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Migration

Public health services must be completely open to people of other than German origin, according to the authors of this FORUM. First of all Dorothea Grieger reports on the hurdles which exist according to Federal Government Commissioner for Migration, Refugees and Integration and on actions at federal level to improve healthcare provision for migrants. Particular attention is paid to the discrimination suffered by girls and women, about whom many stereotypical ideas exist which quite often prevent adequate treatment or advice.

The gynaecologist Neslisah Terzioglu examines migration as a risk factor in pregnancy. In the study by Nürnberg Süd Hospital (Klinikum Nürnberg Süd), deficits in care for pregnant migrants were systematically researched over five years and, in cooperation with advisory centres, the necessary screening services were adapted to these women's requirements.

Migrants from Vietnam and Poland, who up to now had received little attention in the field of migration research, were asked about their health situation and their need for psychosocial care was established.

Homosexuality has not been talked about up to now in Turkish/Kurdish, Polish and Russian speaking families. Since the family is of immense importance for all family members because of cultural factors and partially also because of their migrant status, identity conflicts associated with homosexuality may emerge particularly dramatically here. Renate Rampf reports on the ambitious Berlin model project 'Homosexuality as an issue in immigrant families'.

First generation Turkish men, the preconceptions associated with them and their actual conceptions of partnership and upbringing are the subject of Margret Spohn's investigation.

Daniel Kunz examines how *pro familia* is repositioning itself in the current social debate, and Stéphanie Berrut of the BZgA introduces the newly developed prevention file for sexually transmitted diseases, a comprehensive aid to multipliers which can also be used without any specialist knowledge in the health field.

So it's all happening in the area of migration. We should be pleased if we could start the new year with your response to one or another of the items in this edition of FORUM.

The editorial team

Health and migration

The aim of equitable access to public health services for migrants is still not a reality. This article outlines political measures for the intercultural opening up of health care and deals particularly with the requirements of girls and young women with a migratory background. The aim of equitable access to public health services for migrants is still not a reality. This article outlines political measures for the intercultural opening up of health care and deals particularly with the requirements of girls and young women with a migratory background.

Access to health services

The provision of equal access to health care is an important component in the integration of migrants, since integration means equal rights to share in the key benefits available to society as a whole. Health is such a commodity. National origins should not play any part in the type and quality of essential treatments. However, the actual situation is rather different: hurdles still exist that make it difficult or even impossible for migrants to gain access to health screening, advice and care. These hurdles include a lack of information, a shortage of screening and rehabilitation services, language and cultural barriers, as well as legal restrictions.

But we have to look closely: just as there is no such thing as a “typical” migrant, there also exists no single definition of what constitutes a sick person. Up to now, health reporting has only enabled definite conclusions to be drawn regarding the health of populations with a migratory background in a few areas. For this reason, improved health care delivery for migrants requires a different method of health reporting. The burden will fall particularly on the public health service and its facilities.

Health and illness depend on many factors. Migration can be one factor. But migration as such does not make people ill; it can even inspire the creation of resources. The sum of all the factors plays a role: diseases can occur as the result of harmful working conditions. Higher unemployment rates can have a detrimental effect on health just as much as unsatisfactory living conditions. Some of these factors apply to migrants, in particular:

- They are still disproportionately represented in particularly harmful occupations and are more threatened by unemployment.
- Older female migrants are particularly susceptible to poverty.

- Migrants still have less and poorer living space per head than long-established Germans.
- The particular situation of refugees often leads to uncertainties of law and perspective. Consequently, doctors and other personnel in the health system are often not consulted early enough.

As was confirmed again recently by a Council of Europe recommendation on the health of migrants¹, health also depends on social factors. The continuing disadvantages in the social situation of many migrant groups must be broken down. In the long term, migrants must be guaranteed equal opportunities of access to the education and employment system. People who are granted only a reduced right to treatment under the law on asylum seekers must not suffer any adverse effects with regard to their health as a result of not being treated for a lengthy period. There must also be discussion of requirements and ideas for achieving the aim of better treatment of patients who are living in Germany illegally².

The points just mentioned are risk factors for migrants, but their resources must also be taken into account. Patients have potentials that can be used in the healing process. Taking account of the health concepts encountered in migrants’ countries of origin, for example, tends to enrich the social discussion here with regard to precisely how health and disease should be defined. Integration, including in matters of health, demands that Germany opens up the existing system to all people living here and their health concerns, needs and requirements. This requirement for interculturalisation of regular services must be converted into practice.

Political measures to open up health care

How can this be achieved? For example, in the complicated process of disease and healing, making oneself understood is very important. Linguistic and cultural communication barriers on both sides are a considerable obstacle. They may be a deterrent to demanding health care, particularly for older migrants. Young women and men who enter the country because of the immigration of their family are also affected.

¹ Recommendation on health services in a multicultural society, adopted 08.11.2006, Council of Europe

² See the recommendations of the study group ‘Armut und gesundheitliche Versorgung’ [Poverty and Health Provision], and the subgroup ‘Migration und gesundheitliche Versorgung’ [Migration and Health Provision], for the Federal Ministry of Health in 2001 (www.bmfsfj.de/Publikationen/genderreport/01)

Here we need multi-language information media and a countrywide network of free interpreting services so that, where necessary, qualified interpreters and translators can be used.

For too long not enough attention was paid to the reality of immigration into Germany. This ignorance led to a mistaken policy: people with a migratory background were generally not taken into account either as demanders or as creators of public health care delivery.

The policy must play its part:

- In order to satisfy migrants' cultural and linguistic requirements, existing regulated health and social care institutions must extend the range of services which they provide.
- There must be more health services and facilities for the elderly, nurseries and clinics in which intercultural teams are present as a matter of course. The medical and nursing care of immigrants can be improved by staff who speak their language. When taking structural decisions, health care institutions (e.g. hospitals, health authorities) should therefore also focus upon ways in which to create an intercultural organisation.
- Staff must be trained and training curricula must be extended to include intercultural contents.
- Already appropriately qualified specialist personnel should increasingly be employed.
- It must be made easier for foreign doctors and psychotherapists to get a licence to practise their profession on an inpatient and outpatient basis.
- Health research and reporting must take more account of the migration aspect.

Only then can fair and equitable access to regulated public services become a reality for the whole population. The many and varied interactions between migration in its various forms and health can be seen daily, particularly in the public health service. Such barriers mostly lie in the communicative or administrative area. Public health care as a whole is required here, and particularly the public health service which, with its administrative involvement and its mandate, can and should step in as a special advocate for migrants to our country. In the light of increasing migratory movements and an increasingly worsening social gap, it is increasingly taking on the role of guarantor for equal opportunities in health.

The study group 'Migration and public health'

The countrywide study group 'Migration and public health' sees itself as the facilitator and advocate for the health of immigrants to Germany. Interdisciplinary and intercultural work, medicinal and health promoting initiatives for the populace and, especially, close collaboration with the public health service characterise the study group, which champions the health of the multinational population of the Federal Republic of Germany.

The study group was created in November 1994 by the then Federal Government Commissioner for Foreign Nationals, CORNELIA SCHMALZ-JACOBSEN. From 1998 to autumn 2005 it was coordinated by the Federal Government Commissioner for Migration, Refugees and Integration, Marieluise Beck. Since December 2005, the Minister of State Prof. Dr. MARIA BÖHMER, the Federal Republic's

Commissioner for Migration, Refugees and Integration, has been coordinating the countrywide study group.

As there are now more than 14 million people in Germany with a migratory background, an integration service must also be provided for health care. The study group bases its work on the all-embracing concept of the World Health Organisation, according to which health is not just the absence of illness, but a condition of complete physical, spiritual and social well-being.

According to this view, there exists a close correlation between health and illness and other important factors for integration such as education, financial resources and social involvement.

If we wish to guarantee the same health opportunities to everyone, the range of services for treatment, prevention, health promotion and health education provided by social insurance agencies as well as the Federal Government, states and municipalities must also include specific approaches for migrants. Eleven of the sixteen Federal States have so far developed integration concepts, and nine of these also pick out the health situation and care of migrants as a central theme. Some of these concepts already include approaches to shaping diversity (diversity principle), where possible also including people with a migratory background in devising solutions.

The study group 'Migration and public health' plays a part in ensuring that the situation and requirements of the immigrant population are properly taken into account in health care delivery. Its primary aim is to create equitable access to health care screening, advice and care for migrants. This assumes that the existing services apply to all people living here and their health concerns and requirements.

The study group promotes the migration-sensitive expertise of the health services and cooperating institutions in the field of personnel and organisational development with regard to the target group of migrants. It collaborates in the design of a public health service model which satisfies the existing heterogeneity of the population. The study group also lobbies for more people with a migratory background being employed at all levels in health care. A further aim is to provide contributions to a necessary discussion on various concepts of illness, health and treatment.

The study group is made up of managers and employees of state and communal health authorities, doctors from practice, universities and research institutes, public health care academies, ethnomedicinal facilities, hospitals and state ministries of the German Federal States, as well as health insurance associations. The Federal Government is also represented on the study group with the Federal Ministry of Health and the Federal Centre for Health Education (BZgA).

The subjects currently being processed are:

- Age and health
- Health promotion and preventive measures
- Non-somatic diseases
- Institutional and sociospatial conditions
- Qualifications and training
- Communication, understanding, involvement
- Legal status, legal issues
- Health reporting, research
- Information, education, counselling.

The study group has brought together model projects of good practice on these subjects which have just been published in a handbook entitled 'Health and integration – a handbook for models of good practice'³.

Girls and women – gender-related aspects of health education

Gender-specific differences with regard to health and clinical symptoms cannot only be determined for German patients; they apply equally to female migrants in the German health care delivery system. As confirmed by a report by the Wissenschaftliches Institut der Ärzte Deutschlands (Scientific Institute of the German Medical Association) (WIAD 2000) on the psychological, psychosocial and psychosomatic health and care of female migrants in NRW, these gender-specific differences are just as significant as the differences relating to the cultural origin of the patients. Not only cultural, but also gender-sensitive contact with female migrants is therefore urgently needed.

Female migrants encounter prejudices and stereotyping in the health care delivery system like few other groups. Assumptions based on the culture or nationality of women affect their treatment and counselling. However, female migrants as a group are characterised by great heterogeneity. In order to give consideration to this heterogeneity, internal differentiation in contact with the group of female migrant patients by age, circumstances, social stratum and other viewpoints is indicated.

The gender difference is reflected in the health sector in the different way that men and women are treated. Women with a migratory background tend to suffer more severe discrimination than men.

The situation of older female migrants (the 'first generation') is assessed as being particularly disadvantaged. However, women with a migratory background also have many resources which should be recognised and promoted (such as their position as the health manager in their families).

In addition, access to information and communication with doctors and other health professionals is limited, for example because of the women's low level of education or inability to speak German (the older female migrants of Turkish and Arabic origin, amongst others). There may also be specific cultural barriers. For example, the degree of difficulty in reaching boys and girls with a migratory background for sex education varies depending on their gender. The development of an appropriate range of services for migrants based on gender aspects is therefore required.

Care of the elderly

Older migrant workers are a fast growing group who are affected by diseases in greater numbers and earlier in life than German senior citizens. This is attributable, amongst other things, to their often particularly stressful working conditions.

In terms of demographic development, facilities for the elderly face a particular challenge to open themselves up to this clientele in order to satisfy their mentoring and care requirements. The services provided for migration-sensitive care and help for the elderly have improved recently, even though there is still much to do.

The 'Memorandum for culture-sensitive help for the elderly', which was passed in 2002, therefore led to the 'Culture-sensitive help for the elderly' campaign. This has lobbied, for example, for migrants in facilities for the elderly to be treated and mentored in accordance with their values and requirements, thus enabling them to age with dignity. Since February 2006, it has continued in the form of a 'Forum on culture-sensitive help for the elderly'⁴. For older female migrants who consider their health situation to be particularly poor, explanation of their legal entitlements, including in the rehabilitation sector, is particularly necessary.

The 'Living in multiple worlds' study

The field of sex education – which includes preventive explanation about contraception, HIV and other sexually transmitted diseases – has always been a delicate subject, not only for female migrants. However, according to many specialists, girls and women with a migratory background are particularly sensitive to sex education subjects. The lack of knowledge about their own body and health-promoting factors, as well as different inhibitions as a result of their social background may be factors here. The investigation 'Living in multiple worlds' (BOOS-NÜNNING/KARAKASOLU 2005), in which 950 girls and young women with a migratory background (Turkey, Greece, Italy, Yugoslavia and settlement countries) aged 15 to 21 were questioned, produced some interesting findings on health and health-related behaviour. The following statements related to the subjects of sexuality, body awareness, sex education and utilisation of information centres.

The relationship of the young women questioned to their own bodies is typically ambivalent for their gender and age group, but is not particularly problematic. In terms of health-care, visits to dentists and control of body weight are important features. Only a minority regularly see a gynaecologist, the lowest proportion being amongst respondents with a Turkish background (only 14%), the highest being those with a Greek background (42%).

A sexual relationship without or before marriage is accepted by most girls (58%). The virginity standard (virginity before marriage) is of paramount importance to girls with a Turkish background (59%), although about 25% of the girls with an Italian or Yugoslavian background also speak of the importance of the virginity standard. The acceptance of the virginity standard does not indicate any negative feeling towards sexuality. Over two thirds of those questioned – without any significant differences relating to their background or religion – speak in favour of fulfilled sexuality as the basis for a good partnership.

The girls and young women with a migratory background primarily receive information about sexuality and love from friends, older sisters and media such as teen magazines or television. Teachers follow in fourth place. The internet (still) does not have any part to play. Sexuality appears to be a taboo subject between mothers and daughters in most female migrant groups.

³ The free publication is issued by the Federal Government Commissioner for Migration, Refugees and Integration; to order go to as@bk.bund.de

⁴ www.kultursensible-altenhilfe.net

The girls and young women with a migratory background have only rarely sought help in conflict situations. There is great willingness to seek professional help in the case of psychological problems: 60 to 80% would definitely or most likely seek advice if they had drug problems, an unwanted pregnancy, an eating disorder or depression, or in the case of household violence. Enlisting external help in the case of family problems is most commonly refused.

Sex education for female migrants

These results mean that the following conclusions can be drawn regarding sex education measures for female migrants:

1. Particularly younger female migrants often have a relatively uncomplicated relationship with their body. Also, contrary to the usual stereotype, they predominantly have positive perceptions of fulfilled sexuality.
2. Sex education is not openly discussed in the family; it is a taboo subject particularly in respect of the mother and older female relatives. Where it is spoken about, the parties involved in the conversation are of a similar age. Only in extreme emergencies are conflicts taken outside the family since the attitude that problems must remain within the family is very firmly established. Thus, according to Boos-Nünning, an important starting point for an increase in sex education for this target group would be to produce material in their native language which could be included in teen magazines.

The BZgA instruction materials, as well as for example the suggestions given in 'Medipäds – Lehrer und Ärzte im Team [teachers and doctors in the team]' (2002) are very suitable for explaining sexuality in general, as they appeal sensitively to various age groups and are partially conceived to be gender-orientated. If, in addition, they are designed with migration in mind, they are also well suited to migrants. However, the prevention of sexually transmitted diseases and contraception are subjects which are perceived as very delicate by many female migrants. There is also the factor that female migrants as a target group are often not reached at all in the communication of such subjects.

The BZgA has produced up-to-date media which should facilitate access to female migrants. Firstly, on the subject of 'family planning', new ground has been broken in the translation and distribution of a brochure in Turkish and Russian on sexuality, contraception and pregnancy counselling⁵. Secondly, the 'Prevention file for Sexually Transmitted Diseases', which can best be used by trained mediators using personal communication, has been developed. In the last contribution to this issue, Stéphanie Berrut gives a detailed report on the development and the elements involved in this new aid.

Dorothea Grieger

5 'The morning after pill' leaflet, order no. 130 610 00 (German), order no. 130 610 60 (Turkish), order no. 130 611 10 (Russian)

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Migration – a further risk factor in pregnancy?

According to studies, foreign women, especially those of non-European origin, appear to be exposed to particular risks during pregnancy; at the same time they utilise screening services considerably less than German women. A research project at Nürnberg Süd Hospital (Klinikum Nürnberg Süd) systematically examined deficits in the care of pregnant migrants over five years and had great success with a model project in which screening services were provided on a trial basis in the native language.

Germany is de facto an immigration country. On 31 December 1999, the proportion of foreign nationals in the population was 9%, and this has not changed in recent years. 27.9% of all foreign nationals living in Germany have Turkish nationality (FEDERAL STATISTICAL OFFICE 2000).

This multicultural reality is also reflected in the health care delivery system. Depending on the location and catchment area of a hospital or a practice there is a migrant population of varying size amongst the patients, meaning that the specifics of advice and medical treatment provided to migrants must be varied. Particular problems with understanding the language (taking the medical history, communicating the diagnosis and explanation of the procedure before operations and other treatments) lead to great difficulties in medical care (see DAVID/BORDE 2001).

Specific health risks for migrants

Migrants are exposed to specific health risks (BORDE 2000). Various studies have shown that foreign nationals, particularly from non-European countries of origin, are over-represented in pregnancy risks (e.g. miscarriages, stillbirths, pregnancy-induced hypertension¹) (RAZUM 1999). Below-average demand for screening examinations for foreign women during pregnancy has also been observed (BEIER 1994; TERZIOGLU 2002). Federal Government Commissioner for Foreign Nationals reported in 2000 that the mortality of foreign infants was 29% higher than for Germans. It should also be emphasised that the 'migration status' causes additional psychosocial stress for those concerned. A pregnancy with such stress is a somatic risk for both the mother and the child (YILDIRIM-FAHLBUSCH 2003).

In the Ottawa Charter for Health Promotion of 1986, the participants in the conference called for action to 'reduce health differences within the community and to seek to counteract health inequalities created by rules and traditions'. Since 1998, evaluation of the causes of the lower level of care provided to pregnant migrants in Northern Bavaria has been ongoing. A further aim is the establishment and quality assurance of effective measures to reduce the deficits in the healthcare delivery system for pregnant foreign nationals.

Care situation for pregnant migrants at the obstetrics and gynaecology department of Nürnberg Süd Hospital

To assess the deficits in pregnancy screening, a retrospective analysis of the care situation for pregnant migrants was initially carried out from 1 January 1998 to 31 December 2002 at the obstetrics department of Nürnberg Süd Hospital. In the five years of the assessment, 1998 to 2002, an increase in the proportion of foreign nationals from 27% to 34% was observed. The proportion of women of Turkish origin, the largest collective of foreign patients, increased similarly from 8.8% in 1998 to 14% in 2002. The frequencies of births also showed a very significant difference: 34.4% of female migrants, but only 24.2% of German women had had two or more pregnancies.

In the statistical assessment of the progress of pregnancies and births during the above-mentioned period (approximately 11,000 pregnancies and births were recorded), there were likewise significant differences between German and foreign pregnant women were also observed with regard to their utilisation of preventive measures and the health situation of the neonate (fetal outcome): for one in five pregnant women of foreign origin, the time of the first screening and ultrasound examination was after the 12th week of pregnancy, and was therefore considerably later than for German women. In both 1998 (16% vs. 12%; $p < 0.01$) and 1999 (19% vs. 14%; $p < 0.01$), a stay in hospital before delivery was significantly more common and was longer in the case of pregnant migrants (TERZIOGLU 2003a).

Unlike the infant mortality in Nürnberg from 1980 to 1995, the perinatal mortality in 1998 (14‰ vs. 8‰) in the foreign collective was higher than for the Germans (TERZIOGLU 2000).

1 Hypertension = High blood pressure

The communication factor

'The health situation of migrants is affected by complex interdependent processes of various factors in life abroad ... the lack of language skills is one of these factors.' (FEDERAL MINISTRY OF HEALTH 2001).

As part of the model project, and also to record the care situation, a prospective cross-sectional study to evaluate socio-demographic data, language competence and comprehension problems of foreign pregnant women was carried out from 1 April 2002 to 1 April 2003 in the obstetrics and gynaecology department. In this period, 57% of the women treated as inpatients were from the indigenous population and 43% were migrants. Patients of Turkish and Russian origin formed the largest subgroups.

As before, there was a communication problem: slightly more than a quarter (25.2%) of the migrants were poorly informed or unaware of the reason for their admission, as against only 16.6% of the indigenous population.

According to this, almost a quarter (22.9%) of the female migrants had poor, very poor or absolutely no ability to read or write in German. In addition, 20% of them also assessed their ability to speak German as poor, very poor or totally lacking (TERZIOGLU 2003b).

The foreign nationals who were pregnant on average had lower school leaving or training qualifications. Fifteen per cent of all female migrants had only attended an elementary school, they had no school leaving qualifications or had never attended school. The values for secondary general school examinations were comparable in the two groups (38.2% vs. Germans 36.6%). The migrants had more vocational school qualifications (12.2% vs. 9.7%) than Germans. In terms of intermediate school leaving examinations (12.2% vs. 22.4%), A-levels (9.8% vs. 11.9%) and university degrees (9.2% vs. 14.9%), however, the Germans did better.

In the collective examined, 33.6% of the migrants had no vocational training qualifications, against 6% of the indigenous population. The tendency recognised in 'learned trades' for a lower participation rate of migrants in the higher educational qualifications was seen even more clearly in the purchasing status. More than twice as many foreign women as Germans (64.5% vs. 30.8%) indicated that they belonged in the 'unemployed' or 'housewife' group.

The largest proportion of female migrants had statutory insurance with the AOK (local health care fund) (58.0%). Half as many female migrants were insured via statutory health insurance companies or privately. Amongst the total group of Germans studied, this situation was reversed: half as many Germans were insured with the AOK, whilst twice as many were insured via health insurance companies or had private insurance. There was no group within the group of German people studied who could be compared with the 6.1% of female migrants insured via the social welfare office.

The diagnoses of anaemia, vaginal infection, hyperemesis (vomiting during pregnancy) and abortus imminens (threatened abortion) were more common in the collective of foreign nationals, but were easily recognised in the pregnancy screening examinations, so that various treatments could be initiated.

2 Disorders which have their origin in the psychological condition of the person affected

Fig. 1

Conformity of the patient's knowledge with the diagnosis on discharge

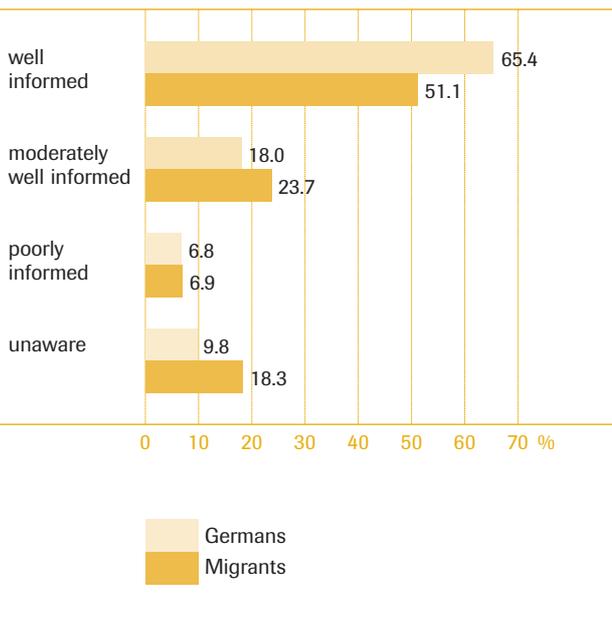
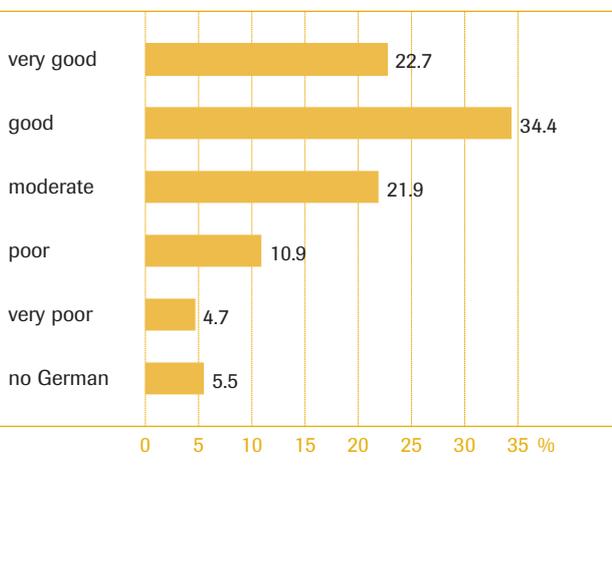


Fig. 2

Female migrants' self-assessment of their capabilities in German



If all pregnancy disorders are separated into essentially somatic or essentially functional disorders², it is recognised that the collectives compared do not differ significantly in terms of their share of somatic disorders (77.9% for Germans, 74.5% for migrants). However, foreign nationals were considerably over-represented in the group of functional disorders. Since the lack of language skills represents a psychosocial stress factor for migrants, a relationship between functional disorders and language skills was established. This showed that the proportion of female migrants with functional disorders (14.6%) who spoke good to very good German was almost the same as that of the German patients

(15.0%). On the other hand, this rate increased to 23.5% of the collective concerned in the case of migrants who did not speak German or only spoke it very poorly.

The Nuremberg model project

In view of the factors mentioned, a model project was initiated in 1998 by the obstetrics department of Nuremberg Hospital, in cooperation with the health authority of the city of Nuremberg and the Evangelical Family Education Centre. The aim of this ongoing model project is to make the utilisation of preventive measures easier for pregnant migrants by means of special services provided in their native language. To this end, as part of the project, antenatal courses are offered in Turkish, English, Polish and German, and a gynaecological clinic is provided in Turkish, English and German in the part of the city with the highest density of migrants.

Further targets are to reduce the perinatal mortality and to increase the utilisation of after-care measures such as recuperation exercises and neonatal early recognition examinations: foreign families are to be more intensively targeted and informed about prenatal and postnatal care.

The increased utilisation of preventive measures and the reduction in lengths of stay in hospital also mean relief for the German health budget when one considers that, for example, the daily rate for the obstetrics and gynaecology department at the Nürnberg Süd Hospital (maximum care hospital) is 300 to 400 euro. In addition, the care costs for a premature infant are approximately 38,000 euro for the first three months.

Our model project makes a contribution to equalising the existing deficits in the care of female migrants, while at the same time offering a stimulus for curbing costs.

Results of the project

Increased utilisation of preventive measures was achieved: whereas in 1998 20% of female migrants had their first screening examination after the 12th week of pregnancy, by 2002 this had been reduced to 14.7%. However, this still represents an inequality with the German pregnant women, of whom only 6.9% saw their gynaecologist for the first time after the 12th week of pregnancy in 2002. Whereas in 1998 approximately 7% of migrants were examined less than six times during their pregnancy, in 2002 this had reduced to 3%. The German proportion in 2002 was only slightly smaller at 2.4%.

The most significant point is the difference between foreign nationals and Germans with regard to the time of the first ultrasound examination. In 1998, about one in five foreign nationals (21%) and about one in ten Germans (11%) had their first ultrasound examination after the 13th week of pregnancy. Since then, the values have come closer together (16.5% vs. 9.6%); a slight trend towards earlier ultrasound examination can also be noted here.

In 1998, only a few pregnant women of foreign origin attended the antenatal course that was offered in the family education centre. In 2001, the antenatal course was oversubscribed with 15 to 21 women of foreign origin, half of them Turks, each week. Since October 2001, two antenatal classes – one of them in Turkish only – have been offered.

In terms of the length and frequency of a stay in hospital, the foreign collective differed significantly from the German population in 1998. The difference reduced in the following year and in 2001 even reversed to the disadvantage of German women, who in this year on average spent slightly longer in hospital. The difference in terms of the frequency of stay between the two collectives still remained to the disadvantage of the migrants. Fortunately, however, the difference between the two groups reduced.

The preventive measures taken meant that the previously considerably higher perinatal mortality in the foreign collective in the 1998 comparison was reduced to a similar level to that of the indigenous collective (2001: 10‰ vs. 12‰). It should be added that, owing to the deficiency in sample size, the figures for perinatal mortality are subject to severe fluctuations.

Outlook

Continuation of this project is planned. The aim in the coming years is to increase the utilisation of preventive measures for pregnant migrants, thereby further reducing perinatal morbidity³ and mortality in neonates of foreign origin. The continuing reduction of perinatal mortality in the foreign collective is of great importance in the interest of the community and in the financial interest of the health care service of the city of Nuremberg.

The ethnomedicinal training of doctors, midwives and nursing staff initiated by the model project serve to sensitise them to the special requirements of foreign pregnant women in terms of origin, culture, religion and the different conception of health and illness and will contribute to the professionalisation of medical treatment and care.

The presence of medical specialists who speak their language, the acquisition of intercultural expertise and interdisciplinary cooperation are absolutely essential to steer the 'fate of migration' towards 'integration of migrants into the health care system'. For quality assurance purposes, migration-specific and sociodemographic data in obstetric and perinatal medicine must be assessed at regular intervals.

Neslişah Terzioglu

3 Morbidity = degree of illness, illness number



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Open to all?

Psychosocial health and care of immigrants and strategies for improvement

Using the example of Polish and Vietnamese migrants in Leipzig, the health situation and care requirements for these groups of migrants, who up to now had been paid little attention, is illustrated. The underlying study shows that psychosomatic complaints, in particular, play an important role. The existing psychosocial care and strategies for improvement are discussed.

Introduction

Empirical studies on the health of migrants in Germany are still rare. They are often characterised by low numbers of cases and limitation to certain diseases or geographical areas (old federal states). So the studies are generally not representative and are rarely comparable with each other. However, analysis of the health situation of migrants is an essential requirement to enable satisfactory health and psychosocial care for these people. On the basis of a study, the health situation and care requirements of Vietnamese and Polish migrants in Leipzig are discussed and care concepts are considered in more detail.

Migration and health

As already mentioned, in view of the different ethnic composition of migrants, health reports from Western federal states cannot simply be transposed to the new states. The following study addresses this point and describes the health situation of two groups of immigrants who up to now had been paid little attention, the Polish and Vietnamese minority, using the city of Leipzig as an example of the new federal states.

In the new federal states, Leipzig has the largest proportion of foreign nationals, at 6.1%. This has increased continuously since 1990. The largest foreign migrant group in Leipzig are the Vietnamese. They were the largest group of foreign workers in the GDR.

The majority of them worked in light industry and lived in separate residential blocks. With the unification treaty in 1990, the Vietnamese migrants came under the Federal German Aliens Act. This gave them a temporary residence permit for the period agreed in the contract of employment. In view of the economic changes in the new federal states, many Vietnamese were given notice. In this situation only a third of them remained in Germany. The right of residence was first regulated in 1993. Until the residency status was finally determined with the regulation of the right of residence for contract workers from Vietnam in 1997, the majority of them tried to earn a living, for example, by operating fast food stalls or by working in the travel business (MERBACH 2005).

The history of Polish immigration is also characterised by job migration, although the vast majority of Polish migrant labourers do not settle permanently in Germany. Consequently, the number of Poles registered in Germany fluctuates considerably. In 2003, they formed the largest migrant group in Leipzig. Within a year, the number of residents of Polish nationality registered in the city had halved (MERBACH 2005). This shows that there is migration back and forth between Poland and Germany, depending on the employment situation at the time.

In order to ascertain the health situation and care requirement, in 2004 a postal survey was carried out in Leipzig of persons of Polish or Vietnamese nationality who were selected at random on a quota basis. The questions related to subjective morbidity and the use and knowledge of psychosocial care services. 140 questionnaires from Polish migrants and 88 from Vietnamese migrants were assessed. The term migrants refers here to those people who have migrated independently and who do not hold German nationality.

In comparison to the Germans surveyed, the migrants from Poland and Vietnam suffer from more complaints (figure 1). The Vietnamese migrants have the most complaints and West Germans the least. There is a tendency for women to be more affected than men. Physical complaints also increase with age in all the groups.

The values on the anxiety and depression scale in both groups are also raised when compared with the German comparative sample (see figure 2). The high anxiety levels in both migrant groups are noticeable here. In all the groups women are more inclined to anxiety than men.

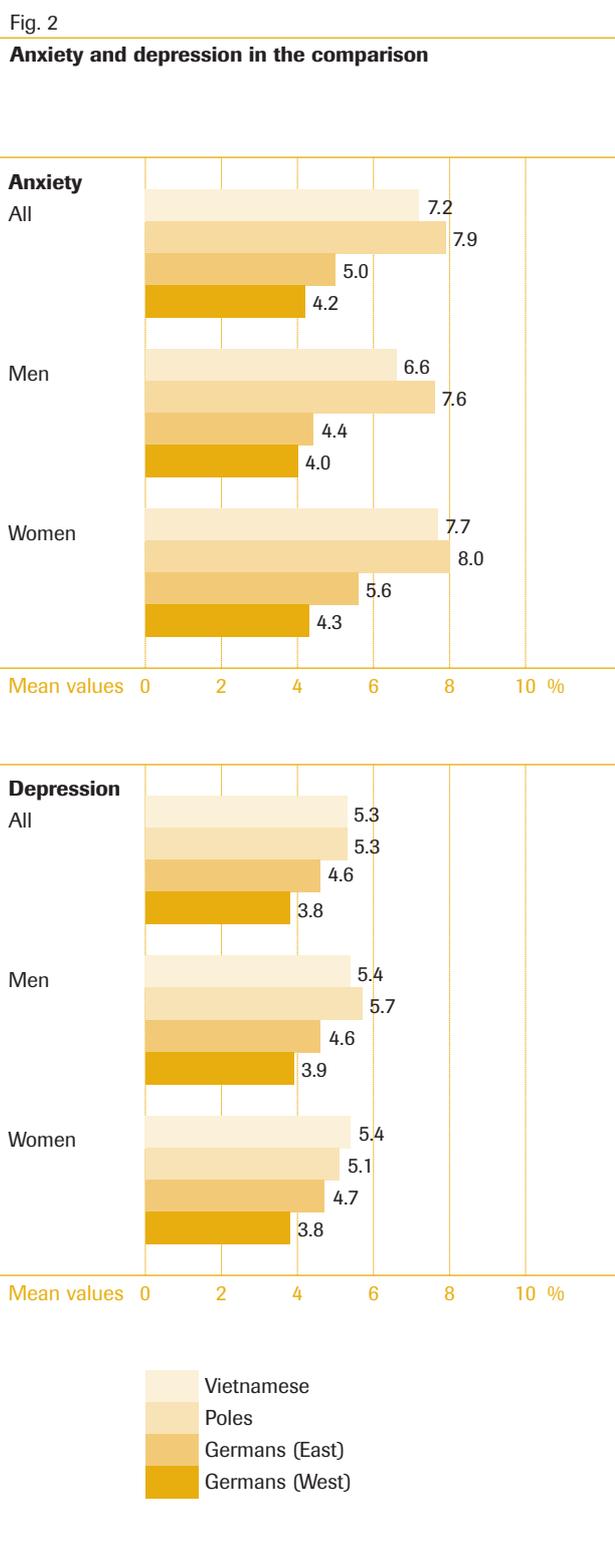
The depression values for migrants from Poland and Vietnam are only moderately higher than those of the indigenous population. The Polish migrants have the highest depression values.

The higher level of physical symptoms and the higher anxiety and depression values of migrants from both groups are covered in the numerous studies on migration and mental health, in which migration is seen above all as a psychological strain which tends to 'lead to illness' (SIEFEN/BRÄHLER 1996; SUNDQUIST et al. 2000; RITSNER et al. 2000; WITTIG et al. 2004). Psychosomatic complaints predominate, and there is evidence of a greater frequency of complaints.

SUNDQUIST et al. (2000) found complaints such as sleep disorders, tiredness and headaches in migrants in Sweden more frequently than in the indigenous population. RITSNER et al. (2000) described high rates of somatisation in Jewish migrants from former Soviet Union countries to Israel. SIEFEN and BRÄHLER (1996) demonstrated high levels of complaints in Greek children and adolescents in Germany, while MERBACH et al. (2004) showed increased complaints even at the time of arrival, both for Turkish migrants and resettlers.

Critics of this approach that regards migration as a critical life event with 'adverse health effects', explain the increased complaints in migrants on the basis of the relationship of illnesses to social strata. Thus, people from lower social levels generally have a poorer health situation (ROBERT/HOUSE 2000; SIEGRIST 2000). The fact that migrants predominantly come from these levels (higher unemployment rates and a higher proportion of work with low qualifications among the immigrants), justifies this argument in line with their worse health situation.

A third thesis takes the viewpoint that migrants do not actually have more symptoms, but perceive and express symptoms differently. Thus in some cultures depression is experienced physically rather than psychologically. The starting point for these considerations is that one's own health situation, and especially the perception of symptoms, is determined by the environment, that is by one's culture, society, family and life history (PETERMANN/MÜHLIG 1998; MCELROY/JEZEWSKI 2000). Illness and health are therefore dependent on one's culture.



Psychosocial care

The generally poorer health situation of migrants must be seen alongside inadequate utilisation of the psychosocial care facilities. Causes of this imbalance which have been discussed are the widespread lack of language skills, other assistance, lack of knowledge of the care structures, as well as the image of information centres as places of authority and the fact that health care is not open to migrants (MINISTRY FOR WOMEN, FAMILY AFFAIRS, YOUTH AND HEALTH, NORTH RHINE-WESTPHALIA 2000). The opinion of migrants themselves on this matter was rarely sought.

Table 1 shows that the current counselling services are scarcely known to migrants from Poland and Vietnam, much less that they are actually being used by those questioned. Migrants are most familiar with the youth welfare office. Generally there is a higher degree of utilisation by the Polish migrants.

There are gender-based differences in both groups, although they differ between the groups. Among the Polish respondents, the women have more experience with the psychosocial counselling services, especially the psychological or psychotherapeutic services. In the Vietnamese group more men say that they are aware of the youth welfare office and youth and social counselling, while the women more often know about family and addiction counselling.

Table 2 shows the problems with which the family was already confronted. It is noticeable here that more problems are indicated by the Polish group than the Vietnamese group. The Polish respondents give relationship problems as by far the most significant. The Vietnamese most often quote migration problems. Here too there are gender-based differences. Polish female migrants tend to report more problems than the male migrants, whereas for Vietnamese immigrants it is the men who report more problems than the women.

In general, very few migrants seek out psychosocial care services: only 16 of those surveyed from Poland and six from Vietnam. The Polish migrants are most likely to use counselling services for psychiatric problems and educational problems. Five out of the six Vietnamese migrants seek help for problems with schools and generational conflicts.

In the event of possible problems, the respondents of both groups would particularly seek out family, friends and acquaintances. In the Polish group, psychologists and psychotherapists are in third place and doctors in fourth place. The Vietnamese migrants would call upon doctors as their third option. Psychological counselling services are hardly acknowledged. Here again there are significant gender-based differences. Polish and Vietnamese men, for example, are happier to consult a doctor than the women. Overall, female migrants require more help than male migrants.

For both groups a high level of stress as the result of a problem is the decisive argument for utilising counselling, and counselling in their own home tends to be seen as an inhibitory condition. Other beneficial conditions are anonymity of the counselling, the fact that it is free of charge and professional discretion. Interestingly the Polish migrants find counselling by a German more acceptable than counselling by someone with Polish as their native language. In the Vietnamese sample the situation is reversed, mainly through the men who have a clear preference for counselling in their native language.

On a general level, studies on the utilisation of psychosocial facilities are rare. The studies mostly question the providers of psychosocial care as specialists, or reports from information centres are assessed. Then, using conclusions about the lack of migrant-specific information material, linguistic and cultural communication problems, the lack of migrant-specific care services and their coordination, conclusions are drawn about migrants' requirements.

Specialists often report low utilisation of public information centres by migrants, with the information centres being used for non-personal problems, such as help in finding accommodation and more rarely for family problems. The preventive, educational services of the establishments do not seem to appeal to the foreign population, and experts point

out that migrants only use such care services in hopeless situations (SCHAHNAZ 1998). This may be due, on the one hand, to the distance and fear about the documentation of personal information and on the other hand to the fact that most information centres are not allowed to make contact with the migrants of their own accord (MINISTRY FOR WOMEN, FAMILY AFFAIRS, YOUTH AND HEALTH, NORTH-RHINE WESTPHALIA 2000).

It is only through providing migrant-specific services that utilisation will increase (KIRKCALDY et al. 2006). The use of specialists from the countries of origin of the migrants enables appropriate mentoring and lowers language barriers. In addition, misunderstandings arising through the lack of cultural knowledge by the advisory staff can be minimised. Experience of this has been gained particularly in AIDS counselling and sex education (HEGEMANN/LENK-NEUMANN 2001).

Registered doctors in Berlin see deficits in the care of migrants in terms of diagnostics, treatment, health education and preventive measures. From a medical viewpoint, the deficit is caused by communication difficulties, legal limitations on residence, social limitations and a lack of qualified interpreters and translators and native-language specialists. In addition, for their part doctors complain of a lack of information about services specifically for migrants (DAVID et al. 2000).

Migrants experience many kinds of disadvantage in terms of their psychosocial care which require rethinking of the care structure.

Strategies for improving psychosocial care

On the basis of this analysis of requirements, only strategies for improving psychosocial care are to be presented. In Germany, this has resulted in conflicting opinions being expressed by those responsible for the intercultural opening up of regulated services and those who demand migrant-specific care.

Interculturalisation of health care

Interculturalisation requires the development of personnel (increase in intercultural expertise, employment of native language specialists), organisational development (information material in various languages, living environment) and structural development (possibly bundling of services) in existing facilities.

The advocates of this concept see interculturalisation as a prerequisite for integration, as the same institutions are created for all and there is no poorer, 'second class' care for migrants.

One example of interculturalisation of psychosocial care would be to increase the intercultural expertise of counsellors, therapists and doctors.

Here KUNZE (2001) provides a useful model for psychological counselling contact, which could very well be extended to intercultural contact and thus to the medical context.

He talks about various levels of understanding (layers of understanding) in intercultural contact. For example, one 'layer' is psychological and medical understanding: What does the problem involve? What, for example, is the reason for the client's anxiety? How did the diabetes develop and how can it be treated?

Table 1

Knowledge about psychosocial counselling services in Leipzig (in %)

	Poles				Vietnamese		
	not known	known	tried		not known	known	tried
Social counselling	96.4	2.9	0.7		87.5	8.0	4.5
Family counselling	88.2	11.0	0.7		90.9	6.8	2.3
Addiction counselling	95.6	4.4	0		96.6	3.4	0
Youth counselling	94.1	5.9	0		94.3	5.7	0
Psychologists	81.2	11.6	7.2		93.1	6.9	0
Social services youth welfare office	85.4	12.4	2.2		84.9	15.1	0
Debat counselling	94.9	4.4	0.7		97.7	2.3	0

Table 2

Psychosocial problems in families (in %)

	Poles				Vietnamese		
	Total	Men	Women		Total	Men	Women
Relationship problems	52.9	53.8	52.5		23.9	17.5	29.8
Generational conflicts	30.7	43.6	25.7		28.4	20.0	36.2
Psychiatric problems	28.6	20.5	31.7		10.2	10.0	10.6
Problems with schools	23.6	20.5	24.8		21.6	20.0	21.4
Debts	22.9	20.5	23.8		8.0	10.0	6.4
Addiction problems	21.4	17.9	22.8		5.7	5.0	6.4
Educational problems	19.3	17.9	19.8		27.3	32.5	23.4
Migration problems	10.7	7.7	11.9		29.5	32.5	25.5
Problems with violence and racism	9.3	7.7	9.9		17.0	5.0	12.8
Children's developmental problems	5.7	2.6	6.9		15.9	20.0	12.8
Sexual abuse	3.6	0	5.0		3.4	5.0	2.1

A second layer is the minority/majority relationship: migrants are always members of a minority and in most institutions meet members of the majority community. Even if these are also immigrants, they are still representatives of the system and have greater authority. The migrants' experience of discrimination and migration comes into effect. This difference also always influences contact between the advice seeker and the advisor.

The third layer is the cultural layer: this means, in brief, that there are differences in values, standards, language, religion, etc. between the advice seeker and the advisor.

Excessive accentuation of one layer of understanding generally means blind spots in terms of the others. This could result in the psychologisation (even medicalisation), politicisation or ethnicisation of the client. A female migrant is then diagnosed prematurely as having reactive depression, she may be given poor treatment (perhaps because the therapist unconsciously discriminates) and insufficient work is done with her because she cannot express herself effectively.

Since these three layers always take effect in intercultural contact, according to Kunze they must always be taken into account.

Migration-specific care

Specific care for migrants necessitates the creation of a separate care delivery system. This might include, for example, information centres specifically for migrants (e.g. Turkish family counselling centres), care homes, hospitals, etc. Here the market has already created certain services, for example the creation of a Turkish-speaking nursing service in Berlin. The advocates of this initiative consider that certain problems are specific to migrants and therefore specific care services are required. Examples which are repeatedly quoted in this connection are the trauma centres for refugees and the phenomenon that elderly people increasingly retreat into their culture of origin and German care homes are not always able to respond appropriately.

As already indicated, both models have their advantages and disadvantages. There is therefore no point in discussing these approaches only in a controversial manner. In health and psychosocial care both strategies are certainly reasonable: for migrants with poor language skills or specific diseases or who, in certain circumstances, would have problems within an intercultural open care system, migrant-specific facilities are more suitable. On the other hand there will be migrants

who are fundamentally distrustful of migrant-specific services. In order to achieve integration in health care, general services must be opened up interculturally at the same time. Only through a two-way approach is appropriate care of migrants possible.

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Doing Diversity: Information about homosexuality in the context of migration

‘Homosexuality as an issue in migrant families’ is the name of a model project that the Lesbian and Gay Association (LSVD) has been running in Berlin since the beginning of 2005. The target groups are Turkish/Kurdish, Polish and Russian speaking families in which homosexuality up to now has been an almost completely taboo subject. The author reports on the project’s experiences and the questions posed in associated scientific research.

Everyone is talking about diversity. The term stands for educational, political and social efforts to recognise the diversity of humans. Differences resulting from origin or religion, cultural and gender-specific characteristics or diversities in aptitudes, as well as differences in sexual orientation, should be respected equally. Who can be against that? Even article 2 of the German constitution (The Basic Law) refers to the great humanistic dream of accepting every person at the same time as individually different and yet having equal rights. However: representatives of all minorities have stories to tell of how difficult it is to be accepted. Groups combine to enforce their rights. Associations of the parties involved act alongside each other and not infrequently against each other. Communities emerge in which the particular nature of that community becomes the norm. Every representative, every equal opportunities unit and every integration board is testimony to how difficult it is to bring the idea of diversity fully to life.

It is particularly difficult for those who are different in more than one respect: gay and lesbian migrants, for example. Who knows what it could mean to a gay Turk or a lesbian Russian to be accepted in Germany? Most homosexuals with a migratory background do not feel comfortable in the gay and lesbian scene. But coming out to their family or the community is also out of the question. They live hidden, isolated or apparently adjusted lives, with extremely fragile life plans, even though for many of them the persecution and discrimination against homosexuals in their home lands was the reason for their migration to Germany in the first place.

In order to escape the dilemma of double discrimination and false identity and to become politically active, homosexual youths and adults with a migratory background have been involved for many years in the Lesbian and Gay Association (LSVD). In 1996, the first TürkGay&Lesbian self-help group was established in Cologne. Soon afterwards there were also TürkGay&Lesbian Ruhrgebiet [Ruhr region], TürkGay&Lesbian Nord [north] as well as other groups in Aachen, Augsburg, Berlin and Stuttgart. This was followed in 1999 by the formation of Ermis, the Greek lesbian and gay community in the LSVD. Meanwhile the Russian speaking community became more and more vocal. Who

would have thought that in Berlin alone there would be at least three venues for lesbians and gays from the former USSR states? In Cologne, the group is called Soyuz, and is currently preparing its internet website. There are now also gay and lesbian venues for adolescents and young adults with a migratory background as well as counselling and self-help services, not just in Cologne and Berlin, but also in many other places (see below for addresses).

But homosexuality is not a subject just for adolescents and young adults. It is true that there are still far too few services available for education in schools and youth work. But most people live in and with families. The family must therefore also be considered. And: homosexuality is not a subject just for lesbians and gays. How society deals with people who are in a minority, what the expectations are for women and men and, not least, what is supposedly accepted, but in reality is not allowed, should actually concern everyone – at least everyone who believes that diversity or self-determination are values which are worthy of some commitment.

Is homosexuality not an issue for families?

‘Homosexuality as an issue in migrant families’ is the name of the model project which the LSVD has been running in Berlin since the beginning of 2005. The aim of the project, which is supported by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ), is the education and sensitisation of families with a migratory background. The target groups are the Turkish/Kurdish, Polish and Russian speaking community. In these often very traditionally oriented communities homosexuality is an almost completely taboo subject.

Most people think that homosexuality is not a matter for families, so many girls and boys live for years with the fear or the certainty that they are homosexual without having anyone to confide in. Every now and again remarks are made without thinking. People talk about Carsten Flöter from the Lindenstraße or the famous singer Zeki Muren. If a child believes he could be homosexual, he will listen closely: What do his father and mother say when lesbians

and gays are talked about? It is often careless remarks which determine whether a child confides in his parents.

The tolerance towards homosexuals propagated in German society has hardly touched families yet. About two thirds of all parents in Germany would take a negative view if their daughter or son were homosexual. Investigations and reports on the people affected show again and again that the most severe forms of denigration come from parents and close relatives. Many gays and lesbians have to do without the family as emotional support: coming out as a homosexual is generally associated with mistrust or even a breach with the parents.

Gay and lesbian migrants: It's no good without a family

The demands of migration tend to strengthen family ties. That is because migration is less an individual project and much more a family-oriented process. Even the legal regulations on immigration and naturalisation are based on family structures. In addition, social problems and economic concerns are dealt with as a family. The migrant family does not stand for the mother, the father, the children and the relations, but for home, social interrelations, economic certainty and cultural identity.

Young migrants generally accept the values and standards of their parents, but on a day-to-day basis try repeatedly to get around them. The family thus becomes the place for arguing about values, standards and life styles. The longing for the freedoms which school friends and boyfriends/girlfriends so obviously enjoy puts the parents' traditional values and their authority to the test. Girls and boys are torn between the desire for a self-determining lifestyle and the wish not to risk their family's reputation. The innovations which young migrants take into their families and the migration communities are limited by sexuality being a taboo subject.

Traditional role expectations, assumed religious commandments, fear and the lack of assertiveness mean that sexuality is not discussed as a matter of course. Much too often homosexuality and a self-assured display of female sexuality is seen as a disgrace for the whole family. Coming out at the expense of family relationships often appears to be impossible. Personal, economic and social connections with the community are simply too important.

We believe: a family must not break apart because of homosexuality. But all too often coming out as a homosexual is associated with a break with family ties or unwanted marriage ceremonies. Where the family is at the same time a replacement for the homeland, a homosexual identity is a severe test for all concerned.

So adults also need information on the subject of homosexuality. It is important to include families, extended families and relations in the educational process. The activities of the LSVD project for migrant families are therefore not aimed specifically at the persons concerned, but at the whole family environment.

Self-reflection, not instruction

A fear is often expressed that the LSVD wants to use its events to teach heterosexuals how best to deal with homo-

sexuals. In fact, using methods such as role playing or quiz questions, we create a dialogue situation which provides space for exploring one's own assessments. Self-reflexion, not instruction is our motto. 'What to do if Ümit is gay?' When the LSVD team asks mothers and fathers this question (see page 20), it is not part of a test which has to be passed. What happens is that one person from the group takes the role of a parent who has problems with a homosexual son. This person asks the others for advice: 'What would you advise me to do?' The participants become actors. They set the conditions of the discussion, a thorough and honest exploration of their own thoughts, feelings and experiences. It is not always pretty and for many is definitely not easy, but it is a necessary step towards understanding and respect.

At these events migrants often report problems because of the dominant influence of religion. Even if individuals are prepared to accept homosexuals, reactions are still caught up in interpretative models which demand that they distance themselves from any such persons. It appears that the tension between tradition and modernity also tends to separate perceptions and emotions. Here the dominance of traditional religious views which are hostile to homosexuality is no indicator of a particular ethnicity or religion. What is more significant is whether, in their daily lives, families have examples of a tolerant, enlightened form of tradition. This applies to Islam just as much as to the Roman Catholic Church. If there are no such role models, respect for homosexuals is exclusively a personal matter, which often has to be retained in the face of authorities. That too deserves respect.

What do young people – the parents of tomorrow – think?

In Germany there is no systematic form of education about homosexuality in and for migrant families. We are currently not able to resort to scientific knowledge on manifestations and backgrounds. From working with homosexual migrants, many individual fates are known. These experiences lead us to suppose that the rejection of homosexuality in the essentially traditional migrant communities in the cities often takes tragic forms. Counselling sessions have repeatedly dealt with suicide attempts, violence and forced marriages. But these are individual cases which do not form a basis for generalisations. People who do not have any problems do not seek advice. Dramatisations are not appropriate or helpful. Rather, it is important for the work to know the interrelations. Attitudes towards homosexuality are influenced by personal experience, the community environment and values. Anti-homosexual feelings also feed on these sources.

Anyone wanting to develop a formula for lasting education must know what backgrounds and experiences influence positive or negative attitudes to homosexuals. To this end, in association with the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ), the LSVD has commissioned a study which is to outline a scientifically based 'map' of the central aspects of attitudes to homosexuality. Management of the study was entrusted to Prof. Dr. Bernd Simon of the Institute of Psychology, Chair of Social Psychology and Evaluation at the University of Kiel.

What to do if Ümit is gay?

Mothers and grandmothers of Turkish origin approach the taboo subject of homosexuality

Twenty-five Turkish women, all of whom were not born in Germany, are taking part in the LSVD event. They understand German to some extent, but are not used to discussing complex subjects in German. Some of them, it is assumed, find writing difficult; the average age is 45. They come from towns and from the countryside and in the main are not particularly religious. None of those present wears a headscarf. They represent the middling section of the Turkish/Kurdish community: neither very poor, nor very wealthy. The atmosphere is friendly, curious.

Gay sons and lesbian daughters are a problem for parents. Asked what they would do if their son were gay or what they would advise others to do, most of them are at a loss. Azize Tank, a migration representative from Berlin-Charlottenburg-Wilmersdorf, plays the mother Sevinç, who asks her friend for advice because her son is gay. The suggestion quickly comes that a psychologist should be brought in. Yes, the psychologist should help to change the homosexuality. This suggestion is often made. Many people also think that homosexuality is something like a hormonal disorder. The LSVD guests clear up this preconception by referring to trials and results of hormonal treatments (female hormones make gays more feminine, then men grow breasts. Male hormones increase the sex drive, but the orientation of the libido towards men remains unchanged). So the search for an authority continues: the doctor is mentioned, and then later the Imam.

'Is it congenital? Is it ordained by God? Then we must accept it. But how should we deal with it? How do we know what to do; no-one talks about homosexuality.' More and more questions are put to Azize Tank: 'What was Ümit like as a child? Did he play with dolls? Did you introduce him to girls enough?' Azize makes it clear that 'incorrect' upbringing is not the cause of homosexuality.

Bit by bit the women approach the difficult problem. The reactions become more and more personal. One after another of them tries to imagine the unthinkable: 'What would I do if my son were gay?' Shock is added to helplessness. They all say they would be very, very sad. Azize Tank digs deeper and asks the mothers to explain why. Now the fears become clear. The family would break up, they would no longer be able to celebrate events together, and relatives would not accept it. And then there is the father – there is a fear of violent, bad reactions from the male side. A conflict between the parents can be expected. Perhaps even a struggle between mother and father about acceptance of the son. And then suddenly it is obvious what has to be done: we must stand by our children no matter what anyone else says.

At the end many of the mothers want more information. The brochures provided ('Kai is gay, Murat too', in German and Turkish) are ripped out of the hands of the LSVD guests. Their interest has been roused. The discussion lasts two hours, but the questions will occupy those who were there for a long time yet.

Do migrants who come from Turkey or the former USSR think differently about lesbians and gays than a comparative German group? The survey design links gender-specific approaches with social psychological problems. Personal interviews and extensive samples will supply meaningful data. The investigation is directed at young people, as they are the parents of tomorrow. The scientific team is asking girls and boys between the ages of 14 and 20, particularly those from comprehensive schools and high schools, in Berlin about their understanding of gender roles and the significance of religion, as well as asking for information about inclusion and exclusion.¹

In terms of its intention and scope, the study is not designed as a representative survey of the extent of anti-homosexual attitudes. It does not claim to give a representative portrayal of how many of the young people accept homosexuals and how many reject gays or lesbians. The aim of the quantitative study is rather to identify the interrelations between anti-homosexual attitudes on the one hand and religious and ethnocultural ideals or roles on the other. With a view to intervention and preventive work, it is particularly important to obtain statistically reliable knowledge of possible cause and effect relationships. Initial results of the investigation can be expected from April 2007.

Worthy of imitation!

The aims of the project are the removal of taboos and the provision of education as contributions to integration and the strengthening of family ties. For example, a mixed gender and ethnically mixed team, in cooperation with migration representatives, migration or district projects, is organising workshops or discussion afternoons for mothers, grandmothers and fathers from various cultures. Cooperation is a hallmark of the project. It lays the foundation for an equitable dialogue between the cultures and the exchange of know-how. It has thus become possible to develop educational instruments which are specific to the target group and sensitive to the culture.

The project team has set about this task with about 40 events between January 2005 and September 2006. For many migrants these hours were their first contact with the subject of homosexuality. Multipliers and many mothers and fathers thus had the opportunity to approach the subject through questions and discussions in an intimate circle. In numerous discussions with experts, the life situation of homosexual migrants was addressed and support facilities were pointed out. Multipliers and increasing numbers of

¹ This includes questions about the social and economic status of the family, the type and extent of social contact with Germans and other items which affect the degree of integration.

parents are turning to the project team with requests for advice and clarification. The work is based on close cooperation with the various communities and private agencies.

The subject of homosexuality, like other taboo subjects, is filled with anxiety. Educationalists, advisors and other multipliers therefore generally avoid addressing the subject. They do not want to alienate either the other families or the persons concerned. So the taboo is perpetuated. It is therefore important to encourage other people to get involved in the education. We in the project are available with advice and practical support for duplicating the idea and we are due to produce an online handbook in 2007. This will explain the modules developed by us and the backgrounds: what basic conditions must be observed, what methods are used for addressing taboos and how the frequently asked questions can be answered. Not only our partners, but also other multipliers are thus challenged to copy us.

Renate H. Rampf



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LSVD federal association: The Lesbian and Gay Association in Germany (LSVD) is the largest civil liberties organisation and lobby group for lesbians and gays in Germany

www.berlin.lsvd.de

LSVD Berlin-Brandenburg.
State association of the LSVD, concentrating on the rainbow families and migration projects
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ERMIS, the Greek lesbian and gay community in the LSVD

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Federal association for parents, friends and relatives of homosexuals (BEFAH).
Countrywide contact for advice and self-help for family members concerned

First Generation Turkish men in Germany – well known but still completely unknown¹

On the basis of 20 intensive interviews with first migrant generation Turkish men, the author provides information on the origin, development and transmission of family-related male identities and attitudes to partnerships and upbringing of children.

Hardly any other migrant group has been the subject of so much research or had so much published about it as the people who came to Germany from Turkey. The literature on women and girls from Turkey, the family structures, their attitude to education and their sex lives fills whole libraries. So it is easy to get the impression that everything has already been said which needs to be said about these people. It is therefore all the more surprising that new research continues to appear that again and again shows an apparently different picture. I recall the recent publications by NECLA KELEK (2005) and the furore caused in Germany by her theses on forced marriages. It is noticeable in the whole of the literature that men rarely remain 'neutral' and tend to have negative connotations. The reason for this must be that in recent years the focus of science has increasingly been placed on the sociocultural living conditions of women and girls who have migrated. But is the assertion - that all research which does not explicitly deal with women and girls is automatically male research - necessarily true?

Although there is no explicit research on first generation men, in the broad circles of science and in public there is a very clear picture of the Turkish man and in particular the father generation, the so-called 'first generation'. Studies of women and girls and practice reports of mostly German social workers and social educationalists give a far from positive picture of these men. They are seen as

- authoritarian and aggressive,
- repressive of wives and daughters
- incapable of adapting to modern society
- being against modernity with its varied concepts of life, even appearing ready to kill in the name of honour.

Although little research has so far been carried out on first generation Turkish men, ever since the 1980s they have been attracting considerable public attention as pensioners. But here too the picture is a bleak one:

1. They are ill because they have spent their productive years working in activities that are harmful to health.
2. They are lonely because they have become estranged from their children.
3. They are in need of help as there is no-one there to take care of them.

4. They are poor, as their pension is not enough (see SCHULTE 1993, p. 29 ff.).
5. They are isolated from German society because in their old age they are returning to their ethnicity, so their contact with Germans, if they have any, is reducing all the time (see DIETZEL-PAPAKYRIAKOU 1990, p. 347f.).
6. They are rootless because they do not feel at home either in Germany or in Turkey (reference: Dilemma of going back and forth, see DIETZEL-PAPAKYRIAKOU 1993, p. 46).
7. They are frustrated and have failed in life because their great life's dream, of returning to Turkey as pensioners, has failed.

If we observe where all these statements come from, it is interesting to note that there is virtually not one single qualitative study in which the first generation men are allowed to have their say. So what I have called 'second-hand images' are created. Knowledge about migrants' living conditions comes either from what their wives and children say, from the observations of predominantly German social workers or are even third hand, with academics relying on what third parties have told them about the target group.

The idea for this work came from my own experience and curiosity. Privately I had got to know numerous fathers of Turkish friends who did not in any way fit the image of Turkish men. They were neither authoritarian family patriarchs nor helpless, lonely and embittered. Their life was not defined by the 'Dilemma of no longer being able to return home', as so vividly described by DIETZEL-PAPAKYRIAKOU in their works. In fact, these men took an active part in the development of their children and had dealt very intensively and reflectively with their situation in Germany.

I have investigated the origin, development and transmission of family-related male identities² in the context of life histories, thereby confronting the prevailing conception in German migration research about first generation men

¹ The contribution integrates relevant articles from the monograph 'First generation Turkish migrants tell their story', transcript Verlag, 2002. In other parts it corresponds to a talk which I gave at the Heinrich Böll Foundation in Berlin in December 2005 and which has been published by the foundation.

with the results of this empirical work and possibly giving an impetus for a more sophisticated depiction of Turkish men (not only of the first generation).

The current migration discourse about people from Turkey is centred on the debate concerning forced marriages and honour killings. It is men from the first immigration generation who are held responsible for these infringements of human rights. If we follow the present debates, often we can only ask in amazement how any girl from a family which has migrated from Turkey can ever succeed in having a self-determined, happy, fulfilled life, can finish her education or a course of studies and marry a partner whom she has chosen herself – when there are droves of male relatives, brothers, cousins, father and uncles, not forgetting the male members of the whole neighbourhood, who are working together to mould her into a rigid, antiquated role, to marry her against her will and chain her to the kitchen sink. Perhaps somewhat exaggerated, but essentially it makes the point. The debate is one-sided. And again the men concerned do not have their say.

This article will therefore let the first generation speak. Only when it is clear what perceptions of partnerships these men have and how they themselves chose their wives can we understand the current debates and make differential assessments. In 20 problem-centred qualitative interviews with a strong emphasis on biography I examined the family-related images of masculinity of the interviewees. I was interested in their perceptions of themselves as a son in Turkey, as a husband and father in Turkey and as a husband, father and son (now as an adult) in Germany.

Analyses of individual cases enabled me to develop the relevant comparisons. It was evident that family-related masculinity played a large part for all the interviewees. This masculinity was clear in the situations in which the interviewees spoke about their childhood, their marriage, being a father and their interaction with their (extended) family. Assessment of the individual case analysis brought up a number of questions:

- Do the perceptions of family-related masculinity and self-positioning change? If so, why? If not, what are the reasons?
- In which men do these perceptions change and why?
- What role is played by socialisation in Turkey and life in Germany?
- Is this a reflection of their own masculinity?
- What influence did/does the Turkish and German environment have on attitudes to and consideration of their (own) masculinity?
- Did migration mean a break with what they had been before? Did it perhaps enable a form of continuity or the beginning of something new?
- Did the men interviewed decide deliberately or unconsciously on one or another form of family-related masculinity?

My investigation was now directed to the question of what model the men had before migrating to Germany, whether this had changed with life in Germany and if so, whether

there was a theme to this change. Here the models of 'interdependence', 'independence' and 'emotional interdependence' developed by KAGITCIBASI in conjunction with family research were helpful. The interdependence model is characterised by very strong family cohesion. The individual lives with, through and within the extended family, which is seen as the production unit. Marriages benefit the overall household. (Many) children are necessary to ensure survival in old age – a collectivist principle. Obedience is a central value in children's upbringing.

In contrast, the independence model is characterised by an individualistic structure. The nuclear family has replaced the extended family. Children are brought up individually and are no longer used to ensure the family's survival. Marriages are made by personal choice and on an individual basis.

The emotional interdependence model represents a hybrid of the two other models.

None of the men whom I interviewed has changed from the emotional interdependence model to the independence model. For those men who had already swapped the interdependence model for the emotional interdependence model, this would be going too far. Fourteen men also continue to live with the same model in Germany as they had in Turkey. For the six men who live by the interdependence model, this means a considerable balance between their own life model and that of the environment. More than for almost any other men, religion gives them the necessary security in a changing world, in which even their own children are changing. It is in relation to their children that the fathers repeatedly have to make unwanted compromises. Particularly in old age, any change in their own model would give rise to a considerable loss of status. The belief that their own efforts as fathers will be positively rewarded by their children enables them to hold on firmly to this model.

In these cases migration plays a role in two respects. It enables the men to retain the belief that in Turkey everything will 'stay as it was', that is the command structures which they have known from their youth continue to hold sway. This becomes very clear in the case of Mr Hacıoğlu, who clings to the belief in an ideal rural world even though for a long time he has had terrible conflicts with his sons who are still living in Turkey and who no longer recognise their father's authority. But on the other hand migration also emphasises the loss of status experienced as a foreign man, and as a person, in Germany. Both experiences lead to turning again to a model in which this group of persons (older men) are afforded particular respect.

So migration cannot be assessed as a general rift in the life of the men interviewed. In some cases it is only through migration that they are enabled to follow their own beliefs and wishes.

The men in the independence model experience the least severe problems in finding their way in the German environment. However, it is just this supposed equality which enables them to develop fine sensors for the unequal treatment of foreign nationals in German society. In particular the future of their own children in Germany is always a subject that triggers concern and anxiety and which brings a strong feeling of being powerless against the unjust treatment. At the same time, the openness to the receiving society is shown by the fact that this group has the most German children-in-law. On the other hand, no child from the interdependence model has a German partner. Migration to Germany does not

2 This investigation was not concerned with identity as a worker, a religious person or a politically active member of society. Rather it is based on the statements of the men regarding identity and family

represent a rift for men who were brought up in the interdependence model. However, their recognition is changed by the environment. Both Mr Çınar and Mr Fener make an issue of the sudden loss of status which they have experienced in Germany.

On the other hand, for some men migration has meant that they can live their desired and chosen lifestyle. It was only when he came to Germany that Mr Polat was able to divorce his first wife, and Mr Volkan was not able to lead a self-determining life until he came here.

Five men have moved from one model to another during the course of their lives. Some of the men precipitated this process deliberately, mostly as the result of negative experiences in their own youth (no access to education, working from early childhood, forced marriage, fear of their father, feelings of uncertainty). The lessons learnt are taken as a yardstick for bringing up their own children. Often the conflict with the values and standards of their own youth was only triggered by the migration process. In the conflict with the German environment their own behaviour was critically challenged and then altered. It is these children particularly who benefit from a partnership relationship with their fathers. However, it is the relationship between the married couple which benefits the most from this change. The position of the wife becomes more equitable and the couple acts more strongly together.

But it is not always the declared aim to do everything differently to the way in which it was done in one's youth. The example of Mr Korkmaz shows clearly that he keeps verbally to the standards of his youth and is convinced that he will pass these on to his children. However, when comparing his stated convictions and what he actually practices, we see that he has been following a different model for a long time. If Mr Korkmaz had remained in Turkey, he would possibly have cracked under the weight of his own demands of himself and the pressure of the authoritarian environment. It was only migration which enabled him to keep formally to the traditional values and standards while in practice living by a different model.

In the case of men who have undergone this transition passively, there is no critical consideration of their own past. However, on the basis of differences between their own upbringing and that of their children it becomes clear that a drastic change has taken place. In these cases migration has meant that they have adapted their own patterns of behaviour in relation to the environment and the claims of their children without giving this any deep consideration.

At this point I would like to look briefly at the results which are affected by the relationship between the spouses in the various models:

Marriage in the interdependence model

(Table 1)

Here the parents choose wives for their sons without the marriage being made on the basis of interpersonal feelings. With the son's wife a new source of labour comes into the peasant production unit. The young age at which sons marry is notable in cases where the marriage was made at the instigation of the parents.

The marriage ceremony is the only area in which a small proportion of the men interviewed from this model defied their parents' wishes in any way. If the sons married a woman of their choice, the age at which they married was considerably higher. Mr Nazim and his wife were both 23

and Mr and Mrs Inan were 19 when they married against their parents' wishes. The 'kidnapping of the bride' with her consent, while not desired by the parents, did represent a quite legitimate means in rural Turkey of marrying the spouse whom the bride or groom had chosen. This arbitrary decision by sons did not lead to a rift with the parents.

The generally early age of marriage and the choice of a wife by the parents irrespective of individual wishes and feelings prove to be of great significance in the relationship between the married couple. The marriage represents a partnership of convenience; it is the framework in which children are brought up. Decisions are more likely to be made in consultation with the father than with the wife. This is noticeable throughout the interviews: if the wife is consulted at all, it is only in her function as a mother, not as a life partner, with whom one discusses things and then decides jointly on the important matters in life.

Marriage in the independence model

(Table 2)

Here the courtship is largely carried out on the basis of individual affection.

The age of marriage of both partners, but particularly of the men, was significantly higher than in the interdependence model. In the cases in which the marriage went ahead under pressure, there was severe alienation from the wife. Mr Polat divorced his unloved first wife and married again in Germany – this time without any form of family influence. Mr Volkan lives a very individual life in Germany, without his wife and children. Both men are vehemently critical of the pressure put on them by their family, relatives and neighbours and distance themselves explicitly from this form of marriage.

The relationship between this type of married couple is characterised by verbalised affection and a common life project. It becomes clear in the interview that the men do their share of household tasks and at least verbally accept shared responsibility for the household area. The women are not talked about principally as mothers of their shared children, but as wives.

Marriage in the emotional interdependence model

(Table 3)

As in the interdependence model, it is the father (or uncle) of the men interviewed who has chosen his son's (or nephew's) future wife. One man kidnapped his girlfriend, with her consent, another 26-year-old man married his cousin, under protest from his mother (his father had already died). The age of marriage is higher than in the interdependence model.

The change from the interdependence model to the emotional interdependence model is very well demonstrated by the relationship of the spouses. Several men refer to this change. They report that during their time in Turkey, the men had the say and the women obeyed. With migration this relationship changed. Mr Mardin and Mr Sert in particular describe this change. The knowledge that the past was different from the present and that the past is gone characterises this type. The concept of the couple as the persons in charge of a jointly-designed life came up more often in the interviews than for other types. As young married couples, the men and women to some extent secretly opposed the authority of their parents and in-laws in order to achieve their aims (migration to Germany). However, they did this with a bad conscience and in the knowledge that they

Table 1			
Age of marriage of the spouses			
Name	Man's age	Woman's age	Circumstances of the marriage
Mr Tufan	18	9 first marriage	Pressure from parents Proposal and acceptance
	25	15 second marriage	
Mr Hacıoglu	17	12	Pressure from parents
Mr Olgun	17	13	Pressure from parents
Mr Levent	14	11	Pressure from parents
Mr Nazim	23	23	Own choice
Mr Inan	19	19	Own choice

Table 2			
Age of marriage of the spouses			
Name	Man's age	Woman's age	Circumstances of the marriage
Mr Polat	15	?	Pressure from neighbourhood Own choice
	40	22	
Mr Fener	22	16	Own choice
Mr Bilen	27	20	Own choice
Mr Ergin	31	43	Own choice
Mr Volkan	23	16	Pressure from father
Mr Çinar	29	26	Own choice

Table 3			
Age of marriage of the spouses			
Name	Man's age	Woman's age	Circumstances of the marriage
Mr Demir	25	17	Mediation and acceptance
Mr Mardin	22	18	Own choice ('kidnapping')
Mr Korkmaz	20	?	Pressure from parents
	22	17	
Mr Uçar	23	16	Mediation and acceptance
Mr Sert	26	28	Own choice

were doing something which was forbidden. But in this type, solidarity with the wife is more highly valued than solidarity with the family of origin. As for the men in the independence model, the marriage is defined as a partnership. In the men's narratives, the woman is not reduced just to the role of mother, but appears to be a valued companion and advisor.

All these men's wives are employed. In this they are like the women of the independence model and differ from the women of the interdependence model, the only group in which there are 'Only housewives'. However, gainful employment is no indicator of the distribution of household tasks. It is true that the men no longer explicitly refer to gender-specific work-sharing and say that they help in the

house to a greater or lesser extent. Some even clearly state that a partnership includes housework which is shared by the partners. However, in most cases it appears that the main burden of housework is borne by the working women themselves.

Summary of the research results:

- The dichotomisation between the supposedly rural conservative structures in Turkey on the one hand and the industrially advanced Germany on the other cannot be kept up.
- The current debate about forced marriages fails to recognise the fact that the first generation has already had to deal with this subject and to some extent has taken up very clear

positions against such practices. This is discussed far too little.

- Like Germany, even at times of migration, Turkey was characterised by social pluralism and therefore various forms of hegemonic masculinity.
- When migration takes place, a family model increasingly develops which is characterised by individualism while at the same time maintaining strong emotional relationships within the family.
- In this context migration should not necessarily be seen as a rift in a person's way of life and expectations of life. Often it is only migration which enables an individual and desired life plan to be accomplished.
- In contrast to the research by *NAUCK* (1988, page 506), which refers to the change in Turkish families as an 'opportunity structure', this work found that there had been a definite value shift.

Margret Spohn



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Careful consideration and daring – Reorientation of sex education in the immigrant community. The current debate in the pro familia association

This article outlines how various sociocultural paradigm shifts and the resultant developments are integrated in the reorientation and specialist discussion in the pro familia association in the sex education area.

A year ago the pro familia federal association published an article (KUNZ 2005)¹ with the aim of initiating an internal debate about the future outlook and direction of sex education, taking into account the latest social and institutional general conditions.

There follows a brief overview of how five social developments exert a significant influence on discussions within the association. They are actually independent of each other, they have been developed or described by different originators and proceed at very different rates, and yet they all have something in common in terms of a paradigm shift: they deal with the self-determination of the individual in terms of his possibilities, sexual equality and participation of everyone within a democratic society.

1. Institutional changes

In 1994, the largest and most important international UN conference on population ever up to that point took place in Cairo. According to THOSS (1997; 2004) and PRACHT/THOSS (2005), for the first time it was not population growth which took centre stage, but sexual and reproductive health and rights, particularly of women and girls. Sexuality, reproduction and health were for the first time linked with general human rights. This new approach recognises that all people – irrespective of ethnic origin, colour, gender or sexual orientation, family situation, position in the family, age, language, religion, political conviction, national or social origin, property, birth or any other status – have the right to sexual and reproductive health and access to the appropriate information.

A new rationale for the family planning organisations (FPO) was the result of this. This meant that sexuality and reproduction could be dealt with more comprehensively than before, could go beyond the group of persons of reproductive age, and services could be provided².

In the charter for sexual and reproductive rights (IPPF Charter 1996), the FPOs incorporated in the International Planned Parenthood Federation (IPPF) produced new orientation guidelines as a basis for their work. The charter forms a response to the challenge to define sexual and reproductive rights as human rights and to facilitate the acceptance of these by society and demand that they be observed. pro familia is therefore considered as a human rights organisation in its areas of operation.

This new rationale was also confirmed at the 2004 general meeting with the clearly expressed wish to formalise and implement sexual and reproductive rights in all of pro familia's spheres of action.

2. Changes in the whole of society

Since the beginning of the 1990s, social and political discussions have taken place, some of them quite animated, about how Germans and migrants can live together as a 'multicultural society'. In the course of these debates about the form of living together and integration, Germany got its first migration law in January 2005. Since then, immigration has been institutionally recognised and promoted with the aim of integrating the migrants into Germany's democratic society; this is regarded as a two-way process. It requires migrants to accept the basic democratic consensus and the living conditions here and to become actively involved in the further development of the civil society by learning the German language and acquiring basic knowledge about the German legal system, culture and history.

From the point of view of the receiving society, the political requirement for intercultural opening up of organisational and social services is connected, that is services should be organised in such a way that all population groups – including migrants – have equal access and can play an active

¹ The text can be downloaded at www.profamilia.de/getpic/2675.pdf

² See the pro familia federal association's brochures in the series 'Sexualität und Alterwerden' [Sexuality and ageing] or state association services regarding 'Kinder und Sexualität' [Children and sexuality]

part in the provision and orientation of services (see 2004 welfare work pages). This also applies to *pro familia*³.

3. Debate by the experts

In discussions by experts in recent years the meaning of the term 'integration' has changed and now also includes the creation of expertise, both in the immigrant and the receiving society. Such expertise should enable the existing differences to relate constructively to one another in an interacting pluralistic society based on democratic principles (CARIGIET/MÄDER/BONVIN 2003). In many areas of education, health and welfare, therefore, forms of intercultural or transcultural intervention which have been developed and described in theory and practice therefore become established as a basis for understanding.

In the sphere of action of sex education some authors (e.g. SALMAN/RENZ 1998; BACKES/WRONSKA 1999; MARBURGER 1999; KUNZ/WRONSKA 2000; ditto 2001a; ditto 2001b; SIELERT 2005) have described approaches in which emancipatory sex education can initiate a demand for intercultural opening up, meaning that the environment of all – especially young people with a migratory background – is properly taken into account. This is a decisive contribution to the implementation of their demand that all target groups should have access to the values and standards structure of the receiving society in terms of sexuality, gender roles and gender relations.

4. Practice of sex education

The practice of sex education repeatedly throws up irritating, sometimes unsettling experiences in contact with multicultural groups. Those involved in sex education are confronted with their own feelings of powerlessness, helplessness and indignation when they come up against completely or partly pejorative reactions from the identity-seeking young people or their social environment⁴. They quite often meet this pattern in the immigrants who are (still) strongly bound to traditional religious contexts⁵. These 'new' experiences and the active argument of *pro familia* sex educators against them can be expressed in the following questions:

- How tolerant do we have to be in our work? What do we have to put up with?
- How do we position ourselves? With what ideas of values and standards do we work?
- What values are not negotiable?

5. Polarising perceptions of sexuality

In the immigrant communities of the Western industrialised countries, the cultural significance of sexuality is polarising – not only, but partly as a result of migration and globalisation. Sociologists talk about a process of 'divided modernisation': on the one hand, outdated value patterns are being massively eroded and new ideals are emerging, as is clear, for example, from the assessment of sexuality and partnership (*pro familia* 2001). As is generally known, there has basically been a paradigm shift from basically generally valid sexual morals to negotiated morals: nowadays, what is allowed sexually is what has been mutually agreed. These negotiated morals are a

component of a civil and democratic society in which individuals with the same rights live and act in line with their individual levels of intimacy, while respecting the limits of others (SCHMIDT 2004).

However, at the same time, traditional viewpoints still have the same validity for all those who for various reasons would not or could not take part in the social and culture-based processes of the last 30 years. This applies to a significant number of migrants from almost all parts of the world who come from rural areas, are poorly educated and for whom corresponding traditions are still a significant factor in the social life of their country of origin; the identity-defining significance of religion for migrants and evacuees should also not be underestimated here (KHOSROKHAVAR 2005). Even for some sections of the indigenous community the 'sexual morals of old' are becoming attractive again within the context of the revitalisation of religious life and the associated apparent safety within the community which can be seen in some places.

Those involved in sex education are therefore confronted in multicultural groups with perceptions that correspond to traditional patriarchal ways of life and life plans, including regulations according to which sexuality is only allowed within marriage and for reproduction, the requirement of virginity before marriage, clear hierarchical distribution of roles between men and women and consequently the inferior position of the woman, strict obedience by the children who, for example, do not decide themselves whether, whom and when they marry, discrimination against homosexuality, etc.

The limits of the conflict are not between religions and cultures; rather they divide those social forces which approve and recognise individual self-determination, where humans live together, from those forces which, because of a particular philosophy or religious conviction, have a firmly fixed world view and demand that individuals conform to this and adhere to the prescribed customs and practices unconditionally and without question.

In summary:

- Since the Cairo conference and against the background of the IPPF Charter, family planning organisations have considered themselves as human rights organisations.
- Migration is a reciprocal process which requires individual openness, as well as a willingness to learn from and with one another, by all concerned.
- Integration means the creation of expertise aimed at understanding of/introduction to the values and standards system of the receiving society.
- In the context of human rights education and relatively fast changes in society, sex education is required to accompany and explain these developments and, through education

3 Although *pro familia* has worked regularly with multicultural groups for decades, young people with a migratory background and their families have in many cases not completed the social transformation in terms of sexuality, partnerships and democratisation of gender roles. The *pro familia* sex education unit must therefore ask itself to what extent and why it has not been able to meet its targets.

4 See footnote 1

5 A good example of this (amongst many) is the subject of virginity. At the meta-level, for example, it may only represent a means to an end, that is as a means for a woman in a patriarchal society to achieve wealth, safety and protection through marriage. The fact that this means is no longer appropriate in our society should then be pointed out so as to raise awareness in the educational work, while at the same time respecting the aims of this woman.

about their sexual and reproductive rights, to strengthen the life skills of those concerned.

- The conflict is not between cultures, but between divergent concepts of life.

The standpoint of pro familia

The social developments as outlined above have led to a repositioning of pro familia on the basis of the IPPF charter.

In this sense, and as a response to the uncertainties expressed by those involved in practical sex education with regard to questions of expertise for dealing with ethnic matters, this article also shows how pro familia sex education based on human rights could be carried out.

Such sex education for indigenous young people and young migrants is to deal with themes of sexual and reproductive health and lead to a process of developing awareness about their rights. Sex educational material therefore carry messages about human rights education and develop awareness in this direction. It is assumed that anyone who knows his/her rights will not only claim them as necessary for himself/herself, but will also demand that they are observed and implemented for others.

Naturally the themes of physical and sex education, the prevention of unwanted pregnancies, protection against HIV/AIDS and prevention of sexual violence will continue to be included in the programme. What is new, however, is that they are to be regarded as a means of achieving the aim of providing education about sexual rights.

Discussion within the association

Three significant lines of argument are distinguished in the discussion:

- According to critics, the approach based on human rights brings with it the risk of reducing the problems of young people with a migratory background to cultural affiliations and could lead to the individuality of the young people being ignored. Instead of seeing them as victims of their upbringing and families of origin, their available resources should be realised. The aim cannot be to communicate generally valid values. That would be seen as indoctrination of (western) values and, as a consequence, a one-sided adaptation to the values and standards structure of the receiving society. There is a fear that these young people will have to give up their own identity-defining orientation guidelines and/or their behaviour patterns.
- Other critical voices point to the comparatively small cultural differences in their presentations. Generally, as in sex education subjects, they do not see any aspects which are relevant to culture. They therefore try to keep cultural idiosyncrasies as small as possible and tend to refer to them as consequences of social relationships.
- Finally there are those people involved in sex education who already to some extent base their work on human rights laws, as discussed in the debate. Against the background of the history of pro familia, in discussions about sexuality they demonstrate the social change, look for correlations and through discursive dialogue give encouragement and ideas in the sense of sexual self-determination and equality of the sexes. They see the information about sexual and reproductive rights as an offering which

the young people at the event can refuse, accept or even partially accept. They give them a chance – which they otherwise might not have – to find out about their rights.

Outlook

If we are successful in getting a consensus within the association for sex education based on human rights, it could play an important role in integration and coming to terms with the life skills of young people. It would take account of the specific requirements both of indigenous people and immigrants, thereby offering all the participants opportunities to learn. With the communication of human rights and the contents of the IPPF Charter, pro familia is making a significant contribution to the future development of the immigrant community, particularly in the complex areas of sexuality and living together because it supports access to Germany's standards and values system, makes an issue of basic values and thus contributes to the further development of civil society. It is only in this way that we can implement what THOSS (1997) spoke of when looking at the new rationale of the association: 'Sex education is exemplary democratising work.'

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Prevention File for Sexually Transmitted Diseases. Information and advice for people from different cultures

The Federal Centre for Health Education (BZgA) has developed a new medium for its advisory work with migrants that is aimed at supporting personal communication in the area of migration and sexual health. This article reports on the development and content of the prevention file.

Migration and health

There are 15.3 million people with a migratory background living in Germany (FEDERAL STATISTICAL OFFICE 2006); these are generally referred to as migrants. There are various approaches to defining this group. Put simply, it comprises all those people who are either foreign nationals (without German citizenship) or who permanently left their country to live in Germany or whose parents did so.

Just from the large number of migrants it can be deduced that these are people with very varied life situations. Their original culture, residency status, reason for immigration, experiences during migration and in Germany, social inclusion, socioeconomic background and many other variables make people with a migratory background an extremely heterogeneous group.

As with the variety of life situations of migrants, their health status and access to the services of the health system also vary. So, on the one hand, many migrants are in particularly good health: Those who have endured the stresses and strains of migration often represent a positive selection compared with the population of their country of origin in terms of their physical health and resources. Migrants can also bring a lower risk of certain diseases (e.g. cardiac infarction) from their homeland and maintain it, depending on their lifestyle in Germany (RAZUM et al. 2004).

On the other hand, however, the conditions of migration and life as a migrant in Germany are often so harmful that the person's health is affected: traumatic experiences in the country of origin and while fleeing from that country, separation from family or uncertainty about the possibility of being allowed to remain in Germany are all factors which can lead to illness. In addition, the migrants sometimes have a low socioeconomic status (in some cases as a result of the migration), which in itself – even for the population without a migratory background – gives rise to poorer health opportunities.

It should also be noted that the database on the health situation of people with a migratory background is very weak. Often only isolated studies have been carried out, so information is only available on certain illnesses for certain groups of people.

Migration and sexually transmitted diseases (STDs)

The situation with sexually transmitted diseases is similar to the general health situation of people with a migratory background. Here too there is only a weak data base. And in the case of sexually transmitted diseases too the effect can be very varied: thus, for example, in the case of HIV/AIDS, there are migrant groups who, because of their sociocultural lifestyle, have an extremely low risk of infection. Other population groups have comparatively high vulnerability. The ROBERT KOCH INSTITUTE established several years ago that in Germany, people from so-called high-prevalence countries are disproportionately affected by HIV. It is assumed that most of the people affected have already acquired the HIV infection before coming to Germany, but infections during later trips back home or in Germany through sexual contact with persons from the same region of origin are not to be ruled out (ROBERT KOCH INSTITUTE 2006).

The AIDS morbidity rate is also higher in people from high prevalence countries, which is at least partially attributable to their poorer access to the German health care system in that they learn later about their infection, receive treatment more rarely and discontinue it more often.

The poorer health care provision is associated with the poorer reach of preventive measures as far as certain migrant groups are concerned. Practitioners agree that some migrant groups are scarcely reached at all by the prevention messages which are ostensibly directed towards the general population. One study showed that the migrants interviewed were better informed about sexually transmitted diseases, but less well about HIV and AIDS, than the general population. This applied particularly to women from south eastern Europe (STEFFAN/SOKOLOWSKI 2005).

The reasons why a whole range of people with a migratory background are scarcely reached by mass communication prevention messages are complex. Some of them are described below.

Possible barriers to prevention messages

In the subject area of health and migration, various barriers are described which have the effect of making the healthcare system and its services poorly accessible in some cases to people with a migratory background. The first thing which is often mentioned is the language barrier: finding one's way through structures without the appropriate language skills is difficult and takes some effort. The likelihood of meeting qualified personnel who speak the migrant's native language is still small in Germany. If migrants have incomplete vocabulary regarding their body, health and sexuality, this tends to make already difficult communication with specialist personnel even worse, as for the specialist personnel a simple mode of expression is often difficult.

Cultural barriers such as varying concepts of health and illness are also often encountered. Western medicine, and therefore communication by the qualified personnel, has a scientific basis. The biomedical explanatory model of HIV infection and AIDS morbidity does not necessarily conform to the perception and experience of people from a different cultural background (see RAKELMANN 2005, BEIER 2005). In addition, in the area of sexually transmitted diseases and particularly HIV/AIDS, there are varying forms of contact with subjects such as sexuality, body awareness and – not least – homosexuality.

We should also not underestimate experiences in Germany such as discrimination, lack of understanding or being unwanted which can lead, not only to lasting physical damage, but to fear of using the services – for example the fear of deportation in the event of a positive HIV test.

Successful prevention work requires migration-sensitive approaches which take into account the fact that language, cultural or other factors can be effective barriers. It is important to note that preventive access to people for whom the reach is limited due to barriers such as these is easier to achieve in the form of (migration-sensitive) personal communication than in the form of mass communication messages. Personal communication means that the prevention content is communicated in personal contact and is adapted to the persons being addressed. In order to produce this contact, seeking out strategies in the form of the settings approach (NAIDOO/WILLS 2000) are often used. With the prevention file for sexually transmitted diseases, BZgA has developed a means by which it intends to support personal communication in the area of migration and health.

The Prevention File for Sexually Transmitted Diseases

This new medium includes all knowledge bases and themes which are necessary for the prevention of sexually transmitted diseases. It is divided into six chapters, 'Body, infection, HIV/AIDS (including the immune system), other sexually transmitted diseases, protection and prevention'. It also contains recommendations and instructions for use.

The prevention file contains a folder which can be arranged like a flipchart, with 40 text and 41 illustration sheets which are slightly larger than A4. The folder can be used flat or can be set up so that people can sit next to or opposite each other. It is therefore equally suitable for individual sessions and small groups. The illustration sheets are available as overhead transparencies or can be downloaded from

the internet. Prevention events with large groups are therefore also possible.

The text and illustration sheets represent a pool from which any qualified person can compile his/her own presentation. The text sheets are used for preparation and to provide key words during counselling sessions or events. But they are produced linguistically and artistically in such a way that they can also be used as handouts to be taken home. The illustration sheets show the most important information by means of pictures and are intended firstly for the advice seekers or the public.

Principles in developing the prevention file

1. Involvement of qualified personnel with a migratory background

Qualified personnel with a migratory background were involved in all phases of development. Thus, for example, in the concept phase in 2003 a workshop was carried out by BZgA in which numerous specialists in the theory and practice of health promotion in the area of migration took part. One result of this workshop was the decision to develop a multiplier medium (using materials which are already available) to enable STD prevention with various target groups, particularly those who can scarcely be reached, or cannot be reached at all, with traditional communication strategies.

2. A versatile medium

As already stated, personal communication, in conjunction with the settings approach, is the method of choice for reaching target groups who cannot easily be reached with the mass communication measures for AIDS education. An important request to the BZgA by practitioners was therefore to develop a medium for supporting dissemination work. However, at the same time the need to provide material for the final recipients was expressed. A technically versatile medium was therefore produced.

3. One medium for as many people as possible

Owing to limited resources it is not possible to produce media for all groups in Germany with the necessary internal differentiation (e.g. for all the regions of origin, women, men, age groups, degrees of integration, etc.). At the 2003 workshop, the decision was taken to develop a medium which, in terms of language, content and illustrations, is accessible to as many people as possible and addresses the lowest common denominator. This means, for example, that the text of the medium is in very simple German – generally the only language which, at least in elementary form, is shared by the participants in multicultural prevention events. The prevention file is also based on the western world's biomedical explanatory model for HIV/AIDS, as it is this which the migrants will generally be confronted with in Germany.

4. Use of available material

In its texts and illustrations the prevention file for sexually transmitted diseases utilises tried and tested media from Germany and other countries. It follows many years of collection and assessment of AIDS and STD prevention materials from all over the world. Many of these have been included in the content, texts or illustrations. The medium

‘Sexual and reproductive health’ from Switzerland (FEDERAL OFFICE OF PUBLIC HEALTH 2001), which has a similar concept, had a special influence on the prevention file. This served as a model, although it was then developed considerably to meet the needs in Germany.

5. Taking the barriers into account

The barriers described above are taken into account in a versatile way in the prevention file. Thus, an introductory text gives recommendations for carrying out prevention events in intercultural contexts. The aim is to sensitise disseminators who have little experience with multicultural advisory situations or prevention events to the backgrounds described above and to encourage them to carry out preventive measures.

The prevention file is also deliberately designed in such a way that people who are not active in the health field can also give correct information about sexually transmitted diseases and protection from them. This enables qualified personnel from other areas, for example counselling/mentoring of refugees, who deal with the subject of AIDS and STDs to devote themselves to the subject in contact with their clients. People with a migratory background can therefore obtain information from the people with whom they have already made contact.

Language barriers are countered by dealing with the complex subjects of STD prevention in very simple German. On the basis of experience in prevention events within courses for German as a foreign language, rules for linguistic simplification are implemented, and these are also described in the recommendations for multipliers. The text sheets can serve as models for simple wording. (In this context it should be pointed out that the BZgA also offers AIDS education materials for multipliers and final recipients in up to 29 languages).

Careful selection of content and illustrations is very important in terms of reaching the target group. So, with the continuous involvement of qualified personnel with a migratory background, care was taken to ensure that the content of the prevention file is very relevant for some migrants groups. Examples are female circumcision (so-called female genital mutilation), male circumcision, certain means of transmission of HIV and STDs, etc. In the illustrations, naked people for example are depicted demurely and without any personal features or only as outline drawings. For the portrayal of means of transmission, various illustrations are available which can be used depending on the composition of the target group.

6. Testing in practice

The prevention file for sexually transmitted diseases was subjected to a wide-ranging practice test in which 18 prevention specialists and numerous migrants took part. The experts assessed the prevention file with regard to content, texts and illustrations, both on the basis of their professional experience and its use in advisory situations and prevention events with the target group. The persons who were advised and informed by the prevention file corresponded to the heterogeneity of the target group for the medium in terms of countries of origin, age, gender, sexual orientation, HIV status, etc. The practice test resulted in a high level of validation for the form and content of the prevention file and various suggestions which were incorporated in the file.

Stéphanie Berrut



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Availability:

The prevention file for sexually transmitted diseases can be ordered in writing by multipliers quoting their institution, and is available at a nominal cost of 8.00 euro from:

BZgA, 51101 Köln

Fax +49 (0)221 8992 257

order@bzga.de

Order number 70400000

A flyer is also available for advertising the file.

Order number 70401000

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BROCHURES

Wegweiser für das deutsche Gesundheitssystem [Signposts for the German health care system] from the BKK

How can people who have not lived in Germany for long get health insurance? Who can they turn to if they themselves are ill or a member of the family becomes ill? Does one go first to a doctor or directly to the hospital? And if one goes to a doctor, which one? Answers to these and similar questions are given by the Wegweiser für das deutsche Gesundheitssystem [Signposts for the German healthcare system], which the Bundesverband der Betriebskrankenkassen (BKK) [Federal Association of Company Sickness Funds] has developed jointly with the Ethnomedizinisches Zentrum [Ethnomedicinal Centre] in Hanover and issued in several languages. It provides a comprehensive orientation guide and contains the addresses of offices, institutions, associations and organisations which can provide further help if the Wegweiser leaves any detailed questions unanswered.

The Wegweiser für das deutsche Gesundheitssystem is available in German, Arabic, English, French, Croatian, Russian, Serbian and Turkish. It is available as a printed version (free of charge for single copies, up to 10 copies for 4 euro, up to 20 copies for 6 euro, etc.) and can be downloaded from the internet.

Address for orders:
praevention@bkk-bv.de
www.bkk-prommig.de

Standpunkt Schwangerschaftsberatung [Attitude to pregnancy counselling]

The pro familia federal association has published a new position paper:

‘Standpunkt Schwangerschaftsberatung. Standards und aktuelle Herausforderungen’ [Attitude to pregnancy counselling. Standards and current challenges] describes the profile and the legitimisation of pro familia pregnancy counselling in the context of sexual and reproductive health and rights. It makes clear what consequences result for the work of pregnancy counselling from the characteristic pro familia approach which links health, sexuality and human rights.

The aims, functions, advisory contents, professional standards and quality assurance of the pro familia pregnancy counselling are described in detail. A second part deals with current challenges which pregnancy counselling faces, such as increasing poverty, immigration, HIV and AIDS, prenatal diagnostics and preimplantation diagnostics.

‘Standpunkt Schwangerschaftsberatung’ expands upon the position papers that have already appeared in this series, ‘Standpunkt Schwangerschaftsabbruch’ [Attitude to termination of pregnancy] and ‘Standpunkt Pränatale Diagnostik’ [Attitude to prenatal diagnostics].

Address for orders:
pro familia Bundesverband
Stresemannallee 3
60596 Frankfurt am Main
Telephone +49 (0)69 63 90 02
Fax +49 (0)69 63 98 52
www.profamilia.de
info@profamilia.de

Wechseljahre – Aufbruch in eine neue Lebensphase [Menopause – heading into a new phase of life]

This easy-to-understand guidebook for women and multipliers has been published again in a revised and expanded new issue (104 pages). The brochure looks critically at hormone replacement therapies and provides information on all important points

relating to the menopause and ageing with a holistic approach.

Changes in lifestyle and more balanced nutrition, more exercise and a reduction in stress levels are often sufficient to alleviate menopausal symptoms. The brochure contains self-help tips and deals with diseases such as depression and heart disease in women, which can emerge increasingly in this phase of life. Another main focus is the prevention and treatment of osteoporosis.

The new issue of ‘Wechseljahre – Aufbruch in eine neue Lebensphase’ is available from bookshops or via the Feministische Frauen Gesundheits Zentrum [Feminist women’s health centre] at the price of 6.80 euro.

Address for orders:
Feministisches Frauen Gesundheits Zentrum e.V.
Bamberger Straße 51
10777 Berlin
Telephone +49 (0)30 213 95 97
Fax +49 (0)30 214 19 27
ffgzberlin@snaflu.de
www.ffgz.de

SURVEYS

Die Gesundheit von Migrantinnen und Migranten als Voraussetzung für Beschäftigungsfähigkeit im Alter [The health of migrants as a prerequisite for employability when older]

This survey by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) contains comprehensive data on particular health problems suffered by migrants, perhaps caused by occupational diseases and accidents, road accidents or diseases. The problem areas for migrants are analysed and assessed in comparison with German employees. One chapter is also devoted to the care requirements of elderly people with a migratory

background and the intercultural opening up of facilities for the elderly.

The 'Conclusions and recommendations' chapter discusses particular impairments and barriers to inclusion in social or health opportunities, rehabilitation measures, etc. and identifies initiatives for change.

The survey is published in Berlin in Volume 6 of a series of the Deutsches Zentrum für Altersfragen [German Centre of Gerontology] (DZA) and appears in LIT-Verlag Münster. The volume is entitled 'Lebenssituation und Gesundheit älterer Migranten in Deutschland' [Life situations and health of older migrants in Germany]. It costs 24.95 euro.

Available from:

Bookshops

DOCUMENTATION

Migrants and health in Saarland

At the conference 'MigrantInnen und Gesundheit im Saarland. Interkulturelle Öffnung als Voraussetzung für bessere Gesundheitschancen' [Migrants and health in Saarland. Intercultural opening up as a prerequisite for better health opportunities] health care delivery for migrants, health and illness from a 'foreign' perspective and the intercultural opening up in health care, amongst other things, were discussed. The documentation of this conference, which has been issued by the Ministerium für Justiz, Gesundheit und Soziales des Saarlands [Saarland Ministry of Justice, Health and Social Affairs], is now available in print.

Address for orders:

Referat für Presse- und Öffentlichkeitsarbeit

Franz-Josef-Röder-Straße 23
66119 Saarbrücken

www.justiz-soziales.saarland.de

Telephone +49 (0)6 81 9 36 21-400

Fax +49 (0)6 81 9 36 21-943

broschueren@soziales.saarland.de

SINNVENTUR – Situation analyses and prospects for sex education

In November 2005, the Dortmunder Institut für Sexualpädagogik [Dortmund Institute for Sex Education] (isp) and the Gesellschaft für Sexualpädagogik [Association for Sex Education] (GSP)

jointly ran a symposium, the documentation of which is now available as a download.

160 participants discussed the current state of affairs in sex education. Key words for the range of subjects covered are teenage pregnancies, gender identities, cyberspace and homosexual sex education versus working with girls and boys. As well as the speeches, the results of seven specialist forums are documented. A printed version is not planned.

Contact:

www.isp-dortmund.de/Dokumentation_SINNVENTUR.pdf

Migration and masculinity

In the series 'Schriften zur Geschlechterdemokratie' [Articles on gender democracy], no. 14, the Heinrich Böll Foundation has published a documentation on the symposium 'Migration und Männlichkeit' [Migration and masculinity] (Berlin, December 2005). Amongst other things this deals with the everyday life of migrant workers in Germany, identity and reference to families by first generation Turkish men (see the article by Margret Spohn in this issue), work with fathers with a Turkish and Arabic migratory background and finding a role and role conflicts in settler families.

Address for orders:

Heinrich-Böll-Stiftung

Hackesche Höfe

Rosenthaler Straße 40/41

10178 Berlin

Telephone +49 (0)30 285340

Fax +49 (0)30 28534109

info@boell.de

www.boell.de

MAGAZINES

Betrifft Mädchen [For girls]: Migration

The theme of the January 2007 edition of the magazine 'Betrifft Mädchen' of the NRW state study group on working with girls is 'Migration'.

Address for orders:

Landesarbeitsgemeinschaft

Mädchenarbeit in NRW e.V.

Robertstraße 5a

42107 Wuppertal

Telephone +49 (0)202 75 95 046

Fax +49 (0)202 75 95 047

lag@maedchenarbeit-nrw.de
www.maedchenarbeit-nrw.de

WEBSITES

Collection of material on migration and health

The North Rhine-Westphalia coordination centre for women and health has made available a well researched, very extensive collection of material on the subject of 'Migration and health' on the internet. According to the foreword, 'Since migration-sensitive health research is still in its infancy, in future it will be a case of pointing out the requirement for further research and making efforts to establish a network of people in charge. To achieve this aim, relevant information should be available to all actors'.

The collection of material is also available as a printed version.

Contact:

FGZ HAGAZUSSA e.V.

Roonstraße 92

50674 Köln

Telephone +49 (0)221 801 77 78

Fax +49 (0)221 240 36 53

www.frauengesundheit-nrw.de/ges_them/migrantin/migration.htm

Cool clicks for little thinkers ...

The portal 'Wissen und Wachsen' [Knowledge and growth] of the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) and the initiative D 21 on infantile development is introducing the model project 'Coole Klicks für kleine Denker mit Migrationshintergrund' [Cool clicks for little thinkers with a migratory background] under the heading 'Bildung und neue Medien' [Education and the new media]. The project is centred on children who are disadvantaged because of their foreign language background and their basic conditions in terms of space and social situation. In the project the possibilities of the 'playground computer' for educational processes for this target group were tried out and appropriate educational play and learning programs corresponding to the children's requirements were selected.

Children with poor German were able to master many learning programs on their own relatively quickly, while

others required intensive support and direction from the educational staff. For this reason, the programs were divided into three categories, indicating the amount of support required. The contents of the games, their degree of difficulty and their possible applications are explained.

The project is intended to support integration-oriented education, to provide children with little knowledge of German with multimedia opportunities and educational possibilities in line with their curiosity and desire to learn.

Contact:

www.wissen-und-wachsen.de
www.coole-klicks.sin-net.de

pro familia website

If you enter the search term 'Migrantinnen' [migrants] on the pro familia website you will find a great deal of information on media and events on the subject of migrants in the sexual and family planning advice section.

Contact:

www.profamilia.de

Donna Mobile

Donna Mobile is also active in various spheres of action, with the aim of improving delivery of health care to female migrants and their families and to open up health care services more in line with the health concerns of female migrants. Publicity is used to provide information about the health situation of female migrants and their families, and health advice and events, as well as support and monitoring of self-help groups are offered. A further focus of the work is advanced training of multipliers to ensure that they are qualified to work with migrants.

Contact:

www.donnamobile.org/uns/uns.html

Prevention of sexual violence on the internet

After many years of research experience with the subjects of sexual violence and prevention, an internet project was established in Munich as a learning facility for young people from the age of 12; this then developed into the website www.niceguysengine.de.

Here, boys and girls learn to recognise sexualised violence in their environ-

ment and in their own behaviour. They report on their own experience by means of questionnaires, text contributions, interviews and videos.

Boys might, for example, record their contact with pornography and work out what is fun and where violence begins. The young people learn what behaviour patterns are defined as sexual harassment. They learn about the extent of and backgrounds to sexual assaults, recognise peer pressure and are encouraged to stand up for their beliefs: How might refusal and engagement appear? Use is free of charge and a CD-ROM is also available.

Contact:

www.niceguysengine.de
Further information:
perincioli@sphinxmedien.de
a.heiliger@t-online.de

Child credit calculator goes online

Since December 2006 a new service has been available on the internet: the 'Parents' allowance calculator' from the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ).

The service helps expectant parents and women and men who want to have children to plan jointly for the early time after the birth of the child. For women and men whose child is born on or after 1 January 2007, the parents' allowance replaces the previous child-raising allowance.

The parents' allowance calculator makes clear what the legal regulation actually means for the parents. The parents' allowance claim is calculated in five stages: first all the necessary general information is given. In a second stage, the income before the birth is to be entered. Then the assumable parents' allowance claim appears as a provisional result, whereupon the desired payment period is to be selected. If a person wishes to get parents' allowance while still working part-time, in a fourth stage he/she must indicate what income he/she expects from the activity for this time.

At the end of the process, a printable summary appears showing how much the fathers and mothers are provisionally entitled to in the individual months. In addition to the detailed calculation, a quick overall calculation is also available.

However, the parents' allowance calculator cannot provide any legally

binding information. The final decision on the parents' allowance entitlement can only be carried out by the responsible office where the application for parents' allowance must be made after the birth of the child.

There is a list of these offices and further information on the parents' allowance on the website.

Contact:

www.bmfsfj.de/elterngeldrechner

Migration and public health

The BZgA offers an information service on the internet which always has up-to-date reports on publications, projects, ideas, target dates, conferences and further training in the subject area of migration and health. This information service is also published in printed form four times a year.

Contact:

bzga.de/service/infodienste

PROJECTS

Model project for young women with a migratory background

The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) is increasing its commitment to improve the prospects of young women with a migratory background in the labour market by providing technical and methodical support to an innovative project by the Katholische Fachhochschule NW (Catholic College of Applied Sciences in North-Rhine Westphalia).

In the project 'Kulturelle Vielfalt als Impuls für Entwicklung und Wachstum: Wertschöpfung durch Wertschätzung' [Cultural diversity as an incentive for development and growth: added value through valuation] project groups in two model regions – Dresden and Cologne – are to explore how young women and men with a migratory background can use their knowledge and abilities even better in their work. The local economy should also benefit. One study group is utilised in each city, consisting of representatives from commerce, counselling and migration self-help groups. The multilingual ability and other cultural resources of young women and men with a migratory background could perhaps be used increasingly in tourism or the banking

sector, thus creating more qualified work and training places.

The progress of the model and initial results are to be presented to the public in a comparative East-West presentation as part of the 2007 European Year of Equal Opportunities for All.

Contact:

Christina Schlich
Katholische Fachhochschule NW
Projektkoordinatorin
Wörthstraße 10
50668 Köln
Telephone +49 (0)221 77 57 317
Fax +49 (0)221 77 57 319

Network for women and men with a migratory background

The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ), together with the Thomas Morus Academy Bensberg, has started a one-off model project: 'Network.21' is aimed at young women and men with a migratory background.

The model is based on 'tandems', consisting of two women or two men who are at the stage of transition from school or studies to the world of work and specialists from various professions. They each form a teaching, learning and advisory partnership. A total of 21 of these so-called 'mentoring tandems' are planned each year, 14 women's teams and seven men's teams.

Alongside these there are programmes for strengthening the participants' key skills. These are, especially, central multidisciplinary skills such as conflict resolution, leading discussions, process and project planning or intercultural sensitivity.

In addition, the Thomas Morus Academy as the project initiator is offering various seminars as the basis for engagement with civil society, which are being supported by a circle of voluntary committed young women and men with a migratory background themselves. The aim is to build up a network of a new generation of committed academics, who will actively campaign for intercultural learning, carrying others along this route and supporting them.

The model programme is designed to last three years, with support from the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) and funding from the European Social Fund. There is also scientific monitoring to support the

Federal Ministry. Anyone interested should apply directly.

Contact:

Thomas-Morus-Akademie Bensberg
Overather Straße 51-53
51429 Bergisch Gladbach
Telephone +49 (0)2204 40 84 72
Fax +49 (0)2204 40 84 20
akademie@tma-bensberg.de

Migration and public health study group

There are more than 14 million people in Germany with a migratory background, for whom an integration service must be provided for health care. The countrywide study group 'Migration and public health' was founded in 1994 with the aim of providing equitable access to health screening, advice and care for migrants.

In a current position paper, this committee has specified focal points, with the ultimate aim of opening up health services so that they are sensitive to migration. In particular, this involves development of awareness and training of qualified personnel. The study group also campaigns for more people with a migratory background to be employed at all levels of the health care service.

Contact:

The Office of the Federal Government Commissioner for Migration, Refugees and Integration [Büro der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration]
Postfach
11012 Berlin
Telephone +49 (0)1888 400 1625
Fax +49 (0)1888 400 1606
dorothea.grieger@bk.bund.de
www.integrationsbeauftragte.de

DVDs

Condoms: Only using them provides protection

Three video clips on the subject of condom use are included on one BZgA DVD and can be seen on the internet: '69 Cent' (approx. four minutes), 'einTÜTen' [Bag it] (approx. one minute) and 'Condom Manual' (approx. two minutes), an introduction to the use of condoms in German, English, French, Russian and Turkish. Information on the BZgA and the prevention project JungPositiv [Young positive] is also provided. The DVD is available free of charge.

Address for orders:

BZgA
Fachreferat 1-12
51101 Köln
www.gib-aids-keine-chance.de

STUDIES

Youth Sexuality 2006

As of November 2006, the BZgA's representative repeat survey of youth sexuality is also available as an English translation.

Address for orders:

BZgA
51101 Köln
order@bzga.de
Fax +49 (0)221 8992 257
Order no. 133 161 70

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FORUM *Sex Education and Family Planning*

A series of publications from the Federal Centre for Health Education (BZgA), Department of Sex Education, Contraception and Family Planning
Ostmerheimer Straße 220
D-51109 Köln, Germany

www.sexualaufklaerung.de

The German Library – CIP unit acceptance
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