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Dodds, C; Hickson, F; Chinouya, M; Chwaula, J; Weatherburn, P
(2008) The knowledge, the will and the power: a plan of action to
meet the HIV prevention needs of Africans in England. Technical
Report. Sigma Research, London.

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THE KNOWLEDGE, THE WILL AND THE POWER

A plan of action to meet the HIV prevention
needs of Africans living in England

by the partners of the **National African
HIV Prevention Programme (NAHIP)**

Sigma
RESEARCH

 **African**
HIV Policy Network
empowering African communities affected by HIV

NAHIP 

PREFACE

African people comprise more than half of all those diagnosed with HIV in England every year. This document describes the current state of the HIV epidemic among African people living in England and what changes are required in order to reduce the number getting HIV or exposing others to HIV when having sex.

Funded by the Department of Health and managed by the African HIV Policy Network, the National African HIV Prevention Programme (NAHIP) works mainly with African-led organisations to deliver HIV prevention interventions across England. NAHIP aims to enable Africans to access appropriate information and services to equip them to make informed sexual health decisions and to fight discrimination and stigma.

The NAHIP partner organisations have worked closely with Sigma Research to devise this consensus document. It articulates the central issues for planning sexual HIV prevention interventions targeting Africans living in England. This document describes some of the obstacles to meeting HIV prevention need and focuses on overcoming these barriers in order to achieve change. This document is a plan for action.

Many different people influence sexual HIV transmission to and from African people living in England. They include Africans (with HIV and without HIV), people planning and delivering HIV prevention interventions,

community leaders, health care providers, faith leaders, educators, police, commissioners of services, charitable funders, legislators and researchers – the actions of each can make significant contributions to meeting HIV prevention needs and thereby decreasing the likelihood of HIV transmission.

One of the aims of this document has been to foster a sense of common purpose among a very diverse group of organisations undertaking HIV prevention, treatment and care interventions with African people living in England. The result of this collaborative process is a plan of action that offers a clear and purposeful vision. We are proud of the commitment to partnership that this plan embodies and are hopeful that it will support all those who are concerned with HIV infection and who have the capacity to influence it.

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African Institute for Social Development
African Support and Project Centre
Black Gay Men's Advisory Group
Black Health Agency
Centre for African Families Positive Health
Congoese Youth Association

Community of Congolese Refugees in Great Britain
The Crescent
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Health Action Charity Organisation
London Ecumenical AIDS Trust
MDC Training & Consultancy
National Institute for African Studies

Naz Project London
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Terrence Higgins Trust
Uganda AIDS Action Fund
West African Network Initiative
Youth Projects International

ACKNOWLEDGEMENTS

***The Knowledge, The Will and The Power* was researched, developed and written by Catherine Dodds, Ford Hickson, Martha Chinouya, Jabulani Chwaula and Peter Weatherburn.**

Many individuals within and outside the NAHIP partnership commented on and contributed to the plan at all stages of its development. We are indebted to the following individuals who participated in discussions, offered feedback and gave guidance on the plan (affiliations are those at the time of contribution).

Godwin Yomi Adegbite (Terrence Higgins Trust)
Anna Aguma (Health First)
Mesfin Ali (Ethiopian Community Centre in the UK)
Eddy Aroda (Youth Projects International)
Yusef Azad (National AIDS Trust)
Robert Berkeley (Black Gay Men's Advisory Group)
Thomas Bubi Mukambilwa (African Support and Project Centre)
Georgina Caswell (African HIV Policy Network)
Maria Chimpolo (Lusoginal)
Toju Cline-Cole (The Crescent)
Maurice Cunningham (MDC Training & Consultancy)
Kolade Daodu (The Crescent)
Valerie Delpech (Health Protection Agency)
Ibidun Fakoya (University College London)
Celia Fisher (Leicestershire AIDS Support Services)
Walter Gillgower (African HIV Policy Network)
Robert Goodwin (Department of Health)
Alain Ikete (Community of Congolese Refugees in Great Britain)
Sukainah Jauhar (Lambeth PCT)

Linda Johnson-Laird (Department of Health)
Amdani Juma (African Institute for Social Development)
Fred Kamugwiina (Organisation of Positive African Men)
Mary Lima (Terrence Higgins Trust)
Maria Loizou (Health First)
Taiwo Makanjuola (African HIV Policy Network)
Simon Mwandepole (Uganda AIDS Action Fund)
David Musendo (London Ecumenical AIDS Trust)
Julian Mushayi (Black Health Agency)
Tina Murphy (Health Action Charity Organisation)
Joe Murray (National AIDS Trust)
John Nakuti (Pan-Afrique Community Centre)
Syson Namaganda (Black Health Agency)
Angelina Namiba (Positively Women)
Peter Nieuwets (West Sussex PCT)
Kay Orton (Department of Health)
Gertrude Othieno (African Culture Promotion)
Wa Gamoka Pambu (Community of Congolese Refugees in Great Britain)
Stephen Penrose (London Ecumenical AIDS Trust)
Elias Phiri (Terrence Higgins Trust)
Krishna Regmi (National Institute for African Studies)
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Rhon Reynolds (African HIV Policy Network)
Sam Robbin-Coker (West African Network Initiative)
Margareth Rungarara (Naz Project London)
Sara Shokai (Leeds Skyline Services)
Ted Taziveyi (Terrence Higgins Trust)
Cheikh Traore (Greater London Authority)
Tamala Weeks (African HIV Policy Network)
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This report is available to download at:
www.sigmaresearch.org.uk/files/report2008a.pdf

Published by Sigma Research ©
March 2008 • ISBN: 1 872956 93 9

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EXECUTIVE SUMMARY

The Knowledge, The Will and The Power is a statement of what we, the NAHIP Partners, plan to do to prevent HIV transmissions occurring during sexual activity among the diverse population of Africans living in England (Chapter 1).

SHARED PROGRAMME GOAL

- Minimise the number of sexual HIV acquisitions and transmissions involving African people living in England.

We describe the size and context of Africans living in England (Chapter 2), the size of the HIV epidemic and the number of new infections occurring (Chapter 3), as well as the behaviours and facilitators of new infections (Chapter 4). We then articulate how the NAHIP partners intend to influence future behaviours (Chapter 5).

STRATEGIC BEHAVIOURAL AIMS

- Reduce the length of time between HIV infection and diagnosis.
- Reduce the number of HIV sero-discordant unprotected intercourse events by increasing the number of times that sex is deferred or declined, by choosing non-penetrative sex and by using male and female condoms.
- Reduce the number of condom failure events by increasing correct use of condoms.
- Reduce ejaculation and the presence of other STIs when exposure occurs by increasing withdrawal and STI testing.
- Increase post-exposure prophylaxis in people sexually exposed to HIV.

PRIORITY GROUPS FOR PREVENTION

1. People with HIV.
2. People in sexual relationships with people with HIV.
3. People with multiple sexual partners.
4. People who have sex with people with multiple sexual partners.
5. People who are or will be sexually active.

The final three chapters describe what is required in order to meet the HIV prevention needs of individual African people (Chapter 6), of NAHIP partner organisations (Chapter 7) and of those undertaking decisions related to policy, planning and research (Chapter 8). Summarised below are the aims that pertain directly to the HIV prevention needs described in the planning section of this document.

HIV PREVENTION AIMS FOR AFRICANS (Chapter 6)

Africans aim 1: Africans reduce sexual HIV risk behaviours in a range of possible ways.

Africans aim 2: Africans decline unwanted sex or have non-penetrative sex.

Africans aim 3: Africans correctly use male and/or female condoms for intercourse.

Africans aim 4: African couples establish and maintain HIV concordancy.

Africans aim 5: Africans with undiagnosed STIs get them diagnosed and treated.

Africans aim 6: Africans who have unprotected intercourse practice withdrawal before ejaculation when partners are not

confident they have the same HIV status.

Africans aim 7: Africans without HIV who are sexually exposed to HIV take post-exposure prophylaxis (PEP).

Africans aim 8: African people in sero-discordant relationships that want to conceive reduce HIV risks in doing so.

AIMS FOR NAHIP PARTNERS (Chapter 7)

Organisational aim 1: NAHIP partner organisations increase the amount of funding they receive to undertake HIV prevention interventions.

Organisational aim 2: Organisations increase the priority given to HIV prevention needs by improving their leadership profile.

Organisational aim 3: Organisations increase the extent to which they collect and utilise evidence in order to better meet HIV prevention need.

Organisational aim 4: Organisations prioritise and promote confidentiality.

Organisational aim 5: Organisations increase the extent to which they work in partnership with HIV-specific, African-specific and other specialist agencies and institutions.

Organisational aim 6: Organisations recruit and retain board members, workers and volunteers who share characteristics and experiences with the target group.

Organisational aim 7: Organisations ensure that workers and volunteers have the skills and attitudes that ensure they are approachable and trustworthy.

Organisational aim 8: Organisations ensure that all board members, workers and volunteers can model frank and open discussion about sex and sexuality.

Organisational aim 9: Organisations ensure that all board members, workers and volunteers can identify which service users' needs they are not able to meet, and make appropriate referrals.

Organisational aim 10: Organisations ensure that all board members, workers and volunteers adhere to clear standards of equality.

POLICY AIMS (Chapter 8)

Policy aim 1: The Department of Health provides strategic and financial support for the appropriate national delivery of HIV prevention interventions for Africans.

Policy aim 2: The Department of Health reconsiders its view on charging irregular migrants with HIV for their treatment and care in recognition that it is a practice that costs more than it saves.

Policy aim 3: The Department for Children, Schools and Families incorporates into the national curriculum, a programme of sexual health and relationships education that reflects the experiences and practices of people of diverse sexualities and backgrounds.

Policy aim 4: Anti-racist and anti-homophobic education initiatives are maintained and extended throughout the education system.

Policy aim 5: All agencies involved in criminal prosecutions for the reckless sexual transmission of HIV (Home Office, Ministry of Justice, Crown Prosecution Services, NHS services and the Association of Chief Police Officers) reconsider and clarify their approaches to such prosecutions in light of the detrimental public health impact that they are likely to have.

Policy aim 6: The Border and Immigration Agency (part of the Home Office) and Offender Health (a part of the Department of Health) increase their actions to ensure prison and detention services meet the HIV prevention, treatment and care needs of inmates of prisons, young offenders institutions and migrant detention centres.

Policy aim 7: The Home Office reconsiders its policy of dispersing asylum seekers across the country in light of the general health and HIV prevention needs that can be met when people are able to socialise and live in areas of their choosing.

Policy aim 8: The Home Office reconsiders its policy of disallowing asylum seekers from seeking legal employment in light of the impacts that this restriction has on health and well-being in general and HIV transmission in particular.

Policy aim 9: Central government departments (particularly the Department for International Development) intensify their roles in the development of international policies and activities that directly and indirectly influence the HIV pandemic.

Policy aim 10: An increase in the proportion of Strategic Health Authorities that include targets for HIV in their planning and performance monitoring mechanisms.

Policy aim 11: NHS commissioners ensure that HIV prevention is adequately resourced, and that such funds are not diverted to help manage shortfalls in other areas.

Policy aim 12: All NHS and local authority commissioners increase consortia commissioning arrangements for programmes of HIV prevention for African people across PCT and local authority boundaries.

Policy aim 13: An increase in sexual health promotion interventions for African people already diagnosed with HIV by HIV care and treatment providers.

Policy aim 14: NHS service providers ensure that HIV prevention interventions targeting Africans are accessible, appropriate and effective.

Policy aim 15: NHS providers reduce the extent to which service users are subjected to discrimination based on ethnicity, sexuality, gender, migration status or HIV status.

Policy aim 16: All clinical staff in primary care, emergency services, specialist care and GUM services (either clinic or community-based) increase offers of HIV tests to African men and women attending for STI screening or presenting with HIV-related illnesses, and seek informed consent for testing.

Policy aim 17: All emergency and GUM services (either clinic or community-based), increase the availability of post-exposure prophylaxis (PEP) to African people (and the sexual partners of African people) that may have been sexually exposed to HIV.

Policy aim 18: Local service providers increase the delivery and commissioning of services which reduce the HIV prevention needs of African people.

Policy aim 19: All local authority and NHS commissioners responsible for HIV and / or sexual health increase their contribution to the national sexual health and HIV evidence base by collecting and making available transparent data for evaluating policy change, including the publication of resource allocations.



OVERVIEW AND CONTEXT

OVERVIEW AND SCOPE

This document is a collaborative plan of action to minimise the number of sexual HIV acquisitions and transmissions involving African people living in England. In this document ‘we’ refers to the National African HIV Prevention Programme partner organisations (called the NAHIP partners) listed in the *Preface*. This is not a statement of everything that all NAHIP partners do but a statement of what we share in common with regard to preventing HIV.

The Knowledge, The Will and The Power states what we will do and how we intend our activity to contribute to our overall shared goal of reducing HIV transmissions. This document describes, in broad terms the chain of influence outlined in Figure 1a.

To approach this task we have attempted to answer the following questions:

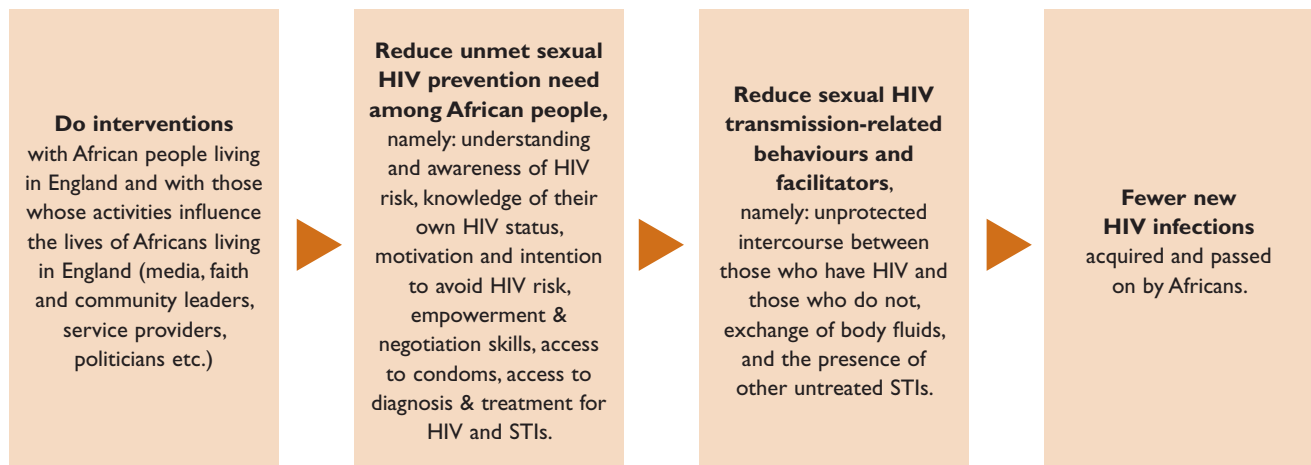
- How many new HIV infections involving Africans are happening in England and which segments of the population are most likely to be involved?
- What behaviours (or inactions) are causing (or failing to prevent) these new infections?
- What are the essential values that support our decisions about how to undertake HIV prevention with Africans living in England?

- What unmet needs (ignorance, lack of motivation, lack of power) facilitate these behaviours (or inactions) and which segments of the population are most likely to have which needs unmet?

Given that sexual exposure accounts for the vast majority of HIV infections diagnosed among African people in England this plan is concerned with preventing future sexual HIV transmissions. The plan does not encompass prevention needs related to mother-to-child transmission, or transmission during needle-sharing or medical interventions. Information and guidance on those modes of transmission can be found elsewhere (see for instance: Audit, Information and Analysis Unit 2007, Health Protection Agency Centre for Infections *et al.* 2006, Department of Health 2004). However, meeting our aims with regard to sexual transmission will have a positive effect on reducing HIV transmission through all other routes.

We are concerned with all people living in England who consider themselves African, irrespective of their country of birth, current nationality, ethnic group or religion, and irrespective of the length of time they have been in England or how long they will stay in the future. This population will include those on short-term visas, with temporary and permanent leave to remain,

Figure 1a: HIV prevention chain of influence



students, asylum seekers, irregular (or undocumented) migrants, those with unresolved immigration applications and British and EU citizens.

We are concerned with the future sexual activity of African people in England. Meeting their HIV prevention needs will increase their ability to avoid HIV transmission with sexual partners in this country, as well as any sexual partners they have elsewhere.

We are therefore concerned with sexually active African men and women and those who will be sexually active in the near future. This includes African men and African women who will have sex with men, women or both. We are also concerned with non-consensual sex. This document does not address unintended pregnancy or other sexually transmitted infections, except where they increase the likelihood of HIV transmission.

We are concerned with African people acquiring HIV during sex and African people passing on HIV during sex. We are therefore concerned with both HIV infected Africans (diagnosed and undiagnosed) and HIV negative Africans. We are concerned with Africans passing HIV to their sexual partners whether or not they have had their own infection diagnosed. This will include Africans acquiring HIV from non-Africans and Africans passing HIV to non-Africans, as African people living in England do not have sex only with other Africans (Chinouya & Davidson 2003). Therefore meeting the sexual HIV prevention needs of Africans will also benefit the sexual health of other ethnic groups. However, this document is directly concerned only with the HIV prevention needs of African people.

The phrase *HIV prevention intervention* refers to any finite, defined and purposeful action intended to meet

HIV prevention needs. The NAHIP publication *Doing it Well* (Pulle et al. 2004) describes best practice in HIV prevention interventions and summarises the uses and shortcomings of different methods. It provides commissioners and service providers with a clear set of choices when undertaking interventions. This planning document plays a different function than *Doing it Well*. Here, we contextualise and explore the **purpose, aims** and the **targets** of HIV prevention interventions, while *Doing it Well* focuses on their **format**.

Even if the level of HIV prevention needs were the same in different groups, some groups may differentially benefit from interventions to meet those needs. No single intervention can meet all HIV prevention need for all Africans. This requires a range of different interventions, coming from diverse sources, all contributing to the overarching goal of minimising HIV incidence. This plan outlines a wide range of activities that organisations delivering HIV prevention for Africans should use when selecting and prioritising aims in their own strategic planning.

Our collective capacity to reduce new HIV infections relies on collaboration between NAHIP partners as well as our working with organisations beyond the partnership, including non-HIV and non-African organisations. Our success rests on the commitment of a diverse group of organisations and individuals with different histories and constituencies, including both large, securely-funded organisations and small community groups. This diversity demands a multi-level approach to realise the goals of HIV prevention. To this extent, every person's contribution to, and support of this vision is crucial.

SOCIAL CONTEXT FOR AFRICANS IN ENGLAND

This chapter describes the broad context of HIV prevention with Africans living in England. As members of a visible ethnic minority, many Africans experience covert and overt racism, particularly in the areas of employment and health care. Migration, public policy, racism and sexism negatively impact on the HIV prevention needs of Africans living in England. This chapter provides the context in which HIV prevention with this population is planned, delivered and received.

When focussing on HIV and the factors that contribute to HIV prevention needs, there is a tendency to represent all Africans living in England as living abject, impoverished and fearful lives. To the extent that available data allows, we try in this chapter to present a balanced perspective on the lives of Africans in the UK – including strengths as well as challenges.

2.1 BLACK AFRICAN IDENTITY

The continent of Africa has 53 countries and several thousand languages and dialects. As a result, Africans living in England comprise a very diverse population on which to target this planning document. Africans living in England comprise people of different colours, with differing religious faiths and practices, political affiliations and migration histories, food and household practices, as well as variety in gender, sexuality, age, region of origin and length of time in England. This means no intervention can be appropriate for all Africans living in England (and no intervention should have 'Africans' as its target group).

The notion of 'Black African' identity is commonly used in HIV prevention policy, programme planning and intervention delivery but there is little clarity about whom or what it describes. Both the validity and the utility of the category 'Black African' is unclear. The term is fuzzy, masking linguistic, national and religious differences and rendering invisible discrete national groups, as well as ethnic groups that are sub-divided within and across geo-political boundaries (Aspinall &

Chinouya 2008). Some people from Africa do not identify themselves as 'Black Africans', instead choosing to describe themselves in terms of nationality (Elam *et al.* 2001). People with one parent of African heritage may not include themselves in a 'Black African' category. 'Black African' may not always be a personally meaningful form of identity, and the group itself is not fixed, being subject to personal choices and experiences underscored by socio-political contexts.

NAHIP partners therefore aim to meet the needs of a population that is, by its very definition, a contested one. The history of many partner organisations is rooted in service delivery for groups of African migrants from particular national and ethnic backgrounds, with founding members often motivated to meet the needs of their fellow expatriates (resulting in the formation of organisations such as Ugandan AIDS Action Fund, Congolese Youth Association, Community of Congolese Refugees in Great Britain and Ethiopian Community Centre in the UK) and those from regions (such as the West African Networking Initiative, and NAZ Project London's services for people from the Horn of Africa). Over time, and as population shifts and funding demands have changed, many partner organisations now define potential service users as anyone who considers themselves African (inclusive of race, country of birth, migrancy *etc.*).

Where we use the term 'Black African' in the remainder of this document – we are specifically referring to research data that uses Black African as a self-selected identity category (for instance, the Census). Otherwise, we use the term 'African' to refer to people who consider themselves African, be they African nationals, migrants from Africa, or direct or indirect African descendants.

2.2 ROUTES TO BEING IN THE UK

Migration into Europe has greatly increased in the last 30 years, from 19 million in 1970 to 33 million in 2000. It has been estimated that by 2002, almost 250,000 people from sub-Saharan Africa had migrated to the UK (International Organization for Migration 2005).

African people enter the UK under a wide variety of circumstances and access arrangements, including:

- Ordinary and business visitors (approximately 640,000 in 2006).
- Work permit holders and their dependants (approximately 12,600 in 2006).
- Student visas (approximately 24,000 in 2006).
- Commonwealth citizens with a UK-born grandparent and eligible for settlement (approximately 2,200 in 2006).
- Spouses or fiancées of UK residents (approximately 7,200 in 2006).
- As persons seeking asylum at ports or in country (approximately 10,300 in 2006).
- As persons who evade border or immigration controls.

(These estimates relate specifically to UK entries by African nationals and were obtained from the Research, Development and Statistics Directorate of the Home Office 2007: Tables 1.1, 2.3, 2.4, and 2.5)

There is little information on the numbers of people leaving the UK after short and long visits, or after having settled in the UK. The numbers of annual arrivals are much higher than those accepted annually for settlement (Office for National Statistics 2004c). The majority of Africans entering the country are visitors who leave. Others are either settled for short-term or long-term settlement, or alternatively, become a part of the irregular migrant population. The majority of African migrants living in England have legal residency status.

Where the following sections focus on those with uncertain or irregular migration status, this is because of a higher level of need among this group. NAHIP provides HIV prevention interventions irrespective of immigration status, in the interests of improved public health among the population of Africans living in England.

2.2.1 Seeking asylum and gaining refugee status in the UK

A refugee is a person who has been granted permission to stay in the UK under the terms of the 1951 Refugee Convention because of a well-founded fear of persecution due to race, religion, nationality, political opinion or membership of a social group. Those who have applied for refugee status (or asylum) are referred to as asylum seekers. Although the British media tends to characterise most African migrants as asylum seekers, the figures given in section 2.2 demonstrate that these only make up a small proportion of African people entering and living in the UK. The numbers of people seeking asylum in the UK reflects the political situation in other countries. In 2002, Zimbabwe was the country from which most Africans sought asylum in the UK. In 2006, of the five source countries with the highest number of asylum applications, only two were African – Eritrea and Somalia (Research, Development and Statistics Directorate of the Home Office 2007). This picture will continually change depending on international and domestic politics.

The proportion of asylum applications that are successful has declined in recent years, leading to a likely increase in the number of irregular migrants remaining in the country (see section 2.2.2 below). In 2006, of the 9,300 applications from Africans upon which a decision was reached, 6,905 (74%) were refused (Research, Development and Statistics Directorate of the Home Office 2007: Table 3.3). Acceptance rates vary by the nationality of the applicant and changing political situations in source countries.

Planners and providers of HIV services have an obligation to provide services to men, women and young people who are seeking asylum or who have refugee status. Wilson *et al.* (2007b) report a range of forces that shape the health of asylum seekers and refugees, including: experiences of persecution; rape and sexual violation; overcrowding and poor quality housing; racism and hostility in the media; and difficulties in communicating their needs.

Health planners in the UK have often been confused about the rights and entitlements of asylum seekers to free primary and secondary care treatment. According

to the Department of Health (2007) asylum seekers with pending applications, including appeals, are entitled to free primary and secondary health care services. Failed asylum seekers who have exhausted the process of appeal can gain free HIV testing and counselling but are required to pay for treatment, including HIV drugs unless the course of HIV treatment began before any appeal processes ended, in which case the HIV treatment remains free as long as the individual remains in the UK (Department of Health 2007b).

2.2.2 Irregular migrants

Irregular migrants are people who are liable for deportation for issues related to their immigration status (Farrant *et al.* 2006). The Home Office estimates that there are approximately 430,000 irregular migrants in the UK (Woodbridge 2005). This estimate includes those who were never given valid leave to enter the country, whose leave has expired, or whose asylum applications have been unsuccessful. Some irregular migrants will be African, although numbers are unknown.

The majority of African migrants living in the UK are legally entitled to full residency and / or citizenship and all of the social and economic benefits that accompany legal status. In contrast, the lives of irregular migrants are generally characterised by destitution, which directly impacts on the extent to which their HIV prevention needs are met. Charities supporting migrant populations (upon whom the burden of support has fallen) have protested that migration policy has served to deny such individuals their most basic human rights (Refugee Council 2004, Kelley & Stevenson 2006). The lack of legal status leaves irregular migrants vulnerable to financial exploitation by employers, resulting in unsafe conditions and poor pay (Farrant *et al.* 2006). Individuals in such circumstances might be particularly unwilling to access health promotion interventions, given their fear that any contact with 'officialdom' may lead to arrest, detention and deportation. Nonetheless, many community organisations offering HIV support and prevention provide services to irregular migrants.

Government policy has increasingly focussed on returning irregular migrants (as well as migrants with criminal convictions) to their country of origin. Some of those awaiting deportation are placed in detention

centres (alongside some who await the outcomes of their pending asylum applications). Placing people in detention centres to await deportation denies freedom of movement to people who have often come to the UK for fear of persecution in their home countries. In September 2007, it was estimated that 42% (965 of 2,325) of migrants held in detention in the UK were African (Home Office 2007: Table 14).

Current legal precedent suggests that lack of access to HIV medication is not an adequate argument for leave to remain in the UK (*N v Secretary of State for the Home Department* [2005] UKHL 31). As stated above, NHS charging arrangements stipulate that unless HIV treatment has already begun, irregular migrants diagnosed with HIV in the UK will be charged for their treatment and care (Department of Health 2007b).

2.3 INTERNAL MIGRATION

Africans living in England are concentrated in Greater London (home to three quarters of Africans in the country) and also in Birmingham, Manchester, Leeds and Liverpool. However, the government's policy of dispersing asylum seekers has resulted in many towns with transitional populations of people from a large number of backgrounds, including Africans (Bitel & Kauffman 2005).

From living in London many African people have migrated to surrounding counties to access education, family, employment and community interaction. Africans living in such areas tend to be less aware of sexual health services and providers of sexual health services in these areas report limited competence in dealing with ethnic, linguistic and religious diversity (Chinouya *et al.* 2003, Mayisha II Collaborative Group 2005).

While several NAHIP partners are based in London, others deliver services in and around Slough, St. Alban's, Reading, Doncaster, Nottingham, Leeds, Manchester, Gillingham and Luton. One partner delivers services in eighteen towns and cities across England (as well as Scotland and Wales). The partners do not cover *all* places in England where there are African communities but NAHIPs scope is extensive.

2.4 EDUCATION AND EMPLOYMENT

As a whole, African people are among the most highly educated in the UK, yet some sub-populations of Africans are likely to be among the least educated. For instance, Muslims are by far more likely than those from other religious backgrounds not to have any qualifications (Office for National Statistics 2006).

The healthcare sector provides just one example of the extent to which skilled African professionals benefit the United Kingdom. The number of nurses from other countries applying to the UK register has increased dramatically in the last decade, and in 2003-04 alone included the following numbers of nurses from African countries: South Africa=1689, Nigeria=511, Zimbabwe=391, Ghana=354, Zambia=169 (Nullis-Kapp 2005). The outward migration of skilled professionals from Africa can have severe implications for domestic services and economies. As a result there is now a cap on the number of healthcare workers that are recruited to the UK from countries in Africa and elsewhere.

Higher education statistics from 2001 (HESA 2003) indicated an enrollment of 12,870 full-time overseas students from Africa into UK institutions. In 2006 more than 24,000 Africans entered the UK on student visas. This indicates a large number of African people who enter the country with strong academic and professional aspirations. In addition, the international student market is a significant element of the British higher education economy, with African countries being a major target for recruitment (Universities UK 2006).

Ethnic minorities have higher unemployment rates than White British people (Office for National Statistics 2004a). Despite a general fall in unemployment, these trends have persisted over time (Data Management and Analysis Group 2007, Bourn 2008). Census data from 2001 highlights unemployment rates for women from the Black African, Black Caribbean and mixed ethnic groups (at 12%) were relatively high and around three times the rate for White British women (4%). Where African women were employed, they tended to remain in full-time employment throughout family formation whereas White and Indian women were more likely to be in part-time employment (Dale *et al.* 2004).

African people in the UK are frequently employed in work that does not reflect their educational qualifications (Elam *et al.* 2001). This may be because African qualifications are not always considered to be equivalent to British qualifications. It can be difficult for migrants to attain English recognition of their professional or technical qualifications gained abroad. Those whose first language is not English will also find that gaining appropriate employment can be a significant challenge.

African men and women who have difficulty accessing decent employment in England (whether due to racial discrimination, lack of skills or both) may find themselves isolated and heavily dependent on their partners and extended family. This can damage self-esteem, making people feel that they have lost their identity and their dignity.

For African people living with HIV, poverty creates challenges with everyday activities such as healthy eating and travel (Weatherburn *et al.* 2003, Crusaid 2006).

2.5 FAMILY LIFE

An extended family living in the UK, in Africa, and elsewhere in the diaspora is a common feature of the lives of African adults in the UK. There is often an expectation (particularly for older siblings) to send money to family members back home. These responsibilities can coincide with supporting dependents in the UK. Global remittances make up a significant element of the global economy, including \$300 billion that is sent from the UK to other countries, including many in Africa (Ratha *et al.* 2007).

Many Africans have dependent children. Most children are born to married or cohabiting couples. However, over 45% of Black Caribbean, Black African and mixed ethnicity families were headed by a lone parent, compared with 25% of White families (Office for National Statistics 2005b). Some African children provide informal care to relatives, whereas the need to care directly for older relatives is less common because they frequently live elsewhere (Chinouya & O'Brien 1999).

African family life is diverse, and there is increasing recognition of the roles that gay men, lesbians and bisexuals play as mothers, fathers, brothers and sisters (Lubbe 2007).

A quarter of Black African adults report a spouse / partner living abroad (Mayisha II Collaborative Group 2005). Trans-national living arrangements can involve leaving children behind in the country of origin, and geographical distance makes communication about HIV between family members problematic (Chinouya 2006a, Othieno 2006).

There is a tendency for first generation migrants from Africa to have a strong attachment to values such as family dignity, honour, and respect for the authority of men and of elders (African Issues Group 1999, Chinouya & O'Keefe 2004). African women may be particularly subjected to domestic violence in households where these values are undermined by poverty, instability and stress (Kesby *et al.* 2003, Chinouya *et al.* 2005).

2.6 SEX AND SEXUALITY

Africans reflect the same diversity of human sexuality as most other geographically defined groups of people. Sexual attitudes and practices can differ across African regional, ethnic and religious backgrounds. For instance, as a value system in some regions of Africa, polygamy (having more than one spouse at the same time) plays a significant function in the economic and social life of communities. Although its prevalence in African and diaspora settings has changed over time, polygamy and the existence of multiple concurrent sexual partners continues to be highly valued by some, while being quite far outside the experience of others (Hayase & Liaw 1997).

As in many other communities, open discussion of sexuality in public, or in mixed social settings is a taboo for most African people (Department of Health *et al.* 2004). As is the case among people from a broad range of backgrounds, many African parents tend not to offer information about sex to their children, with this responsibility passing (formally or informally) to other family adults (African Issues Group 1999, Elam *et al.* 1999, Chinouya 2006a) or to peers. Young Africans in the UK find (as do many other young people) that there is often a gulf between a silence at home, sex and relationships education at school, and the apparent sexual freedom displayed in British media and marketing. Muslim men and women can perceive particular social

and cultural distance from prevalent norms relating to sexuality and gender (Camden Primary Care Trust 2007).

Both African men and women often subscribe to patriarchal values about sex, accepting (or rewarding) in men behaviours for which women would be scolded or castigated. Expectations of strong independent men and protected dependent women often result in boys being left to their own devices in terms of sexual development and exploration, while girls are frequently given prohibitive and negative messages about sex (Elam *et al.* 1999).

2.6.1 African homosexuality and African heterosexism

Significant sexual contact between same-sex partners takes place among Africans in Africa as well as in the UK (Mayisha II Collaborative Group 2005, Johnson 2007, Dodds *et al.* 2008). When dealing with same-sex desire and practice, language becomes an ideological battleground. Terms such as 'gay', 'lesbian', 'homosexual' and 'bisexual' mean different things to different people and will sometimes, but not always be chosen by African men who have sex with men (MSM) and women who have sex with women (WSW) to refer to themselves. On the other hand the terms MSM and WSW have been criticised as terms by which heterosexist authorities erase the social context and networks of lesbian, gay, bisexual and transgendered people (Young & Meyer 2005).

Although the human rights of sexual minorities are recognised and protected in the South African Constitution, this has not translated into freedom from violence. In other African countries the state is complicit in persecution (Human Rights Watch & The International Gay and Lesbian Human Rights Commission 2003). Rather than championing the rights of their gay and lesbian citizens, governments justify state homophobia through the existence of societal homophobia. In language, practice, and tradition, heterosexuality is generally portrayed as the only acceptable option for African men and women. This approach is often justified (in both Africa and by Africans in the UK) by identifying homosexuality and gay culture as White and therefore alien to Africa. African

MSM living with HIV in the UK report rejection by families due to the ‘double stigma’ of HIV and homosexuality (African HIV Policy Network 2007a, Doyal *et al.* 2007).

2.6.2 Commercial sex work

African women and men are represented in the commercial sex industry and have been for a long time. Africans who find themselves unable to earn a living wage may turn to sex work. There also exist people-traffickers who entice and trap women and children from a range of countries into sex work in the UK (Home Office & Scottish Executive 2007).

A project in South London found that many female African sex workers were irregular migrants, and they tended to express shame about the work they undertook to survive (Othieno 2006). As a result, many isolated themselves from friends and relatives in the community and socialised exclusively with other sex workers. Need for money meant many did not insist on the use of condoms or negotiate less risky sexual practices with clients requesting unprotected intercourse. Fear of contact with the Home Office means sex workers are unlikely to be registered with a GP and most may be unaware of sexual health services including those that offer HIV testing.

The experiences and needs of African men engaged in commercial sex work remain relatively unknown.

2.7 RELIGION

About two-thirds of Black Africans in the UK are Christian (Office for National Statistics 2005a). People from particular regions in Africa (particularly in the North, and the Horn of Africa) are predominantly Muslim, and Africans accounted for six percent of Muslims in England in the 2001 Census. One-in-six (17.6%) of Africans taking part in the BASS Line 2007 survey identified as Muslim (Dodds *et al.* 2008).

There is a considerable amount of attention being paid to the potential for HIV prevention interventions in faith-based settings (African HIV Policy Network 2007b). Such work starts from the standpoint that faith-based approaches to mutual care and responsibility often share much in common with health promotion

approaches. However, there are also considerable challenges to interventions in such settings, given religious prohibitions against sexual activity that is pre-marital, extra-marital or non-procreative. Some African faith leaders hold conservative views on same sex relationships (particularly between men) and are disinclined to support men who have sex with men (MSM) with HIV. However, many are willing to support heterosexuals and children affected by HIV in order to reduce the stigma associated with the disease (Chinouya & Muza 2007).

Many Africans living with HIV find that prayer is a source of strength, and many report that their religion plays an important part in taking their medication as prescribed (Chinouya & Davidson 2003). Africans with HIV often identify church as a supportive place but do not share their diagnosis with faith leaders whose preaching about HIV generates and compounds stigma (Chinouya & O’Keefe 2005).

2.8 HEALTH STATUS

Similar proportions of Black Africans and White British people report having a long-standing illness or disability. Among Black Africans, women are more likely than men to report long-standing illness (Office for National Statistics 2004b). Many men (including African men) access health care services only when acute need arises.

Black people (Africans and Caribbeans) are three times more likely to be admitted to mental health hospitals than other ethnic groups, more likely to have been admitted under the Mental Health Act or through the criminal justice system and, once admitted, are more likely to be restrained and isolated (Health Care Commission 2006).

Migration reduces relative economic and social power. Migrants often have complex social care, support and health-related needs. Health is severely compromised by experience of conflict, poverty, trauma, and the presence of communicable diseases in the country of origin (Health Protection Agency 2006) and can also be exacerbated by conditions of arrival, reception and settlement (especially inadequate housing). Access to all services, including health services, tends to be diminished for those whose first language is not English.

2.9 HIV CONTEXT

Experiences of HIV in Africa inform understandings of HIV in England. Although there is global progress towards universal treatment access, only 28% of people in sub-Saharan Africa who require treatment are currently receiving it (World Health Organisation *et al.* 2007). Without an understanding of the availability of sexual health services and the effectiveness of treatment in England, some African people continue to believe that HIV infection inevitably leads to illness and death. Lacking knowledge of HIV treatments (and therefore not perceiving the benefits of diagnosis and being very fearful of finding out their status) is one of the reasons why some Africans with HIV spend a long time undiagnosed, and have poorer health outcomes.

Misinformation and HIV-related stigma tend to reinforce one another. Past experiences of discrimination and perceptions of anti-migrant and anti-African stigma prevent some Africans from accessing services (Anderson & Doyal 2004, Dodds *et al.* 2004). Little is known about the impact of interventions to reduce HIV-related stigma among Africans (Chinouya 2006b). For many Africans, HIV is associated with infidelity, promiscuity, homosexuality and (consequently) sinfulness. There is some evidence that fear of stigma and discrimination prevents Africans from accessing HIV testing services (Elam *et al.* 2006, Dodds *et al.* 2008), and that the uptake of testing for HIV is relatively low among many Africans despite a higher

utilisation of GP and outpatient care (Burns *et al.* 2008). Stigma also plays a role in the very common perception that HIV happens to ‘other people’.

HIV stigma threatens the most valued means of support in England for Africans – their personal network of migrant African family and community members (Dodds *et al.* 2004). Stigma can result in social rejection, physical hostility and homelessness. Fear of rejection causes some people to keep their diagnosis to themselves, creating a sense of isolation (Flowers *et al.* 2006). Others find that disclosing to loved ones, when they are able to exercise control over the process, results in emotional and practical support.

African women with diagnosed HIV are more likely than their male counterparts to access service and support from statutory providers. African men with HIV can feel isolated and emasculated by ill health and often experience difficulty providing financial support for their family (Anderson & Doyal 2004, Doyal *et al.* 2005). Local networks and support groups for Africans living with HIV are a valuable resource for emotional and information support. Many Africans who are unable to read or understand English receive informal translation support from support group members and staff (Ssanyu Sseruma 2007). At a broader, societal level, interventions to support the mainstream and BME media can help to reduce the extent to which they contribute to HIV-related stigma (African HIV Policy Network 2007c).

HIV INFECTION AMONG AFRICANS IN ENGLAND

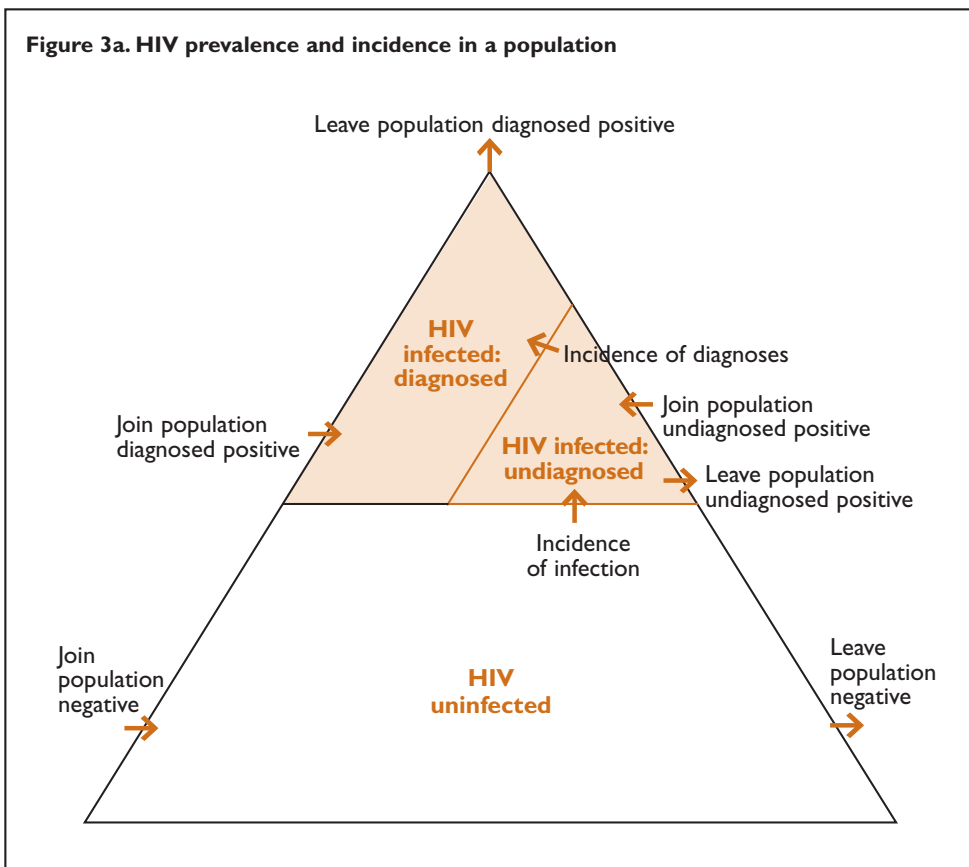
This chapter looks at the size of the African population in England and the scale of the HIV epidemic among that population, as well as the changes in sub-population sizes.

3.1 A MODEL OF CHANGES IN AN HIV EPIDEMIC

The African population in England is in constant change with people moving in and out of the country, both with and without HIV infection. In addition, some Africans living in England are passing on and acquiring HIV. Infection is diagnosed in some Africans while they live in England and others will leave the country (or die) before any diagnosis is made.

Figure 3a. illustrates HIV prevalence (how many people have HIV) and HIV incidence (the rate at which people become infected with HIV). The whole triangle represents the sexually active population of Africans living in England. The population is split into those with HIV infection (the upper triangle) and those who do not have HIV infection. Those with HIV are divided between those who have had their HIV diagnosed, and those who have not yet been diagnosed.

Individuals can join the population by becoming sexually active or arriving in England. They can join the population, with HIV (diagnosed or undiagnosed), or without HIV. Individuals can leave the population by



departure from England, by ceasing sexual activity or by death. They can leave with or without HIV infection.

Within the population, moving from the HIV uninfected section into the (undiagnosed) HIV infected section represents a new infection. These events are the main concern of this document. The second movement within the population is people with undiagnosed HIV infection moving to the diagnosed section by having their infection diagnosed. Diagnoses occur in both people who moved to England with HIV infection and in people living in England who acquire HIV.

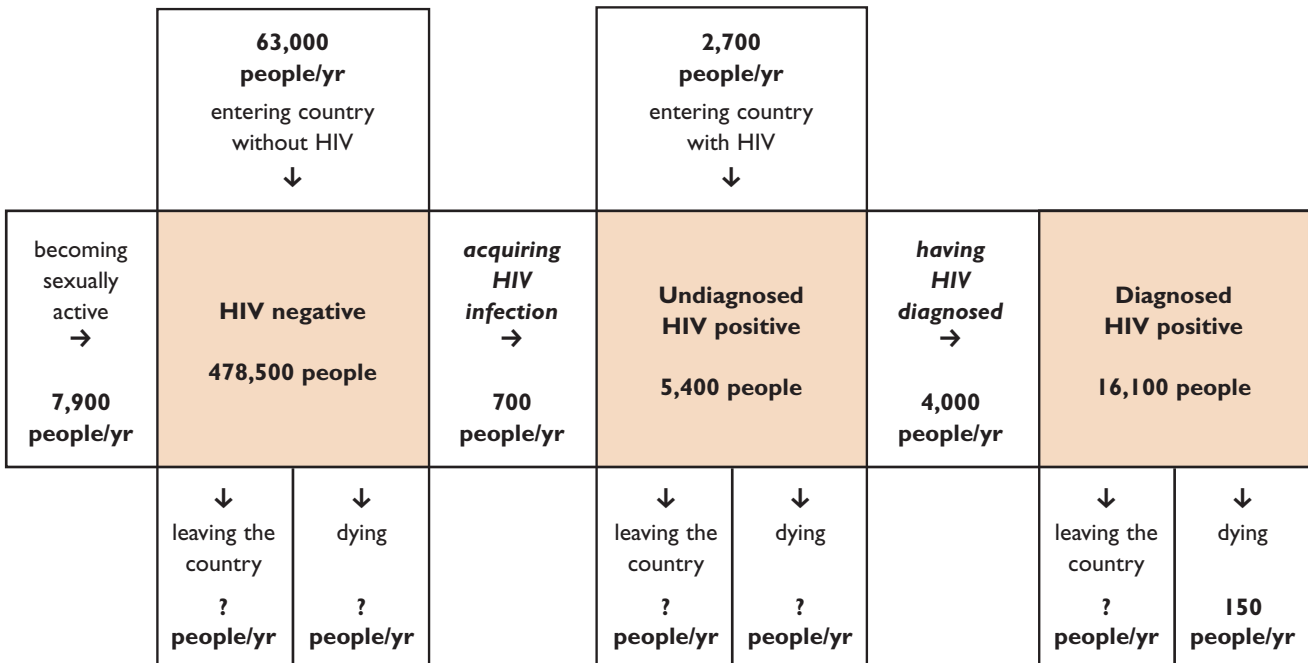
So the number of people with HIV increases as people move to England with HIV and as people in England acquire HIV, and it declines only when people with HIV leave England or die.

3.2 THE SIZE OF THE HIV EPIDEMIC AMONG AFRICANS LIVING IN ENGLAND

Figure 3b. represents the model and puts numbers to the HIV negative, undiagnosed HIV infected, and diagnosed HIV positive sub-populations, as well as the flow of people into and out of these three groups. The figures are for the UK as a whole. As the majority of Africans in the UK live in England it is likely that the majority of those represented in these figures are in England. Also, the figures refer to people born in Africa which is not identical to our population of concern (people who consider themselves African).

The numbers in this figure are approximate and are intended to give an indication of the scale of HIV problems we are facing.

Figure 3b. Approximate size and flow of the African population in the UK and HIV infection
(based on figures from 2005)



3.2.1 Current population sizes

The total number of Africans (approximately 500,000) comes from the Office for National Statistics through the Census. The number of Africans with HIV (diagnosed and undiagnosed) come from the Health Protection Agency's (HPA's) HIV surveillance systems (UK Collaborative Group for HIV and STI Surveillance 2006). In 2005 the prevalence of HIV among Africans living in England would therefore be estimated at 4.3%, of which 75% had been diagnosed.

3.2.2 Joining the population

Although not all young people will become sexually active at a set age, assuming the vast majority start having sex at some point, this number (approximately 7,900) approximates the number of those 10-19 year olds recorded in the 2001 census who are likely to become sexually active in a one year period.

If someone with HIV moves to Britain, when their infection is diagnosed they will be reported as a new diagnosis even if they were previously diagnosed with HIV in another country. For this reason, in figure 3b, there is no estimate for 'moving into the country' directly to the 'diagnosed HIV positive' section. New arrivals with HIV are considered undiagnosed whether or not they know they have HIV.

In 2005 there were 3,366 new HIV diagnoses in African people (which was 51% of all diagnoses made that year where ethnicity was recorded). Adding 51% of the diagnoses where ethnicity was not recorded brings this to 3,903 (HPA and the Scottish Centre for Infection and Environmental Health 2007). We have rounded this number to 4,000.

The HPA estimate that 80% of all heterosexually acquired HIV infections diagnosed in the UK were probably 'acquired abroad'. The way in which clinicians determine where infections were probably acquired is unclear and this means we might underestimate the proportion of infections that are acquired in the UK. We also acknowledge that the category 'acquired abroad' will include both Africans who migrated to the UK with HIV and Africans living in the UK who acquired HIV on a foreign trip. Nevertheless, we have used the estimate of 80% of infections acquired abroad to split

the number of diagnoses in Africans in 2005 into 2,720 which were in people who moved to the UK with HIV and 680 which were acquired by people while living in the UK (whether or not they acquired their infection on a trip abroad). We have rounded this number to 700.

If the prevalence of HIV infection among Africans entering the UK is the same as the prevalence of HIV among Africans already in the UK, then the 2,720 Africans moving to the UK with HIV represent 4.3% of all Africans moving to the UK, which leaves approximately 63,000 Africans moving to the UK *without* HIV.

3.2.3 Leaving the population

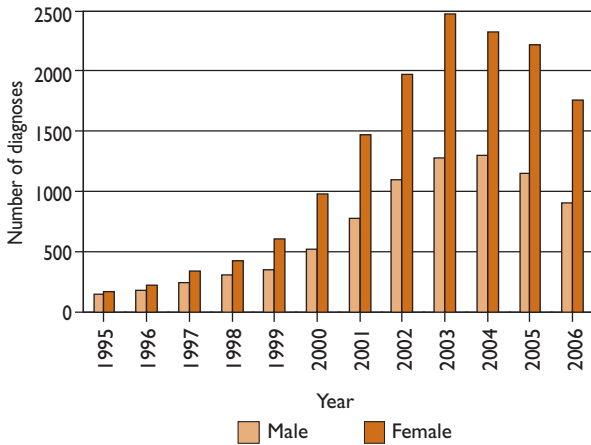
The number of deaths in African people with diagnosed HIV in 2005 (n=150) in Figure 3b. comes from the Health Protection Agency. It is not possible for us to estimate how many African people with or without HIV leave the country in a given period, nor are recent figures on non-HIV related deaths in the population available.

3.2.4 Changes within the population: HIV infections and HIV diagnoses

There is no direct measure of new HIV infections (incidence) among Africans in the UK. Also, our picture of the length of time people live in the UK with undiagnosed HIV is weak. This includes both the length of time between arriving in the UK with HIV and subsequent diagnosis, and the time between becoming infected in the UK and diagnosis.

Information about morbidity at the time of HIV diagnosis does indicate a significant level of clinical need among Africans living in England. It is estimated that 41% of the Black Africans diagnosed with HIV in 2006 had a CD4 cell count below the threshold at which therapy should start (currently 200 cells/mm³), providing evidence of the lag between HIV infection and diagnosis in this population (UK Collaborative Group for HIV and STI Surveillance 2007). This is reinforced by the large proportion of diagnoses among Africans with HIV-related symptoms (Burns *et al.* 2008). Therefore, while we know something of the average time between infection and diagnosis, our understanding of how migration history interacts with the period of time that people live with undiagnosed HIV is severely limited.

Figure 3c. Number of HIV diagnoses among African people made in the UK to the end of June 2007 by gender and year of diagnosis.



(Source: Health Protection Agency Centre for Infections & Health Protection Scotland, 2007: table 10)

Ethnicity has been collected for new HIV diagnoses since 1995. Between 1995 and March 2007 there had been 23,157 HIV diagnoses in Black African people (see figure 3c.). Of these: 21,698 were sexually acquired; 37 through injecting drug use; 964 mother-to-child; 126 through medical procedures; and 332 had an undetermined route. So 95% of HIV diagnosed in African people in the UK was sexually acquired.

3.3 THE GENDERED NATURE OF THE EPIDEMIC

Approximately twice as many African females as males are diagnosed with HIV in the UK each year. While women are more likely than men to be in contact with medical services where the opportunity for HIV testing is increased, this does not provide an explanation for

their different rates of diagnosis, as almost all HIV infections will eventually be diagnosed. Therefore, differences in diagnosis reflect differences in the incidence of HIV among men and women. For instance, across most sub-Saharan countries, women with HIV far outnumber men, and three quarters of all women living with HIV in the world are sub-Saharan African (UNAIDS 2006).

Another gendered aspect of the HIV epidemic is its disproportionate impact on African gay men, bisexual men and other men who have sex with men. Among African men in England, men who have sex with men are twice as likely to have HIV than those who do not have sex with men (Mayisha II Collaborative Group 2005). Among men who have sex with men in England, African men are twice as likely to be living with HIV as White men (Hickson *et al.* 2004).

Socio-economic status and behavioural factors provide a partial explanation for the gendered nature of the epidemic. These will include issues such as control over condom use, sexual partner choice, and the ability to negotiate sex that avoids the risk of transmission. Furthermore, it is likely that receptive partners are more at risk than insertive partners. That is, in HIV sero-discordant unprotected vaginal intercourse, an uninfected woman with an infected man is more susceptible to HIV than an uninfected man is with an infected woman, and in HIV sero-discordant anal intercourse an uninfected receptive partner (male or female) is at greater risk than an uninfected insertive partner (by definition male). These biological susceptibilities relate to the area covered by the mucous membranes of the different organs, and the quantity and infectiousness of body fluids involved (vaginal fluids, semen, anal mucus).

INFLUENCING BEHAVIOURS

TARGETING BEHAVIOURS CAUSING NEW INFECTIONS

This chapter identifies the sexual behaviours and facilitators causing HIV acquisition and transmission among African people living in England. The five conditions that are **necessary** for sexual HIV transmission to occur are:

- sexual contact between infected and uninfected partners (what we will call 'HIV sero-discordant sex');
- which includes a sexual act that provides a route for HIV to pass from the infected to uninfected partner (often called 'unsafe sex', for example intercourse without a condom);
- through which a quantity of specific body fluid (semen, vaginal fluids or blood) containing HIV is transferred from the infected to uninfected partner through either a mucous membrane (in the vagina, urethra or anus) or directly to the bloodstream (through broken skin);
- with a sufficient concentration of HIV particles (called viral load) in the bodily fluid of the person with HIV; and
- an uninfected partner who is susceptible to HIV infection (which everyone is).

We now consider each of these conditions in turn in order to separate those causes which we think we can influence from those which we cannot. This results in a set of population level targets and priority groups for interventions.

4.1 SERO-DISCORDANT SEX

All sexual HIV transmissions occur during sex between partners who are infected with HIV and those who are not. That is, for sexual HIV transmission to occur, someone with HIV (diagnosed or undiagnosed) must have penetrative sex with someone without HIV.

Targeting HIV prevention interventions requires that we identify and prioritise those groups that are most likely to participate in sero-discordant sex.

Target Group 1:

The first priority group for HIV prevention with African people living in England is people with diagnosed HIV.

Since they are in the minority, people with HIV have much more opportunity for HIV sero-discordant sex than do people without HIV. Given that HIV infection cannot be cured and that NAHIP partners agree that it is unethical to try to stop people with HIV from having sex, it is vital that the HIV prevention needs of people with HIV are met. Since interventions can only be targeted at people with HIV if they have their infection diagnosed, these people are the first priority group for prevention programmes.

This does not mean that NAHIP partners think people with HIV have *more* responsibility for HIV transmission than HIV negative people, but simply that they have more opportunity for involvement in transmission. As a result, unmet prevention need in people with HIV is more likely to result in new infections than unmet needs in people without HIV. The prevention needs of people with undiagnosed HIV cannot be targeted separately from people without HIV. We therefore want all Africans to know whether or not they have HIV.

- **NAHIP partners aim to influence Africans so that they know whether they have HIV or not through testing for the virus.**

The relationship between knowledge of HIV status and infectivity is described below (section 4.4). HIV testing is a behaviour that has its own associated needs, and these are described in more detail in Chapter 6.

Target Group 2:

The second priority group for HIV prevention with African people living in England are people in sexual relationships with people with HIV.

People in relationships with someone of a different HIV status to themselves have much more opportunity for

sero-discordant sex than people not in such relationships. Many of the 21,500 Africans with HIV in the UK are in sexual relationships with people without HIV. For example, among Africans with diagnosed HIV attending services in North East London, 20% of the heterosexual men were in a relationship with an HIV negative woman and another 14% were in a relationship with a woman whose HIV status they did not know. Similarly, among the heterosexual women with diagnosed HIV, 22% were in a relationship with an HIV negative man and another 18% were in a relationship with a man whose status they did not know (Elford *et al.* 2007).

NAHIP partners agree that it is unethical to attempt to break up relationships where one partner has HIV and the other does not, in order to reduce sero-discordant sex. Similarly, NAHIP partners are not trying to reduce the frequency of sex in HIV sero-discordant relationships. Therefore it is essential that people in sexual relationships with people with HIV have their HIV prevention needs met.

Target Group 3:
The third priority group for HIV prevention with African people living in England are people with multiple sexual partners.

Compared to other ethnic groups, African men have been found to have the highest median number of lifetime sex partners (Fenton *et al.* 2005). Compared to African women, African men are more likely to maintain more than one sexual relationship at the same time (Mayisha II Collaborative Group 2005) and to have new sexual partners when travelling abroad (Fenton *et al.* 2005).

The more sexual partners someone has, the more likely one of their partners will have a different HIV status. So people with multiple sexual partners, such as homosexually active men, commercial sex workers, and people in (formal or informal) polygamous relationships, are more likely to have sero-discordant sex than those with fewer partners. Furthermore, participation in unprotected intercourse while travelling (for instance, on return visits to African countries with high HIV prevalence) may increase the likelihood of transmission (Health Protection Agency 2006). NAHIP partners think

it is feasible and ethical to influence people to reduce the frequency with which they have intercourse with new partners, particularly if they are already in a sexual relationship.

Target Group 4:
The fourth priority group for HIV prevention with African people living in England are the sexual partners of people with multiple partners.

Those who have unprotected sexual intercourse with a man or woman who has multiple sexual partners (either concurrently or non-concurrently) need to be aware that their partner has an increased likelihood of having HIV. This will particularly apply to homosexually active men whose male partners have multiple sexual partners, clients and other partners of commercial sex workers and those in relationships who know or think that their partner may be having sex with others.

Target Group 5:
The fifth priority group for HIV prevention with African people living in England are all other African people who are sexually active, or who will be sexually active in the future.

It is possible for people to choose to reduce their risk of HIV transmission by having sex only with someone they know has the same HIV status as themselves. HIV testing allows people to know *their own* HIV status. However, establishing the HIV status of a prospective sexual partner is more difficult and requires a great degree of trust (see section 6.5). Although people can ask, high levels of undiagnosed infection means there are several thousand Africans in the UK who have not tested HIV positive but who have HIV and are therefore unable to tell a prospective partner of their infection. NAHIP partners are not trying to influence HIV negative Africans so that they are better able to detect and reject HIV positive potential sexual partners.

However, NAHIP partners do think it is possible to influence Africans so that they know whether or not they and their partner have HIV. The needs associated with talking to a sexual partner about their HIV status and testing for HIV are described in chapter 6.

4.2 SEXUAL ACTS PRESENTING A ROUTE FOR TRANSMISSION

Men and women with HIV (whether diagnosed or undiagnosed) can pass HIV to male and female partners through a limited number of sexual acts. There are four sexual organs that can be involved in the acts that transmit HIV: the penis, the vagina, the anus and the mouth. Prevention can occur both through avoiding a sexual act or during an act through the use of a barrier which blocks the body fluid carrying the virus. The acts which NAHIP partners believe are capable of transmitting HIV are shown below.

The number of new HIV transmissions occurring through each of these routes is poorly understood. We think the majority of transmissions occur through unprotected vaginal intercourse (UVI) because this is common and it has a higher probability of transmission than all other acts except anal intercourse (UAI).

Unprotected vaginal intercourse (UVI) is a common behaviour. About half of intercourse events involving Africans are unprotected. Reporting on their last occasion of intercourse, 51% of women reported that it was unprotected, compared to 43% of men (Mayisha II Collaborative Group 2005). Engagement in UVI by Africans with diagnosed HIV is also relatively common: 43% percent of women and 37% of men with diagnosed HIV reported unprotected intercourse in the last year (Chinouya & Davidson 2003). However, the majority had UVI with partners they knew also had HIV. Far fewer Africans with diagnosed HIV engaged in UVI with a partner they did not know to also have HIV. Elford *et al.* (2007) found 6% of men and 8% of women with diagnosed HIV to have done so in the last three months.

The number of HIV sero-discordant unprotected intercourse events could be reduced both by reducing the number of intercourse events and by increasing condom use during intercourse.

Figure 4a. Sexual routes of HIV transmission

FROM...			...TO
<i>How HIV infected people pass HIV</i>	+ve	-ve	<i>How uninfected people get HIV</i>
<i>Men can pass HIV to women...</i>			<i>Women can get HIV from men...</i>
insertive vaginal intercourse	penis	vagina	receptive vaginal intercourse
insertive anal intercourse	penis	anus	receptive anal intercourse
being 'sucked'	penis	mouth	'sucking'
<i>Men can pass HIV to men...</i>			<i>Men can get HIV from men...</i>
insertive anal intercourse	penis	anus	receptive anal intercourse
being 'sucked'	penis	mouth	'sucking'
receptive anal intercourse	anus	penis	insertive anal intercourse
<i>Women can pass HIV to men...</i>			<i>Men can get HIV from women...</i>
receptive vaginal intercourse	vagina	penis	insertive vaginal intercourse
being 'licked out'	vagina	mouth	'licking out'
receptive anal intercourse	anus	penis	insertive anal intercourse
<i>Women can pass HIV to women...</i>			<i>Women can get HIV from women...</i>
being 'licked out'	vagina	mouth	'licking-out'
'tribbing'	vagina	vagina	'tribbing'

4.2.1 Reducing the proportion of sexual sessions that feature intercourse

NAHIP partners consider it both feasible and ethical to reduce the proportion of sexual sessions that feature intercourse. Although many Africans equate 'sex' with 'vaginal intercourse', NAHIP partners believe it is possible to influence people so that they are able to choose non-penetrative sexual acts instead of intercourse if they choose to have sex, especially with a new partner.

- **NAHIP partners aim to influence Africans so that they reduce the proportion of sexual sessions that feature vaginal or anal intercourse (in order to reduce the number of HIV sero-discordant unprotected intercourse events).**

The needs associated with choosing non-penetrative sex are described in Chapter 6.

4.2.2 Increasing male and female condom use

During HIV sero-discordant intercourse, male or female condoms can block the route through which HIV is transmitted. Many Africans are familiar with condoms, given that 40% of African people with diagnosed HIV participating in the Padare project (Chinouya & Davidson 2003) used a condom on some occasion in the last four weeks. NAHIP partners consider it feasible and ethical to increase the proportion of intercourse events that feature male or female condoms.

- **NAHIP partners aim to influence Africans so that they increase the proportion of vaginal and anal intercourse events that feature male or female condoms (in order to reduce the number of HIV sero-discordant unprotected intercourse events).**

The needs associated with using male and female condoms are described in Chapter 6.

4.2.3 Reducing condom failure

A male condom can break when applying it to the penis or during use, and it can slip off during use. In addition to manufacturing errors, condom failures can occur when they are not used correctly. Common behaviours that can cause male condom failure include: using a

condom after its use-by date has expired; damaging the condom when opening it; unrolling the condom before putting it on the penis; using an oil-based lubricant (which damages rubber); not using any oil-free lubricant.

Female condoms (eg. Femidoms) are not degraded by the use of oil-based lubricants and are more durable than male condoms, giving them a longer shelf life. Reducing female condom failure requires: correct knowledge of where and how it is inserted, and ensuring that male and female condoms are not used at the same time (as this increases friction).

NAHIP partners believe it is feasible and ethical to influence all these behaviours and therefore reduce condom failure.

- **NAHIP partners aim to influence Africans so that they reduce the behaviours causing condom failure and increase the correct use of male and female condoms (in order to reduce the number of HIV sero-discordant unprotected intercourse events).**

More research is needed on which are the most common causes of condom failure among Africans living in England. The needs associated with reducing condom failure are described in Chapter 6.

4.3 TRANSFER OF BODY FLUIDS

The body fluid in which HIV is transmitted differs by the sexual act which presents the potential route for transmission. The more of the body fluid that is transferred, the more likely HIV infection is to occur. Preventing infection could occur through preventing body fluids being passed from infected to uninfected partners.

When HIV comes through the penis of an infected man the virus is carried in his pre-cum (pre-ejaculatory fluid) and semen.

- **NAHIP partners aim to influence HIV positive African men so that they avoid ejaculating into their partner if they have unprotected intercourse.**

The needs associated with doing this are described in Chapter 6.

When HIV comes from the vagina of a woman infected with HIV, the virus is carried in her vaginal fluids and in her menstrual blood. NAHIP partners do not think it is feasible to influence Africans such that less vaginal fluid is passed from HIV infected women during sero-discordant unprotected vaginal intercourse. HIV transmission is more likely to occur during UVI between an uninfected man and an HIV infected woman if the woman is menstruating (Mattson *et al.* 2007). NAHIP partners think it is possible to reduce the number of UVI events that occur when HIV infected women are menstruating.

- **NAHIP partners aim to influence HIV-infected African women so that they avoid unprotected intercourse during their period.**

When HIV comes from the anus (of either an infected man or woman) during anal intercourse the virus is carried in anal mucus and, if there is anal trauma, in blood. NAHIP partners do not think it is feasible to influence Africans such that less anal mucus or blood is passed during unprotected anal intercourse.

4.4 INFECTIVITY AND VIRAL LOAD

For HIV to be transmitted in a body fluid, that body fluid must contain sufficient HIV particles to be infectious. During sero-discordant unprotected intercourse, transmission is more likely to occur when the HIV infected partner has a higher viral load (Quinn *et al.* 2000, Gray *et al.* 2001).

Viral load is higher when HIV has been recently acquired (acute infection), when someone becomes ill, and if they have another sexually transmitted infection (STI). Viral load is likely to be lower if the person is on anti-HIV treatments. A recent consensus statement by the Swiss Federal Committee for HIV/AIDS asserted that people with HIV are not sexually infectious if they are treatment adherent, have had an undetectable viral load for at least six months and have no other STIs (Vernazza *et al.* 2008). Although there is international consensus that higher viral load increases infectiousness, there is not a consensus that an undetectable viral load means someone is not infectious (Bernard 2008, Centres for Disease Control and Prevention 2008), not least because a range of co-factors beyond STI infection

are thought to influence the likelihood of transmission. However, HIV diagnosis is the necessary gateway to clinical care and to reduced infectiousness through access to anti-retroviral treatment.

In the second National Survey of Sexual Attitudes and Lifestyles 44% of African women and 36% of African men in the UK reported having had an HIV test at least once (McGarrigle *et al.* 2005). The large proportion of diagnoses among Africans with HIV-related symptoms indicates a long time gap between infection and diagnosis (Burns *et al.* 2008). This is reinforced by the estimate that 41% of the Black Africans who were diagnosed with HIV in 2006 had a CD4 cell count below the threshold at which therapy should start (200 cells/mm³), indicating that their HIV infection had remained undiagnosed for a significant period of time (UK Collaborative Group for HIV and STI Surveillance 2007).

The presence of another sexually transmitted infection in a person with HIV can increase their viral load (Rottingen *et al.* 2001, Celum *et al.* 2002). It is therefore vital that the sexual health of people with diagnosed HIV is maintained through screening for other STIs.

In order to reduce viral load in people with HIV, **NAHIP partners aim to:**

- **minimise the length of time between Africans with HIV migrating to England and having their infection diagnosed.**
- **Minimise the length of time between Africans living in England acquiring HIV and having their infection diagnosed.**
- **Maximise the proportion of Africans with HIV who are successfully taking anti-HIV treatments.**
- **Minimise the length of time Africans with HIV have untreated sexually transmitted infections.**

The needs associated with these tasks are described in chapter 6.

4.5 SUSCEPTIBILITY OF THE UNINFECTED PARTNER

We think that everyone is susceptible to HIV infection. Where the necessary conditions for HIV transmission exist, a person without HIV can become infected. However, not every exposure results in transmission. There are some things that increase or decrease an individual's susceptibility to HIV.

4.5.1 Other sexually transmitted infections (STIs)

The presence of a genital infection increases vulnerability of both men and women to HIV if they have unprotected intercourse with an HIV infected partner. Where an STI results in broken skin in the genital area (such as a chancre or an ulcer), HIV is more likely to be transmitted and acquired (Dickerson *et al.* 1996, Fleming & Wasserheit 1999, Bonell *et al.* 2000).

- **NAHIP partners aim to reduce the amount of time that Africans have untreated sexually transmitted infections.**

The needs associated with STI diagnosis are described in Chapter 6.

4.5.2 Female genital mutilation

The World Health Organisation defines female genital mutilation (FGM) as a range of procedures involving “the partial or complete removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reason”. FGM is also known as female circumcision or female genital cutting. The Female Genital Mutilation Act (2003) prohibits FGM in the UK and the taking of girls or women out of the UK for the procedure. Of the 28 African countries where FGM has been widely practised, half have introduced legislation forbidding it, although application of these laws can be challenging (World Health Organisation 2008).

At least some forms of FGM can lead to chronic problems with delayed healing, urinary tract infections, pelvic inflammatory disease, and genital injury due to vaginal tearing during sex (Brady 1999). All of these features probably leave women with FGM more vulnerable to HIV acquisition, as well as being more likely to pass it on.

NAHIP partners support the legislative prevention of FGM in the UK and elsewhere. The organisations provide advice, referral, and HIV prevention support for women who have experienced FGM.

4.5.3 Harmful vaginal practices

Some methods for cleaning the vagina as well as the use of substances that tighten, dry or heat the vaginal area in preparation for sex can cause increased inflammation and lacerations. Specifically, some practices have been linked with disruption of the vaginal tissues and the loss of healthy vaginal bacteria (Hilber *et al.* 2007). Bacterial vaginosis can result when the chemical balance in the vagina is disturbed. The presence of bacterial vaginosis, alongside other vaginal tissue disruption and lacerations makes the transmission of HIV more likely.

NAHIP partners think there is too little evidence of harmful vaginal practices during or prior to HIV sero-discordant intercourse (Fenton *et al.* 2002, Dodds *et al.* 2008) to make it worth introducing specific interventions to reduce their use. However, awareness of such practices and their potential impact on transmission will be of value to those providing support and advice to people involved in potentially sero-discordant sex.

4.5.4 Male circumcision

Removal of the penile foreskin is thought to reduce the susceptibility of men to sexually transmitted infections, including HIV. A review of observational studies from Africa shows regional variation in HIV prevalence which coincides with male circumcision – areas where males are not usually circumcised were found to have higher rates of HIV prevalence (Bailey *et al.* 2001). Bailey and colleagues argued that the studies were not supported by evidence found in Europe where HIV acquisition among men is associated with injecting drug use and unprotected anal intercourse. This review found a protective effect of male circumcision against HIV infection with a few studies indicating some protective and less a non-protective effect. Prospective studies have also found a protective effect of male circumcision save for confounders such as the degree of circumcision, religions and age of circumcision (Bailey *et al.* 2001). Authors of a randomised controlled trial in South Africa conclude that male circumcision provides a degree of

protection against acquiring HIV infection, equivalent to what a vaccine of high efficacy would have achieved (Auvert *et al.* 2005). Male circumcision is associated with a significantly reduced risk of HIV infection among men in sub-Saharan Africa, particularly those at high risk of HIV (Weiss *et al.* 2000, Bailey *et al.* 2007, Grey *et al.* 2007). No studies on the role of circumcision on HIV prevention have been conducted in the UK.

NAHIP partners are not attempting to increase circumcision among African men in England. They do want to ensure that all Africans know that it is still possible for a circumcised man to acquire HIV through his penis during unprotected intercourse with an infected partner, and that circumcised men with HIV can still pass their infection to an uninfected sex partner during unprotected intercourse.

4.5.5 Post-Exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) involves taking a one month course of anti-HIV drugs starting within 72 hours of exposure to HIV (Fisher *et al.* 2006). PEP decreases the likelihood of HIV infection by inhibiting viral replication following HIV exposure. The sooner PEP is taken, the more likely it is to prevent infection, though it does not prevent infection for 100% of people exposed (Tsai *et al.* 1998, Roland *et al.* 2005). Prompt access to PEP will be most feasible among people who already have some understanding of HIV treatments.

- **NAHIP partners aim to increase awareness and availability of PEP for African people who may have been sexually exposed to HIV.**

4.6 SUMMARY OF AIMS AND PRIORITY GROUPS

4.6.1 Strategic behavioural aims

- Reduce the length of time between HIV infection and diagnosis.
- Reduce the number of HIV sero-discordant unprotected intercourse events by increasing the number of times that sex is deferred or declined, by choosing non-penetrative sex, and by using male and female condoms.
- Reduce the number of condom failure events by increasing correct use of condoms.
- Reduce ejaculation and the presence of other STIs when exposure occurs by increasing withdrawal and STI testing.
- Increase post-exposure prophylaxis in people sexually exposed to HIV.

4.6.2 Priority groups for prevention

- 1 People with HIV.
- 2 People in sexual relationships with people with HIV.
- 3 People with multiple sexual partners.
- 4 People who have sex with people with multiple sexual partners.
- 5 People who are or will be sexually active.

INFLUENCING BEHAVIOURS RELATED TO HIV TRANSMISSION

This chapter reviews the core values and ethical principles that guide the ways in which the NAHIP partners seek to influence behaviours related to HIV transmission. It presents a theoretical approach to influencing HIV transmission-related behaviour that is informed by the shared ethics and values of NAHIP partner organisations. Chapter 6 describes the specific HIV prevention needs NAHIP partners want to address.

In order to reduce the number of HIV transmissions to and from Africans living in England, NAHIP partners agree that the selection and implementation of HIV prevention interventions requires sound evidence where possible, as well as practical experience and logic. All information or data, in the process of becoming evidence, must be placed within a theory, which is in turn tested by practice and proof.

Which theories we start with, and therefore what data we collect to test them, is guided by our ethics and values. For instance, we can imagine that at a population level, if everyone was force-fed a daily dose of vitamins, this might improve health. However, such an approach runs counter to basic rights and freedoms (such as the freedom to control one's own body) and it would be rejected as a public health option, regardless of its possible effectiveness.

5.1 NAHIP PARTNERS RESPECT CHOICES AND PROMOTE HUMAN RIGHTS

If health is a fundamental human right, it follows that sexual health and well-being is also a basic human right. Good health stretches beyond just the avoidance of illness, and good sexual health extends beyond the management of STI and HIV risk.

Sexual and reproductive health and well-being involves the ability to freely participate in the enrichment that sexual activity can bring, including: pleasure, sensuality, intimacy, conception and emotional expression (World Health Organisation 2006). Ensuring that people's sexual

and reproductive health needs are met can go a long way toward meeting HIV prevention goals.

Health promotion is the process of enabling people to increase control over, and to improve their health.

Ottawa Charter for Health Promotion
(Canadian Public Health Association *et al.* 1986)

Sexual desires and practices are diverse. In accordance with their sexual rights, different people place different importance on sex and they express their sexual desire in different ways. For example:

Some people prefer to have sex often, some prefer to have sex rarely and some prefer to never have sex (or abstain).

- Some people prefer sex with only one partner, some like to have sex with many partners.
- Some people equate sex with intercourse, some see intercourse as one thing that can be included or not included when they have sex.
- Some people (some of the time) will aim to conceive children when they are having sex, and others will never use sex for reproductive ends.
- Some people find intercourse with condoms better than without them, others find condoms reduce the pleasure of intercourse and others find they ruin it.

The highly diverse population of Africans resident in England do not approach sexual contact, intercourse, reproduction or condom use in a single way, or attach to these things the same degree of importance, nor would we expect them to.

Health promotion fosters conditions in which people have the maximum control over their own lives. In the broadest sense, health promotion interventions work towards the continual improvement of the fundamental conditions for health, which include: peace, shelter,

education, food, income, ecological stability and equality. The more social stability and equality there is across a given population, the more likely it is that health and sexual health needs are met, and the more likely it is that interventions to improve health will be accessed and implemented by people who need them. Where basic needs are met and human rights are prioritised, individuals are more able to make informed decisions about their sexual lives.

5.2 NAHIP PARTNERS INCREASE THE CONTROL AFRICANS HAVE OVER HIV TRANSMISSION IN THEIR LIVES

People make sexual choices every day, usually in conjunction with their sexual partners. Health promotion interventions can only indirectly influence sexual decision-making. It is not possible for us to control the sexual behaviour of African people in England. Successful interventions will be based on increasing the control that people have over their own behaviour.

Health promoters are responsible for improving people's knowledge, power and motivation. The responsibility for sexual decision-making belongs to the people who have sex. In health promotion the ends do not justify the means – NAHIP partners do not bully, intimidate, stigmatise or misinform people in order to reduce their HIV risk behaviours. Denying people information and resources to restrict their options or influence the decisions they may make, is a breach of sexual rights.

African people in England who want to reduce their risk of acquiring or passing on HIV require a clear path that will help them do so. Different people will require different paths – that is the nature of diversity. Effective health promotion enables people to determine the right path for themselves. It can also help them to reflect on whether changing their social, emotional or material circumstances could provide them with a better grounding for reaching their goals.

Acknowledging people's freedom to make decisions does not stop health promoters from being clear about the relative effectiveness of different means of reducing HIV transmission risk. Indeed, one element of quality

prevention includes unambiguous, accessible guidance on avoiding HIV risk. People should be encouraged to examine the potential consequences of their actions, while being given the opportunity to acquire the skills, confidence and resources to increase the control they have over their sexual lives.

There is a difference between making authoritative statements about the most sure ways of avoiding HIV transmission and making normative or judgmental statements about *right* and *wrong* ways to behave. NAHIP partners enhance trust in their own expertise by their use of clearly evidenced information, their professionalism and their capacity to reduce unmet need. Partner organisations do not employ tactics that make people feel chastised or judged for their sexual behaviour, or for any other aspect of their life, nor do they diminish one group in order to achieve a particular aim for another. In this way, NAHIP partner organisations' practices resist the stigma that is often associated with HIV.

Gathering an evidence base requires assessment of the needs of individuals and groups. Which services are useful to people often depends on their prior knowledge and experience as well as their current circumstances and abilities. For example, information for young people who are not yet sexually active should differ from information for couples who are considering conception – one single intervention can never meet everyone's HIV prevention needs.

5.3 NAHIP PARTNERS RECOGNISE THAT THERE IS NO SINGLE AFRICAN CULTURE

The experiences and viewpoints of particular groups are often described under the umbrella heading of *culture*. This results in concepts such as *youth culture* or *African culture* being used to categorise and account for a diverse set of behaviours. Yet the idea of a singular *culture* is largely an illusion, masking differences between people. The idea of a singular *culture* can also freeze an imagined community in time and space, with little recognition that location, information and changing social and material circumstances will influence the way that people respond and behave. It encourages us to skim past particulars, in favour of a generalised and

stereotyped view of motivations and actions. As a result, the idea of *culture* is often burdened with impossible and contradictory meanings. In relation to this document and its intentions, we do not pretend that there is one African *cultural* approach to dealing with sex and sexuality, as this would obscure potentially valid health promotion options.

At the same time, some African people living in England (like other diaspora groups) can benefit from close contact with other people from their home continent. This ‘pan-Africanism’ which purposefully overrides national, linguistic or other group differences, can help to foster a network that provides emotional and material support (Dodds *et al.* 2004). This can be of significant value for those who confront racism and xenophobia in their daily lives, and for UK-born Africans who are developing their own experience and identity.

Taking these features into account allows us to better focus on the actual social networks, life experiences and beliefs that influence Africans living in England. Needs assessment and prevention planning should be cautious not to make assumptions about the cultural backgrounds of service users. These processes will therefore require the participation of a broad range of African men and women.

Social attitudes toward sex and sexuality can have a great deal of influence over what is generally acceptable to display or discuss in public. These attitudes are patterned by age, ethnicity and religion. People often present a publicly acceptable sexual identity (*ie.* monogamous married couple; or celibate daughter) that is in accord with socially acceptable standards held by family members and peers. This public identity can be radically different from private sexual practice, and it is incumbent on those planning health promotion to recognise the difference between these two realities.

5.4 NAHIP PARTNERS PROMOTE A COMMUNITY ETHIC

The rights of individuals and couples to determine their own sexual behaviour are central to the values underlying this document. At the same time, people are enmeshed in their social world.

The notion that ***a person is a person through other people*** emerges in sayings in a number of southern African languages. For instance:

Ndebele – *Umntu ngumuntu ngabanye.*

Xhosa – *Ubuntu ungamntu ngabanye abantu.*

Zulu – *Umntu ngumuntu ngabanye.*

(Tutu 1999)

Ubuntu describes an ethic of community, most clearly articulated in the Bantu family of languages. The concept appears in many different forms across central, southern and eastern Africa (Murithi 2006). It refers to the mutual care, belonging and interdependence that is initially fostered within extended families and can be broadened to one’s community.

The people around us shape the contours of our lives to the extent that our respect and concern for their well-being can positively influence our own. Such values can play a significant role in the reduction of HIV transmission, where people come to recognise that their own health impacts on health and well-being at a familial and communal level. *Ubuntu* is an ethic that encourages people to act to improve the community around them. In doing so they also strengthen themselves. NAHIP partners exhibit through the delivery of all interventions, an ethic that promotes the value of the individual as a part of the community. In HIV prevention terms, *ubuntu* can foster people’s motivation to avoid sex with a risk of HIV transmission.

As with any effort to increase and strengthen group norms, it is important to recognise the potential for *ubuntu* to be mis-used in ways that may castigate others, or to alienate those who choose not to identify with a particular community. Such activity would not help to meet HIV prevention need, and we mention this simply to highlight the ways that group values can be employed for destructive as well as constructive purposes.

5.5 NAHIP PARTNERS INCREASE THE KNOWLEDGE, THE WILL AND THE POWER OF AFRICANS TO REDUCE HIV TRANSMISSION RISK

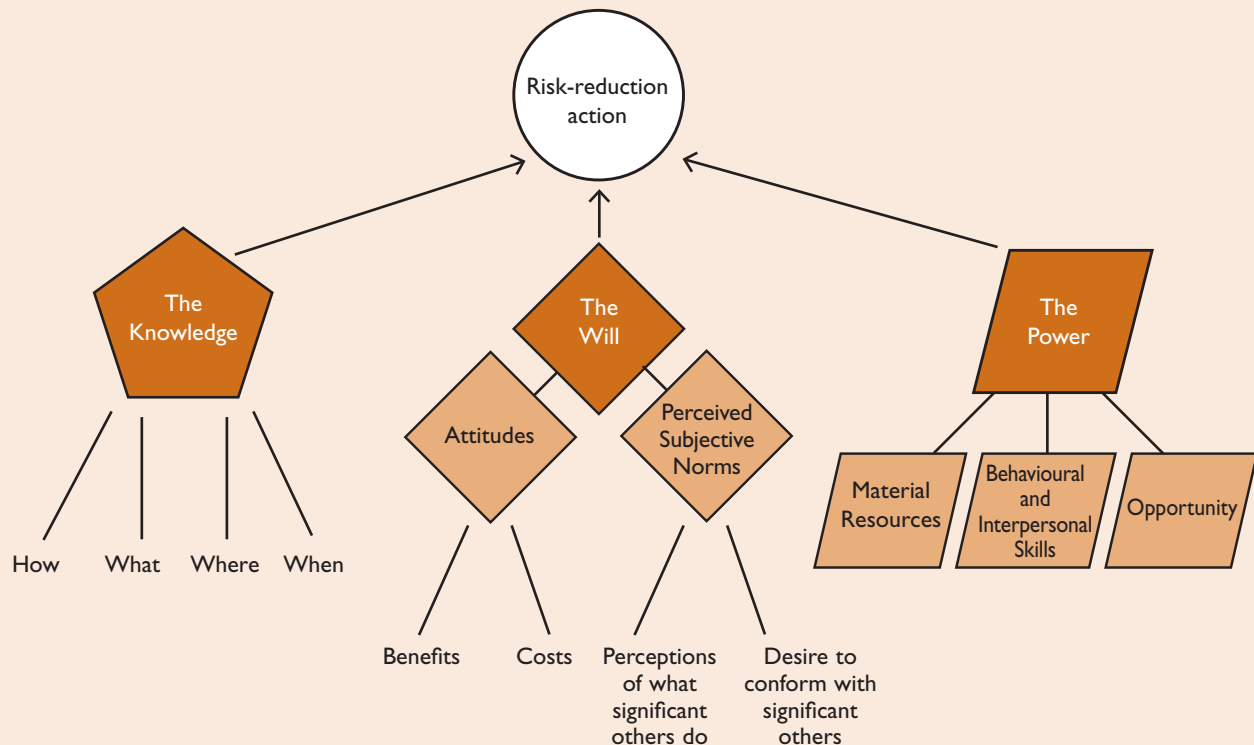
The values and ethics that underpin the NAHIP partners' approach to influencing HIV prevention behaviours already covered in this chapter include:

- a human rights approach to sexual and reproductive health;
- an approach to HIV prevention that is focussed on HIV while being mindful of the broader social and health issues faced by Africans;
- clear delineation between the roles and responsibilities of health promoters; and the rights of people to make their own decisions about the sex they choose;
- valuing and nurturing mutuality and interdependence among Africans living in England.

Within this ethical framework NAHIP partners will increase three things that all people need in order to act to reduce HIV transmission: the knowledge, the will and the power (Fisher & Fisher 1992). All three needs are important and HIV prevention interventions should aim to meet those that are least well met in the target population.

Figure 5a. gives an overview of the way that the knowledge, the will, and the power collectively contribute to people's capacity to reduce the risk of HIV transmission. The remainder of this section describes in some detail the way that each of these three factors combine to influence decision-making and action. Where there is a deficit in any one of these factors (either the knowledge, the will or the power) – then the other two are necessarily diminished. Conversely, where any one of these factors is increased, it improves the likelihood that the other factors will also be improved.

Figure 5a. The knowledge, the will and the power: necessary elements of reducing risk



5.5.1 The knowledge

African people with an opportunity for sex need to know what HIV is and how it is and is not transmitted. They also need to know what they can do to reduce the risk of getting HIV, and of passing it on if they are infected. People need to be aware that HIV transmission is harmful, and to know what actions they can take to make that harm less likely to occur.

Very few Africans have never heard of HIV. However, which options people choose to reduce their risk (for example: not having sex, having non-penetrative sex, using condoms for intercourse, ensuring they and their partner have the same HIV status before having unprotected intercourse, and taking PEP if they are exposed) may mean they need more specific knowledge to make that choice.

There are different levels of knowledge related to different risk-reduction options. Not everyone needs to know everything. Too much information can be as unhelpful as too little. However, the benchmark for all information given by NAHIP partners is the reality of the HIV epidemic. We endeavor to make sure people know what living with HIV is like, what the real risks are and what can be realistically done about them.

Although knowledge is necessary for action, it is not sufficient. Knowledge is not enough. People also need to want to act and they need to be able to act.

5.5.2 The will

In addition to the knowledge and understanding of HIV risk, people require the will to act to reduce risk.

The will to take HIV preventive action is influenced by the perceived benefits and costs of risk behaviours and the risk-reducing alternatives. For example, someone considering whether or not to begin a discussion with a new sexual partner about testing for HIV might be thinking of avoiding HIV transmission (benefit) versus the possibility of putting off their partner (harm). Someone else may think that condoms reduce sexual pleasure (harm) without recognising that they also bring protection from HIV (benefit). In each case, such thinking may result in unprotected intercourse. For the individuals involved, in the context of uncertain outcomes (such as HIV transmission), these benefits and

potential harms must be weighted for their judgements of how likely different outcomes are.

This suggests HIV prevention interventions could attempt to:

- (1) reduce what people think is good about unsafe sex and / or increase what they think is harmful about unsafe sex,
- (2) increase what they think is good about risk-reduction and / or reduce what they think is harmful about risk-reduction.

We can imagine this attitudinal process of weighing up benefits and costs as a see-saw, that tips in favour of one side or the other. The tipping point will depend on how important the potential benefits are to the individual (or indeed, how many benefits stack up) and how significantly they regard the potential harms. For instance, someone dependent on a sexual relationship for financial and emotional stability may not want to risk introducing condoms into the relationship if they think it may cost them all the benefits of that relationship. In addition, the extent to which people value the benefits of avoiding participation in HIV transmission will depend on the extent to which they value themselves and their sexual partners.

Knowledge influences motivation. For example, knowing that there is effective HIV treatment and whether or not they are entitled to it enables people to make a better judgement about the potential harms and benefits of taking an HIV test and therefore their will to do so.

The will to reduce risk is also influenced by what we think is acceptable to those who are significant to us, by what we think our significant others would do in the same situation, and by how much we want to conform with our significant others. In other words we emulate the attitudes of those we hold in esteem. So friends and family, and sports and music personalities, as well as other people who are well-regarded, can influence the attitudes and motivation of others to reduce their HIV risk. If we believe that people we respect are willing to participate in activities that reduce the risk of HIV transmission (for instance, by knowing their HIV status, by using condoms, by avoiding unprotected intercourse with multiple partners, etc.) we are more inclined to do the same.

Building up these norms at a community level is what is meant by developing a 'safer sex culture'. This includes encouraging people to know that within their peer group it is acceptable to discuss HIV and it is desirable to reduce risks during sex. However, undertaking HIV prevention that aims to influence and shift these norms requires close consideration of the capacities, priorities and degree of social conformity in the target population.

Although the will to act is necessary, it is not sufficient. The will to reduce risk is not enough. People also need to know what they can do to reduce risk and they have to have the power to do so. They need the knowledge, the will *and* the power.

5.5.3 The power

People may understand the importance of a particular behaviour (knowledge), and they may want to undertake it (will) but lack the actual capacity (power) to do so. In order to act on their intention to reduce risk, people need to have the necessary material resources, skills, and opportunities. Things that increase Africans' power to act to reduce HIV risk therefore include:

- access to (male and/or female) condoms and lubricant;
- access to HIV testing;
- being able to properly use condoms;
- assertiveness and other interpersonal skills;
- being free of physical force; and
- having a choice.

Where resources are lacking, choice is constrained. Condoms cannot be used by someone who has no access to them. Also, some of the behaviours that relate to the avoidance of HIV transmission require specific skills – particularly those relating to negotiation and communication. Acquiring skills requires other resources such as access to the internet, or mobility.

An individual's power is influenced by their status relative to others in the family, in the community, and in the country where they live. Therefore, the extent to which others consider them a valued and respected member of the community will have direct impact on the resources they can bring to bear in avoiding HIV transmission. Furthermore laws and policies that influence the planning and delivery of local and national services significantly

affect the extent to which individuals have the power to avoid participating in HIV transmission.

Although the power to act is necessary, it is not sufficient. The power to reduce risk is not enough. People also need to know how they can act and they need to want to do so.

5.6 NAHIP PARTNERS INFLUENCE COMMUNITIES, POLICY MAKERS AND SERVICES TO SUPPORT RISK-REDUCTION

Just as Africans with an opportunity for sexual risk require knowledge, motivation and ability to reduce the HIV risk-related behaviours they are involved in, so the many actors involved in African people's lives can help them do so. Friends and family and other members of social networks can support each other to reduce risks. Researchers can do useful investigations and policy advisors and decision-makers can lobby for and make enabling policy. All health, education and social services can act in a way that makes them accessible, acceptable and effective for African people.

Many of the contextual features of African lives in England that were discussed in chapter 2 will have a significant role to play in contributing to or detracting from people's power to act to reduce risk. For instance, a regular and sufficient income, adequate housing and access to health services and information will all contribute to individuals' skills and capacities to participate in HIV prevention. Legislation and policy at local, regional and national levels of government will all have a part to play in shaping the power of individual African people to avoid participating in HIV transmission.

However, all these actions also require the knowledge, the will and the power to do them. As well as directly influencing African people who may have sex, NAHIP partners must increase the power, will and the knowledge of other actors to also meet their HIV prevention needs.

Chapter 6 outlines the knowledge, the will and the power NAHIP partners aim to directly increase in African people with an opportunity for sexual risk.

Chapters 7 and 8 outline the knowledge, the will and the power of all other key actors to act in a way that ensures Africans have the knowledge, the will and the power to reduce their HIV prevention risks.

HIV PREVENTION AIMS

HIV PREVENTION NEEDS OF AFRICANS LIVING IN ENGLAND

This chapter describes what the NAHIP partners believe and agree is required for Africans to have control over the HIV risk behaviours and HIV preventative behaviours identified in chapter 4.

STRATEGIC AIM FOR AFRICANS HAVING SEX:

Africans reduce HIV risk behaviours and increase preventative behaviours.

The specific behaviours NAHIP partners are trying to change are shown in Figure 6a. They include both transmission behaviours (which we are trying to reduce) and prevention behaviours (which we are trying to increase). Note that one risk behaviour (unprotected intercourse without being confident of sero-concordancy) has a number of preventative alternatives

(no sex, non-penetrative sex, etc.), while there is no risk behaviour that STI testing or taking PEP replaces.

The needs described in this chapter arise directly from the values and theories outlined in chapter 5. Other values and other theories of influence will necessarily result in a different understanding of need. Our general model of need is that in order to reduce the risk of HIV transmission, people need the **knowledge** of HIV risk and prevention, the **will** to avoid risk behaviours, and the **power** to enact preventative behaviours. NAHIP partners believe that there are very few contexts in which people are unable to reduce their risk of involvement in HIV transmission.

Figure 6b. presents an overview of the choices available to people when they are presented with an opportunity for sexual activity. Many factors influence how people respond to that opportunity and we recognise that an individual's choices might change from one opportunity

Figure 6a. Behaviours that NAHIP partners are trying to change

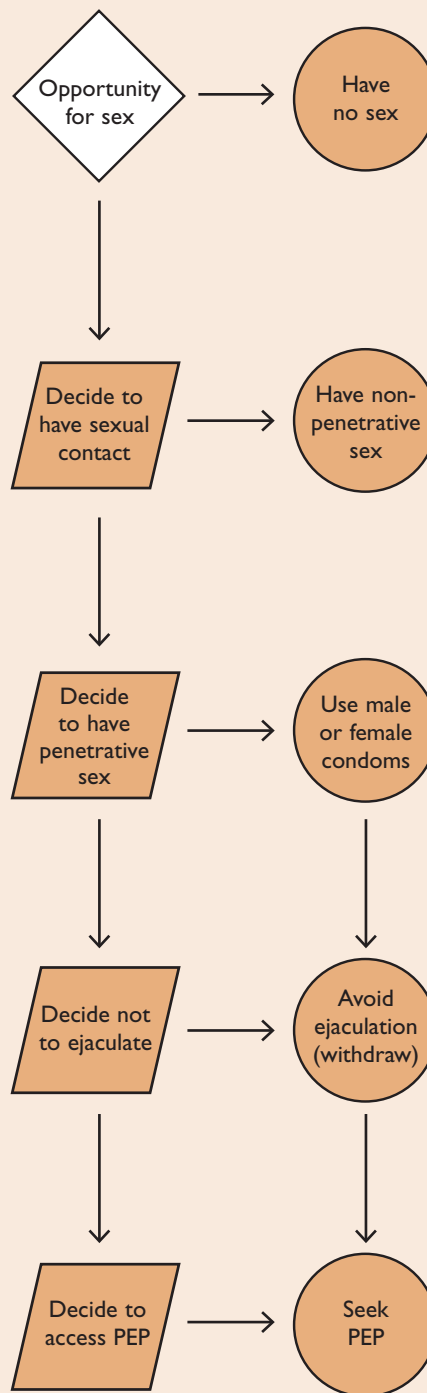
Reduce HIV risk behaviours	Increase HIV preventative behaviours
	<ul style="list-style-type: none"> • testing for HIV • testing for other STIs
<ul style="list-style-type: none"> • unprotected intercourse except where both partners are very confident they have the same HIV status 	<ul style="list-style-type: none"> • declining sex • having non-penetrative sex
	<ul style="list-style-type: none"> • couples establish HIV concordancy and maintain monogamy
	<ul style="list-style-type: none"> • correct use of male or female condoms
<ul style="list-style-type: none"> • condom failure behaviours (eg. using oil-based lubricant) 	
<ul style="list-style-type: none"> • ejaculation into a partner's body without a condom 	<ul style="list-style-type: none"> • withdrawal before ejaculation
	<ul style="list-style-type: none"> • taking PEP if sexually exposed to HIV

to the next. For example, people may want to decline some opportunities for sex but not others. They may have intercourse with some sexual partners but not others. They may want to always use condoms unless they meet someone they trust, with whom they negotiate a monogamous relationship, and where they both test for HIV and decide not to use condoms. This chapter describes the needs associated with each of these choices.

For all risk-reduction choices people need the will to reduce their risk. However, the knowledge and power to implement risk-reduction choices vary depending on which choices they make. For example, while we need a condom to use one, we do not need a condom to choose not to have sex, or to have sex only with our monogamous partner who we know has the same HIV status as ourselves. On the other hand, to choose a monogamous HIV concordant relationship we need HIV tests (which we do not need if we choose to always use a condom). All the risk-reduction actions share a number of common needs. For example, choosing to reduce risk through any of these means requires understanding of HIV and how it is transmitted, and all require the skills to negotiate and assert sexual decisions with partners.

NAHIP partners recognise that even if someone has all their HIV prevention needs met, they may still engage in risk behaviours. This is the meaning of freedom. However, we believe that someone who has the following needs met is less likely to take a risk than if they do not have these needs met. Meeting HIV prevention needs will support people to better manage HIV risk during sexual intercourse on *more* occasions. This can be described as a harm-reduction approach to HIV prevention. Toward the end of this chapter, we describe some additional needs associated with preventing sexual transmission of HIV when people with diagnosed HIV (or their partners) wish to conceive.

Figure 6b. Making decisions to reduce the risk of acquiring HIV through sex



6.1 NEEDS RELATED TO REDUCING HIV RISK BY ANY MEANS

This section outlines the needs associated with all the ways by which people can reduce HIV transmission risks.

6.1.1 Knowing HIV exists, the harm it can cause and how to reduce risk

Some knowledge is relevant to all Africans who are sexually active, or who plan to be sexually active in the future. NAHIP partners make no presumptions about individual Africans' pre-existing knowledge about HIV in relation to their age, number of years in the UK, or country of origin. Nor do we assume that all recent migrants have little understanding of HIV, as HIV education is widespread in most African countries (particularly those in sub-Saharan Africa). Also some Africans migrating to the UK have previously lived and been educated in North American and European countries.

In order for people to reduce their risk they need to know about HIV, how it is transmitted and how they can prevent it. Basic aspects of HIV transmission knowledge include:

- Awareness of the existence of HIV.
- Understanding how HIV is and is not transmitted.
- Knowing that the presence of untreated STIs makes HIV transmission more likely.
- Understanding that HIV can be treated but not cured.
- Knowing that HIV treatment is freely available for people legally residing in England.
- Knowing that it is not necessary to run the risk of HIV exposure in order to have a child.
- Understanding that taking measures to prevent HIV transmission, having an HIV test and receiving medical treatment are compatible with religious faith and prayer.

Some studies have found low levels of sexual health knowledge among Africans living in England (Fenton *et al.* 2002, Chinouya & Davidson 2003, Chinouya *et al.*

2003). BASS Line respondents (Dodds *et al.* 2008) demonstrated relatively high levels of basic knowledge about HIV, how it is transmitted, and the existence of HIV medication. However, they were less aware that taking medication before becoming ill could help people with HIV to stay well. Particularly lacking though was an understanding of the extent of HIV prevalence among Africans living in England (Dodds *et al.* 2008).

People need to know what are effective and less effective ways in which they can reduce HIV risk. As long as sexual assault remains a reality there is no way to eliminate sexual HIV risk. However, it is usually within someone's power to completely minimise risk by avoiding sex altogether. The second most complete way of minimising risk is by having non-penetrative sex (that is, avoiding vaginal, anal and oral intercourse). However, engaging in any sexual activity increases the chance that sexual force may be used by a partner, or that desire will overcome harm-reduction strategies. Use of condoms during intercourse reduces the risk compared with having unprotected intercourse, but condoms can break. Establishing HIV concordancy and negotiating unprotected intercourse in a monogamous relationship carries the risk of a partner having unsafe sex outside the relationship and bringing HIV into it. Withdrawal before ejaculation during unprotected intercourse reduces the risk for the receptive partner but still carries a risk of HIV from pre-ejaculate and of the insertive partner mis-timing the withdrawal.

Someone for whom sex is very valuable will be willing to accept a greater level of risk than someone for whom sex is unimportant. Therefore, health promoters cannot choose for people the level of HIV risk they are able to accept for the sexual, material and emotional value of the activity they wish to undertake. Health promoters can help people with the knowledge, the will and the power to minimise their HIV risk while engaging in a level of sexual activity that best suits them.

6.1.2 The motivation to reduce the risk of transmission

Simply knowing about HIV is not enough to cause people to reduce risks. They also need to *want* to not be involved in HIV transmission (by either not passing on HIV, or by not acquiring it). The vast majority of

Africans do not want to be involved in HIV transmission (Dodds *et al.* 2008). However, when faced with an opportunity to have sex, many believe that the benefits outweigh the potential risk of infection.

The motivation to reduce risk is a consequence of people's assessment of the benefits and costs of acting to reduce risks and whether they think it is socially acceptable to do so. The benefits and costs of acting to reduce risk vary, depending on whether someone has HIV or not.

We therefore want:

- all Africans living in England to know whether they have HIV infection or not.

The only way to know one's own HIV status is by having an HIV test. We therefore want to meet Africans' needs related to testing for HIV. Not testing for HIV is related to low self-perceived risk (Erwin *et al.* 2002, Dodds *et al.* 2008) and is therefore related to low motivation to reduce HIV transmission risks. In order to increase the likelihood of HIV testing, sexually active African people will require knowledge of HIV, how it is sexually transmitted, and the availability of highly effective treatment (described in 6.1.1).

People who do not know their HIV status need to be assured that testing for HIV will not result in discrimination or loss of privacy, and they will need to know where trusted services can be accessed. They also require an understanding of the meaning and potential impact of HIV test results, including knowledge of the window period when a recent infection may not be detected.

People testing for HIV also need to know that a negative test result does not mean that they are immune to HIV, and that subsequent sexual exposures will require future HIV testing in order to establish whether infection has or has not occurred.

The majority of people with HIV do not want to pass it to someone else, least of all the sexual partners with whom they are in a loving relationships. Some people with HIV however, are unconcerned about passing on their infection and need an increased appreciation of the harm they could be causing to others. We recognise that having an HIV positive diagnosis does not

automatically give African people the knowledge, the will and the power to ensure that their subsequent sexual behaviour never exposes their infection to others.

People without HIV need to perceive themselves as being at risk from HIV in order to take action to avoid it (Elam *et al.* 1999). This means knowing that it is possible their partner has HIV and that it is not possible to identify people with HIV based on appearance, lifestyle or social standing. Assumptions are made about the ability to select partners that are unlikely to have HIV, and this is linked to a belief in the ability to distinguish between partners that will be 'safe' and those who will be 'unsafe' (Elam *et al.* 1999, Mayisha II Collaborative Group 2005).

We therefore want people to:

- Understand that 1-in-20 Black Africans living in England have HIV, making this the ethnic group with the highest prevalence in England by far.
- Recognise that the low rate of HIV-related deaths in England relates to treatment success, and is not an indication that there is no HIV in this country.
- Know that there is no way to distinguish between people who have HIV and those who do not, other than through an HIV test.

In the UK fewer than twenty people with HIV have been prosecuted and imprisoned for passing on their infection during sexual activity where their partner was unaware of infection. However, African people with HIV need to be aware of particular sexual situations that could result in a prosecution being brought against them.

Many people expect that someone with HIV will disclose this before having sex. However, this does not always occur, both because a third of the Africans with HIV are not aware of their infection (and therefore cannot tell their partners) and because the stigma associated with HIV makes it very difficult for people to be open about their HIV diagnosis. Those who have never tested, those who have tested HIV positive, and those who have tested HIV negative are likely to make different types of assumptions about the HIV status of their sexual partners. Such assumptions are likely because of differing levels of HIV awareness, which can

result in a projection of this awareness onto sexual partners. Lack of awareness of the potential for HIV sero-discordancy is one reason people give for having unprotected intercourse.

Having a community ethic that includes care and compassion for our sexual partners means we are more likely to want to protect them, as does having a sense of social responsibility (see section 5.4). Needs associated with establishing and maintaining sero-concordancy between couples are described below (section 6.5). Concern for current and future children can reinforce a desire to remain HIV negative.

We therefore also want people to:

- care for their sexual partners and to know that reducing risks protects their partners and children as well as themselves.

Other needs associated with motivation include:

- Believing that we are able to make a difference to our risk ('self-efficacy').
- Self-esteem and hope for the future that makes reducing risks worthwhile.
- Awareness that motivation to manage HIV risk can be compromised or challenged in new settings (such as returning home for a visit).
- Freedom from anxiety and depression (and the multiple causes of these).

People need to be able to choose to take preventative actions without being chastised or rejected by their sexual partners or peers. People are more likely to act to reduce risks if they believe people they admire also act to reduce risks. In other words, we want people to believe their peers recognise the value of abstaining from sex, having non-penetrative sex, using condoms, testing for HIV and using PEP.

6.1.3 The power to act to reduce HIV transmission risk

All people who wish to reduce their HIV risk require physical autonomy and freedom from sexual force. Autonomy relates to the ability to direct one's own activities. In order to be able to choose not to have sex when the opportunity arises, or to choose to have a

particular kind of sex (non-penetrative sex or intercourse with a condom), people need to be free from sexual force and have control over their own bodies. Normative expectations and gender roles can limit sexual autonomy. Men and women need to exercise respect for themselves and for others by understanding that 'no always means no'.

Those who are trafficked into this country as cheap labourers or to work in the sex industry are usually deprived of the right to refuse sex, as are many of those subjected to domestic violence. Other factors related to vulnerability to sexual force are: poverty; social isolation; lack of legal rights (as in the case of undocumented migrants); and involvement in illegal activity as discussed in chapter 2. Men and women who physically lack control over how, when and with whom they have sex are vulnerable to many harms, including participation in HIV transmission.

In order to take risk-reduction action, people need to express what they want clearly and without bringing harm to others. Being able to communicate to partners the desire for safer sex or no sex makes risk-reduction much more likely. Assertiveness is a key HIV prevention need.

Pressure to conform to others' expectations influences communication and sways sexual decision-making. What is often regarded as 'feminine' sexual propriety undermines women's capacity to encourage their male partners to use condoms, as well as leaving them ill-equipped to negotiate about if and how they have sex. Alongside this, the common idea that 'masculinity' is demonstrated by dominance leads to the belief that strong men should disregard sexual negotiation. Men who conform to these values often measure their self-worth by the number of sexual 'conquests' they have achieved.

Where alternative forms of masculinity and femininity are developed and advocated by African men and women in England, they will be more able to choose to refrain from sex or to engage in sexual activity founded on negotiation. The development of alternative expressions of masculinity and femininity has a close connection to reducing homophobic attitudes, as these are frequently bolstered by strict norms about how

men and women 'should' behave. Rather than regarding the power to dictate if, how and when sex will happen as being in the domain of only one partner, new models of relations between men and women will help people to regard sexual power as shared power.

One of the ways people lose the will to reduce risks and the power to do so is through being drunk or on drugs. African people who identify that they lack control over their alcohol and/or drug use require clinical and psychological support. Drug and alcohol support services that are tailored for African men, women and young people will help to increase uptake and to sustain long-term success particularly where specific cultural and religious norms prevent participation in counselling interventions and openness about substance use (Johnson *et al.* 2006).

HIV-related stigma has a significant impact on HIV prevention need. People with diagnosed HIV who experience stigma can struggle with low self-worth and hopelessness as a result (Dodds *et al.* 2004). This can reduce their capacity to use support services, and it can also reduce their motivation to protect sexual partners from transmission. Concerns about discrimination and rejection can mean that those with diagnosed HIV tend to tell very few people about their infection (Weatherburn *et al.* 2003). This keeps the realities of HIV, including the potential to live well with the infection, relatively unknown among many Africans living in England.

Stigma associated with the virus can lead to an understanding of people with HIV as 'others' who are 'untrustworthy', 'unclean' and 'unsuitable'. This leads to a strong desire to be distanced from the illness, and therefore disassociated from those attributes. This very practice of distancing stops individuals from recognising that people like themselves and their sexual partners (be they married or unmarried, committed or casual) can have the virus. This in turn reduces the likelihood of recognising the risk of transmission, a need for testing, and acting to reduce risks (Chinouya & Davidson 2003, Mayisha II Collaborative Group 2005). Africans attending for HIV testing were twice as likely as White attendees to be worried about future discrimination if they tested positive (Erwin *et al.* 2002).

The stigma associated with HIV for Africans includes stigma associated with disease and illness, sexual activity and homosexuality. It functions to reinforce the inequalities that drive racism, xenophobia, sexism and homophobia (Dodds *et al.* 2004). Therefore, addressing HIV-related stigma requires interventions that directly tackle some of the most significant social inequalities in our society.

6.2 NEEDS RELATED TO AVOIDING OR DECLINING SEX

People who decide to avoid (or postpone) any sexual activity in order to reduce their HIV risk require little beyond the basic set of needs outlined above. However, people who choose not to have sex in order to reduce risk need to know that there are very low risk sexual activities that they can choose to engage in should they wish to.

6.3 NEEDS RELATED TO HAVING SEX WITHOUT INTERCOURSE

Penetrative vaginal intercourse is commonly represented amongst Africans as the definitive and ultimate aim of 'having sex'. Any other kinds of sexual activity are either seen as 'messing about' or as a prelude to intercourse. However, neither anal nor vaginal intercourse is compulsory when sex occurs. People need to know this and to know that other means of sexual satisfaction can be pursued. People also need to know that unprotected intercourse is not the only means of achieving conception (and that conception is not the only way to become a parent). Being able to discuss, learn, and talk to partners about non-penetrative sex requires comfort with the idea that we all have a right to choose from a range of sexual activities on our own and with partners. It also requires comfort with the idea that sex is pleasurable, and that there are more means of gaining sexual pleasure than through intercourse alone.

Alternatives to intercourse include:

- Self-masturbation (stimulating yourself sexually – alone or in the presence of others).
- Manual stimulation of a partner's genitals (including penis, vagina, clitoris and anus).

- Fellatio (stimulation of a male partner's genitals using the mouth).
- Cunnilingus (stimulation of a female partner's genitals using the mouth).
- Use of sex toys (alone and with a partner).

People choosing to engage in sex without intercourse need to know that HIV can be acquired orally by 'licking out' a woman, 'sucking' a man to ejaculation, and can be passed on by sharing vibrators and sex toys (used by an infected partner immediately followed by an uninfected partner).

6.4 NEEDS RELATED TO CORRECTLY USING MALE AND FEMALE CONDOMS

Many people choose to reduce their HIV risk by using male condoms when they have intercourse. Far fewer people use female condoms, although these are perceived as a means of offering women greater control over their ability to reduce HIV risk behaviours.

There are a number of needs related to condom use. Some of these needs have already been discussed in previous sections of this chapter. For instance, choosing to use a male or female condom with a sexual partner requires knowing about condoms and being able to access them, and perceiving a risk of HIV transmission during intercourse.

There are high levels of dislike of condoms among men and women (Mayisha II Collaborative Group 2005), with discomfort and genital irritation given as common explanations. People are more likely to choose condoms if they are accurately informed about their value, and if they are aware that they can access more than one type of condom. Many attitudes towards condoms are based on negative assumptions about what they are like and a predisposition to reject their use. People need to know that they prevent pregnancy and protect against other STIs as well as HIV, and that some sexual partners respect and are impressed by men and women who use them. Recognition that the use of condoms is an act of care and respect will help to reduce the likelihood that their introduction into a new or existing relationship is regarded with suspicion (Mayisha II Collaborative Group 2005).

In order to use condoms correctly, people need: access to (male and/or female) condoms; the skills and confidence to use them; and an understanding of which behaviours make them less likely to break or come off during intercourse.

All of the following make male condoms more likely to break or come off:

- using a oil-based lubricant,
- not using additional water based lubricant,
- using saliva as a lubricant,
- putting lubricant inside the condom before putting it on,
- using a condom that is past its expiry date,
- unrolling the condom before putting it on the penis,
- tearing the condom with jewellery or fingernails,
- using a condom that is too short for the penis,
- having intercourse for over half an hour without changing the condom.

In the case of female condoms, the risk of failure can be reduced by ensuring that users know where and how to insert them, and that they do not use the female condom at the same time as a male condom. Most of the other behaviours listed above that make male condom failure more likely do not apply to female condoms, as they are not degraded by the use of oil-based lubricants and they have a long shelf-life.

The costs of purchasing condoms (especially female condoms) can be prohibitive, and embarrassment can be another factor that dissuades people from buying them. Condoms are freely distributed by HIV organisations and in many healthcare settings. However, awareness of condom distribution programmes may not be widespread among sexually active Africans. African sex workers require access to free condoms in large quantity, something that can be difficult in hand-to-hand distribution contexts (Othieno 2006).

People also need to be aware of and able to access male condoms in a range of shapes and sizes, and made from a range of materials (*ie.* non-latex) so that they are able to find a type that best suits the needs of both

partners. They also need to be aware that some spermicides used on male condoms can irritate and inflame vaginal and anal tissues, thereby increasing the likelihood of discomfort, cystitis (in women) and HIV transmission (Niruthisard *et al.* 1991, Phillips *et al.* 2000).

6.5 NEEDS RELATED TO COUPLES ESTABLISHING AND MAINTAINING HIV SERO-CONCORDANCY

New HIV infections cannot occur when two HIV negative people have unprotected intercourse together or when two HIV positive people do so. Once a couple are sure that they have the same HIV status, they can have unprotected intercourse without a new infection occurring. However, sex often takes place prior to any discussions about sexual history (Elam *et al.* 1999).

Couples who wish to conceive without risking HIV transmission need to establish if they are both HIV negative before engaging in unprotected intercourse. For those couples where one or both partners have HIV, other ways of conceiving that reduce sexual HIV transmission risks are possible (see section 6.9).

If people are choosing to have unprotected intercourse (either because of sexual or emotional desire, a desire to conceive, or both), we want them to know whether they have HIV or not.

In order to determine whether or not they have HIV, people need to be able to access and use HIV testing services. In the UK, HIV tests are available through specific health services. Choosing to be tested requires knowing what is involved in taking an HIV test, and being aware of the likely outcomes of a negative or a positive diagnosis (see sections 6.1.2 and 8.2).

If two people who know they are HIV negative choose to have unprotected intercourse, they need to be clear and confident that neither will bring HIV into the relationship by having unprotected intercourse with others. This needs negotiation and agreements about whether sex can occur outside the relationship, what type of sex that is, and what happens if one of the partners breaks that agreement.

Generally, men take the lead on using condoms or not in longer-term relationships (Mayisha II Collaborative

Group 2005). This suggests that many women would benefit from increased assertiveness to protect themselves.

Key values in relationships are trust and faithfulness (Mayisha II Collaborative Group 2005). These are often underpinned by religious beliefs. However some people with HIV, especially women, acquired the virus from a partner whom they believed to be monogamous. People choosing to have unprotected intercourse in relationships they believe are HIV concordant need to know that this happens.

6.6 NEEDS RELATED TO HAVING SEXUALLY TRANSMITTED INFECTIONS DIAGNOSED AND TREATED

People with and without HIV need to know about the existence of other STIs and about where and how they can be tested. They also need to be aware of the benefits and costs of testing for other STIs and to be able to do so. Meeting these needs will help to reduce time people have undiagnosed and untreated STIs, thereby reducing the likelihood that another STI is present when sexual HIV exposure occurs.

6.7 NEEDS RELATED TO WITHDRAWAL BEFORE EJACULATION WHEN PARTNERS ARE NOT CONFIDENT THEY HAVE THE SAME HIV STATUS

HIV is present in the semen of men with HIV infection. If men having insertive unprotected vaginal or anal intercourse withdraw the penis prior to ejaculation, then there is less likelihood of transmission from the insertive to receptive partner than if they do ejaculate.

People considering this risk-reduction tactic need to know that on many occasions where men intend to withdraw they find it impossible to do so and end up ejaculating into their partner. They also need to know that HIV can be transmitted through pre-ejaculatory fluids (or pre-cum).

6.8 NEEDS RELATED TO TAKING PEP FOLLOWING SEXUAL EXPOSURE

For a variety of reasons people without HIV may find that they engaged in unprotected intercourse with a partner they know has HIV or who may have HIV. Such situations include sexual assault, condom failure, the heat of the moment, and finding out a partner is HIV positive after the event.

In such circumstances people may benefit from PEP. In order to take PEP people need to know about it, to appreciate the costs and benefits of taking it, and to be able to access it and take it correctly. They will also need to be aware that the sooner PEP is taken after exposure (no more than 72 hours), the more likely its effectiveness. They may require the skills to communicate this urgency to reception and non-specialist staff in clinical settings (Dodds *et al.* 2006).

6.9 NEEDS RELATED TO CONCEPTION IN COUPLES WHERE A PARTNER HAS DIAGNOSED HIV

Many people think that unprotected vaginal intercourse is the only way to conceive and that HIV transmission risk is therefore a necessary part of trying to conceive. However, there are other ways to conceive that can reduce the risk of HIV transmission which people with HIV and their partners can explore in consultation with their HIV clinician if they are considering conception.

This plan focuses on preventing the sexual transmission of HIV. We do not address mother-to-child transmission re-infection, or super-infection between two individuals with HIV. Information and guidance on those topics can be found elsewhere (see for instance Audit, Information and Analysis Unit 2007, Fakoya *et al.* 2007).

People who want a child and who also want to avoid the sexual transmission of HIV need to know that these aims are not mutually exclusive. No one should have to choose between having a child and risking HIV infection. NAHIP aims for couples (where one or both partners is African) who have determined that they want to conceive, to undertake HIV tests and to share the results of their HIV tests with each other (see sections 6.1.2 and 6.5). If both partners are HIV negative, they will need to negotiate a monogamous relationship if

unprotected intercourse is to be on-going. If one or both partners have HIV there are a number of options.

6.9.1 Adoption

Any couple considering conception and wanting to minimise HIV transmission risk needs to know of the availability of adoption services. The option of adoption will be reduced for those who are unstable financially, whose immigration status is unresolved, or who are in ill-health. The successful uptake of this option will also require that the peers and family members of potential adoptive parents have a positive regard for adoption and the benefits it brings.

6.9.2 Sperm-washing for HIV positive men

Where a man is diagnosed with HIV and his partner is not, the man's semen can be treated in a way that separates his sperm from other seminal fluids that carry the HIV virus. This is achieved by placing semen in a centrifuge which separates the sperm from the seminal fluids. The man's partner can then be inseminated with his sperm, either by intrauterine means, or by using *in vitro* fertilisation treatment, where the woman's egg is fertilised by male sperm in a laboratory, and the resulting embryo is implanted directly into the woman's uterus.

Sperm-washing services should be made available and accessible for all people living with HIV in England who require them. Sperm-washing requires significant ongoing contact with clinical professionals. This process does not eliminate the risk of HIV transmission, however it significantly reduces the likelihood that transmission will occur.

6.9.3 Self-insemination for HIV positive women

Where a woman is diagnosed with HIV and her partner is not, she should receive instructions on how to carry out self-insemination of her partner's sperm at the time in her cycle when she is ovulating. If a condom is used during intercourse with her partner to the point of ejaculation, she can later inseminate herself with semen collected from the (non-spermicidal) condom using a syringe. As there is no transfer of fluids from a positive to a negative person using this technique, it does not carry any risk of HIV transmission.

6.9.4 Suppressing viral load for both HIV positive men and women

Those who will not or cannot access the options for conception listed above might consider confining unprotected sexual intercourse only to those periods when the positive partner's viral load is categorised as undetectable. Effective ARV treatment regimes can significantly reduce the viral load (the amount of virus that is present in the blood) in a person with diagnosed HIV. In a sero-discordant partnership, the partner who is diagnosed with HIV is likely to have access to information about his or her viral load if they are in regular contact with clinical services.

There is a lack of international consensus about whether or not a person with undetectable viral load (and no other STI) can pass their infection sexually. The Swiss Federal Committee for HIV/AIDS recently asserted that those who maintain an undetectable viral load for six months or more without any other STIs cannot transmit HIV (Vernazza *et al.* 2008, Bernard 2008). The Centres for Disease Control and Prevention in the United States points out that "there are no scientific data that the risk of transmission in these circumstances is zero" (Centres for Disease Control and Prevention 2008). The BHIVA guidelines on HIV and reproduction suggest doctors discourage people using this approach (Fakoya *et al.* 2007).

Viral load may be interpreted as an indicator of infectiousness, however there can be a significant difference between the amount of virus that is present in the blood, and that which is present in sexual fluids such as semen and vaginal mucus. Therefore, a low (<1000 copies/ml) or even an 'undetectable' viral load measure in the blood may not guarantee that a person will not transmit HIV when having unprotected sex. Confining unprotected intercourse to only those days in the month when the woman is ovulating would, however reduce the likely number of HIV exposures if this method of conception is chosen.

6.10 HIV PREVENTION AIMS FOR AFRICANS WHO ARE OR WILL BE SEXUALLY ACTIVE

AFRICANS AIM 1:

Africans reduce sexual HIV risk behaviours in any way available to them.

This will require:

- Knowledge about HIV and how to prevent it.
- Motivation to reduce the risks of transmission.
- Knowledge of whether or not they have HIV and how to access HIV testing.
- Knowledge of HIV treatment and who is eligible to receive it in England without charge.
- Awareness of the potential for HIV sero-discordancy with sexual partners.
- Freedom from pressures to conform to behaviours that risk transmission.
- Skills to communicate openly with sexual partners about HIV risk-reduction and to influence partners' behaviour.
- Freedom from sexual force.
- Control over the use of substances such as alcohol and drugs.
- Freedom from HIV-related stigma.
- Freedom from sexism and homophobia.
- Freedom from racism and xenophobia.

AFRICANS AIM 2:

Africans decline unwanted sex or have non-penetrative sex.

This will require:

- Appreciation and enjoyment of the benefits of sexual pleasure when a choice is made to be sexually active.
- Confidence and skills to refuse sexual contact when it is not desired.
- Acceptance of sexual contact other than intercourse as valid and pleasurable.
- Access to resources to expand their sexual repertoire.
- Confidence and skills to introduce sexual contact other than intercourse with new or existing sexual partners.

AFRICANS AIM 3:

Africans correctly use male and/or female condoms for intercourse.

This will require:

- Knowledge of the availability of free and affordable male and/or female condoms and water-based lubricant.
 - Access to as many male and/or female condoms (and appropriate lubricant) as they require.
 - Awareness of and access to different types of condoms and water-based lubricants in order to maximise comfort and minimise failure.
 - Skills to use condoms and lubricant correctly.
 - Confidence and skills to introduce male and/or female condoms and appropriate lubricant with new or existing sexual partners.
 - Knowledge of the factors that contribute to condom failure.
 - Awareness that condoms may fail even if they are used correctly.
-

AFRICANS AIM 4:

African couples establish and maintain HIV concordancy.

This will require:

- Accurate clinical knowledge of their own *and* their partner's HIV status.
 - Negotiation skills in order to ensure the use of male or female condoms until HIV statuses are determined and to ensure monogamy.
-

AFRICANS AIM 5:

Africans with undiagnosed STIs get them diagnosed and treated.

This will require:

- Knowledge of the existence of other STIs and of testing and treatment services, appreciation of the costs and benefits of testing for other STIs and the existence of testing and treatment services.
-

AFRICANS AIM 6:

Africans who have unprotected intercourse practice withdrawal before ejaculation when partners are not confident they have the same HIV status.

This will require:

- Knowing that during unprotected intercourse with an HIV-infected man that transmission is less likely to occur if he withdraws before ejaculation than if he does not.
 - Knowing that HIV transmission can still occur even in the absence of ejaculation because HIV is present in pre-ejaculatory fluid (pre-cum).
-

AFRICANS AIM 7:

Africans without HIV who are sexually exposed to HIV take post-exposure prophylaxis (PEP).

This will require:

- Awareness of the existence of PEP treatment and what its limitations are.
 - Appreciation of the costs and benefits of taking PEP.
 - Swift access to PEP should they be exposed to HIV.
-

AFRICANS AIM 8:

African people in sero-discordant relationships that want to conceive reduce HIV risks in doing so.

This will require:

- Awareness that intercourse is not the only means of achieving conception.
 - Accurate clinical knowledge of their own and their partner's HIV status.
 - Freedom from psychological and emotional pressure to bear children.
 - Access to adoption services and recognition of adoption as a viable option.
 - Knowledge of sperm-washing services and access to them (where the male partner has HIV and the female partner does not).
 - Knowledge and skills required to undertake self-insemination techniques (where the female partner has HIV and the male partner does not).
 - Knowing that reduced viral load in the partner with HIV, and limiting unprotected intercourse to only take place during ovulation, will lessen but may not eliminate the risk of HIV transmission.
-

NEEDS OF NAHIP PARTNERS TO ACT

This chapter describes the needs of organisations (and the board members, staff and volunteers that work for them) to deliver effective HIV prevention interventions. Meeting these needs will enable organisations and individuals to deliver more and better HIV prevention interventions to African people living in England. In the next chapter we consider supportive government policy on education, health and immigration, as well as community practices that encourage inclusion and diversity.

STRATEGIC AIM FOR ORGANISATIONS:

Organisations act to meet HIV prevention needs among African people living in England by influencing them directly and by influencing the environments in which they live.

7.1 ORGANISATIONAL DEVELOPMENT

There is currently no single agency or institution with overall responsibility for reducing HIV incidence through sex between African people living in England, nor any single group of organisations with sufficient expertise, resources and respect to ensure that it occurs. This plan requires a multi-level, strategic approach to realise its goal. This requires different organisations to select and prioritise different sets of aims and activities according to their various targets and strengths. Its success rests on the commitment of a wide diversity of people and organisations and on the degree and success of our collaboration.

In order to deliver targeted HIV prevention interventions to African people living in England we require a diversity of organisations that are HIV- and African-specific, working in close collaboration with organisations that are neither HIV-specific, nor African-specific.

As this is a planning document for the NAHIP partnership we concentrate on the needs of organisations delivering interventions that target African people in England, regardless of whether or not the

organisations provide services that are HIV-specific or African-specific. We also imagine that these organisational aims will be of use to other organisations that are not in the NAHIP partnership but deliver HIV prevention interventions to this population.

7.1.1 Ability to maintain financial stability

NAHIP plays a central role in supporting partner organisations to secure funding for the delivery of evidence-based HIV prevention interventions for African people living in England. However, their success in building capacity within the sector is challenged at a time when HIV prevention funding has become harder to secure as the political profile of the epidemic diminishes. While NHS and Local Authority HIV commissioners consistently prioritise African people in their commissioning intentions (Weatherburn *et al.* 2007) this prioritisation does not translate into substantial and consistent investment in meeting the HIV-related needs of Africans living in England. For example, although 70% of all Africans living in England live in London, it is a full seven years after an HIV prevention programme was established for gay men and other homosexually active men that a pan-London programme has been initiated to deliver HIV prevention for the African population across the city.

Programme funding is vital for the provision and sustenance of HIV prevention interventions.

Those responsible for the management of HIV prevention organisations report spending up to 80% of their time on the completion of funding applications, monitoring, and reporting back on contracts held (Weatherburn *et al.* 2007). This situation is likely to be particularly acute in African organisations that lack core funding.

A continuous crisis-driven existence weakens service user confidence and staff morale, and causes distraction from core prevention activities. All NAHIP partner organisations require senior staff with the skills and resources to ensure successful competition for funding from a diverse range of sources. This requires a good understanding of the funding environment and coherent,

confident relationships with those who commission NHS and Local Authority HIV prevention services and other charitable funders. Senior staff will also need to understand the necessity for financial accountability and the need for effective monitoring of services contracted and provided.

7.1.2 Ability to provide leadership

The leadership qualities that have been actively supported by NAHIP since its inception – such as clear communication, high expectations and motivation – require ongoing strengthening across all partnership organisations, and in their dealings with each other.

Staff and volunteers need to provide, and service users need to receive, HIV prevention services that are free from racism, homophobia and gender-bias. Organisations that promote and prioritise equality will function as models for such attitudes in the wider community.

Some organisations delivering HIV prevention to Africans may be inclined to retain an exclusive focus on ‘service delivery’. However, community-based organisations also have a mandate to speak for their service users by: undertaking activism; clearly articulating the HIV prevention needs of users; responding to consultations; and interacting confidently and proactively with the media. African- and HIV-specific organisations that command respect and demand action will help to change discriminatory practices and increase the attention and resources devoted to targeted HIV prevention activities among African people in England. The actions of such organisations will also provide models of leadership for potential service users.

Political campaigning by local and national HIV organisations working in partnership has led to significant policy change in the past. Some examples include: the Disability Discrimination Act 2005, the repeal of Section 28 of the Local Government Act 1988, and modifications to Home Office and Crown Prosecution Service policies. All demonstrate that activism and community leadership can have an impact on government policies and hence HIV prevention need.

Continued achievement of such change depends on HIV prevention managers working collaboratively to develop and implement joint policy priorities and also to

influence local and national decision-makers, in order to increase the priority given to the HIV prevention needs of Africans. While national policy campaigns may emanate centrally from within the African HIV Policy Network, it is essential that organisations understand, value and participate in such campaigns in order to improve their impact.

7.1.3 Ability to assess and meet need

Needs assessment involves making informed judgements about the extent to which health promotion aims are unmet in target groups. It requires skills to interpret existing research, knowledge of local need, and ability to advocate for the collection of evidence. It also requires partnership work with service users and researchers to ensure that needs assessments result in information that is coherent and useful. The assessment of need is vital to planning – it ensures that resources are targeted in areas of greatest need.

An assessment of need can consider:

- the extent to which a specific aim(s) is met for an entire population, for example,
 - ▶ Which African people in England would benefit from increased assertiveness?
 - ▶ Which NHS staff would benefit from increased skill in sexual history taking with Africans?
 - ▶ Which MPs would benefit from knowing about HIV stigma in African communities and its impact on HIV prevention?
- the extent to which all of the aims are met for a specific sub-population, for example,
 - ▶ What are the unmet HIV prevention needs of African Muslims?
 - ▶ What do faith leaders need to reduce the HIV prevention needs of their congregations?
 - ▶ What are the needs of PCT commissioners with regard to HIV prevention for Africans?
- the extent to which specific aims are met for a specific sub-populations, for example,
 - ▶ What don't Ugandan men know about how to access free condoms?
 - ▶ What are the community involvement needs of homosexually active African men?
 - ▶ What do NHS staff need to manage an African woman with HIV who wants to conceive?

The health promotion needs of African people described in Chapter 6 are broadly similar for all women and all men, but the extent to which they are met will vary between sub-populations and between individuals. A needs assessment for a sub-population should make an estimate of its size, its relationship to other population groups and make an assessment of how far away each is from the aims described. Needs assessments are independent of the programme of activities intended to address them. Whether or not an aim is met for a target group is not dependent on the availability of a service to address that need. An assessment of need should not be guided by the range or configuration of existing services. Further discussion of local, regional and national needs assessment can be found in the following chapter (section 8.3).

7.1.4 Ability to prioritise and promote confidentiality

Potential clients need to know exactly how information about their sex lives and other private details will be managed by staff and volunteers providing an HIV prevention service. Staff and volunteers must be able to operationalise and clearly communicate their agency's confidentiality policy with all potential service users. Confidentiality policies should not confuse service users nor be any impediment to service users being open about HIV if they choose.

Services must do their utmost to protect the safety and security of service users, staff and volunteers. Concerns about lack of privacy (and its implications) keep African people from accessing HIV prevention interventions. NAHIP partnership organisations must ensure that confidentiality policies are developed, described, enforced and widely publicised. No African person attending an HIV prevention service should fear that their identity or private information will be treated as a subject of gossip as a result.

7.1.5 Ability to work in partnership

HIV prevention interventions across the NAHIP partnership should be designed to be complimentary rather than contradictory. This requires ongoing and active communication within and outside of the partnership about current research, effective planning and prevention activities. Close working relationships,

joint planning, and the provision of HIV training for local statutory and voluntary sector organisations will enable effective referrals and support for individuals and families with complex needs.

Other partner organisations and institutions can include (but are not limited to):

- migrant and BME support charities,
- local organisations delivering HIV prevention, treatment and care that targets Africans,
- African cultural and home country organisations,
- social services providers (and commissioners),
- local NHS Primary Care and Acute Trusts (and commissioners),
- Strategic Health Authorities,
- faith groups,
- African and BME media outlets and businesses,
- schools, colleges and universities,
- Lesbian Gay Bisexual and Transgender community organisations,
- citizen's advice bureaux,
- local police,
- housing associations.

Partnership working within and beyond the HIV sector can provide an opportunity for a broader range of trustees and board members to offer their varied skills and experience to service providers.

7.2 WORKFORCE DEVELOPMENT AND RETENTION

A key challenge for NAHIP partners and other African HIV organisations is the retention of trained staff and volunteers who have developed skills and expertise. Where staff receive sufficient pay and are supported and valued in their work, they will stay in post for a longer period of time. Where volunteers are motivated and appreciated, they are more likely to dedicate more of their time to HIV prevention, and will be more likely to pursue paid work in the field. Participation in peer

education programmes and volunteer skills training can be motivated by a desire to improve job prospects elsewhere. This can mean that the potential for ongoing application and further development of skills relating to HIV prevention is undervalued. All health promotion training that is devised across the NAHIP partnership should include structures that help to retain contact with participants (ie. short-term organisational placements, newsletters and contact databases) in order to sustain individuals' interest through awareness of research developments, campaigning issues, sector updates and staff vacancies.

Staff and volunteers are central to ensuring that effective HIV prevention interventions reach people with unmet HIV prevention needs. They often provide the first point of contact for service users. This means that direct contact staff and volunteers require a set of characteristics and abilities that instill confidence in the organisation and the services being provided.

7.2.1 Sharing characteristics and understandings with target audiences

People using services are most likely to relate to health promoters who share some of their own personal characteristics, including an African language, and an understanding of their experiences, values and beliefs. Shared identity increases people's trust in staff members and volunteers, and will help them to feel that they will benefit from an intervention. African people accessing HIV interventions require health promoters who are similar to themselves across a range of basic dimensions, including age, gender, sexuality, religious background and ethnicity.

7.2.2 Skilled and approachable staff and volunteers

Shared demographic characteristics are not sufficient to ensure the success of interventions that are delivered face-to-face.

Respondents to one survey were asked: *For you, what is the most important characteristic or quality of someone giving you information or advice about HIV?* (Weatherburn *et al.* 2005). Answers focussed on the following themes:

- Honesty, confidentiality and non-stigmatising approaches.

- Being able to identify with the service user and gain their respect.
- Keeping a professional distance, speaking with authority, appearing to be trustworthy, knowledgeable and credible.
- Having the required skills and competence in the topic, being easy to understand and being approachable.

All people accessing HIV interventions, including Africans, require health promoters to provide information honestly and credibly, and without moral judgement. Those accessing HIV interventions require health promoters that establish a professional distance, which allows for mutual respect from both parties, and clarity about the anonymity and confidentiality of the interaction. African people accessing HIV prevention interventions require workers with the skills to assess their existing level of knowledge and needs.

African people accessing face-to-face HIV interventions need contact with African health promoters who can model open and frank discussion about sex that does not involve censorship, squeamishness, judgment or surprise. This modelling will ultimately influence the acceptability of open discussion about sex in the community and between sexual partners.

The needs of African people accessing HIV prevention interventions are best served when staff and volunteers make it clear what expectations they can meet, and which ones are best addressed elsewhere. This requires that staff members and volunteers can utilise resources and contacts relating to a broad range of voluntary and statutory organisations that can help the service user best meet a range of other needs and follow clear referral protocols.

All of the skills described above require continuous organisational maintenance of the basic principles and practices of equality. It must always be made clear to staff, volunteers, board members and service users that homophobia, racism and sexism have no place in NAHIP partner organisations.

7.3 ORGANISATIONAL AIMS FOR NAHIP PARTNERS

ORGANISATIONAL AIM 1:

NAHIP partner organisations increase the amount of funding they receive to undertake HIV prevention interventions.

This will require:

- Skilled senior staff (and board members) with an understanding of the funding environment, awareness of diverse funding sources and fund-raising experience.
- Implementation of financial transparency, service monitoring and evaluation.
- Confident relationships with NHS, local authority and charitable funders.

ORGANISATIONAL AIM 2:

Organisations increase the priority given to HIV prevention needs by improving their leadership profile.

This will require:

- Board members and senior staff who model and maintain a commitment to lobbying and community-led activism and encourage the take-up of such activities among all workers and volunteers.

ORGANISATIONAL AIM 3:

Organisations increase the extent to which they collect and utilise evidence in order to better meet HIV prevention need.

This will require:

- Recognition of the value of specific HIV prevention needs data.
- Skills to interpret existing data and access to emerging evidence.
- Commitment to participation in local and national needs assessments, and to ensuring that their value is recognised by staff, volunteers and service users alike.
- Recognition of the different ways in which need can be assessed, and being sure not to be guided by existing service provision in the assessment of need.
- Access to PCTs, local authorities and national

research organisations to ensure that their assessments of need capture the specific health needs of migrants, members of Black and ethnic minorities, and people with diagnosed HIV.

ORGANISATIONAL AIM 4:

Organisations prioritise and promote confidentiality.

This will require:

- A written policy on how confidentiality is managed in the organisation, and how breaches of confidentiality are managed.
- Ability to use and store private information, and to explain the policy to service users.
- Board members and senior staff with the communication skills and managerial ability to enforce the policy.

ORGANISATIONAL AIM 5:

Organisations increase the extent to which they work in partnership with HIV-specific, African-specific and other specialist organisations and institutions.

This will require:

- Recognition that partnership work increases skills and strengthens outcomes.
- Management in planning priorities and aims in partnership with relevant organisations.
- Development of local and national databases of relevant organisations alongside the development of referral protocols with those agencies.

ORGANISATIONAL AIM 6:

Organisations recruit and retain board members, workers and volunteers who share characteristics and experiences with the target group.

This will require:

- Community-based recruitment, and a commitment to ensuring that staff and volunteers feel valued, well-regarded and supported in their work.

ORGANISATIONAL AIM 7:

Organisations ensure that workers and volunteers have the skills and attitudes that ensure they are approachable and trustworthy.

This will require:

- Clearly articulated expectations of the non-stigmatising approach to be undertaken.
- Access to, and ability to interpret current HIV prevention evidence.
- Job specifications and recruitment processes that clearly identify essential criteria.

ORGANISATIONAL AIM 8:

Organisations ensure that all board members, workers and volunteers can model frank and open discussion about sex and sexuality.

This will require:

- Clearly articulated expectations of the professional and non-judgmental approach toward all expressions of sexuality.
- Access to sexuality training and an ability to interpret sexual behaviour research data.
- Job specifications and recruitment processes that clearly identify essential criteria.

ORGANISATIONAL AIM 9:

Organisations ensure that all board members, workers and volunteers can identify which service users' needs they are not able to meet, and make appropriate referrals.

This will require:

- Understanding of the organisation's mission and aims.
- A database of related specialist organisations and strong working relationships with those agencies where the highest number of referrals are likely to be made.
- Referral protocols that pay attention to issues of consent and privacy.

ORGANISATIONAL AIM 10:

Organisations ensure that all board members, workers and volunteers adhere to clear standards of equality.

This will require:

- Awareness and application of equalities legislation as it applies to gender, race, sexuality and disability.
 - An organisational equalities statement that includes clear protocols for action when equalities standards are not met.
-

NEEDS RELATED TO POLICY, PLANNING & RESEARCH

This chapter focuses on the needs of researchers, commissioners, and policy makers to contribute to the reduction of HIV transmission involving African people living in England. All of the HIV prevention aims in the previous two chapters are influenced by the decisions, activities and resource allocations of those in positions of power and influence (many of whom are listed in the box below).

International research suggests that it is these key players who have the greatest influence on (and therefore greatest responsibility for) HIV incidence (UNAIDS 2002, Barnett & Whiteside 2003). The target audience of HIV prevention interventions can include people in these organisations. It is therefore possible to have interventions that make a significant contribution to reducing the number of HIV transmissions from and to African people in England without mention of sexual practice, HIV or condom use. Examples of this include progressive and substantial changes to equality and

human rights legislation (for instance, Human Rights Act 1998, the Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005, and Equality Act 2006). Many of the needs described below will be met by NAHIP partner organisations working in partnership with the African HIV Policy Network to address the continuing inequalities that undermine HIV prevention need among African people living in England. In addition to the expertise and support offered by voluntary organisations and through familiarity with strategic planning documents such as this one, decision-makers require financial resources and the political will to reduce HIV transmission.

STRATEGIC AIM FOR POLICY MAKERS:

Policy makers, planners and researchers act to improve the capacity of individuals and organisations to meet HIV prevention needs among African people living in England.

Policy-makers and commissioners

Central Government
 Department of Health
 Expert Advisory Group on AIDS
 Independent Advisory Group for Sexual Health
 Department for Children, Schools and Families
 Office for Standards in Education
 Treasury
 Ministry of Justice
 Home Office
 Criminal Justice and Community Safety
 HM Prison Service

Local government
 Local authorities
 Councillors
 Police authorities

National Health Service
 Strategic Health Authorities
 PCTs and their board members
 Local Commissioning Consortia

Medical Research Council
 Sexual Health & HIV Research Strategy Committee

National Institute for Health and Clinical Excellence

Crown Prosecution Service

Equality and Human Rights Commission

Professional Associations

Association of Chief Police Officers (ACPO)
 British Medical Association
 Medical Foundation for AIDS & Sexual Health
 British Association for Sexual Health and HIV (BASHH)
 British HIV Association (BHIVA)
 The Children's HIV Association (CHIVA)
 The HIV Pharmacy Association (HIVPA)
 National HIV Nurses Association (NHVNA)
 Royal College of Nursing
 Society of Sexual Health Advisors (SSHA)
 Trade Unions including the National Union of Journalists (NUJ)

Surveillance and information providers

Health Protection Agency
 Communicable Disease Surveillance Centre
 Health Development Agency

Policy & research charities

National AIDS Trust
 African HIV Policy Network
 Terrence Higgins Trust
 Cancer Research UK
 Universities including Medical Schools
 AIDS Funders Forum

Policy forums and networks

African HIV Research Forum
 African Forums
 All-Party Parliamentary Group on AIDS
 All-Party Parliamentary Group on Refugees
 HIV and Sexual Health Commissioners Group England

8.1 NEEDS RELATED TO CENTRAL GOVERNMENT POLICIES

For sexual ill-health in England to be minimised, sexual health and HIV must be given adequate resources and attention across Government policies. The impact of policy changes on the incidence of HIV requires consideration by governmental departments beyond the Department of Health. For instance, policy decisions relating to immigration, criminal justice, prison and detention services, social services, education, and international development can all impact on the transmission of HIV to and from Africans in England.

“What is this addiction to naming obstacles? [...] The desperate, continuing imperative is leadership and political will. Somehow we have to diminish the incessant throb of high-level and low-level meetings, each with their latest declaration of intent, all sound and fury signifying so very little. We simply have to get down to work, country by country, with an urgency that knows no bounds.”

Stephen Lewis (2006: 202)

8.1.1 Health policy

There are many successes in the delivery of HIV prevention, treatment and care services in England that provide a strong foundation upon which all future prevention activity can build. For example, self-referred HIV and STI testing is freely and confidentially provided in clinical and non-clinical settings for all people in England, regardless of their residency or migration status, and high quality HIV treatment and care is freely available for all eligible residents. In addition, policy arising from the National Sexual Health Strategy (Department of Health 2001) has led to a widespread reduction in waiting times for appointments in clinical sexual health services.

At the national level, spending on HIV prevention targeting African people living in England continues to increase, although prioritisation of Africans with the highest degree of HIV prevention need remains a challenge. However, most organisations delivering services to this population perceive funding to be diminishing and inadequate (Weatherburn *et al.* 2007).

We believe this is because the Department of Health's intentions to expand specialist sexual health services are frequently over-ridden by re-prioritisation of funds at local level, although this is difficult to confirm because there is no monitoring or control of the ways in which PCTs allocate their spending (House of Commons Health Committee 2005).

Continued leadership from the Department of Health on HIV prevention for African people is clearly required. Further change requires that the Health Protection Agency continues to communicate the extent to which the heterosexual HIV epidemic in England is primarily comprised of African people, and that national HIV prevention funding provided through the Department continues to prioritise the prevention needs of Africans alongside those of men having sex with men.

The high costs of HIV treatment can mean that HIV prevention lacks priority in local NHS planning. However, the tangible public health and economic benefits of ensuring that fewer people ever require treatment must be used to challenge such tendencies. There is a need for political leadership to support the Department to find innovative ways to ensure that local services prioritise targeted HIV prevention for African people with the highest degree of unmet need.

HIV is the only serious communicable disease for which the Department of Health charges irregular migrants for the provision of treatment and care. Whereas public health outcomes take priority for other sexually transmitted infections or contagious illnesses (such as tuberculosis), the immediate costs of HIV treatment for irregular migrants appear to outweigh concern for longer-term costs to individual and public health (House of Commons Health Committee 2005). Where African people with HIV are undiagnosed and/or untreated they have an increased likelihood of participation in transmission (due to their ignorance of their HIV status) as well as a higher viral load, without effective treatment. Thus, it is difficult to understand how a government that campaigns for universal access to HIV prevention, treatment and care, simultaneously denies free treatment to anyone within its own borders.

The policy of charging a minority of African migrants for HIV treatment and care further impacts on HIV

prevention need within the entire population because it leads to confusion about who is eligible for free treatment, and in what settings service users may be asked for evidence of their immigration status. More must be done by the Department of Health and service providers to ensure that African migrants understand exactly who is liable to pay for HIV treatment, and what the confidentiality of services actually entails. Without clarity, confusion is likely to affect the perceived benefits of HIV testing.

At a time when political and public discourse is filled with anti-migrant sentiment, the Department will require a significant amount of political will to ensure that its charging policies do more to support health.

8.1.2 Education policy

Educational settings are an important place for young people to explore and learn about sex and relationships. Sex and Relationships Education (SRE) that reflects the experiences and practices of people of diverse sexualities and diverse religious and ethnic backgrounds should be a mandatory element of the National Curriculum. This will help to ensure that expert teachers deliver a holistic programme of education that meets HIV prevention needs among all young people, including Africans. In establishing SRE as a mandatory element of education, the government would signal to parents and families that this is a valuable and necessary aspect of developing healthy attitudes and practices among all young people. SRE that is delivered by confident, open, professionals is judged to be the best way of meeting parents' and young people's information and support needs and can improve communication about sex and sexuality within the home. This requires that the Department for Children, Schools and Families (DCSF) understands and applies evidence about best practice in SRE delivery to its curriculum planning, which should be a key outcome of its forthcoming review (Department for Children, Schools and Families 2007).

Schools are an important place for sharing core social values. This theme has featured prominently in policy shifts toward the prevention of bullying (Smith 2000, Jenett 2004) and the addition of Citizenship to the mandatory curriculum. Schools are now expected to take

a proactive stance against discrimination and harassment – including that driven by racism, sexism and homophobia. As a result of such interventions, young people and those who educate them should be increasingly aware of the importance of promoting diversity and equality for a healthy and prosperous society. Such work needs to be sustained with appropriate resources – which requires that the DCSF and the Children's Commissioner monitor and evaluate current practice and extend the interventions that are most successful.

8.1.3 Prison and detention policy

People who are confined in prisons or detention centres (due to either criminal or immigration matters) often lack the resources to avoid involvement in sexual HIV exposure (National AIDS Trust & Prison Reform Trust 2005). This vulnerability and its sexual health (and human rights) implications should be recognised by the Home Office and the Ministry of Justice. Departmental support of sexual health promotion programmes currently being carried out in prisons and detention centres (largely funded by PCTs) requires assessment of the level of HIV infection and HIV risk in custodial settings. The Home Office and the Ministry of Justice will also benefit from conferring with one another, and with health professionals and relevant communities when considering intervention and policy options for incarcerated populations.

Established health policies in prisons tend to mean that expert treatment and care for inmates with HIV is available. However, provisions for the health of irregular migrants and asylum seekers being held in detention can be *ad hoc* and intermittent (National AIDS Trust 2007a). This is particularly detrimental for people with diagnosed HIV who require regular clinical checks and ongoing treatment. Where people with diagnosed HIV are in regular contact with HIV clinical specialists, their health outcomes are improved, and they are less likely to transmit HIV as a result. The Border and Immigration Agency (an executive agency of the Home Office) will require close liaison with the Prison Service (a part of the Ministry of Justice), Offender Health (a part of the Department of Health), clinical HIV specialists and community organisations in order to better develop its delivery of specialist HIV and general health care to its detainees.

8.1.4 Criminal prosecution policy

Since 2003 a number of individuals have been criminally prosecuted for the reckless sexual transmission of HIV in England, under the *Offences Against the Person Act 1861*. Many of the defendants (as well as complainants) have been African migrants, resulting in custodial sentences that are accompanied by recommendations that deportation is considered. Despite the small number of prosecutions to date (fewer than twenty), ill-informed and sensationalist media coverage has increased concerns about discrimination among African people with diagnosed HIV (Dodds & Keogh 2006) and undermined the public profile of HIV as a long-term, manageable condition.

Some countries have drafted HIV-specific legislation, and some undertake criminal prosecutions simply for exposure to HIV (Nyambe & Global Network of People Living with HIV Europe 2005). The current application of existing assault law to cases in England involves only those where HIV transmission has occurred. Despite a host of legal and academic discussion, there remains little clarity about what may specifically be used as evidence in order to bring a prosecution, and which preventive actions would provide a legal defence (Weait 2007). HIV support organisations report that there is wide variation in the approaches to such cases taken by police investigators, crown prosecutors and HIV clinicians. In short, the lack of consistent policy and clear guidance on how such cases should be conducted, and how personal information about HIV status should be handled, has contributed to widespread confusion about criminal prosecutions among people with diagnosed HIV and those who work with them. The Department of Health, Ministry of Justice and a range of HIV organisations have consulted with the Crown Prosecution Service in their development of prosecution guidelines for such cases, which, it is hoped, will offer some clarity on the issues raised above.

Concerns about the detrimental effect that criminal prosecutions have on HIV prevention aims have been brought to the attention of representatives from the Department of Health and the Home Office. Ongoing liaison between the two departments on the particular issue of criminal prosecutions is to be encouraged. HIV experts' contribution to the development and provision

of HIV guidance and training with the Association of Chief Police Officers, the Crown Prosecution Service and the judiciary may help to diminish the harmful impact of such prosecutions. Furthermore, the provision of basic legal, data management, and media training for health professionals, including HIV service providers, will help them to better meet the needs of service users. Detailed information and recommendations to help achieve these aims can be found elsewhere (see for instance, Dodds *et al.* 2005, Anderson *et al.* 2006, Bernard 2007).

8.1.5 Immigration policy

People who are able to exercise control over their daily lives will be more able to control the extent to which they avoid participating in HIV transmission. Immigration policy that dictates that asylum seekers cannot be gainfully employed and cannot choose the town or city in which they live, places conditions on individuals and families which effectively eliminate control over their own circumstances (African HIV Policy Network 2006). Among African asylum seekers, such policies exacerbate HIV transmission risk. Enabling those seeking asylum to earn and pay taxes while their claims are processed will benefit the lives of other migrants in the community, as well as local and national economies. The Border and Immigration Agency would benefit from Health Impact Assessment data in determining the cost and ongoing feasibility of such policies (see section 8.3 below).

8.1.6 International policy

All the investment in HIV prevention, treatment and care that occurs at a global level inevitably impacts on the domestic HIV epidemic among Africans in England. Since 1997, the Labour Government (and, the current Prime Minister, Gordon Brown in particular) has provided international leadership on issues of international development including attainment of the Millennium Development Goals and global debt repayment. The Labour Manifesto of 2001 pledged its commitment to universal HIV treatment access by 2010, and UK research funding continues to drive progress toward the development of safe and effective HIV vaginal and rectal microbicides as well as a preventive HIV vaccine. The UK is at the forefront of development and international HIV prevention goals, and all departments involved, from the Prime Minister's Office,

to the Treasury, to the Department for International Development require ongoing support from non-governmental organisations and the broader public to achieve their aims (House of Commons International Development Committee 2006).

8.2 NEEDS RELATED TO LOCAL GOVERNMENT AND NHS POLICIES

8.2.1 Strategic planning in the NHS

There are 10 Strategic Health Authorities (SHAs) in England that oversee the activities of 150 Primary Care Trusts (PCTs). SHAs are responsible for developing plans to improve local health services, ensuring that local NHS organisations are performing well, increasing capacity, and making sure that national priorities are delivered at a local level. Ultimately, SHAs are responsible for performance management of NHS services in their area.

Therefore, where the Department of Health releases additional monies with specific spending priorities attached, it is the responsibility of the SHAs to ensure that PCTs deliver. This requires that SHAs are aware of the strategic plans, and patterns of commissioning and service delivery in the PCTs in their area. Prioritising (local) HIV prevention will also require transparent monitoring of spending and activity as distinct from general sexual health spending and investment in clinical services. It will further require local HIV prevention needs assessment and Race Equality Impact and Health Impact Assessments, in close collaboration with local HIV and African community-based organisations.

8.2.2 Commissioning of NHS and community-based HIV prevention

Primary Care Trusts control approximately 80% of all NHS spending. The difficulties related to the diversion of sexual health funding at PCT level have already been raised. Commissioners within the NHS are responsible for making sure that HIV prevention is adequately resourced.

Commissioners require a high degree of familiarity with the HIV prevention interventions that they fund, as well as reliable evidence of uptake and effectiveness (National AIDS Trust 2007b). Strong relationships with

African community-based organisations, and up-to-date knowledge of local HIV prevention need among Africans will enable commissioners to advocate for appropriate resources. Consortia commissioning for programmes of HIV prevention for African people across PCT boundaries will improve the extent to which knowledge, expertise and resources are efficiently shared.

Commissioners should prioritise HIV prevention interventions that meet the needs of African people already diagnosed with HIV, as this is the group within the African population that is most likely to participate in HIV transmission. Such interventions may be delivered by HIV care and treatment providers, with whom such individuals will already be in regular contact.

Clinical and non-clinical sexual health (GUM) services should prioritise sexually active African people in England as a client group. This will require resources in order to better promote services among African people, and to provide services that are available at accessible times of the day, in accessible places, and in languages that are most likely to increase uptake.

8.2.3 Provision of NHS services

Local NHS services are partly or wholly responsible for HIV prevention interventions that target African people. Provision for the sexual health needs of this population requires understanding and recognition of traditional, religious and sexual practices that will impact on sexual health outcomes. African community-based organisations' participation in the design and delivery of services targeting Africans is therefore crucial to their success.

Further to this, all health providers (from general practitioners, to maternity unit staff, to specialist HIV clinicians) must ensure that health decisions are always subject to informed consent, and that security of personal health information is prioritised. In addition, the NHS is responsible for ensuring that all service users are treated with respect and dignity. This will require that local NHS providers proactively address racism, xenophobia, gender-bias, homophobia and HIV-related stigma in the attitudes and practices of their staff, and in recruitment and employment practices. NHS managers therefore require the resources and skills to enable them to prioritise equality in all healthcare settings.

African people without diagnosed HIV who access primary care and sexual health services need to know that HIV testing is available in these settings. This requires that GPs, nurses, acute care specialists and GUM (clinic and community-based) staff have the resources and skills to offer HIV testing to African service users with fully informed consent.

The work that has been undertaken to improve homosexually active men's access to post-exposure prophylaxis (PEP) following sexual exposure to HIV has dramatically improved this population's awareness of PEP as a treatment option (Dodds *et al.* 2006). It is likely that in time, more people exposed to HIV through homosexual and heterosexual contact – including African people – will come forward to request PEP treatment. Local NHS managers should work in conjunction with HIV voluntary organisations, community groups, and professional HIV clinical associations (BHIVA) to ensure that staff in acute services (Accident and Emergency) and sexual health (GUM) service providers understand and can apply the correct assessment and prescribing protocols in such situations (Fisher *et al.* 2006).

8.2.4 Commissioning and provision of services other than health

The provision of essential services such as safe and accessible housing, social services, policing, legal advice and welfare benefits advice for African people living in England will help to meet HIV prevention needs within this population. Improving HIV prevention outcomes means that the social care needs of African people with diagnosed HIV are a priority, followed by the social care needs of all African people. Knowledge of this document can improve the HIV prevention impact of these services. Research evidence and support from HIV and African community-based organisations will help in the development of planning that contributes to HIV prevention.

Local service providers (schools, police forces, social services etc.) should be vigilant about resisting racism, homophobia and HIV-related stigma in their own employment practices, among their staff, and among those who access their services. This requires clearly articulated and continually enforced equality policies.

Those who manage the delivery of services will need access to the resources and skills to enable them to prioritise equality in the working environment.

8.3 NEEDS RELATED TO PLANNING AND THE EVIDENCE BASE

Chapter 7 provided some discussion of NAHIP partners' roles in assessing the HIV prevention needs among African people in their local population. Needs assessment also plays a role in the delivery of statutory service delivery.

The NHS plan describes how PCTs should actively address the health needs of the local community. All PCTs have a statutory responsibility (Department of Health 2001, 2003) to assess the HIV health promotion needs of their resident population. They also have a responsibility to commission services to meet as much need as possible in the most equitable manner. However, the extent to which some health promotion aims are met, the obstacles to them being met and the health promotion initiatives that may best achieve them, can transcend PCT boundaries. Some needs therefore require assessments across geographic areas larger than single PCTs. Provision and planning for such assessments will require support from Strategic Health Authorities, from the Department of Health, and from HIV and African community-based organisations.

From 1st April 2008 the Local Government and Public Involvement in Health Act (2007) imposes a duty for PCTs and upper-tier local authorities to undertake Joint Strategic Needs Assessments (JSNAs) in order to better understand the current and future health and well-being needs of their populations. This system of joint strategic needs assessment will form the commissioning evidence base for interventions that result in improved health and well-being outcomes, and in the reduction of health inequality (Department of Health 2007a). In addition to this, the Equality and Human Rights Commission (EHRC) established under the Equality Act 2006 operates to safeguard policy and practice responding to the particular needs of ethnic and sexual minorities. Support from the EHRC will be critical in order to ensure that Race Equality Impact Assessments are undertaken in respect of procurement and service delivery. Such assessments of health and race impact can

provide a tremendous amount of leverage to ensure that the HIV prevention needs of Africans are appropriately met.

A reliable sexual health and HIV evidence base requires not only the participation of individuals and service providers, it also requires that local commissioners and national funders collect and make available transparent data for evaluating policy change, including the surveillance and publication of resource allocations.

8.4 POLICY AIMS

POLICY AIM 1:

The Department of Health provides strategic and financial support for the appropriate national delivery of HIV prevention interventions for Africans.

This will require:

- Knowledge of PCT spending on sexual health promotion and HIV prevention.
- Evidence of the social, medical and economic impact of the HIV epidemic in the UK.
- Knowledge of interventions that meet HIV prevention needs.
- Pressure from HIV and African community-based organisations.

POLICY AIM 2:

The Department of Health reconsiders its view on charging irregular migrants with HIV for their treatment and care in recognition that it is a practice that costs more than it saves.

This will require:

- Political support from MPs, local councillors, and African community-based organisations.
- Research evidence collected by public health and social science experts with support from statutory and community based organisations delivering services to African people.

POLICY AIM 3:

The Department for Children, Schools and Families incorporates into the national curriculum, a programme of sexual health and relationships education that reflects the experiences and practices of people of diverse sexualities and backgrounds.

In order to do so, it will require:

- Support from MPs, parents, teaching associations, and faith groups.
- Research evidence collected by public health and social science experts.
- Resources to establish a curriculum and train professionals for its delivery.

POLICY AIM 4:

Anti-racist and anti-homophobic education initiatives are maintained and extended throughout the education system.

This will require:

- Initial and continuing provision of equality training for all staff (including non-teaching staff).
- Improved access to resources.
- Equality auditing in all educational settings that includes input from students and staff.
- Evaluation of the Citizenship curriculum in relation to equality outcomes.

POLICY AIM 5:

All agencies involved in criminal prosecutions for the reckless sexual transmission of HIV (Home Office, Crown Prosecution Services, NHS services and the Association of Chief Police Officers) reconsider and clarify their approaches to such prosecutions in light of the detrimental public health impact that they are likely to have.

In order to do so, they require:

- Evidence of the health and race equality impact of prosecution.
- Interaction with people representing people with HIV and those working with them.
- Collaboration with and support from the Department of Health.

POLICY AIM 6:

The Border and Immigration Agency (part of the Home Office) and Offender Health (a part of the Department of Health) increase their actions to ensure prison and detention services meet the HIV prevention, treatment and care needs of inmates of prisons, young offenders institutions and migrant detention centres.

In order to do so, they require:

- Liaison with each other and cross-departmental consultation on best practice in detention.
- Evidence from clinical HIV specialists and public health experts on the needs of inmates and detainees.
- Political and public support for improved conditions in migrant detention settings, prisons and youth offender institutions.

POLICY AIM 7:

The Home Office reconsiders its policy of dispersing asylum seekers across the country in light of the general health and HIV prevention needs that can be met when people are able to socialise and live in areas of their choosing.

This will require:

- Evidence from Local Authorities, Strategic Health Authorities, voluntary sector organisations and PCTs assessing the race equality and health impact of dispersal.
- Political and public support for improved living conditions for people seeking asylum in England.

POLICY AIM 8:

The Home Office reconsiders its policy of disallowing asylum seekers from seeking legal employment in light of the impacts that this restriction has on health and well-being in general and HIV transmission in particular.

This will require:

- Evidence from Local Authorities, Strategic Health Authorities, voluntary sector organisations and PCTs on the social and health impact of poverty and unemployment.
- Political and public support for improved living conditions for people seeking asylum in England.

POLICY AIM 9:

Central government departments (particularly the Department for International Development) intensify their roles in the development of international policies and activities that directly and indirectly influence the HIV pandemic.

This will require:

- Motivation to deliver on international level agreements.
- Improved cross-departmental collaboration between the Home Office, Ministry of Justice, Department of Health and Department for International Development to ensure that domestic and international agendas are mutually supportive.
- Lobbying from HIV and anti-poverty organisations.
- Collaboration among scientists in order to ensure that advances are shared fully and expediently.
- Continuing pressure on pharmaceutical companies to reduce the costs of all HIV anti-retroviral treatments.
- Contributing the promised amount to the Global Health Fund.
- Meaningful participation in global monitoring exercises including those carried out in relation to the United Nations International Declaration on HIV / AIDS (2001), to which the UK is a signatory.
- Continued support to strengthen health professional infrastructure (i.e. resources for training, improved pay and working conditions) in developing countries, such as that pioneered by DFID in Malawi.

POLICY AIM 10:

An increase in the proportion of Strategic Health Authorities that include targets for HIV in their planning and performance monitoring mechanisms.

This will require:

- A nominated lead for sexual health and HIV at every SHA.
- Knowledge of local HIV epidemic, priority groups and prevention needs.
- Health promotion expertise.
- Data on HIV prevention spending in each PCT (disaggregated from sexual health spending).

POLICY AIM 11:

NHS commissioners ensure that HIV prevention is adequately resourced, and that such funds are not diverted to help manage shortfalls in other areas.

This will require:

- Accessible information on current and past HIV prevention spending (clearly disaggregated from sexual health spending) in every PCT.
- Access to evidence of local HIV prevention need among Africans, alongside Race Equality Impact, Health Impact and Joint Strategic Needs Assessments, as well as the skills and capacity to interpret and act on these
- Lobbying from HIV and African organisations.

POLICY AIM 12:

All NHS and local authority commissioners increase consortia commissioning arrangements for programmes of HIV prevention for African people across PCT and local authority boundaries.

This will require:

- A planning framework with real input from the community organisations and individuals.
- A consensus between PCTs and HIV health promoters on the minimum standards for local HIV prevention programmes.

POLICY AIM 13:

An increase in sexual health promotion interventions for African people already diagnosed with HIV by HIV care and treatment providers.

This will require:

- An understanding of unmet HIV prevention need among service users.
- Knowledge of interventions that meet HIV prevention need.
- Knowledge of other (non-clinical) services for referral.

POLICY AIM 14:

NHS service providers ensure that HIV prevention interventions targeting Africans are accessible, appropriate and effective.

This will require:

- Confidentiality policies that are understood by service users.
- Knowledge of the practical and linguistic needs of service users.
- Understanding and recognition of traditional, religious and sexual practices that will impact on sexual health outcomes.

POLICY AIM 15:

NHS providers reduce the extent to which service users are subjected to discrimination based on ethnicity, sexuality, gender, migration status or HIV status.

This will require:

- Access to evidence of discrimination in the delivery of health services.
- Knowledge of interventions that reduce practices of inequality in the delivery of health services.

POLICY AIM 16:

All clinical staff in primary care, emergency services, specialist care and GUM services (either clinic or community-based) increase offers of HIV tests to African men and women attending for STI screening or presenting with HIV-related illnesses, and seek informed consent for testing.

This will require:

- Policy on offering HIV testing and the skills to identify opportunistic illnesses that indicate HIV infection.
- Ability to raise and talk about HIV testing without making service users feel obliged to take a test.
- Ability to explore past and potential opportunities for infection and onward transmission with clients.
- Ability to educate service users about the benefits and drawbacks of both a positive and negative test results.
- Ability to clearly identify for service users who is and is not eligible for HIV treatment without charge.
- An appreciation that some Africans will decline HIV testing without wishing to disclose a reason.
- Agreed minimum quality standards for testing services.

POLICY AIM 17:

All emergency and GUM services (either clinic or community-based), increase the availability of post-exposure prophylaxis (PEP) to African people (and the sexual partners of African people) that may have been sexually exposed to HIV.

This will require:

- Access to guidance on the use of PEP.
- Clinicians with the skills to assess men's and women's need for PEP.
- An accessible evidence base about the performance qualities of interventions.
- Community support and lobbying for making PEP available.

POLICY AIM 18:

Local service providers increase the delivery and commissioning of services which reduce the HIV prevention needs of African people.

This will require:

- Understanding of and access to local and national evidence of HIV prevention need among African people.
- Knowledge of interventions to meet HIV prevention need.
- Clearly articulated and continually enforced equality policies.
- Lobbying from equality bodies such as the Equality and Human Rights Commission to undertake Race Equality and Health Impact Assessments on procurement and delivery of services.
- Collaboration with community-based HIV and African organisations.

POLICY AIM 19:

All local authority and NHS commissioners responsible for HIV and / or sexual health increase their contribution to the national sexual health and HIV evidence base by collecting and making available transparent data for evaluating policy change, including the publication of resource allocations.


This will require:

- Adequate and stable intervention monitoring systems.
 - Research designs that take account of the context of service delivery.
 - Research funders to specify service involvement in research design.
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