Capital assets

a community research intervention by The African Forum in Redbridge and Waltham Forest (London)

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Executive summary

In a unique community-led initiative, over 1000 Africans resident in Redbridge and Waltham Forest have been asked about their assets and health needs. This report describes the survey which was undertaken by community groups themselves in collaboration with professional social researchers. This community-based research intervention is the first major initiative of the Redbridge and Waltham Forest African Forum. The Forum grew out of a recognition that HIV-related needs among African communities would best be addressed by the communities networking and engaging with the statutory services.

The survey was designed both to gather information from the communities and to provide information to them. The information sought was not simply about the participants information needs but also about the assets they have to address those needs within their own communities. The project sort to provide information about the relationship between Africans living in Redbridge or Waltham Forest, their assets, health needs and the potential for interventions. It did so by:

- providing all stakeholders with clear and accessible information about the demography of the local African communities
- mapping the priorities and needs of the groups
- assessing knowledge about HIV and preventing infections
- mapping linguistic assets and social structures of participating community groups that may contribute to meeting these needs
- identifying acceptable, culturally appropriate methods of intervention.

The Forum invited Sigma Research, a university affiliated independent research organisation, to provide the design of the survey, the input and analysis of the data and the writing of this report. Questionnaire content was led by the members as was the structure and commentary in this report. Members of community groups interviewed (mainly) members of their community. The report is on the findings of the survey. It is not an evaluation of the interventions that occurred during the collection of the findings.

Between them, 41 interviewers talked to 1008 residents. The majority of African women and men living locally are at an age when people can be at their most active physically, mentally and economically. Mental health and HIV/AIDS were the major health concern for this group, and these concerns were associated with country of birth. Many respondents lacked basic knowledge of HIV transmission. There is a need for more awareness of clinical sexual health services in Waltham Forest and Redbridge. For example, 63% of community members had not heard of Whipps Cross Sexual Health Clinic and a very small proportion (3%) had ever used it. Language ability and social networks are common assets for health. English is spoken by 78% of participants and 88% of the entire sample mentioned at least one person they were close to.

In conclusion, the survey provides information that helps to identify key areas where community organisations and statutory services working in partnership can improve quality of life and access to services.

1 Introduction and methods

1.1 LONDON BOROUGH OF WALTHAM FOREST AND LONDON BOROUGH OF REDBRIDGE

Waltham Forest and Redbridge are two of the Outer London local authorities, situated on the north east side of the capital. Redbridge has 232,600 residents, making it the eleventh most populated of London's 33 Local Authorities, and Waltham Forest has 220,249 residents, the fifteenth most populated. Both boroughs have high rates of unemployment generally, and especially among ethnic minorities. They also have high numbers of people with literacy or numeracy needs, lone parents, ex-offenders, homelessness and other indicators of deprivation.

The area covered by the two Local Authorities is the same as that covered by the *Redbridge & Waltham Forest Health Authority*, one of London's sixteen Health Authorities. The total population of Redbridge & Waltham Forest Health Authority is therefore 452,849. Estimates of the number of African people resident in the Health Authority vary considerably. The 1991 Census (Coleman & Salt, 1996) suggests 10,000, the majority (about 70%) of whom live in Waltham Forest. Later estimates are much higher with a recent estimate of 25,000 (Focus Consultancy, 1999). There is consensus, however, that in both Waltham Forest and Redbridge, African communities are mainly resident in the Southern parts of the boroughs.

African communities resident in Waltham Forest are mainly of Somali and West African origin (Nigeria, Ghana and Sierra Leone). While Redbridge is also mainly populated by Somalis it also includes Eritreans, French speakers, West and East Africans. 'New arrivals' and asylum seekers are assumed to be more common in Redbridge, while Waltham Forest residents are assumed to be more 'long-settled'. Age profiles of African populations are similar across the two boroughs (Focus Consultancy, 1999).

1.2 REDBRIDGE & WALTHAM FOREST AFRICAN FORUM

The Redbridge & Waltham Forest African Forum ('The Forum') is a community development initiative funded in partnership by both local authorities and the health authority through: the HIV Care Management Team (London Borough of Waltham Forest); the Community Care HIV Team (London Borough of Redbridge); and Redbridge & Waltham Forest Health Authority. It was developed with support from the Family Services Unit (London Borough of Waltham Forest). Family Service Units (FSU) is a national registered charity helping people to deal with family crises, poverty and social exclusion by providing community based family support services through a network of Units in England and Scotland. In 1997 Waltham Forest FSU was commissioned by the Health Authority and the Social Services Department to facilitate early access to support services for Africans affected by HIV. Part of the work involved developing awareness within the communities particularly affected. This led to the development of the Forum with a co-ordinator based in the FSU.

The Forum was developed to respond to HIV-related need among African people in the two boroughs. It grew out of a recognition by community members and funders of that these needs would best be addressed through engagement with local African communities, and by encouraging and sustaining inter-community relationships through sharing information and networking. Forum members recognised that despite their wide-ranging geographical origins and variety of culture and languages, the problems and challenges African people face as immigrants to the UK are markedly similar. While the term 'African communities' highlights differences, the inclusive term 'African community' reminds us of the similarities.

The Forum is currently (Autumn 2000) made up of twenty five community organisations representing many areas of the African continent. The groups cover a diversity of languages, cultures and religions. The Forum has no firm criteria for membership and is not limited to agencies involved in (or concerned with) health or employment, or any specific issue.

As with many community development initiatives, the interests of those instigating the project (the health and local authorities) were not wholly co-terminus with those of the community groups who became involved. While HIV need is a central shared concern, this is not the only health issue for Forum members, and health is not their only concern. Hence, the precise remit of the Forum is fluid, but its initial membership has done much to define its current roles and work programme. This process is wholly in line with the present government's agenda as well as that of the health and local authorities, which recognise that if communities are to create change, they must initiate and control the processes.

1.3 INVESTIGATING BOTH SIDES OF THE COIN: NEEDS AND ASSETS

This community-based research intervention is the first major initiative of the African Forum. It addresses the information needs of African communities in Redbridge and Waltham Forest. The tone and nature of the project was the outcome of considerable discussions among the members of the African Forum. It was designed both to gather information from the communities and to provide information to them. Hence it was both a research investigation and an educational intervention. More importantly, the information sought was not simply about the participants information needs, but also about the assets they have to address those needs in their own communities.

Many migrants who come to Britain are educated and occupationally qualified but upon arrival are all too often rendered dependant. The approach of statutory authorities to dealing with these communities is usually one-dimensional, failing to recognise the positive contribution they can and do make to society.

The Forum wanted to investigate not only the HIV prevention information needs of the communities but also the assets that could be utilised for the benefit of others. In the process, they provided opportunities for interviewers and participants (who were often members of the same community) to talk about HIV. This approach offers a particpatory, creative and empowering alternative to standard needs assessment. It does not compound the disadvantage of existing communities by defining them simply as the sum of their needs. It recognises that in order to develop communities from within there is a need to use approaches that highlight their assets and abilities.

The success of the project depended very much on the relationships that exist between community organisations, communities and statutory organisations. It is a community initiated research intervention that promoted partnership working. Because it is largely community driven, it builds on the problem solving strategies of the communities using their own priorities as a starting point. It moves away from the usual approach of identifying what is lacking, what they do not have and how others can help them, to a more positive approach of acknowledging and utilising the strengths that exist within the communities.

The project was a multi-component research intervention which combined identifying the strengths of the communities in Redbridge and Waltham Forest, assessing needs and actively engaging the communities with information. The project sought to provide information about the relationship between African communities, their assets, health needs and the most effective interventions.

It did this by:

- providing all stakeholders with clear and accessible information about the demography of the local African communities.
- mapping the priorities and needs of groups.
- assessing knowledge about HIV and preventing infection.
- mapping linguistic assets and social structures of participating community groups that may contribute to meeting these needs.
- identifying acceptable, culturally appropriate methods of intervention.

The Forum started with the observation that the local African community is not so large or so disparate that services cannot be developed and targeted effectively.

1.4 METHODS: BOTH RESEARCH AND INTERVENTION

The idea of a research investigation that also benefited those taking part was proposed and discussed by the African Forum members. It was agreed that a relatively short and simple interviewer administered questionnaire should be developed that Forum members could administer to members of their own communities. The Forum invited Sigma Research, a university affiliated research unit, to assist with the design and implementation of the survey.

The process of questionnaire development was undertaken in partnership with Forum members. After initial meetings with the Forum to discuss topic areas, a draft questionnaire was developed and reflected back to the members. After feedback this was modified and shared with members again. The process was inclusive and reflexive with all parties involved in discussions regarding prioritisation of question areas and topics. The interview was designed to last about 15 minutes, excluding questions and discussion at the end.

When the final draft of the questionnaire was ready the Waltham Forest Family Services Unit together with the Health Authority facilitated a one day training event for Forum members, and other likely interviewers. The morning concentrated on basic awareness of HIV and other health problems. The afternoon was used to discuss the final amendments to the questionnaire, and then focussed on recruitment and interviewing skills, community ethics and confidentiality. It was agreed that usually the interviewer would conduct the survey (rather than allow self-completion) and that the interview would be in English unless the participant was not comfortable with this. Interviewers suggested they concentrate on recruiting participants from their own communities, which also allowed them to use whatever alternative language was shared if participants were not comfortable responding in English.

Ultimately there were 41 interviewers representing a huge variety of community and ethnic groups. When they collected the printed questionnaires interviewers were provided with a sheet reminding them of the key points of the training day. They were also given laminated identity (ID) cards. Interviewers were paid for each interview they completed and returned.

All interviewers were briefed to defer any questions arising during the interview until the end. They then invited and answered questions, distributed the written resources provided and made referrals into services if required.

The HIV knowledge section of the interview consisted of giving participants statements and asking them if they thought they were true or false. In fact, all nineteen statements were true. This allowed the interviewer to state a number of facts about HIV, minimised confusion, and made addressing errors at the end of the interview easier. The interview process therefore also served as a simple educational intervention which could develop into a longer discussion if the participant wished to pursue it.

In these ways the research process itself functioned as an intervention. Over a thousand African people took part in conversations about HIV infection that included the stating of a large number of educational facts about HIV with many including an additional discussion. The entire project models one means of implementing a recent recommendation for primary prevention among African communities in London:

> 'Outreach and peer education models need to be developed in community organisations, clubs, churches and on a one-to-one basis. Volunteers of community organisations should be trained to provide effective HIV prevention messages.' (Mukasa, 1999, p.43)

In the case of the current project, it was the volunteers who led the training process. All interviewers attended a feedback and debriefing session, where issues of concern were addressed and where they could compare experiences.

1.5 CONTENT OF THE REPORT

This is a report on the findings of the survey. It is not an evaluation of the interventions that occurred during the collection of the findings. The next chapter describes the participants in the survey (or the sample). The third chapter looks at their health concerns in general and their HIV prevention information needs in particular. The fourth chapter reports data about two existing assets of the participants in addressing their own health needs: their collective linguistic abilities and their social networks. Finally, chapter five presents survey findings relevant to the potential for general health and HIV prevention interventions.

2 Description of participants

This chapter describes the people who participated in the research.

2.1 THE INTERVIEWERS

The energy and optimism that interviewers and participants alike brought to this project is reflected in the numbers involved. There were 41 interviewers in total, of whom 16 carried out 20 interviews or more (the remaining 25 interviewers each carried out nine interviews or less). In investigations in which the needs of the researchers are uppermost, multiple interviewers are often seen as a drawback. They result in greater variation in interview technique so data validity is more often questioned. However, in terms of participant-led research where the research process itself can be thought of as an intervention, the more interviewers the better.

Community members undertaking the research interviews averted the credibility problems that have been associated with 'outsiders' carrying out research on minority ethnic groups. In a very tangible way they have begun the process of changing the perception within and outside the African community of Redbridge and Waltham Forest that research is something done by white people to black people, where the latter are relatively powerless.

The language skills of community members have largely been overlooked as an asset. Almost a quarter of participants did not have English as a spoken language (see chapter 4). This meant the language abilities of the community interviewers were a key to our success in involving such a diverse range of participants. The community assets for health promotion are also assets for health research.

2.2 THE INTERVIEWEES

Between them, the 41 interviewers talked to 1008 residents. This project confirms the conclusion of another social diffusion intervention among Africans in London which pointed out that:

> 'rather than drawing the conclusion that the intervention is an effective way of reaching communities that are 'hard to reach', it suggests that the communities are relatively easy to reach when culturally appropriate methods of reaching them are used.' (Bitel, 1999, p.20)

The following describes these 1008 people using eleven key characteristics asked as part of the interview.

2.2.1 Age and gender

More men than women participated in all age bands, with men accounting for 56% of all participants (gender was missing for five participants).

There was no difference in the age profiles of the men and women. Over a third of participants (36%) were between 25 and 34. Approximately one quarter (25%) were under 25 and more than a third (39%) were 35 or older.

The sample suggests that the majority of African women and men living locally are at an age when people can be at their most active, physically and socio-economically.

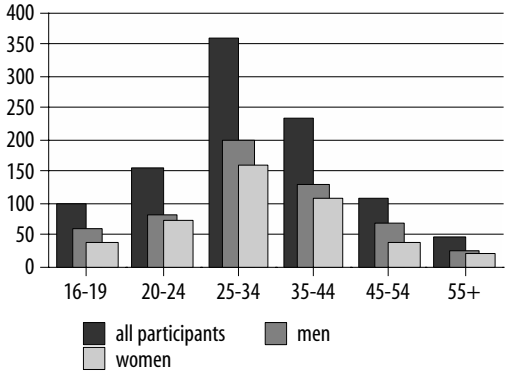

Figure 2.2.1: Age profile by gender (502 men, 430 women)

2.2.2 Borough of residence and length of time in London

More of the participants lived in Waltham Forest (59%) than Redbridge (41%). Although the proportion of men and women was similar, more of those living in Redbridge were aged under 20 or over 45 compared with people living in Waltham Forest.

The majority (58%) of participants had been resident in the UK five years or less, including a sixth(17%) that had been resident in the UK less than 1 year. Almost a third had lived in the UK between 5 and 10 years (30%), 10% over 10 years and small proportion (2%) had always lived in the UK (ie. had been born here).

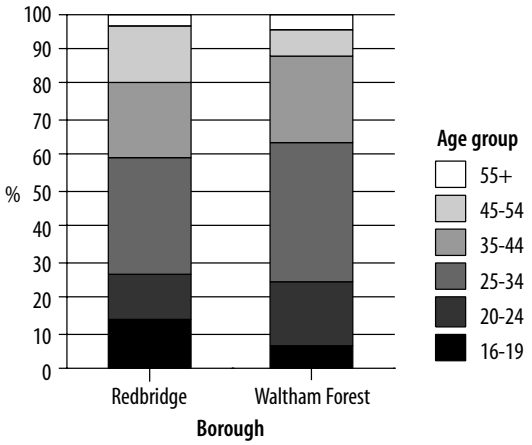

Figure 2.2.2a: Age profile by borough of residence (N=399 and 583)

- **This is an incoming population to the UK.**

More of those living in Redbridge had arrived in the UK within the last year compared with those living in Waltham Forest. As a group overall, the women had been resident in the UK longer than the men. Or to put it another way, more of the recently arrived are men.

The association between age and length of residence in the UK is complex.

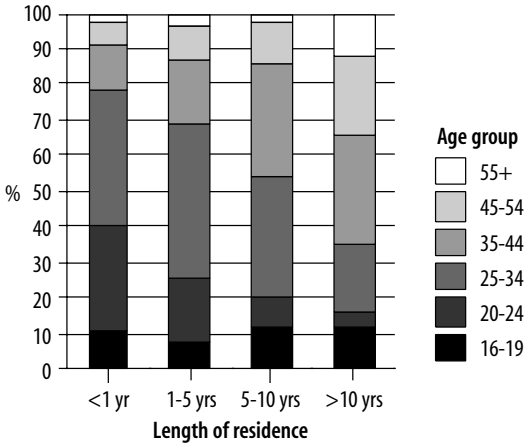

Figure 2.2.2b: Age profile by length of UK residence (N=167, 401, 293, 100)

Recent arrivals (ie. people who had lived in the UK less than a year) are mostly aged between 20 and 35. People who have lived in the UK for longer periods are therefore both older and younger than this.

2.2.3 Marriage, children and household

Almost half of the participants (46%) were single and had never been married and this was similar in the two borough sub-samples.

Over a third (38%) were currently married and 16% were separated, widowed or divorced. Women were slightly more likely to be currently married (40%) compared to the men (37%). Women were also more likely to have been separated, widowed or divorced. Therefore a smaller proportion of the women were currently single than the men. Unsurprisingly, being single became less likely with increasing age.

Participants were also asked '*Who do you live with*'. The majority lived with another person (66%).

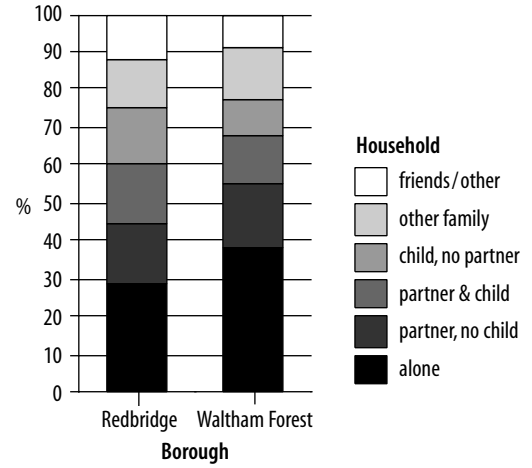

Figure 2.2.3a: Household across local authority of residence (N=398, 574)

Most commonly with a partner only (17%); partner and child/ren (13%); child/ren but not a partner (12%); other family (13%) and other (1%).

Those who live in Redbridge were more likely to live with a child and no partner, with friends or with a partner and child. Those who live in Waltham Forest were more likely to live alone.

Similar proportions of men and women lived with a partner only, or a partner and child. However, men were much more likely to live alone and women were much more likely to live with a child only.

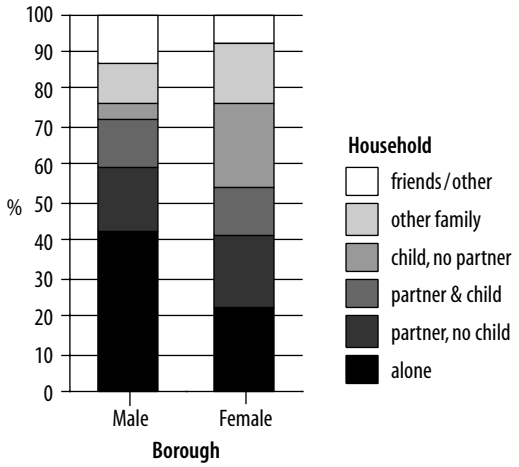

Figure 2.2.3b: Household living arrangements by gender (N=555, 430)

Living alone was most common for the 20-24 year olds and the over 55 year olds. Living with children was progressively more likely up to the oldest age group where it decreased again.

Those who have lived in the UK for under a year were the most likely to live alone and the least likely to live with a child. Those who had lived here over 5 years were the most likely to live with a partner and/or children.

2.2.4 Education and employment

The Forum embarked on this project aware that many Africans arrive in the UK with skills, experiences and qualifications that the wider community often overlook. In this survey however, 24% of the sample had no educational qualifications. This perhaps reflects the socio-economic background of the African immigrant population of (North) East London, which has always been a gateway for 'poorer' immigrants. Wars and famines in the late 1970s and 1980s in Africa led many refugees and asylum seekers to flee and settle in the UK. These immigrants come from every social and economic stratum in their countries of origin. Until this phase of migration, the African population of the UK was fairly transient, with most people arriving here for education and training before returning to their countries of origin.

With the changes in migration patterns the (West) African community has now become a longer-established community in the UK, with more educationally and occupationally qualified people.

The educational systems of many African countries are based on that of the UK. Although a quarter of the participants had no qualifications, three quarters (76%) of them had qualifications including 31% with 'O' levels or equivalent; 17% with 'A' levels or equivalent; 17% with a 'diploma' or other professional qualification and 12% with a degree or higher.

The longer participants have lived in the UK the greater the likelihood they will have formal educational qualifications.

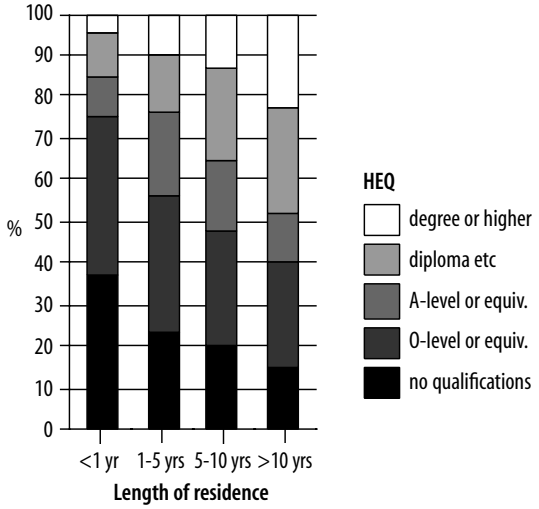

Figure 2.2.4a: HEQ by length of UK residence (N=162, 400, 290, 100)

Generally, the men had higher educational qualifications than the women: fewer had no qualifications and more had a degree. Older people were more likely to have no educational qualifications.

Those resident in Waltham Forest were better educated than those resident in Redbridge.

Just over a third (37%) of participants reported that they currently worked. Men (39%) were more likely to report working than women (33%) and employment is most common among those between 35-44 years of age and least common amongst those aged under 20 and over 55. However, only in one age group (35-44) were more people employed than not.

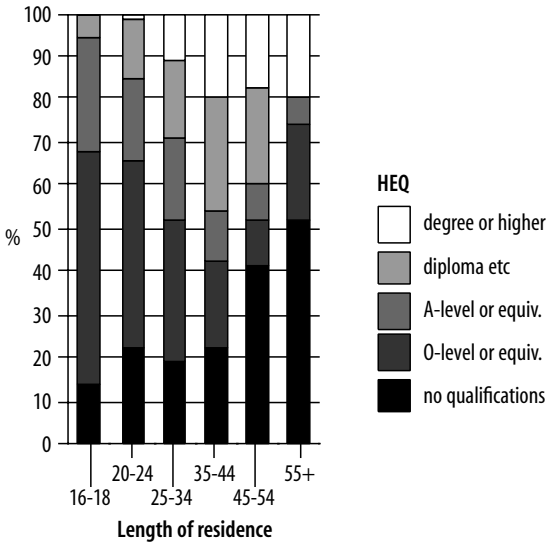

Figure 2.2.4b: HEQ across the age range (N=96, 148, 354, 229, 106, 42)

The level of unemployment in this relatively young and educated group of people is worryingly high. The average (median) length of unemployment for those unemployed was 2 years (n=307, mean average was 43 months, range 1 to 480 months). Length of unemployment was associated with age: older people who were unemployed had been without employment for longer than younger people.

Employment is associated with education. Compared to those that were unemployed those in employment had higher educational qualifications. However, a substantial proportion of participants with degrees and professional qualifications were not employed.

Employment became more likely the longer people had been resident in the UK.

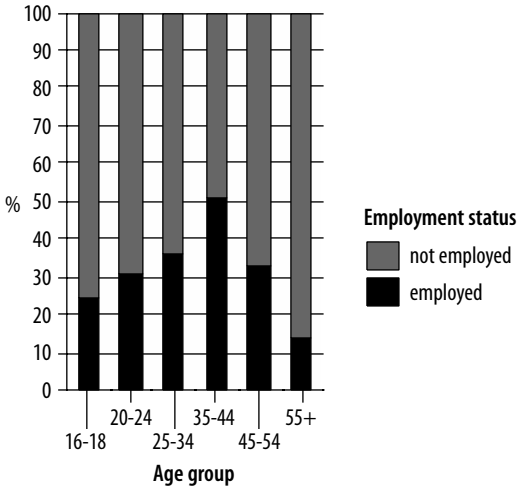

Figure 2.2.4c: Current employment across the age range (N=97, 152, 356, 229, 106, 44)

Those employed were less likely to live alone but more likely to live with a partner and no child, or partner and child. Those who were not employed were more likely to live with a child but no partner or to live with other family (not a partner).

2.2.5 Ethnicity

Ethnicity is a composite concept and not a single, unambiguous variable. People are aware of their ethnic group membership, and it is very important to many. Rather than simply feeling part of a single group, how you identify at any particular point is related to who else is around you. To describe the ethnicity of the participants we asked their country of birth, what ethnic group they felt part of and what languages they used (see chapter 4.1).

Participants were asked 'which country where you born in'. More than three quarters were born either in Somalia (48%), The Congo (13%), Algeria (10%) or Ghana (6%). The remaining quarter were

born in the following countries (in order of the most common): Uganda, Zambia, Kenya, Tunisia, Nigeria, Angola, Ethiopia, United Kingdom, Côte d'Ivoire, Zimbabwe, Egypt, Morocco, France, Cameroon, South Africa, Sudan, Togo, Senegal, Sierra Leone, Burundi, Belgium, Djibouti, Eritrea, Gabon, Italy, Madagascar, Qatar, United Arab Emirates and Pakistan.

- **African residents of Redbridge and Waltham Forest were born in very many countries.**

The numbers of people participating allow us to make comparisons between those born in Algeria (n=98), The Congo (n=127) and Somalia (n=482). While the proportion of Somali's in the borough sub-samples were similar, the Redbridge sub-sample had more people from The Congo and fewer from Algeria compared to Waltham Forest residents. Conversely, those from The Congo were more likely to live in Redbridge, those from Algeria more likely to live in Waltham Forest.

A much smaller proportion of those born in Algeria were women (17%) compared with those born in Somalia (42%) or The Congo (48%). Those from Algeria were also more likely to be 25-34 years of age and less likely to be between 16 and 19. No participants from Algeria or The Congo were 55 or over.

Those from Algeria had on average been resident in the UK for a shorter time than those from Somalia or The Congo.

The gender difference is reflected in the fact that those from Algeria (who are mainly men) were more likely to be single than those from Somalia or The Congo. Similarly, those who had arrived in the UK more recently were more likely to be single.

Those from Algeria were the most likely to live alone; those from The Congo the least likely.

Compared with those born in Somalia (28% were employed) or Algeria (22% were employed), those born in The Congo were more likely to be currently employed (41% were).

Those from Somalia had fewer educational qualifications than the other two groups.

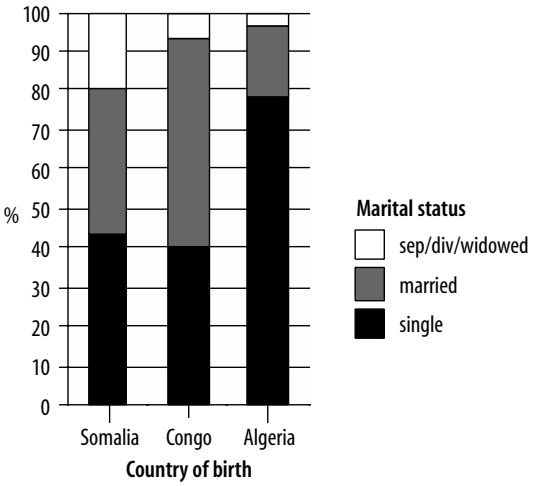

Figure 2.2.5a: Marital status by the three most common countries of birth (N=476, 125, 98)

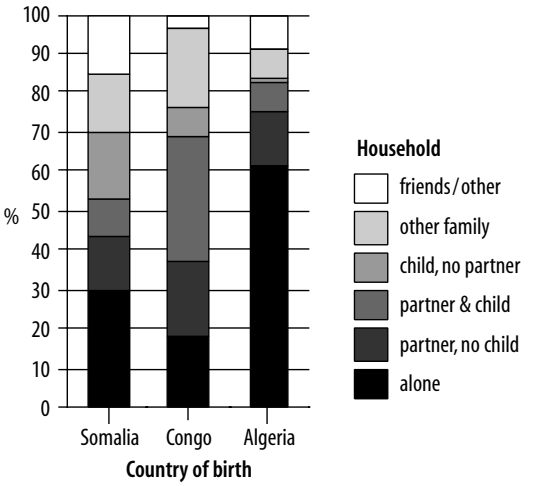

Figure 2.2.5b: Household by the three most common countries of birth (N=470, 125, 97)

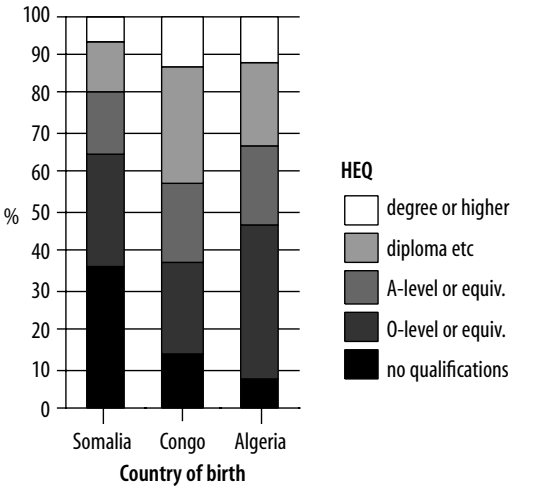

Figure 2.2.5c: HEQ across the three most common countries of birth (N=468, 125, 98)

Participants were also asked how they would describe their 'ethnic group' with no set answer. While country of birth is generally simple and unchanging, ethnic group is fluid and relative. Their answers reflect this, with some giving nationality (eg. Algerian), and others using much larger racial, cultural, or religious groups (eg. African, Muslim) or a combination of these (eg. Arabic Algerian).

Almost half the sample described their ethnic group as either 'African' (26%) or 'Black African' (22%). Another quarter (26%) described their ethnic group as Somali. These very large groupings may be overestimated due to the survey being a project of the African Forum.

The remaining quarter of the sample used a very wide range of terms to describe their ethnicity. The box gives the ethnic groups nominated by the sample (in order of the most common).

- **There are African people from very many ethnic groups in Redbridge and Waltham Forest.**

Country of birth and self-nominated ethnic group did not wholly overlap. That is, groups of people born in the same country used a wide variety of terms to describe their ethnic groups.

Self-nominated ethnic groups of members of African communities resident in Redbridge and Waltham Forest

African
Somali
Black African
Algerian
Congolese
Algerian Berber
Arabic/Arabic Algerian
Tunisian
African Somali
Kenyan
Moroccan
Egyptian
Nigerian
Ghanaian
Arab
North African
Black
East African
Somali African
Zairean
Cameroon
Asian Ugandan
Ivorian
North African Arab
Ethiopian
French Berber
North African Algerian
Bantou-Kongo
Zaire (Lingala)
African Black Congolese
Moroccan (Chluh)
Black African Somali
Zairean (Congolese) Muslim
Asian Kenyan
Afro Caribbean
Nigerian
Côte d'Ivoire
Ugandan Asian
Bajona (Somali)
Asian
African Asian
Bravanese Somali
Mrundi
North African Berber
Akan (Akwapin)
Arab African
Ugandan (Bantu)
Somali Bundi
Baganda

3 Health concerns and needs

3.1 PERCEPTIONS OF MOST COMMON HEALTH PROBLEMS

Prior to all other questions regarding health needs and access to services all participants were asked '*What would you say were the three biggest health problems in your community*'. One participant in eight (119 or 12% overall) did not answer this question.

Two thirds of those answering (664 or 66%) mentioned at least one health problem. That is, a fifth (189 or 19%) mentioned one problem, another fifth (212 or 21%) mentioned two problems, and a quarter (263 or 26%) mentioned three. Overall then 664 participants cited 1401 health problems. A further sixth of all participants (178 or 18%) said they were unsure or did knot now and a smaller proportion (47 or 5%) said there were no health problems in their community. The table below summarises the health problems cited.

What would you say were the three biggest health problems in your community? (N=889 people naming 1401 health concerns)	Number	% of those responding who cited this problem
Mental health problems / stress / anxiety	226	25
HIV and / or AIDS	204	23
UNSURE OR DID NOT KNOW	178	20
Tuberculosis	109	12
High blood pressure / Hypertension	109	12
Diabetes	103	12
Asthma	74	8
Colds and flu	64	7
NO HEALTH PROBLEMS IN COMMUNITY	47	5
Heart disease / stroke	45	5
Cancer	42	5
Poverty / poor housing / unemployment	41	5
Skin infections	39	4
Alcohol and drug use	31	3
Digestion / intestinal problems	30	3
Rheumatism / arthritis	22	2
Problems with medical staff and NHS (including access)	21	2
Liver/ kidney disease	19	2
Malarial infection	18	2
Migraine / headache	14	2
Diet and nutrition	12	1
Sexually transmitted infections (other than HIV)	12	1
Disability	10	1
Gynecological problems	10	1
'Language problems'	9	1
Isolation / loneliness	9	1
Other (see below)	86	10

Other includes items cited by less than one per cent of participants including: back or spinal problems; meningitis; pollution / environment; blood disorders (not hypertension); dealing with social security; general health problems; 'lack of education'; hepatitis; allergy; deafness / blindness; antenatal / childbirth problems; obesity; gerontological health and care; fever; anger; fatigue; dental health; 'united to solve these problem'; 'time: the time is very short'; 'children taught sex education while young at school'.

This list will include people's health concerns that arise from their own experience of ill health, the experience of people around them, knowledge of incidence of disease, exposure to news media about disease and influences from health education campaigns. It is worth noting that some people cite social determinants of ill health such as 'poverty, poor housing and unemployment' (at 5%) rather than actual illnesses or diseases. Others cite problems of access to appropriate services for the diagnoses and treatment of illness, including 'problems with medical staff or the NHS' (2%) or 'language problems' (1%).

The two main health problems listed were hazards to mental health (25%, see list in box) and HIV or AIDS (23%). Both were mentioned by about a quarter of all participants who answered the question. While 'mental health problems' is a generic phrase for a range of problems with a huge variety of causes and effects, it is obviously a major concern for many African communities.

Depression
Depression & hopelessness
Depression & stress
Mental health
Mental health disease
Mental health problems
Mental illness
Mental problems
Nervousness
Psychological
Stress
Stress & other health problems
Stress from housing & DSS
Tension

Answers grouped as mental hazards

Mentioning mental health problems among the top three health problems was more common among men (28%) than women (19%) and became more common with increasing age (12%, 16%, 28%, 26%, 29%, and 23% across the six age bands, see Section 2.2.1). Mentioning mental health problems was also far more common among participants born in Algeria (68%) compared with those born in Somalia (22%), while those born in The Congo were unlikely to mention this problem (7% did). In terms of living arrangements, mental health problems was most commonly cited by those who lived alone (31%) and in terms of employment those who were not employed (as opposed to students or retired) cited mental health problems most often (35%).

- **Mental health problems are a major health hazard for African people in London, particularly middle aged males who are out of work.**

Conversely, mentioning HIV and AIDS as among the top three health problems was more common among women (30%) than men (18%) and was equally common among all age groups. Citing HIV and AIDS as a common community problem was almost universal among those from The Congo (74%), but was much less common among those from Somalia (6%) and was only cited by one person from Algeria (1%). These differences reflect the extent of the HIV epidemic in The Congo and Algeria (UNAIDS, 2000; this document does not describe the extent of the epidemic in Somalia).

HIV and AIDS is the specific illness most commonly cited as the biggest health problem in African communities. It is cited as such by twice as many people as the next most common illnesses listed – tuberculosis, high blood pressure / hypertension and diabetes. HIV and AIDS is also cited by five times as many people as two of the most common causes of death in the United Kingdom – heart disease / stroke and cancer. These differences reflect the differences in the diseases that people get (and die from) in Africa and the UK.

3.2 NEED FOR HIV KNOWLEDGE

Given concerns about the prevalence of HIV among Africans resident in London, additional questions were asked regarding knowledge of, and attitudes to HIV.

3.2.1 How is HIV transmitted?

All participants were asked '*How do you think HIV is transmitted from one person to another?*'. This was the first question to ask about HIV and AIDS directly, but no prompts were provided by the interviewers.

In total 928 participants answered the question and gave a total of 1529 answers (56% gave one answer only, 26% gave two answers; 16% three answers; and 2% four answers). Overall, one participant in twelve did not answer this question (n= 80, 8% overall).

The table below outlines answers to the question. More than two thirds (68%) of all answers specified 'sexual contact' with most answers being no more specific. The more specific answers included 'unsafe/unprotected sex' (15%), sex with an infected person (4%) and sex between men (2%). Other answers reflected the predominant modes of non-sexual HIV exposure via injecting drugs use, blood or blood products and mother to child.

How do you think HIV is transmitted from one person to another? (open ended answers: N=928 people giving 1529 answers)	**Number**	%
Sexual contact/intercourse (general answer)	634	68
Unsafe/unprotected sex (specifically)	142	15
Sexual contact with someone with HIV (specifically)	36	4
Sex between men (specifically)	15	2
Injecting drug use/sharing syringes/drugs	220	24
Blood transfusion	136	15
Contact with blood (more general answer)	126	14
non sterile medical equipment/needle stick injury	21	2
UNSURE OR DID NOT KNOW	88	10
Mother to child/birth/breastfeeding	61	7
Social contact	14	2

While the answers of the majority reflected a basic understanding of HIV transmission, almost one in ten said that they were 'unsure' or did not know how HIV was transmitted. Social contact was also mentioned as a means of transmission by a small minority (2%).

3.2.2 Prevention facts

Following on from this general question regarding HIV transmission, participants were given 19 specific statements regarding HIV and services associated with sexual health. They were asked '*Are the following statements about HIV and AIDS true or false?*'. This was the heart of the HIV prevention aspect of the project. In fact all the statements were true. Although this probably reduces the extent of need uncovered, phrasing the questions in this way allowed the interviewers to state a number of facts about HIV prevention. At the end of the section, interviewers were able to tell the participants that all statements were true, and to talk about the ones they thought were false. In the debriefings the interviewers reported that this format worked very well, as it provided information in a rich but nonthreatening manner, and the questions acted as an individualised needs assessment for the conversation which followed.

The following table gives each of the statements, the overall proportion who did not know this (who either said 'false' or 'don't know'), and the separate proportions for men and women. Where there is a statistically significant difference (p. <.05) between the answers of men and women, **the group in more need is shaded**.

Are the following statements about HIV and AIDS true or false? (n=1008)	**% saying false or don't know** (n)	**% saying false or don't know** men	women
HIV is a serious health problem for many African people living in London. (missing = 43)	**61** (585)	63	58
Drugs can stop many pregnant woman with HIV passing it to their child. (missing = 53)	**55** (520)	56	53
Sexual health clinics in London are free and confidential. (missing = 44)	**50** (487)	50	52
Condoms are free from sexual health clinics. (missing = 42)	**50** (479)	50	50
HIV is never transmitted by insect bites. (missing = 48)	**46** (442)	47	45
A woman with HIV can pass it to her child during breastfeeding. (missing = 52)	**42** (400)	43	40
There are drugs which help many people with HIV stay well. (missing = 42)	**39** (379)	43	35
AIDS stands for Acquired Immune Deficiency Syndrome. (missing = 48)	**38** (367)	38	40
HIV is a serious health problem for many people in Africa. (missing = 45)	**38** (379)	35	39
There is no vaccine against HIV. (missing = 40)	**38** (363)	37	39
You cannot tell whether someone has the virus by looking at them. (missing = 44)	**31** (300)	28	36
A pregnant woman with HIV can pass it to her child during birth. (missing = 45)	**31** (295)	31	31
HIV is never transmitted through shaking hands or touching people. (missing = 48)	**30** (288)	29	32
AIDS is caused by a virus called HIV. (missing = 43)	**27** (257)	25	30
Condoms stop HIV being transmitted during sex. (missing = 45)	**25** (240)	22	30
People can have HIV without knowing it. (missing = 43)	**23** (222)	20	27
There is a medical test that can tell whether or not someone has HIV. (missing = 45)	**17** (165)	15	20
A woman with HIV can pass it to a man during sex. (missing = 44)	**10** (99)	9	12
A man with HIV can pass it to a woman during sex. (missing = 41)	**10** (99)	9	12

The table shows the proportion of men and women who did not know the fact (that is, the proportion in need of knowledge). The facts most commonly unknown (those at the top of the table) were equally unknown to both men and women. However, women were generally in more need of information. The only fact which men were less likely to know than women was the existence of drugs that can help people with HIV stay well.

Less than two fifths (39%) of the participants knew that HIV is a serious health problem for many African people living in London. Although substantially more (62%) knew that it was a serious health problem for many people in Africa, even this proportion might be considered 'low' given the scale of the HIV pandemic in many African nations. These figures are consistent with the quarter (23%) of participants that mentioned HIV as one of the biggest health

problems in their community, without any prompting. It should be noted that saying 'no' to the statement '*HIV is a serious health problem for many African people living in London*' may reflect a (not unreasonable) desire not to be associated with a stigmatising illness.

Need for basic knowledge of the medical aspects of HIV and AIDS was extensive. The findings of this survey confirm earlier work which concluded:

> 'There is a clear need for further work around basic awareness of HIV transmission … the knowledge that participants had about HIV was not just out of date but in some cases was non-existent.' (Ndofor-Tah, 2000, p.3)

Over a third were unaware that there are drugs which help people with HIV stay well and similar proportions did not know what AIDS stands for or that there is no vaccine against its cause, HIV. Almost a quarter did not even know that AIDS is caused by a virus called HIV although fewer were unaware of a test HIV. This last figure indicates that a sixth of all participants did not know that there exists a test that could diagnose HIV infection. Since diagnosis is a pre-requisite for accessing HIV treatments, care and support this figure is important, especially given widespread concerns that UK-resident Africans with HIV are commonly diagnosed after the onset of symptomatic HIV. Equally of concern is the finding that half of participants did not know that sexual health clinics in London are free and confidential.

Basic knowledge of the sexual transmission routes of HIV was higher than medical knowledge. One in ten did not know that HIV can pass from man to woman and from woman to man during sex. A quarter did not know that condoms stop HIV being transmitted during sex and a half did not know that condoms are free from sexual health clinics.

HIV transmission from a woman to her child, either during birth or during breastfeeding, was far less widely known about than sexual transmission. Surprisingly, women were no more likely to know about it than men. Fully 30% did not know a mother could pass the infection to her child during birth, 42% did not know it could occur during breastfeeding and over half did not know that there are drugs which could make these events less likely.

Finally, 22% did not know that people can have HIV without knowing it and almost a third did not know that you cannot tell that someone has the virus by looking at them. Almost half were not sure that HIV is never transmitted via insect bites and almost a third were not sure that it is never transmitted through shaking hands or touching people.

Epidemiological data (Unlinked Anonymous Surveys Steering Group, 1999) suggests the prevalence of HIV and AIDS in London-residents of African descent, especially those that are recent migrants, is substantial and probably second only to the prevalence among homosexually active men (Unlinked Anonymous Surveys Steering Group, 1999). Combined with a broad understanding of the terrible impact of HIV on the populations of many African nations, these data lead to widespread assumptions that African community members should be well informed about HIV. Such assertions are common, irrespective of the recognition that the topic of HIV and AIDS is substantially taboo in most African communities (Anderson & Weatherburn, 1998; Anderson *et al*., 2000).

This data suggests the lack of basic HIV knowledge among African people in London is extensive and there have been few targeted and culturally appropriate interventions that aim to address this need. While calling for more educative interventions that are culturally and linguistically appropriate is reasonable it is also necessary to recognise that substantially more financial investment in such activities is necessary. With few very notable exceptions London Health Authorities have

consistently under-invested in such activities and continue to do so even though African people were highlighted by the Department of Health as a priority target group for HIV prevention interventions as long ago as 1995 (UK Health Departments, 1995).

3.3 DESIRE TO KNOW MORE ABOUT HIV?

All participants were asked '*Would you like to know more about HIV?*'. One participant in fifteen did not answer this question (n= 70, 7%). Of the remaining 938 participants almost two thirds (62%, n= 582) said NO, and only 38% (n=356) said YES, they would like to know any more about HIV.

Wanting to know more about HIV was equally common among men and women and did not vary by marital status. Wanting to know more did vary by age. Of the 16-19 year olds, 30% wanted to know more, while 45% of the 20 to 24 year olds did. It then became less common with increasing age; 42% of the 25-34 year olds, 35% of the 35-44 year olds, 36% of the 45-54 year olds and 22% of those over 55 years old.

In terms of the three most common countries of birth, wanting to know more about HIV was most common among those from The Congo (62% wanted to know more), less common among those born in Somalia (39%) and least common among those from Algeria (18%). This pattern follows the groups who most commonly identified HIV as a major health problem in their community.

3.4 NEED FOR AWARENESS OF SERVICES IN WALTHAM FOREST & REDBRIDGE

The table below outlines awareness and use of local health and social care services.

Service	% never heard of it (n)	% heard of it but not needed it (n)	% needed it but not used it (n)	% used it (n)
Waltham Forest Social Services (n= 910, missing = 98)	**25** (225)	**55** (505)	**2** (14)	**18** (166)
Redbridge Social Services (n = 926, missing = 82)	**36** (335)	**48** (441)	**2** (20)	**14** (130)
Whipps Cross Sexual Health Clinic (n = 935, missing = 73)	**63** (584)	**34** (319)	**1** (7)	**3** (25)
Voluntary Action Waltham Forest (n = 900, missing = 108)	**67** (605)	**30** (269)	**1** (13)	**1** (13)
London East AIDS Network (LEAN) (n = 955, missing = 53)	**73** (696)	**24** (233)	**0** (0)	**3** (26)
Social Justice Unit (n = 958, missing = 50)	**79** (757)	**20** (189)	**<1** (3)	**<1** (9)
Social Services Equality Unit (n = 967, missing = 41)	**79** (766)	**19** (181)	**<1** (7)	**1** (13)

Awareness of Waltham Forest Social Services (at 75%) and Redbridge Social Services (at 64%) is relatively high, as is ever having used the services they provide (18% and 14% have done so respectively). Conversely, awareness of the additional services they provide is far less substantial as is use of them (21% had heard of the Social Services Equality Unit and only 1% had used it).

More surprisingly, perhaps almost two thirds (63%) of community members had not heard of the Whipps Cross Sexual Health Clinic, and a very small proportion (3%) had ever used it.

Finally, awareness and use of voluntary sector services was not particularly high. More than two thirds (67%) had not heard of Voluntary Action Waltham Forest, and almost three quarters (73%) had not heard of London East AIDS Network (LEAN).

4 Assets for health

4.1 LANGUAGE ABILITIES AS A COMMUNITY ASSET FOR HEALTH

Needs assessment treats lack of English as a specialist health need. In this sample, just under a quarter (22%) did not speak or understand English. However, all those people who did not speak English did share one or more other languages with many other community members. This means that the shared languages of the community (other than English) are an invaluable resource for communication and information about heath. The participation of a quarter of the sample in this research was only possible due to the language abilities of the community interviewers.

More than 50 languages were recorded as understood, spoken or read. The six most common were: Somali, English, Arabic, Lingala, French and Italian. (Due to the Italian occupation of the Horn of Africa during the Second World War, many Ethiopians, Eritreans and Somali speak Italian, even if their own native languages are not mutually intelligible.) Overall, 85% of participants listed two languages they were competent in and 40% listed three. Given the high level of social contact that takes place within the African community, and the number of people with multiple languages, the community offers enormous potential for peer education and other forms of communication in the field of health promotion.

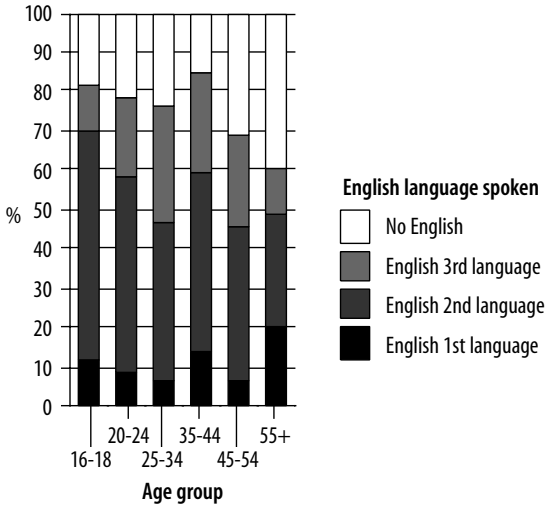

Figure 4.1a: English language spoken across the age range (N=98, 155, 359, 234,106, 45)

English *is* spoken by the majority of participants (78%). Almost ten percent speak it as a first language (10%), nearly half (44%) as a second language and a quarter (24%) as a third language. Whether English was spoken did not vary by gender or by which borough people lived in.

It did vary with age: those who were younger were generally more likely to speak English, particularly as a second language.

Competence in English also varied by country of birth. Those participants born in Algeria were most likely to speak English, compared to those born in Somalia or The Congo.

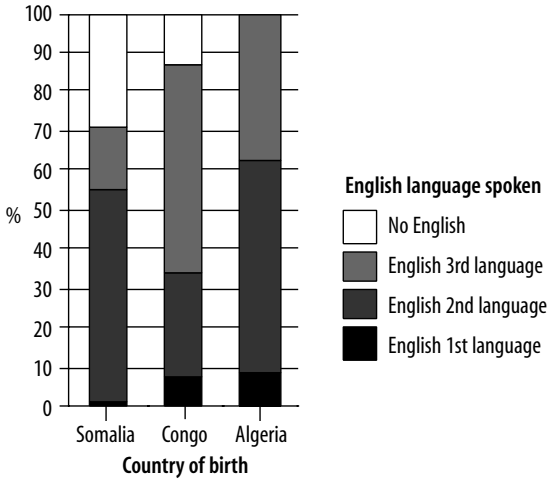

Figure 4.1b: English language spoken across three most common countries of birth (N=482, 127, 98)

English ability was associated with employment, with those for whom English was their first language being most likely to be employed (58%), those who did not speak English being least likely to be employed (14%).

Unsurprisingly, English ability became more common the longer people had been in the UK. Those who did not speak English had been

resident in the country for the least amount of time. Those for whom English is a first language were by far the most likely to have always lived in the UK.

Those with no educational qualifications were much less likely to speak English.

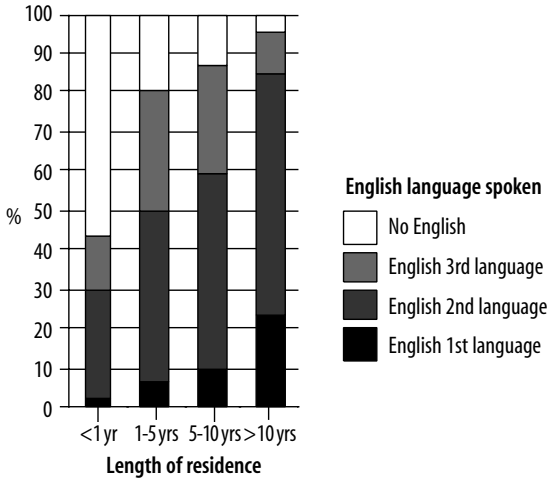

Figure 4.1c: English language spoken by length of UK residence (N=167, 407, 298, 101)

4.2 MEETING POINTS AS AN ASSET FOR HEALTH

Kinship or the extended family system is very important organising principle of African communities. Away from such familiar support systems, African immigrants in the UK set up their own organisations to carry out welfare roles of advice, advocacy, interpreting and adapting their practices and habits to the new environment and for social contact in their lives. The majority of these have been initiated and managed by African people themselves, although there have been some groups facilitated by statutory authorities, especially among those communities most affected by HIV.

This type of social network is strongest among West Africans, with many migrant groups, known colloquially as *home town* associations. There are also alumni associations and others based on religious, gender, ethnic and professional lines. Some operate as a network of organisations, for example, Ghana Union UK & Ireland, and the Nigerian Organisation of Women. The grassroots community organisations greatly value their autonomy and linking with such networks is as a federation of independent groups rather than as satellites of an 'umbrella' organisation. There are others who simply operate as social clubs where people levy themselves and meet simply to have a good time.

Irrespective of how and why these groups are set up, these grassroots organisations play very important roles in the lives of Africans in the UK and are important and legitimate communication channels to and within the community.

Participants were asked the open-ended question '*Which social or cultural groups in your community do you know about?*' and up to four social and cultural groups were recorded. Overall, 584 participants (58%) mentioned at least one group (32% mention one group, 9% mentioned two, 3% mentioned three, and 14% mentioned four).

Algerian Education Project
Church
Community Group / Centre
Coreco
Elderly Group
Lisalisi Project
Risa
Somali Community
Somali Women's Association
Usalisi Project
Womens Group
Youth Group

Social foci (mentioned by ten or more participants)

Between them, these participants mentioned a very large number of groups which were extremely diverse, encompassing the formal and informal, the large and small. Similar proportions of men and women, and all age groups mentioned at least one group.

How often do you go? (Missing = 51)	**Number**	%
Never	81	7
Most days	139	13
Weekly	612	55
Less often	272	25
Total	**1104**	**100**

They were then asked whether and how often they attended those groups. In 1104 instances participants answered how often they went to a specific group. The majority of people mentioning a group went weekly or more often (68%).

Each participant was then asked '*Where else do you go to meet your friends?*' and up to four responses were recorded. They were again asked to report how often they went to this venue (on a 4 point scale). Overall, 90% of the entire sample (910 participants) mentioned at least one place (34% mention one place, 27% mentioned two, 16% mentioned three, and 13% mentioned four).

In 1800 instances participants answered how often they went somewhere to meet a friend/s. The majority of people mentioning a place to meet friends used that venue weekly (54%) or more often (29%).

4.3 SOCIAL NETWORKS AS AN ASSET FOR HEALTH

Participants were asked to '*think about the five people you are closest to and who you talk with the most*'. For each one, they were asked their gender, age, relationship to them, regularity of seeing them, and which topics (family, money, health, sex, work and politics) were discussed with them. Overall, 883 participants (88% of the entire sample) mentioned at least one person they were close to. In total, the 3642 different people were mentioned.

This data suggests that there is a sizable minority (12%) of Africans resident in Waltham Forest and Redbridge who are socially isolated.

- **Although social networks are common and strong, not all Africans have them and some are socially isolated.**

Most participants (883 or 88%) mentioned the gender of at least one person who they were close to (6% mentioned one only, 9% mentioned two, 10% mentioned three, 6% mentioned four, and 56% mentioned the gender of five friends). In total, the gender of 3642 close people were mentioned.

Of all the (3642) close people mentioned, just over half (54%) were male and just under half (46%) were female. Overall, men were more likely to cite men and women were more likely to cite women. Overall, 78% of the first person described by men were also men and 22% were women. Overall, 62% of the first person described by women were also women and 38% were men. Therefore, women were more likely to cite men as the first person close to them (38% did) than were men likely to cite women (22%).

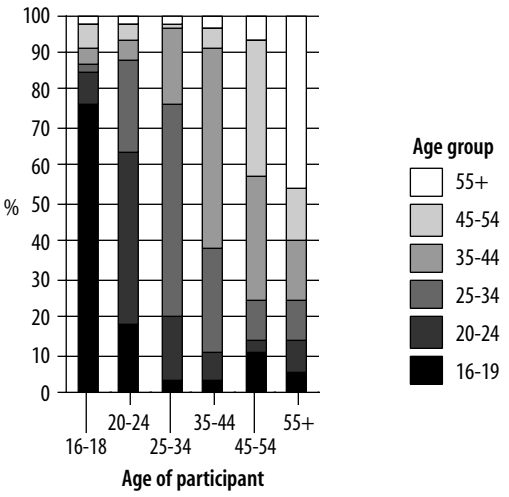

Figure 4.3: Age of the first close person described by age of participant (N=89, 143, 320, 212, 94, 37)

The most common relationship to the first person described for both men (60%) and women (56%) was 'friend'. Second most common for both genders (21% of men and 20% of women) was a relative other than a spouse, parent or child. Far fewer described a spouse (6% or men, 8% of women), a parent (4% and 6%), a child (3% and 8%) or a work colleague (4% and 5%). Similarly, for the second, third, fourth and fifth person described, the participants relationship to that person was most commonly described as 'friend' or relative other than immediate family.

The age profile of the people participants described as 'close' to them was variable but broadly similar with the age profile of the entire sample. This was because generally, the people participants described as close to them were in their own age groups. As figure 4.3 demonstrates, this was especially common among the 16 to 19 and the 55 plus age groups.

Participants reported how often they saw the people who were close to them.

This information was given on a total of 3585 individuals. Almost three quarters (72%) saw the people they had a close relationship with at least weekly.

Think about the five people you are closest to and who you talk with the most. What is your relationship to that person? (of 3612 close people described)	**Number**	%
Father/mother	185	5
Son/daughter	202	6
Other relative	962	27
Friend	1790	50
Work colleague	231	6
Other (eg. 'student', 'family friends' and 'pastor')	119	3
Partner/Spouse	123	3

Think about the five people you are closest to and who you talk with the most. How often do you see them? (of 3585 close people described)	**Number**	%
Most days	1410	39
Weekly	1174	33
Every few weeks	732	20
Less often	269	8

5 Potential for HIV prevention interventions

5.1 WHETHER AND WHO PEOPLE TALK ABOUT HEALTH AND SEX WITH

As section 4.3 has outlined all participants were asked to '*think about the five people you are closest to and who you talk with the most*'. The survey wanted to find out if social networks had any potential for conveying information about matters concerning health broadly and sexual health particularly. We particularly wanted to ask participants if they discussed health and/or sex with the people they were close to. Instead of asking only these two questions, participants were asked which of six areas of discussion they engaged in with each person they were close to: family matters, money, health, sex, work and politics. Where there is a statistically significant difference (p. <.05) between the answers of men and women, the area of the table is shaded to highlight this.

What things do you discuss with (first close person described)?							
	% of all participants	% of men	% of women	% of men describing…		% of women describing…	
				men	women	men	women
family matters	73	72	75	71	72	79	74
money	64	68	59	70	62	65	57
health	64	63	66	63	66	71	63
work	49	55	41	59	43	46	39
sex	33	38	27	35	52	37	22
politics	28	34	20	40	22	20	20

For the first person described, almost two thirds of participants said they discussed health with that person. This topic was less common than discussion of family matters and just as common as discussion of money matters. While family and health were equally likely to be topics of discussion for women and men, men were more likely than women to talk about money, work, sex and politics.

- **Health was a very common topic of conversation with friends.**

For the first person described, exactly a third of participants said the discussed sex with that person. This topic was less common than family, money, health and work and more common than politics. Overall then, 38% of men said they talked about sex with the first close person described, compared with 27% of women. Male participants were more likely to talk about sex with women (52%) than with men (35%). The same pattern was seen for female participants: of those describing close men, 37% talked about sex, compared with 22% of women describing close women.

- **Sex was a relatively common topic of conversation with friends, particularly in conversations between men and women.**

% who discuss sex		Age of first close person described					
		16-19	20-24	25-34	35-44	45-54	55+
Participants age	16-19	43	33	50	25	0	0
	20-24	62	58	47	0	0	0
	25-34	8	43	38	37	0	0
	35-44	0	29	29	35	22	0
	45-54	0	33	20	27	17	40
	55+	50	0	0	0	20	12

The proportion of close persons with whom sex was discussed varied by the relative age of the participant and the person they were describing (table above). It seems that sex is more likely to be a topic of discussion when the two people are relatively close in age. This suggests that the social networks which can carry communications about health and HIV prevention are age comparable ones.

- **Sex is most commonly discussed between people of a similar age.**

5.2 WHERE PEOPLE WOULD TURN FOR HELP WITH HEALTH PROBLEMS

After having been asked what they thought the most common health problems in their community are (see Section 3.1), participants were also asked '*If you had one of these problems, who would you go to for help?*' While 664 participants listed at least one health problem, more (742) listed a place they would go to for help if they had a health problem. Almost a quarter (230 or 23%) did not answer this question at all.

Three quarters of participants (742 or 74%) mentioned at least one source of help if they had a health problem. That is, four in ten (385 or 38%) mentioned one source of help, a fifth (201 or 20%) mentioned two sources of help, and a sixth (156 or 16%) mentioned three sources of help. Overall then 742 participants cited 1257 places where they would seek help with a health problem. A further small proportion (18 or 2%) answered that they did not know or said that they would go 'no where' or to 'no one' or did not need any help (18 or 2%). The table below summarises the sources of help listed by participants.

If you had each one of these problems, who would you go to for help? (N=778 people naming 1257 sources of help)	**Number**	%
Medical professional (doctor/GP/Consultant)	640	82
Medical environment (Hospital/Clinic/NHS/Surgery)	317	41
Friends/partners/relatives	132	17
Community group or organisation	43	6
Religious group/professional/prayer/organisation	42	5
Advice or information service/help-line	25	3
Counsellor/psychologist/psychiatrist	22	3
Other	22	3
UNSURE OR DID NOT KNOW	18	2
NO WHERE	18	2
Local authority services	14	2

Others included: educational institution/college/university (3); publication/literature (1) and several answers that were difficult to categorise, such as 'pub', 'employment agency'.

Almost all participants listed a medical professional such as a doctor (82%) or a medical environment such as hospital, clinic, or surgery (41%) as the first point of call if they had one of the health problems they had cited.

Many participants also cited non-medical sources of support, advice or help to which they would turn if they had a health problem. Most common (at 17%) were friends, partners and relatives. Less common were community groups or organisations and religious groups, although these are obviously important to some community members. The range of responses highlights the strength of family, friendship and other community bonds and their role in ensuring good physical and mental health.

Although they may not be the first point of call for all health problems 91% (819) of participants are registered with a General Practitioner. This is substantially more common than registration with a dentist (at 69% of the sample).

5.3 HOW PEOPLE WOULD LIKE TO KNOW MORE ABOUT HIV

Everybody learns about HIV in a wide variety of ways. Previous research among minority ethnic groups in London has found that:

> 'Information about HIV, AIDS and other STDs had come from a variety of sources, including their personal experiences and knowledge of people who had STDs or were HIV positive. For all groups, general media sources were important, with information coming from advertising campaigns, fictional stories on the TV and radio that had characters who were HIV positive, and news stores about famous people who had AIDS. GPs and leaflets found in GP surgeries were also a very important source of information.' (Elam *et al*., 1998, p.93)

In this survey we sought to find out how people *would like* to find out more, rather than how they did find out information. Those participants that suggested they would like more information about HIV (n=356) were asked '*Ideally, how would you like to find out more about HIV?*'. Over a quarter (26%) said they were unsure or did not know or said 'any way' (n = 97, 28% of those wanting more information). The remaining 244 participants answered the question by making 399 suggestions for methods and/or settings in which they would like to learn more about HIV (54% listed one method or setting; 32% listed two; 14% listed three or more).

The methods and/or settings proposed are outlined in the table below.

Ideally, how would you like to find out more about HIV? (N=341 suggested 399 settings or methods)	**Number**	%
UNSURE OR DID NOT KNOW	97	28
Books/magazines/newspapers (media)	88	26
Medical/professional setting	63	18
Talk/lecture/conference/workshop	61	18
Leaflet/poster/video/awareness campaign	33	10
Information service or centre	33	10
Request for information in community language	29	9
Community group	28	8
Church organisation	22	6
Work/college	7	2
Internet	5	1
Other	30	9

Most of the methods and settings are fairly standard including generic coverage in the media and awareness campaigns (including leaflets and posters), with additional work undertaken in medical settings. While there were some specific requests for written materials in 'community languages' relatively few people suggested using the specific social and religious groups that other parts of this survey suggest are important to these African communities.

6 Summary and recommendations

The formation of a local African Forum has provided a channel through which community groups and service providers can engage with each other to explore local community assets and needs. It has enabled service providers and community members to jointly consider the initiatives that are appropriate to meeting needs and utilising the assets of the communities. It has also begun a process of community empowerment, and given a space for individuals and groups to highlight issues that affect them directly to service providers instead of being represented by others. The existence of the Forum has helped to confirm community views that local health and social services need to be more accessible.

This survey is the largest of its kind and has been undertaken by African community members themselves. It helps identify key areas where community organisations and statutory services working in partnership can improve access to services and quality of life. It highlights the potential for community organisations to develop education and training to increase employment prospects for community members. At the same time, this research provided an opportunity for service providers to network and engage with community groups.

The survey has identified aims for HIV prevention initiatives by giving providers an invaluable insight into gaps in community members' knowledge of HIV transmission This information will go some way in assisting London Health Authorities to commission more HIV prevention work with African communities.

The recommendations listed below are designed to serve as a guideline for the future work of statutory and voluntary organisations, as well as assisting the community organisations themselves in initiating projects in the various highlighted areas.

- A key health issue identified by community members was mental health. Therefore, there is a need for mainstream mental health providers to forge closer links with African community groups to identify culturally appropriate interventions, demystify the services they currently offer and facilitate easier access to them.

- This report has demonstrated that knowledge around HIV prevention is variable and often poor within some African communities. It highlights the need for intensive work concerning HIV prevention issues. In anticipation of this finding, Redbridge and Waltham Forest Health Authority has created a Health Promotion Advisor post for African communities – HIV and AIDS. It has also made available a Small Grants Scheme that groups (and individuals) can access to undertake HIV prevention initiatives. Local community groups need to ensure that they take an active role in initiating work around HIV prevention.

- The report highlights that African and other organisations need to consider providing training to community members in specific areas (such as helping people gain employment). This training should be resourced by statutory services and undertaken after consultation with targeted communities concerning the type of training they require.

- This survey has demonstrated that many people from African communities need to be made aware of the existence of the services available locally and encouraged, through the Forum and other outreach programmes, to access these services.

- The report demonstrates the substantial linguistic abilities of many community members (50 languages were read or understood within the sample). These skills can be utilised as a substantial aid to health promotion. It is recommended that service providers consider training community members as link workers or interpreters to help improve access to mainstream services available locally.

- Consultation needs to take place with the community groups with regards to devising initiatives that will utilise the substantial number of social sites and social networks as an aid to health promotion, perhaps especially with regard to HIV prevention.

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