Newsletter

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Dear valued partners, friends and supporters of aids&mobility europe!

This edition of the AIDS&Mobility newsletter again features some personal experiences from mediators, illustrating how important it is to adapt HIV prevention activities to local migrant community cultures and languages. You will also find an update on community information sessions, some relevant reports highlighting current scientific and advocacy news, links to useful resources and announcements about upcoming events.

As the current transcultural mediator pilot project enters its final phase, we would like to celebrate our achievements in the next newsletter with more stories from local mediators and with examples of building sustainability into local A&M activities. Please send in your contributions at any time – your local experience can be a valuable source of new ideas and an inspiration to others.

Master Toolkit Advisory Board

The third and last AIDS&Mobility Master Toolkit Advisory Board (MTAB) meeting took place in Brussels on March 28th, making its final comments on the A&M materials and last recommendations for the Master Toolkit. The Networking Work Package leader, the European AIDS Treatment Group (EATG), is currently finalising this main product of the A&M project.

The toolkit has been developed so that anyone interested in training activities for migrants may benefit as much as possible from the work, experiences and learning the A&M project partners 2008-2011 have accumulated during the pilot implementation of the A&M transcultural mediator model for HIV prevention across six European project sites.

It is difficult to capture the lively, creative, challenging, dynamic, joyful and inspiring moments we experienced implementing the project with our total of 116 mediators in Istanbul, Rome, Tallinn, Copenhagen, London and Hanover in a collection of documents.

However, the core documents for implementing the model, complemented by background materials from previous work and references to similar models used elsewhere, will give local and national organisations the backbone for their own version of a living, vibrant and successful HIV prevention project using transcultural mediators.

What will you find in the Master Toolkit?

- A&M background materials, giving an overview of HIV and AIDS and migration. They include case studies, country reports, research and policy documents.
- A&M training materials: practical tools to use and adapt for training transcultural mediators, reaching key populations, evaluating the project etc.
- A&M promotional materials: examples of flyers and posters that show how project partners recruited candidates for mediator training and participants for community information sessions.
- Other selected resources: a selection of models and materials that use similar principles and methods or have similar goals to the transcultural mediator model. They are included to show that different approaches can lead to success and that it is useful to consider existing options and the experiences of others before creating new versions of HIV prevention activities with migrant and mobile populations.

Local and national organisations interested in implementing the mediator model for migrant and mobile groups are encouraged to use and adapt these resources for their activities. The Master Toolkit will be distributed later this spring. If you would like to receive the toolkit, please register your interest with Ana Lucia Cardoso at analucia.cardoso@eatg.org.

The EATG and the A&M network would like to thank the members of the Master Toolkit Advisory Board: experts from Naz Project London, Ethno-Medical Centre Hanover, SOA AIDS Netherlands, Correlation Network II, The African Eye Trust, AIDES, MDM, Tampep, GAT Portugal, Polish National AIDS Center and the International Association of Patients' Organisations (IAPO) for their time and dedication throughout the project.

A&M surpasses target: 2803 young migrants reached

The 116 transcultural mediators trained as part of the A&M project in Tallinn, Copenhagen, London, Hanover, Rome and Istanbul have organised 203 community information sessions with more than 2800 participants to date, many more than the project target of 2400.

This achievement is due to the dedication of all involved in the A&M project and a cause for celebration. Taking HIV prevention information to those who need it most is never an easy task and depends on many factors. Mediators use their personal connections as well as their detailed understanding of the life circumstances of their communities to make it work. The support of the A&M partner organisations through training, coaching, de-briefing and back-up has also been crucial in achieving this important milestone.

Community information sessions still continue in some sites and partners are working on making them sustainable

beyond the end of the current project. We will report on these efforts in the next newsletter.

Here are some thoughts from transcultural mediators in London on the challenge of bridging cultural and language divides with black and minority ethnic communities. First, here is Abubacker Buhari reporting on his experience:

"Conducting community events did not come without hurdles. Sometimes no one turned up to the community events I organised and sometimes only a single person turned up. For some events, surprisingly, quite a number of people from all walks of life turned up, telling me how much the event meant to them, helping them to take control of their health and behaviours.
I noticed that there were cultural and religious sensitivities and some aspects of language were a problem. For example, it took a lot of time to help participants understand the A&M questionnaires within the UK context. For example the word *treatment* for some participants is the same as *cure* in colloquial language. I also learned that there is no community that is "difficult to reach". Rather, we as professionals have to change our perspective towards them, arrest our barrage of criticism and change our culture of blaming these vulnerable communities on the basis of their faith and cultural practices. We have to be inclusive of all faiths, ethnic and cultural groups."

Lucy Asesa writes about her efforts in reaching larger groups of participants for her community information sessions:

"When I started I was one of a group of three, and we concentrated on putting together groups of people from communities and conducting community events on HIV. It was summer, so we organised barbeques, called friends in for tea and had health talks. The downside to this method of mobilising people was that it proved expensive and it could also not guarantee wide coverage as the people who came over were friends and friends of friends and there weren't that many. I particularly faced problems in mobilising people: I was dealing with immigrant communities who more often than not have little time for activities that don't generate them money! Bringing them together proved difficult and when I did, they expected transport reimbursement or handouts as a thank you.

Lucky for me, NAZ Project London (NPL) staff were there to advise, and although I was a bit hesitant, I decided to go solo. The first months did not bear much fruit as I went through all my friends' BBQs and my neighbours, and then found that I had no further audience. Again I sat down with someone from NPL and discussed my difficulties, and I was advised to use already existing groups. This was very successful.

All in all I am very happy I took part in the transcultural mediator training programme. I am a different person from before I began: I gained massive knowledge in sexual health, brushed aside the stereotypes from my African background, gained practical skills in mobilising and raising awareness and built my confidence. I am confident that I have changed people's lives over the past couple of months and also learnt a lot and met new people."

nam aidsmap: sharing knowledge, changing lives

(Adapted from www.aidsmap.com)
NAM was founded in 1987 and the name originally stood for 'National AIDS Manual', a document produced at a time where there was little information, lots of hysteria and limited medical treatment. It was an important, evidence-based reference point for medical and other professionals as well as people diagnosed with HIV and AIDS.

The information materials produced by NAM have evolved to reflect the changing epidemic, developments in treatment and care and the changing information needs of people living with and working in HIV all over the world.
It now makes a large range of resources available online and in print, and tailored to different needs. Many of the materials are also available in different languages.

The essence of NAM's approach is providing calm, reliable, authoritative, independent information to anyone who needs it.

NAM believes that, wherever you are in the world, having independent, clear and accurate information is vital in the fight against HIV and AIDS. It enables individuals and communities affected by HIV to protect themselves, care for others, advocate for better services and challenge stigma and discrimination.
NAM produces useful information that you can trust, and it tries to make sure it is there for anyone who needs it.

When you go to http://www.aidsmap.com/translations, you will find a range of resources translated into the languages that you can see in the list on the left hand side of the screen. Simply select the language you want, and scroll through the "carousel" to find the resources you are interested in.
You will find basic information in the form of illustrated factsheets as well as straightforward booklets. There are even some translations of news stories so you can keep up to date with new developments.

Substandard HIV care for some immigration detainees in the UK

(Adapted from an article by Roger Pebody, published 23 March 2011 on www.aidsmap.com)

Many HIV-positive people held in immigration detention in the UK receive substandard healthcare, including forced treatment interruptions, inadequate clinical investigation and breaches of confidentiality. People are removed from the UK with inadequate supplies of antiretroviral medication or against medical advice.
The charity *Medical Justice* catalogued significant failings in treatment, although immigration detainees may experience problems locally rather than consistently across the country.
The UK Border Agency oversees ten Immigration Removal Centres (IRCs), prison-like structures used for detaining people whose asylum claim is being considered, those who have been refused and migrants to be removed from the country. Detainees are entitled to healthcare "equivalent" to that of the National Health Service (NHS). This is an operating standard for the private companies that run IRCs on behalf of the government. Private contractors provide primary healthcare and should facilitate

access to HIV treatment through local hospitals.
The UK Border Agency does not accept advice from the British HIV Association (BHIVA) and the National AIDS Trust (NAT) to ensure that care is indeed at NHS standard. *Medical Justice*'s report describes numerous breaches of this advice:
Detainees referred to *Medical Justice* had experienced interruptions to their access to medication. Drugs were confiscated from people arriving at an IRC and individuals were not always given a sufficient supply. Some detainees were not taken to their medical appointments, leading to treatment interruptions. Such treatment interruptions risk the development of drug resistance, necessitating the use of more complex drug regimens, which may be unavailable in the country a person is deported to.
People were obliged to share cells with people with TB and other infections, or forced to attend medical appointments chained to guards. Some had their HIV status revealed to others. Clinicians failed to carry out resistance tests or advise of results.
The largest group of problems concerns deportation. Although people should be fit to travel and medically stable, a number of individuals who had just started a new drug regime or who were waiting for important test results were removed, or would have been removed had lawyers not intervened. Recommendations that those being deported should be given a three months' supply of medication, contact details of support organisations in the destination country and a letter for the next HIV clinician were widely ignored.

One of the detainees commented: "The research highlights the way people like me are not treated like human beings in detention… I was scared that I was going to die in Yarl's Wood when they refused to give my medication. It was as if they were turning off my life support machine."

Medical Justice believes that given these failures to provide adequate clinical care, people with diagnosed HIV should not be detained at all. The NAT believes that a wider audit of health care for people with HIV at the full range of Immigration Removal Centres needs to be conducted.
Reference
Burnett J et al. *Detained and Denied: the clinical care of immigration detainees living with HIV.* Medical Justice, 2011.

European Parliament resolution calls for vulnerable groups to have access to healthcare

(Excerpts from http://bit.ly/fVK9Sd, 08 March 2011)

This recent Resolution from the European Parliament underlines that everybody should have access to healthcare systems and affordable healthcare. The specific needs of vulnerable groups such as women, older patients, undocumented migrants and ethnic minorities need to be taken into account more. Here are some of the most relevant sections of the resolution:

5. (The European Parliament) Calls on the Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; calls on the Member States to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation;

6. Calls on the Member States to take account of the specific health protection needs of immigrant women, with particular reference to the guaranteed provision by health systems of appropriate language mediation services; those systems should develop training initiatives enabling doctors and other professionals to adopt an intercultural approach based on recognition of, and respect for, diversity and the sensitivities of people from different geographical regions; priority must also be given to measures and information campaigns to combat female genital mutilation, including severe penalties for those who practice it;

7. Calls on the EU and the Member States to rapidly find ways of combating ethnic discrimination, particularly in certain Member States where Council Directive 2000/43/EC has not been implemented and where women from ethnic minorities have little or no social protection or access to healthcare;

8. Calls on the Member States to promote access to high-quality legal advice and information in coordination with civil society organisations to help ordinary members of the public, including undocumented migrants, to learn more about their individual rights;

9. Emphasises that the economic and financial crisis and the austerity measures taken by Member States, in particular on the supply side, may lead to a reduction in the level of funding for public health and health promotion, disease prevention and long-term care services as a result of budget cuts and lower tax revenues, while the demand for health and long-term care services may increase as a result of a combination of factors that contribute to the deterioration of the health status of the general population;

EMIS: The European MSM Internet survey (EMIS)

(adapted from www.rki.com)

This important study unites academic, governmental, and non-governmental partners from 33 countries in Europe in collecting data on homosexuality, homosexual behaviour and STIs.

Its online questionnaire was translated and is now used in 25 different languages: български език, Čeština, Dansk, Deutsch, Eesti keel, Ελληνικά, English, Español, Français, Italiano, Latviešu valodam, Lietuvių kalba, Magyar nyelv, Nederlands, Norsk, Polski, Português, Română, Русский язык, Slovenščina, Srpski, Svenska, Suomi, Türkçe and Yкраїнська мо́ва.

The survey asks MSM to self-report their sexual identity, knowledge, sexual history and behaviour as well as their experience of discrimination and access to prevention and other health services in order to investigate four main research questions:

- What are the levels and distributions of sexual HIV/STI exposure and transmission facilitators?
- What are the levels and distributions of unmet (prevention) needs of MSM?
- What is the population coverage / what are the biases of prevention interventions?
- What information is needed to compare samples and target interventions?

The data EMIS collects can be used for behavioural surveillance, but also for

comparing different groups of MSM, different countries or regions.
EMIS is the first study to enable direct comparisons among 33-40 countries, providing research information on homosexuality for the first time for some of them. Results will be used to plan prevention targeting MSM.

The first easy-to-read community report is now available. It provides insights into participation rates, HIV knowledge and HIV testing in the previous 12 months. The final report is expected in September 2011.

EMIS is co-funded by a grant of the European Union (EU Health Programme 2008-2013). Go to

http://www.rki.de/EN/Content/Prevention/EMIS/EMIS__node.htm/

to find out more.

Data from EMIS show wide variation in quality of sexual health screening across Europe: countries with specialised clinics do better

(adapted from an article by Roger Pebody, published 16 March 2011 on www.aidsmap.com)

In the majority of European countries, most sexual health check-ups for men who have sex with men (MSM) do not include basic physical examinations or diagnostic procedures to diagnose rectal gonorrhoea, chlamydia or warts, Axel J. Schmidt and Johanna Rankin told the 14th annual CHAPS conference in Manchester.

Countries that perform better have well developed networks of specialised sexual health clinics.
Men who visited a sexual health clinic or community testing service for their most recent HIV test were more likely to be satisfied with confidentiality and the opportunity to discuss sexual behaviour.
These data are some of the first from the European MSM Internet Sex Survey (EMIS). With a total of a total of 180,988 responses, it is probably the largest international study of the sexual health of gay and bisexual men ever conducted. The response rate was particularly high in Germany, Switzerland, Luxembourg, Ireland, Portugal, Slovenia and Austria. It was lowest in Turkey, Moldova and Russia.
Depending on the country, between 20 and 50% of men had had a sexually transmitted infection (STI) check-up in the previous twelve months. Men in central European countries were particularly unlikely to have had a recent check-up.
While 80% or more of check-ups included blood tests, the only sexually transmitted infections detected this way are syphilis and viral hepatitis.
In 33 of the 38 countries surveyed, less than 40% of check-ups included an inspection of the anal and penile area or an anal swab. In over two-thirds of European countries, less than 20% of check-ups included anal swabs. The countries that didn't perform physical examinations were generally the same that didn't do anal swabs.
The researchers point out that in these countries, anal warts, genital warts, rectal Chlamydia and rectal gonorrhoea probably remain profoundly under-diagnosed. As a result, men's sexual health suffers, the risk of HIV infection or transmission is greater and comparisons of STI rates in different countries will be misleading.

Four countries performed notably better in these areas than others - Malta, Ireland, the United Kingdom and Sweden: each has a network of specialised sexual health clinics.
Some rich countries such as Germany and France performed particularly poorly. Compared to men in Germany, men in the UK or Ireland were over six times more likely to have had a genital and anal examination during their last check-up. Men in France were even less likely than those in Germany to have been given an anal swab.
Overall, around 35% had taken an HIV test in the previous twelve months. Testing for HIV in the last year was most common in Spain, Portugal, Belgium and France. In each of these countries, the most common place to test was with a practice-based physician (such as a family doctor). In several countries of central and Eastern Europe, the most common place for men who have sex with men to take an HIV test was at a community service such as a testing site run by a gay community organisation. In Bulgaria, the most common place to test was at a mobile outreach van. Discussing sex was far more common at a community service (52%) or at a sexual health clinic (64%).

References

Schmidt AJ. “Differences in STI testing in selected European countries”, 14th CHAPS conference, Manchester, 10 March 2010.
Hickson F. “European MSM Internet Sex Survey (EMIS)”, 14th CHAPS conference, Manchester, 9 March 2010.
There is more information about EMIS here.

Upcoming Conferences and Events

The AIDS 2011 conference “HIV in European Region- Unity and Diversity” will take place in Tallinn, Estonia, from 25th to 27th of May, 2011. www.aids2011.com.

FEMP 2011
The Future of European Prevention among MSM

This conference will take place in Stockholm, Sweden, 10th and 11th November 2011 www.femp2011.eu

Contact us

Let us know about your work on HIV and migration, or any news stories or events you think our network of partners would be interested in.

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Executive Agency for Health and Consumers

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