Newsletter

Issue 8

September 2010

Welcome to the eighth edition of the a&m newsletter!

In this edition of the a&m newsletter you will find highlights from the 2010 World AIDS Conference (IAC) in Vienna and a summary of the latest HIV/AIDS epidemiology in Europe. Most importantly, we bring you first person accounts from some of the 117 transcultural a&m HIV/AIDS mediators working with migrant and mobile communities right now!
You will also have the opportunity to get to know the winner of this year's aids&mobility europe Young Social Entrepreneur of the Year Award, Dynka Amorim. As always, we appreciate your interest and welcome your feedback and contributions at news@aidsmobility.org!

Your a&m team

IAC 2010 Vienna

This time the biennial gathering of HIV/AIDS community activists, scientists, program managers, policy makers and project workers was held with a focus on the currently fastest growing HIV epidemics in Eastern Europe and Central Asia. This epidemic could be reigned in if only there was the political will to stop repressive and ineffective policies, and instead implement harm reduction and opioid substitution therapy for people who inject drugs and access to treatment: To highlight this fact, the Vienna Declaration (www.viennadeclaration.com) on the de-criminalisation of drug use and evidence-based policy was published and so far has been endorsed by over 15,000 individuals and associations.

'Broken Promises kill'. With this slogan, more than a thousand activists peacefully 'invaded' the opening ceremony of the conference. Target of the protest were the unfulfilled commitments towards the Global Fund for AIDS, TB and malaria by governments around the world.
Professor Julio Montaner, outgoing president of the International AIDS Society and co-chair of the Conference, said:
'I cannot hide my profound disappointment and deep frustration with the recently concluded G8/G20 meetings in Canada. By failing to take responsibility for the Universal Access pledge, and more importantly for failing to articulate next steps to meet not just the 6th MDG, but all of them by 2015, the G8 has, quite simply, failed us.' In fact, funding the Global Fund adequately would be possible by introducing something like a tax on financial transactions.
According to UNAIDS, 6 million people need antiretroviral therapy and do not have access to it. When Kofi Annan launched the Global Fund to Fight AIDS, TB and Malaria in 2001, he said that to bring the epidemic under control we would need 10 to 15 billion dollars per year. So far only 13 billion dollars have been collected.
The EU satellite session 'What else do we need to know about the epidemic in Europe for policy making?' highlighted the fact that >30% (!) of HIV diagnoses in Europe are in late presenters, that there is a high TB mortality among PLHIV in the east and that only 24% of PLHIV have ever been advised

about ART. European standards for testing, treatment and care were recommended. Henrique Barros suggested that different countries have different levels of experience with immigration, and that this influences their response. The main effects of migration are language, cultural and religious barriers as well as lack of access to services. He recommends community-based VCT using rapid testing technology with the integration of culturally appropriate lay counselling. Lucas Wiessing reported that the prevalence of injecting drug use in the EU is stable or declining, however it may be rising in Eastern Europe. HIV prevalence among IDU is high in the East and on the Iberian Peninsula, and HCV prevalence is very high at >60%. The challenges are to increase coverage of OST, NSP, ART and VCT, and to combine these services for IDU to improve access. Co-morbidities (TB, HCV) are also a challenge, as is the de-criminalisation of drug use.

In 'Effective HIV policies and measures in Europe to address key populations', Morten Kjaerum said that Migrants feel discriminated against in the health care system. There are difficulties with language and, in addition, there is HIV stigma. Undocumented Migrants are afraid to access the system for fear of being reported to the authorities. Henning Mikkelsen asked for policies for effective prevention, with a focus on Eastern Europe: 'Bad policies waste resources and kill people, sound responses save money and lives'. He said we need better data to tailor local solutions and to keep track of dynamic changes in MSM/IDU/Sex Worker etc. communities. We also need a high level policy commitment with civil society involvement and we need to scale up access to treatment.

In the debate about starting treatment earlier, some now recommend it as soon as HIV is diagnosed: damage to the immune system increases morbidity and mortality before the current threshold CD4 count of 350 is reached, and vastly increased treatment numbers could cut transmission by a third. UNAIDS is calling for the development of a simpler first line combination treatment with a low side effect and resistance profile, low cost and point of care monitoring only.

There has been a big advance towards a vaginal microbicide containing tenofovir. The reported trial was conducted in South Africa and showed 39%-54% effectiveness in preventing HIV infection, depending on the level of adherence.

For the first time there was a plenary on Hepatitis C Cure and Control. For PLHIV, HCV is a major health challenge, which can and should be controlled: 80% of IDU who acquire HIV have HCV co-infection, and HIV makes all stages of HIV infection worse. HCV co-infection can be lowered by NSP programs. For now, the basic response should include screening of blood donations for HCV, implementing universal precautions in health care settings as well as harm reduction measures (OST, NSP). Worldwide there is a lack of access to testing and the costs of treatment can be prohibitive. Less than 10% of the 170 Million people with HCV worldwide are currently in care.

The potential of pre-exposure prophylaxis (PREP) is still being debated. It would mean administering a therapy to people who are uninfected, but have a high risk of infection because of their behaviours: sero- discordant couples (where one partner is HIV positive and the other negative) or those in the gay community who have multiple partners and risky sex.

The published research data cannot be considered sufficient in proving the capacity of PREP to protect against HIV infection. Also, if resistance develops, the transition to second line therapy would be much more complex and sero-negative people taking PREP could lose a therapeutic option even

before they got infected - and there aren't so many. The side effects produced by introducing such strong drugs into a healthy body must also be considered.
But there is also another issue of great importance: Rather than intervening in risk behaviour by conducting prevention and information campaigns, giving 'heavy' treatments to healthy people in this way does not try to change these behaviours. There is a risk of promoting a false sense of protection and, paradoxically, risky behaviours could be promoted. PREP is not a vaccine which patients would take once for guaranteed immunity. And, what is more, States and governments may not take responsibility for implementing preventive actions and individuals may not take responsibility for avoiding risky behaviours.

a&m in action: Mediators talk about their training and work

Abubacker Buhary (London): Since the completion of the training, working in the field has been an exciting experience for me: it made me realise that I am not just a member of the community but also a professional Health Mediator. I anticipated that involving communities in promoting HIV and AIDS awareness was not an easy task. Parenting groups, places of worship and festivals were the most effective settings for reaching the target communities. This may be due to the fact that the majority of black and minority ethnic communities have faith/religious backgrounds. It was important to see that the information and messages being distributed were sensitive to their sacred places of worship for them to welcome them. I did find reaching youth and teenagers very challenging. Providing 'edutainment' activities and some sort of reward may have improved my chances!

Lydia (Copenhagen): At the beginning of the course I never thought that I could come up with the two groups of participants required. I was so nervous and worried as I feared that I would not be able to organise the community sessions. I must say that I was very surprised when I did! I managed to get participants of varying ages and discovered that most, irrespective of age, had burning questions. During the sessions I discovered that most participants had very limited knowledge about hepatitis. Most admitted that they had a vague idea about the disease but did not know how it was transmitted and they were not sure of the part the body the disease affected.

I believe my sessions were a success as I passed on the knowledge about HIV, AIDS and hepatitis. After the second session I was energised and ready for more - unfortunately it is not possible to facilitate further sessions at this time. I would like to thank the organisers for giving me the opportunity to take part. I will pass on the knowledge, to whoever needs it, wherever I go!

Kellen (Copenhagen): It was very difficult to gather young people for teaching. All those I asked showed interest in attending, but many of them could not find time. Even those who promised to come started cancelling as the teaching day drew near! Attendance at my first event was frustrating. However, those who attended both the first and second event showed keen interest. They listened, took information in and asked questions. It was enjoyable to inform them of what I have learned. The eager faces of the young people encouraged me in what I was telling them. I am happy that I got the opportunity to do the course and to pass on what I have learned to others.

Mehmet Aşan (Istanbul): The beginning of the session was a bit difficult because the participants were shy. They could not ask what they wondered about, but after some conversations they started to be more open and talkative. I was also a bit nervous because I was not sure if I had enough

knowledge about AIDS and if I was able to do this session. But then it got easier for me, also because of the participants, and also because I could answer all questions…
The second one was easier and the participants were more open minded and easy going than before. I felt I was really doing something for society and Kurdish people... I think participants were also happy about these sessions because it's not easy to find answers for these kind of questions…

M. Elfatih Abbakar (Istanbul): Before I started the training I was very anxious to know about the disease, its effects and all other necessities. I thought that I already knew enough, but as I went through the training my knowledge of AIDS and healthcare has tremendously increased. I am very proud of the knowledge I acquired at that time, hoping to use what I learnt to teach others.
If there ever was another AIDS training program I would highly appreciate it as I know now that I have enough knowledge to teach those who are less fortunate in its education. It was a great experience also in terms of culture as we get to know a lot of different people from different countries and this is quite nice. We got to meet a lot of new faces and make new friends. I am very happy the training was a success and would like to thank the NGO for the great idea.

Ismail Farouk Labaran (Istanbul): Well, when I heard about the program, I got interested because I don't have much knowledge about AIDS. When I got into the first session I was a little bit nervous because I did not know many of the participants and the program is in Turkish. I learned more about family planning and birth control which will be very useful for me in future.
The social interactions of the program are another interesting part that I like about the program. I really missed it and hope one day we will all get together again. When I am with my friends and we are talking about AIDS/HIV, family or birth control, sex and any other topic that I learned at this program, I help them out with some topics. I'm proud I know what they don't know and am helping them out with it.

Yelene Skylarova (Istanbul): I agreed to take part in the project because I thought it would somehow get me out from university captivity. I said 'Yes! It's time to get out and look at the world outside'. During my own presentations the responsibility was over to me, so I felt the significance of letting people know the right information. I had fun and have to confess I learned a lot. I opened for myself a world of talented people, their resourcefulness and charm. The project gave me a lot of information about AIDS I had not known and also gave me an opportunity to have close communications with friends.

HIV Infection and Migration in Europe (EU/EEA) 2006

Worldwide there are **192m** international migrants. Most migrate from China, India, and the Philippines and the countries with the biggest intake are the USA, Russia, Germany, Ukraine and France.

- HIV Prevalence: Western and Central Europe **0,3%** (UNAIDS 2009)
- IN EU/EEA countries, there were **26712** new HIV diagnoses in total

- **53%** (**14157**) were transmitted heterosexually. Of these, the country of origin is not the country of notification in **65%** (9202) of cases (**35% or** 5046 cases from sub-Saharan Africa (SSA))
- **37%** (**9883**) were MSM: of these, the country of origin is not the country of notification for **18%** (1779 cases, esp. from Latin America, Western Europe)
- **9%** (**2404**) were IDU: of these, the country of origin is not the country of notification for **14%** (336 cases, esp. from Western and Eastern Europe)

- Mother to Child Transmission (MTCT) has not been completely eliminated: **169** cases, of these **41%** (69 cases) were in people from SSA.
- High proportion of late diagnoses: EU/EEA average **50%**

Large differences in the proportion of migrants among new HIV diagnoses exist between countries: low (e.g. Central Europe), medium (D, NL, A), high (N, B, LUX, F, IR, UK). The location where the infection occurred is mostly unknown, but estimates of the time elapsed between time of arrival and CD4 count at diagnosis indicate that most migrants from SSA have acquired the infection there. However, the proportion of infections acquired in Europe is increasing (IDU: mostly acquired in Europe).

Die HIV epidemic among migrants in Europe mirrors global trends. Access to prevention, diagnosis (testing), treatment and care as well as migration-specific factors such as lack of information and limited access to the health care system all play a role. ECDC reports that there is evidence that migrants from High Prevalence Countries (HPCs) experience a higher HIV risk in general. However, for other migrants this is not the case independent of other risk factors (such as injecting drug use). There is no agreement about a generally higher risk for younger age groups: risk behaviour has to be taken into account.

a&m Young Social Entrepreneur 2010

Migrant youth are taking the lead in developing new approaches to HIV-prevention targeting their own communities. In 2010, a&m again called for nominations of outstanding young individuals who initiated new activities and run successful programs.

Dynka Amorim is a young migrant living in Lisbon (Portugal). He is 26 years old and a student of Political Science and International Relations at the University of Nova (Lisbon). When he was 18 years old, he started his HIV/AIDS youth movement in High School as the coordinator of an informal group of young people called ‘Bué Fixe’, meaning ‘very cool’ in English, in Sao Tomé and Principe (island nation in Westafrica) in 2003. Together with his friends at the organization he started developing new means of communication. ‘Bué Fixe’ also became the name of a digital and printed youth magazine to inform young people about HIV.

In 2005, when Dynka moved to Portugal to continue his studies, he became an active member of the NGO Citizens of the World/Bué Fixe, which promotes access to social services and human rights for African Migrants living in the Lisbon area and focuses on STI/HIV/AIDS prevention.

Dynka also volunteered at the NGO AJPAS in a quite vulnerable community of migrants, where he works with children in order to promote better hygiene, as well as with young migrants leading discussions regarding their sexual and reproductive health.
He then became a radio producer addressing young migrants coming from Portuguese

speaking countries in Africa. In his radio program a variety of issues are being addressed, including the environment, human rights, youth participation and HIV/AIDS.

In 2010 Dynka Amorim was a member of the Youth Force for the XVIII International AIDS Conference. He coordinated the Youth Media project 'to destroy' the HIV/AIDS virus, supported by MTV Stay Alive and the Youth in Action Program.

Dynka Amorim will receive the 2010 a&m Young Social Entrepreneur Award on 30th November 2010 in Brussels.

a&m Literature Review Update: How you can help

The a&m literature review is an important document informing the development of the project's strategies and evaluation. In its current draft form it includes literature published between 1998 and 2008. We may now have the opportunity to update this document for use in future projects, and the wider application of the transcultural mediator concept in particular. We know that as readers of the a&m newsletter you may know about and have access to important research that should be included in this update. Please send us citations or, even better, relevant published articles or conference abstracts published since the beginning of 2009 on:

- Migrants, mobile populations and ethnic minorities
- HIV/AIDS awareness and testing activities (education, transcultural staff/volunteers)
- Interventions compared with no intervention Increasing program participation, awareness, access to prevention and care.

Please send your suggestions and articles to news@aidsmobility.org and put 'a&m literature review update 2010' in the subject line. Your help is much appreciated!

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.

You can contact us by email at:
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Co-funded by the European Union under the Programme of Community Action in the Field of Public Health 2003-2008/ Executive Agency for Health and Consumers.

Co-funded by the Portuguese High Commissioner for Health.