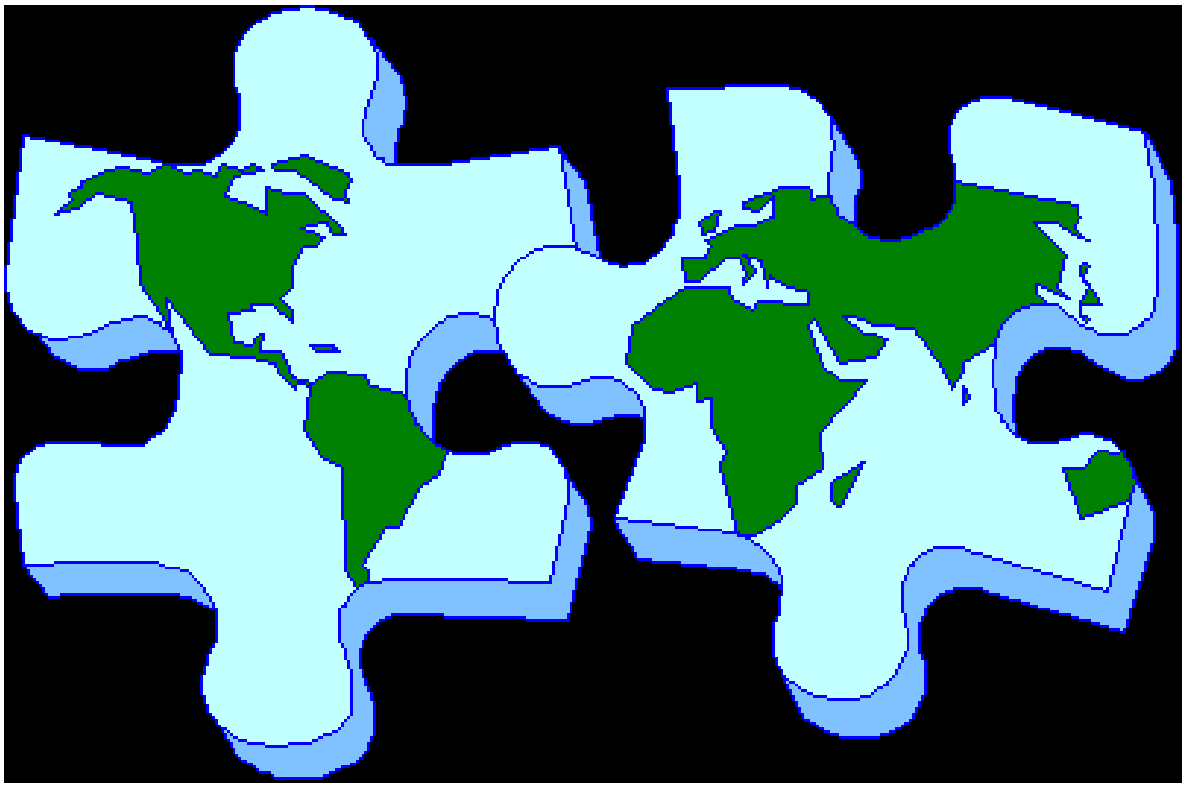
"Being part of the solution"

The HIV prevention potential of African Social Networks in NHS Greater Glasgow & Clyde



Waverley Care 21
making a positive difference

Final Report
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NHS
Greater Glasgow and Clyde

Contents

1. Executive summary

Following the upsurge in new HIV diagnoses among African communities in Greater Glasgow and Clyde from 2005 onwards, NHS Greater Glasgow & Clyde (NHS GG&C) has been actively strengthening its HIV prevention interventions among this population subgroup. A rapid needs assessment was conducted in 2009, which highlighted both the heterogeneity of African communities and also their distinct needs. In the light of these findings, NHS GG&C commissioned Waverley Care to conduct a more detailed exploration of social networks within Black African communities in Greater Glasgow and Clyde, to inform development and delivery of effective HIV prevention initiatives. This report provides a summary of its findings.

This project provided a structured understanding of where Africans meet together, who they meet with and why. It also identified key community leaders and provided some information about broad HIV prevention themes that were perceived as important by Africans in Glasgow. With respect to the variety of places where African people spend their leisure time, churches were identified most frequently, followed by African shops and informal social events. Dance clubs attracted considerable numbers of younger Africans and had the added advantage of a resident DJ, who indicated willingness to work together with the African Health Project on HIV prevention. As well as family and friends being valued sources of support and information, community leaders, particularly pastors and church ministers, were considered to lend credence and import to key messages, as these roles are considered to represent authority and 'father' figures. Medical staff, in particular GPs, were also seen as holding positions of authority and trust and, as such, are key people who will be listened to when HIV prevention topics are raised.

The project identified key themes that should be applied to future HIV prevention work with Black African population subgroups in NHS GG&C. Promising locations for HIV Prevention Opportunities with Black African social groups

2. Why was this work done?

HIV infection disproportionately affects Greater Glasgow and Clyde's Black African subpopulations; over the past decade, both the absolute numbers and the proportion of all new diagnoses in black African people have progressively risen. In addition, Black African people have a greater propensity to present with later stage disease, when treatment is less effective.

Mounting an effective HIV prevention strategy among the black African subpopulation is currently hampered by poor knowledge about the cultural and social characteristics of the communities affected. We sought to address this knowledge deficit by building a more differentiated understanding of the characteristics of "Black African" communities in NHS Greater Glasgow and Clyde in two respects; firstly, by developing a clear definition of the social and cultural characteristics of the population/s at risk; and, secondly, to identify promising ways of delivering HIV prevention interventions of proven effectiveness to different subpopulations.

The term "Black African" is a gross oversimplification of what is, in reality, a disparate mix of linguistic, ethnic, national and religious groups.[2] Planning more appropriate HIV prevention interventions for these communities required a clearer picture of the ethnographic and network characteristics of "Black African" communities in NHS GG&C, incorporating a more structured understanding of social interactions between Black African people. We sought to ascertain where members of relevant communities meet and why, how information is shared, whom people trust and listen to, how HIV information is viewed and how it could be shared and disseminated for the purposes of preventing HIV transmission, encouraging diagnosis at an earlier stage and ensuring continuing engagement with treatment and care services.

3. What did we know at the start?

3.1 Migration patterns

The number of Africans moving to Scotland had been increasing until the mid 2000s, although this is now declining. Political and economic difficulties in Africa have been a strong influence on people to move and seek a better life elsewhere. Africans move to Scotland for many diverse reasons, including education and employment opportunities, internal migration to Scotland from London and the South East or as a dispersed asylum seeker. However, following the sharp decrease from their peak in 2002 (84,130), asylum applications for the UK as a whole have remained at a much lower and stable level since 2005; in 2009 the number of asylum applications received was 24,485.

3.2 Sexual attitudes and lifestyles

Africans reflect the same diversity of human sexuality as most other geographically defined groups of people. Sexual attitudes and practices can differ across African regional, ethnic and religious backgrounds. For instance, as a value system in some regions of Africa, polygamy (having more than one spouse at the same time) plays a significant function in the economic and social life of communities. Although its prevalence in African diaspora settings has changed over time, polygamy and the existence of multiple concurrent sexual partners continues to be highly valued by some, while being quite far outside the experience of others.[3]

Knowledge on sexual health issues for Africans living in the UK primarily comes from four reports based on research in England (mainly London) and one report in Scotland. Two of the English reports, the 'Padare' study, the 'Shibah' report and the Scottish based report 'HIV Becomes Your Name', collected information and conducted in depth interviews with Africans living with HIV, mainly from Congo, Kenya, Uganda, Zambia and Zimbabwe.[4-6] The two 'Mayisha' studies included a survey of sexual attitudes and lifestyles from over 2,000 black African men and women aged 16 years and over in London, Luton and the West Midlands.[6] A synthesis of evidence from these reports indicates the following common themes:

- gaps in HIV knowledge;
- variable condom use;
- frequent casual relationships;
- evidence of sexual mixing with other ethnic groups.

The authors of the 'Padare' report concluded that "The data suggest significant levels of sexual behaviour that places both the individual living with HIV and their sexual partners at risk of transmitting HIV and other STIs."[4] 'Mayisha' raised issues around the impact of migration on relationships, with a quarter of married men and women having a partner who lived abroad.

The Department of Health's framework for HIV prevention and care services for African communities highlighted the importance of building a clear understanding of the dimensions of need in local communities as the first step in effective HIV prevention work.[7] It identified widespread unmet need for basic information on HIV transmission, testing and treatment; it highlighted the following cultural practices as disproportionately placing some Africans at particular risk of HIV:

- perceptions about condoms
- cultural norms around polygamy
- attitudes surrounding sexual behaviours, reproduction and breast-feeding
- secrecy and taboos regarding sex and relationships.

As is the case among people from a broad range of backgrounds, many African parents tend not to offer information about sex to their children, with this responsibility often passing (formally or informally) to other family adults or to peers.[8-10] Young Africans in the UK find (as do many other young people) that there is often a gulf between a silence at home, sex and relationships education at school, and the apparent sexual freedom displayed in British media and marketing. African men and women often subscribe to patriarchal values about sex, accepting (or rewarding) in men behaviours for which women would traditionally be castigated. Role expectations of strong independent men, in contrast to protected, dependent women can result in boys being left to their own devices with respect to their sexual development and exploration, whereas girls are more likely to be given prohibitive and negative messages about sex.[10]

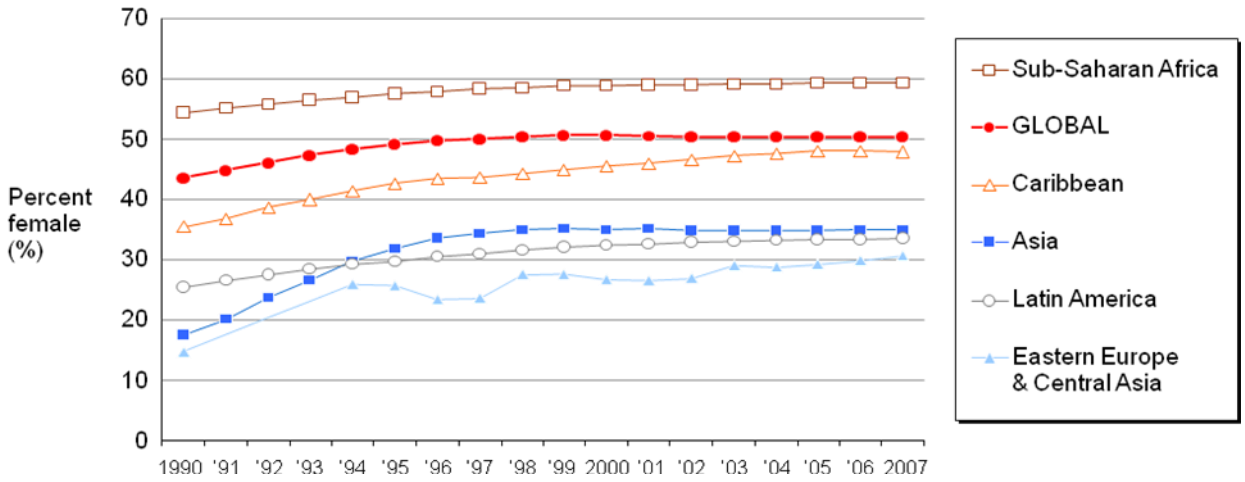
3.2 Attitudes to HIV testing

Late diagnosis of HIV (defined as a CD4 count of 350 or less, after the point when antiretroviral therapy would normally have been commenced) is a major issue in the African subpopulation.[11] It

has been variously attributed to stigma, religious faith and lack of awareness of HIV, particularly in Scotland, where HIV is comparatively less visible than in many African countries. Some reports also suggest that lack of understanding of UK health services, suspicion of statutory agencies or adverse experiences of healthcare in African countries of origin also contribute to late diagnosis. However, whilst all of these theories have some validity, the evidence is that the majority of those who do not test simply do not consider themselves to be at risk.[2]

Approximately twice as many African females as males are diagnosed with HIV in the UK each year. While women are more likely than men to be in contact with medical services where the opportunity for HIV testing is increased, this does not provide an explanation for these differential rates of diagnosis, as almost all HIV infections will eventually be diagnosed. Therefore, differences in diagnosis are likely to reflect real differences in HIV infection risk between men and women. In some settings, this contributes to a three times higher infection rate among young women (15-24 years) compared to young men (Figure 1). Across most sub-Saharan countries, women with HIV far outnumber men, and three quarters of all women living with HIV in the world are sub-Saharan African.[11] Socio-economic status and behavioural factors provide a partial explanation for the gendered nature of the epidemic; these will include issues such as control over condom use, sexual partner choice and the ability to negotiate sex that avoids the risk of transmission. In some countries men are encouraged to have more than one sexual partner and it is common for older men to have sexual relations with younger women.

Figure 1: Percent of adults (15+) living with HIV who are female, 1990–2007.
Source: UNAIDS 2008[12]



In the 'Mayisha' survey, around half of female respondents and 43% of the men reported having had a confidential HIV test, the majority within the last five years. Respondents' accounts cited the importance of community outreach work and HIV awareness-raising as key factors in motivating them to take a voluntary HIV test, however, conversely, fear of stigmatisation and/or deportation and expectations of HIV as a 'death sentence' continued to deter people from testing. Although trust in the monogamous nature of relationships and fidelity to one partner were highly valued by respondents, men and women's accounts provided clear evidence of concurrent relationships.[6]

3.3 Religious faith

About two-thirds of Black Africans in the UK are Christian. However, in particular regions within Africa (particularly in the North, and the Horn of Africa) the population is predominantly Muslim; Africans accounted for six percent of Muslims in England in the 2001 Census.

Accordingly, much has been written about the potential for delivering HIV prevention interventions in faith-based settings, based on the belief that faith-based approaches to mutual care and responsibility share common objectives with health promotion.[3] Many Africans living with HIV report that prayer is a source of strength, and many report that their religion plays an important part in taking their medication as prescribed.[14] Africans with HIV often identify church as a supportive place, yet few share their diagnosis with faith leaders, whosepreaching about HIV is perceived to generate and compound stigma.[12,13]

However, there are also considerable challenges to interventions in faith settings, which may explicitly prohibit sexual activity that is pre-marital, extra-marital or non-procreative. Some African faith leaders hold conservative views on same sex relationships (particularly between men) and may be disinclined to support men who have sex with men (MSM) with HIV. This contrasts with their willingness to support heterosexuals and children affected by HIV.[13]

3.4 Social and sexual mixing patterns within UK

As long as there are links between the UK and Africa, migration will continue. When the movement of people from African countries increases, so too will the numbers of people living with HIV in Scotland, increasing the potential for onward transmission of HIV within sexual networks. The assumption that Africans in Scotland are a relatively closed group, socially and sexually, is not borne out by impressions gathered by African outreach workers in the field, nor does it tally with Berrington's sociological work on ethnic partnerships in London.[4] Census data appear to confirm that Africans are one of the most integrated of minority ethnic groups: of the 761 couples who were married or cohabiting with someone of the opposite sex, 47% had partners of another ethnicity, usually white.[14]

4. What did we do?

4.1 Aim

The project sought to build a picture of the ethnographic and network characteristics of "Black African" communities in NHS GG&C, which would then be progressively enriched with a more structured understanding of social interactions between Black African people, ascertaining where people meet and why, how information is shared, whom people trust and listen to, how HIV information is viewed and how it could be shared and disseminated. The project was not intended to deliver or evaluate existing HIV prevention interventions, rather it sought to identify potential opportunities for these. As social meeting places and networks are fluid and changing, and as the African community in Greater Glasgow and Clyde is itself growing and changing, this information was intended to provide a snapshot in time, to be maintained and developed.

4.2 Methodology

Social Network Analysis (SNA) is a sociometric technique for describing the qualitative and quantitative features of a network, through numerical and/or visual representation. In this work, we did not use the statistical methodology in its original mathematical sense, but combined its formal observation of relationships between individuals, groups and organisations, with another methodology, *ethnography*, to study social interactions, behaviours and perceptions within Black African groups and communities in Glasgow. Both techniques enable relationships between people to be systematically mapped and understood, using a range of tools including observation, interviews and questionnaires.

4.3 Project logistics

A member of Waverley Care's African Health Project staff, Nathan Mwesigwa (NM), was employed to deliver the project two days per week over a period of five months, from April to August 2009. He was supported by representatives from NHS GG&C and executives in Waverley care to form an informal Steering Group, with regular meetings held to ensure that the project delivered its core aims, whilst evolving iteratively when appropriate in the light of emergent evidence. The SNA was grouped into four discrete phases; however, this was an iterative and cyclical process, rather than sequential steps and, as there was already knowledge shared between African Health Project staff, volunteers and service users, several phases ran in parallel.

4.4 Phased approach

Phase 1: NM engaged with members already participating in the African Health Project, by attending group meetings, explaining the rationale for the SNA, seeking the group's support, opinions and endorsement. A focus group discussion was conducted to elicit a preliminary typography of the physical and social spaces occupied by African people in Greater Glasgow and Clyde. The Women's Group did not agree to have the session recorded, preferring to write down their responses; these were collated and are included in the report findings. The group included five participants, aged from 31-40, four from Zimbabwe and one from Burundi.

Phase2: Exploration of the social and physical spaces occupied by African people in Greater Glasgow and Clyde, using systematic ethnographic observations at meeting places, including shops, public and (where appropriate) private spaces, churches and other locations. The locations were informed by Phase 1 and existing knowledge about places where Africans in Glasgow frequently meet, including shops selling African food, African hairdressers, clubs, churches and African Community Associations. The following observations were systematically recorded at each location:

- Setting: description of physical environment and social context
- Behaviours: what is going on? What kinds of behaviours are observed? Is there a definable sequence of activities? How do people interact with each other?
- People: Who is there? Is there a definable social circle of people who appear to know one another, interact closely and seem socially cohesive?
- Index individuals: Which individuals are the circle's social and affective centres of attention?

Participant observation during Phase 2 required NM to engage with settings in an informal and natural way, to avoid raising any suspicions that might have triggered unnatural responses. To ensure a high degree of accuracy, the researcher maintained an up to date fieldwork diary for each

visit to all sites. Fieldwork diaries were submitted for each visit, from which a thematic table was produced to create a typology of physical spaces used by Africans and the potential for doing different types of HIV prevention work there.

Phase 3: This phase of the work was focused on the role of peer/opinion leaders (index individuals). NM approached and actively engaged with each index individual, explaining the rationale for the SNA and seeking their support, opinions and endorsement of the work. An attempt was made to interview each index individual privately, covering the following topic areas:

- What other African people does the index individual knows how well and in what capacity?
- Who are the friends with whom they most like to spend time?
- Who are the people they feel closest to?
- Who are the people they trust most?
- How well do they know other people's knowledge and skills?
- What do they believe to be the main issues for Africans around HIV?
- Who or what gives them information about HIV?
- What resources do they use to find out information about HIV?
- What resources do people use to share information about HIV?

By the end of June, six interviews had been conducted with index individuals. At this point, the Steering Group agreed that if it were possible to conduct a few more interviews then the priorities would be: another faith leader; a pastor's wife (in particular how her role differs from her husband's); a group of pastors. The interview with one pastor highlighted the conflict between treatment and prayer and we agreed that it was important to ascertain how common this theme is. Accordingly, these themes were elicited in a further four interviews with faith leaders.

Phase 4: Characterisation of extended social networks accessed through index individuals and undertaking a questionnaire survey of those network members. The main purpose of this phase was to characterise network relationships and knowledge flows, with a particular focus on how these structural characteristics might create opportunities for HIV prevention and future interventions. 100 questionnaires were distributed at church visits, accompanied by stamped addressed envelopes; however, very few (n=25) were returned, despite redistribution with a request to complete the questionnaire at the time of the church meeting.

5. What did we find out?

5.1 Phase 1

The African Women's Group provided NM with a picture of their typical week; four of the five women attended college and two were involved in a voluntary activity. On top of college demands, one woman also managed her children's welfare and their journey to and from school. Weekends were the time for shopping, visiting friends and recreational activities (eg swimming and walking). On Sundays, the majority attended church to 'maintain the Sabbath'. Places of worship included Paisley Baptist Church, AFM Church on Maryhill Road in Glasgow, the Church of Scotland at St. Rollox in Sighthill and Destiny Church, Pollokshaws Road. Shopping was generally done around the city

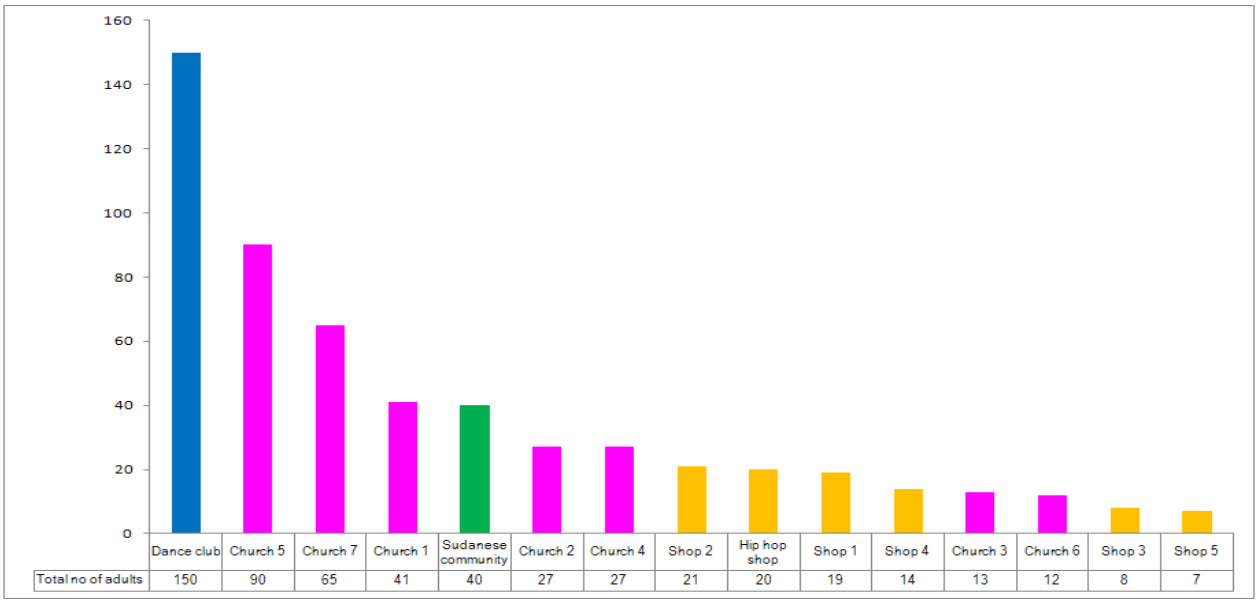
centre. Specialist goods and services, particularly African merchandise (food and beauty products), were purchased from shops such as 'Solly's' (an African shop on Great Western Road), local shops (eg Huntington Square in Sighthill), 'Molokai's' on Paisley Road, 'Sisa's' Hair Salon (Duke Street), 'Fremu' Salon in Paisley and Braehead shopping centre. In their leisure time, participants often visited friends, work colleagues, fellow church members, college mates and the friendship formed at social groups, especially the African Health Project. Friends engaged in walking, religious fellowship activities, studying, chatting about college assignments and situations back home in Africa, as well as debating business prospects or immigration issues. Some also enjoyed going to the salon for grooming, which offered the added advantage of catching up on what had been happening around the area.

Women also described some of the community organisations which they attended, particularly 'Karibu' as well as the African Health Project itself, where once a month the women gathered for an interactive evening facilitated by the African Health Project at their Bath Street base. Recent discussion topics at the African Women's Group had included sharing of personal issues, as well as educational programmes addressing use of condoms and relationship issues.

5.2 Phase2

During this phase, an ethnographic profile of Africans attending locations identified during Phase 1 was generated, to characterise key opportunities for delivering HIV prevention interventions. NM attended selected locations, based on i) venues suggested by African women in Phase 1; ii) venues cited by Waverley Care African volunteers as locations frequently used by Africans in Glasgow as social spaces. The dance club had by far the highest number of African attendees at any single location. Churches represented collectively the largest type of location in which African people congregated (Figure 2).

Figure 2: Estimated total number of adults present at each site on the first visit

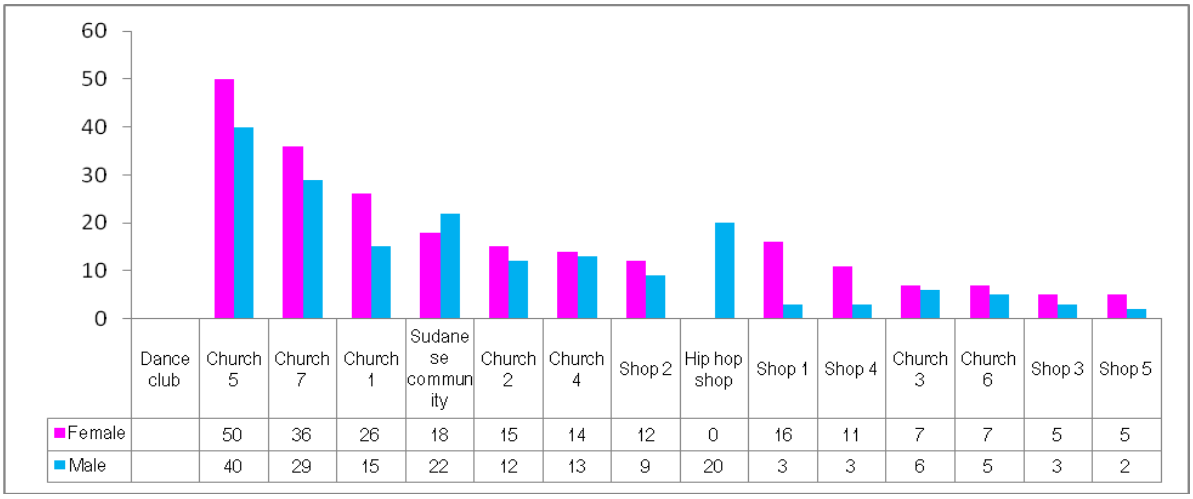


	Dance club	Church 5	Church 7	Church 1	Sudanese community	Church 2	Church 4	Shop 2	Hip hop shop	Shop 1	Shop 4	Church 3	Church 6	Shop 3	Shop 5
Total no of adults	150	90	65	41	40	27	27	21	20	19	14	13	12	8	7

The principle limitation of the methodology used is that not every black person observed will be African, though at the majority of the churches we were able to enquire about nationality and

confirmed that those attending were virtually exclusively sub-Saharan Africans. The atmosphere in the places of worship was friendly and sociable, with evidence of coherent groups as people talked about home and relationships. The brochures displayed in some of these establishments indicated that individuals visited each other at home for prayer meetings and celebratory occasions, typically birthdays and anniversaries. The number of African attendees at found at the Sudanese community event were unusually high because a special annual event coincided with the first visit. The estimated total number of people observed at Site 1 (the dance club) was very approximate and it was difficult to make a good guess about gender breakdown because of limited visibility, congestion and frequent mobility of the crowds. For the remaining 14 sites, there was some level of certainty. There were more women (221) than men (183) for all venues put together (Figure 3).

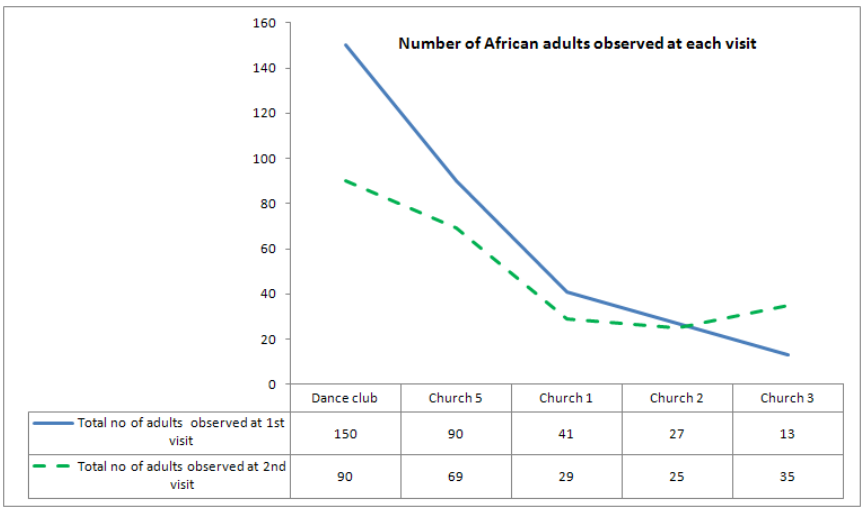
Figure 3: Gender distribution at each site on the first visit



	Dance club	Church 5	Church 7	Church 1	Sudanese community	Church 2	Church 4	Shop 2	Hip hop shop	Shop 1	Shop 4	Church 3	Church 6	Shop 3	Shop 5
Female		50	36	26	18	15	14	12	0	16	11	7	7	5	5
Male		40	29	15	22	12	13	9	20	3	3	6	5	3	2

Although many of the physical locations where African people congregate are clearly well established, there is considerable fluidity in the numbers who attend from week to week. Follow up visits to five locations allowed an estimate of the size of this fluctuation (Figure 4).

Figure 4: Enumeration of African adults at first & second visits



	Dance club	Church 5	Church 1	Church 2	Church 3
Total no of adults observed at 1st visit	150	90	41	27	13
Total no of adults observed at 2nd visit	90	69	29	25	35

At the dance club, there was a substantially smaller number of Africans present at the second visit, which was explained by the observation that the first visit had been during the Easter weekend, when a famous African musician from London had performed later in the evening, whereas on the second visit, the only draw was the regular dance competition. Similarly, Church 3 had more people present at the second visit, because they were hosting a number of visitors from Edinburgh and young people who had been away for fellowship on the first visit were back in church on the day of the second visit. Church 5's congregation had diminished in size at the second visit as a result of the church's expansion into the Clydebank area, necessitating a split.

5.3 Phase 3

NM identified key index individuals (ie those identified as peer/opinion leaders) at each site (Table 1).

Table 1: Index individuals identified at fieldwork sites visited during Phase 1

Typology	Age range (est.)	Gender		Total number of adults	Ethnicity	Behaviour	Index individual
		Female	Male				
Dance club	18-35			150	Black African/ white	Jovial	Mr. M
Shop 1	30-39	16	3	19	Black African	Customers	
Hip-Hop Shop	20-29		20	20	Black African	Friendly	Mr. J
Church 1	14-40	26	15	41	Black African	Community	Mr. L, Mr. F; Mr. D.
Church 2	20-50	15	12	27	Black African	Close community	Pastors: Rev. A &M.
Shop 2	16-60	12	9	21	Black African	Customer/ friendly relationships	Mr. Muppet
Church 3	30-50	7	6	13	Black African	Family-like	Mr. KY
Shop 3	30-40	5	3	8	Black African	Clientele	Mr. S
Church 4	20-59	14	13	27	Black African	Familiar to each other	Pastors: O &HM
Shop 4	25-45	11	3	14	Black African	Customers	Zim
Church 5	20-50	50	40	90	Black African	Congregation	Pastor Mak & Ed
Shop 5	20-40	5	2	7	Black African	Customers	
Church 6	20-60	7	5	12	Black African	Coherent group	Deacon & Minister
Sudanese Country Assoc. meeting	16-50	18	22	40	Black African	Group-consciousness	SI- interim association leader
Church 7	18-50	36	29	65	Black African	Close and very happy group	Pastor OC &Interpreter

An extract from the fieldwork diary at a visit to the dance club describes the behaviour of the club DJ, 'Mr M', who commanded the attention of club- goers:

"*At around midnight 'M' made his way to the DJ's box to start a dance competition between club-goers dubbed 'who runs the dance floor'. Everyone gathered to see the participants. Each of them tries to 'out-dance' the others and in the end the person displaying the best technique wins. This time it was a girl whom 'M' judged as deserving. In all this, the index person seems to assert his position in the night club; as the man who makes it happen…..*"

5.4 Phase 4

The original intention had been to survey social networks accessed at all 15 sites, working with the index individuals identified in each location. However, it was clear that this was likely to take much longer at some sites than the available time permitted. Accordingly, the dance club and a church were identified as two key networks. The questionnaire was piloted with index individuals prior to wider use in Phase 4. A number of semi-structured interviews were also held with index individuals. Table 2 and Figure 5 show the characteristics of questionnaire respondents.

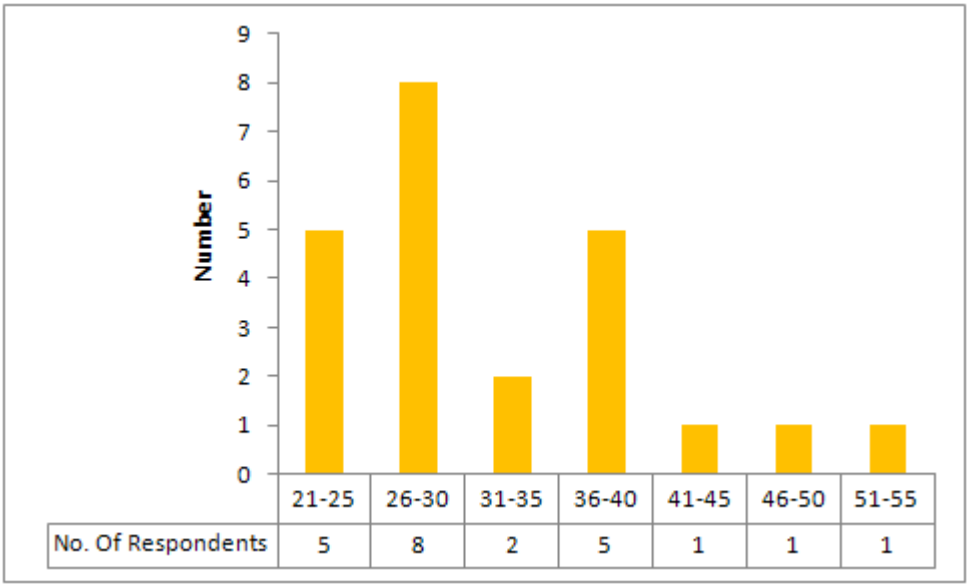
The questionnaire elicited further detail from attendees at each venue on reasons for going to different places, whom they met there and what they did. It also asked people to describe their week, what they did in their leisure time and who they spent most time with.

Table 2: Characteristics of Phase 4 survey respondents, by nation of origin & gender ((n=15)

Nation of origin	Number of respondents per country	Gender	
Nigeria	16	14 Males	11 Females
D R Congo	2		
Kenya	1		
Uganda	1		
Zimbabwe	1		
Swaziland	1		
Malawi	1		
Zambia	1		
Ghana	1		

As shown in Table 2, the gender distribution of respondents was well balanced, with 14 male and 11 female participants. However, in terms of nationality, Nigerians far outnumbered other participating individuals. This reflects selection of one of the Nigerian churches as a suitable network, because Black Africans at this venue were very supportive of the SNA work and members were keen to complete the questionnaires. This obviously represents a potential source of selection bias, which should be addressed in any future work using this approach; given more time, it would have been the project's intention to follow up all the discrete social networks identified at each location, rather than simply to select those who were most supportive of the work. Figure 5, overleaf, shows that the majority of Phase 4 participants were under 30.

Figure 5: Characteristics of Phase 4 survey respondents, by age (n=15)



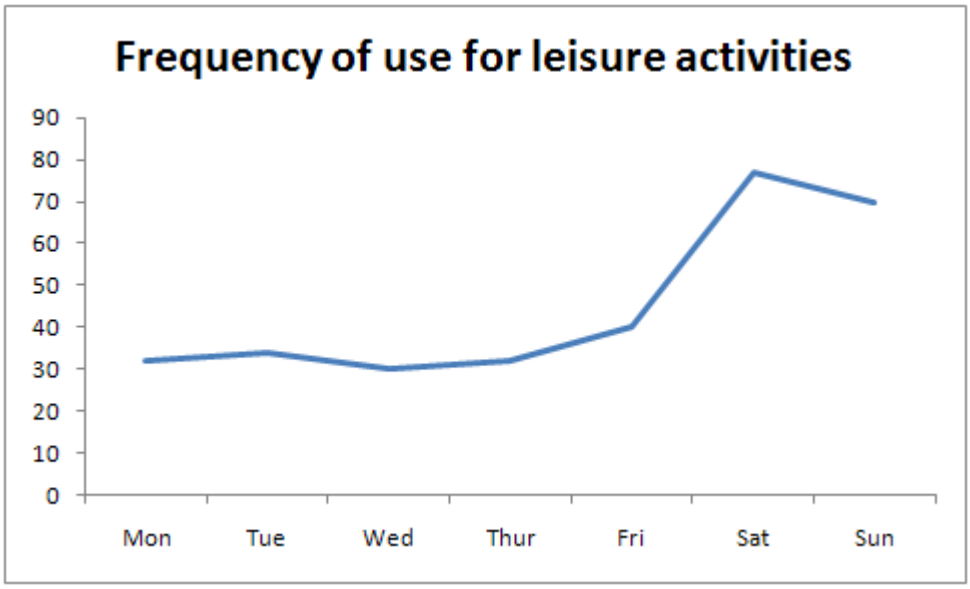
The responses to the questionnaire indicated that most participants spent a lot of leisure time with their families in a typical week. Although spending time with families was allocated a substantial amount of time, meeting with friends, going to church and participating in some form of physical activity were also highly valued.

Table 3: Cumulative frequency of specified leisure activities each week (n=15)

Activity code	Activity	Total
1	Time spent with family	91
2	Meeting friends	49
3	Meeting other relatives	25
4	Going to church	35
5	Visiting hairdressers or beauty shop	10
6	Going to pub or club	10
7	Going to shops	31
8	Attending country associations	4
9	Going to social events (e.g. party, wedding, christening, etc)	15
10	Volunteering	11
11	Exercising	26
12	Other: work	7
13	Other: University	4

As shown in Figure 6, Saturdays and Sundays were the days on which most Africans frequently participated in leisure activities.

Figure 6: Frequency of leisure activities, by day of week (n=15)



There also appeared to be an association between staying with family and meeting with friends on Saturdays, suggesting that groups of families are frequently hosts or guests. The same appears to be the case for Sundays, when spending time with families and church attendance were the most frequently cited activities, suggesting that these activities often overlap and are undertaken as a single activity. Evidence to support this suggestion was noted in Phase 2, when most churches visited were observed to be very child-friendly; in some children sat next to their parents or guardians while other churches had Sunday school/crèche facilities.

When asked to specify the social groups with whom respondents spend their time, friends and church members feature almost equally (Table 4).

Table 4: Who respondents spend time with (n=15)

People most likely to spend time with	Number of responses for each type of person
Friends	14
Immediate Family	15
Other Relatives (cousins, aunts etc.)	3
Members of my church	8
Pastor/Minister	4
Neighbours	4
Other: Workmates	1

In this particular network, these patterns may have emerged because of the comparative lack of an extended family in Scotland, thus enhancing the social role of the church, who fulfil roles described by NM as similar to 'aunts and uncles'. In churches, people appeared to find peers with whom they felt free to discuss personal and/or more sensitive issues, especially those of a sexual nature, as this topic is regarded as 'taboo'. Importantly, the findings of Phase 3 suggest that older people may find

it hard to listen to what younger people have to say. Workmates were identified as people the respondents were least likely to spend time with. This may be because people are not working (immigration conditions may not allow some people to work) or chose not to mix with work colleagues socially.

Finally, the project sought information on the perceived importance to respondents of obtaining information about HIV, both for themselves and for fellow Africans. It also sought to elicit details of how people would prefer to obtain information about HIV and how they thought information might best be made available more widely (Table 5).

Table 5: Perceived importance of HIV information (n=15)

Perceived importance	To respondents	To other Africans in Glasgow
	Number of responses	
Very important	19	15
Quite important	2	3
Not sure	2	5
Irrelevant	0	0

As shown in Table 5, information about HIV was overwhelmingly perceived as personally very important to the majority of the respondents. Some of the reasons given for the value placed on this kind of information were the importance of knowing one's own health status and the need to protect oneself and others. In addition, this was a subject close to the hearts of many, having learnt of countless deaths of fellow countrymen and relatives. For others, HIV information was seen as helping to raise awareness about an epidemic which to them had acquired the status of a 'killer disease', a matter of 'life and death' as elaborated by two of the participants. A smaller number of respondents were less sure about the importance of such information; to quote one comment "because I don't have it I don't have to worry'.

With respect to participants' perceptions regarding the importance of this type of information to other Africans living in Glasgow, responses were similar. Explanatory reasons mentioned included to support prevention work; to raise awareness about the indiscriminate nature of HIV/AIDS which could kill anyone 'no matter whoever and wherever they were'; for those who had lost dear ones, having migrated from high prevalence countries; as a way of promoting tolerance and support for those infected; to obtain up to date advice on the best preventative measures; to raise awareness of other infections like hepatitis C. Again, a few individuals were less sure of the benefits of this information to Africans who lived in Glasgow; reasons given varied from people not knowing their own status; HIV being a topic that friends never wanted to discuss; never having met anyone with HIV in Scotland, despite having encountered it frequently in Africa.

The majority of respondents would wish to obtain information about HIV from medical professionals, specifically GPs, or HIV organisations (Table 6). Other sources of information were fairly evenly spread, with commercial media rated at a similar level to medical settings or staff featured within the 'other' option, with counsellors and STD clinics mentioned. Traditional methods of word-of-mouth in informal settings, targeting specific peer groups, were seen as helpful, as was

deployment of the media (radio; TV). Advice to others on the use of condoms and the benefits of testing were highlighted and again the role of the GP in the fight against HIV was strongly reiterated.

Table 7: Preferred source of information about HIV (n=15)

Where or who to get the information from	Number of responses for each item
Friends	3
Radio/TV	6
Family Member	4
Posters	4
Pastor/Minister	3
Magazine/Newspapers	3
Leaflets from NHS or HIV Organisations	10
GP	14
Hospital Doctor	5
Other	7

When asked to suggest best ways through which Africans living in Glasgow could share information about HIV, the commonest suggestions were workshops or seminars conducted within church, school and hospital settings; included in this was the importance of distributing leaflets from the NHS and HIV organisations to churches.

5.5 Interviews: thematic analysis

5.5.1 The challenge of stigma: Most respondents recognised the familiar theme of HIV stigma that so often thwarts opportunities for individuals and communities to discuss HIV openly:

"*Stigma within the African communities does make it hard for individuals to be open. The fear of being isolated is also a key issue. As Africans value community involvement so they 'd rather not speak about it*."

It was felt that more effort should be invested in destigmatising HIV:

"*The only danger is that if people hit the streets with leaflets saying Africans do you know you should do this sexually whatever, whatever, that could create another stigma where Africans might say these guys are targeting us, they think we all have AIDS. That might be another problem I guess. It's a sensitive issue as you know, they will say, why us?*"

"*Let's talk to supermarket bosses then we put pamphlets for everyone to see - putting posters up where people can see generally – not necessarily specifically geared to African people*"

"*It helps to have people in the public view testing and talking about HIV*"

One of the respondents spoke of the importance of openness about HIV status by people who are personally living with HIV: "*It will be good to hear from individuals who are infected in order to try and change people's perceptions around HIV*. "

5.5.2 The importance of continuously refreshing the message: Respondents also emphasised the need to keep reminding people about the messages about testing, so that they did not forget or become complacent:

"*Sustaining the effort to sensitise Africans rather than a one-off message and then all goes quiet yet risky behaviour most certainly continues thereafter*."

5.5.3 Messages about testing even in the absence of symptoms: Many respondents identified the need for greater emphasis on why it is important to know HIV status, even in the absence of symptoms, with a common perception that Africans won't choose to go for a test unless they are ill. One participant said:

'*It's a very big problem. It's a subject that you can't talk about with somebody, you know, especially when I said to my guys, guys I am going for an HIV test, they went mad, they said "are you crazy?"* .

"*You are fit, man you are fit. Have you ever been ill, No". "So why should you bother". "Secretly I just went. I lost a lot of good friends of mine. I'm lucky I'm here. You know I have a future, so then I need to know my status basically, so that's why I came to my decision. I was never ill*.'

"… (*get the message out) through media, through television…. Let people know that it is better to know your status rather than - you know that because you are seriously ill. I don't know how they would put it, but they would have to try to encourage Africans that it is vital that you know your HIV status before it's too late. It would need to be done in a diplomatic way*."

5.5.4 The role of community and faith settings: It became clear very early on that churches are a vital element of Africans' social networks in Glasgow. Accordingly, we concentrated on building a typology of their pastors and congregations, in order to identify the potential of doing HIV prevention work in partnership with faith communities. It was tempting to make immediate use of any HIV prevention opportunities identified to deliver interventions immediately, however that was not the primary purpose of this exercise. Overall, NM was more than pleasantly surprised by the enthusiastic and supportive response from most of the churches; many pastors allowed the questionnaires to be handed out and encouraged us to return to follow up with information and workshops.

Social events were identified as key avenues, especially those that are planned by African organisations, such as Country Associations and through African churches. Coupled with this was the recruitment of community leaders, for instance pastors and church ministers, to lend credence and import as they are considered to be authority and 'father' figures. One key informant said:
"*I know some individuals that have influence and are not afraid to speak up. The pastors in my church have got the skills. If tailored information is delivered to them they can deploy their sermon delivering skills to inform the church members about HIV*."

However, the content of interviews highlighted the need for caution when identifying churches and faith leaders as conduits of HIV information, to ensure the scientific accuracy of prevention messages. In a semi-structured interview with one African pastor, they explained:
"*From my point of view as a minister, God can cure anything. Individuals should reconcile with God and change their lifestyles. Individuals should have a policy of openness with their partners about issues concerning HIV*."

The same pastor also recognised the potential for internal conflict among African people at risk of HIV:

"*I get issues of individuals who think they are infected and they are in dilemma of which step to take next, either to go for a test or not. Adherence to treatment is also an issue. Individuals know that God can cure any disease but taking medication may show a lack in faith. So they end up struggling to come to terms with what they should do as a final step*."

Pastors also acknowledged that working in partnership could be difficult; for example a faith leader might agree to work with an HIV agency, yet this could potentially be used against them by other faith leaders or influential people in their congregation. An example was given where the head of the community agreed to work with an HIV organisation but was then ostracised when the message was that they were "*bringing AIDS into our community*" as opposed to supporting people with useful information.

5.5.5 Need for generation-specific interventions: Participants acknowledged that generational differences can both help and hinder open discussions:

"*Through small focus groups as this helps to organise individuals in peer groups which may allow for open discussion without them being suppressed by older individuals and this is a common issue within the African communities. The old often do not take advice from the younger ones*."

5.5.6 The scale and complexity of the communication challenge: The final section of the survey (in both the written and interview forms) invited participants to identify any other issues or make any further comments. One person advised that people should:

"*avoid fornication, be careful with sharp objects and abide by the laws in The Bible*"

Others called for improved means of enabling individuals within the African community itself to strive to be more accepting and helpful to one another; loving, encouraging and to show some hope. One person commented that it was important that the community itself was involved as part of the solution to the problem. Some felt that the NHS needed to adopt policies which did not further marginalise Africans, whilst others welcomed the fact that a survey of this nature was being conducted, as they felt that HIV should be made public through proper information. Suggestions for further awareness raising included Community Health Partnerships organising HIV themed social events, such as a rally and events that involved Africans living with HIV talking publicly to others.

6. How does this fit with existing knowledge?

These findings corroborate and build on knowledge from previous Waverley Care activities with Africans in both Glasgow and Edinburgh.

6.1 Engaging with African people for the purpose of HIV prevention

We learned from "It's good to go for a test" (2008) that engaging with African people was best done through formal and informal social events and that whilst fliers and posters are useful, word of mouth and, more particularly, the invitation of someone regarded as a friend, was perceived as the most effective form of communication about HIV issues.[2] The emphasis on family in the current project was a prominent emergent theme; whilst it may be, in part, specific to the network we engaged with, the importance of family or family type connections cannot be underplayed.

Consultation by Waverley Care in 2008 with Africans living in Lothian about reproductive and sexual health issues, including HIV, suggested that the best ways to provide information to Africans should begin with the community, making use of existing links and developing new links. Suggestions included:

- Emails or text messages
- Tapping into African DJ's – using their flyers to get across sexual messages or contacts
- Having information available at African small businesses, churches
- Partner with African groups
- Social events – either specifically organised or tapping into other African events
- Word of mouth, social events, information leaflets
- Designing leaflets and distributing them among the African community
- Using language that made sense to Africans
- Using the African elders

6.2 Increasing the uptake of testing

In the same study, looking at what might make HIV testing easier, suggestions included; information about where to go; out of hours clinics; GPs offering HIV tests; make it as quick and easy as possible. In "It's good to go for a test"; just over half of those surveyed preferred to us specialist services for HIV testing; GPs were the favoured option for testing; not only did people prefer to go to their GPs but informants felt that GPs should take a more active role in inviting people to be tested.

In common with the present project, one of the findings in "It's good to go for a test" was that the accounts of the life experiences of HIV positive people were seen as particularly inspiring and encouraging as part of HIV awareness and prevention.

The AHPN newsletter issue 13 (2009), "Putting the pieces together – testing, support, treatment and prevention" backs up this approach. In 2008 the AHPN hosted two roundtable discussions about HIV testing strategies and undertook a series of visits to HIV testing centres in different country settings

(Ghana, South Africa, Malawi, Ethiopia and the USA). Discussion participants identified a need for HIV testing related activities outwith sexual health and antenatal settings, both to encourage attendance in these settings and to establish new community based or healthcare settings. The popularity of strategies grounded in outreach and community mobilisation was a prominent feature. At the heart of such strategies were programmes that worked with local peer educators or "champions" to address fear of diagnosis, raise awareness of the success of treatment and tackle barriers stemming from HIV related stigma. Providers were adamant that HIV testing would not be taken up unless the target community was prepared and ready to test. In addition attaching HIV testing to wellness projects offering a range of health checks or other services such as advocacy and independent living skills were used to motivate uptake of HIV tests.

6.3 Sustaining the HIV prevention effort

Community development is the favoured approach in all recent writings about working with African communities in the UK on HIV issues. This involves listening to and involving communities in responses. Communities can identify the challenges to health promotion and can work to tackle HIV stigma and dispel myths surrounding condoms, HIV treatment and access to services. Key to more advanced HIV prevention work with community, however, involves providing clear, validated and detailed scientific information, training and support to index individuals within the community so that they could take messages onward to their own peers. This approach would build the strength of the African community itself to deliver appropriate models of HIV prevention.

7. What needs to happen now?

This project identified key themes that should be applied to future HIV prevention work with Black African population subgroups in NHS GG&C. Promising locations for HIV Prevention Opportunities with Black African social groups are further detailed in Table 8.

7.1 Where the opportunities are

- Working alongside African led churches and with African faith leaders
- Developing the relationships with community leaders identified through the SNA and seeking their support in delivering HIV prevention messages
- Developing the relationship with other community settings e.g. shops and identifying ways of using them to disseminate HIV information
- Working through informal family and friend social gatherings
- Working with generational groups

7.2 Promising approaches

- Training and support network for African faith leaders
- Leaflets available in churches and shops
- Training peer volunteers to work in more informal settings
- Developing the role of Africans living with HIV

- Making use of existing web-sites/face books e.g. the club DJ to promote HIV prevention
- Identifying different sites for condom distribution

7.3 Issues to be aware of

- Ensuring that faith leaders have accurate and up to date information and are giving the message we want delivered
- Ensuring that approaches are not going to increase stigma
- Piloting approaches with Africans
- Ensuring that communication with communities is sustained
- Ensuring that the messages we want to get across are sustained
- Keeping the information about community based groups up to date
- Keeping the links with community leaders active

Table 8: Location of HIV Prevention Opportunities with Black African social groups, by location

Site	Contact	Typology	Opportunity
African Heath Project (support groups)	Waverley Care in Glasgow.	Service users' group	Group of those directly affected of infected with HIV.
Byblos Club	64 Albion St, Glasgow, G1 1NY. 0141 552 3895	Discotheque	Many black people gather here on weekends and public holidays particularly men. Condom display in the toilets.
Kashmir Stores	469-471 Eglinton Street, Glasgow G5 9RU. 01414 297892	Butcher & African Foods	A very convenient shop for the display of information.
Urban Hip-Hop Shop	21 Wellmeadow Street, Paisley, PA1 2EH.	Music and urban outfits	Near other shops selling African produce and it is close to the University of the West of Scotland which is popular with many young and trendy Africans.
Caledonian University African Church (on Sundays)	Hamish Wood Building. Glasgow Caledonian University, City Campus 70 Cowcaddens Rd, Glasgow, G4 0BA 0141 331 3000.	African Church	Coherent groups with mixed nationalities
Destiny Church	1120 Pollockshaws Road, Glasgow, G41 3QP. 0141	African Church	Popular among Zimbabweans

Site	Contact	Typology	Opportunity
	616 6777		
Revival Evangelical Mission International (REMI) – Church of God Sighthill.	St. Kevin's Primary School, 25 Fountainwell Road, Sighthill, Glasgow, G21 1TN. 0141 574 6326.	African Church	Mixed congregation of Africans.
FREMU Salon	23 Wellmeadow Street, Paisley, PA1 2EH. 0141 848 9333.	Salon and African shop; shipping agent.	The attendants are very interactive a quality vital for passing on information informally. People go there to inquire about social events at the moment.
St Rollox Church of Scotland.	9 Fountainwell Road, Sighthill, Glasgow.	Place of worship	Apart from church work the organisation runs an asylum support project selling second hand items and local affordable food provided by the North Glasgow food Initiative
SDA Church	Faifley Parish Church, 164, Faifley Road, Clydebank, G81 5AR	Seventh Day Adventist Church	Although a small congregation it has a family feel and the elders there were very receptive of the objectives of the consultation.
Solly's African and Caribbean shop	381 Great Western Road, Glasgow, G4 9HY	Shop	Popular for its variety of products and would be ideal for distribution of leaflets and displaying posters.
The Christian Centre.	348 Cathedral Street Glasgow, G1 2BQ 0141 333 1224	Church	Attended by many African students and people that stay around the city. Note: multi-racial congregation
Molokai Place	Paisley Road West, Ibrox, G51 1BU	Shop	Liked by Africans and the shop assistants are very engaging.
African Embassy	293 Duke Street, G31 1HX	African Shop	Good for leafleting and posters.
The Redeemed Church of God.	Maryhill Community Hall, 304 Maryhill Road, Glasgow, G20 7YE.	African Church	One of the biggest congregations of Nigerians.
Adonai Bible Church	The Pearce Institute, 840	Church	It accommodates a

Site	Contact	Typology	Opportunity
International	Govan Road, G51 3UU		smaller group of people but a quite close-knit one. The deacon runs an African shop which would serve the purposes of an information distribution centre along other activities.
Pentecostal Church of Redemption.	25 Rhymer Street Glasgow, G21 2NF.	African Church	Most members are from the Democratic Republic of Congo
AFM Church	Maryhill Glasgow	African Church	One of the places of fellowshipping.
YWCA Glasgow	3 Newton Terrace, Glasgow G3 7PJ. 0141 248 5338	Community organisation	Their projects attract many African women.
Red Road Women's Centre.	Red Road Recreation Centre. 100 Petershill Drive. Glasgow. G21 4DR.	Community Organisation	Information and advice facility in a place with a higher concentration of black immigrants.
Scottish Refugee council.	5 Cadogan Square 170 Blythswood Ct, Glasgow, G2 7PH 0141 248 9799	Community organisation	This is the initial port of call for asylum claimants and after-care services for refugees. They offer information packs which could incorporate that regarding HIV.
Karibu	Albion Street. 0141 237 7926	Women's organisation	Advocate for minority women's issues.
African Caribbean Network.	2nd Up Right, 34 Albion Street, Glasgow. G1 1LH	Voluntary organisation	This is an amalgamation of around 40 African and Caribbean groups in Scotland.
KFC and Nandos	These are scattered around the city.	Fast food chains.	These two places are preferred by many African who might fancy eating out on occasions.

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