Department of Public Health, Malta

Disease Surveillance Unit

International Organisation for Migration, Malta

EU PARTNERSHIPS

TO

REDUCE HIV & PUBLIC HEALTH VULNERABILITIES ASSOCIATED WITH POPULATION MOBILITY

In support of the technical preparation for the national AIDS Coordinators meeting: EU, WHO EURO and neighbouring countries, 12-13 OCTOBER 2007

COUNTRY REPORT

MALTA

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EU Partnerships to reduce HIV & Public Health vulnerabilities associated with population mobility

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ABSTRACT

Background:

A current important public health issue in Malta is that of migrant health, in particular issues related to policies and interventions for tackling communicable diseases such as Tuberculosis, HIV/AIDS and sexually–transmitted infections with an increasing concern about the access to prevention, care and support services. Accessibility and quality of health care services for everyone is a main issue in health policy. An adequate use of health care services is an important precondition for health. Little is known about health care utilisation of migrants, ethnic minorities and mobile populations in Malta. Research on the factors that affect health care utilisation of migrants is scarce and little is known about their needs, health behaviour and the possible barriers they experience in their use of health care services.

Aims of the Study:

The aim of this study was to document the key HIV, TB and HIV/TB co-infection mobility-related vulnerabilities of migrants in Malta through the conduction of a rapid mapping assessment of vulnerabilities and hotspots. It also aims to give an insight in the health care utilisation of migrants in Malta, the differences with Maltese nationals and the factors that can explain these differences. The study also aims to depict how the migrants themselves report on their utilisation of HIV/TB-related healthcare services, the quality and accessibility of HIV/TB-related care, treatment and preventive services they receive and how their perspectives compare with those of healthcare providers. The findings will be added to those from other five countries to generate evidence base for policy dialogue on reducing inequities and vulnerabilities to HIV and related TB co-infections amongst migrants in the EU.

Methodology:

The first part of the report involved conducting a literature review of HIV and TB statistics, migration data and policy recommendations. The data was then mapped. Immigration, migration and emigration data was used for mapping component layer 1 which consisted of: the locations of migrants and Diasporas communities, coding by country of origin and country of destination and the location of prison and-or detention centres where irregular migrants and other migrants are present. A second mapping layer was produced by using the epidemiologic data to map geographically the prevalence in the country of HIV and TB. In the second part of the study, the key migrant aggregation points in the country were chosen to do an in-depth assessment through the administration of a questionnaire which was distributed to 105 migrants from different settings. The data that was collected was used to map the locations of health services facilities being utilized by the migrants and Diasporas, coded according to the type of facilities and providers, producing map versions of services and utilisation according to both the migrants and authorities/health service providers. Interviews were held with the health service providers to obtain information on the health services, the prevalence of HIV, TB, HIV-TB co-infection and Sexually-transmitted Diseases affecting migrant populations, the use of the health services and problems and difficulties encountered in treatment of migrant populations when compared to nationals.

Results:

The review of HIV and TB epidemiology in Malta shows that the prevalence of HIV is significantly higher in migrants than in nationals and that the prevalence is higher in particular migrant groups mainly migrants from third word countries and Sub-Saharan Africa, a finding confirmed by mapping which pointed hotspots and vulnerabilities in the areas where these migrant groups reside. The review of policies and information on health services and service utilisation shows that integration and healthcare policies for migrants are in place and the necessary structure and services are available, however, there are still disparities in health and access to preventive, health promotion and curative services related to HIV and TB, between migrants and nationals. Twenty two percent (22%) of migrants responding to the questionnaire have described no difficulties in obtaining information, with the remaining 78% mentioning at least one barrier. The major barriers to obtaining information included: fear of discrimination (19%); cultural

differences (15%); and language problems (14%). Eighteen percent (18%) had no difficulties in accessing healthcare services related to HIV and TB, with the remaining identifying at least one barrier, the commonest of which were: fear of discrimination (23%); cost (20%); language barriers (13%); cultural differences (12%); distance (6%); and fear of deportation (6%).

Conclusions and Recommendations:

The recommendations that emerge include the production of clear written policies related to migrants' access and entitlement to healthcare, the use of culturally and linguistically appropriate information targeted towards the needs of migrants, in particular information on entitlements to healthcare and health promotion material, making use of healthcare interpreter services, multilingual health promotion materials, the use of multilingual signs and symbols and the promotion of migrant-friendly hospitals and services. Services should reach out to the most vulnerable migrants, in particular undocumented migrants. Policies and programmes related to migrants, health should be integrated with other local policies and programmes. Migrants should be empowered to act. More research is required on migrants' information and healthcare needs as seen from the migrants' perspective.

BACKGROUND

Population mobility brings into contact migrants and residents of transit and host communities. The respective vulnerabilities increase the risk of the spread of infectious diseases, in particular HIV and tuberculosis (TB).

The relationship between mobility and health is gaining rapid significance. Migration has been identified as a cause of disease diffusion[1]. In general, migrants often have special health needs in excess of those in a fixed population. Their shelter is disrupted; their nutritional requirements many times are not met in quantity or quality; and they are often physically and psychologically traumatized from their experiences. These pose health risks to the migrants, particularly with regard to communicable disease control, and surveillance, reproductive health, occupational health and sanitation. Some live in crowded places, temporary or semi-permanent settlements in unsanitary conditions and that increase their health risk. When separated from spouse and family, migrants, are more vulnerable to risk behaviour, resulting in a higher risk of sexually transmitted infections, including HIV and in case of women, rape and unwanted pregnancies. Migrants get excluded from the opportunities of preventive and curative health care due to their mobile status and their migrant status. This reduces their health services utilisation. Unsuitable timings and negative experiences limit the use of health services. Accessibility and utilization of health facilities is constrained due to their working hours. Informational and educational campaigns and awareness of the health programmes with information about risk don't reach those who are constantly on the move. Language problems can be significant barriers. Health-seeking gets delayed most of the time due to lack of awareness and time.

The International Organisation for Migration (IOM) has cited the following main ways in which mobility and the spread of HIV/AIDS are linked[2].

1. Mobility often encourages people to engage in risky or vulnerable behaviour e.g. young men, for example, are often separated from wives or partners for extended periods of time.
2. Mobility often isolates people, making them difficult to reach and stay in contact with for health education, testing, condom provision or treatment and Migrants in new and unfamiliar countries might not even by familiar with local languages.

3. Mobile populations can display high percentages of HIV/AIDS because they often include people marginalised socially, economically or politically.

Mobility not only affects the health of the people on the move, but also the health of communities in which they stay, whether for long or short periods, and the home communities to which they return.

Effective public health strategies need to be targeted to respond to these vulnerabilities in the context where migrants and resident communities interact. In this context, vulnerability reduction encompasses prevention, treatment, care and support.

AIM OF THE STUDY AND REPORT

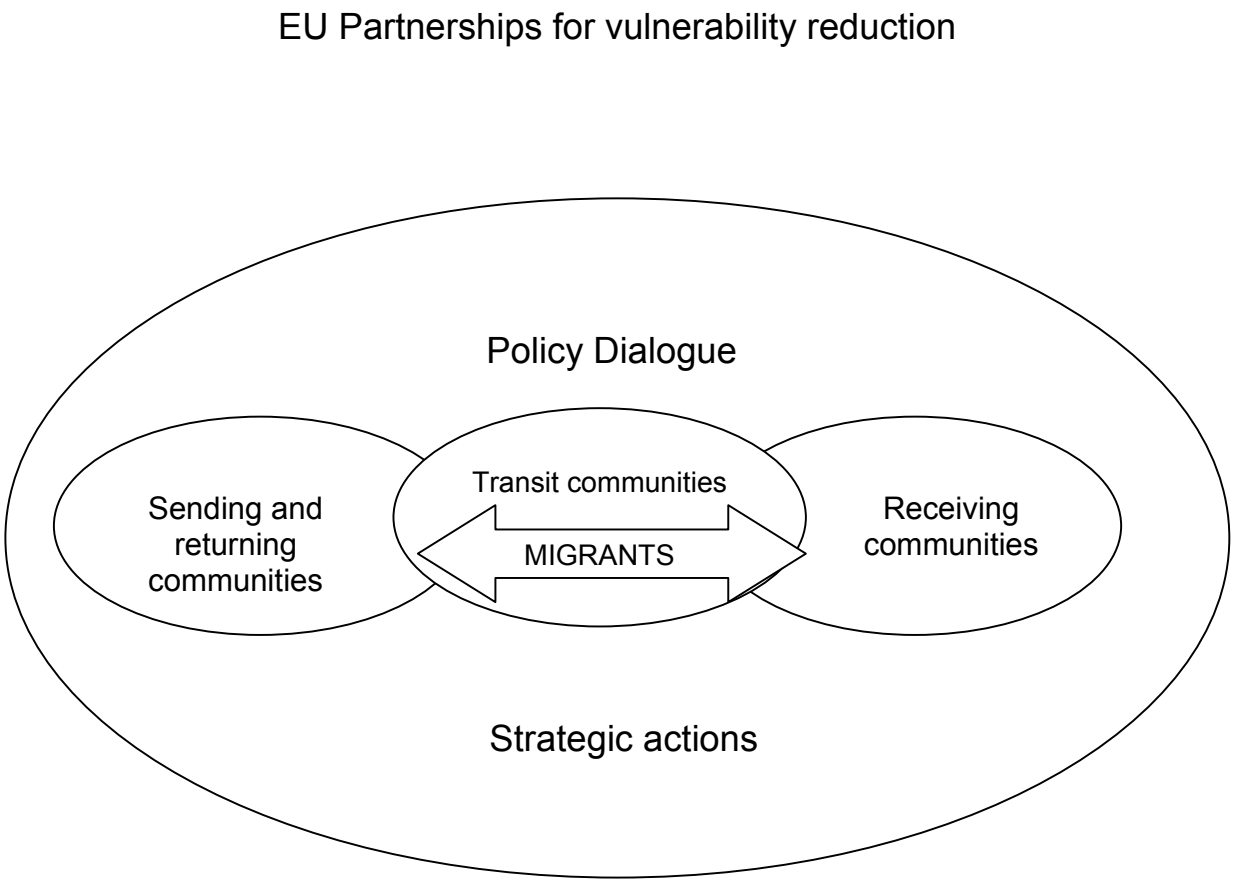
The goal is to strengthen and establish where necessary, partnerships between EU members and with neighbouring countries to reduce vulnerabilities leading to the spread of infectious diseases, focusing on HIV, including TB co-infection.

The objectives of the report are to:

1. Document the key HIV and mobility related vulnerabilities within the EU.
2. Enhance partnership policy dialogues for potential joint actions.

Figure 1:

Source: Hsu and du Guerny, 2007[3]



PROJECT IMPLEMENTATION ISSUES

The national AIDS coordinator and was invited by the International Organisation for Migration to conduct a research project on the situation of the vulnerabilities in mobile populations in relation to HIV, including TB co-infection vulnerabilities. The aim of this study is to identify and reduce inequalities and vulnerabilities among migrants in the EU and hence put forward recommendations for policy and programme actions. Malta was one of six countries who accepted to participate in this study. The country selection process was based on the different profiles of EU member countries categorized as new members, sending countries, transit countries and receiving countries. Other countries participating in the project include Bulgaria, Hungary, Estonia, Portugal and the Netherlands. Each pilot country has conducted a rapid mapping assessment of vulnerability and hotspots to generate evidence base for policy dialogue on reducing inequities and vulnerabilities to HIV and related TB co-infections amongst migrants in the EU. An expert from International Organisation for Migration visited Malta on the 21st May 2007, in a consultation meeting that had the aim of discussing the methodology for mapping vulnerabilities and identification of hotspots.

METHODOLOGY

The compilation of the report was carried out by performing a secondary and primary data analysis and a mapping component with three layers. The first part of the report involved conducting a literature review of HIV and TB statistics, migration data and policy recommendations. This data was then mapped to produce two layers of the country map.

Immigration, migration and emigration data was used for mapping component layer 1 which consisted of:

- The locations of migrants and Diasporas communities, coding by country of origin and country of destination.
- Location of prison and-or detention centres where irregular migrants and other migrants are present.

The mapping component layer 2 was produced by using the epidemiologic data to map the prevalence in the country geographically based on the stratification available of the HIV, TB, HIV-TB co infection data.

The second part of the study was based on results from mapping layers 1 and 2, whereby the key migrant aggregation points in the country were chosen to do an in-depth assessment through the use of a specific tailor made questionnaire. A range of locations studied was chosen to represent different settings or to concentrate on a specific group of migrants. The data collected was then used to produce the third mapping layer of the country report. In this third mapping component (Mapping Component layer 3), the locations of health services facilities being utilized by the migrants and Diasporas were coded according to the type of facilities and providers and were mapped. Two map versions were produced:

• One according to the migrants,

• One according to the authorities

Information on the health services, the prevalence and magnitude of HIV, TB, HIV-TB co-infection and Sexually-transmitted Diseases affecting migrant populations, the use of the health services and problems and difficulties encountered in treatment of migrant populations when compared to nationals was obtained through interviews with or specific requests for information from the following:

• The Disease Surveillance Unit within the Public Health Department within the Ministry for Health, Elderly and Community Care;

• Medical staff from Sir Temi Zammit Unit (Infectious Disease Unit, St. Luke's Hospital);

• The Genitourinary Clinic, Sir Paul Boffa Hospital;

• The Sexually Transmitted Infections Prevention Committee (Malta);

• The Chest Unit, Qormi Health Centre (A section of he Disease Surveillance Unit);

• Physicians providing services from state health centres;

• The Port Health service providers;

• Substance Misuse Outpatient Unit (Detox);

• The outsourced health service providers providing medical services within closed detention centres;

• The state Pharmaceutical services;

• Correctional facilities authorities;

• Authorities in charge of closed detention centres (including mainly the Armed Forces of Malta and the Police, under the Ministry for Justice and Home Affairs)

• Entities in charge of open centres (under the Ministry for Family and Social Solidarity);

• and NGOs working with migrant populations (asylum seekers and refugees);

These persons/entities provided information and explanations with respect to the local situation in respect of HIV/AIDS in Malta, and provided data and access to relevant documents. Information that is specifically related to mobile populations in Malta was very limited prior to the first country report in "HIV and Population Mobility in an enlarged European Union"[4] which was published in 2006.

Statistical Packages

The data collected from the questionnaire was cleaned, was coded and entered in Excel sheet database. The classifications used for educational level, occupations and country codes were the same ones that are used nationally. Occupations were coded using ISCO 88 (International Standard Classification for Occupations -88[5] and countries were coded using ISO 3166-1[6] numeric (a three-digit numerical system). The data was then exported and analysed using the statistical package SPSS (Statistical Package for Social Sciences) version 15.0 for Windows[7].

Mapping of data was carried out using ArcView GIS software version 9.2[8] together with shape files and maps produced by the Malta Environment and Planning Authority (MEPA).

RESULTS

a) Policy and legal context

Legal Framework for the Prevention of HIV

Communicable disease surveillance and control in Malta are currently governed under the Medical and Kindred Professions Ordinance and the Public Health Act[9] of the Laws of Malta. Currently, a framework exists whereby HIV infections are statutory notifiable to the Superintendent of Public Health and notifications are managed by the Disease Surveillance Unit. HIV became a notifiable disease in January 2004 in additionary legislation in the Public Health Act. The Public Health Act (2003) stipulates that any person will be guilty of an offence should he/she be aware of having a notifiable disease or infection but does not take precautionary measures to prevent the transmission of the disease.

National Policies, Strategies and Action Plans related to HIV prevention, treatment services, care and support programmes.

The Disease Surveillance Unit formulated a communicable disease strategy whereby HIV/AIDS and sexually transmitted diseases were defined as priority diseases and a strategy was compiled to identify control measures to control the diseases. The "Communicable Disease Report" 2005[11] defines a strategy against HIV/AIDS, other sexually transmitted infections and their complications. The strategy includes a list of interventions and activities to prevent these infections. The areas covered include surveillance, epidemiological and clinical research, provision of laboratory and clinical services, treatment and guidance of the exposed partners of sexually transmitted infections sufferers, training of health professionals, health education and behavioural interventions.

Currently, a National Sexual Health Strategy is being formulated and is in an advanced stage of drafting. HIV/AIDS prevention is incorporated in the main objectives of the National Sexual Health Policy which in relation to HIV/AIDS and other sexually transmitted infections, it aims to:

- Ensure that all young people in Malta receive effective education about sex and relationships as part of their personal and social development.
- Improve young persons' attitudes to moral values with respect to sexual matters
- Ensure that all sexually active persons in Malta have access to good quality sexual health services, support and advice.
- Reduce the prevalence of undiagnosed HIV and sexually transmitted diseases and therefore the complications that may arise from these.
- Reduce illegal abortions.
- Reduce the transmission of HIV and sexually transmitted infections and the incidence and prevalence of these sexually transmitted infections in Malta.
- Promote a more supportive environment which encourages openness, knowledge and understanding about sexual issues and fosters good sexual health.
- Reduce the stigma associated with HIV and sexually transmitted infections.
- Strengthen monitoring, surveillance and conduct research to support future planning of sexual health services and interventions.
- Improve health and social care for people living with HIV.

The National Sexual Health Strategy that is being formulated does not however include a specific section on migrants.

Sexual Health Promotion and Immigrants in Detention and Open Centres

Sexual health promotion in immigrant populations in Malta is a relatively new issue which has been identified as an issue that needs to be addressed. Besides other categories of immigrant populations in Malta, one of the migrant sub-groups whose specific sexual health needs had not been as yet addressed was identified as being that of immigrants in detention and open centres. During the year 2005, the Health Promotion Department held discussions with the Policy Co-ordinator at the Ministry for the Family and Social Solidarity to explore opportunities of promoting sexual health and genitourinary screening uptake among irregular immigrants in detention and open centres across the island. A networking system is currently being set up composed of governmental and nongovernmental agencies to support this particular group of immigrants, in which the Health Promotion Department will be involved in light of their specific sexual health needs[12].

The Medicine du Monde have been working in Malta for the past few months. They have been given permission to work with persons staying in the open centres. In particular, they provide a general practitioner service on a daily basis in the evening. During theses sessions, the migrants refer for their clinical problems and are given the appropriate treatment by a registered doctor. During these sessions, the opportunity is taken to give health promotional advice focusing on sexual health. Leaflets in various languages are also available. High risk persons are referred to the Genito-Urinary Clinic for HIV and sexually transmitted disease screening. To date, none of the referred cases were found to be positive for HIV. Sessions on reproductive health for the female population are also being carried out.

Institutional Framework and Financial Resources for HIV/AIDS prevention

The main state-run bodies involved in HIV/AIDS prevention are the national Sexually transmitted Infections Prevention Committee (STIPC) and the Health Promotion Department. Excluding funding from sponsorships by private organizations, the STIPC receives an annual fund of approximately 27,000 Euros while the Health Promotion Department allocates 25-30% of its annual budget of 151,000 Euros to sexual and reproductive health.

Non- Governmental Organisations and HIV Preventive Services

Most NGOs are involved in the delivery of preventive services. The NGOs include Caritas Malta, the Standing Committee on Reproductive Health including AIDS and the Malta Gay Rights Movement

Medical Healthcare Provision for Maltese Nationals and EU/EEA Citizens Resident in Malta:

The Ministry of Health is responsible for the financing and provision of publicly funded health care services. Health care in public services is generally free at the point of use. Persons who are living in Malta and are covered by Maltese social security legislation are entitled for public health care services in accordance with entitlements as determined from time to time by the Ministry of Health.

EU citizens resident in Malta are entitled to equivalent consideration. Their entitlement, however has to be confirmed with and certified by the Entitlements' Unit within the Ministry of Health. This official certification together with a personal identification document will be enough to receive health care in public health care services[13]. Without a Certificate of Entitlement (E Form), the relevant Public Hospital or Clinic will ask for payment for services. This affects all EU/EEA citizens resident in Malta irrespective of the current residency status. The criteria for the granting of an E form are laid down by a resident's country of origin, which ultimately reimburses the country of residence for medical care provided.

Basically, the two E forms that are mainly involved for EU citizens resident in Malta are:

E106 - for residents – for non-pensioners and those working in Malta
E121 - for residents – mainly for pensioners and other benefit recipients

EU citizens paying national insurance contributions in Malta will be eligible to receive the European Health Insurance Card (EHIC formerly known as the Form E111) from the Entitlement Unit of the Maltese Health Division to cover emergency treatment during visits to other EU/EEA countries.

Medical Healthcare Provision for Temporary Visitors from EU/EEA countries

Temporary visitors from EU member states have direct access to the health care from publicly funded health care services upon presentation of an EHIC (European Health Insurance Card) together with an identification document. EU citizens are advised that an original EHIC will be required in case of document usage of public health care facilities. If the relevant card is not presented, health care bills must be paid in full prior to leaving the health care facility.

In case emergency treatment is required, EU citizens temporarily visiting Malta who present proof of EU-nationality and a valid EHIC will be given urgent medically necessary care at the Accident and Emergency Departments of public hospitals and at Government Health Centres free of charge. Bills will eventually be issued to the EU institution indicated on the EHIC and it shall include the cost of being conveyed to a public hospital/health centre by emergency ambulance if their emergency care so requires.

For medical emergency care that requires admission to government hospitals for services, such as in-patient care, day care services, diagnostic services or out-patient visits, patients will not be charged if they present proof of EU nationality and a valid EHIC. The bill for the service given will be sent to the EU institution indicated on their EHIC. The cost of all prosthesis and medication prescribed for follow-up care after hospital in-patient treatment (except medication for the first three days after discharge) or as part of day care or outpatient care shall be borne in full by the person concerned.

Provision of Medicines

All drugs used in in-patient treatment and for the first three days after discharge are free of charge for the patient. The cost will be included in the eventual bill issued to the institution which has provided the relative EHIC to EU citizens on temporary stay who require health care.

If a sickness needs the usage of drugs/medicines or the usage of medical devices at a primary care level or at out-patient level or after discharge from daycare or inpatient car (except the first 3 days for drugs/medicines), a prescription from a licensed medical practitioner is required. Drugs and medical devices can be purchased in any of the retail pharmacies in Malta (there are more than 200) and the cost is totally borne by the

patient through out-of pocket payment. There are only two exceptions to this rule and these apply to persons living in Malta who are covered by Maltese social security legislation. In the case of these two exceptions, medicines and medical devices are exclusively dispensed from Government pharmacies or facilities:

(I) Persons who are in the low-income group, as determined by a means test, are entitled to free medicine/drugs from a restricted list of essential drugs and some medical devices (subject to certain conditions and the payment of a refundable deposit); and

(ii) Persons who suffer from chronic diseases included in a specific schedule incorporated in the Social Security Act are entitled to free medicines/drugs strictly related to the particular chronic disease and this benefit is independent of financial means.

Reciprocal Agreements

A number of reciprocal agreements are in place (with UK, Australia and Libya).

Medical Healthcare Provision for Asylum seekers:

Section 10(1) of the Refugees Act (2000) grants free medical services to asylum seekers.

> *"10. (1) Notwithstanding the provisions of any other law to the contrary, an asylum seeker shall not be removed from Malta before his application is finally determined in accordance with this Act and such applicant shall be allowed to enter or remain in Malta pending a final decision of his application. He shall also have access to state education and training in Malta and to receive state medical care and services."*

In the case of rejected asylum seekers, by the issuance of a short-term visa, the Maltese State acknowledges the presence of rejected asylum seekers on the territory. With this visa, rejected asylum seekers are entitled to access to healthcare, accommodation in open centres and financial support for food but are not entitled to access the labour market. Rejected asylum seekers without a visa have to hide from the authorities because of their irregular stay on the territory. In general, illegally staying third-country

nationals have no legal entitlements to access health care. However, on the basis of information provided by NGOs, in practice illegally staying third-country nationals do receive emergency care. According to JRS Malta[14] the situation is different for those illegally staying third-country nationals, including rejected asylum seekers, who have been released from detention: the practice is that free health care is usually provided to them.

Rights to HIV prevention and access to ART by persons residing in the territory of the country

There is no specific law that covers rights to HIV prevention and access to ART by persons residing in the territory of the country but confidential diagnosis and treatment of sexually transmitted Infection, and other genital conditions, not necessarily sexually acquired and counseling and testing for HIV is given free of charge through the Genito-Urinary Clinic in Boffa Hospital to both Maltese and non-nationals. http://www.sahha.gov.mt/pages.aspx?page=299

Visa requirements, asylum seeker requirements, resettlement requirements, and immigration requirement pertaining to HIV and TB status

There is no law that prohibits the continued stay or will prevent people living with HIV to be in the country. Irregular immigrants and asylum seekers are not routinely screened for HIV. HIV testing is only done in cases where it is clinically indicated, in cases requiring hospitalization and surgical operations and in pregnant females.

b) Immigration and migration profile

Range of international migrants living in the country

The international migrants living in the country are classified and defined mainly as:

1. Returned migrants: Defined by the National Statistics Office as Maltese nationals who are former emigrants returning to Malta.
2. Non- Maltese nationals or Foreigners settling in Malta: Defined by the National Statistics Office as people of other nationalities settling (regularly) in Malta.
3. Asylum seeker: The Refugees Act (2000) defines an asylum seeker as a person who has made an application for refugee status in terms of Article 8 of the Act. These include:

- Those persons held in detention until their application for protection is determined;

- Those who enter Malta legally and apply for refugee status

- Those who apply for refugee status prior to apprehension by the immigration authorities for illegal entry or stay and thus are not detained

- Those persons who are released from detention after 18 months but are still awaiting the outcome of their appeal to the Refugee Appeals Board.

4. Refugees: These are asylum seekers who are duly recognized as refugees. They are given the right to work and are eligible to receive social assistance, free education, free medical care and a Convention Travel Document[15]. Under Maltese law, refugee status is granted is a person who falls within the definition of refugee given in the 1951 Refugee Convention.197 Pursuant to Article 2 of the Refugees Act, refugee status is granted to a third-country national who, "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events is unable or, owing to such fear, is unwilling to return to it."

5. Humanitarian Status: The Refugees Act 2000 allows for the granting of humanitarian protection to people who in the opinion of the Refugee Commissioner, cannot return safely to their country Humanitarian Protection can be issued if a person does not qualify for recognition as a Convention refugee. Humanitarian Protection is considered to be special permission to remain in Malta until such time as the third-country national concerned can return safely to his country of origin or otherwise resettle safely in a third-country. Temporary Humanitarian Protection (THP) is normally granted to people coming from a country where there is war or violent conflict, e.g. Somalia, Iraq, the Darfur region of Sudan. Humanitarian Protection is terminated if the relevant authorities are satisfied that such protection is no longer necessary.

6. Rejected asylum seekers: a third-country national or a stateless person who has made an application for asylum and against whom a final decision on asylum status has been reached.

7. Overstayers: these are persons who arrived legally in Malta, ie: with a visa, and have overstayed (and would consequently be irregular)

Information Sources on Migrants

The main information sources on migrants include:

1. National Statistics Office, Library and Information Unit, Lascaris, Valletta, CMR 02, Malta. Website: www.nso.gov.mt
2. Ministry for the Family and Social Solidarity, Palazzo Ferreria, 310, Republic Street, Valletta, VLT 2000, Tel: 2590 3100, Fax: 2590 3216
   E-mail: info.mfss@gov.mt
   Website: http://www.mfss.gov.mt
3. Armed Forces of Malta
4. Immigration Section, Police General Headquarters
5. Jesuit Refugee Services, JRS Malta, SAC Sports Complex, 50, Triq ix-Xorrox, B'Kara, BKR 12, Malta, Tel: +356-21-442751, Fax: +356-21-442752, Email: info@jrsmalta.org
   Website: http://www.jrsmalta.org
6. Office of the Refugee Commissioner
7. Emigrants Commissioner, Dar l-Emigrant, Castille Place, Valletta VLT 01, Malta
   Phone (+356) 21- 222644, 21- 232545, 21-240255
   Fax (+356) 21- 240022
   E-mail: mec@maltamigration.com
   Website: http://www.maltamigration.com
8. Dar il-Qawsalla- Birkirkara
9. Peace Lab- Hal Far
10. Dar is-Sliem- Santa Venera
11. Dar il-Liedna- Fgura
12. OIWAS (Organisation for the Integration and Welfare of Asylum Seekers). OIWAS started functioning in February 2007. The main functions and work done by OIWAS so far have been coordinating the open centre network, standardizing procedures, service agreements, identification of new centres, the building of professional teams to cater for vulnerable groups of immigrants, the implementation of several projects in closed centres, intensive networking with

UNHCR, IOM, and NGOs and contribution to the policy-making functions of MFSS.

13. The University of Malta
14. The Employment and Training Corporation
15. Language schools.

Migration Flows and Estimated number of migrants in the country

Migration Flows

The total population in Malta at the end of 2005 was estimated at 404,346 persons, with a Maltese population of 391,295, implying that 3.2 percent of the total population were foreign citizens. The basic variables used in the calculation of net migration (the difference between immigration and emigration) in Malta are (1) the number of returned migrants and foreign settlers which amounted to 187 in 2005, (2) the number of new work permit holders, which also amounted to 187 in 2005 and (3) the number of adoptions, registrations and naturalizations, which amounted to 624 during the same year.

The number of recorded immigrants in each year of the analysed period is significantly higher than the number of recorded emigrants. The recorded immigration number of 965 persons in 2000 increased to 1,002 persons in 2001, before decreasing to 915 persons in 2002. Not until the year 2003 did the number of immigrants increase to 1,239 persons. The flow of emigrants never exceeded 100 persons in a single year. The number of emigrants increased from 67 persons in 2000 to 75 in 2001, on to 96 persons in 2002. In 2003, however, the number of emigrants decreased by over 50 percent compared to the year before, reaching a low of just 40 persons. The massive difference in magnitude in these two categories created a net migration which was steadily positive. The net migration always amounted to over 800, reaching its highest level in 2003 with a number of 1,199. This year was characterised by an increase of immigration and simultaneously a notable decrease of emigration. This resulted in a level of net migration that was 32 percent higher than in 2002.

Documented Migrants

The total population is made up of Maltese citizens and citizens of other countries who are resident in Malta (the non-Maltese segment of the population). In 2005, 392,850 residents, or 97.0 per cent of the population, were Maltese nationals while the other 12,112, 3.0 per cent, were foreign nationals. Compared to 1995, the Maltese-national segment has decreased. In fact, in 1995, Maltese nationals accounted for just over 98.1 per cent of the population. Maltese nationals comprised 194,907 males, or 49.6 per cent, and 197,943 females, or 50.4 per cent. At 6,200, or 51.2 per cent of all foreign nationals, the female element was more pronounced in the foreign-national segment of the population. In line with the geographical distribution of the population, the majority of residents with a foreign nationality resided in the Northern Harbour District, translating into 41.2 per cent of all foreign nationals. The proportion of Maltese nationals resident in this district was calculated at 29.1 per cent of all Maltese citizens. Table 7 shows the distribution of foreign nationals residing in Malta by nationality and sex in respect of 2005. It shows that the predominant foreign component in the population of Malta is British, with 38.9 per cent of foreign nationals[16].

Citizenship	Total		Males		Females	
	Number	Percent	Number	Percent	Number	Percent
British	4713	100	2177	46.2	2536	53.8
Italian	585	100	419	71.6	166	28.4
French	127	100	52	40.9	75	59.1
German	518	100	221	42.7	297	57.3
Other EU country	1079	100	504	46.7	575	53.3
Other European country	2033	100	920	45.3	1113	54.7
American	255	100	121	47.5	134	52.5
Canadian	170	100	71	41.8	99	58.2
Australian	372	100	120	32.3	252	67.7
Libyan	493	100	335	68.0	158	32.0
Other citizenship	1569	100	864	55.1	705	44.9

Stateless	196	100	108	54.5	90	45.5
Total	12112	100	5912	48.8	6200	51.2

Source: National Statistics Office. Census 2005 Report, Volume 1[16].

Table 1: Immigrants by Main Groups of Citizenship, 2005.

Map 1 in Annex 5 shows the proportion of migrants to the total population in each locality..

Table 2 shows the number of immigrants to Malta within five years of Census Day by sex and locality of immigrant

	Males	Females	Total
Maltese Islands	3689	3531	**7220**
Malta	3288	3178	6466
Gozo and Comino	401	353	754
Southern Harbour District	256	242	498
Northern Harbour District	1526	1327	2853
South Eastern District	337	332	669
Western District	223	256	479
Northern District	946	1021	1967

Table 2: Immigrants to Malta within five years of Census Day by sex and locality of immigrant (The statistics include foreigners residing in Malta from five years from census. They include refugees but do not include asylum seekers, persons who have been granted temporary humanitarian protection or rejected asylum seekers.)

Table 3 shows the documented number of irregular migrants and asylum seekers residing in detention centres and the location of their residence in Malta (as on 6th August 2007):

Detention Centre	**Number of Immigrants in Detention**

	Centre
Safi	699
Lyster	635 of which- 481males 122 females 32 children / minors
Ta' Kandja	69
Hal Far C	Nil
TOTAL	**1410**

Table 3: Documented number of irregular migrants, refugees and asylum seekers residing in detention centres and the location of their residence in Malta (as on 6th August 2007):

Table 4: shows the documented number of irregular migrants, refugees, THPs and asylum seekers residing in open centres and the location of their residence in Malta (as on 6th August 2007):

Centre	**No. of residents**
Hal Far Tent Village	679
Dar il-Liedna (familes)	20 Including children
Dar il-Qawsalla (families)	45 Including children
Hal Far/ OIWAS (ex-Appogg centre)	117 Including children
Malta Emigrants' Commission	323 Including children
Marsa Open Centre	630
Peace Lab	20
Dar is-Sliem (unaccompanied minors)	24
Dar il-Liedna (unaccompanied minors)	16
Total	**1874**

Table 4: Documented number of irregular migrants, refugees and asylum seekers residing in open centres and the location of their residence in Malta
(as on 6th August 2007):

Persons living within the open centres can be asylum seekers, refugees, persons granted temporary humanitarian status as well as rejected asylum seekers.
Map 2 (Annex 5) shows the location of the open and closed centres on the island, whilst Map 3 (Annex 5) shows the number of migrants residing within both the open and closed centres.

Table 5 shows the number of applications for asylum decisions, the number of applications processed by the Office of Refugees Commissioner, the number of asylum seekers who were granted a refugee or humanitarian status and the number of rejected applications[17].

Asylum Applications Received and Decisions taken by the Office of Refugees Commission from 2002 to May 2006.					
Year	Number of received applications	Granted refugee Status	Granted humanitarian Status	Rejections	Decisions taken
2002	474	22 (5.3)	111(26.6)	286 (68.3)	419
2003	568	53 (9.3)	328 (57.7)	187 (32.9)	568
2004	997	49 (5.6)	560 (64.5)	259 (29.8)	869
2005	1199	36 (3.3)	510 (46.3)	556 (50.5)	1102
Up to May 2006	557	12 (2.1)	272 (47.1)	293 (50.8)	577

(the figures in brackets represent the percentages from the total decisions taken during that year)
Source: National Statistics Office with data originally provided by the Office of the Refugees Commissioner (table modified by author).
Table 5: Asylum Applications Received and Decisions taken by the Office of Refugees Commission from 2002 to May 2006.

The percentage granted refugee status/humanitarian protection and the percentage of the rejected applications do not sum up to the total number of applications received by the Office of the Refugee Commissioner. The reason is that these are part of a continuously shifting procedure with a number of applications still in the processing stage and a number of others being withdrawn.

The total number of applications examined by the Office of the Refugees' Commissioner during 2006 was 1210, as follows:

Category	**Number**
Persons recognized as refugees	28
Persons granted humanitarian protection	522
Rejected applications	637
Persons who withdrew application	23
Number of cases still under consideration (including 54 applicants without documents claiming to be unaccompanied minors)	211

Table 6: Total number of applications examined by the Office of the Refugees' Commissioner during 2006
Source: Annual Departmental Reports, Ministry for Justice and Home Affairs (MJHA), 2006.

The total number of persons recognized as refugees or granted temporary humanitarian protection by the Office of the Refugee Commissioner from January 2002 to December 2006 was:

- Refugees: 186
- Temporary Humanitarian Protection: 1005

Foreign Students in Malta

The number of foreign students in Malta has doubled over the past decade[19] rising from 30,000 in 1996 to 62,000 last year. The majority of international students in Malta are in Malta earning credentials in English as a second language (ESL), an industry that provides US$125million and 1,800 jobs to the Maltese economy each year.

The English language teaching to foreign students (ELT) sector has become an important tourism related industry for Malta[20]. In 2005, it attracted nearly 62,000 foreign students or 9.4% of the total tourist arrivals from non-English speaking countries**.** This amounts to 5.3% of all tourist arrivals in Malta. The average length of stay is of these TEFL students totaled 17 nights when compared to the national tourist average of 8 nights. The growth rate of English Language student arrivals over the last 4 years averages an impressive 2,500 annually. There was an increase of 6,029 students in 2005 over the previous year. The European Union is Malta's major and traditional EFL market. The Russian Federation is recently occupying the fifth place in the list of student numbers visiting Malta. As in previous years, the highest number of students in 2005 came from Germany. These students made up 25.8 per cent of all students, followed by the Italians with 17.1 per cent. Austrian and French students accounted for 8.7 and 7.6 per cent respectively. European students made up 94.1 per cent of all foreign English language students, with 71.9 per cent coming from EU Countries. Students from other European countries accounted for 22.2 per cent. Asia represented 4.5 per cent, Africa 0.8 per cent, N. America 0.4 and Oceania 0.2 per cent.

Country	**2002**	**%**	**2003**	**%**	**2004**	**%**	**2005**	**%**
Germany	15,125	26.0	13,302	25.0	134,596	26.3	15,915	25.8
Italy	9,691	18.0	9,325	17.5	8,080	14.5	10,543	17.1
France	6,081	11.3	7,196	13.5	7,138	12.8	7,975	12.9
Austria	3,385	6.3	4,822	9.1	4,781	8.6	4,672	7.6
Russia	4,944	9.2	3,964	7.4	4,500	8.1	5,351	8.7
Others	14,749	27.1	14,632	27.5	14,483	29.8	17,15	27.8
Total	53,975	100	53,241	100	55,578	100	61,607	100

Table 7: Number of English learning students studying in Malta by year and nationality

Entry into Malta

The island's points of entry are controlled by the Immigration Branch of the Police of Malta. The tasks of the Immigration Branch include conducting checks to prevent illegal entry of foreigners and to detect forged documents. It has entry points at the Airport, Seaport and Yacht Marina as well as a seasonal port at Mgarr, Gozo. Police and civilian personnel man entry points at the airport. During 2006, the number of persons who arrived in, or left Malta by air, was as follows[21]:

Arrivals: 1,347,473
Departures: 1,348,561
Transit: 5,590
The filling of embarkation cards are now restricted to arriving passengers, who are not members of the EU.
The number of ferry passengers, excluding cruise liner passengers, who were processed at the seaport was as follows.
Arrivals: 96,511
Departures: 101,974

The possible explanations for the discrepancy between arrivals and departures, with arrivals being lower than departures could be many, including:

(a) Some Maltese go abroad and do not return within the same year from departure. Malta has recently experienced an efflux of high highly qualified Maltese who go to work abroad, mainly to other EU countries. It is thought that in the long run this could lead to a brain drain.

(b) Another possibility is that Malta has been experiencing an influx of asylum seekers mostly since 2004. Those asylum seekers who were refused a refugee or temporary humanitarian protection would have accumulated on the island till repatriation was possible. Repatriation is often lengthy because it is expensive and also because it takes long to ascertain the country of origin of the rejected asylum seekers as often they do not have any documents.

The Immigration branch also houses an office that deals with the processing of visas[21].

Maltese laws for immigration generally follow EU legislation. Therefore EU nationals do not require a visa nor a passport (an ID card is enough) to enter the country. Citizens of a number of other countries are also not required to apply for a visa and require only a valid passport when residing in Malta for up to three months. Visas for other nationalities are valid for one month. Immigrants are required to apply for a work permit. This exception to EU law was agreed upon before accession to safeguard the Maltese labour

market. In practice though, all work permits to EU nationals are granted, and currently this exercise is only used to monitor the labour market for any needed intervention.

The issue of entry to Malta of irregular (mostly undocumented) migrants by sea has started to hit the island in unprecedented waves since 2002[22]. Before that, incidents of irregular entry to Malta by "boatpeople" were few and far between. Owing to its strategic geographic position along the migration path of those fleeing from Africa and Asia, the exposed coastline and size, Malta is thus more vulnerable than other European countries to these irregular migratory flows. Investigations into these incidents of arrival of irregular immigrants have led the authorities to establish that in such cases, Malta was not the target country for these migrants but they invariably end up on Maltese shores or territory by accident on their way to mainland Europe, namely Italy. It has also been established that these crossings originate from North African shores, namely Libya. Most of these illegal trips start in the fishing ports of Zuwara and Zliten. During the years 2002 to 2004, over 3500 people have been apprehended in Malta after having left Libya illegally. The crossing of a range of countries before reaching final destination is called transit migration[23].

Figure 1: Migration Routes most commonly used by irregular immigrants from Sub-Saharan Africa. Source: European Commission[22]

Distribution and integration of migrants

The two Open Centres in Hal Far are geographically remote. They are situated far from the daily activities of the Maltese society. In practice the centres are surrounded only by fields and air strips/runways and the required physical amenities such as shops, services, health services etc are distant. As a result, the residents of the Open Centres tend to stay between themselves as the Maltese shops, hairdressers and other facilities are far away. For this reason residents have set up small enterprises for themselves within the Centre. Because of this remoteness from Maltese society, those residing in these Open Centres, are socially excluded and integration into society is hindered.

On the other hand, Marsa centre is on the edge of Valletta, and residents can easily go into Valletta on foot or by public transport. However an activity of special interest which has contributed greatly to the integration of migrants at the Marsa open centre is the holistic approach used by Suret il-Bniedem in running the centre rather than its physical location. Marsa open centre is undoubtedly a highly innovative refugee facility particularly due its emphasis on non-reliance on the state and on charity but on the empowerment of the residents, which can be observed through the success rate of the refugees, for instance, both a Somali, Congolese and a Sudanese restaurant have been established and English, culture, as well Islamic courses are being taught. The immigrants are expected to be independent and autonomous once they are out of detention. Life at the open centre includes creative work (through workshops that can be used by residents for different types production and working skills) and also shared responsibility for the running of the centre. The residents are involved in exercises and practices, such as Maltese and English language classes, lectures and debates on European culture, democracy, human rights, peace, diplomacy, law and order, women's rights, working rights and obligations. The centre has been transformed into a tool to prepare immigrants for what they are to expect, their entitlements and what they are expected to do in Malta. It is not the first time that it has been debated whether Marsa Open Centre could be an exportable model for integrating such migrants. This approach, aimed at personal fulfillment and access to the labour market, is the first stage towards integration into Maltese society.

In addition to the three large open centres run by the government (one in Marsa and two in Hal Far) there are other smaller facilities run by the state and NGOs, where integration of these migrants is also good.. The state run residential homes cater for vulnerable persons e.g. unaccompanied minors and families with minors. The NGO facilities cater for a wider variety of people. These other small open centres are located in villages where physical access to essential services and access to medical care is easy.

Migrants' ability with the country's official language

Most of the officially documented non-Maltese nationals settling in Malta usually come from the United Kingdom (usually over half of the migrants) and another significant proportion coming from the United States and other English-speaking countries. English is the second national language in Malta and thus these categories of migrants usually have less language barriers.

On the other hand, many asylum seekers do not speak Maltese or English and language barriers represent a significant problem. Some of the asylum seekers can speak French. Many foreign nationals express their frustration at the difficulties encountered in communication with health care staff, due to language and cultural barriers. They would indicate with gestures what the ailments are, hoping that the problem would be understood. Such a situation may potentially jeopardise the foreign nationals' health. In some cases, another foreign national is used as an interpreter, a situation which also gives rise to problems such lack of confidentiality.

Support in learning of the official languages is provided to children of migrant workers. Legal notice 259/2002[24] entitled 'Migrant workers (Child Education) regulations' defines 'children of migrant workers' as any child residing in Malta for whom school attendance is compulsory under Maltese law and who is a dependent of a migrant worker'. The legislation has become operative as from October 2003. All children of migrant workers within the compulsory school age group (5 to 16 years) are provided with the school-based measures contemplated in the legislation, among them support for the learning of any of the official languages. The legislation also provides for the teaching of the language and culture of the country of origin of immigrant children. According to Maltese law, children including unaccompanied minor migrants up to the age of 16 have access to free education. Apart from this the Refugees Act determines that a person who is declared to be a refugee shall be entitled to have access to state education and training in Malta (Part III Article 11 c, Refugee Act). This does not only apply to persons with full refugee status only, but also to those under temporary humanitarian protection. At the Residential Homes Dar is-Sliem and Dar Liedna, there is a part-time English and Maltese teacher who is financed by the Department of Education providing English classes to the minors[25].
The Department of Further Studies and Adult Education[26] organises voluntary literacy courses in both basic Maltese and English for those adult immigrants wishing to learn either or both of the two languages. These courses are organised in the evening and are held in schools in the locality where they live.

Maltese is the only language of the Afro-Asiatic language family (traditionally named Hamito-Semitic) spoken indigenously in Europe. The language is a member of the

Western group of the Semitic branch of languages, the latter originating in the Arabian Peninsula where Common Semitic is spoken. Maltese was originally a variety of Arabic, alongside the other Arabic dialects, and in fact retains many features reminiscent of the contemporary Arabic varieties, above all those spoken in the Magreb (North Africa, from Morocco to Libya), features which are not found in classical Arabic[27]. Maltese however, is always written in Latin alphabet and not in Arabic script, and has been transformed into a mixed language over the time by massive Romance relexification. The significant Semitic component of the language partly explains the why immigrants from North African countries quickly gain familiarity with the Maltese spoken language.

Countries of Origin of Migrants in Malta

The countries of origin of irregular migrants arriving in Malta by boat are shown in Table 8 and 9.

Table 8: Number of irregular migrants coming to Malta by country of origin 2002 to 2006

Nationality	Year of arrival					
	2001	**2002**	**2003**	**2004**	**2005**	**2006**
Gambia		4				1
Egypt	56	298	217	174	376	312
Morocco	1	92	65		23	157
Tunis		24	10	5	24	17
Algeria		1		1	1	9
Iraq		138		8	36	7
Libya		1				
Palestine		19	5	100	42	4
Bangladesh		20		5		
Eritrea		334	1	199	362	368
Ethiopia		63		16	98	142
Somalia		246	86	533	150	282
Sudan		27	45	64	438	67
Lebanon		2			1	
Syria		10				1
S. Leone		10		3	11	9
Chad		13	2	1	14	13
S. Africa		1				1
Botswana		1				
Congo		44	45	109	2	7
Cameroon		7	2	2		3
Ghana		45		2	24	85
Guinea		4	1			4
Ivory Coast		5	27	52	77	58
Kurds		31				1

Liberia		153	4	10	28	4
Mali		7	1	1	2	40
Mauritania		1				2
Togo		2		2	16	22
Djibouti		1				
Nigeria		25			45	54
India		1	4	8	4	1
Pakistan		20	3	41		1
Senegal			1			1
Burk. Faso				2	4	19
Polisaria				1		
Casamace				1		
Burundi					1	
Niger				5	41	39
Benin					3	2
Guinea Bissua						2
Tanzania						1
Zimbabwe						1
Papua New Guinea						1
Afghanistan						1
Total	**57**	**1686**	**502**	**1388**	**1822**	**1780**

Table 9: Percentage of irregular migrants coming to Malta by country of origin 2002 to 2006

Country of origin	**2002**	**2003**	**2004**	**2005**	**2006**
Gambia	0.24				0.06
Egypt	17.67	43.23	12.54	20.64	17.53
Morocco	5.46	12.95		1.26	8.82
Tunis	1.42	1.99	0.36	1.32	0.96
Algeria	0.06		0.07	0.05	0.51
Iraq	8.19		0.58	1.98	0.39
Libya	0.06				
Palestine	1.13	1.00	7.20	2.31	0.22
Bangladesh	1.19		0.36		
Eritrea	19.81	0.20	14.34	19.87	20.67
Ethiopia	3.74		1.15	5.38	7.98
Somalia	14.59	17.13	38.40	8.23	15.84
Sudan	1.60	8.96	4.61	24.04	3.76
Lebanon	0.12			0.05	
Syria	0.59				0.06
S. Leone	0.59		0.22	0.60	0.51
Chad	0.77	0.40	0.07	0.77	0.73
S. Africa	0.06				0.06
Botswana	0.06				
Congo	2.61	8.96	7.85	0.11	0.39
Cameroon	0.42	0.40	0.14		0.17
Ghana	2.67		0.14	1.32	4.78

Guinea	0.24	0.20		0.00	0.22
Ivory Coast	0.30	5.38	3.75	4.23	3.26
Kurds	1.84				0.06
Liberia	9.07	0.80	0.72	1.54	0.22
Mali	0.42	0.20	0.07	0.11	2.25
Mauritania	0.06				0.11
Togo	0.12		0.14	0.88	1.24
Djibouti	0.06				
Nigeria	1.48			2.47	3.03
India	0.06	0.80	0.58	0.22	0.06
Pakistan	1.19	0.60	2.95		0.06
Senegal		0.20			0.06
Burk. Faso			0.14	0.22	1.07
Polisaria			0.07		0.00
Casamace			0.07		0.00
Burundi				0.05	0.00
Niger			0.36	2.25	2.19
Benin				0.16	0.11
Guinea Bissua					0.11
Tanzania					0.06
Zimbabwe					0.06
Papua New Guinea					0.06
Afghanistan					0.06

Some of these irregular migrants will have been repatriated almost immediately, e.g. irregular migrants from Egypt, Morrocco and Tunisia, These people would not have been living in the community but would have remained detention till they are repatriated. As regards repatriation, during 2006, a total of 780 foreigners were repatriated in line with immigration procedures.

Of those who are released from detention, data related to age, sex distribution, country of origin and length of presence in Malta, is accessible from both the closed and open centres where they are aggregated.

Migrant workers

Migrant workers are over- or under-represented in specific sectors and occupations. This is mainly influenced by the skills that these workers hold. Legal migrant workers who are third country nationals are generally over represented in highly skilled positions such as engineers, technicians and doctors. Migrant workers who are refugees, have a legal right to work, whilst asylum seekers whose application has been pending for 12 months and those who have been granted temporary humanitarian protection, are given access to

the labour market. Refugees, asylum seekers and those who have been granted temporary humanitarian protection are usually over represented in low skilled and elementary jobs. A specific sector where such migrant workers are over represented is construction. Many migrant workers under humanitarian protection work as cleaners and plasterers[28].

A specific skill shortage is one of the reasons for such over- or under- representation. Third country nationals do not automatically get a work permit but the Employment and Training Corporation (ETC) decides whether an employment license is issued for these persons, after consultation with a number of departments related to the specialised jobs. Often, only those that are highly skilled and/or have skills in demand are given a work permit. Hence, ETC targets the type of employment for the migrants that the country needs. Other reasons for over representation in low skill and elementary jobs are that these migrant workers take up jobs that the nationals refuse, such as jobs in the construction industry. Furthermore, most of the migrants who are automatically given a work permit (including asylum seekers, refugees and those under humanitarian protection) have no trades, education or other necessary skills required to occupy higher occupations. Presence of non EU migrant workers does vary significantly in the different sectors according to nationality.

When migrant workers obtain a work permit they are treated as normal employees. However, migrants with an automatic work permit usually have very low wages when compared to national, often the minimum wage. One plausible reason for this situation is that these migrant workers do not have much information about their rights, the employment laws and regulations and the cost of their work in the local labour market. On the other hand illegal migrants, with no work permit, are treated differently and are even paid less for the same work carried out by national workers. This is mostly seen in the construction industry, where many migrants with THP, refugees and asylum seekers are forced into the black market due to a number of factors including xenophobic sentiments, lack of information etc.

Sex Workers and human trafficking

There is not much available data on foreign sex workers The Vice Squad's Annual report 2006 states that in its work to curb loitering and prostitution, the Vice Squad, special

attention was given to those areas which are notoriously known for loitering by prostitutes and possible new ones. These areas included Gzira, Msida, Marsa and Ta' Xbiex, and also Hal Far, since there were allegations of prostitution by foreign women and that the fight against the trafficking in human beings for sexual exploitation continued and persons were charged in court following investigations in this regard. The Squad also focused on the curbing of foreign prostitution where very good results were claimed. A considerable number of foreign women who were suspected to be indulging in prostitution locally were referred to the Immigration Branch for removal from Malta. The statistics given are that the Vice Squad was involved in the investigation of 4 suspected foreign prostitutes.

Irregular Migration and Malta

Irregular migration is an important issue for Malta. Malta is located at the southern borders of the European Union, is a small island of 316 sq. km with a population of 400, 000 and a population density of 1200 people per sq. km, and clearly has only a limited capacity to take in and accommodate the migrants and asylum seekers who regularly land in large numbers on its coastline. Libya is considered to be one of the main African countries from where thousands of illegal immigrants coming from all over sub-Saharan Africa embark on ramshackle boats in a desperate attempt to reach EU shores. The majority of irregular immigrants who ended up in Malta during the last years were coming from Libya as the offtake shore. For various reasons, usually bad navigation or emergencies with their boats, they strike Malta first. Further comparing the situation to the large influx of illegal immigrants being experienced in the Spanish Canary Islands, Maltese Foreign Minister Michael Frendo said "Relatively speaking, 967 illegal immigrants in Malta translate into the arrival of 135,380 in Italy, 145,050 in France, 96,700 in Spain and 198,235 in Germany. This is the magnitude of the problem of illegal immigration in Malta where the population density is 1,200 per square kilometre."[29] Although only about 1,800 immigrants came from Africa to Malta last year, the government argues that relative to the country's size and population this is an enormous number. "It is as if 280, 000 people had landed in Germany last year"[30]. The annual average number of people arriving in Malta is equivalent to 45% of the number of births in Malta and in relation to population, one arrival in Malta corresponds to 114 in Italy, 150 in France and 205 in Germany, In 2005 Malta took in 2.9 asylum seekers for every

1000 inhabitants putting it in second place in the EU behind Cyprus. The country spends 1% of its national budget on coping with the current situation and employs a significant proportion of its army and police force, more than 10% of manpower, in dealing with the humanitarian emergency and managing detention and reception centres[31].

Another significant issue for Malta but however on which there is not much data available is the issue of over-stayers in Malta. These persons would have entered Malta legally but remain in the country once the visas have expired.

Detention Policies

An administrative practice of releasing migrants who had been in detention for more than 18 months has now been adopted. This unwritten criterion applies to all foreigners, whether asylum seekers or irregular migrants. That practice was officialised, in 2004, when the Ministry of Justice and Home Affairs and the Ministry for the Family and Social Solidarity adopted a policy document on irregular immigrants, refugees and integration. Section 5 of the document states that irregular immigrants are to remain at closed reception centres until their identity is established and their asylum request processed. The Office of the Refugee Commissioner examines applications for recognition of refugee status in Malta and recommend or otherwise their acceptance. No immigrant is to remain in detention longer than 18 months. According to a further administrative practice the authorities nowadays release asylum seekers after 12 months' detention. The measure had been adopted to bring the situation in Malta into line with the European directive on minimum standards for reception of asylum seekers, which required that, on certain conditions, member states grant asylum seekers access to their labour markets after a year's proceedings and in Malta, this provision was interpreted as containing an indirect obligation to end asylum seekers' detention after 12 months.

Detention policy and vulnerable persons

The detention of foreigners is currently governed by the following rules: after one year's detention, asylum seekers are to be released; in all other cases foreigners are kept in detention for a maximum of 18 months. While the general rule is that the foreigner will be released after 12 or 18 months of detention, the Maltese authorities have introduced a speeded-up release procedure for "vulnerable" persons. A policy which is applicable to families, sick persons and pregnant women has been introduced gradually in response

to cases and problems actually observed. It has led the various services involved – immigration, the police, health and welfare – to adopt procedures to facilitate speedy releases. Firstly the detention authorities report the presence of any potentially vulnerable individual or persons: families with children, pregnant women, people with disabilities (and their families) or elderly people. The administrative authorities then register the persons concerned – indicating whether they have an asylum application – and conduct a medical examination. When a medical certificate states that they are free of any contagious disease, they can be immediately released.

Older people and people with disabilities should, in theory, qualify for similar treatment. However, in the absence of a clear definition of vulnerable categories, it is for the detention authority to make its own assessment in each individual case, which leaves doors open to discretionary practices and differences of treatment.

OIWAS is responsible for processing “vulnerable” persons.

Open centres for refugees and regular and irregular migrants.

Shortly after the Council of Europe Commissioner for Human Rights’ visit, the Maltese authorities began releasing asylum seekers, particularly families, more systematically. Open reception facilities were therefore set up to meet the needs of those newly released – asylum seekers, refugees and migrants in an irregular situation. The facilities are of different types. Firstly there are centres directly run by NGOs or charities such as Peace Laboratory or the Emigrant Commission. Former closed centres have been converted into open centres falling under the responsibility of the Ministry for the Family and Social Solidarity (MFSS). OIWAS are now responsible for a number of open centres, as is Suriet il-bniedem. Food is no longer provided, but a daily allowance is. Allocation to the centres is based on availability of places and the intended use of the particular centre – some of them have better facilities for unaccompanied minors, families or single women than others, for example. According to NGOs, the conditions vary greatly, the government centres often being below minimum reception standards, particularly one of them, Hal-Far. The centres’ aggregate capacity exceeds 1,000 places and the next stage of conversion work at some of them should bring capacity to 1,200. That increase would seem essential, as this is long-term accommodation until people find accommodation of their own and available places are very limited. In addition, further places will be needed for those currently in detention. However, it is worth

mentioning, that some migrants, recently released and after having spent some time in open centres, found private accommodations.
Since December 2006 the policy changed and instead of providing free food supplies, the residents receive limited daily financial support ranging from Lm 1.25 to Lm 2.00 (approximately € 3 to € 4,60) depending on their status.

Entities designated with the responsibility to manage migrants

The Ministry for the Family and Social Solidarity (MFSS) is responsible for the social welfare of the immigrants irrespective of whether they have been granted refugee or humanitarian status or are still without official status (Irregular Immigrants, Refugees and Integration: Policy Document, 2005). This Ministry collaborates with other Ministries and also liaises with the NGO forum, which brings together all NGOs and International Organizations involved in the provision of services to asylum seekers.

The Detention Service, established on 18 August 2005, made up of personnel seconded from the Police Force and from the Armed Forces of Malta under one Command is a new department that falls under the responsibility of the Ministry for Justice and Home Affairs (MJHA). The Detention Service was tasked with the security of the Closed Centres while providing:

- adequate accommodation, including the necessary toilet and shower facilities;
- basic needs, such as food, clothing, hygiene and safe environment;
- access to medical care;
- access to the asylum system, that is, Commissioner for Refugees;
- access to non-governmental organisations;
- means of contacting home or their country representative in Malta.

c) Emigration

The Destination Countries

The principal destination countries for Maltese migrants settling elsewhere are the United Kingdom, Australia, the United States of America and Canada.

Emigrants						
Country of Future Permanent Residence						
Year	Australia	Canada	United	USA	OTHER	Total

			Kingdom			
1993	31	8	10	12	5	66
1994	54	3	9	35	3	104
1995	55	3	10	36	3	107
1996	51	-	43	-	-	94
1997	10	-	63	-	-	73
1998	34	-	87	-	-	121
1999	13	-	54	-	-	67
2000	-	-	67	-	-	67
2001	-	-	73	-	-	73
2002	-	-	96	-	-	96
2003	-	-	40	-	-	40
2004	-	-	70	-	-	70

Source: National Statistics Office

Table 10: Numbers of Maltese emigrating to other countries according to the principal destination countries

Deficiencies are found in migration data related to emigration from Malta since the Labour Department dismantled its section of Emigration in January 1995. The only sources for prospective emigrants were those from the Embassies and the High Commissions. Since 2000 only the High Commission of Britain was complying with requests for data. However since Malta joined the EU on May 2004 even data from the UK Embassy stopped since with the Freedom of Movement Act, the UK Embassy had no data of Maltese citizens going to the UK to stay for more than one year.

Migration management strategies and information available to migrants about "migration experience" and possibilities at destination

Potential migrants can obtain information about the migration experience and the possibilities at destination by contacting the Emigrants' Commission[32]. The Emigrants' Commission is a non-governmental, non-profitable, voluntary organisation, which is established to help and protect people in need by offering them free services, counselling and protection. It came into being in 1950 due to the huge exodus of Maltese

to foreign lands because of overpopulation and unemployment. The aim was to offer help to those who intended to settle abroad. Now its services cover all those affected by migration including immigrants, refugees and tourists. Under the patronage of the Emigrants' Commission there are other organisations whose activities are orientated to help immigrants and tourists in more specific areas and it also houses Associations such as: the Maltese - Canadian Association, the Maltese - American Association, the Friends of Australia Association, the International Wives Association and the Association of Families of Migrants.

Bilateral, international and labour agreements in place

Malta secured a special deal during negotiations with the EU on free movement of persons. The negotiations, which were concluded in June 2001 allowed for restrictions in case of a big influx of EU workers into the country to be adopted unilaterally, whilst ensuring that Maltese citizens could move freely to seek work in other EU countries from the first day of membership. The deal covers a period of seven years after membership, during which Malta can apply safeguards on the right of EU nationals to work in the country, thus retaining the work permit system in relation to EU workers and the right to withhold work permits in the case of a threat of disruption to its labour market[33].

d) Epidemiological country context

HIV/AIDS Situation in Malta

Although data on AIDS cases has been collected since 1985, HIV only became notifiable on the 27th January 2004 and so, data on HIV started being collected in January 2004. Between the 1st January 2004 and 31st December 2006, a cumulative total of 65 HIV/AIDS cases have been reported. Table shows the transmission category of these 65 cases.

Transmission category	Number of persons in category
Sexual contact between men	17
Heterosexual sex	32
Injecting drug use	6
Unknown cause	10

Table 11: Reported cases of HIV/AIDS by transmission category (2004 to 2006)

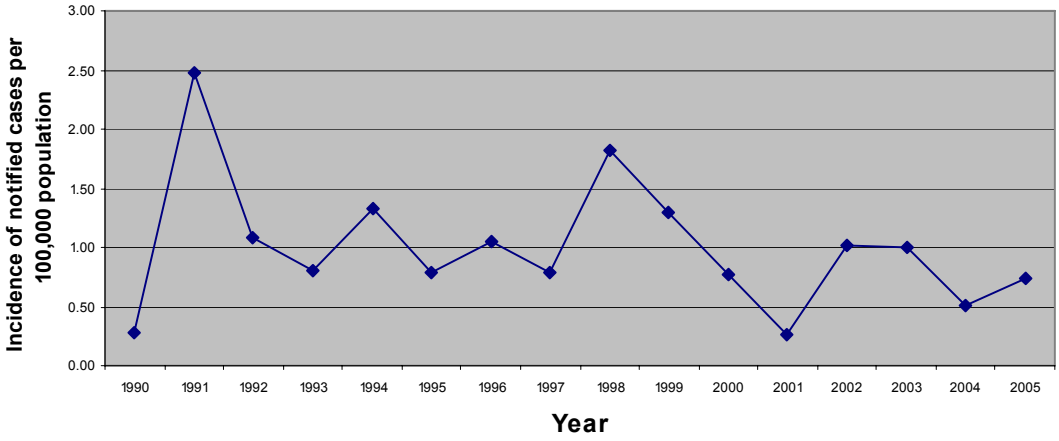


Figure 2: Reported incidence of AIDS in Malta (1990 to 2005)

Since the beginning of the year 2005, there have been 4 notifications of HIV/AIDS in irregular immigrants. 2 of these 4 cases now have a Maltese ID card and have a residence in Malta.

Map 4 (Annex 5) shows the epidemiology of HIV/AIDS in Malta categorized into Maltese and foreigners

Co-morbidities among Persons Living with HIV/AIDS (as on 31st December 2006)

Co-morbidity		Reported Number	Estimated Number (where reported number is not available
Hepatitis B	Total number of persons living with HIV/AIDS who were tested for Hepatitis B		95%
	Number of persons tested who were co-infected with Hepatitis B virus		5

	Numbers of those co-infected with HIV/HCV having chronic Hepatitis B.		5
Hepatitis C	Total number of persons living with HIV/AIDS who were tested for Hepatitis C		95%
	Number of persons tested who were co-infected with Hepatitis C virus		4
	Numbers of those co-infected with HIV/HBV having chronic Hepatitis C		4
Tuberculosis	Total number of persons living with HIV/AIDS who were tested for Tuberculosis	100%	
	Number of persons tested who were co-infected with Tuberculosis	2	
	Numbers of those co-infected with HIV/TB having active Tuberculosis	2	

Table 12: Co-morbidities among Persons Living with HIV/AIDS (as on 31st December 2006)

National Tuberculosis Prevalence:

The incidence rate of TB among the Maltese population is one of the lowest from a global perspective between 3 - 7 per 100,000 population with a preponderance of cases in the elderly denoting mostly old infection (as opposed to new infection in the younger age groups)[34]. It has not followed the upward trend shown in many neighbouring countries such as Italy, UK, Libya, Algeria, Spain and Switzerland. Also drug resistant strains have not yet featured among the Maltese population.

Tuberculosis Prevalence in Migrants:

The number of infectious diseases in this group of persons is much higher than the general population in Malta. International data shows an increase in the number of tuberculosis (TB), malaria and HIV/AIDS in migrants traveling from areas of high rates of these diseases to areas of lower prevalence. In Malta we have had a number of cases of TB in irregular migrants over the recent years (Table 13).

Year	No of cases of pulmonary TB	No of irregular migrants screened
2002	8	1595
2003	0	949

2004	9	1965
2005	9	2773
2006	10	2600

Table 13: Number of cases of pulmonary TB in irregular immigrants 2002-2006.

Source: Disease Surveillance Unit

Map 5 (Annex 5) shows the epidemiology of TB in Malta categorized according to Maltese nationals and foreigners.

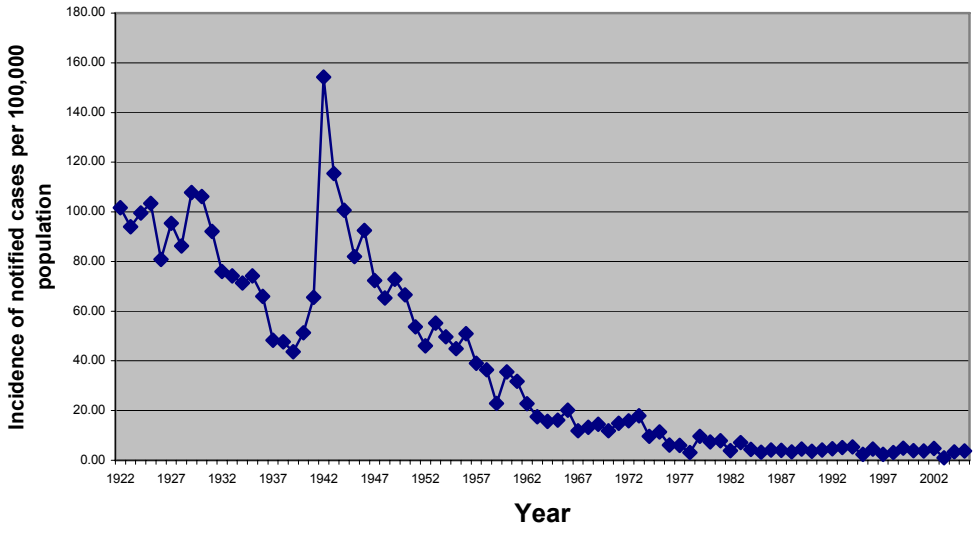


Figure 3: Reported incidence Of Pulmonary TB cases (1990-2005)

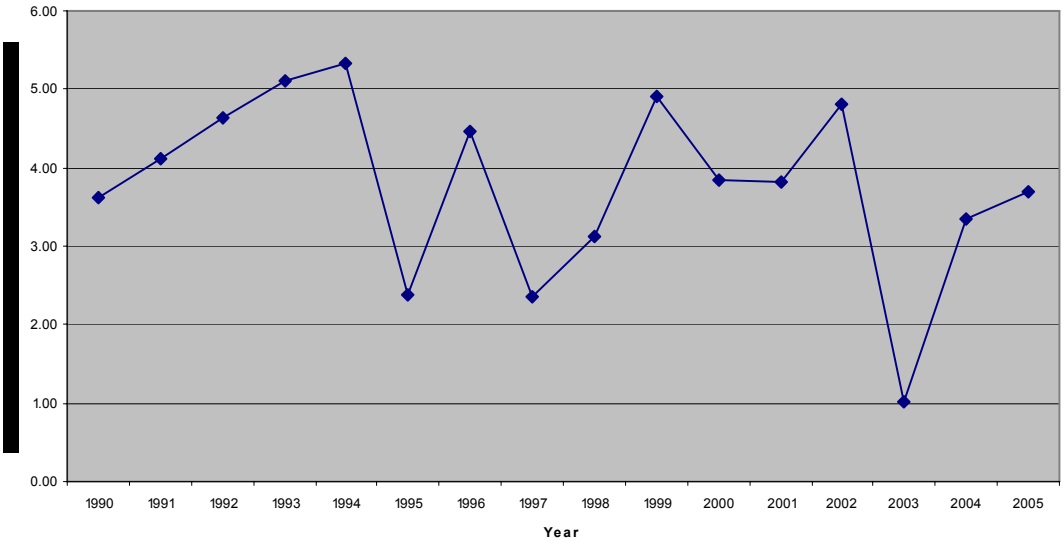


Figure 4: Reported incidence of sporadic Pulmonary Tuberculosis in Malta (1990-2005)

During the year 2006, there were 36 TB cases notified and confirmed[35]. These were categorised as:

- 16 pulmonary TB cases in Maltese nationals
- 13 pulmonary TB cases in foreigner nationals
- 4 extra-pulmonary TB cases in Maltese nationals
- 3 extra-pulmonary TB in foreigners nationals

Data shows that transmission of TB occurs in detention centers primarily as a result of undiagnosed TB. Such infected persons place other irregular migrants and staff at risk for TB and when released, these persons also can infect persons living in the surrounding communities. At present the situation in Malta is such that when a number of irregular migrants arrive, they are housed with the rest of the immigrants who have been already screened. Hence the "new" comers until they are screened, can infect those who have already been screened. It has been estimated that TB occurs at a rate of one per 100-200 arriving irregular immigrants and then at a same yearly rate. In this way, unless the persons develop symptoms, they will not be picked up and since they are living in a very over crowded place, they can infect others with the consequence of the spread of TB throughout the closed detention centre and also posing a risk to the staff. The number of TB cases in irregular immigrants/asylum seekers notified in 2005

was 13. Of these 9 were pulmonary TB cases and 4 were extra pulmonary TB cases. Of these, 5 notified pulmonary TB cases entered Malta in 2005. The rest entered Malta before 2005. From January to mid June 2007, 60 irregular migrants have been admitted to St Luke's hospital with respiratory symptoms and a presumptive diagnosis of TB (Figure 5).

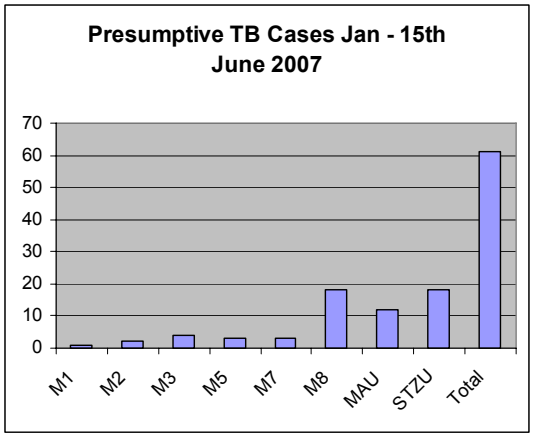


Figure 5: Presumptive Tuberculosis cases admitted to hospital January 15th to June 2007

Such cases are being hospitalized for isolation from detention centers. These include those persons who are in good physical condition but are awaiting results of investigations.

Although Malta has had a low reported incidence rate of tuberculosis over the last years, the island has an influx of people coming from high-risk countries. These include irregular migrants, people seeking employment, students and tourists. In an effort to control TB irregular migrants coming from high-risk countries, a protocol regarding TB screening in irregular migrants was set up by which all cases are currently screened. The following protocol is used:

Screening and Immunisation of High Risk Immigrants

Detection of cases with tuberculosis

Active screening by a radiographic examination of the chest among irregular immigrants is implemented on all subjects. It is done shortly after arrival in order to detect, isolate and treat cases and hence to prevent transmission to other individuals. Chest X-Rays

are taken at St. Vincent de Paule Hospital and evaluation of chest radiographs by radiologists is carried out without delay. Details of names and surnames and an individual identification number are given upon arrival. Suspected cases are brought to the attention of the Consultant on Infectious Diseases, the tuberculosis specialist in charge of the chest clinic within St. Lukes' Hospital and the Public Health specialist in charge of the Chest unit within Qormi Health Centre for clinical evaluation and any necessary management.

Plans are in place to set up a primary closed reception centre where newly arrived illegal immigrants who have not yet been screened are placed. The reception centre will be equipped with isolation premises for persons having symptoms suggestive of tuberculosis and other infectious diseases, a clinic where the immigrants can be examined on the day of arrival and medical staff to supervise administration of treatment, including Directly Observed Treatment (DOT) of Tuberculosis patients and translators.

1. A designated radiographer and chest X-ray machine facilities will be provided on site for the screening of these immigrants, with all radiographs being examined without delay by a designated radiologist who sends the results to the Chest Unit thus suspected cases are brought to the attention of the medical officer running the Chest Unit. The patient would then be referred for clinical evaluation and treatment. In-patient treatment at St. Luke's Hospital would be necessary only for patients with severe illness, for those whose medical circumstances or other reasons make treatment at the immigrants' quarters difficult or impossible, and for patients with sputum-positive pulmonary tuberculosis who need to be placed in a single room with negative pressure ventilation. Before release from this primary closed reception centre to the other closed barracks the irregular migrants should have medical clearance from the Department of Public Health.

Screening of pregnant irregular immigrants for tuberculosis in Malta

The pregnant female will be screened by 2 clinical procedures:

• The tuberculosis skin test, which is not contraindicated in pregnancy

• Clinical examinations of the patient for signs and symptoms of active tuberculosis disease. This is done at the Chest Clinic, within Qormi Health Centre.

If the tuberculosis skin test is negative or weakly positive i.e. the patient is not infected (does not have the TB microbe) and the patient has no clinical signs of TB, the chest x-ray can be taken after pregnancy. The patient can be released immediately on public health grounds.

If the tuberculosis skin test is strongly positive i.e. the patient is infected (has the TB microbe) but she has no clinical signs of TB, one has a clinical suspicion that the patient may have active TB disease. In this case the chest x-ray can be taken after the first trimester of pregnancy. During those first 3 months of pregnancy the patient is followed up at the Chest Clinic, St Luke's Hospital. The patient can be released after the first trimester of pregnancy if the chest x-ray is normal **. If the patient refuses to take the chest x-ray she will continue to be followed up until termination of pregnancy. The chest x-ray will be taken after pregnancy and the patient can then be released if the chest x-ray is normal **, on public health grounds.

If the tuberculosis skin test is strongly positive i.e. the patient is infected (has the TB microbe) and she also has clinical signs of TB, then the potential risk to the foetus of a chest radiograph will have to be weighed against the possibility that the patient could have active TB and its potential risk on the foetus, on the patient, and on the community. In this case one has a strong clinical suspicion that the patient may have active TB, and the chest x-ray cannot wait after pregnancy but taken immediately. If the chest x-ray is normal**, the patient can be released. If the patient refuses to do a chest x-ray she will be given empirical TB treatment because of the strong clinical suspicion of active TB disease. She will be released when she finishes the treatment for public health reasons.

**In all cases if the chest x-rays have abnormalities compatible with active pulmonary TB disease, the patient will be given curative TB treatment and will be released on termination of treatment, for public health reasons.

Tuberculosis Screening Activity

Tuberculosis (TB) Screening of Irregular Immigrants in Malta for Active TB Disease

Chest x-ray is the most practical and sensitive approach to discover abnormalities compatible with TB of the respiratory tract. It is done shortly after arrival to prevent transmission to other individuals. Suspected cases are referred for clinical evaluation to a specialist. Those patients with active TB disease are given curative treatment free of

charge. The specialist follows up the patient regularly during the course of treatment and the treatment is supervised daily by a nurse to make sure it is taken as prescribed. - DOT. This supervision of treatment is ordered by the consultant or specialist whose care these patients have been under and organised by Chest Unit Public Health.

Map 6 (Annex 5) shows the distribution of TB cases in Malta who are on DOTS treatment

Tuberculosis (TB) Screening of Irregular Immigrants in Malta for Latent TB Disease

TB screening of immigrants also has the aim of detecting latent TB infection which might develop into active TB later on. A 5% chance exists of a person with TB infection of developing active TB disease in the first 2 years after infection. For this reason, preventive treatment is offered to prevent the emergence of TB disease. This preventive treatment is offered but can be refused by the patient.

Co-infection data of Tuberculosis cases with HIV is categorized and the details are available for each case, including details on whether the patient is a Maltese national, a foreigner settling in Malta or an illegal immigrant. Other details about the gender, mode of transmission, country of origin, date of entry in Malta, address of current residence and the list of contacts are available for public health reasons.

Sources of information for HIV-TB data

1. The Disease Surveillance Unit: this unit falls under the Public Health Directorate. This unit is responsible for the surveillance and control of infectious diseases. The unit receives notifications of notifiable diseases from various sources including medical doctors, laboratories (both state and private laboratories) and death certificates. Both HIV and TB are notifiable diseases under the Public Health Act.
2. Sir Temi Zammit Ward and Sir Temi Zammit HIV Outpatient Clinic within St. Luke's Hospital. This unit specializes in the clinical management of communicable diseases. In particular, it provides treatment for people diagnosed with HIV/AIDS and serves as an outpatient HIV clinic on a once-weekly basis. HIV treatment services provided through this unit include: baseline investigations,

CD4 testing and viral load counts and anti-retroviral treatment. In addition, post-test counseling is also provided through this unit.

3. The Genito-Urinary Clinic within Sir Paul Boffa Hospital.
4. The Chest Clinic within Qormi Health Centre.
5. The Chest Unit within St. Lukes' Hospital.

PART TWO: PRIMARY DATA COLLECTION THROUGH RAPID, PARTICIPATORY ASSESSMENT

a) Health services facilities providers

The main health service providers that provide health services to migrants (including HIV and TB services) and are directly involved in working with them are:

• The Disease Surveillance Unit within the Public Health Department within the Ministry for Health, Elderly and Community Care;

• Sir Temi Zammit Unit (Infectious Disease Unit, St. Luke's Hospital);

• The Genitourinary Clinic, Sir Paul Boffa Hospital;

• The Chest Unit, Qormi Health Centre;

• The Chest Unit within St. Luke's Hospital

• Physicians providing services from state health centres;

• The Port Health service providers;

• The Substance Misuse Outpatient Unit (Detox), Sedqa and others;

• The outsourced health service providers providing medical services within closed detention centres;

• Other health service providers working within the state hospital including physicians, and particularly relevant are chest physicians with special interest in the treatment of Tuberculosis, gynaecologists/obstetricians who are often involved in the diagnosis and treatment of sexually transmitted diseases, in screening of pregnant females and management of prevention of maternal to child HIV transmission, the Infection Control Unit, microbiologists and related professionals working in diagnostic laboratories.

• The state Pharmaceutical services;

• Medicin du Monde, which at present are also operating clinics in open centres, but however, this service will expire in September 2007

• Clinics within Correctional facilities;

• All other private medical service providers.

Key persons from the above entities were interviewed; the services provided were discussed, together with the use of these services made by migrants and any difficulties experienced in delivering of these services to migrants particularly in relation to treatment of HIV, TB and sexually transmitted diseases.

Services Offered to Irregular Migrants by the Port Health Services:

All irregular migrants are subject to an initial medical examination organised by the police at the Police General Headquarters and conducted by the port health services immediately after their apprehension (before being assigned to a detention centre), and those who need particular medical attention are taken to St. Luke's Hospital. During 2006 examinations were performed on 1786 irregular immigrants. The examination involves a physical examination, including a chest examination together with a detailed enquiry on symptomatology suggestive of TB. All the immigrants are examined and they cannot opt out. In general the age range of the irregular migrants or “boat people” varies from children of a few days to adults of 58 years, with an average age of 25-30 years. The male to female ratio is about 1:10. In general, upon arrival one out of every 3 persons would have chest symptoms, and one out of every 20 persons would have symptoms and signs suspicious of sexually transmitted diseases. Shortly after the immigrants’ arrival, arrangements are made for a chest X ray to be done at the Chest Clinic in Qormi Health Centre to screen for Tuberculosis.

Services Offered by the Chest Unit at Qormi Health Centre:

The services offered by the Chest Unit at Qormi Health Centre include:

1. Provision of curative anti -TB treatment to all individuals with TB disease free of charge.
2. Supervision of anti -TB treatment to make sure that the treatment regime is adhered to and taken properly. This also includes directly observed treatment (DOTS) where a nurse or other qualified personal watches the patient take his / her treatment.
3. Contact tracing - screening of people exposed to a case of infectious.
4. Related to migrant health, the Chest Unit performs Tuberculosis screening of the following identified high risk groups:

• Refugees, asylum seekers, irregular immigrants and displaced persons

• All foreigners from countries with a high incidence of TB seeking residency in Malta like those applying for a work permit and their family members, and students

• Correctional facility inmates

5. Treatment offered to infected individuals.

6. BCG vaccination

The categories of clients at risk tested during 2006 and the subsequent outcomes are shown in Table 14:

Category	**Total**	**Outcome**
Foreign work permits	Applicants: 1574 Family members: 47	There were 8 abnormal Chest X rays which were followed at Chest Clinic in St Lukes. None required preventive treatment
Corradino Correctional Facility	Maltese inmates: 43 Foreign inmates: 62	No cases of active TB found
Foreign Students	Students: 253	Two (2) high tuberculin reactors who were referred to Chest Clinic SLH where one was given preventive treatment
Irregular migrants on their arrival in Malta	1431	17 abnormal Chest X rays which were followed up at Chest Clinic SLH
Screening of immigrants held in detention before release from detention	1169	48 strong tuberculin reactors; 33 abnormal chest X rays; 31 referred to chest clinic SLH
Miscellaneous referrals to Chest Unit	54	23 abnormal Chest Xrays; 34 strong tuberculin reactors; 17 referred to Chest Clinic SLH

Source: Public Health Department Annual Departmental Report, 2006[35]

Services Offered Sir Temi Zammit Unit:

This ward specialises in the clinical management of infectious diseases and also has an Outpatient HIV Clinic run on a weekly basis. The major problems encountered there, according to healthcare workers are that treating migrants poses certain difficulties that are less encountered when treating nationals. The main problems described include that migrants less readily keep their appointments, sometimes do not take the medicines as prescribed, sometimes because cultural reasons prevent the patient from following the medical treatment and sometimes because treatment regimes are poorly understood due to communication problems. Adherence to Tuberculosis treatment regimes is ensured through DOTS (Directly Observed Treatment Supervision). In the case of open detention centres, at the moment the responsibility of DOTS is entrusted on to a co-ordinator. On the other hand, the responsibility of DOTS is entrusted upon community nurses. For anti-retroviral treatment, on the other hand the medications are given directly to the patient. Since in the case of treatment with anti-retroviral agents, the treatment regimes are complicated and communication for instructions on medication taking is complicated by language barriers the staff have found ways of creating posters with photographs of the tablets used in the treatment regimes and describing pictorially the treatment regime, making the instructions more clear even for persons who have language problems. Correct medication taking is thus guaranteed. Anti-retroviral treatment is more commonly refused by migrants and compliance is less good. This is even evidenced by the fact that anti-retroviral treatment drug resistance is not present in Maltese nationals due to compliance and proper adherence with treatment. On the other hand, in the case of anti-tuberculous drugs, there have been no reported cases of multi-drug resistance in Maltese and multi-drug resistance has only been encountered in foreigners and migrants.

All patients who are referred for the treatment of Tb are also screened for HIV. In general the male: female ratio for HIV is approximately 4:1. Since the last 5 years, there have been in all five (5) cases of HIV/TB co-infection, of which one was Maltese and the other 4 were foreigners.

Services offered by the Genito-Urinary Clinic at Boffa Hospital

The Genito-Urinary Clinic in Boffa Hospital provides confidential diagnosis and treatment of sexually transmitted Infections, and other genital conditions, not necessarily sexually

acquired. Counseling and testing for HIV is given free of charge to both Maltese and non-nationals. Referrals to the clinic include self-referrals, patients referred by doctors, and those referred through Xefaq (a service by Caritas Malta that offers both a phone service and confidential face to face pre- and post- HIV testing counselling and helps the persons requesting Xefaq services make contact with the Genito-Urinary Clinic for blood testing). The number of persons referred to the genitor-urinary clinic is continuously on the rise. The year 2005 saw an increase of patients from 1595 in 2004 to a total of 1832 (of which 70.6% or 1294 were new patients). During 2005, 174 of the new patients were non-residents (13%) From the 1st January 2007 up to mid 2007, there were 730 referrals of which 22 were foreigners. HIV testing is suggested to the persons attending for screening and treatment of other STIs and they can opt out. Informed consent is always obtained. In general the difficulties encountered are communication difficulties because of language problems, making counselling more difficult. Cultural problems are also common and are these differences and problems tend to be particular for different ethnic groups e.g: some females from certain ethnic groups refuse to be examined by a male doctor. Persons coming from other European countries generally have less problems with the language and experience less problems with communication. Persons who result to be HIV positive are then referred to Sir Temi Zammit Unit (STZU) for further evaluation and management including treatment with anti-retroviral agents. At STZU all HIV positive persons will eventually be screened also for TB.

Services Offered to Immigrants in closed detention centres:

For immigrants held in detention in closed centres, the provision of medical services (free for the migrants) has been contracted out to outsourced private medical service providers. The services – with presence of a doctor every weekday morning started in 2006. For treatment of the most serious conditions migrants are taken to the hospital emergency service. The persons held in detention are not tested for HIV. HIV testing is done only when it is clinically indicated. Informed consent is obtained and the person can refuse to be tested when the test is offered. The person can at his own request be tested for HIV and the test is done anonymously with the result being known only to the doctor who has ordered it. According to medical staff, in practice this test is rarely requested by the persons held in detention as most fear the consequences of a positive test, mainly fear of breaches in confidentiality and the fear that if the result is positive and the results leak out there would be discrimination from other persons in detention, from the medical staff and from the persons providing custodial care. Pre-test counselling is rendered difficult as in all medical communication by language barriers. No interpreters

are available and sometimes other persons held in detention are asked to translate. This often gives rise to problems of confidentiality, invalidity of consent, inferior quality of translation as the other residents often have inexperience in medical terminology and occasionally distortion or altering of the intended communication. Difficulties are encountered in explaining medical treatment. Occasionally medical doctors and medical staff such as nurses sense that initially, till a patient-health provider rapport starts being built, they are mistrusted by the residents as they are sensed as being part of the authorities who are keeping them in detention. Any persons who result to be HIV positive would be referred to Sir Temi Zammit Outpatients clinic (specializing in infectious diseases) and in particular to the HIV clinic for further evaluation, monitoring of CD4 counts and anti-retroviral treatment.

Persons who are newly admitted to closed detention centres are screened for TB by means of a chest X-ray shortly after admission. Those who have active TB requiring treatment are given DOTS (Directly Observed Treatment Supervision) which is given by adequately trained community nurses.

Services offered from state health centres, outpatients department and Acute and Emergency Department.

Recent migrants and refugees

Though refugees and persons who are granted humanitarian status are entitled to the full range of national health services treatment free of charge these persons state that they experience particular barriers to gaining access and utilising health services. Health care workers have differing attitudes to accepting refugees. Negative attitudes are associated with the special needs of these groups, general practitioners find it increasingly difficult to deal with tropical and imported diseases in which these have relatively little experience. In addition, some migrants are afraid of disclosing certain conditions as they are afraid either of being sent back to their country or of being kept in detention. Difficulties are also encountered due to the high rates of psychological distress in these immigrants and due to language difficulties. Interpreters are not available and other immigrants try to act as interpreters. Such conditions may lead to the immigrants not fully disclosing their worries and concerns due to embarrassment especially in discussing sexual health issues. Currently there are plans to obtain funding for a pool of interpreters who are not immigrants themselves. Doctors find it increasingly difficult even to explain treatment regimes to patients and often this leads to lack of

compliance and adherence with treatment. Due to all these reasons such patients may take up a disproportionate amount of clinic time. In addition, immunisation rates may be low and medical records not available. Difficulties are encountered in dealing with the patients' cultural beliefs. Some groups have particularly high rates of service use, which again may be influenced by cultural and behavioural factors as well as by possible differences in disease prevalence. Post traumatic stress disorder, stress associated with the particlar migratory process, poor living conditions and poverty could all be factors that increase vulnerability to illnesses. Considerable numbers of patients consult 'unnecessarily' with medical 'trivia' and thus display 'inappropriate' patterns of service use. Others take too long to consult with the result that certain conditions are seen in advanced stages. Often, the patients have underlying fears of stigma associated with medical diagnosis. Concerns about discrimination by the service providers are also sensed as common.

Services offered at Detox (Substance Misuse Outpatient Unit- SMOPU)

The Substance Misuse Out-patients Unit (SMOPU) offers maintenance, substitution and symptomatic treatment to individuals predominantly dependent on opiates. The service operates on a daily basis. The team of Medical Officers attached to the Unit provides specialised drug and alcohol treatment which ensures a provision of comprehensive medical care adapted to the needs of the individual substance misuser. Another important role is the concrete preventive work carried out, such as blood screening for Hepatitis B, Hepatitis C, HIV, and also routine blood tests in respect of general health. Other services provided at this Unit include Hepatitis B immunization, a Well Woman Clinic and Human Papilloma Virus screening in women at risk[36].

The total number of individual patients including nationals and non-nationals who made use of SMOPU in 2003 and 2004 was 958 and 1,053 respectively. Of those, 114 and 140 were new clients in 2003 and 2004 respectively. The age of persons attending the unit varies from 16 years to 60 years. The approximate ratio of females to males attending the unit is 1:5. In 2003, 13.7 % of all clients were female, which increased to 15.3 % in 2004. It is important to note that of the new patients in 2003, 14% were female whilst in 2004 the number of female new clients increased to 19.3 %. Thereby, there was an increase in the percentage of female clients attending the services.

By the end of 2004, 584 patients had completed their Hepatitis B immunization process, 269 discontinued their course and 43 were in the process of being immunized.

A significant proportion of patients attending SMOPU are foreigners. Any individual who has a drug-related problem and who does not possess a Maltese Identity Card can benefit from this service, however, s/he will be asked to pay for the services rendered[37]. Even though these services are not completely free, the fee is a nominal fee (Lm 10), though this could theoretically contribute to an underestimate of foreigners.

2004		2005		2006	
n	%	n	%	n	%
63	6.0	55	5.1	63	5.8

Table 15: The percentage of foreign client s amongst all clients attending SMOPU in a given year whose Nationality was known

The HIV testing policy of the unit is one where HIV testing is initiated by the provider. The patient's consent is obtained and the person can opt out of testing. All patients having blood screens are given pre- and post testing counseling. Persons who result HIV positive are then referred to Sir Temi Zammit Unit for further evaluation and treatment. At present there are four HIV positive persons attending SMOPU, of two are Maltese nationals and two are foreigners. All are being given anti-retroviral treatment. There are no reported cases of HIV/TB co-infection in persons receiving treatment at SMOPU. Problems that are commonly encountered in migrants are that they often do not take the medicines as prescribed and healthcare workers experience difficulties in communicating with them due to language barriers. They are less likely to keep appointments and are more easily lost to follow-up. They tend to have greater difficulties in accessing the service as those who are employed, often do not have good conditions of work, have long hours and do not afford to get time off from work to attend the Unit. Often, they finish attending only a few sessions and so there is less time and opportunity for pre- and post HIV testing counseling. In addition HIV saliva tests are not yet available and if the pre-HIV testing counseling and the time taken for the HIV result to be issued is long, there is a greater probability of the patient being lost to follow-up before the HIV result is known.

Services provided within Corradino Correctional Facility

There is a significant number of foreigners who are detained at Corradino Correctional facility. The table below shows that there was a total of 369 Maltese and 153 foreigners detained in the Corradino Correctional Facility in 2006.

Prisoners by nationality, Year 2006			
Nationality	**Sentenced**	**Awaiting Trial**	**Total**
Algerian	1	1	2
American	-	1	1
Australian	-	2	2
Belgian	-	1	1
British	2	7	9
Canadian	-	1	1
Chadian	1	1	2
Chinese	-	3	3
Dutch	-	1	1
Egyptian	3	5	8
Eritrean	1	5	6
Ethiopian	-	5	5
Georgian	-	1	1
Indian	1	1	2
Italian	1	5	6
Ivory Coast	-	2	2
Latvian	-	1	1
Libyan	11	44	55
Maltese	137	232	369
Mexican	-	2	2
Niger	-	3	3
Nigerian	2	10	12
Pakistani	-	1	1
Palestinian	-	2	2
Panamanian	-	1	1
Romanian	-	2	2
Serbian	-	1	1
Somali	-	5	5
Sudanese	1	8	9
Syrian	-	3	3
Tunisian	-	2	2
Turkish	-	1	1
Ukrainian	-	1	1

Table 16: Corradino Correctional Facility inmates by nationality, Year 2006

Up to the date of the study, there were 264 Maltese and 115 foreigners with an age range of the inmates varying between 16 and 76 years.

HIV Prevention, Testing and Treatment Policy

Currently the medical services offered within the Corradino Correctional Facility include the services of three medical doctors on call, a psychiatrist and a dentist. Upon admission to the correctional facility, besides having a general medical check up, the inmates are screened for Hepatitis B, Hepatitis C, HIV and VDRL/TPHA and have a chest X ray done. For HIV, consent is obtained and some pre-test counselling is given by the correctional facility doctors. Thus, HIV testing is provider initiated. The inmates can refuse to do the test. The correctional facility authorities' state that no health promotion campaigns have been conducted within prisons and not much health promotional material is present within the correctional facility, however the doctors taking care of services within the facility, in practice are always available to answer any difficulties that inmates might have**.** Sexual health commodities such as condoms are not provided.

If a person is tested and results positive for HIV, the person is referred to Sir Temi Zammit Out patients HIV clinic for evaluation, monitoring of CD4 counts and any symptoms suggestive of conversion to AIDS and for anti-retroviral treatment if necessary. Here, as part of the evaluation, HIV positive patients are invariably tested for TB.

Prevalence of HIV in non-migrants in correctional facility: Currently there are no HIV positive Maltese inmates.

Prevalence of HIV in migrants in correctional facility: Currently there are 3 HIV positive migrant inmates in the correctional facility, of whom 2 are on anti-retroviral treatment.

TB Testing and Treatment Policy in Corradino Correctional Facility

All inmates are tested for TB on admission to the correctional facility by means of a chest X ray. If the chest X ray results positive for TB, the inmates are referred for further evaluation at the Chest Clinic in Qormi.

Prevalence of TB in non-migrants in correctional facility: There are no Maltese inmates resulting positive for acute TB.

Prevalence of TB in migrants in correctional facility: Currently there are no acute TB positive migrant inmates in the correctional facility.

Pharmaceutical Services

The total number of HIV/AIDS patients seen for care at the Infectious Disease Unit (Sir Temi Zammit Unit) during 2006 was 100[38]. Out of these, 32 were not Maltese citizens or nationals. The following table shows the modalities of treatment that the HIV/AIDS patients seen for care were receiving:

Modality of Treatment	Reported Number of HIV/AIDS Patients on Treatment Modality
Mono Antiretroviral therapy	0
Duo Antiretroviral therapy	0
HAART (Highly Active Antiretroviral therapy- a combination of three or more drugs)	56
No antiretroviral therapy	44
TB prophylaxis with anti-TB drugs	1
Treatment for co-infection with Hepatitis B disease	0
Treatment for co-infection with Hepatitis C disease	0
TMP-SMZ prophylaxis	14

Table 17: Number of HIV/AIDS Patients Classified by Treatment Modality

As on the 31 December 2006, the number of persons who were not Maltese citizens or nationals and who were receiving Highly Active Antiretroviral Therapy was 11. During 2006, the total number of not Maltese citizens or nationals was five (5).

All the persons living with HIV/AIDS and who had attended for care in 2006 were tested for Tuberculosis. Of those tested, two (2) patients were co-infected with tuberculosis. Both patients who were co-infected with HIV/TB had active tuberculosis.

Part 3: RESULTS OF STUDY ON MIGRANTS, DIASPORAS AND EMIGRANTS

The questionnaire was administered on a total of 105 respondents which included migrants, diasporas, irregular migrants not part of diasporas, foreign students studying in Malta, foreigners applying for a work permit, Corradino Correctional Facility inmates, migrants attending the Substance Misuses Out Patients Unit and some tourists. The baseline demographic profile of the respondents is shown in Table 18.

DEMOGRAPHIC CHARACTERISTIC	RESPONDENTS (%)
Gender	
Males	59.6%
Females	40.4%
Age	
Minimum Age	14 years
Maximum Age	59 years
Mean age	29.49 years
Possessing Maltese citizenship	
Yes	10.6%
No	88.5%
Legal Status	
Humanitarian status	21.6%
Refugee Status	1.0%
Asylum seeker	16.5%
Failed asylum seeker	2.1%
Over-stayer (expired VISA)	2.1%
Third country national Work Permit	15.5%
Citizen from other EU country working in Malta	3.1%
Student	11.3%
Migrant resident	4.1%
Maltese citizen living abroad	1.0%
Other	21.6%
Work Permit	
Yes	39.4%
No	60.6%
Highest Education Level Achieved	
None	0%
Special school	0%
Primary	15.3%
Secondary	46.9%
Post secondary	19.4%
Non tertiary	1.0%
Tertiary	17.3%

Table 18: Demographic Characteristics of Respondents

The sample consisted of 59.6% males and 40.4% females.

DEMOGRAPHIC CHARACTERISTICS

The mean age of the respondents was 29.49 years with a standard deviation of 9.316 years. The age distribution is shown in Figure 6.

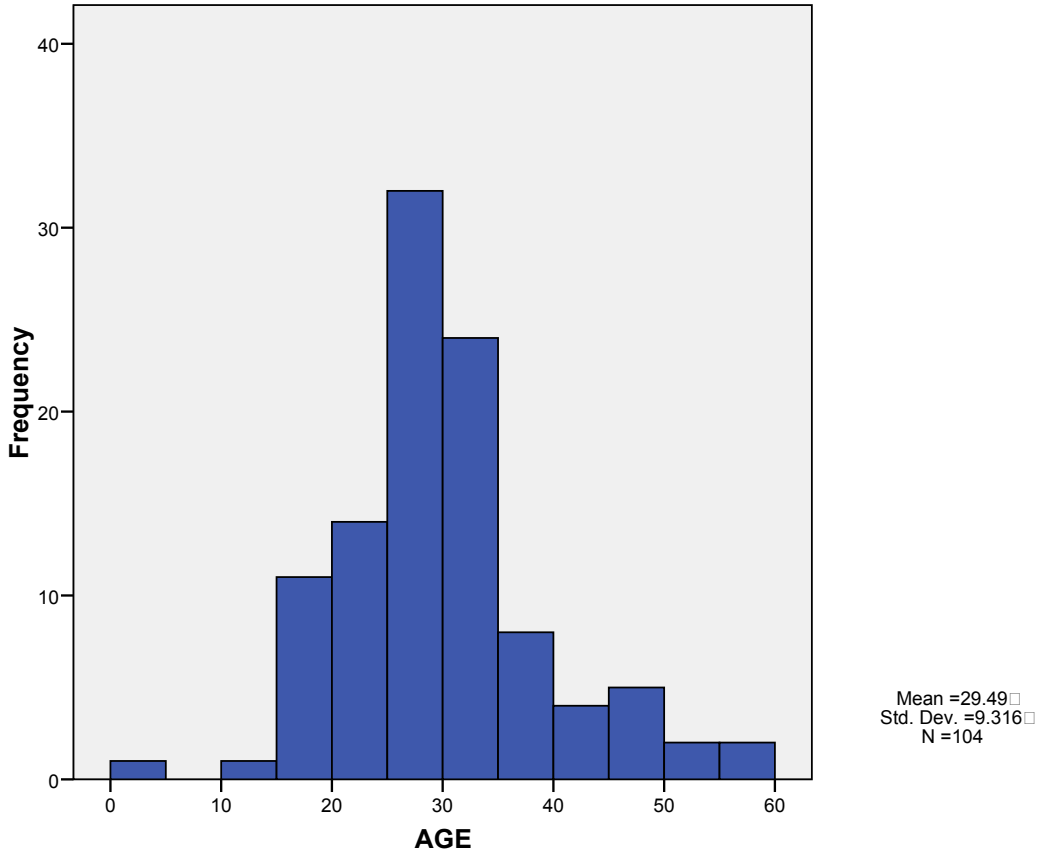


Figure 6: Age distribution of respondents.

CITIZENSHIP

Only about 10.6% of migrants had a Maltese citizenship.

LEGAL STATUS

The commonest legal status was that of a humanitarian status (21.6% of respondents). This was followed by persons who were asylum seekers (16.5%). Only 1% had a refugee status. A significant proportion of the sample was made up of third country

nationals in possession of a work permit to work in Malta. Only 39% of respondents had a work permit.

EDUCATIONAL LEVEL

About 15% of respondents had attended only primary school, while a majority (46.9%) had attended school up to secondary level only.

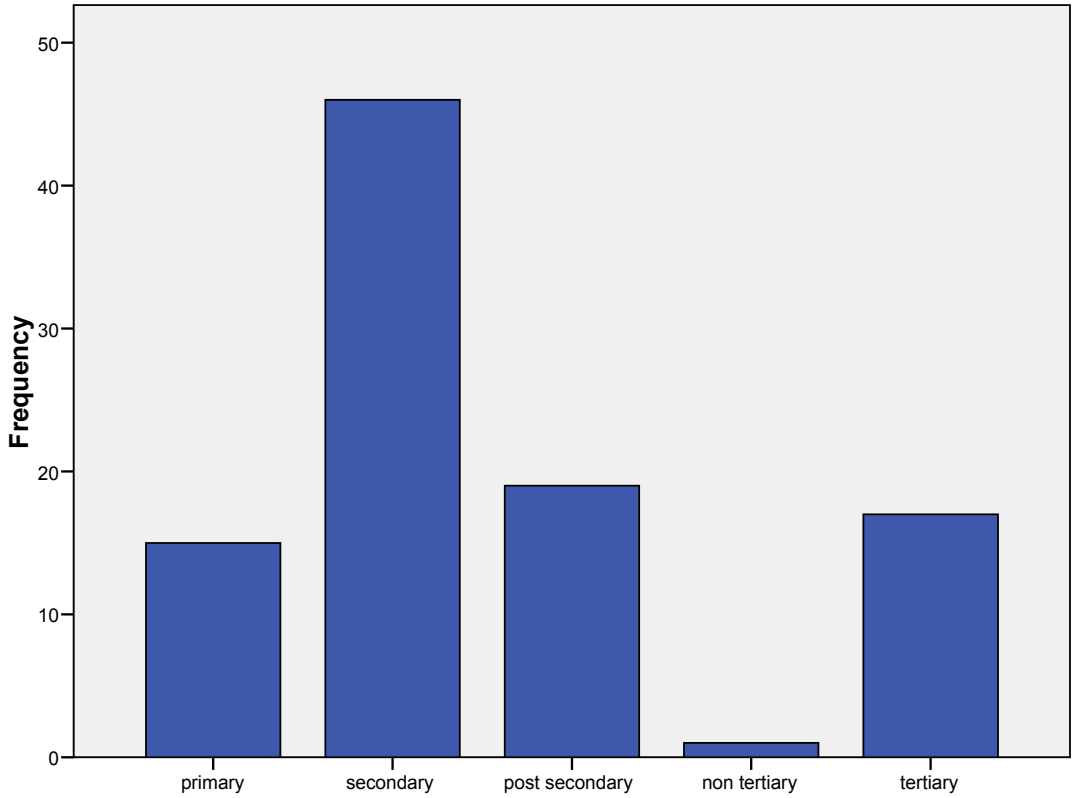


Figure 7: Highest educational level achieved by migrants

OCCUPATION

CATEGORY ACCORDING TO ISCO-88 MAJOR GROUPINGS	
Students	20.2%
Housewife	1.9%
Unemployed	10.6%
Undisclosed occupation	6.7%
ISCO 88 group 1- Legislators, Senior officials and Managers	4%
ISCO 88 group 2- Professionals	18.5%
ISCO 88 group 3- Technicians and associate professionals	6.9%

ISCO 88 group 4- Clerks	2%
ISCO 88 group 5- Service workers and shop or market sales workers	3%
ISCO 88 group 6- Skilled agricultural and fishery workers	1.9%
ISCO 88 group 7- Craft and related trades workers	12.5%
ISCO 88 group 8- Plant and machine operators and assemblers	1%
ISCO 88 group 9- Elementary occupations	11.6%

Table 19: Migrants' Occupations

LENGTH OF STAY IN MALTA

The mean length of stay of the migrants in Malta up to the time of the study was 33.7 months (Standard deviation = 49.1 months).

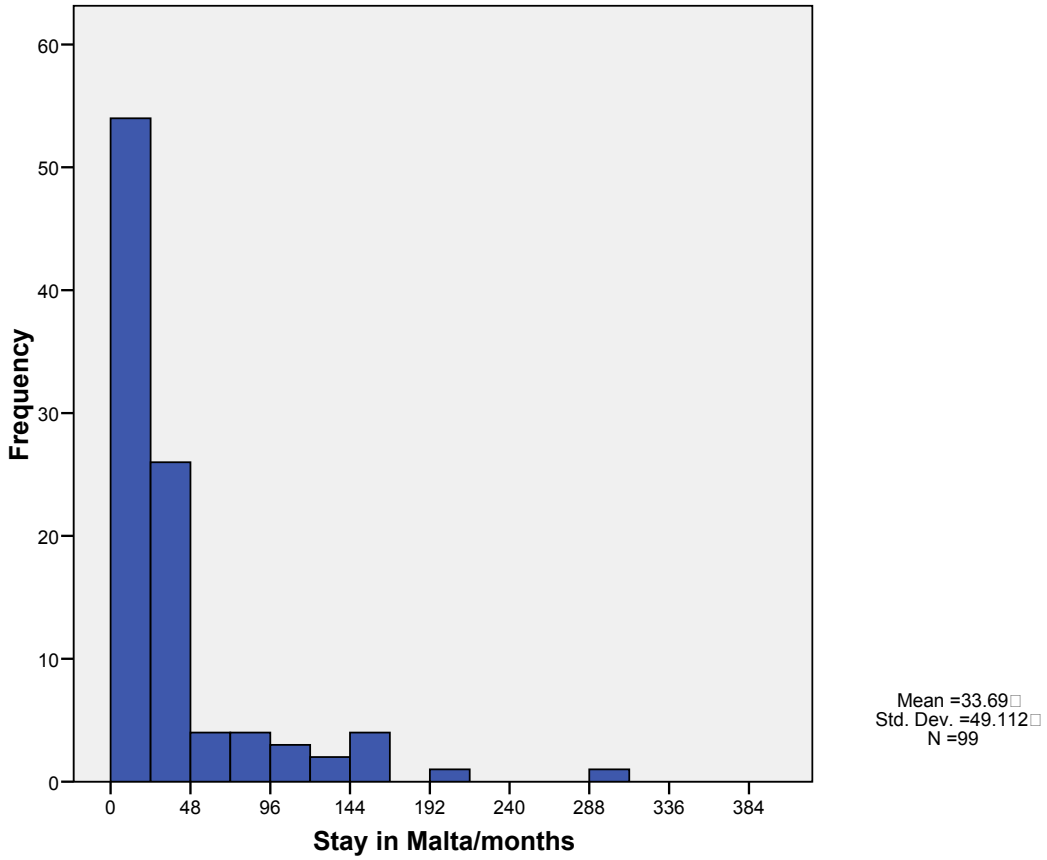


Figure 8: Average length of stay of migrants in Malta from time of arrival.

COUNTRIES OF ORIGIN

The commonest countries of origin were Eritrea (11.5%), Somalia (11.5%), Germany (7.7%), Malta (5.9%- in case of returned migrants) and Libya (4.4%),

TRANSIT COUNTRIES

In 26.9% of cases, Malta was the immediate destination. However, in 18.3% of cases, Libya was a second transit country in 18.3% of cases and Sudan the second country in transit in 13.5% of cases

TRANSIT TIME FROM COUNTRY OF ORIGIN TO MALTA

The mean transit time from the country of origin to Malta was 28.4 months.

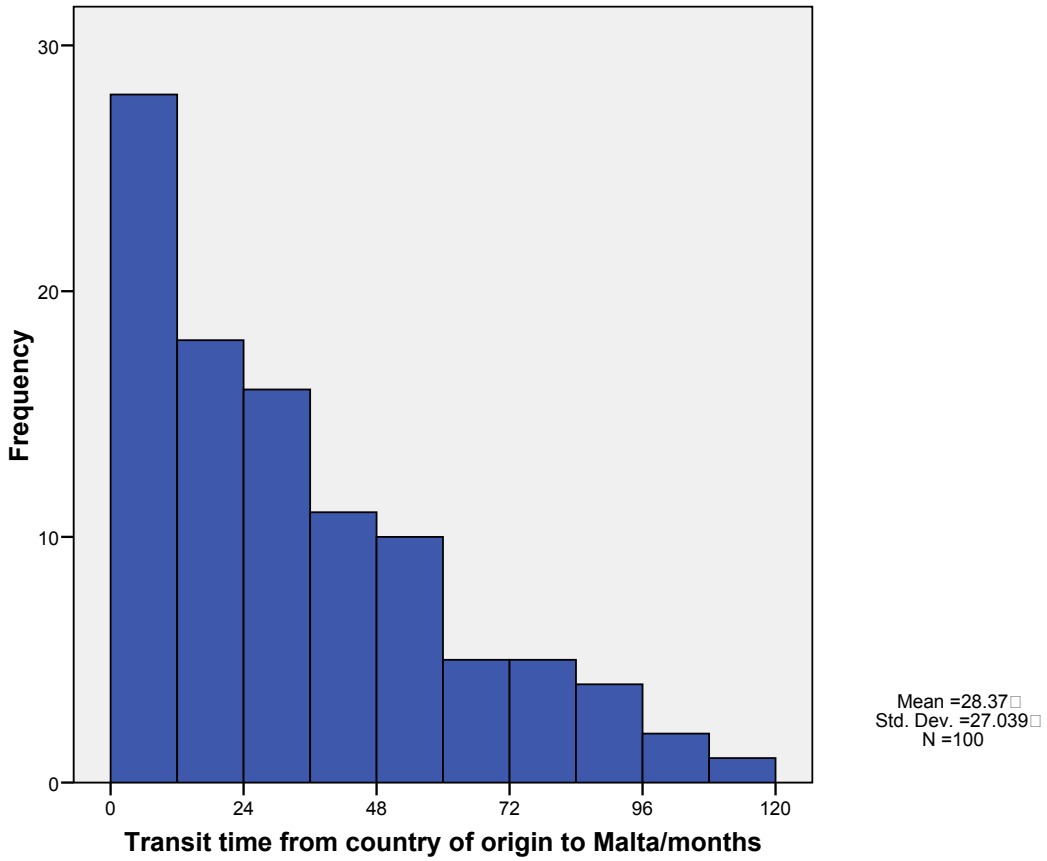


Figure 9: Transit time from country of origin to Malta

35% of migrants had come directly to Malta. The commonest country where the migrants were in transit before arriving in Malta was Libya (in 23.8% of migrants) and Sudan (in 17.5% of migrants).

HOUSING

TYPE OF HOUSING	
Own house	4.9%
Rented	22.3%
Shared rent	23.3%
Social housing	1.9%
Closed centre	12.6%
Open centre	15.5%
In community, not paying rent	0%
In a house, not paying rent	2.9%
With a host family	2.9%
In University residence	0%
In a hotel	4.9%
In a correctional facility	4.9%
Others	3.9%

Table 20: Type of Housing Migrants are living in

LANGUAGES UNDERSTOOD / SPOKEN

The languages spoken or understood by the interviewed migrants are shown in Table 22. English was the most commonly language spoken to or understood by the migrants.

LANGUAGES UNDERSTOOD / SPOKEN	
Amharic	10.6%
Arabic	27.9%
Tigrinyan	16.3%
French	24.0%
English	93.3%
Italian	18.6%
Spanish	13.6%
Russian	5.8%
Maltese	25.2%

Table 21: Languages spoken and understood by migrants

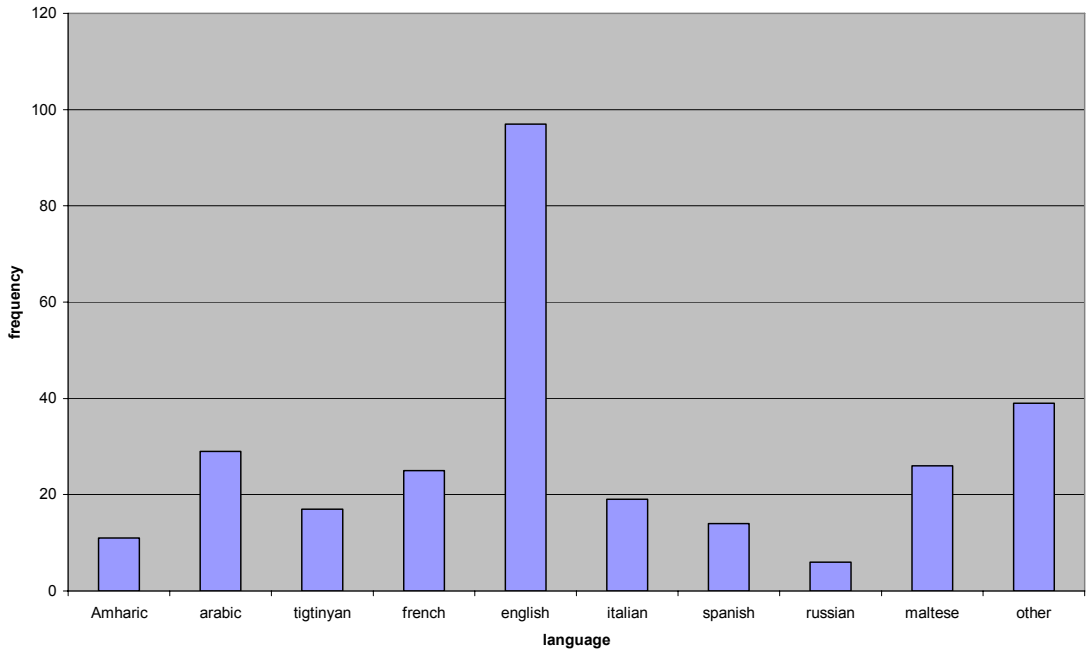


Figure 10: Languages spoken and understood by migrants

FAMILY MEMBERS LIVING WITH MIGRANTS

The study showed that the migrants had a range of 0 to 7 family members living with them, with a mean of 0.76 and a median of 0. The number of children living with the migrants had a range from 0 to 5 and a median of 0. The number of persons sharing the sleeping quarters with the migrants is shown in Figure11. 20.2% did not share the sleeping quarters with anyone, 24% shared them with one person and 14.4% with 7 persons. The range varied from 0 to 13 persons.

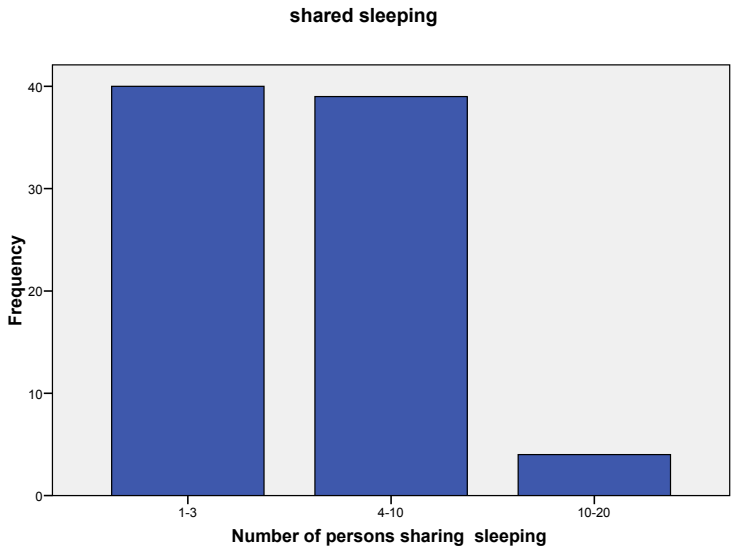


Figure 11: Number of persons sharing the sleeping quarters with migrants

The nationality of the other persons living with migrants is the same in 28.8% and different in 26.6% of respondents. The number of persons providing financial support and who reside with the respondents varies from none to 6, with the commonest being one other person in 44.7% of the respondents.

ACCESS TO HEALTH SERVICES

ACCESS TO FREE MEDICATIONS

ACCESS TO FREE MEDICATIONS	
Yes	36.5%
No	26.0%
No response	12.5%
Don't know	25.0%

Table 22: Access to free medications

About 37% of the respondents said that they had access to free medicines. About a quarter of the respondents were unsure about their entitlement, while about 12.5% of the respondents gave no response, giving a total of 40% of respondents who neither said that they had access to free medications or that they didn't.

A statistically significant difference in access to free medications was found across the different legal status categories (Chi-square = 16.97, df = 9, p = 0.049)

Type of Healthcare sought.

Where to seek help	
Private General Practitioner	15.5
Health Centre General Practitioner	32.4
Medicare	19.6
Private hospital	20
State hospital	52.9
Other	10.6

Table 23: The type of health care service immigrants would seek to ask for help.

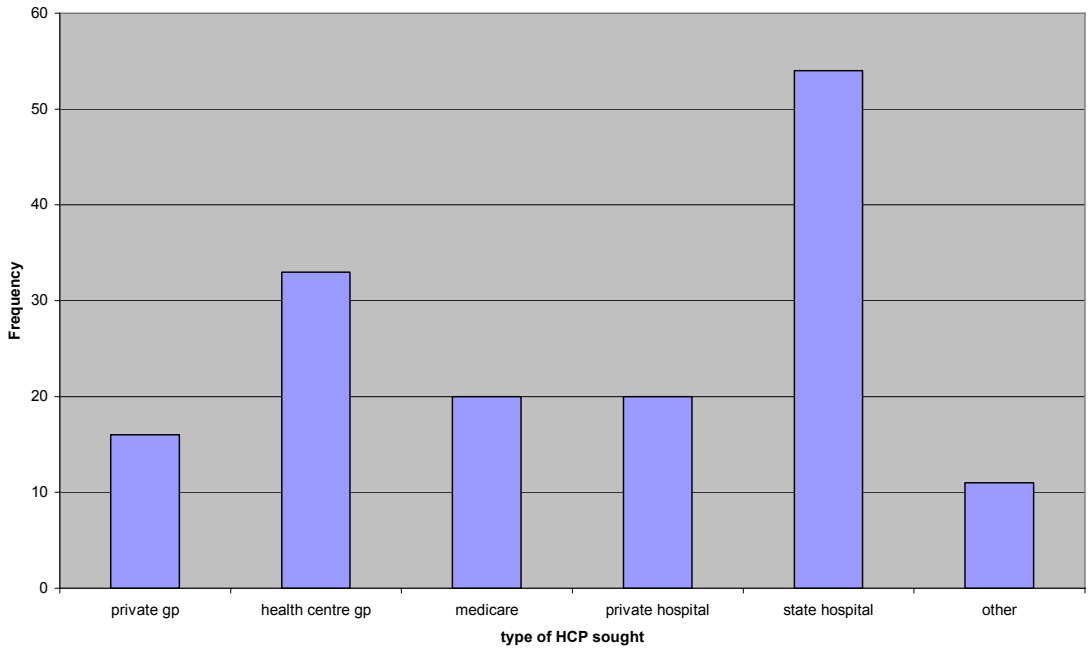


Figure 12: Type of Healthcare Professional sought.

TYPE OF HEALTHCARE SERVICES USED LAST

TYPE OF HEALTHCARE SERVICES USED LAST	
Private General Practitioner	14.9
Health Centre General Practitioner	3
Medicare	11.9
Private hospital	5.9
State hospital	23.8
Other	4

Table 24: Type of healthcare services used last by the immigrants.

HIV/AIDS and STI Awareness

HIV AWARENESS

98.1 % of respondents replied that they were aware of HIV, 1.9% saying that they were not.

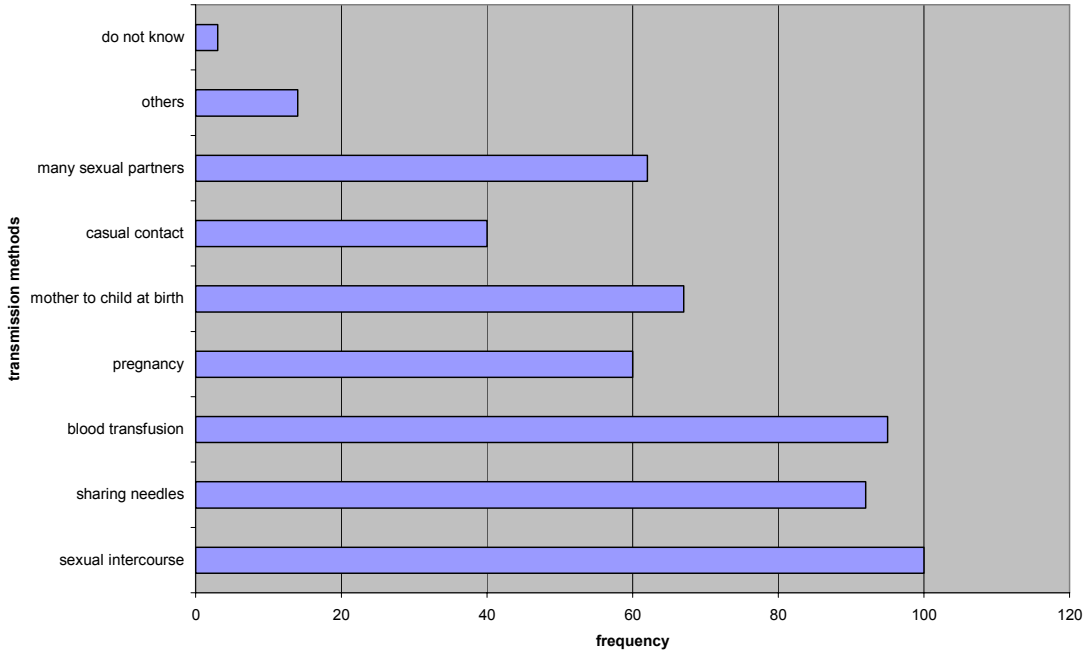


Figure 13: Means of transmission of HIV according to the migrants

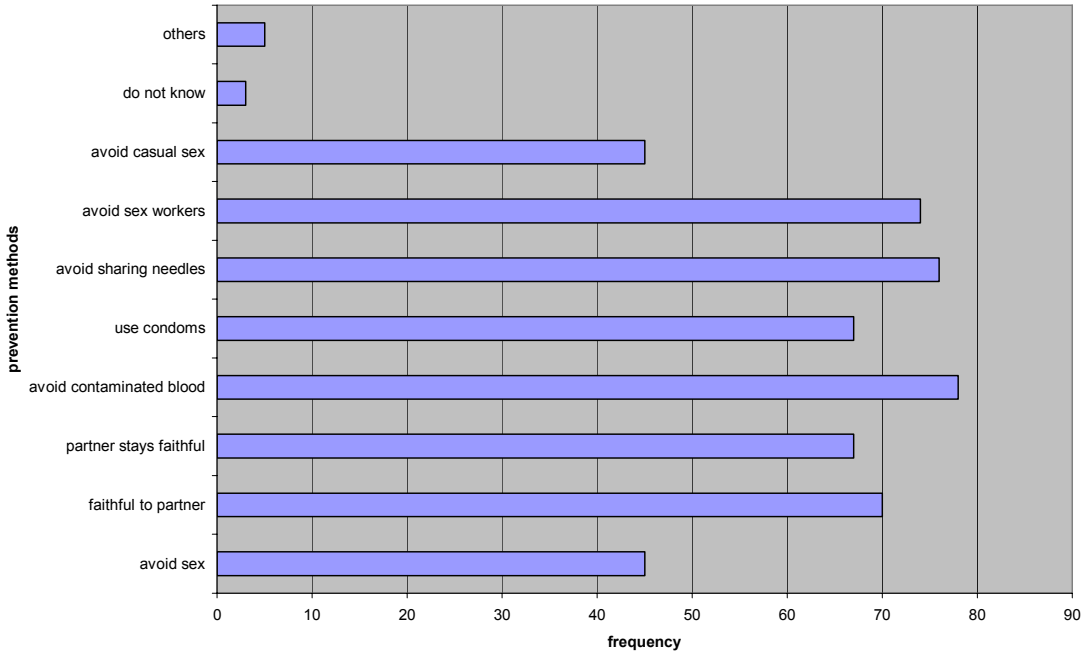


Figure 14: Means of preventing HIV according to migrants

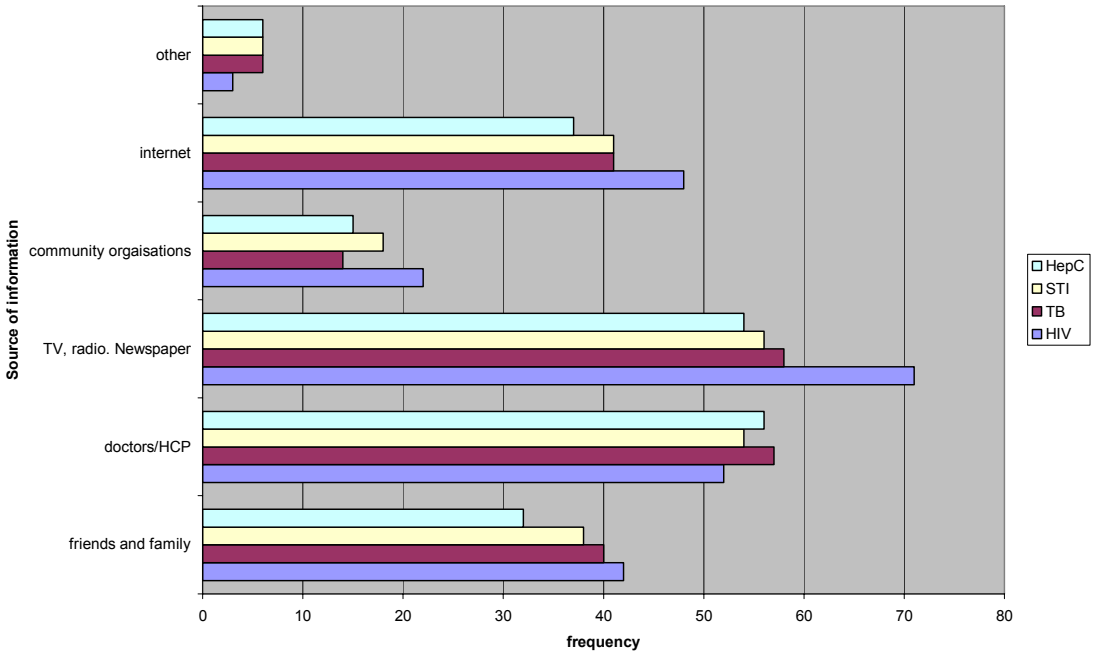


Figure 15: Sources of information used by migrants to obtain information on Hepatitis B, STIs, TB and HIV

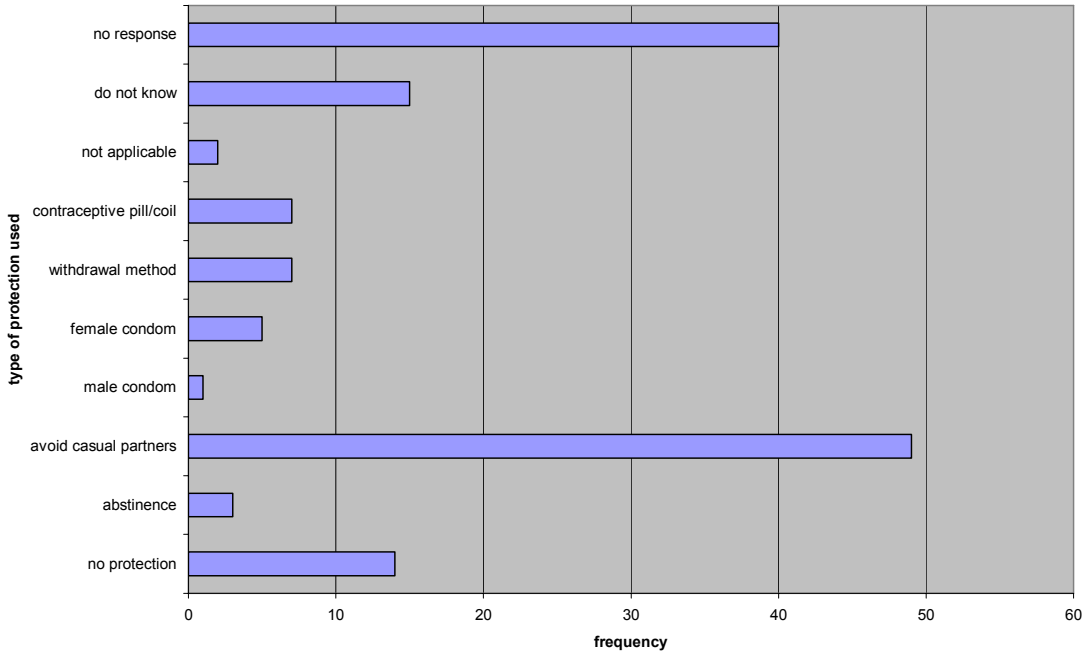


Figure 16: Type of protection used by migrants to prevent acquiring HIV

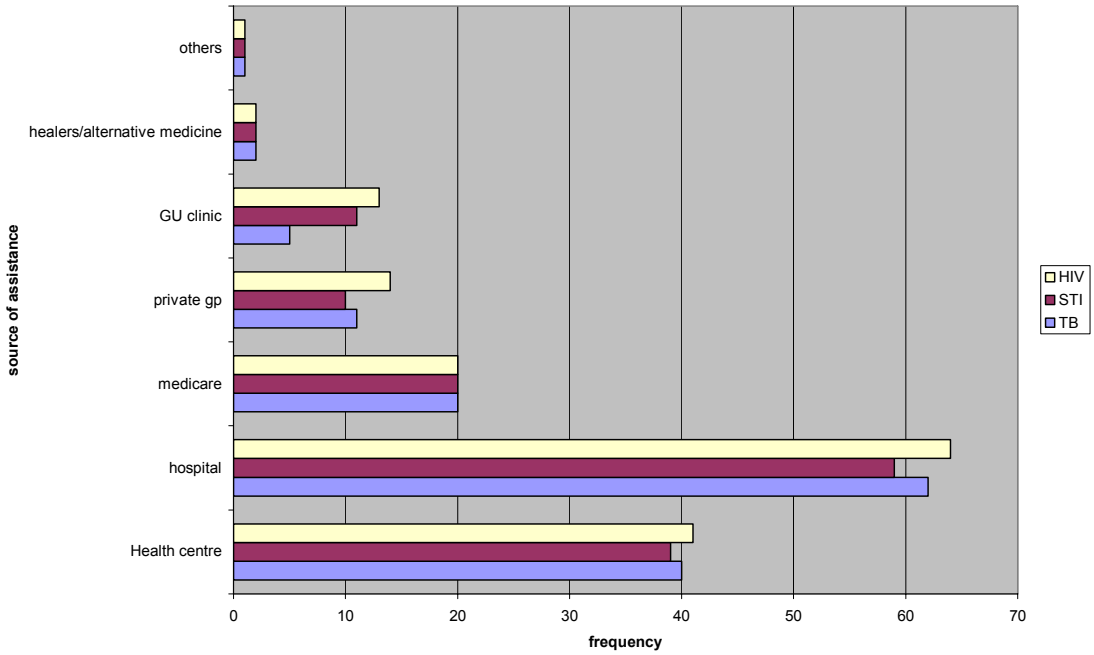


Figure 17: Source of assistance to be sought in cases of HIV, STIs and TB according to the migrants

Paid Sex

Two of the questions asked in the questionnaire to migrants were if they ever paid or were paid for sex (Annex 1). 4.8 % of the respondents claimed that they paid for having sex, 79.8 did not pay for sex and 15.4% gave no response. On the other hand, when asked if they get paid for having sex, 15.4% gave no response while 84.6% said that they were not. There were no respondents who said that they get paid for having sex.

Access to Condoms

When asked whether they had access to condoms, 55.8% of migrants replied yes, 26.9% replied no and 17.3% gave no response. When asked if they have access to free condoms, 8.7% replied yes, 59.6% replied no, 13.5% did not know or were unsure and 18.3% gave no response.

Barriers to Accessing Information and Accessing Health Services

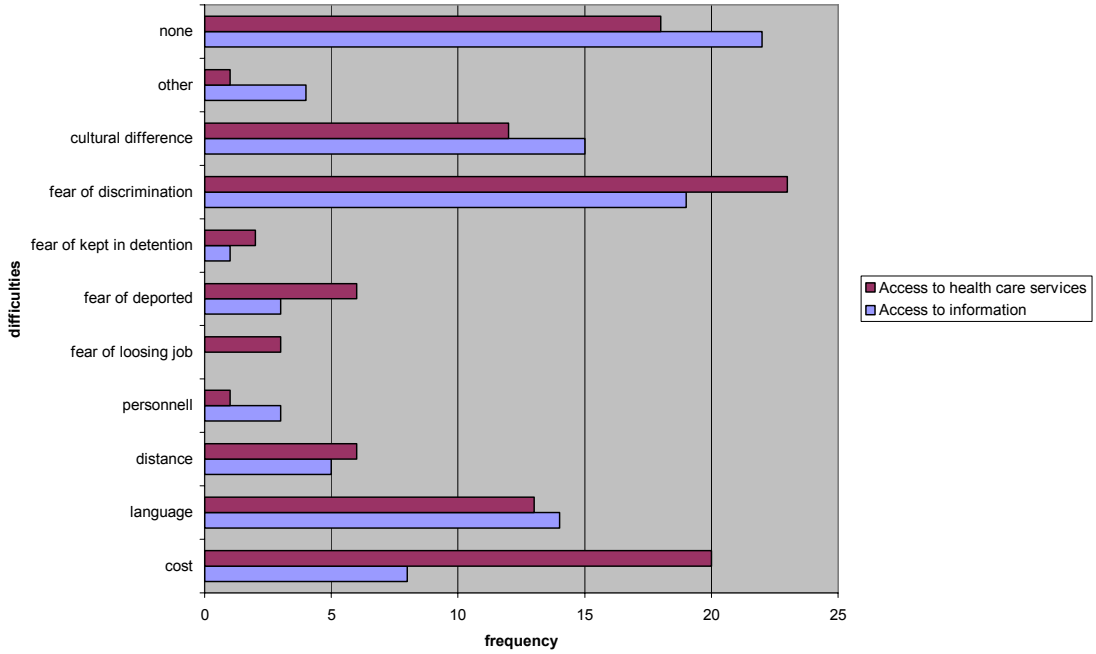


Figure 18: Difficulties encountered by migrants in obtaining:
- Access to healthcare services
- Access to information

DISCUSSION

Epidemiological evidence and migration data show that with an increasing number of migrants in Malta and an increasing influx of migrants from countries where HIV and TB are common, the epidemiology of HIV and TB and the socio-demographic characteristics of persons living with HIV in Malta is changing, making it vitally important to address the changing health needs. Migrants are a very diverse group in terms of their reasons for migration and their country of origin. Migrants have a range of health needs reflecting the diversity of the group but affected by three key determinants: their individual characteristics (e.g. age, sex and ethnicity), their country of origin and the circumstances of migration, and the socioeconomic conditions in the host country. Research should be focused on identifying migrant groups that are disproportionately affected so services are tailor-made reflect the particular needs of these groups. Immigration in Malta is a relatively recent phenomenon. The country has a long history of emigration. Till now,

Malta has mostly had first generation immigrants. A phenomenon which we know nothing about is therefore the health of second and third generation migrants

Knowledge about transmission of diseases such as AIDS is vital for the adoption of healthy lifestyles and preventive measures. The results of the questionnaire distributed to migrants have shown that some migrants have poor knowledge on the ways of transmission of HIV and means of preventing transmission. A situation has occurred where no targeted campaigns were being conducted probably because of fear to stigmatise these “others” in a climate of increasing xenophobia.

Although the necessary structures and healthcare screening, preventive, health promotional and treatment services are available, between migrants and nationals there are still disparities in health and access to these services. Ensuring availability of such services is not enough as healthcare in a multicultural setting is complicated by various issues such as lack of knowledge about available services, language barriers and attitudinal and cultural differences to health

Migrants’ access to healthcare services in the destination country can be affected by a series of factors, which can be basically divided into formal and informal barriers. Informal barriers to healthcare access can be divided into language barriers and socio-cultural factors. Access will often be affected by a complex interaction between these factors. Socio-cultural barriers include differences between healthcare professionals and migrants in relation to procedures, patterns of communication, roles, and levels of knowledge about illness and about the way the health services are organised. It is not only important to use quantitative measures of service utilisation but also to get a perception of the qualitative experience of migrants in using the health services. The study results revealed several access barriers experienced by migrants regarding HIV and TB health care. The barriers included fear of stigmatization/marginalization, cost (20%), language barriers (13%), cultural differences (12%), distance (6%) and fear of deportation (6%).

Several healthcare workers who were interviewed pointed out differences in compliance and adherence to treatment between migrants and nationals. In the case of TB, this is supported by the fact that multi-drug resistant Tuberculosis is non-existent in nationals,

while the multi-drug resistant cases that have been reported have occurred exclusively in migrants and foreigners. Resistance to anti-TB drugs in populations is a phenomenon that occurs primarily due to poorly managed TB care. Problems include incorrect drug prescribing practices by providers, poor quality drugs or erratic supply of drugs, and also patient non-adherence[39].

The mapping of both TB and HIV shows that there is a concentration of cases of both TB and HIV in persons living in the tent villages and open and closed centres in Marsa and Safi. This is not linked directly to the housing but just because asylum seekers and persons arriving irregularly in Malta mainly from areas which are highly endemic for HIV and TB, and are thus importing these diseases are held in detention in such centres.

Limitations of the Study

The study is a rapid assessment of the overall situation and was limited by time and human resources constraints. The sampling methodology used was not completely random but based on a convenience sample of the migrants who were accessible to the researchers. Participation in the study was on a voluntary basis and this could have introduced an element of volunteering bias where volunteers who are more interested in their health were more likely to participate. There was no attempt to identify the characteristics of non-respondents. In order to have representation from all categories of migrants in the country, samples from all the migrant categories were used, however weighting or standardization were not performed in the sampling or the statistical analysis and thus the results cannot be generalized to the total migrant population in Malta. The questionnaire used on all migrants was in English, however information was collected through researchers who generally knew the migrant's own language or a language which the migrants knew and they acted as translators. Migrants who speak English, could have possibly volunteered more readily to participate in a questionnaire written in English and those not speaking or understanding English could possibly have been more reluctant to participate In addition, there are a significant number of students (most of them attending English language schools) and the number of students in the study is not representative of the total mobile population The number of foreign students included in the study, thus tend to unbalance the results of the sample for rapid assessment, skewing education level results, etc. From all interviews that were carried

out, however it came out that many healthcare workers consistently commented that language constitutes a barrier to proper communication.

The respondents were aware that a study was being conducted and this could have given rise to the well documented “Hawthorne Effect” whereby the respondents singled out for a study improve their performance and modify responses because of the attention they receive in the study and their intent to do well in the responses and therefore gave responses they perceived right or were expected out of them.

RECOMMENDATIONS

The recommendations that emerge from the study are:

- The rights of people and standards for access to care are unclear and therefore there is a need of clearer, consistent written policies specific to health.
- There is a need to develop linguistically and culturally appropriate information directed specifically to meet the needs of migrants, in particular information about social entitlements, immigration matters, and health and labour rights. The lack of basic knowledge of the availability of services in general has a direct influence on the ability to access services specifically related to HIV and TB. To encourage the production of culturally and linguistically appropriate information developed by migrants for their own communities to increase knowledge and thus influence help-seeking behaviour. Migrant friendly hospitals and health services should be aimed at.
- As language is considered a barrier, there is the need of the development of a health care interpreter service pool and multilingual health promotional resources and multilingual signs and symbols. Health care interpreters are to be used in all health care situations where communication is essential including, admission, consent, assessment, counselling, discharge, explanation of treatment, associated risks and side-effects and health education.
- Policies and practices across all sectors should include all migrant groups, among them the most vulnerable ones such as undocumented migrants. State-provided services should increase efforts to reach out to undocumented migrants. There is the need to stress that their access to and contact with services is not only important for the health of the individual, but also for public health in the respective country. These services and disease prevention

programmes should ensure access to care and be integrated with other local and national infectious diseases programmes.

- A factor that is not taken into account is the fact that migrants and refugees need a special approach and treatment (for instance, an interpreting service).
- The standards of communication about testing for HIV are far from satisfying. There is a need of developing counselling appropriate for migrants. Such counselling was attempted by Medicines du Monde but it should be continued and enhanced in the long term.
- More research is needed on the information and service needs of migrants living with HIV and needs of migrants described from the migrants' perspective. The availability of research data on the health situation of specific populations, such as refugees and asylum seekers, is limited.
- There is a need to train health care providers to be more sensitive to the needs and backgrounds of migrants. Health care workers need more background information about cultural differences and how to deal with them.
- Health promotion campaigns should be organized in open and closed centres
- There is insufficient representation and participation of migrants in society and social life and it needs to be improved.
- All efforts should be made to combat racism, discrimination and exclusion

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- The National Statistics Office
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REFERENCES

1. Dr. Chandrima B. Chatterjee. Mapping the Health Vulnerabilities of Poor Migrants in Urban Areas. Available online at:
http://vakindia.org/vikalp8.html
(Accessed August 2007)

2. International Organisation for Migration. "HIV and People on the Move: Risk and vulnerabilities of migrants and mobile populations in Southern Africa" December 2006. Available online at:
http://www.iom.org.za/Reports/HIVandPeopleOnTheMove.pdf
(Accessed August 2007)

3. Hsu and du Guerny, 2007.EU Partnerships for vulnerability reduction.

4. Pisani M. Country report- Malta in "A United Europe, a shared concern. HIV and Population Mobility in an enlarged European Union". AIDS and Mobility Europe/NIGZ, September 06. Available online at:
http://ws5.e-vision.nl/systeem3/images/A%20united%20Europe%20a%20shared%20concern.pdf
(Accessed August 2007)

5.International Labour Organisation. ISCO 88 (International Standard Classification for Occupations -88). Available online at:
http://www.ilo.org/public/english/bureau/stat/isco/isco88/alpha.htm
(Accessed August 2007)

6. ISO 3166 Maintenance Agency (ISO 3166/MA). ISO 3166-1. Available online at:
http://en.wikipedia.org/wiki/ISO_3166-1
(Accessed August 2007)

7. SPSS (Statistical Package for Social Sciences) version 15.0 for Windows. Information on statistical package available online at:
http://www.spss.com/?source=homepage&hpzone=nav_bar
(Accessed August 2007)

8. ESRI GIS and Mapping Software. ArcView GIS software version 9.2.
http://www.esri.com/software/arcgis/arcview/eval/evalcd.html

9. Laws of Malta. Chapter 31-Medical and Kindred Professions Ordinance.
http://docs.justice.gov.mt/lom/legislation/english/leg/vol_3/chapt31.pdf
(Accessed August 2007)

10. Laws of Malta. Chapter 465 - Public Health Act, 2003
http://docs.justice.gov.mt/lom/Legislation/English/Leg/VOL_14/Chapt465.PDF
(Accessed August 2007)

11. Ministry for Health, Elderly and Community Care. Communicable Disease Control Strategy for Malta, 2005. Available online at:
http://www.health.gov.mt/dsu/publications/Comm_Strat.PDF
(Accessed August 2007)

12. Annual Reports of Government Departments. Annual Report 2005, Ministry for Health, Elderly and Community Care. Available online at: http://www.sahha.gov.mt/showdoc.aspx?id=12&filesource=4&file=mhec_annualrep05.pdf (Accessed August 2007)

13. Ministry for Health, Elderly and Community Care website. Healthcare in Malta. Available online at: http://www.sahha.gov.mt/pages.aspx?page=184 (Accessed August 2007)

14. Jesuit Refugee Service Europe. Report on Destitute Forced Migrants. Available online at: http://www.jrseurope.org/EPIM/Destitute%20Forced%20Migrants.pdf (Accessed August 2007)

15. Irregular Immigrants, Refugees and Integration: Policy Document, 2005. Available online at: http://www.mjha.gov.mt/downloads/documents/immigration_english.pdf (Accessed August 2007)

16. National Statistics Office. Census 2005 Report, Volume 1.

17. NSO. News Release. World Refugee Day. Dated 19th June 2006.. Available online at: http://www.nso.gov.mt/statdoc/document file.aspx?id=1785 (Accessed August 2007)

18. National Statistics Office, Malta. Demographic Review 2005. Demographic Review 2005. – Valletta : National Statistics Office, 2006. ISBN-10: 99909-73-46-6; ISBN-13: 978-99909-73-46-4; ISSN 0076-3470. Available online at: http://www.nso.gov.mt/statdoc/document_file.aspx?id=1916

19. World Education News and Reviews (WENR). Malta. Foreign Student Enrolment Doubles. Available online at: http://www.wes.org/ewenr/06oct/europe.htm (Accessed August 2007)

20. Federation of English Language Teaching Organisations Malta. English Language Teaching Industry in Malta. Available online at: http://www.feltom.com/_mgxroot/page_10750.html (Accessed August 2007)

21. Ministry for Justice and Home Affairs. Annual Report 2006. Available online at: http://www.mjha.gov.mt/news/annualreports/5_mjha_2006_final.pdf (Accessed August 2007)

22. European Commission. Technical Mission to Libya on Illegal Immigration. 27 Nov – 6 Dec 2004. Report. Available online at: http://www.statewatch.org/news/2005/may/eu-report-libya-ill-imm.pdf (Accessed August 2007)

23. Frank Duvell. Crossing the Fringes of Europe: Transit Migration in the EU's neighbourhood. Centre on Migration, Policy and Society. Working Paper No 33, 2006. Available online at: http://www.compas.ox.ac.uk/publications/Working%20papers/WP0633-Duvell.pdf

(Accessed August 2007)

24. 'Migrant workers (Child Education) regulations'. Subsidiary legislation 327.220. Legal notice 259/2002 Available online at:
http://docs.justice.gov.mt/lom/legislation/english/subleg/327/220.pdf
(Accessed August 2007)

25. Nathalie Schlenzka. Berlin Institute of Comparative Social Research. 2007. "The Risk Group of Unaccompanied Minors: Protection Measures in an Enlarged European Union". Financed by: European Commission, Daphne II Programme. Available online at:
http://www.zrs-kp.si/EN/Projekti/Daphne/MinOrs_Malta.pdf
(Accessed August 2007)

26. Department of Further studies and adult education. Adult Learning Section: Courses. Website: http://www.eveningcourses.gov.mt/courses.asp?catid=11
(Accessed August 2007)

27. Ignasi Badia i Capdevila. A view of the linguistic situation in Malta. Available online at:
http://www6.gencat.net/llengcat/noves/hm04primavera-estiu/docs/a_badia.pdf
(Accessed August 2007)

28. Christine Farrugia for EUROFUND (European foundation for the Improvement of Living and Working Conditions). Working and employment conditions of migrant workers – Malta. Available online at:
http://www.eurofound.europa.eu/ewco/studies/tn0701038s/mt0701039q.htm
(Accessed August 2007)

29. http://www.workpermit.com/news/2006_07_04/europe/malta_illegal_immigration.htm
(Accessed August 2007)

30. Financial Times. Malta pleads for help with illegal migrants. Published: July 4 2007. Available online at:
http://www.ft.com/cms/s/93ee2662-2a3d-11dc-9208-000b5df10621.html
(Accessed August 2007)

31. European Parliament. European Parliament resolution on the situation of refugees in Malta. 2006 , April 4.
http://www.europarl.europa.eu/sides/getDoc.do?type=MOTION&reference=B6-2006-0268&language=EN
(Accessed August 2007)

32. Emigrants Commission website at: http://www.mecmalta.com/emmcomm.html
(Accessed August 2007)

33. Rieck Zahra, R. 2001. Negotiations Closed on Free Movement of Persons. Aggornat. Published by Malta-EU Information Centre, Special edition number 3, August 2001. Available online at:
http://www.forummalta.gov.mt/Portals/FME/Documents/AGGSE03e_FMOP.pdf
(Accessed August 2007)

34. Pace Asiak A. Today is World TB Day. Available online at: http://www.stoptb.org/events/world_tb_day/2002/Events/Malta_WTBD.pdf (Accessed August 2007)

35. Public Health Department Annual Departmental Report, 2006

36. SEDQA. Foundation for Social Welfare Services. Sedqa Biennial Report 2003-2004. Available online at: http://www.sedqa.gov.mt/pdf/information/sedqa_biennial_report_20032004.pdf (Accessed August 2007)

37. Ministry for the Family and Social Solidarity. http://www.msp.gov.mt/info/faqdetail.asp?serviceid=32 (Accessed August 2007)

38. Infectious Disease Unit, St. Lukes Hospital, Malta –records at doctors' antiretroviral clinic and records at Pharmacist's anti-retroviral clinic

39. World Health Organization. WHO concern over extensive drug resistant TB strains that are virtually untreatable. 2006. Available online at: http://www.who.int/mediacentre/news/notes/2006/np23/en/ (Accessed August 2007)

ANNEXES

ANNEX 1: Questionnaire used for the Migrant Population Survey

EU MOBILITY & HEALTH VULNERABILITY (HIV, TB) SURVEY

Module 1 – Demographics and background information

INDIVIDUAL INFORMATION

1. Sex: Male □ Female □ Transgender □

2. Age _____

3. Current locality of residence Street _____ Locality_____

4. Education – highest completed level:
□ None
□ Special School
□ Primary
□ Secondary
□ Post secondary
□ Non tertiary
□ Tertiary
□ Unknown

5. Occupation _____

6. Do you have Maltese citizenship?
□ Yes □ No

7. If not, legal status
□ Humanitarian status
□ Refugee status
□ Asylum seeker
□ Failed asylum seeker
□ Over-stayer (expired VISA)
□ Third country national (TCN) Work Permit
□ Citizen from another EU country working in Malta
□ Student

- ☐ Migrant resident
- ☐ Maltese citizen living temporarily abroad
- ☐ Other

8. Do you have a work permit?
☐ Yes ☐ No ☐ No answer

9. When did you arrive in this country? _____ /_____ / _____

10. What is your country of origin? _____

11. How long have you lived away from your country of origin? _____

12. And where did you live since you left your country of origin?

Country	Dates	
_____	From _____	To _____
_____	_____	_____
_____	_____	_____

13. Which languages do you speak or understand?

	Yes	No
Amharic	☐	☐
Arabic	☐	☐
Tigrinyan	☐	☐
French	☐	☐
English	☐	☐
Italian	☐	☐
Spanish	☐	☐
Russian	☐	☐
Maltese	☐	☐
Other language	☐	☐

Please specify _____

FAMILY MEMBERS

14. How many people from your family live with you? _____

15. Does everyone who live with you have the same nationality?
☐ Yes ☐ No ☐ Not applicable

16. How many children live with you? _____

HOUSING

17. Is the place where you live:

- ☐ your own
- ☐ rented
- ☐ shared rent
- ☐ social housing
- ☐ a closed centre
- ☐ an open centre
- ☐ in community but not paying rent
- ☐ in a house but not paying rent
- ☐ with a host family
- ☐ in the Universiy Residence
- ☐ in a hotel
- ☐ in a correctional facility
- ☐ others, please specify

18. How many persons share with you the sleeping quarters/ unit? _____

19. What is the number of people providing financial support that live together with you? _____ Not applicable

Module 2 – Access to health services (HIV, TB, STI, HEPATITIS C)

20. Do you have access to free medications?

☐ Yes ☐ No ☐ No response ☐ Don't know

21. If you or anyone living with you needs health care, where would you go?

	Yes	No
Private general practitioner	☐	☐
Health centre doctor	☐	☐
Medicare (service provided at detention centre)	☐	☐
Private hospital	☐	☐
State Hospital	☐	☐
Other (specify) _____	☐	☐

22. When was the last time you sought medical treatment? _____(give approximate date)

23. Where did you get the treatment from?

	No	Yes
Private general practitioner	☐	☐
Health centre doctor	☐	☐
Medicare (service provided at detention centre)	☐	☐
Private hospital	☐	☐
State Hospital	☐	☐
Other (specify) _____		

24. What was the illness? _____

25. Have you heard about HIV/AIDS?

□ Yes □ No □ Unsure □ No response

26. Do you know what HIV is?

□ Yes □ No □ Unsure □ No response

27. Do you know about other sexually transmitted infections (STIs)?

□ Yes □ No □ Unsure □ No response

28. Is HIV transmitted by or through?

	Yes	No
Sexual intercourse	□	□
Sharing needles/ unclean medical equipment	□	□
Blood transfusion	□	□
During pregnancy	□	□
Mother to child during birth	□	□
Casual contact with an infected person	□	□
By having many sexual partners	□	□
Others	□	□
Don't know	□	□

29. How can you prevent getting HIV?

	Yes	No
Avoid sex completely (abstinence)	□	□
Stay faithful to partner	□	□
Encourage partner to stay faithful	□	□
Avoid contaminated blood	□	□
Use condoms at every act of sexual intercourse	□	□
Avoid sharing needles	□	□
Avoid commercial sex workers	□	□
Avoid casual sex	□	□
Don't know	□	□
Others	□	□

(please specify) _____

30. Are you aware of other persons who have HIV or AIDS?

□ Yes □ No □ Unsure □ No response

31. Where can you get information about

	Friends & family 1	Doctors/ health care workers 2	TV radio, or newspaper 3	Community Organizations 4	Internet 5	Others (specify) 6
a. HIV						
b. TB						
c. Sexually transmitted diseases						
d. Hepatitis C						

32. Do you have access to condoms?

□ Yes □ No □ No response

33. Do you have access to free condoms?

□ Yes □ No □ No response □ Don't know

34. What is your sexual preference?
- □ Persons of the other sex
- □ Persons of the same sex
- □ Persons from both sexes
- □ Don't know
- □ No response

35. Do you pay for sex?

□ Yes □ No □ No response

36. Do you get paid for sex?

□ Yes □ No □ No response

37. What type of protection do you use?

	Yes	No
No protection	☐	☐
Abstinence	☐	☐
Avoiding casual partners	☐	☐
Male condom	☐	☐
Female condom	☐	☐
Withdrawal method	☐	☐
Contraceptive pill / Coil	☐	☐
Not applicable	☐	☐
Don't know	☐	☐
No response	☐	☐

38. Where would one go to get help if one has anyone of the following? Please check the correct space.

	Health Centre	Hospital	Medicare	Private general Practitioner	Genito-urinary Clinic	Traditional Healers/ Alternative medicine	Others specify
	1	2	3	4	5	6	7
a. TB							
b. STI							
c. HIV							

39. What are the difficulties you encounter (check where applicable)?

	To get information				
	Yes 1	No 2	Don't Know 9	No answer 0	Not applicable
a. Cost					
b. Language					
c. Distance (specify distance)					
d. The hospital or service personnel was Intimidating * Nurse, doctor, reception, (specify)					
e. Fear of losing job					
f. Fear of being deported					
g. Fear of being kept in detention					
h. Fear of discrimination					
i. Cultural differences					
j. Other, specify					
k. None					

40. What are the difficulties you encounter (check where applicable)?

	To get healthcare services				
	Yes 1	No 2	Don't Know 9	No answer 0	Not applicable
a. Cost					
b. Language					
c. Distance (specify distance)					
d. The hospital or service personnel was Intimidating * Nurse, doctor, reception, (specify)					
e. Fear of losing job					
f. Fear of being deported					
g. Fear of being kept in detention					
h. Fear of discrimination					
i. Cultural differences					
j. Other, specify					
k. None					

41. Have you ever had any of the following tests?

	Undisclosed	Yes	No	Year done
a. TB				
b. HIV				
c. Sexually transmitted disease				

ANNEX 2: HEALTH SERVICE PROVIDERS QUESTIONNAIRE

Health service providers are to separate the question for migrants and for nationals

1. For HIV treatment providers, what is the main problem encountered with patients (make a distinction between migrants and nationals)?
   - Do not take the medications as prescribed
   - Do not keep appointments
   - Cultural reasons prevent the patient from following the medical treatment
   - Do not have money to pay
   - Others, specify

2. For general health centre providers
   - What is the HIV testing policy of your centre?
   - Do you initiate a HIV test (provider initiated HIV testing)?
   - If so, do you first get the patient's consent?
   - Can the person opt out?
   - Does your office provide pre and post test counselling?

3. Quick survey of HIV prevention and treatment service providers

   Age range of patients
   Estimated proportion of males and females

		Screened for TB	Not screened for TB	Who refers the patient to you?	Who do you refer The Patient to?
HIV patient	On treatment				
	Not on treatment				
Non-HIV patients					

		Screened for HIV	Not screened for HIV	Who refers the patient to you?	Who do you refer The Patient to?
TB patients	On treatment				
	Not on treatment				
Non-TB patient					

ANNEX 3: DETENTION CENTRE HEALTH SERVICE QUESTIONNAIRE

For migrants and for nationals
Country of origin _____

- HIV, TB prevention, testing and treatment policy

    1. Does the detention centre authority provide HIV prevention information?
    2. Is the information culturally and linguistically appropriate?
    3. Does the detention centre authority provide sexual health commodities e.g.: condoms?
    4. Are all the detainees tested for HIV?
    5. If a detainee refused to be tested for HIV, what will be done?
    6. Is there pre- and post- testing counselling?
    7. If upon testing, a detainee was found to be positive for HIV, what are the procedures following the test results?

        1. treatment referral
        2. continued monitoring if not requiring treatment
        3 are HIV positive detainees tested also for TB?

    8. Prevalence of HIV among migrants in detention centres
    9. Prevalence of HIV among non migrants in detention centres

- TB testing policy

        1. Are all detainees tested for TB?
        2. Do detainees who result positive for TB get HIV testing?
        3. Prevalence of TB among migrants in detention centres
        4. Prevalence of TB among non-migrants in detention centres

ANNEX 4: PRISON HEALTH SERVICE QUESTIONNAIRE

For migrants and for nationals
Country of origin _____

- HIV, TB prevention, testing and treatment policy

    1. Does the prison authority provide HIV prevention information?
    2. Is the information culturally and linguistically appropriate?
    3. Does the prison authority provide sexual health commodities e.g.: condoms?
    4. Are all the prisoners tested for HIV?
    5. If a prisoner refused to be tested for HIV, what will be done?
    6. Is there pre- and post- testing counselling?
    7. If upon testing, a prisoner was found to be positive for HIV, what are the procedures following the test results?

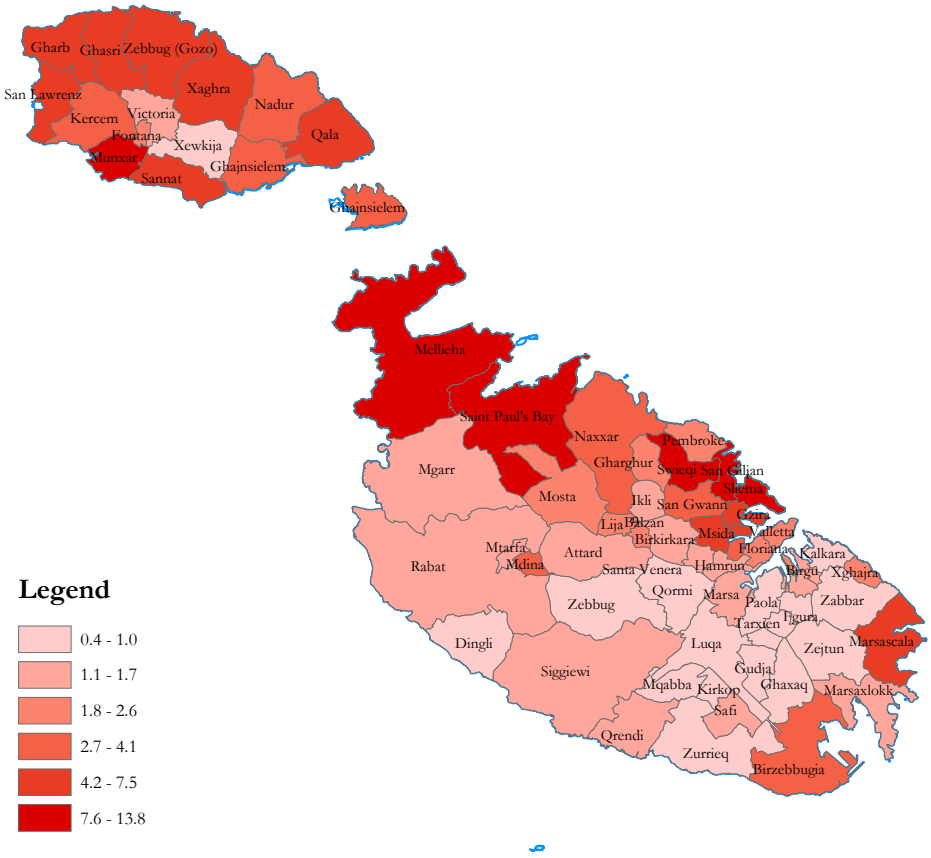
        1. treatment referral
        2. continued monitoring if not requiring treatment
        3. Are HIV positive prisoners tested also for TB?

    8. Prevalence of HIV among migrants in prison
    9. Prevalence of HIV among non migrants in prisons

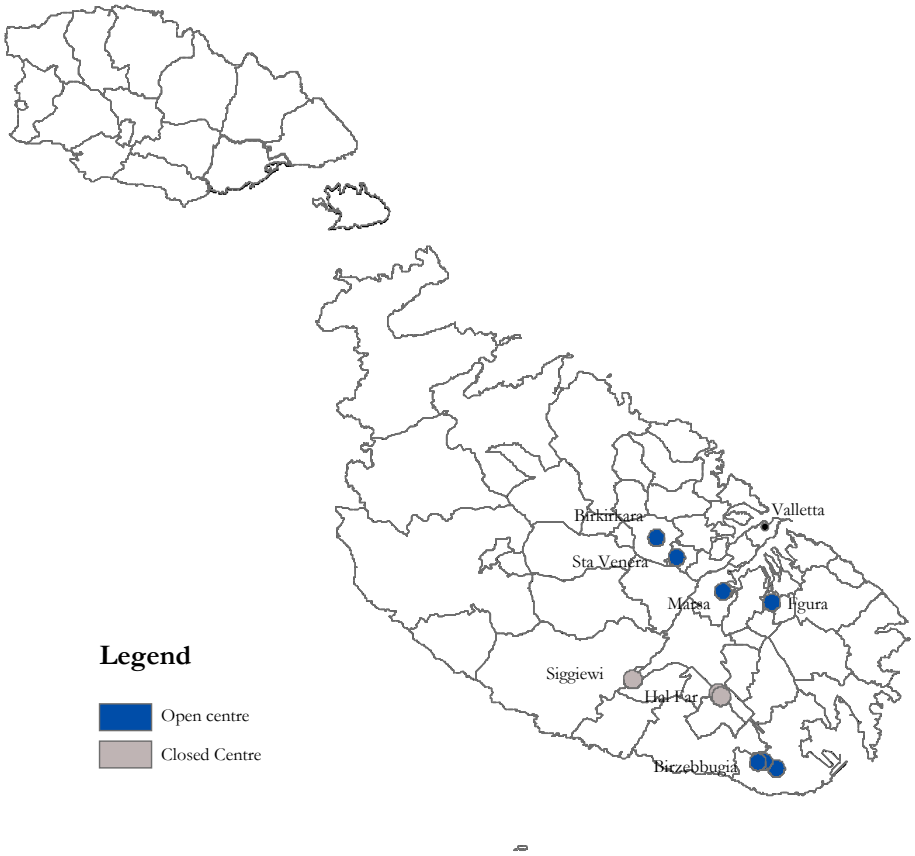
- TB testing policy

        1. Are all prisoners tested for TB?
        2. Do prisoners who result positive for TB get HIV testing?
        3. Prevalence of TB among migrants in prison
        4. Prevalence of TB among non-migrants in prison

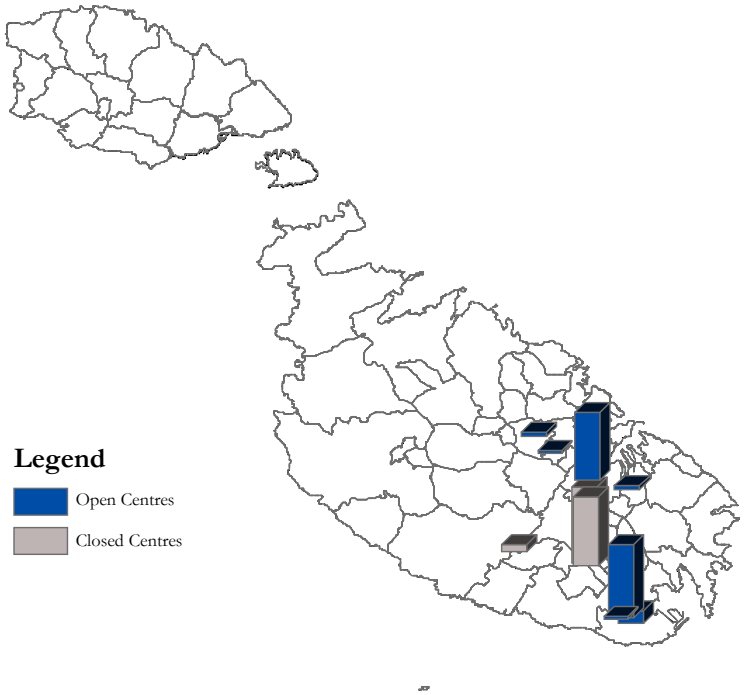
ANNEX 5: MAPS



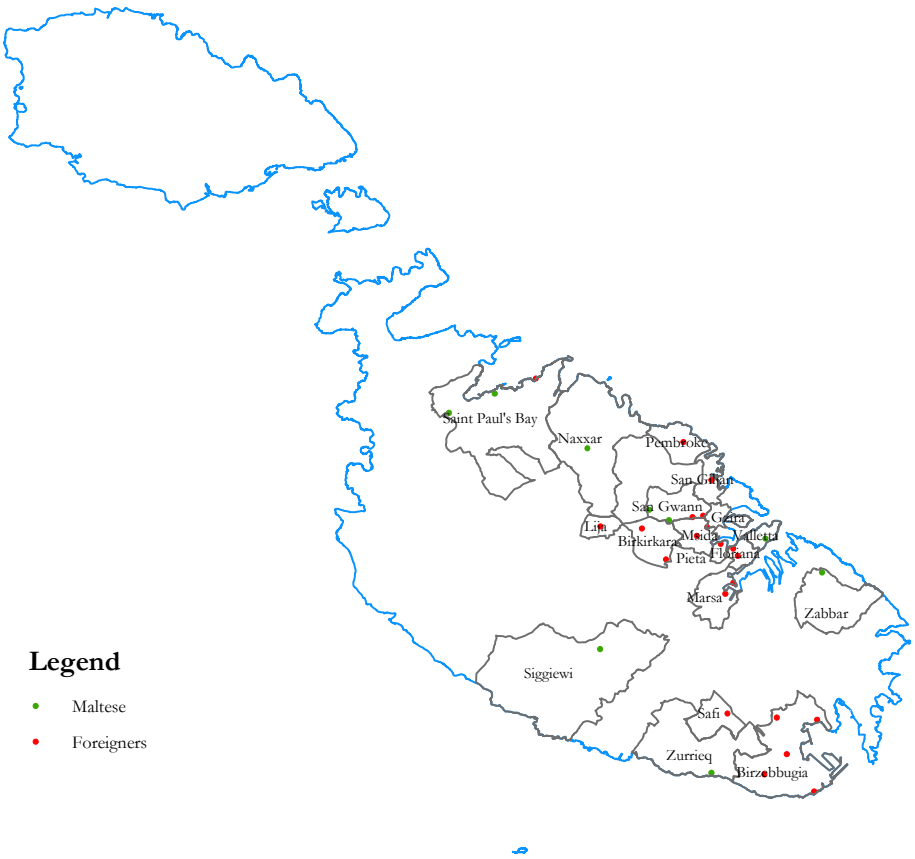
MAP 1: Proportion of migrants in total population of locality



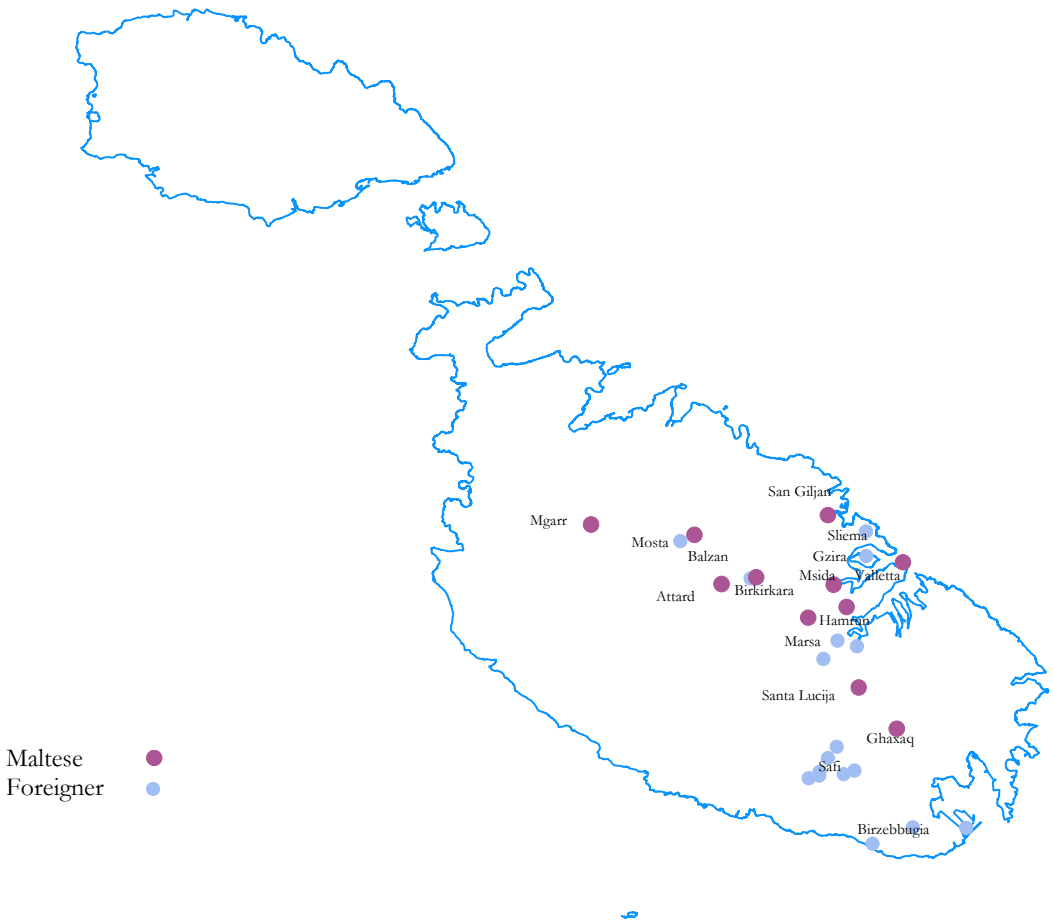
MAP 2: Location of Open and Closed Centres



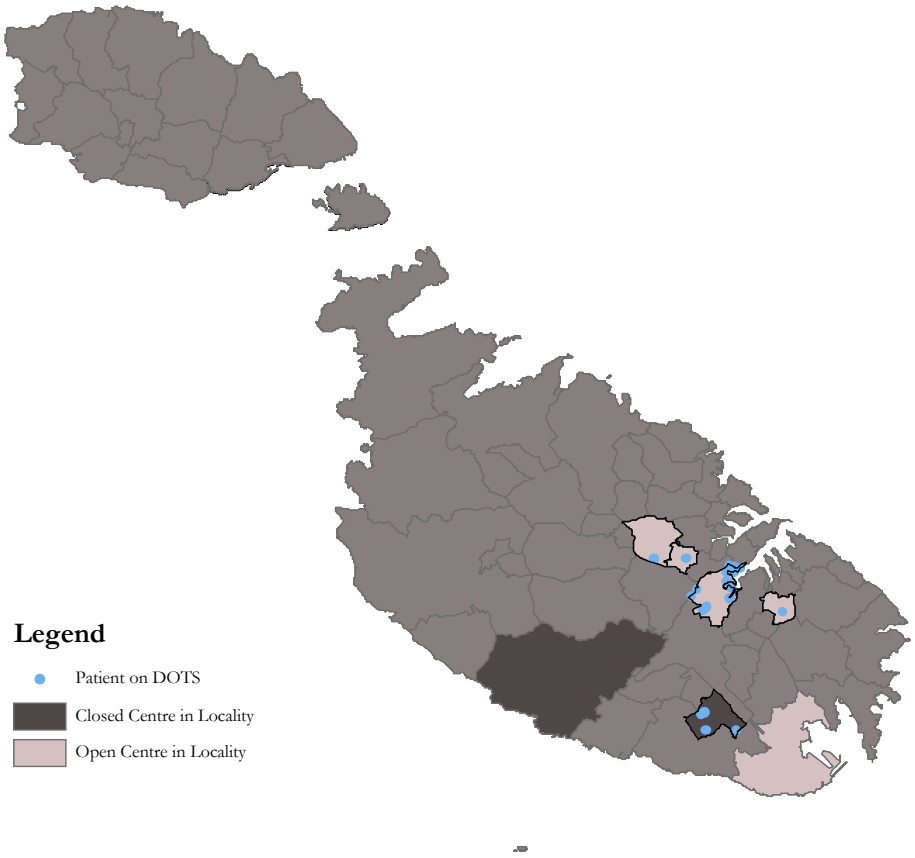
MAP 3: Location of Open and Closed Centres and Number of migrants in centres



MAP 4: Mapping of HIV Cases



MAP 5: Mapping of TB cases



MAP 6: Mapping of TB cases on DOTS