

**A Global Review of Policy and Programmatic
Responses to HIV/AIDS in the African and
Caribbean Black Diaspora**

***African and Black Diaspora
Global Network on HIV and AIDS (AB-DGN)***

Literature Review and Global Consultation

March 2010

Summary Report

Acknowledgements

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Key Recommendations

- *Knowledge and Resource Sharing:* Existing evidence-based practices and interventions on HIV prevention, treatment, care and support from the UK, the US and Canada should be shared across global contexts, particularly in areas where resources are more sparse (Countries in Western Europe, areas of Canada and states in the USA, Australia and New Zealand).
- *National HIV Strategies for ACBD Populations:* Countries with large African and Caribbean Black Diasporas (ACBD) should develop national policy and strategic frameworks on HIV prevention, treatment and care that reflect the needs and diversity of ACBD populations. This should be resourced by national governments and informed by the existing evidence of effective interventions, and informed by meaningfully engaged communities (ex: Black AIDS Institute, African HIV/AIDS Policy Network). Policy responses to the needs of the ACBD should represent a multi-sectoral collaboration that engages departments of health, social services and labour, immigration services, labour, the criminal justice system and community-based organizations.
- *HIV Prevention and Treatment Information:* The development of effective HIV prevention and treatment education and programming hinges on a better understanding of the information needs of ACBD communities. Regional experience, language, culture, community, migration status and social networks will all play a role in the development and delivery of information.
- *Stigma and Discrimination:* There is a need for targeted evidence-based interventions that address the impacts of multiple structural and systemic sources of oppression based on race, gender, inequality, faith/belief, disability, age, legal status, sexuality and other dimensions of difference that harm individual and community responses to HIV and AIDS.
- *Action Planning and Targeted Resources:* There is a need to develop and expand policy and action plans in areas where ACBD populations are disproportionately represented in the HIV epidemic. It is imperative that communities are properly engaged in the development of policies that affect their lives and that resources are targeted at the self-defined priorities and needs of communities.
- *Capacity Building and Service Collaboration:* There is room for greater exchange of information, collaboration and capacity building among policy makers, major donors, community-level service providers and People Living with HIV/AIDS (PLWHA), to build on the existing body of knowledge at country, regional and global scales. There is also a need to identify gaps in the current research, to engender good practice interventions and engage in the policy development process.

- *Gender-focused programming and policy:* There should be more documentation about successes and challenges of HIV interventions and policies for ACBD populations particularly focusing on how gender and gender inequalities shape attitudes, beliefs and experiences. The literature and programmatic response to sexual minorities and people living with or affected by HIV/AIDS is also lacking.
- *Legal and Immigration Resources:* An assessment of existing policies, legislation and laws that disproportionately affect ACBD populations is needed. that impact a myriad of issues including citizenship, access to government programs and supports, employment and education opportunities, family stability, and other determinants of health which can put ACBD populations at a disadvantage and higher risk for HIV transmission. Further, we need to identify how ACBD communities understand and access their legal rights, and highlight community developed responses and solutions to the diverse and interrelated legal and migration issues experienced by ACBD populations.
- *Ethno-specific Contexts:* There are a diverse range of factors including length of time in the developed world (e.g. recent immigrants vs. seasonal migrants vs. established immigrant communities), the size and cohesion of particular ACBD communities, diverse language capabilities, and community held values, beliefs and practices from one's country of origin, that need to be considered when developing strategic responses to HIV/AIDS for ACBD populations. Greater awareness of the unique ethno-specific contextual factors that impact the success of targeted community and individual interventions is needed.
- *Meaningful Involvement of African and Black PLWHA – Based on the Greater Involvement of People with HIV/AIDS (GIPA):* There is a need for greater participation and contribution from African, Black and Caribbean PLWHA throughout the development, implementation and evaluation of policy, programming and research.
- *Effective Knowledge Translation and Information Dissemination:* Information, knowledge and resources need to be conveyed using effective and cross-disciplinary strategies, including multimedia and interactive approaches, taking diverse community, linguistic and cultural contexts into account.

- *Research Priority Areas:*
 - *Age Disparity:* Additional studies are required to inform effective policy and programming responses to the needs of older adults and youth, the two ends of the age spectrum that seem to be largely neglected in the literature, although they continue to be greatly affected by the impact of HIV/AIDS
 - *Migrant/Seasonal Workers:* Some literature exists on the attitudes, beliefs and experiences of migrant workers, however more research is required to better understand the current education and service gaps experienced by these populations. Additionally, further research is required to identify the prevention, treatment and support needs of migrant workers and their families.
 - *Street Involved People, People who Inject Drugs and People who are Incarcerated:* There is a need for ethno-specific data on the needs of street involved people, people who inject drugs and people who are incarcerated from the ACBD who are at an even higher risk of being infected by HIV and at the same time require culturally-specific services
 - *The Role of Sexuality in Prevention, Treatment and Care:* There should be more documented data on the needs of, and interventions with African MSM. Additionally, there is a gap in the data on bisexual people and WSW or women who identify as being gay.

Abbreviations

ACBD	African and Caribbean Black Diaspora
ACCHO	African and Caribbean Council on HIV/AIDS in Ontario
AFAPAC	African Foundation for AIDS Prevention and Counseling (Netherlands)
AHPN	African HIV Policy Network
AIDS	Acquired Immune Deficiency Syndrome
APPA	Africans in Partnership Against AIDS
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
BAI	Black AIDS Institute
BCAP	Black Coalition for AIDS Prevention
BMSM	Black Men who Have Sex with Men
CAHR	Canadian Association of HIV Research
CAS	Canadian AIDS Society
CATIE	Canadian HIV Treatment Information Exchange
CBO	Community Based Organizations
CHC	Community Health Centre
DOH	Department of Health
GO	Governmental Organization
GIPA	Greater Involvement of People Living With HIV/AIDS
GUM	Genito-Urinary Medicine
HAART	Highly Active Antiretroviral Therapy
HPA	Health Protection Agency
HIV	Human Immunodeficiency Virus
IDU	Injection Drug User
IOM	International Organization on Migration
KAP	Knowledge, Attitude, Practices
LSHTM	London School of Hygiene and Tropical Medicine
MSM	Men Who Have Sex With Men
NAHIP	National African HIV Prevention Programme
NAM	National AIDS Map
NAT	National AIDS Trust
NGO	Non-Governmental Organization
NHS	National Health Services
OHTN	Ontario HIV Treatment Network
PCT	Primary Care Trust
PHAC	Public Health Agency of Canada

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1. Literature Review Framework

1.1 Background

The purpose of this review is to scan the available academic resources and grey literature to identify evidence-based interventions, and other publications documenting policy and programmatic responses to the needs of HIV-positive or at-risk African and Caribbean Black Diaspora (ACBD) communities living with or affected by HIV. Through the completion of an extensive literature review and global resource scan, this project seeks to identify current gaps in the global response, discourse and to identify opportunities to address the specific needs of this population.

1.2 Methods

A review of the literature was conducted, identifying publications, evidence-based resources and grey literature from community based organizations that included policy and programmatic responses to the needs of ACBD populations living with or affected by HIV/AIDS. This review seeks to create an inventory of relevant projects and programs for PLWHA from the ACBD.

When conducting the literature review, we asked the following questions: What are the current policy and programmatic responses addressing the needs of ACBD populations? What resources are available to the priority group? What challenges or gaps exist?

Keywords used included: African, Caribbean, Black, HIV, AIDS, Diaspora, migrant, health, community development, interventions, stigma, disclosure, policy, programmes/programs, organization, research, interventions, services, faith groups, stigma, community and support groups. Continent, country and city names were also used to identify regionally-specific documents (e.g. Australia, Europe, Canada, London, and New York).

To achieve a comprehensive review of global resources, consultants in the UK, Canada and the US conducted a broad scan of existing databases. Search engines used to complete this review consisted of ProQuest, Google Scholar, Scholar's Portal, the

Cochrane Library, CINAHL, PubMed, AIDS Action Europe Clearing House, the London School of Hygiene and Tropical Medicine (LSHTM) library archive.

Relevant grey literature and agency reports were drawn from a range of regional and international websites including those of relevant governmental and non-governmental organizations. Appendix A outlines some of the websites accessed throughout the literature review, sorted by regional focus. Basic internet searches were conducted to identify additional resources. Further documentation and resources were provided by AB-DGN governing council members working from various countries. Once relevant resources were identified through search engine queries and consultation, secondary materials that were germane to the research topic were identified.

1.3 Inclusion Criteria

Articles were selected on the basis of relevance to the research questions and area of inquiry, which focused on the identification of programming and policy responses to ACBD populations living with or affected by HIV. Abstract-only publications were included in the review when they covered a relevant area of focus. The strategy used to search for publications was limited to studies from 1995 to 2010. Restrictions were not put on study language, design or outcome assessed.

1.4 Scope of Literature

The search for literature and resources covering policy and programming responses to HIV/AIDS in the ACBD resulted in several thousand hits. From this total, 195 studies and reports were included in the compendium of literature. Of this total, 111 studies were presented in this summarizing report, with 59 studies drawn from Europe, of which 44 studies were UK-based, 25 studies from Canada, 15 from the US, 6 from Australia and 3 from New Zealand. Additionally, there were 3 studies that focused on the global ACBD population. In total, 60 references were drawn from peer-reviewed journals and the remaining documents were taken from the grey literature published by government bodies, policy groups and community organizations. The majority of resources found were studies conducted in the UK, representing a notable country bias in the results. This discrepancy might be explained by the size of the ACBD populations living in the UK, as well as the size of the HIV epidemic. Additional factors such as the history of migration and race discourse in the UK and government investment in HIV public health

interventions may also contribute to the greater availability of documentation. Many studies focused on behavioural research, exploring the knowledge, attitudes and practices of people from the ACBD affected or infected by HIV/AIDS. Other common themes included the experiences of PLWHA from the ACBD and epidemiological studies. Only 7 studies examined the effectiveness of evidence-based interventions.

Table 1: Scope of Literature

Publications Included in the Review (n = 111)
• Peer- Reviewed Studies (n= 60)
• 'Grey Literature' publications (n=51)
• Interventional Studies (n=7)

Limitations to the Study

Given the global nature of this review, the literature found included languages other than English and French, and due to limited resources translation was a challenge. Similarly, some websites accessed, while searching for organizations, were in languages other than English, with no translation options. However, in many cases it was possible to use programs such as Google Translator to get a general overview of these articles and websites. Additionally, the accessibility of resources was a challenge at times. In some instances only abstracts or overviews were available. Other articles required purchase. These resources were used only when deemed relevant to the scope of the study. Finally, some organizations and institutions may have published literature that was not available on-line at the time of our search.

To address language and accessibility gaps, the next step of this project will involve a global consultation that will be carried out with key organizations identified throughout the review. The consultation will be conducted in three languages: English, French and Spanish, reflecting languages spoken within ACBD populations where HIV is prevalent. Additional languages (German, Italian, Dutch, Portuguese, etc.) may be added to the consultation as required, following a review of initial findings. In some instances, abstract-only study reviews were available, thus limiting our ability to review the full-text

article for a deeper understanding of the methodology, sample, and results of a particular study.

Moreover, the global scope of this review signifies that the review will be limited by the on-line availability of regional content, as well as the scope of resources provided by our local contacts. Nations with a larger ACBD population will often, though not always, have a more expansive database of studies and interventions focused on addressing HIV/AIDS throughout this population. Finally, the socio-political landscape of each country or region will impact the available literature. For instance, the existing literature and programming will often reflect the funding and resources available to researchers and NGO's as well as the scope of governmental agency involvement in developing effective policies and services (i.e. in the UK where there is a National Frameworks addressing their prevention and treatment needs include reference)

Research Approaches

The body of literature available on ACBD communities and HIV/AIDS is largely represented by studies based in the UK, Europe (Sweden, Germany, The Netherlands, France), the US and Canada. These geographic regions also reflect the areas with the largest ACBD populations (ECDC, 2009; CDC, 2009; PHAC, 2009). Some seminal studies from Australia were also identified. The types of studies we came across were mainly quantitative descriptive studies; qualitative studies ranging in scope and methodology; observational studies; and intervention-based studies. Many studies also involved a mixed-method approach combining quantitative data with qualitative approaches, designed to understand the experiences of migrant African and Caribbean populations. The studies also included epidemiological reports, a review of existing programs and interventions, as well as case studies. Although key insights and effective interventions can be drawn from existing literature, regional reporting is an important aspect of understanding how HIV is contextualized and experienced among local migrant ACBD populations.

Regional Overview

Europe

Countries such as the UK, France, Portugal, Spain, Germany and Italy have high populations of African Diaspora, with latest UN figures showing France had an African Diaspora population of 274,538, England 249,720, and on a smaller scale, Germany and Italy, with 154,564 and 137,780 respectively (UNAIDS, 2008; IOM 2003). This, among other reasons, could be attributed to the socioeconomic links of African Diasporas to the former colonial powers. As of 2007, the estimated number of PLWH in France, Germany, Portugal, Spain, and Italy are 140,000, 53,000, 34,000, 140,000, and 150,000 respectively (UNAIDS, 2008).

The majority of resources reviewed were drawn from the UK, Netherlands, Belgium, Switzerland and Sweden. The bulk of information for this research work was retrieved from Western Europe, in particular the UK, which has a large ACBD, within the context of Europe and globally. There is a National African HIV Prevention Programme (NAHIP) that 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 programme, a collaboration between community-based organizations (CBOs) to address HIV prevention needs for Africans in England, is funded by the Department of Health and managed by the African HIV Policy Network (AHPN). Countries like the Netherlands, Belgium, Switzerland and Sweden also have resources for ACBD populations, however one can conclude from this exercise that they are not as vast and extensive as those of the UK. No resources or strategies that explicitly addressed the needs of Caribbean populations were identified.

Canada

In Canada members of the ACBD are disproportionately affected by and infected with HIV/AIDS. The African and Caribbean population living in Canada is estimated at 662,210 (PHAC, 2009). In Canada, there are an estimated 58,000 HIV infections, with 7,500 of case 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. It is important to note that while many countries in Africa and the Caribbean are HIV endemic, this is not exclusive to these regions; emerging epidemics in countries in Eastern Europe, and South and East Asia are also showing endemic HIV rates. The majority of these infections are transmitted

through heterosexual contact. In both countries, women from the ACBD are overrepresented by the HIV epidemic.

A strong Afro-Caribbean research base also seems to have emerged from the Canadian context, with early reports dating back to the mid-1990s. Studies from Canada explore topics including the following:

- 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 behaviours (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 ACBD (Tharao *et al.*, 2005)
- Sexuality (Husbands *et al.*, 2009; George *et al.*, 2007; Lewis-Peart, 2007; Myers *et al.*, 2001).

United States

In the US, statistics on the ACBD are included in the total Black/African American population. As there is generally no distinction between more recent migrants from Africa and the Caribbean and African Americans who have lived in the US for generations, the estimated number of all Black people in the US is approximately 41.1 million. The estimated number of HIV infections among Black/African Americans was 510,100 in 2006, representing over 45% of the estimated 1.1 million HIV/AIDS cases in the US (CDC, 2009).

There is an abundance of literature emerging from the USA, however the majority of these studies focus on African-American populations rather than investigating the experiences of African and Caribbean people (Fullilove, 2006; Clark *et al.*, 2003; Fullilove *et al.*, 1999)... Understandably, the cultural, social and biomedical experiences of Black Diaspora populations will be distinctly unique from that of African-Americans

who have lived in the US for generations. The lack of distinction between African and Black populations in the US represents a significant imbalance in the literature. Nevertheless these studies are relevant to understanding how “Black” populations are conceptualized in the US, how these identities influence self-conceptualization, and how various socio-cultural determinants impact health and wellbeing. To this effect, the Black AIDS Institute has worked to fill gaps in the policy and programming response to HIV/AIDS (Wright & Patterson-Gatson, 2009; Wilson *et al.*, 2008; Wright, 2006).

In the US, studies that focus on the experiences of migrant African populations are generally centralized to areas or cities with larger migrant populations from specific African countries. The goal of these studies was to 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 African migrants from specific Sub-Saharan African countries (Foley, 2005; Eteni & Wood, 2003; Beyene, 2000).

Australia and New Zealand

In Australia, HIV/AIDS is largely experienced among gay men and MSM. This exposure group accounts for 81% of infections reported by 2007 (Lemoh *et al.*, 2008). The number of PLWH in Australia is estimated at 18 000 (UNAIDS, 2008). 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 immigrants only account for 6% of all HIV infections, this group represents a unique sub-population. Unlike the experience of other Australian populations, HIV is predominantly transmitted within the ACBD population through heterosexual contact, both prior to migration and once in Australia. This has important implications for the way health promotion information and prevention strategies are disseminated.

Additionally, it seems that African-born migrants 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 migrants (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 immigrants 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 ACBD population is less than 15,000 in New Zealand (Statistics New Zealand, 2007). Currently, the literature on the experiences of African and Caribbean populations is sparse. However, we did identify one study on the education and prevention needs of African refugees settling in New Zealand (Worth, 2003).

1.5 Global Consultation

As part of the literature review and collection of resources, a global consultation was conducted in collaboration with AB-DGN Governing Council members and consultants in the UK, the US and Canada. A detailed inventory was created documenting organizations and individuals working with African, Caribbean and Black populations in the Diaspora as well as key documents to be included in the literature review. This inventory included service providers, researchers, policy makers, community leaders (cultural, faith-based, media) and the type of interventions they are undertaking within the target population. Relevant academic, non-governmental and institutional organizations, academics, community-based organizations, and faith-based groups were contacted to identify additional resources, interventions, policy and programming where gaps appeared in the literature review. Governing council members and key contacts also provided support in identifying resources, organizations and literature, where apparent gaps arose. This was especially helpful for accessing resources from Australia, New Zealand and from European countries apart from the UK.

2. Emerging Themes

Six principle themes have been identified in the literature on the policy and programmatic response to HIV/AIDS in the ACBD. The areas of focus presented here are not exclusive, as many of these themes intersect to influence the overall

experiences, challenges and opportunities faced by ACBD populations. Additionally, the complexity of ACBD experiences cannot be fully captured by this overview. However, these categories are presented to provide insight to the principle themes emerging from the literature.

- Gender and Sexuality
- Institutional Barriers and Socio-Cultural Dimensions
- HIV Testing, Prevention and Support
- Stigma and Discrimination
- Attitudes and Beliefs
- Human Rights Issues: Migration Status and Criminalization of HIV Transmission

2.1 Gender and Sexuality

Gender specific studies are critical to understanding the scope and impact of the HIV/AIDS epidemic among ACBD populations. As HIV/AIDS among African and Caribbean populations is largely transmitted through heterosexual contact, it is important to understand the linkages between gender, sexuality and HIV/AIDS. Constructions of gender reflect culture, community and self-image, affecting women (Drummond *et al.*, 2008; Newman, 2008; Pourette, 2008; Foley, 2005; Tharao *et al.*, 2005), men (Doyal *et al.*, 2009; Gadon *et al.*, 2007) and transgendered people (Garofalo, *et al.*, 2006). Sexuality also plays a role in describing the experiences of people living with, or at risk of 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 (Doyal, 2009; Husbands *et al.*, 2009; Papparini *et al.*, 2008; Elford *et al.*, 2007; Dougan *et al.*, 2005; Zavuga, 2003). Much of the research on gender and sexuality is drawn from studies based in Europe, Canada and the US.

Women

The available literature looks at HIV/AIDS prevention, support and education needs from a gender-sensitive point of view. However, the majority of the data is drawn from observational or qualitative studies, which examine the experiences of women within a socio-cultural and migration context (Ndirangu & Evans, 2009; Doyal & Anderson, 2006; Anderson & Doyal, 2004, Oxman-Martinez *et al.*, 2000) with little evidence-based documentation of programmatic responses (Bertens *et al.*, 2009; Nobles *et al.*, 2009). Studies that explore the ethnographic experiences of HIV-positive African women seem

to indicate that gender, sexuality, cultural background, migration status, education and other socioeconomic factors influence HIV prevention strategies, service utilization and access to support (Doyal & Anderson, 2006; Doyal & Anderson, 2005; Foley, 2005; Gulland; 2001).

In an article by Jane Anderson, looking at the experiences of migrant women from Africa living in the UK, she found that African women living with HIV/AIDS in London face a number of challenges, stemming from their position in the society as migrants, as women, and as PLWHA (2003). Anderson recommends that strategies to overcome HIV-associated stigma should be a top health priority. This needs to be the starting point both for future research and for the planning of services to meet the needs of HIV-positive African women. Newman and colleagues also explore 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. Additionally, Newman and colleagues recommend that health promotion interventions that are directed to African and Caribbean women should account for gender equity, greater agency over health care and economic decisions and the reality of discrimination in the health care system.

Poverty is often a reality for immigrant women and the added pressure of living with HIV/AIDS presents an additional burden. In some cases, migration status as well as language and cultural differences can create barriers to accessing care and support. However, studies from the UK demonstrate the creative coping strategies adopted by African-migrant women navigating HIV/AIDS (Doyal & Anderson, 2006; Doyal & Anderson, 2005). Even though most of the women participating in these studies live in poverty, they demonstrate enormous commitment and considerable creativity in the struggle to sustain their own health and that of their families in what is often a very hostile environment.

The literature exploring sexuality among African and Caribbean women, the literature is sparse. A study by Arendt & von Giesen found that female migrants tested positive at a younger age than non-migrants, and for the most part were infected through

heterosexual intercourse (2003). We found no studies that specifically examined the needs of women who identify as being lesbian, bisexual or women who have sex with women (WSW), despite the fact that these groups are also at risk of HIV exposure and infection. The scope of most studies looking at heterosexual HIV transmission and sexual risk behaviours look at the experiences of men, despite the particular vulnerability of women who are biologically more susceptible to HIV infection.

Men

Population-specific literature focusing on the experiences of Black gay men, bisexual men, men who have sex with men (MSM) and transgendered men is more extensive than the literature available for women. Several studies have been conducted in the UK and Europe (Elford *et al.*, 2008; Papparini *et al.*, 2008; Prost *et al.*, 2008; Elford *et al.*, 2007; Dougan *et al.*, 2005; Dougan *et al.*, 2004; Quinn *et al.*, 1986), in Canada (Husbands *et al.*, 2009; George, *et al.*, 2007; Lewis-Pearl, *et al.*, 2007; Myers *et al.*, 2001), in the US (Ward, 2005) and in Australia (Lemoh *et al.*, 2008).

For the most part, studies that focus on men also consider both gender and sexuality. One example from the literature is the Canadian MaBwana study (Husbands *et al.*, 2009). The goal of this initiative was to provide a better understanding of the socio-demographic characteristics, experiences, sexual relationships and behaviours of African, Caribbean and Black gay and bisexual men, as a way to inform more effective HIV prevention campaigns. Another Canadian study on MSM populations explored possible differences between psychological characteristics and sexual risk behaviours based on country of origin (native, non-native) and ethnicity (white, non-white). Results emphasized the importance of designing prevention and support interventions that consider possible cultural and ethno-specific factors that require tailored and targeted approaches. (George, *et al.*, 2007).

Doyal and colleagues present a UK-based study that delves into the experiences of heterosexual African men who are HIV-positive, exploring how conceptualizations of masculinity impact the experience of living with HIV/AIDS (2009). 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. Evans (2009) and Dodds (2006) take a similar approach to

understanding the effect of HIV/AIDS on African men living in UK, in particular those living London. The authors note that strategies developed to prevent HIV transmission are rarely based on detailed knowledge of the men whose behaviours they are intended to change. To address this disparity, they conducted a qualitative study on African men living with HIV/AIDS, documenting their feelings, their needs, their hopes and their desires as they negotiate their lives in the Diaspora. Dodds indicates that prevalent social discourses of homophobia, racism and xenophobia underpin individual experiences of HIV-related stigma (2006). Moreover, these studies find that members of marginalized communities themselves employ HIV-related stigma as a governance mechanism to exclude positive people from tightly woven networks of support.

An exploratory study from by Papparani and colleagues examined the lives of Black MSM living in the UK, who struggled to strike a balance between their identity as gay/bisexual men, as African men, and as PLWHA (Paparini *et al.*, 2008). Managing these multiple identities can have implications for testing and disclosure, access to support and resources, social integration, service utilization, sexual relationships and practices and survival strategies. Men who faced barriers such as unofficial residency and unemployment experienced additional stress. The author suggested that experience of real and perceived stigma represented an important challenge for Black MSM, as they sought out support and resources from organizations, family members and faith-based groups. In a US-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).

Presently, Sigma Research is conducting a 2½-year HIV and STI transmission study entitled the *European MSM internet survey on knowledge, attitudes and behaviour* (EMIS). The goal of this project, which concludes in 2011, is to improve existing prevention strategies and behavioural surveillance among MSM throughout Europe.

Transgendered People

The literature currently available on African and Caribbean migrants who identified as being transgender is minimal. A US-based study by Garofalo and colleagues takes a look at the experiences of African-American male-to-female (MTF) transgender youth aged 16-25 years who are living with HIV/AIDS (2006). A number of variables were indicated as barriers to prevention treatment and support. These included imprisonment, homelessness, sex in exchange for money/resources or forced engagement in sexual activity, substance use, unemployment and inability to access health care. The authors recommend that additional research is required to understand the needs and challenges faced by this group, suggesting that targeted broad-based interventions will best address risk reduction among MTF transgender youth.

2.2 Institutional Barriers and Socio-Cultural Dimensions

African and Caribbean migrants living in the Diaspora face a broad and overarching spectrum of social cultural barriers when navigating HIV prevention, testing, treatment, care and support. Stigma and shame play a large role and in the way HIV is conceptualized and experienced, creating barriers to testing and treatment (Fakoya *et al.*, 2008), disclosure and service utilization (Calin *et al.*, 2007; Foreman & Hawthorne, 2007). Several studies demonstrated that HIV/AIDS was often viewed negatively within ACBD communities, provoking feelings of shame and increasing exposure to higher risk behaviours (Bischofberger, 2008; Beyene, 2000). Foley conducted a study to examine the social and structural barriers faced by a group of Africans living with HIV/AIDS seeking care at public health centers in Philadelphia (Foley, 2005). The study indicated that legal status, language differences, fear and uncertainty about accessing services in a new country, a lack of understanding about HIV transmission, prevention and treatment options all contributed to the experiences of migrants navigating care. Culturally-specific factors should be considered when developing evidence-based interventions for the ACBD. As stated by Burns (2003): “community involvement should include input to ensure there is: better cultural understanding within the health care system; normalization of the HIV testing process; and a clear message on the effectiveness of therapy” (p. 102).

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 ACBD populations. Restrictive migration policies and a lack of clear policy directives at national and regional levels also impede the effectiveness of HIV/AIDS interventions, especially in the promotion of testing and treatment (Fakoya *et al.*, 2008; Gardezi *et al.*, 2008). Immigration policies that inhibit integration of new migrants are also prohibitive (Foreman & Hawthorne, 2007).

2.3 HIV Testing, Prevention and Support

Substantial work has been carried out on assessing HIV testing and diagnosis needs among African communities living in the Diaspora (ECDC, 2009; Kalichman *et al.*, 2009; Fakoya *et al.*, 2008; Foley, 2005). 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 migrants 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).. This may also be connected to feelings of shame and stigmatization, as well as uncertainty in negotiating services in an unfamiliar health care system. Fakoya *et al* conducted a study at the UCL Centre for Sexual Health & HIV Research in the UK, identifying several social, cultural and structural barriers to testing including: non-access to testing and care, fear of death and disease, fear of stigma and discrimination in the community, lack of political will, restrictive immigration policies and the absence of African representation in decision-making processes (2008). A similar study by Yandell *et al.*, at the University of Bristol, UK, and the University of Bern, Switzerland, discovered that some of the major barriers to HIV testing among African communities in the UK include fear, denial, stigma and risk, cultural norms, health beliefs and spiritual beliefs (2006).

In Europe and the UK, Black and Minority Ethnic (BME) organizations have undertaken many interventions on early HIV testing, particularly among men. In Belgium, the Institute of Tropical Medicine, Antwerp carried out two studies in 2006 and 2008 respectively in order to implement evidence based interventions for the promotion of Voluntary Counseling and Testing (VCT) as well as to further develop culturally adequate prevention strategies. The study conducted in 2006 revealed that participants from African migrant communities in Belgium were in principle in favor of VCT but the barriers outweighed the advantages. Such barriers included fear of positive test results

and related personal and social consequences, lack of information, lack of preventive health behaviour, denial of HIV risk, and missed opportunities. Limited financial resources are also of concern, among young people, asylum seekers, and recent migrants (Manirankunda *et al.*, 2009). The second part of the qualitative study was completed in 2008 and it was aimed at identifying the perceptions, practices and barriers and the needs of general practitioners and specialized physicians in the area of VCT. The HIV-Sub-Saharan African Migrant (HIV-SAM) project was implemented to carry out a research on evidence-based interventions. The HIV prevention and promotion work was undertaken in collaboration with HIV networks. Secondary prevention for PLWHA from the African migrant community included a professionally facilitated patient support group (Muungano) as well as complementary culturally sensitive individual counseling. In addition, in Antwerp preparations were undertaken to offer an English-speaking group to PLWHA. Some initiatives have been taken in the Netherlands by organizations such as AFADAC foundation to ensure that PLWHA obtain help, irrespective of their ethnic background. Research conducted by Gama and colleagues on African migrants in Portugal, also reveals significant association between HIV testing and socio-demographic factors (2010).

In Switzerland, a study looking at health perceptions of African PLWHA and their physicians by Dao and colleagues found that patients and physicians did not agree in their evaluations of patients' health status (2009). Patients did not perceive their health only through biological markers, but also linked their mental health with their socioeconomic existence and context. Findings also indicated that some physicians underestimated patients' biological health and their own evaluations of overall health. Further, the study highlighted the importance of physicians to access and incorporate patients' perspectives in primary care assessments of a patient's health status.

Counseling

The availability of counseling prior to and following HIV testing, whether the test result is positive or negative, is an important stage of service provision. Counseling provides an opportunity to provide information on HIV transmission, protection and resources. Where there is a positive test result, counseling is essential for providing the test-taker with appropriate resources, connecting them with culturally appropriate services and support networks. A study from Canada, which looked at the pre and post HIV test

counseling experiences of African and Caribbean women in Ontario demonstrated that testing consent and counseling experiences were often inadequate (Tharao *et al.*, 2009). This study discusses the impact of missed counseling opportunities including, among others, limited education about HIV and transmission, fear and shock due to inadequate support at time of diagnosis, misunderstanding of plan of action and next-steps for health care and mistrust or perception of differential treatment due to race, refugee status or gender. These outcomes have implications for the treatment, care and support services accessed by mothers and their children post diagnosis.

Prevention and Treatment Information

Studies show that HIV awareness among African migrants is high, however this does not necessarily correlate with testing, treatment or service utilization and perceptions of risk (Burns & Fenton, 2006). A Swiss study identified that sub-Saharan migrant populations had a succinct knowledge of HIV treatment, in spite of feelings of shame and risk that can often hinder access to services (Bischofberger, 2008).

On the other hand, Project Nasah, an initiative investigating HIV treatment information and other needs of African people with HIV/AIDS residing in England found that Africans were eight times more likely to report a need for information about ART than other PLWH (Weatherburn, 2003). They argue that the most widely used treatment information interventions were talking with doctors and nurses and information materials available at GUM clinics. Erwin & Peters examine issues relating to treatment among Black African PLWH in London (2009).

HIV prevention among Black Africans in England is a complex challenge (Owour, 2009). Apart from high HIV/AIDS prevalence, the potential to benefit from available treatment and care is limited by many factors, such as late diagnosis, stigma and discrimination, unemployment, poor living conditions and uncertain immigration status for some. Tarsisio Nyatsanza from Waverley Care, UK explored some of the issues that have been identified by African service users. The two challenges most often mentioned are an anxiety about the understanding of confidentiality within medical services and a lack of trust within the African community itself. 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. With regards to good practice, Terrence Higgins Trust (THT)

devised a street-to-counseling intervention whereby trained counselors interact with young people in non-therapeutic settings in order to become known and trusted.

Williams *et al.* (2009) conducted a study with Black Canadian women to better understand how the attitudes and knowledge of African and Caribbean migrants in Canada would influence the adaptability of HIV/AIDS vaccines and associated prevention methods. The findings of this study are reported in *Sisters, Mothers, Daughters, and Aunties; Protecting Black Women Against HIV/AIDS* a document that discusses the development of a conceptual framework to understand how women from African and Caribbean populations manage prevention strategies (Newman *et al.*, 2009).

Prevention Interventions

Two

key interventions were identified in the US literature. The first is a study examining the impact of the Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention Program, based on an African-Centred Behavioural Change Model that incorporates cultural understanding into behavioural interventions (Nobles *et al.*, 2009). The model posits that behavioural change can be achieved when women engage in re-socialization and culturization, resulting in cultural realignment, increased self-worth and decreased participation in risky sexual practices. Othieno discusses the implementation of the *Rapid Assessment, Response, and Evaluation* intervention developed as part of the *Care System Assessment Demonstration Project* based in Minneapolis-St. Paul and Minnesota (2007). This project was developed to identify barriers to care and to provide prevention resources for community organizations working with underserved minority populations.

Prost *et al* present a literature review exploring the available socio-behavioural and intervention-based HIV/AIDS research on people of sub-Saharan African origin living throughout Europe (2008). Five key categories were identified including (1) HIV testing; (2) sexual lifestyles and attitudes; (3) gender; (4) use of HIV services; (5) stigma and disclosure; (6) immigration status, unemployment and poverty. The study concludes that additional research is required to develop sustainable and evidence-based interventions with effective monitoring and evaluation.

In the Netherlands, *Uma Tori!* Is an evidence-based HIV and STI prevention intervention developed to serve women of Afro-Surinamese and Dutch Antillean descent by

empowering women to be more sexually assertive, to improve communication skills and to negotiate safer sex within their intimate relationships (Bertens *et al.*, 2009). The program also provided participating women with resources and information to increase their awareness of HIV transmission and protection.

In Switzerland, a study evaluating HIV and AIDS prevention for migrants and ethnic minorities has highlighted the need for culturally and linguistically appropriate prevention efforts that use already-existing community structures, as well as the need to identify and train people from within communities to carry out local prevention interventions (Haour-Knipe *et al.*, 1999). Outcome evaluation has shown that a government sponsored HIV and AIDS prevention programme can meet with acceptance by migrant communities; considerable engagement in prevention activities can be mobilized; and AIDS prevention among such communities can be effective. One can argue that such efforts can create levels of sensitivity to HIV issues and of protective behaviour that are equal to those of the host country population.

2.4 Stigma and Discrimination

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). However, factors such as social support, mental health, physical wellbeing, treatment adherence, and “acculturation” were not found to have an influence on disclosure patterns. As stated by Calin and colleagues, disclosure decisions were based on reasoning, interpersonal relationships and individual assessment. This signifies that disclosure and barriers to disclosure are highly personalized, rather than a factor influence by community or cultural ties. Anderson and colleagues looked at HIV and AIDS-related stigma and discrimination experienced among Caribbean people living with HIV/AIDS in the United Kingdom and found that compared to UK-born respondents, the accounts of Caribbean-born respondents, most of whom were born in Jamaica, include more reports of severe HIV and AIDS-related stigma and discrimination, particularly violence and employment discrimination (2008).

A principle theme explored through the literature included the role of HIV/AIDS stigma and culture, as it pertains to self-acceptance, disclosure, survival and coping. Several European studies focus specifically on the impact of discrimination on Caribbean people

living with HIV/AIDS (Anderson *et al.*, 2009; Kalichman, 2009; Anderson *et al.*, 2008; Beier, 2005), linking cultural and faith-based beliefs with experiences of stigmatization and resilience.

In Sweden, Åsander carried out a study looking at social networks, disclosure, parenthood, and knowledge about HIV transmission among African parents living with HIV/AIDS in Stockholm (2010). She found that parents living with HIV/AIDS in Stockholm had small social networks with few persons informed about their HIV status. The lack of a social network was especially prominent among single women, this study discovered.

Several programs address the issues of stigma and discrimination in African and Caribbean communities in UK. For example, the Monya Project implemented by Naz Project London, UK addresses HIV-related stigma among Black MSM (Naz, 2009). A discussion paper was published in 2009 by African HIV Policy Network, Naz Project London and other partners from the HIV sector to discuss on a range of proposals on ways in which Muslim and Christian faith leaders could work together with HIV/AIDS organizations on the issue of HIV/AIDS in the UK and the stigma and discrimination issues related to HIV (AHPN, 2009). The AHPN, in response to this issue, has (through the NAHIP programme and key partners) developed resources for Christian and Muslim faith leaders and African community based organisations. The materials are used to increase the levels of awareness of HIV/AIDS and to change perceptions of HIV/AIDS and Africans in the UK. The AHPN also advocates for the participation of faith leaders in informing key policies regarding HIV/AIDS and African communities and encourages an active approach to challenging stigma and raising awareness. A forthcoming directory of faith based groups undertaking work on HIV/AIDS, is about to be published by AHPN, and this is a practical tool which can be used to signpost services and CBOs across the UK. AHPN, Thomson Foundation, and Panos London have identified the importance of positive media attitude towards the ACBD in HIV prevention, through past and present interventions.

In the US, 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).

Gulland outlines a UK-based intervention involving nurses, tribal chiefs and church leaders who are working together to improve women's access to services (2001). Such cross-cutting and interdisciplinary approaches are a necessary component of tackling the HIV/AIDS epidemic.

Two key studies have been conducted in Canada to address the scope and impact of stigma within ACBD communities. In 2004 ACCHO and researchers from the University of Toronto conducted a study to document how members of Toronto's ACBD communities conceptualize, experience and respond to the stigma, fear and discrimination that are often associated with HIV/AIDS. They produced a report entitled "HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People from African and Caribbean Communities in Toronto", outlining key recommendations and strategies for organizations and institutions serving members of the ACBD community, health-care and service providers, policy makers, faith leaders, education leaders, funding bodies as well as all levels of government (Lawson *et al.*, 2006). Principle strategies include anti-oppression and anti-racism training, increased funding to address HIV-related stigma, collaboration with faith based leaders to address stigma within congregations, community mobilization, greater involvement and respect for PLWHA and media engagement. An earlier study conducted by the HIV Endemic Task Force, the organization that preceded the formation of ACCHO, laid the framework for understanding the impact and scope of HIV-related stigma among ACBD communities in Canada (HIV Endemic Task Force, 2001).

2.5 Knowledge, Attitudes and Practices

It seems that current conceptualizations of HIV prevention, treatment availability and support services are based on indigenous attitudes and beliefs (Beyene, 2000; Gadon *et al.*, 2001). Beyene explores existing discrepancies in the intervention strategies focused on providing effective and culturally-specific HIV transmission and prevention education to Ethiopian and Eritrean immigrant populations that have settled in California (2000). Behavioural patterns associated with a higher risk of HIV were identified including: refusal to use condoms; multiple sexual partners; alcohol consumption; reluctance to access HIV testing (linked to stigma, fear, denial); and traveling between the US and Ethiopia/Eritrea. The author indicates that guidance from community leaders and culturally appropriate programming is required to break "the silence surrounding HIV

risks". Another US study looks at (Eteni & Wood, 2003) the Ethiopian and Eritrean population, with similar outcomes.

Many other studies have focused on perceptions, attitudes, and experiences of Africans living with HIV/AIDS in the Diaspora. The Padare Project, funded by the Camden and Islington Health Authority, in London, aims to develop the methodology and collect preliminary data regarding HIV related knowledge, attitudes and practices (KAP) amongst Africans living with HIV/AIDS and accessing services in Camden and Islington Project (Chinouya & Davidson, 2003). Question domains covered demographics, HIV/AIDS knowledge and attitudes, sexual behaviour, service use, disclosure, sexually transmitted infections, reproduction, discrimination and sexual dysfunction. Of the 214 respondents, 73% of the sample were women. Of the 74% of respondents who reported penetrative sex in the previous month, 40% indicated either occasional or no condom use. 61% of respondents reported having unprotected sex with one or more partners in the previous year. 45% of the sexually active participants who believed they could not contract HIV reported inconsistent or no condom use in the previous month. 20% of the men and 5% of the women in the sample reported having same-sex partners.

Sexual Attitudes and Lifestyles

The Mayisha II initiative is an extensive participatory mixed-methods study exploring the sexual attitudes and lifestyles of African migrant communities in England. The study reviewed the acceptability of oral HIV testing and provided information relevant to culturally-specific behavioural interventions and health promotion activities. Through the combination of qualitative and quantitative methods, the study found out that the impact of discrimination and stigma is widespread within the lives of Africans – influencing their partnership choices, decision to take an HIV test, uptake of services, risk behaviours, and ability to disclose to colleagues and loved ones (Health Protection Agency, 2005; Sadler *et al.*, 2006). The Mayisha II study estimated HIV prevalence and the distribution of high risk sexual behaviours, sexual health service use, and HIV testing among black Africans aged 16 years or over in England (Sadler *et al.*, 2007). A major finding was that despite about half the sample having had an HIV test at some time in the past, 9.2% of respondents had an undiagnosed HIV infection.

2.6 Human Rights: Immigration Status and Criminalization of HIV Transmission

Criminalization

Criminalization of PLWHA for non-disclosure is a concern faced by many African and Caribbean immigrants. Reports from the UK (Elford *et al.*, 2008) indicate that ethnicity and migration status are factors influencing the disclosure patterns of PLWHA. For many, fear of criminalization or prosecution for transmission of HIV represents strong motivations for how disclosure is approached. Meanwhile the criminalization of non-disclosure of HIV status has become a highly racialized and stigmatizing issue, with the majority of cases reported in the media being Black men. Ultimately, the prosecution of HIV-transmission may contribute to greater HIV/AIDS stigma. Although the academic literature on this topic is not expansive, this is an emerging issue of great concern among AIDS service and policy organizations. To address increasing concerns over criminalization of HIV transmission, the Canadian HIV/AIDS Legal Network hosted a 1st Annual Symposium on HIV, Law and Human Rights in June of 2009. In a speech by Justice Edwin Cameron of South Africa's Constitutional Court held during this symposium he noted that "the global trend towards criminalization of HIV is accelerating, with significant human and legal consequences" (2009).

Local ethno-specific AIDS organizations are also developing programs and materials for African and Caribbean clients to address the issue of HIV criminalization (ACCHO, BCAP). A new initiative by Women's Health in Women's Hands is based on the development of an effective and adaptable HIV serostatus disclosure model to assist African and Caribbean women who are negotiating the disclosure process. This intervention incorporates consideration for the legal implication of non-disclosure.

In a paper titled "Criminal prosecutions for HIV transmission: people living with HIV respond", the majority of study respondents expressed concern about the way in which criminal convictions conflict with messages about shared responsibility for 'safer sex', and the extent to which such cases will exacerbate existing stigma and discrimination related to HIV (Dodds & Keogh, 2006). Most felt that the successes achieved by human rights approaches to HIV prevention, treatment, and care were placed under threat by the growing culture of blame encouraged by criminal prosecutions.

Immigration Status

In a 2008 report by National AIDS Trust, (NAT, 2008), entitled "HIV and the UK Asylum Pathway", an overview of the pathway an asylum seeker takes in the UK from

application to either integration or removal was given. This report concluded that further research is needed in this area, and that the role of healthcare staff in providing necessary care to asylum seekers is paramount in protecting public health in the UK. In addition, AHPN has carried out vast work on the issues surrounding deprivation and legal status of African PLWHA in the UK.

The AFAPAC foundation in the Netherlands wrote an article on African migrants facing discrimination and mandatory testing (Adanse-Pipim, 1996). They argue that Africans from sub-Saharan Africa who live in the Netherlands still face discrimination with respect to HIV infection. The policy of the Dutch Blood bank is that persons from Africa and people who have had contact from persons from these areas and especially from Sub-Saharan Africa should not donate blood. 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 migrants 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).

3.0 Literature Findings: Gaps and Opportunities

3.1 Regional Gaps

Europe

Presently there are a number of HIV/AIDS health care interventions and ongoing policy work in the UK, Switzerland and Belgium targeting PLWHA from the ACBD population. Although we were able to identify 17 organizations (NGO's, CBO's) that cater specifically for the needs of the ACBD in the Netherlands, 13 organizations in France, 10 in Germany, 7 in Denmark, 5 in Sweden, and 3 in Portugal, we could not find adequate documentation on the policies and programs addressing the needs of PLWHA of the African Diaspora in these countries. It is possible that such documentation exists, but is not available online. Also, many of the interventions may not have sufficient monitoring and evaluation processes in place.

Despite a large number of migrants, France, Germany and Italy had no concrete strategy or policy, nor adequate freely available and accessible documentation on sexual

health targeted to ACBD populations. The websites of the World Health Organization (WHO) and the International Migration Organization (IMO) were consulted in order to discern possible reasons for the paucity of resources from various countries in Europe. One of the gaps identified was the lack of published research focused on the impacts of HIV/AIDS within ACBD communities. In addition, contacts in Eastern Europe believed the relatively small numbers of ACB populations led to the lack of targeted programs, services and resources. However, we also identified the same gaps in European countries with high ACB populations.

North America

In Canada, the ACBD population is largely composed of African and Caribbean people who have migrated to Canada since the mid 1960s. The ACBD population is mostly concentrated in urban centers (PHAC, 2009). This can be advantageous for outreach, education and service utilization, as well as research purposes. Subsequently, a number of projects have been conducted to better understand the factors influencing HIV infection, diagnosis, treatment, service utilization and disclosure among African and Caribbean populations. These studies mostly do not differentiate between immigrants of African or Caribbean descent, despite research data, service provider recommendations and client feedback. This suggests that distinct socio-cultural factors shape the attitudes, beliefs and coping strategies adopted by each group.

Reporting in Canada is increasingly focusing on the ethno-cultural dimension of the epidemiology of HIV/AIDS. Situational reports and epidemiological updates provide data on how the HIV epidemic has affected people from HIV-endemic countries living in Canada, with reports ranging from 1981-2009 (PHAC, 2009; PHAC, 2005; Remis & Merid, 2004; Remis, 2003; Remis & Whittingham, 1999). These reports have helped to map out the needs and gaps as well as the opportunities for prevention, treatment and support across a national scale and within regional contexts. Additionally, there are a number of Afro-Caribbean organizations providing cultural, faith-based and public health resources and support. These include, Black Coalition for AIDS Prevention (BCAP), the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) and the Africans in Partnership Against HIV/AIDS (APAA).

The experience of Africans and Caribbean populations in the US is outlined quite differently throughout the literature. Although the body of literature out of the US is extensive, most reports and studies focus on African-American populations, rather than specific African or Caribbean Diaspora populations. In most instances, investigations are specific to the national or regional implementation of public health programming and policy as it pertains to socio-cultural considerations. As a result, it can be difficult to distinguish studies that look explicitly at the experiences of ACBD populations from that of African Americans and to draw out recommendations for appropriate programming and support.

Summary of Existing Literature by Geographic Focus

From this research, one can conclude that literature from certain regions is quite limited, and in some cases non-existent (Eastern Europe, and countries in South Europe such as Albania, Andorra and Cyprus). However a large part of this disparity may be accounted for by the relatively small Diaspora population size in these regions. Additionally, some initiatives and project reports may not be available on-line. While the ACBD is extensive throughout several South American countries, few reports documenting existing HIV programming and policy initiatives were identified. A paper by Del Amo and colleagues, researching HIV/AIDS monitoring and evaluation in Europe's migrant communities and ethnic minorities noted that many European countries still have relatively limited systems with which to adequately describe the evolution of infectious diseases among migrant communities and ethnic minorities (2004). While efforts have been made to include country of origin in European HIV/AIDS surveillance, monitoring HIV/AIDS in ethnic minorities has been less successful. Del Amo *et al* pointed out that the involvement of the affected communities and community-based organizations (CBOs) into research processes will facilitate the achievement of common goals and reduce the negative impact of HIV/AIDS on affected communities. These recommendations are likely applicable to the monitoring and evaluation systems in other countries with large ACBD populations.

3.2 Summary of Emerging Themes

Gender and Sexuality

Articles reviewed were mainly observational studies, discussing experiences, perceptions, and attitudes of African men and women living with HIV/AIDS in the

Diaspora. There is little documentation on the programmatic responses and gender sensitive policies for Africans and people from the Caribbean living with HIV/AIDS in the Diaspora. We recommend that there should be more gender-sensitive documentation about successes and challenges of HIV interventions and policies for ACBD populations, especially in countries with large migrant populations.

Institutional Barriers and Socio-Cultural Dimensions

The primary gaps emerging from the literature are largely framed as a lack of culturally-appropriate interventions and policy initiatives to address the needs of ACBD communities. HIV education and awareness found in immigrant populations seems to reflect beliefs, attitudes and behaviours demonstrated in countries of origin, particularly among more recent migrants (Beyene, 2000; Gadon *et al.*, 2001). Although new programs are emerging in response to the needs of migrant ACBD populations, there is still much to document the unique ways that HIV is experienced within Black culture and society. Presently, Diaspora populations lack the political will, as well as the availability of funding and resources they require to effectively manage prevention, treatment and support.

HIV Testing, Prevention and Support

Most of the treatment and prevention research has been conducted in the UK (Health Protection Agency, 2005; Weatherburn *et al.*, 2003), Canada (Williams *et al.*, 2009; Lewis-Peart, 2007; Teclom, 2006) and elsewhere in Europe (Dogan *et al.*, 2005). The body of research on HIV treatment focuses mainly on the provision of treatment and prevention information, as well as the applicability of new strategies (Williams *et al.*, 2009).

In Europe, NHS websites provided information on available treatment options however these treatment protocols and services were not tailored to address the needs of African and Caribbean migrants. Information drawn from North America provides a similar scope of information. In Canada, organizations such as the Black Coalition for AIDS Prevention (BCAP) and the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) have worked extensively to promote HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities, effectively addressing existing institutional gaps.

We have not identified any interventions that aim to know the effect of HIV treatment in shaping people's sense of future. We also did not find any research conducted to know the quality of treatment services for members of the ACBD. Williams *et al.* (2009) and Newman *et al.* (2009) both published reports discussing the acceptability of prevention strategies such as an HIV vaccine among women from the ACBD in Canada. However, beyond this study, there were no additional studies discussing treatment quality and adaptability. Therefore, we recommend that research on the HIV treatment and information needs of ACBD populations should encompass knowledge and attitudes, treatment acceptability and risk perceptions. The development of targeted interventions on treatment is another priority area of research. Research should be targeted to explore the effect of treatment in the lifetime of PLWHA from the ACBD and the quality of available treatment services.

We observed an important point that the needs of ACBD populations are usually lumped together, disregarding the different cultures and backgrounds of these communities. We therefore recommend that the needs of African and Caribbean groups be addressed with regard for the specific needs of people from the ACBD of different countries, faiths or backgrounds.

Stigma and Discrimination

As preventative measures are closely linked to attitudes and understandings about HIV/AIDS, stigma represents a critical area of focus for addressing the transmission of HIV in African and Caribbean communities. Much research has been done to explore how stigma influences service utilization, including testing, treatment, preventative measures and care. Several studies have been produced in the UK and Sweden to address this issue. We could not find any research, policy papers or interventions in the rest of the European Diaspora. The resources reviewed on stigma and discrimination mainly provide information on the causes and impact of stigma in the lives of ACBD people influencing services, choice of partners, family and ART usage. Existing projects focus largely on the empowerment of PLWHA to become advocates for their own care and to normalize HIV, but there are presently no interventions in place that would significantly target broader social support and social conditions for change. The individual effort will not be maximally effective without broader social support.

We recommend that there should be more research work on addressing stigma and impact of it in the lives of ACBD populations and thereafter developing targeted interventions to address this issue. The booklet *Give Stigma the Index Finger*, which documents initial findings from “The People Living with HIV Stigma Index”, is an example of initial steps that can be taken toward this (The People Living with HIV Stigma Index, 2009). The evaluation of anti-stigma and discrimination interventions in the UK can collaborate with national and local networks to disseminate findings. We found a draft action plan to address stigma and discrimination in the UK. The action plan of the Department of Health in the UK incorporates the programme to sensitize broader social support with HIV stigma related issues. There is a need to develop similar policy and action plans in the Western European Diaspora, where there are high migration trends of ACBD populations, as well as in the United States where, according to the US Census and the Migration Policy Institute, Africans are the fastest growing immigrant group in the nation.

Knowledge, Attitudes and Practices

We came across literature reviewing successes of interventions for the ACBD that included a cross-section of the population including MSM (Mayisha 1 and 2, Health Protection Agency, 2005). Other studies focused explicitly on the experiences and needs of MSM (Husbands *et al.*, 2009; George *et al.*, 2007). There were also numerous studies discussing perceptions, attitudes, and experiences of Africans living with HIV/AIDS in the Diaspora (Padare project). Most studies focusing on MSM were UK or Canadian-based. We also did not come across data on sexual lifestyle policies specific to Africans and people from the Caribbean living with HIV/AIDS. We recommend that there should be more documented data on the needs of, and interventions with African MSM, in Western Europe, outside of the UK, in Canada, the US and the Australia.

Human Rights: Immigration Status and Criminalization of HIV Transmission

The AHPN has done vast work on issues surrounding deprivation and legal status of African PLWHA in the UK, in both policy and frameworks for programmatic interventions. We found data from the Netherlands documenting experiences of Africans living with HIV/AIDS and Africans in general, but we did not come across concrete data on policy or outcomes of any interventions put in place outside the UK. We recommend that

countries that have high numbers of ACBD, irrespective of legal and immigration status, should implement sufficient programs to cater for their needs, especially individuals living with HIV/AIDS.

4.0 Recommendations

4.1 Policy and Programming Recommendations

Areas where there are opportunities for policy and programming improvements are also identified throughout the literature. The overwhelming message emerging from studies in Australia, Canada, the US and the UK suggest that HIV interventions, including education and programming should be developed according to socio-cultural characteristics, demographics and migration status. Moreover, there is a need for greater participation and contribution by PLWHA from the ACBD throughout the development, implementation and evaluation of research, programming and policy initiatives.

Applying a *Social Determinants of Health Lens*

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

Ethno-specific Contexts

Another theme that was prevalent in the literature was the impact and effectiveness of advocacy campaigns and public health interventions aimed at ACBD populations (Bertens *et al.*, 2009). The development of effective HIV prevention and treatment education and programming hinges on a better understanding of the information needs of ACBD communities. Regional experience, language, culture, community, migration status and social networks all play a role in the development and delivery of information. Greater awareness of the unique ethno-specific contextual factors that impact the success of targeted community and individual interventions is needed. Moreover, African

and African-Caribbean groups be addressed separately, and the specific needs of each group addressed.

Gender-focused Programming and Policy

There should be more gender-sensitive documentation about successes and challenges of HIV interventions and policies for African Diaspora particularly focusing on the experiences of young men and women, and how gender shapes attitudes, beliefs and experiences. The literature and programmatic responses to transgendered (TG) people living with, or affected by HIV/AIDS was also lacking.

The Power of Community Mobilization: Knowledge and Resource Sharing

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). This is viewed as a way to mitigate personal risk perceptions and prevention/testing/treatment attitudes. Studies have also demonstrated that many Diaspora communities are knowledgeable about HIV/AIDS transmission routes, protection methods and treatment availability; however the delivery and context of public health messages may influence how this knowledge is applied. Existing evidence-based practices and interventions on prevention, treatment, care and support from the UK, the US and Canada should be shared across global contexts, particularly in areas where resources are more sparse (Western Europe; areas of Canada and the US; Australia; New Zealand).

Stigma and Discrimination

Targeted interventions that account for race, gender and sexuality are required to address the impact of stigma, self-image and discrimination as well as the barriers it creates for people accessing prevention, treatment and care services and separately how they navigate their lives as PLWHA including disclosure to family, friends and service providers.

National HIV Policy Directives

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

testing and disclosure that reflect the needs and diversity of ACBD populations. It is also imperative that communities are properly engaged in the development of policies that affect their lives and that resources are targeted at the defined priorities and needs of communities. This should include government-led policy initiatives, informed by the ongoing work of national and international policy think tanks, working with and represented by members of the ACBD (ex: Black AIDS Institute, African HIV/AIDS Policy Network).

Capacity Building and Service Collaboration

There is room for greater exchange of information, collaboration and capacity building among policy makers, major donors, community-level service providers and PLWHA, to build on the existing body of knowledge at country, regional and global scales. There is also a need to identify gaps in the current research, to engender good practice interventions and engage in the policy development process.

Legal and Immigration Resources

An assessment of existing policies, legislations and laws that negatively impact members of the ACBD 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 ACBD populations at a disadvantage and higher risk for HIV transmission. Further, we need to identify how ACBD communities understand and access their legal rights, and highlight community developed responses and solutions to the diverse and interrelated legal and migration issues experienced by ACBD populations.

Part of this evaluation process should involve studies that identify the knowledge, attitudes and practices of members of the ACBD in terms of accessing appropriate services and supports, and understanding their rights. Studies should also explore how communities respond to policies, legislation or laws that disproportionately impact members of the ACBD. This should also include consideration of the impacts of the criminalization of HIV transmission and migration policies that limit or exclude the HIV services and treatment options available to refugee and migrant populations.

4.2 Research Priority Areas

The following list outlines some of the key research priority areas that were identified in the literature.

Age Disparities

The majority of studies focus on the experiences of African and Caribbean migrants 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. Additional studies are required to inform effective policy and programming responses to the needs of older adults and youth, two ends of the age spectrum that seem to be largely neglected in the literature, although they continue to be greatly affected by the impact of HIV/AIDS

Street Involved People, People who Inject Drugs and People who are Incarcerated

There is a need for ethno-specific data on the needs of street involved people, people who inject drugs and people who are incarcerated from the ACBD who are at an even higher risk of being infected by HIV and at the same time require culturally-specific services

The Role of Sexuality in Prevention, Treatment and Care

There should be more documented data on the needs of, and interventions with African and Black sexual minorities including gay men or men who have sex with men. Additionally, there is a gap in the data on bisexual people and women who have sex with women or gay women.

Immigration Status

Another area that could be further expanded is the way that migrants are conceptualized in the literature. While some studies look at the experiences of recent migrants, many studies do not report the length of time that members of a community have been living in their surrogate country. Doubtless, the length of time that a person has been

established in a new country has implications for the way that health care and wellbeing are managed, including access to services and personal agency. This may also have implications for protection, testing, treatment, service utilization and participation in support groups and programming. For instance, the experience of ACBD populations who settled in Canada will be different from the experiences of migrant Africans in other countries, in terms of language, familiarity with existing social services and available programs, membership or participation in faith-based, cultural or ethno-specific groups, knowledge, attitudes and beliefs. At the same time, European reports focusing on the experiences of recent migrants provide insights that may not be applicable to the experiences of people who have settled in Canada or the US for longer periods of time.

4.3 Next Steps

Global Consultation Survey

Following the completion of the literature review, a global consultation will be conducted. A survey has been created for this purpose based on literature review findings and governing council member recommendations. The goal of this survey is to identify best practices, and gaps within current health promotion, programming and policy responses to HIV/AIDS within ACBD communities. It will be distributed to the individuals, organizations and networks identified through the global inventory. At least 150 surveys will be distributed and tabulated using Survey Monkey (See Appendix B). The survey will be available in English, French and Spanish. Additional languages will be made available where applicable. For a more in-depth exploration of the themes identified throughout the review, 30 brief interviews will be conducted with key informants from Canada, the United States, Europe, the Caribbean and Australia.

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6.0 Appendices

Appendices

Appendix A: Internet Resources

International
<p>AIDS Portal http://www.aidsportal.org/</p> <p>Avert http://www.avert.org/</p> <p>The Body http://www.thebody.com/</p> <p>International HIV/AIDS Alliance http://www.aidsalliance.org/</p> <p>International Organization on Migration (IOM) http://www.iom.int/</p> <p>The Joint United Nations Programme on HIV/AIDS (UNAIDS) http://www.unaids.org</p> <p>World Health Organization (WHO) http://www.who.int/</p>
Canada
<p>AIDS Committee of Toronto (ACT) www.actoronto.org</p> <p>African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) http://www.accho.ca/</p> <p>African Partnership Against AIDS (APAA) http://www.apaa.ca/</p> <p>Black Coalition for AIDS Prevention (BCAP) http://www.black-cap.com/</p> <p>Canadian AIDS Treatment Information and Exchange (CATIE) http://www.catie.ca/</p> <p>Canadian HIV/AIDS Legal Network http://www.aidslaw.ca/</p> <p>HIV Studies Unit http://www.hivstudiesunit.ca/</p> <p>Ontario HIV Treatment Network (OHTN) http://www.ohtn.on.ca/</p> <p>Public Health Agency of Canada (PHAC) http://www.phac-aspc.gc.ca/</p> <p>Women's Health in Women's Hands (WHIWH) http://www.whiwh.com/</p>

Europe/UK

African HIV Policy Network (AHPN)

<http://www.ahpn.org/>

European AIDS Treatment Group (EATG)

<http://www.eatg.org/>

European Centre for Disease Prevention and Control

<http://www.ecdc.eu.int/>

Health Protection Agency (HPA)

<http://194.74.226.162/>

National AIDS Map (NAM)

<http://www.aidsmap.com/>

National AIDS Trust (NAT)

<http://www.nat.org.uk/>

United States

Black AIDS Institute

<http://www.blackaids.org/>

Center for Disease Control and Prevention

<http://www.cdc.gov/>

Coalition for a National AIDS Strategy

<http://nationalaidsstrategy.org/>

National Minority AIDS Council

<http://www.nmac.org/>

South America

La Red de Mujeres Afrolatinoamericanas, Afrocaribeñas y de la Diáspora

<http://www.mujeresafro.org/>

Caribbean Regions

Caribbean Vulnerable Communities (CVC)

<http://www.cvccoalition.org/>

The Pan Caribbean against HIV/AIDS

<http://www.pancap.org/>

Appendix B: Global Consultation Survey

AB-DGN Global Consultation Questionnaire

We are conducting a global consultation on behalf of the African/Black Diaspora Global Network on HIV and AIDS (AB-DGN). The AB-DGN works to strengthen the response to HIV and AIDS epidemics and associated stigma and discrimination among African/Black communities in the Diaspora using a rights-based approach. We envisage that as a unified “network of networks”, we will share community experiences of triumph, hope and success and together build effective responses to address the multiple impacts of HIV and AIDS on the lives of African/Black people living in the Diasporas.

Our goal for this consultation is to identify key individuals, organizations and institutions engaged in policy and programming responses that address the needs of HIV positive and/or at-risk African, Caribbean and Black communities living in the Diaspora. We are also seeking to document the strategies and interventions being undertaken with our target populations across various global regions. As an active contributor to this cause, we invite you to complete this brief survey to help us in the development of a global inventory of organizations, individuals and evidence-based interventions.

A. General Details

Name:	
Country of Origin:	
Current Country of Residence:	
Position/Title:	
Organization Name:	
Organization Target Population:	
Organization Website Address:	
Organization Scope of Work Related to HIV and AIDS for African and Black Populations in the Diaspora:	Describe:
Are you an independent consultant?	YES NO
Email:	
Telephone:	
Skype Address (if applicable):	
Mailing Address:	

Please indicate any **organizations, networks or groups** you work with locally, regionally or internationally to address HIV and AIDS for African and Black populations living in the Diaspora.

Name:	
Website Address:	
City and Country Location:	
Type (i.e. NGO, Peer Group, Research Institution)	
Name:	
Website Address:	
City and Country Location:	
Type (i.e. NGO, Peer Group, Research Institution)	
Name:	
Website Address:	
City and Country Location:	
Type (i.e. NGO, Peer Group, Research Institution)	
Name:	
Website Address:	
City and Country Location:	
Type (i.e. NGO, Peer Group, Research Institution)	

B. Profile of the African and Caribbean Community

- 1) Where do African and Black people in your region live? Please check all that apply
- In the city and other urban centres
 - In rural communities outside of the city and urban centres
 - In ethnic specific neighbourhoods
 - Spread out across the region

- Don't know
- Other
- Additional comments or information:

2) What are the most common countries of origin for the African and Black populations living in your region? Please list below

-
-
-
-
-

3) How would you describe the current level of stigma and discrimination surrounding HIV/AIDS in your region?

Stigma and discrimination within African and Black communities	Low	Medium	High	Very High
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stigma and discrimination from outside African and Black communities	Low	Medium	High	Very High
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) What are the primary sources of stigma surrounding HIV/AIDS within the African and Black communities in your region? Please check all that apply

- Gender
- Sexuality
- Race and ethnocultural background
- HIV/AIDS status
- Level and type of employment
- Level of education
- Religious affiliation
- Legal status within country
- Marital status
- Age
- Income
- Physical Mobility
- Country of Origin

Any additional comments?

B. Service, Resource and Program Utilization

1) Please tell us the names of the organizations or programs where African and Black populations in your region access HIV/AIDS services, resources and programming?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

2) Generally speaking, who is accessing services, resources and programming through your NGO, organization or institution? Please list below:

- Recent immigrants (migrated within the past 5 years)
 - Seasonal migrants
 - Long-term permanent residents (residing in the region for 5 years or more)
 - All of the above
 - Don't know
 - Other _____
-

3) Are the services, information, resources and/or programming provided by your NGO, organization or institution directed to a specific group of people? If so, please specify below:

- Women
 - Men
 - Youth/Children
 - Older Adults
 - LGBTQ (*Lesbian, gay, bisexual, transgender/transsexual/two-spirited, queer/questioning, including MSM and WSW*)
 - Country-specific (Please indicate which countries if this is the case)
 - Faith-based (Please indicate which faith or affiliation if this is the case)
 - Other _____
-

4) Does the country of origin of African and Black populations reflect who is accessing services, resources and programming?

- YES
- NO

Please explain in more detail:

What groups are not accessing services, resources and programming?

Please explain in more detail:

C. Policy and Programming Responses

1) How would you describe the current policy response to HIV/AIDS for African and Black populations in your region?	Very Poor	Poor	Good	Excellent
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q	q	q	q
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Additional Comments?

2) How would you describe the current programmatic response to HIV/AIDS for African and Black populations in your region?	Very Poor	Poor	Good	Excellent
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q	q	q	q
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Additional Comments?

3) Does your region currently have campaigns, promotion strategies or interventions to address ethno-specific HIV stigma?

- YES
- NO

If you answered yes, please describe the name of the campaigns, programs or strategies, and the organization(s) responsible below:

4) How were these campaigns or programs launched and/or implemented? Please check all that apply

- On-line (e.g. website, twitter, Facebook)
- Public print media Campaign
- School-based (high school or university/college)
- Through a community group or center
- In a specific geographic region (ex. neighbourhood)
- Within a specific ethno-community (based on country of origin)
- Through a faith-based group
- Workplace
- Public venues (transit, public areas/parks)
- During specific events (e.g. festival, conference, workshop)

5) Please identify up to 5 recent campaigns that have been successful. Please include details.

Name of campaign	
What approach was used? Why was it successful?	
Name of campaign	
What approach was used? Why was it successful?	
Name of campaign	
What approach was used? Why was it successful?	
Name of campaign	
What approach was used? Why was it successful?	
Name of campaign	
What approach was used? Why was it successful?	

6) Please identify up to 5 recent campaigns that have not been successful. Please include details.

Name of campaign	
What approach was used? Why was it not successful?	
What approach was used? Name of campaign	
Why was it not successful?	
Name of campaign	
What approach was used? Why was it not successful?	
Name of campaign	
What approach was used? Why was it not successful?	

Name of campaign	
What approach was used? Why was it not successful?	

7) What are the best locations to promote programs/services/campaigns targeted at African and Black populations in your region?

- Cultural Organizations*
- Faith-based Groups*
- Community Centers*
- Sporting Clubs*
- Ethno-specific neighbourhoods*
- In the workplace*
- Organization websites*
- Government/Immigration service organizations*
- Local ethno-specific newspapers*
- Ethno-specific stores (e.g. grocery, barbershops, travel agencies)*
- Other* _____

Any additional comments?

8) What type of media is generally most effective in reaching out to African and Black populations in your region? Please check all that apply:

- Radio*
- Internet*
- TV*
- Cell phones (ex SMS)*
- Poster Campaigns*
- Public presentations in community venues*
- Workshops*
- Mail-outs*
- Videos*
- Word of mouth*
- Other* _____

9) Has your organization developed any tools to evaluate the programs, services or campaigns you are involved in targeted at African and Black populations in your region?

- YES
- NO

If you answered YES, please explain:
