Companion paper¹:

Migration and HIV, AIDS and TB : moving forward at country level in the European Union²

Migration and Health Department

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This report has been produced within the framework of the IOM project ‘EU Partnerships to reduce HIV & public health vulnerabilities associated with population mobility’ funded by the Portuguese EU presidency and implemented in collaboration with the governments of Bulgaria, Germany, Hungary, Italy, Malta, Portugal and the Netherlands.

¹ This companion paper refers to ‘Key Issues on HIV, TB and international population mobility’, MHD, IOM, September 2007.
Migration and HIV, AIDS and TB: moving forward at country level in the European Union

In the present companion paper to “Key issues on HIV, TB and international population mobility”, authors of country reports have elaborated on examples of approaches and activities in their country which are relevant for the European Union, but also for neighbouring countries.

The sixteen examples cover a wide range of issues in order to illustrate, as shown in the table below, the already existing wealth of experience which can be built upon.

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The three examples provided under the heading “Setting a framework under international standards” show that by doing so, the integration of vulnerable groups such as migrants into national plans and strategies can be facilitated, their needs better taken into account while ensuring the coherence of health strategies.

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3 Issues identified in the country reports by Jacques du Guerny and Lee Nah Hsu and compiled by Claudia Natali.
Organization issues exist at the national level, but also at the local level: both levels need to be addressed. Furthermore, they can be seen both from the point of view of health systems in order to ensure the best quality services, but also taking into account the needs of migrants are of prime importance. Facilitating the overcoming of barriers, ensuring close to home support, identifying the most important issues for migrants are all ways in which problems can be solved and better health ensured.

Easy access to data and information can contribute greatly to evidence based decision-making. Two examples which contribute to improving data collection and analysis by very different approaches are provided to show that a lot can and needs to be done in this area.

Finally, the need to specifically train staff, whether medical or social support staff coming into contact with migrants was a recurrent theme in country reports. An example of a specifically designed university course is provided to show what type of activity can be organized to solve some of the problems encountered by the interface of migrants and health personnel.
1. Setting a framework under international standards

BULGARIA: The road to Fight AIDS

The coordinated national response to AIDS led by the government and supported by all major stakeholders in Bulgaria highlights that the multisectoral approach is a reality. However, a lot of time, efforts and expertise have been invested to make this happen. It is also important to mention that the Bulgarian government fully recognizes that concrete actions need to be doubled with strong political will and significant financial support.

This policy line has been appreciated and therefore supported by a number of multilateral and international organizations including through technical guidance and support to policy development, financial support to implement activities in the National HIV and AIDS Action Plan, technical support to introduce international standards and best practices.

A major challenge and success related to national HIV and AIDS policies has always been the design of a country-specific response while being flexible in programme adaptation to follow changing country realities and at the same time aiming to contribute to achieve global goals in the fight against HIV and AIDS.

Country Context and National Commitments

1996 – Establishment of the National committee on prevention of AIDS and STDs at the Council of Ministers – policy-making and coordinating governmental institutions

1998 – Establishment of the UN Theme Group on HIV/AIDS – strengthening existing HIV/AIDS-related bodies and systems in the country and mobilizing the multisectoral approach

1998-2000 - The Ministry of Health, with the financial and technical support of UNAIDS, conducted a Situation and Response Analysis in relation to HIV/AIDS and STIs

2000 – Establishment of the ANTIAIDS Coalition of 48 civil-society organizations


2002 – Country Coordinating Mechanism to Fight AIDS and Tuberculosis (CCM) – active involvement of civil society and non-governmental sectors in policy development and control

2004 – Begin to implement the Program “Prevention and Control of HIV/AIDS” with Global Fund grant

International Commitments

2001 – The country joined the UNGASS Declaration of Commitment on HIV/AIDS

2003 - The national report “Millennium Development Goals – Bulgaria 2003” sets forth country indicators and targets till 2015

2004 - Following UNAIDS recommendations, Bulgaria committed to have in place and fully operational the Three Ones to ensure effective national HIV/AIDS response

2004 – The Dublin and the Vilnius Declarations
2003-2005 - Bulgaria took part in the development of the European strategy to the
fight against HIV/AIDS in the European Union and the neighbouring states
(2006-2009)

2006 - National consultation on Universal Access to HIV Prevention, Treatment, Care
and Support for all who need to 2010

2007 – EU membership and joining the Bremen Declaration

The Situation and Response Analysis conducted in the period 1998-2000 led to the
identification of the main target groups of the National HIV/AIDS Response: injecting
drug users; sex workers; Roma people; men having sex with men; prisoners; young
people and people living with HIV.

Identification of migrants as a new target group of the national HIV prevention policy
is based on the following assumptions:

(1) Analysis of the implementation of the National Strategy and National Program for
Prevention and Control of HIV/AIDS and STIs (2001-2007) showed that high
population mobility, especially labour mobility, are among the indirect determinants
with increasing impact on the country situation thus needs to be given special
attention.

(2) Large part of the foreigners who received continuous and permanent residence
permit, as well as persons who were granted refugee and humanitarian status in
Bulgaria, come from countries with generalized HIV epidemics and there is already
epidemiological evidence that they are more likely to be infected and contribute to an
increase in the number of HIV cases in the country.

(3) Analysis of epidemiological data and investigation of the first HIV cases since
registration began in 1986, as well as behavioural data from the Second Generation
HIV Surveillance among most-at-risk groups on the one hand, and analysis of data
on the large number of emigrating Bulgarians, including short-term and long-term
labour mobility on the other hand, support the conclusion that increased mobility is
related to an increasing number of HIV vulnerabilities. This can further contribute to
rapid increase in the number of HIV cases in the country.

(4) There is a need to conduct situation analysis, including needs and resource
assessment, regarding HIV and TB co-infection among migrants in order to ensure
evidence-based design of specific interventions and planning of activities.

(5) Given that Bulgaria is an EU member and has become one of the external border
of the Union, cooperation with EU members and neighbouring countries in the field of
HIV and migration should be strengthened and opportunities for joint projects should
be explored.

ITALY: Guiding principles for HIV and TB programmes for migrants

1. The guidelines of actions and programmes for TB surveillance and control
and the legal directives for the HIV prevention are in line with the European
guidelines and with the principles of accessibility and universality spelt out for
foreigners in Art 34 and 35 (Legislative Decree of the 25th of July 1998 n°286 title V,
item 1).

2. There are a lot of different and specific interventions for HIV, AIDS and TB
prevention programmes carried out by State agencies and NGOs.
Health care challenges for migrant populations:
There are variations in the implementation of the health care services for migrants among the different regions in the country.

Practical approach in health care services for migrant populations:
- Identify good practices and promote their implementation
- Analyze local practices in order to promote a more consistent Health care services
- Assess the existing health information reporting system from the regional to the national levels
- Develop training guidelines for health workers serving migrants
- Health workers training for migrants health services including the legal, social and cultural aspects
- Improve epidemiological surveillance system at the national level including health data for migrants
- Disseminate of culturally sensitive approaches in health services
- Increase the utilization of cultural mediators in the health services as well as social and welfare services

Information, education and communications for migrant populations:
- On laws for the access to health services including requirements, modalities and procedures
- Target campaigns to reach specific migrant groups on issues relating to workplace and domestic work safety, reproductive health and child care.

PORTUGAL: A holistic approach for the integration of immigrants and their improved health

The High Commission for Immigration and Intercultural Dialogue (ACIDI, I.P.)⁴, created in 1996 and reinforced in 2002 and in 2007 - is a State service with the main mission of promoting the integration of immigrants and the intercultural dialogue in Portugal. ACIDI, as a transversal intervention service, reports to the Prime-Minister and, since the first of June 2007 became a Public Institute. In other words, the Portuguese State, recognising the importance of this service to immigrants, reinforced ACIME powers and intervention.

To accomplish its mission ACIDI assures the participation and cooperation of representative immigrant associations, social partners and State Services in the definition and assessment of policies on immigrants’ social insertion and on prevention of exclusion and discrimination.⁵

Within the framework of a “State of Law with a human face”, ACIDI have the following priorities:
- To assure the real exercise of equal rights and duties among nationals and foreign citizens and fight all forms of ethnic or racial discrimination or any other expression of xenophobia.

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- To reinforce information systems and support to immigrants in order to facilitate their integration in Portugal – whether in paper (brochures), telephone (SOS phone line to immigrants and telephone translation service), electronic (www.acidi.gov.pt) or by personal reception (with socio-cultural mediators).
- To create friendly interfaces and integrated solutions between Immigrants and the Public Administration, through the National and Local Immigrant Support Centres.
- To deepen knowledge of the realities of Immigration, adhering unwaveringly to the motto “Getting to know more, so as to act better”, through studies carried out by the Immigration Observatory.
- To promote the teaching of Portuguese Language and Culture to immigrants.
- To raise public opinion to tolerance and diversity and to galvanise the mass media into making a contribution towards integration and fighting the stigmatisation of immigrants and those from ethnic minorities (namely through the Journalism for Tolerance Prize).

Recognising the importance to define a Portuguese holistic strategy for the integration of immigrants, the High Commission for Immigration and Intercultural Dialogue (ACIDI, I.P.) promoted the definition of the National Action Plan for Immigrants Integration.

The Plan for Immigrant Integration⁶, published in though the Council Resolution n.63-A/2007 on May 3rd, involved the commitment of 13 different Ministries and has defined 122 measures. Those measures were organised in several thematic sections: welcoming (with 4 measures), work, employment and professional training (9 measures), housing (8 measures), health (9 measures), education (16 measures), solidarity and social security (4 measures), culture and language (9 measures), justice (11 measures), society of information (2 measures, sport (5 measures), descendents of immigrants (7 measures), the right to live as a family / family reunification (1 measure), racism and discrimination (6 measures), religious freedom (2 measures), immigrant association membership (7 measures), media (2 measures), relations with countries of origin (6 measures), access to citizenship and political rights (5 measures), equality of gender (5 measures) and human trafficking (4 measures).

Although this plan is still under implementation (until the end of 2009), it becomes clear that health was identified as one of the priorities of the Portuguese government to the promotion of immigrants’ integration. Under those main measures are:
- to carry out training, education and community schemes to combat the lack of information held by immigrants in relation to Portuguese heath services and encourage them to use the national heath system;
- to promote immigrant access to health services;
- to guaranty the access to health for immigrants with illegal status in Portugal;
- to implement the integration of Portuguese hospitals into the model of the European Network of “Migrant Friendly Hospitals”;
- to develop training schemes on interculturality for National Health Service professionals;
- to guaranty the recognition of qualifications of immigrant doctors and their integration in the National Heath Service;
- to develop a programme of Socio-Cultural Mediation within the heath services localised in regions with large number of resident immigrants;
- to develop partnerships between NGOs, the National Health Service and other organisations that promotes immigrant and ethnic minorities access to health in Portugal;

⁶ Available at http://www.acidi.gov.pt/docs/PII/PII_Inq.pdf
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- to publicise the conditions for access to health in the Consulates of the countries of origin.

The implementation of this Plan is guaranteed by a ministerial commission that will evaluate the measures outcomes through identified indicators and will produce reports every six months. Those reports will have to be presented periodically in the Advisory Council for Immigration Affairs (COCAI). Accordingly the process of implementation and development of this Action Plan is based on a strategy of co-responsibility and participation of both the State and the Civil Society.
2. Strategic organization issues

BULGARIA: Scaling-up HIV prevention, diagnosis, treatment, care and support services

Bulgaria ensures an integrated and balanced approach to fight HIV through access to prevention, diagnosis, treatment, care and support services to all who need it, including people affected by the disease. These are among the guiding principles of the National Strategy for Prevention and Control of HIV/AIDS and STIs (2001-2007).

Geographical equity in provision of HIV-related services to the general population is achieved mainly through the implementation of the National Action Plan for Prevention and Control of HIV/AIDS and STIs (2001-2007). Annually, significant allocations from the budget for the Ministry of Health are used to ensure the following:

- Safety of each unit of donated blood supply;
- Universal and free HIV testing throughout the country;
- Free and universal provision of antiretroviral therapy to those in need. Access to antiretroviral treatment in Bulgaria is universal, which means that all persons, who meet the criteria for initiating antiretroviral treatment, are provided with most up-to-date HAART therapy regardless of their social and health insurance status;
- Free antiretroviral prophylaxis to prevent mother-to-child transmission of HIV;
- Annual National and Local ANTI-AIDS Campaigns to deliver specific messages through national media coverage, health promotion and condom distribution;
- Large-scale capacity development for HIV prevention and control in the health, social and education sectors with resources from the Global Fund grant.

An important advantage of the country in this respect is the well-established infrastructure which is in service to the network of health institutions responsible for HIV prevention and AIDS control: Regional Public Health Inspectorates in each of the 28 administrative districts, 5 Centres for Hematology and Transfusiology (blood banks); 17 Dermatology and Venereology Dispensaries and hospital wards; decentralized provision of HAART in 4 treatment centres.

Rapid scaling-up of specific HIV prevention among the most-at-risk groups and achieving high population coverage was achieved through the implementation of Program “Prevention and Control of HIV/AIDS”, implemented with a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Its main focus is the preventive work among the groups most-at-risk (injecting drug users; sex workers; young Roma people with risk behaviours; men, who have sex with men; prisoners; young people in and out of schools), as well as care and support for people affected by AIDS. Activities are aimed at disseminating information and education, increasing knowledge, reducing risky behaviours, harm reduction, reducing stigma and discrimination in order to keep HIV prevalence low. Effectiveness and service coverage are ensured through several important steps listed below:

- Programme interventions are based on situation analysis and assessment of local needs and resources to select priority districts reflecting the potential rapid spread of HIV
- Selection of reliable non-governmental organizations to implement Programme activities and provide HIV prevention services to the most-at-risk populations.
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- Recruitment and continuous development of qualified NGO outreach teams.
- Development of municipal networks for partnership and referral to existing health and social services.
- Development of professional networks for exchange of experience, guidance and support among NGOs while boosting national standards and best practices.
- Regular supervision, monitoring and evaluation of programmatic and financial performance.
- Provision of health education to young people in and out of school with a special focus on HIV and STIs prevention, reproductive and sexual health and rights, together with the development of youth-friendly services.

Services to target groups are provided mainly in 19 of the 28 districts in cooperation with 52 NGOs, 10 Regional Inspectorates for Protection and Control of Public Health, the National Center of Infectious and Parasitic Diseases, and 138 schools (see Map). Additional infrastructure has been established to ensure accessibility and coverage of specific services to hard-to-reach populations, including 18 Voluntary Counseling and Testing centres, 12 mobile medical units, 5 low threshold centers for injecting drug users and 8 community-based health and social centres for Roma people.

Major Challenges for the future are listed as follows:

- To ensure cost-effectiveness of low-threshold HIV prevention services, they need to be gradually integrated into routine medical and social services;
- To assure quality for routine medical and social services, there is a need to improve the development of guidelines, operational procedures and establish a system for regular supervision;
- To ensure sustainability, there is a need for local authorities to recognize their roles and responsibilities related to strategic planning and financing for municipal HIV action plans;
- In terms of ensuring high coverage of young people, collaboration with the Ministry of Education should be strengthened to introduce Health Education as a compulsory subject in the curricula of Bulgarian schools.

GERMANY: Refund of travel to access services

The principle of a social state is enshrined in the German constitution - its capacities and economic conditions changing as it evolves dynamically (Artikel 20 Abs. 1 und 28 GG). Particular protection and care are guaranteed for e.g. mothers (Artikel 6 Abs. 4 GG). The legal framework (Sozialgesetzbücher) encompasses a number of statutory insurances (e.g. unemployment, health care). Welfare support also includes mobility as a human right. However, health insurance reforms have over the last ten years come to restrict expenses of transport. Today, only few health insurers cover travel expenses (voluntarily) for certain groups of patients (e.g. to allow daily substitution of IVDU with methadone or buprenorphine). In situations, where such an insurance does not cover and individuals end up in need they are entitled to public support in Germany.

In our report we find that local authorities in the Oldenburg region are extending a "helping hand" (social support) to individuals resident in their district (here: people with tolerated stay). This support is for travel costs (e.g. to see a psychiatrist or the AIDS-Hilfe) or for an interpreter (e.g. to enable treatment). In Hamburg state and municipal authority, budgets and services overlap. An effort to decrease debt has resulted in cuts in the public budgets over recent years.

Transfer costs in the Oldenburg region are higher due to longer geographic distance. In addition interpreters are more dispersed.

Benefits
1) If a statutory health insurance does not cover the cost for travel e.g. to see a specialized physician (e.g. quarterly HIV-check up) and this care is considered to be medically necessary the public social services are entitled to provide this support on a case by case basis. In fact some municipalities and states do provide individual and (in prisons) structural support to this end.
2) In essence this is also a mechanism to make up for the effects of involuntary geographic distribution following entry procedures of asylum seekers and refugees.

Drawbacks
1) This support is for travel costs (e.g. to see a psychiatrist or the AIDS-Hilfe) or for an interpreter (e.g. to enable treatment) undergoes frequent revision. Its is based on individual assessment of needs (Bedarfsgemeinschaften).
2) The level of support granted is depending on the economic situation of the public payer. Limitations in public social funding have pronounced needs assessment and individualisation of support. Numerous legal proceedings are evidence to an evolving situation. The extent to which social services are covering individual needs thus depends in part on the state or municipality (its social "climate") covering the expenses. NGOs offer informal legal advice to individuals and assistance in court. The primary social courts are for free.
HUNGARY: Recommendations based merely on the findings of the Hungarian Rapid HIV/AIDS Assessment

The initiative for starting with the systematic data collection of non Hungarian citizens and to detect, classify and analyze the relevant data was itself already a primary benefit of this call for Rapid HIV/AIDS Assessment. Difficulties experienced during this work have highlighted the gaps in the regulations and legislation, shortages and lack of relevant data sources and weaknesses, constrains and contradictions of health policy in this field – both on country and on EU level. This situation is relevant for all type of migrants and even more tangible when aiming to approach the undocumented ones.

CONCLUSIONS (main problems to be solved and goals for the future)

1. Only sporadic information is available about HIV/Hepatitis incidence along the eastern border region (Ukraine, Romania). This weakness should be improved significantly.

   By 1st of January 2008 Hungary together with Slovakia and Poland will provide the new eastern Schengen border of EU. It is forecasted that this would make even more ‘delicate’ this border for illegal crossing and as a consequence: the number of undocumented migrants in the border area might increase rapidly. That is why - either to prove or to deny the hypothetic relation - solid data would be needed about the related possible public health hazard and the dynamic of the case incidence. HIV and Hepatitis could be a good marker for this. These data could serve as basis for planning properly the public health services as well as would provide hard evidence based arguments for the development of both: the related Member State (MS) and EU level policy.

2. Health data of undocumented migrants are not systematically collected in Hungary, therefore neither public health services nor the Border Guard administration can provide information. Lack of data hinders significantly the preparation for prevention and planning the development of the adequate health care sector.

   Luckily IOM in cooperation with the University of Pecs (Hungary) and with the support of the European Commission and the relevant governments has launched currently a project along the new Eastern EU Schengen Borders (Hungary, Poland, Slovakia) aiming to assess the current public health situation and develop minimum public health standards in the border management. It is expected that following the pilot phase the minimum standards and the related training for BG and health staff developed by the project team would be accepted and introduced in all EU MSs. ECDC, WHO EURO and FRONTEX are also participating in this project.

3. Migrants’ health status data collection must be urged in this field in order to map up the accumulated problems and trends for the future in order to prepare for an early intervention policy.

   At present the planning procedure of health services (total and specific capacity, geographical distribution etc.) on country and local government level are based only on the data registered by the National Health Insurance Fund. The lack of migrants’ specific data prevents any proper planning and preparations. Moreover it hinders
the health care system being prepared to facilitate the integration of migrants and launch community level health promotion actions for them.

4. **There is need for project focusing on refugee camps, providing voluntary counseling and testing (VCT) among target groups and risk groups, as well as health education, primary prevention, risk reduction and early intervention.**

   Refugee camps, detention centers are the best and easily reachable places to start with preventive actions like testing, counseling and launching health promotion, health education programs.

5. **An in-depth assessment should be performed on the real dangers of spreading HIV and hepatitis C infection and TBC by risk groups, migrating from the countries alongside the Hungarian eastern border (e.g. by Ukrainian injecting drug user (IDU) and commercial sex workers (CSW)). Awareness of decision makers, especially of health and of migration authorities should be raised.**

   As explained under ‘1’ these data are highly needed and beside the border region the systematic data collection should cover the mainland as well.

6. **A very intensive, well-targeted prevention campaign should be performed among CSWs who are in frequent contact with migrants.**

   High proportion of CSWs is migrants (many of them are trafficked) and they on the one hand are at high risk of being infected and on the other hand possible vectors of the infections. A prevention campaign among them would target on key actors indeed.

7. **Intensive and well planned health education programs, prevention messages on how to avoid HIV and other STIs and how to prevent injecting drug use should be developed and launched among young Hungarian people just like for youngster in all the EU countries. This age group is at increased risk for STI when travel abroad or contact foreigners coming into Hungary.**

   Health education, school health education in Hungary is weak; in most of the EU MSs it is better integrated into the formal education. This is a field where urgent governmental level measures are necessary and expected.

8. **Peer educators among migrants of different countries of origin should be trained and their prevention work should be supported with professional guidance and training, as well as with prevention brochures and funding.**

   According to international experiences this is one of the most effective types of health education interventions.

9. **In the case of HIV/hepatitis/TBC infection a partner notification system should be developed.**

   Discovering and following the contact chain is an effective tool for the prevention of further spread of the infection as well as for the more successful treatment at the early stage of the infection and/or disease. Nevertheless one has to keep it in line with privacy, confidentiality and human rights.

10. **In the case of HIV/hepatitis/TBC infection a very clear referral system starting from primary health care (PHC) up to hospitals should be designated.**
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This is a ‘must’ tool for both: effective treatment and systematic data collection as precondition of analysis and planning.

11. A clear, free and checked vaccination program should be introduced against HBV, HAV, and HPV.
Vaccination is cost effective tool for controlling these infections. At present mostly governmental budgetary problems and lack of effective health education hinders the full coverage in Hungary.

12. Training programs for health and social care staff assisting migrants either individually or on community level.
Not only in Hungary but EU wide there is a shortage or lack of training programs preparing health and social personnel for the special aspects of migrants’ health care, health intervention for migrants’ communities. This is much more than how to cope with the language barriers. Understanding the complex nature of migration (push and pull factors), being open and sensitized towards their specific problems and personal history (smuggled, trafficked persons), towards transcultural aspects reflected also in differences in health beliefs and health attitudes, different morbidity profile etc. etc. are fundamental when providing health assistance to them. University of Pecs within the frame of a consortium of other EU MS higher education institutions has started to develop a multilevel education program on migration health. This interdisciplinary curriculum aims to train health and social care professionals EU wide for this specific task.

13. Need for projects for HIV positive migrants to facilitate their employment.
Experiences indicate that the best way to keep them in relatively good health is to keep them employed.
Employment provides not only financial stability but practices a significant positive impact on the psychic stability and wellbeing of the HIV positive persons. A supportive working environment is an important factor as well. Nevertheless it is not easy to launch these types of programs of a kind of ‘positive discrimination’, not speaking about difficulties in keeping the confidentiality and privacy of the target group members.

MALTA: Integration of Migrants in Open Centres: The impact of physical location of open centres and the integrative preparatory programmes within open centres

Location does play some part in the integration or seclusion of the migrants in particular as pointed out in the report that migrants residing in remote areas such as Hal Far obviously find more difficulties in integrating due to remoteness of the places (in practice they are surrounded only by fields and air strips/runways and the required physical amenities such as shops, services, health services etc are distant). On the other hand, Marsa open centre is very close to the capital city. However an activity of special interest which has contributed greatly to the integration of migrants at the Marsa open centre s the holistic approach used by Suret il-Bniedem in running the centre rather than its physical location. Marsa open centre is undoubtedly a highly innovative refugee facility particularly due its emphasis on non-reliance on the state and on charity but on the empowerment of the residents, which can be observed
through the success rate of the refugees, for instance, both a Somali, Congolese and a Sudanese restaurant have been established and English, culture, as well Islamic courses are being taught. The immigrants are expected to be independent and autonomous once they are out of detention. Life at the open centre includes creative work (through workshops that can be used by residents for different types production and working skills) and also shared responsibility for the running of the centre. The residents are involved in exercises and practices, such as Maltese and English language classes, lectures and debates on European culture, democracy, human rights, peace, diplomacy, law and order, women’s rights, working rights and obligations. The centre has been transformed into a tool to prepare immigrants for what they are to expect, their entitlements and what they are expected to do in Malta. It is not the first time that it has been debated whether Marsa Open Centre could be an exportable model for integrating such migrants. In addition to the three large open centres run by the government (one in Marsa and two in Hal Far) there are other smaller facilities run by the state and NGOs, where integration of these migrants is also good. The state run residential homes cater for vulnerable persons e.g. unaccompanied minors and families with minors. The NGO facilities cater for a wider variety of people. These other small open centres are located in villages where physical access to essential services and access to medical care is easy.
NETHERLANDS: Coordination between Government organizations and NGOs

In the Netherlands, the Centre for Infectious Disease Control of the Department of National Institute for Public Health and the Environment, Ministry of Health, in close cooperation with other national and regional experts, is responsible for an integrated policy on HIV and STI prevention and control.

At the beginning of the HIV epidemics in the Netherlands, different national NGOs were formed based on the needs and interests of specific high-risk groups. HIV prevention was initiated by a variety of NGOs for different target populations. Where relevant, the Centre for Infectious Disease Control, delegated to NGOs to coordinate the HIV prevention programme targeted at specific risk groups. The NGOs carry out prevention activities in collaboration with the Centre for Infectious Disease Control (CIDC) and other institutes and relevant regional health services. The NGOs receive funding from the government for this via the CIDC.

In addition, the regional infectious diseases control is designated by the Centre for Infectious Disease Control to regional health services. These regional public health services are also responsible for prevention activities. This arrangement is meant to ensure close collaboration between the public health services and the NGOs. These regional health services receive funding from the government via the CIDC.

The NGO STI Aids Netherlands coordinates prevention programmes for ethnic minority populations as well as for young people, sex workers and their clients. STI Aids Netherlands undertake a range of prevention activities for ethnic minority populations as follows:

- Support the regional health services (GGD) with preventive information materials or expertise on STI and HIV for ethnic minority populations (brochures, meetings, etc).
- Work directly with the target populations to ensure that these populations take ownership of the STI and HIV issues and come up with solutions and interventions for their own communities.
- Network with other organisations at a European level (AIDS & Mobility)
- Cooperate and support intermediaries and professionals in delivering sexual health care service to ethnic minorities that is tailored to their context.

In the Netherlands, the regional health services are responsible for the control and prevention of TB, HIV and STI regionally. In some regions these control and prevention activities are well integrated whereas in other regions, the coordination and integration are work in progress.

NETHERLANDS: Centres of expertise on HIV and AIDS

In the Netherlands, HIV treatment is decentralized in the HIV treatment centers (HTC) of 24 hospitals. Since the treatment of HIV is very complex, it was obvious that expert knowledge was required to provide optimal treatment of HIV, and effective counselling in connection with that treatment. This expertise can only be guaranteed if a center has a minimum number of patients. For that reason, the Ministry of Health, Welfare and Sport has decided that HIV treatment will be under the Special Medical Procedures Act (WBMV) as from January 1, 2002 (Borst-Eilers, 2001). As a result, HIV may only be treated in these HIV treatment centers (HTC) of the 24 designated hospitals.
Since the Netherlands is a small country, these 24 HTC are distributed evenly across the Netherlands (see Figure 1) and in practice each geographical region has one or more HTCs. If the complexity of HIV treatment reduces in the future, HIV treatment service may become more decentralized. An advantage of these HTCs is that the data collection for HIV surveillance purposes among registered patients is well organized.

*Figure 1 Geographical distribution of HIV Treatment Centres in the Netherlands*

Source: HIV Monitoring Foundation, the Netherlands
3. Local Organization Issues

GERMANY: Entrepreneurs Without Borders

Founded by individual entrepreneurs of various nationalities as a non-profit association in 2000, "Unternehmer ohne Grenzen" (German name) sees itself as the mouthpiece for immigrants in starting and running a business, as well as in qualifications. Economic integration is seen to increase social integration resulting in improved standards of living. Unternehmer ohne Grenzen functions as a link between new entrepreneurs and local institutions for economic development.

Besides aiming to strengthen, support and mobilise entrepreneurship and training, the organization aims to promote networking, raises public awareness and facilitates (international) exchange of experiences.

Start-Up services (with a particular focus on women) have been provided through a number of programmes and a service centre in St. Pauli. Today activities are supported by the Hamburg Senate, the European Union, the Federal Ministry for Labour and Social Affairs within the community initiative “Equal”.

Recently, in an effort to improve living conditions in Wilhelmsburg, a new office was opened and a first analysis of local living conditions revealed a number of deficits. Within the health sector the number of physicians in Wilhemsburg has been declining during recent years (practices moving to more lucrative parts of town). In addition in Wilhemsburg language barriers are of concern in health care.

Hidir Demirtas, who runs the Wilhelmsburg office, devised an enabling strategy to improve health-care in his district. “If we want to make living in Wilhelmsburg more attractive, we also need to take health services into account.” In consequence he invited the Ethno-Medical Centre (EMZ) from Hanover to advise his organisation. Meanwhile two workshops and a hearing have been invited by Entrepreneurs Without Borders. One workshop aimed to bring together experts from science and the community, physicians and public health actors. In essence this workshop confirmed an alarming situation. Of the 40 participants numerous suggestions were made on how improve the situation. In a second workshop some 15 actors came together to discuss linking improvements in health services to the International Architecture Exhibition (IBA 2012 in Wilhelmsburg).

Links to the work of migrants in HIV/AIDS prevention have been established between Entrepreneurs Without Borders, KiFaZ Schnelsen and the EMZ. Currently, Entrepreneurs Without Borders (in Wilhelmsburg) aims to make use of and expand services provided by transcultural health mediators (including HIV/AIDS prevention).

Benefits
1) a migrant organisation from outside the health field enable discourse on aspects of prevention, treatment and care.
2) migrant businesspeople develop a common strategy towards improving
health care

Drawbacks
1) provision of health services is an area dominated by Germans and strongly
   guarded by professional interests of health care providers
2) room has yet to be made for services to be provided by migrants (e.g. health care
   and social services, interpreters)

Currently, activities by Entrepreneurs Without Borders together with the Ethno-
Medical Centre in the health sector are not evaluated.

ITALY: National Institute for the Promotion of Health of Migrant
Populations and the Prevention of Diseases of Poverty’ (NIMPD),
San Gallicano

Since 1st January 1985 a Department of Preventive Medicine for Migration has been
established at the San Gallicano Institute. For years the Department has represented
the only public referral point not only for assistance and treatment but also for
medical-epidemiologic, social, anthropologic research concerning immigrant,
nomadic and homeless populations. Besides offering free daily service, the
Department represents a valid observatory centre for studying and monitoring health
conditions of these particular groups and the health hazards they are subjected to.
The services of the Department are particularly addressed to regular, irregular
immigrants, homeless, nomads and those having health problems but without a
health insurance card.

Lately, the Minister of Health, Livia Turco has established a “National Institute for the
Promotion of Health of Migrant Populations and the Prevention of Diseases of
Poverty”, utilizing the extensive experience of the Department of Preventive Medicine
for Migration at the San Gallicano Institute (IRCCS), Rome. This Centre’s task is to
develop initiatives directed at the promotion of health of the migrant populations as
well as to the protection of the Italians’ health. Among others, the Centre will also
deal with the monitoring and evaluation of the health needs of the migrant
populations. It will try out new models of health assistance. It will take care of the
training of medical social workers and of the counselling training aimed at
intercultural approaches. Finally, it will promote the collaboration among international
networks of institutes of scientific research.

Linguistic and cultural mediators for health and its determinants

Every year, in collaboration with Lazio Regional Government and Rome City Council,
the Department organises an International Course on Transcultural Medicine,
addressed to medical social workers, public administrators, teachers and volunteers,
with the aim of promoting interest, understanding and exchange of experiences about
the complex reality of health care. Since 1996 the Department has been assisted by
linguistic-cultural mediators, who provide welcoming reception and translating
facilities to foreign patients in their own languages. Not only they facilitate cultural
and interpretative understanding for diagnostic and therapeutic purposes, but they
can provide social, legal, housing and employment support to the needy people. The
main languages spoken are: French, English, Spanish, Portuguese, Arabic, Kurd,
Lingala, Swahili, Tigrigna, Amharic, Filipino (Tagalong), Tamil, Bangladeshi, Serbo-
Croatian, Bulgarian, Polish, Russian, Rumanian and Albanian.
What has been learnt from the San Gallicano experience?

The experience of the Department of Medicine of Migration at San Gallicano Hospital in Rome is a unique facility in Italy. It has influenced the development of modern legislation regarding the care of migrants that allows, at least from a legal and theoretical standpoint, access to the National Health Service by all foreigners, regularly or irregularly in Italy. WHO EURO, recognizing the overwhelming evidence of the close relationship between poverty and ill-health and the responsibility of health systems to improve the health of the poor, has conducted analysis on action taken by Member States to reduce poverty and improve the health of poor people. A collection of case studies, entitled Health Systems confront Poverty, was discussed at the fifty-second session of the WHO Regional Committee for Europe in Copenhagen, Denmark, 16 to 19 September 2002. One of these case studies was the Italian responses to Migration, Poverty and Health. The care of immigrants’ health is of the utmost importance, entailing feedback for the health preservation of Italian citizens, limiting, for example, the spread of communicable diseases. Moreover, the Department’s preventive and screening activities allow the prevention/prophylaxis and detection/treatment of diseases at early stage, optimize the cost-effectiveness of responses before a more severe clinical picture appear which would necessitate hospitalisation thus averting costly burden on the Italian National Health System.

PORTUGAL: Local Immigrant Support Services (CLAI)

One of the main priorities of ACIDI is to facilitate the immigrants contact with Public Administration and support services for the resolution of their problems regarding integration. The National and Local support centres were set up precisely with that aim. Their establishment seeks to provide an integrated and efficient humanistic response to problems of integration posed by immigrants who have chosen Portugal as their host country.

The 63 Local Support Centres (CLAI) dispersed along the country develop their main activities in articulation with the two National Support Centres – CNAI (in Lisbon and in Oporto) – that have the Health Support Office.

The CNAI, in a logic of one-stop-shop, bring together a number of public services related to immigrants (e.g. Service for Border Control and Aliens, Social Security, the General Inspectorate of Labour, Ministries of Health, Education and Justice) and offers specific support offices that promote immigrants integration in Portugal (e.g. Entrepreneurship, Legal Advice, Family Reunification, Employment Support). The CNAI aims to provide a step forward regarding the integration of Portugal's immigrant population by offering competent, efficient and humane assistance in order to respond to migrants' needs. Socio-cultural mediators, who originate from the different immigrant communities, play a key role in all CNAI' services. Accordingly, each CNAI provides a range of services all under one roof in a variety of languages (Portuguese, Cape Verdean and Guinean Creole, Romanian, Russian and English).

In the specific case of the Health Support Office, a team with two socio-cultural mediators has been mainly answering to problems related to immigrants’ access to the health services in Portugal. Although by law the immigrants (even the ones that have an illegal status) have the right to health care in Portugal, several hospitals and health centres refuse to give them support. Accordingly the Health Support Office of
CNAI has a fundamental role of both informing immigrants about their rights and duties on the access to health services in Portugal and creating awareness of the health services to immigrant rights defined by the law. This office does not provide health care but mainly is defined as a provider of health care rights for immigrants.

The Health Support Office receives in average around 600 users per year (please see the graph below):

![Chart showing Health Support Office users per month in 2006](chart.png)

To support immigrants in understanding the formalities that are behind the access to health services in Portugal, ACIDI has been promoting the publication of several informative brochures: (1) *Health Guide for Immigrants* (also available in the internet) and (2) a special chapter on health services in a brochure with a framework on legislation and services that immigrants need to be aware of – *Immigration in Portugal. Useful Information*.

In articulation with the General Health Directorate of the Ministry of Health, ACIDI also had promoted an informative campaign about tuberculosis. In that context several brochures in Portuguese and in Russian with relevant information about tuberculosis (e.g. symptoms) were distributed. With a similar strategy, the ACIDI supported the National AIDS Commission in the definition and publication of an informative brochure for immigrants about sexually transmitted diseases. As in the former case, the contents of the brochure were also translated to Russian.

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ITALY: Instruments of particular relevance for HIV and TB data collection

HIV surveillance
There is no national HIV surveillance system. Only 5 out of the country’s 20 regions and 5 out of all the provinces have created their own local surveillance systems. For example, the Regions of Lazio and Friuli Venezia-Giulia began collecting the new HIV diagnoses from 1985; the Region of Veneto from 1988; the Region of Piemonte from 1999; and the Region of Liguria from 2001. In addition, the Provinces of Modena, Trento, and Bolzano began collecting the new HIV diagnoses from 1985; and the Provinces of Sassari and Rimini from 1997 and 2002, respectively.

A person with a new diagnosis of HIV infection (ELISA confirmed by a Western blot) is reported, in an anonymous fashion, to public health authorities at the regional or provincial level. The data are then transmitted to the National Coordinating Centre: National Health Institute, where they are aggregated and analyzed. The information collected include: sex, age, nationality, date of first HIV positive test, date of last HIV negative test, risk factors, CD4 counts at the time of HIV diagnoses.

It is important to highlights that the lack of local surveillance systems in the South of Italy can lead to the misperception that migrants in the North of Italy are more likely to be HIV infected.

AIDS Surveillance
In Italy AIDS cases have begun to be registered on a voluntary base in 1982, and in June 1984 the National Surveillance System was officially established, which collects notifications from all infectious disease units in Italy. The Ministerial Decree (DM) n.288 del 28/11/86, posed AIDS as infection with a mandatory notification by doctors. Nowadays, AIDS is included within infective pathologies Classe III (DM del 15/12/90), under a special notification. Since 1987, the AIDS Surveillance System is coordinated by the Centro Operativo AIDS (COA) within the National Health Institute.

The information available are: gender, date of birth, nationality, place of birth, place of residence, educational level, date of first HIV positive test (recorded since 1996), date of last HIV negative test, risk exposure, CD4 cell count and viral load at the time of HIV diagnoses, CD4 cell count and viral load at the time of AIDS diagnoses, prophylaxis at AIDS diagnosis, type of antiretroviral therapy taken before AIDS diagnosis (recorded since 1999), type of opportunistic disease at AIDS diagnosis, date of death. Although the reporting of death is not mandatory, the National Coordinating Centre periodically conducts studies on the vital status of persons with AIDS.

Migration and AIDS surveillance
Evidences from the June 2006 National AIDS Bulletin published by the NHI, confirmed that 70% of foreigners as opposed to 30% among Italians were diagnosed with AIDS within six-month of having discovered to be HIV positive. This difference could be related to an unequal access to the health care providers or to the high number of people coming from hyper-endemic countries as suggested by other authors (Lancet Infectious diseases, Vol.3, May 2003).
One of the key objectives of the newly established ‘National Institute for the Promotion of Health of Migrant Populations and the Prevention of Diseases of Poverty’ is the promotion and coordination of migration and health data collection including profit, no-profit associations and public health institutions in a multi-disciplinary and integrated approach.

NETHERLANDS:  **HIV surveillance in the Netherlands**

The Centre for Infectious Disease Control, Department of National Institute for Public Health and the Environment, Ministry of Health is the lead institute in the control of HIV and STI in the Netherlands. Surveillance of HIV and STI is coordinated by the Centre for Infectious Disease Control's HIV and STI Surveillance Unit. The aim of the Surveillance Unit is to collect, compare and interpret all information on HIV and STI surveillance activities. In the Netherlands, HIV is not a notifiable infectious disease. The Centre regularly reviews different surveillance sources to monitor HIV trends in the Netherlands. The following are the list of sources of information used for monitoring of the HIV and STI epidemics:

- **STI surveillance system** in which number of HIV tests and results from each STI clinic are collected.
- **Anonymous HIV screening** among STI clinic attendees at the Amsterdam and Rotterdam STI clinics. Currently, both clinics are implementing opting out method for HIV testing for all clinic attendees.
- **Unlinked anonymous HIV surveys** among high-risk groups, including injecting drug users (IDU), migrants from HIV endemic countries and commercial sex workers in the Netherlands.
- **Registration of newly diagnosed HIV cases** at the HIV Monitoring Foundation (HMF). Data from HIV patients under treatment care is collected by the 24 decentralized HIV treatment centres in the Netherlands and is reported to the HMF and analysed jointly by HMF and the national Surveillance Unit on HIV and STI.
- **National HIV screening of pregnant women** since 2004. Data from this screening is currently being analysed and the screening evaluated.
- **Amsterdam Cohort Studies in Men having sex with men (MSM) and IDU.**
- **Screening of HIV among blood donors.**

An annual epidemiological report on the current status of the HIV and STI epidemics, integrating different surveillance systems, is published by the Surveillance Unit of the Centre for Infectious Disease Control.
5. Staff Training

ITALY: The Centre of Migration and Social Medicine training course on migration health

The Centre of Migration and Social Medicine, in collaboration with the Tor Vergata University, provides training courses for the following audience:

A) Students attending the 6th and last year of Medicine and Surgery course

There will be 1 year of internship thereafter

Duration: 1 week

Objectives:
1. to study the association between diseases and poverty; to conduct field study on the epidemiology of poverty-related diseases;
2. to get a better understanding of migrants’ health profile and the related social, cultural and economic issues;
3. to improve the ethical consciousness of clinical performance, promoting the study of humanistic sciences, and of the classical, modern and international literature;
4. to analyse doctors-patients relationship issues.

At the end of the course, students are evaluated according to the following scores:
3. objective fully reached
2. objective reached
1. objective partially reached
0. objective not reached

The course started on September 2006; since then, 300 students have attended the course.

B) Medicine and Surgery graduates, before taking the State licensure examination, which is required in order to become the specialist professional

Duration: 1 month

Objectives: to analyse the emergence of poverty-related diseases, which affect vulnerable and marginalized groups, including immigrants.

The course started on January 2005; since then, 30 new graduates attended the course.

c) Final year students on Medicine and Surgery, Psychology

The students attending post graduate courses on Infectious diseases, Parasitology, Gynaecology

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Servizio di Medicina Solidale e delle Migrazioni-SMSM
The Centre of Migration and Social Medicine has been chosen as the reference department for preparing undergraduate and post graduate thesis aimed at identifying emerging pathologies among immigrants, Roma population and vulnerable groups (including Italian population), with a particular focus on women and children immigrants.

Since 2005, 7 degree thesis have been completed.

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