AFRICANZ HEALTH

Mark Henrickson, Nigel Dickson and Fungai Mhlanga
with Adrian Ludlam
An HRC/MOH funded project

OVERVIEW

- AfricaNZ Health is a two-phase study to consider
  - The scope of African new settler populations in NZ (Phase 1)
  - Knowledge, attitudes, behaviours and beliefs about HIV (Phase 2)
  - Educational needs of these communities in respect of HIV prevention and management(Phase 2)
  - Recommendations to the Ministry of Health (Phase 2)
- AfricaNZ Health was a collaborative project between Massey University and the University of Otago
  - AfricaNZ Health was highly collaborative and consultative with Black African communities throughout NZ and Black Africans living with HIV
- Ran for 18 months between January, 2012 and June, 2013

OVERVIEW

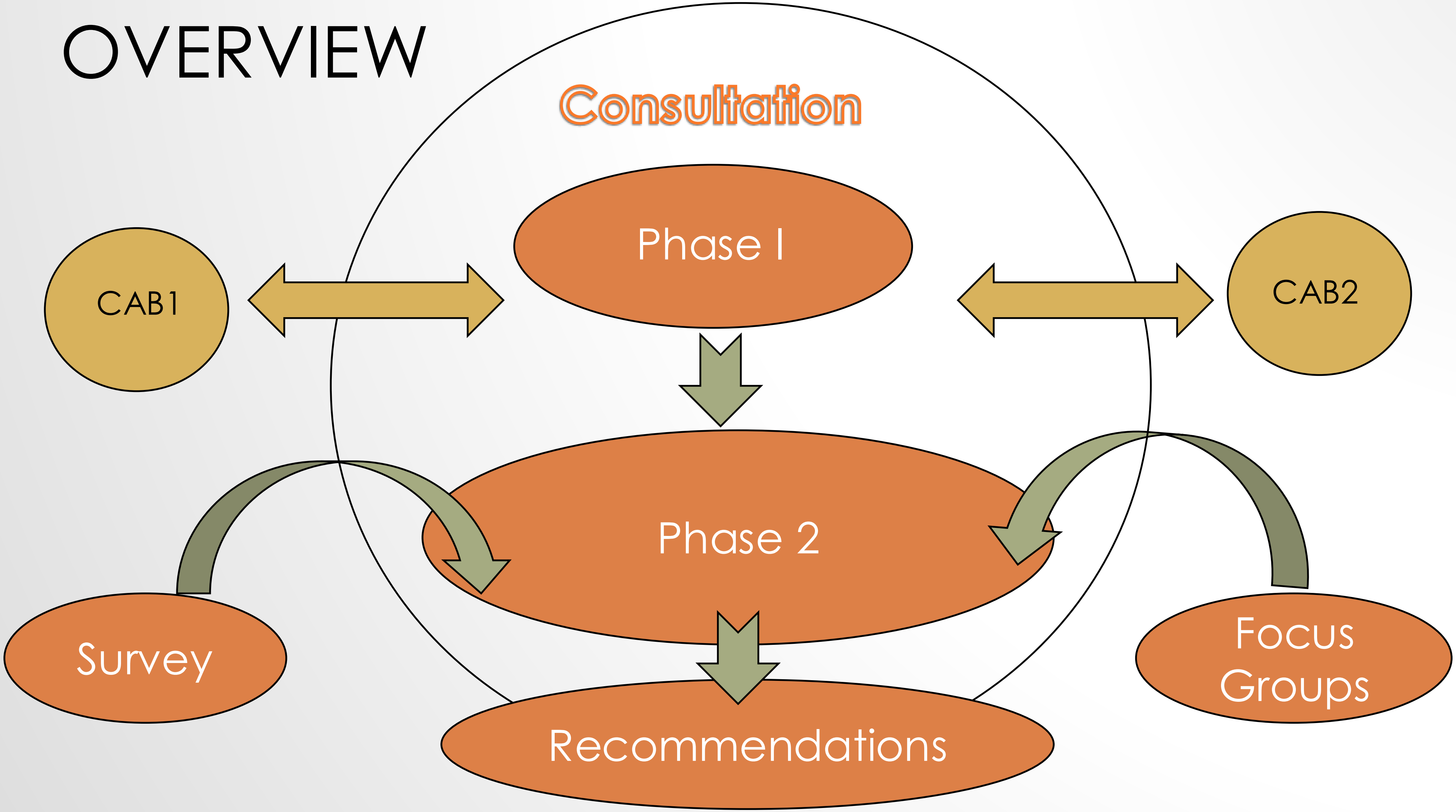
- Community Advisory Groups
  - The first thing we did was to meet with key African community and religious leaders to recruit their support and their participation in a stipended advisory group
  - All agreed to support, and most agreed to be part of a CAB
  - It then became clear that two separate advisory groups would be required as most Black Africans living with HIV did not wish to disclose to the wider community
  - Both groups met in-person three times during the project, and project staff consulted with them throughout the active life of the project
    - Both CABs actively contributed to and supported final recommendations

OVERVIEW

- Staff
  - Project Coordinator was Fungai Mhlanga
  - In Phase 2 we established local area coordinators in major African settlement centres of Auckland, Hamilton, Wellington and Christchurch
  - Casual staff were recruited as surveyors and focus group leaders; most of these were Black African
  - Staff also provided valuable input to the project implementation

  - We acknowledge the expertise, passion and hard work of our CABs and staff, and the courage of our HIV+ participants in a CAB

OVERVIEW



Consultation

CAB1

Phase I

CAB2

Phase 2

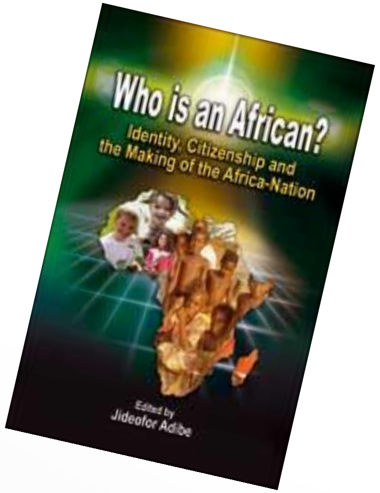
Survey

Focus Groups

Recommendations

OVERVIEW

- Our first challenge was to consider ‘Who is African?’
  - This is a fraught and largely unanswerable question, and the subject of much debate even in African nations
    - This debate was mirrored in our own community advisory groups
  - Our response was to define our communities of research interest in terms of their risk for HIV
  - Based on recently published African data, and confirmed by our own NZ data, we focused on Black Africans



METHODOLOGY: PHASE 1

- Our task was complicated because no one had ever counted Africans or Black Africans in NZ
  - The data we needed are not collected in any existing formal data base; therefore our results, are necessarily inferential and indirect estimates from Census and from canvassing HIV care providers
  - We considered key indicators of
    - Ethnicity (this is a free-response question on Census)
    - Place of birth
    - Language
    - In-and out-migration
    - Religion

RESULTS: PHASE 1

- We estimated 61,400 people born in an African country in 2006 NZ Census
  - 9,510 were Black Africans and South African ‘Coloured’
  - We estimated a net gain of 2,323 Black Africans from 2006-2011, therefore
  - We estimate thed total Black African (and South African ‘Coloured’) population in NZ at 12,500 at the end of 2011
    - They were located primarily in Auckland, Waikato, Wellington and Canterbury, which combined account for 87.6% of the total
    - Countries of birth with largest numbers were (in order): New Zealand, Somalia, Zimbabwe, ‘Elsewhere’, Ethiopia, South Africa, Sudan, Kenya, Nigeria and Ghana
    - 55.5% identified as Christian, 30.5% identified as Muslim
    - One in five people born in Africa in NZ is Black African

RESULTS: PHASE 1

- We estimate the number of adult Africans living with HIV at the end of March 2012 at 420
  - The total number of Africans diagnosed with HIV from 01/06-03/12 is 205, or 17% of all people diagnosed with HIV during this period
  - Most common age group is 30-39y
  - Most report heterosexual transmission
  - HIV clinical specialists are providing care for 295 adult Black Africans, which is 19% of all their HIV patients
    - There are <10 white Africans in care
  - These data suggest an adult prevalence of approximately 5% (which is not evenly distributed throughout all African communities)
- These data provided a sampling frame for Phase 2

RESULTS: PHASE 2

- **Survey participants**
  - 703 usable surveys
    - 49% men, 50% women (1% NR)
  - Respondents born in 23 countries
    - Men: 25% from southern Africa and 23% from Horn
    - Women: 37% from southern Africa
  - 68% have lived in NZ five years or more; 6% in NZ <1y
  - 81% Christian, 13% Islam, 4% other
    - 69% attend religious services 1x week or more

RESULTS: PHASE 2

- Knowledge
  - High level of knowledge about HIV and transmission
  - Moderate level of knowledge about the benefits of treatment
  - Less knowledge that circumcision offers some protection against infection
  - Young men (16-24y)
    - had less knowledge than other groups
    - had more negative attitudes about people with HIV
    - had more negative attitudes about condom use

RESULTS: PHASE 2

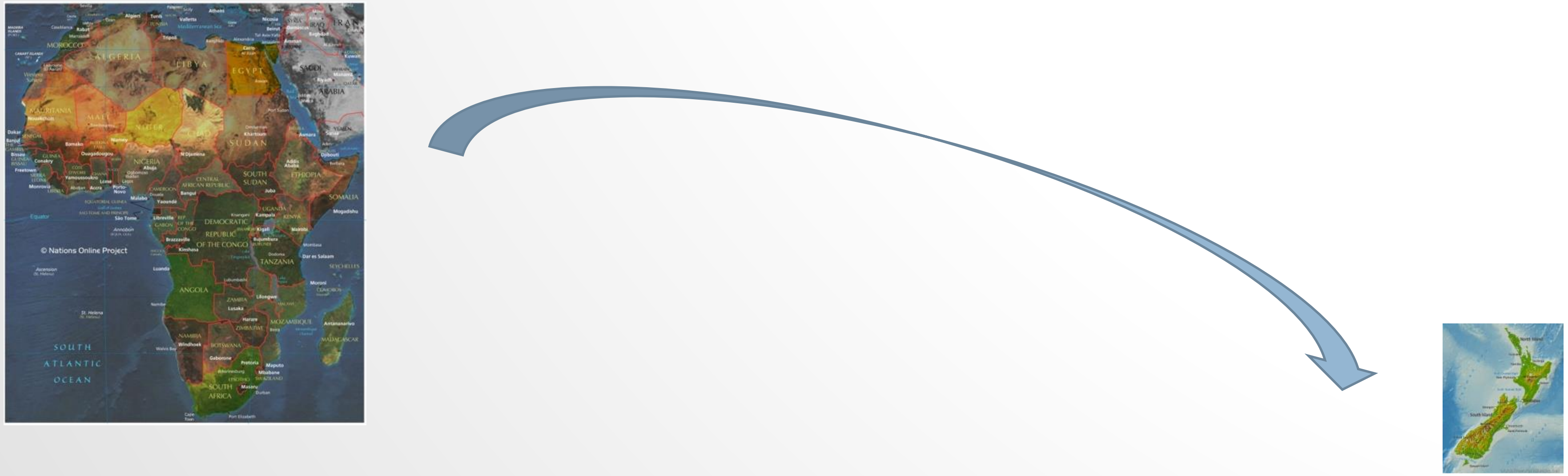
- Behaviours
  - More men (65%) than women (57%) reported intercourse in the previous 12 months
    - most reported only a single sexual partner in previous 12 months
  - Men more likely to have non-African partners than women
  - 40% men, 22% women reported condom use at last sex
  - 69% of respondents ever tested for HIV, mainly for immigration
    - 3% of survey respondents were HIV+
  - We have some questions about the possibility of social desirability bias in some responses

RESULTS: PHASE 2

- **Focus Group participants**
  - 131 people participated in 23 focus groups
    - 58% female, 41% male (1 NR)
    - 66% Christian, 24% Muslim, 4% no religion, other or NR
    - 78% identified as heterosexual, 1.5% as ‘homosexual’ and 20% said ‘none of these’ or NR
    - 77% identified as HIV-, 2% as HIV+, and 12% ‘did not know’; 11 NR
      - We believe ‘do not know’ is code for ‘do not wish to disclose’
    - Mean time in NZ is 7.5y, ranging from 2.5y (Ethiopians) to 11.5y (Somalis)
    - While 2 participants identified as ‘homosexual’, 9 (7%) said they were in some kind of relationship with a person of the same sex
      - We must therefore be very cautious in using Western sexual identity taxonomies with these communities

RESULTS: PHASE 2

- Key findings include:
  - Settlement
    - Most participants maintained their cultural identities, and close cultural ties with ‘home’ and family in Africa
    - Participants experienced difficult challenges with the host culture, noting that they felt singled out and stigmatised because of their nationality or colour



RESULTS: PHASE 2

- Education
  - Agreement that African communities need more education about HIV, not only to prevent infection, but to address stigma about PLWHIV
  - Education about HIV stigma should be provided to *all* New Zealanders
  - Not only are people with HIV highly stigmatised among African communities, but people who think they might be at risk for HIV avoid testing because the very act of testing risks that same stigmatisation
  - Information about the risks of HIV transmission via male-to-male sexual activity should also be directed to African communities, although the words ‘gay’ and/or ‘bisexual’ will not be meaningful
  - Schools are important sources of information
  - Existing educational campaigns about HIV do not appear to be reaching a wide audience.
  - Although most participants were adherents of some religion, there was agreement that these organisations were not providing leadership on HIV

RESULTS: PHASE 2

- Sexual behaviour
  - The specific age when it was appropriate to engage in sexual activity varied widely from the late teens to mid twenties
  - While the survey suggests that women have the right to refuse unprotected sex, women in focus groups felt at risk and also felt that they had no right to refuse unprotected sex from a husband
  - There is a high level of ambivalence about same-sex sexual activity

RESULTS: PHASE 2

- Reported condom use in the survey shows some awareness of the risk of unprotected sexual intercourse
  - Condom use reported by focus group participants is at variance from the findings in the survey
    - Condoms are not used because of
      - Religion
        - *“I’m a Catholic, we don’t use condoms” (Auckland male)*
        - *“We don’t even know what a condom is…because we haven’t used it or seen it.” (Wellington female, translated)*
      - associated with ‘players’
      - associated with mistrust in relationships
  - Because of NZ’s low HIV prevalence, condoms are *less* likely to be used than if participants were in African environment

“If someone is in a jungle they are very aware of danger so they are on their guard. When you take them out of that jungle you’re very cautious because they drum it in our ears on radio, on TV, in everything. So when people leave the environment they think they are safe… They look at New Zealand and say ‘Well, I’m out of that environment, now it’s a bit safe’.” (Auckland male)

RESULTS: PHASE 2

- HIV and testing
  - Difficulties with immigration law and authorities were the source of distress for many participants, particularly PLWHIV
  - Stigma about HIV is a primary reason that participants do not test for HIV or disclose their HIV status
  - Some PLWHIV felt very strongly that information about their HIV status had not been well managed during clinic visits
    - they were reluctant to disclose their status to non-medical staff

"There is no confidentiality in hospitals… Information needs to be managed better… Hospitals are terrible. Sometimes people leave a file open on their desk and anyone can read it. Because it is obvious from the way people are treated [in clinic waiting areas] who is HIV positive. Hospitals and clinics must change procedures and manage privacy better. They are trying to save time, but at the cost of patient confidentiality." (HIV+ male)

RESULTS: PHASE 2

- Research
  - There is ambivalence about research
  - There was significant concern that Black African communities would be perceived as blameworthy, or somehow responsible for HIV in New Zealand
    - Great care should be taken in the dissemination of any results from research so that African communities and people living with HIV are not further stigmatised

RECOMMENDATIONS

- **Advice to Ministry:** The Ministry of Health should develop an advisory group to itself at both national and regional levels in order to create an integrated national strategy about HIV in African communities, and to follow up on the recommendations from this report
- **Ministry infrastructure:** There should be dedicated Ministry staff to work with the HIV community around planning and funding decisions; it should not be assumed that the existing infrastructure is adequate
- **Prevention education:** There is an array of education-related recommendations. Many respondents and focus group participants noted the lack of general national HIV education messages in New Zealand

RECOMMENDATIONS

- **Prevention education:** Enhance HIV education in schools, and add to sexual health education curricula
  - Resource schools to do HIV-related projects
- **Testing:** Encourage voluntary testing, normalise testing and counselling at GPs
  - However, a number of community advisory group participants also related experiences of feeling stigmatised by GPs because they were Black African, and felt some pressure compelled to undergo HIV testing even when there was no or minimal risk; this initiative should therefore follow education of health providers as above
  - The pathway for offering HIV testing to asylum seekers—who do not enter the country through the refugee pathway—should be made clearer and more robust

RECOMMENDATIONS

- **Context:** HIV needs to be contextualised within other chronic, life-threatening health issues in African community, such as cancer and diabetes
  - A World AIDS Day strategy inclusive of Black African communities should be developed
- **Research:** Follow-up research in African communities is needed, especially among Black African men who have sex with men
- **Services:** Many Black Africans living with HIV do not feel empowered to access necessary services, such as medical care and transportation
  - The Ministry should consider putting case managers in place to work with African persons living with HIV who voluntarily refer to such a service in order to assist with access to services, overcoming barriers, and ensuring an African voice at all stages of service management and delivery (Suggested by a group of advisors living with HIV)

RECOMMENDATIONS

- **Education of health providers:** Health providers (community, clinic and hospital), dental providers and their support staffs (including administrative and human resources staff) must be further educated on HIV transmission, stigma, human rights and current law as it relates to stigma and discrimination against people and employees with HIV, and management of confidential patient and employee information (Suggested by a group of advisors living with HIV)

RECOMMENDATIONS

- **Education of employers:** The Ministry should advice employers, insurers, and the Department of Labour (including Immigration New Zealand) that with appropriate care HIV has become a chronic manageable condition, not transmissible through ordinary workplace contact (Suggested by a group of advisors living with HIV)
- **Research:** Provide follow up to the community on outcomes of research
  - Academic, community, and policymaker worlds must be bridged; we must contextualise research beyond Africans
  - Further studies in this area will be important to develop more detail about specific subpopulations (e.g., MSM, women, younger people), and to assess social desirability bias in specific subpopulations

RECOMMENDATIONS

- **Empowerment:** African community must have a voice not only in the development of policy and educational initiatives, but also in other forums
- **Community responsibility:** African communities need to continue to talk with each other to develop an environment where people living with HIV can feel safe to disclose their status within their communities, and to develop partnerships with community, religious and educational leaders

CONCLUSIONS

- Cautions
  - For historical reasons, African communities in New Zealand have a higher prevalence of HIV than other communities, and this means that there is increased risk of HIV within and beyond these communities
  - While this risk need to be addressed, it should not be construed as a reason to discriminate or further stigmatise an already vulnerable population for any social or political reason, either intentionally or unintentionally

CONCLUSION

- Thank you!
- See the complete reports and full project website at

  http://africanz.massey.ac.nz