



M-CARE

TRAINING REPORT

TABLE OF CONTENTS

i) Acknowledgements:	3
ii) Background:	4
iii) Preparation for the Training:	4
iv) Methodology:	5
DAY ONE:	5
1.1 Opening and Introductions:	5
1.2 Prevalence of HIV, HCV and TB among Migrant Communities:	6
1.3 Infection Routes of HIV, HCV, HBV and TB:	7
1.4 Testing on HIV, HCV, TB and Barriers to Testing for Migrant Communities:	7
1.5 Meeting with Representative of Siréas:	8
DAY TWO	9
2.1 Treatment of HIV, HCV and TB:	9
2.2 Barriers to Treatment and Care for Migrant Communities:	10
2.3 Introduction to Clinical Research in Europe:	11
2.4 Barriers for the Participation of Migrant Communities in Clinical Trials:	12
DAY THREE	13
3.1 Patients' Rights and Doctor-Patient Relationship:	13
3.2 Barriers to Good Doctor-Patient Relationship:	13
3.3 Introduction to Lobbying and Advocacy:	14
3.4 Stakeholder Mapping:	14
DAY FOUR	15
4.1 Group Work-Development of Advocacy Strategy:	15
4.2 Closing:	16
ANNEXES:	16
Annex I: Follow Up Projects:	16
Annex II: Training Agenda:	17
Annex III: Participant List:	18
Annex IV: Evaluation	18

i) Acknowledgements:

The European AIDS Treatment Group (EATG) and the European African Treatment Advocates Network (EATAN) would like to thank everyone who submitted applications to attend the M-Care training programme. We are grateful to the training development team for putting together a robust and rich course content, and to the training committee for the effort and time spent reviewing applications and shortlisting candidates for the training.

Special thanks goes to our 4 wonderful trainers Prof. Julia Del Amo, Damian Kelly, Dr. Edwin Mapara and Dr. Ann Ferrara for delivering a truly remarkable 4 days of training. Their excellent presentations, technical ability, resourcefulness and warmth were invaluable to the programme.

We wish to thank all participants who took part in the training. We had a fantastic group of individuals from diverse backgrounds with a lot of experience and expertise in their own areas of work, which was very enriching for the discussions. Everyone was engaged, active and showed a lot commitment and enthusiasm throughout the training.

We would like to acknowledge the excellent work done by Kristjan Jachnowitsch, EATG Training Coordinator and Denis Onyango, EATAN Executive Director, in planning for the training. The long hours spent on training preparation and set-up, quality assurance, selection of trainers and participants, logistics, and interaction with all individuals involved in the programme ensured we had a highly organised and successful training programme.

We would also like to acknowledge the financial support from Gilead Sciences, Merck Sharp & Dohme, ViiV Healthcare and Bristol-Myers Squibb which made it possible for us to plan and deliver this key programme. We hope that you will be inspired by the success of the first M-Care training and look forward to a continued partnership.

European AIDS Treatment Group (EATG)
Place Raymond Blyckaerts, 13
B-1050 Brussels, Belgium
T: +3226269640
E: office@eatg.org
www.eatg.org

European African Treatment Advocates Network (EATAN)
76 Elmer Road
London SE6 2ER
United Kingdom
Tel: +4420 8698 6920
E: info@eatan.eu
www.eatan.eu

All Rights Reserved. No part of this report may be reproduced, stored in a retrieval system or utilised in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the permission in writing from EATG and EATAN

Written by: Denis Onyango, EATAN

ii) Background:

Mobilising Migrant Communities via Capacity and Access Resource Development (M-Care) was a four-day training programme jointly delivered by the European AIDS Treatment Group (EATG) and the European African Treatment Advocates Network (EATAN). The training was targeted at advocates, treatment activists and professionals working with migrants in Europe within the HIV, Hepatitis and Tuberculosis (TB) fields as key activators or influencers for active engagement of the diverse migrant communities, especially those from Sub-Saharan Africa, into healthcare services.

EATG and EATAN developed the M-Care training programme to address existing healthcare barriers within migrant communities in Europe, which make access to HIV prevention, testing, treatment, and care difficult or in many cases impossible. These include legal restrictions, cultural barriers, stigma, discrimination, socio-economic factors, difficulty in accessing timely and appropriate information and support, the problem of late HIV diagnosis and the vulnerability and risk among key sub populations such as migrant LGBTs, women and sex workers.

The knowledge and skills acquired at the M-Care training should equip the participants with the necessary competencies and ability to engage their communities in early testing initiatives, treatment, clinical research and clinical trials, among others. The advocacy and lobbying skills gained should enable the advocates to effectively engage and influence policy and practise in their localities and to empower migrant communities to become active participants in promoting healthcare access.

Following the completion of the training programme, M-Care issued a call for proposals to fund follow-up project ideas by participants. The funding initiative provided participants with the opportunity to implement ideas and concepts that they developed during the training as possible solutions to problems identified within their respective migrant communities.

iii) Preparation for the Training:

The first M-Care training took place on 10-14 November 2016 in Brussels and involved 16 participants from across Europe, 4 trainers and 2 EATG and EATAN staff.

The training programme was independently developed by EATG and EATAN with input from individuals from migrant communities. The content was independently reviewed and approved by EATG and EATAN training committees. Gilead Sciences, Merck Sharp & Dohme, ViiV Healthcare and Bristol-Myers Squibb, the sponsors of M-Care, had no control or input into the structure or content of the programme.

The call for M-Care trainers and participants both went out in August 2016. A total of 17 trainers applications and 87 participant applications were received. Both the trainer and participant applications were independently reviewed by two panels that recommended the four highest ranked trainers and 16 participants for selection to the training. The selection criteria was based on experience of being a migrant or working with migrants, experience of working on HIV, Hepatitis C (HCV) and TB, the ability to influence policy and practice, regional representation, gender balance and fair representation of specific risk groups. The selected participants came from Germany, Italy, France, Netherlands, Romania, Greece, Belgium, Norway, Portugal, Finland, Switzerland and United Kingdom. A full list of participants and trainers is available in Annex II of the report.

The training ran over 4 days and included topics on prevalence, pathology and treatment of HIV, HCV and TB among migrant communities in Europe. It also explored specific barriers that migrants experience in prevention, testing, treatment and care and how they can be overcome. Other topics included clinical research, doctor-patient relationship, and the challenges and barriers migrants in Europe experience with regard to healthcare. The last part of the training was dedicated to stakeholder mapping, lobbying and advocacy. Participants were expected to work together to design advocacy strategies applicable to real life scenarios within their own communities or areas of work.

iv) Methodology:

The M-Care training programme employed participatory learning approaches, i.e. interactive discussions, sharing of experiences, case studies, question-answer sessions and group work, thus enabling each participant to actively contribute to the learning process.

The participants and trainers had ample time to contribute to the discussions through questions, comments, feedback and sharing perspectives and experiences. The trainers' and participants' backgrounds as professionals, migrants, advocates in diverse health and social care systems provided a broad and rich mix of examples, case studies and references for the discussions.

As part of the training agenda, a meeting with Maureen Louhenapessy, director of Siréas, a Brussels-based organisation working with migrants on health and other social care programmes and in particular on HIV, HCV and TB had been organized. This was to give participants some insight into the barriers experienced by migrants in accessing services in Belgium.

Group activities enabled participants to work together and to collectively suggest solutions to barriers that affect good health outcomes within migrant communities in Europe. The interactions among students and trainers during coffee, lunch breaks and dinners fostered togetherness and sharing of ideas. Participants were also able to discuss in more detail their respective organisations' work and opportunities for collaboration and partnerships.

DAY ONE:

I.1 Opening and Introductions:

Kristjan Jachnowitsch opened the training by welcoming all participants and providing a brief background of the M-Care training programme, its aims and the expected outcomes. He encouraged participants to actively contribute to the sessions and share their experiences. He also outlined training ground rules, e.g. the need for punctuality, respect and confidentiality.

Prior to arriving in Brussels, each participant had been asked to prepare a short presentation on the migrant populations they work with and the specific issues or barriers experienced in accessing healthcare services. Each participant was allowed three minutes to introduce themselves, their background, roles and provide a summary of key points relevant to their work with migrants.



I.2 Prevalence of HIV, HCV and TB among Migrant Communities:

The session on HIV, HCV and TB prevalence in migrant communities in Europe was led by Prof. Julia Del Amo who started off by defining the role of epidemiology, the principal measures used and examples of health outcome measures in epidemiological studies, e.g. morbidity, mortality, vaccine efficacy.

She also explained the relationship between “prevalence” and “incidence” through relevant examples and defined the concepts of “numerator” and “denominator” as key factors in measurement of disease frequency in a given risk population over a period of time.

An illustration on how the prevalence of HIV, HCV, Hepatitis B (HBV) and TB among migrant populations in Europe can be calculated was given and common errors when measuring frequency of diseases were discussed, noting that such measurements usually take into account factors such as age-based incidences, gender, socio-economic status, and social determinants of health.

Participants discussed and shared their own understanding of the term “migrant” noting that migrants are heterogeneous groups of people with different migration drivers and distinct health risks.

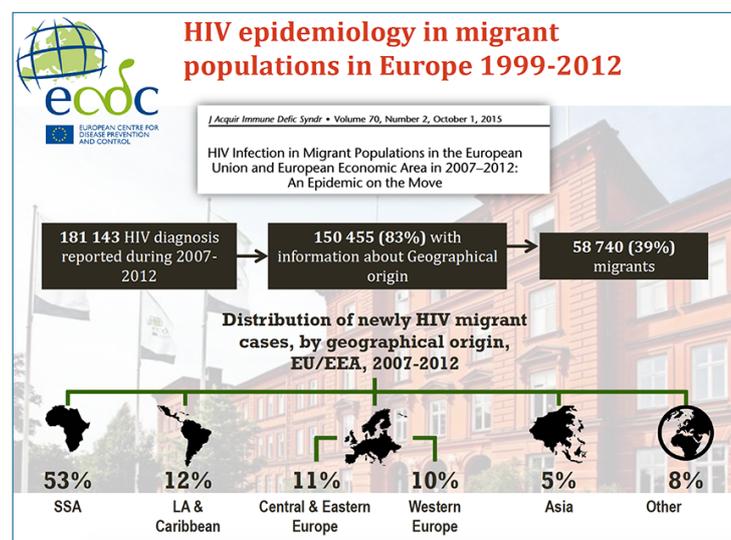
The session also explored equality, rights and legal entitlement in the context of migration and the difficulties that migrants experience in being fully accepted, embraced or integrated as equal members of society in host countries even when they have gained citizenship or have been born in these countries, as is the case of second or third-generation migrants.

Key considerations for studying of health issues among migrants were discussed, among of which was the need for context specific data and the desire to improve the health of migrant populations. On the subject of HIV in migrant populations in Europe, the trainer cited the UNAIDS GAP report highlighting healthcare inequalities among vulnerable key populations; Global HIV/AIDS statistics and the ECDC Technical Report on Epidemiology of HIV/AIDS in migrant communities in Europe were some of the resources referenced.

Epidemiological data among migrant populations and the changing trends in HIV diagnoses in Sub-Saharan African migrants in Europe were discussed and undocumented migrants singled out as the sub population in which estimation of HIV prevalence could present a challenge as they mostly appear in “numerators” (HIV/AIDS registries) than in denominators (censuses and population registries).

On the frequency of HCV and HBV in migrant populations, the trainer provided a global overview of the statistics and mortality rates. It was highlighted that as HCV and HBV are largely asymptomatic, many patients who might benefit from treatment remain undetected. Prevalence among migrants in Europe is estimated to be very high even with the little data available from national registries on numbers diagnosed.

In the case of TB participants discussed the disproportionate burden of the overall TB cases in European countries notably because of migration patterns from high TB burden settings. Participants discussed the need to review policies on TB screening, treatment strategies and to address barriers migrants face in accessing TB services.

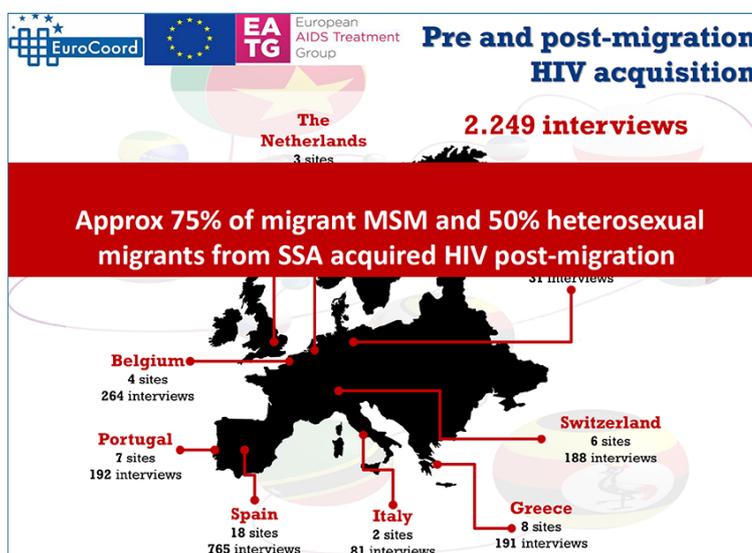


I.3 Infection Routes of HIV, HCV, HBV and TB:

During this session, Prof. Julia del Amo outlined the main transmission routes of HIV, HCV and HBV as blood borne viruses and TB as a bacterial infection. The presentation also covered risk factors, disease progression and testing approaches. She outlined factors determining how incidences of active and latent tuberculosis occur among migrant and mobile populations from high TB-burden countries as well as a range of risk factors, e.g. overcrowded living- and poor working conditions, low socio-economic status, increased vulnerability to HIV infection, treatment interruption, etc. Participants shared their own knowledge and experiences of screening migrants for TB, i.e. pre and post-arrival active and latent TB screening.

The session noted that HIV, HCV and TB awareness testing and treatment policies in many EU countries are not responsive to the needs of migrants. Lack of credible data, discriminatory practices and assumptions of low risk levels in host countries are leading to more infections among migrants. For example, HIV positive migrants have traditionally been assumed to become infected in areas of high prevalence, e.g. in this case Sub-Saharan Africa. However several studies have shown that majority of migrants are acquiring the infection in Europe. The aMASE study shows that approximately 75% of migrant MSM and 50% of migrants from Sub-Saharan Africa have acquired HIV after the migration. There is therefore the need to increase awareness and screening while not forgetting that testing has to go hand in hand with treatment.

Participants highlighted the need for improved testing and treatment strategies, with the trainer emphasizing that migrants, including undocumented ones, should be enabled to access testing and be promptly linked to care. She noted that the excellent HIV treatment available and the revolutionary new HCV drugs should inspire the fight for the rights of these patients to access treatment.



I.4 Testing on HIV, HCV, TB and Barriers to Testing for Migrant Communities:

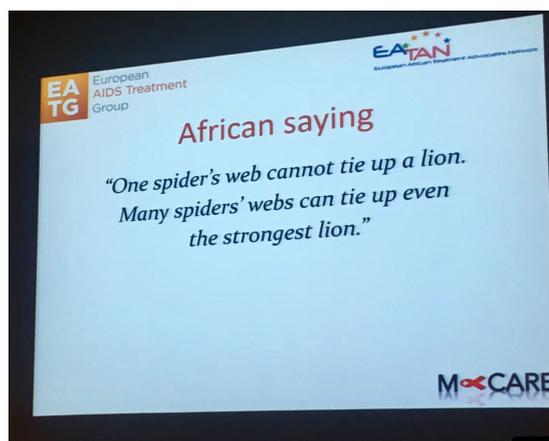
Dr. Edwin Mapara delivered the session on HIV, HCV and TB testing using his AIDUCATION model of picture use in HIV awareness. He provided an overview of testing strategies and guidelines in Europe and contrasted these with his experiences working in Zambia, Botswana and the UK.

Participants discussed the WHO, UNAIDS and various national testing guidelines for HIV, HCV and TB and the justification for timely and appropriate testing for migrants as well as testing methods and technologies for HIV, HCV and TB. Dr. Mapara highlighted the need for clear guidelines on screening vulnerable or mobile populations, e.g. migrants in refugee camps and undocumented migrants, noting that history, social habits, attitudes, culture and surroundings determine how successful testing and treatment programmes will be.

Participants were encouraged to be innovative and bold in promoting testing even with existing challenges. He recalled that at the height of the HIV/AIDS epidemic in Botswana, the government took several drastic measures to stem the rise of the epidemic including suspension of ordinary blood transfusion and introduction of mandatory simultaneous testing for HIV and TB as well as HIV screening in ante-natal services.

It was generally observed that more frontline clinicians such as GPs, pharmacists and nurses should be exposed to more experiences of dealing with HIV among migrants, preferably through specific competency training and having user-friendly practices so that they are able to convey correct testing messages and make every opportunity to test for HIV count.

Dr. Mapara recalled that in Botswana the majority of clinicians had a lot of practical experience in spotting HIV risks and symptoms and in dealing with different categories of patients due to the very high HIV infection rates and AIDS related deaths.



The final part of the session was dedicated to exploring barriers to testing among migrant communities in Europe, i.e. economic, social, cultural, legal, physical and geographical barriers and those relating to systems and practices in healthcare settings such as attitudes of key healthcare workers.

Participants contributed to drawing a list of barriers that migrants face based on their personal experiences as migrants, situations in their localities, interactions with healthcare services or their work with migrant individuals, families and communities. Lack of knowledge, stigma, housing conditions, confidentiality, faith and cultural myths and taboos, criminalisation, legislation, gender based violence and homophobia were some of the issues highlighted.

1.5 Meeting with Representative of Siréas:

The participants had the opportunity to learn about the Belgian migrant community perspective from Maureen Louhenapessy, the head of Siréas, a Brussels-based NGO that works to improve the health of the migrant population through HIV/AIDS and STIs awareness, support, capacity building and creative arts activities. The organisation works closely with social services and local hospitals to support migrants.

She provided a brief overview of the HIV prevalence in Belgium noting that of the 28,051 people diagnosed as HIV positive, 45% are Africans, two-thirds are women and 30% are Belgian citizens. She noted that there has been a marked decrease in the number of diagnoses in people infected through heterosexual contacts among Sub-Saharan African migrants, i.e. 33% decrease for women and 46% decrease for men between 2012 and 2014 in Belgium. She highlighted that there are increasing cases of HIV among MSM migrants and that women still continue to be over represented among people living with HIV.

Maureen Louhenapessy highlighted that in Belgium, as in other European countries, migrants mainly from Congo, Guinea, Cameroon, Rwanda, Nigeria and other Sub-Saharan African regions continue to face serious inequalities in prevention, diagnosis, treatment and care and called on Belgium and other European countries to put in place better health and social care systems and practices towards migrants.

She mentioned that Siréas model of support takes great interest in the trajectory of migration and appreciated that each individual migrant has a unique journey and experience. The organisation focuses on understanding what happens when a migrant arrives Belgium, i.e. the situation in their country of origin, and their interactions with social and healthcare workers and other professionals in Belgium.

She also highlighted the fact that undocumented migrants encounter many barriers accessing services and many have faced discrimination due to their HIV status while a lot of MSM migrants usually hide their sexuality because they fear stigma and homophobia. She also observed that the organisation sees a lot of internal discrimination against migrants. Apart from training and working closely with other services and professionals to enhance access, the organisation has put in place a safe and reassuring environment for migrants to discuss sensitive issues around stigma, sexuality, domestic violence, immigration and to access support.

DAY TWO

2.1 Treatment of HIV, HCV and TB:

Damian Kelly delivered the session on HIV and HCV treatment and started by enquiring about the participants' levels of treatment literacy and showing a short video of the HIV life cycle. He defined the concept of therapy, HIV type 1 and 2 strains and their classifications as well as the categories of drugs used to treat HIV.

Participants were provided with an overview of the various recommended standards of practice, i.e. when to start therapy according to WHO, IAS, US, BHIVA and similar guidelines.

In order to reinforce learning of various drugs and combinations used in therapy, participants were given a partially filled drugs chart and have been asked to identify drug names and place them under various categories. A full chart with relevant classifications was provided afterwards.

The trainer discussed in detail the various therapy combinations as well as drug efficacy, interactions, resistance and side effects. He illustrated through diagrams, how the HIV virus attacks the human cell and the action of various drugs on the HIV virus. He also listed 10 recommended first line drug choices for HIV treatment according to WHO, US, IAS, EACS and BHIVA guidelines and clarified that these recommendations are usually based on drug virology activity, safety and tolerability, convenience, access and cost as well as life expectancy. The trainer also gave the example of Liverpool HIV Interactions website, as a useful, clinically approved and free resource for information on drug interactions. The session also discussed treatment cascades and strategies in Europe for diverse patient categories.

On HCV, Damian Kelly gave a brief overview of the various classifications of viral hepatitis, transmission, incubation period and cure. He discussed common symptoms of hepatitis and several methods of diagnosis, including viral antibody (HCV/Ab), Surface Antigen test for HBV (HBsAG), ultrasound and fibroscan, which he mentioned are mostly preferred these days to liver biopsy.

He discussed disease progression and complications of liver failure, i.e. infection, disorders, inflammation, cirrhosis, and liver cancer. The session also looked at the various genotypes of HCV and treatment progress milestones, e.g. use of interferon in 1991, ribavirin, peg-interferon and currently Direct Acting Antivirals (DAA), which he mentioned can now cure HCV in a matter of weeks.

He discussed the HCV life cycle, the various DAA classifications and drugs names and where the DAA drugs work in the body of the cell. Participants also discussed HIV-HCV co-infection and treatment regimens as well as drug-drug interactions between DAAs and Antiretrovirals (ARVs). The trainer provided a list of four classes of therapy approved across Europe and discussed the characteristics that determine treatment option selection such as prior treatment, drug-interactions, HCV genotype, co-morbidities and severity of liver disease.

Dr. Ann Ferrara presented about TB treatment and started by asking participants whether they thought HIV/TB testing, treatment and screening should be the responsibility of the host country or not in the case of migrants. She discussed WHO, BHIVA and national screening and treatment guidelines. She drew on her experiences working in clinics in South Africa with HIV/TB co-infected patients and also with migrants in the Netherlands and the stigma and barriers that patients face, especially those living in poverty. She said that in her view HIV positive migrants, especially newly arrived ones, should be offered screening for TB.

She provided an outline of recommended treatment regimens at intensive and continuation phases of TB treatment and discussed how to manage drug interactions, e.g. rifampin with some ARVs. She also discussed multi-drug resistant and extensively drug resistant TB as well as major presentations of immune reconstruction inflammatory syndrome (IRIS) in TB patients and how to manage it.

2.3 Introduction to Clinical Research in Europe:

The session was led by Damian Kelly who gave a brief overview of the whole drug research and development process leading to a clinical trial, i.e. research process, discovery, development and preclinical stages.

He explained the process of new drug discovery, i.e. basic research to understand the disease and to find potential agents to target the disease; the discovery stage, which involves finding a drug candidate; the drug development stage where approval is sought to test the new drug in humans; the pre-clinical stage where extensive testing occurs in labs and eventually the clinical trials where the drug is tested on “healthy volunteers”. He also provided an



overview of the Food and Drug Administration (FDA) approval processes and timelines including that of the review stage where all clinical and pre-clinical results are reviewed by independent advisory committees to determine whether the drug should be approved.

The trainer defined clinical trials and the approaches that may be used, e.g. a biomedical intervention, new medicines, surgical procedures, or a new way to use an existing device or medicine, e.g. PrEP.

Participants were interested to learn about the history of clinical trials through the Oranges and Lemons tale of 1747 and references to observational studies in HIV treatment. The trainer referred participants to the EUPATI website which has some excellent training materials on clinical trials.

Following the definition of HIV Clinical Trials as a research process to find better ways to prevent, detect or treat HIV/AIDS the session looked at various trial designs such as randomised control trials, case-control, cross-sectional and cohort studies and expert opinion. Participants and trainers gave their own views and preferences on these study designs and majority agreed that randomised control trials provide the best evidence in clinical trials.

Participants learned about the six clinical trial phases:

1. The Pre-Clinical Phase, involving testing of a drug on non-human subjects to gather efficacy, toxicity and pharmacokinetic information
2. Phase 1, involving testing a drug on a small group of humans to determine safety, side effects and dosage
3. Phase 2, where the drug is given to a larger group of people to evaluate its safety
4. Phase 3, involving testing in larger groups of people to confirm effectiveness, collect information and compare to other treatments
5. Review Stage for ethical approval
6. Phase 4 is where studies are carried out when the drug is in use to gather more data.

The session explored the role of community engagement in clinical trials noting that participants are homogenous groups of people including patients, stakeholders, adults and children. He discussed the importance of involvement, participation, and appropriate resources. Damian mentioned that M-Care programme is keen to understand migrant community views and motivations regarding clinical trials and indicated that there is room for participants and migrant community members to become involved in the development of patient information sheets for clinical trials, as well as becoming members of a trial management board, which is made up of various stakeholders.

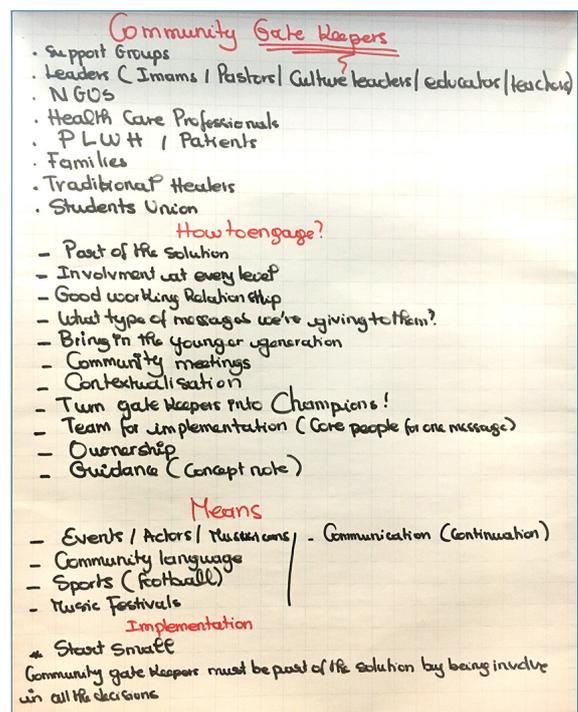
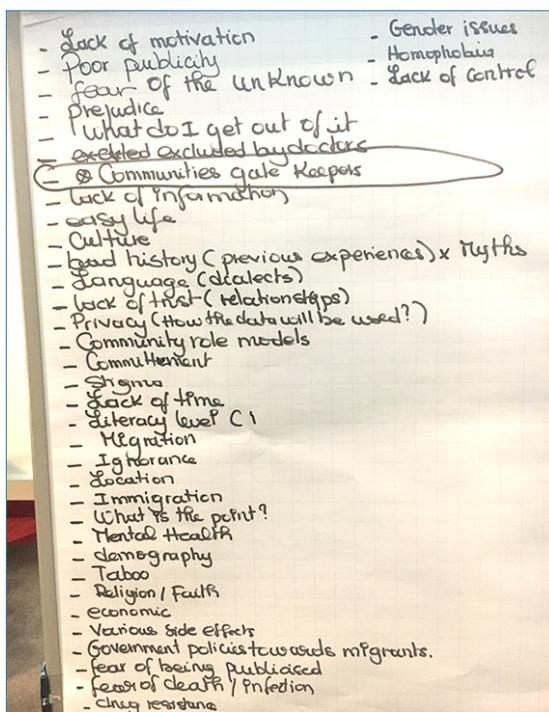
2.4 Barriers for the Participation of Migrant Communities in Clinical Trials:

This session was dedicated to understanding reasons why individuals and especially migrant community members do not get involved in clinical trials and was led by Damian Kelly. The participants shared experiences and perceptions from their own communities as to why migrants do not participate in clinical trials. One outstanding fact was that there is very little information on clinical trials at community level. Others mentioned bad experiences of past research and clinical trials especially in Africa. Myths, taboos and misconceptions about clinical trials as well as homophobia were identified as reasons for non-engagement.

Participation in clinical trials and length of commitment are also affected by cultural, language and faith barriers, the stigma that is attached to some diseases, and the working and living conditions of immigrants. Privacy issues, data protection and how the data is going to be used were some of the concerns shared. It was noted that there is a critical lack of community leaders or gatekeepers in research who can motivate others to get involved. Researchers do not have a bridge into the community and are always viewed with suspicion and so relationships are not well managed. Others see clinical trials as being too scientific and not for them. For example in the case of PrEP, some HIV negative people fear drug resistance, HIV infection or reproductive health effects.

The second part of the session involved group work and participants were asked to choose one barrier from the list as an example and use it to develop a community engagement strategy for involving migrants in clinical trials. The participants opted for community gatekeepers as important enablers for the involvement of migrants in clinical trials.

Participants identified categories of gate keepers which included, NGO/support group leaders, imams, pastors, cultural leaders, educators, charity workers, teachers, cultural mediators, patients, traditional healers, healthcare professionals and student union leaders. The session trainer asked participants to think of what kind of keys (information) these gate keepers are going to be given to promote migrant community participation in clinical trials and how to involve them at every level, i.e. design, implementation and evaluation. They worked on ways of engagement and means of promoting clinical trials in the community through identified gate keepers. Participants also worked through other barriers to identify effective ways of addressing them and to turn community gatekeepers into clinical trial promoters. At the end of the exercise, the trainer challenged all participants to commit to speaking to at least one gatekeeper within their community about promoting clinical trials and to give feedback to the entire group how he/she did it and how it has been received.



DAY THREE

3.1 Patients' Rights and Doctor-Patient Relationship:

Dr. Edwin Mapara led the session on doctor-patient relationship and highlighted Human Rights as a central issue that determines a good doctor-patient relationship. Reflecting again on his experiences in Botswana, he noted that HIV epidemic is driven by Human Rights violations by the community, political leaders, workplace, healthcare workers, teachers, faith and community leaders, legal professionals and others. This, he said, manifests itself in form of stigma, discrimination, violence, homophobia, isolation, ostracisation and victimisation. He emphasised that people living with HIV must know the law and have access to appropriate information about their condition, so that they are not merely passive patients.

On the subject of doctor-patient relationships, he emphasised important roles and responsibilities that healthcare professionals must have to ensure that patients are not denied treatment, stigmatised or discriminated against.

Healthcare professionals must communicate effectively, treat patients with dignity and respect, listen to views and concerns of patients and, most importantly, involve patients in all decisions about their treatment and care. They are also expected to ensure privacy, dignity and confidentiality.

The session also looked at patient's rights and responsibilities in terms of basic rules of engagement between patients and healthcare professionals, i.e. the patient's ability to have an open and honest communication and to ask questions without fear of being rebuked. He also stressed that there is the expectation that migrant patients will be active partners in their healthcare plans to ensure optimum care.

He stated that African migrants mainly come from experiences of imbalanced relationships with doctors where patients don't have much to say in their care and therefore must be empowered to become active partners in healthcare.

Participants also discussed the need for better systems in healthcare settings in Europe, including providing appropriate training for frontline healthcare professionals and staff to have migrant friendly services, attitudes and engagement strategies. The session also observed the need for guidelines and toolkits to assist healthcare professionals in effectively working with migrant communities. The session was concluded with screening of a video clip on doctor patient relationships as well as sharing of resources from the Positive Conversations Resource Pack.

3.2 Barriers to Good Doctor-Patient Relationship:

The session was delivered by Dr. Ann Ferrara who observed that barriers to good doctor-patient relationship start with issues around communication and trust between the doctor and patients. She emphasised the need for migrant communities to build strong treatment teams and that doctors and patients should see themselves as being in the same team, with doctors empowering and encouraging patients to be equal partners in their care.

Some key barriers that have been highlighted included lack of respect for patients and their cultures, patient rights, language difficulties, e.g. difficult medical terminology, issues of communication and trust, confidentiality, lack of self esteem, mental health problems and lack of supportive community networks. The session concluded that there is need to explore models for improving patient-doctor interactions. Training of more treatment advocates to facilitate such initiatives was one of the suggestions put forward.

DAY FOUR

4.1 Group Work-Development of Advocacy Strategy:

During this session participants have been assigned to four groups, with each group working on a pre-selected topic to develop advocacy strategies. The topics were as follows:

Group 1: Promoting HIV testing:

The group designed a strategy to promote HIV testing for diaspora migrant students who have been identified as having difficulties accessing healthcare services due to lack of awareness and information. The strategy would use the European HIV testing week to run the campaign. Activities such as sports, poetry, and music were to be used in the campaign to make it interesting and non-stigmatising. The motto was to “test and treat and to encourage people to speak about HIV”.



Group 2: Education of Healthcare Workers:

This group designed a strategy to educate healthcare workers about immigrant’s experiences and needs in healthcare access and at the same time creating awareness among migrants on how to effectively engage with healthcare services. The key healthcare professionals targeted in this campaign were GPs, pharmacists and receptionists and the campaign was supposed to begin at a local level, with the possibility to expand.

Group 3: Fighting Stigma and Discrimination:

The group designed an advocacy strategy to fight stigma and discrimination towards migrant communities by increasing knowledge and understanding among professionals on migrant Human Rights and healthcare access rights. The objective was to reduce stigma and discrimination among health and social care professionals by using the national health registry of GPs and migrant registration authorities. The initiative would create a comprehensive database of agencies and individuals to target with information and training on cultural awareness, rights, and dignity. Migrant healthcare professionals were to assume the function of champions to educate their peers.

Group 4: Access to Information and Services:

The group came up with a project labelled ‘Portugal, Italy, Greece and Spain (PIGS) at Work’ that focuses on Southern Europe, a region with less well-established HIV systems and services for migrant communities, yet with many challenges.

The strategy was to improve the availability of HIV related services and information within the health services through the use of technology in form of an app or text messaging system for migrants. The service will use the location feature in healthcare settings to suggest HIV testing services to migrants visiting these facilities. The service would further provide resources in multiple languages for migrants and use the app to link migrants to other services.

At the end of the session, many participants indicated that the exercise had been a highly engaging and rewarding experience with four excellent ideas developed.

4.2 Closing:

Participants were informed of the follow up grant application scheme that would be made available after the training. The purpose of the grants was to allow participants of the M-CARE training programme to develop and implement projects within their own local communities. Participants were talked through the application process, the deadline for applying and the date of selection of projects.

Denis Onyango and Koen Block, Executive Director of EATG, each gave brief presentations about their respective organisations and invited the participants to become actively involved in both organisations' activities. This was followed by a closing round by all participants after which the training program was officially closed.

ANNEXES:

Annex I: Follow Up Projects:

The following two projects were awarded the M-Care follow-up grant:

a) Manchester Voices of Faith Project's (MVFP)

Manchester Voices of Faith Project's (MVFP) is a project being implemented by Reinventing Success, a social enterprise in Manchester. MVFP will target hard-to-engage groups of Christians and Muslims of African origin above 18 years of age living in Manchester through the support of faith leaders who are highly trusted by African immigrants. They will be trained and supported to play pivotal roles in delivering HIV prevention interventions to their communities. The project will facilitate their understanding of HIV and the development of action plans that meet the needs of their communities. Key outcomes include:

- 20 faith leaders successfully engaged and empowered with enhanced sexual health knowledge, care and compassion to work with members of their congregations.
- Visible reduction in HIV related stigma within the communities of faith leaders involved by October 2017.

b) Inform Yourself

"Inform Yourself" is a project by SidAids that aims to address refusal of care and discrimination against people living with HIV (PLHIV) in general and migrant PLHIV within medical facilities in Brussels. The project will develop an information tool for healthcare professionals to highlight situations of discrimination. The project will engage and encourage healthcare professions to inform themselves about migrant needs and improve their attitudes and relationships with migrant patients. This will limit the negative impact of refusals of care on the quality of life of migrants living with HIV. The tools will be fully implemented by a group of migrants living with HIV, who will work at all stages of the project to directly engage with healthcare professionals with the idea of empowering them in their professional practice. Key outcomes include:

- Mobilisation of 15 migrants living with HIV and involvement of doctors in co-creation and pre-test phase activities and implementation of the project
- Production and dissemination of 300 toolkits in form of brochures to healthcare facilities and professionals
- A full listing of medical organisations and facilities on the resources for migrants

Annex II: Training Agenda:

Thursday, 10 November 2016	
20:00	Dinner and unofficial welcome
Friday, 11 November 2016	
08:30 – 08:45	Registration
08:45 – 10:00	Opening and introduction
10:00 – 11:15	Prevalence of HIV, HCV and TB among migrant communities in Europe
11:15 – 11:30	Coffee Break
11:30 – 13:00	Infection routes of HIV, HCV, TB
13:00 – 14:00	Lunch
14:00 – 15:30	Testing on HIV, HCV and TB and barriers to testing for migrant community
15:30 – 16:00	Coffee Break
16:00 – 17:30	Meeting with Maureen Louhenapessy from Sidais Migrants/Siréas asbl
19:30	Dinner
Saturday, 12 November 2016	
09:00 – 11:00	Treatment of HIV and co-infections
11:00 – 11:30	Coffee Break
11:30 – 13:00	Barriers to treatment and care for migrant community
13:00 – 14:00	Lunch
14:00 – 15:45	Introduction to clinical research in Europe
15:45 – 16:00	Coffee Break
16:00 – 17:30	Barriers for the participation of migrant community in clinical trials
19:00	Dinner
Sunday, 13 November 2016	
09:00 – 10:30	Patients' rights and doctor-patient relationship
10:30 – 11:00	Coffee Break
11:00 – 12:30	Barriers to good doctor-patient relationship for the migrant community
12:30 – 13:30	Lunch
13:30 – 15:30	Introduction to lobbying and advocacy
15:30 – 16:00	Coffee Break
16:00 – 17:30	Stakeholder mapping
19:30	Dinner
Monday, 14 November 2016	
09:00 – 11:00 (incl. Coffee break)	Group Work – development of advocacy strategy
11:00 – 12:30	Discussion of group work results
12:30 – 13:00	Overall feedback, outlook and evaluation
13:00	Lunch

Annex III: Participant List:

Name	Country
Ataulhaq Sanaie	United Kingdom
Adela Mugabo	United Kingdom
Ballet Brice Stephane Djedje	Germany
Boniface Oburu	United Kingdom
Dynka Amorim	Portugal
Elena Patratanu	Romania
Elizabeth Bos-Muchembre	Netherlands
Evgenia Kountouri-Tsiami	Netherlands
Grâce Ntunzwenimana	Belgium
Jean-Pascal Nkuibo	Germany
Letonde Ablawa Hermine Gbedo	Italy
Lenio Capsakis	Greece
Marta Luz	Portugal
Maryan Ahmad Said	Norway
Walter Baertschi	Switzerland
Walter Byaruhanga	France
Trainers	
Name	Country
Ann Ferrara	Netherlands
Damian Kelly	United Kingdom
Edwin Mapara	United Kingdom
Julia Del Amo	Spain
Organizers	
Name	Country
Denis Onyango	United Kingdom
Kristjan Jachnowitsch	Belgium

Annex IV: Evaluation

I) Suggested Actions and Topics for the Future:

In their feedback, the participants suggested the following actions and topics for future training programmes.

- Gender issues, underrepresented migrant populations, e.g. sex workers, trafficked women
- Engaging with faith communities on HIV and HCV work and minority sexual rights
- Production of patient-doctor relationship resource to reduce stigma and discrimination, e.g. an online video
- Training focusing on migrant MSM
- HIV treatment, scientific research and PrEP
- Human Rights of migrants in European countries
- More topics on research among migrant populations in Europe

ii) Summary of Evaluations

The participants were asked to score each training topic basing on a scale of 1 to 5, i.e. Totally Disagree (1) ; Disagree (2); Neutral (3); Agree (4) and Totally Agree (5) . They provided feedback on the reasons for the scores; key learning points from the sessions and what they would take back to their work places. Below is an overview of participants’

DAY ONE					
<i>(i) Prevalence of HIV, HCV and TB among Migrants (ii) Infection Routes of HIV, HCV and TB (iii) Testing on HIV,HCV and TB and barriers (iv) Session on the work of SIREAS’</i>					
Evaluation Statements	Avg Score		Avg Score		Avg Score
<i>My Knowledge on the topics has been enhanced/ improved</i>	4.5	<i>Content was interesting and engaging</i>	4.6	<i>Content was relevant and appropriate level for me</i>	4.4
Feedback on the reasons for your score on evaluation statements (Sample Comments)	<ul style="list-style-type: none"> • <i>Very interesting and engaging , the group was amazing</i> • <i>The training met my expectations. Provided me with an up-to-date information on HIV, HCV, TB</i> • <i>The presentation done by the speaker was very detailed</i> • <i>I have received a lot of information about infectious router on HBV and TB and the importance of testing and using the test result for healthy life purposes</i> • <i>The training was great, the trainers have expertise in the field and I like the way we were allowed to ask questions</i> 				
Summary of Key Learnings from the session- (Sample Comments)	<ul style="list-style-type: none"> • <i>Testing is the means to get people treated and not the end</i> • <i>Sharing the best practice</i> • <i>Different interventions in Africa, I will investigate the Botswana model</i> • <i>Migrants have similar barriers despite living in different countries, Empowerment of migrant communities to take care of their health needs</i> • <i>The necessity of working with GPs</i> 				
Summary of Key Learnings for work place (Sample Comments)	<ul style="list-style-type: none"> • <i>Engaging leaders of different faith, TB screening and HIV testing, STIs testing, user involvement and empowerment, not making assumptions when working with migrant communities</i> • <i>More valid argument to advocate for universal free testing and treatment for migrants</i> • <i>Apply knowledge gained and work more on co-infections stressing their importance and addressing the main barriers to testing and treatment</i> • <i>It was good to listen and share experiences from different countries</i> 				

DAY TWO					
<i>(i) Treatment of HIV, HCV and TB (ii) Barriers to Treatment and Care for Migrant Communities (iii) Introduction to Clinical Research in Europe (iv) Barriers to Migrant Community Participation in Clinical Trials</i>					
Evaluation Statements	Avg Score		Avg Score		Avg Score
<i>My Knowledge on the topics has been enhanced/ improved</i>	4.6	<i>Content was interesting and engaging</i>	4.6	<i>Content was relevant and appropriate level for me</i>	4.4
Feedback on the reasons for your score on evaluation statements (Sample Comments)	<ul style="list-style-type: none"> • <i>The subject was interesting but the time was limited. Group work is also very important</i> • <i>Awesome trainers</i> • <i>Well addressed but I experienced a lot of clinical language in some of the topics</i> • <i>Treatment of HIV and co-infection had a lot of information to process in a short time</i> • <i>Fantastic integration with group and trainers.</i> 				
Summary of Key Learnings from the session- (Sample Comments)	<ul style="list-style-type: none"> • <i>New drugs and classification of drugs very interesting</i> • <i>Engaging community gate keeper is very crucial</i> • <i>The meaning HIV/AIDS Clinical trails, PrEP</i> • <i>How barriers to care and treatment are and can be surmounted</i> 				
Summary of Key Learnings for work place (Sample Comments)	<ul style="list-style-type: none"> • <i>Implement contact strategies with communities gate keepers</i> • <i>I will share and inform my organisation on clinical trails</i> • <i>Help implement the clinical trials in my community</i> 				

The participants were asked to score each training topic basing on a scale of 1 to 5, i.e Totally Disagree (1) ; Disagree (2); Neutral (3); Agree (4) and Totally Agree (5) . They provided feedback on the reasons for the scores; key learning points from the sessions and what they would take back to their work places. Below is an overview of participants' feedback;

DAY THREE		(i) Patient Rights and Doctor-Patient Relationships (ii) Barriers to Good Doctor Patient Relationships for Migrant Communities (iii) Introduction to Lobbying and Advocacy (iv) Stakeholder Mapping			
Evaluation Statements	Avg Score		Avg Score		Avg Score
My Knowledge on the topics has been enhanced/ improved	4.4	Content was interesting and engaging	4.2	Content was relevant and appropriate level for me	4.3
Feedback on the reasons for your score on evaluation statements (Sample Comments)	<ul style="list-style-type: none"> Very interesting differentiating between the rights and duties of a doctor and other stakeholders as far as patient treatment is concerned Steps to follow while advocating 				
Summary of Key Learnings from the session- (Sample Comments)	<ul style="list-style-type: none"> Limits of advocacy and lobbying There is always a dilemma when it comes to confidentiality issues : team approach may work well Right based approach and stakeholder mapping 				
Summary of Key Learnings for work place (Sample Comments)	<ul style="list-style-type: none"> Community advocacy can take many different forms and happens at many levels Stakeholder part will help my organisation expand the work we are doing to many other directions Good interaction between participants especially during the group activities Group work helped me to learn of different faces by migrants It was good to share experiences and to find solutions 				

DAY FOUR		(i) Group Work- Lobbying and Advocacy			
Evaluation Statements	Avg Score		Avg Score		Avg Score
My Knowledge on the topics has been enhanced/ improved	4.8	Content was interesting and engaging	4.9	Content was relevant and appropriate level for me	4.8
Feedback on the reasons for your score on evaluation statements (Sample Comments)	<ul style="list-style-type: none"> Working in groups: learnt new ideas from other people and this has given the courage to continue working with migrant HIV patients Making an advocacy plan was the best experience Very interesting and well carried out training Advocacy strategy is important 				
Summary of Key Learnings from the session- (Sample Comments)	<ul style="list-style-type: none"> How to develop an advocacy strategy Thinking outside the box a very important factor in making an advocacy plan Engaging more with the community to help break the barriers Working as a team from different backgrounds with different experiences and opinions Reducing stigma and discrimination while empowering the communities Careful when dealing with the media 				
Summary of Key Learnings for work place (Sample Comments)	<ul style="list-style-type: none"> Initiating a local community advocacy plan I will take the contacts of local projects and different interventions Push forward, stick to ideas and implement them How to advocate for christians, LGBTIQ and PLWH Education of health care workers is still much a needed strategy 				

Supported by:

