HIV and BAME populations

Webinar: Wednesday 24 July 2019, 1pm
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HIV PREVENTION ENGLAND

IT STARTS WITH ME

NATIONAL HIV TESTING WEEK

HIV in BAME Populations

HIV Prevention England Webinar, 2019

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NHS Trust

Lucky Tiger – Ed Gray (2008).

Plan for session

- Epidemiology of HIV in BAME populations in the UK
- Case presentation
- Barriers to care
- Impacts of institutional racism on health
- Ways forward
- Examples of good practice

BAME populations in the UK

BAME = Black, Asian and Minority Ethnic

- Term used in UK government policy

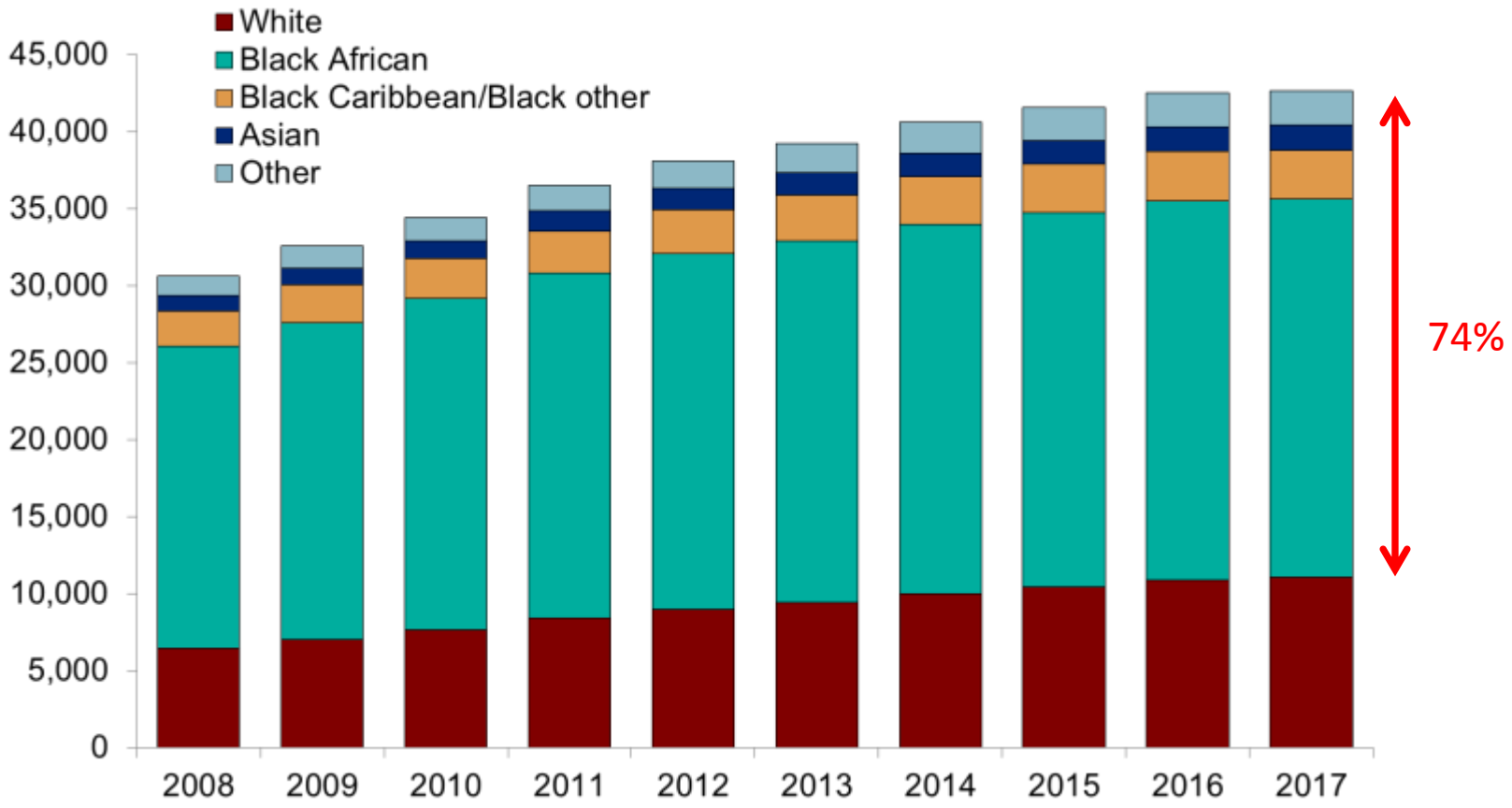
England and Wales Census 2011

Total population 56.1 million

- 80.5% White British
- 4.4% Other White
- 7.5% Asian
- 3.3% Black
- 2.2% Mixed
- 1.0% Other

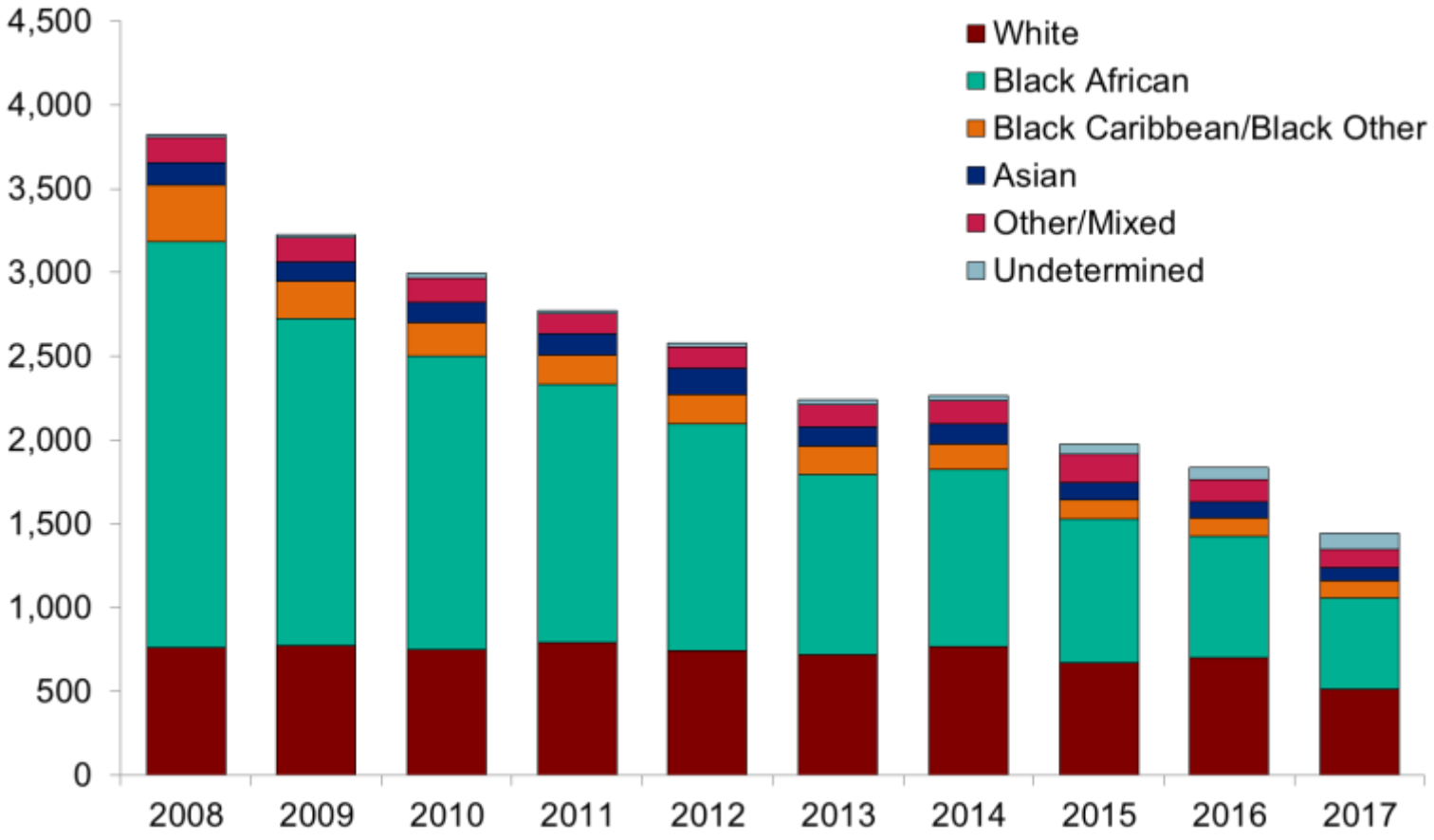
14% of the population (7.9 million) classified as "non-White"

Trends in heterosexual men and women seen for HIV care by ethnicity: UK, 2008 to 2017



HIV in the UK 2018. PHE

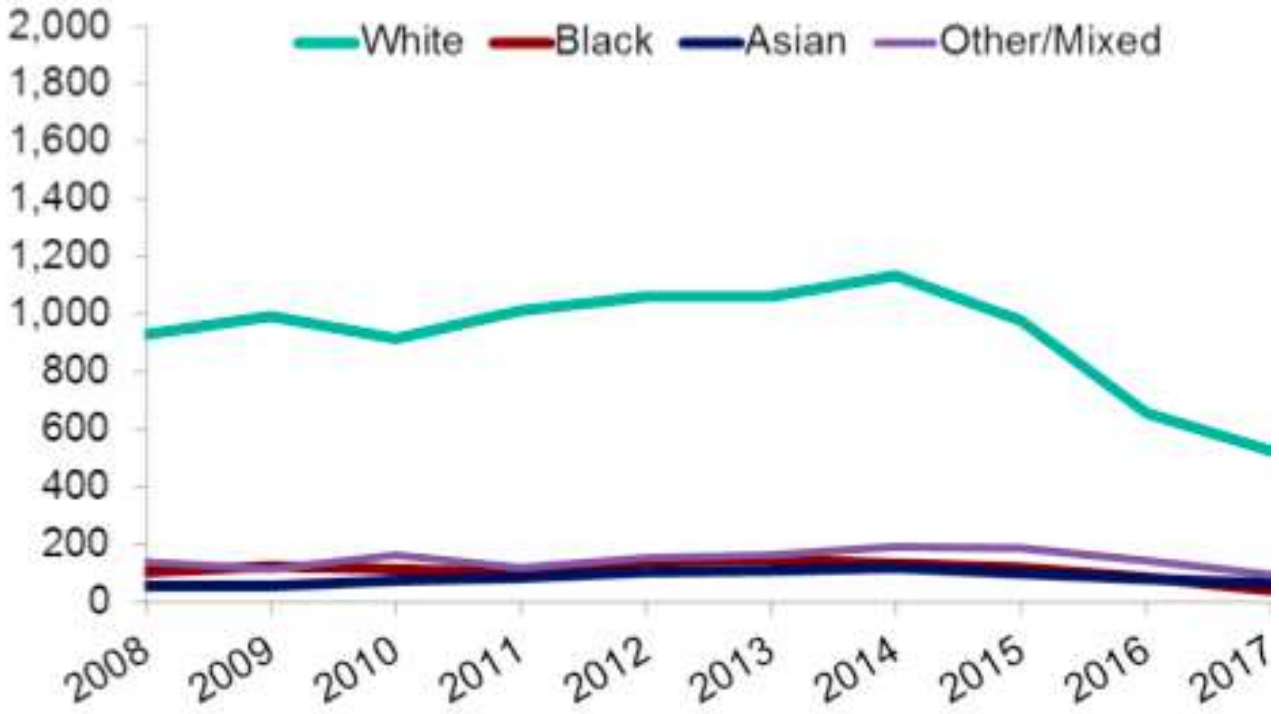
New HIV diagnoses among heterosexuals by ethnicity: UK 2008 to 2018



Values are adjusted for missing ethnicity

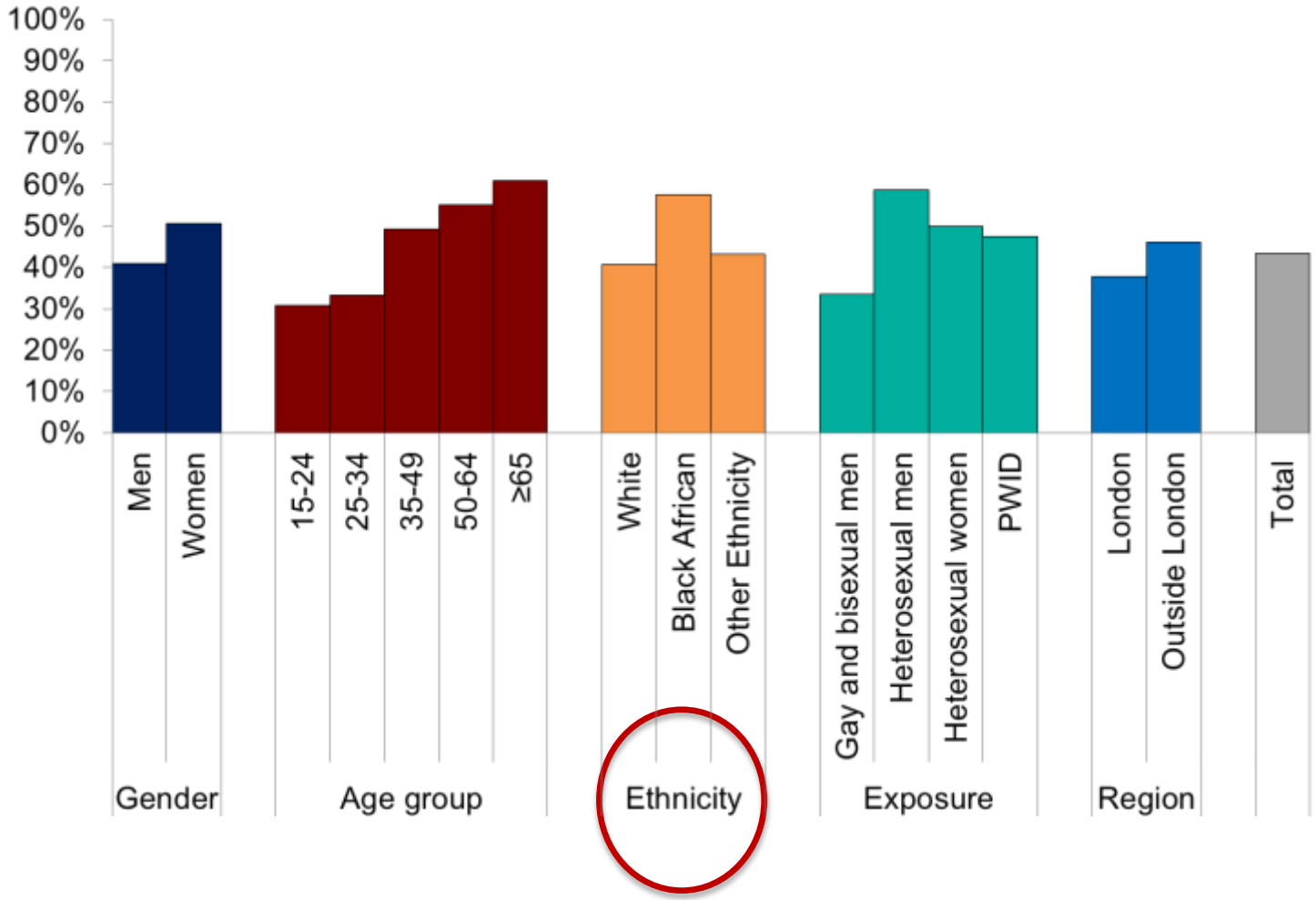
HIV in the UK 2018. PHE

HIV diagnoses among gay and bisexual men, by ethnicity: London, 2008 to 2017



Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK , 2017. PHE

Proportion of adults diagnosed late with HIV by demographic group: UK, 2017

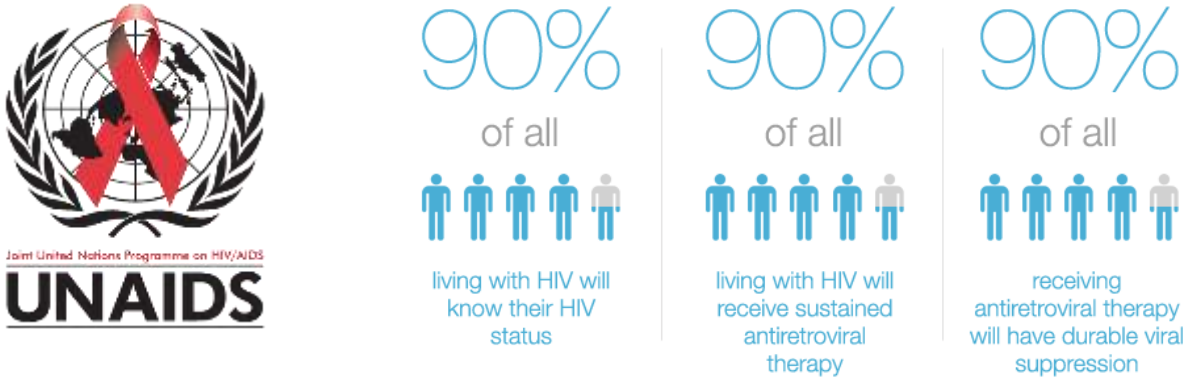


Late diagnosis: CD4 <350 cells/mm^3 within three months of diagnosis
PWID: people who inject drugs

HIV in the UK 2018. PHE

BAME populations are disproportionately affected by HIV.

- Some groups within BAME populations are more affected than others eg. people of Black African heritage.
- Why is this important?



90%
Quality
of Life

- Who is being left behind?
- Can we reach our target of preventing new HIV infections by 2030 unless we address these inequalities?
- *This is an issue of social justice and human rights.*

“Imran”

- 32 year old Bangladeshi man newly diagnosed with HIV. No previous HIV test.
- Wife recently tested positive at GP whilst undergoing fertility tests.
- Seen in HIV clinic with a Bengali interpreter.
- Asymptomatic.

“Imran”

- Past medical history:
  - Depression
  - Seen in urology clinic for erectile dysfunction 3 years ago

“Imran”: social history

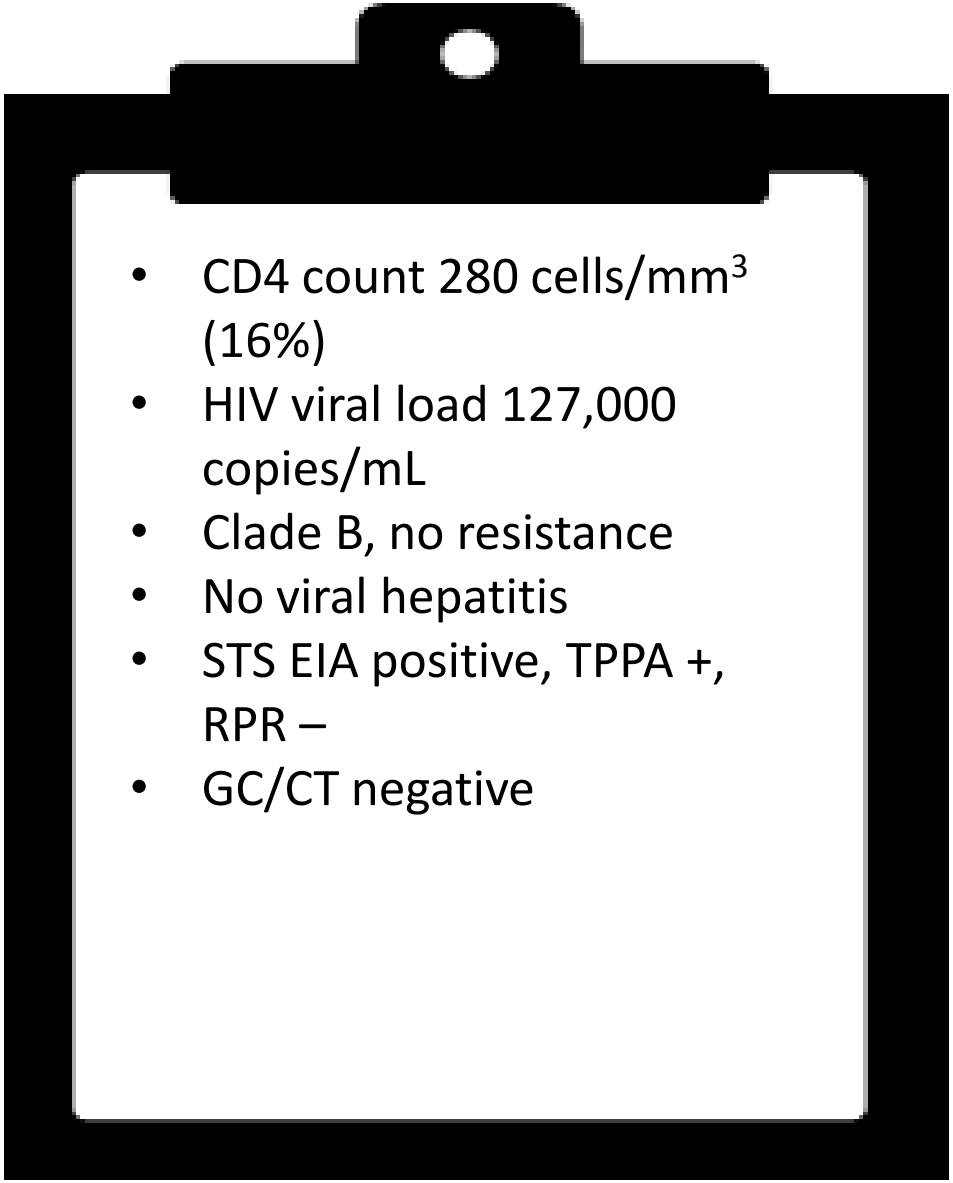
- Moved to UK aged 24. Leave to remain and applying for indefinite leave.
- Works as a mechanic.
- Muslim – attends mosque regularly.
- Lives with wife of 8 years and parents in law.
- Unsuccessfully been trying to conceive for several years.

“Imran”: sexual history

- Sex with men in saunas – uses condoms rarely.
- Describes ‘urges’ to have sex with men.
- Erectile dysfunction with his wife only.
- Under pressure from family regarding lack of children.
- Has told his wife about his urges since his HIV diagnosis.
- Would like to see a counsellor to “cure him of these urges” as he wants to be a “good Muslim” and a “good husband”.

“Imran”

On examination:
No abnormalities



Sexuality

Faith

Community

Migration

Language and stigma

- Knowledge of HIV prevention
- Accessing testing and care
- Impact on health outcomes

“Imran”: Management

- Started ART and treated for syphilis.
- Discussed TasP, U=U and advised regular STI screening and condom use.
- Psychology focused on acceptance of his sexuality, not “curing” him.
- Referred to HIV charity for peer support.

Barriers to attending for care

- Knowledge of sexual and reproductive health – access to comprehensive SRE, cultural taboos around discussing sex
- Health literacy - lack of awareness of services and how the health system works
- Worries about confidentiality in small communities
- Language difficulties
- Immigration status – “hostile environment”
- Structural barriers to attending clinic – time, finances, access to child care
- Health services that are culturally insensitive

Institutional racism – the elephant in the room?

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin".

It is seen in "processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people".

William Macpherson, "The Stephen Lawrence Inquiry" 1999.

Institutional racism in healthcare

- Many historical examples:
  - Eugenics, forced sterilisations, Tuskegee and Guatemalan syphilis studies, development of oral contraceptive pill, grave robbery etc etc
- And now, for example:
  - Racial bias in prescribing pain medication
  - Maternal death rates 5x higher for Black women than White women in the UK
  - BA, BC and Asian people more likely to access mental health care through a criminal justice agency than via primary care
  - Upfront charging and other NHS immigration policies

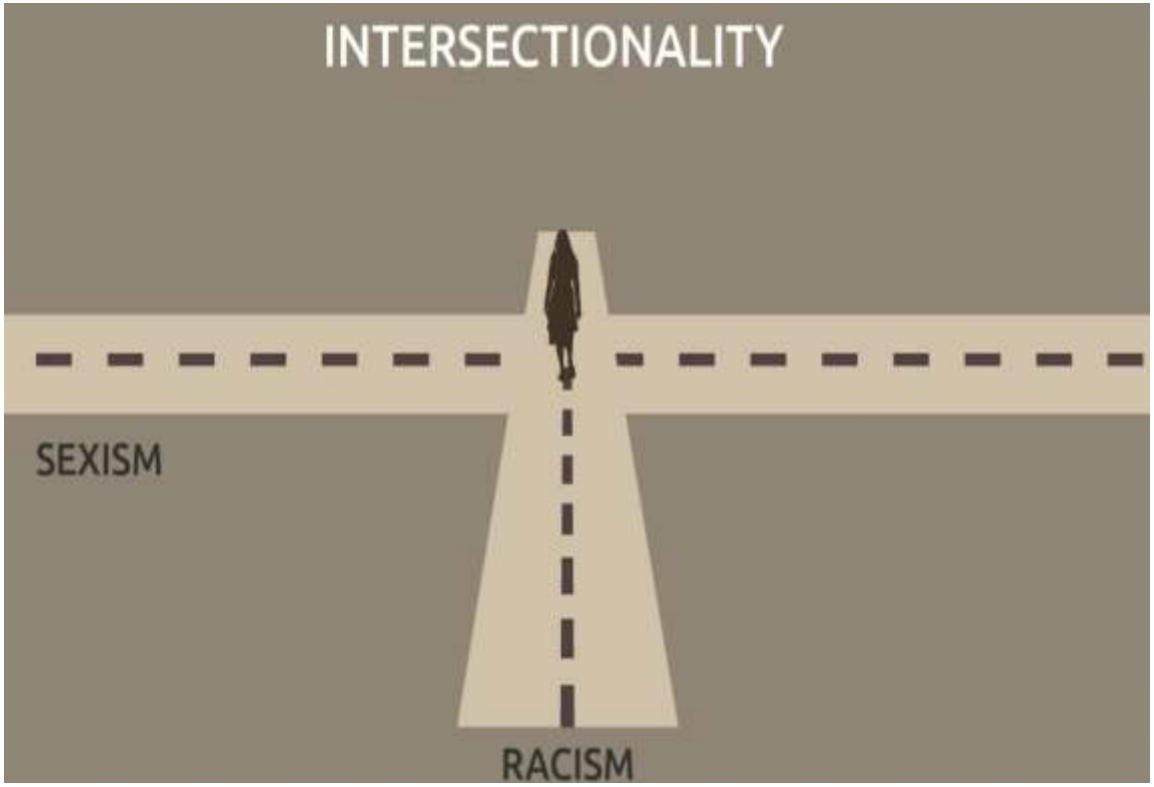
Impacts of institutional racism

- Deters people from accessing or engaging with healthcare
- Communities may distrust or fear health services
- Socioeconomic consequences may impact on health and access to healthcare:
  - Good quality housing, air quality
  - Poverty, educational opportunities, employment
  - Access to healthy food, exercise
- Exposure to daily discrimination and racism is a chronic stressor that can affect mental and physical wellbeing

How can we address racial inequalities in HIV care?

Intersectionality Theory

Kimberlé Crenshaw (1989)



- https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality#t-737664
- Caiola C, Docherty S, Relf M, Barroso J. Using an Intersectional Approach To Study the Impact of Social Determinants of Health for African-American Mothers Living with HIV. ANS Advances in nursing science. 2014;37(4):287-298.

Social GRRAACCEESS

A model looking at what makes up a person's identity.

Dynamic - some aspects may be more important at certain times and situations

J Burnham et al (2008)

In clinic

- Creating a welcoming clinic environment and building trust.
  - Staff awareness of different cultural expectations and norms around healthcare.
  - Confidentiality, interpreters
  - Providing accurate information on the NHS and care of migrants and referral for advice.
  - Specific clinical issues: fasting practices, travelling overseas.
  - Culturally sensitive psychological support

Outside of clinic

- Increasing access: sexual health education, mainstream and social media, outreach HIV testing.
- Encouraging support beyond clinic: peer support, referral pathways for help with benefits/housing, non-HIV community groups
- Empowering communities to create solutions
- Community-based participatory research – what are the questions and how to answer them?

Looking inwards

Instead of labeling communities “hard to reach” what are **we** doing that deters people from engaging with care?

- Reflecting on our own implicit and explicit biases - we are products of society and reflect societal views. Medical education also reflects society.

  eg. Studies in the US found that doctors were more likely to describe African American patients as “non-compliant” with medications. Why don’t they “comply”? Is it distrust in the system, poor explanation of the treatment etc?

- Being aware of the power imbalances we have with patients and how they may affect the way they engage with us.

In conclusion

- BAME populations are disproportionately affected by HIV at each stage of the continuum
- BAME populations are not a monolith. We need to avoid stereotyping and create personalised, holistic management plans which aim to empower individuals to have the agency to look after their health.
- Interventions aimed at specific communities should be led by those communities. Funding should reflect this.

Examples of Good Practice