

What is this booklet about?

Understanding culture and its impact on service delivery is important in tailoring services for particular communities. Issues such as spirituality, language, ways of coping and perception of life and health can impact on service use. An increasing number of people from the African communities are accessing services and some professionals lack the necessary skills to deal with this client group.

This booklet attempts to highlight some of the issues that professionals need to be aware of and offers some suggestions on how to deal with them. It must be remembered that Africa is a big continent with many countries, ethnicities, religions and languages. There is no such thing as a uniform African culture. This booklet just gives some guidelines which are by no means comprehensive.

Although the purpose of this book is to help professionals work better with people from the African Communities - most of the issues are quite general and apply across all community groups. This booklet can therefore be used by anybody working in sexual health.

Who is it for?

- Professionals working in the field of sexual health and HIV
- Voluntary HIV organisations and other support services.
- Social services
- Primary care professionals

Introduction

What do we mean by the term African?

This term is used to refer to people who originate from the continent of Africa and are living in UK for various reasons including education, employment and more recently political asylum. Professionals are also likely to come in contact with a significant number of Africans who are in UK as visitors or over-stayers.

The vast number of Africans in the West Midlands region originate from English speaking sub-Saharan Africa, but there is also a significant number from French speaking central and west Africa.

Background of Africans in UK

- The Majority came into the UK in the past 7 years
- They are struggling to reconcile two or more cultural backgrounds with the western culture.
- Like other ethnic minorities in UK, they experience social exclusion and this has a negative impact on their health. (Social exclusion leaflet, march 2000, Sessay 1999)
- Issues like housing, unemployment, financial or immigration pressures make it difficult for many Africans to prioritise health. (Sessay, 1999)
- Africans are the second largest group affected by HIV in UK after gay and bisexual men (PHLS 2000, Bhatt 1997)
- Their uptake of services is low and commonly present late.
- HIV is heavily stigmatised in African communities (Goldin, 1994; Bhatt,1996; Erwin1999)

Important Considerations

- Most people find the open discussion of sex difficult. In many African societies this natural reticence is exacerbated by cultural norms that consider any open discussion of sex highly offensive
- HIV and the stigma attached to it can fuel racism, discrimination, social rejection, ostracism leading to isolation of affected individuals and depression

- Be aware of the diversity within African communities in the UK eg: people who share a common cultural background could still be divided by political, religious or social factors.
- Too much focus on culture can lead to stereotyping of individuals and community groups as being responsible for HIV
- Service givers need to be aware of their own stereotypes and prejudices, identify personal gaps and lack of understanding in order to seek appropriate support and training.

Cultural Considerations

Sex and sexuality

In many African cultures, sex is a private and taboo subject and is not discussed openly. Many will lack the confidence to discuss it openly. Heterosexual orientation is considered to be the norm, so homosexuality is not openly acknowledged. Some individuals may actually be offended if inquiries are casually made about their sexuality, so such issues need to be brought up with sensitivity.

Because of the prejudices against homosexuality in this community (Big up, 1999), individuals of such an orientation may not be very willing to open up and hence may need a lot of support from professionals.

Language

Because sex and sexuality are not openly discussed in African culture, language problems present an even bigger block in communication and information flow. Appropriate interpreting services need to be readily available together with suitable sexual health training for the interpreters

Spirituality

Some people's spiritual beliefs may influence the way they accept and use services. Some may not feel very uncomfortable to discuss intimate details of their life with people of the opposite sex. It is also important to avoid making assumptions about people's religions.

Views on life, health and risk

Many Africans believe that they only need to use health services if they are actually ill. The concept of check ups and follow ups may not be clearly understood and hence may not be well attended. Risky behaviour may only be perceived as sleeping with a stranger or someone who is known to be of 'loose' morals.

Sex between people who have known each other for a while even if its unprotected may not actually be perceived as risk by some. Although they are part of a high risk population in which HIV diagnoses continue to rise, most Africans do not actually consider themselves at risk of contracting HIV (Mayisha Study 2000; Mayisha Study 2005), so may, understandably do not think practising safer sex is of relevance to them.

Denial

This may or may not be related to culture but many individuals and communities would be in denial about the extent of the HIV problem around them. They may appreciate the problem but would not actually want to face up to it and come forward for testing.

Gender Dynamics

Some important gender problems among Africans have been identified as important in the context of HIV. (Singhateh, S., 1996)

- The African man is economically and socially more powerful than the woman and makes most of the important decisions.
- Some African women may be aware of risky behaviour by their husbands or partners, but are powerless to stop it or to introduce safer sex into the relationship. They may be financially dependent on the partner and would not want to do anything to jeopardise the relationship, at any cost. Women are vulnerable and more susceptible to violence and all forms of abuse including rape.(Erwin,1999, Lamping et al 1996)
- Child rearing and family caring take up most part of women's time and energy. This has serious implications for women's health and their participation in other activities that would improve their status and that of their family.

Family structure

The extended family network in African communities has a lot of influence in shaping the individual's identity, behaviour and capabilities. Decisions about childbearing, childcare, where someone lives or where they go when they are unwell may not be made by the individual alone, but by the larger family. These factors are even more important if the individual is female. It can be safe to say that in the most traditional of African culture and in certain parts, women have very little in the way of rights, and the important decisions are made by the husbands and families. Africans in the UK however, respect and practise their culture to varying degrees, depending on their education, strength of family ties and maybe length of residency in the UK. Appreciation of such differences helps staff to improve their professionalism and deliver a service tailored to the needs of a particular individuals.

Immigration

Ignorance about rights, services and support available are the main factors contributing to fear and mistrust of services by these migrant communities.

An individual's immigration status affects the way they view and access services. Some will be afraid that testing for HIV may jeopardise their rights of stay, whilst those applying for asylum may feel that an HIV test if it comes back positive may lead to their application being turned down. In most cases only reassurance is needed to put the individual's mind at rest.

Sometimes professionals make the wrong assumption that their clients are aware of what is available. Information that is culturally and religiously appropriate needs to be made available.

The HIV Test

Because of the rising number of new HIV diagnoses among Africans, professionals will continue to see more and more people from this communities accessing services. The following section looks at some important considerations when offering an HIV test to people from African communities.

Pretest discussion

Confidentiality

Creating the right environment

The importance of confidentiality in this group can never be overemphasised. Because of their small numbers in UK (compared to the general population), Africans in one locality tend to know each other and be closely knit, news spreads round fast. Those using services need the reassurance, not only about confidentiality, but also that the service is non discriminatory and non judgmental.

Other issues like mail outs, telephone calls and home visits, if the need for them should arise, they need to be discussed carefully before hand.

Accurate risk assessment

As mentioned earlier in this document, the concept of risky behaviour in Africans may be very different when viewed from an African perspective. Professionals need to be aware of that so that they ask relevant and pertinent questions. Use of standard questions that elicit specific risky behaviour is encouraged rather than general questions about risk. Professionals must always be aware of gender dynamics and create an optimum environment for the interview. As mentioned earlier, some clients may not be comfortable discussing their sexual lives with a member of the opposite sex. Indeed, some may not even feel comfortable discussing such issues with a member of staff from their own culture.

Treatments

The fact that treatments that can prolong life are available and affordable is information that is not generally known by recently arrived Africans. They often associate an HIV diagnoses with death within a few months.

Availability of information on treatments and that they are effective often puts people's minds at rest and encourages them to test. The difference between an HIV positive test and AIDS also needs to be well explained.

It is well worth dispelling that HIV treatments cure the illness. If people mistakenly believe that there is a cure for HIV, they maybe complacent and not take advice seriously.

Immigration

Clients need reassurance that their employment, scholarship, residency or asylum application will not be affected by the results of the test.

Availability of support

There is need to discuss about who the client should tell about the decision to test and why? It may be a good idea to tell a friend or family member so they can get support, but they also need to consider the prevailing attitudes and prejudices carefully.

They may need help discussing it with a partner. Other forms of support that are available need to be discussed at this point.

Highlight the other advantages of taking the test

- Current and future partners can be protected.
- Vertical transmission can be prevented, this is very important in African culture where children are very important.
- Early diagnosis and treatment is crucial to long term survival
- Other sexually transmitted infection and re-infection with HIV can be prevented
- Knowing HIV status, risky situations may need to be avoided. For example health care workers at work, for those whose work may involve performing risky procedures or being in risky areas like infectious diseases wards. The point needs to be made that HIV positive individuals are more at risk themselves from occupational exposure to certain infectious diseases than pose a risk of passing HIV to their patients. So in most cases assessment of risky situations benefits the HIV positive individual.

Special needs

- Specific issues for women for example: Is the person pregnant, or planning to get pregnant? Children are very important in African culture and women will need a lot of help and information around what might happen and their options if they test positive.
- Beware of the stigma, fear of rejection, panic and even denial. Its not uncommon for people to want to withdraw into their closet and wait to die, when they get given a positive diagnosis. Most Africans from the Sub-Sahara will have vivid images of friends and relatives whom they witnessed dying of untreated HIV related illnesses, its important to highlight the positive aspects of taking the test
- Oral information is likely to be more effective than written.

Post test

discussion / issues / considerations

- Assumptions must not be made about family or partner knowing, even if they live in the same household. It is not uncommon for 2 or more members of the same household to be accessing services and keeping it away from the others. Appointments will need to be planned in such a way that they don't end up in the clinic on the same day or at the same time.
- Reassure about confidentiality.
- Advise relationships and sexual health.
- Certain individuals, because of their immigration status, may not be entitled to free treatment. Some may commence treatment, then be required to leave the country when their visa runs out. Situations in most African countries are such that individuals who return there may not be able to continue the treatments they started while in UK because they are too expensive or unavailable. Even more complicated, are cases where someone has started anti-HIV treatment in this country and wish to apply to remain in this country on compassionate grounds. Some will have family and children back in their home countries and will be torn

between going back to re-join their families or staying in UK to continue treatment. Indeed some will want to have their families come to join them in UK.

- The UK immigration law around HIV is a complex and highly specialised area and can only be interpreted by specialist immigration lawyers. Professionals should not try to advise their clients on these matters, but to refer them to legal firms qualified to give such advice. A list of HIV friendly immigration solicitors can be obtained from the **Terrence Higgins Trust** on **0121 694 6440**. By law, it is an offence to give such advice if one is not qualified to do so. Incidences are common where clients have been given conflicting (and misleading) advice from unqualified (but well meaning) professionals working in different fields. Clearly such incidences need to be avoided because they may fuel panic and hopelessness, in some cases they may give false hope to individuals in difficult situations.

Other considerations

Body language

In many African cultures, it is considered rude, or conveying a lack of respect to look people in authority in the eye, whereas in western culture not doing is perceived as if the person is dishonest. Professionals need to be aware of this so they build a good rapport with their clients. Women are more likely to reflect this trait than men.

Time keeping

The concept of time keeping for hospital appointments may not be very well understood by a significant proportion of clients from the African community. This may be related to being used to a different system where its on a first come first served basis, or maybe family pressures or childcare responsibilities. Services need to be more flexible to allow for this if they are to maintain services for African clients

Introduction to Female Genital Mutilation (FGM)

MANY CULTURES PRACTICE OR HAVE SOME FORM OF “RITES OF PASSAGE”, WAYS TO MARK THE GROWTH OF A CHILD INTO ADULTHOOD.

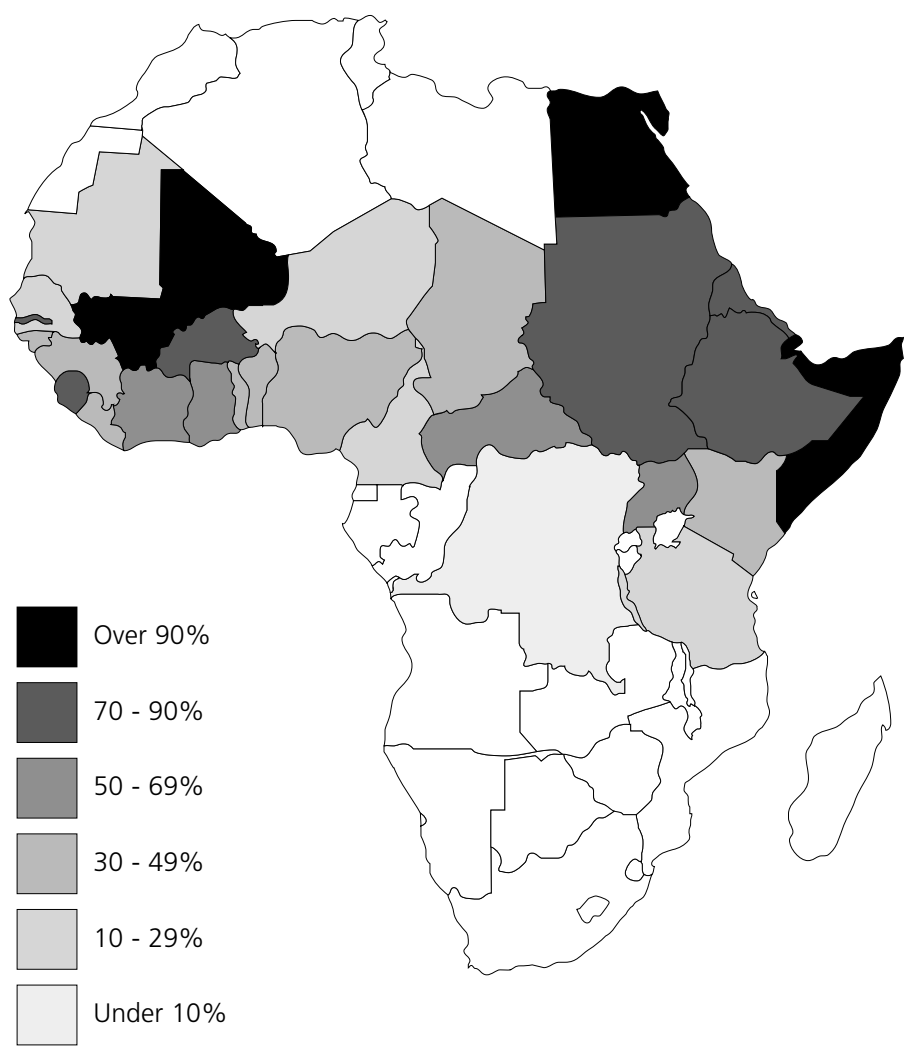
A NUMBER OF AFRICAN, ASIAN AND MIDDLE EAST CULTURES PRACTICE A HARMFUL CULTURAL RITE OF PASSAGE ON FEMALE CHILDREN KNOWN AS FEMALE CIRCUMCISION (FC) OR FEMALE GENITAL MUTILATION (FGM), WHICH INVOLVES PHYSICAL INTERVENTION ON A CHILD'S BODY.

FGM is a collective term for all procedures which include partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons.

FGM is very harmful. It is not like male circumcision. It can cause long term mental and physical suffering, difficulty in giving birth, infertility and even death.

It is estimated there are around 74 000 women in UK who have undergone the procedure, and about 7000 girls under 16 who are at risk. This estimate is based on the number of women and girls living in UK who originate from countries where FGM is traditionally practised. The countries where it is practised include Yemen, Oman, Malaysia, Indonesia and the United Arab Emirates as well as 26 countries of Africa including Somalia, Sudan, Ethiopia, Egypt, Uganda and parts of West Africa.

Estimated prevalence of female genital mutilation in Africa



WHO 1997

Legal Position

FGM is illegal under the Female Genital Mutilation Act 2003. The act makes it illegal for anyone to circumcise children or women for cultural or other non-medical reasons. It is an offence under the act to arrange, procure, aid or abet female genital mutilation. Parents or carers may therefore be liable under the act. It is also an offence under the act for a person to conspire to commit or procure FGM outside the country, regardless of the law in the country in which the act was committed. Penalty for disobeying the law is up to 14 years in prison.

Main Forms of FGM

There are many types of FGM, but the World Health Organisation (WHO) has classified 4 main ones:

1. Excision type 1 - removal of the hood of the clitoris
2. Excision type 2 - removal of the clitoris with partial or total excision of the labia minora
3. Infibulation - removal of the clitoris, labia minora with narrowing/stitching of the vaginal opening.
4. All other types including piercing, inserting substances or any of the above

Consequences of FGM

Many women appear to be unaware of the relation between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth, which may occur many years after the mutilation has taken place. Depending on the degree of mutilation, FGM may cause immediate fatal haemorrhaging.

Short term health implications

- Severe pain and shock
- Infections
- Urine retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Death

Long term health implications

- Excessive damage to the reproductive system
- Uterus, vaginal and pelvic infections
- Difficulties in menstruation
- Difficulties passing urine
- Increases risk of HIV infection
- Infertility
- Cysts
- Complications in pregnancy and childbirth
- Psychological damage
- Sexual dysfunction.

Reasons given to try and justify FGM

- Custom and tradition
- Family honour
- Hygiene and cleanliness
- Preservation of virginity or chastity
- Social acceptance, especially for marriage
- The mistaken belief that it is a religious requirement
- Sense of belonging to the group/fear of social exclusion.

Signs and indicators

Some indicators that FGM may be about to or has already taken place are:

The family comes from a community known to practise FGM and

- A conversation with a girl may refer to FGM, she may express anxiety about a “special procedure” or event that is to take place
- A prolonged absence from school/college and a noticeable change in the girl's behaviour on her return, including a reluctance or inability to take part in physical activity.
- A prolonged family trip to the country of origin
- A child may spend long periods of time away from class during the day - perhaps indicating bladder or menstrual problems

- A midwife/obstetrician/gynaecologist/general practitioner may become aware that FGM has occurred when treating a female patient. This should trigger concern for other females in the household.

Practical guidelines

1. Any information or concern that a child is at risk of or has undergone FGM should result in reference to organisational policies and procedures, and possible child protection referral to Social Services and the Police.
2. FGM places a child at risk of significant harm and will therefore be investigated under section 47 of the Children's Act.
3. Prevention requires sensitive community education and intervention. Give yourself time to know the families/communities - gain their trust. Find out if there are responsible community leaders who speak out and are against FGM
4. A child who has already undergone FGM should be seen as a child in need and should be offered services as appropriate. The risk to other female children in the family should also be considered.
5. If a woman has already undergone FGM, consideration needs to be given to any child protection implications e.g. for female siblings and extended family members. If a woman is the mother of a female child or has the care of female children, professionals need to assess the potential risk to female children in the family and need to identify the most appropriate and sensitive way of informing the parents.
6. Contact the agencies mentioned below for help and support.

Terminology

TERMS TO AVOID WHEN ENGAGING WITH SERVICE USERS

FEMALE GENITAL MUTILATION

OPERATION / SURGERY

CHILD ABUSE / HUMAN RIGHTS

COUNSELLING / MENTAL ILLNESS / PSYCHOLOGICAL PROBLEMS

WHAT TO SAY

- YOU COME FROM A COUNTRY WHERE GIRLS OR WOMEN ARE CIRCUMCISED - DO YOU THINK YOU HAVE GONE THROUGH THIS?
- ARE YOU CLOSED/STITCHED OR OPEN?
- HAS ANYTHING BEEN DONE TO YOU DOWN THERE OR ON YOUR BOTTOM?
- DO YOU WANT TO TALK TO SOMEONE WHO WILL UNDERSTAND YOU BETTER?
- ARE YOU AWARE THERE IS A LAW IN THE UK AGAINST CIRCUMCISING GIRLS?

OR contact the agencies below for support, help and advice

FGM support agencies.

- **Agency for Culture and Change Management Sheffield (ACCM)****
www.accmsheffield.org.
Helpline 0114 2750 193
info@accmsheffield.org
- **Forward (UK)**
www.forward.org.uk.
0208 960 4000

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