Written evidence from Naz Project London

About NAZ
NAZ is one of the longest-running and largest sexual health charities in London. Led by people recruited from within the communities we seek to impact, NAZ focuses predominantly on sexual health improvement and HIV support services for Black Asian and Minority Ethnic (BAME) communities.

Our work spans across four key areas: Support services for people living with HIV; sexual health promotion; clinical services (counselling and HIV and STI testing); and research, influencing and policy. In the past year, NAZ has given 1-1 assessment to 700 people, supported 334 people living with HIV, and run 1060 rapid HIV tests with 18 new HIV diagnoses.

The work we do is made urgent by a sobering reality: there is a significant gap in the sexual health outcomes of BAME communities compared to the general population.

Urgent action is needed
The cuts to the public health grant imposed on local authorities by national government has resulted in significant financial pressures that have directly negatively affected frontline integrated sexual and reproductive health and HIV services. There has been a continued decline in the number and volume of services local authorities are providing despite a clear rise in the demand.

In a context in which BAME communities are already negatively disproportionately affected, this decline in opportunities for access only compounds the health inequalities of these marginalised communities further. There needs to be a national commitment of resources to better understand what contributes to this gap in BAME communities and define how best it can be addressed.

Sexual health inequalities exist for BAME communities in the UK

New HIV diagnoses and testing
- In 2017, 39% of all new HIV diagnoses are among BAME [1], compared to BAME being 13% of the UK population [2]
- Increasing numbers of black African women are declining HIV test when offered – the number declining has increased by 52% since 2012 [3]
- The African Health and Sex Survey in 2013-2014 found that among survey participants, 35% had never had an HIV test [3]

Living with HIV
- BAME ethnicities constitute 13% of the UK population [11], but account for 45% of people accessing HIV care [1]
- In 2017, 79% of all women accessing HIV care in the UK were from BAME communities, predominantly Black African [1]
- 40% of BAME people living with HIV sometimes or often go short of food, compared to 27% of non-BAME [4]
• Black ethnicities living with HIV are less likely to be undetectable (and therefore untransmissible) than White (94%) or Asian (95%) [1] –  
  o Black African 93%  
  o Black Caribbean 91%  
  o Black Other (including Black British) 90%  
  o Other BAME also lower at 93%  

**BAME people are more likely than White people to die following HIV diagnosis**  
• BAME are more likely to test late (2017 data) [1]:  
  o White 41% tested late; black Africans 58% late; other BAME 43% [1]  
  o People diagnosed late are 16x more likely to die within 1 year of diagnosis [5]  
  o Even for people diagnosed promptly, black African and other non-white ethnicities are more likely to die within 1 year of diagnosis [5]  

**While black Africans have the highest HIV prevalence, other BAME communities are also disproportionately affected by HIV, eg Latin Americans**  
• 8% of MSM diagnosed with an STI in 2013 were born in Latin America (PHE 2014)  
• In 2013, HIV prevalence in London was 30% higher among Latin Americans compared to that of the general population  
• In 2017, NAZ tested 213 people from the Latin American community  
  o 26% had never used UK health services before  
  o 52% had never tested for HIV before (either in UK or other country)  
  o 17 reactive HIV cases  

**Other Sexual health inequalities**  
• The highest population rates of STI diagnoses are among people of black ethnicity [6]  
• Asians are 2x as likely to test positive for Hepatitis B than White People (2016, PHE data)  

**Reproductive health**  
• Emergency contraception use was most commonly reported by black Caribbean (30.7%) and mixed ethnicity women (28.2%) then White and other ethnic groups [7]  
• BAME women are less likely to access cervical screening and understand the rational for it [8].  

Why do these inequalities exist? - Complex factors  
Broad systemic and societal inequalities render many within BAME communities invisible. From migration status to socioeconomic deprivation, gender-based violence and public funding cuts, BAME communities continue to bear the burden of poor sexual health outcomes. Redressing the inequalities and fighting for good sexual health for all is a collaborative approach that will require the continued dedication and innovation of passion-driven people and programmes designed by, for and with BAME communities in mind.  

The inequalities in BAME sexual, reproductive health and HIV have been well documented for over a decade. However, current data from Public Health England is still insufficient to fully understand the STI burden in BAME communities. Whilst there has been research and public health funding to understand and address these inequalities, the wholesale change anticipated by recent interventions have not had the desired effect to significantly reduce
poor sexual health in BAME communities and create a level playing field with that of the
general population.

This gap between BAME communities’ sexual health and the general public is further
widened by persistent late diagnosis of HIV among black ethnicities, a lack of PrEP take up
by BAME communities and other non-MSM groups [9] with half these places on the IMPACT
trial being reallocated to MSM; Latin Americans in London are a fast-rising demographic
vulnerable to HIV, and South Asian MSM remain one of the most overlooked groups when it
comes to HIV prevention. Of S Asian MSM testing at NAZ, 41% reported sex without a
condom as a reason for seeking an HIV test, and had the highest levels of reporting sex
without a condom on a regular basis (47%), and only 9% having heard of PEP and only 8%
knowing about PrEP, less than half the proportion of other BAME MSM we tested.

HIV testing at NAZ
NAZ has run POC HIV rapid tests since 2013. In the last 3 years we have conducted 3471
tests with 54 reactives, a reactivity rate of 1.5% (higher than the rates for community testing,
home sampling and sexual health clinics nationally, at 0.6%, 0.7% and 0.2% respectively)[3]
and identified an additional 47 eligible for PEP and referred to clinic. Nearly all of our tests
(96%) are carried out with BAME groups; 24% are refugees or asylum seekers; 48% had
never had an HIV test before, and 19% have never used any UK health services before.

30% of our tests were to BAME MSM who have even starker figures, with 65% never had an
HIV test before. Of 443 who answered our survey on sexual behaviours, 40% only used
condoms with their regular partner or other partners ‘sometimes’ or less frequently;
highlighting the need for increased sexual health awareness within BAME MSM.

Of our 54 reactives, 79% gave their reason for attending at our POC test as opposed to a
clinic was that we spoke their language, highlighting the need for specific provision tailored
to BAME communities.

NAZ’s ethos and approach
At the heart of all our work is a passion and drive to not only redress sexual health
inequalities but enable all people from BAME communities to enjoy positive sexual health
and wellbeing. To make this a reality, sexual health programmes and policy for BAME
communities should be culturally-specific; driven from within the community; using an
integrated approach which draws on BAME experiences of race, culture, religion and
sexuality; and working meaningfully to involve BAME communities in the thinking, strategy
and research agenda for their sexual health promotion.

As an example, twice as many BAME people living with HIV are active in a faith community
as non-BAME individuals (60% vs. 28%) [4]; Southwark has probably the greatest
concentration of African Christianity in the world outside of Africa [10]. NAZ’s Testing Faith
project engages with faith leaders in African-majority churches, and mosques, around sexual
health and HIV, then works with them to deliver workshops and HIV testing to their
congregations, testing around 110 people a year. Most BAME people living with HIV felt well
supported upon telling someone in their faith community about their status (59%) [4]

Recommendations:
1. There should be greater scrutiny of the impact that poor reproductive health, sexual
health and HIV have had on BAME communities in the UK and the cost this has had to
the public purse, and within the communities socially, emotionally and economically.
a. Current sexual health data needs to be released with sufficient ethnicity and demographic data to allow trends among different BAME groups to be followed (this need not be publically released)

2. There needs to be a focused, culturally appropriate sexual health review/strategy for BAME communities which aims to redress the intergenerational legacy of poor sexual health and begins to build a culture of sexual health well being

3. Greater resources and support needs to be given to commissioners and policy makers to:
   a. Understand the diverse needs of BAME communities
   b. Have knowledge of interventions which have been successful at improving sexual health in BAME communities, and how best to commission these

4. A solid commitment should be made by policy makers, parliamentarians, public health, NHS and other stakeholders to ensure BAME communities are at the centre of services design and the current culture of “cut and paste what has been effective with other high risks groups” desist.
   a. Encourage creation of opportunities for work with other stakeholders outside the sexual health sector to deliver services relevant and fit for purpose. As an example, NAZ is hosting a 12-month knowledge transfer programme called Back2BLAQUE to discuss how the HIV and sexual health sector can raise the profile of sexual health outside of the sexual health sector, reach Black and Minority Ethnic (BAME) groups at scale and thereby improve BAME experiences of sexual and overall health, bringing together organisations, influencers and thought-leaders from the political, charitable, clinical and corporate sectors
   b. Leadership around BAME sexual health needs to come from BAME leaders

5. The Government’s Budget and Spending Review should be revised to include an increase in public health funding to fully fund local sexual health services.

6. The ring-fence for local authority public health funding should remain indefinitely.

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References
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