

HIV AND SEXUAL HEALTH SERVICES FOR ETHNIC MINORITY COMMUNITIES

SAFE HAVEN?**Immigration, asylum and HIV**

Naz Project London recently held a national conference "Safe haven? Immigration, asylum and HIV". The following is a summary of the morning panel discussions on relevant policy, legislative and service developments. The panel members were:

Chair: Tom Ojwang (TO),
Hammersmith Fulham
PCT Panel:

Gaenor Bruce (GB),
Barrister, Immigration & Asylum,
Tooks Court

Emma Colyer (EC), Director,
Body & Soul

Neil Gerrard MP (NG), Chair of
All-Party Parliamentary
Group on AIDS

Caroline Seddon (CS), Head of
Science and Education, BMA

Max Sesay (MS), Director,
African Policy Network

Surinder Singh (SS), Royal
College of General Practitioners

Q/ What is being done to speed up applications for asylum seekers? (Health Advisor)

NG: Just to qualify, that I don't represent the Home Office and that I have voted against the last few asylum bills. There is still a backlog, but it is going down anecdotally, the Home Office seems to be running 2 queues; applications that are put in now are being dealt with quickly, even in a matter of weeks in some cases, but they don't seem to be as concerned with the older applications; of course, the Home Office doesn't admit to the 2 queue system the backlog is not as bad as it used to be; with some old cases, the problem has been because of ineffective solicitors, or other reasons, and this has meant that the applicant has lost the right to appeal



GB: I also agree with NG, but there is a further point to consider; a couple of weeks ago the Home Office abolished the Emergency Leave to Remain which HIV often falls under the new category, which HIV could fall under, is Humanitarian Protection this will probably mean further delays because applications will require more in depth examination

NG: This probably means that they may be sent back easier because of the temporary status

GB: The ongoing review process means the Home Office can change the initial decision upon review

continued on page 2



George Alagiah, BBC News presenter and NPL Patron, opens Safe Haven Conference.

COMMUNITY FUND SUPPORTS RESEARCH ON SEXUAL HEALTH NEEDS OF BME YOUTH

This research is the product of a collaborative application between Naz Project London (NPL) and The Trust for the Study of Adolescence (TSA). Funded by the Community Fund (the operating name of the National Lottery Charities Board), over two years, NPL acts as the applicant organisation and TSA as the research partner. A core group of interest to NPL is young people who have not yet, or may have just started, upon their sexual careers.

continued on page 4



Tahera Aanchawan
(NPL Chair)
and **Lisa Powers** (THT)
at Conference

Contents

Safe Haven	1.
Sexual Health and BME youth	1.
Monsoon	4.
Complex needs of BME women	5.
Employment project	6.
Number of volunteers on the rise	7.
Gambling with AIDS	7.
Naz Diary	8.

continued from page 1

EC: At Body and Soul we do see clients experiencing these problems and facing double discrimination because they are dealing with HIV and being an asylum seeker there are problems with treatment and the type of accommodation given to them. Young people are also facing dehumanising situations, often leaving a traumatic situation and then facing another one here in the UK the asylum support system is not empowering or supportive for those who are trying to deal with the system.

CS: First of all, the BMA is against detention centres if looking at dispersal, there has to be appropriate medical care, although at the moment it is being developed and is not up to standard yet. The new centres are supposed to have basic medical care, but this won't be enough for Asylum seekers who need a fully supportive medical care model

Q/ Does the new policy apply to existing applications? (Voluntary Sector Volunteer)

GB: No, just for new ones that fall outside the refugee application system

Q/ What about primary care and the role they have to play, considering that many asylum seekers do access primary care? Also, how does the

voluntary sector and GPs fit in? (NGO Programme Manager)

SS: The strength of the primary care system is that it is available to the whole population; but it is not as simple as that because there is a resource problem (4/5 of GPs in my catchment are closed for new patients) in my own practice, I have taken on asylum seekers and I will continue to do so; it is hard but rewarding. In a recent paper (In journal 'Primary Practice'), GPs were identified as a great way to identify welfare and needy patients - primary care is the place to identify these needs another problem is that welfare advice is hard to access because of awkward hours (only open 5 hours a day in South London) the voluntary sector is important to provide much needed support and GPs can help with the interpretation of medical care for patients - there is a whole host of understanding needed, and GPs can help with this

Q/ When is it too late to apply for asylum? And what to advise if someone is destitute? (Health Advisor)

GB: This is a good question; as of January 8th, the new policy clearly states that if you don't claim asylum as soon as you arrive, you will be left out of social services. The Refugee Council already reported

100 applicants who fall into this category. The Home Office hasn't released a statement about this yet

NG: The Home Office NASS policy bulletin on the internet discusses how this will be interpreted there have been anecdotal cases that even 2 days could be refused I have no doubt that there will be legal challenges to this, but it still won't change things the Home Office will look at individual cases only, which may take time it could take 2 or 3 years for the Home Office to sort this out we already see people who don't fit in the system now, but it will get even more nasty in the future

Q/ Is there mandatory testing for asylum seekers? (Pharmaceutical Company)

CS: No, and the BMA is against mandatory testing; but if a general health exam points to a test, it would be encouraged so that the person could get appropriate care

MS: This issue has been in the media for a while (article in Times) with people supporting mandatory testing. It is possible that sooner rather than later the government will support this - it can't be ruled out

SS: In the clinic, there is a problem of language and furthermore, it is often hard to determine what tests have actually been done on asylum seekers when they come into the country. Why can't there be a one-page summary that is given to the person after they have their health check?

Q/ 1. What about the issue of entitlement to care for asylum seekers? Doctors are coming into conflict with commissioners.

2. There needs to be consistency in policy, otherwise it is forcing people to go underground

3. Need to look into health seeking behaviour - maybe people aren't testing because of policy?

4. How many asylum seekers have been tested? (HIV Consultant)

GB: The main refugee category includes reasons such as nationality/ethnicity/social group/religion/ politics - if an applicant doesn't fall into

those categories, then they could try under article 3 (Human rights)

SS: 1/3 of HIV cases are unknown, so we don't really know what the numbers are; of course you can't test without consent and often there are problems with language/vocabulary

MS: These are difficult areas for African communities - on one hand, the communities are already marginalised, on the other hand, they face another label if they test positive.

Voluntary organisations struggle with financial problems but continue to get more clients because they are being encouraged to test. The problem is that numbers increase and then everyone thinks HIV + Africans are flooding the UK we can't encourage testing and then demonise them

NG: Entitlement to care is a difficult issue, the problem is people whose immigration status is unclear it is hard to get statistics on how many HIV +ve people have been deported; also don't have the numbers of how many asylum seekers are +ve there will never be a policy that says anyone with HIV won't be deported

CS: Have to remember that HIV testing is not just about taking blood; the resources and confidentiality would need to be paramount doctors shouldn't be used as policing agents.

EC: In regards to entitlement to care, different hospitals do have different policies (can be refused); there is inconsistency in policy in both health-care and social services for example, 3 teens were left on their own after their mother died and were told they were going to have to go back to Uganda - this discussion took place at a bus stop.

People don't know what they are entitled to the new sexual health strategy encourages testing, but the money available for social support has decreased the mental health aspect of care is often forgotten, especially with asylum seekers

SS: We are working with the RCGP to encourage GPs to encourage testing with pre-test 'discussion' vs. counsel-

ling, so that GPs feel that they can fit it into their already busy schedules

Q/ What is the policy on disclosing patient's HIV status e.g. for insurance purposes? (Voluntary sector)

SS: The RCGP is very clear; a GP cannot let a 3rd party know about medical information without patient consent if in doubt, don't give information; if form has to be filled out, will have to talk to the patient.

Anecdotally, we know that some GPs do this without patient consent

GB: Letters from the Home Office can insinuate that because the request is coming from the Home Office, they can have access to this information; this is not the case and consent is still needed

Q/ In our experience, we have found that with some patients, finding out about their positive status has helped with their applications - doesn't it depend on what mandatory testing is for (i.e. not to turn them away but to help give good care)? (Consultant)

GB: The Home Office policy is that if there is 'credible medical evidence that if you return, there will be no care' does not guarantee their application will be approved people are being denied even from such places as The Congo the question becomes: can you access ART or palliative care? If there are any of these services, they can be turned down Zimbabwe seems to be okay at the moment (for applicants from there), but this may change depending on political climate

NG: There are other issues such as country of origin, family here etc HIV status can be used as part of the argument if it can strengthen a case, is appropriate and is wanted by the client

EC: Declaring their positive status has helped with some applications, but it is not straightforward are we really in favour of anyone having compulsory HIV testing? Especially in a such a vulnerable group

would we do this to any other group? Have to be careful with this line of thinking

Q/ What advice should we give to overstayers - particularly from the Caribbean? (Health Advisor)

GB: They should attempt to regulate themselves to get their status sorted out. Jamaica is more favourable for applicants from there; if they are gay, they can seek asylum, if +ve, there is no treatment available

NG: It is important for applicants to be careful of solicitors and make sure they are on the approved list from the Home Office.

Q/ Compulsory testing is a racist issue as HIV is seen as an African problem - is this seriously being considered?? (Amrit Wilson)

GB: it is a political issue not one of welfare; e.g. Zimbabwe is in the bad books with UK government right now

NG: We don't know with any certainty whether mandatory testing will happen there have been things in the media (Anthony Brown, Healthwatch UK). Recently, there was the Department of Health paper outlining how people coming to the UK to work in healthcare system in certain jobs will be tested this seems to be all part of a pattern, therefore it is a possibility; it would be a huge undertaking to say the least

Q/ What should we say to patients about whether to disclose their status or not (to the Home Office)? (Health Advisor)

GB: Tell them to contact an appropriate person who is accredited to give advice e.g. list through Law Society etc basically, disclosure isn't going to harm an application.

Q/ At the moment, it is actually harder for people from Zimbabwe because of the new visa scheme there seems to be a clampdown on people applying from Zimbabwe on treatment grounds. Pharmaceutical companies need to work with clinicians to tell the Home Office that one trial doesn't mean treatment is available for all (Lisa Power THT)

Q/ Why is the Home Office in such a bad way? Is it just politics? (Health Advisor)

NG: Populist is popular the Home Office is an administrative disaster area; papers and passports get lost all of the time they are trying to find a legislative solution when the system is the problem much of the time

Q/ With the issue of late diagnosis, isn't there a case for promoting voluntary testing to provide better healthcare? (CDSC)

SS: Yes, the RCGP would like to encourage more testing but once again, it is the devil and the deep blue sea; there is an epidemiological problem that 1/3 are undiagnosed, but can the system handle it?

Kimberley Gray

Community Fund supports research on sexual health needs of BME youth

continued from page 1

To meet this mission, NPL requires accurate and up-to-date data on the sexual beliefs, attitudes, lifestyles and behaviours of these BME youth. Detailed information on the sexual behaviours of these young people is essential to understand their current levels of sexual health, and would help ensure that the services of NPL are targeted to those in greatest need and in the most appropriate manner. However, this crucial information is currently unavailable. The lack of such data has been demonstrated from a literature review of existing research and surveillance data, and further verified through consultation with practitioners and professionals working in this area.

In order to help obtain this detailed sexual health information from BME youth, that is so urgently required, NPL approached TSA to carry out this research. TSA is a registered charity and approved research and training organisation. TSA's primary commitment is to improving the lives of young people and believes that there is a lack of knowledge and understanding about adolescence and young adulthood. TSA is working to close this gap by undertaking applied research, as well as by providing training for professionals and producing and marketing publications for

parents, professionals and young people. TSA's research team is multidisciplinary and focuses upon adolescent health, social action, education and parenting and family life.

The ultimate objective of this research is to identify the sexual health service and support needs of young people from BME groups. To achieve this ultimate objective, the following three immediate objectives will be met:

1. To undertake quantitative and qualitative research to identify, explore and help explain the sexual beliefs, attitudes, lifestyles and behaviours of BME youth aged 15-18 years.

2. To use this information to develop an evidence-based sexual health educational resource suitable for use among practitioners and other professionals working to improve the health and social well-being of these young BME groups.

3. To widely disseminate the research findings and resource throughout the UK.

This project will officially commence in Autumn 2003.

MONSOON

HIV positive Asian women's group

The Monsoon support group was established in August 02, by a group of 5 South Asian women living with HIV. As the client worker at NPL I created the forum for all of them to meet one another in a safe and comfortable space. They said they wanted to create a space where South Asian women could come together and not be in the minority. Many of them had been to other social support groups and found they were often the only South Asian person there and they felt even more on the margins.

The first meeting was at London Lighthouse. The sun was shining. The group members sat in the garden and had lunch. They left the children in the crèche and went out for coffee. Then the women named

the support group Monsoon. And the group began.

The group has met monthly since last August, sometimes meeting in the drop in at Naz Project London (NPL) so the women can have a monthly catch up. Special social trips to the theatre and to museums for specifically Asian themed events such as Bombay Dreams and the Bollywood Exhibition at the Victoria and Albert museum proved very popular.

Eight months on and the good news is the group is still meeting. They have undertaken an article in the national HIV press - Positive Nation - complete with photographs, encouraging other Asian women to come and participate in Monsoon. Connections have been made, friendships have blossomed and a level of isolation reduced. One of the Monsoon members spoke openly about her experiences of living with HIV to a public audience at NPL's Annual General Meeting 2002. This was the first time ever a South Asian woman had spoken on a platform with other HIV positive people.

Although the main language of the support group meeting is English, many other languages are spoken

at the group, e.g., Gujarati, Urdu, Punjabi, Hindi and Swahili. This enables access to support for women for whom English is not their first language.

Growth is slow. To date, only seven women have come and participated in the group's activities. One of the main challenges of co-ordinating a support group is increasing its capacity to accept new members, women with childcare responsibilities, women with limited mobility, women who work, women with limited English and confidence to travel to other parts of London.

For one 3-hour support group, a band of volunteers and facilities are required to execute a successful gathering. Volunteers to pick women up and drop them off at the end of the meeting. A crèche staffed with registered child minders and stacked with toys and stimulating activities. When working with women, it's important to remember that you are often providing a service for a whole family, not just one person. Your organisation, planning and finances have to reflect this inclusive approach if you are to encourage new members to come and access your services.

Capacity building to deliver inclusive services has to be a key priority for any agency involved in service delivery. When working with BME communities there is also the added difficulty of the double edged sword syndrome: there are some members who seek out solidarity by being with other people who are also living with HIV, while other group members are still extremely anxious about confidentiality and do not want to meet other people from their community for fear of stigma and prejudice.

For these reasons, many BME people are reluctant to access services. Certainly this is the message consistently given to NPL by social services departments across London. However the experience at NPL has been that from fledging HIV positive support groups with small memberships like Monsoon to larger ones like Grupo Amigos (Naz Latina), if a well-structured consistent service is provided service users will attend over time and confidence levels will increase.

Parminder Sekhon
Client Support Services
Co-ordinator

COMPLEX NEEDS OF BLACK AND MINORITY ETHNIC (BME) WOMEN

Recently the Public Health Laboratory Service (PHLS) reported that there has been a 30% increase in the last three years among young people contracting Sexually Transmitted Infections (STIs), such as Chlamydia, Gonorrhoea, Syphilis and Genital warts. Unlike men, most STIs are not symptomatic in women and are more likely to remain undetectable thereby putting women at risk of developing Pelvic Inflammatory Disease, Ectopic pregnancy and infertility. Chlamydia is the most common STI among women in England with the highest rates seen in those women under the age of 24. Gonorrhoea has its highest infection rate among women between the ages of 16-19 and Syphilis (which features disproportionately in London) in women of aged 20-24.



Bisrat Yigletu (NPL Women's Sexual Health) and Mohamud Yasin (Co ordinator of Bilan)

An increasing number of people newly diagnosed with HIV have also been seen in the United Kingdom since the late 1990's with a disproportional increase in women in recent years. By the end of September 2002, it has been reported that 11,600 (22%) of the total newly diagnosed were women, 69% of which were from Africa. The number of Afro-Caribbean and Asian women has also been increasing, but at a slower rate than Africans.

To investigate the sexual health needs of BME women, a preliminary survey was conducted by NPL's Women's team. This involved a comparison between Horn of African (HOA) women, which includes Ethiopian, Eritrean & Somali women, and other BME women living in the inner London area. The questionnaire included topics on knowledge of HIV and STIs, accessing information and services, sexual health information targets and religious influence on views and sexual health attitudes.

No significant difference was seen in the level of knowledge on HIV/AIDS between the two groups of respondents but surprisingly 79% of all respondents were not aware of the difference between HIV and AIDS.

When asked about STIs, more than half of the BME women (66%) were aware of the common STIs, Gonorrhoea, Chlamydia, Syphilis, Genital Herpes, Genital Warts and Hepatitis B compared to 30% of the HOA women.

Similarly the BME women were more aware of the different methods of contraceptives than the HOA women; 87% are aware of condoms and 53% aware of femidoms, which are used to prevent HIV/STIs and pregnancy unlike other contraceptives. Among the HOA women, 68% were aware of condoms, while only 16% had heard about femidoms.

Among BME women, 64% have attended a sexual health clinic in the past, of which 70% were under the age of 20, while with HOA women only 39% had previously attended a clinic of which 48% were aged between 21-29. This supports the PHLS report that more teenagers are increasingly accessing GUM clinics. Our research shows that

although BME women have knowledge of STIs and contraception, this did not necessarily mean that they were less likely to be infected. This indicates there are possibly other relevant issues shared by the wider BME women which impact on their sexual practices. These include having low self-esteem and also an imbalance of power in respect of sex with their partners.

The HOA women being less aware of STI/HIV and contraceptive methods would be more likely to be infected and correspondingly would also obtain a late diagnosis, which is a trend shared with other African people. Although all of the respondents have varying religious upbringings, only 30% of the BME and 54% of the HOA women said their religious upbringing has influenced their views and behaviour concerning sexual health. Similarly only 2.2% of the BME and 20% of the HOA women preferred to get sexual health information and advice from religious leaders. More than 50% of both groups of respondents said everyone who has sexual relationship should be targeted with sexual health information and only 2.3% of the BME and 4.5% of the HOA women said that it should be targeted to married couples.

Women are seen as natural carers in society, providing guardianship, control, supervision and protection for children and partners as well as care of the sick and elderly in their communities. However, when it comes to their own health, this is often not a priority due to their time and attention being consumed by the care they give to others.

Women are vulnerable biologically and also as a result of sexual practices which cultural and social norms impose on them. Moreover these same norms often allow men to seek sexual activity outside of the home thus making them more susceptible to acquiring sexually transmitted infections, including HIV.

The conclusions that one can draw from this research are that such young women are being influenced by Western culture and attitudes to sexual health. This naturally sees a weakening of traditional religious influences over sexual behav-

our. Though this could be viewed as a positive, access to drugs and alcohol could also be detrimental to the sexual health practices of some women. NPL identifies from its research that information and advice alone is insufficient in reaching the wider BME women. What is called for is collaborative efforts between the various health service providers to have a holistic view in dealing with BME women clients. Their needs are sophisticated, encapsulating physical, social, mental and emotional considerations about their sexual health as a whole.

Bisrat Yigleu
Women's Sexual Health Officer

'ROUTES INTO WORK':

AN EMPLOYABILITY PROJECT

The Positive futures 'Routes into work' project is a pilot initiative designed to support people living with HIV back into work.

Routes into Work offers 4 ways of supporting people wishing to enter or return to the world of work.

Re-accreditation of existing qualifications - This scheme is aimed mainly at people with overseas qualifications, which require UK accreditation and who may require additional training.

Vocational training scheme - This will provide funding towards the cost of vocational course fees for up to 1 year.

Supported employment scheme - Will provide focussed financial and other support to people who are seeking to enter employment and have a job in mind.

Employer focussed training - This will provide vocational training with employers in recognised skills shortage areas. To be considered for any of these schemes, you must fulfil the following: Living with HIV - Currently unemployed - Citizen of the UK or eligible to live and work in the UK - Not on New Deal - Wanting/ready to return to work

For further information and application details, **please ring 020 8694 2290.**

Or www.positive-futures.org

NUMBERS OF VOLUNTEERS ON THE RISE

On March 2 2003, The Naz Project London ran their first volunteer training programme since the re-launch of their volunteer programme in 2002. Parminder Sekhon and Roiya Rastagar facilitated the session, training a total of nine new NPL volunteers.

Incorporated into the training was a teach-in on AIDS/HIV, aimed at standardising volunteer knowledge of the epidemic. All the volunteers found this information helpful. Many volunteers reiterated that the training course effectively gave them the opportunity to "learn more about HIV and the effect it has on people and their lives."

Volunteers also engaged in a number of activities that presented them with real-life situations they may encounter while volunteering at NPL. These activities were "very helpful and engaging as well as educational."

As one volunteer noted, "The atmosphere was friendly and open." All those involved in the training seemed to enjoy the opportunity the session gave to learn about AIDS/HIV, prepare themselves for their roles at NPL and have a good time.



For further details on the training or opportunities for volunteering at Naz Project London, contact Parminder Sekhon, 020 8741 1879, parminder@naz.org.uk.

Roiya Rastagar

GAMBLING WITH AIDS

The chance of becoming infected with HIV is one of the numerous risks we each face daily. Living in what the German sociologist Ulrich Beck has called our "risk society" we each have to manage these risks mentally or we would never step outside our own front doors!

Politicians have recently played on our perceptions of the risks of terrorism, heightened since the events of 9/11, to justify actions in the Middle East. But for the majority of people in the world, the risk of dying from diseases such as AIDS, TB or malaria is substantially greater than the risk posed by terrorism. There is often a vast gulf between our perceptions and the reality of the risks the world faces. This is what has enabled President Bush to request over \$75 billion from Congress towards the first month of his war, while contributions to the Global Fund to fight AIDS, Tuberculosis and Malaria currently total just over \$3 billion.

At a personal level, managing the risks we face is often a complex process. Delegates at the NPL "Safe Haven?" conference in January

discussed the numerous risks faced by asylum seekers and refugees arriving in the UK. Lack of adequate housing, food and income are risks which are inevitably prioritised over those relating to sexual health and HIV. Even amongst established black and minority ethnic communities, inaccurate perceptions of sexual health risks may encourage individuals to engage in unsafe behaviours.

What lies behind these perceptions of risk?

A series of interviews carried out with some of NPL's South Asian clients revealed some answers. All respondents agreed that South Asians living in the UK generally assume they are not at risk of contracting HIV. This assumption seems to relate to their preconceptions about the 'types of people' for whom HIV is a risk, namely homosexuals, drug users, and prostitutes. Their perception of their own immunity is inextricably linked to the assumption that South Asian communities do not contain these 'types of people'.

South Asians who are gay, lesbian or bisexual are obviously aware that such assumptions about

their communities are false. Consequently, you might assume that these individuals would have a more realistic appreciation of the HIV risk their communities face. Interviews revealed, however, that even amongst gay South Asians perceptions of HIV risk are unrealistically low.

One respondent commented that South Asian gay men, "feel that HIV... is nothing that ever occurs in the South Asian community, [and that] if they keep to their "own kind"... it can't affect them." Despite their good theoretical knowledge about sexual health and HIV, members of the NPL's Masala youth group admitted feeling surprised when it was suggested that some of the people attending Club Kali could be HIV positive.

These findings underline the importance of the work NPL does with South Asian communities in the UK. Rationalising the many risks we face in daily life is a necessary process which enables us to function in the world. But discounting risks to our sexual health on the basis of unfounded cultural stereotypes and assumptions is a dangerous gamble.

Hannah Weston

NAZ DIARY



Khaiser Khan (NPL young men's sexual health advisor)

Naz Latina Support Group

Grupo Amigos, a support group for Spanish-speaking Latin Americans living with HIV/AIDS, meets every month. For further information, contact Naz Latina on 020 8741 1879

DOST friends

Visit NPL'S support group for South Asian, Middle Eastern and North African gay, bisexual and men who have sex with men. DOST is a safe, confidential and informal space to socialise and discuss sexuality, safer sex, drug use, marriage, culture and more. Meet first Wednesday of each month, 7:00pm, at Govinda's Restaurant, Soho St - near Tottenham Court Road station. Call Suki on 020 8741 1879 to find out more.

Kiss group

The Kiss group is for lesbian and bisexual and questioning women of South Asian, Middle Eastern and North African origin. Whatever your age, whether married or single, clear or confused about your sexuality, you will meet women like yourself. We provide friendship and support in a safe environment for women only. The Kiss group meets the last Thursday of every month at the Glass Bar in Euston (opposite Euston train station) from 7:00 - 9:30pm. Call Parminder confidentially on 020 8741 1879. See www.planetkiss.org.uk

Club Kali

An authentic mix of South Asian spices with Bhangra and House, Hindi and Soul, Swing and Arabic flavours. Naz has a stall on the third Friday of each month, with information, advice and resources for your sexual health. Club Kali is on the first and third Friday of each month, from 10:00pm- 3.00am. Venue: The Dome Nightclub, 1 Dartmouth Park Hill, London N19. Nearest tube: Tufnell Park.

Masala

A friendly social support group for young gay and bisexual men, aged 16-25, from the South Asian community. It meets on the second Tuesday of each month, 7:00pm, at Govinda's Restaurant, Soho St, nearest tube Tottenham Court Road. For more information call Suki on 020 8741 1879.



Grupo Vida Pau Brasil

Naz Brasil offers advice and support on HIV, AIDS and sexual health for Portuguese-speaking people in London. Pau Brasil is the monthly support group for HIV-positive, gay men.

Grupo Vida is a support group for Portuguese-speaking HIV-positive heterosexuals.

Contact Naz Brasil on 020 8741 1879 for more information.

Monsoon


Monsoon is a South Asian HIV-positive group for women. Meetings take place once a month. For further information about meeting times and place, call Parminder on 020 8741 1879.

Mardi Gras 2003 Gay Pride

This event takes place 26th July. If you want to march with NPL, call Sukhi 020 8741 1879

Malada

Malada is an Ethiopian Social Support Group for Ethiopian people living with HIV. For further information contact Bisrat confidentially on 020 8741 1879

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