

Stigma, lack of knowledge and prevalence maintain HIV risk among Black Africans in New Zealand

Mark Henrickson,¹ Nigel Dickson,² Fungai Mhlanga,¹ Adrian Ludlam³

In Aotearoa, New Zealand (NZ), HIV has followed the same pattern as in most developed nations, appearing first in gay male communities,^{1,2} which created the first comprehensive approaches to prevention.^{3,4} These approaches resulted in relative control, with a drop in the number of new diagnoses among the group mostly affected – men who have sex with men (MSM) – up to the mid-1990s. Beginning in 1998, NZ began to experience a change in the profile of HIV diagnoses. From 2000 to 2005 the number of newly identified HIV infections nearly doubled.³ The new infections did not only occur among MSM; they also included heterosexuals. In 2006, the peak year of heterosexually acquired HIV diagnoses, nearly three-quarters of MSM diagnosed with HIV were infected in NZ, while 82% of heterosexuals were infected overseas.⁵ The peak in the heterosexually acquired diagnoses has been attributed to both an increase in immigration from high-prevalence countries, and a 2005 change in immigration policy requiring HIV testing. Between 1992 and 2001, about 3,000 refugees, immigrants and asylum seekers from the Horn of Africa settled in NZ.⁶ In addition, NZ's 2004 Special Zimbabwe Residence Policy, along with a subsequent 2006 waiver allowing Zimbabweans living with HIV to apply for residency, resulted in nearly 1,000 Zimbabweans applying to remain in NZ.⁷ By 2012, the number of people diagnosed with heterosexually acquired HIV had dropped, as had the proportion acquired overseas.⁸

Black Africans in NZ carry a disproportionate burden of HIV, and are the second most

Abstract

Objective: The *AfricaNZ Health* project aimed explore HIV risks in Black African communities in NZ with a view to informing HIV infection prevention and health promotion programs.

Methods: *AfricaNZ Health* was completed in two phases. The first developed desk estimates of the resident Black African population in New Zealand, and Africans living with HIV. The second comprised two arms: an anonymous survey administered at African community events and a series of focus groups around the country.

Results: High levels of knowledge and positive attitudes about HIV were more often found in older than younger age groups. Condom use was higher in the younger group than in older age groups. Traditional attitudes still inform some beliefs about HIV. Stigma about HIV and anyone at risk for HIV remains very high among Africans. Western sexual identity constructs are not meaningful.

Conclusions: A culturally informed strategy for risk and stigma reduction is urgently needed.

Implications: The existing prevention and care infrastructure, informed by MSM experiences, must address increased risk to Black African new settlers, but this is not a reason to discriminate or further stigmatise an already vulnerable population.

Key words: African diaspora, AIDS/HIV, new settler, New Zealand, stigma

affected group after MSM.⁹ Nevertheless, to date there have been no national studies that examined the demographics of African new settlers in NZ, or the scope of HIV in African communities. This study, called *AfricaNZ Health*, addresses that gap, and this paper presents some key findings with a view to reconsidering the prevailing paradigm of HIV prevention and treatment services in NZ.

A major challenge in research with Africans is a consideration of the complex and contended question of who should be considered 'African'.^{10,11} The term 'African' can be interpreted in a number of different ways as the social constructs of ethnicity, 'race' and nationality, and the residue of European colonialism, are considered. A household

survey in South Africa in 2008¹² found that the prevalence of HIV among Black Africans, Whites and Coloureds was 13%, 0.3% and 1.7% respectively. Although a relatively large number of White Africans have migrated to NZ in the last several decades, they do not demonstrate high levels of infection with HIV. As the researchers wished to focus on African communities in NZ with the greatest need for HIV-related medical and social services, and prevention education, they chose to focus on Black Africans. Black Africans are at increased risk for HIV infection because of high HIV prevalence in sub-Saharan nations for a number of multifarious and contested reasons, the intersection of overlapping forms of exclusion and oppression, and barriers to

1. School of Health and Social Services, Massey University, New Zealand

2. AIDS Epidemiology Group, University of Otago, New Zealand

3. University of Auckland, New Zealand

Correspondence to: Dr Mark Henrickson, Massey University - School of Health and Social Services, Private Bag 102904, North Shore MSC, Auckland 0745, New Zealand;

e-mail: m.henrickson@massey.ac.nz

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care in Africa and the African Diaspora.¹³ High HIV prevalence would therefore be expected in these communities in NZ.

Objective

The aim of the *AfricaNZ Health* project was to explore HIV risks in Black African communities in NZ with a view to informing HIV infection prevention and health promotion programs. To do this, a demographic estimate of currently resident Black Africans in NZ was first undertaken. Knowledge, attitudes, behaviours and beliefs of these communities were assessed quantitatively and qualitatively, and recommendations were developed by the research team in collaboration with African community advisory groups.

Methods

The research team worked closely with community advisers recruited nationally from Black African communities. There were two advisory groups: a group of 15 community and religious leaders (no-one in this group disclosed that they were living with HIV), and a group of six Black Africans living with HIV. These two groups each met three times over 18 months, and were consulted electronically between those meetings.

The study was completed in two phases. The first developed an estimate of the currently resident population of Black Africans and the number of Black Africans living with HIV. This phase relied on various sources of data that are presented below. The second phase comprised two arms. The first was an anonymous quantitative self-completed survey. The second was a series of focus groups that were recorded and transcribed. Survey questions were adapted from the UK *Mayesha II*¹⁴ and *Bass Line*¹⁵ studies, and developed in close consultation with the NZ community advisory groups. Topic areas and specific questions were piloted with Black African communities, and adjusted accordingly. Ethics approval was given by an accredited human ethics committee. In the absence of a sampling frame, a convenience sample was recruited into both arms of the second phase at community and sporting events, festivals and pageants, churches and other events in the four centres with the largest concentrations of Black Africans: Auckland, Hamilton, Wellington and Christchurch.

Great care was taken to protect participant identities. Potential survey participants were approached by surveyors (most of whom were Black Africans) at community events, and invited to participate. If they agreed, they received a brief information sheet with information about the study to take away, a pre-addressed envelope, and a copy of the survey that they either completed and returned to the surveyors, or returned via FreePost to the project office. Most surveys were returned to the on-site surveyors. Survey team members estimate that less than 5% of the people approached declined to participate.

Potential focus group participants, also approached at community events, received an information sheet explaining the project and, if interested, were invited to join a group at a local venue. Most group leaders were Black Africans conversant in at least one African language as well as English. Participants not comfortable speaking English had a summary of the study and their rights explained in their own languages. All groups but one were held in English, although in some groups summaries or simultaneous translations in relevant languages were provided if required. Once the focus group convened, participants provided fully informed consent and were asked to sign a confidentiality agreement and to choose a pseudonym for the purposes of the group. Focus groups lasted about 90 minutes and were semi-structured. At the end of the group session, participants were invited to anonymously complete a short demographic questionnaire, put it in an envelope and deposit it in a box. Audio recordings were uploaded into password protected 'cloud' storage, accessible only to the focus group leader, the paid transcribers and the project researchers who undertook a thematic analysis. Once the focus group leaders had reviewed and edited the transcripts for accuracy and clarification, their access was removed.

There were two other sources of data. A debriefing meeting with focus group leaders gathered 'intangibles'. In addition, verbatim minutes of the two community advisory groups to this project were used as data. Members of those groups authorised the use of their anonymised remarks.

Results

Phase I: Demographics and epidemiology

The 2006 NZ census was used to estimate the number of Black Africans living in NZ. The census question on ethnicity, however, does not offer the option of 'African', so individuals wishing to identify as such must tick 'Other', then write 'African'. The census also solicits country of birth and languages spoken. Based on the Statistics New Zealand classifications, 10,725 people were classified as African. Of these, 1,419 had identified themselves as 'African-Americans/Afro-Caribbeans' who were then excluded. In addition, there were 204 'South African Coloured', a group the research team opted to include because of HIV prevalence cited above. Researchers estimated under-counts of Black Africans of around 200 using African languages, and an additional 500 using country of birth. Permanent and long-term immigration and emigration from and to Africa was examined, resulting in an estimated net increase of 2,323 Black Africans between 2006 and 2011. Combining these data and estimates of under-counts, researchers estimated the number of Black Africans living in NZ at the start of 2012 to be about 12,500.

Reports provided to the AIDS Epidemiology Group by clinicians showed that from 1996 (when ethnicity was first included) to the end of 2011 there were 498 Africans diagnosed with HIV in NZ, or 19.4% of all diagnosed people.¹⁶ A number of these will have died, gone overseas or otherwise opted out of care, but this number is unknown. A survey of HIV medical specialists in the main centres undertaken for this study in early 2012 found they were providing care for 139 African men and 156 African women (11% of men and 51% of women under their care) and 30 African children (43% of all children). It was assumed that 5%¹⁷ of all Africans with diagnosed HIV have remained in NZ but are not under the care of these specialists, which the specialists anecdotally confirmed, and that 21% of Africans with HIV were undiagnosed – the proportion found among MSM in an Auckland-based behavioural study.¹⁷ Based on all these data and assumptions, it was estimated the total number of Africans living with HIV in NZ in early 2012 was around 420. These data suggest an adult prevalence of HIV among adult Black Africans of just less than 5%.

Phase II: Knowledge, attitudes, behaviours and beliefs

Overall, 703 usable surveys were collected, 49% from men and 50% from women (some questions, including that on gender, were unanswered). Respondents were generally highly educated, with 65.8% (n=463) reporting some tertiary education, which may be a reflection of NZ immigration policies that favour higher levels of education. Only 31.5% (n=219) had lived in NZ five years or less, meaning many would have arrived prior to HIV testing being an immigration requirement. Regarding religion, 81.2% (n=571) were Christian, and 13.4% (n=94) Muslim. A variety of relationship arrangements were reported: 38.8% (n=268) were married and living with their spouses; 38.4% (n=265) were single; and smaller numbers reported that their spouses lived overseas (n=33), they were unmarried but living with their partners (n=46) or had a regular sexual partner but did not live together (n=62). Not surprisingly, more of the older respondents were married and living with their spouses than younger ones. Some of these data are summarised with the focus group data in Table 1.

A relatively high level of knowledge about HIV was reported, although the two older age groups (ages 25–39 and ≥40 years) were more knowledgeable than the younger group (16–24 years). Most (91.7%, n=621) knew that AIDS was caused by a virus called HIV, and most (80.9%, n=531) that “You cannot tell from someone’s appearance whether or not they have HIV”. Most (87.6%, n=590) knew that people can have HIV without knowing it, and 92.2% (n=615) knew there was a test that could show whether an individual had HIV. However, fewer (67.6%, n=449) knew that HIV treatments can reduce the risk of infected people transmitting HIV, or that HIV medications work better if people take them before they become very ill (63.5%, n=424). Younger people had less knowledge about these two areas than the older two age groups. However, most (89.7%, n=605) knew that HIV is never passed on by touch, and 72.9% (n=491) knew that HIV is not transmitted by insects. Again, the younger age group was the least knowledgeable about transmission.

Most respondents (88.4%, n=596) knew that condoms can reduce the risk of HIV transmission; this knowledge was consistent across all age groups.

Regarding HIV testing, 31% (n=211 of 680 responses) reported they had never been tested for HIV. This is a key finding because, according to our advisory groups, many people (including Africans) assume that all new settlers are tested for HIV. Of those who had been tested, 66.3% (n=451 of 680 responses) reported being HIV negative, and 2.6% (n=18) positive. However, our advisory groups warned that respondents may not answer this question, or could say “I don’t know” if they are positive; 23 people did not answer this question. Of those who had tested HIV positive, 53% (n=8 of 15 responses) had been tested more than five years previously; and 80% (n=12 of 15 responses) had tested positive in NZ. Of all HIV negative or ‘never tested’ respondents who answered the question, 67.4% (n=390) knew where to go for an HIV test.

Attitude questions were scored on a five-point scale (strongly agree, agree, don’t know, disagree and strongly disagree) with questions posed both positively and

negatively. Three of these questions (“People with AIDS will not join their ancestors”, “AIDS is the result of witchcraft”, and “I think of people with AIDS as already dead”) followed up findings from a recent NZ study with African new settlers living with HIV.¹⁸ Table 2 summarises these results.

While most attitudes about people with HIV were generally positive, it is worth noting the combined “don’t know” and negative attitude responses to questions involving traditional beliefs. More than one-third (34.7%) agreed with the statement (or did not know) that people with AIDS “will not join their ancestors”, a sign of a meritorious life.¹⁹ Nearly one-quarter (23.3%) believed or did not know if AIDS is the result of witchcraft, and 18.2% thought of people with HIV as “already dead” – meaning they had so far transgressed social boundaries that they must be treated as outcasts^{18,19} – or did not know if they thought this. This relatively high number of “don’t know” and negative responses suggests that traditional beliefs may play an enduring role

Table 1: Demographic profile of research participants, Survey and Focus Groups.

	Total N	Gender n (%)		Religion n (%)			HIV status n (%)		
		Female	Male	Christian	Muslim	Other	HIV-	HIV+	DNR, DK ** or Never tested
Survey	703	351 (49.9)	343 (48.7)	571 (81.2)	94 (13.3)	18 (2.5)	451 (66.3)	18 (2.6)	211 (31.0)
Focus groups	131	76 (58.0)	54 (41.2)	88 (67.1)	31 (23.6)	18 (13.7)	101 (77.1)	2 (1.5)	16 (12.2)

**Not all data will add to 100% because of rounding, or non-responses; only major categories of responses are reported.*
*** Did not respond or Don't know*

Table 2: Respondent attitudes to HIV. (Total possible N=703)*

	Strongly agree/agree (%)	Don't know (%)	Disagree/Strongly disagree (%)
Most people with HIV deserve what they get (n=650)	12.9	16.7	70.3
People with AIDS will not join their ancestors (n=630)	7.9	26.8	65.2
AIDS is the result of witchcraft (n=640)	4.8	18.5	76.6
I think of people with AIDS as already dead (n=623)	7.8	11.4	80.7
If I were infected with HIV I would not tell my immediate family (n=640)	11.3	19.0	69.7
People with HIV should be allowed to participate fully in our community (n=650)	84.9	8.9	6.2
If I carried a condom I would worry about what people thought of me (n=635)	35.6	20.1	44.3
I think I am at risk of getting HIV (n=633)	14.8	15.8	69.4
It's OK for men to have other sexual partners when they are married or in a relationship (n=633)	6.2	7.9	85.8
People with AIDS have a right to the same health care as other people (n=653)	87.3	6.4	6.3
If I found out a friend had HIV I would not maintain the friendship (n=648)	15.1	11.2	73.6
All women who feel at risk for HIV or other STI have the right to refuse sex without condoms (n=646)	74.3	11.6	14.1

**Not all respondents answered all questions; percentages may not sum to 100 because of rounding*

in shaping attitudes towards HIV; traditional beliefs cannot simply be dismissed as cultural curiosities that are somehow shed during migration.

The number of sexual partners reported by respondents is associated with age group and gender. Of participants who reported having any sexual intercourse in the 12 months prior to the survey (n=385, 60.9%), 73.8% (n=127) of men and 88.2% (n=143) of women reported only one partner. However, 78.6% (n=22) of young men aged 16–24 reported more than one partner, while only 6.5% of men age 40 and older reported this. Among women respondents, 37.0% (n=10) of young women and 2.1% (n=1) of women age 40 and older reported more than one partner. Similarly, condom use was associated with age group and gender, as well as partnership status. Of participants with a regular partner reporting sexual intercourse in the 12 months prior to the study, 24.2% (n=36) of all men and 9.2% (n=13) of all women used condoms with their regular partners. However this proportion rises to 100% (n=14) for young men, but only 38.8% (n=7) for young women; the difference could be a reflection of over-reporting by the young men. Only 25.4% (n=13) of men and 9.5% (n=4) of women aged 40 or older reported using condoms in the previous 12 months with their regular partner. Fifty per cent (n=34) of all men and 34.4% (n=11) of all women “always” use a condom with non-regular partners. In young men, 88.0% (n=22) reported using condoms in the previous 12 months “always or usually” with non-regular partners, as did 66.6% (n=8) of young women. Reported condom use shows some awareness of the risks of unprotected sexual intercourse, even if there is social desirability bias in these responses.

Of people who responded to the question and who reported any sexual experience in the previous 12 months, (200 men, 171 women, or 52.8% of total survey respondents), 94.0% of men (n=188) and 88.8% of women (n=152) report that their sexual partner(s) were only of the opposite sex. This means that at least some sexual experience with the same sex was reported by 6.0% (n=12) of men and 11.1% (n=19) of women. Reported rates of same-sex sexual activity are not inconsistent with other accepted population prevalence estimates.

About 45% (n=289) of all respondents recognised branding and could answer basic questions about the sole, longstanding HIV-prevention education initiative in NZ targeted at Black Africans.

Focus groups

Twenty-three focus groups, comprising 131 people, were held around the country. Groups ranged from two to 11 participants with a median of five. Participants in focus groups were 58% (n=76) female and 41% (n=54) male; one participant did not disclose their gender on the exit form. In respect of religion, 66% (n=88) were Christian, and 24% (n=31) Muslim; the balance did not specify a religion. Participants had been in NZ for a mean of 7.5 years, and came from at least 18 different African nations. Overall, 78.6% (n=103) identified as heterosexual, 1.5% (n=2) identified as homosexual, 8.4% (n=11) said “none of these” and 19.8% (n=26) did not answer this question. No respondents identified as bisexual. Of participants who answered the question about HIV status, 77.1% (n=101) reported being HIV negative, 2.3% (n=3) positive and 12.2% (n=16) said they did not know. As noted above, the number of living with HIV is possibly an under-count.

We asked participants about their relationship status. Of women who responded, 32 said they were in a relationship with a man, one said she was in a relationship with a woman, and two said they were in relationships with both men and women (these were the response options). Of men who responded, 33 said they were in a relationship with a woman, five said they were in a relationship with a man, and one said he was in relationships with both a man and a woman. Fourteen said they were not in a relationship. While only two participants identified as ‘homosexual’, nine respondents reported that they were in some kind of relationship with someone of the same sex. While it is possible that participants did not clearly understand one or both these questions, these responses suggest that commonly used English language categories and labels may not be useful when working within an African context, and that behaviours – rather than identities – are more important to address from a risk-reduction perspective.

We believe there is less likelihood of any social desirability bias in focus groups because participants could engage around issues, and trained focus group leaders could probe and follow up statements.

Attitudes to testing and people living with HIV

Participants were clear that people with HIV remain highly stigmatised within African communities.

The big issue to the African community if you are a positive person, man [it] is a really big thing. Because the stigma is very high here, and, like, people will just push you away or disassociate with you ... [It] is like you're a sinful person, someone who has sinned a lot, and so nobody wants to associate with someone who is sinful and is been punished. (HIV+ female)

However, people who even think they might be at risk of HIV also experience similar stigma; thus many Africans may avoid prevention information (or condoms) publicly, and avoid testing, because these activities imply that they are engaging in risk behaviours. As in the survey, many participants seemed unaware of treatment options for people with HIV.

I think if you ask many people “Do you want to be tested?” those who have not been tested will say ah, “No, it better for me not to know”. Because of the stigma, because someone will be tested today and given the results after two weeks of not sleeping. They're thinking ah, “So I'm finished”, something like that. So I think we need a lot of education. (Christchurch male)

One woman said that even though she was tested at a refugee centre she did not receive sufficient follow-up information and support.

When I was at [the refugee centre] they test you, but it is up to you to talk with your partner. They tell you that you are positive, but there is no education. They can't tell your community sponsor. It took me two years after testing positive to get a medical appointment. I got a letter, but as a new refugee I barely knew the language. I didn't even know how to catch the bus. I didn't know what to do with this letter. What if I'd been here with my husband? (HIV+ female)

Partners and condom use

Attitudes towards condom use were complex, and were shaped by religion, culture and gender. In general, participants did not use condoms and had a negative view of them. Some believed contraceptives were to be used when medically necessary, but not for protection against infection.

If a woman is married, she's not supposed to use any birth control, unless there is a major medical issue. Like if she has been having operations when she's giving birth. That time maybe they can use. But is not allowed even in this land... (HIV+ female)

Adherents of religions that oppose birth control, such as Roman Catholics and Muslims, opposed the use of condoms.

This is what the mosque can teach: they can't teach [people] to use condoms. They can't because before marriage sex is haram [forbidden] and if they are teaching to use condom, who are they? Are they the leaders? Or are they someone else, and we are not going to listen to them? (Wellington male)

Condoms were not used by married couples, because that would be an inappropriate statement of mistrust of one's spouse.

Although some women knew that their husbands had other sexual partners, and this put them at risk for HIV and STIs, at least one participant said she did not feel that women had a right to refuse unprotected sex with their husbands.

I would say that married woman is more at risk than the casual sex worker, because the casual sex worker is in the business of getting different partners; they are bound to protect themselves ... But then when that man comes back home she doesn't know what has happened. When you need protection you can't be asking to use the condom every day for no reason, so in the home you are more at risk because you're just blind, you don't know what's happening. (Auckland female)

Participants generally opposed providing condoms to young people in schools.

What concerns me again is about the school children. You find at high schools they're given condoms. Even the child who didn't want to participate in a sexual relationship, once they have this condom and it's accessible I think they're bound to start thinking about having sex... (Auckland female)

Sex education for young people is made more complex by the disruption of traditional family structures during migration. Parents are not traditionally the educators of their children about sexual matters, and aunts and uncles may not be available:

For me, it's more about the change that has come about because we are far away from home. I have got a 14-year-old daughter. Traditionally, she would be going to her aunts to talk about things like all these sexual things. Myself as a mother, I wouldn't really be involved in that, but since coming over here we've left the aunts behind and the children are becoming more and more exposed at an earlier age. (Auckland female)

Same-sex and multiple partner sexuality and relationships

Respondents reflected many different attitudes towards same-sex sexual behaviour, some claiming that they had never heard of such a thing, while others acknowledged that same-sex behaviour and relationships were beginning to be more public in African countries, although rarely discussed.

Maybe in Africa there are, but they hide it. Now here, because they know they have rights, they are now more open into that. (HIV+ female)

I think in Africa it's not there. If it is there it's hidden. But here it's on the front page so some Africans, they want to try everything, they want to go into adventures at the end of the day. I don't know what will get them but it is not being in their life until they came to discover this [thing] right in a foreign land. (Christchurch male)

Similarly, the existence of multiple-partnered relationships was tacitly acknowledged, although rarely discussed openly in a NZ context.

The community that I come from, like men have the upper hand. They can have up to four female partners but the women [are] not supposed to have any other partner, just one, while the men has to have four. ... But I think with the New Zealand thing, if they have more than one or two partners it's usually like an affair and it's all hidden. In Africa, if they do that they, like you have four wives, it's out in the open, you married four women, which is kinda gross, but you did and everyone knows it. (HIV+ female)

While HIV was part of the ordinary discourse in their home countries that heightened awareness, participants mentioned the apparent silence about HIV in NZ. Paradoxically the low incidence and the concomitant low public awareness of HIV may be placing Black African new settlers at risk:

If someone is in a jungle, they are very aware of danger so they are on their guard. When you take them out of that jungle, you're very cautious because they drum it in our ears on radio on TV, in everything. So when people leave the environment they think they are safe because they are looking at the percentage. They play with the numbers; they think "What are the chances?" ... But here they look at New Zealand and say, "Well, I'm out of that environment, now it's a bit safe"... Possibly someone was more careful back home. (Auckland male)

Discussion and conclusions

The limitations to this study include issues related to self-selection in both phases, and potential social desirability biases on sensitive issues. By consulting closely with our community advisory groups throughout the project, including the analyses and interpretation, it is our hope to have avoided misinterpretation of the data. We also considered projects with similar aims^{9,14,20} and, while there are some differences with international studies (notably with more HIV testing occurring in NZ), our findings are not inconsistent with other NZ data.⁹ While there is a relatively high level of knowledge and awareness among Black African new settlers in NZ, there is need for an explicit strategy for this group that includes improved education for risk and stigma reduction, particularly among men and women in younger age groups. Participant responses suggest there is a core of positive attitudes to build on within African communities as well as some traditional negative beliefs to address.

Nevertheless, stigma about HIV and anyone at risk remains very high among Black Africans. There is also an apparently shared belief that in NZ, a low-incidence country with low levels of publicity about HIV directed beyond MSM communities, HIV is not an important issue. Once Africans go to environments where the dangers are not so obvious, they are – as one participant put it – no longer “on their guard”. Awareness of treatment options and the advantages of medical interventions in people who test positive for HIV is low. Same-sex sexual activity and relationships occur, but they are not described using Western vocabulary and constructs; likewise, multiple partnerships are not public, as they might be in home countries, but instead are more likely to be concealed or informal in NZ, and thus the ‘wives’ may be less aware of their status and risk. Community awareness of current prevention education in NZ is low. Furthermore, education of children about sexual matters is not traditionally done by parents; and since traditional family structures are often disrupted during migration, other options must be considered.

Implications

With HIV seroprevalence estimated around 5%, high levels of stigma associated with education and testing, and low awareness of HIV risk in NZ, Black African communities

remain at elevated risk of increased HIV transmission unless robust strategies are developed, funded and implemented for and in these communities. Such strategies should not assume that same-sex sexual activity and multiple partnerships are not occurring in Africans living in NZ; however, using Western language, constructs and values about these behaviours and relationships will not be useful. Educational campaigns should take into account Black African cultural beliefs and practices. Stigma around HIV and testing must be addressed. Testing should be made routinely available in general health care environments, although providers should take care to not assume that simply because someone is Black African they are automatically at increased risk for HIV, and not to coerce people into being tested. Existing public health organisations, AIDS service organisations – most with deep roots in MSM communities – and funders must ensure the capacity and resources to undertake such initiatives; and must work very closely with African new settlers to ensure that their assumptions, language and messages are appropriate and effective.

The researchers have proposed that, for what should be considered historical reasons, Black African new settlers have a higher prevalence of HIV than other ethnicities within NZ, and are an emergent population at increased risk for HIV. The existing prevention and care infrastructure must take this into account. However, this must not be construed as a reason to discriminate against or stigmatise an already vulnerable population for any social or political reason, intentionally or unintentionally. Similarly, the researchers have made every effort in our dissemination of findings to ensure that we do not create an environment of blame or stigma.

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