy, in particular in Rome and Turin (25% of the interviewees were of an Eastern European nationality, the great majority being Romanian).

11.4 Health problems and treatment experiences

Thirty-seven interviewees (49%) reported that they were dependent on heroin, and 18 of these said they had been so for more than seven years. Comparing the entry time in Italy and initiation into heroin use by the Rome group, only two out of the thirteen who had arrived in Italy before 1986 had been using heroin before that date. Overall, only three interviewees had begun to use heroin before they arrived in Italy. Those people were of Croatian, Ukrainian and Egyptian nationalities. On average, the time between arriving in Italy and initiation into heroin use was eight years. All the heroin users except one, were being treated with methadone at the time of the interview.

25 interviewees (33%) reported problematic use of alcohol, but none of them were in treatment for this⁵.

Eight people reported other health problems in addition to drug dependency, but only four of them had received treatment for these. 57 interviewees had previously received various treatments for other health problems from different health services (34 from a hospital emergency department, 20 in prison and three from a General Practitioner or other private specialist) as follows:

- check-up or treatment with prescribed drugs (42)
- treatment for small wounds (19)
- cures for asthma and gastritis (5)
- treatments for infectious diseases (4)
- dental treatment (3)

In general, more of those in the Rome group had received health care than those in the Turin group: 35 “Romans” reported 52 contacts to different health services, whereas of the 40 people in the Turin group reported only 25 contacts. However, it should be taken into consideration that the Rome group was older than the Turin group and had also been living in Italy for longer.

50 of the 57 interviewees who had been treated in the Italian health system reported that they had received adequate and professional treatment. Seven interviewees were dissatisfied, however: five claimed they had suffered racial discrimination, and two had

5 AA.VV., “Il consumo di alcool nella popolazione adulta in Italia – Rapporto 2005”, pag. 84 – Istat, Roma 2006.

been denied help because they did not have a permit to remain in Italy.

20 interviewees reported having been in prison after being convicted of (usually a relatively small) criminal offence.⁶ A significant number of them were drug users, implying that their crimes were drug-related.⁷ It should be noted here that in Italian prisons, 40% of prisoners have a migrant background. On arrival in prison, prisoners have an mandatory health check which is based on a national regulation. In the case of some migrants,⁸ this is their first contact with Italian health services, even if they have been in the country for many years. It should also be noted that in the case of some illnesses, the prison health service is the only one which is allowed to treat migrants (e.g. HIV-therapy).

11.5 Conclusions

On the one hand, the results from this pilot study indicate good accessibility to health services for the majority of the drug dependent migrants, who reported receiving the health assistance they required and being treated with humanity and professionalism. This satisfaction is higher than expected, although the experiences of those who did not experience a good treatment must be taken seriously. Five people reported racial discrimination, and any follow-up study to this pilot work needs to gather more data on this issue. On the other hand, it seems that there is a treatment gap for migrants with an alcohol problem, since none of those who reported this had received any treatment for it (although in Italy, there is a general lack of alcohol treatment services, even though the problem is relatively common).

A result that requires further exploration is that almost all the heroin addicts initiated into heroin use after they arrived in Italy and, on average eight years after arrival. What happens between arrival and the start of heroin use? It may be substance use by migrants begins with alcohol (as in the Turin group, who were younger and more recently arrived in Italy) and heroin use begins later, for complex reasons, including factors hindering integration

6 This number does not include those who may have been detained in the CPT (First Accolience Centres) or other similar Centres.

7 P. Gonnella, "Prison, Population in Italy" in "European Prisons – Starting a Debate" , pp. 8 - 9 - coord. A.P. Dores, Celta Editora, Oieras 2003.

8 Cfr. P. Gonnella, *Ibidem.*, pp. 71 – 73.

such as unemployment, poor housing, uncertainty over immigration status, and so on: there is an inextricable link between social exclusion and the risk factors for problematic drug use.⁹ The gap between arrival in Italy and drug use may be explained as a period during which new arrivals come to realise that they remain socially excluded, and they therefore retreat into the solidarity of the migrant community and become influenced by those already using drugs.

9 Cfr. Patel et al., University of Central Lancashire – Centre for Ethnicity and Health, Faculty of Health, “Young refugees and asylum seekers in Greater London: vulnerability to problematic drug use”, Greater London Authority, 2004 – pp. 163 – 164.

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12

Mobile drug users in Europe – an example from Amsterdam

Enzo Crolle, Eberhard Schatz



12.1 Introduction

Mobile drug users are persons who are staying in regions where they are not administratively registered: thus it is difficult for them to achieve their judicial, social and medical rights. Many are undocumented migrants and face problems with the criminal justice system, suffer from serious illnesses, are not socially integrated, are homeless, have no health insurance, etc. They can be tourists, refugees, asylum seekers, immigrants, commuters (persons who live in border regions and cross the border daily in order to buy and use drugs), and their numbers are growing as a consequence of increased international mobility and migration.

There is a highly mobile flow of drug users to the 'old' European Union (EU) countries by Central and Eastern Europeans. The causes of this phenomenon are the supposedly more liberal way that drugs and drug users are dealt with in the old EU countries, flight from repression and prosecution, economical reasons and the search for another way of life. Often, this journey ends in unexpected difficulties for which there is no apparent solution. With no financial resources, in a poor state of health and, in some cases, without identity papers and health insurance, these migrants fall through the host country's social security net. The absence of adequate assistance and of social and health service contacts in the mother country and, sometimes, the threat of imprisonment can make it very difficult to return.

There are no reliable statistics or studies at the pan-European level about the background and the reasons why these persons choose to stay in Western Europe. A preliminary survey conducted by the European project for mobile drug users AC-Company showed that a section of this group, particularly those from Poland, the Czech Republic and Slovakia can be defined as 'drug tourists' who speak little English but are not generally known to have major problems. On the other hand, the group of drug users from Russia, the Ukraine and other countries of the former USSR represent a more difficult situation. Here, one finds considerable language and communication barriers, particularly from the point of view of accessing assistance from drug-related services. This group is also characterised by specialised, and to some extent mafia-like organisational structures. It can be confidently stated that the group of mobile drug users from Eastern Europe is likely to enlarge in the future, and as a result, more research, more intensive efforts by drug services to contact the target group and more networking with the relevant institutions in the countries or origin will be required.

12.2 Background

The Amsterdam Oecumenisch Centrum (AMOC) is a unique organisation in Europe, which works only with mobile drug users from abroad. AMOC was founded in 1978 and is mainly financed by the city of Amsterdam. Its purpose is to offer help to migrants with drug problems and to migrant sex workers (male and female). A large part of this client group is homeless and they come from all over Europe, mostly from the UK, Italy, Germany, Central Europe (mainly Poland and the Czech Republic) and Eastern Europe. These AMOC clients have no health insurance, so they have no access to the mainstream health care network. AMOC has no medical personnel: the task of care in cases of medical emergencies are the responsibility of a section of the GGD (National Health Services), which also decides whether or not methadone can be given (only in an emergency and for a strictly limited period of time).

AMOC's work is to prevent the marginalisation of its clients; to offer crisis intervention and drug treatment; to make the necessary referrals to other professional help; and to organise treatment and other support in the country of origin. An important aspect of the work is the constant attention to safer sex and safer drug use. AMOC consists of a daytime shelter / drop-in and a user room where people can use drugs in secure surroundings, with clean needles and spoons, bandages, etc. AMOC employs social workers who provide the service users with social and psychological counselling when needed. We also visit clients in prison and at police stations, at home or in hospitals. AMOC have an evening consultation three times a week for young male sex workers (who are mainly Romanian nationals). We address personal neglect by providing basic support (food, shower, clothes, night shelter) and limit drug-related nuisance in the local area. When requested by the client, we can prepare for and arrange a return to the country of origin utilising, in most cases, the network built first by the AC-Company and maintained by the Correlation project. It should be emphasised here that, without insurance, this is the only solution when an AMOC client requires treatment.

12.3 The Dutch situation

In general, the Dutch legal and social system can be said to be characterised by a pragmatic approach to drugs and addiction. The emphasis is not on tightening drug laws and raising penalties, but rather on harm reduction. In the middle sixties, a large group

of young European people began to move to Amsterdam, attracted by the liberal way of living. They were looking for new ways of life and also experimenting with drugs. With this group of mobile users came the need for new initiatives from society and the law. In 1976, a commission was implemented and accepted the proposal that would divide drugs into two groups: hard and soft. This is known as the Opium Act. From this point onward, the Netherlands started developing drug laws, and addiction is today, as then, viewed and treated with a pragmatic and realistic approach.

The aim of Dutch drug policy is the prevention and alleviation of social and individual risks caused by drug use. Although the use of drugs is not punishable by law, the sale of hard drugs is not tolerated in any premises open to the public. Because Dutch law and drug policy focuses on harm reduction and using drugs is not considered a crime, it is possible for organisations such as AMOC to establish drug user rooms. There is, however, a strong emphasis on avoiding public nuisance. This means that any facility that works with drug users must, at all times, make sure that they are not considered a threat to the local public order, and that the safety and health of people living in the area is not at risk. If that happens, the mayor of any Dutch city can close down the facilities. Nevertheless, it should be emphasised that Dutch drug policy is nowhere near as tolerant of foreign drug users: this is relevant when it comes to the work that AMOC does on a daily basis and is especially the case when it comes to clients' general health care.

12.4 Mobile drug users from Central Europe at AMOC

The majority of the people AMOC sees are homeless and drug dependent, with all the implications that such conditions carry with them, including being considered small-time criminals and a threat to society and public order. They are denied access to most health services, since it is almost impossible to get help without an address or insurance. It is important to be clear, however, that the AMOC's clients who are EU citizens are not living illegally in the Netherlands.

Because of the ever-growing number of persons arriving in the Netherlands from Central and Eastern Europe, we decided to conduct a study of drug users from these countries. The aim was to acquire a picture of why they migrate (to the Netherlands in this case), and explore their difficulties and satisfaction regarding basic social and medical services. A questionnaire was prepared for this purpose and the interviews took place on AMOC's

premises. Considering our group of clients, we can say that the response was satisfactory: 15 interviews were conducted. In some cases, language could have been a barrier but was overcome because a native Polish worker and students from other nationalities were involved in the project. Practically all the interviews were administered to people from Central Europe (Poland, Czech Republic), mirroring the nationality of the persons using our services. Those from Eastern European countries (Bulgaria, Russia, Kazakhstan, etc.) were more reticent to participate and only one of them did so.

12.5 Study results

The average age of the persons interviewed was 35, with a range of 27-45. All the interviewees were males except one woman from the Czech Republic. The persons interviewed were evenly divided between Czech and Polish nationals and there was also one Russian. The sample's level of education varied between secondary school and university (usually not completed). They were all unemployed at the time of the interview, except the Russian citizen who was working illegally in the building sector. This man rented his own room, but some of the others were homeless or lived in squats. Almost all of them had a current passport or an I.D.

When asked for the reasons they left their countries, responses comprised finding a job, changing their life, family problems, legal problems and because there was “nothing to do” in the home country. When asked if Amsterdam had lived up to their expectations 70% responded positively but the remainder thought it was “difficult” and that “people are not open” and “bad”.

The average age of the first use of alcohol was 15 and only one interviewee thought he had an alcohol problem. Amphetamines were a popular drug, with an average age of first use of 19. Amphetamine users started using the drug in their home country and continued to use it in the Netherlands. All the interviewees also used cocaine and heroin (the majority by injection), although they had started using these drugs at an older age than other substances. They had begun using heroin and cocaine in their home countries, but use had increased in the Netherlands, probably because of easier availability.

We examined the drug users' treatment/service history, their perceived needs and access barriers. We also asked how these services in the Netherlands compared with those in

their home country. Results included that only one person had accessed a rehabilitation centre in their country of origin and very few had accessed a needle exchange and/or methadone treatment there. In the Netherlands, though, all the interviewees said that needle exchanges were easy to access. About half of the sample also said that they had had methadone treatment. However, although it is likely they had been given methadone for a limited period, for medical reasons, none of them were on methadone programme run by the GGD (National Health Services) at the time of the interview.

Only two persons reported that they had accessed a general practitioner and four had been treated in a hospital emergency department. Social workers and drug user friends were mentioned as the people who gave the most support in finding drug services in the Netherlands. When asked to list, in their opinion, the main reasons that deter drug users from using services, the most popular answer was that drug users are not understood, followed by services being too judgemental and unwelcoming/unfriendly. The sample also reported that they had no involvement in the planning and development of relevant services, since their participation had never been sought. Furthermore, they said service providers were seldom interested in how satisfied the client was with the services they had received. The sample were asked if they knew what a drug user group is and if they knew of one in their country of origin: 60% knew what a drug user group is, and the same proportion said there was one in their country of origin. Half of the sample were members of a drug user group at the time of the interview.

12.6 Some considerations

- The interviewees comprised different nationalities, but the involvement of a native Polish worker was an important factor in terms of language and the trust they created because of their cultural understanding of Polish interviewees.
- There was quite a high level of education amongst the interviewees, reinforcing the major reasons they gave for migration as being unable to see a future and obtain employment in their countries of origin.
- The only person who had a job and housing was a Russian national. It cannot be assessed how typical of all Russians at AMOC this interviewee was, as other Russians refused to take part in the study, because they were suspicious of it

and may not have felt comfortable with the proposed interviewer who they saw as “part of the system”.

- We found it striking that even though there was a low degree of satisfaction regarding access to services, more than 70% of the sample said they were quite happy about their situation in the Netherlands and very few said they wanted to return to their home country (unlike AMOC’s clients from Western Europe). Is this a case of interviewees misunderstanding the question or a lack of expectations? Is the novelty of living in a different country exciting and will wear off when their difficulties increase/persist?
- As discussed shortly, there is a high level of mutual support, especially amongst the Polish clients.
- The sample’s average drug intake is medium-low compared to Western European nationals. It is important to consider the pattern seen in other ethnic groups in the Netherlands (Moroccans, for example). We suspect that drug consumption will escalate, and intervention, prevention and education initiatives are therefore particularly needed.
- Contrary to our expectations, not one of the interviewees reported initiating hard drug use in the Netherlands. There was a pre-existing dependency, which, in some cases, reached higher levels in the Netherlands.
- There is distrust of social services and most of the interviewees did not ask them for help. Some related this to not having a residence permit, insurance and having to deal with a drug problem.
- Some interviewees (usually the youngest age group), enjoy being in the Netherlands and many saw it as a temporary experience and had no intention of long-term integration. A few said that, “when the right time comes”, they will move to a different country - Spain being the most popular choice.
- AMOC’s Central and Eastern European clients are overwhelmingly male. The ratio of male:female in all AMOC’s clients is around 4:1, reflecting the situation in many other drug agencies around the world. Of our female clients, only very few originate from Central and Eastern Europe, and to understand why would require a separate study.
- People who are using opiates are seldom given methadone by the Dutch health system, and a foreigner without insurance is refused a methadone maintenance programme. We therefore regularly see “dope-sick” persons who are incapable

of answering questions for a study such as the one reported here. In some cases, the moment came when could ask a few questions, and again, the involvement of a native Polish worker was crucial. The employment of workers of the same nationality as their clients has long been suggested and for some of our clients should be considered essential.

- There is not a regular pattern or flow of new individuals seeking help from AMOC. For some reason we cannot yet explain, there is no new intake from our target group countries for many days and then there are days in which we have one after another. We can hypothesise that this situation is linked to the circumstances of life on the street (police action, the availability of drugs, weather conditions etc.).
- The treatment reserved for Central and Eastern European nationals by the social and medical services of Amsterdam is not in any way different to the one which is available to other foreigners of different nationalities.

12.7 Conclusions

In this study, we obtained first-hand accounts of what is happening in some AMOC clients' lives. Gathering these data was greatly facilitated by AMOC being a familiar setting for many interviewees, and those who are homeless almost consider it as "home". Clients and staff are familiar to each other and in such a setting, it is easy to approach clients for an interview. If there was a problem, it was due mainly to the drug users' hectic timetables: the search for money and buying and using drugs was clearly prioritised by them. Those wanting to conduct the interviews therefore had to carry out their task with subtlety and patience.

We can think of two main reasons why the small group of Russians refused to take part: communication was extremely difficult because they spoke only Russian, and their undocumented migrant status, along with their drug use, meant they were distrustful of other service users and feared the authorities and deportation. Understandably, they therefore did not want to reveal personal information, even if anonymously. A Serbian and a Bosnian client also refused to participate. Their refusal was not so much dictated by language difficulties, but by the concern that AMOC may have links to the authorities. As much as we can be skilled workers and build up good relations with clients who are undocumented migrants, the reality is that they take as few risks as possible to prevent detection of this status.

Despite some refusals to participate, AMOC is a good example of a setting conducive to research since, because we work only with foreigners in the Netherlands, a multinational team has been created. This facilitates a good relationship between staff and clients because of common language(s), cultural empathy, and so on. This was even more evident in the case of Central and Eastern European clients. An atmosphere of trust was established by the interviewers and interviewees were open about their situation. That said, we noticed that there was some misunderstanding in the interpretation of a number of questions, even though we had tried to make them straightforward. When the data were analysed, some of the results did not make much sense. Reasons for this could include clients wanting to finish the interviews as quickly as possible, a lack of trust, or giving answers they thought would please the interviewer.

A few years ago, we prepared a similar questionnaire for the AC-Company project. It was intended for people of every nationality, with the aim of gathering data to better understand

their problems. We noticed then that one of the most interesting and valuable aspects of the study was that the interviews resulted in “food for thought” for the interviewees. It is not unusual that people begin to reflect on a deeper level about their present condition when questioned closely about it, and, as a consequence, take life-changing decisions.

In conclusion, we interviewed this particular group of migrants because we noticed a sharp increase in their presence in the Netherlands – a situation that is occurring across Europe. No doubt this trend will continue and we have to be prepared and skilled to address their needs. At the moment, it is important to offer migrants very basic help within a structure such as AMOC. There is evidence of a higher degree of mutual support amongst members of the same nationality, meaning that it is unlikely to see individuals leading a solitary life: they tend to stay in group and appear keen to help each other when needed. This is making their life more comfortable and organised in comparison to their Western counterparts who have a longer history of homelessness and social exclusion and who are, in most cases, extremely lonely. Could it be just a question of time? Could it be that after a period of non-integration that Central and Eastern Europeans will embark on a heavier use of drugs and a more difficult life? How can we try to prevent this from happening? We do not have a magic solution, but we do know that we have to stay in touch, to listen and to talk, to inform and to educate and to build up trust that, among some nationalities, is currently mostly confined to their own culture.

It is our responsibility as professionals to continue to advocate for the rights that are too often ignored, not only in the case of the groups that were the subject of this research, but for any other minority ethnic group, whether or not they have a drug dependency problem. They must all be respected and accepted regardless of ethnicity, gender, religious beliefs and personal dreams.



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Licia is an Italian who has lived in the Netherlands for many years. She is a sociologist and since 1992 has been the general co-ordinator of TAMPEP (European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers), a network aimed at carrying out and implementing multi-faceted strategies for health promotion and social support for migrant and mobile sex workers. Since 1980, she has carried out research and promoted projects for sex workers in different regions in the world. She is a consultant for several European and international agencies.

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Jez has an academic background in law and social work and has worked in a range of social care settings including equality and diversity, substance use, homelessness and mental health. Jez has been leading the Centre for Ethnicity and Health's Community Engagement Programme since 2000.

Crolle, Enzo, Regenboog/Amoc, Amsterdam, Netherlands, www.amoc-dhv.org, ecrolle@amoc.demon.nl

Enzo is a counsellor who qualified in the U.K. where he worked for residential addiction treatment centres in Kent and London. In 1997, he moved to Italy where, on behalf of Gruppo Abele, he was responsible for the implementation of an experimental therapeutic community for so-called “chronic” drug users with psychiatric pathologies and HIV/AIDS-related problems. Furthermore, he coordinated “Project Hudna” that aimed to assist drug dependent North Africans who were undocumented migrants. Since 2000, he has been working as social worker in Regenboog/AMOC, Amsterdam which is an organisation that provides services to foreign drug users in the Netherlands.

Domenig, Dagmar, PhD, Director of Health and Integration Department, Swiss Red Cross / SRC, Bern/Wabern, Switzerland, www.redcross.ch, dagmar.domenig@redcross.ch

Dagmar has a degree in law, is a registered nurse and a social anthropologist. In the 1990s, she worked as a researcher at the Institute of Social Anthropology at the University of Bern, where she conducted research with Italian migrant families with illicit drug problems and developed her transcultural competence concept for health and social institutions. During the last ten years, she has focussed mainly on the transcultural competence of health professionals and has developed and taught on training courses. Dagmar’s transcultural competence concept has been widely published, and she has edited a widely-used handbook for practice and education. She has been working for the Swiss Red Cross for about seven years in different roles and recently became director of the health and integration department.

De Giorgi, Marco, Ser.T. ASL 4 (NHS), L’ago nel pagliaio – onlus (NGO), Turin, Italy.

Marco is a sociologist. He started to work in the social field in 1990, with an experience of eight years in Gruppo Abele. During that period, he spent six months in 1994 working for AMOC in Amsterdam. Since 1999, he has been the coordinator of the National Health Service (NHS) Street Unit of Turin “CanGo”. He is also the president of “L’ago nel pagliaio” – onlus (a needle in a haystack), an NGO to support the NHS in the management of low threshold services, and to organise and lead training courses on topics such as harm reduction strategies, peer support and peer education, self-help and so on.

den Otter, Joost J, PhD MD, Johannes Wier Foundation for health & human rights, www.johannes-wier.nl, j.denotter@bavo-europoort.nl.

Joost completed his advanced medical training at Leiden University. He also received a degree in clinical epidemiology and a public health degree. Joost has been working as a medical adviser with the National Agency of Correctional Services, a senior consultant with the Pharos Expert Center for Refugees and Health and as a general practitioner in reception centres, and previously as a SHO in an academic psychiatric hospital. He has been involved in several projects dealing with undocumented migrant drug users. Joost currently works at a youth department of BAVO-Europoort, a mental health organisation, as a member of an assertive community treatment team. He is a board member of the Johannes Wier Foundation for health and human rights.

Fountain, Jane, PhD, Professor of Substance Use Research, Centre for Ethnicity and Health, University of Central Lancashire, UK. <http://www.uclan.ac.uk/facs/health/ethnicity>
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Jane has been researching issues surrounding illicit drug use and the related service provision for twenty years. This work has concentrated particularly on those vulnerable to problematic drug use. Most recently, she has focussed on addressing drug-related issues amongst a wide variety of Black and minority ethnic communities, with a particular emphasis on the risk factors for problematic drug use that are associated with social exclusion. Jane is a research consultant for several European and international organisations, including the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Council of Europe Pompidou Group, and the United Nations Office on Drugs and Crime (UNODC), and is active in the European Society for Social Drug Research (ESSD). Her work has been widely published in academic journals and as reports, and she has edited several books.

Lago, Miguel Angelo Mendes, Villa Maraini Foundation, Rome, Italy, Oporto, Portugal.

Miguel studied philosophy in Portugal and in Italy, obtaining his degree in July of 2006. He worked in drug related harm reduction with “Associação Sol Nascente” (Portugal) as a street operator, and is now doing his post lauream internship at the Villa Maraini Foundation, with a scholarship from the Leonardo Da Vinci Programme. He works closely with migrants at the drop-in centre of the Foundation, as a cultural mediator.

Lutz, Roland, social pedagogist, Germany.

Roland studied social pedagogy in Germany and since 1977 has worked in different fields of drug services. He has been involved in AIDS work (with his main focus on drug users) for more than 20 years. From 2000 – 2004, he was responsible for coordinating the European SEARCH project that aimed to develop tailor-made drug prevention programmes for asylum seekers and refugees in 12 European countries, using and exploring the Rapid Assessment and Response research method. Since 2004, Roland has been working in an alcohol detoxification clinic in Germany.

Matheï, Catharina, Free Clinic, Antwerp, Belgium, KUL, Leuven, Belgium.

Cathy is a medical doctor. For 12 years she has worked at the Free Clinic in Antwerp, a low threshold ambulatory centre providing services to problematic drug users. She combines this clinical work with research on the epidemiology of infectious diseases at the Katholieke Universiteit Leuven. In 2006, she obtained her PhD degree with a dissertation entitled “The epidemiology of hepatitis C among drug users”.

Patel, Kamlesh, Professor Lord, OBE, Centre for Ethnicity and Health, University of Central Lancashire, UK. <http://www.uclan.ac.uk/facs/health/ethnicity> CentreEthnicityHealth@uclan.ac.uk

Kamlesh Patel has 20 years of experience in the health and social care field as a practitioner, manager and an academic. He is currently head of the Centre for Ethnicity and Health which he established in 1998 at the University of Central Lancashire. Kamlesh was appointed a cross-bench Life Peer in May 2006 and is also Chairman of the Mental Health Act Commission; a non-executive board member and chairman of the Audit and Risk Committee of the National Treatment Agency for Substance Misuse; a patron of the National Men’s Health Forum; a trustee and commissioner of the UK Drug Policy Commission; and a member of the Global Task Force, UNICEF.

Patrino, Fabio, psychologist-psychoterapist, Villa Maraini Foundation, Rome, Italy, www.villamaraini.it.

In 1976 Fabio was one of the founding members of the Villa Maraini Foundation complex established in order to help drug users and since then has continued to occupy several key responsibilities in the Foundation. In the meanwhile, he worked part time in PTCs,

hospitals, prisons and in the Regional Department of Epidemiology. In 2003 he was elected Vice-President of the ERNA Network (www.erna.sk) which joins 40 different Red Cross Red Crescent National Societies. From 2004, Fabio has coordinated, in close cooperation with the IFRC (International Red Cross Red Crescent Movement), the training programme “To build up harm reduction capacities in Eastern Europe and Central Asia”.

Schatz, Eberhard, Correlation network Regenboog/AMOC, Amsterdam, Netherlands.

Eberhard is coordinator of the European Network Social Inclusion and Health (Correlation) and previously coordinated a network on mobile drug users. He works for the Amsterdam-based agency Regenboog/AMOC, which provides services for foreign drug users and sex workers. He was involved in the development and implementation of cross-border projects between Germany and the Netherlands. Eberhard studied social work and has a degree in bioenergetic analysis.

Sprocatti, Davide, Ser.T. ASL 4 (NHS), Turin, Italy.

Davide is a professional educator. He is 25 years old and started to work on Street Unit CanGo in 2006, after his degree and one year as a volunteer on the agency's bus.

Voets, Ancella, Mainline Foundation, Amsterdam, Netherlands.

Ancella has a Bachelor's degree in International Business and a Master's degree in Anthropology. She has been working in the drugs field since 2002, with a special interest in migrant drug users. From 2004 until 2006, she worked as an outreach worker and a trainer for the Mainline Foundation, an organisation that works to improve the health and quality of life of (injecting) drug users. She recently started coordinating several international projects (including in the Ukraine) for this organisation.

