



**HIV/AIDS Impacts Within the
African and Black Diaspora**

POLICY PAPER



AFRICAN and
BLACK DIASPORA
GLOBAL NETWORK
on HIV and AIDS

Prepared for
The African and Black Diaspora Global Network on HIV and AIDS
c/o Women's Health in Women's Hands (Toronto, Canada)

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Executive Summary

Executive Summary

Introduction

The African and Black Diaspora Global Network on HIV and AIDS (ABDGN) was launched at the International AIDS Conference held in Toronto, Canada in 2006 to highlight the HIV/AIDS-related issues affecting African and Black populations living in developed countries, including migrant, immigrant and refugee (MIR) populations, and people of African descent who have been in developed countries for multiple generations. The purpose of the ABDGN is to advocate and support the development and implementation of a coordinated global response which is informed by evidence of best practices and research emerging from various countries. The network has three strategic directions that provide the foundation for all of its activities:

- To continue strengthening the network's infrastructure to facilitate ability to respond to the needs of targeted populations
- To demonstrate leadership in research related to ABD
- To become the lead global voice on HIV/AIDS concerns of the ABD

This policy paper is intended for individuals involved in the development of HIV/AIDS policy, program, advocacy, and research activities targeting African and Black Diaspora (ABD) populations. The purpose of this paper is to inform policy makers, governments, researchers, and service providers about HIV/AIDS issues affecting ABD populations, describing the current situation in developed countries, gaps in responses, and program and policy directions at domestic and international levels. The paper summarizes key themes, identifies gaps, priorities for action, and strategic directions across four domains (advocacy, policy, research, programmatic response) to inform the work of ABDGN and other major key players.

African and Black Diaspora Population Composition

Today's African Diaspora is a mixture of willing and unwilling migration from the African continent. People of Sub-Saharan African (SSA) descent number at least 800 million in Africa and over 140 million in the Western Hemisphere, representing around 14% of the world's population (World Bank, 2010).

Table 1: Estimates of the size and composition of ABD populations in Europe, Canada, and the USA

Country/ Region	ABD Population	Description
Europe France England Germany Italy	274,538 249,720 154,564 137,780 (UNAIDS, 2008; IOM 2003).	<p>High ABD populations in the UK, France, Portugal, Spain, Germany and Italy could be attributed, among other reasons, to the socioeconomic links to the former colonial powers. Approximately 13% of the EU27's foreign-born population comes from Africa (Eurostat, 2008).</p> <p>The 3.5 to 8 million SSA migrants in Europe are concentrated mainly in Belgium, France, Italy, the Netherlands, Portugal, Spain and the United Kingdom. These figures are likely to underestimate the African migrant population due to factors such as illegal migration (Council of Europe Parliamentary Assembly, 2008).</p>
Canada	662,210	<p>According to the most recent census (Statistics Canada, 2007), 1.1 million immigrants came to Canada between 2001 and 2006, 6% (374,565) of whom were of African origin, and 5% (317,765) of Caribbean origin.</p> <p>Of the 1.1 million new immigrants to Canada between 2001 and 2006, 87,190 (7.9%) came from countries where HIV is endemic, comprising 2.8% (30,680) from Caribbean countries (mainly Haiti, Jamaica, and Trinidad and Tobago), and 5.1% (56,500) from SSA (primarily Nigeria, Ethiopia, Sudan, Kenya, Somalia, and Ghana).</p>
United States	37.3 million	<p>Of the 37.3 million African-Americans in the USA, 3 million were foreign born, representing 8% of the total Black population.</p> <p>Of the foreign-born Black population, 54% were born in countries in the Caribbean including Jamaica (19%), Haiti (17%), and Trinidad and Tobago (6%). An additional 34% were born in countries in Africa, including Nigeria (6%), Ethiopia (4%), and Ghana (3%). An additional 34% were born in countries in Africa. Approximately 5% were born in countries in South America (US Census, 2010).</p>
New Zealand	Less than 15,000	ABD population is less than 15,000 in New Zealand (Statistics New Zealand, 2007)

HIV Rates within the African and Black Diaspora

Table 2: Summary of HIV and AIDS statistics among ABD in various countries

Country/Region	Year(s)	Proportion of HIV among ABD Populations	Source
UK	2004-2006	70% HIV incidence accounted for by MIR <ul style="list-style-type: none"> • 90% migrants from SSA • 85% of those migrants were infected before leaving country of origin 	HPA, 2006
UK	Up to 2009	25-25% of HIV-positive African residents and ~50% of HIV-positive African MSM may have acquired their HIV infection in the UK	ECDC 2009c, 34
Belgium	Up to 2006	people categorized as foreign-born account for more than 50% of all reported HIV cases	EuroHIV, 2006
France	1999-2004	AIDS cases among MIR increased by 20%	EPI-VIH Study Group, 2002
EU27 plus Norway and Iceland	2006	Of those with known geographical origin, 77% (1050) AIDS cases were from SSA. Of the 57 cases of AIDS due to MTCT with known geographical origin, 13 (23%) were from SSA	ECDC 2009c, 18
		Out those with known geographical origin, 60% (5046/8354) HIV infections were from SSA. In HIV cases with known geographical origin due to MTCT, 41% (69/169) were from SSA	ECDC 2009c, 22
Belgium	Up to 2009	foreign-born people account for more than 50% of all reported HIV cases	ECDC 2009b, 4
France	1999-2004	reported AIDS cases among MIR increased by 20%	EPI-VIH Study Group, 2002
Canada	Jan 2002 to Dec 2006	2567 applicants who underwent an Immigration Medical Examination tested positive for HIV <ul style="list-style-type: none"> • In 2006 alone, of the 597 applicants who tested HIV-positive through this process, 417 (69.8%) were born in Africa 	PHAC 2009, 24
Canada	Up to end of 2005	12.2% (7,050 / 58,000) of HIV infections attributed to the HIV-endemic exposure subcategory	PHAC 2009, 17
Canada	2005	16% (400-700 out of 2300-4500) of new HIV infections were attributed to the HIV-endemic exposure subcategory	PHAC 2009, 17
United States	2006	45% (510,000) of the estimated 1.1 million HIV/AIDS cases in the USA among Black/African Americans	CDC, 2009
United States	2003-2004	African-born individuals constitute 16% of all HIV infections in black people due to heterosexual sex (or where the risk was unknown). African-born persons accounted for 0.6% of the population and 3.8% of HIV diagnoses in participating areas. Up to 41% of diagnoses in women (mean: 8.4%, range: 4%-41%) and up to 50% of diagnoses in blacks (mean: 8.0%, range: 2%-50%) occurred among African-born individuals.	Kerani, 2008
Australia	2004-2008	People born in SSA accounted for 6.4% (2004) to 9.5% (2008) of new HIV diagnoses	National Centre in HIV Epidemiology and Clinical Research, 2009
New Zealand	1996-2009	10% of all reported HIV cases were in people of African descent were diagnosed with HIV	McAllister, 2009

Key Discussion Themes

A key conceptual framework for any discussion of HIV vulnerability amongst the ABD around the world is the intersectionality of overlapping forms of exclusion and oppression. Gender, race and poverty intersect with HIV/AIDS-related stigma, denial, fear and discrimination. The following discussion themes are shared between ABD populations in the EU27, Canada, USA, Australia and New Zealand. The discussion themes, while presented separately, are overlapping and intersecting issues of risk and vulnerability faced by ABD populations, regardless of geographic locale.

Social Exclusion

Social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Some MIR persons or groups may face additional health risks due to a socio-economic environment which is largely determined by dominant cultural values that contribute to the perpetuation of social exclusion.

Low social integration, economic struggles, separation from family, and cultural alienation all contribute to HIV vulnerability and risk behaviors (PHAC 2009, 30). In addition, several studies demonstrated that HIV/AIDS was often viewed negatively within ABD communities, provoking feelings of shame and increasing exposure to higher risk behaviors (Bischofberger, 2008; Beyene, 2000 as cited in ABDGN 2010, 20).

Gender and Sexuality

As HIV among ABD populations is largely transmitted through heterosexual contact, it is important to understand the linkages between gender, sexuality and HIV/AIDS (ABDGN 2010, 16). Gendered norms in Black communities make both men and women vulnerable to HIV. They prescribe roles based on male domination over women (patriarchy) and characterize the associated behaviors as “cultural” or “religious” norms (PHAC 2009, 36).

Patterns of Sexual Behaviour

HIV is predominantly transmitted within the ABD population through heterosexual contact, both prior to migration and once in their new country of residence. Data from a national survey indicate that African-Americans are more than 2.5 times more likely than the USA population as a whole to have had concurrent sexual partnerships in the previous year (Adimora et al., 2007 cited Black AIDS Institute 2008, 28).

There tends to be a double standard regarding the practice of having multiple sex partners: this behaviour is allowable and sometimes expected of men but not of women. While female partners may be aware of this behaviour and its potential risk for HIV infection (because of lack of condom use), they may accept to maintain a relationship for financial, emotional or social reasons (PHAC 2009, 36).

Cultural Practices and Beliefs

Cultural attitudes, religious beliefs, taboos, fear of discrimination and limited knowledge of HIV within migrant communities were highlighted as factors that increase vulnerability, as were negative social attitudes towards MIR, racism, poverty and services that are not culturally sensitive (ECDC 2009a, 5).

Language barriers, marginalization and social exclusion, cultural attitudes, religion, fear of discrimination, low HIV knowledge, beliefs around sex, sexuality and death, and legal obstacles were reported as the most common factors contributing to the HIV vulnerability of MIR (ECDC 2009a, 1; PHAC 2009, 33). The use of traditional rituals, therapies and treatment can also affect vulnerability to HIV (PHAC 2009, 33).

Racism

Institutional barriers and systemic racism further contribute to reduced access to HIV/AIDS treatment and care, inadequate integration of health care services with ethno-specific support organizations, and a lack of cultural understanding by some service providers for the needs of ABD populations (ABDGN 2010, 20).

While ethno-specific surveillance data is essential informing programs and policies, it is essential to acknowledge the potential misuse of data in promoting xenophobia and further stigmatization of MIR and ethnic minorities affected by HIV/AIDS (ECDC 2009c, 11).

Homophobia

Another significant issue characterizing the social environment around HIV/AIDS in Black communities is homophobia or the denial of the existence of homosexuality within the community. HIV is often viewed, mistakenly, as a gay disease, and people who are HIV-positive are therefore perceived to be deserving of their situation (e.g., HIV/AIDS is a “gay disease,” promiscuity leads to infection, HIV is associated with death). Consequently, people who identify themselves as lesbian, gay, bisexual, transgender or queer often do not “come out” for fear of being stigmatized or ostracized within the community. Instead, they keep their sexual orientation or gender identity a secret, and may also engage in relationships with people of the opposite sex (PHAC 2009, 31).

Barriers to Disclosure

Stigma is identified as one of the primary factors influencing disclosure men and women of Black African descent living with HIV/AIDS (Calin et al., 2007, as cited in ABDGN 2010, 25). Time and again, stigma within clinics and other medical settings have been identified by African PLWH as their primary reason for not disclosing their HIV status (ABDGN 2010, 23).

There is also stigma from outside the community, where HIV is often viewed as a Black or African disease. This, too, contributes to the denial of HIV within the community and increases its vulnerability (PHAC 2009, 31), and may deter them from seeking screening, counseling or testing (ECDC 2009b, 3). Criminalization of PLWHA for non-disclosure is

also a concern faced by many African and Caribbean immigrants (ABDGN 2010, 29).

Barriers to Accessing Services

Legal status, lack of residence status and health insurance, lack of culturally sensitive information in relevant languages, suitably trained professionals and services tailored to the specific needs of MIR, culture, religion, beliefs about health, disease prevention and healthcare and limited knowledge of available services can prevent uptake of services (ECDC 2009b, 3).

Less access to quality care results in late presentation and diagnosis of HIV. In some countries, treatment is not available to MIR without health insurance or residence permits (ECDC 2009a, 6). Lack of prenatal care among MIR women is well documented and the major obstacles to access prenatal services are also well known (ECDC 2009c, 34).

Incarceration

Just as African-Americans are more likely than other racial and ethnic groups to be imprisoned in the USA, they are also more heavily affected by HIV in correctional settings (Black AIDS Institute 2008, 34). The physical environment associated with incarceration also places Black communities at particular risk of HIV. A disproportionate number of Black people are incarcerated in Canada and people in prison are 7 to 10 times more likely to be infected with HIV than people who are not incarcerated (PHAC 2009, 32).

Youth

Young members of ABD populations, like many young people globally, often have dangerous misconceptions about HIV, worsening AIDS stigma and potentially discouraging young people from taking necessary precautions to prevent transmission (Black AIDS Institute 2008, 32). Particularly vulnerable are children and youth who were born and are living with HIV/AIDS and children and youth who have been orphaned as a result of AIDS (ECDC 2009c, 34). Issues facing children and youth of ABD descent living with HIV, or the specialized support services they need are topics which warrant further research and discussion.

Immigration Policy

Limited access to or low utilization of services by MIR is due to a mix of legal, administrative, linguistic and cultural factors. Legal status — lack of residence status and health insurance, especially for undocumented MIR — and regulations governing service delivery limit access to services in some countries. Policies of government departments of immigration, justice or interior, for example, with strict policies regarding deportation of undocumented migrants, may make it more difficult to reach MIR with public health interventions (ECDC 2009b, 8).

MIRs from all over the world often have their right to confidential and non-discriminating HIV testing and counseling violated. Early diagnosis of HIV infection should be a right to all people, irrespective of their migrant status, but denial of entrance or work permit on the

basis of their HIV result is against the above mentioned guidelines (ECDC 2009c, 12).

Funding

Limited financial resources put pressure on health services in general, and HIV-related services in particular, while at the same time there are economic arguments for early testing, prevention, treatment and care interventions (ECDC 2009a, 12).

Community consultations with ABD communities indicate that HIV is not a policy priority in relation to MIR populations. HIV prevention is not always addressed by asylum centres or included in wider education and integration services for MIR (ECDC 2009a, 6).

In Canada, although there has been a growing body of research and increasing ABD community mobilization on HIV issues, there is a lack of policy leadership and funding allocation within the national HIV strategy to effectively meet the needs of ABD communities.

Inadequate Surveillance and Migrant Data

Interpreting the contribution of MIR to the absolute and relative trends of HIV reports over time is difficult given the heterogeneity in the implementation of the HIV reporting systems across the EU and the poor completion of the variable 'geographical origin'. In fact, the very high proportion of missing values in this category is a caveat in the interpretation of figures (ECDC 2009c, 34).

There is no common definition of migrant and the term is used in different ways by different European countries. Similarly, there is no consistent approach to recording migrant status in health records (ECDC 2009b, 7). Achieving a better understanding of the patterns and locations associated with the acquisition of infection could lead to better prevention, diagnosis, care, treatment and support services among people from countries where HIV is endemic (PHAC 2009, vii).

Strategic Directions

The continued severity of the epidemic among ABD communities underscores the need to sustain and accelerate prevention efforts in this population. In addition, PHAs in ABD communities need specialized programs to encourage them to access HIV testing, treatment and support. The following are recommendations synthesized from the seven source documents, organized thematically:

Increased Surveillance and Standardization

Migration in the EU remains poorly understood, and more studies should be conducted to improve understanding of migration patterns in Europe (ECDC 2009b, 7). Improved data collection should include monitoring access to treatment for MIR, incidents of perinatal HIV infection (ECDC 2009c, 34).

Members of the ABDGN should collaborate to establish standardized surveillance of HIV and migration in Europe, Canada and the USA to allow better comparison between countries, and to improve understanding of the relationship between migration and infectious diseases and the burden of infectious diseases in MIR and allow data comparison between and within countries (ECDC 2009b, 7).

Community-Based Research and Evaluation

Very little research (including community-based research) and comprehensive evaluations have been conducted to determine the effectiveness of interventions in preventing new HIV infections or responding to the needs of those living with HIV/AIDS in the ABD population (PHAC 2009, viii). Areas in need of further attention include the access to prevention, diagnosis, care, treatment and support services for ABD populations (PHAC 2009, 61).

Another priority should be evaluation of HIV prevention interventions to contribute to the development of good practice (ECDC 2009a, 12).

Strategic Directions

- More research on migration patterns
- Improved and standardized HIV surveillance regarding transmission categories, crossed with ethnoracial data
- Monitoring MIR access to and uptake of prevention, treatment and care services
- Developing data collection models that avoid stigmatization and discrimination

Strategic Directions

- More research and evaluation regarding HIV effectiveness of interventions targeting ABD populations
- More research on access to HIV-related services by ABD communities
- More research attention to ABD subpopulations (youth, people who use drugs, incarcerated, GLBT)
- Building systems for knowledge sharing regarding promising practices

A possible strategic direction is to develop knowledge sharing systems that increase awareness of, access to, and valuing of such grey literature.

More Diverse and Culturally Appropriate Programming

The needs of African and Caribbean groups should be addressed with regard for the specific needs of people from the ABD of different countries of origin, faiths or backgrounds (ABDGN 2010, 34).

A comprehensive response needs to address the linguistic and communication needs of the Black population, recognize its diversity; be culturally competent; provide appropriate information; and engage caring and culturally competent health care providers (PHAC 2009, 58).

To effectively prevent HIV amongst ABD communities, prevention efforts need to be culturally and linguistically appropriate, building on already-existing community structures, identifying and training people from within communities to carry out local prevention interventions (ABDGN 2010, 25).

Policy Changes

Countries with large ABD populations should develop national policy strategies for prevention, testing and disclosure that reflect the needs and diversity of ABD populations (ABDGN 2010, 37). A key recommendation is that sustained funding be available for NGOs providing HIV and related services for migrant communities (ECDC 2009a, 12).

The ABDGN can take a lead in formulating clear recommendations and guidelines for all Member States on compassionate policies for undocumented HIV-positive MIR from countries with limited treatment access. Members of the ABDGN can also work to sensitize policymakers on migration and HIV in Member States (ECDC 2009a, 12), and to advocate for a review of laws and policies related to MIR and HIV. An assessment of existing policies, legislations and laws that negatively impact members of the ABD are required (ABDGN 2010, 38).

Strategic Directions

- Recognize heterogeneity within ABD populations
- Build more culturally safe programs and services
- Build comprehensive interventions that address intersecting issues faced by MIR from the ABD
- Build partnerships with collaboration with socio-cultural organizations, churches and ethno-specific agencies

Strategic Directions

- Develop national policy strategies that reflect the needs and diversity of ABD populations, with dedicated funding for research and interventions
- Analyze intersections between HIV, discrimination, criminalization and deportation issues
- Assess existing policies, legislations and laws that negatively impact ABD populations

Mobilizing and Involving Migrant ABD Communities

There is a need for greater participation and contribution by PLWH from the ABD throughout the development, implementation and evaluation of research, programming and policy initiatives (ABDGN 2010, 36). While many ABD communities are knowledgeable about HIV/AIDS transmission routes, protection methods and treatment availability, the delivery and context of public health messages may influence how this knowledge is applied (ABDGN 2010, 37). The role of community organizations and cultural leaders is identified as a critical piece in the successful implementation of education, prevention services and support (Burns, 2007).

A priority for the ABDGN should be establishing a mechanism to improve sharing of resources and information about HIV-related services for MIR and good practice, and to facilitate access to expertise (ABDGN 2010, 37).

Strategic Directions

- Support greater participation and input from PLWH from ABD
- Build partnerships with community leaders (formal and informal) within ABD populations
- Engage community organizations and cultural leaders in planning and implementing interventions
- Build a mechanism to improve sharing of resources, expertise and information about HIV-related services for MIR
- Increase cooperation with countries of origin to build effective HIV/AIDS interventions

Conclusion

Although ABD communities in the EU, Canada, and the USA have many diverse stories of when, how and why they found new homes in western countries, they face common challenges which make them vulnerable to HIV. These common experiences unfortunately include various forms of social isolation and exclusion, such as racism, unemployment or underemployment, and economic hardship. These compounded with HIV-related stigmas, homophobia, gender inequities, and unhealthy sexual practices have given ABD communities a higher burden of HIV prevalence than the rest of the population.

International, cross-sectoral and cross-jurisdictional activities to share best practices, to increase partnerships among a wider range of stakeholders and to better use evidence in the development of strategies and interventions should be fostered and encouraged.

Acronyms

ABD	African and Black Diaspora
ABDGN	African and Black Diaspora Global Network on HIV and AIDS
ADC	AIDS-defining condition
AIDS	Acquired Immune Deficiency Syndrome
EU27	European Union's 27 countries
HIV	Human Immunodeficiency Virus
MIR	Migrant, Immigrant and Refugee
MSM	Men who have sex with men
PLWH	People Living with HIV
SSA	Sub-Saharan Africa
UK	United Kingdom
USA	United States of America



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Introduction

African and Black Diaspora Global Network on HIV and AIDS

The African and Black Diaspora Global Network on HIV and AIDS (ABDGN) was launched at the International AIDS Conference held in Toronto, Canada in 2006 to highlight the HIV/AIDS-related issues affecting African and Black populations living in developed countries, including MIR populations, and people of African descent who have been in developed countries for multiple generations. The purpose of the ABDGN is to advocate and support the development and implementation of a coordinated global response which is informed by evidence of best practices and research emerging from various countries. The governing council of the network has global representatives from organizations and networks located in Canada, the United States, United Kingdom, France, Germany, and the Caribbean.

As a unified “network of networks” the ABDGN aims to facilitate knowledge translation and exchange, collaborations, capacity building and foster emerging partnerships needed to build effective responses to address the multiple impacts of HIV and AIDS on the lives of ABD. The network has three strategic directions that provide the foundation for all of its activities:

- To continue strengthening the network’s infrastructure to facilitate ability to respond to the needs of targeted populations
- To demonstrate leadership in research related to ABD
- To become the lead global voice on HIV/AIDS concerns of the ABD

Health Canada and several members of ABDGN were involved in the planning of UNAIDS Programme Coordinating Board’s one day thematic meeting on “People on the move - forced displacement and migrant populations”, in June 2009. This meeting focused on the HIV-related aspects of migration in order to better understand the barriers to universal access and to identify solutions.

The mission of the ABDGN is to strengthen the response to emerging HIV and AIDS epidemics among African/Black communities in the Diasporas.

ABDGN Governing Council organizations:

- WHIWH CHC (Women’s Health in Women’s Hands Community Health Centre-Canada)
- ACCHO (African Caribbean Council on HIV and AIDS in Ontario-Canada)
- ICAD (Interagency Coalition on AIDS and Development-Canada)
- BAI (The Black AIDS Institute-USA)
- ASC (African Services Committee-USA)
- AIDES (France)
- LIGHT OF AFRICA NRW e.V. (Germany)
- CVC (Caribbean Vulnerable Communities-Jamaica)
- AHPN (African HIV Policy Network-United Kingdom)

Through participation in this UNAIDS meeting, previous International AIDS Conferences and other country-specific, regional and international events, ABDGN has identified the following:

- a need to gather and disseminate knowledge on research, policy and programming responses
- best practices and approaches emerging from various regions
- stimulate regional and global debates on various HIV related issues specific to ABD.

These activities and initiatives have been and will continue to inform domestic and global policies, facilitate the sharing and application of best practices, and strengthen leadership capacities and efforts to coordinate a targeted global response to HIV/AIDS for ABD populations.

Intended Audience

This policy paper is intended for individuals and institutions involved in the development of HIV/AIDS policy, program, advocacy, and research activities targeting African and Black Diaspora populations (ABD). The primary target audiences include international government policy units and NGOs, donors, multilateral global networks, researchers, civil society organizations and other relevant stakeholders working in or interested in HIV/AIDS in ABD populations.

Purpose

The purpose of this paper is to inform policy makers, governments, researchers, and service providers about HIV/AIDS issues affecting ABD populations, describing the current situation in developed countries, gaps in responses, and program and policy directions at domestic and international levels. It synthesizes seven key documents from the United States, the European Union, Canada, Australia and New Zealand, which highlight domestic, regional and global considerations in research, policy and programmatic responses to HIV/AIDS for ABD populations. The paper summarizes key themes, identifies gaps, priorities for action, and strategic directions across four domains (advocacy, policy, research, programmatic response) to inform the work of ABDGN and other major key players.

This paper complements a larger ABDGN project funded by UNAIDS, Health Canada and the Ford Foundation to develop a three-year strategic plan; develop and launch a website for the network, and the preparation of activities for the International AIDS Conference taking place in Vienna 2010. Further, this paper will act as a key foundational document in future global policy dialogues

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Background

African and Black Diaspora

Today's African Diaspora is a mixture of willing and unwilling migration from the African continent. The term African Diaspora is applied in particular to the descendants of the Africans who were captured and shipped as slaves to the Americas by way of the Atlantic slave trade, with the largest population in Brazil, then later to Europe, the Middle East and other places around the globe. People of Sub-Saharan African (SSA) descent number at least 800 million in Africa and over 140 million in the Western Hemisphere, representing around 14% of the world's population (World Bank, 2010). The seven source documents which formed the basis for this paper referred variously to:

- "African/Black communities in the Diasporas"
- "African and Caribbean Blacks"
- "African and Black migrant populations in their countries of destination"
- "African/Black Diaspora populations"
- "African-descendant communities"
- "people from countries where HIV is endemic"

In Canada, the epidemiological term "people from countries where HIV is endemic" refers to a population that is largely composed of Black people of African and Caribbean descent. This group forms a diverse community, which largely came to Canada through the immigration waves of the last five decades, although a number of Black Canadians trace their roots in Canada to the early 1600s and 1700s (PHAC 2009, vii). Blacks vary extensively in their roots, with some born in the Caribbean, others in Africa, while yet others have been in Canada for many generations.

Population Composition

Table 1: Estimates of the size and composition of ABD populations in Europe, Canada, and the USA

Country/ Region	ABD Population	Description
Europe France England Germany Italy	274,538 249,720 154,564 137,780 (UNAIDS, 2008; IOM 2003).	High ABD populations in the UK, France, Portugal, Spain, Germany and Italy could be attributed, among other reasons, to the socioeconomic links to the former colonial powers. Approximately 13% of the EU27's foreign-born population comes from Africa (Eurostat, 2008). The 3.5 to 8 million SSA migrants in Europe are concentrated mainly in Belgium, France, Italy, the Netherlands, Portugal, Spain and the United Kingdom. These figures are likely to underestimate the African migrant population due to factors such as illegal migration (Council of Europe Parliamentary Assembly, 2008).
Canada	662,210	According to the most recent census (Statistics Canada, 2007), 1.1 million immigrants came to Canada between 2001 and 2006, 6% (374,565) of whom were of African origin, and 5% (317,765) of Caribbean origin. Of the 1.1 million new immigrants to Canada between 2001 and 2006, 87,190 (7.9%) came from countries where HIV is endemic, comprising 2.8% (30,680) from Caribbean countries (mainly Haiti, Jamaica, and Trinidad and Tobago), and 5.1% (56,500) from SSA (primarily Nigeria, Ethiopia, Sudan, Kenya, Somalia, and Ghana).
United States	37.3 million	Of the 37.3 million African-Americans in the USA, 3 million were foreign born, representing 8% of the total Black population. Of the foreign-born Black population, 54% were born in countries in the Caribbean including Jamaica (19%), Haiti (17%), and Trinidad and Tobago (6%). An additional 34% were born in countries in Africa, including Nigeria (6%), Ethiopia (4%), and Ghana (3%). An additional 34% were born in countries in Africa. Approximately 5% were born in countries in South America (US Census, 2010).

It would be useful to know the percentage that ABD populations comprise in each country relative to the whole population, particularly as a point of comparison to the burden of HIV prevalence/incidence within ABD communities. Inconsistencies in enumeration make it difficult to calculate these proportions, as each country classifies ethnoracial groups differently and HIV epidemiology classifications of ethnoracial groups do not necessarily match census classifications.

Although there are no population estimates for people of African or Caribbean descent for Australia or New Zealand in the documents reviewed, census data from 2006 indicates that the ABD population is less than 15,000 in New Zealand (Statistics New Zealand, 2007). Further analysis may be warranted despite the possibly small numbers of ABD in these two countries.

HIV Rates within the African and Black Diaspora - Regional Overview

Discussing the country of probable HIV infection is controversial as it has, unfortunately, given rise to overtly racist reactions. However, understanding where HIV infection and the development of AIDS took place has important implications from a public health perspective as it may represent failure in primary HIV prevention, secondary HIV prevention, or both (ECDC 2009c, 34).

Europe

Within the EU27, the most relevant migrant populations in terms of HIV rates originate from SSA, Eastern Europe and Asia and, in some specific European countries, from Latin America and the Caribbean (ECDC 2009a, 1). MIR from SSA were reported most frequently as the most relevant for HIV prevention, treatment and care, followed by MIR from Eastern Europe and Asia (ECDC 2009a, 5).

Those who are foreign-born are disproportionately represented in HIV statistics in the Netherlands, Germany, Sweden, Ireland, Spain and Italy (UNAIDS, 2008 - as cited in ECDC 2009b, 4). In 2005, 46% of heterosexually acquired HIV infection in Western Europe involved MIR from high prevalence countries (EuroHIV, 2006; Hamers et al., 2006 - as cited in ECDC 2009b, 4). In 2006, 26,712 HIV infections were reported in the EU27 plus Norway and Iceland. It is worth highlighting that 7812 (29%) HIV reports from 2006 did not record the geographical origin of the case. The largest number of HIV cases among MIR, both in absolute and relative terms, is attributed to heterosexual transmission.

Many MIRs from outside the EU come from countries where prevention and control of infectious diseases such as TB, HIV and hepatitis is inadequate and the risk of exposure to these diseases is higher than in most EU countries (ECDC 2009b, 4). From 1999 to 2006, 16,222 TB cases were reported as the initial AIDS-defining condition (ADC), of which 8028 were diagnosed in people whose country of origin was the same as the one reporting the case, 3 883 in people from SSA and 2684 had unknown geographical origin. Forty percent (40%) of people from SSA had TB as their initial ADC (ECDC 2009c, 28).

MIRs from SSA are over-represented amongst female cases of HIV in the EU27. In fact, among HIV infections reported in women with known geographical origin, the number of HIV-positive women from SSA outnumbers that of native European women and that of HIV-positive African men (ECDC 2009c, 33).

Table 2: Summary of HIV and AIDS statistics among ABD in various countries in the EU

Country/Region	Year(s)	Proportion of HIV among ABD Populations	Source
UK	2004-2006	70% HIV incidence accounted for by MIR <ul style="list-style-type: none"> • 90% migrants from SSA • 85% of those migrants were infected before leaving country of origin 	HPA, 2006
	Up to 2009	25-25% of HIV-positive African residents and ~50% of HIV-positive African MSM may have acquired their HIV infection in the UK	ECDC 2009c, 34
Belgium	Up to 2006	people categorized as foreign-born account for more than 50% of all reported HIV cases	EuroHIV, 2006
France	1999-2004	AIDS cases among MIR increased by 20%	EPI-VIH Study Group, 2002
EU27 plus Norway and Iceland	2006	Of those with known geographical origin, 77% (1050) AIDS cases were from SSA. Of the 57 cases of AIDS due to MTCT with known geographical origin, 13 (23%) were from SSA	ECDC 2009c, 18
		Out those with known geographical origin, 60% (5046/8354) HIV infections were from SSA. In HIV cases with known geographical origin due to MTCT, 41% (69/169) were from SSA	ECDC 2009c, 22
Belgium	Up to 2009	foreign-born people account for more than 50% of all reported HIV cases	ECDC 2009b, 4

Canada

In Canada, people from countries where HIV is endemic are a key population identified in the and for whom Federal Initiative programs and activities are targeted. People of the African and Black Diaspora (ABD) living in Canada are disproportionately affected by and infected with HIV/AIDS. Epidemiological data, program reviews and evaluations suggest that this population is particularly impacted by HIV/AIDS.

In Canada, there are an estimated 58,000 HIV infections, with 7,500 (12%) of cases reported among people from countries where HIV is endemic (PHAC, 2009). The rate of HIV is estimated to be 12.6 times higher among people from HIV endemic countries than other Canadians. The majority of these infections are transmitted through heterosexual contact and women are overrepresented.

Table 3: Summary of HIV and AIDS statistics among ABD in Canada

Year(s)	Proportion of HIV among ABD Populations	Source
Jan 2002 to Dec 2006	2567 applicants who underwent an Immigration Medical Examination tested positive for HIV <ul style="list-style-type: none"> In 2006 alone, of the 597 applicants who tested HIV-positive through this process, 417 (69.8%) were born in Africa 	PHAC 2009, 24
Up to end of 2005	12.2% (7,050 / 58,000) of HIV infections attributed to the HIV-endemic exposure subcategory	PHAC 2009, 17
2005	16% (400-700 out of 2300-4500) of new HIV infections were attributed to the HIV-endemic exposure subcategory	PHAC 2009, 17

Ontario and Quebec share the highest number and proportion of reported AIDS cases for the HIV-endemic exposure subcategory. While it is expected that Ontario and Quebec would have the highest proportion of cases based on the geographic location of the Black population in Canada, the number of reported AIDS cases are not distributed proportionally between the two provinces. Which approximately 62.1% of the Black population in Canada resides in Ontario, the proportion of AIDS cases for the HIV-endemic exposure subcategory is approximately 36.1%. Quebec on the other hand has approximately 23.0% of the Black population in Canada, but 55.3% of the national proportion of AIDS cases. This suggests that the Black population in Quebec seems to be overrepresented in its proportion of AIDS cases. (PHAC 2009, 19)

United States

Black/African American men and women are estimated to have an incidence rate seven times higher than the incidence rate among whites. CDC’s new estimates confirm that African-Americans are more severely and disproportionately affected by HIV than any other racial/ethnic group in the United States. Trend analyses show that HIV incidence among African-Americans has been roughly stable at an unacceptably high level since the early 1990s (except for a brief fluctuation in the late 1990s) (CDC, 2007).

Current USA surveillance data do not routinely include information on individuals’ country of origin. Therefore it is probable that a significant number of HIV infections currently classified as being amongst African-Americans are likely to involve recent MIR from Africa. African-born individuals in the USA have a disproportionately high prevalence of HIV. Overall, HIV and hepatitis infection rates reflect the infection pattern from an individual’s country of origin, with high prevalence rates among those from countries most impacted. Black communities also experience higher prevalence of undiagnosed and untreated STDs, which greatly facilitate HIV transmission (Black AIDS Institute 2009, 14). In 2006, Black Americans had higher rates of all STDs than their peers. Black women were 16 times more likely to have syphilis than white women, 15 times more likely to have gonorrhoea and seven times more likely to have Chlamydia (Black AIDS Institute 2009, 15).

Table 4: Summary of HIV and AIDS statistics among ABD in the United States

Year(s)	Proportion of HIV among ABD Populations	Source
2006	45% (510,000) of the estimated 1.1 million HIV/AIDS cases in the USA among Black/African Americans	CDC, 2009
2003-2004	African-born individuals constitute 16% of all HIV infections in black people due to heterosexual sex (or where the risk was unknown). African-born persons accounted for 0.6% of the population and 3.8% of HIV diagnoses in participating areas. Up to 41% of diagnoses in women (mean: 8.4%, range: 4%-41%) and up to 50% of diagnoses in blacks (mean: 8.0%, range: 2%-50%) occurred among African-born individuals.	Kerani, 2008

Australia and New Zealand

In Australia, HIV/AIDS is largely experienced among gay men and MSM and more than 65% of all HIV cases are among people who are Australian-born. Subsequently, much of the available literature reflects this reality. However, there seems to be a recent emergence of studies reflecting increased migration from Western African populations. Although African MIR only account for 6% of all HIV infections, this group represents a unique sub-population (UNAIDS, 2008).

African-born MIR in Australia are disproportionately represented when accounting for new HIV infections, with a greater number of people obtaining a positive diagnosis long after symptoms have appeared (Biggs et al., 2006). Recent studies explore the sexual health attitudes and beliefs of African MIR (Drummond et al., 2008) and the impact of migration on service utilization and prevention (Lemoh et al., 2008; Körner, 2007). McMichael's report on sexual health promotion among resettled and refugee youth also provides insight into the experiences and understandings of young MIR from the Horn of Africa (2008).

In New Zealand there were an estimated 3192 HIV infections reported between 1996 and 2009 (McAllister, 2009). The ethno-specific data indicates that 229 people of African descent were diagnosed with HIV in New Zealand between 1996 and 2009, representing a little over 10% of all reported HIV cases. Census data from 2006 indicates that the ABD population is less than 15,000 in New Zealand (Statistics New Zealand, 2007).

Table 5: Summary of HIV and AIDS statistics among ABD in the Australia and New Zealand

Country/Region	Year(s)	Proportion of HIV among ABD Populations	Source
Australia	2004-2008	People born in SSA accounted for 6.4% (2004) to 9.5% (2008) of new HIV diagnoses	National Centre in HIV Epidemiology and Clinical Research, 2009
New Zealand	1996-2009	10% of all reported HIV cases were in people of African descent were diagnosed with HIV	McAllister, 2009

Key Discussion Themes

A key conceptual framework for any discussion of HIV vulnerability amongst the ABD around the world is the **intersectionality** of overlapping forms of exclusion and oppression.

As highlighted in Canada's Stigma Study (Lawson et al., 2007), gender, race and poverty intersect with HIV/AIDS-related stigma, denial, fear and discrimination. An understanding of these multiple issues is not limited to local experiences, but is situated in global processes, such as crossing borders in search of better opportunities, safety and security; the isolation of living in a foreign place; the loneliness from missing loved ones, the difficulty of trying to establish new relationships and networks, and the decision to shield family 'back home' from an HIV-positive diagnosis received in Toronto (Lawson et al., 2007 cited in PHAC 2009, 38).

Similarly, the most common features affecting SSA MIR living with HIV/AIDS in the EU27 are: more advanced disease at the time of HIV diagnosis, higher rates of TB, major difficulties related to their immigration status, social discrimination and stigma presenting barriers to accessing HIV prevention and care), and high levels of poverty and unemployment (ECDC 2009c, 11).

A strong ABD research base is emerging from several countries. In the Canadian context starting in the mid-1990s, researchers have been exploring:

- the role of culture in immigration and settlement (Baxter et al., 1999);
- social, cultural and institutional barriers affecting service utilization (Calzavara et al., 2000; Foster, 2007; Foreman & Hawthorne, 2007);
- attitudes, health-related beliefs and behaviors within the ABD population (Lawson et al., 2006; HIV Endemic Task Force, 2001) explored in the contexts of prevention (Williams et al., 2009; Gray et al., 2008; James, 2006; Teclom, 2006), testing and treatment (Tharao et al., 2001)
- culturally-specific epidemiological reports on HIV/AIDS within African and Caribbean populations (PHAC, 2009; PHAC, 2005; Remis & Merid; 2004; Remis, 2004)
- gender and the experiences of women from the ABD (Tharao et al., 2005); and
- sexuality (Husbands et al., 2009; George et al., 2007; Lewis-Pearl, 2007; Myers et al., 2001).

There is an abundance of literature emerging from the USA, however the majority of these studies focus on African-American populations, with limited investigation of the experiences of African and Caribbean MIR in the USA (Fullilove, 2006; Clark et al., 2003; Fullilove et al., 1999). Understandably, the cultural, social and biomedical experiences of MIR Black populations will be distinctly unique from that of African-Americans who have lived in the USA for generations. The lack of distinction between MIR and African-American populations represents a significant imbalance in the literature. Nevertheless these studies are relevant to understanding how "Black" populations are conceptualized in the USA, how these identities influence self-conceptualization, and how various socio-

cultural determinants impact health and wellbeing (Wright & Patterson-Gatson, 2009; Wilson et al., 2008; Wright, 2006).

In the USA, studies that focus on the experiences of MIR African populations are generally centralized to areas or cities with larger MIR populations from specific African countries. These studies identify existing cultural and structural barriers to prevention and service utilization among African women representing a new patient cohort for HIV service providers and support workers. Most studies provide insight into the contextualized experiences of Black MIR from specific SSA countries (Foley, 2005; Eteni & Wood, 2003; Beyene, 2000). Although race itself is not a risk factor for HIV infection, a range of issues contribute to the disproportionate HIV risk for African-Americans in the United States, including poverty, stigma, higher rates of other STDs, and drug use (Black AIDS Institute, 2008).

The following discussion themes are shared between ABD populations in the EU27, Canada, USA, Australia and New Zealand. The discussion themes, while presented separately, are overlapping and intersecting issues of risk and vulnerability faced by ABD populations, regardless of geographic locale. These discussion themes are:

- **Social Exclusion**
- **Gender and Sexuality**
- **Patterns of Sexual Behaviour**
- **Cultural Practices and Beliefs**
- **Racism**
- **Homophobia**
- **Barriers to Disclosure**
- **Barriers to Accessing Services**
- **Incarceration**
- **Youth**
- **Immigration Policy**
- **Funding**
- **Inadequate Surveillance & Migrant Data**

Social Exclusion

Social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Some MIR persons or groups may face additional health risks due to a socio-economic environment which is largely determined by dominant cultural values that contribute to the perpetuation of social exclusion.

Social exclusion makes MIR highly vulnerable to HIV (ECDC 2009c, 5). Cultural, socioeconomic and language barriers increase vulnerability not only by limiting access to HIV/AIDS prevention and care (ECDC 2009c, 10), but also by generally exacerbating disadvantages with respect to structural and social determinants. Low social integration,

economic struggles and cultural alienation all contribute to HIV vulnerability and risk behaviors. In addition, several studies demonstrated that HIV/AIDS was often viewed negatively within ABD communities, provoking feelings of shame and increasing exposure to higher risk behaviors (Bischofberger, 2008; Beyene, 2000 as cited in ABDGN 2010, 20).

Social exclusion for MIR is further exacerbated due to loss of support, particularly of extended family and support networks, when they arrive in their country of destination in the developed world. The immigration and settlement process sometimes separates partners as well as parents from their children for extended periods of time. This can leave families fragmented and vulnerable to a host of health and social issues including HIV/AIDS (PHAC 2009, 30).

Conditions of social exclusion experienced by people from ABD:

- Marginalization
- Stigmatization
- Loss or devaluation of language and culture
- Lack of access to culturally appropriate health care and services
- Negative attitudes towards MIR

(PHAC, 2009; ABDGN, 2010; ECDC 2009)

Due to low income and poverty, many ABD communities in Canada have limited access to safe, affordable housing and instead live in segregated neighbourhoods with limited access to services and greater incidences of violence. This dimension of social exclusion increases vulnerability to HIV and compromises the health of Black people living with HIV/AIDS (PHAC 2009, 32). These issues are likely to be common for ABD communities in the USA and the EU. The documents reviewed did not include data specific to New Zealand and Australia.

Negative attitudes towards MIR exacerbate marginalization and exclusion. The media plays an important role in influencing attitudes and debate in society, but the way in which the media represents MIR and reports on HIV is not always helpful. Analysis of daily newspapers showed significant differences in how print media report migration and HIV (del Amo et al, 2006). In some countries, print media strive to achieve a sensitive, balanced approach, but in others, newspaper reporting is less balanced (ECDC 2009a, 12).

Gender and Sexuality

In the EU, Canada, the USA and Australia, HIV incidence within mainstream populations is primarily driven by injection drug use and sexual contact between men who have sex with men (MSM). As HIV among ABD populations is largely transmitted through heterosexual contact, it is important to understand the linkages between gender, sexuality and HIV/AIDS. The role of sexuality and sexual orientation is an important aspect of how HIV/AIDS is experienced and conceptualized within African and Caribbean populations (ABDGN 2010, 16). While there was no mention of issues facing lesbian and transgendered people within ABD populations in the documents reviewed, there is likely community-based research reported in grey literature about these sub-populations.

Gendered norms in Black communities make both men and women vulnerable to HIV. They prescribe roles based on male domination over women (patriarchy) and characterize the associated behaviors as “cultural” or “religious” norms (PHAC 2009, 36). A UK-based study on the experiences of heterosexual African men who are HIV-positive, explored how conceptualizations of masculinity impact the experience of living with HIV/AIDS. The researchers challenge existing behavioural public health interventions, recommending that a better understanding of Black men’s experiences is critical to developing culturally-based programming (Doyal et al., 2009 cited in ABDGN 2010, 18)

Prevention and control programmes have paid insufficient attention to differences in vulnerability in different subpopulations of MIR and the specific health and welfare needs of women and children (ECDC 2009b, 8). Women of childbearing age (ages 15 to 44) from countries where HIV is endemic are an important sub-category within the ABD community for prevention and testing initiatives (PHAC 2009, 24). The feminization of the HIV/AIDS epidemic amongst migrant populations to the EU mirrors the epidemics in SSA, warranting gender-specific HIV prevention and treatment policies (ECDC 2009c, 6). The conference Health and migration in the EU called for actions to improve sexual and reproductive health and access to family planning education and services for MIR (ECDC 2009b, 8). The impact of human trafficking on the health of women and girls, particularly with respect to HIV, also merits greater attention (ECDC 2009b, 8).

Patterns of Sexual Behaviour

Unlike the experience of the mainstream populations, HIV is predominantly transmitted through heterosexual contact within the ABD population, both prior to migration and once in their new country of residence. This has important implications for the way health promotion information and prevention strategies are disseminated.

Data from a national survey indicate that African-Americans are more than 2.5 times more likely than the USA population as a whole to have had concurrent sexual partnerships in the previous year (Adimora et al., 2007 cited Black AIDS Institute 2008, 28). African-American and MIR share a common factor driving high rates of concurrent partnerships—the frequent absence of men/women from their communities. In MIR communities, male absenteeism is due to migration, with their primary sexual partners left in their country of origin, while frequent incarceration is the principal cause for the absence of males in many African-American communities in the USA. High incarceration rates are strongly correlated with the rapid spread of HIV infection within social networks (Black AIDS Institute 2008, 28).

There tends to be a double standard regarding the practice of having multiple sex partners: this behaviour is allowable and sometimes expected of men but not of women. While female partners may be aware of this behaviour and its potential risk for HIV infection (because of lack of condom use), they may accept to maintain a relationship for financial, emotional or social reasons (PHAC 2009, 36).

Cultural Practices and Beliefs

Cultural attitudes, religious beliefs, taboos, fear of discrimination and limited knowledge of HIV within migrant communities were highlighted as factors that increase vulnerability, as were negative social attitudes towards MIR, racism, poverty and services that are not culturally sensitive (ECDC 2009a, 5).

Various personal health practices and coping skills contribute to making people from the ABD vulnerable to HIV/AIDS. Difficulties in discussing or silence around health, sex and sexuality have affected Black communities' ability to access and receive HIV/AIDS information, whether it is for prevention purposes or targeted at people living with HIV/AIDS (PHAC 2009, 32). Language barriers, marginalization and social exclusion, and legal obstacles were reported as the most common factors contributing to the HIV vulnerability of MIR. Cultural attitudes, religion, fear of discrimination and low HIV knowledge in MIR communities were also cited (ECDC 2009a, 1).

The use of traditional rituals, therapies and treatment can also affect vulnerability to HIV. In the case of Black communities, these include vaginal cleansing (drying out vaginal secretions) and douching, unsafe male circumcision and female genital mutilation (PHAC 2009, 33). Experience in some countries indicates that there are challenges in reaching the children of MIR with routine vaccination services, because their parents are either unaware of these services or are unwilling to use them for cultural, religious or other reasons (Smailbegovic et al., 2003; Alfredsson et al., 2004; Henderson et al., 2008 as cited in ECDC 2009b, 6).

The majority of Black people in Canada have some religious affiliation. The basic lack of knowledge about HIV coupled with a strong self-identity as being religious appears to inform views about HIV/AIDS and coping strategies. This results in particular beliefs – and consequently, behaviors – that may increase the vulnerability of Black communities to HIV/AIDS. Of particular importance are beliefs around sex, sexuality and death (PHAC 2009, 33).

Racism

The experience of racism actively intersects and interacts with other systemic issues, such as those based on gender, sexual orientation and socio-economic status, to produce particular risks of HIV infection and a particular experience of living with HIV for Black community members. This highlights that risk of HIV infection within the ABD is not simply a matter of individual behaviour, but rather is part of a larger system that informs that behaviour (PHAC 2009, 37).

Institutional barriers and systemic racism further contribute to reduced access to HIV/AIDS treatment and care, inadequate integration of health care services with ethno-specific support organizations, and a lack of cultural understanding by some service providers for the needs of ABD populations (ABDGN 2010, 20).

While surveillance data is essential for understanding which populations are most vulnerable, developing appropriate preventive and healthcare responses, monitoring interventions and informing public health policy, there are implications for racism. It is essential to acknowledge the potential misuse of data on the epidemiology of HIV/AIDS in MIR and ethnic minorities in promoting xenophobia and further stigmatization of MIR and ethnic minorities affected by HIV/AIDS (ECDC 2009c, 11).

Homophobia

Another significant issue characterizing the social environment around HIV/AIDS in Black communities is homophobia or the denial of the existence of homosexuality within the community. HIV is often viewed, mistakenly, as a gay disease, and people who are HIV-positive are therefore perceived to be deserving of their situation (e.g., HIV/AIDS is a “gay disease,” promiscuity leads to infection, HIV is associated with death). Consequently, people who identify themselves as lesbian, gay, bisexual, transgender or queer often do not “come out” for fear of being stigmatized or ostracized within the community. Instead, they keep their sexual orientation or gender identity a secret, and may also engage in relationships with people of the opposite sex (PHAC 2009, 31).

Many gay and bisexual Black men in the USA exhibit attitudes and behavioral patterns that are consistent with international studies in other regions. In a survey of HIV-infected gay and bisexual men, 34% of Black men reported also having sex with women, compared to 13% of white men (Montgomery et al., 2003 as cited in Black AIDS Institute 2008, 32). In New York City, the population rate of Black men who report having sex with both men and women is four times higher than among whites (Sackoff & Coffee, 2004, as cited in Black AIDS Institute 2008, 32).

In a USA-based study that looked at homophobia in Black churches, Ward found that a lack of openness and acceptance contributed to both stigma within the church community, and damaging conceptualizations of masculinity among Black gay and bisexual men (2005). The findings also indicated this environment contributed to psychosocial distress and hindered access to important support networks and resources (2005). (ABDGN 2010, 20)

In the USA, Fullilove’s exploration of stigma within African American community, the author discusses how the presence of homophobia in Black churches hinders the ability of gay men in accessing services, thereby increasing the spread of HIV/AIDS (1999). (ABDGN 2010, 26)

Barriers to Disclosure

Stigma is identified as one of the primary factors influencing disclosure among men and women of Black African descent living with HIV/AIDS (Calin et al., 2007 as cited in ABDGN 2010, 25). Time and again, stigma within clinics and other medical settings have been identified by African PLWH as their primary reason for not disclosing their HIV status (ABDGN 2010, 23).

A significant issue in the social environment of Black communities is the stigmatizing attitudes towards HIV-positive people within the community itself, based on assumptions about the infection. This results in denial, whereby HIV is viewed as something that happens to “others.” Gossip, verbal harassment or ridicule, and ostracism are the frequent community responses to HIV. There is also stigma from outside the community, where HIV is often viewed as a Black or African disease. This, too, contributes to the denial of HIV within the community and increases its vulnerability (PHAC 2009, 31).

Stigma and discrimination associated with TB and with HIV may be exacerbated in the case of MIR who are already socially isolated and fear further stigma, discrimination and marginalization. This may deter them from seeking screening, counseling or testing (ECDC 2009b, 3).

Criminalization of PLWHA for non-disclosure is a concern faced by many African and Caribbean immigrants. For many, fear of criminalization or prosecution for transmission of HIV represents strong motivations for how disclosure is approached (ABDGN 2010, 29).

Barriers to Accessing Services

In spite of health promotion initiatives aimed at normalizing the testing experience and the availability of much improved treatment options, African immigrants seem to delay accessing HIV/AIDS support and services. Several studies have indicated that African MIR living with HIV/AIDS access HIV testing and services much later, compared with non-African service users (Burns et al., 2007; Burns et al., 2001; Sinka et al., 2003 – as cited in ABDGN 2010, 21).

Policies, laws and regulations governing service delivery, the characteristics of MIR communities and wider social attitudes can all influence access to and uptake of services. Legal status, for example, lack of residence status and health insurance, is often a barrier to healthcare. Lack of culturally sensitive information in relevant languages, suitably trained professionals and services tailored to the specific needs of MIR are also barriers. Within MIR communities, culture, religion, beliefs about health, disease prevention and healthcare and limited knowledge of available services can prevent uptake of services (ECDC 2009b, 3).

Factors most frequently mentioned as obstacles to accessing prevention services:

- lack of culturally sensitive information in relevant languages
- inappropriate or poor quality services.

These, in turn, are caused by:

- lack of funding
- lack of NGOs working with MIR
- lack of suitably trained health professionals
- lack of translation services
- lack of information about MIR populations
- HIV is not high on the agenda of many MIR organizations
- lack of community-based HIV testing

(ECDC 2009a, 6)

In the Netherlands, illegal migrants are unable to seek health care because most of the health institutions only care for persons officially registered as residents. This discourages African MIR who have been at risk of HIV infection to get tested for HIV because they do not have money to pay for treatment and are afraid of getting arrested and/or deported (Dodds et al., 2007, cited in ABDGN 2010, 30).

Researchers have explored many reasons for the racial disparity in AIDS deaths in the USA. While many factors are poorly understood, one contributing factor that seems certain is the fact that African-Americans are less likely to learn about their HIV infection before they get sick and, thus, before the infection reaches an advanced stage. The CDC estimates more than half of HIV positive African-Americans are undiagnosed. Black gay and bisexual men are particularly likely to discover their infections only after they have reached advanced stages. CDC and others speculate that this late stage diagnosis is in part owing to African-Americans' limited access to preventive health care. And that limited access to care, broadly, is itself likely an additional factor driving the racial disparity in deaths. Study after study has shown Black Americans overall to have less access to quality care than their peers. More than one in five African-Americans lacked health insurance in 2006, twice the rate among whites (US Census Bureau, 2007 as cited in Black AIDS Institute 2009, 22). This unequal health care system produces starkly unequal results with African-Americans faring far worse with a range of preventable, treatable diseases than any other racial or ethnic group (Black AIDS Institute 2009, 22).

As with prevention, the main factors in poor access to HIV treatment were lack of information about treatment and available services, which can result in late presentation and diagnosis of HIV, and fear of stigma and discrimination. Other factors that prevent access to treatment included stigma within MIR communities towards people living with HIV and concerns, especially among undocumented MIR and asylum seekers, that revealing their HIV status may result in expulsion or have an adverse effect on the asylum process (ECDC 2009a, 6).

Barriers to HIV testing:

- fear of positive test results and related personal and social consequences
- lack of information
- lack of preventive health behavior
- denial of HIV risk
- limited financial resources

(Manirankunda et al., 2009, as cited in ABDGN 2010, 21)

Limited access to HIV treatment for MIR is also a critical factor. Legal status was mentioned most often as an obstacle to accessing HIV treatment. In some countries, treatment is not available to MIR without health insurance or residence permits (ECDC 2009a, 6). For Black communities, numerous barriers to accessing appropriate and responsive health services have been documented, including: institutional discrimination and the poor representation of Blacks among health care personnel, especially at the decision-making levels; lack of awareness by community members of the services available to them (PHAC 2009, 35).

For Black people living with HIV/AIDS, accessing support services can lead to a number of concerns, particularly around issues of confidentiality, anonymity, privacy, stigma and discrimination. Fear and anxiety about these issues can make individuals reluctant to disclose their HIV status, because of the potential negative impacts on relationships and livelihoods. By neglecting to seek support to help them better live with HIV/AIDS, people become socially isolated, which may, in turn, compromise their health (PHAC 2009, 30).

Lack of prenatal care among MIR women is well documented and the major obstacles to access prenatal services are also well known. In France testing during pregnancy is the most common reason to diagnose HIV in women from SSA and second most common cause in French women. African women present a higher proportion of delayed diagnoses at pregnancy and were more likely to have late access to prenatal care and HIV treatment. However, once they do have access, the uptake of HIV treatment and elective caesarean section was the same of French women's, and so were the outcomes. The missed opportunities to prevent perinatal HIV transmission relates mainly to pregnant women not having received prenatal care, to a lack of HIV testing before delivery and to not receiving appropriate interventions to prevent transmission of the virus to her infant (ECDC 2009c, 34).

Incarceration

Just as African-Americans are more likely than other racial and ethnic groups to be imprisoned in the USA, they are also more heavily affected by HIV in correctional settings. In New York State correctional facilities, for example, HIV prevalence is six times higher among Black inmates than among their white counterparts (Black AIDS Institute 2008, 34). The physical environment associated with incarceration also places Black communities at particular risk of HIV. A disproportionate number of Black people are incarcerated in Canada and people in prison are 7 to 10 times more likely to be infected with HIV than people who are not incarcerated (PHAC 2009, 32).

The documents reviewed did not have sufficient data on incarcerated populations in the EU27, Australia, or New Zealand.

Youth

HIV prevention efforts focused on young people share key challenges in Black America and in other parts of the world. For example, young African-Americans, like many young people globally, often have dangerous misconceptions about HIV, worsening AIDS stigma and potentially discouraging young people from taking necessary precautions to prevent transmission. Globally, only 40% of young males (ages 15-24) and 36% of young females had accurate, comprehensive knowledge regarding HIV—significantly below the 95% global target for 2010 (Black AIDS Institute 2008, 32).

In 2006, the CDC found that Black men between the ages of 13 and 29 accounted for more new HIV infections among gay and bisexual men than any other race or age group. And more than half (52%) of all Black gay and bisexual men infected that year were under

30 years old (Black AIDS Institute 2009, 13). Young Black gay and bisexual men do not perceive themselves to be at great risk for HIV, which in turn may make them less likely to learn their HIV status and to take steps to protect themselves or their sex partners (Black AIDS Institute 2009, 13). This disconnect between actual and perceived risk is partly due to the fact that young Black gay and bisexual men do not think they are at greater risk for HIV because they aren't doing things they've been told would put them at greater risk (Black AIDS Institute 2009, 13).

Taking into consideration the fact that the Black population is younger than the overall Canadian population and that 80% of HIV test reports and AIDS cases in the HIV-endemic exposure subcategory were reported in people aged 39 years and younger, initiatives targeting the young Black population are an integral part of a comprehensive response (PHAC 2009, 56).

There is little discussion about childhood sexual abuse in Black communities (in general, the issue of sexual violence is seldom discussed). When documented, it was noted that childhood sexual abuse may directly lead to HIV infection or, in its aftermath, compromise one's ability to practice HIV prevention (PHAC 2009, 34).

Two groups within Black communities that have received little attention but are particularly vulnerable are children and youth who were born and are living with HIV/AIDS and children and youth who have been orphaned as a result of AIDS. Close to 40% of the HIV reports infected through MTCT were children from SSA and this proportion has increased from 1999 to 2006 (ECDC 2009c, 34). Within this context, particular issues surface for parents that inform their children's development. For example, HIV-positive parents are concerned about disclosure and who will care for their children in the event of illness or death. This added stress can affect the rearing of their children. HIV-positive parents may be separated from their children, may care for children who are also HIV-positive, and may experience guilt associated with having an HIV-positive child (PHAC 2009, 34).

The documents reviewed provided minimal discussion of issues facing children and youth of ABD descent living with HIV, or the specialized support services they need as they transition from childhood to adulthood. These are topics which warrant further research and discussion.

Immigration Policy

Limited access to or low utilization of services by MIR is due to a mix of legal, administrative, linguistic and cultural factors. Legal status — lack of residence status and health insurance, especially for undocumented MIR — and regulations governing service delivery limit access to services in some countries. Policies of immigration, justice or interior departments, for example, with strict policies regarding deportation of undocumented migrants, may make it more difficult to reach MIR with public health interventions. There has been little focus on the human rights dimensions of healthcare

in the context of migration and ensuring that MIR and health providers are aware of and encouraged to exercise these rights (ECDC 2009b, 8).

There are tensions between EU and national policies related to migration and health and universal access to HIV prevention, treatment, and care and support, and those related to illegal residence status. Strict policies with respect to deportation of undocumented MIR may be counterproductive to public health. Respondents noted that the recently adopted EU Directive on Return of Undocumented Immigrants could increase marginalization and make it more difficult to reach MIR with public health interventions. As noted earlier, respondents also reported that dispersal policies may be counterproductive to effective service provision for MIR (ECDC 2009a, 11).

MIRs from all over the world often have their right to confidential and non-discriminating HIV testing and counseling violated. Early diagnosis of HIV infection should be a right to all people, irrespective of their migrant status, but denial of entrance or work permit on the basis of their HIV result is against the above mentioned guidelines (ECDC 2009c, 12).

The introduction in January 2002 of the mandatory medical screening of immigrants to Canada for HIV infection has had an impact on the ABD community. Some immigrants became aware of their positive HIV status through this process. The potential implications are numerous, particularly if persons testing positive are unaware of their rights, fear that the positive diagnosis will jeopardize their chances of staying in Canada, or are unable to access care and services. A positive diagnosis in Canada may also pose challenges around disclosure and reunification with children and family, and may affect a person's ability to work and send money to family outside of Canada. Issues such as these highlight the transnational realities of HIV/AIDS for many ABD people in Canada, as they are often linked, through ancestry or current relatives, to other countries (PHAC 2009, 39).

Lack of policy coherence: “It has to be firmly stated that in a framework of prosecution of [MIR], irrespective of their administrative and legal residency status in a given country, all recommendations aimed to decrease language, cultural and gender barriers within both service providers and users are bound to fail. Fear of deportation may abort many of the public health initiatives aimed to prevent HIV and AIDS in [MIR].”

(ECDC 2009c, 35)

In the EU, there is no clear and consistent legal framework for MIR rights with respect to health, social and related issues or one that supports a rights-based approach to public health. Even policies that support the rights of HIV-positive undocumented migrants to access services, such as the 1999 regulation for undocumented migrants in France (PICUM 2007), are coming under pressure (ECDC 2009a, 11).

It has been noted that during times of transition when stress accumulates, resiliency is even more important. This may be particularly relevant as many MIRs have had to cope and recover from major shocks or trauma related to their experiences with war, violence, refugee camp conditions and the immigration process (PHAC 2009, 2).

Funding

The US Centers for Disease Control and Prevention's domestic HIV prevention and research budget has never reached \$800 million a year—a fraction of what the USA has spent in a week of war in Iraq—and was cut or held flat every year of the Bush administration. Meanwhile, 56,300 new infections were logged in 2006 alone, the last year for which data is available. (Black AIDS Institute 2009, 14)

As governors and state legislators scramble to deal with exploding budget deficits, AIDS programs are as likely as any other to face serious budget cuts. This, just as more people lose private insurance and turn to the public system. In many states, particularly in the South, AIDS programs are likely to be among the most vulnerable. Yet, the already tattered AIDS safety net—which has been severely neglected over the past eight years—can hardly afford that financial instability (Black AIDS Institute 2009, 21). To this effect, the Black AIDS Institute has worked to fill gaps in the policy and programming response to HIV/AIDS. The USA administration has pledged to make sure that AIDS funding reflects the demographics of the epidemic, meaning that more resources will be allocated to Black communities, among gay and bisexual men and in the South (Black AIDS Institute 2009, 21).

Limited financial resources put pressure on health services in general, and HIV-related services in particular, while at the same time there are economic arguments for early testing, prevention, treatment and care interventions. Respondents raised concerns about the sustainability of projects and interventions, especially those implemented by NGOs that rely on international funding (ECDC 2009a, 12).

Community consultations with ABD communities indicate that HIV is not a policy priority in relation to MIR populations. HIV prevention is not always addressed by asylum centres or included in wider education and integration services for MIR. Some policies, for example dispersal of MIR to different areas of a country, may hinder provision of HIV prevention interventions for these populations (ECDC 2009a, 6). For example, despite a large number of MIR, France, Germany and Italy had no concrete strategy or policy, nor adequate freely available and accessible documentation on sexual health targeted to ABD populations (ABDGN 2010, 30). Translating EU policy commitments into practice, and addressing administrative barriers to HIV prevention, treatment and care at service delivery level is a challenge. Furthermore, the influence of the EU on national provision of services is limited (ECDC 2009a, 11).

In Canada, although there has been a growing body of research and increasing ABD community mobilization on HIV issues, there is a lack of policy leadership and funding

allocation within the national HIV strategy to effectively meet the needs of ABD communities.

Inadequate Surveillance and Migrant Data

Interpreting the contribution of MIR to the absolute and relative trends of HIV reports over time is difficult given the heterogeneity in the implementation of the HIV reporting systems across the EU and the poor completion of the variable 'geographical origin'. In fact, the very high proportion of missing values in this category is a caveat in the interpretation of figures (ECDC 2009c, 34).

There is no common definition of migrant and the term is used in different ways by different European countries. 'Migrant' may or may not include short-term and long-term MIR, transit populations and settled communities, people with and without legal residence papers, first, second and third generation MIR. Lack of data standardization across countries makes it difficult to compare the situation of MIR within the EU. Similarly, there is no consistent approach to recording migrant status in health records, so comprehensive and comparable data about the health of MIR is not available. Most data are drawn from small studies, unrepresentative samples or questions added to other data collection exercises. These shortcomings limit understanding of migration and health, including infectious diseases (ECDC 2009b, 7).

For example, surveillance data from Ontario (Canada) shows significant infection rates among Black men who have sex with men (MSM), however, little is known at this time about the overall number of Black MSM who are infected with HIV nationally. Similarly, rates of HIV infection among Black injecting drug users (IDU) and prison inmates and rates of hepatitis C co-infection are not well documented which limits effective planning of prevention, care, treatment and support activities (PHAC 2009, vii).

Immigration alone cannot explain the high prevalence of HIV and AIDS in ABD populations. Through immigration health examinations, immigrants who are HIV positive can be linked with appropriate services. For those who are tested in Canada, surveillance data cannot identify whether HIV transmission occurred abroad or in Canada. Achieving a better understanding of the patterns and locations associated with the acquisition of infection could lead to better prevention, diagnosis, care, treatment and support services among people from countries where HIV is endemic (PHAC 2009, vii).

Collecting and presenting relevant information regarding ethnicity in the surveillance data presents several challenges:

- categories for reporting ethnicity are quite broad and some individuals may not clearly fit into any particular category, creating the potential for misclassification
- there still remains a number of large gaps in the completeness of ethnicity data reported nationally for HIV cases
- difficult to decipher overlap of risk exposure categories (e.g., in Canada, the heterosexual exposure sub-category entitled “origin from an HIV-endemic country” does not include ABD people within other exposure categories, such as MSM and IDU)
- the definition of an “HIV-endemic country” inevitably changes over time as HIV and AIDS cases continue to affect a growing number of people from other regions in the world outside of Africa and the Caribbean and these changes will complicate the interpretation of trends

(PHAC 2009, 61)

Analytical Lenses

Given the intersecting and overlapping vulnerabilities faced by ABD populations, HIV policy directions must adopt analytical lenses that put various forms of oppression at the forefront. As described in the discussion themes above, gender, race and poverty intersect with HIV/AIDS-related stigma, denial, fear and discrimination. Since the very early days of the HIV/AIDS epidemic it became clear that ensuring the rights of the PLWHA was one of the pillars of the fight against the epidemic (ECDC 2009c, 12). Consolidated guidelines on HIV/AIDS and human rights (recently developed by the United Nations Office of the High Commissioner for Human Rights and UNAIDS) call upon governments to fulfill their obligations on non-discrimination, rights to health and employment in order to reduce the vulnerability of PLWHA.

To effectively address these multiple vulnerabilities, any strategic directions should be guided by **human rights**-based approaches, **gender**-based analysis, **anti-oppression** frameworks, and **population-specific** approaches. Applying these analytical lenses in research, policy and program development and advocacy will ensure that efforts focus on the “root causes” at systemic and structural levels. These analytical lenses can be operationalized by:

- focusing on addressing stigma and its impact on the lives of ABD populations (e.g., analysis of media contributions to stigma and discrimination and develop strategies to support for positive reporting)
- developing a stronger evidence base on strategies to generate healthier gender norms (e.g., interventions to empower Black women and to alter male attitudes and behaviors, and to change social norms around sexual partner concurrency)

Strategic Directions

The continued severity of the epidemic among ABD communities underscores the need to sustain and accelerate prevention efforts in this population. In addition, PHAs in ABD communities need specialized programs to encourage them to access HIV testing, treatment and support. The following are recommendations synthesized from the seven source documents, organized thematically:

Increased Surveillance and Standardization

Migration in the EU remains poorly understood, and more studies should be conducted to improve understanding of migration patterns in Europe. Relatively little is known about the number of people moving in and out of countries and their duration of stay. Another needed area of research is a review of the impact of EU enlargement on the HIV epidemic, e.g. the impact of increased migration within the EU from east to west on IDU-related prevalence (ECDC 2009b, 7).

Given that the proportion of HIV reports whose transmission category is unknown is alarmingly rising in the EU, there is a need for reinforced HIV surveillance in order to assure the required quality standards (ECDC 2009c, 34). More research is also needed to assess the situation in different EU countries and to account for the apparent differences in prevalence of infectious diseases between countries (ECDC 2009b, 7). Data collection should include monitoring access to treatment for MIR, including identifying appropriate and feasible indicators and reporting mechanisms.

Nancy Krieger in her editorial ‘Counting Accountably’ addressed the negative side effects of racially-specific surveillance data (as discussed in the “Racism” section above). In her opinion, the answer is not to stop collecting racial/ethnic data but rather to end ‘the racialization’ of these data, improve the quality of the data collected and ensure that public health research and programs address racial discrimination (ECDC 2009c, 11).

Every perinatal HIV infection should represent a sentinel health event that should warrant an enquiry. Therefore, to strengthen and sustain measures so as to maximally reduce perinatal transmission, public health activities should give high priority to the collection of

Strategic Directions

- More research on migration patterns
- Improved and standardized HIV surveillance regarding transmission categories, crossed with ethn racial data
- Monitoring MIR access to and uptake of prevention, treatment and care services
- Developing data collection models that avoid stigmatization and discrimination
- Production of country specific reports
- Development of mechanisms for sharing lessons between countries and regions

(Manirankunda et al., 2009, as cited in ABDGN 2010, 21)

data that would allow identifying where missed opportunities occur and target prevention efforts accordingly (ECDC 2009c, 34).

Members of the ABDGN should collaborate to establish standardized surveillance of HIV and migration in Europe, Canada and the USA to allow better comparison between countries. Developing a common definition of ‘migrant’ and standardized definitions for collection of communicable disease and epidemiological data would improve understanding of the relationship between migration and infectious diseases and the burden of infectious diseases in MIR and allow data comparison between and within countries (ECDC 2009b, 7

Community-Based Research and Evaluation

Very little research (including community-based research) and comprehensive evaluations have been conducted to determine the effectiveness of interventions in preventing new HIV infections or responding to the needs of those living with HIV/AIDS in the ABD population. Such information is integral to developing future evidence-based interventions (PHAC 2009, viii). While the relationship between immigration and HIV/AIDS has been the focus of some research, projects and community-based initiatives, the ability of HIV-positive MIR to connect with, and benefit from, health and HIV/AIDS services upon their arrival in countries of destination needs to be further examined. Areas in need of further attention also include the access to prevention, diagnosis, care, treatment and support services for migrant workers moving to regions experiencing rapid economic growth (PHAC 2009, 61).

Funders should prioritize research on HIV related issues that ABD communities share across countries. ABD communities lack key tools needed to ensure a successful response to AIDS. The range of validated prevention strategies for ABD populations is too limited, and proven interventions are needed to address the factors that increase HIV vulnerability and contribute to the continuing burden in these communities. Efforts to improve treatment outcomes for HIV-positive people from ABD communities would benefit from a stronger evidence base, including effective strategies to encourage knowledge of serostatus, promote access to care, and increase treatment adherence. Government and non-government funders should step forward with greater resources to fill the gaps in the evidence base for effective AIDS action (Black AIDS Institute 2008, 43).

Strategic Directions

- More research and evaluation regarding HIV effectiveness of interventions targeting ABD populations
- More research on access to HIV-related services by ABD communities
- More research attention to ABD subpopulations (youth, people who use drugs, incarcerated, GLBT)
- Building systems for knowledge sharing regarding promising practices

The majority of studies focus on the experiences of African and Caribbean MIR of

reproductive age. While this group represents an important aspect of the epidemiological and sociological impact of HIV, there is a lack of insight into the experiences of children, youth and older adults who are living with, or at risk of HIV/AIDS (ABDGN 2010, 39). There is also a need for ethno-specific data on the needs of street involved people, people who inject drugs and people who are incarcerated from the ABD who are at an even higher risk of being infected by HIV and at the same time require culturally-specific services (ABDGN 2010, 39).

Several studies have utilized a social determinants of health approach to understanding the impact and scope of HIV/AIDS within ABD populations. Another theme that was prevalent in the literature was the impact and effectiveness of advocacy campaigns and public health interventions aimed at ABD populations (Bertens et al., 2009, cited in ABDGN 2010, 36).

Another priority should be evaluation of HIV prevention interventions to contribute to the development of good practice (ECDC 2009a, 12). Organizations involved in the delivery of the HIV/AIDS response to the Black community have built solid networks, which have encouraged knowledge exchange and culturally relevant approaches to HIV/AIDS. Strengthening their evaluation capacity will be important to determine whether current programs, interventions and activities adequately meet the prevention, care, treatment, and support needs of this population.

It should also be noted that rich community-grounded information exists within the grey literature (i.e., papers or reports where publication is not the primary objective) such as community-based research and evaluation reports, environmental scans, needs assessments and articles authored by non-academic stakeholders. A possible strategic direction is to develop knowledge sharing systems that increase awareness of, access to, and valuing of such grey literature.

A holistic understanding of how health and wellbeing intersect with culture, biology, education, employment, access to resources, migration experiences and identity is critical to effectively addressing HIV and AIDS in our target populations

More Diverse and Culturally Appropriate Programming

The ABD populations should not be lumped together, disregarding the different cultures and backgrounds of these communities. Therefore the needs of specific subpopulations within ABD, taking into consideration different countries of origin, faiths or backgrounds should be addressed (ABDGN 2010, 34).

Evidence highlights the influence of stigma, discrimination and racism on access to programs and services. Therefore, programs should utilize comprehensive approaches to HIV interventions and services that address wider issues, e.g. gender, sexual violence, trafficking and social exclusion. A comprehensive response needs to address the

linguistic and communication needs of the ABD populations, recognize its diversity; be culturally competent; provide appropriate information; and engage caring and culturally competent health care providers (PHAC 2009, 58).

Health professionals need training and guidance on provision of culturally sensitive prevention, treatment and care services, and for development of culturally appropriate materials. In Canada, some projects aim to increase the capacity of service providers to deliver more effective services to African, Caribbean and Black communities (PHAC 2009, 58). To effectively prevent HIV amongst ABD communities, prevention efforts need to be culturally and linguistically appropriate, building on already-existing community structures, identifying and training people from within communities to carry out local prevention interventions (ABDGN 2010, 25).

Almost all of the countries in the EU are reported to be implementing services or projects to address the HIV needs of MIR. These range from comprehensive services for specific groups, for example pregnant migrant women, to projects targeting specific sub-populations such as migrant sex workers, MSM and prisoners (ECDC 2009a, 8).

In Canada, save for a few projects that include elements of harm reduction or deal with street-involved individuals (e.g. youth), incarceration, addictions and injection drug use are not being addressed in the response for people from countries where HIV is endemic (PHAC 2009, 59). Also missing from research, policy and program discussions is attention to vulnerable subpopulations within the ABD population, such as people who are transgendered or lesbian.

Canadian researchers (Newman et al., 2008 cited in ABDGN 2010, 17) have explored the structural barriers faced by Black women living in Canada, noting that discrimination, disconnection from cultural and faith-based institutions and stigma were factors associated with the decreased effectiveness of prevention strategies (2008). The report suggests that collaboration with socio-cultural organizations, churches and ethno-specific agencies can contribute to more successful HIV prevention initiatives (ABDGN 2010, 17).

Policy Changes

There is a need to develop and expand policy and action plans in areas where ABD populations are disproportionately represented in the HIV/AIDS epidemic. Countries with large ABD populations should develop national policy strategies for prevention, testing and

Strategic Directions

- Recognize heterogeneity within ABD populations
- Build more culturally safe programs and services
- Build comprehensive interventions that address intersecting issues faced by MIR from the ABD
- Build partnerships with collaboration with socio-cultural organizations, churches and ethno-specific agencies
- Build capacity of health care providers

disclosure that reflect the needs and diversity of ABD populations (ABDGN 2010, 37).

In the USA, it has been recommended that to effectively respond to the generalized epidemic in Black America, the USA must use more generalized approaches, supplementing targeted programs for high risk populations with broader-based initiatives that mobilize entire communities and protect individuals whose low levels of risk behavior nevertheless place them at risk of HIV infection. (Black AIDS Institute 2008, 11)

As of October 2008, approximately 350 organizations and 1200 individuals in the USA had signed a Call to Action for a National AIDS Strategy. This strategy has a primary focus on the prevention and treatment needs of African Americans and other communities of color, women of color, gay and bisexual men of all races and ethnicities, and other groups at elevated risk for HIV (Black AIDS Institute 2009, 30). A key recommendation is that sustained funding be available for NGOs providing HIV and related services for migrant communities (ECDC 2009a, 12).

There are tensions between EU and national policies related to migration and health and universal access to HIV prevention, treatment, and care and support, and those related to illegal residence status. Policies of government departments of immigration, justice or interior (for example, strict policies with respect to deportation of undocumented migrants) may be counterproductive to public health. The recently adopted EU Directive on Return of Illegal/Undocumented Immigrants could increase marginalization and make it more difficult to reach MIR with public health interventions. Dispersal policies may also be counterproductive to effective service provision for MIR (ECDC 2009a, 11).

The ABDGN can take a lead in formulating clear recommendations and guidelines for all Member States on compassionate policies for undocumented HIV-positive MIR from countries with limited treatment access. Members of the ABDGN can also work to sensitize policymakers on migration and HIV in Member States (ECDC 2009a, 12), and to advocate for a review of European laws and policies related to MIR and HIV, including discrimination, criminalization particularly of non disclosure of HIV transmission and deportation issues. This review should also assess what happens to undocumented HIV-positive MIR following deportation.

An assessment of existing policies, legislations and laws that negatively impact members of the ABD is required. Legal and migration issues encompass a myriad of challenges including citizenship, access to government programs and supports, employment and education opportunities, family stability, and other determinants of health which can put ABD populations at a disadvantage and higher risk for HIV transmission (ABDGN 2010, 38).

Strategic Directions

- Develop national policy strategies that reflect the needs and diversity of ABD populations, with dedicated funding for research and interventions
- Analyze intersections between HIV, discrimination, criminalization and deportation issues
- Assess existing policies, legislations and laws that negatively impact ABD populations

Mobilizing and Involving Migrant ABD Communities

Community involvement has played an important role in the HIV response. While most country respondents reported that migrant communities are involved in interventions, relatively few reported the participation of MIR in policy processes (ECDC 2009a, 10). There is a need for greater participation and contribution by PLWH from the ABD throughout the development, implementation and evaluation of research, programming and policy initiatives (ABDGN 2010, 36).

While many ABD communities are knowledgeable about HIV/AIDS transmission routes, protection methods and treatment availability, the delivery and context of public health messages may influence how this knowledge is applied (ABDGN 2010, 37). The role of community organizations and cultural leaders is identified as a critical piece in the successful implementation of education, prevention services and support (Burns, 2007).

Black organizations, individuals, and public and private funders need to be mobilized to offer far greater and meaningful support to the work of Black leaders (Black AIDS Institute 2009, 36). In Fall 2008, the CDC solicited proposals for its ACT Against AIDS Leadership Initiative. The initiative, a part of the CDC's Heightened National Response to HIV/AIDS among African Americans, was designed to build mobilization efforts within the Black community by strengthening and extending the reach of community groups (Black AIDS Institute 2009, 38).

The UK's National African HIV Prevention Programme (NAHIP) focuses on HIV prevention, information sharing and education for the purpose of addressing stigma, encouraging informed sexual health decision-making and advocating for change. The NAHIP provides a model for how to support collaboration between community-based organizations to address HIV prevention needs for ABD populations.

Through networking, joint action and collaboration, organizations and individuals working in HIV and migration can exchange research findings and promising practices. A priority for the ABDGN should be establishing a mechanism to improve sharing of resources and information about HIV-related services for MIR and good practice, and to facilitate access to expertise. In addition, there are opportunities to increase cooperation with countries of origin. Since many MIRs maintain close contact, there is frequent travel and mobility

Strategic Directions

- Strategic Directions:
- Support greater participation and input from PLWH from ABD
- Build partnerships with community leaders (formal and informal) within ABD populations
- Engage community organizations and cultural leaders in planning and implementing interventions
- Build a mechanism to improve sharing of resources, expertise and information about HIV-related services for MIR
- Increase cooperation with countries of origin to build effective HIV/AIDS interventions

between home and host countries, which may have an impact on the development of the epidemic, and methods and materials in countries of origin could help develop interventions in host countries. In addition, the ABDGN could work to strengthen links between professional associations, e.g. of physicians, nurses and social workers, migrant organizations and human rights organizations (ECDC 2009a, 13).

Existing evidence-based practices and interventions on prevention, treatment, care and support from the UK, the USA and Canada should be shared across global contexts, particularly in areas where resources are sparser (Western Europe; areas of Canada and the USA; Australia; New Zealand). (ABDGN 2010, 37)

Conclusion

Although ABD communities in the EU, Canada, and the USA have many diverse stories of when, how and why they found new homes in western countries, they face common challenges which make them vulnerable to HIV. These common experiences unfortunately include various forms of social isolation and exclusion, such as racism, unemployment or underemployment, and economic hardship. These compounded with HIV-related stigmas, homophobia, gender inequities, and unhealthy sexual practices have given ABD communities a higher burden of HIV prevalence than the rest of the population. Regardless of geographic location, ABD communities have a disproportionately high burden of HIV incidence and prevalence.

There are important lessons from the research, policy, and program responses to HIV amongst ABD in the EU, Canada and the USA. Best practices for this population could assist the response across the various ABD regions. As such, international, cross-sectoral and cross-jurisdictional activities to share best practices, to increase partnerships among a wider range of stakeholders and to better use evidence in the development of strategies and interventions should be fostered and encouraged (PHAC 2008, 62).

A balance must be struck between developing ABD-specific interventions and avoiding stigmatizing ABD communities by associating them with stereotypes surrounding HIV risk behaviors. HIV within ABD communities is primarily transmitted through sexual contact, both through multiple concurrent heterosexual partnerships, as well as through unprotected sex by men who have sex with men. Homophobia is a key driver in sexual risk patterns of MSM (many of whom are also having sexual relationships with women), and in deterring individuals from seeking HIV services.

A human rights framework, including laws, that protects MIR rights, as well as the rights of PLWH, will go a long way to stemming HIV-related stigma and discrimination. The trend toward criminalization of HIV non-disclosure (particularly in Canada) places in jeopardy ongoing attempts to de-stigmatize HIV and encourage testing and disclosure.

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