

# HIV Prevention Interventions within African Communities

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# African communities and the role of sexual health services in HIV prevention strategies

What barriers do individuals from African communities face in accessing sexual health services in the UK?

- Language difficulties
- Cultural issues (e.g. sexuality, gender)
- Lack of information on available services and entitlement to them
- HIV related stigma, discrimination
- Immigration status (e.g. asylum seekers etc.)
- Fear of breach of confidentiality
- Individual knowledge and perception of risk
- Religion (e.g. access to contraception)
- Fear of discrimination



# Role of sexual health services in HIV prevention

- Provide advice and information on HIV and AIDS and how to prevent onward transmission
  - Maintain the sexual health of people living with HIV
  - Diagnosis and treatment of HIV and other STIs
  - Promotion of HIV testing
  - Increase uptake of HIV testing
  - Provide outreach services when offering testing (e.g. testing in community settings)
  - Reduce transmission of HIV
  - Reduce mother-to-child transmission
  - Promote safer sex/condom use
  - Promote better access to services
  - Work with faith groups/religious leaders/barbers etc.
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# HIV testing and African communities

Why is HIV testing an important part of sexual health services?

## ❑ **Prevalence of HIV infections in UK**


- Estimated 83,000 in the UK were infected at the end of 2008, of whom over a quarter (27%) were unaware of their infection
- HIV testing can help monitor prevalence
- Onward transmission is more likely if people do not know they are infected

## ❑ **To reduce the proportion of individuals with undiagnosed HIV infection**

- Over 27% of the people infected with HIV in the UK do not know they are infected

## ❑ **Late diagnosis**

- Late diagnosis is associated with more serious disease, increased mortality, and impaired response to HAART (Highly Active Anti-Retroviral Therapy) and increased cost to health care services



-Percentage of late diagnosis (42%) is highest among Black Africans. Most of them received a late diagnosis in 2008 and had been in the UK for more than 2 years

#### **□ Detection and Prompt management**


- Early diagnosis is essential for initiating prompt antiretroviral treatment
- Early diagnosis of HIV is associated with improved survival of the individual
- Increased access to HIV prevention and treatment services will help individuals to appropriately manage their HIV status from the outset (i.e. it will help to initiate or maintain behaviours that will prevent acquisition or further transmission of HIV, better cope with HIV infection, plan for the future, reduce stigma and discrimination associated with HIV and AIDS and mobilise support for appropriate responses)

#### **□ Prevention of mother-to-child transmission**

#### **□ Benefits to individuals and public health**


- Knowledge of HIV status is associated with a reduction in risk behaviour
- Early diagnosis results in reduced onward transmission and consequently reduced cost to health care services

#### **□ Access to services**

- Knowledge of HIV infection is essential to access many forms of HIV related support, treatment and care services
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## Factors that affect uptake of HIV testing among African communities:

- Fear of being judged
  - Misconception that testing positive would lead to deportation
  - Fear of unknown/rejection
  - Perception of risk
  - Social exclusion (mostly affects women)
  - Lack of positive images of HIV (e.g. somebody from their community who is HIV+ talking about how they live with HIV)
  - Socio-economic factors
  - Lack of knowledge
  - Confidentiality
  - Fear of criminal prosecution
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## **Possible strategies that may be used to maximise uptake of sexual health services, and encourage the use of prevention measures by individuals within African communities in the UK**

- ❑ Provide HIV prevention and sexual health education programmes
- ❑ Provide targeted HIV prevention interventions
- ❑ HIV testing in community settings
- ❑ Outreach work in community settings
- ❑ Information dissemination in settings used by the target population
- ❑ Provide high quality, easily accessible sexual health services
- ❑ Promote innovative sites for delivery of sexual health services
- ❑ Ensure confidentiality of services
- ❑ Increase access to free condoms
- ❑ Promote access to STI screening
- ❑ Promote behaviour change e.g. using safer sex practices, partner notification, partner change reduction
- ❑ Training to increase knowledge and understanding of HIV, how to prevent onward transmission, negotiation skills, acceptance and use of condoms

# HIV & African communities data

- ❑ Black Africans are the heterosexual group most affected by HIV in the UK and most of the infections among this group were acquired outside the UK (mainly in Sub-Saharan Africa)
- ❑ In 2008, 2790 (38%) of the new HIV diagnoses in the UK were among black Africans
- ❑ The majority of black Africans living with diagnosed HIV in the UK are aged between 20 and 49 years
- ❑ Late diagnosis was highest among black Africans at 42%

Source: HIV data for black African communities in HPA, 2009a

# Objectives of HIV treatment

- Reduce the level of HIV virus in the blood
- Slow down or prevent damage to the immune system
- Improve the quality of life
- Extend life expectancy
- Prevent further spread of the virus in the population (e.g. from an infected mother to a child)

# HIV prevention needs among African communities in the UK

## □ Personal factors:

- Lack of knowledge about how HIV is transmitted and risk reduction options
- Lack of knowledge of HIV treatment (including PEP) and its effectiveness in reducing viral load (quantity of the virus in body)
- Lack of knowledge about available sexual health services
- Lack of will/motivation to reduce the risk of acquiring or transmitting HIV
- Ability to access and use HIV testing services
- Lack of power to act to reduce risk
- Skills to communicate openly with sexual partners about HIV risk reduction to influence partners' behaviour
- Awareness of other STIs and benefits of testing and where to go for testing
- Control over the use of substances such as alcohol and drugs
- Awareness of, and ability to access, male and female condoms
- Impact of HIV related stigma and discrimination
- Need to understand safer sex (i.e. skills required to adapt and maintain safer sex practices and information on the effectiveness of condoms in reducing HIV transmission)
- Gender related issues such as domestic violence and rejection with their communities
- Cultural practices that put them at risk, so that they can make informed choices about levels of risk they are prepared to take
- Fear which prevent some people of their community from: discussing HIV, seeking help, taking HIV antibody tests, notifying partners, disclosing their HIV status, accepting their HIV status and planning for the future.

# Theories and models in HIV prevention

- ❑ **Biomedical interventions** – focus on: treatment and control of STIs, partner notification, HIV treatment and reduction of viral load, reduction of mother to child transmission.
- ❑ **The Health Belief model** – according to this model, a person must hold the following beliefs in order to change behaviour: perceived susceptibility to a particular health problem (Am I at risk of HIV?); perceived seriousness of the condition (How serious is AIDS, how hard would my life be if I go it?); belief in the effectiveness of new behaviour (whether the new behaviour works in preventing harm?); perceived benefits of preventative action (if I start using condoms I can avoid getting HIV?); barriers to taking action (I do not like using condoms).
- ❑ **Reasoned Action model** – this model assumes that most forms of human behaviour are a matter of choice and the most immediate determinant of any given behaviour is an individual's intention whether or not to adopt that behaviour.
- ❑ **The Information-Motivation-Behavioural Skills model** – focuses on: providing information to raise awareness; self-reflection opportunities (to boost perception of vulnerability to HIV infection and HIV prevention motivation); practical skills to develop the capacity to assist change.
- ❑ **Social Cognitive (or learning) model** – e.g. HIV advocacy, peer education etc
- ❑ **Social inoculation model** – this model assumes that social and environmental changes are necessary in order to change individuals behaviour, and that influencing group norms, social policy, sexual mixing behaviour patterns and the social and medical infrastructure are the key routes to achieving this change. The key element is the necessity of working with social groups, not individuals.

# Factors to consider when planning HIV prevention interventions with African communities

- ❑ **Personal factors** as discussed earlier
- ❑ **Diversity** (religion, culture, language, traditions, political affiliations)
- ❑ **Country of origin & migration patterns** (reasons for migration may form basis of settlement patterns)
- ❑ **Acculturation** (concerned with language used, extent of mixing with other cultures)
- ❑ **Stigma & discrimination**
- ❑ **Social attitudes** ( people present in public acceptable sexual identity which may be different from private sexual practices)

# Levels of HIV prevention interventions

- ❑ **Individual level interventions** – one-to-one or face-to-face interactive interventions (e.g. telephone advice, internet-based work, face-to-face outreach, condom distribution) and operating on personal modifying factors e.g. knowledge, attitudes, intentions, skills and self-esteem.
- ❑ **Group level interventions** – facilitated sessions delivered to small groups of individuals (e.g. seminars, workshops, group discussions/support groups) and operating on personal modifying factors. They can also modify social factors e.g. peer and group norms.
- ❑ **Community level interventions** – target defined “communities” such as religious leaders, people living with HIV etc. Interventions at this level can also target organisations and professionals working with specific populations. Examples: small media (leaflets and booklets); mass media (posters and advertisements in newspapers); peer education (condom and lubricant provision); community events; community empowerment and development and some internet interventions e.g. website, chat rooms.
- ❑ **Socio-political level interventions** – aim to change structural modifying factors e.g. legislation, equality interventions, regulation, resource allocation etc.

# Key messages to consider when planning HIV prevention interventions within African communities

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