



## **MEETING** REPORT

# Responses to HIV and migration in western industrialised countries: current challenges, promising practices, future directions

Special satellite session at the  
19th International AIDS Conference, Washington, DC

22 July 2012

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# Contents

Abbreviations .....	iv
Executive summary .....	1
Monitoring and surveillance of migrant health and HIV .....	1
Migrant-sensitive HIV programmes and services .....	1
1 Background and meeting objectives.....	3
2 Context: Addressing HIV vulnerabilities of migrant populations in western industrialised countries.....	4
2.1 Experience of migrant populations with HIV vulnerabilities in western industrialised countries .....	4
2.2 Global perspectives .....	4
Monitoring migrant health .....	5
Migrant-sensitive health systems.....	5
2.3 Regional perspectives .....	5
Canada .....	5
Europe .....	6
United States .....	7
3 Emerging themes of discussion .....	9
3.1 Monitoring HIV among migrant populations .....	9
Data requirements .....	9
Promising practices.....	10
Strengthening HIV monitoring and surveillance systems.....	11
3.2 Migrant-sensitive HIV prevention and treatment programmes and services.....	12
Barriers and challenges to effective prevention and care .....	12
Success factors for effective programmes and services .....	13
Promising practices.....	15
4 Summary and conclusion .....	17
Monitoring migrant health and HIV.....	17
Migrant-sensitive HIV programmes and services .....	17
Appendix A. List of participants .....	18
Appendix B. Migration and HIV satellite session agenda.....	20
Appendix C. Post-presentation question and answer session .....	21

## Abbreviations

ABDGN	African Black Diaspora Global Network
ACB	African-Caribbean-Black
AETC	AIDS Education and Training Centers – United States
AHPN	African HIV Policy Network
AIDS	Acquired immunodeficiency syndrome
ARV	Antiretrovirals
ART	Antiretroviral treatment
CAAT	Committee for Accessible AIDS Treatment (Toronto, Canada)
CD4	CD4 molecules found on T lymphocytes (T cells)
CDC	Centers for Disease Control and Prevention (United States)
CIC	Citizenship and Immigration (Canada)
CTN	Canadian Institute for Health Research’s Canadian HIV Trials Network
ECDC	European Centre for Disease Prevention and Control
EU	European Union
EU/EEA	European Union and European Economic Area
GARP	Global AIDS Response Progress
GMG	Global Migration Group
HIS	Health information systems
HIV	Human immunodeficiency virus
HRSA	Health Resources Services Administration (United States)
IBBS	Integrated behavioural biological survey
IDP	Internally displaced person
IDU	injection drug users; people who use injection drugs
IFHP	Interim Federal Health Program (Canada)
IOM	International Organization for Migration
MSM	Men who have sex with men, HIV exposure group
MTCT	Mother-to-child transmission, or ‘vertical’ transmission
NCPI	National Commitments and Policy Instrument – UNGASS
NGO	Non-governmental organisation
NHAS	National HIV/AIDS Strategy (United States)
NHS	National Health Service (United States)
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RCT	Randomised control trial
SES	Socio-economic status
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UK	United Kingdom
UMBAST	United States/Mexican Border AETC Steering Team
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly High Level Meeting on HIV and AIDS
US	United States
WHIWH	Women’s Health in Women’s Hands (Canada)
WHA	World Health Assembly
WHO	World Health Organization

## Executive summary

On 22 July 2012, the International Organization for Migration (IOM), the Public Health Agency of Canada (PHAC), the United States Centers for Disease Control and Prevention (CDC), and the European Centre for Disease Prevention and Control (ECDC) co-sponsored a special satellite session entitled 'Responses to HIV and migration in western industrialized countries: current challenges, promising practices, future directions', in conjunction with the 19th International AIDS Conference (AIDS 2012) in Washington, DC. Over 70 healthcare practitioners, researchers, non-governmental and governmental representatives participated, primarily from Europe, the United States and Canada.

The AIDS 2012 special satellite session followed a series of global and regional dialogues on issues relating to the health of migrants and explored two priority action areas identified at the March 2010 Global Consultation on the Health of Migrants in Madrid:

- Monitoring HIV among migrant populations
- Migrant-sensitive HIV prevention and treatment programmes and services

The session provided the opportunity for information exchange to invigorate future action on the health of migrants living with, and at risk of, HIV and AIDS as well as to potentially have a multiplier effect on other migrant health issues. Three complementary components supported the dialogue and information exchange: a keynote presentation to provide the perspective of migrant persons living with, and at risk of, HIV and AIDS; a panel of presentations on global and regional contexts; and participant break-out discussion groups and plenary on the two session themes.

### Monitoring and surveillance of migrant health and HIV

Participants discussed the importance of strengthening monitoring systems to include migrant populations and to inform the HIV response. Resources and stigma were identified as two particular challenges with respect to improving data on migrant populations and HIV. Barriers to healthcare-seeking and disclosure of information by migrants make it challenging and unrealistic to achieve a complete reporting of relevant data. Name-based HIV reporting may be a barrier for undocumented/illegal immigrants who may face criminalization or deportation. Overcoming stigma to achieve early testing and treatment (upon arrival) can identify those infected and help to break transmission.

A number of approaches were discussed as possible ways forward in the area of monitoring migrant health and HIV:

- Developing partnerships in areas of migration and HIV, such as:
  - supporting cross-fertilisation of innovative approaches that address broader migrant health issues;
  - standardising monitoring and reporting tools (UNGASS, WHO, Dublin Declaration); and
  - engaging migrant communities in the response.
- Capturing, supplementing and sharing surveillance and monitoring data, including behavioural and social determinants of health (SDOH) aspects.
- Using the data to target prevention intervention and treatment services ('Data for action').
- Enhancing both monitoring and follow-up mechanisms; i.e. access to care, access to anti-retroviral therapies and adherence to therapy.

### Migrant-sensitive HIV programmes and services

With respect to developing migrant-sensitive programmes and services, participants identified a range of barriers and challenges. Many migrants living with HIV are undiagnosed and unaware of their HIV infection before entry, which may delay testing and access to care. Discussion focused on overarching themes of fear, stigma, discrimination, and lack of information at individual and systemic levels. Many factors may prevent migrants from seeking HIV testing and care in their host country, including the following issues: having had negative experiences with access to care or inaccurate prevention messages in their home country prior to arrival; having low perception of risk or limited general health-seeking behaviours; existence of HIV stigma within migration sub-groups; language and cultural barriers; confidentiality and disclosure issues in health services and when using translators; lack of awareness about where and how to access services; and challenges of navigating fragmented services.

To address these barriers, policy and service planning could take into consideration the following approaches to enhance prevention, treatment, care, and support efforts:

- Integrating HIV prevention and treatment within a broader health delivery approach to address issues of stigma, racism and discrimination.

- Removing financial barriers to accessing prevention, treatment and care, e.g. migrants included in healthcare coverage/health insurance.
- Ensuring providers/clinicians are trained and supported in both cultural sensitivity and linguistic capacity to work more effectively with migrant populations.
- Integrating migrant health services with social supports (i.e. housing, transport, income).
- Increasing sensitivity to possible stigma introduced by increased visibility or targeting of migrants.

Participants also exchanged promising practices for migrant-sensitive programmes and services, with examples focused on participatory research, community involvement in design and delivery of services, building the capacity of health service providers and community members to ensure culturally sensitive services, developing integrated health service delivery models, using positive health promotion messages, and implementing policies that improve access to treatment and care for undocumented migrants.

# 1 Background and meeting objectives

On July 22, 2012, the International Organization for Migration (IOM), the Public Health Agency of Canada (PHAC), the United States Centers for Disease Control and Prevention (CDC), and the European Centre for Disease Prevention and Control (ECDC) co-organised a special satellite session on 'Responses to HIV and migration in western industrialized countries: current challenges, promising practices, future directions', in conjunction with the 19th International AIDS Conference in Washington, DC. This report provides highlights of the information exchanged and a synthesis of the key discussion points from the session, attended by over 70 health practitioners, researchers and government representatives primarily from Europe, the United States and Canada.

The event followed a series of global and regional dialogues on issues relating to the health of migrants. In March 2010, the Global Consultation on the Health of Migrants took place in Madrid, aiming to operationalise the 'Resolution on the health of migrants' (WHA61.17) adopted by the World Health Assembly (WHA) in 2008. This Resolution outlined priority actions in four thematic areas: 1) monitoring migrant health; 2) migrant-friendly health services; 3) policy and legal frameworks on migrant health; and 4) partnerships, networks and multi-country frameworks.

The AIDS 2012 special satellite session explored two of these four thematic areas with a special focus on HIV and the public health response:

- Monitoring HIV among migrant populations
- Migrant-sensitive HIV prevention and treatment programmes and services

A steering committee, supported by a technical advisory committee, collaborated to develop the session agenda and the discussion paper which outlined global and regional contexts, observations of select HIV prevention and treatment strategies, key barriers, challenges and promising practices targeting the needs of migrants living with, and at risk of, HIV and AIDS. Participants received the discussion paper in advance of the meeting to raise awareness of pertinent issues and to serve as a launch point for discussion.

The half-day session at AIDS 2012 provided the opportunity for information exchange to raise awareness and invigorate future action on the health of migrants living with, and at risk of, HIV and AIDS, in addition to potentially having a multiplier effect on other migrant health issues. Three complementary components supported the dialogue and information exchange: a keynote presentation to provide the perspective of migrant persons living with, and at risk of, HIV and AIDS; a panel of presentations on global and regional contexts; and participant discussion in break-out groups and plenary on the two session themes. See Appendix A for the list of participants and Appendix B for the session agenda.



## 2 Context: Addressing HIV vulnerabilities of migrant populations in western industrialised countries

A keynote address and panel session provided context for discussion. This section provides highlights only of the panel presentations. More detailed information and supporting references are included in the Power Point presentation decks (see Appendix C) and the discussion paper. A question-and-answer session followed the presentations (see Appendix D).

### 2.1 Experience of migrant populations with HIV vulnerabilities in western industrialised countries

Keynote presenter Ms Winnie Ssanyu Sseruma, Community Health & HIV team, Christian Aid, United Kingdom, grounded the discussion in the reality of the migrant and HIV experience by sharing her personal story. She has lived with HIV for the past 25 years, experiencing first-hand the barriers and challenges faced by migrants in accessing treatment and care and overcoming persistent stigma and discrimination. In 1988, living in the United States, she received an HIV-positive diagnosis and, without health insurance, could not afford treatment (antiretroviral medication). Returning to her home country of Uganda, her health seriously deteriorated until she relocated to the United Kingdom (which was possible as she was born in the UK) and was able to access combination therapy to recover and live a full life. Since that time, she has been a strong advocate for better access to treatment, for example during her time as chair of the African HIV Policy Network (AHPN).

Ms Sseruma called for action to eliminate the many types of stigma and discrimination faced by migrants in some jurisdictions, including the threat of lengthy detention on arrival, involuntary testing, possible deportation of those identified as HIV positive, denial of treatment and care in the receiving country, and poor access for those living in rural areas. In addition to issues of testing and treatment, migrants living with HIV may face mobility restrictions travelling across borders or experience profiling related to their HIV status (e.g. being kept aside for lengthy questioning).

Ms Sseruma stated that models that work for migrant communities are needed, for example, models that provide opportunities for voluntary testing within their own communities. Better data is needed about the vulnerability of migrant communities to HIV to inform the creation of effective prevention and health promotion programmes, but also to address stigma and discrimination. For example, in the UK there is a misperception that many migrants arrive in the country as HIV positive; however, new evidence suggests that many acquire HIV in the UK. For prevention to be effective it is important to stop blaming people who come forward to access care, whether that be from inside or outside their community. It is critical to eliminate this barrier to seeking testing and treatment since most new infections originate from those who are undiagnosed and do not know they are carrying the virus.

In conclusion, she expressed hope that the dialogue moves the response in the direction of tackling stigma and discrimination, strengthening approaches for monitoring, and developing new approaches to prevention and treatment for migrants.

### 2.2 Global perspectives

Ms Barbara Rijks, Migration Health Division, IOM, provided the global context for discussions relating to migrant health and HIV. She noted that the IOM, now in its 60th year, has focused on bringing a rights-based, inclusive approach to migrant health. The current global era is one of great human mobility, with approximately one billion migrants, of which 215 million are international migrants. There is a trend toward urbanisation and feminisation – with women accounting for more than 50 per cent of migrants – and a range of factors currently driving migration: demographic shifts (population replacement rates in industrialised countries and high birth rates in developing countries), demand for labour (labour shortage in the industrialised world; labour surplus in developing countries), shrinking distances due to technology and faster travel, the availability of real-time information as a result of the digital revolution, migrant networks, economic and social disparities between North and South, and disasters leading to displacement of populations (natural, man-made, slow-onset).

Due to variations in the health infrastructure and global disease distribution, migrants may experience a disproportionate burden of disease, including HIV. Social vulnerabilities associated with the process of migration may also put migrants at greater risk of HIV infection during travel and transit or after their arrival in the host country. The effects of HIV-related stigma are also magnified among socially vulnerable minority groups, including migrants.

Ms Rijks identified the main global commitments to address migration-related health challenges; these include the UNGASS 'Political declaration on HIV/AIDS' (2011), which specifies the need to address the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support (Paragraph 84) and the 2008 World Health Assembly (WHA) 'Resolution on the health of migrants' (61.17), which calls upon Member States to promote migrant-sensitive health policies. Ms Rijks highlighted the emerging challenges in monitoring migrant health and HIV and approaches to developing migrant-sensitive health systems, two of the priority action areas identified by the WHA 'Resolution on the health of migrants' and agreed to at the 2010 'Global consultation on the health of migrants', and the focus of this special satellite session.

## Monitoring migrant health

Few countries have health information systems (HIS) that are capable of disaggregating data in a way that permits analysis of the main health issues found among migrants or resulting directly from migration. Without solid evidence, it is difficult to provide guidance to decision-makers helping them to plan and implement an effective response. Specific monitoring challenges include diversity in source data (differing definitions and denominators), dynamics of modern migration (evolving population dynamics), health effects of migration extending beyond the first generation, and difficulties in accessing some populations and communities.

## Migrant-sensitive health systems

Migrant-sensitive health systems seek to consciously and systematically address the health of migrants and incorporate their needs into all aspects of health services, i.e. financing, policy, planning, implementation and evaluation. The goal is to ensure that health services and goods are available, accessible, acceptable, and of good quality along the migration continuum. Key components include language services, culturally-informed healthcare services, culturally-tailored health promotion and disease prevention, and institutional and community-based cultural support staff (i.e. intercultural mediators).

## 2.3 Regional perspectives

### Canada

Dr. Howard Njoo, Centre for Communicable Diseases and Infection Control, PHAC, discussed the epidemiology of HIV, the determinants of health as applicable to HIV vulnerabilities for migrants in Canada, and the federal public health and community responses to HIV.

#### *Migration context and trends*

Canada admits approximately 250 000 permanent residents and over 200 000 temporary residents each year. The term 'migrant' is used in a broad sense to include anyone who comes to Canada (immigrants, students, foreign workers). In 2006, almost one fifth of the Canadian population over 15 years of age (6.18 million) were born in another country, with most living in the larger urban centres of Toronto, Montreal, and Vancouver. Approximately 10 per cent of Canada's migrant population comes from countries where HIV is endemic.

#### *Epidemiology of HIV and migrant populations*

In 2008, PHAC estimated that 65 000 people (or 0.2 per cent of the population) were living with HIV and AIDS in Canada. In Canada, people from countries where HIV is endemic are disproportionately affected by HIV and AIDS. While they represented 2.2 per cent of the population in 2006, people from countries where HIV is endemic represented an estimated 16 per cent of new infections in 2008; therefore the estimated incidence rate was approximately 8.5 times higher than among other Canadians.

The vast majority of HIV endemic countries are in Africa and the Caribbean. There are some limitations in the data collection, with tracking of exposure category for people from countries where HIV is endemic limited to heterosexual exposure. For example, a person from a country where HIV is endemic may be 'hidden' by being assigned to another exposure category such as men who have sex with men (MSM) or people who inject drugs (PWID).

Migrants coming to Canada may experience increased vulnerability to HIV for a variety of reasons including settlement challenges, having a perception of lower HIV risk in Canada, or experiencing barriers to accessing health services (lack of trust and/or cultural competency, linguistic and cultural challenges). Gender roles, religious values and a 'code of silence' about sexuality may stand in the way of seeking testing, treatment or support.

#### *Public health response*

Under the 'Federal initiative to address HIV/AIDS in Canada', the Canadian federal government identifies eight key populations at risk of HIV and AIDS, including people from countries where HIV is endemic. Population-specific approaches address the impacts of HIV and AIDS in these key populations, with funding provided for targeted surveillance, practice guidelines (e.g. for HIV testing), laboratory services, research, and programmes. Good examples of the community-based response include Women's Health in Women's Hands (WHIWH) in Toronto,

providing HIV education, prevention, treatment and care for African Caribbean Black (ACB women), and GAP-VIES in Montreal, working with the Haitian community to deliver prevention and support services.

### ***Challenges and opportunities***

Dr. Njoo concluded by noting current challenges and future opportunities for the Canadian response. Challenges include surveillance limitations (e.g. improving completeness of data on country of birth), designing a response that reflects the diversity of migrants in Canada (i.e. the one-size-fits-all approach does not work), and addressing ongoing issues of stigma and discrimination, both internal and external to African, Caribbean and Black (ACB) communities. Future opportunities include learning from the existing, evidence-based, population-specific response led by the ACB community and from international promising practices.

## **Europe**

Dr. Marita van de Laar (Programme on HIV/AIDS, Sexually Transmitted and Blood-borne Infections at ECDC) presented the European perspective on addressing the HIV vulnerabilities of migrant populations. ECDC coordinates case-based HIV surveillance and monitors the HIV response across the 30 European Union and European Economic Area Member States in support of the Dublin Declaration on Partnership to Fight HIV and AIDS in Europe and Central Asia.

### ***Epidemiology of HIV and migrant populations***

Migrants from countries with generalised HIV epidemics who live in the EU are disproportionately affected by HIV. In 2010, 27 116 newly diagnosed cases of HIV infection were reported by 28 (of the 30 total) countries of the EU/EEA. In 2010 in the EU/EEA, the predominant mode of transmission for HIV infection was MSM (38 per cent of the reported cases), followed by heterosexual contact. In total, around 35 per cent of the new heterosexual HIV diagnoses in the EU were diagnosed in individuals originating from countries with generalised epidemics, primarily sub-Saharan Africa, ranging from very low levels in the eastern parts of the EU to approximately 60 per cent in Belgium, Sweden, and the United Kingdom. These percentages are most likely to be an underestimate of the true figures.

Although migrants from countries with generalised HIV epidemics represent many of the HIV cases in the EU, more than 60 per cent of heterosexuals from generalised epidemic countries present at a stage in their illness when they are already in need of antiretroviral therapy, with a CD4 count of less than 350 copies/mL.

### ***Public health response***

ECDC collects surveillance variables related to migrants; however, the data are not complete (country of birth: 62 per cent; country of nationality: 20 per cent; region of origin: 70 per cent; probable country of infection: 34 per cent). For heterosexual and mother-to-child transmission (MTCT), additional information is collected on source of infection (related to countries with generalised epidemics).

In Europe there are three major monitoring systems in place to track the national response to HIV and AIDS response: ECDC is responsible for monitoring implementation of the Dublin Declaration; UNAIDS is responsible for monitoring implementation of the Global AIDS Response Progress (GARP, formerly known as UNGASS); and WHO and UNICEF are responsible for monitoring implementation of the health sector response.

In 2011, in collaboration with UNAIDS and WHO, ECDC launched a harmonised country reporting system that aimed to reduce the burden of reporting for EU Member States with indicators that were tailored to issues of relevance for HIV response in the European region. Through the new monitoring system, migrants were added as a special at-risk population along with PWID, MSM, sex workers, and prisoners. A new indicator on late diagnosis was added for at-risk populations to allow for comparison across Europe. In the 2012 Dublin Declaration/GARP monitoring process, several indicators related to prevention and response among migrants have been added and are have been reported on by countries across the European Region.

In 2012, 76 per cent of European Member States identified migrants as an important sub-population in their national response to HIV. As such, many EU countries have developed targeted prevention programmes for migrants; however, fewer countries monitor their response to HIV prevention and care among migrants, and even fewer have any quantitative data to show the quality and scale of these targeted programmes.

### ***Challenges and opportunities***

In sixteen EU/EEA countries, antiretroviral therapy (ART) is not readily available for undocumented or irregular migrants. ART availability is extremely important to monitor progress from a programmatic perspective, but this issue is also used to gauge political leadership in the Member States of the EU.

Dr. van de Laar concluded by noting future opportunities for action. There is a need to improve the availability of data related to the provision, quality and scale of HIV services targeted toward migrants. Existing monitoring systems can be used to generate relevant information that key decision-makers can act upon. Different countries and regions can collaborate and challenge each other to improve services and monitoring practices.

## United States

Dr. Kevin Fenton (National Center for HIV and AIDS, Viral Hepatitis, STD, and TB Prevention, CDC) presented on the migration challenges and implications for HIV in the United States.

### *Migration context and trends*

As of 2010, approximately 40 million foreign-born people live in the United States, representing 13 per cent of the US population, with 28 per cent of this group considered unauthorised immigrants. People born in Latin America and the Caribbean comprise approximately 53 per cent of this foreign-born population; however, over time, the proportion of immigrants from Asia has increased, now representing the single largest group of new foreign-born people. Although foreign-born people live in every state, over half live in California, New York, Texas and Florida.

### *Epidemiology of HIV and migrant populations*

More than one million persons in the United States are living with HIV, with approximately 50 000 Americans infected annually. One in five people infected are unaware of their HIV status and only one in four are receiving the care needed to keep the virus under control.

Information from various studies and surveys provides a picture of the characteristics of foreign-born people diagnosed with HIV. From 2007 to 2010, a total of 191 697 persons were diagnosed with HIV in 46 states and reported with a country or continent of birth. Of these, 16.2 per cent were foreign-born persons. A higher percentage were Hispanic/Latino and had heterosexual exposure compared with US-born persons with HIV. In addition, a higher percentage of foreign-born persons had an AIDS diagnosis within 12 months of HIV diagnosis compared with US-born persons. Based on region of birth, the majority of foreign-born persons with HIV were born in Central America and the Caribbean, followed by Africa and South America.

From 2001 to 2007, foreign-born black people diagnosed with HIV infection in the US represented 12 per cent of the estimated 100 013 black adults and adolescents diagnosed with HIV infection<sup>1</sup>. High-risk heterosexual contact was the greatest risk factor for both foreign-born black males and foreign-born black females. The foreign-born black individuals were more likely than the native-born to be diagnosed with AIDS within one year of their HIV diagnosis; however, they were more likely to survive one year or three or more years after their diagnosis than native-born black people diagnosed with AIDS.

One comparative analysis of HIV characteristics of 1070 foreign-born and US-born HIV patients found that foreign-born individuals enrolled into care at much lower CD4 counts and were late testers (54 per cent foreign born vs. 33 per cent US born), and were more likely to have an AIDS diagnosis and multiple opportunistic infections.

### *Public health response*

Key issues related to migration and HIV in the US involve policy, surveillance, and barriers to testing, care and treatment. As of 4 January 2010, HIV was removed from the list of diseases that can restrict people who are not US citizens from entering the US. As a result, testing for HIV is no longer required as part of the US immigration medical screening process. It is important to note that the CDC does recommend testing for all those between the ages of 13 and 64, with more frequent testing for persons at high risk. Foreign-born persons residing in the US should be tested as part of their regular healthcare, just as US-born persons are. There are ongoing efforts needed to ensure that persons immigrating to the US receive appropriate preventive services and care upon their arrival.

### *Challenges and opportunities*

While the HIV/AIDS surveillance form completed at the time of diagnosis includes a field for country of birth, this information is not always recorded, and data are not collected when persons moved to the US. From 2007 to 2010, 19 per cent of HIV diagnoses from 46 states lacked data, limiting the usefulness of data for planning the response at a time when there is a growing refugee population from high HIV prevalence countries.

Many foreign-born people are not coming forward for testing, but may be vulnerable to infection. One migrant study indicated that more than half of the participants (58 per cent) had never been previously tested for HIV. However, study participants were engaging in a number of risk behaviours, including having two or more sexual partners (44 per cent), having sex while using alcohol or drugs (30 per cent), and transactional sex (27 per cent).

Cultural and language barriers may affect access to healthcare services, with foreign-born people less likely to have health insurance (66 per cent of foreign-born vs. 85 per cent of US-born population, US Census Bureau). Other factors which increase vulnerability include poverty and legal and other barriers for undocumented migrants.

The US government has recently introduced new strategic approaches through the development of a 'National HIV/AIDS strategy' aimed at reducing HIV incidence, increasing access to care and optimising health outcomes, and reducing HIV-related health disparities. As part of implementation of the national strategy, CDC is developing a

<sup>1</sup> In 33 states for which country-of-birth information was available.

report with suggestions for improving HIV surveillance and prevention interventions among Hispanic/Latino migrant communities in US-Mexico border states – Arizona, California, New Mexico and Texas.

Dr. Fenton concluded by summarising key points, noting the vulnerability of foreign-born persons to HIV and the need for more data regarding foreign-born persons and HIV in the US. There is potential for foreign-born persons to benefit from current efforts to incorporate routine HIV testing into medical care, but more examples of successful programmes are needed to reach these populations.

## 3 Emerging themes of discussion

Two concurrent break-out sessions provided participants with the opportunity to explore the two areas of focus of the dialogue: monitoring HIV among migrant populations, and migrant-sensitive HIV prevention and treatment programmes and services.

The following section presents a synthesis of the suggestions and ideas contributed by participants in the break-out sessions. The views expressed here do not necessarily represent the views of the technical advisory committee or partner organisations.

### 3.1 Monitoring HIV among migrant populations

Four groups discussed how to advance the issue of monitoring HIV among migrant populations and identified promising practices. The discussions centred around three key areas:

- Data requirements
- Promising practices for monitoring HIV among migrant populations
- Strengthening HIV surveillance and information systems

#### Data requirements

Participants discussed the importance of strengthening monitoring systems to capture critical information on migrant populations and HIV, with which to inform programmes and policies. Within this broad context, participants identified the following suggestions to improve the completeness and quality of data:

- Clarify the purpose of data collection on migrant health and HIV and emphasise the use of data to inform effective policies and programmes for HIV prevention and care.
- Consider harmonising definitions to support consistent data collection and comparison both within and across regions, while allowing for flexibility in defining the term 'migrant' in a way that is most useful for local/national planning and response. Current data is typically collected within borders; however, linkages could be developed across borders to build a more complete picture, perhaps beginning with standardised minimal data elements.
- Develop a list of clearly defined key variables for collection by surveillance systems and ad hoc surveys, such as country of birth, nationality, parent country of birth, country of infection, date of arrival, legal status and date of diagnosis. If possible, date of AIDS diagnosis, viral load and co-infections (e.g. other sexually transmitted infections, tuberculosis) could also be routinely collected. This information needs to be collected together to support planning and build a better understanding of trends. For example, evidence from the UK in 2009 suggested that the proportion of migrants from generalised epidemics acquiring HIV in the UK was substantially higher than had previously been estimated<sup>2</sup>. According to this study, somewhere between 25–33% of HIV-positive African residents in the UK, and approximately 50% of HIV-positive African MSM, were thought to have acquired HIV in the UK. These findings have important implications for the programmatic response to HIV in countries where HIV in migrant populations accounts for a substantial proportion of newly diagnosed HIV infections and may require countries to divert their prevention spending to those prevention strategies that are likely to have the most effect on curbing the epidemic.
- Explore the feasibility of monitoring viral sub-types. This could help to delineate multiple/different sub-epidemics that may be inadequately addressed.
- Stratify data by risk factors other than heterosexual contact with a partner from a country where HIV is endemic, e.g. male-to-male sex, injection drug use, sex work. In some jurisdictions, current data tends to focus only on heterosexual transmission among migrants, which limits its utility for targeted prevention for other sub-populations. Reviewing data in relation to MSM is particularly important since this may be culturally sensitive and undisclosed.
- Leverage existing data, e.g. through sharing information from existing data sets; opportunities include filling in information gaps in HIV reporting data by using existing behavioural data sets or other available information/data sources, such as immigration data sets. For example, HIV testing has been a mandatory part of the medical examination required by Citizenship and Immigration Canada (CIC) for applications for permanent residence and for some applications for temporary residence; however, there are barriers to accessing CIC data that otherwise could help to fill in some information gaps about country of origin of immigrants to Canada. Issues of privacy and limited administrative resources are currently under discussion to enable information sharing.

<sup>2</sup> Burns FM, Arthur G, Johnson AM, Nazroo J, Fenton KA; SONHIA Collaboration Group. United Kingdom acquisition of HIV infection in African residents in London: more than previously thought. *AIDS*. 2009 Jan 14;23(2):262-6.



- Expand data collection to include HIV testing practices (offer of HIV testing and uptake), barriers to HIV testing, linkage to care and treatment, HIV knowledge and attitudes, and risk behaviours. Data are needed at the individual and country level regarding HIV testing policies and their impact. Behavioural surveillance and ad hoc surveys could be used to complement existing surveillance data.
- Recognise migration as a social determinant of health that increases vulnerability to HIV; however, caution is needed to avoid stigmatising migrant groups when devising policy and programme interventions. Vulnerability to HIV infection relates to the conditions surrounding the migration process, not to migrant groups themselves (e.g. trauma, economic vulnerability, transactional sex, survival sex). In analysing integrated behavioural biological survey (IBBS) data on migrant groups, it is important to present information in the context of the conditions that lead to vulnerability. Recommendations can then address not just behavioural interventions for the population group, but also the processes and conditions surrounding migration that increase vulnerability.
- Link to, or collect, appropriate parallel data to understand predictors and co-factors that lead to vulnerability of migrant populations to HIV infection. Consider intersecting dimensions such as mental health and socio-economic status (SES), as well as larger constructs such as stigma, discrimination and human rights. Measures are needed for stigma: a marker for SES could be developed using various proxies depending on the setting.
- Explore opportunities to share information across jurisdictions; for example, cross-border collaboration to collect data at transit points where there is frequent cross-border migration (refugees, temporary workers), or at points of extreme vulnerability such as farming communities that experience high HIV prevalence.

## Promising practices

Participants discussed promising practices related to defining, collecting and analysing data on migration and HIV to inform the public health response as well as how to reach out to migrants to increase HIV testing and diagnosis.

- ECDC has been successful in moving forward with monitoring without the need for a formal definition of migrant. Each Member State defines migrant based on relevance to their own context. This approach has helped to increase data collection on migrant populations and HIV. Sensitivities to tracking and defining migrants need to be taken into account. For example, objective questions such as country of origin are preferable to tracking race/ethnicity, which is illegal in some jurisdictions and can tend to 'lump together' communities that have different contexts/needs.
- As part of routine HIV case reporting, the UK collects probable country of infection, country of birth and, among persons born abroad, month and year of arrival in the UK. To better understand HIV transmission dynamics among adults born abroad, and to validate previously published national estimates based on clinic reports, a new method has been applied that utilises year of arrival and CD4 cell count at diagnosis to assign whether HIV infection was acquired before or after arrival in the UK. The new method assigns 44% of heterosexual adults born abroad and diagnosed with HIV in 2010 as having acquired HIV in the UK. The comparable figure based on clinic reports was 18%. The research article has recently been published and the authors are looking for critical appraisal of the methodology<sup>3</sup>.
- Some jurisdictions (e.g. Germany, Australia) have surveillance in place that allows disaggregation of data for migrant populations beyond heterosexual – generalised epidemics, including MSM – and has the ability to disaggregate and examine all transmission risks linked to high-prevalence countries and all migrants.
- In Canada, the E-track surveillance surveys will focus on people from countries where HIV is endemic, mostly from sub-Saharan Africa and the Caribbean. The behavioural component will collect data on: socio-demographics, key determinants of health, healthcare access, behavioural practices and HIV testing, and treatment history, etc. Sampling will be done in specific venues. The biological component will involve the collection of a blood specimen for HIV testing, thus allowing calculations of HIV prevalence among the surveyed population. Country of birth is also collected in other 'Tracks' behavioural surveillance systems (i.e. the M-Track which is focused on MSM and the I-Track which is focused on PWID), making sub-analyses possible.
- In southern Africa, IBBS has been done with migrant groups using interview questionnaires administered by peer educators. Questions capture useful planning information, including gender, alcohol use and drug use. Although the approach is time and resource heavy, it has yielded valuable information about farm workers to support prevention and care.
- In the Canadian province of Ontario a questionnaire sent to all people newly diagnosed with HIV and a selected sample of individuals who tested HIV negative. This information has been collected for the past

<sup>3</sup> Rice BD, Elford J, Yin Z, Delpech VC. A new method to assign country of HIV infection among heterosexuals born abroad and diagnosed with HIV. *AIDS*. 2012 Sep 24;26(15):1961-6.

three years, which can help build a more accurate denominator to calculate incidence of infection and person-time of observation, which provides information relating to prevalence.

- In some jurisdictions HIV testing is integrated into general migrant services, and population sampling has been carried out at key community locations, e.g. Women's Health in Women's Hands in Toronto, Canada<sup>4</sup>. These approaches can improve reach to migrants vulnerable to HIV infection, facilitate access to treatment and care, and help to overcome barriers to testing such as fear of stigma and discrimination.
- Some jurisdictions have successfully used social media such as Facebook and Twitter to reach vulnerable populations for participation in surveys, e.g. the experience of MSM in Portugal. In the UK, a sampling tool is being developed which will aim to collect a representative sample of all people living with HIV, including migrants. Once established, it will be used to gain information about perceived barriers to testing and care. Social media is the key theme, used as a recruitment tool for an anonymous questionnaire posted on the internet.
- While anonymous testing can act as a barrier to collecting complete data on migrants and HIV, it may be essential in order to encourage testing, particularly for undocumented/illegal migrants.

## Strengthening HIV monitoring and surveillance systems

Participants discussed a number of approaches that could strengthen HIV monitoring and surveillance systems focused on migrants:

- Define a list of minimal data variables to be collected in HIV surveillance systems, as well as a definition of the term 'migrant' that reflects the diversity among migrant groups and the length of stay in the country.
- Enhance data collection methods to improve quality and completeness:
  - Develop technical guidance documents to help those on the ground collect and submit more standardised data.
  - Build-in accountability measures where states/countries are required to meet certain reporting standards to maintain funding.
  - Follow-up on routine HIV cases reported and consider introducing a secondary data collection method, e.g. a follow-up questionnaire with more in-depth questions on issues related to acquisition of infection, e.g. date of arrival in host country (for foreign-born cases).
  - Consider use of ad hoc surveys to enhance data captured through routine HIV surveillance.
  - Use existing data collection mechanisms and indicators (e.g. Dublin Declaration and UNGASS/GARP) to improve the collection and use of data on migrants for HIV response and programme planning.
- Ensure data is contextualised and meaningful for planning:
  - Develop information about population trends in migration in order to interpret the HIV surveillance data.
  - Capture, supplement and share data relating to behavioural and social determinants of health (SDOH).
  - Examine and compare how public health authorities stratify risk (e.g. by country of origin, manner of exposure) to support informed prevention planning.
  - Ensure that migrant groups are involved in discussions to understand and interpret data (e.g. rates of HIV infection, risk factors for transmission, health behaviours). This can help to reduce stigma, but also can provide groups with evidence that can be used for advocacy, especially economic data that make the case for investment in migrant-sensitive policies and programmes.
- Improve sharing of data:
  - Release aggregated and validated data that currently exist to support policy and programme development.
  - Improve departmental sharing of data/triangulation of data and develop data-sharing agreements across jurisdictions, e.g. across federal and state governments.
- Maximise opportunities and mechanisms for sharing of best and promising practices for monitoring migrant health and HIV.
- Improve understanding of the barriers to access for undocumented migrants and develop strategies to reach out and include them in the design of methods to collect data (e.g. address barriers associated with name-based surveillance).

<sup>4</sup> Women's Health in Women's Hands, Community Health Centre, 2012, <http://www.whiwh.com/index.php?mid=3&smid=0&ssmid=0>



## 3.2 Migrant-sensitive HIV prevention and treatment programmes and services

Four groups discussed how programmes and services can adequately respond to the unique needs of migrants and identified promising practices in developing and maintaining migrant-sensitive programmes and health services. The discussion centred around three key areas:

- Barriers and challenges to effective prevention and care
- Success factors for effective programmes and services
- Promising practices

### Barriers and challenges to effective prevention and care

Many migrants are undiagnosed before entry in the host country which may influence prevention, diagnosis, treatment, care and support issues in the new host country. Discussion focused on overarching themes of fear, stigma, discrimination and lack of information at individual and systemic levels.

- Many factors may prevent migrants from seeking testing and care in their host country, including:
  - negative experiences with accessing care or inaccurate prevention messages in their home country prior to arrival;
  - low perception of risk or low general health-seeking behaviours;
  - HIV stigma within migration sub-groups, e.g. cultural norms and expectations may increase fear to access testing and to receive and adhere to treatment and care;
  - language and cultural barriers, including limited access to good translation services and to culturally sensitive services;
  - issues of confidentiality and disclosure in healthcare settings including when using translators from within the community;
  - lack of awareness of individuals and health service providers about where and how to access services; and
  - fragmented services and issues of navigating them faced by migrants.
- Studies show that misunderstanding persists in migrant communities about how HIV is transmitted (e.g. thinking that transmission happens through casual contact). This causes greater stigma, unwillingness to get tested, and reluctance to access health services.
- Barriers to accessing care or medications for undocumented, illegal migrants include:
  - anti-migrant sentiments within a country;
  - lack of inclusion of undocumented migrants in HIV prevention strategies;
  - policies that require proof of legal entry to the country in order to access needed services or medications (this is the case in some US states);
  - policies that do not support the provision of ARVs to migrants and refugees, regardless of status; and
  - persistent or perceived stigma and discrimination by medical/health personnel, even with good policy in place.
- Multiple intersections of different phobias and oppressions exist (racism, homophobia, xenophobia), leading to multiple discrimination. There is a double stigma where migrants may experience HIV-related stigma within their community/affected group as well as stigma related to the host country's acceptance. Additional stigma may be experienced by gay, lesbian, bisexual, transsexual and transgender migrant communities. Human trafficking is poorly understood within host countries and may lead to judgemental attitudes among the mainstream population, increasing stigma.
- Criminalisation of non-disclosure of HIV to sexual partners can negatively impact health-seeking behaviours, testing and the efforts of community organisations to build leadership capacity in people living with HIV. Migrants may face another layer of vulnerability because of fear of deportation as a result of a positive HIV status.
- There is a limited understanding of HIV transmission in migrant populations, further limiting prevention efforts. Evidence is needed for policy-makers related to the social determinants of migrant health such as under-insurance, housing, homelessness, unemployment and poverty. These factors are central to HIV prevention strategies, settlement success, and general prosperity of migrants in the new host country.
- Resources are limited. In this era of austerity, prevention programmes are being cut and migrant populations' funding may be the first to see reduced or eliminated resources (e.g. migrant-friendly programmes). Economic austerity measures are perceived to be placing economy before health.

## Success factors for effective programmes and services

Participants identified the following factors that contributed to effective migrant-sensitive programmes and services:

- Include HIV prevention as part of the broader concept of health delivery to overcome issues of racism and discrimination.
- Establish complementary health and migration policies to promote access to testing, prevention, treatment and care for all migrants, regardless of status, e.g. health insurance.
- Train healthcare providers and clinicians on cultural sensitivity and build linguistic capacity to work with migrant populations. This will help to overcome problems at the point-of-service level where services may not be culturally sensitive, where services and information are not provided in the migrant's language, healthcare workers do not understand the influence of the migrant's beliefs and values, or do not have the tools to provide culturally-specific health practices, e.g. Western healthcare providers often do not understand migrant health practices, such as Eastern medicine.
- Use trusted translators/interpreters to overcome language and cultural barriers; however, noting sensitivities to the issues of disclosure and confidentiality, as is the case in smaller communities where the translator is from the same community as the migrant PLHIV.
- Balance delivery of routine and targeted testing to reduce rates of undiagnosed HIV cases.
- Deliver strong migrant-friendly health services coupled with robust social support networks.
- Involve the community in design and decisions about how services are delivered:
  - Focus on competencies and resources available in migrant communities to create culturally appropriate interventions.
  - Work with migrants and PHAs to undertake research, develop services and evaluate programmes to ensure cultural appropriateness, e.g. community advisory committees for protocol design and implementation.
  - Provide peer counselling in conjunction with HIV testing and care by those who have 'walked in their shoes'.
  - Have an identifiable person (a community leader or celebrity) help to promote services.
- Ensure a degree of sensitivity regarding the impact of health promotion and prevention campaigns targeted to migrants, taking into account possible increased stigma or discrimination that may be introduced by increasing the visibility of migrants when targeting efforts to reach the community.
- Make the services known to migrants and broader community: market interventions, share information, seek collaboration opportunities.
- Use 'HIV-positive' prevention messages as opposed to fear-based campaigns; eliminate fears and myths concerning HIV risk, HIV transmission, and living with HIV and AIDS through expanded education and knowledge activities.
- Integrate health and social services, e.g. integrate HIV and TB screening with services that address social determinants of health, such as housing and employment.
- Standardise surveillance practices and further investing in, and carrying out, research that:
  - uses a social determinants of health perspective; and
  - provides evidence for policy-makers about the socio-economic cost-benefits of health and immigration policies and programmes on HIV transmission among migrants and the general population.
- Support NGOs to teach people how to advocate for their rights. This can help to address systemic issues, where despite good policy, migrants patients still feel impacts of discrimination and stigma; after diagnosis they are often referred to (mainstream) care where they are 'pushed away' (e.g. hospitals which do not want to provide care to migrants).
- Improve conditions and/or structures throughout Western industrialised countries that make it possible for migrants to articulate their needs, contribute their expertise, competences and resources, and have decision-making power in work processes. This is especially important for prevention work because migrants are an extremely heterogeneous group. Only when knowledge of the language, the living environment, and the culture of the target groups and communities with a migration background flows into the prevention work can prevention measures be successful.
- Develop strategies that address the environment of xenophobia, recognising that anti-immigrant sentiment in some countries presents a real structural barrier to seeking HIV testing and treatment; stigma may deter some migrants from seeking HIV testing out of fear, negative attitudes and suspicion of migrants, especially those who are undocumented. Strategies might include investing in, developing and/or enhancing:
  - government engagement in developing policies and programmes that mitigate racism, xenophobia, homophobia and other forms of stigma and discrimination;
  - community engagement in research and policy-making (enabling action-based and community participatory research);

- education and awareness to address HIV-related stigma and discrimination, with leadership and involvement of affected populations;
- encouragement and involvement of migrants in the political sector<sup>5</sup>; and
- capacity-building interventions/initiatives to bring migrants into the workforce.

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<sup>5</sup> See: Ankersmit F. Democracy and ethnicity: acculturation by politicization. In: Gerrits AWM, Wolfram DJ, editors. Political democracy and ethnic diversity in modern European history. Palo Alto: Stanford University Press; 2005. Ankersmit argues that in order for migrant populations to become integrated in Western European societies they require first to become politicised.

## Promising practices

Participants identified the following promising practices for providing effective migrant-sensitive health programmes and services, with examples focused on participatory research, community involvement in design and delivery of services, building the capacity of service providers and community members to ensure culturally sensitive service, developing integrated service delivery models, using positive health promotion messages, and implementing policies that improve access to treatment and care for undocumented migrants:

### *Community involvement*

- In Canada, the Canadian HIV Trials Network (CTN) uses a community advisory committee to involve community in research protocol design.
- In Canada, the Committee for Accessible AIDS Treatment (CAAT) has a programme that provides PHA peer training in migrant communities. CAAT also provides skill-building for service providers to strengthen cultural competence and multilingual information that respects the sensitivities of marginalised populations such as MSM, IDU and sex workers.
- In the US, the Community HIV/AIDS Mobilization Project (CHAMP) used a community-based, participatory action research approach to reach out to migrants and to build their capacity as leaders in HIV prevention in their communities.
- In Germany, the Pakomi project used a community-based participatory approach to involving migrants in HIV prevention. The approach:
  - involved key people from different communities, educating them as peer researchers and involving them in decision-making;
  - empowered them to do research in their communities, collect information on their needs and create solutions targeting their needs;
  - used simple methods, e.g. community mapping, photo voice, narrative from individual migrants from the community; and
  - developed into a community network of sharing and learning.

### *Integrated services*

- In the US, the San Francisco programme for Asian and Pacific Islanders focuses on community-building and community organising first; through this process, the community was involved in creating a one-stop centre for all relevant services (holistic integrated services). The centre acknowledges the diversity of people affected by HIV and provides targeted services (for people who use injection drugs, transgender people, sex workers, etc.).
- The approach of a generalised health clinic that integrates HIV services is more successful than an HIV-specific clinic (e.g. wellness check). This situation is similar for indigenous communities, where it is more effective to integrate HIV into more generalised services than to provide HIV-specific services.
- Women's Health in Women's Hands integrates wellness and HIV care into a 'one-stop shop' for migrant services targeting African, Black and Caribbean women in Toronto, Canada (e.g. linguistically appropriate services, HIV testing and care).
- In Ontario, a model is used where a primary healthcare clinic covers gaps for homeless persons, migrants, and the under-housed, providing linguistically and culturally sensitive integrated services.

### *Creative marketing and promotion*

- In the US, CDC has examples of positive campaigns based on the message 'Testing Makes Us Stronger' and 'Let's Stop HIV Together'. This move away from fear-based campaigns has been successful, in addition to featuring PLHAs.
- Social marketing messages focused on anti-discrimination have been effective, e.g. 'Saving face can't make you safe; talk about HIV.').

### *Health policies for migrants*

- Ensure that policies for HIV testing reduce stigma and discrimination and facilitate migrants' access to testing, treatment and support services; the evidence supporting differing approaches could be examined, for example:
  - The Canadian approach requires HIV testing for most applicants as part of the immigrant health exam prior to arrival; potential applicants are informed of their HIV status and successful applicants that test HIV positive are provided with a handbook on contacting provincial and territorial public health authorities, which then take action to refer them for support and treatment.
- Work towards a service model of free and accessible care to all, regardless of migration status.
- In the US, the US/Mexican Border AIDS Education and Training Centres Steering Team (UMBAST) is a programme to train providers on both sides of the border to provide continuity of care across borders. Through the programme, migrants can stay on treatment as they go back and forth across the border. There are HIV-related guidelines for detainment at customs to ensure that migrants receive the care they need.

- The US state of Massachusetts has progressive policies in place that support the delivery of health services and medications to refugees regardless of legal status. This could be a model for other jurisdictions. A similar programme in South Africa has experienced barriers in implementing the policy, with some service providers continuing to withhold HIV treatment from undocumented migrants.

### ***Networks and sharing of best practices***

- The African Black Diaspora Global Network (ABDGN) is an example of a global network building connections to carry forward lessons learned and facilitate the sharing of best practices.

## 4 Summary and conclusion

On behalf of the steering committee, the facilitator thanked the participants for helping to build a common understanding of key issues related to HIV and migrants in Western industrialised contexts, noting the challenges and opportunities identified throughout the two thematic discussions – monitoring HIV among migrant populations and migrant-sensitive HIV prevention and treatment programmes and services.

The following is a summary of suggestions and possible ways forward identified by participants in each of the two thematic areas of discussion.

### Monitoring migrant health and HIV

- Develop partnerships in areas of migration and HIV, for instance by:
  - supporting cross-fertilisation of innovative approaches that address broader migrant health issues;
  - standardising regional and global monitoring and reporting tools (UNGASS, WHO, Dublin); and
  - engaging community and migrants in the response.
- Capture, supplement and share surveillance and monitoring data, including behavioural and SDOH aspects.
- Use the data to target prevention and treatment services ('Data for action').
- Share data across jurisdictions, e.g. across regional, federal, provincial and state governments.
- Enhance both monitoring and follow-up mechanisms; i.e. access to care, access to anti-retroviral therapies, adherence.

### Migrant-sensitive HIV programmes and services

- Integrate HIV prevention and treatment within a broader health delivery approach to address issues of stigma, racism and discrimination.
- Remove financial barriers to accessing prevention, treatment and care, e.g. migrants included in healthcare coverage/health insurance.
- Ensure providers/clinicians are trained and supported in cultural sensitivity and linguistic capacity to work with migrant populations.
- Integrate migrant health services with social supports (i.e. housing, transport, income).
- Increase sensitivity to possible stigma introduced by increased visibility or targeting of migrants.

As follow-up to the 2012 satellite session, ECDC will explore the possibility to host a meeting in 2013 to take forward the issue of migrant health and HIV in Western industrialised countries. ECDC, PHAC, CDC and IOM will also explore further opportunities for collaboration on issues related to migrant health and HIV.

## Appendix A. List of participants

### Migration and HIV – alphabetical session list of confirmed participants

CAN = Canada, EU = European region, US = United States, IO = International organisations

CAN	Kwaku (Paul) Adomaka	African and Black Diaspora Global Network (ABDGN), Canada
EU	Nina S Anderson	Norwegian Directorate of Health, Norway
CAN	Chris Archibald	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
EU	Henrique Barros	Predictive Medicine and Public Health, University of Porto Medical School, Portugal
CAN	Laura Bisallion	Ontario Training Centre in Health Services and Policy Research, York University
EU	Alison Brown	Health Protection Agency, UK
EU	Henrikki Brummer-Korvenkontio	THL, Finland
US	Guillermo Chacon	Latino Commission on AIDS
CAN	Sandra Ka Hon Chu	HIV/AIDS Legal Network
EU	Susana Monge Corella	Institute of Health Carlos III (ISCIII, Spain)
IO	Nadine Cornier	United Nations High Commissioner for Refugees (UNHCR)
EU	Susan Cowan	National Institute for Health Data and Disease Control, Sweden
EU	Julia del Amo	Universidad Rey Juan Carlos, Spain
EU	Valerie Delpech	Health Protection Agency, United Kingdom
US	Jennifer Donofrio	Office of International Health and Biodefense, US Department of State
US	Tom Donohoe	US-Mexico Border AIDS Education and Training Team Initiative (UMBAST)
CAN	Monique Doolittle-Romas	Canadian AIDS Society
IO	Sathyanarayanan Doraiswamy	United Nations High Commission for Refugees
EU	Laura Dunkeysun	United Kingdom
US	Teresa Durden	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
CAN	Rainer Engelhardt	Infectious Disease Prevention and Control Branch, Public Health Agency of Canada
CAN	Bersabel Ephrem	Office of International Affairs for the Health Portfolio, Government of Canada
EU	Ibidun Fakoya	University College London, Centre for Sexual Health & HIV Research, United Kingdom
US	Kevin Fenton	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
EU	Tanja Gangarova	German Aids-Help Organisation (Deutsche AIDS-Hilfe e.V.), Germany
US	Deliana Garcia	Migrant Clinicians Network, Inc.
CAN	Marc-Andre Gaudreau	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
US	Emilio German	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
CAN	Danielle Grondin	Health Branch, Citizenship and Immigration Canada
CAN	Jessica Halverson	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
IO	Hussein Hassan	International Organization for Migration, Somalia
CAN	Patricia Hurd	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
EU	Monica Idelstrom	Swedish Institute for Communicable Diseases, Sweden
IO	Chiaki Ito	International Organization for Migration, Somalia
CAN	Michelle Jones	Canadian HIV Trials Network
US	Amy Lansky	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
EU	Stéphane Le Vu	Institut de Veille Sanitaire, France
IO	Chris Lemoh	University of Melbourne, Australia
CAN	Alan Li	Committee for Accessible AIDS Treatment, Regent Park Community Health Centre
US	Faye Malitz	Health Resources and Services Administration
US	Eva Margolies	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
IO	Reiko Matsuyama	International Organization for Migration, Pretoria
EU	Arild Johan Myrberg	Division of Public Health, Norwegian Directorate of Health, Norway
IO	Sikhulile Ngqase	International Organization for Migration, Pretoria
CAN	Howard Njoo	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
US	Chioma Nnaji	Multicultural AIDS Coalition
EU	Teymur Noori	European Centre for Disease Prevention and Control (ECDC), Sweden
CAN	Susanna Ogunnaike-Cooke	Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada
EU	Anastasia Pharris	European Centre for Disease Prevention and Control (ECDC), Sweden
CAN	Valerie Pierre-Pierre	African and Caribbean Council on HIV/AIDS in Ontario

IO	Niurka Pineiro	International Organization for Migration, United States
EU	Maria Prins	Public Health Service of Amsterdam
IO	Rhon Reynolds	UNICEF
EU	Brian Rice	Health Protection Agency, United Kingdom
IO	Barbara Rijks	Migration Health Division, International Organization for Migration
CAN	Tim Rogers	Canadian AIDS Treatment Information Exchange
CAN	Ron Rosenes	Ontario HIV Treatment Network
EU	Luciano Ruggia	Office fédéral de la santé publique, Switzerland
EU	Claudia Santos-Hövenner	Robert Koch Institut, Germany
US	Lina Sheth	Asian Pacific Island Wellness Center, United States
US	Sonia Singh	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
IO	Winnie Ssanyu Sseruma	Christian AID UK, United Kingdom
CAN	Nicci Stein	Interagency Coalition on AIDS and Development
US	Riley Steiner	National Centre for HIV/AIDS, Hepatitis C and Tuberculosis, Center for Disease Prevention and Control
CAN	Wangari Tharao	African and Black Diaspora Global Network (ABDGN) and Women's Health in Women's Hands
IO	Jason Theede	International Organization for Migration, Nairobi
IO	Irina Titarenko	International Organization for Migration, Kiev
EU	Marita van de Laar	HIV/AIDS and Sexually Transmitted & Blood-borne Infections, ECDC, Sweden
IO	Carlos van der Laar	International Organization for Migration, San José
EU	Maaïke van Veen	RIVM, Netherlands
IO	Erick Ventura	International Organization for Migration, Pretoria
EU	Annisabelle Von Lingen	European AIDS Treatment Group, Belgium
EU	Malin Wallin	Swedish Institute for Communicable Diseases
EU	Ruth Zimmerman	Robert Koch Institut, Germany



## Appendix B. Migration and HIV satellite session agenda



### RESPONSES TO HIV AND MIGRATION IN WESTERN INDUSTRIALIZED COUNTRIES:

#### CURRENT CHALLENGES, PROMISING PRACTICES, FUTURE DIRECTIONS

A SPECIAL SATELLITE SESSION AFFILIATED WITH THE XIX INTERNATIONAL AIDS CONFERENCE

JULY 22, 2012, 12:00-4:00 PM

WASHINGTON, D.C., UNITED STATES

FOUR POINTS SHERATON, FRANKLIN ROOM - 1201 K STREET N.W.

The Public Health Agency of Canada, the United States Centers for Disease Control and Prevention, the European Centre for Disease Prevention and Control, and the International Organization for Migration are pleased to sponsor this special satellite session.

The event aims to raise awareness of the pertinent issues related to migration and HIV and provide context from Western industrialized countries in order to focus and generate discussion on the two themes of the session: 1. Monitoring migrant health and HIV; and 2. Migrant-sensitive HIV prevention and treatment programs and services.

AGENDA	
12:00 – 12:30	<b>Registration</b>
12:30 – 12:35	<b>Welcome &amp; Opening Remarks</b>
12:35 – 12:45	<b>Keynote speaker</b> – Ms. Winnie Sseruma
12:45 – 14:00	<b>Opening panel: Addressing HIV vulnerabilities of migrant populations in Western industrialized countries</b> Global perspectives <ul style="list-style-type: none"> <li>Ms. Barbara Rijks - International Organization for Migration</li> </ul> Regional perspectives <ul style="list-style-type: none"> <li>Dr. Howard Njoo - Public Health Agency of Canada Centre for Communicable Diseases and Infection Control</li> <li>Dr. Marita van de Laar - European Centre for Disease Prevention and Control</li> <li>Dr. Kevin Fenton - United States Centers for Disease Control and Prevention</li> </ul> Participant Question and Answer period
14:00 – 14:05	<b>Introduction to Break-Out Sessions</b>
14:05 – 14:20	<b>Break</b>
14:20 – 15:05	<b>Concurrent break-out session – Group A: Monitoring migrant health and HIV</b> <b>Key Questions:</b> <ol style="list-style-type: none"> <li>What data do we need to improve our understanding and inform our response to HIV among migrant populations?</li> <li>What promising practices are in place in relation to monitoring HIV and related factors among migrant populations?</li> <li>How could we use or strengthen existing HIV surveillance and information systems to collect information specific to migrant populations?</li> </ol>
	<b>Concurrent break-out session – Group B: Migrant-sensitive HIV prevention and treatment programs and services</b> <b>Key Questions:</b> <ol style="list-style-type: none"> <li>What are the barriers and challenges to providing effective prevention and care programs/services?</li> <li>What factors are necessary for successful migrant health programs and services?</li> <li>What promising practices are you aware of that may be used for migrant-sensitive programs and health services?</li> </ol>
15:05 – 15:50	<b>Break-out groups report back and group discussion</b>

## Appendix C. Post-presentation question and answer session

Q. What is Canada's rationale for requiring HIV testing as part of the application process for temporary or permanent entry to the country?

A. Canada has a policy in place that requires HIV testing as part of the immigration medical examination (IME) for all potential immigrants and long-term visitors over 15 years of age. The objective of the policy is to protect the health and safety of Canadians. HIV testing is provided in conjunction with pre- and post-test counselling. The intent is not to exclude people from entry because of their HIV status, but to allow diagnosis and referral to health services. The policy is currently under review.

Q. While refugees and family members are permitted entry into Canada regardless of HIV status, there are cases where HIV-positive applicants have been denied entry. What has been the US experience over the past two years with the introduction of its new policy of not requiring HIV testing as part of the immigration medical process?

A. There was much consultation and debate in the US surrounding the change in policy to not ban entry based on HIV-positive status. A key factor in the decision was the recognition that even the process of going through HIV testing would and could generate stigma. For this reason, the policy was changed to not require HIV testing for people thinking of immigrating; however, the intent is to integrate voluntary HIV testing into the care persons receive in the United States.

Q. Recognising the growing Mexican migrant population in British Columbia, Canada, is it currently possible for undocumented Mexican migrants to access medications and treatment?

A. There is a growing migrant population who are temporary farm workers. With respect to coverage, employers in Canada have the responsibility to ensure migrant workers have coverage for medical care. The delivery of healthcare services is under the jurisdiction of the provinces and territories, offering a range of medical services. There is some follow-up that could be done to fully understand any issues of access to care for the growing population of migrant workers.

Q. Recognising that migration itself is a factor that increases vulnerability to HIV infection, why does Canada's Federal Initiative to Address HIV/AIDS (FI) not identify newcomers/migrants as a priority population?

A. People from countries where HIV is endemic are a key population identified under the FI, although this does not include all migrants. There are special epidemiological updates and status reports that examine this population, taking into account social factors such as migration.

Q. The medical community in Canada has raised concerns about recent changes to interim health coverage for some refugees, reducing their access to some healthcare services previously covered. What is the anticipated impact on public health?

A. The policy relating to the Interim Federal Health Program (IFHP) in Canada is to cover the cost of healthcare services for eligible protected persons (including resettled refugees), refugee claimants, and other specified groups who are not eligible for provincial or territorial health insurance. Treatment for HIV and AIDS such as anti-retroviral medications are still provided under the IFHP for all IFHP beneficiaries. In addition, the reformed programme continues to provide coverage for primary healthcare services (e.g. physician and hospital services) that are in line with what Provinces and Territories provide through their health insurance programmes. IFHP beneficiaries living in Canada with HIV will continue to be covered for primary healthcare services (i.e. physician appointments and follow-ups, diagnostic testing) and antiretroviral medications.

Q. What strategies are needed to ensure that national government policies integrate the treatment and care of vulnerable populations and migrants as a normal part of service provision? How can these policies be sustained through changes in government?

A. Sensitivities around migration relate to issues of access and their associated cost implications. National governments have jurisdiction over immigration policies and there is often a reluctance to clearly indicate what support migrants are entitled to. The IOM is following a two-pronged approach. First, a human rights-based approach is being promoted, where countries adhere to international regulations and treaties. Second, public health evidence is being used to advocate for national governments to change to an inclusive approach to provision of treatment and care. The evidence indicates that providing access to primary healthcare for migrants as soon as possible can reduce HIV transmission. For economic reasons alone, this is an important strategy to prevent unnecessary health and social costs.

Q. ECDC highlighted how their monitoring and surveillance work is being harmonised with UNGASS reporting. Are PHAC and CDC considering this approach to reduce duplication reporting?

A. This conversation that has not been had yet at CDC; however, ad hoc analyses are being done more frequently to look at the range of indicators that are consistent with UNGASS. There are challenges with completeness of the surveillance data, with a mismatch existing between what is being requested and the capacity to provide that information.

Canada is in a similar position. Data gaps exist within routine surveillance and additional systematic data collection is needed. Enhanced surveillance will be achieved through E-track. Canada's approach is in the spirit of UNGASS indicator reporting, although there is still work to be done.

Creative solutions can be generated where there is a strong will. For example, significant progress has been achieved through the US/Mexican border initiatives addressing the health needs of migrants in border areas. In Canada, the economy is a priority for government; the impetus for policy change will rest with making the link between health and wealth.