
STI INEQUALITIES FACED BY BLACK CARIBBEAN COMMUNITIES: COMMUNITY RESEARCH REPORT



BHA for Equality in Health and Social Care

BHA for Equality in health and social care aims to challenge and address health and social care inequalities and to support Black, Asian and Ethnic Minority (BAME) individuals, families, and communities to improve their health and wellbeing.

BHA lead the Passionate about Sexual Health (PaSH) Partnership, a collaboration between BHA for Equality, George House Trust, and the LGBT Foundation which delivers sexual health improvement projects in Greater Manchester.

BHA specializes on the delivery of HIV and sexual health services to BAME communities in Greater Manchester. This is our focus as individuals from these demographics are facing higher or increasing rates of HIV or STIs, and experience racial and social barriers to accessing sexual health care and information.

The Project

Statistics show that Black Caribbean communities are significantly more likely to be diagnosed with an STI than any other demographic (PHE fingertips, 2020). This is a clear health inequality which must be addressed.

In this project we have identified gaps in existing research on STIs in Black Caribbean communities and used this information to design questions for a series of focus groups and interviews with people identifying as Black Caribbean in Manchester.

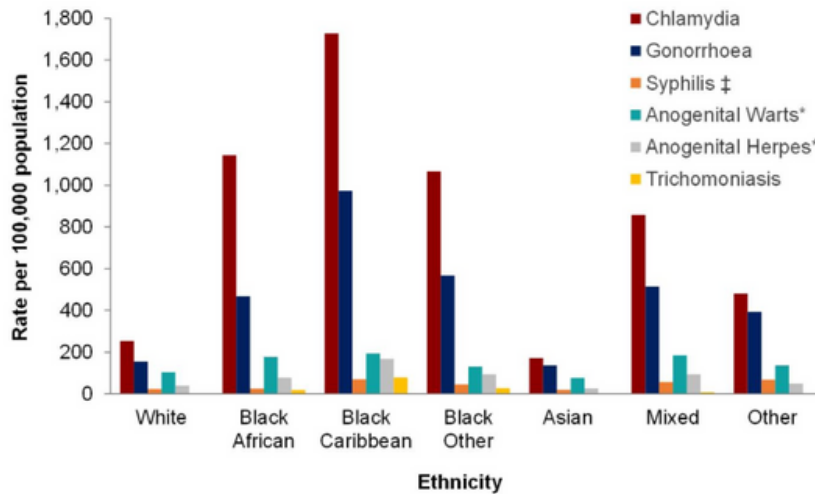
This report details the findings of these focus groups and interviews and has been designed to contribute to general research into the higher rates of STI diagnosis in Black Caribbean communities. It is also intended to be used by policy makers and health professionals to inform policy and healthcare practice.

Alongside the research element of our project, we also launched a campaign to increase awareness of STIs in Black Caribbean communities.

Existing Research + Project Rationale

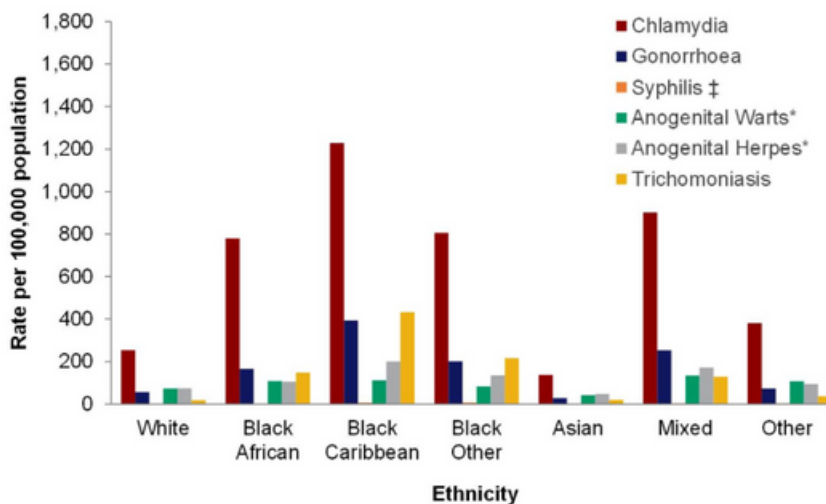
The inequalities in STI diagnosis rates across racial demographics is evident through the quantitative data published by Public Health England (2020).

Rates of STI diagnoses by ethnic group among males: England, 2019



34 Public Health England. 2019 STI Slide Set (version 1.0, published 2 September 2020)

Rates of STI diagnoses by ethnic group among females: England, 2019



35 Public Health England. 2019 STI Slide Set (version 1.0, published 2 September 2020)

From this Public Health England data (2020) it is clear that STI rates are higher in all Black ethnicities but significantly higher in Black Caribbean demographics. However, although this trend has been shown in quantitative data reports (more detail can be found through PHE fingertips) there is a limited amount of qualitative research which aims to understand the complex socio-cultural factors contributing to these statistics.

Understanding this is essential if we are to begin taking real steps towards ending this health inequality currently being experienced by Black Caribbean individuals in England.

Methodology

Initially we aimed to conduct a series of focus groups with individuals identifying as women or men of Black Caribbean heritage. These were to be held as separate 'women' and 'men' focus groups to encourage open discussion. We advertised for participants through social media, stakeholders, our links in the community and incentivized by explaining the campaign and offering all participants a voucher.

We were successful in securing three women for the first focus group and four for the second. However, the second was held over Zoom as the women were not comfortable participating in person.

As we struggled to get individuals identifying as men of Black Caribbean heritage to participate in a focus group setting, we partnered with a local barbershop to hold semi-structured interviews with Black Caribbean men. We were successful in interviewing three men and we were able to open-up a wider conversation about sex and STIs with all customers at the venue.

Due to the success of these interviews, we then conducted two more interviews with women to add further nuance to the community research.

In the focus groups we used a semi-structured question framework to guide the discussion:

What is your understanding or knowledge around the ways STIs can be prevented?

Do you think there is anything in particular which prevents people in the community from effectively negotiating condom use?

What would enable people from the community to be able to discuss testing, STIs, and sexual health with a partner/s?

What do you think motivates people in the community to get regular STI tests, and why?

Do you think people in the community would notify their partner/s if they received an STI diagnosis?

As noted in the project rationale, existing research has not been able to unravel the nuances in Black Caribbean communities which lead to behaviors (unsafe sex, not testing, not sharing STI diagnoses with partners). Understanding behaviours is

crucial as they could be contributing to higher rates of STIs in this demographic.

Our questions were therefore designed with the intention of revealing myths and prevalent misconceptions around STIs, attitudes towards condom use, testing and barriers to sharing STI diagnoses with partners or accessing sexual health services.

However, as well as structuring the focus groups and interviews around these questions, we used a semi-structured method to allow space for other related topics to be discussed by participants.

Using the data from the focus groups, we then identified core themes running across both focus groups: awareness, condoms, STI testing, sharing an STI diagnosis, culture around sex, stigma and poor experiences of sexual health services.

The report is structured around these themes and concludes with a section dedicated to our analysis and recommendations.

Focus Group 1

This group consisted of three women but was slightly limited as two participants had volunteered with BHA in the past and may have more knowledge of sexual health. However, the women were not only able to comment on their own experiences and perceptions but also those within their community.

Focus Group 2

This group consisted of four women and was only limited by the online environment as the women did not turn on their cameras. This was a barrier to having an open and honest discussion and the women did not share as freely as focus group 1.

Interviews

We conducted three interviews in an informal setting at a local barbershop. This enabled a wider discussion to happen in the shop which worked towards breaking stigma around STIs, sex and sexual health. However, this could have influenced some of the answers in the recorded interviews.

We also conducted two private interviews with Black Caribbean women.

Theme: Awareness

In all focus groups and interviews there was a general awareness of STIs and prevention methods.

However, there were several misconceptions held by participants. One being the use of 'clean' and 'dirty' when referring to STIs.

“I’m clean, you’re dirty – washing doesn’t help”.

“My friend says she doesn’t use a condom just has a ‘deep clean’”.

The use of this language contributes to stigma around discussing STI testing with partners or sharing an STI diagnosis.

It is also clearly contributing to misconceptions around STI prevention.

Additionally, there were misconceptions around what counts as ‘sex’ and what might be an STI risk.

There was a tendency to only ‘count’ sex if it was heterosexual, penis-in-vagina sex.

For example, one participant did not think women having sex with other women counted as sex or a risk for STIs:

“I had a boyfriend and girlfriend” she stated, but then admitted that she was not aware of the risk until a clinician explained that women can catch STIs from other women through sex.

There was a tendency to only ‘count’ sex if it was heterosexual, penis-in-vagina sex.

Recommendations

Public Health

- Awareness of all the different types of STIs (particularly less-known types ie. Trichomoniasis) and how they are transmitted/prevented should be improved.
- The seriousness of untreated STIs should be promoted to motivate people to test and to raise STIs as a priority when people engage in sex.
- Information about transmission needs to move away from focusing on heterosexual penis-in-vagina intercourse and cover risk associated with oral sex, anal sex, genital skin-to-skin contact and the use of sex toys between different partners without condoms or sufficient cleaning.
- Language such as ‘clean’ and ‘dirty’ should be challenged through campaigns to tackle stigma.
- Campaigns should aim to de-mystify sex and sexual health in general as other non-STI related misconceptions were evident in the focus groups. For example, the idea that the vagina becomes loose from too much sex.

Health Professionals

- Engage with service users around their use of the word ‘clean’ to break stigma and explain that STIs do not make you dirty and are like any other infection.

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- Cover a range of sexual practices when discussing risk to move the conversation away from only heterosexual, penis-in-vagina sex when discussing risk (oral, scissoring, topping, bottoming, sex toys, etc.)
 - Define what is meant by sex when asking questions as the service user may not ‘count’ some practices as sex if it does not fit into a penis-in-vagina definition.

Theme: Condoms

In all focus groups and interviews there was at least a basic awareness that condoms should be used for protection against STIs.

However, participants made clear their frustration at just being told to wear a condom and that they wanted health professionals to give realistic advice.

“I don’t wear condoms. NO ONE DOES”.

They listed the limitations of condoms:

“Not being pleasurable is a major barrier to overcome”.

“Ignorance of danger of not using condoms”.

“If you didn’t have a condom it’s not going to stop you from having sex, you will just pull out”.

Participants wanted sexual health advisors to realize this fact and be honest about it when campaigning or providing advice.

“People are not equipped to do this [discuss condom use] effectively” due to “a lack of confidence and lack of awareness”.

In several interviews, the nuances, and barriers to discussing condom-use before sex were explored.

Male participants stated a hesitancy to discuss condoms with partners and claimed finding the right time was an issue or that there was a fear of looking like they were only after sex.

“As a guy you can’t go on a date and then the first thing you start mention is about condoms...the girl might be put off by it like that’s what your whole intention innit for the date or why you hanging out”.

“There’s time where you’re with someone and you’re talking with them for a while, it’s not really a conversation that really comes up”.

They went on to explain that the ‘conversation’ when it does happen is usually reduced to a rushed “have you got a condom?”.

Some female participants were also prioritizing pregnancy prevention over STIs and did not consider condoms a reliable contraception method.

“Not gonna put my whole life in a condom. It’s not just as easy as getting an abortion...You can have a normal life with an STI but with a kid it’s hard work”.

“A lot of people think like they’re not gonna catch it ... so they’re not really gonna consider the risk. The kind of thing that happens to someone else but not me”.

However, another interviewee stated that STIs are only a top concern if someone close to them has been affected:

“People get regular testing when maybe they’ve had a scare or they know someone who has been affected. I know my testing went up when a close person to me found out they had HIV and that’s made me more vigilant with protecting myself and making sure people protect themselves as well, because it’s real...”

The participants also urged those looking at this research not to assume it was only women who needed to be better equipped to negotiate condom use as:

“Lack of confidence can be on both sides – not just women. Need to be able to articulate it in the right way and there needs to be respect on both sides”.

In juxtaposition to this, several men in interviews stressed that they felt condom-use was made to feel like the man’s responsibility.

“Usually there’s a lot of responsibility on the man, to have it and use it and there’s been time when a woman wouldn’t even ask if I have one or if I’m using one”.

This points to a need to encourage communication between partners and equip people with the skills to discuss condom-use before sex.

Recommendations

Public Health

- Condoms as an STI prevention method should be combined with messages promoting STI testing and encouraging discussions about testing with partners before sex.
- This combined approach should focus on normalizing these measures and equipping people with the skills for how to approach these discussions.
- Approach to condoms should move away from ‘negotiation’ and take a rights

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- and consent-based approach – for example discussing condoms and STI testing in the context of conditional consent.
 - Condoms should be re-branded as not only a prevention method but also something that can add to pleasure. This can be done by promoting the range of types available (i.e. ribbed/dotted, internal, thin, dental dams) and how they can be incorporated in sex in a positive way.

Health Professionals

- Follow condom advice with ways it can be made pleasurable: Suggest using different condom types, using lube + gel charging for extra pleasure, incorporating condoms into sex by putting it on your partner or continuing to touch or kiss them.
- Encourage service users to carry condoms at all times to be prepared.
- Talk to individuals about conditional consent and how condoms or STI testing can be a condition set for sex.
- Open up the conversation if an individual mentions they or their partner doesn't want to use them – asking why. This may be an opportunity to talk about pleasure, size, etc or to do a condom demonstration.

Theme: STI Testing

In general participants across the focus groups were aware that regular testing for STIs was a prevention method.

However, there were misconceptions about when testing was necessary as participants were not perceiving sex outside of penetrative, vaginal sex as a risk:

There was a lack of awareness about when testing is necessary:

“[People think things like] ‘I did it in the bum so won't catch it’”.

Participants also described the stigma attached to having an STI:

“When I was younger people [I] would look at certain people and make assessments based on how they look. Their lifestyle or their reputation...”.

Despite this, there was an awareness that discussing testing with a new partner before first having sex is the best time to ensure both have a negative STI status.

One participant described how she had done this with her now long-term partner at the beginning of their relationship to impressed silence from the rest of the group.

“I'm straight up – made sure he knew I'm not just gonna have a bit of holiday fun. Made sure we were both clean”.

This then prompted a larger discussion in the group with others sharing their hesitation to discuss testing with partners:

“Never done [had the conversation about testing] in the start of the relationship – because not expecting to go there”.

“Not sure I’d still ask about doing a test”.

“It’s not sexy”.

Participants across the focus groups and interviews identified timing as a barrier to discussing testing – in a similar way to the discussion around condoms (see above).

“At the beginning you don’t know the person and you’re trying to gain trust. So it shouldn’t be at the beginning but in the middle so you can discuss with your partner and really discuss it”.

One interviewee pointed out that there was a fear about discussing testing as it might make their partner think they are cheating or cause an argument:

“Some partners like if you mention stuff like that to them...sometimes you not even finish the subject and they’re thinking [that you are] cheating or thinking about it”.

However, although there were barriers to discussing testing, several participants were beginning to challenge this with attitudes such as:

“What if someone sees me in the clinic, so what I’m here looking after myself”.

“I’ve had something so what? I’ve been seen to”.

“[I know] who I am, what I like and how I look after my body”.

Others had logical approaches to testing:

One pointed to the threat of reinfection and the reality that infidelity can happen.

“I get a test every 6 months because I don’t trust my partner but also because it’s good to do. It’s for me and for the other person.”

Another stated that the prospect of NOT having to wear a condom was a motivator to test:

“Everybody wanna feel the flesh you know... If she decides that no I’m not gonna go with you without condoms then all you’re thinking – I wanna enjoy all of this without

then I'm gonna run and get a test".

However, some participants expressed frustration at the focus on women when it comes to testing. One participant (to loud noises of agreement from the rest of the focus group) asked:

"Why does it always fall on us? Black women? Go get yourself checked...Girls get checked if they're sleeping around...but are the men?"

A general culture of not seeking 'western' medicine was also mentioned:

"Prudish - no one talks about STDS or about general help. Anything is 'have a [herbal] cup of tea', 'you don't need the NHS you just need a cup of tea'".

"Feeling embarrassed after being at the doctors. No one talked about it in family conversations".

One participant then spoke of how she was trying to change this culture by discussing sexual health with her children:

"I'm more open with my kids because my parents weren't open with me".

Participants in both focus groups also had suggestions for things which would motivate Black Caribbeans to test:

"Motivated by my own health".

"They would have to have high confidence in nurses and health professionals at sexual health services".

"Apart from partner saying get tested - fear of getting something".

Recommendations

Public Health

- Regular testing should be promoted to everyone to tackle shame and embarrassment about testing or discussing testing.
- Motivate testing with messaging about the long-term effects of untreated STIs to raise it as a priority for individuals.
- The idea that testing whilst in a relationship is indicative of a lack of trust should be challenged by the narrative that testing is an act of love - for yourself and your partner.
- Promote discussions about STI testing between partners and equip people with the skills to do so.

Testing should be promoted across genders to mitigate the responsibility falling on one in a partnership.

Health Professionals

- Provide real life conversation starters to equip service users to discuss testing with partners. For example, “I haven’t tested since... Shall we book in/order online?”, “When was the last time you took a test?”, “I went to get an STI test today”, “I think you can order online if you want to do one”.
- Advise service users on how they can approach the discussion (setting, timing) and ways it can be made lighthearted.
- Ask service users what is worrying them about discussing testing with a partner. Talk this through with them and give advice on how to deal with reactions they are particularly worried about (anger, repulsion, shame, judgement).

Theme: Sharing an STI diagnosis

From our focus groups and interviews it was clear that sharing an STI diagnosis was extremely difficult in a very socio-specific way for Black Caribbean individuals in Manchester.

Whilst it can be difficult for anyone to share a diagnosis (as taboo around sex exists in all levels of society) the small nature of the Black Caribbean community in Manchester makes it a much more daunting prospect.

“Every Caribbean in Manchester knows everyone. Manchester is small. My own family, sister, Mumma – they’ll be weird”.

This interconnected social space is then compounded by specific stigma’s which exist within Black Caribbean communities around STIs and sex.

There were several responses referencing the connections and stigma attached to sharing:

“No way. The connections – as a woman definitely not”.

“Stigma isn’t it. People don’t want to be attached to that really. It kinda stains you doesn’t it”.

“Some people just ashamed some people don’t wanna hurt their family”.

There was more willingness to share with a current partner – partially because it would be difficult to conceal in a current partnership as there is still a relationship there.

One person had the logical point of the prospect of continual reinfection:

“I would happily share cos if I get treated and then they don’t get treated... I’m gonna get it again [unless] I start using condoms”.

Another participant highlighted shame as a barrier to partner notification:

“I’ve notified a partner and I’ve been in a situation where my girls have notified a partner, or my boys’ have had to notify their partner... Stigma’s out there, I can imagine why people don’t for the fear of shame and things like that.”

There was also a narrative around ‘blaming’:

“Men like to blame ‘who’s given it to them’...Blamed on the women”.

However, one interviewee stated that among his peer group and friends (25-30 age bracket) there was a culture of openness when it came to sharing about a visit to the sexual health clinic, STI test or STI diagnosis:

“We tell each other we’ve gone and had it. I know every single one of my friends that’s had an STD or STI you know what I mean. So it’s not like – I wouldn’t be shocked or anything”.

But when asked about the culture around sharing an STI diagnosis with partners there was more hesitancy to share.

“Depends like what the relationship is like now”.

Recommendations

Public Health

- Taboo around sharing an STI diagnosis (shame, blame, ‘dirty’ associations) should be challenged in campaigns.

Health Professionals

- When dealing with a positive STI result, convey to the individual that although there is a need to find contacts it is not about finding someone to ‘blame’.
- Reassure the individual that having an STI does not make you dirty, it is not theirs or anyone else’s ‘fault’ and they don’t need to moralize.
- Encourage the individual to share connections by moving conversation away from ‘blaming’ and stating that it is important that everyone gets treatment.
- Make sure it’s communicated to the person that they can contact contacts, or the sexual health clinic can do it for them if they want to remain anonymous.

Theme: Culture around Sex

A wider discussion around Black Caribbean culture and sex also developed through

the focus groups.

Again, participants shared misconceptions around what counts as 'sex' in the community:

“People think it’s just kissing. Stuff outside vagina is still sex. What does ‘virgin’ even mean?”.

“You’re not a lesbian if you use a toy kind of thing – is that the same?”.

Across participants, there was much discussion around intergenerational stigma and misconceptions around sex, sexual health and STIs.

One interviewee described the way in which both the stern, protection-based conversations with elders and the progressive, jokey, pleasure-focused conversations with friends both contribute to a complete lack of open discussion about STIs.

“[Sex] comes up in different ways. With your parents or like your elders it will come up but it will come up in an informative way and it will come with stark warnings of like ‘you better not come home with this and that’... Like my mum for example, when it came to condoms all she would ever say was like ‘make sure you wrap up’ and that was it. Nothing else more. But because we don’t feel comfortable speaking like that with our parents and when it comes to like friends or people that are in our social group, age group the conversation is a bit more liberal but it’s more about the act and the enjoyment of it and what we’ve done – not necessarily protection but that’s me”.

He also went on to stress that the protection conversation is always centred on preventing pregnancy and STIs are not high on the agenda.

“[It’s always about] how important it is to protect yourself in terms of having babies but when it comes to catching STDs there’s also a bit of a joke around it where it’s like I’m going to pop a pill”.

However, another interviewee explained that the intergenerational taboo is beginning to be broken down:

“Sex used to be like a behind the scenes thing...it’s just like just easier to break down now ...so [with] my 11-year-old I don’t mind breaking it down to them cos it’s gonna pop up on their phone”.

Recommendations

Public Health

- Challenge pervasive ideas around ‘virginity’ and what counts as sex to challenge stigma around sex, STIs and increase awareness of what counts as risk.
- Facilitate wider conversations in Black Caribbean communities to challenge misconceptions, myths and taboo around sex and STIs.

Health Professionals

- Equip patients with skills to discuss sex and sexual health with younger generations in a way which is not contributing to stigma, shame, etc.

Theme: Stigma

There were also many comments on the stigma around sex, sexual health, STIs and HIV within Black Caribbean Communities.

HIV stigma specifically was mentioned extensively, and one participant shared her own experience of HIV stigma:

“HIV, the stigma still gets to you now – it’s the community which makes you feel like that. People used to go around saying I had HIV”.

It is clear here that the social trauma of HIV (which has disproportionately affected Black communities) has impacted the perception and stigma around STIs in general.

Several participants went on to share their own observations of HIV in the community which we can’t quote as they included details which were too identifiable.

Participants also repeatedly pinpointed stigma as a reason people would not want to test or share an STI diagnosis:

“Having an STD is worst thing ever (not going to tell best friend that)”.

Theme: Poor experiences of Public Health Messaging and Sexual Health Services

In all focus groups there were several criticisms of sexual health services, public health approaches and staff. One participant spoke about a clinician who had breached confidentiality, despite all NHS staff being bound by the ‘Confidentiality: NHS Code of Practice 2003’.

“I had an experience where... I was positive and next thing I knew I started hearing the news all round [the] church we both go to. This was so appalling”.

This was not reported and others in the focus group were not aware this could be reported.

In fact, one person asked for the following sentence to be shared with those in power:

“[There] should be penalties if confidence is broken – by healthcare professionals and policy makers”.

Another stated:

“Policy makers should put in rules and regulations for clinics – information at clinics should not be shared to the public”.

This clearly shows that there is not an awareness that confidentiality is upheld by law and that there would be serious consequences if it was reported.

Others felt there was a lack of empathy from staff – especially with younger people.

“I wasn’t happy [with the clinic]... they were long on the phone. She [young person] was crying and needed to know... [clinic just says] ‘phone back tomorrow at 2’... Listen to them talking to the youth and they talk down to them. They were condescending... [They] need to be more empathetic... We went round all the places. Just wanted someone to talk to her and give her some advice. [They] should allow a representative to call for them. The girls don’t know what to say”.

Participants also felt racially targeted or judged in consultations due to discourse around countries of travel/residence:

“They [sexual health clinics] ask you ‘have you been to countries, high risk countries and if you haven’t been there then HIV is pretty much impossible’. But if you haven’t slept with someone from there then you’re all right”.

The participant then explained how this is misinterpreted to make people think they don’t need to worry about HIV or STIs:

“I think that plays a role ... if those sexual health experts are making it like [that] then we’ll take that into real life going forward”.

When asking questions based on countries and prevalence the reasoning behind the question needs to be articulated to mitigate people feeling racially targeted and to improve overall experience. This is important as there is already a mistrust of institutions due to racism, so steps do need to be taken in this regard.

Being racially targeted also came up when it came to public health campaigns around sexual health. Although it is important to see representation and to target

information at key demographics facing inequities, the reason for this needs to be contextualized.

This is not currently happening, and participants wanted an approach which was ‘more like open’, ‘more like a national thing’, ‘a people thing’ rather than a ‘colour thing’.

When conducting our interviews and focus groups – we experienced resistance when framing the project around the statistic ‘Black Caribbean are 5x more likely to be diagnosed with an STI’. Although we were using this to showcase the inequity and why we wanted to amplify their voices, it was initially taken to be contributing to a racialized stereotype of Black Communities being overtly promiscuous and adulterous.

There was also general frustration that Black communities were always associated with infections (HIV, STIs, COVID) or being seen as a societal ‘problem’ (the centre point of disease or societal issues such as knife crime).

There was also a mistrust of Public Health England statistics and participants wanted the full context of the data as well as our rationale for the project before engaging. Once this was explained, people were onboard, trusted us and opened-up.

Public health campaigns should be framed with this in mind.

Other comments about sexual health services and health campaigns included:

“Easier just going in. Access is bad”.

“Collection points in the community – why not pick one up if it’s just down the road”.

“[In informative videos] seeing people that look like you’ [and the language needs to be] ‘direct’ [and using the language of the community]”.

“Information in different forms – soft human voices, different kinds of awareness”.

Recommendations

Public Health

- Public Health campaigns should focus on healthcare rights, what can be expected when accessing services and how to report issues, concerns and poor experiences.
- Action should be taken to improve access – same day appointments, walk-ins, not having to make an account or ring at a specific time, collection points for

tests in community settings.

- Campaigns targeted at Black Communities need to be contextualized to avoid mistrust, lack of engagement or negative repercussions for Black communities founded on other communities framing stereotypes around them based on campaigns. The reasoning behind the targeting needs to be communicated and any data explained.

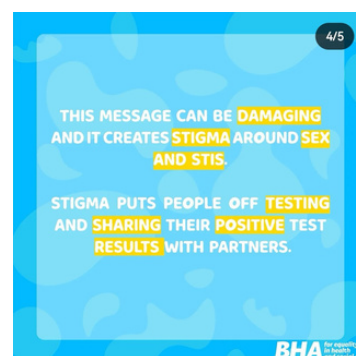
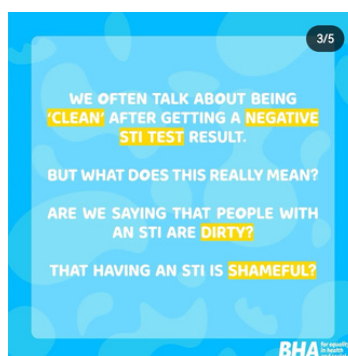
Healthcare Professionals

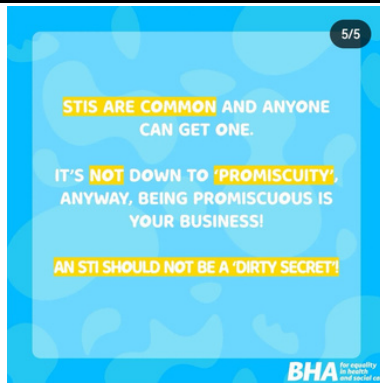
- Reporting and feedback process needs to be clearer on clinical websites.
- Clinicians should be prepared to explain why questions about countries of travel/residence are being asked.
- More empathy is needed when discussing STIs and sexual health with patients.
- Clinicians should consciously use less condescending language especially when talking to younger patients. In this regard it is crucial that patients are not shamed for any sexual activity they share as it is likely that they are already facing stigma around this within their communities.
- If for some reason something can't be done - the reasoning needs to be communicated to the patient.

Our Campaign

After conducting the community research and pulling out the main themes, analysis and recommendations we delivered a social media campaign, prevention video designed for people from the community, and a webinar for health professionals to improve practice.

The social media content was tailored around the nuances unveiled by our research. We commissioned a graphic designer (Florence Peyton Jones) to create content with a bold, bright, fun and informal approach. We also aimed to make the representation intersectional, with sex understood outside of the heterosexual penis-in-vagina definition. Informal language and slang familiar to Black Caribbean communities was used to increase trust in the content.





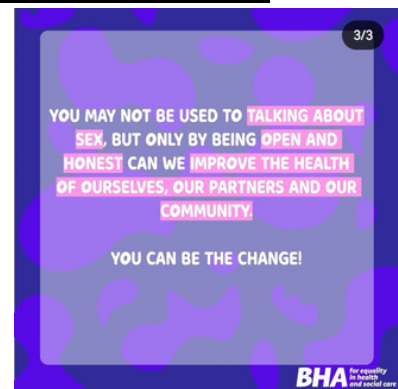
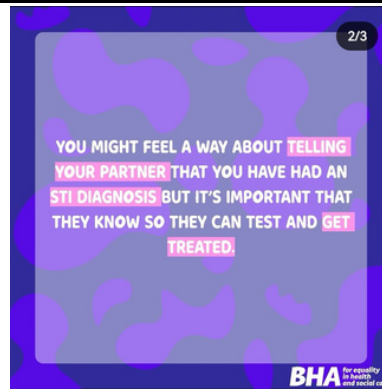
Here we chose to depict a couple in an intimate position to de-stigmatize discussing sex without shame and replicated a conversation likely to be had in real life when discussing condoms and STIs.

We then helped our audience to question why they were using this language, and what it's connotations might be.

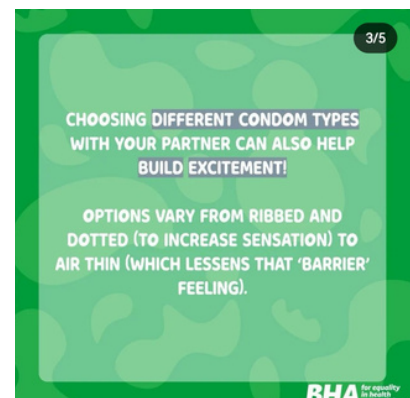
We also reiterated that STIs are not down to 'promiscuity' and shouldn't be a 'dirty secret'.



In our virginity post we used intersectional representation to put across the message that women having sex with women can be a risk and challenged the notion of virginity and put across that all sexual acts carry risk.

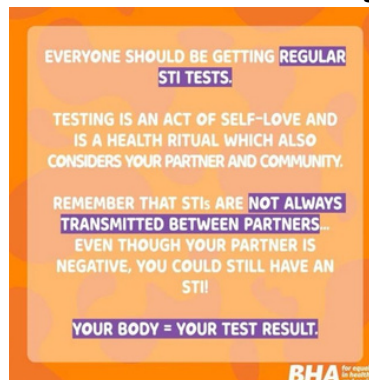


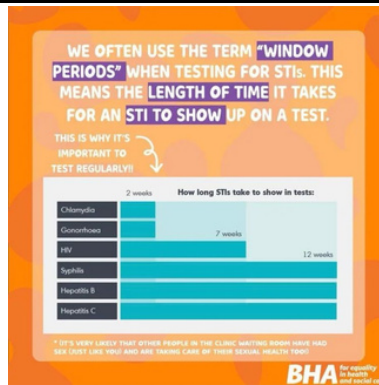
Here, we aimed to let people know they are not alone with their fears around testing and sharing a diagnosis, and also put across the importance of sharing the diagnosis so partners can get treated.



In this post, we challenged common condom excuses, explored ways condoms can be made more pleasurable and integrated into sex and put across the message that they are the only contraceptive which also prevents against STIs.

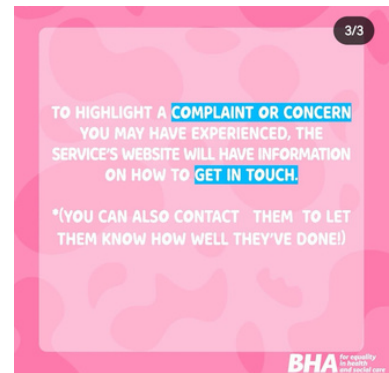
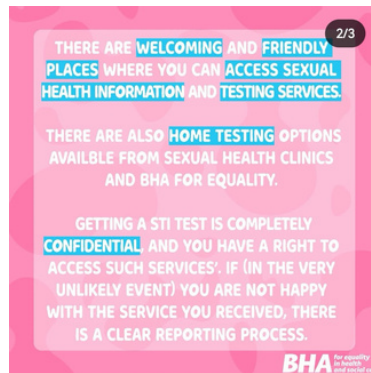
We also promoted BHA's free condom + lube delivery service.





Here we reassured those who are scared to test by putting across messages around treatment and the common nature of STIs. We also encouraged people to test as STIs can have no symptoms and explained the long-term implications if left untreated.

This post also reiterated messages around regular testing, how STIs are transmitted, window periods and when you need to test.



Here, we informed people of their right to healthcare and what they can expect when accessing a sexual health service. We also directed people to finding the information on a clinic website to report a poor experiences, concerns or positive feedback.

Each post was also supplemented with a customized meme to encourage people to engage with the informational posts by reeling them in with a comedic approach.



When someone judges your friend for taking an STI test and looking after their health...



When your boy says they're a virgin but you know they've had head, fingered someone and done anal...

As well as posting this content on our own pages across Instagram, Facebook, and Twitter, we paid two local people living in Manchester and of Black Caribbean heritage to act as 'influencers'.

We recruited these two people to be health influencers as they were influential people involved in lots of different aspects of the community and had a large number of local followers across their social media channels.

We set out to hold a month-long social media campaign which was launched on the 13th June, lasting four weeks. During this period, the influencers shared our tailored content across their pages and allowed a range of reach which would have been impossible if solely posting campaign content on our branded social media.

It also enabled us to co-produce the whole campaign as we shared the content with them for feedback before finalizing.

In addition to the above graphics, suggested messages and scripts were provided with flexibility to allow influencers to tailor the content to their online presence and audience. The authenticity of the influencers encouraged audience trust in the messages that they shared.

This is a model we are using across our PaSH work and has been formalized into a method with a robust training and resource package which is tailored to each new campaign.

The long-term success outcomes of this model are:

Trust and access to a wider audience has led to more nuanced conversations around STIs and sexual health.

We have developed a long-term working relationship with the influencers which has also allowed us to co-produce the model and future campaigns.

Over several campaigns influencers have enabled us to gain an extra 4175 likes,

43638 views, 42 shares and 99 comments.

Impact of the campaign

Throughout the campaign we promoted our free condom & lube delivery service as well as our STI tests.

Over the period of the campaign we received 59 condom & Lube requests from Black Caribbean residents in Greater Manchester. We also completed 15 full screen tests for individuals of Black Caribbean heritage during the campaign.

Mainstream sexual health clinics were signposted throughout so it is likely that an individuals also took up testing offers from there in addition to our own testing.

Prevention Video

We co-produced a prevention video with the same graphic designer as the social media campaign (for aesthetic continuity). This is intended to be displayed in health care waiting rooms and across our social media platforms. The video explores the statistics around the health inequity and uses conversation scenarios to put across key prevention messages around the importance of sharing STI diagnoses, condom use, conditional consent and aims to de-stigmatize conversations about sexual health.

Webinar

A webinar was also delivered for health professionals where we presented the key findings from this research report and put forward our recommendations for more effective consultations.

This webinar was designed to create space for health professionals to come together and think about actionable ways their practice approach can be tweaked to encourage the uptake of prevention behavior, partner notification and conversations about STIs and testing between partners.

We were pleased to be able to deliver both a social media campaign aimed at the community and a webinar for health professionals as we believe action to end STI inequalities must take a two-tiered approach - working to increase awareness and break stigma in the community but also working with services and institutions to ensure that services are designed with the communities facing inequities in mind.

Conclusion

Thank you for taking the time to read the findings of our community research. We hope the nuances we have highlighted through this work and recommendations we have provided will inform your own work and be part of wider action to act on this health inequality currently faced by Black Caribbean communities.

We want to thank all the people who agreed to participate in this research and to our funders at Manchester City Council who made this project possible.

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MANCHESTER
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BHA *for equality
in health
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