

Kensington, Chelsea & Westminster BME HEALTH FORUM:

**TASK GROUP ON FEEDBACK FROM BME
COMMUNITIES ON HIV AND SEXUAL HEALTH
SERVICES**

FINAL REPORT:

SUMMARY AND RECOMMENDATIONS FROM COMMUNITY
CONSULTATIONS

March 2002

The BME Health Forum was asked to facilitate an initiative aimed at getting feedback from BME community groups on issues related to access to HIV Treatment & Care Services, HIV Prevention Services and Sexual Health Services by KCW Health Authority.

The aim of the project was to look at unmet need, as well as ways of ensuring that services are culturally appropriate for Black & Minority Ethnic Communities. The aim of the Task Group was to facilitate local community groups working with black and minority ethnic communities, to be commissioned and funded to run a series of consultations with communities and users with whom they work.

The BME Health Forum would like to thank all those who participated in the Task Group, and especially representatives from community groups who held consultation events in their communities.

METHODOLOGY

The Task Group was made up of representatives from community & voluntary groups, as well as statutory agencies. Monthly meetings were held throughout the process, for a period of 6 months. Community groups were funded to run consultation events with their users and communities, a number of which were run jointly with statutory agencies. The aim of these consultation events was to get feedback from BME communities on their knowledge, experiences and attitudes on HIV and sexual health services. Feedback from qualitative and other research papers that have recently been produced by agencies in KCW has also been included.

This is the final report from the Task Group, that includes findings from the consultations, and recommendations for future service provision. Although this is the end of the Task Group, the group will continue to meet under the auspices of Kensington & Chelsea and Westminster PCTs. The first activity of the new group will be to have a one-day workshop with all members of the Task Group, that will be facilitated by an external trainer to develop an action plan to take forward the recommendations from the report. The BME Health Forum will continue to be involved in this group, as well as to lobby for the recommendations from this report to be taken up by service providers and commissioners.

An important outcome from this Task Group has been the process adopted for the community consultations. A capacity development process was adopted; this involved a training session on how to run community consultations; preparation and planning for running community consultations; development of a pro forma questionnaire; and involvement of the groups and organisations engaged in the process and policy-development aspect of the Task Group. Members of the Task Group felt that the support, training and resources that were provided helped them to run better-planned and more strategic consultation events, that they could see would feed into the policy-making and commissioning process for services.

It is envisaged that after a year, the BME Health Forum – with the members of the Task Group - will conduct a mini-evaluation of developments regarding the recommendations and findings of this report.

Consultations undertaken:

- Two consultation events organised by *African People's Link* with BME Communities from East and West Africa who are residents of KCW (Nov 2001) - 23 service users; 39 participants at a general event
- Notes from two consultation events undertaken by *Parkside NHS Trust* on Sexual Health in the Iraqi Community
- Report from Consultation event organised by *NAZ Project* with Portuguese-speaking gay and HIV+ men (Dec 2001) - 7 gay HIV+ men from Portuguese-speaking Diaspora
- Consultation event organised by the Egyptian Women's Group (in partnership with *Parkside NHS Trust*).

Other Reports:

- A European Qualitative Study Looking at the Knowledge and Attitudes of Immigrant Communities Towards Mother- to -Child Transmission of HIV (UK Collaborators (Aug 2001) – *Al-Hasaniya Moroccan Women's Centre, European Forum on HIV/AIDS Children and Families, Newham Healthcare NHS Trust, College of Health*)
- Final Project Report (Nov 99) –African Women's Health Project- Sudanese and Eritrean Women (*Migrant & Refugee Communities Forum*)
- Personal Assignment: 'Why HIV Positive Black Africans in London Access Health and Relevant HIV Support Services Late' (Nov 2001), (Mary Makarau, *Parkside NHS Trust*)

MEMBERS OF TASK GROUP & PROJECT STEERING GROUP

Elizabeth Allimadi	African People's Link
Peter Bradley	KCW Health Authority
Joan Chakaodza	London Lighthouse
Yohannes Fassil	KCW Health Authority
Grace Manyika	Malawi HIV & AIDS International Network (MAIN)
Manjit Roprah	NAZ Project London
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Mary Makara	Parkside Health
Faith Ndirangu	Uganda Youth Support Group
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Molly Obanshi	Uganda Youth Support Group
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Andrew Reece	RBK&C Social Services
Mohamade Jawata	Parkside Health
Ciaran McKinney	Streetwise Youth
Bridget Davies	Minute taker – BME Health Forum
Samira Ben Omar	BME Health Forum
Aisling Byrne	BME Health Forum

Other organisations involved in Task Group:

Karima Koia	<i>Al-Hasaniya</i> Moroccan Women's Centre
Dr Shatha Jafar	Iraqi Community Association

FINDINGS

1. AWARENESS AND QUALITY OF MAINSTREAM SERVICES

- Although service users from East and West African communities are **much better informed** of services provided both locally and London-wide – both mainstream services, as well as community-sector services, there is still the issue of other BME communities' lack of awareness on HIV/sexual health issues and services available – for example, North African, Asian communities, Middle Eastern and South American communities.
- People from East and West African communities were **generally very happy with services** offered by hospitals and their staff, as well as voluntary and community sector providers.
- Users were also **aware of supplementary services provided** – e.g. hot meals services, skills training, treatment information updates, peer support, informal family support
- Users suggested a **confidentiality contract** with health and social care service providers to give reassurance that confidentiality would be respected at all times. This would be especially useful – in various community languages - for new arrivals to Britain who may have had bad experiences of health professionals abroad. One study found that HIV+ Africans delay presenting for treatment (including after being diagnosed by a GP) due to worries about confidentiality:

“People are afraid of the community – that those around you will know you're infected. So they're afraid of going to the doctor because if you're diagnosed the news will get around ... because you've been seen going to a place where they treat HIV/AIDS” (French-speaking man)¹

¹ All quotes are from A European Qualitative Study Looking at the Knowledge and Attitudes of Immigrant Communities Towards Mother-to -Child Transmission of HIV (UK Collaborators (Aug 2001) – *Al-Hasaniya Moroccan Women's Centre, European Forum on HIV/AIDS Children and Families, Newham Healthcare NHS Trust, College of Health*)

- Users felt that there is a **lack of confidentiality** for people in temporary accommodation.
- Concern was raised about lack of confidence in hospital using **sterilised equipment**, and worries people have about catching infections from hospitals and from blood transfusions – one participant from Central Africa explained:

“We used to call it ‘the scourge’ because HIV was an illness that devastated, killed lots of people. In 1992 there were no more blood donors because then there would be tests on your blood to find out if it was safe and if you had your blood tested you might know that you’d been infected and were going to die”
(French-speaking man)

- It was recognised that BME patients are generally **diagnosed** as HIV positive **at a much later stage** compared to the white community
- People were worried about an **increase in AIDS-related deaths** amongst BME patients
- There was a strong feeling that there was **poor compliance** in rehabilitation and treatment

2. GENDER ISSUES

- In general, women from East and West African communities were more knowledgeable than men in the same communities. **Men have less contact with health professionals** and have a higher mistrust of professionals than women. This is in part due to cultural expectations of men as ‘macho’ – both in African, Arab and other cultures.
- Women were concerned that **men/partners are still not sharing information**, and professionals do not do enough to encourage partners and families to do so. Men also expressed their jealousy at women having more information about health than themselves, at times leading to them banning their wives from attending health sessions.
- Men from Iraqi/Arab backgrounds wait until symptoms are very acute before they seek help and treatment – initially through an Arabic-speaking doctor at the community centre.
- Iraqi men felt that their sexual health needs should be addressed in a **men-only environment**, because if they are not addressed this leads to frustration about health and sexual health issues which can lead to violence against their wives.
- Some women felt that they knew their husbands had extra-marital affairs and that they might have a sexual health problem, but did not seek help, so suffered in silence.
- Women users of sexual health services said they would be more likely to use clinics if they knew that all **staff were women** and that interpreters could be booked.
- Women felt that their concerns about **fertility and IVF** were more important to them than sexual health or HIV. They did express concerns about thrush and urine infections.

3. DIFFICULTIES IN ACCESSING SERVICES

- Difficulties in **accessing information** were still experienced: language problems, information too complicated, transport problems, stigma & fear of harassment and discrimination, ignorance in communities, borough boundaries, cultural barriers and information available through certain channels only – not available in places like pubs, libraries, schools, night clubs, etc., and the lack of information for people who are illiterate.

“Then depending on whether it is positive or negative, they give you advice about where to go. And that way you begin to find out how to integrate yourself. But when we arrive [here in UK] we have communities who are already here and you can get information from them. But you don’t know if it’s based on ignorance or not” (French-speaking man)

People in this [the Congolese] community wouldn’t want to think about it, about the possibility of having AIDS” (French-speaking man)

“There are a lot of people who’ve got the AIDS virus who go right away to Manchester or places like that. And they don’t just go to live there but to find a place to get treated where other people won’t recognise them” (French-speaking man)

- **Young people** find it difficult to access information as it is not distributed through channels such as youth magazines, libraries, local youth clubs, the internet, night clubs, etc:

“I remember back in 1992, they had meetings, cartoons, games for young people to inform them and people in general that AIDS kills. It was on the radio every day” (French-speaking man)

- All groups of users felt that a major problem in accessing services was the **‘Borough boundaries’ limitations**. This applies to statutory service providers, as well as the voluntary sector – for example, London Lighthouse. Users felt that services should be provided based on need and not on where people live.
- Information is **not available in all languages** required – e.g. Swahili, Shona, Luganda, Zulu, Yoruba, Portuguese.
- In addition, **interpreting services** are not available in all languages required.
- Some users said that they would **prefer to use Language Line** or anonymous telephone interpreting rather than interpreters, due to the embarrassment caused. Some users said that GPs do not always offer Language Line as an option because it is so expensive.
- There is a **lack of childcare places**, and users felt that providers need to be more flexible. Most hospital HIV services do not have crèche facilities; thus women do not feel able to access these services.
- Users felt that as **community organisations** are very accessible, they are good places to provide culturally-appropriate services.
- Suggested a Portuguese HIV/AIDS and Sexual Health **Helpline**.
- Users suggested services -providers having facilities for **patients to access the internet** to assist with information on treatments, etc., as well as for friendship and social purposes ,to break down isolation and vulnerability.

- Patients suggested weekly/monthly sexual health sessions at GP' surgeries run by nurses – with interpreters from the main community languages.
- People's concerns and worries about their **immigration status, financial insecurity**, etc. prevent them from seeking diagnosis and treatment.
- A number of users said that their first point of contact for help was a **pharmacist** – especially for ailments like thrush; they are too embarrassed to go to their GP.

4. POVERTY AND SOCIAL EXCLUSION

- Users felt that as many individuals and families live in poverty and social exclusion, service users should be reimbursed for their **travel fares** if they are unemployed. It was felt that time restrictions on 'freedom passes' should be removed. Users felt that they suffer from the expense of living in London where many people can only obtain low-paid jobs.
- Centres should also provide **free culturally-appropriate meals**.
- **Support groups** in various community languages were popular – with focused training on assertiveness, self-esteem, etc.
- More **events** aimed at reducing exclusion should be organised and funded – e.g. cultural events.
- Users requested more **training opportunities** on self-confidence and self-esteem, peer education and employment skills.
- Gay men from BME communities felt that they face **double discrimination** – from the host community, as well as discrimination for being gay and HIV+ from their own community. In some cases, they also experience hostility from mainstream gay community.
- Public information aimed at eradicating stigma is important – for example, to ensure that people do not have the impression that HIV/AIDS is confined to poor black people:

“... They talk of the African continent, of Sub-Saharan countries, not Europe or America. It's stigmatising ... they also think white people are immune and don't get this illness. So people know how it's transmitted but it's also necessary that people know what the statistics are in Europe and worldwide”
(French-speaking man)

5. HEALTH AND SOCIAL CARE PROFESSIONALS

- Users had the perception that **social services staff are less sympathetic** to HIV/AIDS service users than health professionals. Users also felt that GPs are not sympathetic, and reception staff at some mainstream providers' offices can be intimidating (i.e. London Lighthouse)
- Users felt that often **services are not co-ordinated**
- More and improved **cultural awareness training** should be provided for all staff – including front-line staff like receptionists.

6. SUPPLEMENTARY SERVICES

- Users dislike the fact that organisations which offer training courses award **certificates** with the provider's name on the certificate - they felt that certificates should be provided by external bodies, with no reference to HIV/AIDS.

7. PARTICULAR ISSUES FOR ASYLUM SEEKERS

- Asylum Seekers who are HIV positive have major problems when they receive **vouchers** to live on. Although these are being reviewed, people continue to receive vouchers.
- Information on health services given to newly-arrived Asylum Seekers should include information in various community languages on HIV and Sexual Health services available:

"The main problem in our community is lack of information. When I entered the country they gave me a little booklet about refugees' rights. But there wasn't one about what to do if you have a health problem" (French-speaking African man)

8. PREVENTATIVE WORK

- To help earlier detection amongst BME communities, **schools** should include HIV/AIDS and sexual health issues as part of the curriculum.
- **Faith and religious leaders** should be involved in HIV/AIDS and sexual health awareness initiatives:

"When there's a crisis of emotions, what can give you calm is prayer and if you can't find a pastor to calm you or a healer or someone like that ..." (French-speaking man)

- More emphasis needs to be put on getting across **benefits of early detection**:

"It's true that they look after you and treat you carefully so that you're not a danger to others. I think the British government do these things so that people are encouraged to come forward for treatment" (French-speaking man)

- **Basic awareness** on HIV and sexual health issues are still not understood in many communities – e.g. belief that you can catch HIV from toilet seats, etc. leads to rumours and hearsay. In cultures where women have to be virgins at marriage, younger women have anal sex with men in the belief that they will still be virgins despite this practice. Similarly, infections like thrush go untreated for a long time due to embarrassment and shame.

"When I am on the bus, I get paranoid about holding on to the pole. I keep thinking that I can catch it just by touching" (Arabic-speaking women)

- It was felt that there was poor awareness amongst BME communities of **clinical trials**

- It was felt that there is **less effective** primary and secondary prevention amongst BME communities
- Awareness sessions should also be run, aimed specifically at **young people**
- Patients from Arab backgrounds felt that the best way to get across information on sexual health was through **magazines and Arabic TV/radio** – as people do not talk about this with friends or family.
- The best way for raising awareness is through specific sessions in various **community languages** by health professionals or community workers who speak these languages.
- As a result of the stigma surrounding HIV/AIDS in many BME communities, users said that both men and women do not tell their spouse, which can lead to problems where children are concerned.
- As part of an awareness-raising campaign, to make **statistics** about the incidence of HIV and sexually-transmitted illnesses (STIs) in Europe more widely available:

“If you look at the research papers on the internet, you’ll see what the statistics are for Africa, but not for here in Europe. They don’t say what the effect of this illness is in Europe. People in Europe aren’t interested in what the toll of AIDS has been but there are Africans living in Europe who need to know” (French-speaking man).

- Awareness programmes need to **demystify** HIV and STIs and work towards breaking down the mentality of fear. Communities raised concerns about fears of being **ostracised** by their community that leads to reluctance to being tested and to seeking treatment.

“In Algeria, for example, you wouldn’t say that some had AIDS, you’d say they had cancer” (French-speaking woman)

- Educate and inform **religious leaders/spiritual advisers** about HIV and STIs.
- Encourage people who have HIV, regardless of their ethnic background, to **share their experiences** and talk about services available.

9. GOOD PRACTICE IN THE PROCESS OF RUNNING COMMUNITY CONSULTATION EVENTS AND COMMUNITY INVOLVEMENT IN POLICY DEVELOPMENT AND COMMISSIONING FOR SERVICE PROVISION

- An important outcome from this Task Group has been the **process** adopted for the community consultations.
- A **capacity development** process was adopted; this involved organising a **training session** on how to run community consultations, with resources and materials provided; **support** on preparation and planning for running community consultations; development of a **pro forma questionnaire**; and involvement of the groups and organisations engaged in the **process and policy-development aspect** of the Task Group.
- Members of the Task Group felt that the support, training and resources that were provided helped them to run **well-planned and more strategic consultation events**, and to enable them to see how their feedback would feed into the policy-making and commissioning process for services.

- Given this, it was suggested that as good practice, **NHS Trusts should offer capacity development and resource support to community groups** when they are involved in consultation events. This should include payment to the group (for venue, refreshments, childcare, etc.), training on running sessions, production of a pro forma on the aims and objectives of the session, involvement in process of how feedback will be taken up by commissioners and service providers, and involvement in meetings related to the project throughout its duration.
- Given the **requirements of the Race Relations Amendment Act** and the obligation to involve BME communities in consultation and all aspects of the organisations' policies and procedures related to race equality, together with developments relating to the new public and user involvement structures (PALS, Patient Forums, local Commissions, etc.), these good practice recommendations will assist NHS bodies with these requirements.
- It was suggested that the requirement to involve communities in consultation initiatives – as per the Race Relations Amendment Act – should be **built in to service level agreements and contracts** with service providers (statutory and voluntary) to ensure that this process is mainstreamed and that consultation and feedback is received in a sustainable and effective manner.
- One of the first activities of the group in its new format (facilitated by the PCTs) will be to have a **one-day workshop** with members of the Task Group that will be facilitated by an external trainer **to develop an action plan** to take forward the recommendations from the report.

RECOMMENDATIONS

FOR SERVICE PROVIDERS & COMMISSIONERS

(i) Recommendations for mainstream service providers

1. Develop guidelines for **good practice for collaborative work** between statutory providers and community groups – community development, health promotion and education initiatives
2. Need to develop **guidelines and produce publicity on rights and entitlements for refugees, asylum seekers** and migrants vis-à-vis entitlement to services, issues regarding dispersal, etc. – in light of new Asylum Laws vis-à-vis reception, accommodation and detention centres, and policies on removals and deportations
3. Need to improve **early detection systems for refugee and asylum seeker** communities and groups – to include aspects relating to GPs
4. Need to include cultural awareness aspects issues related to HIV/sexual health issues in **diversity training** programmes for professional staff
5. Need for **better understanding of local African communities** in KCW – languages, religion, cultures, practices, etc.
6. Need for **specialised interpreting services** for HIV service users

7. Need to develop initiatives to **recruit and train volunteers** to give non-clinical support and care
8. Users suggested that a **confidentiality contract** with health and social care service providers be drawn up in various languages, to provide reassurance that confidentiality would be respected at all times.
9. Statutory providers need to take into account the fact that for users and patients, '**borough boundaries**' are not relevant at the community level, and at times inhibit access to services. This applies to statutory service providers, as well as the voluntary sector – for example, London Lighthouse. Users felt that services should be provided based on need and not on where people live.
10. Service- providers should look into the possibility of using **Language Line** or anonymous telephone interpreting rather than interpreters, to ensure that users' concerns about confidentiality are respected. Some users said that GPs do not always offer Language Line as an option because it is so expensive.
11. There is a **lack of childcare places** where services are provided, thereby restricting access. Most hospital HIV services do not have crèche facilities, thus women do not feel able to access these services.
12. Suggested a Portuguese HIV/AIDS and Sexual Health **Helpline** be developed
13. Users suggested service- providers having facilities for **patients to access the internet** to assist with information on treatments, etc., as well as for friendship and social purposes, to break down isolation and vulnerability.
14. Regular sexual health sessions at GP's surgeries run by nurses – with interpreters from the main community languages – were suggested to improved access to services.
15. Given that a number of users said that their first point of contact for help was a **pharmacy**, adequate support and information should be provided to pharmacists to pass on to users.
16. Users felt that as many individuals and families live in poverty and social exclusion, service- users should be reimbursed for their **travel fares** if they are unemployed. It was felt that time restrictions on 'freedom passes' should be removed. Users felt that they suffer from the expense of living in London where many people can only obtain low-paid jobs.
17. More and improved **cultural awareness training** should be provided for all staff – including front-line staff like receptionists.

(ii) Recommendations for services provided in the community

18. Community Centres should be funded to provide **free culturally-appropriate meals**.
19. **Support groups** in various community languages were popular – with focused training on assertiveness, self-esteem, etc.
20. More **events** aimed at reducing exclusion should be organised and funded – e.g. cultural events.
21. Users requested more **training opportunities** on self-confidence and self-esteem, peer education and employment skills.
22. Users dislike the fact that organisations which offer training courses award **certificates** with the provider's name on the certificate - they felt that certificates should be provided by external bodies with no reference to HIV/AIDS.

HEALTH PROMOTION

23. Health promotion information provided to users needs to **reassure the public** that all hospital equipment is **sterilised** and all blood for transfusions is checked, to ensure that it is impossible to be infected by HIV or other STIs through this means.
24. Health promotion initiatives need to be **targeted at men** in BME communities as they come into contact, and are less trustful and amenable, to health professionals.
25. Health promotion resources and projects need to take into account **existing myths** in communities, as well as the stigma and fear prevalent in various communities and cultures.
26. Health promotion initiatives need to focus specifically on **young people** in BME communities through creative channels that they will respond to – e.g. youth magazines, libraries, local youth clubs, internet, night clubs, etc:
27. Information should be provided in community languages – some of which are not currently available – e.g. Swahili, Shona, Luganda, Zulu, Yoruba, Portuguese.
28. Public information aimed at **eradicating stigma** is important – for example, to ensure that people do not have the impression that HIV/AIDS is confined to poor black people.
29. Information on health services given to **newly-arrived Asylum Seekers** should include information in various community languages on HIV and Sexual Health services available.

30. To help earlier detection amongst BME communities, **schools** should include HIV/AIDS and sexual health issues as part of the curriculum.
31. Need to involve **Faith and religious leaders** in HIV/AIDS and sexual health awareness initiatives.
32. Creative approaches should be used to get across information on sexual health – e.g. through **magazines and Arabic TV/radio**.
33. As part of awareness-raising campaign, to make **statistics** about incidence of HIV and STIs in Europe more widely available
34. Awareness programmes need to **demystify** HIV and STIs and work towards breaking down the mentality of fear.
35. Educate and inform **religious leaders/spiritual advisers** about HIV and STIs.
36. Encourage people who have HIV, regardless of their ethnic background, to **share their experiences** and talk about services available.

GOOD PRACTICE FOR PROCEDURES ON COMMUNITY INVOLVEMENT IN POLICY DEVELOPMENT AND COMMISSIONING FOR SERVICE PROVISION

37. An important outcome of this Task Group was the **process** adopted for the community consultations and community involvement in policy development work.
38. A **capacity development** process was adopted; this involved organising a **training session** on how to run community consultations with resources and materials provided; **support** on preparation and planning for running community consultations; development of a **pro forma questionnaire**; and involvement of the groups and organisations involved in the **process and policy-development aspect** of the Task Group.
39. Members of the Task Group felt that the support, training and resources that were provided helped them to run **well-planned and more strategic consultation events**, and enabled them to see how their feedback would feed into the policy-making and commissioning process for services.
40. Given this, it was suggested that as good practice, **NHS Trusts should offer capacity development and resource support to community groups** when they are involved in consultation events. This should include payment to the group (for venue, refreshments, childcare, etc.), training on running sessions, production of a pro forma on the aims and objectives of the session, involvement in the process of how feedback will be taken up by commissioners and service -providers, and involvement in meetings related to the project throughout its duration.

41. Given the **requirements of the Race Relations Amendment Act** and the obligation to involve BME communities in consultation and all aspects of the organisations' policies and procedures related to race equality, together with developments relating to the new public and user involvement structures (PALS, Patient Forums, local Commissions, etc.), these good practice recommendations will assist NHS bodies with these requirements.
42. It was suggested that the requirement to involve communities in consultation initiatives – as per the Race Relations Amendment Act – should be **built in to service level agreements and contracts** with service- providers (statutory and voluntary) to ensure that this process is mainstreamed and that consultation and feedback is received in a sustainable and effective manner.
43. It was recommended that the group in its new format - facilitated by the PCTs - organise a **one-day workshop** with all members of the Task Group, that will be facilitated by an external trainer **to develop an action plan** to take forward the recommendations from the report.

This report was written by Samira Ben Omar and Aisling Byrne, Managers of the BME Health Forum. We would like to thank Yohannes Fassil, Head of Diversity at KCW Health Authority for his assistance with this Task Group.

If you would like further information on the work of this Task Group or on the BME Health Forum, please contact us on 020 7725 3252 or bmehealthforum@hotmail.com.

Two additional policy reports were produced based on the work of this Task Group:

- (i) MODERNISING HIV SERVICES IN LONDON:
A Strategy For HIV Prevention, Treatment and Support Services
in London 2002/2005
Consultation Response by BME Health Forum – Task Group on HIV and Sexual
Health Services in Kensington, Chelsea & Westminster
February 2002
- (ii) Paper presented to the Second National African HIV Prevention Conference
'Reducing HIV Transmission in African Communities'
25/26 March 2002
organised by Camden & Islington Health Promotion Service
by Yohannes Fassil, Samira Ben Omar and Aisling Byrne

If you would like a copy of these policy reports, please contact the BME Health Forum on 020 7725 3252.