STEUNPUNT
ALGEMEEN WELZIJNSWERK

The Right to Health is a Human Right: Ensuring Access to Health for Homeless People

National Report for Belgium for the FEANTSA annual theme

Gerard Van Menxel, Aafje De Wacker, Helen Blow

June 2006

The Right to Health is a Human Right: Ensuring Access to Health for Homeless People

National Report Belgium for the FEANTSA annual theme

Copy and editing: Gerard Van Menxel, Aafje De Wacker and Helen Blow

Translation and editing English version: Helen Blow

June 2006

Thanks are due to the following persons:

Ms Jenny Krabbe, SMES, Brussels Bruno Buytaert, VIG
Ms Tessa Windelinckx, Free Clinic, Antwerp
Ms Veerle Dupont, Belgische Projecten Artsen zonder Grenzen
Ms Veerle Evenepoel, Medimmigrant vzw, Brussels
Mr Gert De Volder, Artsen Zonder Grenzen, Antwerp
Mr Gert Leysen Wijkgezondheidscentrum, Antwerpen
Mr Sven Todts, Drug Coordinator (nationaal drugcoördinator FOD justitie), Prison Health Service, Ministry of Justice, Brussels
Our Steunpunt colleagues
And all other informants.

Mission Statement

Questionnaire for the FEANTSA Annual Theme

The Right to Health is a Human Right:

Ensuring Access to Health for Homeless People

AC members are asked to draft a national report for their country, based on responses to the questions outlined in this questionnaire. The reports should be 10 – 15 pages in length, written in either English or French and they should be submitted to the office by June 15th 2006. AC members are asked to consult with all FEANTSA member organisations in their country in the preparation of the reports; a copy of the questionnaire will be circulated to all FEANTSA members. The European report on Delivering Healthcare to Homeless People will be prepared over the course of the summer, on the basis of the responses received, and will be presented at FEANTSA's annual conference in Wroclaw on the 13th of October 2006.

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between health and homelessness. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. A definition of health is set out in the preamble to the World Health Organisation Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health.

There is a range of factors, which may lead to a person eventually becoming homeless and often health issues are among them. Health and homelessness have a relationship of both cause and effect: illness (such as mental illness, substance-abuse or illness leading to loss of employment) may be among the trigger factors that lead to homelessness. Once in a situation of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development or aggravation of substance-abuse and addiction, or health problems resulting from an unsanitary or overcrowded environment. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people.

This health perspective offers many people a better grasp of homelessness and can serve to counteract stereotyped visions. Health is one of the elements that has been used to define homelessness in Australia for example: in Australian legislation, homelessness is defined in the Supported Accommodation Assistance Program Act 1994. This act defines a 'homeless' person as follows:

"For the purposes of this Act, a person is homeless if, and only if, he or she has inadequate access to safe and secure housing. "(Section 4) The Act goes on to define 'inadequate access to safe and secure housing' and the very first criteria that is used is that of health: "For the purposes of this Act, a person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: damages, or is likely to damage, the person's health; or threatens the person's safety…" This offers a concrete understanding of homelessness in terms of a threat to health and well-being that policy-makers are likely to be able to identify with and which is concrete enough to mobilise political will.

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a vital factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic Social and Cultural rights, where it is set down that "the right to health is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation…" So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of homeless people.

Thus it is clear that health has a role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homeless, as meeting health needs is an important step towards tackling homelessness and health services should be a gateway to other services. It is for all of these reasons that FEANTSA has dedicated 2006 to exploring the theme of health and homelessness. This questionnaire will try to establish a broad overview of the issues relating to health and homelessness across Europe. It will look at health profiles of homeless people, access to healthcare, training of health professionals, inter-agency working, data collection on health and the right to health.

Content

Introduction. Nobody chooses to live in poverty

> "The problems people living in poverty are faced with are the result of poverty, not the cause. They have to do with the way society works. In our society, therer are mechanisms which ensure that poor people always end up at the bottom of the pile, no matter what they try.
>
> Many people therefore prefer to speak of social exclusion and income uncertainty rather than poverty. The expression 'poverty' gives the impression of compassion. The expression 'exclusion' refers to 'justice for all'. Social exclusion and income uncertainty are the result of an unequal development of society. The roofless put it thus in a play *'We are the skins of the fruit of economic growth'".*
>
> De Maeseneer, 2003d: 124

We open this report with the citation above because the theme health, in conjunction with the themes social exclusion, poverty and homelessness, particularly lends itself to an individual model of blame. It is easy to think the homeless and their health problems are largely their own fault. Because they do not work and therefore are not covered by health insurance, because they do not take care of themselves and therefore have al sorts of physical complaints, because they choose to live in the streets and therefore must bear the risk of freezing to death, because they drink or use drugs and therefore suffer health risks, because their life styles are deviant and they are therefore declared mad … it is all their own fault, in the mind of the general public.

At the outset of this report, we wish to clearly distance ourselves from such prejudices which blame the homeless themselves. 'Nobody chooses to live in poverty' and therefore, by expansion, nobody chooses to be homeless. We wish to approach the theme homelessness and health from a mdoel that holds society responsible (Vranken e.a., 1991-2005). This is the first precondition for a policy that offers dignity and improves the health of the homeless and includes a rights perspective in healthcare.

In this report we have tried to gather as much information as possible on the health of the homeless, their access and rights to health care and initiatives to improve the situation of the homeless. When we use the term 'homeless' in this report, we use a broad definition which fits with the Ethos typology that Feantsa uses. This means that in this report we will pay particular attention to groups such as asylum seekers and 'sans papiers' (undocumented migrants).

We cannot simply reiterate the usual wail of complaint that there is too little information available. It is not simply there either, cut & dried, ready and waiting. The theme 'homelessness and health' is rarely subject of health research. Apart from a few specific pieces of research, it is also rarely focussed on in research on homelessness. The main sources of information are reports from the shop floor of social work and writings by NGO's who are involved with either health and/or homelessness. The same applies to statistical data: it is not readily available in 'large' databases or surveys, but is supplied by the shop floor itself.

Although more scientific research and data collection would certainly be more than welcome and even necessary, we believe there is actually enough information on which action can be based. Within the process of dialogue that started with the General Report on Poverty (1994), many homeless and roofless people have shared their experiences. Their experiences 'from the bottom of society' are no doubt the most valuable and should serve to change policies and care for the homeless for the better. In our search for 'good practices' we found many organisations, associations, projects, partnerships and networks where people are concerned about the health of the homeless and are doing their best to ensure a better access to healthcare for the socially excluded.

This does not imply that within the limits of this report it will be possible to be exhaustive. We hope thei nformation we offer can contribute to the annual theme of FEANTSA. At the same time, we wish to apologize to all those people who are involved with policy making, research, social work and the homeless, and whose work has not bee mentioned.

1. Social exclusion, poverty and health

Social inequality regarding health exists, in Flanders as in Europe. Research shows that in all European countries there are differences of five to ten years in life expectancy depending on one's position on the social ladder. The difference in expected health is even larger. These health differences are not decreasing, on the contrary, the health gap between rich and poor is increasing.

An important annual publication, in the field of health and poverty, is the Yearbook Poverty and Social Exclusion (Vranken e.a., 1991-2005). It offers an overview of evolutions, research results, practical developments and governmental policy on poverty and social exclusion, in a mix of facts, analyses, theory and expert opinions.

The average life expectancy in Belgium shows strong socio-economic differences. The average life expectancy for a 25 year old man in Belgium without a degree is 48,1, while for a 25 year old man with a university degree this is 53,6 years. Health expectancy shows the same variation: a 25 year old man with the lowest level of schooling can expect 28.1 years of life 'in good health, as subjectively experienced' while for a university graduate this is 45.9 years (Gadeyne, Deboosere, 2002; Vranken e.a., 2001).

The Health Survey of 2001, by the Federal Government, shows a clear link between individual health and level of education. Persons with a relatively low level of educational attainment tend not to be very satisfied with their health. They suffer more chronic ailments (high blood pressure, back pains, …). Persons with a lower level of education also suffer more mental ill health. Finally, lower levels of educational attainment mean less social contacts and a more limited social network than higher educated people, and the content and quality of their social relations is worse (WIV, 2002; De Maeseneer e.a., 2003a-f).

As far as lifestyle, as determinating factor for socio-economic differences, is concerned, there are clear differences between the social classes. Lower educated people are less likely to smoke, do less sport and have a less healthy diet. They are also less inclined to adjust their diet (WIV, 2002; De Maeseneer e.a., 2003).

Lower educated people visit general practitioners more, are admitted to hospital more often and take more prescribed medicine. Higher educated persons consult medical specialists and dentists more often, and use less prescribed medicines (De Maeseneer e.a., 2003). Finally, the poor have more mental and psychiatric problems, research shows, for instance, a connection between poverty and depression (Levecque, 2003).

2. Health profiles of homeless people (Q 1)

2.1. Roofless

Roofless (Ethos 1 & 2)

Ethos: roofless				
	1	*Living in a public space (no abode)*	*1.1*	*Sleeping Rough*
			1.2	*Contacted by outreach services*
	2	*Stay in a night shelter and/or forced to spend several hours a day in a public space*	*2.1*	*Low-threshold / direct access shelter*
			2.2	*Arranged (e.g. low budget hotel)*
			2.3	*Short-stay hostel*

We discuss the health problems of those persons living in a public space and those persons staying in a night shelter together, as there is not much reason to assume there is a significant difference in their health profile. Very few studies make this distinction anyway.

In addition, a few of the health problems mentioned below, also apply to other categories of homeless people (such as those staying in hostels, see 2.2)

Among the homeless, the asylum seekers and in particular the 'sans papiers' (undocumented migrants) are a special category. Many migrants, especially asylum seekers, are not able to make use of the centres for asylum seekers (ethos category 5) but are roofless or very poorly housed (see 2.2.2)

The given definition of multiple needs *(Definition from Homeless Link Good Practice Briefing "Multiple Needs" August 2002)* appears to apply totally to the health related problems of the roofless, be they street sleepers or users of night shelters, in Belgium. Their problems seem most urgent in Brussels and less in the larger cities of Flanders (Antwerp, Ghent, Ostend) or Wallonia (Charleroi, Liège).

"A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services: mental health problems; personality disorders; borderline learning difficulties; disability; physical health problems; vulnerability because of age; misuses various substances; offending behaviour; and challenging behaviours. If one were to be resolved, the others would still give cause for concern."

To this list of problems we could add the lack of safety and the potential for victimization of the roofless. The social lack of well being, diet and extreme weather are important factors too, which can add to the single or multiple health problems of the roofless. .

Table 1 gives an overview of the physical, mental, social and drugs related health problems of the homeless. To a greater or lesser degree this applies to all ETHOS categories. Although there are certainly differences and gradations, and it is sometimes difficult to categorise people. The health problems of the roofless, the homeless, the prisoner, the roofless drug user or asylum seeker, all boil down to the same aspects and problems.

Table 1 – Health risks and needs of roofless people

Aspect	**Problems (needs)**
Personal hygiene	- general body hygiene (washing, lack of hygiene because of lack of basic amenities) - skin - teeth - eyes - feet - …
Physical health problems	- weakened physical condition due to general lifestyle - infections - TBC - HIV - Multitude of health problems - …
Mental, psychic and social-psychological health problems	- Psychic lack of well being - depressive complaints - sleeplessness - lonelyness - anxiety - stress - trauma - …
Psychiatric illnesses	- borderline - psychosis - acute and/or chronic depression - suicide (inclinations) - automutulation

	- schizophrenia - …
Social well being	- lack of self confidence and self respect - lack of privacy - insecurity - discrimination - shortage of secure storage space for personal belongings - street noise - lack of access to medical care - avoiding contact with authorities, with public services or with representatives of the government - unbalanced and chaotic lifestyle - family problems - truancy among children - necessity to find other (possibly criminal) methods of paying for health care …
Addiction	- tabacco - alcohol - soft drugs - hard drugs - …
Food	- lack of food and drink - unhealthy diet - excessive drinking - _
Safety or victimhood of violence	- victimhood and wounds due to streetfights - attacks - murder - victimhood and wounds due to domestic violence - noice, arguments, disputes - sexual harassment - usbstance abuse and agression - police harassment - - _
Extreme weather	- cold - heat - _

2.2. Houseless

Ethos:	HOUSELESS			
	3	Homeless hostel / temporary accommodation	3.1	Short-stay homeless hostel
			3.2	Temporary housing (no defined time)
			3.3	Temporary housing (transitional defined)
			3.4	Temporary housing (longer stay)
	4	Women's shelter / refuge	4.1	Shelter accommodation
			4.2	Supported accommodation
	5	Accommodation for asylum seekers and immigrants	5.1	Reception centres (asylum)

			5.2	Repatriate accommodation
			5.3	Migrant workers hostels
	6	Institutional Release	6.1	Penal institutions (period defined nationally)
			6.2	Institutions (care and hospital)
	7	Specialist Supported Accommodation (for homeless people)	7.1	Supported accommodation (group)
			7.2	Supported accommodation (individual)
			7.3	Foyers
			7.4	Teenage parent accommodation

2.2.1. Homeless people in residential care, women's shelters and temporary accomodation

The health situation of the homeless in Flanders (Van Menxel, e.a., 2004)

Houseless, Residential care and temporary accomodation (Ethos: 3,4, 7)

In this piece of reseach we consider all homeless people who were in a residential hostel or in supported housing run by a Centre for General Welfare Work on a particular day, and we asked questions about their health. (Van Menxel e.a., 2004).

2 in 3 homeless people have health problems

75% of the homeless population faces health problems. In all age groups and for men as well as for women. Exclusively psychological or psychiatric problems (50%) (higher for women). Physical or mentally disabled: 28%. Chronic or life threatening disease: 26%

Two thirds of the homeless have health problems. One could assume that these health problems might increase with age. This proves to be only partially the case. In all age categories, about three quarters of the population are unhealthy. Only two age categories score lower than average (31-35 years old and 56-60 year olds), so these variations cannot immediately be explained. We must remember however, that not all health problems are reported to the social workers.

Tabel 2 – Health problems according to age, 2002 (in %)

Health problems			Total
	Yes	No	
Less than 21	76,9	23,1	100,0
21 - 50	75,4	24,6	100,0
51 and more	74,5	25,5	100,0
Total	75,4	24,6	100,0

N= 260; Missing = 13

According to gender, health problems occur in more or less equal proportions

Tabel 3 – Health problems according to sex, 2002 (in %)

Health problems			Total
	Yes	No	
Man	75,0	25,0	100,0
Woman	76,1	23,9	100,0
Total	75,4	24,6	100,0

N= 268; Missing = 5

Nature of the health problems

Nearly three in four homeless youngsters have psychological problems

If we look at the nature of the health problems reported there are very clear differences according to age and gender. The youngsters under 21 years of age clearly have more psychological problems, for these make up 3.1% of their problems. It is also clear that older people suffer more physical ailments. Nevertheless, even in the age category 21-50 years old (57.8%) and over 51 years old (45.3% the psychological problems are the most important health problem. From 51 years old on, physical problems overtake the psychological.

Tabel 4 – Nature of the health problems according to age, 2002 (in %)

Health problem	Age category			
	- 21	21-50	51 and over	Total
Physical handicap	7,7	10,9	16,4	11,7
Mental handicap	8,0	16,6	18,5	16,2
Psychological problems	73,1	57,8	45,3	56,8
Chronic disease	4,0	13,5	33,3	16,7
TBC	-	3,0	3,7	3,1
Cancer	-	1,7	9,3	3,2
Aids/HIV	4,5	1,2	1,9	1,6
Sexually transmitted disease (STD)	4,5	0,6	1,9	1,3
Other	8,3	17,1	22,6	17,4
Total	100,0	100,0	100,0	100,0

Homeless women have more psychological problems than men

Psychological problems are prominent among both women and men, but women have more problems in this area than men. In the context of the common problem of domestic violence this need not surprise us. Cancer also occurs far more frequently among women than among men.

Tabel 5 – Nature of the health problems according to gender, 2002 (in %)

Health problems	Gender		Total
	Men	Women	
Physical handicap	15,7	3,4	11,7
Mental handicap	19,0	10,5	16,2
Psychological problems	54,5	61,4	56,8
Chronic disease	17,4	15,3	16,7
TBC	3,5	2,4	3,1
Cancer	1,2	7,1	3,2
Aids/HIV	2,4	-	1,6
Sexually transmitted disease (STD)	1,2	1,3	1,3
Other	18,7	14,9	17,4
Total	100,0	100,0	100,0

Health research among users of hostels reception centres in Limburg (Vanheusden, 2004)

Houseless (Ethos 3,4, 7.2)

Comparative research between the homeless and the rest of the population.

Vanheusden (2004) investigated the health, lifestyle and medical consumption among the population of users of Limburg reception centres (ethos 3.1), including emergency shelters (ethos 3.2), centres for battered women (ethos 4). All were questioned at length. Because the same indicators were used as in the national health questionnaire of 2001 the data on the homeless could be compared with that

of the 'average' Limburger (Limburg is a province in Flanders). Street sleepers and marginally housed people were not included in this research.

The aim of this piece of research was to find out what the subjective, physical, and social health situation is, the consumption of alcohol, tobacco and illegal drugs (lifestyle) and the use of health services among the users of the Limburg reception centres. This choice was made because the shop floor was reporting increasing health problems among the roofless and homeless. There was a lack of quantitative data because this group is not included in routine health research.

140 inhabitants of reception centres filled in a questionnaire, a response rate of 92%. The control group consisted of the 555 respondents, older than 18 and living in Limburg, who took part in the national health inquiry of 2001.

Methodology

The subjective experience of health was measured with a general question (what is your general health situation?).

For measuring the physical health the prevalence of various chronic conditions (asthma, back problems and allergies) was questioned.

Mental health was analysed using the GHQ-12, the Symptom Checklist-90 (SCL-90), self reported depression, and the use of psychotropic medicines such as sleeping pills, sedatives and anti depressants. Regarding the social health questions were asked about the scale of the social network.

In addition, questions were asked about *life style indicators*, smoking, use of alcohol and illegal drugs,– and *indicators for the consumption of psychotropic medication* – sedatives, sleeping tables and antidepressants– were included.

As various pieces of research indicate that roofless and homeless people are in frequent contact with psychiatric services questions about this were included in this research.

Results

It was found that the homeless have a significantly worse subjective, physical, and social health than the average Limburg population. The homeless have different lifestyle to the average population, and it is most certainly a less healthy lifestyle, there is more over consumption of alcohol, they smoke more and have more experience with illegal drugs than the average Limburger. IN particular, the enormous differences, between the homeless and the average population, in mental health are worrying. This shows there is a considerable need for more psychosocial support and coaching, in particular as far as use of psychotropic medication is concerned, and there is a need for close cooperation between General Welfare Work and Mental Health Care. Illness and medication work to reinforce homelessness. Vanheusden calls for the development of joint European questionnaires so that more internationally comparative research may be done on the health of the homeless and roofless.

Health situation

In comparison with the average population there is a poor subjective experience of health, much more than users (52%) and Limburger (21%) consider their health as reasonable to very bad. (tabel 6).

Psychological health problems, even non threatening forms, are a drain on ones feeling of well being and on ones quality of life. As far as mental health is concerned, there is a remarkable difference in GHQ-score between the homeless and the average Limburg population, which is 5.14 for the homeless and only 0.99 for the Limburger. This indicates that the homeless have a far greater chance of contracting a mental ailment. In comparison with the average population, the homeless feel seriously unwell psychologically.

For 78% of the homeless – compared with 18.5 % average – there is a possible psychopathology. Even is a stricter threshold is used (4+), in principal the level at which professional help is needed, 64% of the homeless have a possible psychopathology, compared to only 10% of the average Limburg population.

Tabel 6 – Health complaints, consumption of medication, life style indicators and contacts with residential and ambulant care, as percentages of the total survey.

	Homeless		Limburgers	
	N total	%	N total	%
Unsatisfied perception of health	140	52,1	526	21,5
Prevalence van asthma	140	6,4	545	2,9
Prevalence of back problems	140	20	546	12,6
Prevalence of allergy	140	17,1	545	11,6
Average GHQ-score	140	5,14	520	0,99
GHQ [2+]	140	77,9	520	18,5
GHQ [4+]	140	63,6	520	10,2
Self reported depression	140	45	546	6
One or more psychological complaints	140	64,3	555	25,6
Depressive complaints	140	48,6	523	9,8
Anxiety	140	28,6	522	6,5
Sleeping problems	140	46,4	518	21,8
Satisfaction with social relations	140	61,4	529	94,9
Number of good friends and families	140	4	482	9
Use of sleeping medication	141	11,4	547	8,4
Use of sedatives	140	20	547	3,7
Use of antidepressants	140	15,7	546	3,8
Daily smokers	140	87,9	524	27,9
Never smokedt	140	8,6	524	38,9
Use of alcohol 3 times a week and at least 6 glasses	140	21,4	519	2,7
Cannabis use	140	55	517	7,5
Ecstasy/ amphetamine use	140	36,4	509	2,2
Contact centre for alcohol or other drug problems	140	15	N	N
Admission into addiction clinic	140	10,7	N	N
Admission into psychiatric clinic	140	38,6	N	N

Source: Vanheusden, 2004

Some more specific indicators for mental health were investigated, in particular depressive complainsts and anxiety and sleeping problems.

Far more homeless (49%) than average Limburgers (10%) reported depressive complaints. The same applies to the prevalence of self reported depressions, seven times as many homeless (45%) as Limburgers (6%) report a depressive period of more than two weeks over the past year.

In comparison with the Limburg population, there is also a significantly larger share of the homeless who report anxiety problems (29% of the homeless compared to 6.5% of the Limburgers) and sleeping problems (46% of the homeless versus 22%). We can conclude that the homeless suffer more frequent depressive complaints, anxiety and sleeping problems than the average Limburg population.

Despite the greater prevalence of sleeping problems amongst the homeless, their consumption of sleeping tables is not significantly larger than for the average population. The use of sedatives and anti depressives is greater among the homeless, and in particular the use of sedatives is noticeable (20% versus 4%), particularly considering the fact that this target group is actively encouraged by the social workers to take their lives in hand and to get organised.

As far as social health is concerned, the homeless have a more limited social network than the Limburg population, for the average number friends and family is 4 versus 9 persons.

Lifestyle

The use of *tobacco* is immensely different for the homeless versus the average Limburg population. Three times as many homeless people smoke on a daily basis (87.9% versus 27.9%) Only 8.6% of the homeless has never smoked, while 38.9% of the Limburgers have never smoked.

As far as alcohol use is concerned, eight times as many homeless people can be classed as 'excessive drinkers' compared to the Limburg population. As 21% of the homeless drink more than six glasses of alcohol in one day, three or more times a week, while only 3% of the Limburg population do this.

For the experimental use of cannabis, seven times as many homeless (55%) as Limburgers (7.5%) admit to having used cannabis at some point.

The experimental use of XTC/amphetamines is even higher: 36% of the homeless have tried either XTC and/or amphetamines, versus 2% of the Limburgers.

Contacts with ambulant and residential care

The use of services such as drug and alcohol clinics are an indicator for the prevalence of addiction problems among the homeless in residential settings. 15% of the homeless has had contact with an ambulant service of the Centre for Alcohol and other Drug Problems and 10.7% has been admitted to an addiction centre at some point.

The figures on mental health problems were supported by the insitutional past of the homeless. More than one in three homeless persons were admitted into a psychiatric clinic at some point in their lives.

2.2.2. Asylum seekers and undocumented migrants

Immigrants (ethos cat. 1, 2, 5, 8, 11, 12 & 13)

People without a legal permit to stay are officially registered nowhere and are more or less 'invisible' in society. In order to map this class of 'invisibile' people Devillé (2006) did qualitative research based on the 'grounded theory' as developed by Glaser and Strauss, so that the theoretical findings were deduced directly from the experiences and interpretations of the illegal migrants themselves. Particularly noticeable is that the best integrated undocumented migrants – and their individual sense of well being – are those with the largest social capital and this does not always coïncide with the best financial situations. A group of ondocumented migrants form an 'outsider community' in Belgium, a society within society, that is strongly focussed on itself and where the members live in strong solidarity with one another, both legally and illegally.

In 2005 9.925 patients visited the *Medicins Sans Frontières/ Artsen Zonder Grenzen* consultations (AZG, 2006). The two largest groups of patients were undocumented migrants and asylum seekers.

The percentage of asylum seekers in these consultations rose lightly from 3% in 2004 to 3.5% in 2005. The number of undocumented migrants rose from71% to 74%. There were 18% refused asylum seekers among them.

Tabel 7 shows the pathologies and diagnoses of asylum seekers in precarious situations and of undocumented migrants

More men than women come to the consultations. The largest group of men is between 30 and 39 years old, the largest group of women is aged 20 to 29.

The division according to nationality shows 3.2%. The average (20.5%) of the visitors has a Magreb nationality (Marocco, Tunesia, Algeria), followed by European nationals from non- EU countries (Turky, Balkan, ex-USSR) 17.5%. and then Latin America (12.7%) and Asia (11.5%).

More than 75% of the patients have no normal health insurance and therefore no access to health care as it is provided to the general population. In this category, people are included who are eligible for 'urgent medical help'

Tabel 7 – Pathologies and diagnoses of patients of Artsen Zonder Grenzen (Brussels, Antwerp, Liège), 2005

Pathologies	Brussels	Antwerp	Liège	TOTAL
Osteo-articulair	458	365	38	861
Gastro-enterology	441	300	24	765
Gynaecology	272	438	18	728
Dermatology	264	298	19	581
Uro-genital	259	255	14	528
Pneumology	224	275	20	519
Cardiology	244	254	7	505
Nose-throat-ear	276	147	49	472
Certificates	310	50	7	367
General	193	139	9	341
Dentist	185	115	25	325
Endocrinology	140	129	10	279
Various	176	86	11	273
Psychopathology	163	83	24	270
Neurology	118	88	8	214
Oftalmology	112	71	10	193
Medication	133	26	7	166
TOTAL	3968 *	3119 *	300 *	7387*

* Several complaints may be registered per patient.
Source: Artsen Zonder Grenzen, 2006

2.2.3. Prisoners

Penal Institutions (ethos cat. 6.1)

Diseases

Despite the fact that the majority of prisoners are young men, it is a very vulnerable population (written contribution by dr. Sven Tods, national drugscoordinator for the judicial civil service - FOD justitie):

- 20 -30 % is drugs dependent.
- This explains the many infectious diseases :
    - Hepatitis C: 15% versus 1.5 % among the general population.
    - HIV: ten times more than among the general population .
    - TBC: 10 to 20 times more than among the general population
- More chronic ailments (diabetes, high blood pressure, etc). This has to do with factors such as life style, diet and the use of medication.
- Psychiatric problems occur in a ratio of 5 to 20 times as often as among the general population: ca 5 % of the population is psychotic, ca 20 % is clinically depressed.
- Suïcide occurs ten times as often as among the general population.
- A 'new' problem: there is a growing need for specific care for older prisoners (geriatrics). This has to do with the large numbers of sexual delinquents who, since Dutroux, are no longer granted early release on parole.

In the same vain, Polfliet (2005) writes in his report 'Health protection for employees in the social services of the prisons' that there are two illnesses which occur frequently in prisons, tuberculosis and hepatitis.

Prisoners are an important risk group for TBC, probably because many of them are socially marginalised people, and often natives of countries with high TBC rates. On top of that, a proportion of the prisoners are HIV infected (on average 1%) and/or intravenous drug users (15%). Among people with HIV and TBC bacilli the risk of developping TBC is 8 to 10% per year, while for persons only infected with TBC the risk is only 10% in their whole lifetime. When double infections occur, the chances increase that the TBC will evolve to an active illness. .

Intravenous drug users run a higher risk, even if they are HIV negative, of developping TBC. The reasons are not totally clear. .

Life circumstances in the prisons, the overcrowding, lack of daylight and fresh air in the cells, increase the chance of contracting an infection. .

Problems

The main problems for prisoners are, according to dr. Sven Tods, national drugcoördinator FOD justitie:

- The situation of mentally ill inmates for whom there is too little suitable accommodation/treatment
- The professional dependence of the healthworkers on the prison directors.
- The division between care and expertise tasks which should be introduced in the short run.
- The still limited financing.
- The insufficient staffing of the central health service

Drug use in the prisons

In 2003 an investigation into drug use in the prisons was carried out by two NGO's (Modus Vivendi & Street Wise) (Belgian National Report on Drugs, 2005: 93).

The main aim of the research was to evaluate what knowledge the inmates have of the risks connected with drug use, the risks of transmittable diseases (HIV and hepatitis), risks connected with unprotected sexual intercourse and other risky behaviour (piercing, tatooes, sharing injection needles etc.)

According to this piece of research, the prevalence of illegal drugs in the prisons is around 33%. Cannabis is the most used (28.9 %), followed by heroin (13.3%) and 2.5% of the inmates report having injected drugs. For more details see www.belspo.be.

2.2.4. Medical institutions

Medical institutions (ethos cat. 6.2)

No relevant information available.

2.3. Insecure housing

INSECURE HOUSING	8	No tenancy	8.1	Living temporarily with family or friends (not through choice) (Housing /Social Service records)
			8.2	Living in dwelling without a standard legal (sub)tenancy (excludes squatting)
	9	Eviction Order	9.1	Legal orders enforced (rented housing)
			9.2	Re-possession orders (owned housing)

	10	Violence	10.1	Living under threat of violence from partner or family (police recorded incidents)

No relevant information available on Ethos Cat 8.1 & 8.2, 9.1. & 9.2

Violence, ethos cat. 10

This item will be treated in a reader on domestic violence produced by Steunpunt Algemeen Welzijnswerk (forthcoming beginning 2007)

2.4. Inadequate housing

INADEQUATE HOUSING	11	Temporary structure	11.1	Mobile home / caravan (which is not holiday accommodation)
			11.2	Illegal occupation of a site (e.g. Roma / Traveller / Gypsy)
		Unfit Housing	11.3	Illegal occupation of a building (squatting)
	12			
			12.1	Dwellings unfit for habitation under national legislation (occupied)
		Extreme		
	13	Overcrowding	13.1	Highest national norm of overcrowding

2.4.1. Permanent campsite dwellers

Mobile home or caravan (ethos cat. 11.1)

Research carried out in 1997 among campsite dwellers in Flanders indicates that 34% of the campsite inhabitants and 28% of the total number of their family members suffer a chronic disease which has already lasted at least a year. Apart from the 65-plussers there are more healthproblems in all age categories of campsite dwellers than for the average Flemish person. 30% of the campsite dwellers take daily medication. Many 'ill' people moved to a campsite for health reasons, hoping they would feel better in healthy and quiet surroundings (Raymaekers, 1997 in Delcourt e.a., 2000: 41). Earlier research in the province of Antwerp, where many permanent campsite dwellers live, showed that nearly half the dwellers suffer a chronic illness or disability. This is reflected in the high daily use of medication (43% of the dwellers), hospital stays in the past year (33%) and daily alcohol use (22%) (Siersack, 1995: 27).

Other problems for permanent campsite dwellers are safety (fires, burgelary, violence), unhealthy housing (small, damp, unsuitable housing). In certain places there are concentrations of illegal dwelling and dwelling by undocumented migrants.

2.4.2. Illegal campsites/travellers

No relevant information available.

2.4.3. Squatters

No relevant information available.

2.5. Health problems among homeless carrying a public health risk

1.2: Certain diseases, which are widespread among the homeless population, carry a clear public health risk. This is the case, for example, with tuberculosis. Tuberculosis incidence is much higher among homeless people than among the general population and there is a risk of the spread of this infectious disease and the development of multi-drug resistant strains. For this reason, some countries have put in place specific programmes or strategies to combat tuberculosis among homeless people. Please outline list any public health risks associated with the health of homeless people and actions taken to alleviate these risks.

2.5.1. Diseases with a public health risk

The most important diseases with a public health risk are:

- Tuberculosis
- HIV and other STD's
- Hepatitis
- Drug addiction

Specific health risks for other inhabitants/clients of reception centres.

Actions: training/information for the staff and clients of reception centres, cooperation with health workers, local health centres, etc.

2.5.2. Homelessness and drug abuse

In Belgium there is no national registration of the roofless and there have not been any recent studies about drug use within this specific group either. There is a broad range of services for the roofless, such as night shelters (low threshold, alcohol and drugs are usually not tolerated within the center), day centers, emergency centers. The roofless are usually poorly educated males (Philippot e. a. 2003, Mendonck en Van Menxel 2005). Problems with mental health are stressed in the relevant research literature (Philippot e. a. 2003).

In the Flemish community the registration system 'Tellus', run by the Centres for General Welfare Work CAW's, offers a profile of the homeless. In 2003 350 clients out of 100 000 were registered as having an addiction problem upon arrival (75.5% men and 24.5% women). Over half (52.7%) are aged between 26 and 59 years old and about a third (32.2%) is between 18 and 25 years old. 51.3% of them will be offered help in a CAW and 18.6% requests treatment. 34.5% is referred to a specialist center. The majority of these roofless drug users (most of whom are unemployed) are admitted into reception centers.

Very often the 'drug problem' is not noted (De Donder 2004).

The CAW's believe these figures underrepresent drug use because of problems with the registration. In future this will be resolved. (Mendonck en Van Menxel 2005)

Research in the province of Antwerp indicates that of all the clients requesting treatment in any one centre nearly 10% is roofless or lives in a precarious housing arrangement (Colpaert e. a. 2005). Compared to non-roofles clients they seem to be polydrugusers more often, using opiates, cocaine, alcohol and hypno-sedatives, and they have a long treatment history. They are not significantly younger or older. Among roofless drug users the percentage of women is lower (16.4%) than among drug users in a more stable situation. Roofless drug users roam around in the town of Antwerp, far less so in the surrounding towns and communes. A number of reception centres contacted indicate that between one fifth (21.8%) and one third (35.4%) of all roofless people seeking help used illegal drugs and/or alchohol regularly and to an excessive degree. Finally the research also mentions that – even over a limited timeframe of six months – there was considerable overlap between the drug clinics and the reception centres for the homeless: about 25% of the clients with a problem of excessive drug use

were registered in a reception centre and a treatment centre at the same time. The authors stressed the subsequent need for close cooperation between both sectors.

In Belgium there is no national registration of treatments. The data is collected in more than ten different registration systems, many of which have long traditions. These figures cannot be collated to a national figure, and in the past few years, the National Focal oint decided not to include this data in the National Report.

For more information see: Belgian National Report on Drugs, 2005, http://www.iph.fgov.be/reitox/Publications/BNR05NL.pdf

2.6. The mental health of the roofless

Research by Phillippot and others (2003) into the mental health of the roofless is unanimous about the fact that the prevalence of mental ill health is greater among the roofless than among the general population. It also shows that these illness occur before the person in question loses his/her tenancy. However, there seems to be little agreement on the nature of mental illnesses the roofless suffer from. A psycho-epidemic study was conducted amont a panel of 42 Belgian roofless persons. Using a valid evaluation instrument the study aimed to research a wide spectrum of illnesses among a large enough sample to be able to make valid estimations on the prevalence of mental ill health among this target group.

The study confirms that the number of psychiatric illnesses in the roofless population is very large. The most common are depressions, general anxiety and addiction or abuse of addictive substances (alcohol or drugs). Nonetheless, only 12% in the sample were actually ill, the prevalence of psychotic disturbances is worth mentioning because these are relatively rare among the general population (0.5 to 1%). Finally, there are no eating or somatic illnesses noted. This confirms that the roofless are not too concerned with their bodies.

The number of psychiatrically ill persons is rather large: for the representative group, only 7 roofless persons (15%) show no psychiatric disturbances and six (13%) do show signs of only one disturbance. The others have at least two proven psychiatric illnesses.

Within the panel of roofless persons, there are no characteristics which tally with psychiatric illnesses. More specific diagnoses have shown up some interesting patterns. The roofless with a specific anxiety problem (not general anxiety) have a higher level of educational attainment than those without anxiety problems. The aforementioned have all been roofless once before, while the latter have been roofless 1.2 time on average. The age, nationalality and housing do not appear to correlate with the absence of an anxiety disorder. The analysis concerning general anxiety is different. This appears not te be linked to age nor to earlier experiences of rooflesnes, but to housing (people who are naturally anxious suffer more from insecure housing) and education, but this time it is reversed: the trend is that people who are naturally anxious have a lower level of educational attainment than non-anxious people..

Alcohol use does not seem to be connected to the number of experiences of rooflessness. Neither does depression have a link with nationality or other variations. People of African descent nearly all have this diagnosis while it is only found in 7 out of 24 European-born people.

Philippot's research stresses the importance of mental health problems among the roofless. As for the organization of services for the roofless, the high number of depressions and the high risk of suïcide for this population points to the need for personal and individual help/treatment. The organizations for welfare, administration and health are separate and autonomous. This implies the roofless person must go to a range of services and interact with a range of social workers. The mental ill health of many roofless persons makes it difficult for them to adjust to this administrative situation and hinders their reintegration.

As regards the development of a mental health policy for this target group, it is an illusion to expect the roofless toe come and ask for help regularly and of their own accord.

A mental health policy must be developed which is pro active (the mental health doctors must seek out the roofless where they are to be found), personal (they need a fixed anchor person to coordinate their mental health) an designed to reintegrate the roofless into society by developing their social network.

2.7. Problems with the treatment of specific health problems

1.3: Certain health conditions experienced by homeless people pose significant problems of treatment. (For example: tuberculosis treatment can be rendered difficult by a mobile and chaotic lifestyle and overcrowded conditions; there may be availability problems for mental health treatment and drug and alcohol treatment etc…)
Treatment of mental health problems is evolving and deinstitutionalisation has taken/ is taking place in many countries, but this too has given rise to new challenges and problems.
Multiple needs are another factor that can make treatment problematic. Please outline treatment problems encountered when trying to ensure access to health for homeless people.

Problems with the treatment of specific health problems resulting from factors such as:

- The conditions for treatment and therapy are totally different to the territory, lifestyle and experience of the homeless.
- The development of community care poses new questions
- There is a shortage of accommodation/hygienic circumstances for good self care
- There are waiting lists for all patients. The roofless are most certainly bottom of the list, if they are on the list at all (they need medical insurance).
- Emergency services in hospitals are less and less inclined to take care of the roofless because of their many problems (borderline, addiction, …) and their financial disability.

3. Right to health benefit and access to health care (Q2)

Q2: Social Protection: Healthcare entitlements of Homeless People
The healthcare entitlements of homeless people vary from country to country according to the social protection system in place. It may also relate to their administrative status (whether they have registered). It may also vary according to whether the homeless people are nationals or non-nationals. This question seeks to examine the impact on access to healthcare and quality of care available to homeless people.

3.1. The right to health care and access to health care for roofless and homeless persons.

Healthcare entitlements of homeless people
What are the healthcare entitlements of homeless people in your country (for nationals; for non-nationals, including asylum seekers and undocumented migrants)? What are the registration requirements etc.?

3.1.1. Homeless people

Belgium has a well developed welfare system. In theory the whole Belgian population is covered by an obligatory insurance for medical care. In practice however, some people prove not to be covered. The main condition for coverage is membership of a health fund. The health fund is the organisation that refunds medical costs for those people who have built up social rights during employment.

But the system does not work for everyone. The roofless without a fixed address cannot make use of the health reimbursements. This means in practice that the health workers will refuse them because they are not 'in order'. Undocumented migrants and asylum seekers often do not get medical attention, although in theory they should.

Many roofless persons do not have regular careers or have simply never worked. This makes them ineligible for social security and dependent on the CPAS for a minimum income or other forms of support. Here again, a fixed address is a precondition.

3.1.2. Right to health benefits and access to health care for asylumseekers, undocumented migrants non-accompanied minors, delayed returners, temporarily regularised people or family reunions.

Everyone on Belgian territory is entitled to social services by the CPAS. For asylumseekers and undocumented migrants this service is limited. Some strangers are entitled to other social security benefits as well.

For the asylumseekers and undocumented migrants there is a system of *urgent medical help*. This is organised by the CPAS in the area the person happens to be, and only when there is a medical proof written by a doctor which shows that urgent medical help is necessary.

Social services and/or shelter

In principle, *everyone* is entitle to 'social services' offered by the CPAS, if necessary for a dignified human life. This support is intended only as a supplement to income from work or other benefits a person may already receive (minimum income for instance), if the person can prove that their income is not sufficient for a dignified life.

For asylumseekers the federal government subsidises a specific infrastructure as an alternative to the ordinary CPAS offer. For undocumented migrants the service is limited only to urgent medical help.

Other benefits from social security or wellfare

Certain categories of strangers are entitled to financial aid, the access to which is strictly limited by law. These benefits have priority of the general social services and will be taken into account to determine whether or not someone has enough income for a dignified life

See also Medimmigrant:
http://www.medimmigrant.be/Overzicht%20Statuten%20en%20Gezondheidszorg%20DEF.pdf

3.1.3. Inmates

Penal Institutions (ethos cat. 6.1)

In principle, all prisoners have the same rights as ordinary patients, except for those exceptions specified in the Law on Patient's Rights.

The Law on Patient's Rights of 2005 specifies that the quality of health care providion in the prisons must be equal to that in the outside world. T he stipulations of this recent law will have to be put into practice through Royal Decrees and Governmental Memoranda in the coming years. In 2006 a series of memoranda were issued concerning the distribution of medication, the establishment of a High Board of Prisoner's Health, and drugs in prisons.

The legislation ties in with the existing European rules and advice.

Former prisoners should be in order with their health insurance on leaving the prison, but not all health insurances ('mutualiteiten') seem to put this into practice correctly, so hindering people's access to health care.

3.2. Main thresholds for the homeless as far as health care is concerned.

What do you consider to be the main barriers facing homeless people in your country when they try to access healthcare (stigma, financial barriers, administrative barriers, etc.)?

Despite the many efforts made by to improve the access to health care, many (particularly poor) people turn out to still be faced with administrative, financial and social/cultural barriers o health care. The reports of De Maeseneer e.a. (2003) give a very detailed inventory of all the thresholds the poor face, both as far as the range of services available as the range of services needed is concerned. The Associations where the Poor Speak and related organisations have qualitative described the barriers – from experience (Collectief Verenigingen Armen e.a., 2002). The basis for a joint action on the right to health care was established in the General Report on Poverty (Koning Boudewijnstichting, 1994).

3.2.1. Not having a legal residence

Not everyone appears to meet the criteria for access to health insurance (iregistration with a health insurance 'mutualiteit', regular contributions, sometimes there is a waiting period). This can mean that the lack of a fixed address can be a reason why the roofless are not insured. This means that they are not entitled to certani benefits or can be refused help. Also, the costs of medical care can quickly prove to be beyond their means.

For the roofless, this is the most specific threshold to health care. Not having a legal address means no access to regular health care nor to health benefits. People can lose their address when the communal authorities decide to take them off their registers because they no longer live at a particular address. If they do not register as living somewhere else, they have no legal address.

Since 1994 the roofless without a legal address have the possibility to register in the commune they actually stay in by applying for a reference address in a recognised hostel for the homeless. This can be run by the CPAS or by a CAW.

3.2.2. Financial Barriers

The financial situation is as follows: 8.5% of all Belgian households do not visit a doctor at all because of the cost. In Flanders, the figures are slightly better than in the rest of the country. 25% of all households find the personal contribution to the cost of health care (the part that is not reinmbursed) difficult to afford. In the region of Brussels and in the Walloon region, the figures are respectively 44% and 22% (Dierckx, 2002).

If you are short of opportunities and in a complex problematic situation, it is very difficult to find information on financial and other possibilities for access to medical care.

The patient always pays a *personal contribution*. This is intended to put a brake on excessive consumption of medical services. For the poor, this is not a brake but an insurmountable barrier. We know that in a system without such brakes the consumption of medical services is no higher than in our system of payment per service rendered. (Collectief Verenigingen van Armen e.a., 2002: 36).

One solution sometimes locally applied by the reception centres is that the CPAS pays for the entire cost and the reception centre pays the medical worker directly.

3.2.3. Socio-economic barriers

The circumstances of the poor makes for important context-related barriers. (Collectief Verenigingen van Armen e.a., 2002: 11):

- income: the income is insufficient to provide for basic daily necessities.
- employment: the available family income is dependent on finding and keeping a suitable job. This is a major problem for many people.
- housing: decent housing is a precondition for good health. This precondition is frequently not met for financial reasons and because of a shortage of affordable housing available.
- Education & training:not only the health situation, also the use of healthservices is affected by education and training. If someone can scarcely read or write, it is hard to find ones way in the health system and to fulfil all administrative obligations.
- transport: lack of transport possibilities (own car, good public transport) and limited mobility can be an important barrier to access certain services Social and cultural barriers

The place a person takes up with a social network may also be an influencing factor. When one is the sole person responsible for care of ones parents, an (ill) spouse, children, … this will be determining for the possibility to seek medical care for oneself. If one does not have a firm social network to fall back on, the reactions and prejudices versus the poor can be insurmountable. (Collectief Verenigingen van Armen e.a., 2002.)

Some notes specific to the situation of the roofless.

A roofless person will rarely address a medical service directly for a medical problem, unless it is very urgent. Often the reason is a consultation for a medical or administrative problem.

This can be explained by their discomfort at discussing medical problems. They regard their bodies as the only and last thing they still have some control over, and this makes it difficult for them to entrust themselves into the care of professional carers. It is very important to build their trust and to invest in the early contacts between patients and carers.

In addition, the institutional structures and measures taken by the government do not tie in with the experiences and lifestyle of someone living in the streets. They are not used to living in orderely structures. For the roofless in particular the gap between the hospital and 'normal life' is huge.. (De Maeseneer, e.a. 2003d, p. 26). This means that entering a hospital or a service means crossing a substantial barrier. Once that hurdle has been taken, it is important to give the person the time and attention necessary to regain his/her skills for accepting the help offered autonomously.

The specific culture of the roofless is refered to as a possible barrier to professional help. Pride and selfrespect may be a motivating factor, which will give them the energy to ask for help. It is important the help is not forced upon them.

A final remark regarding the roofless, concerning the impact of research on reaching this group. More time, and thus financial resources, are needed to involve this group in research. Also, specific research methodologies are required. (De Maeseneer, e.a. (2003d), p. 72-73).

The role of social networks

Literature (De Maeseneer, e.a., 2003: 34) shows that persons with a low social status and less extensive social network have less social support. At the same time, the social networks and social support are crucial in dealing with stress. Lack of this support system thus influences poor people's health status. Life in poverty however limites the possibilities to establish a sturdy social network.

> "I could say,'I'll go and have a coffee in the café', but that will cost me 60 francs. So I reason, for 60 francs, I can buy a pack of coffee and drink coffee all week at home, without going to the café. But that means you miss out on so many things. You are socially excluded again'. ." [Vzw De Keeting, Mechelen]

Often, meaningful other play a supportive role for an individual. Friends, family, etc are often the ones to encourage someone to seek medical help.

> "She said to me ' it is about time you went to the doctor, I'll pay for it if necessary'. … So I should be grateful to my friend that I'm still alive really. If she hadn't sent me to the doctor, I would have died by now." [DAK, Antwerpen]
> "I don't want anything, a hospital costs money. If you go and lie there, that costs and I cannot afford it. But my sister called the doctor because she was worried, and the doctor came." [Vzw De Willers, Willebroek]

Cultural traditions

Cultural traditions may be an important factor influencing a person's choice on whether or not to get professional medical care.

One of the people in charge in an 'organisation where the roofless speak out', notes that the roofless show a certain pride and want to belong to the group they identify with.

The rules of this group do not always tally with the rules and structures in society or in health care. Hence, people choose to help themselves for as long as possible.

> "We do what we can for ourselves because we're fed up. " [Comme Chez Nous, Charleroi]

> "We pull our own teeth, we even did that on the European market once, we pulled 'M's tooth and he bleed, heamorrhaged. But we do it ourselves. ." [Comme Chez Nous, Charleroi]

> "We know people – really roofless – who are walking around with rotting legs, here in Antwerp. They are very difficult to reach because they are very wary, and it would be near impossible to get them into a hospital!!" [DAK, Antwerpen]"
>
> cited in De Maeseneer, e.a. (2003d), p. 33

3.2.4. Stigma

The respondents refer to the negative reactions they get from other people not belonging to their social group. Often poor people are looked down on for smoking, having a mobile, etc. People living in poverty themselves do not always see these things as luxuries.

> "Non-smokers will always say 'they are poor, but they smoke. They all smoke in the day centre don't they?' but why should only the rich be allowed to smoke?" [Vzw De Keeting, Mechelen]
>
> "We cannot afford certain things and then people say 'well why did you buy a mobile then?' So what? Why can't you be poor with a mobile?'' [Vzw De Keeting, Mechelen]
>
> cited in De Maeseneer, e.a. (2003d), p. 33

3.2.5. Institutional barriers

"For the roofless in particular, the gap between the hospital and the 'real world' seems to be particularly." (De Maeseneer, e.a., 2003d: 107) (see also the paragraph on Mental Health, Phillippot).

More and more public hospitals ask for a down payment before starting up treatment. For urgent medical help there is always the emergency service, but if the medical treatment is not pressing, it becomes unattainable for the homeless person.

3.3. What about initiatives to tackle barriers? How efficients are they?

Have attempts been made to overcome these barriers? Have they been successful?

3.3.1. Policy measures to improve access to health care for vulnerable groups

Some patients like a consultation with the doctor, the dentist or the pharmacist. The federal government has introduced some measures to help reduce the barriers, such as the 'maximum invoice' and the 'third party payment' system, so as to improve access to health care for vulnerable groups.

These rules apply to the roofless – in so far as they have a valid address! – and for patients with a precarious right to stay.

Third Party Payment System

Some patients postphone visits to the doctor, the dentist and the pharmacy because they cannot afford it. The federal government hasintroduced some measures, such as the 'third party payment system' and the 'maximuminvoice' to reduce these access barriers. These are only applicable for those people covered by health insurance.

Normally, the insured person pays the full fee directly to the medic. Then the amount paid (cost price) minus the brake ('the surplus') is refunded by the health insurance on receipt of certified proof.

Only on exception a person can request that the 'third party system' may be applied. The health insurance pays the costprice directly to the medic, service or hospital. The patient only pays the surplus and need to wait for the refund afterwards

The CPAS does not intervene in this procedure. The patient organises this with the medical service provider, who is reimbursed in turn by the health insurance. For some people however, even paying the surplus is a problem. The CPAS can grant an advance or, in exceptional circumstances, can decide to foot the bill. This special request based on need must be approved by the CPAS Board. This can also be done for the high medical costs for a stay in hospital.

In the case of the roofless, it is clear that they can only enjoy these measures if:: 1° they have a valid address in the commune they stay in, and 2° they are registered with a health insurance. . Two conditions which do not always apply for the roofless without an address (although they may be able to

have an official address in the reception centre they stay in) Problemen met de regeling van de betalende derde (Collectief Verenigingen van Armen e.a., 2002: 15):

- depency on the medics benevolence;

- sometimes leads to abuses;

- arrangements made between the patient and the GP are not always adhered to by the emergency doctors on duty after hours;

- a lot of adminstrative work for the doctors

Maximuminvoice (MAF)

The maximum invoice is applicable to everyone. It ensures that the annual medical costs for every family is limited to a certain ceiling, depending on family income. Once that ceiling is reached, the costs are reimbursed in total. There are three possibilities:

* The social MAF

This maximum invoice is determined by the social category of the person entitled to it and applies to people in a socially weak position, such as widows and widowers, handicapped people or people living on benefit. They pay a maximum supplement of 450€ per year for all health care.

* The MAF for limited incomes

The maximum invoice is determined by the family income of the entitled person and is applied by the health insurance bodies. The family income determines what the limit will be. .

* The Fiscal MAF

For people who do not qualify for a social MAF, there might be a fiscal exemption possible. This applies to families who pay taxes. There is a supplement to be paid, determined by gross taxable income.

Once a person's medical costs reach a certain threshold, the expenditure above that limit is covered completely. Not all personal share in the medical cost is taken into account however. Certain supplements on medication and interventions in the costs of old peoples homes or psychiatric care (or supported housing) are not taken into account. Costs for hospital stays from the 91st day in a general hospital or the 366rd day in psychiatric hospital are not covered.

In order to make use of these advantages, the roofless suffer the same problems as mentioned above for the third payment system: not having a legal address means no access to this measure.

Problems with the maximum invoice (Collectief Verenigingen van Armen e.a., 2002: 15)

- The poor are not sufficiently aware of these possibilities and their rights, they do not know the system.
- The maximum invoice will not prevent that people postphone medical care, because before reaching the threshold, the whole cost must be borne individually. As long as the threshold has not been reached, people will still put of health care for financial reasons, thus postphoning their access to the special arrangement at the same time.
- Once the threshold has been reached there are still costs to be borne and reimbursements to wait for.
- The extra costs do not compare to the increased theshold for people in the lowest income category when moving from the social franchise to the maximum invoice.
- Certain costs are still not included.

3.3.2. Medical posts for roofless people in major cities

Médicins Sans Frontières/ Artsen Zonder Grenzen (AZG) has medical posts in Brussels, Antwerp and Liège where people may go for free consultations. The AZG addresses itself mainly to asylumseekers and people without papers. The filosofy is OZG is that they do not wish to replace the government or

subsides care, but offer a complementary service. Thus, there initiatives are by definition temporary. (AZG, 2006; see www.msf.org).

Medimmigrant is an NGO that concentrates on providing urgent medical help and improving access to healthservices for asylumseekers and undocumented immigrants. Other NGO's are active in this area too: including *Artsen Zonder Grenzen*, the *International Red Cross* and *Fedasil*.

3.3.3. Access to psychiatric hospitals

(asylumseekers – undocumented migrants)

Access to psychiatric institutions for asylumseekers and undocumented migrants. Federal minister of social integration, mr. Dupont, declared in 2005 that he was prepared to adapt the CPAS laws so that vulnerable people (including asylumseekers and undocumented migrants) could more easily access psychiatric hospitals, psychiatric nursing homes, initiatives for supported housing for psychiatric patients and medical-pedagogic institutions.

3.3.4. Drugs help in the prisons

Penal institutions (ethos cat. 6.1)

As an example, the Central Reception Board for the Arrest House in Antwerp coordinates all questions on drugs. The project entails that all requests by Antwerp inmates are centralised by the specialised drug care centres and every week at a fixed moment an employee is present for half a day in the prisons so that all requests for help may be recorded. After consultation with the various bodies and institutions concerned the request for help can quickly be answered and treatment/admission can be arranged.

3.3.5. Language problems

(asylumseekers – undocumented migrants)

There are various translation services to improve communication in health care.

Through the website www.communicate-health.org.uk/card/ an appointment can be made in English and translated into 40 common languages.

Translation services, such as Ba-Bel are able to supply translators or one can apply for an intercultural mediator in health care (see www.ba-bel.be).

4. Ensuring access to qualitative health care (Q3)

Q3: Ensuring Access to quality healthcare
This question will explore why homeless people across Europe have difficulty accessing the good quality healthcare that they need. There is a range of services that homeless people should access in order to enjoy good health: these include medical treatment; but also preventative *services (screening, check-ups etc.); specialised services such as dental services; and health promotion services.*

A more selective approach to the roofless and other vulnerable groups is done – or could be done- through social services with a low threshold, De Maeseneer, e.a. (2003:82-88):

- Appointing someone to coordinate health care at the first access level (ie directly accessible help without referral).
- Local area health clinic and neighbourhood centers can offer a more local solution for all sorts of problems the population in that area has to deal with. The neighbourhood centers are also a support network and can work at improving the quality of life in the neighbourhood and the welbeing of the most vulnerable groups such as the roofless. This is achieved through all sorts of activities designed to help people meet each other, and it is supported by volunteers.
- Involving someone the person trusts. .
- Self help groups are important but underfunded.

- Verbal information is very imporant because it is possible to check immediately whether the patient understands the information.
- Low threshold 'medical information points' where patients can ask questions and clarify their needs. An example: in the nightshelter or day centre for the homeless/roofless, there might be a possibility for people come in and ask questions about the health system. Every organisation is responsible for giving clear information on its own services.
- A separate budget for the improvement of information and communication with socially vulnerable people.
- This selective approach gives the possibility to adjust the communication to the target audience (taking language problems into consideration, access to computers/internet, etc)
- Improving access to health care is just one way of reducing differences in health, other aspects must also be dealt with, such as housing (by granting subsidies for insulating houses for instance, and by improving the availability of supported houses or reception centres for the homeless, …)

4.1. Good practises in specialist and/or outreach health care

Good practices: specialist and/or outreach healthcare
3.1: Are you aware of specialist and/or outreach healthcare centres that have been put in place specifically for homeless people? Do you consider that this is a good way to meet the health needs of homeless people? What are the costs and benefits of targeting homeless people in healthcare provision?

4.1.1. Médicins Sans Frontières/Artsen Zonder Grenzen – AZG (Brussels, Antwerp, Liège)

AZG aims to ensure durable access to first line health care (GP's), in three Belgian cities: Brussels, Antwerp, Liège.

This goal will be realised through two approaches:

1. Alle necessary steps for improving the health situation of the patient. This means: a) providing the necessary medical care (consultations, extra investigation, hospitalisation, psychological support, …); b) ensuring that the administrative rights of the patient are met and undertaking all necessary steps to ensure he/she has effective access to health care.
2. Reminding the necessary institutions of their responsibilities by a) gathering concrete information on lack of access to health care; b) collating collected data on the target groups and making the problems of social exclusion explicit; c) questionning witnesses of social exclusion and involved actors on the situation (political, juridical, medical, social)

AZG also wants to improve access to health care in the country of origin for the patient. If access is not secure, the AZG will plead against the explusion of the patient and forced return to his country of origin. The Ithaca project gives the seriously ill stranger information on projects in all countries.

For further reading see: www.msf.be (French)

4.1.2. Medimmigrant and Medical Centre for Undocumented Migrants (Brussels)

Medimmigrant offers its services to the following groups:

1. *Undocumented migrants*: People who do not possess a valid residence permit for Belgium e.g. rejected asylum seekers, clandestine, etc.
2. *Migrants with a precarious residence permit*: people who possess a temporary residence permit, but find themselves with a fragile and often legally unclear residency status, e.g.candidates for refugee status, students, candidates for family reunions, etc.

The individual assistance and structural activities of Medimmigrant focus on three important themes.

Access to health care

The Centre for Social Welfare (OCMW) law and the Royal Decree of 12/12/1996 provides for the right to "urgent medial assistance" for undocumented migrants who are not able to pay for this care themselves. Medimmigrant strives for the improved implementation of the Royal Decree, Urgent Medical Assistance and to raise awareness of this decree amongst the diverse stakeholders.

For people with a precarious residency status, Medimmigrant assesses what form of healthcare they can access given their situation.

Social rights

Medimmigrant is committed to obtaining the right to social services for people who are unable to return to their country of origin as a result of their illness. In keeping with this, Medimmigrant lobbies for the right to work for people, who as a result of medical reasons are regularised for a specified period and for the right to compensation in the event of a work related accident.

Further, Medimmigrant asks consideration of the living conditions of people without a legal residence permit and people with a precarious residency status in terms of psycho-social care.

Permission to stay for medical reasons

Bearing in mind the medical aspects, Medimmigrant tries to direct those involved towards realistic and worthwhile future prospects in Belgium, their country of origin or a third country where they have legal status. This advice is only informative and Medimmigrant does not, for example, prepare residency applications. In context of this orientation aspect of our work, Medimmigrant works towards an amendment of residency legislation and procedures and lobbies for the establishment of a European Medical Database with information covering the accessibility and availability of necessary treatments and medicines.

For more information visit : www.medimmigrant.be

4.1.3. Asbl Infirmiers de rue / vzw Straatverpleging (Brussels)

In Brussels two young nurses have been going out into the streets since early 2006 to care for the roofless' wounds. The Federal Minister of Social Integration Christian Dupont was immediately impressed by these two young Florence Nightingales and decided to support their project with 61.000 €.

The roofless do not go to health services and nobody goes to them. Seeing this made the nurses decide to set off on a daily round to seek out the roofless and to nurse them. They win the trust of the roofless by cutting fingernails, tending open wounds, disinfecting sores. The roofless with serious alcohol problems or psychiatric problems are referred to institutions who are better able to help.

Further reading (French): http://www.infirmiersderue.be/qui.htm,

4.1.4. Cooperation Day Centres for the homeless and Neighbourhood Health Centres

In Antwerp the Day Centre for the Homeless 'De Steenhouwer' has recently set up an interesting project with the local Neighbourhood Health Centre, whereby the nurse from the Health Centre holds consultations on a weekly basis in the Day Centre, behind a simple shield. He keeps medical files, measures blood pressures, tends wounds, and gives health advice. Where necessary he refers to more specialist health services or GP's, and he acts as a liaison officer between the homeless person and the health services, ensuring better access and communication. The project is very small, but it is proving to be successful in meeting a need and achieving results. In Gent and Charleroi there are similar projects.

4.2. Good practises health promotion/preventive health initiatives

Good practices: health promotion/ preventive health initiatives 3.2: Are you aware of any health promotion/ preventative health initiatives that are accessible to homeless people? Do you think that these impact positively on access to employment?

4.2.1. Health promotion for the socialy excluded (VIG)

The VIG is an institution of the Flemish Government and has a specific programme to improve the health of the socially excluded.

See: www.vig.be

4.2.2. Observatory for Health and Welfare (Brussels)

The Observatory for Health and Welfare is an initiative of the Brussels Capital Region and has a team of policy workers concentrating on health and welfare themes. It is a supportive body for all the actors concerned with the Brussels welfare and health policies: politicians, grass roots workers and researchers.

The Observatory coordinates projects on welfare, health and poverty. The publish an annual Poverty Report for Brussels, paying particular attention to poverty.

See: www.observatbru.be/fr/default.asp, www.observatbru.be/nl/default.asp

4.2.3. Santé Mentale et Exclusion Sociale (SMES) (Brussels). Entry point to mental health services for the homeless

The SMES (Santé Mentale et Exclusion Sociale) was founded in 1992 in Rome in the shape of a number of intervision groups, whose goal was to make access to mental health care a theme for the European Forum for Social Exclusion, and to improve cooperation between the two sectors (care for the homeless and care for the mentally ill).

The intervision groups consisted of psychiatrics, social assistants and psychologists who discussed cases together. The 'cases' were of people living in social exlusion and suffering mental health problems. This was undertaken because it was found that psychiatric and social problems were being treated separately and both sectors kept bouncing the ball back to one another.

In 2000 SMES-B was founded in Brussels, with the start of SMES intervision groups. As originally in Rome, the concern of the social sector, and the homeless sector in particular – was that the homeless and otherwise marginalised people with psychiatric problems were unable to get treatment anywhere. Psychiatry referred to the reception centres, calling the problem 'social' and vice versa.

In 2001 SMES-E (Europe) was founded, in order to gather all the groups in the various European countries. Several European seminars were organised and networks were established.

In 2002 SMES-Belgium started a pilot project, called "Cellule d'appui médico-psychologique d'intersection entre la santé mentale et l'exclusion sociale". The SMES wished for this cel to actively go out to find people in the streets and is available for the organisations for the homeless. It works primarily for the member organisations of SMES, including street corner work, reception centres, and Artsen zonder Grenzen, but in principle all organisations confronted with these problems may contact the cel. The cel wil act as a portal to mental health care for mentally ill homeless people and other marginalized individuals. maar in principe kunnen alle organisaties die met deze problematiek worden geconfronteerd, een beroep doen op de cel. (Krabbe, 2006).

Further reading: www.mhe-sme.org (French)

4.2.4. Local initiatives for health promotion and prevention

In the larger towns there are several forms of cooperative initiatives for health and prevention.

There are circles of GP's, the *Huisartsenkringen* (cooperation initiatives between the GP's in larger towns such as Brussels, Ghent, etc …) the LOGO's or local health boards, Preventive Care Centres (such as the Preventive Care Centre in the Dansaertstreet in Brussels).

A number of initiatives focus on specific target groups such as HIV-infected persons (for example. Sensoa, Adzon and Supported Housing in Brussels), Roofless drug users, or projects promoting a healthy diet for socially weak groups.

In Roeselare a night shelter has been set up for addicted homeless people, who may stay for short emergency spells. The social worker visits the person by day, but they are expected to managed to live by themselves in the shelter. The social workers try to encourage the roofless person to accept more long term help in other formats. It seems to be working quite well, and probably the rather small scale of the town helps ensure the projects' success.

4.3. How do homeless people in rural areas access health care?

Not relevant for Belgium.

4.4. Homeless people are discriminated in relation to the general public

3.3: Do you consider the healthcare received by homeless people in your country to be comparable, in terms of quality of care, to that received by the general public? In what health areas is there the greatest lack of access to care and why?

It goes without saying that the quality of health care for the homeless cannot be compared with the health care the average citizen gets.

There are virtually no governmental services or measures focussed on the specific needs of the roofless. There is only the 'urgent medical help' for undocumented migrants and asylumseekers. But there is no comparison possible with the quality and accessibility of health care for the general public. These are only exceptions which ensure an absolute minimum of health care.

Local governments (CPAS's), welfare organisations and NGO's do what they can. This does not mean that important needs do not remain unmet. Attention needs to be paid to the accessibility of health care, the affordability too. A particular sore is the lack of mental and psychiatric health care for the roofless.

The right to sufficient and qualitative health care for the homeless, and for the poor in general, is not sufficiently guranteed.

4.5. Een specific policy on health for the homeless

3.4: In some countries, a specific policy framework and action plan around health and homelessness has been put in place in order to ensure that homeless people can get full access to quality care. Has such an approach been tried in your country?

There is no global policy against homelessness nor on homelessness & health in Belgium or in any of the regions. There are only ad hoc, specific and impromptu measures. There is attention to homelessness and povery in the Flemish and national poverty plans (NAP's)

5. Opleiding van professionele gezondheidswerkers (Q4)

Q4: Homeless people sometimes encounter a lack of understanding and reluctance to engage with them from healthcare professionals that might be overcome through training for health workers on how to work with homeless people, as well as on their specific health issues. The problem of homeless people presenting with multiple needs can also be professionally challenging for healthcare workers. This is another area where training would be useful.
4.1: Do you know of any such training courses (in all areas of healthcare – nurses and doctors, but also mental health workers, dentists, podiatrists etc.) or plans to put them in place, as part of medical training or as follow-up training?

There are no specialisations in either social, educational or medical training programmes. Attention for this target group is ad hoc (practical research or project work).

A new cooperation has just been established between the homelessness services of the General Welfare Work and the training programmes for GP's. The trainee doctors will be able to do practical work in the reception centres and to participate in intervision groups. Within the General Welfare Work itself, there has been a health training session in spring 2006 for the social workers working with the homeless.. These sessions covered subjects such as infectious diseases, policies, financing, patients rights, networking and issues of confidentiality.

6. Networking (Q5)

Q5: Interagency working
Ideally, accessing healthcare should provide a route into other care and integration services, through referral and transfer practices between homeless services, social services and health services.
5.1 Are you aware of instances of this kind of networking in your country?
5.2: Are health and social services supportive of this type of working? Have administrative procedures or agreements been put in place to facilitate transfer and sharing of information and cooperation between different services? What are the discharge practices from hospitals in your country?
5.3: Have you encountered instances where there is an obvious breakdown in this kind of networking? (eg: homeless people being retained in hospital because no other option has been found for them to move on to other services).

Various services are starting to network to improve access to health services for the homeless. This should be apparent throughout this report. However, there is still much to be done, and networks certainly need to be established and expanded.

7. Health indicators, data collection and research (Q6)

Q6: Health indicators, data collection and research
It is not always easy to access information on the health situation of homeless people. Yet such information can be crucial to making the case for political investment in healthcare for homeless people. This question seeks to establish possible effective ways of accessing reliable data on the health situation of homeless people.

7.1. IS there a system of datacollection on the homeless and health?

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, A&E, youth care centres, psychiatric services, etc).

7.1.1. National Institute for Statistics (NIS/INS), health statistics

Portaal van Nationale gezondheidsstatistieken.

Women, children, violence, housing of families with young children (Ethos 4.1, 10.1, 11, 12, 13)

Poverty related statistics:

- Appreciatie van de sociale relaties (WIV en NIS)
- Social health : Reports 2004 & 2001 (WIV en NIS), Interactieve analyses (WIV en NIS), Studies over (o.m. sociale) gezondheid (NIS and other institutions)
- Research into violence against children (kinderen)and women (vrouwen) (European Commission)
- Studies over gezondheid, senioren en handicap (NIS en andere instellingen)

See: www.statbel.fgov.be/port/hea_nl.asp

7.1.2. Flemish Government, Kind & Gezin

Housing, health, work, income and education of children born in poor families (Ethos 11, 12, 13)

Annual report on Children born in poor famililies.

See: Rapporten, www.kindengezin.be/KG/Algemeen/Over_Kind_En_Gezin/Rapporten/default.jsp

7.1.3. Tellus, Steunpunt Algemeen Welzijnswerk

Reference: see bibliography

Relevant data:

Clientregistration of the homeless in the CAW's (cliënt characteristics, sorts of help requested, sorts of help offered)

See: www.steunpunt.be

7.1.4. Annual Reports Artsen Zonder Grenzen

Reference: see bibliography

Data:

Client and service information on asylumseekers and undocumented migrants

7.2. Research undertaken on the health of homeless people

6.2: Do you know of any research undertaken on the health of homeless people by academic or other bodies? (eg: Government reports, NGO reports, scientific reports, etc.)

7.2.1. Inventories of research on health, inequality, poverty and social exclusion

Inventory of research into health and poverty in Belgium

See: www.armoedebestrijding.be/publications/Inventaris/gezondheid.pdf for a 22-page report with references of research at Belgian universities and research centres into health and inequality.

Inventory of research, reports and projects for Brussels

The Observatory for Welfare and Health coordinates projects on welfare, health and poverty. An annual report is published for Brussels were specific attention is paid to poverty. They also have an extensive library.

See: www.observatbru.be/fr/default.asp, www.observatbru.be/nl/default.asp

7.2.2. General research into the health situation and health risks

Federal Government. General Report on Poverty, section 'Health and Poverty', 1994, 2004

General Report on Poverty, section 'Health and Poverty', 1994, 2004

Reference: see bibliography

Abstract:

In 1992, the Ministry of Social Integration gave the Fondation Roi Baudouin/King Boudewijn Foundation the task to coordinate a General Report on Poverty, in close cooperation with the social section of the Union of Towns and Commues and ATD Quart-Monde. The final objective was to create a long term political project to ban poverty and social exclusion.

The report was generated by the poor and their self organisations themselves, at the initiative of the Koning Boudewijnstichting/Fondation Roi Boudouin (www.kbs-frb.be) in the early 1990's and published

in under great political and public attention. The General Report on Poverty is to be considered a milestone in the Belgian history to combat poverty and social exclusion… The report led to the recognition and subsidising of the Regional governments of the 'Associations where the Poor Speak Out' (www.eapn.be) and the establishment of the federal Unit for Combatting Poverty, Inequality and Social Exclusion (www.armoedebestrijding.be) (initially part of the National Centre for Equality of Opportunities and Against Racism www.minderheden.be). The General Report on Poverty was the motor for many policy initiatives and for initiatives and developments in the sector itself.

In 2004 a round up was made of the situation 10 years after the General Report, by the federal Steunpunt tot Bestrijding van Armoede, Ongelijkheid en Sociale Uitsluiting (www.armoedebestrijding.be). This Unit for Combatting Poverty, Inequality and Social Exclusion published a series of reports, including a report on poverty and health, with the King Boudewijn Foundation, and this report also focusses on the homeless.

Two witness reports from the 'General Report on Poverty' on health:

"If I go to my doctor twice and cannot pay, I feel so ashamed I don't go back any more. He needs money to live too!"

"In emergency services, a doctor examines me, gives me a prescription, sometimes he gives a free sample. But afterwards, I still don't have the money to take care of myself. » No one should be unable to take care of themselves medically for lack of money. The priority should be for the children, who should receive what they need. We need to develop a system that is not only for the poor. Without this there are always people who prefer to forego care than to admit they are poor.

Further information (French): www.kbs-frb.be/code/page.cfm?id_page=153&ID=77

Federal Government. Belgian Association for Public Health. Socio-economic inequalities in health. A general overview (2005)

Reference: see bibliography

Abstract:

A recent and general overwiew of socio-economic inequalities in health is offered by the 8th Symposium on Public Health held in Anvers, 27 et 28 October 2005.

That there exist socio-economic inequalities in health (ISS) is established in all countries, but today we have to do more than confirm this fact. Explanatory theories on why there are such social inequalities on health is developing, in certain countries, into action programmes and policies aimed at reducing this inequality.

The symposium aims to answer the question: 'What are the different aspects in Belgian?' both at the analytical leval and at the policy level. Several presentations are devoted entirely to implementations in the field. These can be consulted at : http://www.symposiumpublichealth.be/presentation.htm.

For more information on the Belgian Association for Public Health: www.iph.fgov.be

Federal Government. Health Surveys

Reference: see bibliography

Abstract:

The Scientific Insitute for Public Health, dept epidemiology, carries out health surveys based on samples of the Belgian population, for the federal government. Health surveys were conducted in 1997, 2001 and 2004.

The database offers much comparative material with differentiations according to general demografic and socio-economic indictors. The database is the most important source of information on the health of the Belgian populatin. There is no data on the health of the homeless or the poor however. The main

reason is the large scale of the survey and the fact that the general population by definition does not include the roofless.

See: www.iph.fgov.be/epidemio/epinl/index4.htm

Government Brussels Capital Region. Brussels Observatorium on Welfare and Health

Reference: see bibliography

Abstract:

Annual report on the health situation of the poor in Brussels.

Flemish Government, Health Surveys

Reference: see bibliography

Abstract:

Data on the health situation in Flanders and Belgium according to socio-economic status can be found in the Health Surveys by the Scientific Institute for Public Health. (gezondheidsenquêtes). This data shows that the health situation for people with low levels of educational attainment is worse than for people with more education.

7.2.3. Specific research into health and homelessness

Rea, e.a., Université Libre de Bruxelles (ULB), 2001

Reference: see bibliography

De Maeseneer, e.a., Universiteit Gent (UGENT), 2003

De Maeseneer, e.a. (2003), Toegankelijkheid in de Gezondheidszorg, deelrapport 4 De Toegankelijkheid van de gezondheidszorg gezien door de mensen in armoede, Universiteit Gent i.o.v. de Minister van Sociale Zaken en Pensioenen, Frank Vandenbroucke, pp. 72-73

Reference: see bibliography

Philippot, e.a., Université Libre de Bruxelles (ULB), 2004

Reference: see bibliography

Abstract:

The research project 'Social reintegration of the roofless: attitudes, prejudices and collective identities' was financed by the Federal Programme for Science as part of the research programme Social Cohesion.

The project includes a series of part researches covering the following topics:

- Review of literature;
- Representations and attitudes toward the roofless;
- The roofless in the contemporary Belgian press
- An estimation of the prevalence of various forms of housing insecurity;
- Observations and experiences of people living in the streets;
- The mental health of the roofless.

Research into rooflessness in Europe has developed only in the past decennium. While very few publications appeared on this subject before 1995, the number of publications has grown tremendously. Based on "PsychLit and MedLine", 172 publications were identified and analysed about psychological, sociological or health related problems of the roofless in Europe. The majority of this research is done in the UK (42%) and France and usually university researchers (44%) or people working in this domain (40%).

Many studies are concerned with the physical and mental health of this target group. Some point to the fact that the roofless easily contract illnesses but pay little attention to their physical welbeing (they have very few symptomatic illnesses) and they do not use those health services they do have access to. There is also research that clearly shows that the roofless suffer more mental health problems than the average population. They use more addictive substances and suffer more depressions and anxiety disorders. In most cases the mental health problems precede the rooflessness.

See also paragraph 2.6

Vanheusden, Vrije Universiteit Brussel (VUB), 2004

Reference: see bibliography

Abstract: see 1.2.2

Van Menxel, e.a., Steunpunt Algemeen Welzijnswerk, 2004

Reference: see bibliography

Abstract: see 1.2.2

Godemont e.a., Research Centre on Equal Opportunities, University of Antwerp, University of Hasselt, 2005

Reference: see bibliography

Abstract:

Yearbook 3 on Equal Opportunities with contributions on unequal opportunities throughout life, in education and employment.

Van Regenmortel e.a. Zonder (t)huis, 2005

Reference: see bibliography

Abstract: This study, conducted for the Flemish Minister of Welfare, Health and the Family, wishes to fill some gaps in the available research on homelessness in Flanders. Up to now, the prespective of the homeless had been insufficiently explored: what are their needs and wishes? Is there attention for the skills and capabilities they (still) possess? What are the difficulties, the resistence, the missing link? Does the way care and help are organised actually prevent efficient help? Is care organized to suit the clients' needs or to suit the social organisations themselves? Is care sufficiently tailored to each individual's needs? These questions are addressed by starting with the social biographies of the homeless persons themselves.

In the first part, the homeless persons receiving care and help, as well as those who do not receive help are gtiven the opportunity to speak out. This empiric research and a literature review allow for a description of the social-psychological factors which have a role to play in the process of homelessness. The experiences of the homeless themselves in the 'care for the homeless' institutions is described at

length. Because the homeless persons who are not in contact with the welfare sector are also involved, we find information on resistance against the classic structures of care, the reasons why some homeless people leave care. There is attention to the problem of housing as well as the problem of disaffiliation, and both form an important part of the life stories of the homeless.

From the life stories of the roofless and homeless, and the needs one can distill out of their stories, the second part of the research looks into the social reality and in particular at the care on offer for the homeless. Literature reviews and interviews with key contacts offer an insight into the sociological background of homelessness and the relationship between the homeless and services on offer. There is a critical analysis of the services, both for prevention and reception and integration. A number of 'best practices' illustrates the findings in the second part.

In the third part policy advice takes center stage. Based on the social psychological and sociological analysis of homelessness, several policy measures are advised concerning the care given to the homeless and the prevention of homelessness. The study concludes with four anchor points for care and policy making: recognition of the individual behind the label homeless, positive image building, participation in a dialog driven trajectory with social workers and with policy makers, prevention and pro-active work, and finally a global and shared strategy.

This piece of research aims to be a voice for the homeless and roofless, so that they are empowered. The homeless and roofless deserve more respect than they currently get and are entitled to participate in society. Every form of homelessness or rooflessness is an injustice and a violition of the right to housing and a home. Homelessness deserves to be high on the political agenda and to be made far more visible.

Datacollection on health relevant to homelessness

6.3: Do you know of data collection in the following areas that might be relevant in relation to the health to homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

We have no specific information on the homeless as regards access to health care, mental health and environmental factors. We suspect that there is very little data collected by the federal and regional authorities.

In national surveys the "self-perceived health status" is often used as an indicator for health problems of the Flemish population related to eg socio economic groups.

Such measurements of the national or regional surveys never pay attention to the specific – and for the surveys almost unreachable – groups such as the homeless. On top of that, we wonder if such an indicator would be much use for the hoemelss. We suspect that people with a low opinion of themselves have a tendency to minimalise their health problems and to adjust their standards downwards to fit their circumstances.

7.3. Specific indicators

6.4: Do you know of any indicators used to measure the effectiveness policies/services in the following areas that might be used to get information on the health and well being of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

Insofar as indicators exist they are collected by the NGO's. For instance, every year the Association for Acohol and Drugs publishes a Year Book in which the addiction problems of the homeless and roofless are mentioned. This same information is now included in the Belgian National Report on Alcohol and Drugs 2006. The data published from other, often partial, databases such as Tellus, the clientregistration system of the Steunpunt Algemeen Welzijnswerk.

7.4. Health, housing & work

6.5: In relation to housing, are you aware of any comparisons undertaken between the health of the well and poorly housed populations? In relation to employment, do you know if comparisons between the health and well being of homeless or formerly homeless people who have access too employment and those who don't?

7.4.1. Health and work

«Small and dank dwellings, poor hygienic conditions, uncertain water supplies and lack of electricity and heating cause illnesses. Unemployment or work in poor conditions, an income that does not allow for a healthy and regular diet, stress, accidents and illnesses … they all go together. For certain groups, spare time or holidays to recover physically and mentally are an unattainable luxury. »

Further reading: www.pauvrete.be/themes/default.asp?id=418

An overview of government measures regarding housing and health:

Federal

Quality of housing (Ethos 11.2)

Housing is a regional matter, but at the federal level it belongs to the tasks for the Minister of Social Integration. An interministerial conference coordinates the iniatives (De Decker 2004). The latter states that despite growing resources and more social and political interest, public opinion is becoming more worried about housing in general and the affordability and quality of housing in particular. De Decker estimates the need for new, good quality housing in Flanders is about 300.000 units (REF).

Specialised associations request that the government provides more social housing, exerts more control over rents, adjusts the fiscal policy for private rent, estabblishes a rental committee and introduces rent subsidy. (De Decker 2004).

Inadequate housing (Ethos 12, 13)

See under 'local authorities'.

Flanders

Druggebruikers (Ethos 1.1, 2.1, 3.1,4.1, 6.2, 7.2, 7.4)

In the Flemish Community various therapeutic communities and residential departments for drug users provide a sort of after care including housing. A number of CAW's are specialised in caring for roofless drug users.

Drug users have several possibities to find a roof in centres that are *not specifically intended for them*:

- Reception Centres for the homeless and Women's Refuges. These centers are open to a number of target groups such as homeless men, women, families, adolescents, children, asylum seekers, … The length of the stay and the intensity of the counseling depends on the population and type of centre.
- Night shelters. These organisations accept clients for short stays. They usually offer a bed, a meal, a shower and basic necessities such as peace, quiet and anonymity. During the short stay in a night shelter the client is redirected towards other services who might be able to offer a more lasting solution to his/her problems
- Supported housing. This form of housing was designed for people who wish to live independently but continue ton eed a minimum of support. This external support is offered by the CAW. www.caw.be and www.steunpunt.be.

Although there are several centres where homeless drug users find shelter, recent studies show that there is still a shortage of reception centres for *roofless drug users* in Flanders (Colpaert e. a. 2005; Follon 2003 in Belgisch Nationaal Rapport over Drugs 2005: 95).

Wallonia

Housing (Ethos 2.1, 3.1, 3.2, 12.1)

As far as housing is concerned, the Walloon Housing Code provides for various options:

- Temporary housing for families in difficulties or who temporarily have no housing (six months maximum term, one extension possible) ;
- Reintegration through housing for families in difficulties (maximum term of 3 years); social housing for families in difficulties or with a limited income.
- Emergency accommodation is not regulated by the Walloon Code. This is the responsibility of the Minister of 'Social Action' (welfare) and and includes the reception centres and night shelters for the roofless.

Supported accomodation (Ethos 6.2, 7.2, 7.4)

There are two sorts of supported housing which offer integration into daily life:

- The initiatives for protected living ("Initiatives d'habitations protégées" /IHP) for people with psycho-social or psychiatric difficulties;
- The psychiatric nursing homes ("Maisons de soins psychiatriques"/ MSP) for people with chronic psychiatric disorders, who are stable and do not need hospital treatment. .

The report of the expert group stresses that the problems with access and availability of housing for drug users. It concludes that specialized institutions have insufficient resources and too few technical skills to tackle the problem of housing for drug users and the reception centres are generally absent in the specialised networks concentrating on drugs problems. A number of recommendations of the groups tries to address this (Collège d'experts en assuétudes 2005 in Belgisch Nationaal Rapport over Drugs 2005: 95).

Local authorities

Inadequate housing (Ethos 12, 13)

Public safety and health. A dwelling may be declared unfit for habitation due to article 135 in the New Communcal Law. The mayor may take this decision only when the dwelling is a danger for public safety and/or health. The term 'public' also applies to the inhabitants of the dwelling concerned, as well as the neighbours and coincidental passers by.

Declaring a dwelling unfit for habitation. This may be done based on the Flemish Housing Code and this takes priority of ther mayor's initiatives. The declaration by the mayor may be invoked when the matter is very urgent. The mayor thus has a possibility to use this tool to leverage solutions for acute problems on housing quality.

Stricter safety and quality norms for renting out rooms and lodgings.

The Flemish government has issued a decree that stipulates minimal quality requirements. The local communes have the option of introducing stricter rules on safety and quality, particularly on issues like fire safety. Most (larger) towns have issued such local rules in order to ensure that the quality and safety of lodgings, and of cheap hotels or rooms to let.

7.4.2. Health and work

Specific information on the homeless regarding work and health is not known to us.

Generally a poor state of health, certainly in conjunction with other problems such as bad housing quality, does not improve ones position in the labour market.

8. The right to health (Q7)

The right to health is enshrined in several international human rights texts. You can find the articles on health brought together in FEANTSA's brief on the right to health. It is further strengthened by the right to non-discrimination in the area of access to health. Tackling health inequalities is an ongoing priority at European level. For this reason, expressing homelessness in terms of health has the potential to be a powerful political tool. The right to housing, the right to employment and to access to the services you need are all underpinned by the right to be healthy and to enjoy a state of well-being.

7.1: Do you know of any examples where a rights-based approach has been adopted in relation to health for homeless people or other vulnerable groups, whether in the form of court cases or campaigns?

7.2: Is the health of homeless people a political issue in your country? Could it be a useful campaigning point? Why? Why not?

8.1. Right-based approach

Following initiatives are based on a rights-based approach:

- General Report on Poverty – see point 7.2.2
- The Right to Health is included in the consititution (1993) – see Yearbooks Poverty (Vrancken et al)
- Welzijnszorg, campaign theme in 1998: an annual media campaign to raise awareness on poverty related issues and to give policy makers advice http://www.welzijnszorg.be/politiek/ziek.htm
- 'Rechtenverkenner' a new initiative of the Flemish government, is a websit which gathers information on social benefits and advantages at the federal, Flemish, provincial and communal level, and sorted according to the basic social rights. The website is still in development and not yet complete. There is a subject category 'roofless' and one can find out what one is entitled to in the commune one stays in.

www.rechtenverkenner.be

8.2. Health of homeless people as political issue and a campaigning point?

- Welzijnszorg, campaign theme in 1998: an annual media campaign to raise awareness on poverty related issues and related policies. Although the theme changes from year to year, recent developments are tracked and made available on the website. http://www.welzijnszorg.be/politiek/ziek.htm
- Welzijnszorg, campaign theme 2006 will be a generic campaign on poverty, linked to the millennium goals, and health will probably get a place in the overall theme.

Bibliography

Collectief van de Verenigingen Partners van het Algemeen Verslag over de Armoede, Federaal Ministerie van Sociale Zaken, Volksgezondheid en Steunpunt tot bestrijding van armoede, bestaansonzekerheid en sociale uitsluiting, Vakgroep Huisartsengeneeskunde en Eerstelijnszorg (2002), Eindbesluiten Forum "Armoede en gezondheid: knelpunten in de toegankelijkheid van de gezondheidszorg. Van ervaringen en onderzoek naar beleid". Brussel. Zie: www.armoedebestrijding.be/publications/Conclusies%20Forum%2014-12-2002.pdf

Deleeck, Herman (2002), Dood en verdeling. Over sociale ongelijkheid in ziekte, zorg en dood. Antwerpen, Centrum voor Sociaal Beleid UFSIA, Universiteit Antwerpen

Delcourt, D., e.a. (2000), *Rustig wonen in het groen. Onderzoek naar permanente bewoning op Breebos*, Katholieke Hogeschool Kempen, Departement Sociaal Werk, Geel.

De Maeseneer, e.a. (2003), Toegankelijkheid in de Gezondheidszorg, deelrapport 4 De Toegankelijkheid van de gezondheidszorg gezien door de mensen in armoede, Universiteit Gent i.o.v. de Minister van Sociale Zaken en Pensioenen, Frank Vandenbroucke

Dierckx, Danielle (2002), "De quoi vivons-nous. La pauvreté en Belgique **"** , (OASeS). Une publication de la série "*Horizons* " de Cera Foundation, Bruxelles.

Devillé, Aleidis (2006), De onzichtbare rechteloze klasse. De leef- en belevingswereld van mensen zonder wettig verblijf in Vlaanderen en Brussel, *Tijdschrift voor Sociologie*, jg. 27, nr. 2.

Follon M. (2002), STEM. Een stem voor thuisloze druggebruikers in Limburg, CAD Limburg.

Gadeyne, S., Deboosere, P. (2002), Socio-economische ongelijkheid en sterfte op middelbare leeftijd in België. Een analyse van de Nationale Databank Morbiditeit. Brussel, Vakgroep Sociaal Onderzoek, VUB

Hennion, W. Kansarmoede en gezondheidsbevordering in Vlaanderen
Boek, 123 p

Hennion W., Van den Broucke, S. Toepassingsmogelijkheden van empowerment in functie van gezondheidsbevordering bij mensen in kansarme situaties

Hoefnagels, Kathleen, Ruys, Jerry (2003), De onbewoonbaarheidsverklaring. De huurder in beeld, Berchem, Vlaams Overleg Bewonersbelangen, VOB

Koning Boudewijnstichting (1995), Rapport général sur la pauvreté, Réalisé à la demande du Ministre de l'Intégration Sociale, Bruxelles, Fondation Roi Boudouin, 432 p.

Krabbe, J. (2006), Studiedag "Thuisloosheid schaadt de gezondheid", Steunpunt Algemeen Welzijnswerk, Brussel, donderdag 8 juni 2006

Levecque K. (2003), Armoede en depressie: (g)een evident verband, in: Vranken J., De Boyser K. & Dierckx D. (eds.), Armoede en Sociale Uitsluiting. Jaarboek 2003. Leuven / Leusden: Acco, p. 155-
173.

Marchal C. Recherche-action sur la pertinence de la mise en œuvre d'un projet de réduction des risques visant la prévention d'un usage abusif de cannabis auprès des jeunes. Mémoire en vue de l'obtention du titre de licenciée en Sciences de la santé publique. Faculté de médecine. UCL. Bruxelles 2005.

Van Remoortel, J. (2006). The relevance of the Green Paper on Mental Health
for people who are homeless. *The impact of international human rights instruments on the fight against homelessness. Homeless in Europe. Summer 2006*. Brussels, Feantsa, p. 25

Philippot P. & Galand B. (2003), Les personnes sans-abri en Belgique, Regards croisés des habitants de la rue, de l'opinion publique et des travailleurs sociaux, Série: Problèmes actuels concernant la cohésion sociale, Academia press, Gent, 164 p.

Philippot, P., Lecocq, C., Baruffol, E., Parez, A. & Galand, B. (2004). La santé mentale des personnes sans abri à Bruxelles. In : Acta Psychiatrica Belgica

Godemont, J., Steegmans, N., Goyvaerts, K., Lenaers, S., Spee, S. (red) (2005), Het leven zoals het zou kunnen zijn: (on)gelijke kansen in de levensloop. Jaarboek 3, Steunpunt Gelijke Kansenbeleid, Antwerpen/Hasselt, Universiteit Antwerpen, Universiteit Hasselt, 279 p.

Siersack, L. (1995), *Wonen en leven op een camping in de provincie Antwerpen*, Antwerpen.

Collectief van de Verenigingen Partners van het Algemeen Verslag over de Armoede, Federaal Ministerie van Sociale Zaken, Volksgezondheid en Steunpunt tot bestrijding van armoede, bestaansonzekerheid en sociale uitsluiting, Vakgroep Huisartsengeneeskunde en Eerstelijnszorg (2002), Eindbesluiten Forum "Armoede en gezondheid: knelpunten in de toegankelijkheid van de gezondheidszorg. Van ervaringen en onderzoek naar beleid". Brussel. Zie: www.armoedebestrijding.be/publications/Conclusies%20Forum%2014-12-2002.pdf

Vanheusden, L. (2004), Een gezondheidsonderzoek bij bewoners van Limburgse opvangcentra voor thuislozen. Licentiaatsverhandeling, VUB, 245 p.

Vranken, J. e.a. (1991 t/m 2005). *Jaarboeken Armoede en Sociale Uitsluiting van 1991 t/m 2005*. Leuven / Leusden, Acco.

Vranken, J., Geldof, D., Van Menxel, G. Van Ouytsel, J. (2001) *Armoede en sociale uitsluiting. Jaarboek 2001*. Leuven / Amersfoort, Acco.

Wetenschappelijk Instituut Volksgezondheid. *Gezondheidsenquête door middel van interview, België 2001. Synthese*. Brussel: IPH/EPI Reports nummer 2002-25; 2002.

Wijkgezondheidscentrum Botermarkt (1998). Armoede en gezondheid: de missing link. Onderzoek in opdracht van de Vlaamse Minister van Binnenlandse Aangelegenheden, Stedelijk Beleid en Huisvesting, de heer Leo Peeters en van de Vlaamse Minister van Cultuur, Gezin en Welzijn, de heer Luc Martens. Gent, Wijkgezondheidscentrum Botermarkt.

Websites Consulted

www.symposiumpublichealth.be

www.armoedebestrijding.be/cijfers_daklozen.htm

Belgisch Nationaal Rapport over Drugs: www.iph.fgov.be/reitox/Publications/BNR05NL.pdf
Afdeling Epidemiologie, Wetenschappelijk Instituut Volksgezondheid, December 2005;
Brussel (België)

Interface Demography

www.ufsia.ac.be/CSB

http://www.ua.ac.be/main.aspx?c=*OASESE

www.armoede.be / www.pauvrete.be

Nationaal Instituut voor de Statistiek (NIS/INS), Gezondheidsstatistieken: www.statbel.fgov.be/port/hea_nl.asp

www.thuisloos.be

Steunpunt Algemeen Welzijnswerk (NGO, Flanders): www.steunpunt.be

Public information on Health (Federal government; no focus on homelessness or pauverty): www.e-gezondheid.be

Wetenschappelijk Instituut Volksgezondheid, Nationale gezondheidsenquêtes:
www.iph.fgov.be/epidemio/epinl/index4.htm