Pilot special intervention:
Peer involvement of migrants and refugees to accelerate their access to HIV/HCV/HBV-related information and testing

Report June 2018 – March 2019
Table of Contents

List of abbreviations 4

INTRODUCTION 5
   Summary 5
   Aims of the project 5
   Methods 6
   About Fixpunkt 6
   Priority points of Fixpunkt 6

CONTEXT 8
   Legal, health and social situation of the communities in Berlin 9
   Linguistic and cultural differences within the communities 9

SHORT COMMUNITY ASSESSMENT IN GORLITZER PARK REGARDING HCV/HBV/HIV 11
   General overview 11
   Structure of the assessment 11
   In-depth results of the assessment 14
   Epidemiologic overview and hepatitis C prevalence in the regions 15

ANALYSIS OF THE ACTUAL HEALTH SUPPORT SYSTEM.
   A CASE STUDY ON HEPATITIS B CASES: DIAGNOSIS AND TREATMENT IN GÖRLITZER PARK 16

COMMUNITY EXPERTS MEETING 17
   Fixpunkt experts meeting 17
   Summary 18

TARGET-SPECIFIC CONTENT AND COMMUNICATION CHANNELS
   REGARDING HCV/HBV/HIV 19
      Recommendations for service provider 19
      How to transfer key messages to the communities 20

DOCUMENTATION OF THE INTERVENTION ‘SOCIAL AND MEDICAL SUPPORT’
   FIXPUNKT OUTREACH IN GÖRLITZER PARK (SINCE FEBRUARY 2016) 20

CONCLUSIONS AND RECOMMENDATIONS 22
   Conclusions 22
   Recommendations: 22
List of abbreviations

C-EHRN – Correlation – European Harm Reduction Network
CIS – Community of Independent States
EE – Eastern Europe
EuroNPUD – European Network of people who use drugs
HBV – Hepatitis B virus
HCV – Hepatitis C virus
HIV – Human immunodeficiency virus
Maghreb – Northwest African region
MENA – Middle East and North Africa
Mobilix – Mobile outreach project on HIV/hepatitis infection risks
NGO – Non-governmental organization
OST – Opioid substitution treatment
PaSuMi – Peer group in Görlitzer Park; participative addiction prevention among migrants
SHUKRAN – Addiction care and crime prevention for refugees in several neighbourhoods
SSA – Sub-Saharan Africa
Pilot special intervention:

Peer involvement of migrants and refugees to accelerate their access to HIV/HCV/HBV-related information and testing

INTRODUCTION

Summary

In Europe, contemporary discourses and policies on migration have crystallized into structural patterns of exclusion. An example of this is the circumstances in which refugees and migrants who use drugs have seen their access to social services and health care drastically reduced. If we look at the specific situation in Germany, restrictive laws and social barriers also play a role, in addition to the linguistic and cultural barriers that this community is confronted with. As a result, access to information, testing and treatment with regards to HCV, HBC and HIV is greatly affected.

Aimed at improving and transforming this situation, C-EHRN agreed with the Berlin-based NGO Fixpunkt to develop a ‘Peer Involvement Network’ pilot intervention between June 2018 and March 2019. This intervention, actively grounded in community-based approaches, coordinated activities with and for migrants and refugees with different social and health backgrounds. The main goal has been to improve access to HCV/HBV/HIV information and testing services (including HBV vaccination) in risky environments. To achieve this, the inclusion of peer workers has been a key element.

This report presents an overview of the research and activities carried out within the framework of this project.

Aims of the project

- To improve access to HCV/HBV/HIV information and testing services for migrants and refugees who use drugs in Berlin. Specifically, the project has targeted the highly affected neighbourhoods Görlitzer Park and Kottbusser Tor in the district Kreuzberg, as well as the districts Neukölln and Mitte.
- To research and develop methodologies for peer-driven and community-based interventions in the field of HCV/HBV/HIV (including information, harm reduction, rapid testing and vaccination).
- To develop effective communication strategies and materials that support peer-driven and community-based interventions and that take into consideration the cultural, educational and linguistic context of the target communities.
- To develop customized interventions for community members without legal (illicit or illegalized) residence status. This included investigating the role of harm reduction in this setting and researching the methods through which testing could be offered and how access to further diagnostics and therapy could be organized.
- To create spaces for exchange and dissemination of results and methodologies with other international harm reduction experts. Special attention was given to representatives of users’ organizations in the countries of origin (SSA, Maghreb, Afghanistan, Iraq, Iran, Syria, and former CIS countries).
Methods
• Development of a short assessment aimed at generating data on the target groups of the intervention (e.g., estimated size of the community groups, countries of origin, legal and social situation, risk behaviour patterns).
• Analysis of the actual health support system (including testing and treatment for HCV/HBV/HIV), with an emphasis on identifying gaps in support and on highlighting opportunities for health and legal support of undocumented migrants.
• Establishment of an expert group in which the different communities in Berlin were represented, as well as experts from the identified countries of origin, harm reduction experts from Fixpunkt (Mobilix, SHUKRAN and PaSuMi projects), experts from other European cities facing similar challenges, and experts from the community of people who use drugs (EuroNPUD).
• Development of target group-specific content and communication channels regarding HCV/HBV.

About Fixpunkt
Fixpunkt is a non-profit and non-governmental organization based in Berlin. Fixpunkt is primarily focused on the development and implementation of low-threshold addiction care and infection prophylaxis services. As one of the first organizations working in Berlin in the addiction care field, Fixpunkt is prepared to respond to both existing and new challenges.

The aims of Fixpunkt are:
• to support drug users and to improve their health and social conditions, especially for those who are infected by HIV or hepatitis;
• to support self-help activities, self-control and survival strategies;
• to prevent infections related to injecting drugs, by developing and implementing harm reduction approaches;
• to offer low-threshold employment facilities to drug users.

Fixpunkt currently has several facilities and projects:
• Migrant projects: SHUKRAN (addiction care and crime prevention for refugees in several neighbourhoods) and PaSuMi (a peer group in Görlitzer Park – participative addiction prevention among migrants).
• Mobile and cross-regional harm reduction services including HIV/hepatitis prevention and testing: Mobilix (mobile outreach in Kottbusser Tor and Görlitzer Park, mobile/stationary testing, harm reduction in sex-positive settings ).
• Mobile outreach with integrated drug consumption vans (Charlottenburg, Tempelhof-Schöneberg).
• Low-threshold drop-in centres for support and counselling, situated at Kontaktstelle Leo in Wedding and at SPAX Spandau.
• Community-orientated projects in the public space: NUDRA; Gemeinwesenprojekt Kottbusser Tor; Berlin-Mitte Stadt für alle.
• Low-threshold contact stores with integrated drug consumption rooms (SKA in Kreuzberg and Kontaktstelle Druckausgleich in Neukölln).
• Working projects BeTaMix; IdeFix – Everything a dog needs; Kotti-Fix.
• Prevention machines – providing drug consumption materials 24/7 in several districts.

Priority points of Fixpunkt
• Hepatitis:
  • National Action Plan on Viral Hepatitis;
  • Early intervention and prevention measures for hepatitis C; information/counselling and campaigns focusing on safer use and everyday hygiene;
  • Promotion of blood awareness;
  • Hepatitis A and B vaccination education.
• Information and training measures for the prevention of drug-related emergencies and deaths.
• Distribution of drug consumption, safer use and safer sex equipment.
- Kotti mobile outreach
- Kotti prevention machine
- Fixppunkt outreach
## CONTEXT

### Table 1 – Target groups/communities

<table>
<thead>
<tr>
<th>Region</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA</td>
<td>Refugees and migrants coming from Sub-Saharan Africa (SSA), often from high-prevalence countries like the Gambia, Guinea-Bissau, Guinea-Conakry, Mali, Senegal, Nigeria, Ghana, etc. According to the available data gathered from Fixpunkt projects and other relevant sources, there are over 300 young African men living in and around Görlitzer Park, a well-known social focal point and a main meeting point for West African refugees. They are mainly from the Gambia, Mali, Guinea-Conakry and Guinea-Bissau.</td>
</tr>
<tr>
<td>MENA</td>
<td>Refugees and migrants coming from the Middle East and North Africa (MENA) region: Afghanistan, Iran, Iraq, Pakistan, Tunisia, Algeria, Morocco and Libya. Data derived from Fixpunkt service provision indicate that a majority of the clients from this region can be found in the districts of Mitte (Kleiner/Großer Tiergarten, several train stations) and Kreuzberg (Kottbusser Tor and Görlitzer Park). In Mitte, the client group mainly comes from the Middle and Far East, estimated size: 20-40 individuals. And in Kreuzberg, the group mainly consists of people from North Africa, estimated size: 40-60 individuals. All refugee consumers are men and their estimated average age is under 30 years.</td>
</tr>
<tr>
<td>EE &amp; Russian-speaking countries</td>
<td>Refugees and migrants from Eastern Europe (EE) and Russian-speaking countries. In these countries, the prevalence of drug use is sometimes very high and continues to rise (including co-infections). High numbers of clients from Russian-speaking communities and Eastern Europe can be found in Neukölln, Charlottenburg-Wilmersdorf and Kreuzberg (Kottbusser Tor). No exact data are available, but the estimated size of people who inject drugs in these communities in Berlin is over 100 individuals; the majority are male and under 30 years old. A small number are female (10-20 users).</td>
</tr>
</tbody>
</table>
Legal, health and social situation of the communities in Berlin
Most of the individuals belonging to the target groups of the project (see table 1) experience complex legal, health and social problems. These include poverty, homelessness, consumption of substances, and a lack of future perspectives. In the largest cities in Germany, undocumented migrants and drug users experience great difficulties in gaining access to health care. The only support available to these communities is the medical solidarity networks that have been established in response to this situation. Specifically, these networks have developed systems that provide access to outpatient health services to drug using migrants and refugees living with HIV, HCV or HBV from the above-mentioned communities.

The following excerpt of a conversation between one of our employees and a cultural mediator gives a clear picture of this situation. In it, these two professionals discuss the health and legal situation of MENA communities in Berlin:
“… as bad and worst, including language barriers and no access to health care. Because they have no health insurance or social coverage, even though they are actively consuming psychoactive substances such as heroin or cocaine. Most of the refugees or migrants were registered when they arrived in Germany, and they received their documents. But because they had become addicted to drugs while living in cities other than Berlin, where they had no access to drug consumption facilities or health/addiction care systems, they eventually decided to move to Berlin. Once here, they unexpectedly lost their residence permit and became both homeless and undocumented. Now, whenever it becomes known that they are addicted or consume substances, they are thrown out of their shelters.”

In the same conversation, speaking about ideas for improvement:
“There should be criminality prevention projects, in collaboration with the target groups. Navigating and accompanying them to institutions like the Migration Office for their residence permit, to the Social Department or the Job Centre for their social welfare and means of existence, to language courses, and to lawyers for their asylum cases.”

Linguistic and cultural differences within the communities
Linguistic differences are one of the main challenges facing the communities with which the project works. Migrants and refugees have a restricted access to health information, and their knowledge about the national/local health and social care system is limited. As a result, their health and social conditions are deteriorating.

An example of the correlation between language barriers and health status is the 15% increase during one year (from 2015 to 2016) in new HIV diagnoses in Germany among migrants from Sub-Saharan Africa. As stated by the Robert Koch Institute, migrants from Africa are usually diagnosed later than people from other communities (i.e., the German population, migrants from other EU countries). This is mainly due to the language barriers, which result in a lack of sufficient knowledge on HIV/AIDS safe practices and a low uptake of testing. The same situation has been observed when it comes to the prevention of hepatitis A, B, and C.

However, these are not the only challenges at play. Cultural differences sometimes result in stigmatization, stereotyping and taboos that contribute to a lack of access to health and social support. Deeply rooted traditions, societal rules or religious expectations (e.g., about not talking openly about sex, consumption patterns, and prevention) impact on the problems these communities experience, especially when viewed in relation to the lack of trust and supportive social relationships in these communities. As a result, the level of traumatic experiences and psychological harms is high, and the process of providing social and health support is complicated.
SHORT COMMUNITY ASSESSMENT IN GORLITZER PARK REGARDING HCV/HBV/HIV

General overview
A brief needs assessment was conducted with ten community members in Görlitzer Park. It showed that a large proportion of migrants and refugees have no knowledge about HIV/AIDS and hepatitis (e.g., with regards to the nature, risks, treatment options and even existence of these infections). In this case, offering HIV and hepatitis testing services brings the risk of participation without a full or at least partial understanding of the consequences in case of a positive result. It is therefore necessary to help members of the target group understand the characteristics of these infections: Why is it important to know about these infections? When do they run the risk of becoming infected? How is testing being done? What are the treatment options? And what does it mean to undergo treatment?

Structure of the assessment
In the needs assessment, the following questions provided orientation and guidance for the interviews:
1. What do you know or have you heard about HIV/AIDS and hepatitis?
2. How can people become infected with these diseases and what does that mean for them?
3. Do you think you can become infected? Why? If yes, have you ever been tested?

Flyer for target groups and peers
<table>
<thead>
<tr>
<th>CLIENT INFO</th>
<th>GENERAL KNOWLEDGE &amp; BELIEFS</th>
<th>DISEASE &amp; TREATMENT KNOWLEDGE</th>
<th>RISK KNOWLEDGE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>COUNTRY</td>
<td>HIV</td>
<td>HEPATITIS</td>
<td>HIV</td>
</tr>
<tr>
<td>29</td>
<td>Gambia</td>
<td>Good-Fair (sex, touching blood)</td>
<td>None</td>
<td>Good (traditional medicine from the president, partner testing from Hausarzt or Gesundheitsamt)</td>
</tr>
<tr>
<td>22</td>
<td>Gambia</td>
<td>Basic (said caused by sex – no firsthand knowledge)</td>
<td>None</td>
<td>None (doesn’t know what kind of disease)</td>
</tr>
<tr>
<td>33</td>
<td>Guinea C</td>
<td>Basic (said caused by sex – no firsthand knowledge. Knows cannot be cause by only contact)</td>
<td>None</td>
<td>None (hears it comes from people)</td>
</tr>
<tr>
<td>32</td>
<td>Guinea C</td>
<td>Good (learnt it in school in Guinea, protection barriers)</td>
<td>None</td>
<td>Good (transmission, PMTCT, treatment)</td>
</tr>
<tr>
<td>22</td>
<td>Guinea B</td>
<td>Fair (but doesn’t believe it exists because hasn’t seen it. Aware of barriers of seeking help)</td>
<td>None</td>
<td>None (doesn’t believe it exists)</td>
</tr>
<tr>
<td></td>
<td>Country</td>
<td>Knowledge</td>
<td>Protection</td>
<td>Prevention</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>26</td>
<td>Guinea B</td>
<td>Fair (knows it is not a good sickness but never seen it. Thinks it can kill. Heard about it in Italy)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>28</td>
<td>Mali</td>
<td>Bad (no experience with it, no information about it, someone grows thin when they have it)</td>
<td>None</td>
<td>Fair (infection through blood and sex, (protection using condom and testing)</td>
</tr>
<tr>
<td>33</td>
<td>Chad</td>
<td>Good (informed, internationally known, prevalent in Africa)</td>
<td>Fair (disease of the liver)</td>
<td>Good (infection pathway but says no medicine)</td>
</tr>
<tr>
<td>29</td>
<td>Sudan</td>
<td>Fair (bad disease, stigmatize, can’t get children</td>
<td>None</td>
<td>Fair (infection through blood and sex)</td>
</tr>
</tbody>
</table>
In-depth results of the assessment

• Knowledge about hepatitis
  Five out of ten respondents mentioned that they were not familiar with hepatitis; one out of these five stated limited awareness, however the concept was totally unclear to him. One respondent affirmed that: “I should not have blood contact with someone from my own family.” The remaining respondents had never heard of it or knew nothing about it. Another respondent stated that he had some knowledge of hepatitis and as an example he mentioned that hepatitis affects the liver. Additionally, he said: “It’s worse than HIV, it doesn’t go away, it’s not a disease you can avoid by using a condom.” He then acknowledged having limited knowledge about the differences between HIV and hepatitis. Another respondent declared that he believed that hepatitis is a traditional disease. He concluded by saying: “A person can get it through traditional religious practices, even without having sex. This can be through female genital contact, either during giving birth or genital mutilation. Hepatitis can also be treated, there is a tree in Guinea-Bissau that people use the herbs of to treat such infectious diseases.” Another person said he had heard about the infection, but had no additional knowledge about it. He offered two examples of his familiarity with the disease from the moment he was still in Gambia. First, he declared that the disease was caused by too much salt. According to him, if people get hepatitis, they will collapse and become paralyzed. Secondly, he said: “I know a woman who was infected and people were running away from her.” He also believed that a woman is unable to give birth to a child if she is infected with hepatitis. However, he did not have more information about this.

• Knowledge and experiences about Fixpunkt test facilities
  Three respondents said that they had never been tested before, although one of them was tested the day he was interviewed at a Fixpunkt mobile service. He tested positive for hepatitis B. Another respondent asked for the address of a location where he could be tested. Seven out of ten interviewees were either tested for the first time upon their arrival in Germany in a refugee camp or at another test location. One of these was a person who was recently tested at Fixpunkt and was given a hepatitis vaccination.

• Opinions regarding services offered by Fixpunkt in Göttingen Park
  All ten interviewees stated that the services offered by Fixpunkt were “very good and useful”. They shared that people come to Fixpunkt mobile facilities to relax, drink coffee, get help (socially and culturally) and share their thoughts and ideas regarding infections, prevention and medical health. One respondent mentioned that “condom distribution is not needed, because with condoms, people are more motivated to have sex, which may cause infections later.” Another respondent said that more food should be offered, because many people are very hungry. One person mentioned that he was so proud and happy with the Fixpunkt health services, because Fixpunkt staff had treated his skin disease years ago while he had not been insured. Without Fixpunkt, this treatment would have cost him a lot of money, which he could not afford.
Epidemiologic overview and hepatitis C prevalence in the regions

West Sub-Saharan Africa:
The countries studied in this region are Benin, Burkina Faso, Ivory Coast, the Gambia, Ghana, Guinea-Bissau, Mauritania, Niger, Nigeria, Senegal and Togo. The average prevalence of HCV is 2.4%, ranging from 1.1% to 5.5%, depending on the country. Countries with the highest prevalence are Guinea-Bissau (5.5%) and Burkina Faso (4.9%), those with the lowest prevalence are Mauritania (1.1%) and Benin (1.6%).

North Africa/Middle East:
The countries studied in this region are Algeria, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syria, Tunisia, Turkey, the United Arab Emirates, and Yemen. The estimated prevalence of HCV in the general population is 2.7%, which corresponds to an estimated 12.7 million cases. The average HCV viraemic rate is estimated at 68.8%, accounting for over 8 million of active HCV replication cases. No adult HCV prevalence and/or viraemic data are available for Jordan, Kuwait, Lebanon, Oman, Palestine, Syria, and the United Arab Emirates. The countries with the highest prevalence are Egypt (14.7%), Iraq (3.2%) and Yemen (2.2%), while the countries with the lowest prevalence are Qatar (0.9%) and Turkey (1.0%).

Central Asia:
The countries studied in this region are Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Mongolia, Tajikistan, Turkmenistan, and Uzbekistan. The average prevalence of HCV in the general population is 5.8%, ranging between 11.3% in Uzbekistan and 2.5% in Kyrgyzstan, with a viraemic rate estimated at 48.7%. No adult HCV prevalence and/or viraemic data are available from Armenia.

South Asia:
In this large region, which includes Afghanistan, Bangladesh, India and Pakistan, the prevalence of anti-HCV in the general population is 2.5%, ranging between 6.7% in Pakistan and 0.8% in India, with a viraemic rate estimated at 78.5%.

Central Europe:
This large region includes countries such as Albania, Bulgaria, Bosnia and Herzegovina, the Czech Republic, Croatia, Hungary, Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, and Slovenia. This region can be characterized by an average HCV prevalence of 1.3%, varying between 1.4% in Slovakia and 0.7% in the Czech Republic, and a viraemic rate estimated at 76.6%. We have not found representative data on the HCV prevalence and/or HCV viraemic rate from published studies in Albania, Bosnia and Herzegovina, Croatia, Macedonia, Montenegro, Serbia, and Slovenia.

Eastern Europe:
The average prevalence of HCV infection in this region, which includes Belarus, Estonia, Lithuania, Latvia, Republic of Moldova, Russia and Ukraine, is 3.1%, ranging from 4.5% in Moldova to 1.3% in Belarus, with a viraemic rate estimated at 69.6%. No adult HCV prevalence and/or viraemic data are available from Estonia.
ANALYSIS OF THE ACTUAL HEALTH SUPPORT SYSTEM. A CASE STUDY ON HEPATITIS B CASES: DIAGNOSIS AND TREATMENT IN GÖRLITZER PARK

According to the experiences of the described cases in this report in Görlitzer Park, the process of organizing treatment and medical and social support is complex. Several hepatitis B-positive cases have been registered in the last few years. The majority of these people arrived in Germany via Italy and are in possession of a residence permit, while some are still in the middle of the asylum process in Germany. During a period of mobile testing that Fixpunkt organized in the health van at Görlitzer Park, Sub-Saharan Africans formed the main group infected with hepatitis B.

People who receive a positive diagnosis must be sent to a specialist (a doctor), where they will undergo a full physical examination. The specialist will test their blood to see if their liver is inflamed. If they have hepatitis B symptoms and high levels of liver enzymes, they will be examined with the Fibroscan. Affected persons must be transferred to the specialist’s office and be accompanied by navigators (Fixpunkt staff) to make sure they have access to the examination, required medical care and equipment to conduct this type of testing.

In general, people who are diagnosed with hepatitis B will receive asylum in Germany and gain access to regular treatment. But the process for undocumented people is always complicated, because they have already lived in Germany without any residence permit, so they do not have formal access to medical care. To get access to treatment, coverage of treatment costs must be secured from complementary organizations (such as Medi Büro).

Regarding the sustainability of treatment of people with hepatitis, it is usually unknown whether their infections are fully treated or not after the treatment process has started. While a limited number of clients do come back regularly for treatment, most do not return. Especially when people are moving back and forth from Germany to other countries in Europe, it is difficult for them to adhere to a regular treatment regimen (with daily doses of medication for several weeks and several doctors included in their treatment). Therefore, nothing is known about the development of their cases.

Information leaflet (pictogram-based) developed in this project.
COMMUNITY EXPERTS MEETING

Fixpunkt experts meeting
From 3rd to 6th of October 2018, a community experts meeting took place at Fixpunkt headquarters with experts from the three regions described in this report. Among the participants were Mat Southwell from INPUD, BerLUN, NHS London, a scientist from Gambia, colleagues from the drug counselling programme for refugees GUIDANCE, and Fixpunkt colleagues from the projects PaSuMi (from Gambia), Mobilix (from Kenya and Germany) and SHUKRAN (from Pakistan). The purpose of the meeting was to discuss the experiences of clients from different countries of origin living in Berlin. The following questions were discussed during the meeting:

- Which HIV and hepatitis programmes and services are available in the countries of origin?
- How is the access of people to these programmes and to the healthcare system?
- How can we adapt messages and interventions to community members, especially those who have had no access to education or who are illiterate?
- Which intervention materials are available for the communities?

SSA region:
In this region, several programmes and services are available:
- VCT: Voluntary Counselling and Testing
  - Voluntary principles
  - Explain advantages of testing
  - “Just a virus, we can do a lot”
- HIV: Rapid screen-POCT (point-of-collection testing)
  - Confirmatory test
  - ELISA (demographic health survey)
- PMTCT (prevention among pregnant women)
  - Positive cases are put on antiretroviral treatment (ART)
  - Infants – before 18 months: (PCR) infancy diagnosis
  - Infants – after 18 months: find confirmatory test
  - 18 months ART during breastfeeding
- HEP C/B Rapid Test
  - Rapid test
  - Anti-hepatitis C test (ELISA, western blot)
  - HBsAg antigen, HBe antibody
  - HsAB post vaccination

Access to these programmes and the healthcare system: HIV treatment is accessible and available in some of the SSA countries (Senegal, the Gambia, Mali, Nigeria, and Central and Eastern African countries). In the Gambia for instance, pregnant women have full access to HIV treatment. There are no special places for HIV testing in this country, however testing can be done in any clinic or hospital, in a regular way and anonymously. In other SSA countries on the other hand, the average viral load is significantly high, but access to treatment is poor as a result of the funding crisis and limited range of facilities. Even when treatment is available, there is often no access due to (1) remote location of facilities and staff limitations or (2) low quality of facilities and poor infrastructure. This stands for most African countries.

The SSA region has access to HBV vaccination since 1980, however the prevalence of hepatitis B is still high. Despite existing intervention programmes to increase vaccination levels, 95% of the population is still not vaccinated.

The barriers they had experienced in Africa continue to exist for migrants and refugees after their arrival in Europe. On an individual level, this leads to the following “side-effects”: fear of discrimination and poor treatment compliance. Their individual psychosocial situation plays a vital role in treatment (e.g., traumata). Sufficient attention should be paid to education and awareness about the importance of treatment, so that they better understand why they have to take their prescribed medicines regularly and until the end of the treatment.

Russian speaking countries:
With regards to harm reduction services in the Russian Federation, it should be mentioned that their availability is limited. For instance, needle distribution programmes or OST programmes are largely unavailable. There is only one NGO in the country that is working in the field of harm reduction. Testing programmes are easily reachable. However, there is no hepatitis treatment available; patients usually
acquire their medicines from India. The Russian Federation registers a very high prevalence (70-80%) of HIV and/or HCV infections in the group of injecting drug users. Women are especially vulnerable. The only support drug users receive is coming from fellow users or drug users activists. They have to support each other due to a lack of services provided by NGOs or the government.

In Belarus, in contrast to the Russian Federation, a harm reduction programme ran until 2015 (Global Fund, OST). In that year, the government stopped the programme and started a broad repression of drug users, which subsequently generated mistrust in the services offered. Only 600 places were available for the OST programme at the time and that meant a waiting period of four to six months. Since then, the number of available places has constantly decreased. In Belarus, there are no harm reduction services available in prisons. Prisoners who are known to have used drugs wear a green patch on their uniform, contributing to stigmatization. Testing facilities are generally available, but there are long waiting lists for treatment. Data from 2014 have shown that the police are actively involved in drug markets and drug trafficking.

MENA region:
Below are summarized data from an assessment of the situation of injecting drug users among the refugee population (mainly from Afghanistan, Pakistan, Iran, and Iraq) in the Berliner Park Kleiner Tiergarten in 2015-2016:
• little knowledge of reduced-risk drug use and transmission routes and personal protection strategies (safer use, blood awareness, hygiene);
• short duration of consumption – switch to riskier forms of consumption;
• multiple bio-psychosocial problems;
• legal uncertainty, language and cultural barriers;
• unregulated drug consumption spots in public spaces (like parks);
• no experience with non-governmental assistance;
• tabooing of drug consumption and addiction;
• traumatization as a barrier to build up a relationship and trust.

Summary
The experts from the different regions agreed that the key to sustainable support is guidance and navigation into the care system through language mediation. There is a high level of distrust towards professional helpers and the care system in all groups. These barriers can be overcome through the use of cultural mediators and peers. Images and language-mediated materials (e.g., picture guided materials, pictograms and/or translated flyers) in group and individual settings are useful for the correct transfer of messages. Providing incentives on the topics of safer use and safer sex, and the availability of high-quality materials in the required amount, support the messages about hepatitis/HIV prevention.

Diversity approaches and intercultural openness can help to reduce the barriers in the respective social and medical institutions in order to better reach the various communities. Awareness among service providers must be created, so that these groups are not stigmatized or re-stigmatized by them. Services that provide outreach, are low-threshold, offer harm reduction and are non-judgemental play an important bridging role. The detailed results of the expert meeting and the peer involvement and peer review are summarized in the following chapters.
**TARGET-SPECIFIC CONTENT AND COMMUNICATION CHANNELS REGARDING HCV/HBV/HIV**

**Recommendations for service providers**
The existing programmes, especially those related to people from the migrant communities and undocumented people with limited or no access to these programmes and the healthcare system in general, are in need of structural changes. These can be summarized as follows:

- **Increase basic knowledge on HIV and hepatitis (perhaps in a wider context of health and the human body).**
- **Emphasize the risks and ways of transmission of the various infections.**
- **Communicate available prevention and protection strategies (harm reduction in the context of drug use, safer sex).**
- **Inform about and accelerate access (normally done through navigation) to various services and facilities, e.g., quick tests and laboratory testing; drug consumption rooms; and tailor-made services including prevention, testing and treatment projects like Mobilix.**

**How to transfer key messages to the communities**
How can key messages and interventions be adapted to suit community members, especially those who have had no access to education or who are illiterate?
To find an appropriate answer to this question, two personal exchanges and several dialogues with international experts were successfully organized during the duration of the project (i.e., at the international experts meeting at Fixpunkt headquarters and at the European Harm Reduction Conference held in Bucharest in November 2018). In Bucharest, the mid-term results of the project were presented. In addition, various participants working with drug users, sex workers and migrants offered presentations and workshops where relevant topics could be discussed. The discussions focused on how to tackle discrimination and stigmatization in these communities. It was also discussed how to implement stable and sustainable fast-track interventions to fight against infectious diseases such as HIV and hepatitis within these communities. Fixpunkt has benefited greatly from these meetings because they were attended by the network of people who work in this field and who generously shared their ideas and experiences. In return, other participants have received examples from Fixpunkt about how they could support community building in similar contexts.
As a result of these meetings, the experts (in Bucharest as well as at the meeting in Berlin) discussed and agreed on the following ways to adapt the interventions and transfer the key messages to the communities:

- **Easy language and use of dialect** (including cultural mediation by natives, transdisciplinary work in teams).
- **Pictograms** (pictorial symbols for words or phrases) and picture-based materials (e.g., ‘Med-guide’).
- **Videos** (including training videos for harm reduction workers) and audio guides in various dialects.
- **Physical demonstrations**, e.g., on how to use a condom and what the human body looks like (using an anatomic model).
- **Distribution and development of incentives**: street-packs for refugees, containing injecting materials, infographics, flyers, safer use/safer sex materials and explanation.
- **Social media** (e.g., to inform about test and vaccination services, needle and syringe programmes).
- **Recreational activities as a context for interventions**: football, theatre, film, radio and music.
- **Kits** (for rapid testing).
- **Outreach and mobile health services in the communities** (to increase accessibility of distribution, counselling, medical treatments).
- **Personal, face-to-face communications**: health promotion interventions among hard-to-reach target groups.
- **Personal navigation into the care system.**

In an interview with a colleague from Deutsche Aids hilfe, she offered a recommendation on how to promote the key messages and interventions among community members: “Make it funny, make it broad and give people responsibilities. Especially social workers: involve peers and people who use drugs in activities with a broader context than harm reduction measures only.”
The pictures show the work being done at the Görlitzer Park location:

- Görlitzer Park team: Information event about HIV/AIDS and hepatitis
- Cultural and language mediators at Görlitzer Park
- The mobile vans at Görlitzer Park
- Intervention material
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

• The prevalence of HIV and hepatitis is sometimes very high and continues to rise (including co-infections) in the countries of origin of the target groups.
• High numbers of migrants pose major challenges to the health care and addiction care systems.
• There is a need for access to adequate low-threshold services and basic medical care, including contact/counselling and testing services. This must be ensured especially for vulnerable groups such as migrants and refugees (consumption/dependency, mentally ill people, people at risk of infection: HIV, HBV/HCV, tuberculosis), through:
  • tailor-made services;
  • cultural mediation; and
  • special navigators (peers or professionals).
• Access to treatment is often difficult or impossible due to legal restrictions. That is why prevention, harm reduction and survival assistance are of great importance.
• Prejudices are a key driver of public opinion on migrants, especially with regards to alleged illnesses in this group.
• It often starts with a one-dimensional, non-objective image and negative reporting in the media (e.g., “Refugees bring infections to Germany”). Discrimination, stigmatization, lack of education, culture and traumatization are important conditions that can limit the success of interventions and the uptake of support services, as well as backward and non-human rights oriented policies.

Recommendations:

• Continuous (low-threshold) presence, relationship building and care are guarantors of successful interventions among hard-to-reach migrant and refugee groups.
• Interventions must be tailored to the needs and requirements of each respective migrant subgroup. The methodological approach must differ per experience (e.g., cultural orientation of services; integration of health themes in an informal context, including joint activities like eating and playing football).
• Collaboration with language mediators, including navigators, in an interdisciplinary team, is effective and a basis for successful services.
• Fast transfer to tailor-made auxiliary services: navigation and accompaniment are important to ensure access to testing, treatment and preventive materials.
• Community work and the involvement of peers are important pillars to enable ‘help for self-help’.
• Service providers must be aware of the reproduction of stigmatization.
• Establishment, stabilization and promotion of transcultural services in the field of HIV/hepatitis for people with a migrant background (since medical care must be accessible to all).