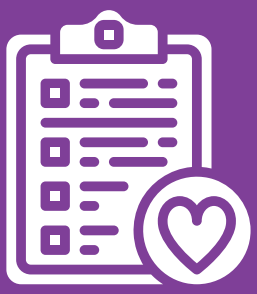
Black History Month Briefing

Decolonising HIV and Sexual Health Services in Scotland



This briefing shares findings from two Black History Month workshops held with Decolonising Contraception in 2020.

What were the workshops about?

Waverley Care held two workshops with Decolonising Contraception in 2020 to develop understanding around how to decolonise HIV and sexual health services and make them more accessible. The first workshop was for professionals delivering NHS or third sector sexual health or HIV services, investigating the additional barriers Black and Minority Ethnic (BAME) people face in accessing sexual health and HIV services by understanding the impact of colonialism on professionals and patients alike. The second workshop provided a safe space for BAME service users to share their experiences of what makes using sexual health and HIV services accessible or inaccessible.

What did we find out?

Before we can decolonise, we must first recognise how society has been colonised.

In the seventeenth and eighteenth centuries, ideas around science and discovery were increasingly developed in Europe. This period, known as the Enlightenment, positioned Europe at the centre of a pursuit for knowledge that was used to justify the use of slavery and colonisation around the world, creating hierarchies based on racial and other biological categories.

This period was physically, mentally, and spiritually very violent. But although slavery and European colonisation have largely ended, the aftermath of this period is still present, especially within our understanding of race and health in Britain.

How does colonisation relate to healthcare today?

The forms of healthcare used today are underpinned by colonial legacies which study science along categories of race and gender. Differentiating BAME races in scientific discourse risks dehumanising these groups and treating them as if they need fixing and surveilling. Examples of this can be seen in the forced sterilisation and experimentation on Black people in the USA, or the West's aid packages to the global south based around ideas of population control.

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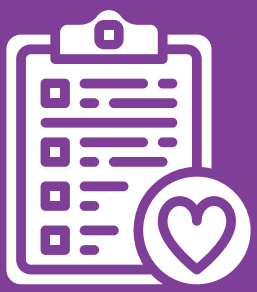

As a result, BAME communities mistrust healthcare systems and service users do not get involved in the design of services they use. Paternalistic approaches to healthcare develop as a result, with guidelines created at a distance from the communities themselves and gaps in services develop that may have great consequences.

What has this got to do with our practice today?

BAME groups have higher rates of HIV and STIs because educational and clinical services are not targeted correctly. They do not factor in different behaviours based on cultural community when supporting BAME people in making choices and receiving treatment. This creates more stigma around HIV and STIs in BAME communities, which creates additional barriers to accessing services.

What does it mean to decolonise sexual health and HIV services?

- Acknowledging the harmful role that colonisation has played in society.
- Questioning how we can dismantle forms of knowledge created from colonialism.
- Centre the experiences of the populations we serve to gain their trust.

"To gain trust, we must first acknowledge the flagrant abuses of the past and the subtler ones of the present"

Professional Workshop

To decolonise, sexual health services need to:

- Build trust within the community.
- Pass the mic and be open to criticism.
- Involve the community in developing, delivering and evaluating services.
- Recognise that you are gatekeepers too.
- Meaningful and practical PPI (personal and public involvement): Financial and capacity-building, including training and development.
- Develop a politics of co-production: What other skill sets can BAME communities contribute other than just 'lived experience'?
- Do not just look at academic papers as credible forms of knowledge, look at what organisations and community groups are actually creating and doing.

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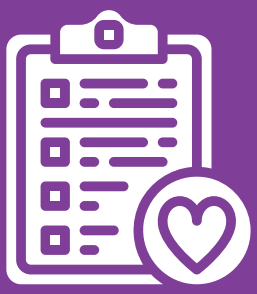

- Think about how spaces are made safe.
- Develop a nuanced approach to service provision: Know how different identities interact and how different disadvantages may impact service users.
- Challenge academia and policy makers: If you ask respectful questions that people care about, no group should be "hard to reach".

What can professionals do?

To decolonise a service, we need to decentre it and create a model of co-production. This starts with professionals acknowledging that they still have much to learn about themselves and others:

- In what ways do you know more about a service than a service user?
- What is their background?
- What are their skills?
- Ask members of the community to design campaigns that feel humanising and that resonate with them.
- Give the community members space to reflect: How was the process? What should we do next time?
- Advocate for a broader spectrum of wellbeing in sex and relationship education that brings in history and reflects on different genders and sexualities.
- Create education that includes stories from all communities so everyone can reflect and be empowered.
- If you witness institutional racism as a white, be an ally. Connect with others in your organisation who notice it and advance it to others. Read up on policies and procedures, and if possible, reach out to local community organisations and get advice.
- Include BAME people in graphics. Representation matters and communications get more engagement if they include BAME communities.

"If you are neutral in situations of injustice, you have chosen the side of the oppressor. If an elephant has its foot on the tail of a mouse and you say that you are neutral, the mouse will not appreciate your neutrality."
- Archbishop Desmond Tutu

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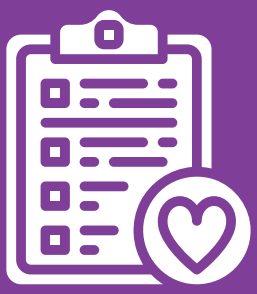

Service User Workshop

How accessible do you find sexual health services?

- Glasgow: Participants found services very accessible because of simple NHS referrals, readily available information leaflets in hospitals and GP surgeries and an accessible location close to the city centre.
- Edinburgh: Participants found the service at Napier University very easy to find and use.
- Stirling: Participants found the location accessible because it is in the city centre. They found the service well-resourced with leaflets in African languages so that they can understand services and terms.

Overall, participants felt that their knowledge of STIs increased after using sexual health services because there was useful information available at the service sites.

Perceived challenges and barriers to access sexual and reproductive health:

- African communities: Participants spoke of the dominant role men can have within the family and so can act as a gatekeeper to contraception.
- Asylum seekers: Participants felt they might not have enough resources to travel and access the services.
- Immigrant communities: A lack of information means they may not know if the service is free or not.
- Women: Participants have had bad experiences with contraception and said they did not know how to talk to professionals about this.
- Age: Many people think that only the young and sexually active need to take care of their sexual health. Participants suggested they wanted information specifically targeted at the over-50s.

What will we do with this information?

With this information we will:

- Share the information with professionals working in sexual health and HIV services.
- Include this guidance in the design and delivery of services.
- Involve people using our services in our engagement and campaign work.
- Create inclusive and reflective resources.