Written evidence from Miss Camille Pegus

Executive Summary

- The key areas covered are prevention amongst black ethnic minorities and access to testing.
- Impact of PrEP
- Digital Health promotion
- Primary Care- GP- Population level approach
- Coordinated community based intervention
- Recommendations

Introduction

1. I have worked in Sexual Health for approximately 15 years. I have worked for the NHS and VSOs, in both clinical and non clinical settings in London. My specialist area is HIV and women reproductive health. My most recent sexual health project involved, launching a new integrated sexual health service, in partnership with an acute NHS trust and four VSOs across three London boroughs. This project also involved the roll out of self testing sexual health e-platform service.

2. I only became aware of this inquiry on 30.09.18, therefore I have had limited time to prepare. However I would to take the opportunity to share my experience and observations of the transformation of sexual health services in the UK. My main focus will be London, where I am based. I have worked across most of London boroughs delivering sexual health services, offering sexual health screening, counselling, peer support, advice, advocacy and project management, with both adults and young people.

3. Firstly I would like to say, I believe the UK have good co-ordinated testing and treatment pathways. I am aware that there are some tensions from sexual health care professionals around the issue of funding. However I genuinely feel an increase in funding is the not the solution to addressing the poor outcomes for black and ethnic minority groups, uptake to be screened and tested.

Discussion

4. Some of the standard approaches to engaging black and ethnic minority groups, has been via peer support, condom distribution and community based prevention projects. There has been solid attempts to engage with faith leaders, which in my experience has proven to an up hill struggle, as there is lot of resistance and a lack of willingness on their path to engage with sexual health providers. I am aware that
there is compelling evidence of the positive impact of engaging with Faith Leaders, however we need to find innovative ways that is not reliant on the involvement of faith leaders, as a means to engaging with ethnic minority faith based groups.

5. If London is to meet the deadline for the UN 90-90-90 and fast track city target, there needs to be a radical overall around the health promotion interventions, we have traditionally relied upon to increase public knowledge around risk, safe sex practices, when and why to get tested.

6. Although there are good results in MSM, accessing testing. There is an increase in late diagnoses in population over the age of 45. Public health England (2015) confirms “ the proportion of people acquiring HIV over the age of 45 has increased from 16% in 2005 to 30% in 2014.” Heterosexual Black Africans are mainly affected by late diagnosis.

7. It is important to consider why health promotion targeting MSM seem to have achieved more favourable results compared to heterosexual black and ethnic minority groups. Firstly MSM seem to have special clinics designed to cater to their needs. This is not the case for black and ethnic minority communities. I am not advocating for a specialist black and ethnic minority groups clinic, however consideration of access to testing services where they feel able to engage with, would need to be considered.

8. Sexual ill health is not equally distributed in a population. Hence the importance of a population level approach. Due to the complex nature of sexual practice, associated with sexuality, culture and social determinants would all be key considerations to any health promotion approach. WHO (2017) “Screening and early detection is of limited value if abnormalities cannot be promptly corrected or treated through services from other parts of the health care system”. They go on to recommend population based screening programs, through health education, screening and increased access to testing. They also highlight the shared goals between disease prevention within health care sector and how they may overlap with health promotion aim to address social determinants.

9. PrEP has been cited as one of the positive factors for reduction of HIV in MSM. PrEP has been widely promoted in MSM clinics. However, access to PrEP presents a significant barrier to heterosexual at risk groups, as it is predominately promoted by gay ,MSM,HIV positive trans and cis women. Heterosexual black and ethnic minority groups, may not easily indentify with this cohort group. Therefore they are less likely to heed health promotion messages, from a group they do not identify with.
10. Also PrEP is promoted on the assumption that the individual believe they are at risk of contracting HIV, Avert (2017) asserts “there is evidence that levels of HIV knowledge among UK public is low.” If people are not aware of risks, transmission routes and the importance of testing, this will affect the up take of testing or access PrEP. Difficult conversations need to had with providers around whether they are using appropriately health promotion messages to engage black and ethnic minority groups, who are often labeled as hard to reach groups. Are they in fact hard to reach or are the wrong tools of engagement being applied?

11. Although the uptake of PrEP has been attributed to the decrease in new HIV infections in MSM. Based on the low up take of PrEP in heterosexuals and black minority groups, there needs to be some broader thinking beyond access to PrEP, as a solution to all at risk groups, especially heterosexual black and ethnic minority groups.

12. The current sexual health prevention promotion seem to be effective in the short-term as there is huge reliance on the individual literacy and capacity to understand the heath promotion message and have a direct impact on desired behaviour change, through the directive approach associated with health education. This model is heavily reliant of a high level of self care in the general at risk group to seek testing. MSM on PrEP are required to have regular testing, plus they have access to targeted health promotion online within their social networks and opportunities for opportunistic testing from providers like Do It London, who are highly visible in LGBTQI spaces.

13. The impact of STI still remains greatest in young heterosexuals and late diagnosis of HIV, which disproportionately affect heterosexuals in black and ethnic minority groups. The data highlights an unmet need in targeting these groups. Current providers of Sexual health services need to be held to account to demonstrate how they are targeting these groups and revise ineffective approaches. Also GP’s in Primary Care need to be involved in active engagement in opportunistic testing.

14. Recommendations

- The term nothing about us without us, comes to mind. Health promotion designed around the stages of behaviour to redress social norms, involve peer education, advocates and specialist clinic used to target hard to reach groups can be effective. Also engaging with groups in their community setting, speaking to them in their language with a nudging approach can also appeal to them.

- Inclusive multimedia health promotion tools, such as using algorithms to target key demographic that are not heavily reliant on visual campaigns reflecting targeted demographic, may also be effective. I
have had lots of feedback of feeling stigmatized by health promotion campaigns from black and ethnic minority groups.

- A population level approach with the proactive involvement of GPs would help with reducing late diagnosis. There is supporting data that suggest there were several missed opportunities for testing during the healthcare system navigation of patients who were diagnosed late.

- DO It London has been a very successful coordinated outreach community testing for MSM across London. Perhaps a similar coordinated approach to target other key at risk groups, will yield similar results. Currently, community based intervention vary in quality and effectiveness of provisions, as multiple VSOs are contracted to deliver services to meet locality need with varying impact and outcomes. One funded provider may also prove to be cost efficient.

- Develop a multi medium access approach, this can include, targeted community health promotion within clinical and non clinical settings, online health promotion, self testing and peer support model.

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Reference:
