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Better
Health
Briefing

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**HIV prevention
among black
Africans in
England:
a complex
challenge**

John Owuor

A Race Equality Foundation
Briefing Paper

April 2009

Key messages

- 1 Black African communities in England experience the highest reported and undiagnosed heterosexually acquired HIV prevalence
- 2 The majority of black Africans in England are tested for HIV very late; most cases, particularly in men, have a high viral load (i.e. a high level of HIV virus in their body) and are thus unable to benefit fully from available treatment and care
- 3 There are more same-sex relationships than reported among black Africans in England
- 4 The sexual health of the black African communities is dependent on diverse socioeconomic factors
- 5 There are many unmet sexual health and social needs among black African communities in England, making them vulnerable to HIV.

Introduction

This paper is about the HIV epidemic in the context of black Africans in England. It gives an overview of the current epidemiological status, HIV support and prevention needs and recommendations for policy and practice. It focuses on black African communities because they are disproportionately affected by HIV compared to other minority ethnic groups.

Although black Africans make up only about 1 per cent of the UK population, they account for almost half of all new HIV diagnoses in the UK ([Morris, 2008](#); [HPA, 2009a](#)). Apart from high HIV prevalence, their potential to benefit from available treatment and care is limited by many factors, such as late diagnosis, stigma and discrimination, unemployment, poor living conditions and uncertain immigration status for some ([Ibrahim *et al.*, 2008](#)).

Throughout this paper, the term 'black African' is used to refer to people who identify themselves as black African, whether they are nationals of African countries, migrants from Africa or just African descendants.

HIV prevalence among black Africans in England

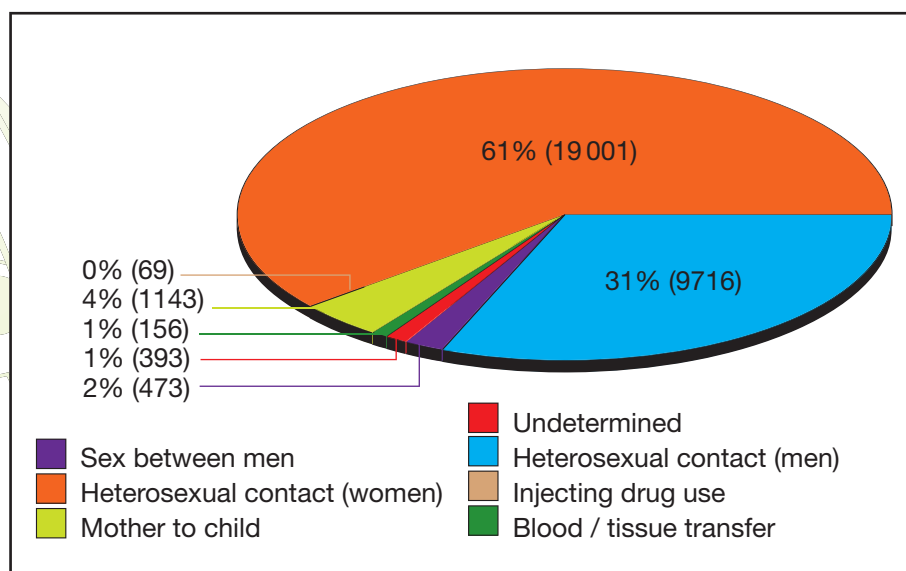
1

HIV prevalence in the UK is low compared to other parts of the world, but is one of the highest in western and central Europe (UNAIDS, 2008). HIV therefore remains a significant infectious disease with profound implications for morbidity and the cost of treatment and care. However, the impact of HIV on mortality in the UK has significantly reduced since the introduction of combination therapy in the mid 1990s (Elford *et al.*, 2008b). This applies only to those who are diagnosed and take up treatment in good time to benefit from therapy.

About 77 400 people were estimated to be living with HIV in the UK by the end of 2007, but a quarter of these (28 per cent) did not know they were actually infected. 7370 new HIV diagnoses were recorded in 2008 (HPA, 2009b). Black Africans are the heterosexual group most affected by HIV in the UK (Elford *et al.*, 2007; Ibrahim *et al.*, 2008; HPA, 2009b). Although most of the infections among this group were acquired outside the UK (mainly in Sub-Saharan Africa, [HPA, 2008a; UNAIDS, 2008]), an increasing number are becoming infected in the UK (Pebody, 2009).

In 2008, 2790 (38 per cent) of the new HIV diagnoses in the UK were among black Africans (HPA, 2009b). This was a decline from a peak of 3976 new HIV diagnoses reported in 2003 (HPA, 2008a). Although the route of HIV exposure is highly dependent on self-reporting and is not easy to establish, Figure 1 shows the mode of infection among diagnosed HIV-infected black Africans up to December 2008.

Figure 1 Pie chart illustrating HIV diagnoses and routes of infection among black Africans in the UK up to December 2008



From HIV data for black African communities in HPA, 2009a

Resources 1

The African HIV Policy Network (AHPN)

has developed 'faith toolkits' to support religious leaders (Christians and Muslims) in their HIV prevention efforts. This is part of the National African HIV Prevention Programme (NAHIP) and the resources can be obtained by contacting AHPN by email: info@ahpn.org, or telephone: 020 7017 8910.

National African HIV Prevention Programme (NAHIP)

For details about the government-funded National African HIV Prevention Programme (NAHIP), visit www.nahip.org.uk

Aidsmap

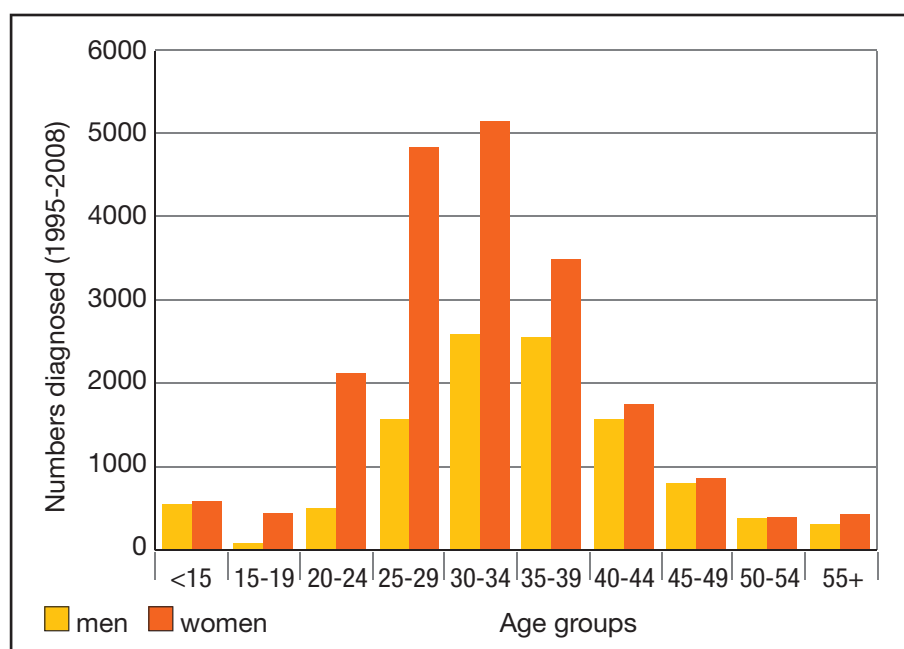
For information on HIV and a list of all organisations delivering services or supporting HIV-related service delivery in the UK and globally, visit Aidsmap at www.aidsmap.com/en/default.asp

AHPN Current campaigns

For current campaigns on HIV issues affecting Africans in the UK, visit www.ahpn.org/campaigns/index.php?camp_id=7%E2%80%9D or www.ahpn.org

The majority of black Africans living with diagnosed HIV in the UK are aged between 20 and 49 years (see Figure 2; [Chinuoya and Davidson, 2003](#); [Dodds et al., 2008](#)). Overall, more women than men have been tested for HIV, possibly through antenatal care to prevent mother-to-child transmission. This suggests the need for testing interventions that target men.

Figure 2 Graph illustrating HIV diagnoses by age group among black Africans in the UK up to December 2008



From HIV data for black African communities in HPA, 2009a

2 Late diagnosis

Evidence suggests that a person in their twenties who starts treatment at CD4 (white blood cells) cell count above 200 copies per cubic millilitre of blood (mm^3) can expect to live to be 70 years old, whereas a 35-year-old who starts treatment at the same level of CD4 cell count can expect to live to be 72 years old. However, those who start treatment with a lower CD cell count will have reduced life expectancies ([Carter, 2008](#)).

Late HIV diagnosis remains a major problem among black Africans in England. In 2007, about 42 per cent of black Africans diagnosed with HIV were diagnosed late ([HPA, 2008b](#)). This compromises their survival chances because evidence indicates that starting treatment with a CD4 cell count below 200 copies/ mm^3 increases the risk of disease progression and death ([Carter, 2008](#); [Gazzard, 2008](#)).

The reasons for late diagnosis among black Africans are not clear-cut, but include persistent HIV-related stigma and discrimination (WHO, 2006). [Fakoya et al. \(2008\)](#) identified cultural, social and structural barriers, such as access to testing and care, fear of death and disease, lack of political will, restrictive immigration policies and lack of African representation in decision-making processes.

In a 2007 survey, [Dodds et al. \(2008, p. 23\)](#) found that many Africans did not test for HIV because they felt they '*had no reason to think they had HIV*'. Other reasons given by the respondents for not testing for HIV included:

- misconception that testing positive would lead to deportation;
- fear of testing positive;
- fear of relationships breaking up after testing positive;
- not knowing where to get tested, which was reported by one in ten respondents;
- fear of changes in life and work or business patterns as a result of a positive diagnosis.

HIV-related stigma also affects HIV status disclosure among black Africans. [Elford et al. \(2008a\)](#) found that, compared to white or minority ethnic gay men, heterosexual black Africans were the least likely to disclose their HIV status ($p < 0.001$) to their partners, family, employers or friends. By not disclosing their HIV status to their employers, such individuals, paradoxically, deny themselves their entitlements under the Disability Discrimination Act (DDA) of 2005. Non-disclosure, especially to partners, can also have legal implications in the light of criminal prosecutions for reckless transmission, which have occurred in England ([Elford et al., 2008a](#)).

Some Africans have come from settings where HIV is thought to be a sex workers' disease, making some people feel less vulnerable. In some resource-limited settings, treatment and care are not universally available and people have seen loved ones die from HIV in the most traumatic circumstances. To such people, positive diagnosis means a death sentence, hence their reluctance to test.

Sexual orientation

3

The needs of homosexual and bisexual Africans are largely unknown ([Chinuoya and Davidson, 2003](#)) or even overlooked ([Paparini et al., 2008](#)). Most black Africans in England came from countries where same-sex relationship behaviour is highly discriminated against, stigmatised and in some cases criminalised. Consequently, there are more same-sex

Resources 2

AHPN Policy issues

For policy issues on HIV and health care, visit www.ahpn.org/policy/index.php or www.nat.org.uk

or www.tht.org.uk/information/resources/policy

The NAZ Project (London)

provides services for African MSM. For details, visit www.naz.org.uk/africanmsm/monya.html

The Terrence Higgins Trust

runs an England-wide programme for young people, called 'Young Leaders', through which young people can be funded to carry out a sexual health intervention project. For more details, visit www.tht.org.uk/howwecanhelpyou/youngpeople/youngleaders

The Terrence Higgins Trust and African HIV Policy Network

through a pan-London partnership will be launching a new website targeting Africans in London. Details will be available at www.tht.org.uk

The website is likely to be operational by early summer 2009.

relationships among African populations than is officially acknowledged ([Population Council, 2008](#)).

Cultural and religious diversity among African communities makes it hard for men who have sex with men (MSM) to pursue their sexual desires openly. Individuals brought up in such discriminatory environments might find it very difficult to disclose their sexuality even if they achieve 'sexual freedom' ([Keogh et al., 2004](#); [Doyal et al., 2008](#)) by moving to Europe or North America, because they still rely on communal networks for social support. When such individuals end up with a positive HIV diagnosis, there is a potential for multiple stigma (HIV, black African, gay/bisexual) ([Positive Nation, 2007](#)).

The black African man who has sex with men in England also faces '*high, but undisclosed, rates of racism among gays and homophobia among Africans*' ([Positive Nation, 2007](#)). This leaves them with limited support options and some end up living a double life ([Positive Nation, 2007](#)). Evidence suggests a discord between stated sexuality and actual sexual behaviour, with a significant number of Africans saying that they are heterosexual when they are involved in same-sex relationships ([Elford et al., 2007](#); [Dodds et al., 2008](#)). In cases where such individuals are asylum seekers, they not only worry about their sexual identities but also fear deportation and lack of treatment in their home countries if they are living with HIV ([Positive Nation, 2007](#)).

[Dodds et al. \(2008\)](#) found that gay and bisexual Africans were more likely to engage in behaviours that increased their risk of contracting sexually transmitted infections, indicating the need for targeted health promotion interventions. Black African MSM test for HIV so late and likewise present for treatment so late, increasing their risk of HIV-related morbidity and mortality ([Positive Nation, 2007](#)).

[Doyal et al. \(2008\)](#) cautioned that although black African MSM in England may come from the same continent, their needs (which are not yet well understood) differ because they migrated for different reasons and from different countries and backgrounds.

4

Sexual health outcomes: the impact of socioeconomic factors

Many HIV positive black Africans face numerous social and economic challenges, making HIV just one of the problems, and of least importance ([Ibrahim et al., 2008](#)). Black Africans in England comprise individuals who identify with numerous nationalities and ethnic roots, and those identities affect

their sexual health attitudes, behaviours and outcomes ([Chinuoya and Davidson, 2003](#); [Dodds et al., 2008](#)).

HIV prevalence among black Africans in England mirrors the prevalence in their native countries. In addition, a person's country of birth can influence the number of their sexual partners ([Chinuoya and Davidson, 2003](#); [Dodds et al., 2008](#)), possibly due to cultural practices in some settings, such as polygamy and wife inheritance ([Owuor, 2008](#)).

Length of stay in England also has a bearing on the sexual health of black Africans. In fact, figures indicate that most black Africans who received HIV tests late had been in England for more than two years ([HPA, 2008b](#)). Evidence further suggests that some black Africans who had lived in England for less than three years did not even know where to go for HIV tests ([Dodds et al., 2008](#)).

For many individuals, the initial years are about meeting basic needs (housing, financial support and securing immigration status) rather than health needs ([Ibrahim et al., 2008](#)). This is a possible indicator that black Africans seeking HIV treatment and care in England are not 'health tourists' ([Gould, 2008](#); [NAT, 2008](#)) as reported in some media (e.g. [Mail Online, 2009](#)).

Many black Africans in England have insecure residency status (those without indefinite leave to remain). This affects their employment possibilities, income, housing and mental health ([Ibrahim et al., 2008](#)). Immigration cases take a long time to be processed by the Home Office. During such prolonged periods of uncertainty, some Africans are forced into sexual risks, such as prostitution, by their circumstances, thus increasing their risk of HIV infection.

In 2004, legislation was passed in England to stop 'health tourism'. Many of the targets of such legislation include failed black African asylum seekers. Such a policy, and the misconception that people are deported for testing positive for HIV ([Dodds et al., 2008](#)), increases not only stigma and discrimination, but also apathy towards HIV testing and health care.

Lastly, studies from the USA have shown that spirituality is important to the psychological health of people living with HIV ([Maman et al., 2009](#)). However, the links between religion and HIV-related attitudes are not yet fully understood ([Zou et al., 2009](#)). Many black Africans in England hold 'strong religious beliefs' ([Chinuoya and Davidson, 2003, p. 22](#)). Christianity and Islam, both of which have a large following among Africans, denounce homosexuality in their teachings ([Doyal et al., 2008](#)). For example, important issues in HIV prevention such as 'sex, homosexuality and drug use are taboo topics in [the] Islamic world' ([Kalkhoran and Hale, 2008, p. 21](#)).

Resources 3

Evidence suggests that the willingness and ability to test for HIV is influenced by the proximity to a testing centre. Whereas there are many HIV testing centres in England, individuals might not easily know where the services are located. The following websites can help locate the nearest sexual health service centres to an individual's post code in England:

www.tht.org.uk/howwecanhelpyou/clinics

or

www.fpa.org.uk/Findaclinic

'The Knowledge, the Will and the Power' (KWP)

All service commissioners, providers and other stakeholders in HIV prevention work involving Africans in England should be familiar with 'The Knowledge, the Will and the Power' (KWP). This is a Department of Health-commissioned plan of action to meet the HIV prevention needs of Africans living in England. It is freely available online at

www.sigmaresearch.org.uk/go.php/reports/african

or

www.nahip.org.uk/newsandevents/index.php?page_id=179

Other studies suggest that membership of some religious subgroups and regular participation in religious services can reduce HIV risk behaviours. Certain identifications - for example, as 'born again' by members of some Christian denominations, or as making 'Tuba' among Muslims - can lead to positive behaviour change ([Trinitapoli, 2006](#)). Religion provides emotional and material support ([Zou *et al.*, 2009](#)) and prayer is used to overcome the shock, sorrow and anger produced by positive diagnosis, which is viewed as God's will by some believers ([Maman *et al.*, 2009](#)).

In recognition of the vital role of religion, the Department of Health (DH) has commissioned the development of faith toolkits (Christian and Muslim). These toolkits have been informed by and developed through the collaboration of various stakeholders in the National African HIV Prevention Programme (NAHIP) and will enable religious leaders to play a major role in HIV prevention among their congregations.

5 Responses and unmet needs: implications for policy and practice

Service and policy responses

The Government, through the DH and the National Health Service (NHS), has instituted structures and programmes to tackle the sexual health problems affecting black Africans in England. For example, in 2004 the DH developed a sexual health strategy aimed specifically at improving the sexual health of African communities ([see DH, 2004b](#)). The Government has also ensured an enabling environment for the establishment of the African HIV Policy Network (AHPN, www.ahpn.org/index.php) to champion HIV and sexual health issues affecting Africans in the UK, as well as for all other organisations involved in the promotion of the sexual health of Africans in the UK.

The DH also supports and funds NAHIP, mentioned in the previous section, which has been managed by AHPN since 2001. In keeping with the White Paper, *Choosing Health* ([DH, 2004a](#)) and the National Sexual Health and HIV Strategy ([DH, 2001](#)), NAHIP is a collaborative programme involving several stakeholders. It is delivered through a partnership involving various community-based African-led organisations jointly called NAHIP partners, who carry out various health promotion campaigns targeting Africans in England at the community level. NAHIP aims to reduce new HIV infections involving Africans by equipping them with the necessary knowledge and skills to enable them to access services and make informed sexual health decisions. Apart

from the national programme, many primary care trusts in England have HIV prevention strategies that target black Africans.

In 2008, the NAHIP partnership (through DH funding) developed an action plan referred to as 'The Knowledge, the Will and the Power' (KWP). This is aimed at all stakeholders interested in reducing HIV infection among Africans in England and is intended to inform and harmonise HIV prevention work involving Africans. During 2009, NAHIP partners will be launching a handbook to help all stakeholders in implementing KWP in their work with African people, again with the help of funding from the DH.

To ensure evidence-based practice and to involve the views of Africans in shaping their sexual health, the DH has, for the past two years, funded national research (BASS line surveys) into the sexual health needs of Africans. The surveys have been carried out by Sigma research (www.sigmaresearch.org) on behalf of the NAHIP programme, and findings for the 2008 BASS line survey will be out by mid summer 2009.

Unmet needs: issues for possible improvement

With due regard for all the efforts and programmes in place, the following recommendations could supplement policy and practice initiatives aimed at improving the sexual health of black Africans in England.

- Late HIV testing and undiagnosed HIV remain a challenge for service providers. All myths and misconceptions about testing and treatment should be challenged in order to encourage testing. More information and education concerning available services, together with more support in regard to these, should be provided, particularly to men and new immigrants. There should be good referral systems within and between organisations.
- Prevention interventions and information should target those with lower education, as well as young black Africans, particularly those in their teens who lack basic information concerning condom access and use and safer sex negotiations, for example. Interventions should also target heterosexual men and MSM.
- There is a need for education in consistent condom use (particularly among men) because many women are vulnerable due to socioeconomic factors and are unable to determine condom use in most cases. In addition, condom distribution, including female condoms (femidoms), should be intensified to increase accessibility.

- People diagnosed with HIV should be involved in the development and implementation of interventions, because they can play a key role in halting transmission and reducing HIV-related stigma and discrimination. However, care should be taken so that their involvement does not lead to further stigma and discrimination.
- Service providers working with Africans should be aware of HIV trends in the countries of origin of their service users, and the local prevalence data in England (borough or council), in order to plan and target their interventions appropriately.
- Since the majority of black Africans belong to various religious faiths, service providers should work with religious leaders to reach wider audiences, and interventions should be sensitive to such religious backgrounds, which have a potential impact on interventions. Some religious leaders might need training in HIV issues.
- Service providers should recognise that there are more same-sex relationships among black Africans than reported, and tailor their services to be more sensitive towards issues of homosexuality and sexual health. Services should seek out gay or bisexual Africans, because they have more unmet sexual health needs and are more likely than heterosexual black Africans to acquire HIV.
- There is a need for continuous information, education and communication on HIV and sexual health, targeting not just black Africans but also the rest of the general population in order to reduce stigma and discrimination, which are undermining the impact of ongoing interventions. Otherwise, there is a risk that HIV will be viewed as a disease of black Africans and men who have sex with men, thus resulting in further stigmatisation - and spread.
- Based on current testing guidelines in England, general practitioners can play a leading role in HIV diagnosis among black African communities. However, this paper acknowledges that this recommendation would face numerous challenges.
- There is a need for continuous research in order to understand the social contexts of HIV among black Africans in England and to develop evidence-based interventions. More funding should be included in programmes such as NAHIP to fund research into lesser known issues, such as the sexual health of black African gay and bisexual men and women.
- Monitoring and evaluation of community programmes targeting black Africans in England should be increased to identify gaps, strengths and weaknesses.

Conclusion

It is hoped that this paper demonstrates to all stakeholders that black African communities in England have a very high HIV-related burden and that in addition to all the good work done so far, a lot more still needs to be done. The omission of details of ongoing prevention efforts within communities is not an oversight; rather, space constraints do not allow their inclusion.

Given the diversity among black Africans in England, and their diverse health requirements, there is a need for multi-agency collaborative work not only to share good practice, but also to harmonise services. This would ensure consistency so that service users have access to seamless services wherever they are within England.

Lastly, the involvement of black Africans, particularly the highly vulnerable subgroups outlined in the strategic documents and various research findings, in all interventions targeting them will go a long way to ensuring the success of efforts. Ideally, their involvement should be at all levels, from decision making to service delivery and evaluation.

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