Between 2002 and 2004, a European Commission-funded research project set out to explore whether migrants had adequate access to the health services and to health-related information, particularly regarding HIV/AIDS prevention, in five EU Member States: Austria, Germany, Greece, Italy and Spain. More than 1,660 migrants (with and without legal status, including 250 sex workers) from 7 macro-regions of origin and 80 health and social professionals took part. The research, based on a combination of quantitative (quota sampling) and qualitative techniques, forms the backbone of this Handbook.

80% of migrants stated that their health was good, but 34% of those who had been in the host country for more than 5 years said it had deteriorated. 63% of the general migrant population had some form of health coverage, compared to 43% of sex workers. 69% said they were satisfied with their experience of the health services, but 40% said they had experienced communication problems. Only 50% were quite sure what HIV/AIDS was and only 40% knew they had the right to a free and anonymous HIV test. 57% were not sure or did not believe that the results of the HIV test would be confidential. Only 58% of sex workers had had an HIV test, only 54% said they always condoms during intercourse with clients, and 68% gave as the reason the fact that the clients paid more for unprotected sex. Migrants without legal status systematically knew and used the health services – even in those countries where they had access to more than the emergency services – less than regular migrants, due to the overriding fear of losing anonymity and being deported. The topic of HIV/AIDS aroused fear of stigmatisation and discrimination in all migrant communities.

Armed with these figures, and a wealth of suggestions from both immigrants and health professionals, the authors of this Handbook present a series of recommendations, mainly for health professionals, managers and policy planners at local level, on how to make health services more "migrant-friendly". An enormous amount of work is already under way in order to increase migrant communities' access to health care and preventive information in Europe, and the book is illustrated throughout with examples of good practice mainly from the five project countries, together with contact details of relevant organisations and further sources of information. Looking at the key areas of service reorientation, legal status, cultural competence, information strategies and how to reach vulnerable groups, the main theme which emerges is the need to work more closely with, not just for, migrant communities. This will, in itself, go a long way towards facilitating the integration of migrants in our societies and dispelling their fears of stigmatisation and discrimination, particularly where HIV/AIDS is concerned.

European Center for Social Welfare and policy
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S.P.I. - Berlin
C.R.R.P.S.

Migrant-friendly health service and HIV/STI prevention: A handbook for health professionals and policy-makers

Migrant-friendly health services and HIV/STI prevention

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Edited by Jane Hughes and Jean-Pierre Foschia

REGIONE DEL VENETO

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The Handbook can be downloaded in English, German, Greek, Italian and Spanish from the website of the coordinating agency, the Veneto Regional Centre for Health Promotion (CRRPS):
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FOREWORD

It is a pleasure for me to present this volume, the fruit of the work and commitment of a team of experts in Italy, Austria, Germany, Greece and Spain. This experience, for us, represents a new step in the process of improving the services and care delivered by the various health and social systems to the whole population, including the migrant population.

This Handbook represents, in my opinion, an interesting example of cooperation between different countries and institutions which, from the perspective of their own specific social, cultural and legal frameworks, have worked together to find some answers to the increasingly complex challenges of integrating different cultures. The approach of this work is based on the direct experience of the services and migrant communities, in an effort to identify examples of good organisational practice in the various countries which could be useful for others, with a view to mutual exchange and benefit.

Health and social services which are able to respond to social and cultural differences are undoubtedly of added value, particularly as EU citizens can now use the health and social services in the various European Member States. It must be emphasised that social cohesion and integration will be achieved through respect for the traditions and values in the host countries. This lies at the root of genuine reciprocal respect, the key to living together and to economic and social development in the future.

Hon. Dr. Giancarlo Galan
President of the Veneto Region

Venice, November 2004

PREFACE TO THE FIRST EDITION

This practical Handbook has been written for local-level health and social professionals, managers and policy-makers working in the field of migrants' health, although it is hoped that other interest groups may find it useful, most notably migrant associations and community-based organisations. It is based on the needs and suggestions of migrants and health professionals who participated in a two-year research project (2002-2004) on access to health services and HIV prevention in migrant communities in five European countries: Austria, Germany, Greece, Italy and Spain.

The purpose of the Handbook is to provide basic information and guidance or “tips” on “migrant-friendly” health services in general, with a focus on services preventing HIV/AIDS and sexually transmitted infections. It does not pretend to offer simple solutions to a complex issue: there is no one hard-and-fast model that will fit all realities. Rather, it seeks to highlight essential common values and quality standards which could be adapted and applied widely in healthcare settings in Europe. The style of the book is therefore down-to-earth and non-prescriptive, drawing in a practical way on the problems that have emerged and the solutions proposed throughout the research project. It is enriched with examples of good practice and experience drawn from the five partner countries, supplemented with a selected bibliography, website references and other contacts.

More than anything, the Handbook represents an attempt to transform research findings into practice. It should therefore not be seen at a final product, but rather the initial input to a participatory action research process. It will be disseminated amongst health and social professionals, migrant associations and other relevant interest groups in the five project countries as well as further afield. The aim now is to gather feedback, gain deeper and broader insight into the issues involved, and document further useful examples of what has been successful - and indeed of what has worked less well - in this challenging field.

It is our hope that this Handbook will in future be updated and used to guide the design and implementation of health promotion and disease prevention initiatives in migrant communities. Readers are therefore warmly invited to contribute to this initiative by sending their comments to any one of the partner organisations listed in Appendix 5.

Dr Franco Toniolo
Health and Social Affairs Secretariat
Veneto Region

Dr Massimo Mirandola
Director
CRRPS

ACKNOWLEDGEMENTS

This Handbook was written by Jean-Pierre Foschia and Jane Hughes (CRRPS Verona), Nicola Oberzaucher (European Centre for Social Welfare, Vienna), Eleni Poulakida and George Nikolopoulos (KEEL, Athens), Ana Rivadeneyra and Joan Carles March (EASP, Granada), Samanta Sokolowski and Elfriede Steffan (SPI research, Berlin), with the contribution of Tzvetina Arsova-Netzelmann (SPI-Research) and Laura di Pasquale (IOM Rome). A preliminary review was conducted by Katinka de Vries, public health consultant to the UN. Final responsibility for the contents lies with the authors and the Director of the CRRPS, Massimo Mirandola. The Handbook was edited by Jean-Pierre Foschia and Jane Hughes. The cover page and layout are by Ruggero Ughetti. The handbook was translated from the English original into German by Rainer Sauter and Petra Kaiser, Greek by Eleni Poulakida, Italian by Sabrina Cecconi and Spanish by Ana Rivadeneyra.

The authors wish to express their gratitude to all the immigrants, interviewers and health professionals who provided valuable information for the research project on *Immigrants from European Southern and Eastern Borders: HIV risks, social conditions and service provision reorientation (2002-2004)*. Thanks also go to Eva Baldassari, Nadia Oprandi, Antonella Strino, Paolo Vareschi, Silvana Menichelli, Silvia Pedrotti (CRRPS) and Natale Losi (IOM Rome) for their work on the project. The project was funded with the assistance of the European Commission (DGV) and coordinated in cooperation with the Veneto Region of Italy: Luigi Bertinato and Francesco Ronfini, Veneto Region Office for International Health, and Gianlorenzo Martini, Director of the Veneto Region Office in Brussels.

NOTE ON THE USE OF EXAMPLES IN THE TEXT

Most of the examples of good practice used to illustrate the text reflect the experience of the countries which participated in the above-mentioned research project. This does not imply that practice in these countries is necessarily better than in other European Union countries. The statistical references are based on the quantitative research findings drawn from a non-representative quota sample of regular and irregular migrants in the five project countries. Quotations from the qualitative research conducted in September 2004 have been selected where they reflect common response patterns across the countries.

NOTE ON TERMINOLOGY

The term “migrant” may imply a person who is still on the move, as opposed to an “immigrant”, who may be temporarily or permanently settled in the host country. However, the two terms are to all intents and purposes used interchangeably in this publication.

ABBREVIATIONS AND ACRONYMS

ARV	Antiretroviral therapy
CBO	Community Based Organisation
CSW	Commercial Sex Worker
EU	European Union
EVYP	Especially Vulnerable Young Persons
FG	Focus Group
GP	General practitioner
GDP	Gross Domestic Product
HAART	Highly Active Antiretroviral Therapy
HPDP	Health Promotion and Disease Prevention
IDU	Injecting Drug User
IEC	Information, Education, Communication
IOM	International Organisation for Migration
MSM	Men who have Sex with Men
M&E	Monitoring and Evaluation
NHS	National Health Service
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PLWHA	People Living With HIV/AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Programme on AIDS
UNHCR	United Nations High Commission for Refugees
UNHCHR	United Nations High Commission for Human Rights
VCT	Voluntary Counselling and Testing

INTRODUCTION

BACKGROUND: MIGRATION AND HIV IN WESTERN EUROPE

It is currently estimated that approximately 175 million people, corresponding to 2.9% of the world's population, are living temporarily or permanently outside their country of origin.[1] In the five countries which participated in the research project on which this Handbook is based (see the following section), the proportion of immigrants compared to the total population is as follows: Austria and Germany 9%, Greece 10%, Italy 4.5% and Spain 3%,[2] and has increased rapidly in all countries in recent years.[3]

In 2003, an estimated 4.8 million people worldwide became newly infected with HIV, approximately 37.8 million people were living with HIV (PLWHA), and 2.9 million died of the disease.[4] More than 90% of PLWHA live in developing countries. In Western Europe, the number of deaths cause by AIDS continues to decline as a result of broad access to life-prolonging antiretroviral treatment (from 3,373 in 2001 to 3,101 in 2002).

However, after a decrease over several years, HIV transmission rates are once again increasing in Western Europe countries. The two countries with the largest epidemics in Western Europe are Italy and Spain, although neither yet have systematic national HIV reporting systems. Unsafe sex is a major transmission route, as evidenced by an increase in the incidence of STIs (sexually transmitted infections).[5] Unsafe sex between men (MSM) still plays an important role in the epidemic in Western Europe, with a reported increase of 22% between 2001 and 2002 and prevalence estimated at between 10-20% in several countries. Of the five project countries, it is the main route of infection in Germany and Greece. In Western Europe, drug injecting accounts for more than 10% of all reported HIV infections.

Heterosexual transmission has also risen sharply, with an estimated increase of 122% between 1997 and 2002 in the 12 Western European countries with data for newly diagnosed HIV infections. In several of these countries, the increase in this type of transmission is dominated by people originating from countries with high prevalence, particularly the Sub-Saharan Region.[6] There has been a significant increase in arrivals of immigrants from Eastern Europe, where the AIDS epidemic has assumed dramatic proportions: there were about 1.3 million PLWHA at the end of 2003. The main source of infection in Eastern Europe is among intravenous drug users (IDUs), particularly among young people under the age of 30. It has been calculated that more than 80% of PLWHA in the region are under the age of 30, compared with 30% in Western Europe.

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[1] *World Migration Report*, International Organisation for Migration (IOM), 2003.

[2] EUROSTAT *Population Statistics 2004*: http://epp.eurostat.cec.eu.int/cacheITY_OFFPUB/KS-BP-04-001/EN/KS-BP-04-001-EN.pdf

[3] National Reports for the research project, January 2003.

[4] Information in this section based on UNAIDS *2004 Report on the Global AIDS Epidemic*. See also UNAIDS *Questions and Answers Section II, Basic Facts about the AIDS epidemic and its impact*, November 2004.

[5] STIs are increasing rapidly because they are much more infectious than HIV. Much more public information is needed, particularly as condom use is not enough to guarantee protection against some STIs. One of the most worrying research findings of this project was the low level of knowledge about STIs (see *Cross Country Statistical Report 2004*, summarised in Appendix I).

[6] There is little data in the five project countries on the incidence of HIV in immigrant communities as a proportion of reported cases for the total population, but it has been estimated in Germany that about 30-40% of newly identified HIV cases are among people of non-German origin (*National Report on Germany* for the research project, SPI-Research, 2003).

EVOLUTION AND OBJECTIVES OF THE HANDBOOK

In 2002, the European Commission (Public Health Directorate G of the Health and Consumer Protection Directorate-General) financed a two-year research project to examine barriers to migrants' access to health care, including measures to prevent HIV/STIs, in five EU Member States: Austria, Germany, Greece, Italy and Spain.[7] The main project aims were to:

- analyse migrants' access to health services, particularly in the light of legal status;
- identify difficulties and shortcomings in service provision, taking account of the views of both representatives of migrant communities and health and social service professionals;
- draw up and pilot a set of recommendations in the form of a manual, based on the research findings and examples of good practice.

The research comprised both quantitative and qualitative methods, as well as a literature review.[8] 300 immigrants from the three or four main migrant communities in each project country answered a standard questionnaire about their reasons for migration, social circumstances, knowledge and experience of the health and social services in the host country, and knowledge, views and behaviour concerning HIV/AIDS and STIs. Of those interviewed in each country, 50 were female commercial sex workers (CSW). As it was impossible to have a representative sample, migrants (with the exception of the CSW) were selected according to a quota based on their legal status, region of origin, sex and age. The research findings were analysed at national and cross-country levels, and the main issues to emerge formed the basis of the qualitative research subsequently carried out, in the form of focus groups with representatives of migrant communities and workshops or in-depth interviews with representatives of the health and social services.

In general, our research showed little difference in HIV/AIDS related knowledge and behaviour between migrants (regular or irregular) and host populations, and in some instances knowledge was actually higher.[9] Satisfaction with services was generally medium to high, and the problem of long queues (reported by 30.6% of those who said that they had experienced problems) is certainly similar to complaints by host country nationals. The main areas of difference were, as confirmed by numerous other studies on this subject, lack of information, problems in communicating with staff and, particularly with regard to HIV/AIDS, an overriding fear of discrimination and stigmatisation.

In response to these concerns, it seemed to be essential to address the issue of HIV/AIDS prevention in migrant communities by drawing attention to the key part to be played by the health sector in multi-sectoral initiatives to integrate migrant communities into European societies.[10] To this end, the Handbook proposes that HIV/AIDS prevention be

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[7] The research project falls within the activities on AIDS and other communicable diseases under the European Commission's Public Health Programme.

[8] A summary of the research methodology and main quantitative and qualitative research findings for each country can be found in Appendix 1. The research tool and full national research reports can be found on the websites of the partner organisations, listed in Appendix 5.

[9] One possible exception is Germany, where host population knowledge of HIV/AIDS is so high (99%) that it almost eclipses the relatively good knowledge of the migrant population. Nevertheless, knowledge of STIs among immigrants, particularly women, was higher than among German nationals.

[10] The timing of this publication is indeed significant. During the course of the project, the European Union increased from 15 to 25 Member States. This obviously means that the "southern and eastern" countries in which we focused our research are no longer the same, and that once migrant-producing countries are now fast becoming countries of destination themselves.

placed in the setting of a “migrant-mainstreaming” approach to health service delivery, facilitating the access of migrant groups to existing health services. This approach needs to be balanced with “positive discrimination” in the form of humane and pragmatic strategies to address the special health care needs of particularly vulnerable groups within migrant populations. These may include migrants who have recently arrived, those without legal status (irregular migrants), sex workers (male and female), asylum seekers and intravenous drug users (IDUs), especially among young people.

CONTENTS OF THE HANDBOOK

The chapters have been structured in response to the following five main challenges:

- service re-orientation
- legal status and access to health care
- culturally competent service delivery
- information and networking
- working with especially vulnerable groups.

Chapter 1 suggests twelve ways of making health services “migrant-friendly” by ensuring that they are adaptable, accessible and culturally sensitive. Some of the key issues highlighted here are explored in greater depth in the subsequent chapters.

Chapter 2 analyses the implications of legal status for access to health care and health-related behaviour, against the background of international legislation and recommendations on the one hand, and the varying national laws, policies and practices of the five project countries on the other.

Chapter 3 analyses the concept of cross-cultural competence within health care organisations and their professionals. It addresses four main intervention domains: staff training and education; interpreting services and translation; interaction and treatment models; community participation and cultural mediation.

Chapter 4 looks at how to provide appropriate information for migrants in the area of HIV/AIDS and STIs. It examines the channels of information preferred by different groups of migrants, types of information campaign which have proved successful and less successful, the use of peer education and, above all, how to actively involve migrant communities in the promotion of their own health.

Chapter 5 focuses on types of pro-active service delivery, principally outreach work, effective in meeting the needs of especially vulnerable groups, including migrants living with HIV/AIDS, sex workers and asylum seekers.

Each chapter contains examples of good practice from the project countries, illustrative quotations from the qualitative research, and a resource section containing useful bibliographic references in English, German, Italian and Spanish, website addresses, as well as contact details for other organisations where relevant.

The Handbook concludes with a *Summary* of the main conclusions and recommendations, and some suggestions for future action.

The *Appendices* contain summaries of the research project methodology and findings, basic fact sheets on HIV/AIDS and STDs, a sample individual self-assessment tool for the staff (administrative as well as professional) of health and social services, and a brief description of the organisations which contributed to this publication.

We wish to reiterate that this Handbook does not pretend to offer an exhaustive and infallible catalogue of "do's" and "don'ts" in migrant healthcare. There is no one right approach or straightforward solution in a field characterised by constant change and endless permutations These include, in addition to wide variations in the political and legal context of the host country:

- rapidly changing countries of origin of migrants arriving in our societies;
- the migrant community's cultural background;
- the individual migrant's history and migration experience;
- behavioural changes in response to new and often harsh living conditions;
- the level of adaptation and presence of personal resources on the part of the individual;
- the existence of community networks and inclusion initiatives in the host country;
- future intentions: some migrants intend to put down roots, others to return, and yet others have no idea of what the future holds.

All these aspects play a part in this complex panorama, and we have deliberately tried to steer clear of a "prescriptive" approach. It is our over-riding hope that this first edition of the Handbook will be of practical use and inspiration to services and professionals often working under financial and time constraints and sometimes faced with stressful human situations in the course of their daily work. We also hope that this book will help to sow the seeds of a more active involvement of migrants and their communities in decisions affecting their health.

A FINAL CONSIDERATION

Host country health services and professionals, even those operating in the smallest and most far-flung communities, should be aware that they are not working in a vacuum, but are part of a continuum of prevention and care. Ideally, this should stretch from the country of departure, through the countries of transit, to the host country. This is particularly the case for services specialising in infectious diseases such as HIV/AIDS, STIs and TB. Some health structures have already initiated direct bilateral contacts with health authorities, embassies and NGOs in the countries of origin and transit with a view to exchanging information, planning information campaigns and providing individualised health care assistance to some people returning to their home country. Such contacts could be promoted by regional and international organisations such as WHO, the International Red Cross and IOM.

As one Spanish medical practitioner interviewed for the research project said: "We need to direct efforts towards the improvement of the situation in the countries of origin and the development of better health systems. This requires the development of more extensive and better collaboration schemes with cooperation agencies at a national and a European level."[11]

WHO has also drawn attention to the problem of the "brain drain", as qualified health professionals from developing countries seek employment in the European Union, with

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[11] Report on workshop with health providers, Granada, September 2004.

profound health implications for those left behind.[12] Initiatives to address the health needs of the few who manage to reach our continent must be placed in the context of the millions who are in desperate need throughout the rest of the world: this is the truly global challenge of migration and health in our times.[13]

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[12] *International Health, Migration and Human Rights,* WHO Health and Human Rights Publication Series, Issue No. 4, December 2003.

[13] None of the project countries meet the UN's recommended 0.7% of GDP from the most developed nations for development cooperation: Austria 0.25%, Germany 0.28%, Greece 0.21%, Italy 0.17% and Spain 0.25% (the lowest percentage in Western industrialised countries is the United States 0.14%, and the highest is Norway 0.92%).

1

MIGRANT MAINSTREAMING IN HEALTH SERVICES

1.1 INTRODUCTION

European countries today are at various stages in the process of adapting existing models of health service provision in order to respond effectively and humanely to the challenges of the “globalisation” of health. Not only are the numbers of migrants in all our countries increasing, as is the range of countries of origin, but health needs are becoming more varied and more complicated. Interventions to prevent HIV/AIDS and STIs in migrant populations need to take place within a framework of “migrant-friendly” strategies if they are to be effective.

This chapter starts by examining the rationale for service reorientation and “migrant mainstreaming”. It sets out some of the basic barriers to healthcare access identified by migrants, including shortfalls in the area of HIV/AIDS/STI prevention. It then proposes a set of 12 key areas for reorientation in order to ensure that services dealing with migrants are adaptable, accessible and culturally competent. These are presented as “bottom-line” suggestions, the basic ingredients for a “migrant-friendly” approach which could be adapted to and applied in most health settings.

I. Adaptable to migrants:

- Reinforcing primary health care
- Integrated multidisciplinary and multi-sectoral approach
- Networking and community participation
- Data collection, needs assessment, monitoring and evaluation

II. Accessible to migrants:

- Favourable regulatory and policy environment
- Person-centred reception
- Flexible opening hours
- Information and communications strategy
- Tailoring services to vulnerable groups

III. Culturally competent:

- Staff recruitment
- Staff training
- Use of cultural and linguistic mediation

1.2 THE RATIONALE FOR REORIENTATION

Across Europe, regulations and practices determining access to healthcare vary widely, particularly where undocumented migrants are concerned [see Chapter 2]. So too do health insurance schemes, patient charges, the relationship between public services and the non-governmental sector (NGO) sector, the definition of “essential” health care and opinions of whether special facilities should be introduced for immigrant patients, or whether this runs the risk of creating “ghettos” within national health care systems.

In spite of the variations in countries’ practical experience in serving migrant communities, influenced by political systems and commitment, reforms in models of service provision and fluctuating target populations, the basic challenges facing health services and professionals today are common. There is gathering momentum to progress beyond an emergency response towards a more proactive and inclusive framework of integration aimed at promoting the physical, mental and social well being of immigrants. There is much debate on how to promote equity and the right of migrants to health, balanced with the need to respect and protect diversity. In particular, regarding the special focus of this Handbook, the battle against HIV/AIDS is by no means won. On the contrary, the explosion of the epidemic in Eastern Europe, together with a resurgence in new cases in Western Europe, leaves no room for complacency [see Introduction].

Migrants are by definition a heterogeneous and ever-changing population group, and it is essential to steer clear of generalisations. However, our research shows that many of the obstacles and opportunities for both migrants and health professionals are also common [see Appendix 1, Summary of Cross-Country Qualitative Research].

A good starting point for any process of “migrant mainstreaming” in existing services is to build on initiatives already taken to promote the health of national populations, in response amongst other things to the recommendations of the WHO Ottawa Charter on Health Promotion. The 1986 Ottawa Charter seeks to ensure that individuals and communities can reach their full health potential and be empowered to take control of the issues that determine their health status. The health sector is called on to “advocate”, “enable” and “mediate” in order to:

- build healthy public policy;
- create supportive environments;
- strengthen community actions;
- develop personal skills;
- reorient health services (see box below).

Reorienting Health Services

“The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which focuses on the total needs of the individual as a whole person.”

WHO Ottawa Charter on Health Promotion, 1986

At a time of cost-cutting in public services in a number of European countries, it is important to bear in mind that reorientation does not need to incur additional health sector expenditure, and could actually lead to savings in the long run. Health professionals in Spain have pointed out that in a context of limited resources, "there is a need to make the best of available resources within the public health system, as well as those of the wider community". Above all, evidence is emerging that measures to promote the health of the immigrant population are also of benefit to vulnerable groups in the host population, including the homeless, the elderly, drug users and nomadic groups.[1]

1.3 BARRIERS TO HEALTHCARE ACCESS

The quantitative findings of our European research project showed that the majority of migrants interviewed had used the health services (public, private or NGO)[2], albeit infrequently, since their arrival in the host country. Irregular migrants used services consistently less than regular migrants. Infrequent usage can in part be attributed to the "healthy migrant" phenomenon, where the strongest and fittest people are the ones to undertake the migration project, thereby needing the health services less.[3] The research also showed, however, that lack of information on the right to use the health services, combined with lack of practical information on how to use the health services, posed a significant barrier to access.

The percentage of migrants who said they were fairly or completely satisfied with their experience of the health services ranged from 44.6% in Greece to 86.1% in Italy.[4] The main reasons for dissatisfaction were difficulties in communicating (40% of all respondents who had experienced problems with the services), long queues 30.7%), inconvenient opening hours (28.5%), and unfriendly staff (21.7%) (see Figure 1 below).

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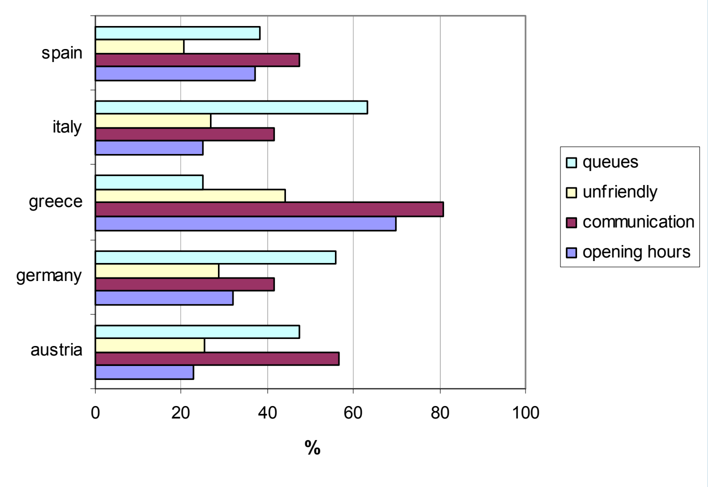
[1] Some health services, such as the San Gallicano Institute in Rome, open their doors to all disadvantaged groups and actively encourage interaction between the host population and migrant users. See *Health Systems Confront Poverty*, WHO Public Health Case Studies, No. 1, 2003.

[2] 86.5% of respondents said they had used at least one health service in the host country. In the 12 months preceding interviews, 12% had not used any health service, 25% had used a health service once, and 24.7% twice. Source: *Cross Country Statistical Report 2004.*

[3] Statistics showed a consistent decline in perceived health status after two or three years in the host country. Some experts have noted that the "healthy migrant period" is becoming shorter (see footnote 1 above).

[4] In Italy, the sex workers (included in these figures), many of whom were recruited through an outreach health service, expressed almost 100% satisfaction.

Figure 1: Migrants' reported problems with health services



Source: Cross Country Statistical Report, 2004

The subsequent qualitative research revealed that barriers to access were largely based on fear and prejudice. Migrants said they were afraid of discrimination, of not being able to understand or make themselves understood, of being reported to the police or immigration authorities [see also Chapter 2, section 2.4], of not being able to afford the treatment and of receiving "second class" service, afraid even of being humiliated or maltreated.[5]

"At the General Hospital we waited for our turn. A doctor looked at me and said: "We are sick of foreigners". I tried to explain, but he couldn't understand."

Male immigrant from the Middle East, Focus Group, Athens

"Medical malpractice occurs often with migrants. I regularly have to send people to the patient advocacy organisation. Migrants are poor, and therefore a group at risk (…) I know of an Austrian doctor who speaks Turkish but asks his Turkish patients to pay him 20 Euro for speaking Turkish with them."

Male health outreach worker from Turkey, Focus Group, Vienna

Barriers to health service access and information are of course particularly relevant in the case of HIV/AIDS prevention. Only 40% of all immigrants interviewed knew of their right to a free HIV test, and only 31.4% had actually had the test (see Figure 2 below). There was an extremely high rate of stated abortions among the women immigrants interviewed: 14.9% of women in the general sub-group, rising to 27.1% of sex workers (the figure for the latter was 47.4% in Austria), evidencing unsafe sexual practices. These figures show that there is still much work to be done in the area of preventive information and activities [see Chapter 4].

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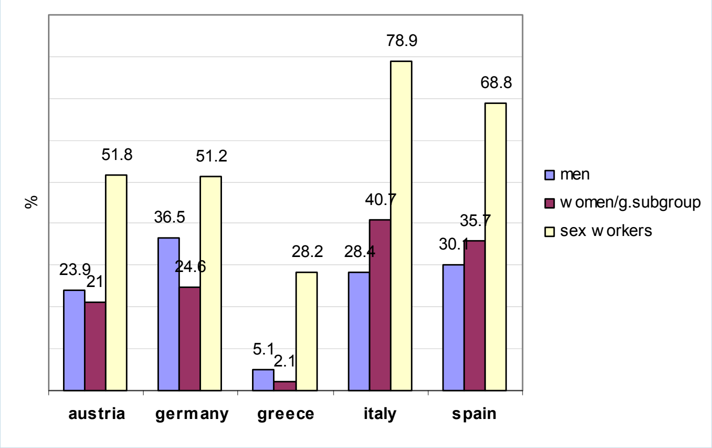
[5] In a question about experience of serious maltreatment in the host country, 4.1% of respondents (65 people) said that they had been maltreated by health service staff.

Figure 2: Immigrants tested for HIV

Males and females from the general subgroup, and female sex workers



Source: Cross Country Statistical Report – 2004

1.4 ADAPTABLE SERVICES

1.4.1 Reinforcing Primary Health Care

One of the key issues in the debate on service organisation is that of whether to provide separate facilities for immigrants (particularly irregular migrants) alongside those for the rest of the population. Some countries and regions are currently experimenting with special healthcare and family planning centres for the irregular migrant population.[6] Many health professionals feel that special services are a necessary but temporary adjunct to regular services for vulnerable groups (including irregular migrants), and that priority should be given to assisting migrants in making use of the regular health care facilities, particularly at primary level, to which they are entitled.

"There is not a need to create special HIV/AIDS prevention or care programmes, but to ensure that migrant populations have adequate information and access to, and are able to benefit from, the existing national prevention programmes and care system. Otherwise, there would be a high risk of stigmatisation and prejudices against immigrants, whether for unfairly associating them with the infection, or for accusing them of making use of extra resources that are not even put in place for the national population."

In-depth interview with a Spanish general practitioner, Granada

"It is important to avoid a two class system, such as services for migrants and services for Austrians or migrants for migrants, and Austrians for Austrians. Start with the political preconditions, catch-up on integration, on planning the integration, simply on language courses."

Participant, Focus Group with migrants, Vienna

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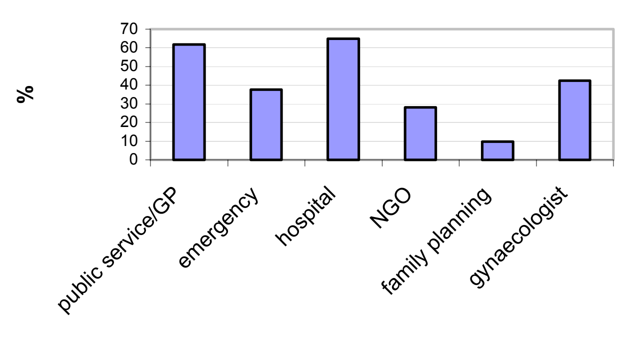
[6] In the Veneto Region of Italy, local health authorities are required to provide special services for irregular migrants in order to fill a need left by national law, which does not entitle irregular migrants to access to a family doctor (GP).

There is a tendency in developed western health systems to neglect the primary health care model in favour of an emphasis on "acute" or "hi-tech" models. However, low-threshold, primary health care structures present distinct advantages for migrant populations as they encourage early intervention and provide an opportunity to give information on prevention. This will avoid delays which may lead to chronic and severe conditions, resulting in excessive use of costly emergency and secondary facilities. Nowhere is this more obvious than in the area of HIV/AIDS where, unlike host country nationals, migrants who undertake the HIV test are often found to have progressed to the stage of full-blown AIDS, sometimes unaware that treatment to mitigate the effects of HIV is now widely available in Europe. 48.3% of migrants interviewed for the research project said that they would like to receive more information about HIV/AIDS from health professionals, and UNAIDS has also highlighted the need for more pro-active, provider-initiated prevention information.[7]

Renewed investment in primary health care facilities may thus promote a more rational use of health sector spending and help to relieve pressure on the emergency services and hospitals which, in all countries covered by our research, tended to be the first port of call of migrants (regular as well as irregular) with health problems (see Figure 3 below). This point is emphasised by WHO, which observes that national health care plans often discriminate against temporary migrants, but that "the strain on emergency care services and the consequent inefficient use of health services has not dissuaded policymakers from maintaining such policies".[8]

Figure 3: Use of health services by immigrants



Source: Cross-country statistical report, 2004

Health professionals have recommended simplifying registration procedures as a means of encouraging access to services and protecting anonymity (in the case of irregular immigrants), asking only the minimum number of personal questions necessary in order to identify a patient's records. In the research project, over 10% of the immigrant users who had some form of health insurance or a health card reported that bureaucracy had been a significant problem.

Facilities dealing with HIV/AIDS and STD screening and treatment should preferable be discreet: immigrants in several countries said they were deterred from requesting an HIV test because the specialist services were too conspicuous. Low-threshold services present an advantage here, as they are accessible to all and it is not possible to identify the exact purpose of the visit. Some primary services offer HIV testing and/or information and guidance to all patients on a routine basis, to avoid stigmatisation. This has been

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[7] UNAIDS 2004 Report on the Global AIDS Epidemic

[8] International Migration, Health and Human Rights, WHO Health and Human Rights publication series, Issue No. 4, December 2003.

welcomed with relief by immigrants who, for cultural reasons, felt too embarrassed to ask for the test or to go to a special testing service (see box on the Verona Family Planning Centre below). Where referral is necessary, clear coordination with specialist services is essential. Some immigrants from North Africa in Spain felt that whereas they received adequate information about general health services when informed of their right to health care, they were not given information about other specialised facilities, such as STI clinics.

"The visibility of the AIDS Help House building – it is clearly marked – makes it a high threshold service. It inhibits female migrants, more or less depending on their cultural background, to enter it".

Austrian health professional, Workshop with Service Providers, Vienna

"I think women would rather come to the hospital than the AIDS Help house. It is anonymous and nobody knows why I go to the hospital. I can tell my husband I go there because I have a headache, but in reality I go there for other information, like STDs or HIV."

Female Croatian psychologist, Focus Group, Vienna

1.4.2 Integrated multidisciplinary and multi-sectoral approach

"Health is not always their [migrants'] first priority, something that sounds inconceivable to Western civilisation."

Greek health professional, Workshop with Service Providers, Athens

"As long as basic rights and needs are not covered, prevention will remain a problem. If people do not have a place to live and are without money, we can tell them over and over again to take care of their health, it won't help much. There are declarations of the UN and WHO that people need certain civil rights, a home, a job, social security. If these basic rights are not fulfilled health prevention is a problem."

Representative of Austrian AIDS organisation, Workshop with Service Providers, Vienna

These statements eloquently demonstrate the need for multi-sectoral cooperation in caring for and promoting the health of immigrants. Indeed, in the words of the Ottawa Charter: "Health is a resource for life, not the objective of living. (…) The prerequisites and prospects for health cannot be ensured by the health sector alone. (…) Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health".

If the health sector is to effectively carry out its full role in terms not only of treatment and care, but also promotion and prevention, particularly close attention will have to be paid to interaction with the social services as part of a strategy to identify vulnerable population groups and to prevent others from falling into marginal situations. An integrated health and social policy framework presents a number of advantages, particularly in developing coordinated strategies in policy areas such as education, housing, and employment, which can have a major impact in strengthening health.[9] It is essential that the health, social and educational sectors work together on HIV/STI prevention.

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[9] The Veneto Region was the first in Italy to adopt an integrated model of local health and social services (ULSS), with joint responsibility in the areas of disability, drug dependency, child and maternal health and mental health. Since 1996, the health and social authorities have cooperated in drawing up community development plans and strategies at provincial level.

The Centre for International Health and Transcultural Medicine (CSI) in Brescia is a service run by the public sector, which takes full charge of the healthcare of irregular and undocumented immigrants. The Centre owes its success over the past 15 years (20,433 patients and 56,412 visits between 1990 and 2004) to its excellent collaboration with a well-functioning network of local organisations sensitive to the issue of migrants and health. The Centre is part of the Primary Care Department of the Local Health Authority and is attached to the one of the main hospitals in Brescia. It works closely with the Department of Prevention, the Department of ASSI (family, infancy and formative years), the Health Education Service, the Training Service, the University of Brescia and affiliated teaching structures, other Local Authority departments, NGOs and local trade unions.

issa1957@libero.it *csi@aslbrescia.it*

Not only is it important to coordinate with other related sectors, but better coordination has been called for amongst the various health and medical services in order to effectively address migrant health needs, including protocols on provision of drugs and treatment of certain pathologies.

Since April 2002, the Office for Mobile Populations in Athens, Greece, has been running a public health programme for irregular immigrants. The team includes a medical doctor, a psychologist and cultural mediators (full-time staff or trained volunteers).

www.keel.org.gr

1.4.3 Networking and community participation

It is vital to include community-based organisations (CBOs) and opinion leaders (though these may not always be easy to identify) in multi-sectoral networks, to ensure that activities are well informed, non-discriminatory and effective, as well as to provide essential feedback in monitoring and evaluation. Networking and “word of mouth” were the main channels of information in immigrant populations in all countries of the research project [see Chapters 3 and 4].

Where they do not yet exist, the establishment of CBOs should be facilitated by the town council and local authorities, who should make a meeting place available and hold regular follow-up meetings, including with directors of health services. Austrian and German health professionals stressed the importance of making funding available in order to set up and run CBOs. Lack of funding was one of the main reasons why some migrant associations and a migrant forum in the Veneto Region of Italy were struggling to survive. Italian migrants also described the lack of contact and cooperation between migrant associations as a major barrier to disseminating information and empowering migrant communities.

Mwangaza: Health and social counselling for women from Africa

This project is based on the cooperation of the Social Welfare Work of the Evangelical Churches Association of the city of Cologne, the Women’s Clinic of Cologne University and the Ministry of Health of the City of Cologne. It offers counselling and accompanying services for African women in health, social and legal issues. The project is funded by the German AIDS Foundation, the European Refugee Fund and the Gerda and Manfred Ulbrich Foundation.

mwangaza@diakonie-koeln.de

Close cooperation between the public sector and NGOs (non-governmental organisations) and civic society is essential. NGOs often provide assistance to individuals or groups of people who, for whatever reason, are or feel excluded from the mainstream services. With the increase in the number of people living in Europe today in marginal situations[10] and the crisis of the welfare state, NGOs and civic society are playing an increasingly pivotal role in assisting underserved communities and advocating for their rights. Health care facilities are often included amongst the practical and material support programmes offered by NGOs. NGOs manage to offer a "human" face and individual approach in their work, whereas state structures may be more fettered by administrative and other considerations.

However, there has been criticism that government passivity or failure to assume responsibility for the needy has opened up the field to unregulated and even unprofessional forms of assistance. Whilst praising NGOs for their caring approach, immigrants have also lamented the fragmentation of financial resources which could be better spent as part of a coordinated and structured public-private partnership.

Task Force on Migration and Health: this task force is made up of the most important NGOs and members of the Council of the City of Darmstadt. It was founded to improve cooperation and networking between institutions that work in the field of health promotion and migration.

interkulterelle@darmstadt.de

It has been suggested that the public sector should draw up protocols or agreements with the NGO/voluntary sector to guarantee adequate standards and resources.

In Verona (Italy) a formal agreement was signed in 2000 between the Local Health Authority (ULSS) and the NGO CESAIM, providing health services for illegal immigrants. The agreement recognised that, although the same services were at the time being offered by the public sector, there was a clear preference on the part of the migrant community to use the CESAIM facilities. Under the agreement, CESAIM provides staff (volunteer doctors) and the Local Health Authority provides: furniture, computers, laboratory analysis, essential drugs, family planning assistance, X-rays, medical receipts from the region, and temporary health cards for illegal immigrants (STP).

CESAIM, Via Giolfino21, 37133 Verona

The Hellenic Institute for Infectious Disease Prevention (KEEL), a public body, has an NGO liaison office on its premises to facilitate public-private planning and coordination.

www.keel.org.gr

It is also essential to include employers, the workplace and businesses in a multi-sector alliance to promote health. This is becoming all the more urgent in view of the devastating personal, demographic and economic effects of the AIDS epidemic, with the loss of skilled workers paying a toll on industrial and manufacturing output in many countries. Immigrants themselves have called for more public health information in the workplace for all workers, including HIV/AIDS prevention alongside issues such as safety. Employers too are increasingly recognising their corporate social responsibility in this area. This would have the advantage of informing male immigrants, a hard-to-reach target in some countries. The EU Workplace Health Promotion (ENWHP) network operates in most European Union countries, with many examples of good practice which could be expanded to include health promotion and disease prevention (HPDP) programmes sensitive to the special needs of migrant workers.[11]

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[10] The figure has been estimated as between 10 and 20 million by the Council of Europe. See *The adaptation of health care services to the demand for health care and health care services of people in marginal situations*, Recommendation Rec(2002)12, 2002.

[11] See www.businessfightsaids.com and http://www.enwhp.org/policy/policy-eu.php

1.4.4 Data collection, needs assessment, planning and evaluation

Data collection, needs assessment, monitoring (ongoing assessment) and evaluation (periodic assessment) (M&E) are vital to any service in order to assess the extent to which needs are being effectively met.[12] The current poor or sporadic information base on migrant health needs and data in many settings has been reported by health professionals and in the research literature, posing a major obstacle to efficient service provision. According to UNAIDS, three-quarters of countries in its 2004 Report claim that monitoring and evaluation is a major challenge.[13] In particular, it is extremely difficult to assess the needs of irregular immigrants.

The Hellenic Centre for Infectious Diseases Control operates the national HIV/AIDS epidemiological surveillance office. There is a network of 9 AIDS Reference Laboratories and 17 Infectious Disease Units which collaborate with the HIV Infection Office. There is a well-established surveillance network. Owing to the reporting procedure, data is highly accurate and under-reporting is less than 10%.

www.keel.org.gr

M&E should be a standard procedure in all service provision, and needs to be built in from the very beginning of any programme dealing with immigrants, as with any other target group. M&E should be interactive, and ideally should be conducted in the context of a multi-sectoral approach to health (see above) as this will make it possible to gain a more complete and accurate picture of the current demand for services. It will also enable professionals to keep track of successful, sustainable initiatives which could then be shared and replicated elsewhere (good practices).

Evaluation for migrants: some special considerations

- Need for sensitivity to context, including culturally relevant measures for assessing the impact of interventions and programmes on the target group;
- Need to involve the target group in evaluation, tailoring methods and questions to the linguistic capacities of the group and to their needs and interests;
- Need to be prepared to work in an environment characterised by change and uncertainty, being aware of the fact that in particular it may be hard to gain support for evaluation and assessment processes;
- Need to concentrate simultaneously on processes and outcomes, to produce a rolling evaluation of needs;
- Need to adopt a flexible approach and use a combination of methodologies, including qualitative and quantitative techniques such as surveys, community forums, direct interviews and focus groups.

In the context of HIV/AIDS, although it is recommended that decision-making responsibility for programmes be decentralised, it is important that the same M&E programme be used nationwide. National AIDS Councils (NAC) are now recommending immediate M&E to determine which programmes and activities are effective. For this purpose, ongoing data collection at local, regional and national level should be collected on the following:

- Epidemiological data on HIV/AIDS and STIs;
- Sexual behaviour (condom use) and injecting drug use (rapid assessment studies among the most vulnerable migrants, including irregular migrants, young people, sex workers, IDUs and MSM);

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[12] The following website contains useul information about a range of M&E techniques: http://www.synergyaids.com/apdime/index.htm#

[13] UNAIDS *2004 Report on the Global AIDS Epidemic.*

- Access to information and media use;
- Institutional capacity of organisations working with irregular migrants;
- The status of women and family patterns;
- Education of vulnerable groups.

Health professionals in Italy, for example, noted that the services did not have an institutionalised, standardised set of values or indicators for evaluating interventions, relying instead on their own internal functioning as an indicator of efficiency. Although M&E require both internal and external mechanisms, voluntary self-assessment tools, if implemented as part of a structured evaluation process, do present a number of advantages for health services and individual professionals wishing to evaluate performance and progress in the provision of interventions for migrant groups. This is particularly the case in an area such as "migrant-friendliness", which is not – as yet – subject to hard and fast rules or established quality standards [see also the sample individual self-assessment tool in the Appendix 2].

Self-assessment must be seen part of an ongoing developmental process, and not a one-off action. It should take place in a non-judgmental way, a part of a process to identify strengths and areas for growth at individual or organisational level, or both. It should be taken a step at a time, and progress is measured against previous scores, not against the track records of other individuals or organisations. The ultimate aim is to provide better service to immigrant communities, not to rate individuals or services. In fact, the score is far less important than the commitment to learn, develop and stimulate meaningful change. The process of self-assessment draws on existing resources within a service, and may uncover talents and skills which have been overlooked.

The benefits of self assessment[14]

Self assessment helps individuals and organisations to:

- Gauge the degree to which they are effectively tackling the needs of immigrant groups;
- Establish partnerships with the communities and stakeholders involved;
- Improve user access to and use of the services provided;
- Increase user satisfaction with the services provided;
- Strategically plan for the systematic incorporation of migrant-friendly and culturally sensitive polices, practices and structures within a service;
- Allocate human and financial resources to enhance the delivery of services;
- Determine individual and collective strengths and areas for growth.

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[14] *A guide to planning and implementing cultural competence organisational self-assessment*, T. Goode, W. Jones and J. Mason, 2002, National Centre for Cultural Competence, Georgetown University Child Development Centre, Washington D.C.

1.5 ACCESSIBLE SERVICES

1.5.1 Favourable legal and policy environment

A favourable legal and policy environment is of course a prerequisite for a migrant-friendly health service, with clear and well-publicised laws on access to healthcare services and well-defined policies on which categories of patients are eligible for which types of health intervention. [See Chapter 2] Although this may at first glance appear to be a matter which lies beyond the sphere of influence of health practitioners and service planners working with and for immigrants on a day-to-day basis, they do have an important role as advocates for those they serve. The Italian law regulating access of foreigners, including irregular migrants, to healthcare was hard-won: one medical practitioner was taken to court seven times for assisting clandestine migrants. His professional experience and views were subsequently taken into account in the drafting of the new legislation.

Even in countries where the legislation is generous, practical problems may persist on the ground. National or regional laws may not be formalised or interpreted clearly at the level of the healthcare provider (local authority, hospital etc.), for example in the form of a strategic plan or service charters for the benefit of immigrant health consumers. Quite simply, staff may be uninformed or unaware of the prevailing legal provisions. This will result in arbitrary application of the law, undermining the confidence of immigrants in healthcare providers and exacerbating the fear of discrimination and of jeopardising residence status.

Local health authority and hospital service charters should explain how national or regional laws are applied at local level. They should ensure that immigrants understand their rights and obligations as health service users, and explain practical ways in which commitments to religious, cultural and ethnic diversity are respected. These should be made available in the relevant languages. In its Service Charter, Venice Local Health Authority (ULSS 12) has published four pages of practical information in Italian and English for foreign nationals in Italy, with a clear reference on the back cover of the publication.

Many Federal States and cities in Germany, such as Hamburg, Bremen and Cologne have produced health manuals for migrants. In these manuals, migrants learn all about the health system in the State and there is also a list with doctors and institutions where the different languages are spoken.

See for example *www.stadt-koeln.de/bol/gesundheit*

Clear and preferably common provisions should be made for the treatment and care of PLWHA in EU countries, including the possibility of obtaining residence permits or suspending deportation orders for those undergoing therapy [see Chapters 2 and 5].

Health staff, including administrative staff as well as medical and nursing professionals, need to be offered regular refresher courses updating their knowledge of the law and how to apply it in their daily work. Lack of information and training on the legislation on immigration and access to health care has been ranked as a major problem by health professionals in several countries. In some health services, only the nurses knew of the legal rights of migrant patients and procedures for treating irregular migrants. Migrants have also observed that staff are sometimes uninformed or incorrectly informed, which is an obstacle to efficient service delivery [see also Chapter 3].

The Regional Health Authority of Lazio has published detailed online guidelines for health service providers on health assistance for foreigners.

www.regione.lazio.it

Some health services also offer legal advice to migrants, including information and assistance in regularising their status, and even information relating to making benefit claims and applying for jobs.

Finally, policy on costs needs to be considered, as fear of being unable to afford health care has been reported by immigrants to be a deterrent from using health services. Many countries have introduced free basic health care for immigrants on the same terms as nationals, or have made provision for waivers in the case of those who are destitute. The right to free health care or to exemption from charges needs to be carefully explained, as the concept may be unfamiliar to many migrants. Others may associate it with poor quality service. Spanish health professionals have described the surprise of new patients attending STI clinics when they are told that HIV testing and treatment services are universal and free even for irregular foreigners.

1.5.2 Person-centred reception

Person-centred reception facilities have been widely recommended, and can serve a number of purposes. They offer a more human contact, particularly in the case of migrants for whom this may be the first contact with a health sector which may seem alien and intimidating. Individualised attention helps people to feel more comfortable and confident, and to openly ask questions or express doubts. Spanish health professionals noted that very often “bad practice” among certain providers might be more related to excessive work loads and time pressure, rather than to prevailing prejudices against migrants.

> “None of the doctors have time, either for their own nationals or for the migrants. (…) The doctors are not guilty themselves, they are in a rather unfavourable position in the time of the health reform, they get little money, have to work many hours and to attend many patients, there are insufficient nurses and assistants, therefore they are so unfriendly.”
>
> *Migrant from Eastern Europe, Focus Group, Berlin*
>
> “Anybody is marked by that very first experience: if you attend the doctor for the first time and you’re not properly attended, you never come back … if you’re not adequately treated and no communication with the doctor is established.”
>
> *Male immigrant from North Africa, Focus Group, Granada*

As doctors in all countries said they were worked off their feet trying to deal with demand, other health workers can be used for this initial contact – some services have health education workers, social workers and psychologists available, as well as clinical staff and cultural mediators.

> “It may happen that you can tell your doctor “I have X and Y problem”, but the doctor does not explain to you … I mean, there is not that required communication … the doctor just sits in front of the computer, writes the prescription and hands it out to you.”
>
> *Female immigrant from Latin America, Focus Group, Granada*

A “patient-centred” approach is extremely important in such sensitive areas as sexuality, reproductive health, and HIV/AIDS and STDs. It should be noted that in some situations (such as discussing problems related to sexuality), patients may feel inhibited in the presence of a cultural mediator from their own nationality or ethnic group. In such cases, either a different cultural mediator could be used, or telephone translation services which exist specially for this purpose in a number of countries.

The local authority family planning centre in central Verona (Italy) has a "Spazio donna straniera" ("Space for foreign women") dealing with large numbers of irregular migrant women twice a week. Women are welcomed in a separate reception room where they speak with an obstetrician and/or social worker who compiles basic data - the centre is also authorised to issue special health cards for irregular migrant women. The way the centre works is explained, health needs are discussed, and the procedures to be performed are explained, as well as the importance of follow-up visits. Cultural mediators are available to assist with translation and explanations of how the health service and family planning centre work. The time spent on each individual woman helps to establish a relationship of trust and encourages follow-up visits and compliance with treatment and medication. The centre also uses this opportunity to propose an HIV test to all patients, referring them to the appropriate service.

www.ulss20.verona.it

A person-centred approach not only offers an opportunity to provide information about the health service and orientation towards the correct health structures where appropriate, but also to gain additional health-related information about migrants through active observation and listening. By making sufficient time available, it is possible to interpret implicit needs on the part of migrants. Spanish health practitioners have suggested that clinical assessment questionnaires could be used at the time of reception, collecting social and demographic data as well as health data, translated into the relevant languages.

Finally, this approach encourages compliance and follow-up. The staff of the family planning centre in Verona (see box above) have noticed that whereas regular migrant women initially sought only terminations of pregnancy, with repeated visits over time and the establishment of a relationship of trust, health demands have also changed. There is now much more demand for family planning and contraception, as well as openness to preventive information.

1.5.3 Flexible opening hours

28.5% of migrants interviewed in the research project said that inconvenient opening hours had been a barrier to accessing health services. Many migrants work long hours, and sometimes have several jobs in order to make ends meet. Migrants working in rural areas are at a particular disadvantage. Some may risk losing pay because of the amount of time needed to reach the healthcare facility and queue for attention. Flexible opening hours promote wider access to early diagnosis and intervention. Some services have extended opening hours specifically to cater for immigrant (including irregular) users. It has been proposed by Spanish health professionals that operating hours for taking blood samples should be extended to take account of sex workers' night schedules and sometimes limited freedom of movement during the day, regardless of their nationality, as these may conflict with hospital and laboratory opening hours. These special services should be available to all sex workers, not just migrant men and women.

The Department of Preventive Medicine of Migration (DPMM) at the San Gallicano Institute in Rome has adapted both prescriptions and opening hours to accommodate diabetic Muslim patients observing Ramadan. The DPMM now remains open at night, to allow for treatment and medication after sunset. Intravenous lines are used at night to allow infusions of fluids and drugs, and injections are given before dawn and after sunset.

http://crs.ifo.it/ISG/migrazioni

1.5.4 Information and communications strategy

There have been widespread calls on the part of immigrants and host country practitioners to establish a clearer information system [see Chapter 4, dealing in detail with the issue of information about the right to health, health services, and HIV/AIDS preventive information]. German and Italian health professionals have observed that there is often no contact between services and no coordination of their activities, and that professionals themselves often do not know where to obtain the necessary information and materials.

A central figure or office within the health system should be responsible for coordinating information and orientation about services available, their location and how to access them. Such a function needs to be a reference point for other related services (social, housing, employment, legal, police) which come into daily contact with migrants.

The Regional Health Authority of Andalusia (Spain) has signed a collaboration agreement with local migrant associations, NGOs and trade unions, whereby these organisations act as link institutions between irregular immigrants and the local health authorities. They conduct all bureaucratic procedures to facilitate immigrants' access to the Health Card and also provide them with information and orientation about their right to health, the functioning of the public health system and the localization of local health services.

www.fundacionprogresoysalud.org/proyectos/convenio.htm

One source of general information should be located in the emergency services, which are the most widely used by immigrants. Migrants have also suggested that family planning clinics would be well-placed to distribute general information on available health services.

The Project "Patienten-info Berlin" is building an online health guideline for migrants, answering specific questions and giving counselling personally, via telephone, e-mail or internet forums.

www.patienteninfo-berlin.de

Where they exist, the health authority or hospital public relations office could deal with inquiries as well as complaints. Staff will require special training in how to handle conflicts in a culturally sensitive way.

1.5.5 Tailoring services to vulnerable groups

All health services need to develop their own, locally appropriate strategy balancing facilitation of access to regular service provision and use of special outreach initiatives to benefit particularly vulnerable or invisible groups within the immigrant population. Such groups include the homeless, nomadic groups, drug addicts, sex workers (male, female and transvestite), irregular immigrants and minors. It should be remembered that some people may be doing sex work to supplement their incomes, and cannot be considered as "commercial" sex workers although vulnerable to the same risks. Informing and treating people on site, in locations such as community centres, parks, stations, nightclubs will prevent them from getting "lost" in the system and promote compliance in situations normally requiring follow-up visits or referrals. The special situation of migrants in prison must not be forgotten. Essential components of special service delivery for vulnerable groups are outreach work and peer education – these issues are discussed in depth in chapters 4 and 5.

"We need to do outreach. These people will not come to our door. The Park Project is an outreach project in some parks in Vienna with a high migrant concentration. We work with trained native speakers who involve migrant men and women in discussions, hold educational talks and distribute information. They are the backbone of the project. Through the project we are well-connected with other organisations and are part of an informal network. The main problems we encounter in our work are prejudice, fear and taboos."

Austrian health professional, Workshop with Service Providers, Vienna.

1.6 CULTURALLY COMPETENT SERVICES

1.6.1 Staff recruitment

It has been recommended that health and social services promote an active policy of recruiting staff from migrant groups with the aim of reflecting the cultural diversity of the local population served. An often overlooked aspect of the immigration phenomenon is that of the brain drain of health and other skilled professionals from developing countries. Participants at a focus group in Padua said that there were many qualified African health professionals in the Veneto Region of Italy, but they were doing menial jobs, often because their qualifications were not recognised.

It is also essential to maximise the use of existing human resources in the form of linguistic and cultural skills of staff who may be from ethnic minorities or have privileged contacts with migrant communities.

1.6.2 Staff training

The most significant problem common to both service providers and immigrant users is that of language and communications. Cultural competence training needs to permeate all levels of the health system, and should therefore be extended to administrative staff and planners. This subject is dealt with in depth in Chapter 3, dealing also with HIV/AIDS counselling skills.

It is worth noting here the need for undergraduate curriculum development and training not just in the area of transcultural skills, but also in how to work as part of a multidisciplinary team.

The Naga Institute, an NGO which has been working with migrants in Milan for 18 years, has a formal agreement with the Faculty of Medicine at the local University, whereby medical students carry out a period of practical training at the Institute as part of their medical studies.

www.naga.it

It would be an impossible task for anyone to become familiar with all the different cultures, languages, health system models and modes of communication characteristic of the immigrant groups in our societies. However, health and social staff, with sufficient training and experience, should ultimately be able to adapt and enrich their communications skills in order to work directly with immigrant patients, including new groups, without the intervention of cultural mediators.

As a corollary to cultural sensitivity in health service delivery, immigrants themselves have called for more language and "civic education" courses in order to promote the integration process. As has been mentioned, health is a crucial component of the inclusion process determining successful integration, and the health sector could promote and participate in such initiatives. There is a reciprocal perception, on the part of both immigrants and health workers, that migrants and migrant associations can and wish to be more proactive in learning the language and customs of the host country, and in approaching the services with their needs and requests. Migrants have emphasised that courses should also be offered outside working hours.

1.6.3 Use of cultural and linguistic mediation

Research and experience have shown that communications barriers can be exacerbated by the lack of a common cultural framework. With time, health and social workers have found that the assistance of cultural or “transcultural” mediators is useful not simply for the purpose of translating or interpreting, but in order to create a bridge between two cultures and promote reciprocal understanding. This is the basis not only of a relationship of trust between practitioners and patients, but also the foundation for a process of integration based on non-discrimination and inclusion in which the immigrant acquires knowledge of the host country culture without losing the attributes of his/her own. The issue of the recruitment, training and use of cultural mediators is discussed in Chapter 3.

1.7 CONCLUSIONS

The key points to emerge from this chapter are as follows:

- Prevention of HIV/AIDS/STIs is more effective in an overall framework of “migrant-friendly” services;
- The main problems of information, communications and fear of stigmatisation can be addressed by using the resources of migrants and CBOs, involving them at all stages of intervention (service planning, delivery and evaluation), and by training staff in the field of cultural competence;
- Special services, including outreach initiatives, may be necessary for certain migrants groups (such as irregular migrants, new arrivals and particularly vulnerable groups), but the aim should be to assist migrants in using mainstream services as soon as possible as part of a structured integration programme.

A detailed list of our final suggestions and recommendations for health services working with and for migrants is set out in the Summary after Chapter 5.

1.8 ADDITIONAL RESOURCES

Migrants’ access to health care

Health For All, All In Health - European experience in health care for migrants,
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2

LEGAL STATUS AND THE RIGHT TO HEALTH

2.1. INTRODUCTION

Notwithstanding the introduction of tough measures to prevent unregulated immigration in European Union countries over the past twenty years, the flow of clandestine immigrants has continued unabated.[1] The access of irregular migrants to national health service (NHS) health care in European countries has been the subject of some controversy. However, where once arguments about additional expense to tax-payers and the need to deter irregular immigration prevailed, governments of all political colours are increasingly recognising that health is a fundamental human right not just for national citizens, but for all individuals within a state's jurisdiction, regardless of legal status. This position is underpinned by a human rights as well as a public health approach. The legal, as well as political, systems of countries also have a profound influence on the course of the HIV/AIDS epidemic in any society. Laws on prostitution, homosexuality or drug use may determine how easy it is to communicate with people in vulnerable situations. Laws governing migrant employment and policies tackling the issue of discrimination may have an impact on the vulnerability of migrants, particularly to the risk of losing their livelihoods if infected with HIV.

The main aim of this chapter is to examine the issue of absence of legal status, as one of the principal barriers to access to health services, in the light of the fundamental human right to health. The chapter:

- provides a brief overview of the international legal and human rights framework covering access to health care, including testing for HIV/AIDS;
- examines how international commitments are translated into national provisions, comparing access for irregular migrants to health care and HIV/AIDS treatment in the five project countries;
- analyses the way in which lack of legal status influences knowledge and use of health services and health related behaviour, including HIV/AIDS;
- concludes by setting out some suggestions for good practice.

Health professionals are addressed in their capacity as “advocates” for healthy public policy – in fact immigrants interviewed in Greece for the research project specifically asked health organisations to mediate between them and the State in order to obtain better health care.

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[1] It is impossible to calculate the exact number of irregular migrants in any country. In Italy, for example, estimates vary between 200,000 and 800,000 compared to 2,600,000 regular migrants.

"Health professionals should act as advocates for persons living in marginal situations who generally have a low access to health services. This role could include lobbying authorities, politicians and international organisations for improving access to health services for these persons."

Council of Europe Recommendation Rec(2001) 12 on the Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations

It should be noted here that there is an important distinction between voluntary and forced migration, in other words between economic migrants and asylum seekers or persons in need of protection. The latter have separate protection and humanitarian needs which need to be addressed, although in practice, it is becoming increasingly difficult to distinguish between these two categories, as more restrictive refugee determination procedures may prevent or deter many asylum seekers from submitting legitimate claims (see also the section on asylum seekers in Chapter 5). Generally speaking, migrant workers are not considered as "forced" migrants. However, in the field of human rights, there is a move to attribute the same weight to "economic, social and cultural rights" as to "civil and political" rights. The extreme poverty and deprivation which "forces" people to leave their homes and families in search of work and better living conditions may be interpreted as a "lack of fulfilment of economic, social and cultural rights". Thus, in some circumstances, economic migration may qualify as a form of "forced" migration.

2.2 THE INTERNATIONAL FRAMEWORK ON ACCESS TO HEALTH CARE FOR ALL

The Constitution of the World Health Organisation (1946) and the Universal Declaration of Human Rights (1948) both declare the attainment of the highest standard of health to be a fundamental human right of all people without distinction of race, religion, political belief or economic or social condition. In formal terms, the health rights of irregular migrants are explicitly recognised in only two international treaties: the 1990 UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and the 1975 Rural Workers' Organisations Convention.

More recent statements by international bodies interpreting the intentions of international human rights provisions clearly indicate that irregular migrants should be included in commitments to universal access to health care.

" States have an obligation to respect the right to health by refraining from denying or limiting equal access – on economic, physical and cultural grounds – for all persons, including … asylum seekers and illegal immigrants, to preventive, curative and palliative health services."

UN Committee on Economic, Social and Cultural Rights, General Comment on the Highest Attainable Standard of health NO 14, 2000 www1.umn.edu/humanrts/gencomm/escgencom14.htm

"One of the best policies (apart from raising the standard of living) for improving their health [persons living in marginal situations or insecure conditions] is to ensure equal access to social and health systems for everybody whatever his/her economic and legal status. It should take into account the fact that new groups and individuals may at any time find themselves in a marginal situation."

Council of Europe Resolution Rec(2001) 12

Whilst the fundamental right to life and health is also enshrined in Article 35 of the European Union's Charter on Fundamental Rights (2000), it is only partly addressed in the legislative framework of the European Union. The 1999 Treaty of Amsterdam authorises the European Union to adopt "the necessary measures in the area of irregular immigration and stay, including the repatriation of people irregularly present".[2] It is currently being argued that this provides the legal basis for an EU provision guaranteeing the right to health for all people present in the territory of the European Union, irregular migrants included: in 2004, an alliance of Italian NGOs presented a proposal for a Council Directive to the Commission to this effect.[3]

Discrimination on the basis of health status (for example the fact of being HIV positive) is not usually explicitly prohibited in international law, although in practice health status is increasingly acknowledged as being included implicitly in the term "other social status", one of the outlawed grounds for discrimination. However, the nature of HIV/AIDS - sexually transmitted, highly prevalent in some regions, elevated cost of palliative treatment and no definitive cure - makes persons living with HIV/AIDS (PLWHA) extremely vulnerable to discrimination. Migrants, especially those coming from high-prevalence areas, fear discrimination by the host country in the form of rejection at the border or expulsion, in addition to loss of livelihood and social exclusion.[4]

WHO is against compulsory screening on entry for the following reasons:

- it is not justifiable on economic grounds, and if it were, it should not be singled out among other comparable health conditions;
- it increases stigmatisation of migrants and wrongly lowers levels of vigilance in the host population;
- it is of limited efficacy because of the 3-6 month "window period";
- it is not in accordance with basic UN and WHO recommendations on HIV testing.[5]

The real challenge facing governments is that of promoting universal access to preventive information, HIV testing and treatment, together with information campaigns to reduce the stigma associated with HIV. In June 2004, UNAIDS issued a Policy Statement reiterating the importance of a human rights approach to HIV testing (see box below).

Ensuring a rights-based approach to HIV testing

The voluntariness of testing must remain at the heart of all policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits. The following key factors, which are mutually reinforcing, should be addressed simultaneously:

- Ensuring an *ethical process for conducting the testing,* including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
- Addressing the *implications of a positive test result,* including non-discrimination and access to sustainable treatment and care for people who test positive;
- Reducing *HIV/AIDS-related stigma and discrimination* at all levels, notably within health care settings;
- Ensuring a supportive *legal and policy framework* within which the response is scaled up, including safeguarding the human rights of people seeking services;

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[2] Article 63, paragraph 3 (b).

[3] NAGA (Voluntary Association providing Social and Health Assistance in support of the Rights of Foreigners and Nomads), Caritas and OIKOS. For information contact: dirittosalute@fastwebnet.it

[4] In the five project countries, only the German Land of Bavaria applies mandatory HIV screening on entry, in the case of all individuals planning to spend more than 180 days in Bavarian territory, with the exception of EU and Swiss citizens.

[5] HIV testing should be based on "the three C's" advocated since 1985: it should be Confidential, accompanied by Counselling and conducted with informed Consent.

> - Ensuring that the *healthcare infrastructure* is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment and related services.
>
> *UNAIDS/WHO Global Reference Group on HIV/AIDS and Human Rights, June 2004*

2.3 NATIONAL LAWS ON ACCESS TO HEALTH CARE FOR IRREGULAR MIGRANTS

> "Doctors take the oath of Hippocrates that says they must care for all, but they don't do that."
>
> *Focus Group with male migrants and asylum seekers from the Middle East, Athens*

Technically, only irregular or undocumented migrants in Europe are generally unable to avail themselves of health and social support except in emergency situations. In practice, most European States do indeed provide at least emergency health care for people without legal status. The comparative table below provides an overview of the main types of health care and health intervention, including treatment for HIV/AIDS, available to immigrants without legal status in the five project countries.

TABLE 1: ACCESS TO HEALTHCARE FOR IRREGULAR MIGRANTS

(As of November 2004)

Host country	Access to Health Care							
	NHS including GP	NHS without GP	Only private or NGO	Urgent NHS care[α]	Essential care[β]	Preventive Health[γ]	HIV antiretroviral therapy	Treatment of AIDS
Austria			X	X				
Germany[δ]		X		X		X		X
Greece			X	X		X	X	X
Italy		X		X	X	X	X	X
Spain[ε]	X			X	X	X	X	X

[α] All emergencies.

[β] Including care for diseases which are not an immediate health threat, but which may cause serious damage to health over time (e.g. diabetes and hypertension).

[γ] Includes pregnancy, maternity and child care, vaccinations and infectious diseases.

[δ] In Germany, irregular migrants only have access to NHS treatment for STIs, family planning, HIV/AIDS counselling and emergency care.

[ε] In Spain, since 2000 irregular immigrants have been eligible for national health (NHS) treatment on the same terms as nationals, provided that the "health card" ("tarjeta sanitaria") has been previously issued following registration in the local municipality's population census. A valid passport and proof of residence are required to register. Otherwise, access to the NHS is restricted to foreigners under 18, women during pregnancy and the perinatal period, and universal emergency assistance.

TABLE 2: EXPLANATORY COMMENTS

Host country	Comments	
AUSTRIA	**1. Links between residence/work permit and health**	Migrants with a valid residence permit need a work permit to access the regular labour market. At first the work permit is restricted to one year and applies only to the specific employer who requested that the migrant worker is granted permission to work. After one year a longer work permit can be obtained. Unlimited access to the labour market can only be obtained after five years. Unemployed migrant workers are entitled to unemployment benefit and continued health coverage.
	2. Access for family members	Family members (spouse and children) of migrants who are covered by health insurance (i.e. who are employed or who receive unemployment benefit) are also covered by health insurance.
	3. Payment	Austria has a compulsory health insurance system covering 99% of the population. Like Austrians, migrants who are employed or receive unemployment benefit are covered by the public health insurance system. Like Austrians, migrants receiving social welfare assistance are not covered by health insurance but are entitled to similar health care. Migrants covered by health insurance have access to free health care (except for cost sharing agreements). Migrants who are not covered by health insurance have to pay for public health services. If they cannot afford it, they have to rely on NGOs or private services.
	4. HIV/AIDS treatment and residence permit	Migrants covered by health insurance, including asylum seekers, have full access to ARV treatment and other HIV/AIDS related health care (e.g. treatment of opportunistic infections). Migrants not covered by health insurance, including migrants without legal status, officially have no access to treatment and care if they do not have the means to pay for it. In some cases NGOs manage to raise funds to pay for treatment.
GERMANY	**1. Links between residence/work permit and health**	The work permit is directly linked to the residence permit: without a work permit, no residence permit can be issued except for family reunification or marriage with a German. The law is due to be changed in 2005, however, and work permits will not longer be restricted to a particular job or employer, enabling migrants to change job. If a migrant worker loses his/her job but still has a valid residence permit, his/her health costs and social welfare are covered by the local municipality. The German law against trafficking allows irregular migrant prostitutes who were the victims of trafficking a period of four weeks in which to decide whether to testify against their exploiters in court. If they do, they have the right to stay ("Duldung" - temporary "tolerated" residence permit - for 6-months, renewable) and will be given a work permit, housing assistance, medical care and social support in cooperation with specialist NGOs.

	2. Access for family members	Access to health care for children is directly connected to the legal status of the parents, therefore if the parents do not have legal status children are only entitled to emergency care. However, public agencies and NGOs (including HIV/AIDS and STI counselling centres) work together to organise social and medical support for family members of irregular immigrants. In practice, this means that maternity care is available for irregular women, and children have access to essential paediatric care, including vaccinations.
	3. Payment	A charge of €10 has recently been introduced in Berlin for the HIV test. The decision to charge a fee is taken by the counselling centre and those who cannot afford it are exempt.
	4. HIV/AIDS treatment and residence permit	If an irregular immigrant can prove that he or she is in need of HIV antiretroviral therapy and that this is not available in the home country, the Government will issue a "Duldung". This entitles the holder to access to antiretroviral therapy and restricted health care only. The immigrant is not entitled to a work permit, but receives basic social assistance. "Duldung" may also be issued for treatment of AIDS and related complications. Under the basic legal provisions on treatment of infectious diseases, irregular migrants may seek assistance in legalising their status in order to be eligible for treatment. However, this was never automatic, and with the current cuts in health spending, it is becoming increasingly difficult to obtain legal status on HIV-related health grounds. Practice varies from Land to Land, and decisions are taken on a case-by-case basis. As antiretroviral therapy is becoming increasingly available in Sub-Saharan African countries and Eastern Europe, German embassies in the countries of origin are now checking wither individual migrants would be eligible for assistance and repatriating them where possible. The only mental disorder eligible for "Duldung" is Post Traumatic Stress Disorder caused by the situation and experiences in the country of origin.
GREECE	**1. Links between residence/work permit and health**	In order to obtain a residence permit, an immigrant must obtain a health certificate from a public health institute (at his or her own expense). The only compulsory health test is for tuberculosis.
	2. Access for family members	Children of irregular immigrants are entitled to health care.
	3. Payment	Irregular migrants may be treated for emergencies and hospitalised in urgent cases, but if they are unable to pay for treatment, they may be unofficially discharged. In the case of chronic diseases, irregular immigrants unable to afford the costs are obliged to rely on NGO health services. No charge is made for nursing and medical or pharmaceutical care for migrant PLWHA or migrants with other infectious diseases, in the event that the necessary care cannot be provided in the country of origin or in any other country to which they may be legally returned.
	4. HIV/AIDS treatment and residence permit	Foreign PLWHA may not be expelled or deprived of the right to asylum on the grounds of being HIV positive. Clinical AIDS tests may not be carried out for the purpose of expelling a foreigner, allowing entry into the country, conferring other privileges or granting asylum. While in need of health care, migrants are entitled to temporary residence and work permits.

ITALY	**1. Links between residence/work permit and health**	Special health cards are issued to “Temporarily Present Foreigners” (STP) without residence permits, giving them access to NHS services excluding a GP. Residence permits are linked to work contracts. Once the residence permit has expired, there is a 6-month period in which to find a new job. The maximum duration of the residence permit was reduced from 4 years to 2 years in 2002. Due to bureaucratic delays, the period of renewal may now take up to 1 year, during which time the applicant becomes irregular and is no longer entitled to full NHS health care (including the right to access to a GP). In practice, some local health authorities give migrants in this situation a period of one month’s “grace”, during which they may continue to use their GP. Sex workers who denounce their exploiters are entitled to “social protection” in the form of a 6-month residence permit for the purpose of study or to look for a job, renewable for up to one year, and to subsequent residence if stable employment is found within this period.
	2. Access for family members	Free maternity care is available for all women. Irregular immigrant women who are pregnant are technically entitled to a residence permit during pregnancy and the first 6 months of the child’s life, but in practice very few ask for it because of the fear of being identified and deported after it expires. If the parent becomes irregular, children are no longer entitled to use their paediatrician (in Italy, children have a “General Paediatrician” until the age of 18), but may continue to use other paediatric and hospital services.
	3. Payment	Irregular immigrants with a special health card for “Temporarily Present Foreigners” are subject to payment of NHS charges (“ticket”) like Italians (maximum €37.50), but charges are waived if the immigrant submits a statement of insolvency. The HIV test is free. Some emergency services are introducing charges for treatment considered to be “non-urgent”. In 2004 the Italian Health Minister proposed that after a first free abortion, a charge should be made for subsequent abortions.
	4. HIV/AIDS treatment and residence permit	Residence permits on health grounds (including HIV/AIDS therapy and treatment) can in principle be obtained, although practice varies from one health authority to another. The holders of such residence permits are not entitled to work.
SPAIN	**1. Links between residence/work permit and health**	Excluding family reunification and extraordinary processes of regularisation, a valid work permit is required in order to obtain a temporary residence permit. The duration of the residence is established by the granted work permit. After one year, the residence permit is renewed for 2 further years and then for 2 more. Permanent permits are granted to foreigners who can prove a five year legal and continuous residence in Spain, provided that there were no irregular exits from the country.
	2. Access for family members	Since 2000, the right to NHS public coverage has been extended to irregular immigrants registered in the local municipality where they reside. Therefore, as foreigners living in Spain, family members can also benefit from their entitlement to public medical assistance.
	3. Payment	Holders of the “Health Card” have free access to all medical services and reduced prices for doctors’ prescriptions. Those without economic resources can obtain prescribed medicines free of charge.

	4. HIV/AIDS treatment and residence permit	The HIV test and treatment are free (see above). Each Autonomous Community has its own specific procedures for issuing the Health Card. Irregular immigrants are required to produce a valid passport and proof of their address in order to register for a Health Card. Spain does not issue a residence permit in the event of proof that treatment for HIV is not available in the country of origin.

In synthesis, in Austria irregular immigrants are not entitled to any NHS health care except for acute emergency treatment. In Germany, they have access only to limited NHS services, as in Italy, where irregular migrants are not entitled to use a GP. In Spain, irregular immigrants have full access to NHS care provided they register with the local authority where they live. To register, immigrants must show a valid passport and proof of their address. In Italy a variety of health services and NGOs are authorised to issue “STP” cards the first time an irregular migrant seeks health care, and no documentation is required. In practice, in both Italy and Spain, irregular migrants often give the address of the NGO or health service issuing the health card. The Greek law is less clear: public health services are under no obligation to offer health care to undocumented migrants, with the exception of hospitals, the emergency services and child health facilities

In terms of HIV/AIDS, free and confidential HIV testing is available to everyone, including irregular immigrants, in all the project countries (although, as mentioned above, there is now a €10 charge for the HIV test in Berlin). This is where the similarities end, however. In Germany, Greece, Italy and Spain, irregular migrants have access to antiretroviral treatment if they cannot obtain it in their home country, although this is becoming harder in Germany. In Austria, irregular immigrants are not eligible for treatment unless they can pay for it. In Germany, Greece and Italy they may apply for temporary residence permits in order to obtain treatment, but these are not granted automatically. In Spain, irregular migrants with a health card may receive treatment, but not a residence permit. In Greece they are also eligible for a work permit, but not in Germany or Italy.

Advocacy organisations in many countries have noted that immigration laws may actually increase situations of marginalisation and vulnerability, impeding access to health care. Since the introduction of the new Immigration Law in 2002 in Italy, for example, health professionals have noticed an increase in the number of precarious situations, with people becoming “irregular” as a direct consequence of the implementation of the law, and a decrease in the number of requests for special “STP” health cards. There has also been a recent increase in indoor prostitution as a result of proposed new law banning street prostitution, with similar consequences (see also Chapter 5).

In spite of the inconsistencies and drawbacks, there are some examples of good practice. In Greece and Italy, for example, irregular migrants who make use of health facilities are not reported to the police or immigration authorities. German law enables public health care centres to offers diagnostics and therapy for STIs Including HIV), hepatitis and tuberculosis anonymously and free of charge, specifically taking into account the situation of irregular migrants. Italian law explicitly prohibits health personnel from reporting irregular migrants to the authorities. Under Italian legislation, social support and rehabilitation are available for women wishing to leave the sex trade, provided they denounce their exploiters. The German law is similar. Again, in Italy there have been a series of “amnesties” for some categories of irregular migrants (domestic assistants and personal carers) enabling them to regularise their situation provided they have employment and their employer is prepared to pay the necessary contributions. A similar measure has been recently announced in Spain, where a new regularisation process will allow undocumented immigrants with work contracts lasting at least six months and proving they were in the country for at least that same period of time, to legalise their status in February 2005 – about 800,000 foreigners are expected to apply.

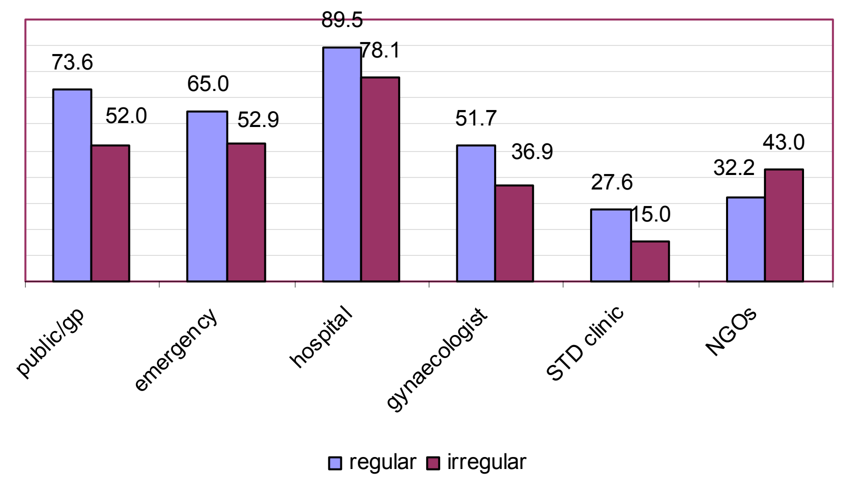
2.4 THE HEALTH IMPLICATIONS OF LACK OF LEGAL STATUS

> "If he/she's a foreigner but with papers, he/she will be confident, knowing that nobody will hurt him/her, but for irregular immigrants, wherever they go, whatever institution, whether it is the police station or a health care centre, even a school, they will always have that fear that someone is going to hurt them, that there will be some retaliation."
>
> *Male immigrant from Latin America, Focus Group, Granada*

The absence of legal status has a number of serious implications for health-related behaviour and health status over and above those derived from the psychological impact of separation from the family and home country, often poor standards of living and precarious and underpaid employment.

1. There is a consistent difference in knowledge of health services between regular and irregular migrants across all countries (see Figure 1 below). These differences cannot be attributed to differences in the length of stay between regular and irregular immigrants, as they persist even among people present in the host country for more than one year. Effective access to health services (use) showed the same differences. With regard to HIV/AIDS, many irregular migrants have less access to information and are therefore either unaware of the existence of antiretroviral treatment or, if they are, believe that they would not be eligible for treatment and are therefore reluctant to take the test.

Figure 1: Knowledge of health services/legal status



Cross country statistical report, 2004

2. Fear of being reported to the police and losing their job, means of livelihood or even being detained or deported, means that health needs are ignored until absolutely urgent, hence excessive reliance on emergency services. In the case of HIV/AIDS, fear of losing anonymity and scepticism about the confidentiality of the results, has been cited as a reason for not taking the HIV test.[6] Many migrants who test HIV-positive have left it so late that they already have full-blown AIDS, whereas this is rarely the case with host country nationals.

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[6] The quantitative research revealed that more than half of all immigrants interviewed were not sure or did not believe that the results would be kept confidential.

"If you were an illegal migrant and you were hit by a car, unless you could not walk, you would immediately leave the place of the accident. You would not wait for help because you would be afraid of being identified as illegal."

Focus Group with immigrants, Berlin

3. Our research confirmed studies that have shown that abortions rates are consistently higher amongst irregular immigrant women than regular[7].

A family planning centre in Mestre (Italy) conducted a survey in 2002-3 which concluded that the rate of abortions among irregular women attending the clinic was 50%, with very many women having repeat abortions. The research found that unwanted pregnancy was linked not to prostitution, but mostly to economic and social difficulties and difficulties in accessing the health services.

Workshop with service providers, Verona

4. The desire for legal status makes irregular immigrants vulnerable to risky practices. In Italy, there have been reports of personal carers who are forced to have sex with employers but are too afraid to report them to the police because they need their job and the employers have the power (under the recent "amnesty" for irregular workers) to regularise their legal situation.

"For many Africans the residence permit is the top priority. The way is to get adopted or marry an Austrian. Austrian women who marry Africans are mostly divorcees and not so well educated/informed. I know of cases where Austrian women regularly have unprotected extramarital sex and the African husband cannot insist on condoms for fear of losing the woman and thus his legal status."

Male immigrant from Nigeria, Focus Group, Graz

5. Fear prevents irregular immigrants from being able to communicate properly with the doctor and disclosing real health needs.

"Because at the beginning, when you have no papers, you feel really unsafe. You think: "They are giving me something I have no right to". You don't feel you can demand anything … You fear many things, you have many things in your mind, but you cannot tell everything to the doctor at that moment"

Female immigrant from Latin America, Focus Group, Granada

6. Irregular immigrants are afraid of being denied treatment or being given poor treatment by the health authorities. Immigrants from Eastern Europe interviewed in Germany and Austria even said they were afraid that they could be infected with HIV as a result of poor standards of hygiene in state hospitals or doctors' surgeries in the host country.

"When I had no papers, I had to go to the doctor, and when I was there, of course I was afraid. Because you always fear whether or not you're going to be received, whether you're going to receive the best or the worst attention, or if you're just going to be left aside in a corner… It is always that kind of fear, fear of thinking you have no papers and you're not going to be attended. And also, you think that the medicine you'll get is not going to be efficient, that you're not going to be properly attended."

Female immigrants from Latin America, Focus Group, Granada

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[7] The standardised abortion rate in Italy among immigrants is 3 times higher than among Italians (source: National Health Institute (ISS) 2004.

7. Irregular immigrants in Italy and Greece were reported to be discharged, or to discharge themselves, from hospital as before completion of treatment.

8. There have been several reports of self-medication and obtaining medication without prescriptions in several countries.

> "Self-medication is rather common among African sex workers – this is a habit. One woman can take the same medication taken by another one if she recognises she has the same symptoms, without going to the doctor or gynaecologist. They will take anything, if it worked for their friend, even if it may not be the same disease. You can pay for medicines and obtain them over the counter, even without a prescription they are easy to obtain in any chemist, 90% of the time it works like this. Many women therefore do not even take the STD test to see exactly what they have."
>
> *African cultural mediator, Focus Group, Mestre (Italy)*

9. The phenomenon of borrowing other people's health cards has been reported in Austria and Germany in order to get health care and medication.

10. Situations of "learned helplessness" arise, where people who feel that they are without rights and disempowered gradually refuse to accept responsibility for their health. This problem has been reported in connection with asylum seekers in Greece, for example.

2.5 CONCLUSIONS AND SUGGESTIONS

The following is a list of key suggestions for improving the health status of irregular migrants:

- Basic health care services, including HPDP particularly in the area of HIV/AIDS/STIs, should be extended to migrants in irregular situations, in line with recent developments in international regulations and recommendations;
- Advocacy activities should be undertaken by health professionals on behalf of irregular immigrants;
- Information on and delivery of health care to vulnerable irregular migrants, including female and male sex workers, should be tailored to their needs [see chapter 5], including the need for anonymity and minimal registration requirements;
- Health professionals should be aware of the hidden health needs, including mental health needs, of irregular migrants arising from their situation of marginalisation and precariousness. This is particularly the case with asylum seekers and women victims of trafficking, who may be suffering from Post Traumatic Stress Disorder (PTSD) and the effects of torture, including sexual abuse, in addition to forced separation from family and friends;
- Health professionals should not be required to divulge the identity or whereabouts of irregular immigrants treated to the police or immigration authorities. This should be made widely known to immigrant communities;
- Consideration should be given to issuing periodic "amnesties" allowing irregular immigrants with jobs to regularise their situation;
- Alongside efforts to prevent trafficking of women and minors, provision should be made for providing assistance and rehabilitation to victims of trafficking and forced prostitution who wish to leave the sex trade;
- More research and data collection on the health situation of irregular immigrants should be undertaken;

- Major information campaigns and other initiatives should be launched to break down the stigma and taboo attached to people with HIV/AIDS to encourage vulnerable irregular migrants to come forward for information and testing [see Chapters 4 and 5];
- Renewed efforts should be made to guarantee the anonymity and confidentiality of the HIV test, and to publicise this fact widely;
- Treatment and rehabilitation, including treatment for HIV/AIDS, should be made available to irregular migrants where they are not eligible for treatment in the home country.

2.6 ADDITIONAL RESOURCES

Migrants' rights

Migrants' right to health UNAIDS/IOM, UNAIDS Best Practice Collection Key Material, 2001
www.unaids.org

International Migration, Health and Human Rights, WHO, Health and Human Rights Publication Series Issue No. 4, December 2003
www.who.int HUMANRIGHTS@who.int (contact: Helena Nygren-Krug)

European Union legal database on immigration
http://europa.eu.int/scadplus/leg/en/s17000.htm#IMMIGRATION

Portal for the promotion and protection of the rights of migrants, with links to many relevant websites.
www.december18.net/web/general/start.php

Migrants' organisation promoting ratification of the 1990 UN Convention on the Rights of Migrants, which entered into force in 2003 (Article 28 deals with health).
www.migrantsrights.org

Migrants with HIV/AIDS and Access to Health Care in Europe, Human Rights Aspects, Van den Berg, RG., Woerden: AIDS and Mobility, 1998

HIV/AIDS care for people with a precarious residence status in Europe - European expert meeting, Report of a European expert meeting in Amsterdam, The Netherlands, 2003
Rapporteur: Rudi Bleys, 2003 (available from book list).
www.aidsmobility.org

AIDS and HIV, Migrants and Refugees: International Legal and Human Rights Dimensions, by Guy S. Goodwin-Gill, in *Crossing Borders: Migration, Ethnicity and AIDS*, ed. Mary Haour-Knipe and Richard Rector, Taylor Francis, 1996.

Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe, Ed. Georg Broring et al. 2003. Contains country reports on comparative access to health care and treatment for HIV/AIDS sufferers.
www.aidsmobility.org

HIV/AIDS and international Human Rights

UN Commission on Human Rights Resolution 1996/43 on discrimination in the context of HIV/AIDS. www.unhchr.ch/huridocda

UN General Assembly Special Session on HIV/AIDS: *Declaration of Commitment*, 2001. Can be used as a benchmark for assessing what governments have and have not done in promoting and protecting human rights in the context of HIV/AIDS.
www.unaids.org

International Guidelines on HIV/AIDS and Human Rights, 1996. 12 guidelines promoting legal reform (with a focus on vulnerable groups), government responsibility for multi-sectoral coordination, and the participation of the private and community sectors.
www.unaids.org/NetTools/Misc/DocInfo

Simplified summary of the International Guidelines:
www.icaso.org/docs/Summary-English%20Web%20after%20move.pdf

The impact of public policies on HIV/AIDS epidemics: *Limits and possibilities*, Case studies in human rights, UNAIDS, 1999

HIV/AIDS and Human Rights in a nutshell, ICASO in cooperation with the Harvard School of Public Health. A quick and useful guide for action as well as a framework to carry HIV/AIDS and human rights actions forward.
www.icaso.org/HIVAIDS_and_HRinNutshell-Webversion-v2.pdf

Handbook for legislators on HIV/AIDS, Law and Human Rights, Action to combat HIV/AIDS in view of its devastating Human, Economic and Social impact, UNAIDS/IPU (1999)
www.unaids.org

A good example of a rights-based approach to dealing with HIV/AIDS, from a Canadian organisation:
www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach.htm

Other

The Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations, Recommendation Rec(2002) 12 and explanatory memorandum, Council of Europe Publishing, May 2002
www.coe.int

Voluntary Counselling and Testing (VCT), UNAIDS Best Practice Collection, Technical Update, Geneva 2000
www.un.org/Depts/dpko/medical/pdfs/602unaidscounsel.pdf

UNAIDS/IOM: "Statement on HIV/AIDS-related travel restrictions"
www.iom.int/en/PDF_Files/HIVAIDS/UNAIDS_IOM_statement_travel_restrictions.pdf

Migrantinnen und Migranten – Fachinformation, wissenschaftlicher Diskurs, Band 41, Deutsche AIDS-Hilfe e.V.

Migration in modernen Gesellschaften. Soziale Folgen von Einwanderung, Gastarbeit und Flucht, Treibel, Annette, München, 1999

"Dass Sie uns nicht vergessen…"- Menschen in der Illegalität in München. Anderson, Philip, 2003: Sozialreferat: München

HIV/AIDS diritti e responsabilità, E.Simeoni G.Serpelloni M.Spiniello, EDAS, 1998
Legal aspects related to HIV infection. Contact: Dr.G. Serpelloni hivgrcvr@ifinet.it

3

CROSS-CULTURAL COMPETENCE IN SERVICE PROVISION

3.1 Introduction

In addition to other migration-related factors, such as economic deprivation and absence of legal status, cultural differences place immigrants at a disadvantaged position in terms of health care access, quality of care and ultimately health outcomes. Experiences with health services in their country of origin, coupled with cultural and linguistic differences in the host country, often mean that immigrants are unaware of how the health care system functions and of their entitlement to access services. This very often translates into fewer visits to doctors and other health professionals and less use of preventive services. In addition, within the context of a care encounter, language barriers and cultural misunderstandings lead to communications problems and distrust towards providers, which in turn might result in inadequate compliance on the part of immigrants with health professionals' recommendations regarding prescriptions, self care and follow-up visits.

All these barriers are particularly forceful as regards immigrants' access to HIV preventive and early intervention services. Many studies have shown that the need to solve more immediate needs or other general health problems discourages many immigrants from approaching available services. Other culture-related factors, such as the strong stigmatisation and prejudice associated with HIV/AIDS in many communities, may increase immigrants' reluctance to approach services for fear of being labelled as homosexuals or drug addicts. In addition, prevailing distrust towards providers, and difficulties experienced by many individuals in talking openly about highly sensitive and often culturally-sanctioned or taboo issues such as sexuality might also stop them from seeking out information and advice. Finally, lack of information and misperceptions about existing services and their professionals also account for immigrants' low utilisation of HIV-related services in host countries.

For these reasons, quality migrant-friendly services in general (see Chapter 1) and HIV-related services in particular need to take cultural and linguistic differences into consideration, as they have a significant impact on access and how health care is delivered and received. It is widely accepted that those professionals who are aware of and sensitive to cultural differences are much more able to incorporate into their practice the specific beliefs and concerns of ethnically diverse communities. From this perspective, the development of culturally-competent health services emerges as a major challenge to lowering barriers to access and ensuring quality care for immigrant populations in European societies.

This chapter analyses in detail the concept of cross-cultural competence within health care organisations and among health service staff, referring to both professionals and administrative or managerial staff. After reviewing the main research outcomes relevant to this topic, it addresses a set of intervention domains in which cultural competence can be manifested in health care organizations. These include: staff training and education;

interpreting services and translation; interaction and treatment models; and community participation and cultural mediation. Each of these domains includes a set of recommendations and strategies to progress towards culturally competent services for migrant populations. The chapter closes with two sections listing relevant resources and organisations in the field of cross-cultural competence.

3.2 Language and cultural barriers to health

> "Cultural differences are really an issue, a complicated issue. Because very often, we tend to give more importance to the language barriers, but as soon as you try to look a little bit further, you realise that very often, when they don't follow your indications, it is not because they did not understand you, but simply because they cannot, or they don't want to, because everything will ultimately rely on their own culture, religion or traditions."
>
> *Workshop with service providers, Granada*

Our research has provided evidence about the cultural and linguistic barriers that migrant populations face when approaching health care services in the five participating countries. As revealed by our survey data, 35.3% of immigrants interviewed in Spain and 44% in Italy were unaware of their right to use the health services regardless of their legal status. In other countries where irregular immigrants are excluded from public medical assistance, such as Austria, only about one fifth of the sample gave a correct response when asked about immigrants' entitlements to health care.[1]

Some of our qualitative outcomes suggest that even individuals who have been in the host country for many years still have problems with the national language. Immigrant participants in focus groups (FGs) acknowledged such difficulties and described how immigrants with poor language skills are very often ignorant of how the system works - some of them even return to their home countries to have health problems treated, due to misconceptions and distrust towards the National Health System (NHS) in the host country.

Survey data also shed some light on the incidence of communication problems and distrust in care encounters with national providers. According to the outcomes of our survey, 40% of the whole study sample had experienced difficulties in communicating with health services, and 21.7% complained of staff's unfriendly attitudes. FG participants also commented on this issue, pointing to the unequal treatment and reduced access experienced by patients who can hardly communicate with service staff. Health providers in Spain identified these barriers as a source of professional frustration and anxiety, and one of them described how very often it is only after successive visits that her patients begin to understand therapeutic indications and advice.

In the field of HIV/AIDS, the stigma and taboo surrounding the infection emerged time and again during our qualitative research as an additional barrier to immigrants' access to information and services. As described at a FG conducted in Spain, in spite of knowing that HIV is not easily transmissible, many immigrants would still be suspicious and disturbed in the presence of an HIV positive person. Furthermore, in almost all fieldwork settings, immigrant representatives pointed to the fear of being associated with HIV/AIDS and of suffering from rejection by their community. They explained that such fears accounted for the infrequent scarce use of preventive and screening services. As stated in a FG conducted in Austria, "*if you enter the AIDS Help House, it is clear that the purpose of your visit is related to HIV/AIDS*".

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[1] For further details, see the research summaries in Appendix 1.

Survey data also confirm that distrust towards screening staff and available services continues to be an issue for many immigrants. Only 41% of the whole study sample thought that professionals would respect testing confidentiality. Similarly, both health providers and immigrant representatives identified such distrust as an important factor deterring many immigrants from undergoing an HIV test. Other factors identified during our qualitative research were fear of finding out one's HIV status, related social stigmatisation and ostracism, and even fear of contracting the infection due to unsafe procedures with blood samples. All these reservations can be interpreted as closely associated with the fear of stigma and the uneasy relationship that characterises many immigrants' perception of HIV-related services and their staff.

As well as providing new and updated empirical evidence on current cultural barriers to quality care for immigrants in European societies, our research findings have also highlighted the need to tailor health care delivery, both in primary care settings and in specialised services - including HIV-related agencies - to the diverse cultural and linguistic needs of migrant communities. This emerges as an essential prerequisite to effectively improving the quality and accessibility of health care systems in EU countries.

3.3 Cultural competence in service delivery

> "As professional workers in the health system, we must admit that we still know very little about the migrant groups. It is a very heterogeneous group between and within nations and cultures. Cultural differences between the communities are considerable."
>
> *Workshop with service providers, Vienna*

The notion of "cultural competence" has been promoted as a way of helping health care staff and organisations to understand and respond with sensitivity to the cultural and linguistic needs of ethnically diverse populations. Many definitions of cultural competence have been developed and yet no single one is universally accepted.[2] Cross et al. defined cultural competence as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."[3] Other definitions have also pointed to "appropriate skills and being able to use them effectively in cross-cultural situations", as well as an "ongoing commitment or institutionalisation of appropriate practice and policies".[4]

According to these definitions, rather than a one-off effort, attaining cross cultural competence is a process that requires participation and commitment to succeed at all levels of an agency, from the individual to the organisational level. While providers are ultimately responsible for interactions with migrant patients, they must be backed by their health systems to ensure the development of appropriate policies and arrangements across all care settings. For this to be possible, health needs assessments must be conducted, and the knowledge gained must be applied in order to improve accessibility and quality of services whilst respecting cultural beliefs and practices.

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[2] The term "cultural competence" is usually broken down into "linguistic competence" described as a more targeted intervention to track the language needs of individual patients, as compared to "cultural competence", more focused on the ability to adequately address the individual's cultural needs or concerns. In this chapter however, we set out from the idea that "cross-cultural competence" recognises language and culture as inseparable, and the term "cultural competence" will be used to encompass both dimensions.

[3] Cross et al. (1989), as cited in Brach C. and Fraserirector I. *Can Cultural Competence Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model. Medical Care Research and Review.* 57 (supp. 1): 181-217. 2000

[4] Brach C. and Fraserirector I. (ibid)

Furthermore, the attainment of cross-cultural competency entails a broader approach, taking into account the heterogeneous nature of ethnic groups and subgroups that characterise migrant populations. In spite of sharing some migration-related factors of vulnerability, immigrants are quite heterogeneous and cannot be approached as a single target group. Rather, service provision must reflect an understanding and appreciation for the differing needs and concerns of specific local communities.

The following pages present a set of spheres or intervention domains for progressing towards a cross-culturally sensitive approach within health care organisations in general, and HIV-related services in particular. Such domains have been identified from our research findings and from a review of existing literature and guidelines about cultural competence provisions for ethnically diverse populations.[5] The domains identified include: (1) staff training and education; (2) interpreting services and translation; (3) interaction and treatment models; and (4) community participation and cultural mediation. The description of each domain is supplemented with a list of concrete recommendations and strategies aimed at improving the ability of health care organisations to provide cross-culturally competent services. Some relevant insights from our qualitative research and examples of documented good practices are also inserted in text boxes throughout the various subsections.

3.3.1 Staff training and education

The delivery of sensitive health services for migrant populations requires arranging cross-cultural education for professionals, both in the context of ongoing staff training and integrated into the academic curricula of health-related professions. The ultimate goal is to promote a broader view about cultural differences in health-related experiences, beliefs and practices, as well as awareness of how these differences shape care encounters with migrant patients. This awareness is expected to contribute to improving communication and avoiding or mitigating cultural misunderstandings when staff interact with people from other cultures. In addition, cross-cultural training programmes should also aim to develop the skills necessary to work respectfully and effectively with culturally diverse populations. In the context of a care encounter, these “cultural skills” will allow staff to adequately access and evaluate an individual’s background and formulate a treatment plan that is culturally relevant.[6]

The lack of cultural awareness on behalf of some doctors was a recurrent issue throughout our qualitative research. Closely connected with the need to tackle communication problems and distrust during care encounters, immigrant representatives pointed to the need to promote staff’s intercultural skills as a prerequisite for developing a more human-centred approach in care encounters. In Italy and Spain, health providers mentioned the importance of developing some basic language courses to ensure a minimum competence in the languages spoken by the local migrant communities.

In the particular field of HIV prevention and counselling, cross-cultural knowledge and skills permit providers to more sensitively address intimate and delicate issues such as sexuality, gender relations, and intravenous drug use with persons from diverse ethnic and religious backgrounds. The resulting enhanced communication allows better assessment of risk exposure, fewer missed opportunities to discuss prevention measures and, consequently, a reduction of unnecessary testing when no risk behaviours exist.

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[5] Section 3.4 of this chapter offers a list of guidelines, toolkits, organizations and resources relevant to the topic of cultural competence.

[6] Brach and Fraserirector, 2000

According to our survey data, only 31% of all immigrants who had been tested claimed to have received counselling before or when receiving the results. This shortcoming was confirmed by immigrant representatives in the qualitative research, who particularly complained about the lack of counselling and preventive information when testing results were negative. This limitation may be related to time pressures at screening services or rather to providers' lack of cultural competence, even "counselling fatigue" – or to a combination of all three.

In Germany, a discussion on pre- and post-test counselling stressed the culturally-specific nature of counselling and raised the need to review current practices in view of counsellors' experiences of burn-out with the national population. Inputs shared during this discussion included the need to strengthen staff's listening and communication skills, as well as their empathetic ability to accompany the client in the decision making. In Spain, an STI nurse raised the need to be particularly sensitive to disinformation, distrust and fear of being deported among the immigrants.

The Psychosocial and Cultural Integration Unit-IOM (IOMPSY Unit) offers training activities relevant to health providers working with migrant populations. Counting on a multidisciplinary group of professionals, the IOMPSY Unit develops training courses in two main areas: (1) *cultural diversity and change management*; and (2) *clinical training* for counsellors, psychologists, and psychotherapists in the field of the mental health. The Unit also offers training courses to international officers and managers who work in multicultural contexts to promote the exchange of professional experiences, develop psycho-cultural sensitivity and manage communication processes in changing situations.

http://www.iompsychosocial.com

Strategies and recommendations

- Support the implementation of cross cultural staff training and continuing education through: (1) cross cultural encounters; (2) workshops on specific ethnic groups' health characteristics and needs; (3) distribution of educational materials in addition to on-site training; (4) development of self-assessment tools; and (4) collaboration schemes with doctors from country of origin of local migrant communities;
- Development and support of cross-culturally competent staff by: (1) recruiting and retaining providers with immigrant background; (2) recognising staff's linguistic skills, cross-cultural knowledge and community contacts; (3) developing a directory of professionals who are familiar with immigrant languages or cultures; and (4) offering language courses for service providers and for front-desk staff;
- Introduction of cross-cultural training in health professionals' curricula and placement of students in internships at health facilities expert in serving migrant populations;
- Introduction of specific training for staff in HIV-related services, to include: (1) information gaps and misconceptions about the infection among local migrant communities; (2) immigrants' beliefs and values on sexuality including condom use and IDU; (3) immigrants' fear of deportation and trouble with law enforcement agencies; and (4) impact of such fears on their willingness to access HIV prevention services.

3.3.2 Interpreting services and translation

> "I see the problem more in the language barrier. Austrians are not racist people, just afraid of speaking English. If you bridge the language barrier, people would go for a test."
>
> *Focus Group participant, Austria*
>
> "There are many materials developed by different organisations. The question is, how do they reach the target communities? Regretfully there is often no contact among the different services and no co-coordination of their activities. Professionals often do not know where they can refer to if they need particular materials. There is no common archive of all the available materials."
>
> *Workshop with service providers, Berlin*

Language barriers significantly impede effective communications between immigrants and providers, and consequently reduce their understanding of and compliance with diagnoses and treatment. This usually results in a negative impact on patients' health outcomes as well as on reduced satisfaction for both immigrant patients and health staff. Providing interpreting services is the most obvious way to overcome language obstacles. Whilst hiring professional interpreters is the best option, service needs and financial constraints might require alternative options such as resorting to external agencies for rapid or urgent assistance, or employing bilingual staff or cultural mediators to solve the most immediate needs.

In the context of HIV counselling and screening services, the availability of interpreting resources will enhance providers' ability to adequately inform immigrant clients about the clinical and preventive benefits of testing and about risk behaviours and risk reduction strategies. By reducing communications barriers, such resources will greatly assist in tackling distrust of staff's likelihood to respect confidentiality and fear of discrimination or legal consequences relating to a positive test.

Family members and friends can also be used to assist in interpreting in certain situations, where immigrant patients themselves feel comfortable with this solution. This option needs to be used carefully in view of the risk of compromising confidentiality or family relationships, particularly where children are concerned.

Staff of one health counselling unit in Germany said they relied on Thai and English interpreting when counselling migrant clients, whilst in all other cases they tried "*with hands and feet*" to make themselves understood. The last resort of employing gestures and available supporting graphic materials or designs was also reported by a nurse working at a local STI clinic in Spain.

Availability of translated materials is also essential to help immigrants understand health education and care indications. Such materials should address the information needs, cultural nuances, and literacy rate of the attended communities - if illiteracy is high, they should employ visual representations and easy-to-read formats. They should also minimise the use of medical jargon and be adequately tested for intercultural and language appropriateness.[7] When addressing sensitive issues such as sexuality, condom practices or drug use, they should incorporate an understanding of the cultural norms and beliefs of the population targeted. All these materials should be disseminated in waiting rooms, treatment rooms and front desks (see Chapter 4 for a detailed discussion on the provision of health-related information for migrant communities).

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[7] Migrants at a focus group in Padua, Italy, pointed out that not only is medical terminology difficult to understand (sometimes even for well-educated native Italian speakers), but that many migrants are unfamiliar with basic human anatomy and find it difficult to explain symptoms.

Qualitative research findings in Austria and Germany support the idea that the provision of translated materials should never substitute individual or group counselling at HIV screening facilities. Rather, they should go hand in hand with personal interaction with health staff or cultural mediators. According to professionals consulted, the availability of staff who can communicate in migrants' languages will facilitate appropriate counselling and more in-depth discussion on sexuality and risk behaviours. Native speaker counsellors can help a lot even when they are only available at the institutions for several hours, as people will call again when they are available (see Section 3.3.4 below on cultural mediation in HIV-related services).

Strategies and recommendations

A. Interpreting resources and support

- Depending on the needs of the service and resources available, the following options are proposed to fulfil interpreting needs: (1) hiring of professional interpreters; (2) use of bilingual staff, community volunteers, cultural mediators or patients' family or friends as *ad hoc* interpreters; (3) telephone interpretation services for rare languages and simple communications;
- Training in interpreting skills and basic medical notions for community volunteers and outreach workers acting as *ad hoc* interpreters;
- Including data on patients' language backgrounds and preferences into their health files.

B. Translation of materials

- Application of new information technologies facilitating providers' and immigrants' access to translated materials (including CART[8] translation, online resources and touch-screen information panels);
- Translated materials for immigrants: (1) information brochures on migrants' entitlements to health and how the health system functions; (2) patient-relevant materials, such as consent forms, health education brochures, health and treatment plan cards and medical or treatment instructions;
- Translated materials for health staff: (1) bilingual phrase sheets for simple inquiries; (2) basic clinical assessment questionnaires; and (3) glossaries standardising medical terminology.

In the last few years, the Regional Health Department of Andalusia (Spain) has produced written health resources relevant to migrant populations and professionals serving them. Materials targeting immigrants include: (i) a manual in six languages explaining their entitlement to public medical assistance, the functioning and required procedures to access the NHS, and available services at primary and specialized care; (ii) a manual for female immigrants with some additional information on sexual and reproductive health services; and (iii) a brochure also in six languages with information about HIV/AIDS and other STIs, risk practices and appropriate condom use. Contact information on health agencies and organizations relevant to migrant populations is also provided. A manual called "*Health Care for Migrant Populations*" has been produced for health professionals with information about the cultural and health characteristics of local migrant communities, relevant considerations about culturally competent clinical assessment, and a glossary of translated medical terms. Other relevant resources include a basic clinical interview available in various languages and additional written materials with information about migrants' entitlement to medical assistance and contact information of local NGOs and agencies supporting their access to health.

www.fundacionprogresoysalud.org/proyectos/materiales.php;
www.fundacionprogresoysalud.org/proyectos/data/materiales_apoyo/manual_atencion_sanitaria_inmigrantes.pdf

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[8] Computer Aided Realtime Translation

3.3.3 Interaction and treatment models

Models for health professionals' interaction and treatment are crucial in determining whether the care delivered is tailored to immigrants' needs and concerns. Cross-culturally competent models can range from those in which evaluation, diagnosis and treatment are conducted in a way that is sensitive to immigrants' language and culture, to models offering interactions with traditional healing beliefs and, if appropriate, inclusive decision-making targeting the family or the community. The effective and adequate application of these models in cross cultural care encounters can contribute to patients' higher understanding of diagnoses and treatment, and thus to increased satisfaction and compliance with behavioural and treatment recommendations. Also, the availability of culturally competent assessment tools can help doctors to maximise their care encounters with immigrants - very often time constraints make them feel rushed and unable to look in depth at patients' individual needs (see also Chapter 1 on the need for a patient-centred approach).

Both health providers and immigrant representatives participating in our research mentioned that reported clinical "malpractices" might be often related to physicians' excessive workloads in primary care settings. As raised during a workshop discussion in Spain, the permanent pressure GPs face in their day-to-day practice makes it difficult for them to devote the time that a migrant patient may need, especially when additional culture or language-related barriers hinder effective communication and mutual trust.

Lack of familiarity with Western approaches to medicine was also raised in FGs with immigrant representatives in several countries, particularly among North Africans. Some of them referred to the differences in approaches to health problems and interpretations faced by some immigrants in their encounters with national providers, a situation that they can experience as a source of discontent and frustration.

Many manuals and handbooks have been developed and disseminated by a range of care organisations and research centres, containing information on relevant cultural and health issues pertaining to selected immigrant communities. These supporting materials offer valuable insights and guidelines on how to ensure a broader view of the influence of cultural background on symptomatology, as well as possibilities for cross-culturally competent treatment tailored to the needs of ethnically diverse populations. This is of special concern if we are to avoid stereotyping of culture-specific characteristics. The final section of this chapter provides a list of some useful resources and tools available on-line.

Strategies and recommendations

- Support health professionals' ability to conduct adequate cross-cultural diagnosis and treatment through: (1) qualitative research on the cultural norms and values of local migrant groups; (2) publication and dissemination of manuals describing clinical issues and health needs of communities targeted; (3) elaboration of guidelines and protocols on how to take medical histories;
- Promote health professionals' familiarity with the traditional healing systems and beliefs of migrant populations, and, when appropriate and possible, integrate traditional approaches into clinical treatment plans; present treatment in a conceptual framework concordant with traditional healing practices;
- Develop providers' sensitivity for the caring and decision-making role assigned to the family and community in certain cultures;
- Provide adequate organisational and staffing arrangements to ensure sufficient time for migrant patients' consultations.

Another example of a useful clinical tool is the Cultural Formulation of Diagnosis (CFD) Interview, a structured interview published by the American Psychiatric Association, 2000, and used by mental health care professionals in the Netherlands. Its aim is to gather information about the cultural background of refugee and immigrant-background patients.

www.centrum45.nl/lectures/ukhrny05.htm

3.3.4 Community participation and cultural mediation

"I would like the communities to get to the point where they understand they have rights and where they request assistance and information. We are a service organisation (Aids Help Organisation), but up till now we have – however – been going to them and telling them what to do. We would welcome to work 'to demand', but it is not that way with migrants yet."

"Even amongst professional health workers there is too little knowledge of where to go. We should contact networks, migrant organisations, and communities to find and recruit mediators. Contacts could also run through organisations which do not specifically work in the health field."

Workshop with service providers, Austria

Establishing linkages with immigrant community-based organisations (CBOs) significantly enhances health care organisations' cross-cultural competence (see also Chapters 1 and 4 on a participatory approach to migrant health care). Cooperation between CBO representatives and key persons in community health care plays a vital role in helping agencies and their staff to learn about support networks, cultural values, beliefs and practices of the target populations. CBOs can also help to identify barriers to health care and design culturally appropriate responses to overcome such barriers. Finally, local immigrant CBOs can contribute to ongoing health education programmes by disseminating relevant information, conducting advocacy and counselling services, taking part in needs assessment and evaluation activities and facilitating referrals of immigrants to public health and social services.

Our qualitative findings confirm CBOs as an effective source of health-related information. Migrant representatives in Spain described how individuals who can draw on the support of relatives or community networks are usually much better informed about their right to health and the functioning of the national or local health system. In fact, both health providers and immigrant representatives in all the fieldwork locations called for the development of special cooperation schemes and effective communications with local non-governmental organisations (NGOs) and CBOs in order to maximise efforts and facilitate access to migrant populations. Overall, they all agreed that health care facilities can benefit from existing links, closeness and mutual trust existing between these organisations and their members.

In regions where immigration is a recent phenomenon, the possibilities of establishing bridges with community networks are severely limited, basically because CBOs are still weak or simply inexistent. As proposed by health providers in Spain, in such circumstances, city council and local health authorities should support the creation and development of these organisations by providing a public establishment where immigrants can meet as a first step towards further community networking. Health providers and immigrants in Austria and Germany also said that funding should be made available for this purpose, as it was impossible to rely on voluntary work alone.

The Minority Ethnic Health Inclusion Project in Edinburgh (MEHIP) is an example of good practice aimed at improving access and culturally sensitive services by linking black, ethnic minority and refugee communities with primary care services. The MEHIP project works towards these goals in a number of ways, such as through providing advice and information to health staff and minority ethnic communities and translating information on resources into minority ethnic languages. It also advocates for increased patient involvement in terms of patients actively taking part in their own healthcare and attempts to bridge communication difficulties and cultural barriers between patients and health services.

Contact: Mehip, Springwell House, 43 Ardmillan Terrace, Edinburgh, EH112JW Tel: 0131 537 7565

Community participation can be considerably enhanced through the recruitment and training of cultural mediators from locally represented ethnic groups. They can serve as intermediaries by relaying their communities' concerns to health care programmes and educating members of their ethnic group on health concerns and about how the health system works. They can also educate providers about cross-cultural issues, channel newly-arrived immigrants to the health system and provide direct services such as health education and disease prevention within their own communities. Outreach and peer-based strategies are also particularly effective in increasing access and quality of care for particularly invisible and vulnerable migrant groups such as sex workers and drug users [this issue is discussed in detail in chapter 5].

Profile of the cultural mediator

The essential human characteristics, abilities, skills and professional profiles of cultural mediators have been outlined as follows:

- excellent level of integration and a migratory process that has been completed;
- medium-high cultural and educational background;
- ability to communicate;
- capacity to empathise, a high degree of awareness and willingness to help;
- absence of prejudice;
- knowledge of the socio-cultural situation and of the network of services;
- awareness of his/her own resources and limits;
- respect for the expressions of privacy proffered by the user;
- ability to stimulate and promote the independence of the user;
- ability to mediate in and manage conflicts.

Discussion session organised by the Italian Aids and Mobility National Focal Point, October 2002
www.iss.it

In Austria, a discussion evolved around the role of cultural mediation in health promotion and education. According to the professionals consulted, cultural mediators can provide a key to gaining access to immigrants' trust, as information channelled through community members usually facilitates social acceptance. Simultaneously, they can create and/or reinforce openings for cooperation and enhanced communication in care encounters. As was also the case in Italy, professionals pointed to the need to obtain public funding for cultural mediators' intervention in health care settings, and for clear agreements as to which service is responsible for payment in situations where more than one service is involved (for example accidents).

In Spain, several initiatives for training cultural mediators have been launched through the last decade. In Madrid, the *Escuela de Mediadores Sociales para la Inmigración* (EMSI, School for Cultural Mediators in Immigration) set up in 1995 offers training courses and education about cross-cultural issues. Training courses address culturally relevant issues in different intervention settings including health care. In Barcelona, the Centre of Tropical Medicine *Drassanes* has trained community health agents from migrant groups since 1994. These community agents become part of the health team and act as link between the health system and the community by improving the flow of communication in both directions. The experience is proving satisfactory and other primary health centres are considering incorporating community health agents into their staff.

www.madrid.org/emsi

In the field of HIV/AIDS prevention, community involvement can help adapting messages to the specific concerns and realities of migrant populations, as well as finding culturally appropriate mechanisms to deliver such information. In addition, the recruitment and training of cultural mediators in prevention campaigns has proved to effectively improve levels of immigrants' information and access to early intervention services. As members of the community, cultural mediators can more sensitively address the stigma and taboo associated with the infection, while simultaneously conduct culturally competent advocacy towards safer practices.

Across all fieldwork locations, participants in our qualitative research raised the need to promote CBO involvement in preventive campaigns as an effective strategy for increasing immigrants' HIV awareness and building up trusting attitudes towards screening services. It was also argued that by maintaining continuous contact and promoting preventive interventions with migrant groups, these organisations can contribute to building trust, a prerequisite for the discussion of sensitive sexual issues and for promoting safer practices. Health professionals from HIV/AIDS services in Austria and Germany, countries with a long tradition of immigration, displayed a good knowledge of existing migrant networks and associations. Their experiences of cooperating with CBOs could also benefit providers in other EU countries.

The Emetis project, started in Barcelona in 2000, is a good example of community-based project addressing HIV prevention and the wider sexual health needs of young immigrants from a cross-cultural approach. It seeks to involve the targeted population in health promotion activities through participatory action research, community networking and inclusive decision making. The ultimate goal of the project is to increase young immigrants' resources and personal abilities in order to reduce their vulnerability to HIV/AIDS and other health risks. In order to reach this goal, the project employs alternative training methodologies (participative workshops on theatre, script writing, radio, music and dance, etc.) to develop young people's negotiation skills and knowledge of health issues and available services.

www.emetisweb.org/esp/index.htm

Strategies and recommendations

- Promote formal and informal mechanisms with CBOs to: (1) involve them in service delivery and evaluation; (2) create referral linkages to facilitate access to cross-cultural and linguistic support; and (3) act as a channel for health promotion activities and information;
- Conduct community-based research (interviews, focus groups, panels etc.) and include outcomes in health care programme assessment, design and organization;
- Train and recruit cultural mediators to act as links between local migrant groups and the health care network, and appoint female cultural mediators to tackle gender issues in sexual and reproductive health programmes;

- Use local resources, such as migrant community newspapers, radio and TV stations, to disseminate health-related information.

3.4 ADDITIONAL RESOURCES

Manuals with information and guidelines for treating patients from diverse ethnic communities

Southern Area Health Authorities - Cultural Handbook for Staff. Information on cultural and health issues in selected communities in Northern Ireland, including guidelines for treating patients with different religious and cultural beliefs.
www.shssb.org/document_library/downloads/Multi-cultural_Handbook.pdf

Handbook on cultural, spiritual and religious beliefs. Summarises the beliefs of the major cultures and religious groups residing in the UK, and their specific healthcare requirements.
www.sdhl.nhs.uk/documents/cultural.html

Culture, Religion and Patient Care in a Multi-ethnic Society: a Handbook for Professionals. Alix Henley and Judith Schott. Age Concern, England (1999). Contains practical examples of issues arising for patients and staff when healthcare needs and religious or cultural duties conflict – and how to solve these issues, with comments from patients and staff.

Religions and Cultures: Guide to Beliefs and Customs for Health Staff and Social Care Services. Revised 5th edition (1999), edited by Dr Moussa Jogee and Mrs Saroj Lal. R&C Publications, PO Box 17249, Edinburgh, EH11 2XZ. Basic guide to information about beliefs and customs of various religious communities for health and social services.

Multikulturelle systematische Praxis. Ein Reiseführer für Beratung, Therapie und Supervision , Schlippe A., Hachimi M., Jürgens G., Heidelberg, 2003

Promoting Health in Multicultural Populations – a Handbook for Practitioners. Robert M. Huff, Michael V. Kline, Sage Publications, 1999. Information on planning health promotion and disease prevention programmes in multicultural populations, with tips for the practitioner and chapters on working with the different ethnic population groups in North America.

Transcultural Health Care Practice: An educational resource for nurses and health care practitioners. Eds: Charles Husband and Bren Torry. Facilitates health professionals' development and training in the field of cross-cultural care. It includes individual modules on midwifery, child health, adult health, learning disability and mental health.
www.rcn.org.uk/resources/transcultural/index.php

Exil und Gesundheit: Ein Praxishandbuch zur Interkulturellen Öffnung im Gesundheitswesen für MultiplikatorInnen und GesundheitsberaterInnen. A practical handbook for health mediators in intercultural opening in health care services. www.zebra.or.at/projekte/hb_gesundheit/Start.htm

Handbook on strategy and policy building – A cultural approach to HIV/AIDS prevention and care UNAIDS/UNESCO Methodological Handbooks, Issue No 2, 2001

HIV/AIDS

Promoting Cultural Competence in HIV/ AIDS Care. O'Connor BB, Journal Association of Nurses of AIDS Care 1996, 7 Suppl 1, 41-53.

AIDS awareness among women: the benefit of culturally sensitive education programs. Majumdar B., Roberts J. Health Care for Women International 1998, 19(2), 141-153.

Implementation of strategies to prevent mother to child transmission of HIV among immigrants in Europe: evaluation of the knowledge and needs of immigrant women in Europe Contact: Dr Carlo Giacquinto, Univsertity of Padova
carlo.giacquinto@unipd.it

AIDS-Prävention und MigrantInnen: kulturspezifische Angebote auf unterschiedlichsten Ebenen – sind wir gemeinsam stärker? , Deutsche AIDS-Hilfe e.V., Frankfurt am Main, 1996

Handbuch Migration für AIDS-Hilfen, AIDS-Fachkräfte und andere im AIDS-Bereich Tätige, Deutsche AIDS-Hilfe e.V., Berlin, 1998

Organisations and resources relevant in the field of cross-cultural competence

The Centre for Cross Cultural Health: a research and information resource involved in the education and training of health and human service providers and organizations.
www.crosshealth.com

The Centre for Evidence in Ethnicity, Health and Diversity: identifies, assesses and disseminates research evidence in the field of ethnicity and health.
http://users.wbs.ac.uk/group/ceehd/home/ceehd_home

A website aimed at helping health professionals to meet the language and cultural needs of minorities, immigrants, refugees and other diverse populations seeking health care.
www.diversityrx.org

Web resource intended to help broaden awareness of the needs of ethnic groups using healthcare services.
www.ethnicityonline.net

A website containing medical and cultural information on immigrants and refugees' groups for health care providers who see patients from different ethnic groups.
http://ethnomed.org

The International Centre for Migration and Health: provides information on health and social aspects of migration, covering three main thematic areas: reproductive health, HIV/AIDS and psychosocial well being.
www.icmh.ch

King's Fund Information and Library service: contains information resources, journal articles and references relating to ethnicity, cultural diversity and health. www.kingsfund.org.uk

Migrations Santé: an organisation aimed at promoting immigrants' health and integration through the promotion of training, research and information exchange activities for health professionals interested in ethnic minority health.
www.migrations-sante.org/index.html

The Research Centre for Transcultural Studies in Health: development of health professionals and health services which deliver culturally competent care.
www.mdx.ac.uk/www/rctsh

Interkulturelle Kompetenz – eine „Schlüsselqualifikation" für das 21. Jahrhundert? Sprung, A. (2000) in: Lenz, W. (Hrsg.): *Brücken ins Morgen. Bildung im Übergang*. Innsbruck/Wien/München S. 91-116, 2000

Migrantinnen im Gesundheitssystem: Inanspruchnahme, Zugangsbarrieren und Strategien zur Gesundheitsförderung, Wimmer-Puchinger, B.; Baldaszti, E. (2001): Wiener Klinische Wochenschrift; 113/13-14: 516-526, 2001

4

REACHING MIGRANTS: INFORMATION STRATEGIES

4.1 INTRODUCTION

> "Migrants should not be seen as a single target group but as a heterogeneous part of the population with special needs due to their socially and often economically disadvantaged situation. Only well-informed people are able to protect themselves and others from HIV/AIDS infection."
>
> *Source: Petra Narimani, 1988*[1]

In this short but eloquent statement, Petra Narimani, a well known activist in the field of migration and health in Germany for many years, puts her finger on the central dilemma in providing migrant-specific prevention measures. She observes that *"Migrants should not be seen as a single target group but as a heterogeneous part of the population"*. Yes, we agree, the specific situation of migrants could be defined as that of non-nationals who are connected by and through a different legal and cultural background, one which is different from the background of the host country nationals. Yet despite this, migrants in general are not a specific target group, but rather "*a heterogeneous part of the population*". Yes, we agree again! So couldn't migrants then be reached by mass media campaigns addressing the population in general? Many activists, non-governmental organisations (NGOs) and professionals working directly in the field of migrants' health, and also the results of our survey, would dispute this. It is a paradox that on the one hand, more culturally and linguistically specific materials are needed, but on the other hand this is not enough.

Many migrants are not sufficiently reached by mass media campaigns because they have *"special needs due to their socially and often economically disadvantaged situation"*, as Petra Narimani puts it. So what is to be done? How can we create specific information for a heterogeneous part of the population? And moreover, one which is *"a heterogeneous part of the population with special needs due to their [migrants'] socially and often economically disadvantaged situation?"* How can we focus on these special needs without concentrating on specific groups and yet at the same time not forgetting the differences?

This chapter endeavours to shed light on these issues and to offer some answers. We start by setting out some selected research findings from our quantitative survey in order to show which channels of information are the ones preferred by the migrants interviewed and what the current needs are in terms of information about the transmission of HIV/AIDS and availability of testing. The chapter then looks more closely at various aspects of migrant-specific information strategies, including planning and assessment, the need to take account of the structural context (social, economic, political and legal factors) and the design of tools and materials. It goes on to discuss two essential components of any information strategy addressed to migrant communities: peer education and community

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[1] Narimani, Petra, 1998: *Zur Notwendigkeit kulturspezifischer Angebote in der HIV/AIDS-Primärprävention*. In: *Handbuch Migration für AIDS-Hilfen, AIDS-Fachkräfte und andere im AIDS-Bereich Tätige*. DAH, Berlin.

networking. The chapter concludes by summarising key suggestions and giving additional bibliographic references and contact details of relevant organisations.

4.2 THE RESEARCH FINDINGS

4.2.1 Sources of information on health and social services

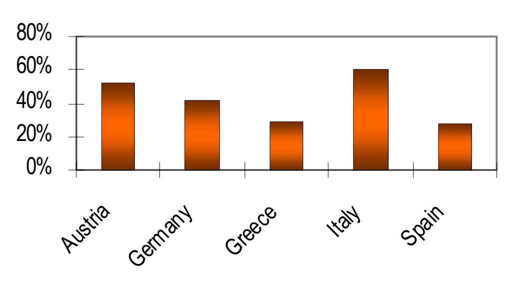
In all the project countries, the majority of the migrants who took part in our survey said they had received information about social and health care facilities and services first and foremost through family and friends, a fact which underscores the importance of the direct social environment.[2] This potential has to be taken into account at all levels of information dissemination.

In Austria, information about health services was most frequently gained through friends (67%) and family/partner (38%). In the case of the social services, friends were the most important source of information for 78% of the respondents, followed by NGOs (38%) and family members or partners (35%).[3] The German results are very similar: friends and family were the main source of information on both the health services (51,5% and 38,8% respectively) and the social services (56.5% and 29.2% respectively). The same was also true in the other project countries.

4.2.2 Sources of information about HIV/AIDS

In contrast to family and friends as the primary source of information about the health and social services in general, the main source of information about HIV/AIDS in all five project countries was not the close social environment but the mass media (see Figure 1 below).[4]

Figure 1: Information on HIV/AIDS received through the mass media



Source: Cross country statistical report, 2004

These percentages might at first glance be misleading because even though in some countries they may seem high, when compared to the figures for the general population they are relatively low. Given that in Germany, 91% of the national population was

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[2] The main sources of information on health were: friends, community or religious representatives (71.5%) and family/partner 28.3%. 19.5% said they had received information directly from health and social services (multiple response question).

[3] The figures contained in this and the following paragraphs are taken from the national and cross-country statistical reports, summarised in Appendix 1 and available on-line from the organisations which participated in the research project.

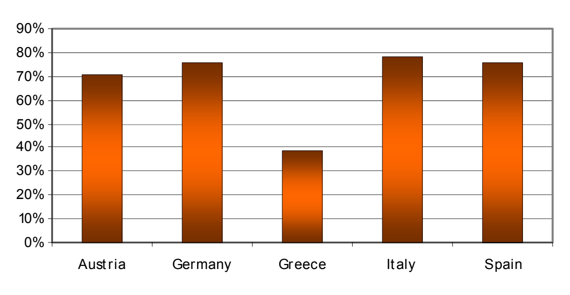
[4] In some countries, for example Italy, many immigrants said they had received most information from the media in their home country or, in the case of English-speakers, from satellite TV stations in the host country, rather than from campaigns in the national host country media.

reached by the messages in the national AIDS prevention campaign in the German mass media,[5] the percentage of migrants (41%) reached through the same intervention is extremely low – less than half compared to the general population. This result provides a first hint that in Germany, the information channels for the general population may be different from those for the migrants we interviewed.

4.2.3 Knowledge of HIV/AIDS and information needs

From the analysis of the survey findings, Germany is the country with the highest percentage of migrants who said they had received information in Germany in their mother tongue or in a language that they understood well (54.4% of interviewees). Figures were less than half this in the other project countries: Greece 25%, Italy 23.4%, Spain 19.5%, Austria 17.8%. However, this fact does not automatically mean that the migrant population in Germany is better informed about HIV/AIDS than migrants in the other countries. We can see the discrepancy in the answers to the question concerning migrants' perception of their own knowledge of HIV/AIDS - see Figure 2 below.

Figure 2: Perceived knowledge of HIV/AIDS



Source: Cross country statistical report, 2004

These data need to be interpreted very carefully: it could be seen as a sign of the success of prevention campaigns for migrants in some countries, but if we scrape beneath the surface, the reality is very different. Even though in Germany 75.6% of the migrants interviewed stated that they knew what HIV/AIDS was, when asked about the means of transmission the results look very different (see Figure 3 below).

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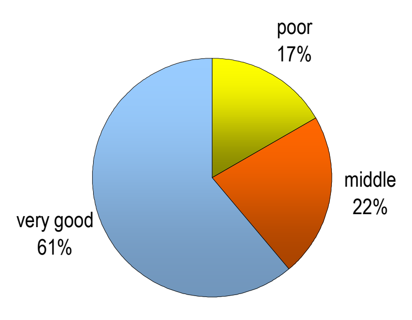
[5] BZgA (2004): *Aids im öffentlichen Bewusstsein der Bundesrepublik Deutschland 2003*, Köln.

Figure 3: Knowledge of the means of HIV/AIDS transmission among migrants in Germany



Source: German National Statistical Report, 2004

The basic level of knowledge of the means of transmission and prevention of HIV/AIDS among the general population in Germany is almost 100% (99%),[6] whereas among the respondents of our research, the quota was “only” 61%.

When asked if they needed more information on HIV/AIDS, migrants’ responses ranged from 81.5% in Italy to 51.4% in Austria. The expressed need for more information in the whole sample was highest among North Africans (86.2%) and people from the Middle East (74.7%). When immigrants were asked about what would be the best way to receive information on HIV/AIDS, the first and most common response was the mass media, showing how important it is to include the mass media in any overall information and prevention strategy for migrants.[7]

These figures provide evidence, once again, that the existing strategies and sources of information for migrants are less efficient than those addressing society in general. As suggested above, the information channels in migrant communities seem to be different from the channels for reaching the general population. This can also be seen also from our data: chlamydia, the most common STI in Germany (and probably in Europe) among young adults, was better known by the respondents of our study than by the general population in Germany. Almost 30% of respondents said they knew about this STI (Italy 35%, Spain 20.6%, Austria 22%), in contrast to the general population in Germany, of whom only 1% could name this disease.[8] Why? The answer is simple: most of the respondents had already received this kind of specific information in their home countries, and in Germany (and all the other project countries), as mentioned above, “word of mouth” - other people from the community (family and friends) - is the main source of information.

Knowledge of the right to an anonymous and free HIV test in the 5 project countries was as follows: Spain 45.6%, Italy 44.9%, Austria 33.6%, Germany 24% and Greece 16.5%. Among the immigrant groups, Latin Americans had the highest percentage of correct knowledge (52.6%) followed by Sub-Saharan Africans (40.2%).

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[6] Id.

[7] The preferred channels of information were: television 55.4%, health professionals 48.3%, schools 41.1% and written information 40.2% (multiple response question).

[8] See above BZgA (2004).

4.3 INFORMATION STRATEGIES

4.3.1 Planning and assessment

As emerged throughout our research project in all five countries, it is important to acknowledge the need to produce information that accurately and appropriately informs migrants: (a) of their right to access the health and social system; (b) about HIV/AIDS and STIs; and (c) of the possibility of free HIV testing and the possibility of treatment, whilst simultaneously dissipating fears and distrust among those who are irregular or live in precarious conditions.

A preliminary communications assessment has to be made to ensure the effectiveness of an information campaign/material. The “rapid assessment process” is recommended for developing effective communication strategies for migrants.[9] The objectives of this assessment are to:

- Synthesise and analyse existing HIV/AIDS social and behavioural related research data among the general public and migrants;
- Assess HIVAIDS communication related obstacles and opportunities (as experienced by the migrants themselves) ;
- Collect lessons learned during the implementation of HIV/AIDS communication related activities over the last 2 to 3 years; and
- Identify political, institutional and societal entry points for strengthening HIV/AIDS related communication with and for migrants.

One of the most important principles of rapid assessment methods is “triangulation”. This involves obtaining data from a variety of sources at the same time, so it becomes possible to check the validity and representative nature of the information collected. This method allows checking for contradictions, conflicts and consensus between different data sources before conclusions are reached.

Planning an information campaign: some key questions[10]

- Information need: what are the main misconceptions?
- Target group size and location: how many people are we trying to reach and where are they?
- Which cultural characteristics have to be considered?
- How explicitly can issues such as sexuality, sexual practices and contraceptives/condoms be addressed or visualised?
- Which media reaches the target group best: written leaflets, pictograms, photo-stories, comics, posters, videos or on-line and other new forms of media?
- What is the importance of personal, face-to-face communication for the group?
- Are there any meeting points of this specific group? What are they?
- Does this group have an established association? What kind?
- Are there any forms of ethnic media (radio or television channels or programmes, newspapers) which could be involved?

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[9] See for example rapid assessment (RAR) guide on psychoactive substance use and EVYP, WHO/UNICEF, 1998.

[10] Müller, Wolfgang: *HIV-Prävention für MigrantInnen durch die BzgA: Konzepte, Erfahrungen, Status, Ausblick*. In: Fachtagungsreihe *Gesund in eigener Verantwortung?* www.dhmd.de

From the very outset of developing a prevention strategy, the extent of available resources should be taken into account, determining whether it makes sense to invest efforts in developing yet another glossy and attractive brochure if it will be only distributed without being accompanied by counselling and support. As one migrant put it: “*It is a shame to waste all that nice money*” and “*No-one will read it anyway.*”[11]

4.3.2 Structural context

The effectiveness of a strategy is not only a question of language, but depends on cultural and, even more importantly, structural issues. Anyone who wants to create lasting behaviour change, by assisting a person in internalising information messages, must be prepared to remain closely in touch with the situation on the ground and the environment in which the behaviour takes place.[12] Information campaigns cannot be divorced from the structural components (economic, social, cultural, legal etc.) of the target community’s environment. The context in which people live (society, culture and family) is as important as their knowledge and attitudes regarding what they actually do.[13] Strategies to prevent the spread of HIV/AIDS and STIs should attempt to improve the social and political context in which migrant groups live in order to enable the individual to better manage his or her specific life-style and risks.

The City of Munich (Germany) has commissioned a survey to investigate the living conditions, including health care, of undocumented migrants in Munich. The City has committed itself to following up the recommendations drawn up.[14]

The director of the Swiss National AIDS Campaign, has recently suggested distributing a leaflet containing basic information on the Swiss health care structure to all foreigners at the moment of entering the country, independent of the purpose of entry.[15]

The government of Germany has produced a handbook called “Handbook Germany” in six languages, designed to help migrants to find their feet in private and public life in Germany. Aspects of German social and political life are explained, together with information on access to the health care system.[16]

In Andalucia (Spain), the Regional Health Authority has also produced a manual in six languages explaining immigrants’ entitlement to public medical assistance, how the NHS works and how to gain access, and available services and programmes in primary and specialised care.

Successful prevention is therefore linked not only with health issues, but also structural ones, including the social and legal situation. Many migrants live in very difficult conditions created, for example, by the lack of legal status (this subject is addressed in Chapters 2 and 5). Approaches that take structural problems into account are needed as a matter of urgency (see Chapter 1 for recommendations on the general migrant-friendly health context).

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[11] See above Narimani, Petra, 1998.

[12] Etgeton, Stefan (2000): *Structural Prevention. The basis for a critical approach to health.* In: Rosenbrock, Rolf; Wright, Michael (Eds.): Partnership and Pragmatism. Routledge, London.

[13] Ibid.

[14] The survey *"Dass Sie uns nicht vergessen...”- Menschen in der Illegalität in München* by Philipp Anderson (2003) can be ordered from the Service for intercultural cooperation, Department of Social Affairs, City Council of Munich yasemin.uzunk@muenchen.de.

[15] Staub, R. (2004): *Prävention - alte Probleme, neue Ideen?* in: Hoffmann/Jäger(ed.): *HIV/AIDS: Bedrohungen und Lösungen, Chancen und Herausforderungen.* For more information see also: Bundesamt für Gesundheit.

[16] *Ein Handbuch für Deutschland - A Reader for Germany* is available free of charge in six languages: German, English, French, Russian, Spanish and Turkish. It can be obtained from: www.handbuch-deutschland.de

4.3.3 Design of tools and materials

The design of information materials targeted to a migrant group has to take into account the way in which the group concerned is accustomed to receive information. Some migrant groups have a strong verbal tradition, which greatly influences the gathering and exchange of information. For these particular populations, written information alone is almost certainly not enough.

> "You should introduce an element of humour, do things that make people laugh. In Africa there are comedians who do sketches on HIV transmission and prevention, and people like them."
>
> *Sub-Saharan African male migrant, Focus Group, Verona*

To be able to reach the various migrant populations accurately, a high level of differentiation is required. Techniques and materials should be differentiated according to the social situation (legal status and economic situation), the gender-specific aspects in the respective groups, the cultural values and social class aspects.[17] These materials need to be produced in such a way that they can be easily and quickly adapted to local needs.

In order to provide information in an effective way, we must stress once again that it is necessary to involve the migrant target group from the beginning of the process, not only on the practical delivery level, but also on the decision-making level and in the development of strategies to ensure that materials are culturally appropriate. Information materials should therefore be created, developed and evaluated together with representatives of the various migrant communities by means of workshops, street work contacts or other kinds of regular meetings. In this way, the materials also become an important didactic tool for use during the training of peer educators. At the same time, they serve to empower through raising awareness and increasing solidarity within and among the migrant groups.[18]

Many things can be said about the need for culturally sensitive information campaigns, and this is of course of paramount importance (we refer again to Chapter 3 on cultural sensitivity). However, what is needed most is not new concepts for new campaigns, but the creation of a platform of awareness that has the effect of *"ringing a bell"* every time the issue is brought up on a poster.

> "Information campaigns should help create a situation where using a condom is just as self-explanatory as brushing your teeth".
>
> *Doctor from the Austrian AIDSHILFE organization, Workshop with service providers, Vienna*

The German mass media campaign based on the slogan *"Mach´s mit"* (a play on words, meaning both "Do it with" and "Join in") has been very successful in raising awareness by "ringing a bell". In this campaign very short slogans, sometimes funny, sometimes cheeky, sometimes serious, have been enormously successful in raising awareness about HIV/AIDS in the general population, but have not been able to reach the different migrant populations to the same extent, as already pointed out above. The slogans of this campaign are in German and English only. Just as an example of how well slogans in different languages work, in the focus groups with migrants in the qualitative part of our research, many participants could literally quote every slogan they had seen in their mother tongue concerning totally different topics (one example given was that of slogans

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[17] Müller, Wolfgang: *HIV-Prävention für MigrantInnen durch die BzgA: Konzepte, Erfahrungen, Status, Ausblick*. In: Fachtagungsreihe *Gesund in eigener Verantwortung?* www.dhmd.de

[18] See for example the TAMPEP information for sex workers, also discussed in Chapter 5 www.tampep.com

for a project for involuntarily pregnant teenagers). This is a valuable piece of information, showing us that one effective approach to raising awareness could be to use simple slogans in different languages that work as *"eye-catchers"* for the different ethnic groups.

In Granada, the local STI clinic has produced stickers with contact information and phone numbers to stick in places frequented by young people such as bars, restaurants, discos and university toilets. This simple intervention has proved effective and successful with the general youth population, and during the Spanish workshop with providers it was proposed that the stickers be translated and stuck in places frequently used by immigrants, such as NGOs, certain restaurants and bars, shelters and hostels.

Printed materials are of course essential instruments for raising awareness of issues and clarifying specific questions. However, it is crucial to understand - and even more important to accept (and act accordingly) - that the mere distribution of leaflets is not enough: a comprehensive approach is needed. It is absolutely fundamental to draw on the resources of the target population group to clarify doubts, answer additional questions, dissipate possible fears and above all, ensure that information is comprehensible, relevant and culturally acceptable. Two key ways of doing this are through peer education and community networking, discussed below.

4.4 PEER EDUCATION

The data collected from all five countries shows a pressing need to promote information that effectively communicates to migrants their right of access to health and social services. In order to do this, information needs to be made available where these groups live, work and spend their free time. Outreach work has been found to be most successful in communicating with groups who are otherwise hard to reach (again, see also Chapters 3 and 5).[19]

Migrants often find it difficult to obtain clear and correct information on certain health-related issues such as access to health and social services, sexuality, substance use, reproductive health, HIV/AIDS and STIs. As already mentioned at the beginning of this chapter, the underlying reasons are not only due to language problems, but also to cultural and especially structural ones. In order to tackle these concerns effectively, it is crucial to employ cultural mediators and peer educators to translate language codes and interpret cultural values.

Peer education has been proven to be extremely effective because it is a dialogue between equals. It involves members of a particular group educating others of the same group. A successful peer educator can emphasise and understand the emotions, thoughts, feelings, language and culture of the particular group and therefore relate better to it.

Numerous studies have demonstrated the effectiveness of peer education programmes in health promotion and prevention of HIV/AIDS.[20] The importance of peer support and information was also clear from our research on migrants. This important fact indicates that peer education programmes on a large scale would be very successful in facilitating the access of migrants to the health and social services, as well as in disseminating information on HIV/AIDS through a combination of personal contact, printed information and media campaigns. Peer education would obviously be very successful in communities

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[19] Luger, Lisa (1998): *HIV/AIDS prevention and "class" and socio-economic related factors of risk of HIV infection.* WZB, Berlin.

[20] See for example www.unescap.org

where word-of-mouth communication is a very important source of information, to try to dissipate fears and prejudices, even between the different ethnic groups.

"There's something that's really important for us Nigerians (…) we have a lot of trust in information given by word of mouth. For example, someone tells you the pill is bad for you, if you take it you can't have children. Women believe more in what their friends say, and this way messages by the doctor could also spread rapidly."

Female Nigerian cultural mediator, Focus Group, Verona

It is very important to be aware of some prerequisites if the use of peer education is to be used to its full potential:

- Peer educators should be accepted by, connected to or embedded in community networks;
- The prejudices and taboos of the specific community should be discussed in the framework of community networking;
- Specific communications structures of the communities should be taken into account;
- The peer educators have to be carefully selected and trained, and have good knowledge of both the health system and HIV/AIDS/STIs;
- Peer educators need to be non-judgmental and open minded.

In this context, it was suggested by immigrants interviewed that famous figures from the different communities could act as role-models, an approach that could also be successful for youth-friendly campaigns. This could also be valuable in dissipating the stigma associated with HIV/AIDS. A number of immigrants, particularly from Sub-Saharan African countries, felt that the host country media projected only a negative image of their countries and communities.

The combination of specifically developed written information and well-trained and integrated peer educators would ensure that the language and messages used are relevant, appropriate and reach their target.

MiMi (Mit Migranten für Migranten): Interkulturelle Gesundheit in Niedersachsen und Nordrhein Westfahlen (Intercultural Health in the Federal States of Lower Saxony and Nordrhein Westfahlen). MiMi trains migrants to become intercultural health mediators, introducing them to health promotion and prevention issues. After the training, the migrants organise information events independently in the different communities. This promotes empowerment of migrant populations.

ethno@onlinehome.de

4.5 COMMUNITY NETWORKING AND POLICY ADVOCACY

There have been many initiatives that have dealt with the issue of health prevention and migration, but not all have been truly successful. These initiatives have come from the most diverse levels, leaving the impression that they have been working parallel to each other and not together. Only a joint and co-ordinated effort by governments, local health authorities, health professionals, NGOs and migrants themselves can be successful. A number of networks link such efforts throughout European Countries, such as the European Union-funded AIDS and Mobility Project.[21]

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[21] See Mary Haour-Knipe: *Migration and HIV/AIDS in Europe*, AIDS Infothèque, Sida Info Doc Suisse 5/00, October 2000, pp.4-14.

The AIDS and Mobility Project launched pilot projects for migrants and ethnic minorities in its early years, and now serves as a co-ordinating centre bringing together national focal points from 14 European countries. It commissions case studies and produces background documents, organises conferences, seminars and networking meetings of people working in the field and serves as a documentation service, increasingly through the internet.

www.aidsmobility.org

As has already been mentioned (see Chapter 3), grass-roots, community-based organisations (CBOs) need to be nurtured and supported if they are to reach their full potential in terms of role and target. In our survey, it emerged that only 16.3% of the whole immigrant sample participated in some form of ethnic association (cultural, religious or solidarity/self-help). In some areas there were none, or they had become "dormant" owing to lack of human resources to keep them active. The Sub-Saharan African community appeared to be the best organised in all countries, with 40.4% of participants saying that they participated in an association. 23.4% of immigrants from North Africa said that they participated in community associations, mostly of a cultural nature.

It is very important to focus not only on the grass-roots level, but also to strengthen policy and advocacy work at regional and national level. Immigrants have the right to speak out in defence of their needs, and should be assisted where necessary in advocating for their health and other rights. An example of good practice here is the African HIV Policy Network (AHPN) in the UK (see box below).[22] Joint projects could be a good answer: one side would provide the institutional and epidemiological knowledge and experience (government, NGOs) and the other side the cultural knowledge (CBOs).

African HIV Policy Network (UK)

This is a national organisation that focuses on policy and lobbying only, not direct service delivery, and serves as the conduit for the transmission of information from the grass-root to policy makers and vice-versa. It also serves as a national forum and voice for African communities.

www.ahpn.org

4.6 CONCLUSIONS AND SUGGESTIONS

We conclude by summarising a number of key points which have emerged in this chapter:

- *Target group*: the term "migrants" does not denote a specific target group in itself, but rather a set of heterogeneous groups which are different from the host country population;
- *Information campaigns*: information campaigns must be part of a strategy which addresses underlying structural issues (economic and social determinants of health) and involves representatives of the targeted communities at all stages;
- *Information materials and interpersonal counselling*: information materials should be developed in cooperation with the target communities and used in conjunction with

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[22] See Dr. Max Sesay (2004), Chief Executive of the AHPN. In: *HIV/AIDS-Prävention für Afrikanerinnen und Afrikaner in Berlin,* Dokumentation der Fachtagung.

interpersonal counselling through counselling centres, outreach work and peer education programmes;

- *HIV/AIDS/STI prevention*: interventions need to be based on sound knowledge of the cultural, social and psychosocial conditions of migrants;
- *Distribution strategies*: HIV/AIDS/STI information needs to be included in general information on the right to health care and how the NHS works, and distributed inter alia in places frequented by immigrants, local media and at border crossing points, for example. Migrants use channels of information which may be different from those used to reach the local population;
- *Mass media*: national awareness campaigns should use short, catchy slogans translated into all the relevant languages (including the host country language) with the aim of "ringing a bell" in people's minds;
- *Strengthening networks of CBOs*: community-based organisations for immigrants need to be set up, strengthened and enabled to act in partnership with each other in order to develop and disseminate information in their communities, interact with health services and undertake advocacy initiatives to influence policy.

4.7 ADDITIONAL RESOURCES

Excellent international webpage with practical information on health communication including HIV/AIDS/STI and many useful links:
www.comminit.com

Health-related Resources for Black and Minority Ethnic Groups, Health Education Authority, London, 1994. Excellent resource by and for people from ethnic minorities, addressing HIV/AIDS and many other health issues.
www.hda-online.org.uk/Documents/healthres_black.pdf

Partnership and Pragmatism. Germany´s Response to AIDS, Rosenbrock, Rolf; Wright, Michael (Eds.), 2000, Routledge, London

Gut *versorgt? Migrantinnen und Migranten im Gesundheits- und Sozialwesen*. Mabuse Verlag: Borde, Theda; David, Matthias, 2003: Frankfurt a.M.

AIDS-Bekämpfung in Deutschland. Bundesministerium für Gesundheit, 1996: BMG: Bonn

AIDS im öffentlichen Bundeszentrale für gesundheitliche Aufklärung, 2004: Bewusstsein der Bundesrepublik Deutschland 2003. BZgA, Köln

Fachkräfte und andere im AIDS: Handbuch Migration für AIDS-Hilfen, AIDS-Bereich Tätige, 1998. Deutsche AIDS Hilfe: Berlin.

Wegweiser Migration HIV und AIDS, Frankfurt/Main, Cochem: Bremm Verlag, Herkommer, H. 2000

HIV und AIDS, Deutsche AIDS-Hilfe, 2001: a handbook for those affected by HIV/AIDS and their counsellors, with basic information on HIV/AIDS in six languages.

Information and explanations on migration and health for everyone working in the field.
www.infodienst.bzga.de

On-line health guidelines for migrants in Germany, as well as telephone counselling and information.
www.patienteninfo-berlin.de

AIDS-Information für Ausländer und Ausländerinnen – ein Projekt der Steirischen AIDS-Hilfe 1995–1997 AIDS Hilfe Styria: AIDS Information for foreigners – a project description by the Strryian AIDS Help organization.

Sozial benachteiligte Gruppen – MultiplikatorInnenschulung: Gesundheitsförderung von sozial benachteiligten Gruppen. 2. Österr. Gesundheitsförderungskonferenz *Partizipative Methoden in der Gesundheitsförderung*, Baldaszti,E.: Innsbruck. Fonds Gesundes Österreich, 2000

F.E.M. Süd Frauengesundheitszentrum: a health care centre for women, parents and girls offering health education and counselling in different migrant languages. The centre is a WHO model project in Vienna, Austria.
www.fem.at

M.E.N : A health care centre for men offering health education and counselling in different migrant languages. The centre is a WHO model project in Vienna, Austria.
www.men-center.at

Omega: Health care centre for migrants in Graz, Austria.
www.omega-graz.at/homeEN.html

5

WORKING WITH VULNERABLE MIGRANTS

5.1 INTRODUCTION

The preceding chapters on service reorientation, cultural competence in health service delivery and information strategies have outlined various ways of increasing the health and social services' capacity to respond adequately to migrants' special needs. It has been pointed out that migrants are a very heterogeneous group and that the situations and needs of various types of migrants may be fundamentally different. When planning health care programmes and initiatives for a particular migrant target group or individual, a range of factors should always be taken into account in order to avoid generalisations. These include sex, age, family status, socio-economic status, education, reason for leaving the country, length of stay in the host country and general living conditions.

Among migrant populations there are some groups which are particularly disadvantaged in their access to comprehensive health prevention and care, which increases, amongst other things, their vulnerability to HIV infection. These tend to be the most marginalised, such as irregular migrants in general (see chapter 2 for a detailed discussion on lack of legal status), and, more specifically, migrant sex workers, asylum seekers, migrants living with HIV/AIDS, migrants in prisons and injecting drug users (IDUs),[1] often young people. This was confirmed by the findings of our quantitative and qualitative research,[2] which showed clearly that irregular migrants and female migrant sex workers were in many ways more disadvantaged and vulnerable than the other women and men interviewed.

This chapter provides selected findings from our research project, introduces a number of national and regional project examples for working with migrants in marginal situations, and outlines strategies and recommendations for health and social services attempting to meet the needs of migrants in marginal situations, in particular with regard to HIV prevention. Given the limited scope of this publication, we will focus on the following specific groups for which we obtained the most direct information during the course of our research:

- migrant sex workers;
- asylum seekers;
- migrants living with HIV/AIDS.

These migrant groups should not be seen as separate from each other or mutually exclusive, however. A migrant sex worker, for example, could at one and the same time be an asylum seeker, HIV positive and an injecting drug user. Specific strategies are needed for individuals who are marginalised in a number of ways, and many suggested interventions may also be relevant to other specific groups. The chapter closes with a summary of the main conclusions, and a list of relevant literature references, websites and contact details of national and international organisations.

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[1] See resources on young people and IDUs at the end of the chapter.

[2] Research Project on Immigrants from European Eastern and Southern Borders - HIV Risks, Social Condition and Service Provision, 2002-2004. See the summaries of the quantitative and qualitative research in Appendix 1.

5.2 STRATEGIES FOR WORKING WITH MIGRANTS IN VULNERABLE SITUATIONS

There are usually not enough programmes and services to cater for the special health and social needs of migrants in vulnerable and marginal circumstances. Understanding the perceptions and health needs of such migrants, and the subsequent sensitisation of health and medical professionals to their needs, is a prerequisite for effective health service delivery, including HIV/STI needs assessment, prevention and care interventions. Marginalised groups are frequently described as “hard to reach” in terms of access to services. Outreach therefore plays a crucial role in promoting and bringing health services to marginalised individuals instead of waiting for them to seek out health and social service providers. Outreach activities should involve cultural mediators and/or peer educators. General approaches to migrants in marginal situations include community mobilisation, working through community associations and immigrant groups, and the establishment of “safe spaces where no questions are asked”.[3]

“Vulnerability” and “vulnerable populations” in the context of AIDS

Vulnerability to HIV infection arises from circumstances that are beyond the direct control of the people involved. Such circumstances include poverty, low social status, inequality, gender discrimination, discrimination, marginalisation and criminalisation. Among other things, these circumstances also reduce or deny a person’s access to HIV information, services, means of prevention and support. Gender inequalities increase the vulnerability of both men and women to HIV infection.

“Vulnerable populations”: (1) are denied their human rights and/or (2) have limited access to HIV information, health services and means of prevention, such as condoms (male and female) and/or (3) have limited ability to negotiate safer sex. Such groups include women and girls in countries where women and girls are discriminated against, poor people, ethnic groups, refugees, migrants, prisoners and children. Other groups, such as men who have sex with men, injecting drug users and sex workers may combine risky behaviour with vulnerability. Their vulnerability usually arises from their marginalisation and/or the fact that their behaviour is deemed illegal. This marginalisation and criminalisation result in much less access to knowledge, means and services necessary to avoid HIV infection.

Most of these groups are also more vulnerable with regard to the impact of AIDS. They have less means to live positively with AIDS, because they cannot afford treatment, cannot access care, may lose their jobs and resources, and may face increased stigma and discrimination due to their HIV status. They are more likely to become (more) impoverished and marginalised, as well.

Source: Basic facts about the AIDS epidemic and its impact, UNAIDS Questions and Answers, November 2004 *www.unaids.int*

It is important to bear in mind that working with people in marginal situations requires a high degree of flexibility and an understanding that not all activities can take place according to established rules and guidelines.

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[3] *Migration and HIV/AIDS in Europe* by M. Haour Knipe, AIDS Infothèque, Sida Info Suisse. 5/00, October 2000, pp. 4-14.

5.2.1 Migrant sex workers

There is a growing number of female and male migrants from Africa, Asia, Latin America and Eastern Europe who engage in sex work in the European Union (EU).[4] In many EU countries, including the five project countries, the number of migrant sex workers is higher than that of local sex workers. Where prostitution is legal if registered (as in Germany, for example), unregistered sex workers, who are often migrants, outnumber registered ones. They may be victims of trafficking, asylum seekers or people migrating to the EU in the hope of escaping poverty, limited economic opportunities and social deprivation, and of improving their living conditions. Once they arrive in the host country, however, lack of employment opportunities is a push factor into sex work. The widespread public image of sex workers as ‘multipliers’ in the spread of HIV increases their isolation and stigmatisation.

There are clearly a number of factors that make migrant sex workers particularly vulnerable to HIV infection. The majority of migrant sex workers do not know much about the sex industry, legal regulations or the health and social system in the host country. They are often not covered by any health insurance and generally lack adequate access to health, social and legal services. This is even more the case when they have do not have legal status or work in places where sex work is not legal, resulting in discrimination and social isolation. Mobility and multiple risk behaviours, including regular alcohol consumption and frequent drug injecting, further exacerbate their vulnerability.

Their often desperate economic plight makes migrant sex workers more susceptible to engage in high-risk practices for which clients are willing to pay more. Sex workers who have least control over their living and working conditions tend to be the most vulnerable. This is certainly the case for the rising numbers of girls and women who are trafficked for commercial sexual exploitation, and for those who have to repay huge debts to the traffickers or others who arranged their clandestine travel to the host country.

Migrant sex workers are often not professionals and work in the sex industry for the first time in their lives. Their knowledge of HIV and STIs and protection measures as well as their risk awareness is consequently low. They do not perceive themselves as sex workers and consider their work as temporary.[5] This makes it all the more difficult to reach them with information, education and communication (IEC) interventions clearly designed for persons engaged in sex work.

Our national and cross-country analysis confirmed the vulnerability of female sex workers:

- In three out of the five project countries, the percentage of sex workers without legal status was higher than those who were in the country legally;
- Sex workers’ level of education and their knowledge of the host country language was lower compared with the other women and men interviewed;
- Sex workers reported significantly higher incidences of abuse and maltreatment compared with other women in the study;
- Sex workers had significantly less knowledge of where to find key health services (except STI clinics) than the other women in the sample;
- Sex workers reported higher alcohol consumption than other women and men (71% drank alcohol every day, several days a week or at least once a week);

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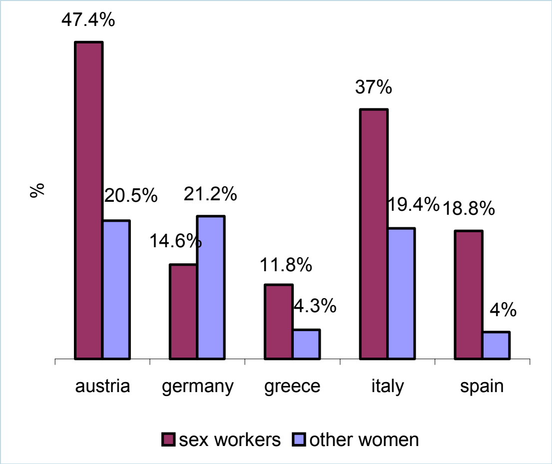
[4] Although our quantitative survey included interviews only with female sex workers (50 interviews out of the total of 300 per country), the number of male sex workers and transvestites is increasing in all the project countries. Our research protocol stipulated that sex workers interviewed had to be at least 18 years of age, but under-age prostitution is also becoming an increasing problem in all countries.

[5] In fact, in our research project, a number of women denied that they were sex workers when answering our questionnaires, even though they had been recruited on the streets by outreach workers.

- Sex workers were significantly less often covered by health insurance than other women;
- In some countries, for example in Austria, sex workers' knowledge of possible causes of HIV infection was significantly lower compared with other women and men;
- The percentage of sex workers who had had an HIV test at least once was 59%, a rather low figure for such a vulnerable group;
- The percentage of sex workers who said they had had at least one abortion was much higher than in the group of other women in all countries except Germany (see Figure 1 below).

Figure 1: Abortions



Source: Cross country statistical report, 2004

Strategies and recommendations

The focus of interventions for sex workers should not be limited to HIV/STI, but rather on enhancing their general health and well being. Sex workers' living conditions and broader needs beyond immediate health care have to be taken into account. Programmers in this area stress the importance of contributing to the empowerment of sex workers, increasing their self-esteem, contributing to their personal welfare and facilitating control over their own lives. Improving sex workers' chances of adopting a healthier lifestyle is a highly effective approach to reducing the spread of HIV and other sexually transmitted infections (STIs).

The provision of health services to sex workers requires a good understanding of the different settings of sex work (e.g. city streets, highways, border crossings, brothels, escort agencies and call services, bars, dance clubs and apartments), their mobility, the consequences of lack of legal status, and the impact of working conditions, which may make it impossible to comply with routine medical advice, such as abstinence from sexual relations during STI treatment.

> "The level of education is low, but the women are very motivated. At SILA (counselling centre for sex workers in Vienna), we perform 'low-threshold' examinations, since we recently acquired a gynaecological chair. The main part of our clients at SILA is uninsured. They have no financial means and no information. On the other hand there are also married women who are health insured via their husbands. But they often don't know how the health insurance works and don't have a GP."
>
> *Austrian gynaecologist, Workshop for Service Providers, Vienna*

Comprehensive services for sex workers, including migrant sex workers, should include the following elements:[6]

- Outreach: this is the principle and sometimes only way to maintain active and continuous contact with sex workers; gain their trust; assess their needs; and provide condoms, lubricants, HIV/STI education and other services;
- Peer education approaches, including the establishment of cooperation between health professionals and peer educators. Sex workers themselves are important resources in educating their peers about HIV/STI prevention issues and in encouraging better protection from infection;
- Inclusion of cultural mediators in the health care system aimed at migrant sex workers, i.e. as street workers and as link workers inside health services;

> "A woman [sex worker] would only trust the services with a known cultural mediator. You need someone to help explain, but it's not just a matter of translating. It needs to be someone who understands the work [sex work]. It takes time to build up a relationship of trust. You would not accept to go to the services for tests with any cultural mediator, even if she spoke your language. You would only go with the person you know and trust."
>
> *Ukrainian sex worker, Focus Group, Mestre (Italy)*

- Information, education and communication (IEC) on HIV/STI prevention and other health, legal and social issues for migrant sex workers and their clients, including the distribution of information materials that consider migrant sex workers' different cultural, health, sexual, ethnic and linguistic backgrounds. Migrant sex workers should be involved in the development of IEC materials;
- Anonymous and free STI examinations and treatment, and voluntary counselling and HIV testing;
- Consideration for sex workers' preferences either for accessible and sensitised mainstream services or for separate special services, to increase their use of services. Access to general medical care services should be available for migrant sex workers not covered by health insurance;
- Access to psycho-social counselling, legal advice and social welfare;
- Harm reduction interventions for drug using sex workers - drug using sex workers are generally in more disadvantaged health and social conditions and in greater need of support. They are also at higher risk of HIV infection;
- Special support to (uninsured) migrant sex workers living with HIV/AIDS, including medical, psycho-social, and legal services;
- Other strategies for delivering health services and education, including mobile health units, drop-in centres and telephone hotlines.

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[6] These recommendations are drawn in part from *Hustling for Health - Developing services for sex workers in Europe*, published by the European Network for HIV/STD prevention in Europe (EUROPAP/TAMPEP), 1998.

In our study, the fact that clients were prepared to pay more for sex without a condom was cited by 68.1% sex workers as the main reason for unprotected sex. Effective HIV/STI prevention should therefore include interventions for the clients of sex workers.

> "In the women's home where I live there are women who are in prostitution for need of money. Sometimes I put condoms anonymously in the hall and after a very short time they are all gone. Austrian clients however, often refuse to use condoms or pay more for sex without a condom."
>
> *Female immigrant from Sub-Saharan Africa, Focus Group, Graz*

In Germany, the workshop with health service providers reported that a recent initiative had been jointly launched by sex workers' organizations and the association of sex trade entrepreneurs to systematically address clients.[7]

The following box gives a number of examples of good practice in HIV/STI prevention and health care for migrant sex workers.

Examples of HIV/STI prevention and health care projects for migrant sex workers

In Villafranca (Verona, Italy) the public health service has opened its services to local sex workers, mainly non-Italian and casual workers. One afternoon a week, free of charge and anonymous tests for HIV, STD, Hepatitis, and TB are offered, as well as to be vaccinations, gynaecological examinations, contraceptive advice and abortion counselling. A street unit, including peer specialists, travels around Verona informing sex workers about this service, making appointments, and accompanying them (from the publication Hustling for Health, 1998).

In Mestre (Italy), the "Città e Prostituzione" service run by the local authority of Venice ensures that sex workers are personally accompanied to necessary health checks by cultural mediators. The relationship of trust which develops between individual mediators and the sex workers is crucial in encouraging them to take the necessary HIV and STI tests, attend information workshops and protect themselves from STIs and unwanted pregnancy.

www.comune.venezia.it/prostituzione

In Berlin (Germany), the organisation "Hydra e.V." is a counselling and meeting point for sex workers from different nationalities. This project trains peer educators for street work.

www.hydra-ev.org

A German study showed that street work in cooperation with native speakers combined with confidential and free of charge counselling and medical care was effective to reach migrant sex workers in Germany.[8]

In Granada (Spain), the Red Cross operates a mobile unit program at crossroads, aimed at promoting sexual and reproductive health among female sex workers, many of whom are of foreign origin. Sex workers are provided with condoms and information about HIV/AIDS and other STI prevention as well as about their right to access health care. Social workers facilitate appointments at the organisation's headquarters where further information and advice about health promotion and disease prevention is provided. Health cards are issued which give sex workers free access to the health care system. They are also informed about the functioning and location of local primary health centres and specialised services – such as the local STI clinic- and hospitals. Where necessary, the social worker accompanies them on their first visits to primary or specialised care facilities to ensure that they are adequately channelled towards the health network. *promujer@cruzroja.es*

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[7] National Association of Sex Trade Entrepreneurs (Bundersverband for Sexuelle Diestleistungen) established in Germany after the new prostitution law came into force in 2002 www.busd.de
Website for CSW clients www.sexsicher..de

[8] *HIV Prevention for migrants in prostitution,* by H. Nitschke-Ozbay, 1999, in Zentralblatt fuer Gynaekologie 1999; 121 (1), pp. 36-41. Medline http://medlineplus.gov

In Vienna (Austria), the organisation “Lefö” reaches out to migrant sex workers to improve their health and living conditions. Lefö provides street work services in Vienna and other federal states by cultural mediators; develops and distributes informative material and folders in different languages; organizes workshops for peer educators and courses for cultural mediators; and acts as spokeswomen for the rights of migrant sex workers. Lefö collaborates with ‘Sila’ a counselling centre for migrant and Austrian sex workers, which also provides gynaecological examinations.

www.lefoe.at *www.sila.org.at*.

TAMPEP (Transnational AIDS/STI Prevention amongst Migrant Prostitutes in Europe Project) has contributed significantly towards the development, implementation and documentation of health promotion interventions for migrant sex workers in Europe, with a particular focus on HIV and STI prevention and treatment. TAMPEP uses as its main working methods peer education and cultural mediation.

www.tampep.com

5.2.2 Asylum seekers

While the number of asylum seekers in the EU[9] has been constantly growing over the past 20 years, the number of new asylum applications has recently declined in many Member States, partly because asylum laws and policies have become more restrictive.[10] Fear of expulsion after rejection of an asylum claim in the determination procedure might discourage people from even applying for asylum, choosing instead to enter and remain in the host country illegally. High levels of mobility make it difficult, if not impossible, to quantify how many asylum seekers are in a given country at a given time.

There are a range of factors that have a negative influence on asylum seekers’ health and increase their vulnerability to HIV/AIDS. Asylum seekers’ access to health and social services varies in the different EU countries, ranging from emergency medical care only to full access to the national health system (NHS). Limited freedom of movement can be a barrier to full use of services offered – many asylum seekers are held in conditions akin to detention, which in itself can have a deleterious effect on their mental health.

“They [asylum seekers] can go for a free check up or HIV test, but if they are not allowed to leave the refugee camp, how is that supposed to work?”

Participant, Focus Group, Berlin

Asylum seekers in most EU countries are not allowed to work while they are waiting for their case to be determined, which can take several months or years. As a consequence some turn to criminal activities or engage as unregistered sex workers to ensure at least a basic income, which makes them vulnerable to abuse and risky sexual behaviour. For others, the anxiety suffered during sometimes prolonged and always uncertain determination procedures and, where successful, lengthy family reunification procedures may also increase vulnerability (many studies have noted that single men are also a vulnerable group).

Participants in a German focus group said that for the majority of their community members (especially those seeking asylum) the whole issue of HIV, including the HIV test,

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[9] This statement refers to the 15 EU countries before the enlargement in 2004.

[10] In the EU as a whole, the number of applications declined from 391,275 in 2000 to 381,623 in 2002 In the five project countries, the number of applications lodged in the period 2000-2002 was: Austria 85,495, Germany 237,978 (the highest not only in the EU but in all Western industrialised nations), Greece 14,246, Italy 32,465 and Spain 23,594. Source: UNHCR, *Asylum Applications Lodged in Industrialised Countries: Levels and Trends, 2000-2002*. For additional statistical information see www.unhcr.ch or www.ecre.org

was of secondary importance. This attitude is not directly related to access and quality of the health service provision, but rather to the general legal and social status of migrants, which determines their daily problems and pushes them ever further out of the reach of assistance and support.

> "Asylum seekers have to take care of their papers, and in addition they have limited freedom here, and lots of problems. The HIV test is of minor importance to them."
>
> *Sub-Saharan African participant, Focus Group, Berlin*

Limited access to information counts as another risk factor. In Germany, FG participants claimed that asylum seekers receive no information materials concerning health issues by official services. One participant said: *"If you could tell this to the foreign police, that would be one way of informing people"*.

Asylum seekers living with HIV/AIDS are in a particularly precarious situation in most European countries. One of the main conclusions of the All-Party Parliamentary Group on AIDS in the UK was that the Government should develop and implement national best practice guidance on asylum seekers living with HIV.[11]

Strategies and recommendations

Humanitarian and pubic health arguments support the timely provision of appropriate health care to asylum seekers. Ideally they should have full and free of charge access to public health care, promotion and prevention services. Studies in the UK suggest that while the average physical health status of asylum seekers on arrival in the UK is not especially poor, it may actually get worse within the two to three years after entry.[12]

A number of asylum seekers participated in a German FG, and made the following recommendations:

- Asylum seekers should receive information about health and social services and where to find them;
- Asylum seekers have to know their rights, to whom they can refer, which are the organizations that can help them;
- To improve the situation of asylum seekers they should have a right to work;
- They should not be prevented from leaving the municipal area where they are registered as asylum seekers. Limited freedom of movement is in many respects a barrier to accessing existing health and other services, some of them tailored specifically to the needs of migrants;
- Asylum seekers should not be treated as irregular migrants.

It has to be strongly emphasised that compulsory HIV tests violate internationally accepted human rights codes (see Chapter 2). In addition, the high costs involved in HIV testing of all arrivals would divert urgently needed resources from prevention interventions.

The following box gives a number of recommendations and standards regarding health care for asylum seekers, including HIV/STI prevention, based on the recommendations of the British Medical Association in the UK, where the law stipulates that health care must be

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[11] *Migration and HIV: improving lives in Britain: an inquiry into the impact of the UK nationality and immigration system on people living with HIV*, All-Party Parliamentary Group on AIDS, London, 2003.

[12] *Asylum seekers: meeting their healthcare needs*, British Medical Association, 2002 http://www.bma.org.uk/ap.nsf/Content/Asylumseekers

free for all asylum seekers and that they have the right to be registered with a general practitioner (GP).[13]

Meeting the health care needs of asylum seekers

- Physical and mental health assessments of asylum seekers should be conducted on arrival and appropriate treatment and/or support provided. For all procedures, informed consent should be obtained. Appropriate pre- and post-test counselling needs to be provided for tests carried out, including HIV tests. Asylum seekers should be informed that all health information is confidential. Medication should be presented as simply as possible. Healthcare professionals must appreciate that some asylum seekers have a fear of health authorities.

- Adequate accommodation should be provided: accommodation centres should have all facilities deemed necessary to meet the health care needs of asylum seekers on-site, including primary care, translators and nearby hospitals. Health care services for asylum seekers dispersed in the communities should be equally available through local GPs.

- Trained interpreters/cultural mediators, rather than family members or friends, should be used wherever possible if the language is not shared. Using the same interpreter for all the patient's consultations can help develop trust. The same interpreter should not be used for members of the same family as this might hamper family members' trust in confidentiality.

- Health care professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers. Training should be provided on healthcare needs of asylum seekers, with particular reference to working with interpreters and cultural mediators.

- Information on health services and how to access them should be provided in a language and format that they understand. Consideration should be given to illiterate asylum seekers. Information should include: an overview of how the health system works; health services and how to access them; where to get support and information, such as the availability of community groups

- Asylum seekers should not normally be held in detention as it can remind torture victims of their experiences and compound the psychological damage/torment that they have already suffered. If asylum seekers are detained, healthcare needs should be met.

- A range of factors over and above their access to health care can influence the health of asylum seekers. Asylum seekers should be provided with sufficient funds with which to maintain a healthy lifestyle while awaiting their decision on their application. The immigration process should be efficient so that claims are decided fairly and quickly.

Source: British Medical Association, 2002

In general, there are very few targeted HIV/STI prevention interventions tailored to the needs of asylum seekers. The following box presents some practical examples, however.

Safer Sex in African theatre play – A peer education intervention by and for asylum seekers[14]

In the Netherlands, an enthusiastic group of theatre makers and actors – most of them asylum seekers themselves – have developed a theatre play that addresses issues such as condom use, HIV transmission and other AIDS related themes in a serious and at the same time playful way. The people behind the play are members of ASERAG – the Asylum Seekers/Refugees AIDS Group, created in 2002. The group of asylum seekers is devoted to combating the spread of HIV and STIs through health awareness campaigns using popular theatre. The group collaborates with a variety of local partners in the field, including municipal health services, refugee centres and AIDS organisations.

aseragholland@yahoo.com

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[13] Ibid.

[14] Aids and Mobility News, June 2004

Project for asylum seekers by Pluss-LMA in Norway

Pluss-LMA, a Norwegian organisation for people living with HIV/AIDS, initiated a project for asylum seekers in the Oslo region. The project educates the staff of selected reception centres on HIV and routes of transmission, and informs asylum seekers about Pluss-LMA's network of volunteers.

www.pluss-lma.no *geir.nese@plus-lma*

Health counselling for migrants and asylum seekers in Austria

In Graz (Austria), Zebra is an independent, private and non-governmental organization offering counselling and care services to migrants and asylum seekers. This includes counselling and assistance for persons with family problems; assistance in health problems; therapies for victims of torture and persons traumatised during war; advice on family planning; and arranging for medical care and treatment.

www.zebra.org.at

5.2.3 Migrants living with HIV/AIDS

The number of AIDS cases has been declining significantly in Western countries since the introduction of HAART (highly active antiretroviral treatment).[15] Life expectancy of people living with HIV (PLWHA) in the developed world is increasing. However, there are inequalities in standards of care and the provision of information. Studies have found that migrant populations tend to receive less HIV counselling and seek HIV testing later than the rest of the population. Thus they are not benefiting from sufficient preventive information (see chapter 4) or practical counselling and early care if infected with HIV. Epidemiological data from Western Europe show that the proportion of non-nationals among people newly diagnosed with AIDS is increasing in some countries (see also the Introduction to this Handbook).

Much remains to be done to improve the situation of migrant PLWHA. They are often stigmatised and marginalised in the host community and their own community. Due to the additional burdens imposed by their life in the host society, migrant PLWHA are usually in a much worse situation than those in the host community. Their health care therefore needs to be more interdisciplinary than usual, and psychosocial and cultural considerations need to be incorporated into service delivery (see also Chapter 3 on cultural competence).[16] Such issues, if not understood, can become obstacles to maintaining continuous relationships with health centres, thus resulting in lack of compliance, neglect of health needs and consequent deterioration of health status.

Stigmatisation becomes a greater issue than for the rest of the immigrant population because PLWHA tend to be more isolated than others. This situation may be aggravated where a high level of stigma is attached to AIDS within the immigrant population.

"Stigmatisation remains a hindering factor on the patient side, particularly for African people. HIV positive people still do not dare to use the help offered by the system, they do not dare to discuss the issue."

Sub-Saharan African participant, Focus Group, Graz

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[15] EuroHIV/AIDS Surveillance in Europe, *End-year report 2003*; 2004, No. 70.

[16] Care and prevention in HIV/AIDS are intertwined in many ways, but it is beyond the scope of this Handbook to do justice to all the issues arising in the care of HIV positive migrants. For further information see resources section at the end of the chapter.

"The concept of taboo plays a very important role here … things that are not to be said … I've asked people whether or not they would tell anyone that they had AIDS if that was the case, and they all told me that they would never say that to their family, rather they would prefer to die. They think that it would be a shame … and they would isolate themselves".

North African participant, Focus Group, Granada

The German research team in our project found that the rejection of PLWHA and their stigmatisation in the community seemed to be so high, that the fear of becoming a scapegoat outweighed by far the fear of remaining alone and dying from AIDS. The anticipation of such discrimination doubles the marginal status of migrant PLWHAs, who fear both the rejection of their own ethnic community, exclusion from German society and even deportation, in case their HIV status should become known.[17]

Medical professionals in Austria stated at a workshop organized by IOM Vienna that it is problematic to put HIV positive asylum seekers and migrants without legal status on (antiretroviral) therapy, as the continuity of treatment cannot be guaranteed if the length of stay in the host country is uncertain. A German participant said: "*There are many migrants with unclear legal status, for example from Africa and Kazakhstan, who hope to be able to remain in the country for humanitarian reasons if they are diagnosed HIV positive. What they do not know is that being HIV positive is not any longer sufficient grounds to be granted refugee status in Germany. Only in case of full blown AIDS can one receive permission to stay and to enter treatment.*"[18]

Strategies and recommendations

Host countries need to improve legal and practical access of migrant PLWHA to local HIV/AIDS care, treatment and support services, including psychosocial support. Access to care and treatment for HIV positive people needs to be granted independently of their legal status. Emphasis needs to be on low threshold counselling and HIV testing services adapted to migrants' needs, and early care for HIV infected persons, including prevention and treatment of HIV related illnesses and access to antiretroviral drugs.

A member of the "African Positive Association" in France said at a recent conference: "*The refusal to regularise the situation of people with HIV is a form of discrimination and stigmatisation*".[19] In order not to cut off foreign PLWHA with unclear residence status from access to treatment, services and support, consideration should be given to granting residence status on humanitarian grounds. Participants at a European expert meeting organised by the AIDS and Mobility network took the position that the goal of their efforts needed to be to ensure that expulsion is made illegal when sustainable and accessible treatment cannot be provided in the country of origin (see also Chapter 2).[20]

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[17] See the Report on the Qualitative Research, Germany, also summarised in Appendix 1.

[18] IOM seminar on migration and health, October 2004; www.fgz.co.at/SeminarMigrationundGesundheitEmpfehlungen.pdf

[19] *The impact of legal regulations on the life of migrants with HIV*, Sanvi Noel Ahebla, African Positive Association, France, in *Access to HIV Care and Support for Migrants and Ethnic Minorities in Europe*, AIDS and Mobility Report, October 2003.

[20] *HIV/AIDS care for people with a precarious residence status in Europe*, Report on a European expert meeting, Amsterdam, 19-21 June 2003. Aids and Mobility, The Netherlands.

> "The policy in Belgium is that mostly people who are tested HIV-positive are not sent back to their country: on humanitarian grounds, they can stay to receive medical treatment. This group does not receive financial support but they do get medical treatment."
>
> *Belgian health professional, Workshop with Service Providers, Vienna*

Again, it must be emphasised that vulnerable migrants should be involved in decision-making and delivery regarding their own health care, and empowered to take control of their health.

> **Ikambere** is an organisation in France founded by migrants whose main aim is to break the isolation of women infected with HIV and help them improve their quality of life. Ikambere is a drop-in centre that helps to promote links between people from developing countries with HIV. The centre enables women with HIV to meet, share their problems and receive practical and social support. The centre provides help with medical care, cultural mediation with health services, housing, legal advice, skills training and information about health issues, including HIV prevention and partner notification. The organisation also operates in hospitals, where the Ikambere women form hospital support groups.
>
> *www.ikambere.com*

Most importantly, interventions to reduce stigma and discrimination associated with HIV/AIDS need to be developed to help people who are positive to come forward and make use of support structures.

> "First and foremost there is a need for an anti-discrimination campaign, otherwise HIV-positive people will not come forward."
>
> *Health professional, Workshop with Service Providers, Vienna*

5.3 SUMMARY OF MAIN CONCLUSIONS

The main points which have emerged during this chapter on working with particularly vulnerable migrants can be summed up as follows:

- *Flexible definitions:* There are no hard-and-fast boundaries separating one special needs group from another: there are no fixed definitions of who is a sex worker and who is not, for example, and an individual may be "classed" simultaneously in more than one particularly vulnerable group;
- *Broad context:* HIV/STI prevention initiatives must take place within the context of broader strategies addressing the general health and welfare needs of vulnerable groups;
- *Interdisciplinary support networks:* Relevant service providers should cooperate closely in order to form a network of support for vulnerable target groups;
- *Outreach:* Successful outreach initiatives for otherwise hard-to-reach migrants need to combine peer education, cultural mediation, networking with migrant communities and use of safe spaces where no questions are asked;

- *Flexible approach*: A flexible approach is needed, as many situations will have to be addressed on a case-by-case basis and it will not always be possible to "go by the book";
- *Involvement of target:* Vulnerable migrants should be involved in decision-making: this will enhance self-esteem and empowerment, as well as increasing the effectiveness of interventions;
- *Address CSW clients:* Strategies to prevent HIV/STIs among migrant sex workers must also include interventions addressing clients, who pay more for unsafe sex;
- *Asylum seekers:* Asylum seekers should not be treated as irregular migrants, and should have full access to NHS care and preventive measures during the entire determination process. Limitations on freedom of movement prevent access to health care, and detention should be avoided wherever possible. Full health care facilities should be available free of charge where they have to be detained;
- *Humanitarian residence permits:* Urgent consideration should be given to granting residence permits on humanitarian grounds to migrants with HIV and to ensuring that no-one with AIDS can be expelled to a country where they would not receive treatment;
- *Tackle stigma*: Major efforts are still required in all countries to reduce the stigma associated with HIV/AIDS, which is a particular burden to vulnerable migrant groups.

5.4 ADDITIONAL RESOURCES

Migrant sex workers

Hustling for Health - Developing services for sex workers in Europe, The European Network for HIV/STD prevention in Europe (EUROPAP/TAMPEP), 1998
Transnational AIDS/STI prevention amongst Migrant Prostitutes in Europe Project
www.tampep.com

Legal Agenda for Migrant Prostitutes and Trafficked Women
www.femmigration.net

Fenarete: Professional training and support for the recruitment and employment of peer educators within interventions aimed at persons who prostitute themselves (including handbooks in English, French, Spanish, Lithuanian and Russian).
www.fenarete.org

Bleib gesund, Deutsche AIDS-Hilfe, 2001. Information brochure for migrants in prostitution in three languages
www.aidshilfe.de

LEFÖ - Counselling, Education and Support for Migrant Women, Austria
www.lefoe.at

Peer education for migrant sex workers, Germany
www.hydra-ev.org

Cultural mediation, information workshops and peer education for migrant sex workers, Italy.
www.comune.venezia.it/prostituzione

East-West Mobility in Europe: Overcoming Barriers to HIV Prevention for Mobile and Migrant Sex Workers ed. Nel van Beelen. Aids and Mobility 2001
Report of a European Seminar among representatives of health services, AIDS service organizations and services for sex workers and drug users. It includes information on the specific needs of mobile sex workers in Europe and current responses from organizations and services.

Sex, Drug Use, Mobility and HIV/AIDS in Central and Eastern Europe: The integration of harm reduction services for people who sell sex and inject drugs ed. De Groot K., Aids and Mobility, 2003.
Report of a European seminar aimed at exploring links between sex work, drug use, mobility and HIV in the Central and Eastern European region. It includes current approaches, activities and examples of best practice from various organizations involved in prevention efforts in the region.

Sila – Counselling centre for sex workers, Austria
www.sila.or.at

HIV/Aids und Prostitution, Kleiber, Dieter, Prof.Dr., Freie Universität Berlin, Institut für Prävention und Psychosoziale Gesundheitsforschung, 2001

Sex Work Toolkit: Targeted HIV/AIDS Prevention and Care in Sex Work Settings, WHO. The toolkit is intended as a resource to guide the development and implementation of effective HIV interventions in diverse sex work settings. It outlines key steps and issues and provides links to many documents, manuals, reports, and research studies containing more detailed and in-depth information.
http://who.arvkit.net/sw/en/index.jsp

Asylum seekers

Crossing Borders: Migration, Ethnicity and AIDS, ed. M. Haour-Knipe R. Rector, Taylor Francis, 1996. See in particular Chapter 12, “Asylum Seekers and Clandestine Populations”, by A. Matteelli and I. El-Hamad.

Health for Asylum Seekers and Refugees Portal (HARPWEB): Three web sites designed to enable easy access to information, practical tools, and articles written by health care professionals, NGOs, researchers with expert knowledge of working with asylum seekers and refugees
www.harpweb.org.uk

Pharos, funded by the Dutch government, supports health care professionals who work with refugees, with prevention and health education programmes, publications, an information and advice telephone line, and a documentation centre.
www.pharos.nl

United Nations High Commission for Refugees
www.unhcr.ch

European Council on Refugees and Exiles, a pan-European network of refugee-assisting NGOs providing advocacy, legal and social support to those in need of refuge and protection in Europe.
www.ecre.org

Asylkoordination Österreich: the organisation is committed to lobbying for the rights of asylum seekers and refugees in Austria. www.asyl.at

PLWHA

Analyse der psychosozialen Probleme von Migranten mit HIV und AIDS, *Aids in der Fremde*, Herkommer, H. Gesundheitsamt, Bremen, 2001

Epidemiologie und psychosoziale Probleme von Migranten mit HIV und AIDS, In: *Handbuch Migration*, Herkommer, H., Deutsche AIDS-Hilfe, 1998

HIV und AIDS Umgang mit Patienten aus Schwarzafrika, Nzimenge-Gölz, Solange, Dr., München, 2001

Access to HIV/AIDS Care and Support for Migrants and Ethnic Minority Communities in Europe, Maureen Louhenapessy, Report of the 7th European Migrants' Meeting, Brussels, 2002 (available in publications list)
www.aidsmobility.org

Protocol for the identification of discrimination against people living with HIV. UNAIDS Best Practice Collection. Geneva. UNAIDS/00.05E

A guide to primary care of people with HIV/AIDS ed. J. Bartlett et al., U.S. Department of Health and Human Services, 2004
http://hab.hrsa.gov/tools/primarycareguide

Compilation of up-to-date articles on HIV/AIDS care interesting for medical doctors
http://aids2004.thelancet.com

Fact sheets on people with ARV therapy (to be published in January 2005)
www.who.int/3by5/en/factsheet.pdf

HIV treatment information for healthcare professionals and HIV-positive people
www.i-base.info

Austrian national Aids organisation
www.aidshilfe.at

Germany national AIDS organisation
www.aidshilfe.de

Italian national AIDS organisation
www.lila.it

Spanish national AIDS organisation
www.seisida.org

Young people, Injecting Drug Users

HIV/AIDS Prevention and Care Among Especially Vulnerable Young people, A framework for action, Peter Aggleton, WHO, April 2004.
www.who.int/entity/hiv/pub/prev_care/en/evypframework2004.pdf

Advocacy and Social Mobilization for HIV/AIDS Prevention in CEE/CIS and Baltics, Obstacles and Opportunities, Katinka de Vries, prepared for UNICEF, 2001. Chapter 3: *Injecting drug Users and HIV/AIDS prevention.* Contact:
katinka.devries@skynet.be

Drug Use and HIV/AIDS. UNAIDS statement presented at the United Nations General Assembly Special Session on Drugs. UNAIDS best practice collection, Geneva, 1999.

Basic principles for effective prevention of HIV infection among drug users WHO EURO - European Council
www.euro.who.int/document/E76650.pdf

Soros Foundations Network, International Harm Reduction Development Programme: a very useful resource for working with injecting drug users.
www.soros.org/initiatives/ihrd/articles_publications/publications

HIV/AIDS e droga, manuale per operatori di prevenzione: l'intervento di strada, G.Serpelloni A.Rossi, EDAS, 1998. Handbook for social and health workers on outreach work in HIV prevention among drug users. Contact: Dr. G. Serpelloni
hivgrcvr@athesias.well.it

SUMMARY

The main findings

This Handbook is based directly on the findings of a two-year research project comprising both quantitative and qualitative research conducted on migrants and health professionals in five EU countries: Austria, Germany; Greece, Italy and Spain. The quantitative research on migrants included those with and without legal status, and was based on a quota sampling method not representative of the migrant populations in the participating countries, the only feasible option given the characteristics of the population to be studied. The research findings confirmed that migrants, particularly those without legal status, have less access to health services and health-related information, including their right to use the health services, and may be more vulnerable to diseases such as HIV/AIDS as a result. It has provided us with up-to-date figures and information indicating that the most pressing needs lie in improving access to migrant-friendly services, culturally competent communication skills, information on health and HIV/AIDS, and strategies for reaching out to vulnerable groups, including migrants without legal status and sex workers.

We have seen, for example, that 80% of migrants rated their health as good, but 34% of those who had been in the host country for more than 5 years said it had deteriorated. 63% of the general migrant population had some form of health coverage, compared to 43% of sex workers. 69% said they were satisfied with their experience of the health services, but 40% said they had experienced communication problems and 21% had found staff unfriendly. Only 50% were quite sure what HIV/AIDS was, and only 40% knew they had the right to a free and anonymous HIV test. 57% were not sure or did not believe that the results of the HIV test would be confidential. 31% of the general subgroup had had a test for HIV and 58% of sex workers. Only 31% had received counselling before or after taking the test. Little more than 50% of sex workers said they always condoms during intercourse with clients, and 68% gave as the reason the fact that the clients paid more for unprotected sex. 14% of women in the general migrant population had had an abortion since arriving in the host country, compared with 27% of sex workers. The topic of HIV/AIDS aroused fear of stigmatisation and discrimination in all migrant communities.

It is not all bad news, however! An enormous amount of work is already under way, across Europe, to address the specific needs of migrants communities and do more to involve them in their own health care as a way of integrating them into our societies. There is growing recognition that the universal right to health includes making health care available for irregular migrants. The laws and health services of some countries have taken account of their needs, and in others NGOs are doing their best to ensure that essential care is available. Outreach work and the use of trained cultural mediators have proven to be effective in reaching vulnerable groups, including sex workers. Many countries have provided health-related information in the languages spoken by their migrant populations. There are increasing numbers of training courses on cultural competence for health staff, as well as courses to assist migrants in integrating into European society.

The main theme which emerges is that the health services need to work much more closely with, not just for, migrant communities. This in itself will go a long way towards promoting the integration of migrant communities into our societies and dispelling their fears of stigmatisation and discrimination, particularly where HIV/AIDS is concerned.

The key recommendations

- Invest more in migrant community-based organisations, empowering migrants to take a pro-active role in protecting their right to health by involving them in the whole process of planning, delivering and evaluating health services;
- Place HIV preventive measures within the broad framework of flexible service provision, with particular emphasis on primary health care, health promotion and sexual and reproductive health;
- Conduct a thorough review of HIV test procedures, to ensure that they are genuinely and widely known, accessible, free of charge, anonymous, confidential and accompanied by adequate pre- and post-test counselling. This should comprise both preventive information and information on how to obtain any necessary treatment and care;
- Launch regular local, regional and nationwide information campaigns on HIV/AIDS addressed to the whole population, host country nationals and migrants alike;
- Make more use of cultural mediators and peer educators, combining targeted written information in the languages spoken by migrants with interpersonal counselling and outreach work;
- Introduce or step up pre-service and in-service staff training in the area of cultural and linguistic competence and make more use of existing talent and resources among staff;
- Conduct more needs assessment and systematic evaluation of existing programmes, as well as more systematic data collection on the incidence of HIV in migrant communities.

The next steps

We would like to expand this modest, first edition of our “Handbook for migrant-friendly health services” to include ideas and experiences from all EU Member States: we are all at different stages along the road to integration, and need to learn from each other. In conclusion, we would suggest that this Handbook serve as a stepping stone towards a future framework of actions, involving migrants and health-related partners at local, regional and national level in Europe, to address the following challenges:

1. Working towards a consensus on a set of core quality standards for delivery of migrant-friendly health care, applicable in all settings.
2. Developing a common set of indicators for evaluating progress in implementing quality standards as part of a process of internal organisational self-assessment.
3. Drawing up a uniform treatment protocol for foreign PLWHA, either granting access to treatment in the host country on humanitarian grounds or ensuring that where adequate treatment is available in the country of origin, programmes of assisted return are put in place.
4. Setting up a pan-European network of migrant associations to ensure access to information on health care for migrants and people on the move, and to advocate and liaise with the health authorities in the countries of origin and host countries.

APPENDICES

Appendix 1	European project on HIV and Immigrants at European Southern and Eastern Borders: Summary of project methodology and main quantitative and qualitative research findings
Appendix 2	Sample individual self assessment tool on cultural competence
Appendix 3	Fact sheets on HIV/AIDS Regional HIV/AIDS statistics and features (2002-2004)
Appendix 4	Glossary of terms
Appendix 5	Details of project partner organisations

APPENDIX 1

EUROPEAN PROJECT ON HIV AND IMMIGRANTS AND EUROPEAN SOUTHERN AND EASTERN BORDERS: HIV HEALTH RISKS, SOCIAL CONDITION AND SERVICE PROVISION RE-ORIENTATION : SUMMARY OF PROJECT METHODOLOGY AND QUANTITATIVE AND QUALITATIVE RESEARCH FINDINGS

A.1.1 Summary of project methodology

As part of this research project aiming to reduce the transmission of HIV/AIDS and sexually transmitted infections (STIs) in immigrant populations, a total of 1,579 immigrants were interviewed in five European countries (Austria, Germany, Greece, Italy and Spain) in the autumn of 2003. The nature and the complexity of the issue and the population being studied[1] ruled out the possibility of using a random sample of interviewees. It was therefore decided to use a quota sample rather than a representative one. Of the approximately 300 interviews carried out in each country, 250 were conducted with people from the macro-areas of origin of the largest immigrant communities (3-5 groups), whilst the remaining 50 were conducted with women who were involved in sex work on a full-time or part-time basis, and were therefore considered to be particularly vulnerable. Interviews were conducted in accordance with a cross-country research protocol to guarantee equivalent sampling and recruitment procedures, respect for the rights of the migrants interviewed and statistical comparison. The protocol and research tool (a standardised questionnaire[2] comprising 108 questions[3]) were approved by ethical committees in the project countries.

The analysis of the data[4] obtained from the interviews provided input into the subsequent qualitative phase of the research project, carried out in September 2004 with representatives of immigrant communities (focus groups) and the health and social services (workshops) in each country. The qualitative research focused primarily, though not exclusively, on the issues of access to health and social services and access to information about HIV/AIDS.

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[1] The five participating countries decided to follow the definitions of "immigrant" used by the World Health Organisation in its Global Programme on AIDS (1995) (see also the Glossary of Terms in Appendix 4). Immigrants were therefore classified as follows: regular immigrants with permanent residence permits, regular immigrants with temporary residence permits, short-term visitors, irregular immigrants with no residence permit or visa, refugees, asylum-seekers and students. The distribution of immigrants according to these categories for each of the project countries was obtained from Question 33 of the quantitative tool: "What kind of residence permit do you have?"

[2] Questionnaires available on request from info@crrps.org in the following languages : English, German, Italian, Greek, Spanish, French, Romanian, Russian, Arabic, Kurdish, Albanian, Turkish and Serbo-Croat.

[3] In Italy, the last question, requesting the interviewee's consent to the use of the data provided, was substituted by a separate form, in response to the recommendation of the Italian ethical committee.

[4] Cross country statistical report available on request from info@crrps.org (in English and Italian).

A.1.2 Cross-country summary of the quantitative findings in the five project countries

Main characteristic of interviewees: A total of 739 males and 840 females, including 251 sex workers, were interviewed. In the general sub-group,[5] 55.7% of those interviewed were men and 44.3% women. 36.7% of the general sub-group were 25 years and under, compared with 51% of the sex worker sub-group. The final distribution according to macro-area of origin was as follows: South-Eastern Europe (including Albania, Turkey and the former Yugoslavia) 30.7%; Eastern Europe 22.6%;[6] Sub-Saharan Africa (17.3%); Asia and the Middle East (17.3%); North Africa (11.8%); Latin America (6.8%) and other countries. Sex workers came mainly from Eastern and South-Eastern Europe (68%) and Sub-Saharan Africa (8.5%) followed by North Africa (8.5%) and Latin America (4.4%). In Spain, Italy and Greece the average length of stay was lower (1, 2 and 4 years respectively) than in Austria and Germany (5 and 8 years respectively). Reasons for migration were primarily economic in Italy and Spain (more than 80% of interviewees). There was a higher proportion of immigrants present for political and humanitarian reasons in Greece (27.6%), Germany (24%) and Austria (29.7%) than in Spain and Italy. In terms of knowledge of the host country language, people from the Middle East (mostly Iraqi refugees in Greece) had the greatest difficulties, followed by Sub-Saharan Africans. 53.4% of interviewees had at least a high school certificate. More than half of the interviewees were single or separated/divorced/widowed. Greece and Italy had the highest percentage of homeless immigrants or people living in abandoned property (20.6% and 12.4% respectively). The highest percentage of overcrowding (more than 4 people per room) was in Greece. Migrants in Germany and Austria reported the highest levels of negative attitudes on the part of host country nationals (24.1% and 18.7% respectively), compared with 8.5% in both Italy and Spain. The highest level of negative attitudes experienced was reported by Sub-Saharan Africans (25%, compared with 14.1% in the whole sample).

Health status and health coverage: 80% of immigrants rated their health status from good to excellent. 29% of the whole sample stated that their health was worse than before arriving. This figure rose from 20.8% in people who had been in the host country for less than one year to 34.5% of people in the host country for more than 5 years. The percentage of reported health coverage (national insurance schemes or NHS health cards) was as follows: Spain 78%, Austria 70.2% Germany 65.8%, Italy 57.7% and Greece 28.8%. 43.5% of the sex workers claimed to have some kind of health coverage compared with 63.5% of women from the general subgroup. Reported difficulties in obtaining health coverage were the greatest in Greece (45.1%) and lowest in Spain (7.6%).

Knowledge and use of health services: there was a significant difference between regular and irregular immigrants in the knowledge of where to find NHS services, emergencies, hospitals, gynaecologists and STI clinics. Women had a better knowledge than men of the following services: GP/public health services, private doctor, mental health services, emergencies and hospital. Sex workers had less knowledge of most of the main services, but better knowledge of where to find STI clinics. The main source of information about the health and social services was family and friend/migrant community (word of mouth), whereas the mass media (particularly in the country of origin) was the main source of information on HIV/AIDS.

Satisfaction with health services: the overall percentage of immigrants who were fairly or completely satisfied their experience of the health services in the whole sample was 69.1%, (86.1% in Italy, 81.8% in both Spain and Austria, 74% in Germany and 44.6% in

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[5] Sub-sample excluding the sex workers.

[6] Interviews took place prior to the recent enlargement of the EU and thus included people from the Czech Republic, Lithuania and Poland, in addition to Belarus, Bulgaria, Moldova, Romania, the Russian Federation and Ukraine.

Greece). The main problems reported were communication problems (40%), long queues (30.6%), inconvenient opening hours (28.5%) and unfriendly staff (21.7%).

Knowledge and information on HIV and STIs: approximately 50% of interviewees said that they were quite sure what HIV was in all countries except Greece (16%). The lowest subjective knowledge was among people from the Middle East and South-Eastern Europe (55.6% and 42,1% respectively). No significant differences in subjective knowledge were found between men and women or between sex workers and the rest of the population. In terms of objective knowledge (based on a score), Latin Americans and Sub-Saharan Africans were the best informed of the modes of transmission of HIV. No difference in objective knowledge of transmission was found between sex workers and women in the general sub-sample. Knowledge of STIs was generally lower than that of HIV/AIDS. Women had better knowledge of all STIs than men. Latin Americans and Eastern Europeans were best informed on STIs. The best known STIs were syphilis, gonorrhoea and hepatitis. Sex workers had better knowledge of STIs than other women (except in the case of Italy, where there was no difference).

HIV test: 40% of all immigrants did not know that they had the right to a free HIV test. The best informed were Latin Americans in Spain and Sub-Saharan Africans in Italy. Men (34.6%) and sex workers (40.7%) were both better informed than women in the general subgroup (28.9%). Sex workers were best informed in Italy and Spain, due largely to the fact that many were recruited through outreach services. 31.4% of all interviewees stated they had had an HIV test, with slightly more women tested (28%) than men (24.6%). 42% of the sex workers said they had not been tested. In the general sub-group, the highest proportion of people who had been tested was in Italy, Spain and Germany. The highest percentage of sex workers tested was in Italy and Spain (due also to recruitment methods), and the lowest in Greece (only 28.2%). Only 31% of people tested said they had received counselling before being tested or when receiving the results. Male immigrants were more worried about getting HIV (48.1% rather or very worried) than female (32.8%). The highest percentage of those who were “very” worried was among people from the Middle East (48.6%).

Sexual behaviour and condom use: 64% of interviewees who had had a casual sexual partner in the last 12 months said that they did not always use a condom. The highest percentage of condom use with casual partners was among Latin Americans (55.8%), and the lowest was among people from Middle East (13.7%). There was no significant difference between sex workers and other women who stated that they always used condoms with steady (not commercial) sexual partners (9.3% and 8.6% respectively). Just over half of the sex workers said that they always used a condom during vaginal intercourse with clients. The main reasons given for not using condoms were because the client paid more (68.8%) or because the client did not want to use them (61.6%). The highest percentage of sex workers who answered that they would have sex anyway even if the client did not want to use a condom was among Sub-Saharan Africans (44.4%), compared with 17.5% of Eastern Europeans, 9.5% of North Africans and 0% of Latin Americans.

Contraception and abortions: 14.9% of women in the general subgroup said they had had an abortion since arriving in the host country, ranging from approximately 20% in Austria, Germany and Italy to approximately 4% in Greece and Spain. The percentage among sex workers was almost double, at 27.1% (Austria 47.4%, Italy 37%, Spain 18.8%, Germany 14.6% and Greece 11.8%). In the whole sample, the highest rate of abortions was among Sub-Saharan African women (23.2%). The most frequently used contraceptive was the condom (33.4%), followed by the pill (22.3%). 12% of the sex workers said they used no contraceptive at all with steady or other (non-commercial) partners, compared with 22.3% of women in the general sub-sample.

A.1.3 Summary of main suggestions to emerge from the qualitative research[7]

Suggestions by health providers	*Suggestions by migrants*
1. General comments on service reorientation	
Aim for integration of services for migrants and nationals. Establish “special services” and increase outreach where necessary for vulnerable migrants.	Do not create a two-tier system where migrants only receive “migrants’ services”. Make special efforts to reach irregular migrants and understand their situation.
Conduct regular needs assessments. Introduce basic quality standards . Conduct more qualitative research among immigrant communities	Conduct ongoing needs assessment. Introduce quality control/assessment mechanisms in health service provisions.
Promote training courses for health providers on differences in the perception of health and illness, religious prescripts determining health behaviours and patterns of action when a health problem arises.	Reduce “uncontrolled” work by some NGOs, resulting in duplication and fragmentation of available resources.
Include courses on transcultural medicine in the curriculum of medical schools and offer internships with health services and other organisations working with migrants.	Provide health professionals with more information and training on migrants’ cultural background and on the legal issues affecting their access to the services.
	Promote courses in civic education and host country language for migrants to enable them to learn about the host country’s legal and social system and codes of behaviour.
2. Information on health services and on HIV	
Provide more and better information on how the health system works, including referrals systems and physical location of services	Establish a coordination office between the health services and related services dealing with the health of migrants. Appoint a liaison person linked with health authorities at points of first arrival.
Translate information tools and materials, including for example clinical assessment forms. Design and use video-based educational materials to be broadcast on in local TV channels on a wide range of health-related topics.	Provide more information on health services, including much more information in languages understood by migrants, especially on HIV/AIDS.
	Do not focus on specific groups, to avoid stigmatisation and discrimination.
Combine written information with personal counselling (cultural mediators and peer educators). Use new technologies, such as video-conferences	Present information in ways accepted by migrant communities (including word-of-mouth, and even a comic touch). Promote the use of positive role models from the

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[7] Full cross-country analysis available on request from: psycho@iom.int

to facilitate mediation in health centres.	migrant communities and countries of origin.
3. Access to health services	
Introduce, or increase availability of, cultural mediators.	Increase use of cultural mediators, including in emergency services. Attempt to transcend need of cultural for mediators in the long term.
Fix appointments.	Extend opening hours of services, offering flexible hours for migrants and groups with special needs.
Ensure that front desk staff are culturally and linguistically competent.	Employ more health staff recruited from migrant communities.
Create a directory of health professionals who can communicate with migrants in their languages.	Establish multi-cultural support teams in clinical settings.
	Ensure that economic migrants and asylum seekers are recognised as distinct categories, ensuring full NHS access to asylum seekers.
Use less detailed personal data when attending to irregular migrant patients.	Introduce a more human approach (client-centred reception) to offset the perceived lack of personal attention in the services.
4. Involvement of migrants	
Maximise contribution of CBOs (community-based organisations) by involving them in decision-making and planning processes.	Promote greater involvement of migrants in service delivery, allowing them to take more responsibility for their health.
Launch initiatives to build trust between communities and the health system. Promote an advocacy role for migrants, to allow them to speak out for their rights.	Strengthen long standing aid and mutual support organisations and foster the creation of new ones, including by providing some financial assistance and meeting-places.
Set up cooperation schemes with doctors from the countries of origin of the migrant communities.	Use migrant representatives to inform health and related professionals about the culture, tradition and habits in migrants' host countries, especially where there are implications for care encounters (e.g. compliance with doctor's advice). More political support and commitment is needed to advance the agenda of improving migrants' health. Give migrants a voice in the media.

A.1.4 Austria[8]

Summary of quantitative research findings

General description of sample: A total of 304 immigrants were interviewed in Vienna and Graz. All were first generation immigrants, and 6% had acquired Austrian citizenship. One third had a household income below the Austrian poverty line. A high percentage were single. 68% said that they spent their spare time with other people from their country, and 27% participated in an organization run by their community.

Knowledge and use of health and social services: Overall, migrants were well informed of where to find health and social services in their area, in particular hospitals, public health care services/doctors (GPs) and the emergency services. Knowledge of more specialised health care was lower, and 7% of respondents did not know where to find any of the health services. Respondents with regular legal status knew and used significantly more health services than those without, mainly NHS services and GPs. There was a significant correlation between speaking German and knowledge of the health and social services. Only 20% of participants answered the question about migrants' right to free access to public medical services correctly. One third of the sample was not covered by health insurance, compared to 2% of the Austrian population. 15% of interviewees said they had to cover the costs of health care themselves

Satisfaction with services: Although a relatively high percentage of respondents who had used the health and social services were either completely or fairly satisfied, almost 50% had experienced difficulties with the health services and 40% with social services. These difficulties were mainly attributed to communication problems and the unfriendly attitude of staff, but also to long queues, unsatisfactory treatment of illness by health services and discrimination.

Knowledge of HIV/AIDS: One quarter of respondents was not sure what HIV/AIDS was or did not know at all. There was a high correlation between the level of education and knowledge of HIV/AIDS. One quarter of immigrants said that they had never received information about HIV/AIDS. Men were more knowledgeable about modes of transmission and protection than women. Sex workers knew less than other women. Only one fifth of respondents were very or rather worried that they might get infected with HIV.

Information about HIV/AIDS: About half of all respondents had received HIV/AIDS related information in Austria, but only 17% in their own language, although a very high number of respondents did not speak and/or read German. Significantly more South-Eastern Europeans had received information in their own language (34%) than immigrants from other regions. Half of the respondents (with significantly more sex workers than respondents from the general population sample) thought that they needed more information about HIV/AIDS. Whereas only one third of the interviewees said that they had received HIV/AIDS related information from Austrian public health services, almost two thirds perceived health professionals as one of the best channels of information on HIV/AIDS.

Condom use: Only half of the respondents had talked about HIV/AIDS with their (non-commercial) partner. Approximately one quarter of men and women (general subgroup) said they used condoms with casual sexual partners only sometimes, rarely or never. Half of the men interviewed said they always used condoms with casual sexual partners but only one quarter of the women, although only 28 out of the 123 women answered this question. More than one third of respondents said they would have full sex "anyway", even if the partner refused to use a condom. Respondents from the general population

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[8] Full reports available on request from: oberzaucher@euro.centre.org

sample said that the main reasons for not using condoms were that they trusted their partner, that they did not think they were at risk of HIV and that they were not used to using condoms.

Sex workers: 40% of the sex workers said they would have sex anyway, even if the client refused to use condoms. 59% of sex workers reported that clients paid more for unprotected sex. Almost 60% of sex workers reported high levels of regular alcohol consumption, which might reduce their condom negotiation abilities as shown in other studies. The most common reason for not using condoms was that clients refused to use them, and almost one quarter of the sex workers said that they did not use condoms because they “did not have any”.

HIV test: 46% of the sex workers said that they had never had an HIV test, compared to 76% of the respondents in the general sub-group. Only one quarter of respondents who had had an HIV test said they had received post-test counselling and the proportion of those who had received pre-test counselling was not much higher. A high number of respondents were not sure if the results of an HIV test would be kept confidential.

Summary of qualitative research results

Method: Two focus groups with immigrants were held, one with African immigrants and one with immigrants from Eastern and South-Eastern Europe. In addition, a workshop with health and social service providers was organised to gather their views on HIV/STI prevention for immigrants.

Factors influencing knowledge about HIV/AIDS: Factors influencing knowledge about HIV/AIDS included age, length of stay, gender, first, second or third generation, social class, integration in the labour market and area of origin (urban or rural). Migrants said that HIV/AIDS was rarely discussed within their communities because risk awareness was low and sexual issues were ‘taboo’ in many cultures. The Sub-Saharan Africans were glad ‘to have left AIDS behind in Africa’ and did not want to be associated with this issue because they feared stigmatisation. They therefore seemed less open to receiving HIV/AIDS related information in Austria than the immigrants from Eastern and South-Eastern Europe

Vulnerable groups: These included married men who frequently sought commercial sex in neighbouring countries; migrants without legal status; men who had several wives in their home country and Austria and frequently travelled between them; sex workers, partly because they were paid more for unprotected sex; and migrant women who tried to get pregnant because they (wrongly) believed that they would receive a residence permit if the baby was born in Austria.

Barriers to access: Illegal status and lack of health insurance were seen as the major barriers to accessing the health care system. Cultural norms could make access to health services more difficult. Turkish participants said that women from traditional families, who were not in much contact with the society of the host country, were not free to access health services. It was also said that some men deliberately kept information on issues such as HIV/AIDS away from women, partly to protect them from unpleasant realities.

HIV test: Free and anonymous HIV testing and counselling facilities were rarely attended by migrants, and a number of explanations were offered: language barriers; fear of doctors; fear of contracting infections in Austrian hospitals and other testing institutions; lack of knowledge of the AIDS help organisations offering HIV tests; fear of medical malpractice; lack of knowledge about treatment options; and fear of stigmatisation and exclusion. Migrants without health insurance were reported to be particularly reluctant to find out about their status because they would have only very limited access to medical care. It was suggested that more people would use HIV testing services if they were based in the clinical setting and not in a separate organisation, such as the AIDS Help organisation. Testing and treatment would thus be more anonymous. Support groups for HIV positive people were urgently needed.

Service reorientation: There were some misconceptions about treatment methods in Austria and distrust of Austrian doctors and health care. Participants agreed that there was a need for more cultural mediation between migrants and the health services to explain procedures and build trust in the system. More collaboration between Austrian health institutions, CBOs, NGOs and cultural health mediators was needed.

Information on HIV/AIDS: The distribution of written information materials to migrants needed be combined with personal interactions with health professionals and informed members of the migrant communities (health mediators, outreach work). Repeated contacts were necessary to build migrants' trust, particularly as regarded sensitive sexual issues. The last public awareness campaign dated back more than five years, and new information campaigns on HIV/AIDS both for immigrants and Austrians were urgently needed.

A.1.5 Germany[9]

Summary of quantitative research findings

Method: A total of 315 migrants were interviewed in Germany, 260 from the general migrant population (Sample A) and 55 from a group of female migrant sex workers (Sample B).

Description of Sample A: The largest group was from South-Eastern Europe (35%), followed by Sub-Saharan Africans (32.3%), Eastern Europeans (23.8%) and Asians (4.6%).The average age of the interviewees (both men and women) was 30.4 years. One third of the sample was married and one third single. 18% were separated or divorced. 32.7% lived with their partner, and of these, 18% also with their children. 23% of women were single parents and 13% of men. Despite the relatively high level of education (47.7% had middle or higher education degrees), 32.2% of the migrants were unemployed (29% of women and 36% of men). 29.6% had a full or part time job. 58.2% lived on less than €1000 a month, thus living under the official German poverty line of €1100. Over a third had left their home country for family reunification (35.8%), 20.4% for political reasons and 17.5% for economic reasons. 45.4% of interviewees had a long-term residence permit and 14.2% a short-term permit. At the time of the interview, 11.2% were waiting for the renewal of their permit or did not have a valid permit.

Description of Sample B: The largest group of sex workers interviewed came from Eastern Europe (85.4%), followed by South-Eastern Europeans (7.3%) and Sub-Saharan Africans (4.9%). The average age of this group was 26.5 years. A very high percentage (78.6%) came to Germany for economic reasons. The majority (67.5%) had a short-term residence permit, 12% had a long-term one and the rest were either in the process of renewing their residence permits at the time of the interview, or did not possess one.

Basic knowledge of HIV/AIDS: A substantial number of the migrants interviewed felt that they were not well informed on the subject of HIV/AIDS. Only half of sample A (49.5%) was sure of what HIV/AIDS was, compared to 65.9% of sample B (and 100% of the German population). 80.8% of Sample A and 93% of Sample B were sure that unprotected sex was a mode of transmission of HIV. 32.2% of Sample A and 53.7% of Sample B thought that kissing was risky, and 13.1% and 12.2% respectively believed that one could become infected through sharing a cup or a glass. Only 77.3% of Sample A and 95.1% of Sample B recognised that sharing needles was a source of transmission. 21% of Sample A and 47% of sample B were very worried about getting HIV/AIDS. In Sample A, the East Europeans were the most worried (over half), and women from South-Eastern Europe were the ones with the least knowledge about transmission routes. A higher percentage of sex workers (Sample B) had received information on HIV/AIDS than Sample A (87.8% compared to 72.5%), and almost three quarters of both samples had received information in a language that they understood very well. In Sample A, the Sub-Saharan Africans were better informed than the South-Eastern and Eastern Europeans.

Information related to HIV/AIDS: As with the German population, the mass media played a key role in the dissemination of information among migrants, followed by personal networks. A shockingly low percentage knew about the possibility of an anonymous and free HIV test: only 24% of Sample A and half of Sample B.

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[9] Full reports available on request from : e.steffan@spi-research.de

Summary of qualitative research findings

Methodology: Two focus groups were held, one with Sub-Saharan Africans (9 persons) and the other with Eastern Europeans (9 persons). A health providers' workshop was attended by 10 health professionals.

Results: Migrants

Attitudes towards HIV/AIDS: The African participants were not surprised that the study showed that the African interviewees were the ones that scored the highest in the HIV/AIDS knowledge scale. The problem of HIV/AIDS, both in Africa and in Germany, was far outweighed by the urgent need to make a living. The issue of discrimination of PLWHA was discussed, and it was reported that stigmatisation in the community seemed to be very high – rather than face rejection, many would prefer to remain alone and die of AIDS in silent suffering.

The HIV test: Although most of the focus groups participants had a fairly positive attitude towards the HIV test, for the majority of their community members (especially those seeking asylum) it was of secondary importance. This attitude was not so much related to access to, or the quality of, health service provision, but rather to the general political and social status of migrants, which pushed them further out of the reach of existing offers of support and assistance.

Knowledge of HIV/AIDS: For the group of the East Europeans, the survey showed that the level of knowledge of HIV/AIDS was lower than the other groups, although they had received more information and were surer that their own knowledge was good. A possible explanation lay in the different ways in which HIV/AIDS has been brought to the public agenda in different countries and regions. While in most countries of Sub-Saharan Africa the disease has become a household topic in the last couple of decades, in Eastern Europe it may still be strongly linked with negative connotations and stigmatisation.

Results: Service providers

Need for information: Two main topics were discussed: the reasons why so many migrants did not know about the possibility of anonymous and free HIV testing, and how information materials/campaigns should be organised to reach migrant communities. The participants of the workshop acknowledged that although the HIV test was anonymous and free of charge (a charge had recently been introduced in Berlin), it was not in itself a sufficiently low-threshold intervention to enable migrants to use the service. Large-scale information activities should be undertaken in order to advertise this service better and to bring the offers closer to the potential clients. Even when migrants were well informed about the HIV test opportunities, several other factors deterred them from taking the test: lack of awareness about HIV, general risky life circumstances, illegal status, fear of rejection from their own community and anxiety and inability to cope with a possibly positive HIV diagnosis.

Pre-test counselling: In the light of these deterrent factors, pre-test counselling had a crucial role in offering possibilities for informed decisions and opportunities to change one’s own behaviour. The quality of the counselling process should not be undermined and should not be reduced to a risk assessment only. Communication skills as well as the ability to empathise and to accompany the client in the process of exploration and decision-making were not sufficiently integrated into the work of the HIV/AIDS counselling units.

Sex workers: Both female and male sex workers continued to be exposed to high risks in their daily work and living conditions. The number of migrant sex workers had increased enormously as a proportion of sex workers in most EU countries, including Germany. Male sex workers seemed to be easier to reach than females.

A.1.6 Greece[10]

Summary of quantitative research findings

Description of sample: A total of 351 immigrants were interviewed, 229 males (65.24%) and 122 females (34.76%). The sample also contained 51 female sex workers. The four sampling sites selected in Greece were Athens, Petra, Corinth, and Ioannina. The average age for the whole sample was 28.9 years. The majority of immigrants were from South-Eastern Europe (56.7%), followed by the Middle East (35.3%). This was reflected in the religious beliefs of those interviewed, the majority being Muslim. Among those interviewed, 179 had regular legal status (51%) and 129 were irregular (36%). 37% of immigrants experienced language difficulties in Greece, both speaking and reading. The reasons for migration were primarily economic, political and social, but also humanitarian (a number of those interviewed were asylum seekers). The rate of unemployment among interviewees was high (19.7%) and in 78% of cases, their monthly income did not exceed €750.

Barriers to access: The most frequently cited difficulties regarding access to health facilities and social services were inconvenient location, opening hours, communication problems and unfriendly staff.

Knowledge of HIV: A significant but not completely satisfactory percentage of immigrants seemed to know how to protect themselves from HIV/AIDS (only 39% of interviewees said they were sure or fairly sure of what HIV was). However a very low percentage (6%) had received information material in their own language. 76.4% said they would like to receive more information. Replies to questions on STIs revealed that 37.9% knew about Hepatitis B and C, but half of all those interviewed had never received any information on the subject.

Sex workers: in the sub-group of female sex workers, consistent condom use was below 30% in all types of sexual activity (vaginal, oral or anal). The client's unwillingness to use condoms and offers to pay more for unprotected sex were the main reasons for not using condoms.

Summary of qualitative research

Method: The qualitative research with migrants took the form of two focus groups with a group of 10 immigrants and asylum seekers from Turkey and the Middle East (Iraq and Syria), and a workshop with health service providers. The two main subjects of discussion were access to information on HIV/AIDS and access to the health services.

Access to information on HIV/AIDS: Health providers noted that the country of origin, religion, sex and educational background were the main factors determining the level of information, gaps and misperceptions, and the perception of risk on the part of migrants with regard to HIV/AIDS. In addition, lack of legal status, fear of the authorities, lack of information about the fact that the test was free and distrust that results would be kept confidential explained why so few migrants took the HIV test. A general observation shared by health workers was that the status of the migrant communities in Greece today was not much different from the social opinion and level of information of Greek, and European, society in the 1980s. On the subject of suggestions for information activities, participants called for joint action taken by stakeholders at all levels, from the state to the local community. The same individuals and organisations needed to work together in order to improve the level of information on HIV/AIDS in the general population.

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[10] Full reports available on request from : epoulakida@keel.org.gr

Access to information on the health and social services: Communications difficulties were described as the main problem faced by health workers when treating migrants. Another difficult area was that of differences in culture and mentality, with sex and religion posing obstacles to medical examinations and deterring migrants from seeking help in hospitals or doctors' surgeries. Legal status and insurance coverage also influenced access to medical treatment. Many suggestions were made about the behaviour of health staff and how to improve communications with migrants.

A.1.7 Italy

Summary of quantitative research findings

Method: In Italy, a total of 307 immigrants, including a sub-group of 57 female sex workers, were interviewed in the Veneto Region. The general sub-group was divided equally between two fieldwork sites, the cities of Verona and Padua, whereas the majority of sex workers were interviewed in the area between Padua and Mestre (Venice). Immigrants were recruited with the assistance of the local health and social services and NGOs, and from places frequented by immigrants (shelter for the homeless, bars and ethnic food stores). The sex workers were mostly recruited with the assistance of outreach workers. The immigrants were interviewed by a trained team of male and female interviewers from 18 countries, matched to the ethnic origin/mother tongue of the interviewees.

Description of sample: The sample of immigrants was made up of 129 males and 178 females, the latter including 54 sex workers. 43% were 25 years and under, whereas the remaining 57% were over 26. The average age of the interviewees was 29.3 years. The distribution of regular and irregular people in the general sub-group (excluding the sex workers) was 40% and 56% respectively. 80% of women in the group of sex workers were irregular. In the general sub-group, the interviewees came from three macro-areas: 80 people from North Africa (31.7%), 82 from Sub-Saharan Africa (32.5%) and 91 from Eastern Europe (36.1%). The sex workers came mainly from Eastern Europe (27 women) and Sub-Saharan Africa (21). 3 women came from Latin America and 3 from North Africa. In 90% of cases, the reasons for migration were economic/work or family reunification.

Legal status was one of the main factors influencing access to health care. Regular immigrants consistently had better knowledge (65%) than irregular immigrants (49%) of their fundamental right to use the health services, even though irregular migrants are also entitled to healthcare in Italy. Knowledge and use of the main health services was also influenced by legal status of immigrants: irregular immigrants knew and used the main health services less than regular immigrants. These differences persisted amongst migrants who had been in Italy for more than a year, and cannot therefore be attributed solely to lack of familiarity among recent arrivals. STI related services were also better known by regular immigrants, as well as the right to free HIV testing.

Gender was another important factor influencing access: women immigrants knew their right to health care better than men (60% of women compared to 44% of men). Hospitals and public health care services/GP were best known by women and the hospital was more used by women.

Perceived health status: The research confirmed the “healthy immigrant” phenomenon, with 80% rating their health as good or very good, although it declined in relation to length of stay.

Satisfaction with health services: Of those who had used one or more of the health services in the previous 12 months (three quarters of the whole sample), 86.1% said they were “completely” or “fairly” satisfied. The most common difficulties experienced were long queues and long waiting lists (similar to the complaints of Italian nationals), followed by communication problems.

Knowledge of HIV: In the whole population sample, Sub Saharan Africans seemed to have a better knowledge of the modes of transmission of HIV/AIDS and on the right to a free and anonymous HIV TEST than the other ethnic groups. Nevertheless in the whole sample, the proportion of people informed of this right was low (41%). Levels of knowledge of the modes of transmission of HIV/AIDS were the same among sex workers as for other women in the immigrant population, as was knowledge of STIs. Sub Saharan Africans showed the lowest level of concern about contracting HIV (15% compared to 34% for East Europeans).

Information about HIV: The majority of immigrants said they had already received information about HIV/AIDS, but 75% said they had not received information in their mother tongue in Italy. More than 80% said they would like to receive more information about HIV/AIDS, citing television, health professionals, schools and printed information (leaflets, posters).

HIV test: In the general subgroup, more women (41%) than men (28%) had been tested for HIV. The HIV test uptake was higher among Sub Saharan Africans (50%), and much higher among the sub-sample of sex workers (79%). Only 50% of women believed that the HIV test results were confidential, and the figure was even lower for men: 24%. Only 20% of people tested said they had received counselling before or after taking the test.

Condom use: 51% of the respondents from the general subgroup said that they always use condoms with casual sexual partner, and there was no difference between sex workers and the other women in stated condom use with steady sexual partner.

Abortion: 37% of sex workers and 19% of women in the general sub-group stated that they had had at least one abortion since arriving in Italy (less than 1% for Italian women).

Summary of qualitative research findings

The qualitative research in Italy (Veneto Region) was carried out in September 2004. A one-day workshop with 24 key health and social professionals was held in Verona. Focus groups were held with migrants from Sub-Saharan Africa and Eastern Europe (Verona), migrants from Sub-Saharan Africa, North Africa and Eastern Europe (Padua), cultural mediators from Sub-Saharan Africa and Eastern Europe (Mestre, Venice) and sex workers from Eastern Europe (also held in Mestre, Venice). The qualitative research was based on the main quantitative research findings, focusing in particular on the issues of access to information about HIV/AIDS and STIs and access to healthcare services. The main points, many of which were common to both providers and immigrants, can be summarised as follows:

Health service adaptation: Immigrants found that the health system needed better information and orientation to assist non-Italian speakers in navigating their way through the complex levels of service provision and referral systems, and health professionals agreed. They recommended a set of external guidelines or standards for dealing with users from different cultures, which should be “bottom-up”, i.e. based on the practical, day-to-day experience of practitioners and planners. In particular, health professionals at all levels needed regular refresher courses to update their knowledge of Italian legislation in the area of migration and health, and the trends in migratory flows and emerging needs. More systematic evaluation was also needed.

Achieving a balance between “dedicated” and “integrated” services for immigrant: Outreach work for vulnerable groups was clearly an enormous asset, as could be seen by the levels of satisfaction and compliance among sex workers in Mestre who had benefited from outreach work. Such services continued to be necessary for new arrivals and particularly vulnerable groups. At the same time, there were calls from health service representatives for a shift away from an “emergency” mentality, offering special services for immigrants, towards a more rational use of services and resources available for the whole population.

Empowerment of immigrant communities: Both the representatives of services and the immigrants called for enabling and facilitating measures to allow immigrant communities to take an active part in promoting and caring for the health of their communities. Some associations had been formed, with some assistance from municipalities and trade unions, but these had gradually declined owing to the difficulty of operating on a voluntary basis. Migrants were keen to accept their share of the responsibility for bridging the cultural gap with Italy, recommending more courses in Italian and civic education. They were enthusiastic about reviving existing associations and creating new ones as a means of disseminating health and other messages in their communities.

Cultural factors influencing knowledge and behaviour regarding HIV/AIDS: Levels of knowledge about HIV/AIDS varied considerably among the various immigrant groups. Some could be attributed to the area of origin (rural or city), others to certain beliefs, for example that homosexuality does not exist in some countries and that condom use signifies lack of trust in the partner. Fear of marginalisation if diagnosed HIV-positive was very strong, and many felt that information campaigns in their home countries had concentrated too much on prevention without linking the test to the availability of treatment. More information was needed in Italy: again immigrants warned against the risk of discrimination and noted that few immigrants read Italian newspapers or watched Italian television.

Vulnerability to HIV/AIDS: Immigrants defined the following as “particularly vulnerable”: single people, people separated from their families, former “street children” from Eastern Europe and sex workers who were offered more money in return for unsafe sex. Health professionals noted the emergence of “precarious” situations as a result of the new Immigration Law, where people who had had regular status lost their right to residence and NHS health care if their work contract was terminated. They also noted that the definition of “prostitution” needed to be applied broadly, as other categories of people – including some personal carers (“badanti”) - also did sex work to supplement their incomes.

A.1.8 Spain[11]

Summary of quantitative research findings

Description of sample: A total of 300 immigrants, 252 from the general population and 48 female sex workers, were included in the study sample. They came in equal proportions from North Africa, Latin America and Eastern Europe. The sample was also divided equally between males and females. Overall, 63% of respondents were >25 years and 60% irregular or undocumented. Among the 48 sex workers, 20 were from Africa, 20 from Eastern Europe and the other 8 from Latin America. 62% were >25 years of age, and 54% were undocumented.

Information and access to health care: While the majority of respondents (80.7%) knew the location of primary care facilities, only 62% reported attending a doctor's surgery (GP) when a health problem arose, and up to 25% had not used any service in the last year. About 60% of respondents with children had used antenatal and paediatric services, while only 32% of all female interviewees had been to a gynaecologist and 9% had used family planning services. Although reporting high levels of overall satisfaction (82.6% of respondents were completely or fairly satisfied), nearly one-half of the sample reported having experienced some difficulties, in particular communications (27%), dissatisfaction with treatment of illness (25%), long queues (25%) and inconvenient opening hours (24%). 64.7% of the sample knew about their right to public medical assistance regardless their legal status, while all others believed that some restriction applied.

Knowledge of HIV/AIDS: Whereas accuracy of knowledge seemed to be high with regard to actual major modes of HIV transmission (90% of interviewees were well-informed), a considerable number of respondents thought that certain behaviours not linked to the infection were risky, such as kissing/coming in contact with saliva (37%), using public toilets (17%) or drinking from the same cup as someone with HIV (17%). Female sex workers, in spite of reporting a somewhat higher knowledge, had similar misperceptions. One quarter of the whole sample (most of them North Africans) said they had never been informed about HIV/AIDS. Only 10% of those who had received information in Spain, had received it in their own language.

HIV-related attitudes and beliefs: Stigma and fear associated with an HIV diagnosis prevent the adoption of prevention and early intervention measures. Asked about possible actions they would take if ever diagnosed positive, whilst a majority of respondents would take prescribed drugs (70%), another 12% said they would do nothing or just wait until symptoms appear. 21% would stop having sex. 22% said they would tell nobody if diagnosed HIV positive, and only 29% would talk with a doctor. The distribution of responses among sex workers was similar.

HIV test: Only 44% of the general sub-sample knew that the HIV test was free in Spain, and only 35% knew of the possibility of free treatment. Only about one-half believed that the HIV test was confidential. Overall, sex workers were better informed, with about half of them knowing about their right to free access to both the HIV test and treatment. 33% of the general sub-sample had been tested, compared to 68.8% of sex workers. 70% of respondents from the general population sub-sample and one-half of female sex workers said they had not received any counselling when tested.

Condom use: Only 6% of respondents from the general population sub-sample consistently used condoms with steady partners, against 60.7% who reported using them with occasional partners. Conversely, occasional condom use with steady and casual sexual partners was reported by 56.1% and 32.7% of respondents, respectively. The main reasons

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[11] Full report available on request from: joancarles.march.easp@juntadeandalucia.es

for not using condoms were not perceiving themselves to be at risk (41%), not being used to them (28.6%), or because they decreased pleasure (19%). Compared to their male counterparts, female respondents reported a significantly lower number of sexual partners (61% with one single partner in the last year against 37% of males); a higher incidence of stable relationships (90% against 54%); and a more consistent pattern of condom use with occasional partners (72.2% against 56%).

Sex workers: Risk exposure in sexual encounters seemed to be somewhat higher among the special group of sex workers with both clients and non-commercial partners. The proportion of women consistently using condoms with occasional partners dropped to 61% (against 72.2% of females from the general population), and almost one-half of them reported having full sex even when their partner refused to use condoms. The main reasons for not using condoms were not perceiving themselves to be at risk (45%), or other reasons potentially linked to their partners' decision, such as decreased pleasure (48%), or their partner does not like using them (30%). With regard to decision making with clients, although most women reported always using condoms (80%), nevertheless all the others were inconsistent in protecting themselves, and 23% reported having sex even if the client refused to use a condom. Reported reasons for not using condoms were because the client did not want to use them or paid more for unprotected sex, or simply not being used to them.

Summary of qualitative research findings

Description of sample: Two workshops with health and social providers from primary health care and specialised HIV services were conducted in Granada and Almería. In addition, 4 focus groups (6-10 participants each) were organised with migrant representatives from Sub-Saharan Africa, Eastern Europe, Latin America, and with a group of female sex workers from Eastern Europe. The qualitative research was based on the main quantitative research findings, focusing in particular on the issues of access to healthcare services and information on HIV and related services.

Experiences of and access to health services: Immigrants made an overall positive assessment of their experience when approaching services, although some of them mentioned a lack of personal skills and communication abilities among certain professionals. A need for a more patient-centred approach in doctors' practice and experiences of discrimination and prejudice among certain health providers were also mentioned. Nevertheless, some focus group (FG) participants associated such attitudes with isolated cases and/or staff's time constraints. Other barriers mentioned by both immigrants and providers were: communication problems due to language and cultural differences, fear and distrust among irregular immigrants, cultural differences and unfamiliarity with the organisation of services and how they worked, rigid operating hours - particularly for those employed in agriculture and with full-day working schedules, and providers' excessive work load. Migrants who were irregular, illiterate, recently arrived, young, single and with no community networks or relatives were identified as the most vulnerable groups with regard to access to health information and services.

Irregular migrants: The "*Health Card*" - the special health coverage for irregular migrants in Spain - was very positively assessed as an effective means of increasing migrants' access and confidence in health services and staff. CBOs and NGOs provided valuable assistance in helping immigrants to obtain this "Card". Over-utilisation of the emergency services was attributed to the possibility of obtaining immediate treatment and access to specialists, without requiring any formal identification or procedure.

Knowledge of HIV/AIDS: There were no very significant differences between immigrants and the general Spanish population regarding levels of knowledge of HIV/AIDS. However, a higher incidence of information gaps, misconceptions, fear of stigmatisation and taboos was associated with individuals with lower levels of education and from rural areas in their country of origin. The higher level of public concern about HIV in Spanish society had increased HIV risk awareness among many immigrants, and consequently, the frequency of condom use. But at the same time, according to migrants, anonymity and lack of social control or parental supervision in Spain had also increased the number of sexual partners, and therefore risky practices, especially among younger immigrants and single males facing economic and social deprivation.

HIV test and treatment: Immigrants were usually not informed about the availability and location of HIV-related services, or about their right to freely access HIV testing and treatment services. Language barriers and bureaucratic procedures contributed to this lack of awareness. Lack of information about specialised services in general was also mentioned. Low use of HIV/AIDS preventive services was attributed to a lack of risk awareness; fear of obtaining a positive result and the risk of social rejection, being deported, losing a job, being labelled as sexually promiscuous, a homosexual or a drug user; and distrust of providers' respect for confidentiality. From the providers' point of view, immigrants were currently less suspicious than some years ago: better knowledge of each other and word-of-mouth information within the migrant community had facilitated a relationship of trust and confidence with them.

APPENDIX 2

A.2 SAMPLE INDIVIDUAL SELF ASSESSMENT TOOL IN CULTURAL COMPETENCE[12]

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level.

Please select A, B, or C for each item listed below.

A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

1. _____ I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my service.
2. _____ I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my service.
3. _____ When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families using my service.
4. _____ I ensure that printed information disseminated by my service takes into account the average literacy levels of individuals and families receiving services.

COMMUNICATION STYLES

5. When interacting with individuals and families who have limited proficiency in the host country language I always keep in mind that:
    - ○ _____ limitations in proficiency in the host country language are in no way a reflection of their level of intellectual functioning.
    - ○ _____ their limited ability to speak the language of the host country culture has no bearing on their ability to communicate effectively in their language of origin.
    - ○ _____ they may or may not be literate in their language of origin or the host country language.
6. _____ I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment,

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[12] Source (adapted): National Centre for Cultural Competence, Georgetown University Center for Child and Human Development http://gucchd.georgetown.edu/nccc

interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

7. _____ For individuals and families who speak languages or dialects other than the host country language, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

8. _____ I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

9. _____ When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

10. _____ I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

VALUES & ATTITUDES

11. _____ I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

12. _____ I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my service.

13. _____ I intervene in an appropriate manner when I observe other staff or clients within my service engaging in behaviours which show cultural insensitivity, racial biases and prejudice.

14. _____ I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

15. _____ I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

16. _____ I accept and respect that male-female roles may vary significantly among different cultures and ethic groups (e.g. who makes major decisions for the family).

17. _____ I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

18. _____ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

19. _____ I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

20. _____ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.

21. _____ I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

22. _____ I recognize and accept that cultural and religious beliefs may influence an individuals or family’s reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.

23. _____ I understand that grief and bereavement are influenced by culture.

24. _____ I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups which use my service.

25. _____ Before visiting or providing services in the home setting, I seek information on acceptable behaviours, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups which use my service.

26. _____ I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale covered by my service.

27. _____ I am aware of the socio-economic and environmental risk factors that contribute to health disparities and/or major health problems of culturally, ethnically and racially diverse populations covered by my service.

28. _____ I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic area covered by my service.

29. _____ I avail myself of professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

30. _____ I advocate for the review of my service's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

How to use this checklist:

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level.

APPENDIX 3

A.3.1 FACT SHEETS ON HIV/AIDS

What is AIDS? What is HIV?

AIDS stands for "acquired immune deficiency syndrome". HIV stands for the "human immunodeficiency virus". HIV is a retrovirus that infects cells of the immune system (mainly CD4 cells and macrophages – key components of the cellular immune system), and destroys or impairs their function. HIV infection results in the progressive depletion of the immune system, leading to "immune deficiency". The immune system is said to be "deficient" when it can no longer fulfil its role of fighting off infection and cancers. Some of the diseases strongly associated with severe immunodeficiency are called "opportunistic infections", because they take advantage of a weakened immune system. The symptom complex associated with acquired deficiency of the cellular immune system was called "AIDS" when scientists realised they were witnessing an epidemic of acquired immunodeficiency for which an explanation was lacking.

How does HIV operate?

HIV attacks two major types of cells that are important in the human immune system. The first is known as CD4 cells. These cells organise the body's overall immune response to foreign bodies and infections. The second type of cells that HIV attacks are called macrophages. Macrophages engulf and destroy infections and ensure that the body's immune system recognises them in the future.

Once the virus has penetrated the wall of the CD4 cell it is safe from the immune system because it copies the cells' DNA, and therefore cannot be identified and destroyed by the body's defence mechanisms. Virus particles remain in these cells until their replication is triggered. Once replication is triggered, new virus particles are made. These emerge from the surface of the cell in vast numbers, destroying the cell in the process. These viruses then infect other cells.

Immediately after infection, a person's HIV status cannot be detected using standard tests because sufficient antibodies have yet to be formed. This is commonly called "the window period" and lasts from several weeks to months. At this stage the person is highly infectious as his or her viral load (the number of virus particles they are carrying) is high.

How is HIV transmitted?

HIV is transmitted through sexual intercourse (anal or vaginal); blood transfusion; the sharing of contaminated needles in drug injection; and between mother and infant, during pregnancy, childbirth and breastfeeding. Sharing of infected blood through blood transfusion or injecting drugs is the most efficient way of transmitting HIV. The virus is not transmitted through air or water or by casual contact.

Sexual transmission

The predominant mode of transmission of HIV is sexual. The type of sexual practice affects the risk of transmission. Anal intercourse carries a greater risk than vaginal intercourse for the receptive partner. Insertive anal sex is less risky than receptive anal sex but the insertive partner can also become infected. Lesions caused by rough sex or rape can also increase the probability of HIV transmission. In the absence of aggravating factors (such as sexually transmitted infections), the virus tends to be more easily transmitted from males to females during sexual intercourse than vice versa. There is increasing evidence that the male-to-female transmission risk is higher in young girls aged 16 years and less, as compared with the risk to older women before the menopause. This may involve higher biological vulnerability because of immaturity of the genital tract, and in particular of the cervix. There is a small chance that HIV can be transmitted through oral sex, especially if a person has abrasions in the mouth or gum disease.

Stage of illness

The stage of illness of an infected person also influences the probability of transmission. People with HIV are more infectious to a sex partner during the earliest phase of infection (the first few weeks following initial infection with HIV) before antibodies are produced and during the later phase of the disease when the immune system is no longer able to effectively fight the virus. At both the very early and late stages of infection, a person with HIV has a very high number of viral particles in the blood. Unfortunately, many people remain unaware that a person who appears to be in perfect health could be highly infectious.

Sexually transmitted disease

There is scientific evidence that a person with an untreated sexually transmitted infection (STI), particularly involving ulcers or discharge, is on average 6 to 10 times more likely to pass on or acquire HIV during sex. The presence of an STI means that there is more chance of broken skin or membranes allowing the virus to enter or leave the body. The very same cells that the virus is seeking to infect will be concentrated at the site of the STI because these cells are fighting the infection. According to current thinking, the risk of becoming HIV-infected from a single exposure is increased 10 to 300-fold in the presence of a genital ulcer caused by syphilis, cancroids or genital herpes (HSV-2).

Transmission via blood and blood products

Transfer of contaminated blood from one person to another through blood transfusion, use of contaminated syringes or surgical equipment is the most efficient form of HIV transmission.

Mother-to-child transmission

HIV can also be transmitted to an infant during pregnancy, labour and delivery or breastfeeding. Infection at delivery is the most common mode of transmission. Breastfeeding increases the risk of transmission by 10 to 15%.

How reliable is HIV testing?

HIV testing is very reliable, through either antibody tests of tests for the virus itself. HIV antibody tests exceed the performance criteria of most other infectious disease tests in both sensitivity and specificity. Recent HIV antibody tests have sensitivity and specificity in excess of 98% and are therefore extremely reliable.

What is “risky behaviour” in the context of AIDS?

Risky behaviour on the context of AIDS refers to behaviour that increases the chances of getting infected by HIV or transmitting the virus. Such behaviours include: having sexual intercourse without a condom (male or female), practising anal sex, having sex with several partners, having sex with a sex workers, injecting drugs and using unclean equipment, and if HIV-positive, going through pregnancy, childbirth and breastfeeding without voluntary counselling and testing (VCT) and other interventions.

What is antiretroviral therapy?

Progression of the disease can be slowed down but cannot be stopped completely. Antiretroviral (ARV) drugs slow down the replication and, therefore, the spread of the virus within the body, by interfering with its replication process in different ways. The use of ARVs in combinations of three or more drugs has been shown to dramatically reduce

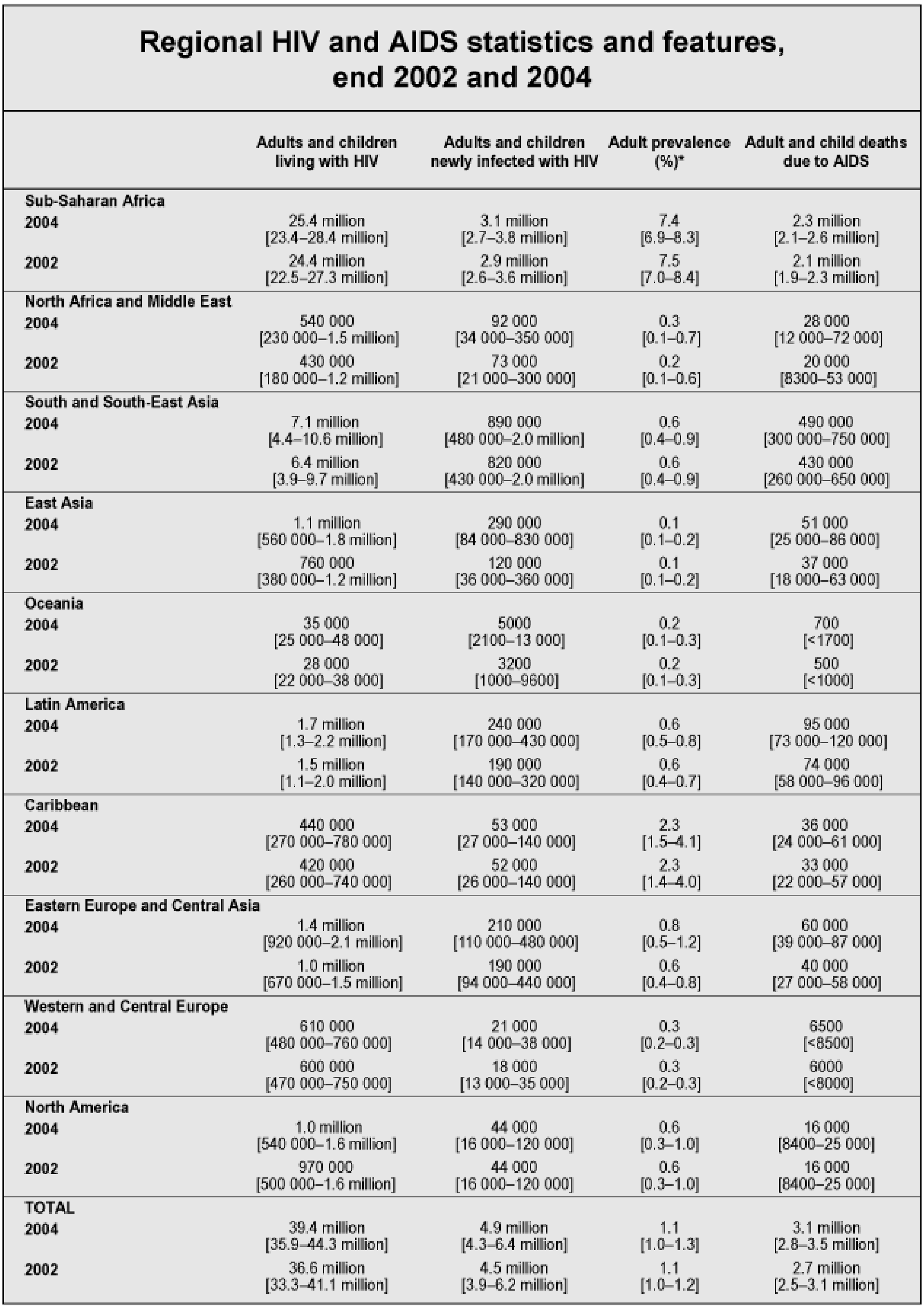
AIDS-related illness and death. While not a cure for AIDS, combination ARV therapy has enabled HIV-positive people to live longer, healthier, more productive lives by reducing viraemia (the amount of HIV in the blood) and increasing the number of CD4+ cells (white blood cells that are central to the effective functioning of the immune system). For antiretroviral treatment to be effective for a long time, different antiretroviral drugs need to be combined. This is what is known as combination therapy. The term 'Highly Active Anti-Retroviral Therapy' (HAART) is used to describe a combination of three or more anti-HIV drugs.

Source: Basic facts about the AIDS epidemic and its impact, UNAIDS Questions and Answers, November 2004, and FAQ
www.unaids.int

A.3.2. REGIONAL HIV/AIDS STATISTICS AND FEATURES (2002-2004)

The following page contains updated statistics on the extent of the HIV/AIDS epidemic worldwide.

Source: UNAIDS HIV Epidemic Update, November 2004
www.unaids.org/wad2004/report.html



Regional HIV and AIDS statistics and features, end 2002 and 2004

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
Sub-Saharan Africa				
2004	25.4 million [23.4–28.4 million]	3.1 million [2.7–3.8 million]	7.4 [6.9–8.3]	2.3 million [2.1–2.6 million]
2002	24.4 million [22.5–27.3 million]	2.9 million [2.6–3.6 million]	7.5 [7.0–8.4]	2.1 million [1.9–2.3 million]
North Africa and Middle East				
2004	540 000 [230 000–1.5 million]	92 000 [34 000–350 000]	0.3 [0.1–0.7]	28 000 [12 000–72 000]
2002	430 000 [180 000–1.2 million]	73 000 [21 000–300 000]	0.2 [0.1–0.6]	20 000 [8300–53 000]
South and South-East Asia				
2004	7.1 million [4.4–10.6 million]	890 000 [480 000–2.0 million]	0.6 [0.4–0.9]	490 000 [300 000–750 000]
2002	6.4 million [3.9–9.7 million]	820 000 [430 000–2.0 million]	0.6 [0.4–0.9]	430 000 [260 000–650 000]
East Asia				
2004	1.1 million [560 000–1.8 million]	290 000 [84 000–830 000]	0.1 [0.1–0.2]	51 000 [25 000–86 000]
2002	760 000 [380 000–1.2 million]	120 000 [36 000–360 000]	0.1 [0.1–0.2]	37 000 [18 000–63 000]
Oceania				
2004	35 000 [25 000–48 000]	5000 [2100–13 000]	0.2 [0.1–0.3]	700 [<1700]
2002	28 000 [22 000–38 000]	3200 [1000–9600]	0.2 [0.1–0.3]	500 [<1000]
Latin America				
2004	1.7 million [1.3–2.2 million]	240 000 [170 000–430 000]	0.6 [0.5–0.8]	95 000 [73 000–120 000]
2002	1.5 million [1.1–2.0 million]	190 000 [140 000–320 000]	0.6 [0.4–0.7]	74 000 [58 000–96 000]
Caribbean				
2004	440 000 [270 000–780 000]	53 000 [27 000–140 000]	2.3 [1.5–4.1]	36 000 [24 000–61 000]
2002	420 000 [260 000–740 000]	52 000 [26 000–140 000]	2.3 [1.4–4.0]	33 000 [22 000–57 000]
Eastern Europe and Central Asia				
2004	1.4 million [920 000–2.1 million]	210 000 [110 000–480 000]	0.8 [0.5–1.2]	60 000 [39 000–87 000]
2002	1.0 million [670 000–1.5 million]	190 000 [94 000–440 000]	0.6 [0.4–0.8]	40 000 [27 000–58 000]
Western and Central Europe				
2004	610 000 [480 000–760 000]	21 000 [14 000–38 000]	0.3 [0.2–0.3]	6500 [<8500]
2002	600 000 [470 000–750 000]	18 000 [13 000–35 000]	0.3 [0.2–0.3]	6000 [<8000]
North America				
2004	1.0 million [540 000–1.6 million]	44 000 [16 000–120 000]	0.6 [0.3–1.0]	16 000 [8400–25 000]
2002	970 000 [500 000–1.6 million]	44 000 [16 000–120 000]	0.6 [0.3–1.0]	16 000 [8400–25 000]
TOTAL				
2004	39.4 million [35.9–44.3 million]	4.9 million [4.3–6.4 million]	1.1 [1.0–1.3]	3.1 million [2.8–3.5 million]
2002	36.6 million [33.3–41.1 million]	4.5 million [3.9–6.2 million]	1.1 [1.0–1.2]	2.7 million [2.5–3.1 million]

APPENDIX 4

GLOSSARY OF TERMS AND KEY WORDS

Accessibility of health care: a measure of the proportion of the population that reaches appropriate health care. It takes account of financial, geographical and cultural accessibility. Cultural accessibility considers whether access to health services is impeded by cultural taboos. Three examples are provided by WHO: (i) Can women use reproductive health services if all the physicians in the facility are males? (ii) Will persons who belong to an ethnic minority use services that are staffed by the majority population? (iii) Will persons use health services for processes that are considered natural, that is without the need for health intervention (such as pregnancy)?

Acculturation/Assimilation: Acculturation is the degree to which an individual from one culture has given up the traits of that culture and adopted the traits of the dominant culture in which he or she now resides. Assimilation is a closely related process to acculturation and is viewed as the social, economic and political integration of a cultural group into a mainstream society to which it may have emigrated or otherwise been drawn.

Asylum seeker/refugee: An asylum seeker is a person who has entered a country or is seeking to enter, and has appealed to the authorities of that country to be recognised as a refugee and allowed to remain temporarily or permanently. A refugee is a person who, owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality (or habitual residence if stateless) and is unable or, owing to such fear, is unwilling to avail himself/herself of its protection. Recognition as a refugee can be granted by the host country, in accepting an asylum seeker's claim, or by the un high commissioner for refugees.

Community: A specific group of people who share a common identity, culture, values and norms and are arranged in a social structure according to relationships which the community has developed over a period of time. A community is often defined by geography, but may be defined by the people themselves – a group with similar ethnic origins, for example, or people who share the experience of living in poverty.

Community based organisation (CBO): Organisation active on a local or community level, usually small, modestly funded and largely dependent on voluntary, rather than paid, effort. Can be seen as distinct from the larger, professionally staffed agencies which are most visible in voluntary sector profiles.

Cross-cultural/Multicultural/Transcultural: The term multicultural refers to a population whose individuals come from various different cultural/ethnic backgrounds. The terms cross-cultural or transcultural refer to a reciprocal process whereby members of two or more different cultural groups are enriched by learning about and understanding each other's values and characteristics.

Culture: There are many ways to define the term culture. One of the most longstanding, but no less valid, is: "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of the society" (Tylor, 1871).

Cultural competence: A process for effectively working within, and participating in, the cultural context of an individual or community from a diverse cultural or ethnic background by learning to be sensitive to, and respect, cultural differences. Cultural competence in health programmes refers to interventions that are relevant and acceptable within the cultural framework of the population to be reached (see also *migrant friendly*).

Cultural/transcultural mediator: A cultural mediator is a trained member of an ethnic group who serves as a facilitator, link worker or intermediary by assisting members of that ethnic group in using the services of the host country and informing service providers in the host country of the group's needs and characteristics.

Determinants of Health: The range of genetic, social, economic and environmental factors which determine the health status of individuals or populations and/or influence their health potential.

Discrimination: A failure to treat all persons equally where no reasonable distinction can be found between those favoured and those not. Discrimination (on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status) is prohibited under Article 2 of the Universal Declaration of Human Rights.

Disease Prevention: Disease prevention covers measures not only to prevent the occurrence of disease, such risk factor reduction, but also to arrest its progress and reduce its consequences once established. Disease prevention is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.

Equity: Equity means fairness. Equity in health care implies that ideally everyone could attain his or her full health potential and no-one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstances. Equity refers to the fair distribution of resources for care, ensuring lack of discrimination in access to care, as well as fairness in treatment, health outcome and direct/indirect costs (for example travel time and waiting time).

Ethnicity: The sense of identity an individual has based on ancestry and national, religious, tribal, linguistic, or cultural origins. It generally implies that there are shared values, lifestyles, beliefs, and norms among those claiming affiliation to a specific ethnic group.

Ethnocentrism: The assumption an individual makes that his or her way of believing and behaving is the most preferable and correct one.

Evaluation: In health, evaluation is the organised assessment of the relative merits of a procedure or pattern of care. One can evaluate both the process and the outcome of an intervention: process evaluation will tell you how you have achieved certain standards, and outcome evaluation will tell you what the impact has been. Ideally, programmes should be evaluated in both these ways.

Exclusion/marginalisation: Refers to the circumstances of people who cannot benefit from a State's social protection system. It includes individuals who are illegally resident in a country, but also vulnerable groups (such as drug users, commercial sex worker, minors and young people who have left home) and people who may not be registered in any "social category", including some groups of migrant people (Roma).

Expulsion: An act by an authority of the State to secure the removal of a person or persons against their will from the territory of that State.

Health: Good health is defined as a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO). Health is a resource for everyday life, not the object of living and is a positive concept emphasising social and economical resources as well as physical capabilities. Health is a fundamental human right and also an essential component of development, vital to a nation's economic growth and internal stability.

Health (Public Health): The science and art of promoting health, preventing diseases, and prolonging life through the organised efforts of society.

Health professional: Usually refers to medical and clinical staff, such as the GP, nurse, midwife, obstetrician, paediatrician and other specialists.

Health Promotion: Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health.

Health sector: The health sector consists of organised public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related non-government organisations and community groups, and professional associations.

Health status: A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards, usually by reference to health indicators.

Health care system: A formal structure for a defined population, whose financing, scope and content is defined by law and regulations. It provides services to be delivered to persons to contribute to their health, delivered in defined settings such as homes, educational institutions, workplaces, public places, communities, hospitals and clinics. The health care delivery system refers to health care services performed in the primary, secondary and tertiary health care sector; it is the system to deal with the medical and therapeutic measures intended to preserve or improve the health condition of a patient.

Illegal/irregular/undocumented migrants: A person who, owing to illegal or irregular entry or the expiry of his/her visa or residence permit, lacks legal status in the host country. An undocumented migrant is one who, in addition to illegal entry or presence, lacks valid identity papers. (WHO suggests that it is inappropriate to refer to “irregular” or “undocumented” migrants as “illegal” migrants).

Immigrant/Migrant: No universally accepted definition of the term “migrant” exists. It is generally understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of “personal convenience” and without the intervention of a compelling external factor. There are some who argue that conditions of extreme poverty and degradation, threatening the right to survival, can be considered grounds for “forced” as opposed to “voluntary” migration.

Integration: Integration policies seek to achieve positive outcomes for immigrants within the domains of key policy sectors including employment, housing, education, health etc. Newcomers and resident immigrants will be better able to achieve these outcomes if they develop certain skills, such as language proficiency and knowledge of the host society.

Low-threshold: Easily accessible services available to all without a referral. The term generally refers to primary services (GP, family planning clinic, emergency services) or specialist services which do not require a referral (STI clinic).

Multidisciplinary/interdisciplinary: A multidisciplinary approach involves joint interventions by a team of actors from a range of related professional backgrounds (for example doctors, social workers and psychologists).

Multisectoral: A multisectoral approach involves coordinated and/or integrated programmes across a range of related sectors (for example health, social, employment and education).

Migrant mainstreaming: The process of institutionalising at all levels of service organisation and delivery awareness of the needs of a group (in this case migrants) which has hitherto been neglected or disadvantaged. This may require some measures of "positive" discrimination in order to achieve a situation of equal rights and opportunities within existing services.
needs of migrants, particularly to promote access to services (see also *cultural competent*).

Migrant friendly: Sensitive to the cultural, religious and other special needs of migrants, particularly to promote access to services (see also *cultural competent*).

Non-governmental organisation (NGO): NGOs are development organizations that do not belong to, and are not associated with, national or local governments. They range from village-level groups, such as women's self-help groups and local farmer associations, to major independent donor charities.

Outreach: The process of taking services to the people who need them "in situ", useful in reaching vulnerable groups and individuals who would otherwise not avail themselves of mainstream services. Outreach can involve mobile units and the use of cultural mediators and peer educators.

Peer education: Dissemination of information and discussion about specific topics (e.g. safer sex practices, drugs or family planning) by members of a person's own age group, occupation, or social and economic status group.

Primary Health Care (PHC): The first level contact with people taking action to improve health in a community. Primary Health Care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. The WHO Alma-Ata Declaration also emphasises that everyone should have access to PHC and everyone should be involved in it. The PHC approach encompasses the following key components: equity, community involvement/participation, intersectoriality, appropriateness of technology and affordable costs. In a PHC system, all initial (non-emergency) consultations with doctors, nurses or other health staff, as opposed to secondary health care or referral services.

Risk behaviour: Specific forms of behaviour which are proven to be associated with increased susceptibility to a specific disease or ill-health. With regard to HIV/AIDS, high risk activities include unprotected sex and the sharing of needles and syringes.

Risk factor: Social, economic or biological status, behaviours or environment which are associated with or cause increased susceptibility to a specific disease, ill-health or injury. With regard to HIV/AIDS, anything that increases the chances of infection, including: unprotected sexual intercourse; sharing needles that have not been sterilised; being born to an HIV positive mother; and receiving a transfusion of HIV-infected blood.

Social care: Services related to long-term inpatient care plus common services, such as day care centres and social services for the chronically ill, the elderly and other groups with special needs. The borderline between health care and social care varies from country to country, especially regarding social services which involve a significant, but not dominant, health care component (for example, long-term care for dependent older people).

Stigmatisation: Attitudes or actions placing a person or groups of persons in a negative light on account of actual or perceived characteristics, often based on prejudice and leading to social rejection and marginalisation.

Trafficking in persons: The recruitment, transportation and receipt of persons, by means of threat, use of force, coercion, abduction, fraud, deception, abuse of power or payment to achieve control over another person, for the purpose of exploitation, often in the sex trade.

Vulnerable groups: Any group or sector of society that is at higher risk of being subjected to discriminatory practices, violence, natural or environmental disasters, disease or economic hardship than other groups with a state.

Glossary sources include: Council of Europe, European Commission, IOM, WHO, Knipe and Rector 1996, Huff and Kline 1999

APPENDIX 5

Contact details of project partners

AUSTRIA

The European Centre for Social Welfare Policy and Research is a UN affiliated intergovernmental organisation with a mandate to promote international cooperation in the fields of social development, health and welfare. It carries out social research and provides technical expertise in a variety of fields, including: HIV/AIDS prevention and care, drug demand reduction, the health and social consequences of drug abuse, and inequalities in health.

European Centre for Social Policy and Research
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www.euro.centre.org

GERMANY

SPI Research GmbH focuses research and action on the hard to reach groups (hidden populations), among which the team has carried out a number of successful studies and model intervention programmes. It offers practical training and individual coaching and counselling both in Germany and internationally. The main focuses of research are health, women, drug use and HIV/AIDS prevention.

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Kohlfurter Strasse 41-43 D- 10999 Berlin
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Chief Manager: Wolfgang Heckmann

GREECE

The Hellenic Centre for Infectious Diseases Control (KEEL), Athens, is part of the Ministry of Health and Social Solidarity . It monitors, coordinates and supports activities for the prevention and treatment of communicable diseases, primarily HIV/AIDS. Its main activities are surveillance and collection of epidemiological data, prevention, care, psychosocial support and legal counselling and training. A Mobile Populations Office has been set up for intervention in emergency settings.

Contact: Hellenic Centre for Infectious Diseases Control
6-8 Macedonias Str., 10433 Athens, Greece
www.keel.org.gr

ITALY

The Veneto Regional Centre for Health Promotion (CRRPS) is part of the public health system of the Veneto Region responsible for guiding health planning and evaluation in the area of health promotion. It operates mainly at Regional level, but also facilitates the development of specific programmes carried out by the Health Education Offices of the 21 Local Health Units in the Veneto Region. The Centre's aim is to promote good health through the empowerment of individuals, groups and communities. Its activities include training, research, dissemination of health-related information and policy advisory activities.

Centro Regionale di Riferimento per la Promozione della Salute
Via Marconi 27F,
37122 Verona, Italy
www.crrps.org
info@crrps.org
Director: Dr. Massimo Mirandola

SPAIN

The Andalusian School of Public Health (EASP) is a publicly-owned institution of the Andalusian Regional Health Department. It provides training, consultancy, international co-operation, and research services in the public health and management of health and social services. It promotes teaching, assessment and research activities, and co-operation and exchange in scientific and technical areas on a national and international scale.

Escuela Andaluza de Salud Pública
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18071 Granada, Spain
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Project co-ordinator: Dr. Joan Carles March Cerdá
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Psychosocial and Cultural Integration Unit, IOM ROME

The International Organization for Migration (IOM) has been collaborating since 1951 with governments, institutions, and migrant and civil-society associations to achieve positive results in migration in more than 100 countries throughout the world. IOM's Psychosocial and Cultural Integration Unit provides its expertise in the fields of mental health, trauma, and cultural integration through training activities, clinical and psychosocial support, research and documentation.

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