MIGRATION AND HEALTH

Caring for those in our midst

MIGRATION AND HEALTH

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With one of every 50 human beings moving across borders—and many more migrating or displaced within their own countries—migration today affects communities everywhere.

Much of this movement is a direct human response to compelling circumstances—war, civil conflict and persecution remain the most dramatic. But millions of people are also forced to move because of environmental degradation, denial of access to land, and the consequences of development models and economic systems which have failed to provide for their basic survival needs.

As government policies become more restrictive and public hostility against foreigners intensifies in every region, Christians and others who want to promote healthy communities are presented with a major challenge. The World Council of Churches’ Central Committee has recently elaborated a new policy Statement on Uprooted People noting that a large proportion of those migrating today are forcibly displaced or “uprooted”. The policy makes explicit the need for “wholistic” ministry with uprooted people.

At the same time, WCC recognizes that the solution to the problem of migration can only be achieved when we address the human rights and economic factors which force people to leave their families and communities.

The human consequences for many of those who do migrate are often devastating. Migrants, especially those who are involuntarily uprooted, experience multiple losses. They leave behind family, friends and community, and familiar spiritual, religious and cultural structures that nurture and define basic human identity. They also lose social status, property and employment. The disruptions facing people fleeing persecution and warfare are especially severe, affecting most of all women and girls.

Hostility in the place of transit or refuge may compound the traumas of migration. Violence, rejection, ethnic and racist hostility often create fear which restricts mobility and prevents participation in society and the ability to obtain employment and services.

We are pleased that Contact has chosen to focus this special issue on “Migration and Health” because the traumas of migration have enormous effects on the well-being, stability and the very identity of the human beings involved. In turn, these effects are often manifested in their physical, mental and spiritual condition. Health workers must be equipped to take into account the unresolved losses and traumas that are usually behind illnesses of migrants and refugees. Without addressing these root causes of physical or mental “dis-ease”, treatments may be ineffective.

Church groups and health care providers working with migrants, immigrants and refugees recognize a tremendous drive, energy and survivor spirit among uprooted people, and they recognize the importance of this drive as crucial to the healing process. They also recognize the need to nurture a sense of cultural and spiritual identity in immigrant groups, including the use of traditional healing methods and language, while providing the information to allow them to access services and to cope with and function in their new land. The old models of encouraging assimilation into the dominant culture of the new land, requiring abandonment of one’s own cultural values and identity, are recognized as carrying a very high cost in loss of well-being and health for the individuals “assimilated.”

This issue of Contact is intended to challenge the thinking and responses of Christian health care providers and others who work with uprooted people to reconsider, especially when treating organic disease, the connections between a person’s health and their culture and identity and the displacement they have experienced.

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WHAT ARE THE HEALTH NEEDS OF MIGRANTS?

Medical experts at the International Organization of Migration describe the stresses and problems of migration whether voluntary or involuntary.

Migration is a special category of human mobility. While many people move during their lifetime from one place to another, a migrant is a person who crosses boundaries for a change of residence intended to be permanent or at least of substantial duration. It has been estimated that out of every three persons who migrate, one settles for good in the host country.

Worldwide, about 85 million people are currently residing outside their country of origin. This estimate includes undocumented migrants, who either enter clandestinely or remain after their visa has expired. African countries host about 20 million migrants, North America 17 million, Central and South America 12 million, Asia 16 million and Europe 20 million. More than one million immigrants are accepted each year by traditional receiving countries alone (Australia, Canada and the United States).

A distinction is often made between migrants, who move for economic reasons, and refugees, who are forced to flee for political reasons. Such a distinction is becoming less and less easy to make. Individuals choose to migrate because of social, economic and demographic pressures. These same pressures often cause political instability or armed conflict. Violence and war are the most immediate reasons for fleeing from home and becoming a refugee elsewhere. For example, the quest for political asylum in industrialized countries has increased more than seven times over the last decade. This has taken place at a time when traditional opportunities for economic migration have been drastically reduced. Politicians in receiving countries often argue that most asylum-seekers are economic migrants, and call for more restrictive asylum policies. However, the complexity of the causes of migration, and the numbers involved, make it clear that a global solution is needed. The problem of the tremendous imbalance of resources between developing and developed nations needs to be addressed by both the receiving countries and the home countries.

Cultural stresses
Migration, even when it is voluntary and planned, is a stressful life event. Either as single persons or as families, migrants...
set of cultural norms, roles and responsibilities is demanding and difficult. Although the move to a new society is often successful in the end, some migrants face difficulties in adapting to a new culture. Social and psychological problems frequently appear during this process. These may lead to poor health, and to problems in the family, at work and at school. Migrant women from developing countries are especially vulnerable. They tend to have little schooling at the time of their move. Lower education levels will restrict them to low-status jobs, and will limit the possibility for interaction with the host community. In addition, women must often move back and forth between two cultures. They are often more vulnerable in confronting conflicts between family members with different levels of acculturation (adaptation to the new culture).

Another cause of considerable stress is the negative stereotyping towards some migrant groups in host countries. Hostile

**Participation can boost migrant health**

A recent report by International Organization for Migration entitled "No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000" recommends the introduction of policies to reduce the health gap between migrants and the national population. It says that efforts to reduce inequalities require the full participation of migrant groups in their new country of residence.

The paper reviews the health care available to migrants and ethnic minorities in selected industrialized receiving countries, and analyses the health of these communities on the basis of the "entitlement approach". This approach takes into account both the material conditions of life and the broader social context in a given society. Entitlement analysis states that, in each social structure, a person can establish command over some alternative commodity bundles – which can be either extensive or very limited. The set of alternative bundles of commodities which the person can command, either in terms of ownership rights or rights of use, can be considered as this person’s entitlements.

Migrants often have reduced entitlements in receiving countries. They may also be exposed to poor living and working conditions, or may have reduced access to health care for a number of political, administrative and cultural reasons. The paper argues that high perinatal mortality and accident/disability rates in many migrant groups are linked to these low entitlements. It recommends action to reduce inequalities and to promote participation of migrant and ethnic groups in mainstream society.

and racist attitudes have been associated in some migrant communities with stress-related diseases, such as hypertension.

Comparative study
According to several health indicators, immigrant communities fare worse than the native population in many countries. This is despite the fact that they have been selected at entry for their good health and ability to work. A recent review in six European countries showed that perinatal and infant mortality rates of some immigrant groups are about twice as high as those of the native population.

In the field of occupational health the situation is less clear. Immigrant workers are commonly highly represented in occupations with high risk of accidents or high rates of absenteeism. In overall statistics, they might thus appear to fare badly but, in age and sex adjusted research within occupational categories, they seem to do at least as well as members of the host population. This field clearly needs further research. Concern has been expressed about other health conditions as well. These include rates of mental disorders, drug abuse and domestic violence.

Several reasons explain the lower health status of immigrant groups in receiving societies. Most first and second generation migrants become part of the lower social groups, which is a determinant of poor health. They often have inadequate access to health care. As well as the economic barriers they face, there are other obvious obstacles such as language and cultural attitudes towards health and health care. Many face racism and discrimination within the health system, which in turn reduces their use of health services. Finally, some groups may also have reduced entitlements to services because of their legal status in the receiving country. The most extreme situation is that of "irregular" migrants (migrants without papers), who have no access to any preventive or curative services, apart from emergency care which normally is accessible one way or the other.

Taking action
Some receiving countries have acknowledged the special health needs of immigrant communities, and have taken steps to ensure that linguistic and cultural barriers are minimized. This may be accomplished by arranging specific services for different ethnic groups. Such special services are more common in metropolitan areas with a high concentration of immigrants. Alternatively, the services may be made better able to adapt by devising organizational changes within mainstream health services to meet the needs of a multi-ethnic clientele. Often this is a combination of these two measures.
A preliminary study conducted in five European countries has shown that adopting a specific health policy for immigrants and ethnic minorities can remove many economic, administrative and linguistic barriers to access to health care.

Pregnancy outcome is a case in point. Over the last decade, Sweden paid considerable attention to understanding the cultural aspects of mother and child care for Turkish women. Services considered to be more culturally appropriate to Turkish women have been provided. As a result, immigrant women reached the same pregnancy outcome as Swedish women, even though perinatal mortality rates in their country of origin are very high. In other European countries, the rate of unfavourable pregnancy outcomes is still high for Turkish women.

The low health status of immigrant groups on certain scores is one of the problems hampering the achievement of equity in health within countries. Yet, simple and relatively inexpensive changes within the health system have been shown to produce substantial improvements in the health of immigrants. Much effort is still needed in order to understand the health needs of migrant groups, and to provide appropriate preventive and curative services.

This article is adapted from one which appeared in *World Health*, November-December 1995. It is by Dr Paola Bollini, Medical Officer, and Dr Harald Siem, Director of Medical Services, International Organization for Migration which publishes the *Migration and Health Newsletter* and produced "Migration and Health in the 1990s" following the Second International Conference on Migration and Health in Brussels, 29 June - 1 July 1992. For further information, write to: International Organization for Migration, 17 route des Morillons, PO Box 71, 1211 Geneva 19, Switzerland.

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**Centre for Migration and Health**

The International Centre for Migration and Health opened in Geneva a year ago. Its mandate is to determine how migration affects health and how the health of migrants can be protected and actively promoted. Underlying its work is the belief that, not only should all migration be a healthy process, but that it is ultimately in the best interests of everyone concerned to try to ensure that it is. The Centre’s work focuses on eight major areas including the epidemiology of medical and psychosocial problems, and the policies of national authorities with respect to the needs and rights of migrants—irrespective of their reason for migration. It is currently assessing the effects of migration on reproductive health, occupational health, infectious diseases and personal adjustment. It also aims at developing relevant postgraduate training in this field for nurses and medical doctors, and helping to define the role played by interpersonal communications in the delivery and utilisation of health services.

For more information, write to: Dr Manuel Carballo, Coordinator, International Centre for Migration and Health, 24 avenue de Beau Sejour, 1206 Geneva, Switzerland.
THE CHURCH SPEAKS UP FOR MIGRANTS

During the Apartheid era, South Africa received an influx of Mozambican refugees who were forced to leave their country because of the war situation. In 1994, President Nelson Mandela came into power ending years of white minority rule, and South Africa has subsequently faced a huge new wave of migrants. The South African Council of Churches (SACC) considers one of its primary roles to be that of defending migrants against growing xenophobia (hostility towards foreigners) in the country with the help of church communities. Here, Rev White Rakuba, SACC’s refugees and emergencies programme officer, describes his work.

The migration problem started to intensify immediately after the Mandela government took office. During this new phase, people have come in mostly from southern African countries, in particular from Mozambique and Angola, and from West Africa. But they also come from all corners of the world, including eastern Europe and Asia. Once the political situation had changed, large numbers of people who had heard about the gold, the wealth and the jobs in South Africa, started to come in large numbers.

Those who left their countries arrived in Johannesburg expecting their new and better life to begin immediately. Many had been so sure that things would go smoothly that they had promised their children and spouses that they would be back in a few months with money and new clothes. The reality of the situation has turned out to be very different for them.

Daily reality
For most of these newcomers, the first encounter with their new life is learning to sleep on the very cold streets of Johannesburg. The shelters that exist are already full of local people who have left the rural areas to come and try their luck in the cities. The churches do their best to help but are finding it extremely difficult to cope.

Some migrants are soon robbed of all they have. Others, having found jobs,
A serious stigma on migrants is associated with the AIDS epidemic.

Become the victims of xenophobia. Sadly, their good fortune has created serious enmity between themselves and the local job-seekers. Often, refugees and migrants are willing to work for very low wages.

Xenophobia has been intensified by reports that migrants are hooked into the drug business. Several much-publicized cases of migrants involved in drug dealing have resulted in all migrants being associated, wrongly, with drugs.

Young male migrants are also being blamed for taking the girlfriends of local men. While their foreign money lasts, those coming from West Africa are particularly successful at attracting local young women.

Health problems
Another more serious stigma on migrants is associated with the AIDS epidemic. The presence of the disease is always blamed on foreigners, and those coming from countries where rates are high are particularly vulnerable to discrimination. It is clear that migration is associated with the spread of HIV. Young male migrants find themselves living alone having left wife and children behind. Young mothers left alone sometimes feel forced to become prostitutes in order to have money to feed their children. However, although the association between migration and HIV transmission exists, the high risk behaviour of some migrants is also found among local people in South Africa.

As soon as the migrants start to feel the reality of their new existence, they become confused and worried. Many come to us with stress-related problems such as headaches, anxiety and nervous breakdowns. Those with families with them in South Africa worry about whether their children will have enough to eat. If

Migration and AIDS

HIV, like any other infection spread from person to person, will follow the movement of people. However, trying to separate migrants from local people as a means of controlling the spread of infection will never work. Long-term, the answer to many of the problems brought about by migration may be population policy, environmental protection, and economic development. More urgently, it is important to provide services in a humane and inclusive way.

According to a report in The Lancet, "In the short term, a policy of providing accessible and acceptable basic health and social services to migrants at their destination has a chance of creating a sense of security and the sense of community that is necessary for health. As long as migrants are excluded from community life and victimised as the carriers of HIV, they will continue by default to organize themselves into anti-communities driven only by the need for daily individual survival. Rapid spread of HIV is one of the consequences of this type of dysfunctional social organization."

the children become sick, parents often find that they cannot afford the medical fees. Nor can migrants’ children attend school.

In the end, migrants often decide that they want to leave, but cannot afford the travel cost involved. Some volunteer for deportation. However, the procedure can be very harsh. One refugee with whom we have been working had decided that he and his wife would ask to be deported. During the procedure, he lost contact with his wife and has not seen her for eight months despite constant searching. Some migrants have turned to drink in their misery. A few have even committed suicide.

Since the beginning of this year, reports of deportation have created another serious concern among migrant communities. More than 45,000 illegal immigrants were arrested and deported to their respective countries during the first two months of 1996, according to statistics from South Africa’s Department of Home Affairs. Requirements for residency in South Africa include that the applicant must not be harmful to the welfare of South Africa and must not follow an occupation in which there is already a sufficient number of local people available.

One of the most difficult tasks faced by those of us in the churches is providing support to the migrants and refugees who come to us. They are often deeply religious, but this can be a period of intense spiritual emptiness for them which we have to try to help them through.

SACC priorities
The programme of the South Africa Council of Churches has to take great care to balance the assistance given to migrants and refugees with that given to local people who also need our help. This sensitivity is vital if we wish to draw on the support of our member churches. Fortunately, we have achieved some success.

In the urban areas, refugees receive pastoral counselling through the urban industrial missions of our member churches. In rural areas, where we concentrate our efforts, member churches have offered substantial support. First, they have made available church land where homes for refugees and migrants are being erected. Second, they have helped us to convince many new arrivals of two important realities. One is that life in the cities is difficult and should not be considered an easy option. The other is that we cannot help migrant families – instead of local destitutes – without provoking a reaction among South African citizens.

Fighting discrimination
Our work in calming the xenophobia and in protecting refugees and migrants from cruel discrimination is crucial. Although our work in the churches helps, the real solution is to provide refugees and migrants with a means of survival. Since we are working in the rural areas, the work is usually agricultural. The migrants, often from farming communities, are keen to work on the land. Although these projects are costly to establish, we believe that they are worthwhile because ultimately they provide the refugees with the means to fend for themselves.

For more information, write to Rev. White Rakuba, Refugees and emergencies programme officer, South African Council of Churches, PO Box 4921, Johannesburg 2000, South Africa. Tel: 27 11 492 1380.
Fax: 27 11 492 1448.

Displaced people in Province of Natal
FROM NICARAGUAN FIGHTER TO COSTA RICAN IMMIGRANT

Costa Rica’s 3.2 million population is host to 400,000 Nicaraguans. A few years ago, these migrants were considered refugees of war, today they are shunned as “illegals.” Gabriela Rodriguez of El Productor describes her work with migrants in Costa Rica and with ex-combatants in Nicaragua.

When I arrived in Costa Rica in 1980, I began to familiarize myself with the complexity of refugee problems in El Salvador, Guatemala and Nicaragua. At that time, hundreds of thousands of people were being expelled from their own countries and forced to migrate.

Today, migrants from Nicaragua comprise 12% of the population of Costa Rica. It is a fact which receives little national or international attention. Costa Rica continues to be considered by the outside world as a country without problems of extreme poverty. This is achieved by systematic exclusion of the life conditions of these migrants from official figures.

Regardless of the social background of the Nicaraguan migrants, all have something in common. The all must face starting a new life, finding a job, making friends and sometimes even learning a new language. All have to hide the deep pain they feel from the violent and traumatic losses of their past. Many suffer physical symptoms such as gastro-intestinal problems, migraines and hypertension. If they are to restore their integral or “wholistic” health, they need to be able to express verbally what is hurting them deep inside.

Sadly, the situation in which they find themselves is more likely to make them maintain their guarded silence than to encourage them to open up what is in their hearts. Not only are their extremely difficult living conditions unknown, they often face daily discrimination from local people.

Church and NGO mission
The role of churches and non-governmental organizations in our region is to comply with the prophetic mission of testimony and accompaniment to the uprooted. We believe that this is the way to make the invisible visible.

My organization, El Productor, comprises an independent, interdisciplinary team involved in promoting the integral health of forced migrants in countries of Central America and in seeking and implementing solutions in defence of
the human rights of the uprooted population in Costa Rica. The ethical commitment of this work is consistent with the approach of the International Migrants Rights Watch Committee* in which we are active participants.

Programme for ex-combatants

In addition to our work in Costa Rica, El Productor is also working in Nicaragua with young men who might be considered "potential migrants". As part of the peace agreements in Nicaragua, it was agreed that the international community would include ex-combatants in development programmes. The situation of these former fighters is a real challenge. Not only are they facing the consequences of trauma of all kinds but also their self-image is badly damaged by their experiences and their daily struggle for survival.

El Productor's programme with them offers agricultural training. However, we certainly cannot transform these soldiers into agricultural producers overnight. The trauma of having lived in war zones during a period of more than 10 years weighs heavily upon them. They have no health and medical attention available as part of any development programme, and therefore their health problems make learning and wholistic recovery very difficult to achieve.

We therefore try to work with them on psychosocial problems along with the formal classes provided within our programme. We encourage the ex-combatants to bring back into their mind what has caused them pain. We suggest that they may need to allow these experiences to become part of their life stories. This programme of reconciling with the past has included bringing together groups of young men who were enemies during the war. Some are now working together in initiatives which we believe will contribute to their reintegration into civil society.

The worst problem for these young men is their constant frustration in trying to solve problems of everyday life. Demoralization leads to anger and a conviction that the only way out is to declare war and fight for their rights. This has already started to happen in parts of northern Nicaragua. The only other option they have is to emigrate to Costa Rica in search of a job. In response, I try to tell them what their experience of emigration is likely to be. Even if they are able to find a job, few Costa Ricans will show any consideration for the poor mental health these former fighters are suffering. If xenophobia (hostility towards foreigners) is bad towards the old, the women and the children who have immigrated from Nicaragua, it is even worse towards ex-combatants.

We encourage the ex-combatants to bring back into their mind what has caused them pain.

Ms Gabriela Rodriguez

For further information, write to Ms Gabriela Rodriguez, Coordinadora, Servicios Profesionales y Técnicos El Productor SRL, Apartado 892-2056, San Pedro, Montes de Oca, San José, Costa Rica. Tel: 506 255 07 29, Fax: 506 255 07 33, e-mail: elproduca@sol.racsa.co.cr

* The International Migrants Rights Watch Committee is the only global body monitoring migrants' rights. For more information write to Patrick Taran at WCC. Address on page 20.
FEELING ALONE

Maria Feliz is a Guatemalan living in southern Florida. Margarita Romo, founder and director of Farmworkers Self-Help in Dade City interviewed her. Margarita believes that it is important for everyone to hear the stories of women farmworkers in the USA, and to be aware of the extent of the poverty which exists.

I come from San Miguel, Guatemala. I've only been in this country for five years. In Guatemala, we had a little farm where we could grow food, but we didn't have any money. There was hardly any money there, so very little changes hands. I was only 14 when my cousin talked me into coming here because there was lots of money to be made. Being 14 years old, I really didn't understand how to make a decision about where to go.

We had a very difficult time coming over. It took between 12 and 20 days to get here. We travelled through the desert and the mountains and slept in the cold. In the daytime it was really hot, but at night it was really cold. We were very hungry and very thirsty. As we came through from Guatemala, we had to go through El Salvador, Honduras, and Mexico. We came through Arizona, and then someone in our group bought a car. With that car we were able to come to Florida.

Hopes dashed
We just wanted money and thought that this was the place to come to, but we found that the work was very, very hard. A lot of people think that the United States has streets made of gold. I came here to work as a farmworker and started picking cucumbers and red peppers and bell peppers. Now I'm picking tomatoes. Coming here was a big change because in Guatemala the women don't work in the fields - only the fathers do.

The tomatoes are hard to pick, and we only get 40 cents for a bucket of them. I have to be very strong because we have to jump up onto the truck to put the buckets of tomatoes into it. Sometimes I make only $20 a day. We're having a difficult time. There is a large group of Guatemalans here. I spend a lot of time thinking and thinking about what I would like to do to make things better. There's not much work, and the work that is available is very hard. When the work stops, some of my people go up north, and some of them go to different places to work.

I have now been here for five years. I came to this country speaking a little Spanish that my grandfather had taught me, but my first language is an Indian one. I'm by myself. I'm a single mother with two little girls. I have a really difficult time because I'm trying to learn English, and I can't speak, so I can't make myself understood. I'd like to learn to speak English, and I'd like to have a job that is not as hard. I would love to be a teacher or a doctor, but I can't because I can't read. I can't write. I only went to school for two months in my whole life. Maybe the children will grow up and study, and maybe they'll even help me.

I was 17 years old when I got married. One day my husband was supposed to go buy a chicken. When I came home from work, he was gone. He had gone back to Guatemala. When my husband left me, I cried a lot. It felt like he had died. My life was just gone and I was very, very upset. It was just like he had died. Now I've gotten over being sad. I feel okay now.

I went back to see my mother and my family a year ago. I'm not happy because my mother is not with me. I'd like to bring her here. I have a brother in Colorado and a cousin in Tampa and other cousins and nephews, but I don't have any family right here in Indiantown. I feel very alone without my parents, just by myself with my two children.

This interview first appeared in Common ground journal. Many, like many migrants from living in southern California, has little access to health services. Tuberculosis rates are rising within her community of migrant farmworkers, according to Margarita Romo, and several are infected with HIV. A one-room clinic for the community is open only when a doctor or nurse is willing to give their free time to provide services. For further information about the work with women farmworkers in Florida, write to: Margarita Romo, Farmworkers Self-Help Inc., 709 Lock Street, Dade City, Florida 33525, USA. Tel: 904 567 1432.
INVESTING IN JOB CREATION AT HOME

Those working at Asian Migrant Centre (AMC) in Hong Kong are determined to help other foreign workers to shape their own futures. One AMC service provides advice to help migrants save money. It also offers information on how to invest savings in projects which are creating employment at home. This initiative, called the Migrant Savings for Alternative Investment (MS-AI) scheme, helps ensure that working abroad provides a stepping stone to future opportunities at home. The following is how the scheme is described in Unlad Kabayan (Citizen's progress) booklet.

I am Precy and I came to Hong Kong in 1992 to work as a domestic helper. I joined my sister and a cousin who had come to work as maids much earlier. The three of us were the core of a small barkada (peer group) of migrant workers coming from southern Luzon and Bicol. We shared the same church and the same dream for a bright future at home. Meeting in each other's homes on Sundays, the barkada, which now has eight members, initially discussed possibilities in which we could return home with enough savings to start a business. Talking about the experience of others, we realized that if we did not start saving quickly, we might end up going home as poor as when we left. In Hong Kong, it is tempting to spend all our incomes on...
perfumes, clothes, shoes and so on. Further discussions led us to a decision to pool our resources in a savings association. We came to study the ways to set up a savings association.

We were helped a lot when the Asian Migrant Centre arranged for the visit of a savings cooperative expert from the Philippines. Brenda worked for KAKASAKA, a non-governmental organization (NGO) in Cebu which was building cooperatives. She shared her knowledge and experiences about how to organize a savings association and how to start a small cooperative business enterprise at the community level.

The group attended seminars led by Brenda for several consecutive Sundays. The topics included the value of saving, bookkeeping and simple accounting. Afterwards we organized ourselves into the Dayuhang Manggagawa (foreign overseas workers) Savings Association Hong Kong (DAMA-SA-HK).

Encouraged by the training programme, DAMA drew up its vision, mission, goals, policies as well as its constitution and by-laws. After some time, we had ourselves registered as a Savings Association under Hong Kong law.

According to the policies we had approved, we each started to save the modest sum of HK$100 per month (about PhP300 or US$12). This represented 0.026% of our monthly income as maid (which was HK$ 3,750 per month). To sustain the association, we also decided to collect monthly dues of HK$5 from every member.

In two months, DAMA’s members had been able to save some HK$16,600 or about PHP50,000.

Eager to invest our savings, we contacted the KAKASAKA Cooperative in Cebu expressing our wish to invest in their projects. We chose to help a community shoe-making cooperative. Located in Carcar, Cebu, the cooperative is run by full-time farmers (men and women) who supplement their incomes by producing and marketing ladies’ shoes. The cooperative had been oper-
ating for several years and was financially stable.

DAMA members are happy to be of service to the shoe-making cooperative at home, particularly when they were able to earn 1.5% per month from their investments. We plan to invest in more cooperatives in Cebu in the next few months. Perhaps in a year or so we shall be able to start investing in projects in southern Luzon and Bicol where several of our DAMA members, including myself, come from.

As a result of this successful activity, DAMA continues to recruit new members and to build up our savings. We are eager to find ways to help our fellow countrymen and women. Meanwhile, other migrant workers in Hong Kong are following the example of DAMA. Several savings associations are being organized at present time.

Apart from developing savings values among migrants, DAMA is also becoming involved in other activities. We help those migrants who are planning to leave to prepare for their return. We are also helping communities at home to start small projects, which helps to generate jobs at home. We feel we are providing a real alternative in foreign investment!

Asian Migrant Centre began in 1989 providing counselling and legal services to Asian migrants in Hong Kong, many of whom were suffering from various violations of their legitimate rights. Later, they became involved in raising public awareness about the working conditions of migrants and helped establish the International Migrants Rights Watch Committee (for further information, contact Patrick Taran, WCC; address on page 20). At present, AMC has several programmes, joint projects and cooperative relations with migrant worker groups in many Asian countries.

For further information, and copies of United Katayan, write to: Asian Migrant Centre, 4 Jordan Road, Kowloon, Hong Kong. Tel: 852 2312 0031. Fax: 852 2367 7355.
ASSYRIAN FAMILIES IN EXILE

The Assyrians have experienced lives of instability for over 80 years. Since the beginning of the twentieth century, they have been forced to flee from massacres, revolution and wars. Assyrians in Lebanon—traditionally a place of refuge for Christians in the Middle East—have endured civil war and neglect by Lebanese government overburdened with other problems. However, there is light at the end of the tunnel. A programme of the Assyrian church is helping the community to begin to put down roots.

After the Lebanese war, many Assyrians left Lebanon despairing of ever finding security and stability there. The community of 6,000 who are left behind are illegal, desperately poor and few have a good education. Two generations of young people have been denied access to colleges and universities because they have no legal documentation.

Today, the community lives in Sad-El-Baouchrieh, a neighbourhood in Lebanon which is full of uprooted, internally displaced and stateless people. Some Assyrian families live seven to a room, and few parents can afford to pay school and medical fees. Their illegal status forces the men to take irregular, poorly-paid jobs as porters or on building sites.

Seeing the situation of their community, the Assyrian church stepped in with a programme for a dispensary, schooling and various social activities. The aim was to help Assyrians to achieve a decent standard of living, and to encourage them to integrate into Lebanese society.

The dispensary, which opened in 1982, now offers far more than the dispensing of drugs. Known as the Assyrian Medical and Social Centre, it welcomes all those in need. It provides counselling services: a full range of primary health care services and medical referral, if necessary. It is also the focus for the programme’s youth groups, women’s activities, business loan schemes and other community-building activities.

The programme covers the costs of all medical fees and therefore frequently saves families from what might otherwise become crises. It also covers half the costs of children’s school fees. The stability provided by these activities may prove to be the catalyst for change that is needed within the community. According to Ms Aline Papazian of Middle East Council of Churches, which supports the programme, “The Assyrians had no services before—with this basic support and now that the naturalization of stateless communities in Lebanon has become a reality, they have a chance to change and to start thinking about ‘rooting’,” she says.

Ms Helene Moussa of World Council of Churches, who visited the programme recently, agrees with Ms Papazian. “Now is the time to work on a plan for community organization,” she says. She was struck by the fact that the older generation had always concentrated on returning rather than building community in Lebanon. “By providing the opportunity for Assyrian youth to share with youth elsewhere, these young people will help create a vision for the community’s future.”
NETWORKING TO SOLVE PROBLEMS

The contribution of black and migrant women – both to their adopted countries and often to their country of origin as well – frequently goes unrecognized. Meanwhile, they experience discrimination, unequal rights in employment and access to services, and poorer health than those of host countries. Mukami McCrum, a board member of Churches' Commission for Migrants in Europe, has been instrumental in establishing a network for black/migrant* women and health in Europe. Here she describes some of the achievements of the network so far.

Three years ago, in March 1993, a seminar on the health and well-being of migrant women in Europe was organized by Churches' Commission for Migrants in Europe and Evangelische Akademie at Bad Boll, in Stuttgart, Germany. It was planned in response to the concern shown by black and migrant people from different backgrounds and ages, about the rise of racism and xenophobia (hatred and dislike of foreigners) and the tightening up of immigration legislation in the European Union since 1992.

The three aims of the conference were:
- to give wider publicity to the inadequate health care of black and migrant women in Europe;
- to contribute towards the creation of a network among black and migrant women together with fellow women workers in matters of health; and,
- to develop recommendations and strategies aimed at improving the provision of health care for black and migrant women.

During the 1993 seminar, and built upon in subsequent meetings in 1994 and 1995, the health problems of black and migrant women in Europe were defined, and the beginnings of the network formed.

Defining the health problems
Definitions of health often fail to take into account what makes black and migrant women ill in host countries. Nor do they take into account how illness is treated. The World Health Organization’s definition of health ignores race, gender and class inequality as factors affecting health. In reality, these are the reasons why the lives of most black and migrant men and women, including some who are second or third generation migrants, are characterised by low pay, difficult, dirty and dangerous work, poverty and appalling living conditions.

Racism also means that many migrants live in fear of being attacked, which in turn restricts their freedom of movement. Unequal gender and power relationships may adversely affect the health of women migrants. For example.

*The World Health Organization’s definition of health ignores race, gender and class inequality as factors affecting health.
women migrants may rely on their husbands for their right to remain in Europe. In some cases, even when a husband has not been violent before, he may use the power given to him by European authorities to threaten his wife if she complains about his maltreatment of her. In other cases, migrant leaders cling to traditional beliefs, such as female genital mutilations, despite their adverse effect on the health of women and girls. With regards to access to care, even when there is no hostility, the impersonal approach of western medical services poses another threat to the health of black and migrant women. Migration has often separated them from family and community members who would have otherwise played a major role in care and support. The “wholistic”, and often gender sensitive, approach to healing which may have existed at home is also lost. Nor are traditional health care methods, such as acupuncture, herbal remedies, healing foods and celebrations likely to be available. Although traditional health care is gaining recognition in the West, it remains controversial!

In some cases, women migrants find that they are blamed for their ill health because of their reluctance to use the services has delayed treatment. While the media was linking AIDS with Africa, some African women living in Europe could not muster the courage to seek any medical care.

Communication difficulties pose an additional strain. It is not merely a question of not being able to speak the language but also that words to describe certain bodily organs or diseases may not exist in their own language. Differences in the explanations and perceptions of certain illnesses compound the problems. Improving communication between women migrants and health and other social service workers is one of the primary roles of many of the organizations involved in the network.

Role of the network
At the first meeting in Stuttgart, it became clear that a network was needed so that groups could share information, provide mutual support, and help avoid wasteful repetitions, isolation and burn-out.

All three meetings, plus informal gatherings such as one that took place at the Beijing NGO Forum in 1995, have built awareness of the issues, and created links and new lines of communication not only between groups but with health authorities as well. Participants have taken home ideas on how to solve common problems, and reports of the meetings have been shared widely.
Success stories always spread fastest. These include the self-help antenatal care programme for Spanish-speaking women in Sweden; discussion groups in Denmark, organised by Soldue, for migrant women to share information about their cultures; and a self-help, volunteer support group for African women in Edinburgh, initiated by Churches’ Commission for Migrants in Europe, which is campaigning to improve communication between migrants and health services. In practical terms, this involves ensuring that migrant women are aware of the interpretation services available to them, and, equally important, encouraging both health workers and migrants to gain a clearer understanding of each other’s perceptions of the services provided.

The network is not without its constraints. Financing activities is always a problem since working with black and migrant women is low on the priority list of many governments. Even when money is available for meetings, many migrant women in Europe need visas and face discrimination at national borders. Language is another problem for a Europe-wide network, both during meetings and in terms of newsletters, publications and videos.

**Into the future**

Despite the resources and commitment needed, it is vital that non-governmental organizations, including churches, and individuals, bear the responsibility of ensuring that the network survives. Having a network for black and migrant women’s health is the key to bringing together the causes of concern and the sources of information which will allow effective campaigning and lobbying within Europe. So far, it has been possible to raise issues from the local to the national level in several countries. We have also lobbied Members of the European Council (MEPs). As the network strengthens, we hope to be able to monitor the impact of health policies at the grassroots level and to influence European policy directly in favour of black and migrant women’s health.

If you have questions about the network, write to: Mulkami McCrum, Churches’ Commission for Migrants in Europe, c/o 203 High Street, Lintworth EH48 7EN, Scotland, UK. Tel: 44 1786 450 025. Fax: 44 1786 451 762. Copies of the reports of the meetings are available from Churches Commission for Racial Justice (CCRJ), Inter-Church House, 35-41 Lower Marsh, London SE1 7RL, UK. Tel: 44 171 820 4444. Fax: 44 171 928 0010.

*Some “migrants”, even though they may be Asian, Latin American or even indigenous in origin (eg gypsies in central European countries), prefer to categorize themselves as “black” rather than “migrant”, aware that the prejudice against them is based on their foreignness, be it their religion, ethnic origin or colour. Many “blacks” are second or third generation immigrants and nationals of the countries in which they live.*

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**Support for Asian women in London**

Asian Women’s Resource Centre in north-west London provides a range of services, including informal counselling and referrals to other available services. “Being Asian women ourselves, we can also communicate effectively information about rights and services,” says Ms Jasbinder Kashmiri (right in the photo).

Open daily, the Centre offers free advice and information on welfare benefits, housing, immigration, employment, child care, health, and physical and sexual abuse. Its programmes include advice about jobs and training, health and relationships, young women and children. It has also provided training sessions for health workers, including sessions for local doctors on domestic violence.

The Centre has a drop-in session every Wednesday from 11.00-14.00, where speakers on a wide range of issues facilitate discussion groups and run workshops. These sessions provide women an opportunity to make friends and build up a new network of support.

For more information, write to Asian Women’s Resource Centre, 134 Mint Avenue, Haringey, London NW10 8AP, UK. Tel: 0181 961 6549/5701.
USEFUL CONTACTS

Address box
World Health Organization
1211 Geneva 27
Switzerland

CIMADE
176 rue de Grenelle
75007 Paris
France

Foundation against trafficking in women
PO Box 1455
3500 BC
Utrecht
The Netherlands

USEFUL PUBLICATIONS

World Council of Churches
Staff of WCC Refugee and Migration service include Melaku Kifile, Joel McClellan, Helene Moussa and Patrick Taran. Information about the "International Migrants Rights Watch Committee", copies of "WCC Statement on Uprooted People", a leaflet entitled "Migrant rights are human rights" are available, as are contact addresses for migrant groups working in different countries.

World Health Organization
WHO has a division of emergency and humanitarian action and a responsible officer for Women and Children in Emergencies. Living on the brink was the title of November-December 1995 issue of World Health magazine. Features covered health issues related to refugees and migrants.

CIMADE
Working closely with the WCC, CIMADE is an association of churches and church organizations in France. Its objective is show solidarity with the suffering, oppressed and exploited by working in their defence. Much of its work relates to refugees and migrants living in France. A current programme lobbies against the expulsion of migrants who are infected with HIV/AIDS.

Foundation against trafficking in women
Trafficking in women relates to criminal practices in which a person is kept in unlawful dependency through coercion, debt bondage, emotional blackmail, physical and sexual violence and so on. This foundation is involved in an international campaign of advocacy and networking, policy and strategy development.

WCC books
The stranger within your gates
This book by André Jacques, former secretary for migration at WCC, is about uprooted people in today's world and is based on the author's longer study "Les déracinés: réfugiés et migrants dans le monde" (1986. ISBN 2 8254 0553 0, 1986, WCC Risk Series, CHF9.90, US$6.50, £3.95 (for prepayment, please add 20% for postage and handling).

Challenging myths and claiming power together
This is a handbook on how to set up and assess support groups for and with immigrant and refugee women. Written by Helene Moussa, prior to her joining WCC, the manual offers a practical approach to responding to refugee women's mental health needs, ISBN 0 920695 04 3. Published by Education Wife Assault, 427 Bloor Street West, Box 7, Toronto, ON M5S 1X7, Canada. Canadian dollars 18, plus postage and packing. It is also available at WCC bookshop, price CHF20 plus 20% postage and packing.

Working with refugee women
This practical guide written for the International NGO Working Group on Refugee Women is intended to raise awareness about the situation facing refugee women in different contexts and to challenge readers to seek out ways of incorporating refugee women's concerns in their work. It is available at WCC bookshop, price CHF15 plus 20% postage and packing.

WCC Bookshop
World Council of Churches
PO Box 2100
1211 Geneva 2
Switzerland

UNHCR
Case Postale 2500
1211 Geneva 2 Dépot
Switzerland

Migrants against AIDS/HIV
14 Bd Pont d'Arve
1205 Geneva
Switzerland

Community services for urban refugees
This useful manual from UNHCR takes a community-based approach to refugee assistance recognizing a systematic shift from individual case management in both urban and camp refugees. UNHCR has also produced several publications on women refugees, including the recent Sexual violence against refugees.

Migrants against AIDS/HIV
This independent newsletter focuses on grassroots activist efforts to end the HIV/AIDS crisis by refugee, migrant, and Black/Third World communities in Europe. Eleven issues per year are published in French and English. Price: CHF 65.00. Tel/fax (4122) 320 0527.
CONTACT EVALUATION: WHAT YOU HAVE TOLD US!

The data from the evaluation of Contact has been processed and we are completing our final report. Many thanks to the hundreds of readers who took part — either by filling in a questionnaire sent to a random sample of readers or by participating in one of the focus group discussions on Contact which took place in Brazil, Chile, Germany, India, Kenya, Nigeria, and Zaire.

In 1992, World Council of Churches’ Unit II commissioners asked us to make an evaluation of Contact. The magazine, which is now almost 26 years of age, aims to address “the varied aspects of the community’s involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development.” We decided to try and find answers to the following questions.

1. Whether Contact was meeting the needs and preferences of its readers
2. How Contact has contributed to community health and education initiatives, and
3. How the “experience sharing” achieved in Contact can be further developed.

Is Contact meeting your needs and preferences?
Contact’s popularity is clear from the large number of readers who returned their questionnaires. Christian and non-Christian readers alike value the Christian perspective on health taken in Contact. They appreciate the fact that we take a "wholistic" approach which is based on the ideas that the body, mind, emotions and spirit form an integrated whole, and that health is strongly related to the environment in which a person or community finds themselves.

They also identify with Contact’s commitment to justice for the poor and to the need for community participation. Several participants in focus group discussions said that they appreciated the gender sensitivity of the publication, while one group said that in reading Contact they gained a sense of "not being alone in the struggle for dignified and integral (‘wholistic’) health."

Readers had many practical suggestions on how to improve Contact. They felt that while the language used was easy to understand, there were too many abbreviations and acronyms. They wanted more illustrations since these were very useful for teaching purposes.

Readers also...
wanted boxes containing “important points visible at a glance”. These suggested changes will be introduced as soon as possible!

On the content of Contact, readers liked the fact that each issue was thematic. However, they wanted more information on the initial community “diagnosis” of a project as well as on the practical processes involved in establishing the activities. They wanted more personal testimonies, more news updates and more readers’ letters and feedback.

Many readers said that they would like more articles from their region or country. Maintaining a balance is not an easy job! However, in Latin America, readers suggested there should be a regional version of Contact while maintaining the international perspective through core articles.

Readers in many parts of the world said they would like more articles from the developed countries. They pointed out that themes such as AIDS, district health systems, tourism and essential drugs were equally applicable in all countries of the world.

How Contact has contributed to community health and education initiatives?

Three examples:

Contact 126 “AIDS: A community commitment” contributed to the success of an AIDS workshop for Christian churches in Chile. “Its theological perspective influenced local participants to adopt a positive position.”

Contact 134 “Resource centres” was used to guide the setting-up of a resource centre in Kenya.

Contact 136 “Writing about health” was used to teach a course on communication at a Nigerian university.

How can the “experience sharing” achieved in Contact be further developed?

There were many suggestions, including:

- By setting up local groups of Contact readers who would meet regularly to discuss contents of Contact, provide feedback and contribute articles from their countries.
- Translation of Contact into more local languages
- Increasing the extent to which distribution of Contact takes place at the local level
- Increasing the number of articles about how churches can be equipped to engage in community health

The results of our evaluation – along with some suggestions for action – will be presented to World Council of Churches Unit II commissioners as soon as possible. We shall let you know their recommendations, and our plan of action, in a forthcoming issue of Contact.

We offer special thanks to Cristina Calvacanti, Sonia Cavarrubias, Christoph Benn, Cherian Thomas, Teresa Obwaya, Rayika Booth, Pat Nickson and Kaswera Vulere who undertook our focus group discussions in Brazil, Chile, Germany, India, Kenya, Nigeria, and Zaire, and to our consultant Alison Warner.
I am a team leader in Sexual Health and HIV/AIDS Prevention and Care Project. At this stage, the epidemic is shaping up to repeat the tragedies which have occurred in Africa and Asia. I recently attended a meeting to discuss strategies for preventing the transmission of the epidemic among youth. One strategy that was strongly endorsed was to conduct targeted training among Church elders and pastors to improve their awareness of HIV/AIDS, and to stimulate them to respond to the challenge. Christian church leaders have a powerful influence in this country.

It was suggested that your organization will have already developed considerable expertise and training materials in HIV/AIDS for church leaders. I am therefore writing to request a set of suitable materials.

Damien Wohlfahrt, Team Leader
Sexual Health and HIV/AIDS Prevention and Care Project
Department of Health
Port Moresby, Papua New Guinea

We were delighted to send Dr Wohlfahrt copies of CMC - Churches' Action for Health publications on HIV/AIDS including: "What is AIDS?", "Learning about AIDS", "A guide to HIV/AIDS pastoral counselling" and "Participatory Action Research on AIDS and the community as a source of care and healing". Editor.

Freda doesn't get pregnant
Written in simple English for teenage girls, this reader provides a self-motivating way of helping young girls learn about the dangers and consequences of pre-marital sex. It tells the story of three teenagers who attend the same school. The lives of two of the girls are ruined by having unwanted children, while Freda is lucky enough to know how to protect herself. Available from TALC, PO Box 49, St Albans, Herts AL1 5TX, UK. Price £1.65 plus £2.50 for postage and packing. Three new slide sets on raising awareness of safe motherhood, river blindness and rehabilitating children with disabilities are also available from TALC.

Midwives and safer motherhood and Baby friendly, mother friendly are two companion volumes which complement traditional midwifery books. Offering a broad public health perspective, experts overview major debates within maternal health care internationally and provide case studies of practical programme implementation and research generated by local needs. The editor is Susan Murray, lecturer in maternal health at the Institute of Child Health in London. ISBN 0 7234 2122 6 and 0 7234 2123 4. Published by Mosby, part of Times Mirror International Publishers Limited, Lynton House, 7-12 Tavistock Square, London WC1E 7DP, UK.

Has your friend stopped receiving Contact?
All those who have not returned our readership confirmation form have been dropped from the mailing list. We have done this to keep our costs down to a minimum. However, if you or your friend wish to be included once more in our free mailing list (developing countries only), simply write to us. Address your letters to Fernande Chandrasekharan, CMC - Churches' Action for Health, World Council of Churches, PO Box 2100, CH-1211 Geneva 2, Switzerland.

"Rebuilding peace" follow-up
Since publishing Contact 148 Rebuilding peace - Together we can overcome violence, we have received several related reports. One is about a WACC project in which communications are being used to promote reconciliation, another is an issue of On the Map newsletter featuring MAP's international Reconciliation Team, and a third is about a new book from Save the Children, UK, entitled "Safety first, Protecting NGO employees who work in areas of conflict".
Health Unlimited (which was featured in Contact 148) wrote to tell us that they work in developing countries of Africa, Asia and Latin America to improve the health of poor people affected by conflict, instability or discrimination. They work in partnership with local people, community organizations, representative bodies and governments to establish locally sustainable primary health care services by providing training and material support.

What makes a mission hospital sustainable?
CMC - Church's Action for Health is launching a major investigation into the characteristics of successful mission hospitals. A first consultation was held in Geneva in 1995. According to Dr Kofi Asante: "We are not concentrating entirely on the financial aspects of sustainability. We also want to know, for example, whether Christian values play a role in determining success." He said that success in sustaining a mission hospital was also linked with good management and governance, and how well the hospital was able to adapt to local conditions and take advantage of local resources.

Primary Health Care - A Christian Mandate
The conclusions of the Christian Medical Association of India consultation held in New Delhi, India, February 1996, highlight CMAI's emphasis on the effects of globalization, structural reforms and marketization on the poor. If you would like a copy of the report, write to: Dr Cherian Thomas, General Secretary, CMAI, Plot No2, A-3, Local Shopping Centre, Janakpuri, New Delhi-110058, India.

An AIDS vaccine soon?
A Media AIDS Information sheet entitled "An AIDS vaccine: Problems and promises" says that three developing countries - Thailand, Uganda and Brazil - have agreed to conduct trials of experimental vaccines. Trials began in Thailand in 1995. However, few scientists believe a vaccine will be available for at least five years, and most believe it will take more than a decade. More information from The Panos Institute, 9 White Lion Street, London N1 9PD, UK. Tel: 44 171 278 1111. Fax: 44 171 278 0345. e-mail: panolondon@gn.apc.org Website: http://www.oneworld.org/panos/

Telling a person: You have AIDS
At the 400-bed church-run Vanga Hospital in central Zaire, a medical and pastoral team have established a counselling team. If you would like a copy of Dr D E Founten's paper on the experience of this programme, please write to us for a copy. It is available in English and in French.

World Breastfeeding Week
Planned to take place 1-7 August 1996, its primary goal is to advocate for a community approach to supporting breastfeeding. For further details write to: World Alliance for Breastfeeding Action (WABA), PO Box 1200, 10850 Penang, Malaysia. Tel: 604 6584816. Fax: 604 6572655. e-mail: secr@waba.po.my

The average cost of producing and mailing each copy of Contact is Swiss francs (CHF) 4 (US$3.50), which totals CHF 24 (US$21) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to Contact to cover these costs. Please note that orders of back issues of Contact are also charged above the rate.