

Germany Country Report

EU Partnerships to reduce HIV & public health vulnerabilities associated with population mobility



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1 Executive Summary

This report aims to both reflect the Federal government's and the community perspective on health and mobility in Germany. Methods of social research are applied to collate the material. Both authorities and NGOs, Germans and non Germans contributed to this report. The report focuses on health policies and legislation related to HIV/AIDS and TB. It also describes the policies and legal frameworks of migration and looks into prisons and deportation facilities. It tried to elucidate the situation of migrants by mapping the national HIV/AIDS prevalence and TB incidence in foreigners and the health care sector in the big city of Hamburg and the medium sized city of Oldenburg regarding migrants.

There is a legal framework to provide universal access to HIV/AIDS and TB diagnosis and treatment to the entire population. HIV policies are based on voluntary and anonymous access while TB policies are those of control and research. The number of HIV-infections diagnosed in people from high prevalence countries (around 300 of 2600 per annum in total) has remained stable since 2001. Tuberculosis cases (above 6.000 annually in national total) are more often diagnosed in foreigners and foreign born individuals.

Today more than 15.3 million people living in Germany are first or second generation immigrants ("migrants"); over 7 million of these are foreigners. The highest numbers of immigrants are found in the conurbations of Western Germany and Berlin. Very few migrants live in the Eastern regions (4%). The largest proportion of migrants is found among the under six year old children (one third).

Migrants are more rarely employed in gainful employment than nationals and more frequently unemployed. More migrant women than German women are not employed and work as housewives. (36.9% compared to 26.3%). Migrants more often work in the trade, hotel and restaurant industry. While particularly active in the small business sector, migrants in Germany (including refugees, asylum seekers, people on remand and undocumented migrants) are more vulnerable to unemployment, poverty and social marginalisation than the non-immigrants. Centralized and decentralized accommodations are used to detain deportees. In prisons foreigners are over-represented

Hamburg is Germany's major sea port. 120 km from the North Sea the Hanseatic city has some 1.7 million inhabitants. First and second generation migrants account for a quarter of the population. Social segregation is combined with other factors increasing the vulnerability of migrants in the city. Undocumented migrants, female and transgender sex workers are highlighted as experiencing increased vulnerability. A civil society support network is overstretched in its resources. Access to health care for migrants is controversial in Hamburg. In this report the situation in the neighbourhood Wilhelmsburg is described as an example.

Oldenburg is similarly in the North of Germany but has only a tenth of Hamburg's population. Only 5% of inhabitants are foreigners. Among the few HIV/AIDS cases in migrants, most occur among women from high prevalence countries. Some are tested HIV-positive during immigration procedures at the local centralized facility ZAAB Blankenburg. Access to health care and psychosocial support outside the facility is organized in a network of committed public and private actors for e.g. pregnant women with HIV/AIDS. Access for undocumented migrants is organized for deliveries and for critical situations. Staff shortage, geographic distances and the lack of qualified language capacity are highlighted as factors of increased vulnerability.

Migrants who are legal residents and their families have equal access to comprehensive health care including prevention, testing, treatment and care as German nationals.

There is no statutory definition of illegal residence and there is no precise information on the scope of illegal immigration and employment. Irregular migrants have access to HIV-testing and – where necessary -treatment. The quality of health care for undocumented, migrants has not been systematically assessed nor has the health care provided to prisoners and people living in entry - and deportation facilities/assigned quarters been subject to more than punctual transparency through independent research. There are efforts to raise the awareness of migrants for prevention through the production of information materials in different languages but the orientation to migrants' needs is only beginning.

The methods of distributing and taking care of refugees, asylum seekers and people on remand as well as people imprisoned before deportation are being challenged by NGOs. Most recently, the UNHCR criticized the practices. The research provided by this report demonstrates the trauma experienced by individuals (e.g. by being separated and isolated from access to specialized medical and psychosocial care for PLWHA). Geographic distances caused by the method of distribution of irregular migrants are identified as a particular strain on NGOs and on health care providers as well as PLWHIA. Some municipalities cover such expenses on a case-by-case basis.

The instruments in place to develop action, i.e. the National HIV/AIDS Action Plan and the National Integration Plan should be further developed and changes in health associated knowledge, attitudes and behaviour of migrants living in Germany should be further assessed. Health service provision to pregnant women (e.g. anonymous birth), volunteer-based charitable services and initiatives by migrant entrepreneurs as well as the reimbursement of travel expenses for NGOs are identified as practice models.

Civil society with some support could contribute more to health related safety for their migrant employees and their families. Health care providers and hospitals are asking to be freed from notification pressure when caring for undocumented migrants. Civil society proposes a foundation to cover costs of health care for undocumented migrants and the prolongation of the tolerated stay to a medically indicated period. Equally, antidiscrimination efforts should more strongly address marginalization of migrant PLWHA from within their communities.

2 Background and Introduction

The Portuguese EU Presidency is preparing a meeting gathering the AIDS Coordinators of the EU, of the World Health Organisation, its EURO Region and Neighbouring Countries offices, to take place in Lisbon, Portugal, on the 12th and 13th of October, 2007 to discuss and agree on European priority policy and programme recommendations. In this context, and as a background document of the above-mentioned meeting, to be entitled “Translating principles into action”, the International Organization for Migration (IOM) commissioned a study on EU partnership on HIV/TB and mobility. Data were gathered in Bulgaria, Germany, Italy, Malta, Portugal and Hungary. The countries were selected according to their admission to the European Union (founding Member State, and later and recent admission) as well as countries having relevant migration profiles.

Migrants have been of concern as a neglected target group in Germany’s AIDS prevention and care programs. The Ethno-Medical Centre in Hanover became actively involved in HIV/AIDS prevention and health education for and with migrants in 1992. When in 2006, for the first time since the start of the HIV/AIDS epidemic, people from high prevalence countries accounted for the second largest risk group in Germany, a couple of alarm bells were rung. They included statements by Action Against AIDS Germany, representing more than 400 organisations, initiatives and activist, by the Advisory Council on the Assessment of Developments in the Health Care System (Sachverständigenrat 2007) and by key individuals including leading politicians.

This report would not have been possible without the dedicated support of the staff and volunteers at the Ethno-Medical Centre, the support by Frau Gisela Lange and her colleagues from the Federal Ministry for Health (chapters 4.1.1 and 4.2), and the guidance by Lee Nah Hsu and her team from the International Organisation for Migration. We have chosen to limit the description of the German health care system to a minimum and would like to refer the interested reader to a report by the European Observatory on Health Systems and Policies.¹ Steps of reform building on the facts described in this paper are mentioned in our report.

We have – unfortunately – not been able to involve some major actors from civil society and from the public side to contribute to this report. This is entirely contributed to resource and time constraints. No disrespect is intended. We know that Deutsche AIDS-Stiftung (the German AIDS Foundation) has been supporting migrants issues both individually and through projects(also addressing the needs of undocumented migrants and PLWHIV in prison awaiting deportation). The Bundeszentrale für gesundheitliche Aufklärung (BzgA) has developed information materials in a number of languages and materials supporting transcultural mediator programmes. The BzgA has also been instrumental in coining Germany’s international prevention efforts, namely in collaboration with the Gesellschaft für technische Zusammenarbeit (GTZ) and its “Back-Up Initiative” in support of the Global Fund. We hope that future efforts can be more inclusive.

¹ Busse, R, Riesberg, S, Health Systems in Transition - Germany, 2005, <http://www.euro.who.int/Document/E85472.pdf>

3 Methodology of the Study

The specific approach taken in Germany is based on work contributed by governmental authorities, non-governmental agencies and individuals. The NAC collaborated with the EMZ to compile the report. The country policy and legal framework are described from the government perspective and reflected in the community participatory assessment (in Hamburg and Oldenburg, reported by EMZ). The discussion takes reference to the rich body of studies and reports identified and aims to identify common issues and points of concern. Finally, this is only the first version of this report. We are aiming to submit this report to undergo future revision as the evidence becomes more clear and the large number of involved parties takes the evidence into account.

Methods used for the general body of the report:

- analysis of public reports, statistics, guidelines and legislation,
- analysis of scientific research papers and NGO reports (namely by Deutsche AIDS-Hilfe supplied as the National Focus Point of the EU-network AIDS & Mobility, TAMPEP-Germany and the Gesellschaft für technische Zusammenarbeit),
- analysis of data provided by German Competence Network HIV/AIDS, Bundesamt für Statistik, Robert-Koch-Institut, Bundesamt für Ausländer, Migranten und Flüchtling
- analysis of semi-structured (expert) interviews,

Methods used in rapid participatory assessment:

The focus on Hamburg is based on information provided:

- analysis of public reports, statistics,
- analysis of (unpublished) scientific research papers and NGO reports,
- interviews (semi-structured) with 4 physicians, 4 NGOs, 1 GO
- focus group discussion
- community questionnaire (N=115, six nationalities)

The focus on Oldenburg is based on information provided by:

- analysis of public reports, statistics, guidelines and legislation,
- interviews (semi-structured) with 2 physicians, 4 NGOs, 1 GO
- focus group discussion

The focus on prisons and detention centres is based on information provided by:

- literature research
- data provided by governmental organizations (Hamburg Senate)
- 1 expert interview (semi-structured) with a social scientist.

Methods used in Mapping

Mapping relied on guidance provided by IOM (UNDP 2004; Fung 2004). Maps for Hamburg (Statistikamt Nord) and Oldenburg (Stadt Oldenburg 2006a) were chosen from publications.

4 HIV, TB and Migration: Country Context Review

4.1 Country Policy and Legal Frameworks

As a federal state Germany develops national and state policies and legislation. In the following section the national level is described.

4.1.1 HIV/TB Policy and Legal Framework

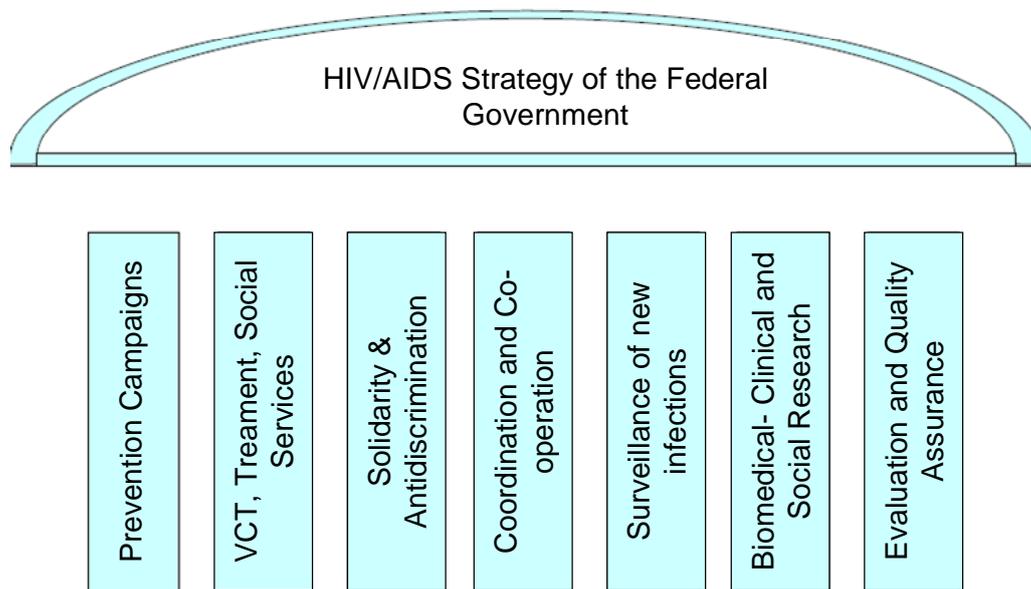
Following previous efforts in strengthening the European HIV/AIDS policies and legislation, and in support of the UNGASS (Declaration of Commitment of the General Assembly of the United Nations of June 25-27th 2001) Germany put HIV/AIDS very highly on the agenda of its presidency of the European Union. Delegations of 40 European States - many of them headed by the ministers of health - met in Bremen and adopted the Bremen Declaration. They committed to political leadership at the national, European and international level in the fight against HIV/AIDS. The Declaration identifies migrants as a particularly vulnerable group and obliges the States to promote civil society including organizations of people living with HIV/AIDS and vulnerable groups. The commitment to raise awareness for HIV/AIDS in all groups of society was taken up in the summit of the Heads of States and governments in their meeting under German presidency.

Germany adopted a national HIV/AIDS strategy in 2005 (Federal Ministries 2005), which was put into concrete terms by a national action plan to implement this strategy in 2007 (Federal Ministries 2007). As Germany is a federal state in which the 16 individual States hold legal authority themselves, the strategy limits commitments to the federal government. The plan appeals to the States, regional and local authorities to pursue prevention, testing, counselling, treatment and care.

These principles of the federal strategy are not controversial between the federal, State and local level but the implementation of actions can differ in the 16 States.

The main goals of the national action plan are:

- prevention of new HIV infections and
- prevention of infections with other sexually transmitted diseases (STIs) and
- further improvement of counselling and care.



Taking into account the UNGASS commitments and the Communication of the European Commission on HIV/AIDS in Europe and the Neighbouring Countries key elements of the German HIV/AIDS strategy are:

1. conducting unbiased awareness and campaigns to prevent new infections and change risk behaviours;
2. providing universal access to voluntary (anonymous) HIV counselling and testing and to adequate therapy for people living with HIV/AIDS, as well as strengthening basic social services;
3. creating a social climate of solidarity and non-discrimination;
4. coordinating activities and ensuring cooperation between government and civil society and among national and international actors;
5. establishing the epidemiology of new infections through surveillance;
6. strengthening biomedical, clinical and social science research;
7. continuously evaluating and improving the quality of national programmes and related activities.

All seven elements are to form integral parts of the overall strategy and should mutually reinforce each other. The action plan notes that during the implementation of action gender-specific aspects of the epidemic need to be accounted for, particularly.

People with an immigrant background are identified as an important target group for both prevention and treatment.

Prevention

In accordance with public policy prevention activities include studies to identify best practices in raising HIV/AIDS awareness among people from a variety of backgrounds. Prevention also provides information and education on sexual and reproductive rights and HIV prevention. Prevention activities also include the provision of means of HIV prevention including harm reduction, as well as prevention materials and services for travellers to regions with a high prevalence of HIV/AIDS. All prevention measures are based on the respect of human rights of the persons concerned and aim at creating acceptance and solidarity for people living with HIV/AIDS.

The Federal Government and the Federal Centre for Health Education cooperate very closely with civil society in the design of prevention campaigns. The largest German HIV/AIDS NGO, the German Association of AIDS Self-Help Groups (DAH, umbrella for some 120 independent local ASOs and self-help networks) is an important partner to the public agencies. The national activities of DAH receive continuing support from the federal government and staff capacity for addressing the issues of migrants was increased in 2007. The Federal Government has taken steps to strengthen collaboration with migrant communities to identify the most appropriate ways to raise the awareness of migrants for sexually transmitted diseases.

The National Integration Plan (Federal Government 2007) addresses challenges of integration for migrants in Germany. It specifically mentions migrant girls and women as target groups for increased efforts in health prevention, sex education and support for the aged (Altenhilfe). The National Integration Plan reaffirms that the German health care system is open to the entire population. It focuses on health needs of migrants further by highlighting the specific needs of those migrants making less use of the health care system – namely those challenged by educational and social disadvantages. Deficits are identified in prevention in dental, maternal and child health. The Federal States (in their authority for health in general) commit to culturally opening the services and to continue to support organisations and initiatives in lowering thresholds to access to care. Cooperative projects in partnerships will aim to address specific target groups. Immigrants living with disabilities are not to be neglected.

Counselling and testing

HIV counselling and testing is provided by every physician and by the local (and some state) public health services. Everybody who lives in Germany including people without health insurance (e.g. undocumented migrants) has access to counselling and testing by the local health authorities according to the Protection Against Infection Act (Infektions-Schutz-Gesetz, IfSG). These services are also to be offered on an outreach basis for people whose circumstances of living entail an elevated risk of infection. People can use these STI-related services anonymously. In individual instances the costs are paid from public funds.

The IfSG does not encompass any general obligation for certain groups of individuals to undergo regular HIV/AIDS tests. Only in justified individual cases can the local health authorities order an examination. The constitutional principle of proportionality must be strictly observed in relation to health examinations, especially as regards HIV infections. The personal data collected may, therefore, only be processed and used for the purposes of protection against infection.

The entry of foreigners with HIV/AIDS into the country is generally not restricted. However, the health of persons wishing to enter Germany can, under certain circumstances, be checked

and taken into account. Only, if there are clear indications of a threat to public health or of dangerous behaviour, persons with an HIV infection can be denied a residence permit.

Treatment and care

Today, everybody residing lawfully is entitled to health insurance in Germany. Insurance premiums will be covered by social security (through social authorities), if people are unable to pay themselves. Statutory health insurance offers the full range of necessary and effective services.

The aim of German policy is for all people in Germany to have access to needs-based medical services. Individuals who have not been insured against the risk of illness so far and who are to be enrolled in the statutory health insurance system will, from 1st April 2007, be subject to mandatory health insurance. Persons who qualify for the private health insurance system will be able, from 1st July 2007, to take out a private insurance at the standard premium at no risk surcharge. Foreigners need adequate health insurance cover if they wish to enter the Federal Republic of Germany.

HIV/AIDS treatment and care are part of the catalogue of benefits under the statutory health and care insurance system open to legal all residents (Social Security Act V and IX). Treatment and care should reflect the newest scientific knowledge and is based on appropriate diagnosis and guidelines. Quality assurance is obligatory.

Every physician (most practice individually) can provide treatment for HIV/AIDS and TB. There are, however, a number of specialized (private practice) centres for the treatment of HIV/AIDS – most of them in the larger cities in addition to services provided by hospitals and university clinics. Special expertise for TB is provided by pulmonologists.

Competent, close-to-home support has yet to be ensured for some people living with HIV and AIDS. This applies often to people who have difficulty accessing the medical service system for example HIV-positive people with an immigrant background, who have to overcome geographical and language barriers. As a result they often only find access to the medical service system at an advanced stage of their HIV infection. Intra-venous drug users living with HIV often require complex medical and psychosocial care, since they often suffer from additional diseases, such as hepatitis C or tuberculosis. The action plan requires health care institutions and doctors to meet the needs of patients from different cultures.

Asylum seekers are entitled to needs-based treatment and medication without health insurance and without legal residence status. This includes medical and dental care in acute cases and also in chronic cases, should treatment be acutely necessary. Costs for ambulatory and hospital care are covered in parallel to laws applying to residents living on social benefit (Social Security Act XII). After a period of 36 months (during the asylum process) the differentiation of acute and chronic illnesses is dropped and asylum seekers can access health services equal to residents living on social benefit. The need to receive care is individually assessed by the treating physician. Individually prescribed treatment of HIV infection (monitoring of laboratory parameters, ART) and other treatments (e.g. for pain) are covered under the Welfare Act for Asylum Seekers (Asylbewerberleistungsgesetz).

The Residence Act forbids deportation if it results in substantial, concrete danger to life, limb or freedom of an individual. Impending danger to life can also arise due to AIDS at an advanced stage if no adequate medication is available in the country of destination. In asylum

cases, a decision on a ban on deportation is taken by the Federal Agency for Migration and Refugees (BAMF) or by the competent aliens' authority after previously consulting the BAMF. The BAMF has to consider the situation reports of the Federal Foreign Office and of international organizations. If necessary in individual cases, Germany's diplomatic missions abroad are requested to provide statements in relation to individual cases. Reports on the possibilities for access to treatment and care for people living with HIV and AIDS in developing countries are to be drawn up on the basis of detailed knowledge of the local care situation. Differences between urban and rural areas are to be taken into account. Qualified non-governmental organizations operating locally have to be consulted where necessary.

Despite the decrease in TB incidence in Germany tuberculosis is still identified to present a significant public health problem, particularly in view of an increasing proportion of MDR-TB in migrants born in high incidence countries in which active TB transmission occurs. There is an identified need to scale up efforts in TB control. Effective strategies for early recognition of tuberculosis and appropriate treatment and contact tracing are required to interrupt chains of infections. Strengthened collaboration of all partners involved in public health as well as enhanced political commitment and financial support investing in public health infrastructure (e.g. local health departments) are being called for. Tuberculosis research for improved drugs, new diagnostics and vaccines is seen to be essential.

TB screening of immigrants

According to §36 of the Federal Protection Against Infection Act (Infektions-Schutz-Gesetz, IfSG) refugees, asylum seekers and repatriates (Spätaussiedler) have to provide a certificate that they are free of infectious tuberculosis to gain admission to a community facility for refugees or asylum-seekers or to an initial reception centre of the Federal Government for repatriates. The certificate for persons aged 15 years or over must be based on an X-ray of the lung. Other groups are not screened for TB.

Medical diagnosis and treatment is guided by identification of clinical symptoms on a case-by-case basis (during physical examination upon immigration procedures in facilities) rather than as a general screening of immigrants. In Hamburg pathology is reported to include TB examination (not HIV) as a screening on unidentified corpses found in the city.

4.1.2 Migration Policy and Legal Context

Introduction and Institutional Framework

German legislation with regard to immigration and naturalization has been reformed in recent years. The most recent reform was the Immigration ACT (enacted on January 1st 2005). With the introduction of the new Immigration Act in 2005, the Central Aliens Register now encompasses new residence categories and simultaneously refines previous ones, allowing for a better differentiation of the figures. As a consequence, the 2006 refugee estimate for Germany cannot be compared to previous ones, and should be considered as provisional pending further details (UNHCR 2007).

Policy and legal issues of migration are within the remit of the Federal Ministry of the Interior. However, the chancellor appointed a Minister of State for Integration in her own office in 2006.

A National Integration Plan (Federal Government 2007) was agreed upon in June 2007 to invest 750 Mio Euro annually in programmes promoting integration e.g. through structured integration and language courses (154 Mio Euro annually from 2008), addressing issues brought up in a common summit with State Governments, NGOs (including migrants organisations) and key individuals. The document makes reference to numerous programmes, addressing a wide variety of issues concerning legal immigrants and the deficits in integration leading to their unequal participation in society and inequitable outcomes (e.g. in health).

The aims of the German migration policy are:

- promoting integration of immigrants in society
- ensuring the safety of citizens and immigrants

Current efforts in legislation are aiming to translate European directives (relating to residence and asylum) into national law, and to solidify the Federal coherence of state policies relating to naturalization, people on remand and their entry into the labour market.

On July 6th 2007 a Federal law was passed introducing the following changes:

- A new residence title for EU citizens (“Erlaubnis zum Daueraufenthalt EU”) was established in addition to the address permission.
- The permanent right to stay for EU citizens and family members was adjusted.
- Victims of human trafficking were given a temporary right to stay to facilitate their collaboration in court proceedings.
- The principle of “requiring and supporting” was introduced through which more integration opportunities are being offered through national programmes while at the same time participation in integration courses is becoming a legally obliged criterion to demonstrate the preparedness of the individual to integrate.
- Foreigners on remand (not covered by the Directive on the Right to Stay, Bleiberechtsregelung) can now enter the labour market equitably after four years of stay.
- A minimum age of sixteen (the legal age in Germany) and basic German language skills were established as requirements for spouses of foreigners before they are allowed to take up residence in Germany.
- A number of changes related to asylum law translated EU directives into German law affecting the legal basis of providing asylum, resulting status, rights

and procedures, and living conditions of asylum seekers. Among these changes is was an extension for the period of tolerated stay needed before individuals can fully benefit from health services (from 36 to 48 months).

- Foreigners can take up residence in Germany, if they invest a minimum amount of 500,000.00 Euros and create at least five jobs (previously 1 Mio Euros and 10 jobs).

In addition the Federal law enacts a regulation (suggested by the Ministers for Interior of the States) generally prolonging the duration of the tolerated stay of migrants, who have lived in Germany for more than six (some 94.000 adults with dependent minors) or eight years (64.000 of these without children). The tolerated term is set to expire by end of 2009². The law is applicable to migrants demonstrating their willingness to integrate, sufficient housing, adequate German language skills, if they have not intentionally made wrong statements to the foreigners office. These individuals are also given the right to work.

² A decision to prolong this period will need to be prepared by the states' ministers for interior. It will be confirmed by Federal law.

4.2 Epidemiological Context

National HIV and TB surveillance systems

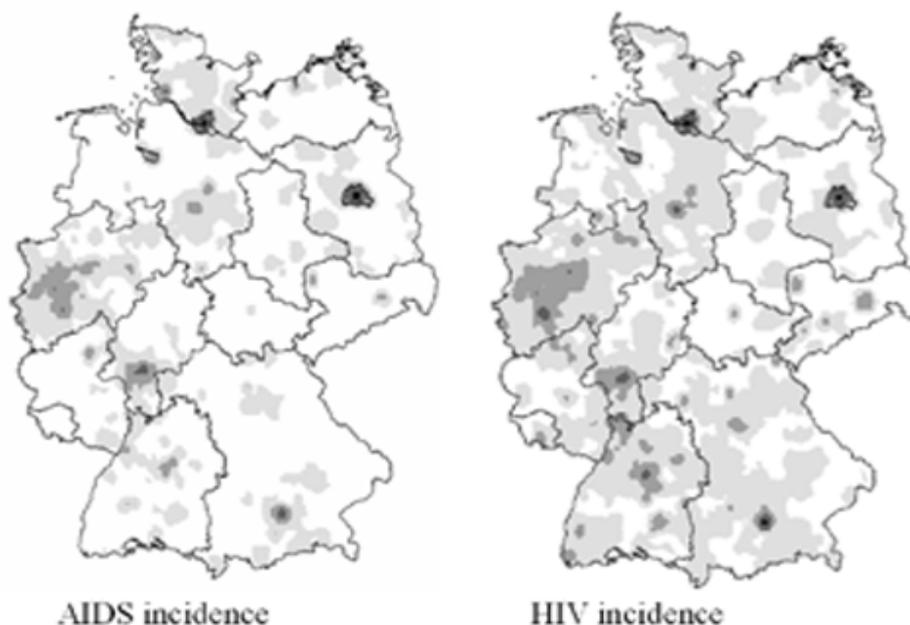
HIV-infections, AIDS-cases and tuberculosis are systematically reported to the state and federal health authorities. Specific surveillance reports for HIV/AIDS are published biannually and yearly for TB. There is an ongoing effort to explore aspects of vulnerability in certain populations at risk and to generate new data. The legal basis for reporting is the federal Protection Against Infection Act (Infektions-Schutz-Gesetz, IfSG) for HIV and TB, since 2001. There is no legal basis for (voluntary) AIDS case reporting. Means of surveillance include compulsory reports (labs, for TB all cases that are being put on combination therapy), voluntary reports and sentinel data from health care professionals. A clinical database is available (German Competence Network HIV/AIDS) through a federally funded research network of competence. General surveillance of HIV patients in clinical care is conducted by the RKI (ClinSurv).

The Protection Against Infection Act based all reporting of infectious disease including HIV, Hepatitis B and C and TB on case definitions including clinical, laboratory and epidemiological criteria. For TB a case based dataset also provides information on drug susceptibility testing and treatment outcomes. Detailed molecular analysis of MDR-TB is done by a national reference laboratory.

Current HIV prevalence

According to the federal HIV registry the number of people living with HIV/AIDS is estimated to be 56,000, of whom 80% are male and 20% are female (RKI 2007). The regional distribution demonstrates an epidemic initially starting in metropolitan areas and now spreading into more rural areas.

Geographic distribution of AIDS/HIV in Germany (Robert Koch Institute 2007a)

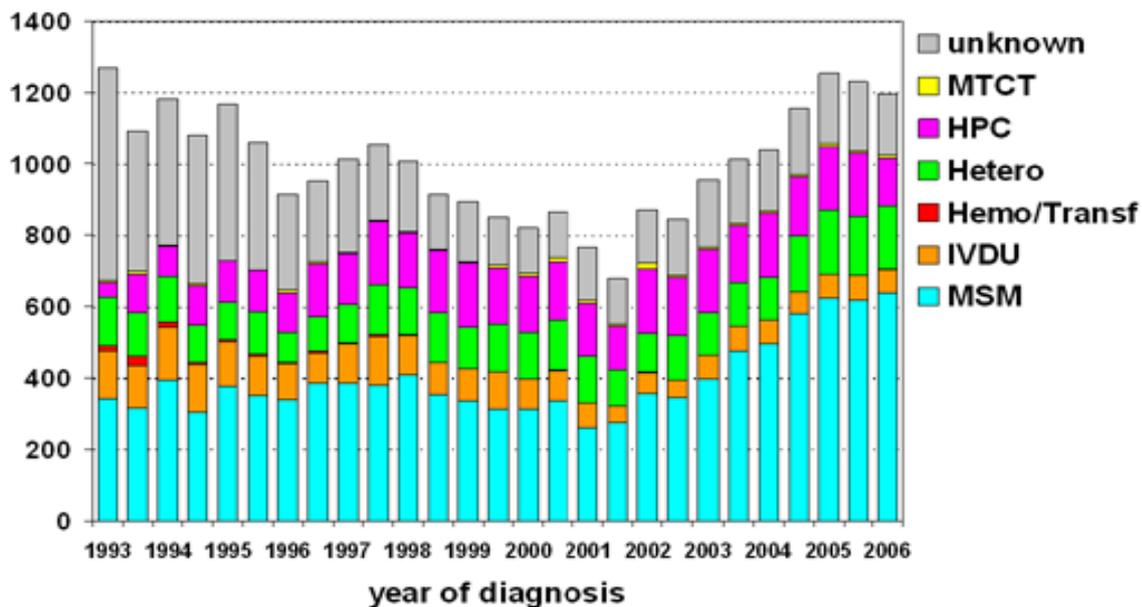


The most common mode of transmission was men having sex with men (60%), injecting drug use and heterosexual sex accounted for 13% of infections each. Some 7,500 are people with

HIV originate from high prevalence regions, who predominantly acquired HIV there by heterosexual intercourse (estimates of the size and regional distribution of this subpopulation may be unreliable, because little is known about which proportion of this group only stays in Germany temporarily). 550 haemophiliacs and recipients of blood products are living with HIV/AIDS. The number of people living with an AIDS-diagnosis is 8,700.

The number of children known to be living with HIV/AIDS from birth is 400 (below age 14). Voluntary HIV-testing is offered routinely to pregnant women and performed in 60-70% of cases (700,000 deliveries per year). It is estimated that there are 250-300 pregnancies of HIV-positive women annually, including 30-60 cases in which HIV-infection in pregnant women remains undetected.

Newly diagnosed HIV-infections by risk-group (6 month intervals), Robert Koch Institute 2006



133 children were diagnosed with HIV between 2001 and 2006. During this period 70/133 children were born in Germany, 29 of these by mothers originating from a high prevalence country and 17 by women with a male partner from a high prevalence country.

The Robert-Koch Institute estimates that 30-35,000 PLWHIV attended a medical check-up at least once in 2006. Of these patients 6-8,000 were not of Germany citizenship. Between 4,500 and 5,000 of all patients attending medical care were infected through iv-drug use.

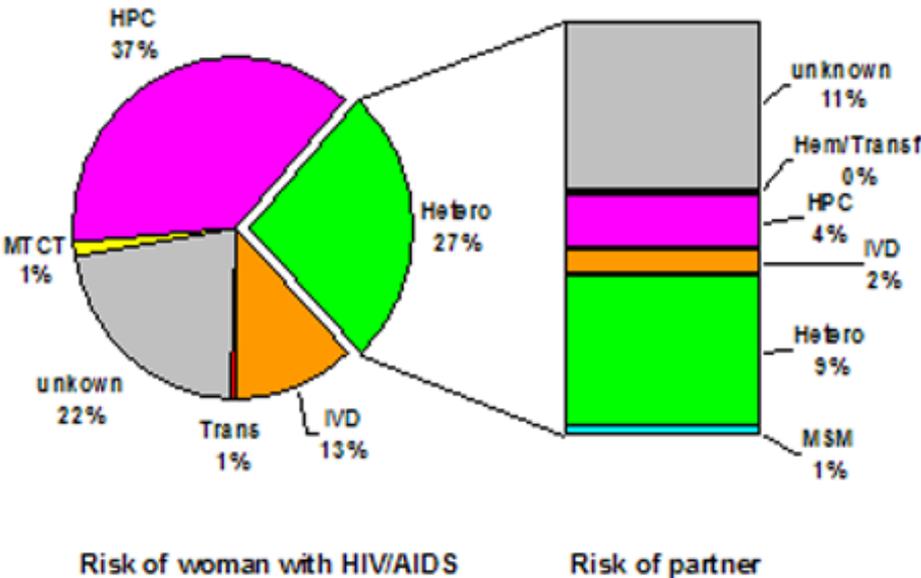
The HIV/AIDS epidemic in Germany (concentrated epidemic) has recently gained some momentum: the number of newly diagnosed HIV infections has risen by 81% between 2001 and 2006 from 1,443 cases to 2,611 cases annually³. This rise is mostly due to a rise in new diagnoses in MSM. 18.9 % of these newly diagnosed infections occurred in women. Of newly diagnosed PLWHIV some 14% are from countries with a high HIV-prevalence. Almost half

³ This is partly due to a change in the epidemiological statistic, to an increase in testing and to a real increase in numbers of newly diagnosed infections in MSM.

of the new cases among women are diagnosed in migrants. There are links to the endemic situation in the countries of origin, but also links to forced prostitution (particularly Eastern European women and young men) and iv-drug use (youth of CIS origin).

Following an analysis by the Robert Koch Institute in 2005 the number of women from high prevalence countries (HPC) diagnosed with HIV is considerable and higher than their proportional part in the general population.

Newly diagnosed cases in women, from 1993 (Robert Koch Institute)



The reported number of newly diagnosed HIV infections was 2,611 in 2006. It is estimated, that the number HIV infections newly acquired in Germany or abroad by German residents was approximately 2,700 in 2006. The number of AIDS cases currently reported is about 600 per year, however, due to considerable underreporting, the actual number must be estimated at about 1,200. Geographical information about HIV and AIDS incidence is based on the first three of five digits in the postal code system (related to the place of residence of the individual, when diagnosed). Incidences of HIV (10- <100/100,000 are reported from areas in Hamburg, Berlin and Munich. Lower than 10/100,000 but higher than average incidence rates are reported from other metropolitan and densely populated areas. AIDS incidence appears to reflect this pattern with the highest rates in Hamburg and Berlin.

Newly diagnosed HIV-infections in people from countries with high HIV prevalence have been accounting to this number with above 300 cases annually. Ten years ago the number of women began to rise, while a decline was noted in the number of men newly diagnosed. The male to female ratio was 1:2.5 in 2006⁴.

⁴ This change is probably due to increased HIV screening in pregnancy

**Reports of newly diagnosed HIV infections in people from high prevalence countries
(1993-end 2006)**

Risk of infection	Year of diagnosis											Total
	93to 96	97	98	99	00	01	02	03	04	05	06	
All	8,725	2,070	1,924	1,746	1,688	1,443	1,717	1,976	2,209	2,500	2,611	28,609
High Prevalence Country of Ori- gin	835	322	330	340	323	273	350	340	346	350	306	4,115
High Preva- lence/male	402	158	150	137	124	111	131	126	118	117	87	1,661
High Preva- lence/female	417	159	165	181	185	152	209	193	220	221	211	2,313
High Preva- lence/gender unknown	16	5	15	22	14	10	10	21	8	12	8	141

(Table modified from RKI: Epidemiologisches Bulletin, 29. Mai 2007, p. 7)

A more detailed analysis of the origin of migrants shows little change between 2001-2004. For at least 27% of the HIV infections newly diagnosed from 2001-2006 the region of origin is not Germany. There are no data on region of origin for 21% of reported infections. Probably most of these 21% are of German origin.

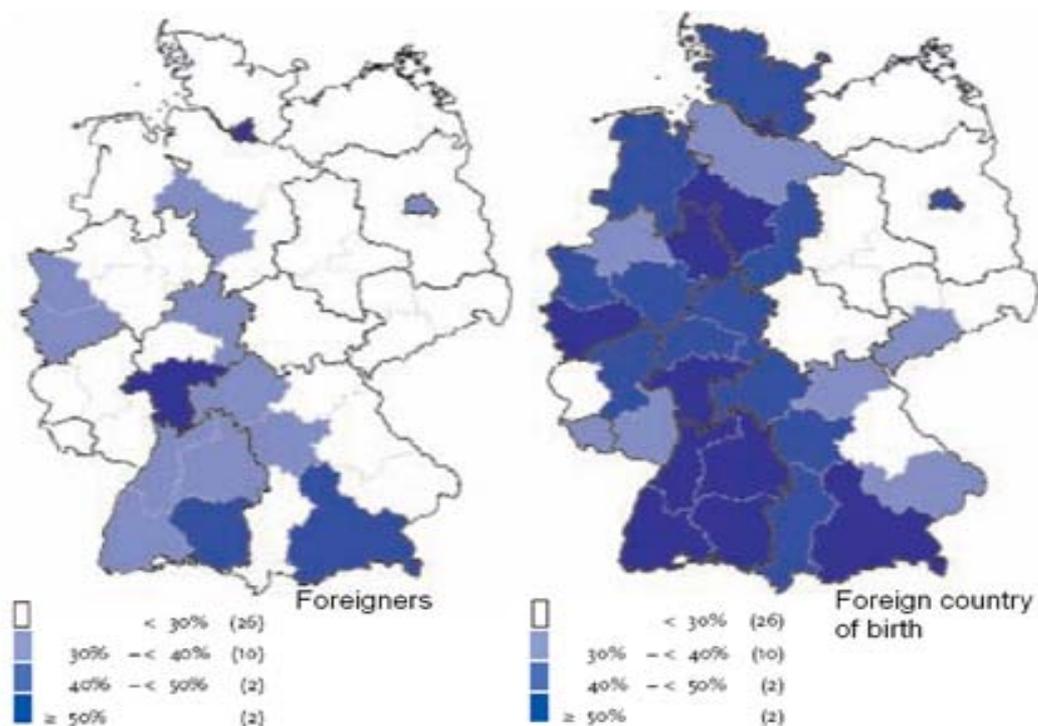
Current TB and HIV-TB prevalence

6,045 people were newly diagnosed with TB in Germany in 2005. An increase in TB (also MDR-TB) was reported in migrants originating from countries with TB-epidemics, e.g. from Eastern European States between 2001-2004 (RKI 2005). No further rise was observed in 2005.

The national incidence is 7.3 cases of TB per 100,000 inhabitants. Higher incidences of TB are reported from the States of Hamburg (10.8 /100,000), Berlin (9.7), Bremen (9.3) and Hesse (9.4) with the metropolitan region of Frankfurt/Main (22.1).

Geographical information about TB is available relating the percentage of newly diagnosed cases among foreigners or among “people born abroad” to the number of cases in the 40 administrative regions of the Federal States. Higher percentages are noted in Western Germany and in Berlin. The percentage of foreigners is usually below 30% (26 regions). 30-50% of cases are foreigners in 12 reporting regions. Foreigners account for 50% and more of cases in the Frankfurt/Main region and in Hamburg.

Percentage of newly diagnosed cases among foreigners or among “people born abroad” (Robert Koch Institute 2007c)



Data for TB are not only available according to citizenship but also to country of birth. In another two regions 50% or more of cases are also diagnosed as occurring in “people born abroad” - in Hamburg and in Berlin. “People born abroad” account for less than 30% of cases in two Western German regions and in all but one region of Eastern Germany (for further details see annex).

The names-based data on TB can legally not be linked to the anonymous data on HIV-infections. Case report forms cannot be combined. Data on TB as an AIDS-defining event in people with HIV are available through the voluntary AIDS registry. On the other hand, the number of people with HIV among patients with TB remains undetermined.

Current HCV and STI prevalence

It is estimated that some 15-20,000 PLWHIV have been tested for co-infections with Hepatitis C Virus (HCV) (RKI 2007). Of these 6-7,000 are co-infected and 5,000 had chronic HCV-infection. This estimate is based on a risk distribution among diagnosed people with HIV/AIDS of 95% co-infected and tested for HBV and HCV among IDUs and haemophiliacs, 70% of MSM co-infected with HBV and 5% with HCV (but only one in two diagnosed), and lower proportions co-infected in the other risk strata.

Recent data from an internet-based survey of MSM indicate that up to 10% have ever had gonorrhoea, chlamydia or syphilis (data may overestimate risk due to sampling bias). In a survey conducted among MSM living with HIV/AIDS in Berlin 30% had ever had syphilis, 70-80% tested positive for HBV-antibodies and 3.5% had antibodies against HCV (both studies RKI 2007).

Of the 14,188 patients where nationality could be established entered into the German Competence Network HIV/AIDS database 51% are reported to be of German nationality and origin (7,244 cases). PLWHIV from Sub-Saharan Africa (508) and Western Europe (314) are the largest groups of foreign nationals. While 9,668 patients acquired their infection in Germany, 680 did so in Sub-Saharan Africa, 320 in Western Europe and 208 in South-East Asia (data kindly generated from and provided by German Competence Network HIV/AIDS, July 2007).

4.3 Country Migration Profile

Migration information sources in Germany

In presenting the socio-demographic situation of documented migrants this report refers to three main sources of information:

1. The Mikrozensus survey: Due the wide variety of survey characteristics and the large number of survey units Mikrozensus is especially suitable for the analysis of subpopulations. The Mikrozensus survey includes households with randomly selected criteria. The number of households is chosen in such a way that representativeness is statistically firm. In Germany the statistical survey is carried out by the Federal Statistical Office and the State Statistical Offices. The Mikrozensus collects data regarding immigrants and people with an immigrant background.
2. The migration report by the Federal Office for Migration and Refugees (BAMF) on behalf of the German government offers in-depth information on the situation of migrants in Germany and on migration behaviour of different groups. In addition the report looks at undocumented immigration. Another section deals with emigration from Germany.
3. The Federal Office for Migration and Refugees (BAMF) also publishes the report „Migration, Integration und Asyl in Zahlen“ (Statistical data on migration, integration and asylum) including tables, charts, maps and statistical information.

Important information on undocumented migrants could also be gathered from other reports by the Federal Office for Migration and Refugees (BAMF):

1. The working paper „Illegalität von Migranten in Deutschland“ (Irregular residence of migrants in Germany) providing an overview on the state of research regarding undocumented migrants.
2. The report „Umfang und Struktur der illegal aufhältigen Migrantenbevölkerung in Deutschland“ (Size and composition of the illegally resident population in Germany) containing some statistical data.

Migration trends

During the past 60 years Germany's development has been marked by a number of migration events. Historically Germany has a rich tradition in immigration, emigration and in integration of migrants of extraordinarily heterogeneous populations (not accounting for "internally" displaced people after WW II and some 3 Mio people moving from East to Western Germany after reunification in 1989).

In 2005 people with an immigrant background ("migrants") numbered 15.3 million which corresponds to 18.6% of the total population in Germany (some 82 million). The 7.3 million foreigners (8.9%) account for almost one half of all migrants. The remainder of 8.0 million (or 9.7%) are repatriated national Germans. Two thirds of all individuals with an immigrant background (10.4 million) have migrated to Germany since 1950 (defined as "population with own migration experience") and among this group the majority are foreigners (5.6 million compared to the 4.8 million immigrant German nationals). Of the foreigners in Germany one of every five foreigners was born here (1.5 million persons) and is thus a second- or third-generation immigrant (BAMF 2006a).

In contrast, foreigners born in Germany constitute only 1.7 million or 2% of the population, while the 2.6 million Germans with a migration background who were born in Germany constitute 3.2% of the population in Germany (Statistisches Bundesamt 2007a).

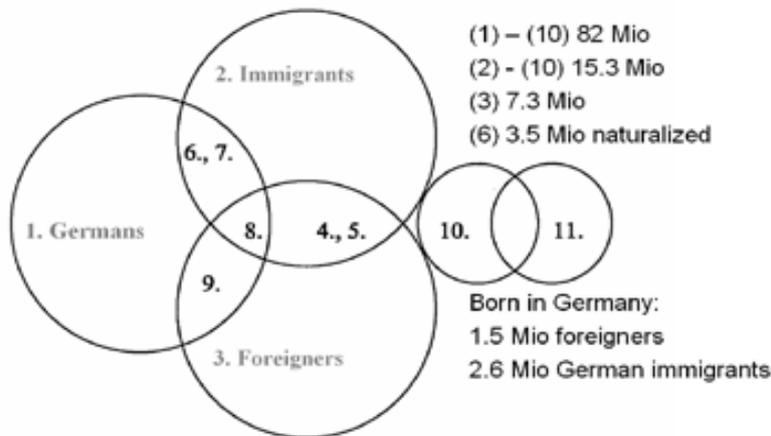
Regular Migration

For statistical purposes migrants have until now mostly been defined as people of foreign nationality. Foreigners ("Ausländer") as a group, however, while reflecting a number of non-German communities, are exclusive of other sub-populations facing challenges of integration which are predominately similar to (or even higher than) those encountered by "Ausländer". These communities include millions of people, who have come to Germany as German citizens from historically connected national communities in Eastern Europe (e.g. Kasachstan, Moldova, Romania).

Ethnic German repatriates (Spätaussiedler) are individuals belonging to the German ethnic community in accordance with Article 116 of the German Constitution. Ethnic Germans who have applied for admission to Germany - except for applicants from the former Soviet Union - must present plausible evidence of personal discrimination based on their German ethnicity or the continued impact of earlier personal discrimination on or after 31 December 1992. The Federal Office of Administration in Cologne determines whether foreigners who have applied for admission to Germany fulfil the requirements for ethnic German repatriates. Family members of ethnic German repatriates are also often admitted to Germany (BAMF 2006a).

In order to overcome the statistical biases of the category "Ausländer" and to better reflect the interaction between social and migrant status a number of efforts are aiming at better defining the indicators needed to identify potentials and deficits.

Definition of “migrants” (modified from Razum 2003):



1. Germans according to citizenship, with German parents *
2. Immigrants with foreign citizenship, holding a residence title
3. Foreigners according to citizenship, born in Germany (not immigrated), holding a residence title
4. Foreigners according to citizenship, immigrated for a short period of time, holding a residence title
5. Foreigners according to citizenship with central focus of life in Germany, holding a residence title
6. Immigrants who acquired German nationality *
7. Ethnic German repatriates (immigrant with German nationality) *
8. Immigrants with dual citizenship*
9. Foreigners, dual citizenship, born in Germany (not immigrated) *
10. Refugees (so-called asylum seekers)
11. Immigrants without legal status (without residence title), illegally resident third-country nationals

* registered as “German nationality” in official statistics

Migrants origins and their distribution in Germany

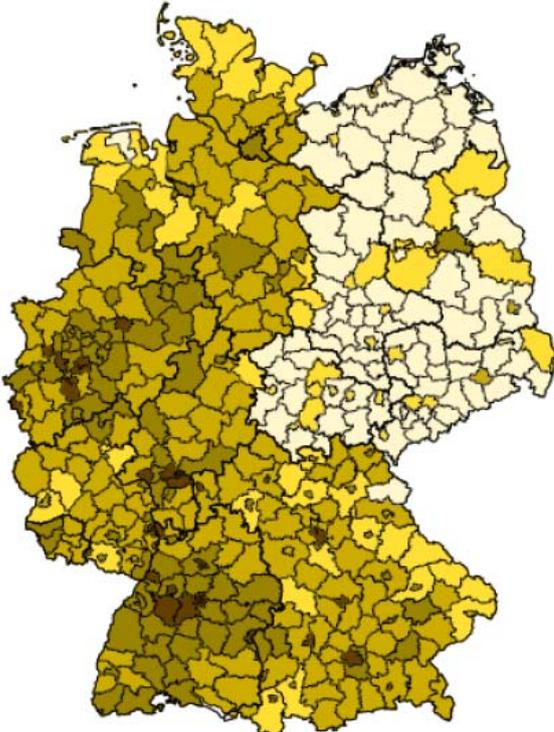
Concerning the migration situation, Europe is quantitatively of particular importance: 61.7% of migrants originate from Europe (23.6% of all migrants came from the 25 member countries of the EU, 38.1% from the remaining Europe). The nine most important countries of origin are Turkey (with 14.2% of all migrants), the Russian federation (9.4%), Poland (6.9%), Italy (4.2%), Romania, Serbia and Montenegro (in each case 3.0%), Croatia (2.6%), Bosnia and Herzegovina (2.3%), and Greece (2.2%) (Statistisches Bundesamt 2007a).

Continuing the trend the majority of immigrants came from European states in 2004: 67.9% originated from Europe (16.3% came from the ten new European Union states, 24.3% from the old states of the European Union). 14.5% of immigrants originated from Asia, 4.1% came from African countries, 6.9% from America, Australia and Oceania. In 2004 the main country of origin was Poland with 139.283 immigrants, two thirds of them men. The immigrations from Poland corresponded to 18% of all immigrations. This is followed by the group of migrants from the Russian federation with 8% and 58,594 registered immigrations to Germany in 2004. A majority of them are ethnic German repatriates (Spätaussiedler) and their relatives. The further main countries of origin were Turkey with 5%, and the USA, Kazakhstan, Romania, Italy and Serbia and Montenegro with 3% each. The migration from Turkey is particularly characterized by spouse and family reunion and applications for asylum (BAMF 2005a).

14.7 million, i.e. 96% of all migrants live in the former West German states and in Berlin. Most of them reside in large cities, particularly in Stuttgart with 40.1%, in Frankfurt/Main with 39.5% and in Nuremberg with 37.3% of the population. The number of foreigners is particularly high in Augsburg, Nuremberg and Wuppertal, the number of immigrants with a German nationality is high in Stuttgart, Frankfurt/Main and Munich (Statistisches Bundesamt 2007a).

In 2004 the highest immigration numbers occurred in North Rhine-Westphalia (134.528 immigrations), Bavaria (126.423 immigrations), Baden-Wurttemberg (121.797 immigrations) and Lower Saxony (119.788). With reference to the respective total population, Hessen had the highest per capita immigration, followed by Lower Saxony, Hamburg, Berlin and Baden-Wurttemberg. (BAMF 2005a).

Geographic distribution of migrants in Germany (BAMF 2005a)



96% of migrants live in Western Germany and Berlin

Highest proportion of inhabitants with a migration background (2005)

Stuttgart	40.1%
Frankfurt/Main	39.5%
Nuremberg	37.3%

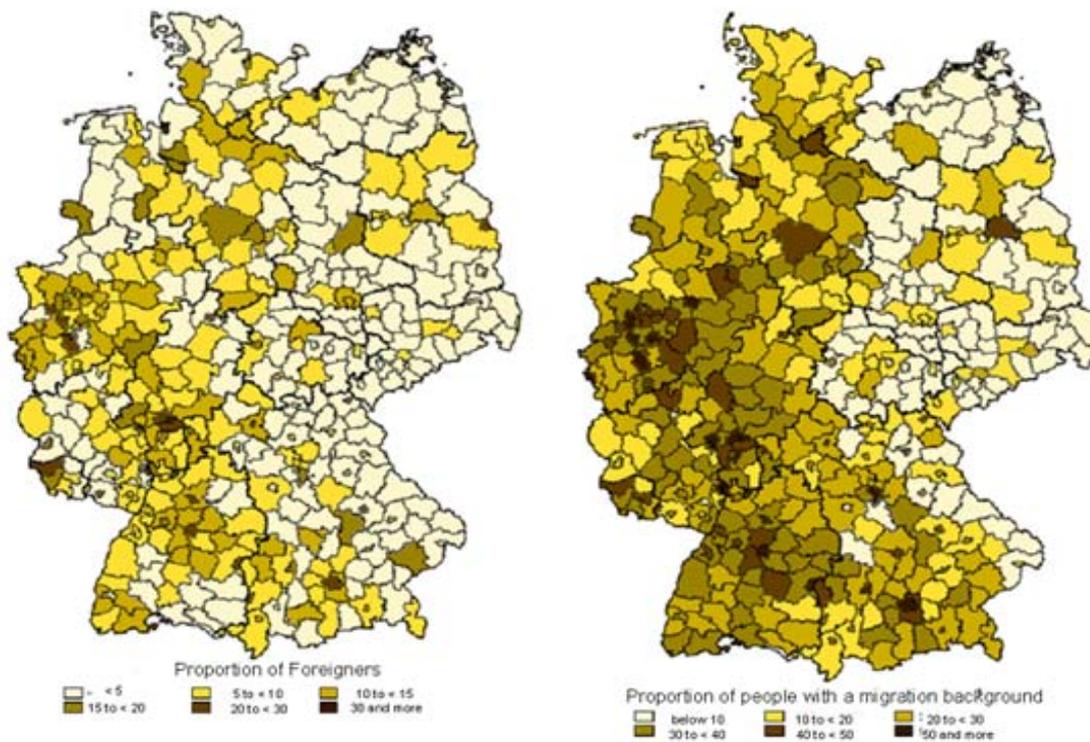
Proportion of inhabitants with a migration background

 < 5%	 5% to <10%	 10% to <20%
 20% to <30%	 30% to <40%	 >40%

Migrants demographic profile

In comparison with the native German population immigrants are on average younger (34.2 vs. 46.5 years), more frequently single (45.7% vs. 37.8%) and male (50.8% vs. 48.5%). Below the age of five migrants’ children account for a third of the population. The number of binational couples (one partner German and one non-native) is approximately 1.3 million (6.6% of all marriages). In 25% of all marriages at least one partner experienced migration. 3.5 million people have previously held a foreign nationality and became Germans by naturalization; they are 41.6 years old on average and have held German citizenship for 13.9 years (BAMF 2005a).

Children below age 10 (BAMF 2005)



Compared to native German population, the households of migrants are larger (2.5 opposite 2.0 persons for each household). Non-natives live more rarely alone than natives. A family structure with parents and children is found more frequently. Married couples without children, educating single mothers or fathers and alternative ways of living with and without children are found less often than in the native population (Statistisches Bundesamt 2007a).

Labour migration and integration issues

Access to the labour market (legal employment or self-employment) are regulated by laws concerning residence status and the right to take up work or open a business for foreigners. Naturalized individuals do not receive specific attention in a legal context.

Foreign residents (e.g. EU nationals) with a settlement permit are not restricted (§9 (1) AufenthG). Recognized asylum seekers and refugees (§4 (2) AufenthG), as well as others e.g. spouses of Germans receive an unrestricted residence title enabling them to take up employment without restrictions (§§25 (1) and (2) AufenthG), and self-employment (§4 (2) AufenthG).

Further restrictions apply to foreigners, who cannot be deported (§25 (3), (4) and (5) AufenthG), or those receiving a humanitarian (§23 (1) AufenthG) or hardship (§23a AufenthG) residence permit. They will only receive allowance to take up employment (by the local foreigners office and by the local labour administration) if a vacancy cannot be filled by a German (or by a foreigner with a less restricted right of residence). The labour administration is also responsible for checking labour standards are not lower for foreigners (§39 (2) 1 AufenthG). Under certain conditions the right to become self-employed is granted (§22, 1 and §23,1 and §25,3 and 4 and 5 or §36 AufenthG).

If residence is only granted temporarily (due to material or legal obstacles to deportation, §60a AufenthG) the local foreigners office (§10 BeschVerfV) decides on a case-by-case basis and without regard to the specific employment sought. In this context the local foreigners office cannot allow access for individuals, who have not been fully cooperative (§11 BeschVerfV). Generally, self-employment is not allowed for foreigners with temporary status (Weiser 2007).

Since 1996 the number of individuals liable for social insurance in Germany (i.e. all those rightfully employed) decreased by more than one and a half million. Only in 1999 and 2000 employment of migrants increased temporarily. At the same time the number of foreigners fully liable for social insurance decreased to a greater extent compared to the total number of persons employed. Whereas in 1996 the corresponding proportion of foreigners accounted for 7.6 % in 2005 it decreased to 6.7 %. The reason for this unfavourable development may lie in high unemployment in the industrial sector which engages an above average proportion of foreigners (BAMF 2006a).

Migrants in the productive age (25 to 65 years old) are more rarely gainfully employed (61.7% opposite 73.0%) and more frequently unemployed (13.3% opposite 7.5%) than native Germans. Concerning the women the differences are particularly obvious: Compared to 66.8% of the native women only 52.3% of the migrated women are gainfully employed. With 36.9% (native: 26.3%) there are more migrant women who are not employed but work as housewives and are responsible for the education of the children or the care of relatives. Among employed persons migrants are twice as frequently workers (48.5% compared to 24.4% of native Germany), employees and civil servants are accordingly more rare among them. Migrants most often work in the industry, in trade and in the hotel and restaurant industry. 63.7% of all non-native residents work in these sectors, but only 50.4% of the native workforce. The average weekly work time of migrants aged 25 to 65 is slightly lower than for native Germans. The proportion of migrants working unusual hours regularly (e.g. on Saturdays, Sundays and public holidays) and in shifts is significantly greater compared to native Germans of the same age group (Statistisches Bundesamt 2007a).

On a national level the distribution of immigrants is highly imbalanced with a small minority (4%) only settling in Eastern Germany (former German Democratic Republic, not Berlin). Within larger cities segregation has been taking place resulting in geographic areas with a higher proportion of migrants among the population. Within these cities there are areas of higher and lower “mingling” or concentration.

In a detailed analysis income, proportion of foreigners, welfare recipients and unemployed people and environmental pollution can be related to further elicit the ecology of segregation and its effects on health determinants and resources.

Three types of settlement can be recognized (Maschewsky, 2003):

Type 1: Low household income (25.000 Euro), high proportion of immigrants (36%), a high proportion of welfare recipients and unemployed, heavy burden of traffic.

Type 2: Median household income (33.000 Euro), low proportion of immigrants (12%), a proportion of welfare recipients and unemployed slightly below average, burden of traffic slightly below average.

Type 3: Very high household income (57.000 Euro), low proportion of immigrants (11%), very low proportion of welfare recipients and unemployed, very low burden of traffic.

In big cities this has led to the development of areas which are described as underdeveloped districts, problem districts, underprivileged districts, neglected areas, marginalized quarters according to context, point of time and author). These districts are targets of intervention of the Federal Programme Social City (Bundesprogramm „Soziale Stadt“).

In these districts there is a high concentration of poor people (e.g. recipients of social benefit), people with low income (who don't receive income support) and often but not necessarily people with a migrant background. Many of the formerly impoverished districts of the inner city became unaffordable for low-income individuals due to gentrification and conversion of rented flats into owner-occupied flats. Beginning circles of displacement lead the former inhabitants via intermediate stops into socially and environmentally neglected districts, often into big housing estates (frequently on the outskirts of town). The tenant selection policies as well as the expiration of rent control regulations resulted in a concentration of poverty.

The segregation of social areas thus appears to involve higher ecological damage for those groups who suffer from social deprivation. Since these groups are under heavier financial strain in their working lives and when making use of services this amounts to an accumulation of risk which is socio-politically counterproductive. The lack of environmental justice i. e. socially damaging unequal distribution of environmental risks or hazards could give rise to health inequality and could also be jointly responsible for the connection between poverty and health. The aim is to conduct environmental planning in a socially sensitive manner e.g. in the residential environment.

Irregular migration

In Germany there is no statutory definition of illegal residency but merely the regulation of entry and residence. As the complex issue of “illegality” comprises several, partly overlapping phenomena (illegal entry, illegal residence, illegal employment), and as various entry points into illegal residency exist, discussions about the issue encounter a variety of problems of differentiation. There is no precise information available (statistics of the Federal Police, criminal statistics, asylum statistics, statistics of the Federal Employment Agency) on the scope of illegal employment, on the affected branches of economy, the spatial distribution and the size of the companies that employ illegally resident migrants. According to different authors the lower limit of illegal residents amounts to 100,000 individuals whereas the upper limit to more than one million. As for the national origin of illegally resident third-country nationals, the quantitatively largest groups were as follows: a) Eastern Europeans, with declining significance since May 1, 2004 though; b) nationals of countries with a history of or ongoing migration flows to the Federal Republic of Germany (e.g. Turkey, former Yugoslavia, Russian Federation, Ukraine, Vietnam); c) nationals of distant countries that are marked by a lack of political and/ or economic security (China, Iraq, Afghanistan, some countries in Africa and Latin America). The analysis of reports leads to the conclusion that the majority of undocumented migrants are between the ages of 20 and 40 years. But there is also subsequent immigration of older family members (often into legally residing families) and a significant number of children living in Germany. The majority of undocumented migrants appear to be single. The sex ratio correlates closely with employment opportunities; e.g. there is a higher proportion of women in West German cities due to high demand in domestic help. On the whole there seem to be more men without legal residence status. Geographically, the majority of undocumented migrants are more often identified in big cities and in regions with sizeable communities of migrants (BAMF 2006b).

If not by right of the European Union, by another statutory order agreement or the association agreement between the European Economic Community and the Turkey of 1963, individuals with a foreign nationality need a residence title for the entry and the stay in the federal territory. Residence titles are given as visa, residence permit or settlement permit (§ 4 (1) AufenthG). If a foreigner does not possess (or no longer possesses) the necessary residence title he or she is required to leave the country. If the concerning person does not follow this departure obligation immediately or within the set period, the stay in the federal territory is considered illegal, i.e. irregular (BAMF 2005b).

The working paper “Illegalität von Migranten in Deutschland“ of the Bundesamt für Migration und Flüchtlinge (BAMF) differentiates three groups of migrants without residence permit:

1. Foreigners, to whom an “exceptional leave to remain“ was given (a deportation is impossible, the conditions for granting a residence title are however (still) not fulfilled. The concerned person remains required to leave the country.
2. Foreigners who are registered as required to leave the country in the Central Register of Foreigners (Ausländerzentralregister) and possess no “exceptional leave to remain“.
3. Foreigners who do not possess a residence title or an “exceptional leave to remain“ and neither are registered in the Central Register of Foreigners (Ausländerzentralregister) nor in any way officially registered.

The term "illegal migrants" is exclusively applied to the third group. It is disputed whether the two first groups are to be likewise regarded as "illegal". These groups are (in contrast to the last constellation) registered by the authorities and their numbers are known (so they are not “undocumented” in a strict sense).

By end of 2004 202,929 foreigners were living with an “exceptional leave to remain“ and 168,145 foreigners were registered in the Central Register of Foreigners (Ausländerzentralregister) as required to leave the country (BAMF 2005b). In 2006 the Federal Ministry of Interior reported 164,000 people with an “exceptional leave to remain”. Of these 94,000 have been living in Germany for six or more years, of these 64,000 for more than eight years (BMI, Press release, July 6th 2007).

Major entry points for irregular migrants to Germany

Due to the centrality of Germany in Europe all borders are affected by unlawful entries and trafficking of humans. Over the past years the majority of undocumented immigrants have been apprehended on the borders with Poland, the Czech Republic and Austria (BAMF 2006b).

In 2004 the Border Police determined 18,215 irregular entries. This represents a decrease of the determined irregular entries by around 1.759 cases (-8.8%) in comparison to the previous year. The majority of the irregular entries in 2004 were - as in the years before – at Schengen internal borders. 10,884 irregular entries were determined at the Schengen borders, among them 4,467 at the German/Austrian border.

Furthermore, in 2004 there was a rise of illegal entries of Ukrainian and Russian citizens at the German/Polish border, with 2.277 irregular entries. The number of the illegal entries of individuals from the Russian Federation (from 1.473 to 1.767) and the Ukraine rose from 1.362 in 2003 to 1.736 detainees. Also the number of the irregular entries of Romanian and Bulgarian citizens rose slightly. On the other hand the number of illegal entries of citizens of the People's Republic of China decreased for the first time since 2001 (from 1.371 in the year 2003 to 1.109 in the year 2004). A strong decrease could be found in irregular entries of citizens from the Iraq (-55.3% on 422) and Turkey (-15.8% on 1.251). Also irregular entries of people from Serbia and Montenegro continued to decrease in a trend see since the Kosovo conflict calmed down in 1999 (from 1.739 in 2003 to 1.555 in 2004) (BAMF 2005a).

Entities in the country designated with the responsibility to manage migrants

On the national level migration policies are being developed by the Federal Ministry of Interior. The Ministry for Social Affairs is in charge of regulating access to the labour market. Access to health insurance is in the remit of the Federal Health Ministry. Government policies are also consulted with the Minister of State for Integration, Refugees and Migrants (in the chancellors office). The National Integration Plan was initiated by the Federal level and developed in dialogue between public actors and migrant communities.

On a state level, internal affairs, social and health matters and the issues of migration are similarly divided in public administration and in the 16 State governments. Common issues of states and federal levels are being addressed through parliamentary (e.g. Bundesrat) or administrative channels (e.g. Bund-Länder-Kommission). State-wide Integration Plans (e.g. Handlungskonzept 2006) are being developed between public and civil society actors.

Most of the individual and case-by-case decisions in social administration are being taken by local or regional actors. On a community-level different posts have been assigned to facilitate and develop policies regarding migration. Most municipalities have designated integration officers, (elected) migrant representatives and/or are investing in community-based programmes.

The German system of migration control includes external controls (e.g. via the visa system and external border controls) as well as a system of internal controls by means of residence and work permits. This is complemented by control mechanisms that work via data exchange, checks at the workplace, close cooperation between authorities and their obligation to forward information (BAMF 2006b).

Emigrants

The term “migration” is for the most part associated only with immigration to Germany only. The fact that there is also a considerable extent of emigration from Germany to other countries is often not considered in this context. The rise in immigration to Germany in the late 1980s was accompanied by a temporally delayed increase in emigration from Germany. Thus 9.68 million individuals left the national territory between 1991 and 2004; of whom about eight million were foreigners. In 2004 697,632 cases of emigration from Germany were registered, among them 546,965 foreign emigrants.

In 2004 German nationals were the largest national group of emigrants contributing one fifth of total emigration (22 % and 150.667 individuals respectively) followed by Polish nationals (14 %). Both Turkish and Italian nationals accounted for 5 % of all emigration cases. The proportion of nationals from Serbia and Montenegro amounted to 4 %, 3 % were of Rumanian origin as well as 3 % of Greek origin. Hungary, the US and the Russian Federation followed with 2 % each. Polish nationals ranked second after Germany in the proportion of immigration as well as emigration. The highest rates of emigration (emigrants per thousand population) in 2004 could be ascertained in Hamburg, Hessen and Baden-Württemberg and the lowest rates in Thuringia, Mecklenburg-Western Pomerania and Brandenburg Mecklenburg-Western Pomerania (BAMF 2005a).

In 2004 the main country of destination was Poland with 104.538 registered cases of emigration from Germany corresponding to 15 % of total emigration in 2004. About 70 % of individuals emigrating to Poland were male. 5 % of emigrants went out to Turkey and Italy respectively and 4 % in each case to the U.S. and Serbia and Montenegro. On the other hand neither the Russian Federation nor Kazakhstan – countries where the majority of ethnic German repatriates (Spätaussiedler) and their relatives come from – are amongst the most frequently chosen countries of destination. Only few of the ethnic German repatriates (Spätaussiedler) and their relatives return to their countries of origin. Looking at the regions of destination more closely the “old” EU member states (EU-14) account for almost a quarter of total emigration (170.603 individuals). The EU-14 member states were the main countries of destination in 2004. 148,821 individuals emigrated from Germany to one of the new EU member states (EU-10). This corresponds to 21 % of total emigration. The proportion of emigration to the successor states of former Yugoslavia (without Slovenia) accounted for 7 % (49,097) whereas emigration to the successor states of the Soviet Union (without the Baltic States) amounted to only 5 % (33,115 emigrations).

Emigrants demographic profile

The Reasons and motives for migration within the EU are above all access to employment and vocational education and training as well as starting or reunifying a family. Both immigration and emigration rates of women are lower than those of men while remaining constant for a long time. It is true though that the immigration rate of women (approx. 42 % since 1999) is constantly higher than the emigration rate of women (approx. 37 % since 1999). Comparing the age structure of migrants in 2004 on average immigrants (30.8 years of age) are two years younger than emigrants (33.1 years of age). (BAMF 2005a).

German citizens leave Germany to a considerable extent for a longer period of time or for good. The number of German emigrants remained constant at 50,000 and 60,000 since the 1970s until it increased to 100,000 per year since 1989. In 2004 over 150,000 Germans left their country. This corresponds to an increase by 18 % as compared with the preceding year in which emigration of 127,000 individuals was registered. 59,000 of those emigrants moved to another member state of the EU, among them approx. 46,400 who moved to one of the old

European Union member states. In 2004 13,000 Germans emigrated to the United States while at the same time about 10,000 Germans returned from the United States to Germany. These emigrants with German nationality are on the one hand “typical emigrants” (e.g. to the US) on the other hand also temporary migrants such as technicians, managers, physicians, pensioners and students as well as their relatives (BAMF 2005a). Polish nationals ranked second after Germans with regard to the proportion of immigration as well as emigration. This shows that migration between Germany and Poland is marked by strong commuter migration flows for the most part because Polish citizens have access to temporary employment in Germany.

Major categories of occupations emigrants engage in destination countries

Emigration from Germany is a neglected field of migration research. There are only few investigations into emigration and its motives. However, interest in emigration has increased in recent years, in particular in connection with the discussion on “competition for the best brains” and the question how to keep highly qualified professionals in the country. In 2004 and 2005 several studies were published on this subject. A study published in August 2005 came to the conclusion that emigration of highly qualified individuals from Germany to the United States is less significant than often suspected. It is confirmed that since the early 1990s both the number of visa for work-related temporary stays of highly qualified labour has increased and the number of those immigrants has risen either converting their temporary residence permits into permanent ones or obtaining a permanent residence permit from the outset. Absolute figures were low, however. The German Federal Government acts on the assumption that in the U.S. the number of German academics amounts to at most 20,000. In the „Current Population Survey“ the U.S. Census Bureau mentions an upper limit of 15,000 up to 20,000 Germans with university degree holding temporary visas and working at universities and in university related areas. Among that group there are 4,650 so-called „German Scholars“ i.e. junior academics with Ph. D. degree who are employed as postdoctoral scholars, visiting professors or research assistants at U.S. universities. The number of highly qualified German nationals with a permanent residence permit amounted to about 3,800 in 2001. This number includes also relatives so that the quantity of highly qualified professionals lacking in the German labour market is substantially lower. Therefore, one may say that more and more Germans stay temporarily in the United States in order to study, to research and gain international work experience. Nonetheless, the majority of these highly qualified professionals returns to Germany or expressed according to surveys a high willingness to return (BAMF 2005a).

Information about HIV/AIDS and issues of destination

Germans taking up work abroad are addressed and educated in specific programmes, also regarding HIV/AIDS and other STIs. The Gesellschaft für technische Zusammenarbeit (GTZ) is a major German development sector NGO. Individual testing and group education is offered to staff returning from or about to be working in projects. A workplace and care policy covers both GTZ-staff as well as people employed in GTZ projects abroad. Also, HIV/AIDS is taught to some 1.300 individuals being prepared for work in other countries by the Vorbereitungsstätte für Entwicklungszusammenarbeit (V-EZ) annually. No similar other activities could be identified.

A part of the group leaving Germany consists of asylum-seekers and refugees. There are two programmes to promote the willingness for voluntary return. These programmes, REAG and GARP, constitute two summarized programmes promoting the willingness for voluntary return of asylum-seeker and persons entitled to political asylum. There are also other groups who are funded partly by government grants and those respective federal states where migrants willing to return to their country are staying (REAG: Reintegration and Emigration Program for Asylum-seekers in Germany, GARP: Government Assistance Return Program).

The REAG programme pays travel expenses and travel grants whereas the GARP programme which is targeted to people from countries of origin with importance in the area of migration policy pays start-up funds. These programmes are carried out by the International Organization for Migration (IOM). Since 1 of September 2003 the approval of government funds has been delegated to the Federal Office for Migration and Refugees (BAMF) (BAMF 2006a).

As part of the repatriation support programme REAG (Reintegration and Emigration Programme for Asylum-Seekers in Germany), which was commissioned by the Federal Ministry of the Interior and the respective state ministries, irregular residents and victims of human trafficking can claim support. At the same time the Federal Government ensures that the federal states comply with their obligation to enforce the duty to leave the country. In order to facilitate the implementation of deportations, the Federal Government coordinates its repatriation policy with the countries of origin and closes respective agreements. In addition, various measures are carried out to counteract problems with the repatriation procedures (BAMF 2006b).

Focus on migrants in prisons and detention centres

On November 30th 2005 76.600 prisoners were counted in German institutions (4,100 female, 5.3%). This included all forms of prisons and detention (excluding only socio-therapeutic institutions) (www.destatis.de). Among prisoners awaiting deportation women accounted for 12%. Data on the nationality of prisoners (not awaiting trial or deportation) are available classified into German/non-German (Statistisches Bundesamt VI B -8.21). 23% of this group of prisoners were non-German in 2006 (up from 12.5% in 1991, when the statistic basis became nationwide). Among prisoners within the legal framework applying to youth the ratio is stable and non-Germans account for some 20% of prisoners across age strata. Among the 203 prisoners aged 18-21 (and imprisoned according to the legal framework applying to adults), however, the percentage of non-Germans is above 40%. Above the age of 50 years the proportion of non-German prisoners is below 15%. Among people detained for safety reasons (after having completed their prison term) the proportion of non-Germans is comparatively low: 82 of 90 individuals thus detained are German.

A research project (four sites) aiming to assess knowledge, attitude, behaviour and infection status of prisoners is ongoing (WIAD und RKI). Early results of the sociological part of the study could be available in October 2007. The data collected will include migration history. There is a legally enforced medical examination during the first 24 hours of imprisonment. Experts confirm that prisons and detention centres are trying hard to achieve this goal. HIV/AIDS-information is provided upon this occasion and voluntary testing for HIV is generally being offered. Testing rates vary widely from site to site. Rates between 10% (e.g. in Bremen) and 95% may be explained by the way testing is being offered (“suggestive or casually”, face-to-face interview Prof. Heino Stöver, Bremen).

There is no national protocol on how HIV/AIDS or information regarding other infectious diseases should be promoted in a prison setting. Individual states have formulated rules or established bodies to guide them. Often, the policy depends on the director of the institution. There are no sanctions for prisoners refusing testing. Staff often follow very basic knowledge regarding health issues and medical staff is not specialised in treating e.g. HIV/AIDS and/or TB. Specialised training is optional. There is little awareness of these limitations in standard of care.

The study “Daily Dose” describes the day-to-day challenges encountered by prisoners treated for HIV/AIDS inside prisons (Stöver/Leicht 2005). (Partial) treatment interruptions (due to a variety of technical, resource and procedural reasons) appear to occur often and patient knowledge seems to be low. Since taking the prisoners to see specialised care is highly staff intensive (and thus may cause delayed access to care) specialised physicians are invited to provide care within prisons (e.g. in Bremen).

In Hamburg and in Lower Saxony undocumented migrants are both decentralized and centralized. A recent report on camps as a structure of German policies on refugees explains the varying practices (Pieper 2006). Hamburg has decreased the number of places in camps (2003: 17,800; 2006: 11,000). Accommodation is largely in camps (50.49%) administered by a government owned private company (Pflege & Wohnen). The centralized facility in Nostorf/Horst (administered by a private charitable company owned by the Order of the Knights of St. John) is 60km from Hamburg in a former military camp (facility shared with the neighbouring State of Mecklenburg-Pomerania). There are three prisons to detain deportees: Fuhlsbüttel (54 places), Hahnöfersand (15 places for male youth) and Holstenglacis (5 places for women, 16 for men).

The number of accommodations for refugees, asylum seekers and people on remand in Lower Saxony is unknown (Pieper 2006). There are three centralized facilities (Blankenburg, Bramsche-Hesepe and Braunschweig). There is one major prison to detain deportees: Langenhagen (140 places for men and 45 places for women). Some small capacities are also being used in Braunschweig, Hameln, Hannover, Lingen, Oldenburg and Vechta.

In 2004 the average prison population in Hamburg was 2.881 people. 545 male and 23 female non-German citizens were prisoners (Bürgerschaft 2007). Medical care costs were 2.43 Euro/prisoner/day, or some 8 Mio Euro annually (2004).

A central hospital (Zentralkrankenhaus) provides 63 patient beds in 37 rooms. 70% of this capacity was used in 2004. One prison provides an additional eight beds for ill prisoners. Public data on the health of migrants in prisons in Hamburg are not available. Physicians speak nine languages – including Arab, English, Ethiopian, French, Italian, Japanese, Polish, Russian, and Spanish. In 2004 seven out of eight prisons in Hamburg reported having bought ART for a total of ca. 219,000.00 Euro (number of patients treated not registered).

Three prisons accommodate women. In 2004 five women were pregnant (2005: 3) (8.5-11.5 months imprisonment on average). One of these women was each Turkish, Tunisian and from Montenegro. Between 2000 and 2005 five births occurred in Hamburg's prisons.

Information on HIV/AIDS and infectious diseases is provided through print-media (produced externally by NGOs and health authorities) in English, French, Polish, Russian, Serbo-Kroat, Turkish and Spanish. Condoms are available. Disinfection equipment is provided where needed for prisoners' vocational activities, as is protective clothing. Diabetic patients can access special educational courses and technical support. Medication adherence can be supervised (daily or weekly distribution).

In 2004 29% of new prisoners were drug-users (e.g. heroin, cocaine, and marihuana). Opiate substitution treatment is provided to opiate dependent prisoners (180/year in 2004). In May 2005 25 of these were HIV-positive. Waiting lists exist for access to external drug rehabilitation counselling (up to 10 weeks).

Prisoners receive health care including Hepatitis A vaccination, screening for cancer and other diseases. There are special arrangements for people with HIV/AIDS to receive counselling through an external (public health) institution (visits to a specialised physician at the Bernhard-Nocht-Institute). Also, the local AIDS-Hilfe (AIDS-Hilfe Hamburg) organises weekly meetings with prisoners in remand. Specific training aspects are included in basic staff training (including Hepatitis B-vaccinations). Collaboration exists with the prison health centre of Lower Saxony (in Celle) the neighbouring federal state.

A set of standard operation procedures and guidelines ("Hygieneordner") has been developed to deal with increased infection risks in the Hamburg prison used to detain people on remand. A commission on hygiene recommends improvements.

Immigrants health profile

Compared to native Germans most migrants are without doubt socially and health wise in a more critical situation. Thus the health report of the "Robert Koch-Institut" (RKI) "poverty, social inequality and health" dedicates a whole chapter to the relation between migration and health (RKI 2005).

Relations between migration and health result from three very different influences meeting in this group of people (see Razum 2003):

- Social inequality leads to the fact that many migrants are more strongly exposed to risks which a low social state brings with itself (besides other stressors this means disadvantageous living conditions which are linked to the social range.)
- Linguistic barriers and cultural differences in the understanding of health and disease are decisive for the use success and sustainability within the health supply.
- In addition, migration is an event in life, which has the ability to shape the individual biography as well as the family development over several generations.

The non-native population was more rarely ill or hurt by accident (10.7% vs. 13.2%) than natives and also more rarely visited a physician or a hospital (10.3% vs. 12.5%). Concerning the smoking habits the differences are small. Migrants over 15-years of age smoke more frequently than those without a migration background (29.5% vs. 26.7%) but less intensive (the group of the strong smokers among the smokers 13.6% vs. 12.3%) and with 18.2 years they started smoking a little later than natives (17.9 years) (Statistisches Bundesamt 2007a).

5 Community Participatory Rapid Assessment in Hamburg and Oldenburg

5.1 Background and Objectives

Evidence suggests that access to services is particularly challenging for migrants. In lack of more refined epidemiological results more grounded data are the only way to find evidence for:

- services available
- points of access used (known to migrants)
- areas of need, and
- pathways of increased vulnerability.

5.2 Methodology

In order to assess the situation more closely, two regions were chosen for further analysis. The Hamburg region was chosen since the city is home to Germany's largest port facilities. Hamburg is also a region which has a high per capita income additionally providing a ground for informal labour in private households. The second region chosen is Oldenburg. Oldenburg being a smaller town does not provide the anonymity and variety of employment opportunities that Hamburg can offer. Also, the smaller overall number of migrants make the formation of community structures less probable.

In Hamburg several studies have already looked into the health situation of migrants. This report is based on published data combined with expert interviews from the health and social services sector. For this purpose semi-structured interviews were conducted. In addition a workshop held by Entrepreneurs Without Borders and the Ethno-Medical Centre on access to health-care (June 20th 2007) and questionnaire data from the MiMi (N=547) and KAMAHH (N=105) projects (2005/2006) were also analysed to account for the situation in Hamburg and one of its parts (Wilhelmsburg) with a particularly high proportion of immigrants among its inhabitants.

In Oldenburg data on the health situation of migrants were collected through expert interviews from the health and social services sector.

5.3 Community Health Service Providers

5.3.1 Hamburg

The Free and Hanseatic City of Hamburg as a city-state is one of 16 States of the Federal Republic of Germany and the second largest city in Germany. Hamburg is the centre of the Hamburg Metropolitan Region, one of eleven European Metropolitan Regions in Germany. The Hamburg Metropolitan Region is the combination of the Free and Hanseatic City of Hamburg, the administrative districts Cuxhaven, Harburg, Lüchow-Dannenberg, Lüneburg, Rotenburg, Soltau-Fallingb., Stade and Uelzen and the Schleswig-Holstein administrative districts Herzogtum Lauenburg, Segeberg, Steinburg, Storman, Pinneberg and Dithmarschen (www.metropolregion.hamburg.de). On December 31st 2006 the number of inhabitants in the Schleswig-Holstein part of the Hamburg Metropolitan Region accounted for 1,242,957, in the Lower-Saxony part for 1,274,539 whereas in Hamburg itself 1,754,182 inhabitants were registered (Statistikamt Nord 2007a).

General issues

The City of Hamburg has 1,754,182 inhabitants. The City covers an area of some 750 km².

Migrants

According to the register of residents there are 257,060 inhabitants of foreign nationality in Hamburg (Statistikamt Nord 2007b). In comparison: 154,000 or 9.7 % in 1987 and 69,170 or 3.9% in 1970. By the end of 2005 the proportion of foreigners had increased to more than 258,000 (with a simultaneous decrease of 14,000 of total population). Among individuals with foreign nationality the percentage of men (approx. 55 %) exceeded that of women (approx. 45%) (Statistisches Bundesamt 2007a).

According to the statistical estimate Mikrozensus 2005 concerning individuals with an immigrant background the proportion of foreigners in total population amounts to 14.2% whereas the proportion of Germans with a migration background accounts for 12.2 % of the population in Hamburg. Thus 26.8 % of the population have an immigrant background. In younger age-groups a balanced ratio is found between subpopulations with and without a migration background. Approx. 48 % of the below-six-year-old and approx. 45 % of the age-group 6-18 have a migration background. The proportion in higher age-groups is substantially lower. 11 % of the over 60 years of age have an immigrant background. Whereas the proportion of Germans with a migration background in younger age-groups is higher than that of foreigners there is a higher percentage of foreigners in higher age-groups. In the age-group over 60 years the ratio is balanced again.

In Hamburg the percentage of migrants with own migration experience is 18.7 % of total population whereas foreigners and Germans with a migration background but without own migration experience account for 8.1 % of total population. The proportion of women exceeds men among German repatriates and in nationalized Germans with a migration background. According to official registration data almost every fourth individual with foreign nationality (58,154 persons on 31st December 2006) in Hamburg is of Turkish origin. The proportion of Polish nationals amounted to under 8 %, that of nationals from Serbia and Montenegro was below 6.5 %, Afghanistan accounted for under 5 %. The proportions of the other nationalities in the population are smaller than 4% in each case (Statistikamt Nord 2007b).

Socio-demographic Data

Hamburg is organised into seven districts – Mitte (M), Altona (A), Eimsbüttel (E), Hamburg-Nord (N), Wandsbek (W), Bergedorf (B), Harburg (H) – comprising 98 neighbourhoods. Foreigners as a core group of migrants make up 18.7 % of resident population. In an analysis income, proportion of foreigners, persons receiving social assistance and unemployed people and environmental pollution were related to one another. For the Hamburg territory three types of settlement can be recognized identifying segregation on a district level (Maschewsky, 2003).

Socio-ecological Settlement Types in Hamburg (Maschewsky 2003)

Settlement Type		
Type 1	Low household income (25.000 Euro), a high proportion of foreigners (36%), a high proportion of persons receiving social assistance and of unemployed, a heavy burden of traffic	19 urban districts, including St. Georg, Altona-Altstadt, Wilhelmsburg
Type 2	Median household income (33.000 Euro), a low proportion of foreigners (12%), a proportion of persons receiving social assistance and unemployed slightly below average, a burden of traffic slightly below average	65 urban districts, including Iserbrook, Rahlstedt, Bergedorf
Type 3	Very high household income (57.000 Euro), low proportion of foreigners (11%), very low proportion of persons receiving social assistance and unemployed, very low burden of traffic	14 urban districts, including Groß-Flottbek, Harvestehude, Wohldorf-Ohlstedt.

Hamburg's average GDP per capita amounts to about 45,000 euros being the highest amount nationwide. At the same time poverty is increasing in the city (Statistikamt Nord 2007c). Single parents, migrants, children and young people under 25 years are particularly affected (Statistisches Bundesamt 2007a).

Education and Work

The plan of action put in place way by the Senate of Hamburg (Handlungskonzept 2006) focuses on integrating people with a migration background living in Hamburg by referring to

- Language, education and vocational or professional training
- Professional and social integration

It is mentioned (Handlungskonzept 2006) that in the field of language 48% of children under six years in the city of Hamburg have immigrant backgrounds. In pre-school-age 45 % of these children were integrated to such an extent that special educational needs in the field of language development could not be detected (in children without a migration background the percentage amounted to 81,7 %). A strong or very strong need for special education was ascertained in the group of preschool children speaking two languages with 25,2 % (with 4 % of German-speaking children). In Hamburg 44,8 % of Children and adolescents between the age

of six and eighteen have a migration background. There is a higher proportion of children and adolescents with a migration background (17% of the schoolyear 2005 - 2006) at Haupt- and Förderschulen [secondary and special schools] (31 % and 36 % respectively). The percentage of children and adolescents with a migration background at German Gymnasien [grammar schools/ high schools] is comparatively low with 11 %. The proportion of adolescents with a migration background without school leaving certificate is comparatively higher (almost twice as high in comparison to Germans of the same age-group). The proportion of adolescents with an immigrant background in the group of adolescents with an entrance qualification for higher education or advanced technical college is also lower (15,45 % in relation to 39,6 %). In 2005 the 285 institutions for children and adolescents in Hamburg were visited regularly by approximately 31000 individuals of whom 60 % had a migration background. Among adolescents and young adults (between 17 and 22 years) the number of foreigners amounts to 20 % whereas their number in apprenticeships in the industry and the public sector is explicitly lower.

In 2005 the proportion of non-German apprentices accounted for below 8 % in all occupational fields and was especially low in the public sector with 5,8 %. While 33,8 % of the individuals between 18 -30 years of age have a migration background (more than half of whom are foreigners) the presumed number of apprentices in the catchments area of the chamber of commerce amounts to 21,1% (of whom one quarter are immigrants: 5 %). Among students at Hamburg's universities the proportion of immigrants is lower than expected on account of population statistics. In 2004/2005 about 5% of the students at German Universities were foreigners (data regarding students with a migration background isn't available)

The report assumes that according to nationwide statistics a higher proportion of students with an immigrant background and a qualification for university entrance from former recruitment countries interrupted their university studies (among students with an immigrant background presumably for financial, health or family reasons) than German students.

The situation of people with a migration background on the labour market in Hamburg is also marked by increased vulnerability. While the proportion of immigrants in the age-group between 18 and 65 accounts for 17,8% of the population, 24,4% of immigrants were unemployed in July 2006 (with a general level of unemployment of 10,3%). According to the report people with an immigration background are underrepresented in measures of extended vocational training. While in recent years the proportion of foreign self-employed individuals has increased strongly in Hamburg the 12.000 companies lead by entrepreneurs with a migration background are often relatively small.

Health

Access to individual health data is restricted by law (due to data protection). In addition, health research hardly works on the access of migrants to the public health system and to healthcare services. There are no comprehensive data available. As public statistics on health examinations for school entry so far only distinguish between "German" and "Non-German" the possibilities of data evaluation are limited. With regard to vaccination against measles, mumps and German measles the vaccination coverage rate is slightly higher in foreign children starting school. At the same time the proportion of overweight foreign children is nearly twice as high as that of German children at school enrolment. The rate of preschool children participating in recommended health screenings U7-U9 is approximately 40 % lower among foreign children than that of German children (77%). The plan of action (Handlungskonzept 2006) put under way by the Senate of Hamburg also refers to the increasing proportion of

individuals with a migration background among elderly people (over 60) living in Hamburg. One assumes that their proportion will increase from 11 % today to 16 % in the years to come until 2015. The number of foreigners over 80 years of age will almost double in the next 10 years (2005: 3.740 men und women, 2015: 5.700).

The plan of action (Handlungskonzept 2006) put under way by the Senate of Hamburg mentions the fact that individuals with a migration background haven't been reached by community-based drug rehabilitation services so far. Their proportion among addicted clients and patients is substantially lower than their share of the population. The percentage of foreigners being treated for alcohol abuse in community-based drug rehabilitation services accounts for 7 % (14 % among individuals with a migration background) and the proportion of foreigners being treated for addiction to opiates, cocaine and other addictive drugs amounts to 8% and 22 % respectively.

Health service providers in Hamburg are generally mentioning language as a major obstacle. There is little standardization of making use of facilitators financed through health insurance. However, in prevention programmes aiming to decrease drug-use a system of health-guides has been established. While language is being identified as the major obstacle in seeking adequate care, few efforts are aiming to not only provide support to patients directly (e.g. through facilitation). One approach to addressing language differences in prevention has been established in Schnelsen – a part of the city where migrants are living “separated” in high-rise housing – is aiming to go one step further in capacitating migrants in prevention and health education, and training and involving community health educators in programmes (the MiMi-project). The Hamburg Senate has come to the conclusion that these projects should be further expanded to develop a broader outreach (Handlungskonzept 2006).

Tuberculosis in Hamburg

The national incidence is 7.3 cases of TB per 100,000 inhabitants and 10.8 /100,000 in the State of Hamburg. Foreigners account for 50% and more of cases in Hamburg (also if categorized as “people born abroad”).

HIV/AIDS

Since the beginning of the epidemic approximately 7200 individuals have been diagnosed with HIV in Hamburg. Within the same period about 2,500 persons had AIDS diagnosed; ca. 2,300 men, 225 women and 10 children were affected. The total number of deaths among PLWHIV amounts to approx. 2,100 since the beginning of the epidemic. At the end of 2006 there are 5,100 people living with HIV/AIDS among whom the number men (4,550) exceeds the number of women (550). In addition, 20 children are reported as HIV-positive (perinatal infections). Altogether there are 700 individuals living with diagnosed AIDS. Analysing the distribution according to risk of infection the group of men having sex with men are at the highest risk of infection with about 3,500 PLWHIV. 325 PLWHIV have been infected through heterosexual intercourse.

575 individuals from high prevalence countries have been diagnosed with HIV in Hamburg. They have become infected predominantly in their countries of origin through heterosexual contacts. Estimating the actual size of this group is very uncertain since there isn't enough data available to determine how many individuals stay permanently in Germany after having been diagnosed HIV positive. The group of intravenous-drug users (IVDUs) who have been diagnosed HIV accounts for approx. 300 individuals whereas the group infected through con-

taminated stored blood and clotting factor concentrates until 1986 includes about 20 individuals.

With regard to recently diagnosed HIV cases a particular situation could be determined for Hamburg. Both the proportion of individuals with high HIV prevalence among the newly diagnosed and the total number of the infected more than doubled between 2001 and 2006. 201 individuals were newly diagnosed with HIV in 2006 including 180 men, 20 women and one child. The registered routes of infection identify 74 % of infections in men having sex with men. 18% are attributed to heterosexual intercourse, 7 % iv-drug use and 1 % MTCT. AIDS incidence was 90 cases in 2006, including 70 men, 15 women and one child as well as 4 non-classifiable cases. The cases of death among PLWHIV amounted to 55 in 2006 (RKI 2007b).

Hamburg disposes of various institutions and organizations in the field of Health services facilities providers offering support and assistance. In this context there is a range of services regarding HIV/AIDS and sexually transmitted diseases, HIV testing, advice and assistance for people with HIV and AIDS and their relatives, respectively. Furthermore there are services for special target groups like homosexual men and women, sex workers and drug users. Tests for HIV antibodies can be administered by general practitioners and in two institutions of the „Behörde für Familie, Soziales, Gesundheit und Verbraucherschutz“. The information and advice centre for sexually transmitted diseases „Zentrale Beratungsstelle für sexuell übertragbare Krankheiten“ and the AIDS advice centre of the Bernhard-Nocht-Institut offer HIV testing and counselling anonymously and free of charge (Email Wessel-Neb).

Health service and undocumented migrants

One of the few possibilities of gaining access to health care in Hamburg is the medical advisory centre for refugees and migrants „Medizinische Vermittlungs- und Beratungsstelle für Flüchtlinge und Migranten“ in the district of Altona that attempts to pass on migrants to corresponding institutions prepared to treat migrants without health insurance. Against this background, the committee of the Medical Association of Hamburg interviewed physicians and dentists regarding treatment of migrants without health insurance. This study that has not been published yet comprises data of 16 registered doctors in private practice with various specialties and from different districts.

More than half of the physicians interviewed maintained that they treated migrants without health insurance more than one time a month, 19 % of whom more frequently than one time. 73% of these physicians stated that the physical condition of migrants without health insurance was worse than among medically insured persons. Besides, they pointed out in this context that in 75% of cases a previous diagnosis was not retrievable. It may be supposed that many examinations are carried out several times requiring more time and money. On the other hand this could lead to a preoccupation with symptoms regarding psychosomatic diseases and have an adverse effect on the course of the disease on the whole. All in all patients without health insurance are younger than the average of those medically insured. More than 60 % of clients are under 40 years of age and all patients were younger than 60 years.

African, Latin-American and Eastern European countries were the most frequently stated countries of origin. The interviewed physicians stated that paying the treatment of non-insured patients was especially problematic. For the most part migrants are treated for free. Occasionally social security, charitable organizations or the affected individuals meet the costs.

Another problem mentioned in the treatment of migrants without health insurance is the lack of interpreters. Furthermore, those physicians responding asked for better cooperation among physicians, improvement of the residence status and the legal situation of physicians (Internal Study of “Medizinische Vermittlungs- und Beratungsstelle für Flüchtlinge und Migranten”).

INTERVIEW DATA

Chargée d’Affaires for Refugees (Protestant Church)

In quoting the public figure of an estimated 15,000 undocumented migrants in Hamburg, the chargée d’affaires for refugees of the protestant church (Frau Dethloff, telephone interview) estimates a number of 100-150,000. She also mentions the existence of at least 600 children of school-age, who are not being officially allowed into schools (due to lack of legal status). Only one in two (or three) Sub-Saharan Africans living in the city is reported by her to be a regular migrant. Another large part of the undocumented migrants is from the Philippines and Latin America (mostly sailors staying as visitors). A third group of undocumented migrants is taken up by family members (e.g. single parents in old-age) or has been staying in Germany after their spouse died without an own personal residence title.

While Hamburg is economically growing it is assumed that three labour markets open for irregular employment:

- 1) working in households, nursing and care of the old
- 2) harbour related work including the unloading and cleaning of containers
- 3) catering business

Health care for undocumented migrants is limited. Frau Dethloff estimates that there are already more than 600 children living in the city, who do not have access to schools due to lack of adequate papers and documents. As there is no hospital in Hamburg, where women can give birth anonymously, birth certificates and early detection of disease in these children is not secured publicly. Also, lack of labour safety has led to spectacular cases of death in the harbour area. Corpses found have for some years not been tested for HIV by public pathology services.

Undocumented migrants in church-asylum and living in guest quarters of the protestant church are reported to have a low health status. In addition the new immigration law - while enabling tolerated stay and health insurance coverage through public social institutions (Lan-dessozialamt) – has introduced the equitable distribution of individuals to other areas in Germany. This is highlighted as an important issue in providing continuous care e.g. to people with HIV/AIDS. One physician (Dr. Buhk) explains that his patients in becoming “regular” often lose their right to stay in Hamburg and are moved to remote areas. “Being confined of a camp or facility in an area of low prevalence and high discrimination is equal to cutting this person off any links with specialized care and access to specialized HIV/AIDS services in general. It has been a death sentence in one case.”

A network of civil society organizations has developed in this context. Combinedly, they offer a wide range of services not funded by the public. The service for homeless people funded and organized by the catholic charity Caritas (directed mostly at Russian speaking migrants) including busses that service the streets. A hospital-based service of the order of the Knights of St. John (Malteser Migranten Medizin) also targets undocumented migrants with ambulatory medical care. The Medical Assistance for Refugees (Medizinische Flüchtlingshilfe) provides access to a network of physicians providing medical care at no cost or at material costs

(e.g. laboratory). Another service offering access to female physicians is volunteered by *Mujeres sin Fronteras*, an intercultural women organisation in Hamburg.

There is concern about the growing network of irregular medical services used by undocumented migrants. African healers, herbal and Chinese medicine are reported being made use of by undocumented migrants (as an alternative to the German system). Also, French speaking migrants are reported to travel to France for access to health care.

Zentrale Beratungsstelle für sexuell übertragbare Krankheiten

Established as a public service to mainly care for female sex workers, the central consultancy service for STDs (*Zentrale Beratungsstelle für sexuell übertragbare Krankheiten*) in Altona is a public institution offering health-services specially for STIs, also to undocumented migrants (anonymously). The *Zentrale Beratungsstelle* uses methods of streetwork to reach its target population. Services include anonymous, voluntary counselling and testing of HIV, Hepatitis B and C, Gonorrhoea, Syphilis and Chlamydia. The *Zentrale Beratungsstelle* also offers PAP-smears and examination of the female breast (palpation) as means of early detection of cancer. However, following diagnosis only the traditional STIs can be treated as well. If patients (undocumented migrants) are diagnosed with cancer or HIV-infection there is often no access to regular treatment. Alternatively, it is sometimes possible to enter these patients into clinical trials, where medication is free. The *Zentrale Beratungsstelle* provides leaflets in a number of languages. Consultation is provided before and after testing. In working with illiterate people and people with limited language skills facilitator services are involved. No quantitative data could be provided (Telephone Interview with *Zentrale Beratungsstelle*, August 6th 2007).

A second public service institution is open for HIV/AIDS and STI diagnosis providing (anonymous, free, voluntary) counselling and testing at the *Bernhard-Nocht-Institute*.

AIDS-Hilfe Hamburg

The *AIDS-Hilfe Hamburg e.V.* is a self-help association, a citizens' movement and a professional institution for counselling and assistance in the field of HIV and AIDS. As a free non-profit organization it is committed to providing information for people interested in AIDS and increasing awareness of HIV, AIDS and other sexually transmitted infections. Set up in 1987 the *AIDS-Hilfe Hamburg* has about 10 regular employees and 90 volunteers.

It is attended predominantly by PLWHIV and their family members as well as by people looking for counselling on HIV/AIDS. The total number of individuals who attended counselling at *AIDS-Hilfe Hamburg* in 2006 accounted for 13,694 clients (of whom 70 % were men). The age range of clients varied between 19 and 65 years. For the most part the PLWHIV are referred to the organisation by HIV specialists and other physicians, AIDS counselling centres, centres for psychological and social help and the department of public relations of the *AIDS-Hilfe Hamburg*.

The *AIDS-Hilfe Hamburg* does not offer HIV testing. By talking to clients they try to identify pros and cons to each case of testing and whether the affected person would be better off living with uncertainty or being tested positive.

The experiences of the *AIDS-Hilfe Hamburg* in the field of compliance of migrants and non-migrants diverge: While nationals for the most part show high compliance it largely depends whether migrants understand why medication is important and should be taken regularly. This depends on the command of German among the affected individuals or rather if they are attended by a compatriote physician or whether they are accompanied by an interpreter. In addi-

tion, problems occur due to a lack of understanding regarding scientific medicine and the question whether taking medication regularly is compatible with life. According to the staff of the AIDS-Hilfe neither migrants nor non-migrants have more difficulty in meeting appointments. This often depends on the state of health among patients.

Funding of medical costs is considered to be another problem. Since in Germany health service reforms were put into effect and a quarterly consultation fee (Praxisgebühr) has to be paid, in some cases it has become difficult for medically insured migrants and non-migrants to pay the "Praxisgebühr" and the medication co-payment charge.

The AIDS-Hilfe Hamburg recognizes the individuals with uncertain residence status can consult a doctor and receive antiretroviral drugs with funding being guaranteed by health insurances. However, "their life is marked by the worry concerning the lack of right to remain, traumatic experiences in their country of origin or during the flight. Non-insured individuals seem to face serious financial challenges because especially their access to HIV treatment is restricted" (Interview AIDS-Hilfe).

HIV Specialists

Of seven HIV-specialist contacted three responded positively. Telephone interview were conducted with two physicians. Medical treatment of migrants accounts for between 5-20 % of patients (data on 1,500 PLWA).

Attending physicians identify lack of compliance as causing considerable problems in this population. The reasons for this are not only the lack of language skills but also cultural differences which cannot be recognized easily by physicians. Furthermore, the financial background and a possible lack of information concerning the German health care system could create barriers for migrants to good medical care (Email Schewe). One a physician states that migrants often are more afraid of attending a specialized practice than non-migrants. Migrants appear to fear meeting acquaintances who then could find out that they are HIV-positive. In addition, migrants are afraid of financial penalties if they cannot go to work on a regular basis because they have to see their physician.

5.3.2 Oldenburg

The Oldenburg region (State of Lower Saxony) covers a part of the North-West plains of Germany with coast line along the North sea, bordering with the Netherlands. It is part of the EU Metropolitan region Oldenburg/Bremen and the administrative centre of the Weser-Ems region (2.48 million inhabitants). Major sea ports close by include Wilhelmshaven and Bremen. The region covers 14,965 km².

General issues

Oldenburg city has 159,060 inhabitants (end 2006), 51.92 % female. The city covers an area of 103 km². Foreigners account for 5.56 % of the population (8.840 inhabitants). This proportion is far below the national average of cities that size. The number of male foreigners is significantly higher. This is interpreted to be contributable to men more often coming to Oldenburg through labour migration.

Migrants

Turkish migrants have contributed the largest number of foreigners of one nationality in Oldenburg for a number of years (2,069 inhabitants in 2005). Turkish people account for more than 25% of non-Germans, while the second strongest group consists of 706 Polish inhabitants, the third largest group is Iraqi (399 inhabitants). The number of Turkish and Iranian nationals has been declining in recent years, also as a consequence of them choosing German citizenship following the enactment of the Naturalization Act in 2000 (Staatsangehörigkeitsgesetzes, StAG). Among African nationalities 74 Cameroonians, 70 Somalis, 53 Maroccans and 48 Angolans are the strongest groups. Among Latin American nationals only the 54 Brazilians form a larger group.

Socio-demographic Data

The population of foreigners is unequally distributed across the city. In the district of Neuenwege Blankenburg (a hamlet around a cloister) is the “ZAAB” (centralized office for entry and foreigners) and among 1,452 inhabitants of the district 584 (40.2%) are foreigners (depending on the number of asylum seekers, refugee and people on remand staying in the facility). Higher numbers of foreigners also live in the city centre district, in Osternburg, Kreyenbrück and Bloherfelde (university student accommodations).

In approaching the situation in this region we first contacted the AIDS-Hilfe Oldenburg – the regional NGO (funded by State government and – to a small degree by local authorities), who supplied us with a list of contacts of social and health care providers. We also contacted the State’s ministry for Social Affairs.

HIV/AIDS

38 individuals have been newly diagnosed with HIV in Oldenburg (2001-2006, data from SurvStat@RKI.de). Of 44 people with AIDS 25 had died by end of 2004 (Robert Koch-Institut Epidemiologisches Bulletin / Sonderausgabe A 12. April 2005).

13 individuals from high prevalence countries have been diagnosed with HIV in Oldenburg between 2001-2006. Estimating the actual size of this group is very uncertain since there isn’t enough data available to determine how many individuals stay permanently in Germany after having been diagnosed HIV positive. 10 cases among MSM and five among the heterosexual

population were registered in these six years. The group of intravenous-drug users (IVDUs) who have been diagnosed with HIV accounts for 2 individuals whereas the group infected through contaminated stored blood and clotting factor concentrates until 1986 includes 5 individuals.

INTERVIEW DATA

AWO Oldenburg Ausländerberatung

The first telephone interview was conducted with the AWO (Welfare for Workers, Arbeiterwohl-fahrt) counselling service for migrants. The interview partner did not have experience with infectious diseases in particular and denied the existence of a specialised service beyond the local AIDS service organisation, but pointed to the fact that facilitators were provided when migrants needed assistance in precarious health situations from the local public health service. Beyond this she stressed the lack of access psychotherapy. Local capacity is limited to one psychologist. Psychotherapy in any other mother tongue but German requires travel to Bremen (40km). Statutory health insurance recently stopped refunding travel expenses. Some links exist with Hanover based multicultural health services (EMZ and ITB). She identified the State Psychiatric Hospital in Wenden and a drug-treatment clinic for youth from families of repatriates (Spätaussiedler) as potential sites of special interest for further exploring integrative practices and vulnerability. She also mention having been asked to provide counselling in the context of the deportation prison in Meppen. The AWO counselling service is part of a cooperative social network of organisations and regional public administration (“Regionalverband cooperative Sozialarbeit”). The interview partner mentions the leading role of the charity “Diakonie” (protestant church-based) and of staff at the Ossietzky-University in Oldenburg.

Carl-von-Ossietzky University

Contacts with the Ossietzky-University were followed up in two telephone interviews and one face-to-face interview. The first contact was a staff member, who reported that recently one professor working on the issues of health and migration had recently died and another one had entered retirement. He promised to follow up. Another call was made following his further reference with no result. The third interview was conducted face-to-face in Bremen. It confirmed a precarious health situation in the prison sector in the region. No activities aiming to particularly address or register the health needs of migrants was identified. AWO called back two weeks after the interview and provided the contacts for a previous employee of the university. His telephone interview is documented below (last in this section).

AIDS-Hilfe Oldenburg

The AIDS-Hilfe Oldenburg organised a staff meeting (3 part-time staff, one male, two female) including a board member (female) to answer the questions posed in the questionnaire sent to them previously and explained in follow-up telephone communication. Confidentiality was assured on individual cases.

In looking at the map of their region staff pointed to twelve sites across the region where they worked in HIV and Hepatitis prevention and support activities involving migrants. They particularly mentioned a prison in Nordenhamm and the collaboration with public health services in Cloppenburg and Vechta (in Cloppenburg there is a large State prison, in Vechta the State’s prison for women and the attached central clinic). In the Cloppenburg prison another NGO

collaborates in drug prevention among youth. In response to the regional map the interviewees provided a city map. The map was drawn by the regional working group on criminal prevention. The page shown highlighted a part of the city with the highest per capita number of police and legal investigations against foreigners in Oldenburg. In asking why this occurred the interviewees pointed to the criminalization of the inhabitants of “ZAAB” (for further details see page 55).

Decentralized accommodation of people on tolerated stay often outstretches resources on both sides. PLWHIV and their children are accommodated across the region. Their travel to psychosocial services is supported through AIDS-Hilfe funds or refunded by local public social services (optional). AIDS-Hilfe staff travels throughout the region to enable a caring environment through education, training and individually supporting PLWHIV in critical life events (e.g. child birth, AIDS diagnosis) and in contacting local social services.

Close links exist to the local addiction service provider (“DROBS”) in Cloppenburg, where German repatriates and Eastern European are forming sizeable communities.

AIDS-Hilfe Oldenburg is linked with the Network for Refugees in Oldenburg (Flüchtlingsnetzwerk Oldenburg) a regional network of support groups. Collaboration exists regarding prevention activities in the ZAAB.

Information on HIV/AIDS, STIs and hepatitis can be provided by AIDS-Hilfe Oldenburg in English, French, Turkish and Russian and a couple of other languages. Leaflets are produced and the specific lack of material in Arabic is mentioned.

The number of migrant PLWHIV is increasing gradually at a steady rate of 2 cases annually. 15/84 adult PLWHIV and 9/39 of their children are immigrants among clients (year end 2006). Mostly women with children are from Sub-Saharan Africa. “For these women AIDS-Hilfe Oldenburg is the point of reference for institutions and NGOs in the region.” The organisation is involved in forming a network to address pregnancy and migration as a topic in research and to improve services for PLWHIV.

The interviewees acknowledge their image as a “public institution” as a threshold in access for migrants. PLWHIV report high levels of anxiety of “coming out” in their own communities. Staff mentions high levels of anticipated self-discrimination heightening the geographical isolation. “They do not want to meet each other in our self-help groups. There is one activist in Bremen, who is trying to form a network. Up until now there is no other effort of self-organisation of interest of migrants around HIV/AIDS identifiable in our region.”

About ZAAB

In Oldenburg the “ZAAB” (centralized office for entry and foreigners) including the local facility “Blankenburg” (capacity up to 550 places) is of particular concern to the interviewees from AIDS-Hilfe Oldenburg. AIDS-Hilfe Oldenburg is regularly called into the facility to provide information and counselling⁵. The high fluctuation of people detained there of concern to their prevention and support efforts. On the other hand some people have been in Blankenburg for some three years (on maximum three months term of tolerated stay). Follow-up is also challenged by transfer of detainees with family members in school-age to a centralized facility for people on remand in Bramsche (outside of the geographical range of the AIDS-Hilfe Oldenburg). Guidelines regarding medical care in the ZAAB are not known to the interviewees. There is a physician in the ZAAB – but staff is reported to change often. A psychotherapist is said to have been denied access to patients. Personal data are provided. Interviewees express concern: “This could possibly be a result of her capacity as a physician to diagnose illnesses posing an obstacle to deportation”.

More recently the ZAAB appears to have experienced a major influx of people from Arab countries and from Asia. Within the facility language capacity is reported to be German, English and French. Facilitation is provided in these languages in the administrative processes (“interview”). Finding assistance in other languages requires volunteered service.

Interviewees were concerned regarding cases described as human rights violations in the ZAAB. Following demonstrations and protest (culminating in a hunger strike to allow people to prepare meals for themselves in November 2006) local activists and people inside the ZAAB have begun to collaborate on health issues. They include (incomplete list):

- *not learning the scope and results of medical tests being routinely applied during the first three days in the facility. Inside the facility medical service does not appear to be resourced to provide basic WHO recommended health care. Having too few physicians in the facility. No facilitation in physician-patient communication is provided. Prevention activities depend on outside intervention which is subject to restrictions (e.g. individual case-based or by invitation only).*
- *not being able to build relationships with health care providers and friendships in a climate of constant threat of deportation (sometimes daily), being moved to another facility or decentralized accommodation elsewhere, and under restrictions on freedom to travel (1-2 days). The facility itself is some 7 km distance from the city centre, bus service costs 3.70 Euros return (of 8 Euros daily allowance) and the schedule is spurious (at 9, 10, 12 and 16.00 hrs).*

Pregnant and other PLWHIV in the ZAAB are receiving waivers to access outside psycho-social and specialist care.

(We also conducted a confidential interview with a person living in Blankenburg. Particular concerns were confirmed through case reports and first-person experience. A group of internal and external activists has been initiated to address patient rights and to educate about basic hygiene and water safety. A recent external offer for group counselling on pregnancy was not accepted by the facilities administration. Psychological trauma is reported to be endemic.)

⁵ Services are names-based.

In conclusion the interviewees of AIDS-Hilfe Oldenburg recommended:

- increasing human rights education in the ZAAB and providing for access to voluntary counselling and testing anonymously and preferably in the language of the migrant.
- establishing a first paid “migrant” staff position at AIDS-Hilfe Oldenburg to stabilize the exhausting volunteer resources for psychosocial support of migrant PLWHIV in the region.
- increasing networking in the region to improve services for female and pregnant PLWHIV.
- acknowledging the important role of the Hamburg (170 km) as the civil society centre for African and Latin American migrants from Oldenburg (estimated 2-300 people in two years) seeking support in a community of compatriots.

Public Health Service

Specialized HIV/AIDS counselling and testing are provided by the Oldenburg municipal public health service. The staff member interviewed by telephone has been active in running the service for over 15 years. She reports to be seeing 18 PLWHIV on a regular basis. Some are coming in on a weekly basis, others choose to only come in when “there is a burning issue”. In addition short term periodical counselling is offered and accepted by more people.

The 18 PLWHIV seen by the interview partner on a regular basis are aged between 24-67 years. Most clients are aged between 30-40 years. Four clients are migrants. Three women aged between 30-40 and one man in his late 30s.

HIV-testing and counselling is offered following a “permissive” strategy:

- voluntary,
- anonymous and
- free.

In addition the public health service aims to provide a low threshold e.g. with flexible opening hours and an informal setting.

Foreign languages spoken are English and Spanish. Interpreters are not used for other languages. Close links exist between the public health service and e.g. the municipal counselling services for people with disabilities, drug users and pensioners. The interviewee has two “big issues” with the migrants among her clients:

- a tendency not to keep appointments,
- denial of HIV-status and transmission risks.

Hepatitis and TB are commonly seen as co-infections in PLWHIV at the Oldenburg public health service. TB cases more often occur in patients from Eastern Europe. Hepatitis is particularly common among iv-drug-users counselled.

HIV Specialist

Specialized HIV/AIDS care is provided in an oncology outpatient clinic run by three specialists. The partner interviewed (face-to-face) responded with regard to 100 patients, of whom some 20 are migrants. In response to the questionnaire she reported a lower degree of compliance among male African migrants. Improved French language skills could bring an advantage for herself. 60% of migrants do not pose particular problems in any way different from Germans. 40% are “cultivating their own sense of time” and “get angry about it”. Missed ap-

pointments are followed by patients having to wait longer times in the city until medication ordered is being delivered. The clinic only sees patients with health insurance or waivers from social authorities. In individual cases, where the German partner of a migrant is affluent, services are privately paid. Until 2005 ambulatory care for HIV/AIDS was provided in the local hospital (where the clinic is now a neighbour), but this service is now out of function. Hospital staff are said to be not in a position to provide care for undocumented migrants.

In communicating HIV/AIDS with her migrant patients she would like to increase her competence. She asked: “How do I approach certain topics with migrants?” – “How do I respond, when their eyes begin to run and they ask: Why me?”

Information material provided (leaflets by provided by AIDS-Hilfe Oldenburg) is considered useful. PLWHIV are seen for routine follow-up on a quarterly basis. 30/100 HIV patients in the clinic have dual HIV/Hep C infections. 15 PLWHIV are treated with HAART. Five have been examined for TB.

The clinic is the reference point for ambulatory care for the local and regional public health service and for the Blankenburg facility. Consultant advice is used through the Hanover Medical School (Medizinische Hochschule Hannover). Weekly the clinic sees 1-2 PLWHIV.

Social Service Coordinator

The interview partner is a social service coordinator for refugees in a charity in the Northwest of the Oldenburg region. In his district 53 people are applying for asylum and 800 people have a tolerated stay. Cost for health care of asylum seekers is covered by the State public service and cost for health care of people with tolerated stay is covered by local authorities. Problems arise when during legalisation cost-coverage changes from public support to statutory health insurance. While the public social support to medical care includes support for travel – health insurance does not provide for these costs. In a limited number of cases it was possible to recover travel expenses through employment services (ARGE). He also describes the lack of suitable psychotherapists in the region as a serious obstacle to better care for patients. Health insurance also does not cover the costs for interpreters.

The interviewee sees no future for the ZAAB system. He has not heard of any effective distribution of people from the centralized facility in Oldenburg over two years. He confirms that people with cancer are not deported. People with psychiatric illnesses often require a second (“less partial”) opinion in courts.

He describes the practice of providing health-care on a case-by-case basis to undocumented migrants in the region. Physicians are providing services for free. Altogether cases of people going irregular (from facilities) are rarely living in the region. Some cases of privately organized asylum and through churches are known. The challenges of legalizing people’s stay are also addressed on a case-by-case basis.

5.4 Diaspora and Migrant Associations

5.4.1 Hamburg

Entrepreneurs without Borders

Entrepreneurs without Borders is an initiative by migrant businessmen and start-ups to improve economic and social integration of migrants. The organisation has recently begun to cooperate with the EMZ to develop new concepts for improving health service delivery.

The accumulation of social and environmental stress in some districts of Hamburg is further heightened by a lower than average number of physicians practicing e.g. in Wilhelmsburg (Type 1). The number of patients/physician (1/4,000) is four times lower than the average for Hamburg. While in St. Pauli a migrants' health centre (including a day-spa) has been established Wilhelmsburg is not yet there. As a consequence of the lack of physicians the organization "Entrepreneurs without Borders" has initiated two workshops to address the issue. EMZ participated in both events. The following information is also based on an a face-to-face interview with Hidir Demirtas and minutes of the meetings (of public and private sector representatives and migrant community health activists).

It is commonly assumed by actors in Wilhelmsburg that only one third of the population of 49132 is native German (Dec 31 2006). It is estimated that undocumented migrants add about 10% to these official figures. The population in Wilhelmsburg is described as being poorer, younger, having a high number of people living on social benefit and female undocumented migrants. Its distance from the city centre (and its virtual isolation – Wilhelmsburg is "a fenced in island in the harbour") entails making use of public transport, which to some people is forbiddingly expensive if they have to use it often i.e. to seek specialized medical care (transportation costs are usually not covered through health insurance).

Proposals (by the group invited by Entrepreneurs without Borders on May 3rd and further elaborated in a planning session on June 20th) to solve the issues of limited access to health services for migrants in Wilhelmsburg include:

- providing incentives to physicians to stay/settle in Wilhelmsburg by subsidizing rents in a migrants' health centre for medical, nursing and psychosocial care
- creating a guide to health services and networking of service providers
- making use of local data (e.g. hospital admissions) and creating local health data with regard to the migrant population
- increasing prevention capacity
- expanding health examination of children in schools
- co-operating with kindergardens and schools on the topics of nutrition and physical activities

In bringing the results of the 45 participants to a podium of public actors (more than 120 migrant businesses and organisations present) the following additional proposals were made:

- raising the percentage of migrants employed in the public sector to 20%.
- strengthening the role of nursing care for the old in the training of migrants as nurses.
- likewise increasing the intercultural competence of migrants' organizations and public services.

- introducing mediator concepts and methods e.g. into home-based education services for migrant families on social benefit.

As a consequence of this initiative taken by Entrepreneurs without Borders the physicians in Wilhelmsburg have organized themselves in an association (Verein Wilhelmsburger Ärzteschaft) aiming to strengthen and bring together medical and nursing care providers as well as established social services (e.g. at the local hospital). “Lack of integration, exclusion and poverty cause illness – integration, information and health therefore need to be addressed together.”

KiFaZ Schnelsen

The MiMi project „With Immigrants for Immigrants” is carried out by the Ethno-Medical Centre Hannover cooperating with other regional partners at various locations in Germany on behalf of the Bundesverbandes der Betriebskrankenkassen (BKK) (federal association of the company health insurance funds). The regional partner in Hamburg is the non-profit association “Verband Kinder und Jugendarbeit e. V.” which is situated in the centre for youth and family (Kinder- und Familienzentrum (KiFaZ)) in district of Schnelsen. The KiFaZ is a neighbourhood facility supporting families which describes itself as an institution in favour of children and families and serves as meeting point and support centre.

„With migrants for migrants” is motto and concept of the project at the same time. By winning immigrants as health mediators these trained immigrants are enabled to inform their fellow countrymen in collaboration with other health care actors about health care in a culturally sensitive way and in different languages. In Hamburg courses can be arranged in African languages (Ewe, Ga, Twe, among others) as well as in Albanian, Arabic, Bosnian, English, Farsi, French, Hindi/ Urdu, Croatian, Kurdish, Persian, Polish, Portugues, Russian, Serbian, Spanish, Thai and Turkish. The course offered as a “standard” by MiMi mediators lasts about three hours providing information on the German health care system.

The content of the second half of the course can be chosen according to interest from the following subjects: health risk overweight/ adiposity, health risk alcohol, health risk smoking, alimentation, mental health, pregnancy and family planning, child health and accident prevention, proper use of medication, aging and care of the elderly, HIV/AIDS prevention and dental health.

A questionnaire was developed and used in the MiMi-project to assess the health literacy and sociodemographic variables of transcultural health mediators and of community members attending group education on prevention and health in their mother-tongue. In addition in a more specific training programme (KAMAHH) addressed HIV/AIDS prevention and information needs and made use of specific questionnaires.

Within the MiMi-project participants in Hamburg data have been evaluated for 2004-2006. Training of mediators started in 2004 (in KAMAHH in 2006) and was followed by public campaigns (self-organized group sessions). Altogether some 80 mediators have been trained in Hamburg and are available for interventions (26 MiMi events in twelve languages and 11 KAMAHH events in six languages are considered here). The majority of participants in MiMi (n= 455) was female (>80%), married (>65%), has two or more children (>60%) and has been staying in Germany for more than eight years (>60%). Community group participants come from Turkey (>30%), former Soviet States (>14%), Germany (4%) and other regions. A social index of migrants participating in the evaluation (composed of school atten-

dance, employment and self-assessed language skills) shows equal numbers of high and low status members (each group above 25%). As a summary outcome participants were asked whether they would need to change their attitudes with regard to health after a community group session. Over 60% agreed that this was true or very true. Top ranking in satisfaction was given by up to 92.5% (“well” or “very well” in 2005).

Between May 2006 and December 2006 eleven community group sessions on HIV/AIDS prevention by migrants for migrants in Hamburg were evaluated fully. They were led in sole responsibility by nine intercultural mediators. The events were accomplished in six languages, one session was conducted in German, because different languages were spoken by participants in the group session. All events (but one) were open to the public and between six and 21 participants attended. The duration of the community group sessions varied between 1,5 and 2,5 hours. The main part of the group sessions consisted of an interactive lecture on HIV/AIDS, followed by an open discussion, feedback and questions and the second part of the questionnaire.

128 participants came from over 15 different countries of origin. 105 participated in the evaluation: 67 women and 37 men (one person did not indicate his/her gender). Approximately 20% of participants came from Iran, Turkey and Afghanistan each. The age of participants varied from 11 - 66 years, the majority was at that time between mid-twenty and mid-forty. Most have been living in Germany for more than 10 years, about 11% immigrated in the past five years. Asked to judge their competence in the German language approximately 40% indicate that they have good or very good German language skills. Four participants said that they have no knowledge of the German language at all. Despite the relatively high education indicated only three individuals are now working in an occupation, which requires a university degree, 17 persons are involved in the low wage segment. In the pre-intervention part of the questionnaire the participants were also asked about their knowledge on HIV/AIDS. Here it turned out that the majority already knew about the connection between HIV and AIDS. Large disagreement prevailed over the origin of AIDS. A remarkable statement can be found in the answer on the question, whether or not only homosexuals can be infected by HIV: Over 30% was completely and/or rather sure that only homosexuals get AIDS. Within the range of the strategies of prevention the knowledge on HIV diverged. The majority is sure that condoms protect against HIV, but is uncertain whether avoiding contact with HIV-positive people, avoiding an operation or a dentist appointment offers a protection from infection. 84% are sure that the use of sterile drug injection equipment is a possibility to minimize the danger of infection. Among HIV/AIDS service providers the AIDS-Hilfe Hamburg and the public health service’s HIV counselling and testing clinic were most commonly known. Physicians specialized in HIV/AIDS were commonly not identified as “known”.

The majority of the participants were very content with the different meetings. Thus also the expectations in the events were fulfilled and 89% indicated that they had learned a lot about HIV/AIDS in the sessions. In post-intervention questioning 86% of the participants answered that they would need to reconsider their attitude after the meeting and reflect their past positions on the topic.

The Centre for Children and Families (Kinder- und Familienzentrum, KiFaZ) in Schnelsen confronted public actors with the results of considerations on health for migrants in Hamburg in a hearing. The public side added some more concrete proposals:

- strengthening the role of nursing care for the old in the training of migrants as nurses.
- likewise increasing the intercultural competence of migrants’ organizations and public services.

- introducing mediator concepts and methods e.g. into home-based education services for migrant families on social benefit.

TAMPEP

TAMPEP (the European Network for HIV/STI Prevention and Health Promotion among Sex Workers) and the Office for Social Affairs and Health (Behörde für Familie, Soziales, Gesundheit und Verbraucherschutz) in Hamburg conducted a project to assess the situation of sex workers in Hamburg (TAMPEP 2007). Data provided by State Office of Criminal Investigation estimate 2,300 sex workers working in Hamburg, of which 50% are foreigners and some 15% irregular residents. 340 apartments and 157 brothels are known. The highest percentage of non-German sex workers is estimated to work in apartments and brothels (the so called “Modellwohnungen”). In this sector 65% (550 out of 850 are foreigners and about 10% of them are undocumented migrants). Also, more than half of the about 30 transgenders working on the streets in St. Pauli are thought to be undocumented.

In talking to more than 1000 sex workers, (2005 and 2006) TAMPEP found a European to non-European ratio of 2:3. The rise seen in women coming from new EU member states is interpreted as a response to greater freedom of travel and stay. TAMPEP also acknowledges the increasing independence of women at work.

TAMPEP concludes from the interviews that working conditions for many sex workers in apartments have recently deteriorated considerably. On the one hand economic pressure has risen due to the growing number of sex workers causing women to accept higher risks for better payment. On the other hand decrepit, unhygienic and neglected apartments have become the rule rather than the exception they were previously. It is concluded that the demand for sex without condoms is on the rise and that specific educational efforts (e.g. safer sex, hygiene, respect for sex workers) should aim to reach the customers, as well.

TAMPEP in reviewing the health care offered to sex workers by 39 governmental and 42 non-governmental organizations (throughout Germany) finds undocumented migrants to be particularly challenged within the governmental sector. In comparison NGO-based services more often also offer legal and psychological advice and make more use of facilitators and cultural mediators. Services are offered anonymously and free of charge.

The main barriers identified for migrant sexworkers accessing social care services in general are:

- Mistrust of public institutions as a result of unfamiliarity with the social system in Germany.
- Confusing NGOs with state offices.
- Undocumented status and fear of the consequences, insecurity
- High rate of mobility
- Poor language competence on the side of the sex workers
- Dependence on pimps, brothel owners.
- Poor intercultural and language competence on the part of the organizations’ (NGOs) and institutions’ (GOs) co-workers
- Lack of awareness of the counselling centres regarding the situation and the needs of migrant sex workers
- Moral inhibitions (fear and shame)
- Experiences of discrimination and stigmatization

5.4.2 Oldenburg

Several attempts were made at directly introducing the questionnaire to a migrant audience in Oldenburg. The timeframe was considered unrealistic providing for the introduction of a research tool in groups either unfamiliar with HIV/AIDS as an issue or not to be contacted or called in time through existing organizations. Overcoming distrust in the application of research tools (questionnaires), language barriers and contempt towards questioning in general – also traumatic experiences and plain concern – were identified as challenges. The Network for Refugees Oldenburg (Flüchlingsnetzwerk Oldenburg) is currently considering our interest in creating data among undocumented migrants throughout their network. There is an interest to contribute to improving the health services for this population. Basic democratic principles require group meetings to discuss our interest. The contact is upheld.

The Network for Refugees Oldenburg has in January 2007 developed a list of demands addressed to the City of Oldenburg concerning improvements to be sought for medical care in the ZAAB Blankenburg. They include:

- full application of §§ 4 and 6 of the Asylbewerberleistungsgesetz (providing access to medical care, see above).
- freedom of choice of physician (no first pass through facility's physician and no limitation to sub-contracted specialists).
- covering the costs of interpreters in medical care.
- providing a waiver for medical treatment unbureaucratically and in time for treatment.
- separating economic and medical interests at the ZAAB.
- covering cost for transport to see a physician.
- improving hygiene through increasing the number of toilets and showers.
- cash payment and provision of kitchens to allow inhabitants to prepare food for themselves.
- establishing a call-system for medical emergencies on facility grounds.
- ending centralized and isolated accommodation of refugees.

5.5 Results of Participatory Assessment

Services available

Both in Hamburg and in Oldenburg anonymous and free VCT for HIV/AIDS is being provided by public health services. Free testing is also provided by physicians as part of the statutory health insurance scheme (as is treatment). In both cities an AIDS-service organisation exists in the private sector (AIDS-Hilfe) providing counselling, support and prevention activities (but no testing). In Hamburg there is a prevention project specialized on addressing migrant communities.

Points of access used (known to migrants)

Both in Hamburg and in Oldenburg the public health service (also in centralized facilities), physicians and NGOs for refugees exist. It is currently not possible to compare their respective reach into the migrant communities (due to lack of performance data). In particular, no figures can currently be presented to provide an impression of the size of the undocumented migrant population and their making use of services. In Hamburg there is some evidence to suggest that the AIDS-Hilfe as well as the respective governmental services are well known to migrants, whereas specialised medical practitioners are not so well known.

Areas of Need

Most service providers stress their need to improve communication with regard to language capacity and intercultural understanding. Few describe not keeping appointments as a “typical” issue with migrants. Migrant organisations, on their own behalf, are also pointing to language issues. However, the more precarious the living conditions of migrants are, the more “burning” are the issues with health care related expenses, e.g. for travel to seek treatment, facilitator costs and co-payments for medication. In Hamburg and in Oldenburg there are human rights based approaches to supporting (irregular) migrants to find access to privately organized care. However, charitable donations are needed and thus continuity of care can be challenging through these networks. In both cities one organisation is the central clearing point for support to undocumented migrants and their health needs.

Pathways of particularly high risk

Considering the high level of coverage of health services for legal residents through statutory health insurance, and besides the specific no-access rule for undocumented migrants there are particular risks associated with legalisation or going irregular. There is also evidence to suggest that levels of (self-discrimination) are high among migrant PLWHIV.

During legalisation health care is provided for by the public social service (either local or State). Some municipalities in the Oldenburg region also cover travel costs and costs for interpreters. There are no co-payments in this phase. Once legalisation is granted and the person becomes covered by statutory health insurance these costs are rarely covered and co-payments have to be made.

Another pathway associated with an increased risk during legalisation is associated with the mechanisms of distribution of asylum seekers, refugees and people on remand according to a mechanism aiming to distribute the social costs of immigration equally among States, municipalities and districts. Thus a person on remand from Hamburg, who is granted an extended

period of tolerance because his health status would not allow deportation to his country of origin (e.g. because treatment can't be assured there), may be sent and restricted to live in a rural setting in the East of Germany (where both migrant communities and specialized HIV/AIDS care are rare).

Centralized accommodation of refugees, asylum seekers and people on remand is also of high risk potential. The medical care provided in Blankenburg is high concern to the community actors interviewed. While there is evidence that there are not necessarily any handicaps to PLWHIV in this facility to find specialized care, numerous vulnerabilities are mentioned when general health is concerned. The health situation described for Blankenburg should not be interpreted out of proportion. However, they are in line with numerous case reports and with descriptions of experiences likened to torture and mal-treatment by human rights organizations (Gierlich 2007).

Going irregular (e.g. by going underground from a centralized facility or decentralized assigned accommodation) appears to produce added risks with regard to health care. While some anonymous services are being provided by public health services, becoming ill and needing treatment is most often depending on voluntary or paid for private services.

Becoming pregnant for undocumented migrants is associated both with an increased probability of being tested for HIV/AIDS and of not finding adequate perinatal care. There is only one hospital reported in the entire material, where deliveries are being offered on an anonymous basis.

Becoming imprisoned reduces the chances of receiving support and being provided with information from the outside. Only under extraordinary circumstances are external NGOs and other providers invited to contribute to the intramural services.

6 Discussion of the Results and Policy Implications

The most recent NGO report on the situation of migrants with regard to HIV nationally was published by the AIDS and Mobility Network in 2006 (Grimalschi 2006). In the report Deutsche AIDS-Hilfe (DAH) describes the situation based on end 2005 statistics and a rising percentage of and disproportionate risk for migrants to be HIV-positive. This assumption must now be challenged based on the data presented in this report. There appears to be no increase in new infections diagnosed among people from countries of high HIV prevalence. There also seems to be a profound healthy migrant effect, namely a prevalence of HIV among non-Germans that is below the prevalence in the high prevalence countries of origin (even though these data also need to find more proper assessment in relation to the countries of reference).

The DAH report estimates that 20% of 400,000 sex workers working in Germany are immigrants. This report finds data that the percentage varies according to place of work and that conditions in a substantial sector of Hamburg's sex "industry" have deteriorated considerably. Namely the risk of infection from unsafe sex has risen according to the report by TAMPEP. New EU countries are well represented among sex workers even though work permits are not issued for this population. The TAMPEP data also point to the highly vulnerable group of transsexual sex workers from Latin and South America.

The activities described by DAH to establish self-help networks of African PLWHIV are ongoing. In Hamburg the AIDS-prevention activities at KiFaZ in have now become part the MiMi-project on general access to health-care and prevention (in collaboration with AIDS-Hilfe Hamburg). In other sites activities in this direction are developing. Yet, demand for such projects still exceeds resources of providers.

The DAH report mentions stress and burnout among volunteers and staff of AIDS-Hilfe organizations. The interviewees in our report contributed their own stories to this end. It appears that the field has been largely volunteer based and driven by human rights activists for years. Funds and staff positions are rarely reserved for this "extracurricular" task. It may also be worth considering at this point, how much more a vintaged AIDS activist can imagine the dreadful fate of someone being deported without the certainty of having access to ART. While, today, images of people dying from AIDS within a very rapid period have largely disappeared from health care in Germany – these images are burning very brightly in the minds of experienced staff and volunteers and also in PLWHIV from a less fortunate country. Losing a client to an uncertain future in his country of origin is associated with death. In a recent meeting of experts in HIV/AIDS patient support (Kasseler Kreis) it was mentioned that the Federal provision for people with HIV/AIDS not to be deported to a country without adequate treatment was answered by one local authority securing the funds for one year of treatment in the country of origin – and proceeding with deportation.

Access to Germany's social welfare system relies on residence status, mostly. Similar to German citizens, EU citizens can receive (almost) free access to high quality health care through the national statutory insurance system. There is, also, a legal mandate to support the basic living and social needs of anybody legally staying in Germany. Such support is either provided through the municipal or through state authorities.

Health is addressed by all public actors on the local, state and federal level, while infectious diseases fall within the mandate of federal governmental agencies. State law translates the

Federal Protection Against Infection Act (Infektions-Schutz-Gesetz, IfSG) into the varying practices of the 16 German states. At the community level, local services for infectious disease control include the public health services, the much larger numbers of medical and care services organized in the statutory health insurance system and those acting privately. HIV/AIDS prevention and care policies are being addressed at all three levels in networks (of varying legal nature, e.g. national AIDS council, community health conference).

Two sectors demonstrate a greater variety of practices within this framework:

- Prisons and people in detention: Care for people in prisons usually is under the sole jurisdiction of the ministries of justice on a state-level.
- Public health service: While prevention and diagnosis are recognized areas of activity in all services, the provision of treatment (e.g. to undocumented migrants) through public programmes is organized differently by each municipality.

The level of HIV/AIDS knowledge in the immigrant population is lower than in the population of German origin (Steffan 2005, Robben 2007). The level of discrimination is in comparison much higher within migrant communities (Ngassa Djomo 2007).

Projects and publications concerning the topic of “illegal” migration are available since the middle of the 1990s. So far no study represents the topic in its entire scope, rather there is a number of smaller, qualitative and locally limited studies, which supply an empirical description of the life situation of undocumented migrants. The field of research is represented generally as difficult to access. Other work and projects are conceptual and theoretical and concentrate on the economic aspects of the phenomenon, on the process of the illegal entry and the organisational structures of facilitators and “Schleuser” (“traffickers”). Altogether it applies that illegality represents a relatively new and little developed field of research in the German social sciences (BAMF 2005a).

Illegality extracts itself by definition from official contacts and thus a statistic collection of data. There are frequently estimations in the public debate concerning the magnitude of irregular migration stays in Germany. These estimations should be – because of the reasons mentioned above - met with scepticism. Since both, the irregular entry and the irregular stay are criminally relevant facts, migrants with such a status are anxious to hide their stay from the German authorities - also because of deportation. The authorities are obliged to report the irregular stay of the migrants, so that sanctions terminating residence can be introduced. Therefore any national registration - e.g. at the reporting authorities, social insurance institution and in schools - is omitted. Thus the migrants living in Germany without permission do not appear in the statistics. Despite the difficulty to determine the number of undocumented migrants there is a possibility to identify some tendencies within the range of irregular migration. Indicators like apprehensions because of irregular entry at the borders or because of irregular stay cannot measure the uncontrolled migration as such, but refer in a limited way to a long-term development (BAMF 2005a). Apart from the facts already addressed, the stay of undocumented migrants is not stable. Generally it applies that an empirical socio-structural evaluation of criteria like national composition, age, sex, education is nearly impossible in Germany.

A study undertaken to identify health care and health care needs of undocumented migrants in Hamburg (Schmitt 2006) reports that the living and working conditions as well as the fact of being without residence permit puts the people under psychosocial pressure. Becoming sick is deteriorating the situation. Being afraid of deportation, because of the costs and/or losing the job while absent at the workplace, ‘undocumented’ migrants wait longer to have diseases treated by physicians with the result that the diseases get worse or even become chronic. Other negative side effects are: ‘doctor hopping’ and discontinuity in treatment, abandoning treatment in hospital by the patients without informing the physicians and pregnant women coming late for check-ups. The study also finds that self medication is one option with the risk of wrong treatment and resistance of pathogens. The lack of a general practitioner as “co-ordinator” of the patients is reported to lead to multiple diagnosing, tying costs and capacities. It also highlights the importance of not only covering cost but also providing a framework that does allow medical care (including in hospitals) to be provided free from the legal threat of penalisation for assisting “illegal residents”.

In 2006 DAH report demanded more financial assistance to migrants’ organisations and securing pilot programmes. There does not appear to be a significant progress to this end.

Three most vulnerable groups among migrants have been identified (Grimaltschi 2006):

- 1) Immigrants whose language and culture sets them apart from German language and German society
- 2) Irregular and migrants with tolerated stay
- 3) Particularly marginalised and discriminated ethnic groups

Further differentiating this classification, women now appear to be the most highly vulnerable group (at least among people from high prevalence countries). Undocumented migrants and migrants with tolerated stay are confirmed as particularly affected by the thresholds of access to statutory health insurance and equitable patients’ rights, and also by the comparative lack of assistance for language problems and geographic distance. Thus legalisation is more clearly identified as a path increasing vulnerability without the adequate support being secured through public social services. In addition we highlight findings of internal discrimination and stigma, particularly against African PLWHIV within their own communities in the Oldenburg region. This is in line with earlier findings in Turkish immigrants discriminating against MSM from their own community and particularly those with HIV (Turkish Youth in Salman 1992, Muslim MSM in Bochow 2005, Turkish MSM living with HIV in Ngassa Djomo 2007). Internalized discrimination lowers the probability of voluntary partner disclosure and increases the risk of transmission of infectious diseases within a community. Whether MSM within migrant communities are a more significant group in numbers than women is currently impossible to assess. The reference of the Robert-Koch-Institute to not knowing the latest place of residence of people with HIV may be further confirmed by UNAIDS asserting that 700 MSM in Turkey acquired their HIV-infection in Germany (oral communication, UNAIDS, in Lisbon May 2007).

The conflicts on reporting or secretly treating undocumented migrants were highlighted in the DAH report. Today, public social services are actively invoking both the Infectious Disease Act and basic human rights in providing anonymous services. Medical care can be financed for compulsory treatments (e.g. Syphilis, Gonorrhoea, TB) and it is also possible find public support for deliveries inside hospitals. HIV treatment is almost impossible to arrange legally for undocumented migrants. It is difficult to arrange care and prevention for people on remand (e.g. in ZAAB Blankenburg) or affected by the system of re-allocation according to the distribution key (from Hamburg).

Networks of physicians and social services are aiming to improve this situation. The Chamber of Physicians in Hamburg has begun to examine the size of this mostly volunteered effort among their members. In the Oldenburg region, addressing the topic of “Pregnancy and Migration” in a network may be used to target the women most in need and to find resonance avoiding the stigmatized label of “HIV/AIDS”. Close links now appear to exist between AIDS service organisations and networks involved in securing support to undocumented migrants in both regions.

The DAH report quoted an estimate of 1.3 million “migrants without residence permits” living in Germany. While in Hamburg the issue is very much on the agenda as a community and civil society concern, this does not appear to be the case in Oldenburg. Rather, it is becoming reasonable to assume that resourceful communities draw compatriots and are more attractive than living with an uncertain status in a centralized facility or elsewhere. It must be assumed that irregularity to some is more attractive than being “tolerated” in Germany. People living with HIV/AIDS could be an exemption to this rule. They appear to live in greater dependence on public social support for their treatment than is available through networks for irregular residents. Context and trajectories as aspects of individual vulnerability (Delor 2000) appear to play an important role in this critical decision. Isolated PLWHIV appear to bear the brunt of this burden (Buhk 1999).

The level of education among children and youth with a migration background is of high concern and is being addressed in the National Integration Plan. In Hamburg, there is certainly a lot of room for improvement in capacity building and equitably providing access to migrants throughout a number of sectors. In Oldenburg the city government has recently asked the State to contribute to improving bus services from and to the ZAAB in Blankenburg.

The social marginalization of immigrants described in the DAH report and the problems with language and treatment culture are confirmed. There is reason to ask to include migrant representatives in the conduct of projects beyond prevention programmes. By involving community groups in research “in all development phases” the efficacy of programmes could be greatly improved. Obstacles need to be overcome in recruitment and in trust among migrant communities – even among migrant based organisations. One of the major obstacles “language” urgently needs to be overcome in research in migrant groups. Effective mechanisms to this end are being developed (Wienold 2007).

TB control in Germany appears to be highly effective. STIs have been well controlled aside from outbreaks associated with sex among highly promiscuous MSM. Here LGV has recently been reported. Also, in looking at recent campaigns to roll out HPV vaccination there does not appear to be a lack of skills in addressing the parents and youngsters among migrants in a number of languages and through various methods and techniques. Also, HIV/AIDS programmes for and with migrants all across Europe – no exception known – are struggling hard to survive. In several countries working on the topic of HIV/AIDS and migrants is still becoming a volunteer activity after more than a decade of experience and lack funding constraints for this most pan-European of challenges in the HIV/AIDS field.

Applying a common standard for providing HIV/AIDS care regardless of residence status in Germany is being asked for (Grimalschi 2006). Pregnancy and psychiatric illness appear to need most attention. Besides the health care system, other sources of public social support for adding to travel and facilitator expenses are needed to provide adequate care. Further specifi-

cation highlights this need in rural areas and sites far away from the next point of access to specialized treatment and psychosocial support (e.g. 80km from Aurich to Oldenburg).

The importance of a broad coalition of actors to eliminate HIV stigma and taboos is stressed. By broad participation of German actors in the Bremen Civil Society Forum, which addressed the issue, by identifying additional resources for HIV and Migration for Deutsche AIDS-Hilfe and in issuing their report through the AIDS and Mobility network, new activities have been contributed. There is apparent confidence among actors that concerted action on a national and regional level is possible between migrant-based and HIV/AIDS organizations. Discussions to establish transcultural HIV/AIDS and drug abuse prevention programmes in more than 40 languages in all major regions across Germany are underway.

The situation in prisons should receive further attention. It appears of concern to both health and social experts that being under the authority (and within the financial responsibility) of a state ministry is not considered equitable access to health care. Public social support from local authorities (guided by local politicians and actors in administration) is obviously of the essence in order to apply appropriate services.

The stark West-East contrast in Germany also needs to be further addressed and responded to adequately. There is evidence linking East-West internal migration of migrants (some into irregularity) due to increasing racism. Since the mechanisms of reporting infectious diseases currently do not allow to control for internal nor for out-movements of PLWHIV questions related to the quality of care and the need for support in very low incidence areas in comparison with high incidence areas (e.g. Hamburg). The stark contrast between East and West in HIV/AIDS cases and the different distribution of migrants living in Germany suggest a more complex relationship.

Mapping (Fung 2004) allowed the identification of networks where to direct migrants for appropriate services and support regarding the contextual level of vulnerability (Delors 2000) regionally. The socio-structural and socio-symbolic dimensions of being an HIV-positive migrant in Germany (trajectory level) and of interaction (between partners) have only briefly been touched. No links to TB networks were identified. Mapping still had to be incomplete at this stage. The interactions between national and other levels are left to be considered.

National integration policies and the ensuing discussion of health determinants of migrants in Germany are focused on overcoming deficits associated e.g. with poverty and lack of education (Federal Government 2007). The example of the Ethno-Medical Centre's activities in Hamburg in addition promotes efforts aiming to overcome deficits in health literacy in other segments and social strata through community-wide capacity building.

It can be concluded from the Hamburg data that adult migrants have difficulty understanding and acting upon health information within the context of the German health care system. There is also evidence from Oldenburg to suggest that some individuals are unaware of their patient rights upon entering Germany. A great deal of health information, from insurance forms to advertising, contains complex text. Even very literate Germans have trouble obtaining, understanding, and using health information. A report by the Institute of Medicine (Institute of Medicine 2004) describes the challenges posed in health literacy and proposes a systematic framework. "Just as a surgeon may have trouble using an insurance form, a science teacher may not understand information about a test of brain function, and an accountant may not know when to get a mammogram."

German language appears to pose a considerable challenge for migrants in first finding basic information. At the same time more experience (and/or learning) is needed before individual migrants obtain, process, and understand the basic health information and services they need in a fashion comparable to their German counterparts (some concepts of statutory health insurance are singularly German e.g. “Kur” – prescribed rehabilitation in a Spa). The skills, preferences, and expectations of health information providers are addressed in a transcultural context: doctors, nurses, administrators, community health workers, the media, and many others need to become involved in a convergence of education, health services, and social and cultural factors. The described activities in Hamburg and Oldenburg are already beginning to bring together research and practice from diverse fields following the initiative of migrants (and their organizations).

7 Conclusions and Recommendations

Since migrants are defined differently, it must be mentioned a priori that this report mostly provides evidence and considerations about the situation of immigrants. Time and resource constraints limit the analysis of emigrants and German people working abroad, tourists and Roma people. Further research including more migrant voices, the German development NGOs, diplomatic service and industry should look into these issues more closely.

- Germany is a low prevalence country for all infectious diseases under concern.
- Federal law enshrines general health insurance for diagnosis and treatment of HIV/AIDS, TB and other infectious diseases. Legal residence is a precondition to statutory health insurance membership.
- Federal law mandates individual support to be made available freely to anybody not covered by health insurance through public services (including STI and TB clinics).
- Federal law mandates access to general health services for acute illnesses (including HIV) for everybody (refugees, asylum seekers, people on remand. and undocumented people). After 48 months of stay full access to health services is provided (also for chronic illness)⁶. Legalization assures stay in Germany on remand until treatment can be assured in the country of origin.
- While foreigners have been recognized as a sub-population in statistics, migrants are not yet fully represented in public statistics. Undocumented migrants are mostly excluded.
- HIV/AIDS policies are formulated through public-community dialogue and oriented towards solidarity, empowerment and support. Voluntary counselling and testing is provided for through public health services and private doctors. Anonymised registration of laboratory test results is compulsory. The number of newly diagnosed HIV-infections in people from high prevalence countries has remained stable in recent years (ca. 300 per annum since 2001). A majority of the 4,115 PLWHIV from high prevalence countries is female (1,206/1,965 cases since 2001).
- TB policies are formulated in public-research consensus and oriented towards monitoring and control. Foreign and foreign born patients have an increased chance of being diagnosed with TB. Treatment is compulsory on a named-patient basis. No further increase was seen in the number of people with TB from Eastern Europe in 2005.
- Migration policies support integration into German society and demand a basic ability to communicate in German. In-country courses provide for education and training of migrants in Germany. Special provisions for immigration of German repatriates (Spätaussiedler) and other groups (e.g. threatened minorities) exist.
- Entry to the labour market is restricted to legal residents. Special provisions for people staying on a tolerated basis exist (after six or eight years). Further exemptions are made.
- The number of undocumented immigrants and of refugees and asylum seekers is apparently diminishing. While this effect may also be statistical (UNHCR 2007) it appears from our research that at least in Hamburg the number of undocumented migrants is rising.
- There is considerable immigration (2004: 697,000) and emigration (2004: 547,000) in Germany. Most immigrants live in Western Germany and most emigrants leave from there. Emigrating pensioners and retirees can carry their social insurance benefits in-

⁶ Gesetz zur Umsetzung aufenthalts- und asylrechtlicher Richtlinien der Europäischen Union, Art 6 Abs 2 (2), Bundesgesetzblatt, 2007, p. 2007

cluding health insurance at the German standard. Health education including HIV/AIDS training is offered to employees before leaving Germany on a mission to high prevalence countries (e.g. in the development sector, police forces and military).

- In health care in general resources are scarcely oriented to migrants' needs. The quality of health care for undocumented migrants has not been systematically assessed nor has the health care provided legally to prisoners and people living in entry- and deportation facilities/assigned quarters been subject to more than punctual transparency through independent research.
- Volunteer-based, and professional service providers, religious groups and opposition parties are asking for equitable access to health care for undocumented migrants.
- The methods of distributing and taking care of refugees, asylum seekers and people on remand as well as people imprisoned before deportation are being challenged by NGOs. Most recently, the UNHCR criticized the practices. The research provided by this report demonstrates the trauma experienced by individuals (e.g. by being separated and isolated from access to specialized medical and psychosocial care for PLWHIV). In mapping resources and exploring demand the geographic distances caused by the method of distribution are identified as a particular strain on NGOs and on health care providers as well as PLWHIV.

Recommendations

Considering the published material and the results of the research for this report all levels of policy and the legal system are to be reminded that the German government and civil society do not follow the same opinions and views with regard to HIV-prevention. There is considerable overlap formulated in the National AIDS Plan and in the National Integration Plan and there is a huge combined effort. Private initiatives carried by a humanitarian spirit are aiming to further expand access to health care for migrants in Germany. This is true for allowing more resources to be allocated to taking care of refugees, asylum seeker and people on remand as well as undocumented migrants in precarious living conditions. This is also true for allowing more resources into prevention efforts based on creating solidarity between and within migrant communities, which in turn can expand to undocumented migrants in precarious living conditions. Some groups ask to end deportation altogether, some want to provide health care regardless of residence status, now. Both positions do not find a majority in society and politics.

There could be common ground on the following recommendations:

- 1) The National AIDS Plan and the National Integration Plan should be further developed to account for incoming results of community based research in migrant populations in Germany.
- 2) The changing health associated knowledge, attitudes and behaviour of migrants living in Germany should be further researched by making use of capacity building programmes empowering migrants and their communities.
- 3) Good practice models of public and private health care and prevention should become more visible including health service provision to pregnant women (e.g. anonymous birth), volunteer-based charitable services and initiatives by migrants.
- 4) Private businesses, families and individuals should be further encouraged to contribute to health related safety for their migrant employees and their families.
- 5) Health care providers and hospitals (particularly those in public ownership) experience legal pressure when caring for undocumented migrants. Lifting this pressure could improve the provision of medical care by creating a safer environment.
- 6) The reliability of health care for undocumented migrants could be improved, while expansion of general health insurance takes form. Setting up a non-governmental foundation (as proposed by the Chamber of Physicians in Hamburg) could be considered as an option to cover costs of health care for undocumented migrants. Public and private funders could be asked to contribute to this health and prevention fund.
- 7) The health of people on remand could be greatly improved by prolonging the terms of tolerated stay to a period long enough for effective health and prevention interventions also in psychiatric cases (as judged by the health service provider).
- 8) Antidiscrimination efforts should be more strongly addressing marginalization of migrant PLWHIV from within their communities.
- 9) Services introducing immigrants to the reforming German health care system and patient rights should be further developed and expanded allowing for different levels of skills and educational needs.

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9 Acronyms

Acronyms

AIDS	Acquired immune deficiency syndrome
ARGE	Arbeitsagentur
ART	Anti-retroviral therapy
AufenthG	Aufenthaltsgesetz
AWO	Arbeiterwohlfahrt
BAMF	Bundesamt für Ausländer, Migranten und Flüchtlinge
BeschVerV	Beschäftigungsverfahrensverordnung
BMI	Bundesministerium des Inneren
BzgA	Bundeszentrale für gesundheitliche Aufklärung
CDC	Centers for disease control
DAH	Deutsche AIDS-Hilfe
DROBS	Drogen-Beratungsstelle
EMZ	Ethno-Medizinisches Zentrum
GO	Governmental organisation
HAART	Highly active antiretroviral therapy
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
IOM	International Organisation for Migration
ITB	Institut für transkulturelle Betreuung
IVDU	Intra-venous drug-user
KAMAHH	Kultursensible AIDS-Meditorenausbildung in der Hansestadt Hamburg
LGV	Lymphogranuloma venereum
MDR-TB	Multy-drug-resistant tuberculosis
MiMi	Mit Migranten für Migranten
MSM	Men who have sex with men
NAC	National AIDS Coordinator

NGO	Non governmental organisation
PLWHIV	Person living with HIV/AIDS
RKI	Robert-Koch-Institut
STI	Sexually transmitted infection
UNAIDS	United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation
WIAD	Wissenschaftliches Institut der Ärzte in Deutschland
ZAAB	Zentrale Aufnahme- und Ausländerbehörde

10 Annexes

Map I: Geographical Distribution of Diaspora Communities at the Country Level

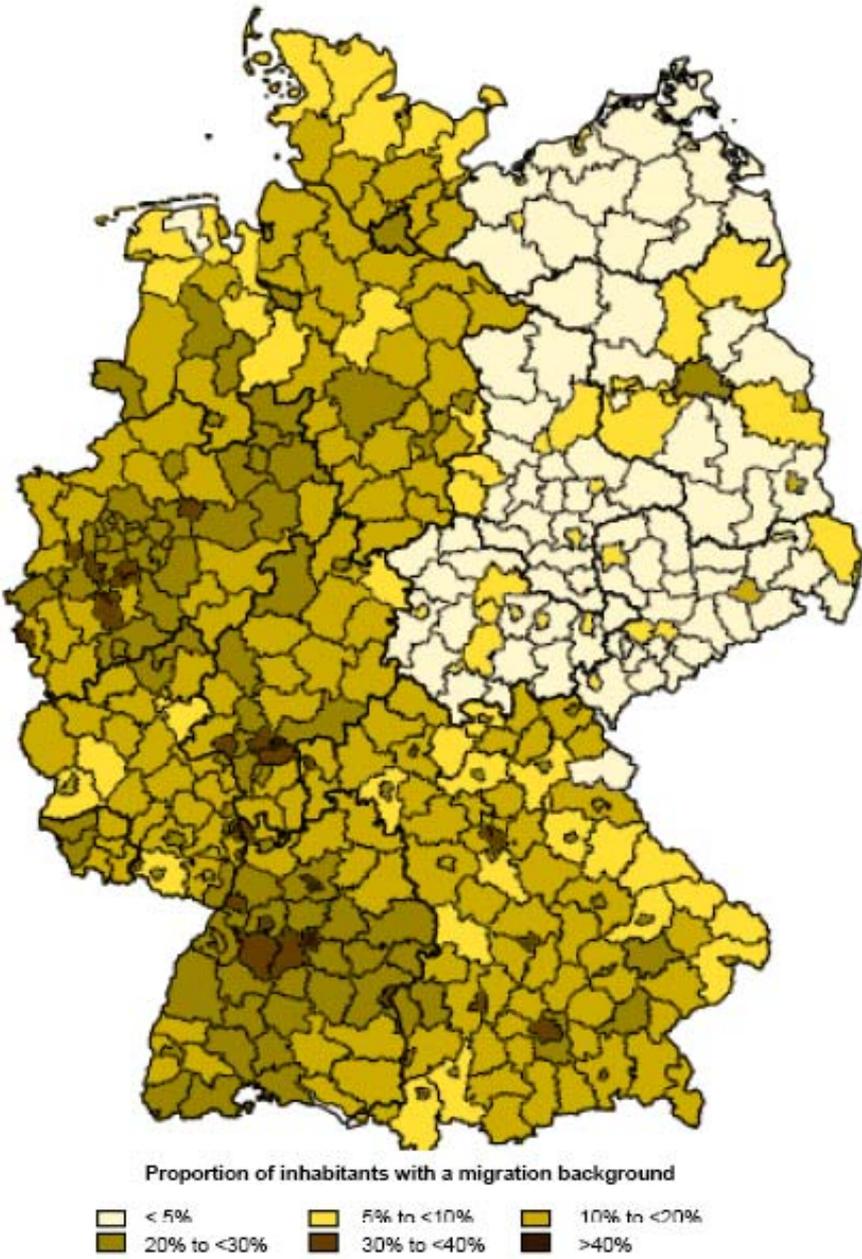
Map II: Geographical Distribution of HIV and TB Prevalence at the Country Level

Map III: Distribution of Health Service Facilities in the Selected Study Spot

Questionnaires

8.1 Map I: Geographical Distribution of Diaspora Communities at the Country Level

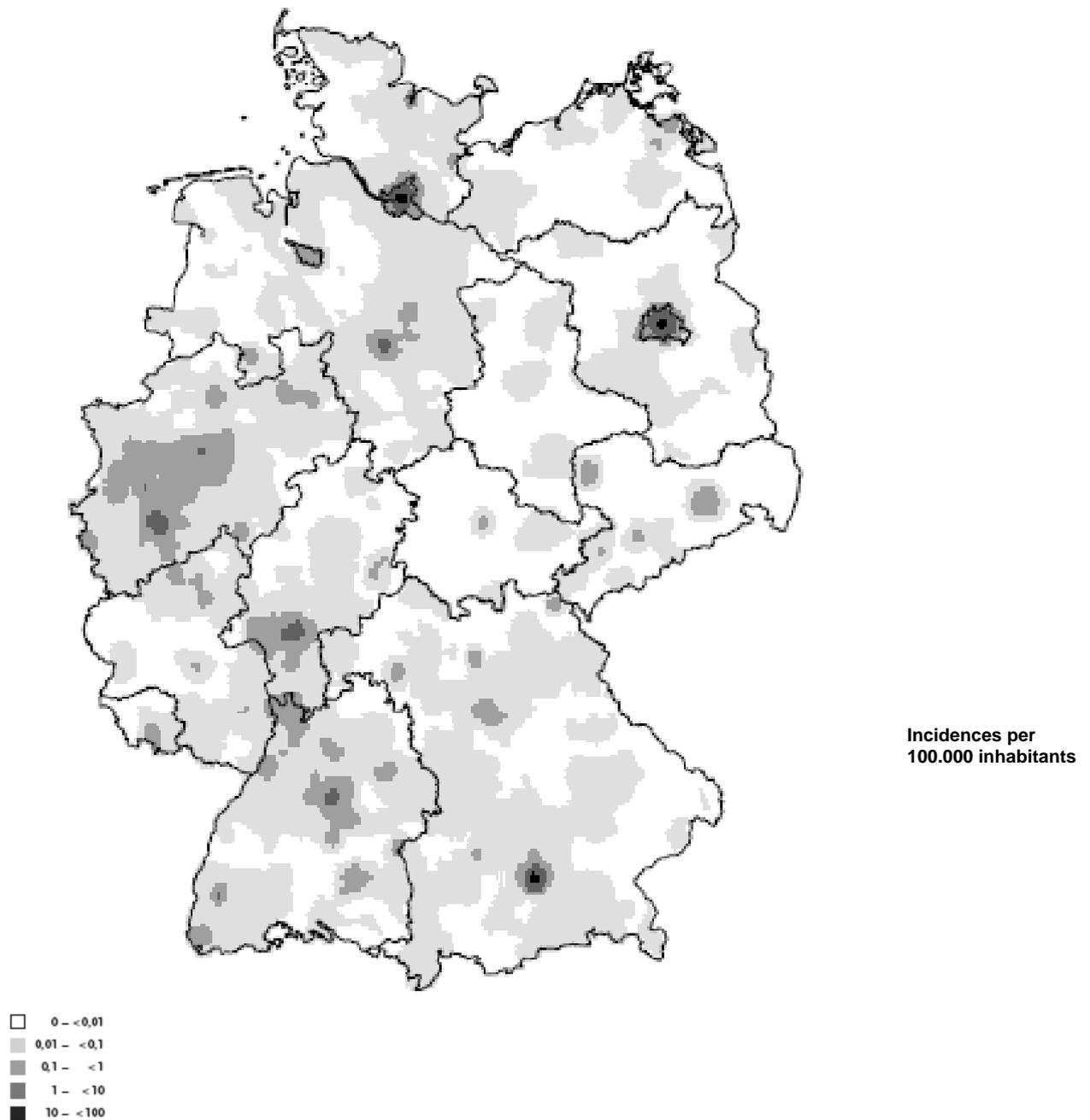
Proportion of people with a migration background (see definition above) in municipalities and districts (2005)



8.2 Map II: Geographical Distribution of HIV and TB Prevalence at the Country Level

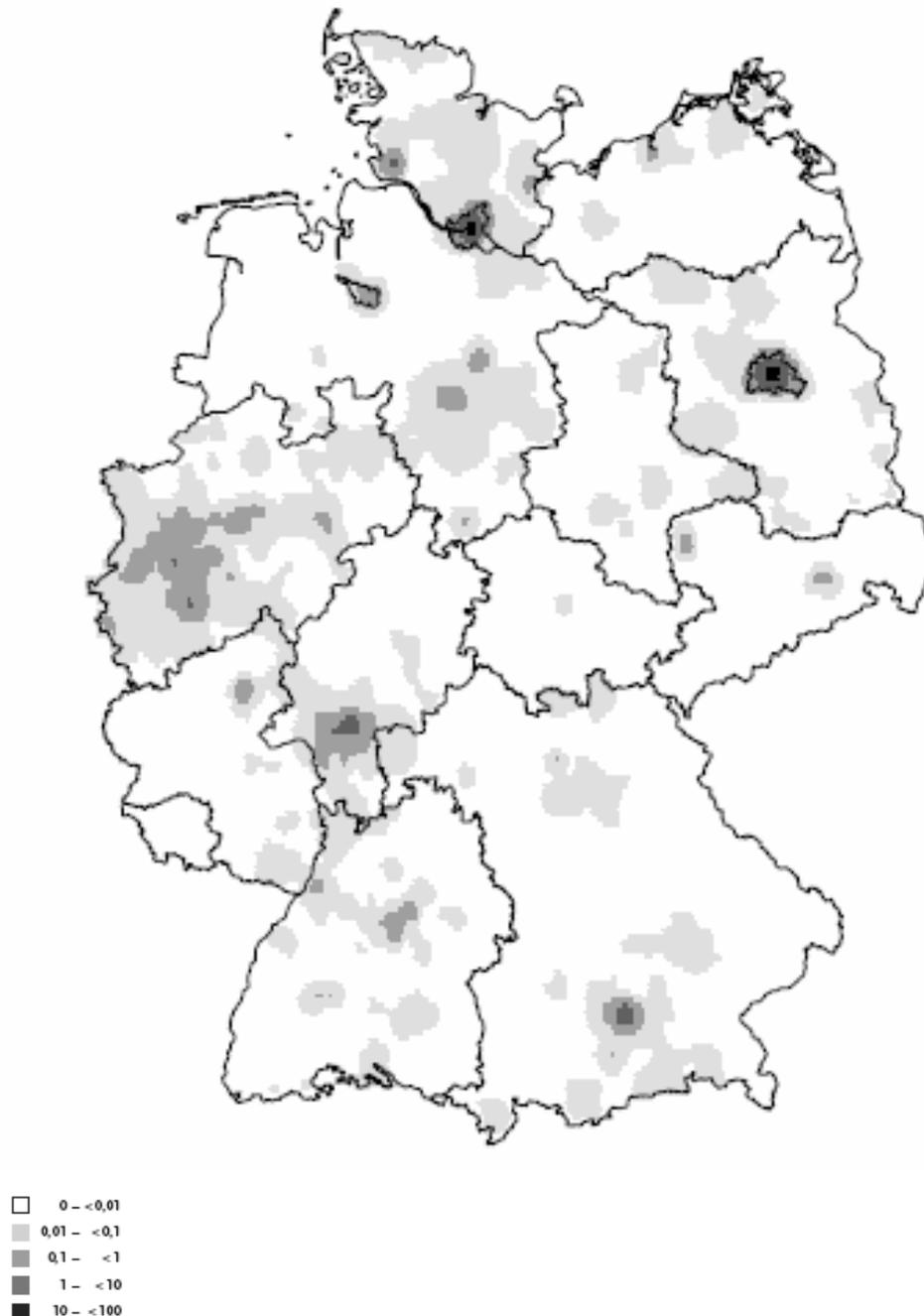
a) HIV in the Federal Republic of Germany

First time registered HIV incidences per 100,000 inhabitants (N=2.611) between 1 January 2006 and 31 December 2006 (based on the population figure of the triple-digit postal code area, rounded)



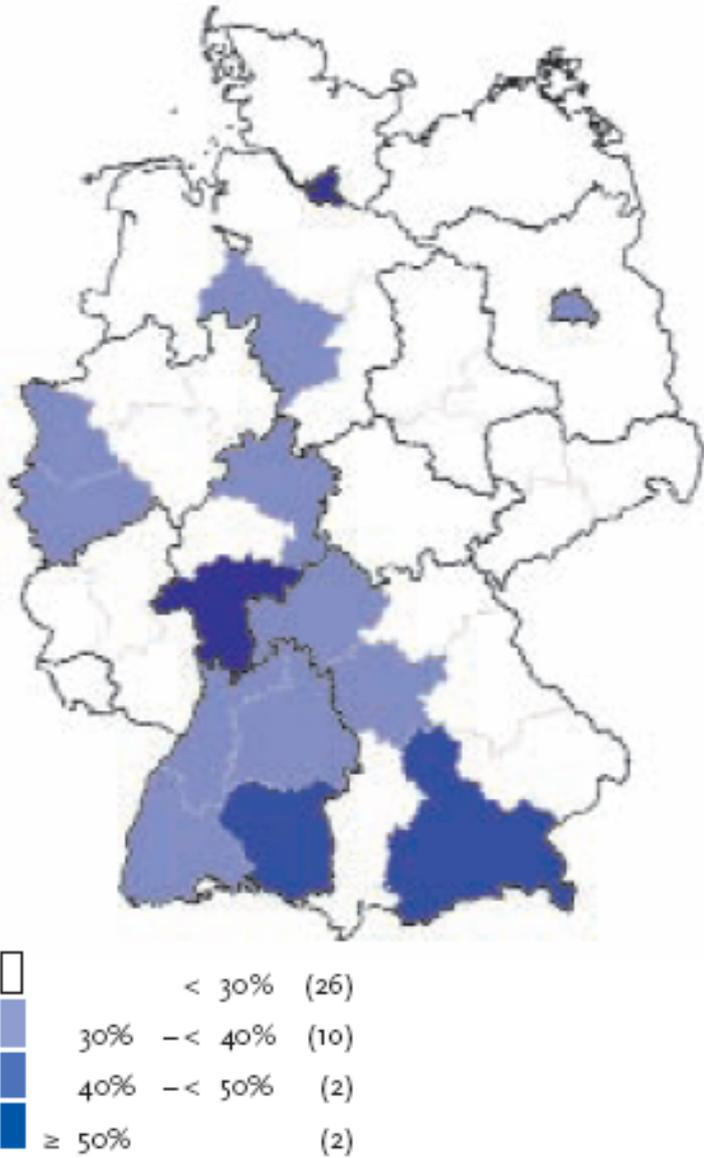
b) AIDS in the Federal Republic of Germany

First time registered AIDS incidences per 100,000 inhabitants (N=1.448) between 1 January 2004 and 31 December 2006 (based on the population figure of the triple-digit postal code area, rounded)

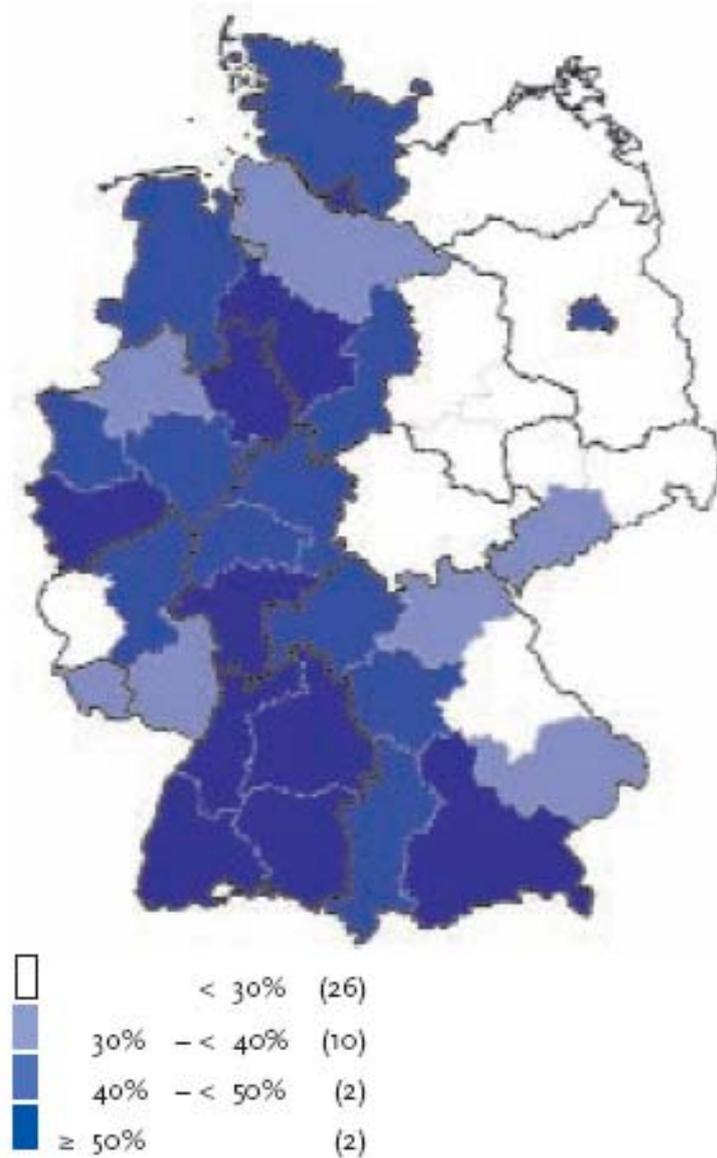


(Figures modified from RKI: Epidemiologisches Bulletin, 29.Mai.2007, p.11)

c) Proportion of TB-cases with a foreign nationality according to administrative district (N=5.852)



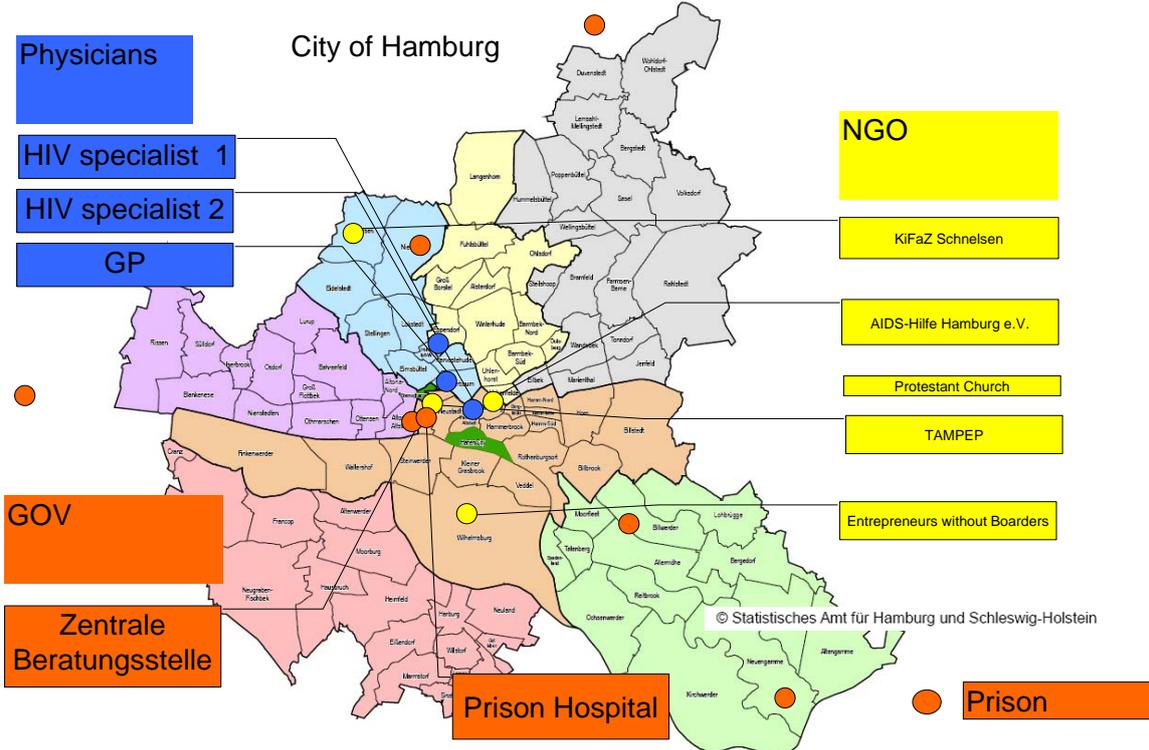
d) Proportion of TB-cases with a foreign country of birth according to administrative district (N=5.795)



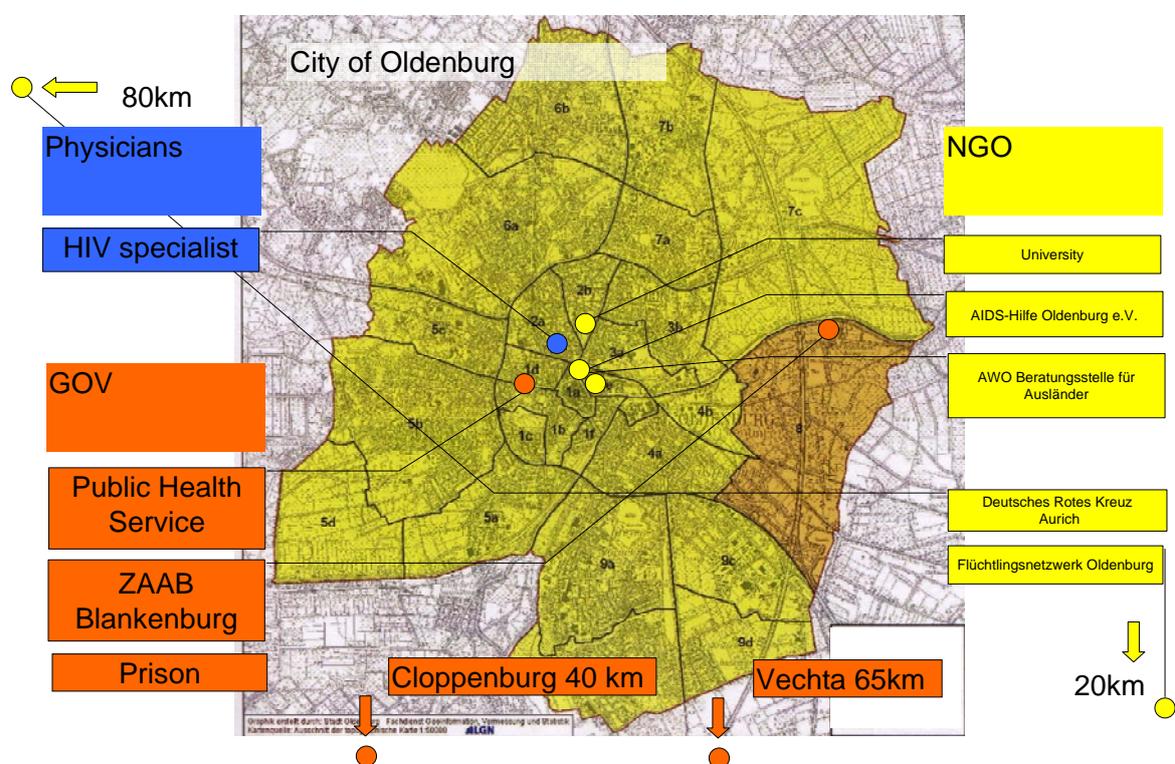
(Figures modified from RKI: Bericht zur Epidemiologie der Tuberkulose 2005, p.62)

8.3 Map III: Distribution of Health Service Facilities in the Selected Study Spot

Distribution of Health Service Facilities in the City of Hamburg



Distribution of Health Service Facilities in the City of Oldenburg



8.4 Questionnaires

8.4.1 Questionnaire for service providers

Gesundheitsversorgende Institutionen

1. Was denken Sie, ist das größte Problem für HIV behandelnde Institutionen, wenn ihre Patienten Migranten sind?
 - die Medikamente werden nicht wie verordnet eingenommen
 - Termine werden nicht eingehalten
 - kulturelle Gründe halten den Patienten davon ab, die medizinische Behandlung durchführen zu lassen
 - die Behandlung kann nicht bezahlt werden
 - Andere Gründe.....

Allgemeine Gesundheitszentren

1. An welche Empfehlungen zur HIV-Testung orientieren Sie sich? Gibt es eine geschriebene Teststrategie?
2. Werden bei Ihnen HIV-Tests durchgeführt?
 - Wenn ja, führen Sie den Test erst nach einer Zustimmung des Klienten durch?
 - Bieten Sie dem Klienten an, den Test nicht durchzuführen?
 - Stellen Sie die Möglichkeit einer Beratung vor und nach dem Test zur Verfügung?

Gesundheitsversorgung im Gefängnis

Zur Strategie der HIV/TB-Prävention, -Test und -Behandlung

1. Wird von der Anstaltsleitung Informationsmaterial zur HIV-Prävention bereitgestellt?
2. Werden alle Insassen auf HIV getestet?
 - Wenn ein Häftling sich weigert den Test durchführen zu lassen, welche Maßnahmen werden dann ergriffen?
3. Findet vor und nach dem Test eine Beratung statt?
4. Wenn der Test eines Häftlings positiv war, was geschieht dann?
 - Behandlungsempfehlungen
 - Wenn keine Behandlung erforderlich ist, wird der Patient weiter beobachtet?
 - Werden HIV-positive Häftlinge auch auf Tuberkulose hin getestet?
5. HIV Prävalenz von Migranten bei den Häftlingen

6. HIV Prävalenz von Nicht-Migranten bei den Häftlingen

TB-Test Politik

1. Werden alle Häftlinge auf TB hin getestet?
2. Werden alle Häftlinge, die TB-positiv sind auf HIV getestet?
3. TB-Prävalenz von Migranten unter den Häftlingen
4. TB-Prävalenz von Nicht-Migranten unter den Häftlingen

8.4.1 Questionnaires for MiMi and KAMAHH included the following items

INDIVIDUAL INFORMATION

1. Sex: M F
2. Educational level
 - primary
 - secondary,
 - university or higher
 - None
3. Occupation
4. Country of origin _____
5. If not, what is your legal status (documented or undocumented)
6. How long have you lived in this country?

FAMILY MEMBERS

7. How many people live with you?
8. How many children live with you?
9. What are the obstacles you encounter when seeking healthcare?
10. Which health care providers are known to you?

In the AIDS-project we also asked:

11. Do you know anyone who has AIDS?