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Migration memories of sexual and reproductive health in late twentieth-century London

Caroline Rusterholz* and George J. Severs

Department of International History and Politics, Gender Centre, Geneva Graduate Institute, Geneva, 1202, Switzerland
*Corresponding author: Department of International History and Politics, Gender Centre, Graduate Institute, 1211 Geneva, Switzerland. E-mail: caroline.rusterholz@graduateinstitute.ch

Abstract

This article examines the sexual and reproductive health experiences of eight people who migrated to London in the late twentieth century from Kenya, Zambia, Nigeria, Sudan, and Uganda. Their experiences were captured through an oral history partnership with NAZ, a sexual health charity run by and for racialized people in London. They illuminate the informal processes of sexual and reproductive health knowledge production before migrating to London, such as jokes and gossip, in the face of minimal formal education on these topics. All of the interviewees studied in this article are living with human immunodeficiency virus (HIV) and moved to London in their early twenties. In this article, we pay close attention to their experiences of sexual and reproductive health services and HIV and acquired immunodeficiency syndrome (AIDS), which provide novel understandings of the ways in which such services were experienced by those who migrated to London. By listening attentively to the interviews and deploying oral history theories around memory and narrative, we argue that migration and the generational shifts of the interviewees acted as major turning points in their sexual and reproductive health journeys by increasing exposure to such services. While often empowering, such encounters were, at times, also experienced as alienating or racist. In addition, the interviews reveal how British public health campaigns resonated internationally and were closely entangled in migration narratives. The interviewees' experiences of HIV/AIDS demonstrate the multiplicity of HIV/AIDS histories, offering new perspectives on HIV/AIDS experiences in Britain.

Keywords HIV; AIDS; sexual knowledge; general practitioners; oral history

Introduction

In an oral history interview in 2024, Jide reflected on his experience accessing sexual and reproductive health (SRH) services in London during the late 1980s and early 1990s. Born in London in 1965 to Nigerian students, Jide and his family lived in London for three years before moving back to Nigeria.[1]

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[1] Jide interviewed by Stephen Hart, 09/07/2024. Interviews are only cited when first introduced.

At the age of 18, Jide 'came home' to Britain and settled there. Growing up, he had no formal sex education and recalled learning about sexuality 'by default' by observing other boys. He soon realized that he was attracted to individuals of the same gender, which created feelings of anxiety due to his family's Christian background. Despite this, he also spoke of the joy he felt in discovering his own body and desires. When he returned to London, Jide began to take more responsibility for his sexual health. He recalled first visiting his general practitioner (GP), who then referred him to a sexual health clinic. Jide went on to explain that while he received treatment for a sexually transmitted disease, he was not taught how to protect himself: 'There was no kind of support to sit me down, to say, you know, this is what happened to you. It could happen again. This is how you prevent yourself. There's none of all of that at all.' Jide came out as gay in 1994 and explained that, since then, he had access to condoms and support through the lesbian, gay, bisexual, transgender and queer (LGBTQ) community, becoming a volunteer himself in different charities promoting sexual health. Ten years after coming out, Jide was diagnosed with HIV in 2004.

Jide's case is emblematic of several throughlines discussed in this article. Just as it did for Jide, London played a central role in providing care for minoritized individuals living with HIV. Moreover, migration acted as a turning point in the SRH experiences of minoritized groups, either heightening migrants' sexual vulnerability or increasing their exposure to SRH services. Finally, National Health Service (NHS)-provided SRH services remained basic and often lacked the emotional support, comprehensive information, and 'cultural sensitivity' that clients truly needed. It was only through services specifically dedicated to SRH, and especially those which were 'by and for' minoritized communities, that clients could access the appropriate information and supportive networks they were seeking. It was in the 1980s, and especially the 1990s, that these services grew and became most visible due to the urgency of the HIV/AIDS epidemic and its impact on particular migrant groups within Britain.[2] Thanks to ongoing historical research, these charities and people's experiences of them are starting to be illuminated.[3] This article contributes to this research by drawing on oral history interviews with eight individuals who migrated to London in the late 1980s and early 1990s and were diagnosed with HIV in Britain.

Until recently, the history of minoritized individuals[4] and SRH has mainly been written from an American perspective, shedding light on the oppression and reproductive constraints faced by women of colour and marginalized communities.[5] In Britain, there has been little scholarly acknowledgement of the racialization within SRH services, nor of how racialized people accessed such services. Race as an analytical framework had first been applied to the broader field of modern British history. Building on the groundbreaking work of Paul Gilroy's *There Ain't No Black in the Union Jack*,[6]

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[2] Naomi Samake-Bäckert's ongoing doctoral work at the Geneva Graduate Institute titled 'Race, health and women's rights: lessons from the Black women's movements in Britain, 1970-2000' is illuminating such services. Many of the women's centres discussed by Charlotte James Robertson did offer SRH support and advice, but these aspects are not discussed in her work. See C. J. Robertson, 'The Women's Refuge as "homeplace": Black and Asian Women's Refuges in Britain as Spaces of Community and Resistance (1980–2000)', *Women's History Review*, 33 (2023), 554–73. For work on 'by and for' health services which were organized around identities of Blackness, see G. Redhead, '"A British problem affecting British people": Sickle Cell Anaemia, Medical Activism and Race in the National Health Service, 1975–1993', *Twentieth Century British History*, 32 (2021), 189–211.

[3] L. Cann, 'Race, Homosexuality, and AIDS in London: The Response of British AIDS Voluntary Organizations to Black Gay Men's Sexual Health Needs During the AIDS Crisis (1980s–2000)', *Modern British History*, 36 (2025), 1–23; S. Biswas, 'HIV-AIDS and the NAZ Project: Race, Sexuality and south Asian AIDS Activism in Britain, 1990-2000', *Journal for the History of Sexuality*, 34 (2025), 2, and G. J. Severs, *Radical Acts: HIV/AIDS Activism in Late Twentieth-Century England* (London: Bloomsbury, 2024), 56–67, 136–45.

[4] 'Minoritized' offers a social constructionist approach to the way that people are actively treated as constituting a distinct minority by others. It provides an intersectional reading of minoritization, and recognizes it as a social process shaped by power differentials rather than a static set of identity categories. S. Selvarajah et al. 'Categorisation and Minoritisation', *BMJ Global Health*, 5 (2020).

[5] K. Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California Press, 2011); L. Briggs, *How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump* (Berkeley: University of California Press, 2018); L. Briggs, *Reproducing Empire: Race, Sex, Science, and US Imperialism in Puerto Rico* (Berkeley: University of California Press, 2002): D. E. Roberts, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (New York: Pantheon Books, 1997).

[6] P. Gilroy, *There Ain't No Black in the Union Jack': The Cultural Politics of Race and Nation* (London: Routledge, 1987).

scholars have analysed ‘racial formation and their residues’.[7] Among them, Jordanna Bailkin has explored the contributions of migrants to the welfare state in postcolonial Britain, while also highlighting their pathologization.[8] Roberta Bivins has demonstrated how migrant bodies became objects of medical control and pathology.[9] This welfare-based racism did not go unchallenged, however; Grace Redhead’s work emphasizes migrant activism in campaigning for medical treatment, while Jessica White has illuminated the resistance and solidarity of Black women, who established women’s centres to address their specific needs.[10]

Yet, in the field of SRH, the focus has mainly been on the history of the creation and expansion of venereal disease clinics, birth control clinics and family planning centres, the political history of sexual health and abortion services, and the sexual and reproductive behaviours of ‘ordinary men and women’.[11] While this scholarship offers fascinating insights into gendered reproductive behaviours and contraceptive decision-making, it does not take a fully intersectional perspective. The lived experiences explored have been largely limited to white Britons. In the past decade, Natalie Tomlinson, Cecily Jones, Caitlin Lambert, Anne Hanley, Laura Kelly, and Caroline Rusterholz have started to centre racialization in their work on SRH.[12] Yet, their work primarily explores discourses on and policies aimed at minoritized individuals, rather than minoritized individuals’ lived experiences of SRH.

Historiographical engagement with HIV/AIDS in the UK has grown considerably over the past decade. Building on earlier scholarship that centred on policy formation, more recent work has been concerned with questions of experience, identity, and activism.[13] Questions of sexuality and gender have particularly concerned these more recent contributions, which seek to understand the ways in which HIV/AIDS impacted individuals and communities more intersectionally. Despite these welcome developments, questions of race, racialization, and racism remain underdeveloped in this literature, especially when compared to the work of historians such as Dan Royles and Antione Johnson who have studied the racialization of HIV/AIDS in the USA, as others have across a range of national

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[7] Quote in M. Matera et al., ‘Introduction: Marking Race in Twentieth Century British History’, *Modern British History*, 34 (2023), 407414. For the new scholarship see in particular work by K. Hammond Perry, *London is the Place for Me: Black Britons, Citizenship and the Politics of Race* (Oxford: Oxford University Press, 2016); C. Schofield, *Enoch Powell and the Making of Postcolonial Britain* (Cambridge: Cambridge University Press, 2013); S. Hirsch, *In the Shadow of Enoch Powell: Race, Locality and Resistance* (Manchester: Manchester University Press, 2020); K. Connell, *Black Handsworth: Race in 1980s Britain* (Berkeley: University of California Press, 2019); S. Peplow, *Race and Riots in Thatcher’s Britain* (Manchester: Manchester University Press, 2019); R. Waters, *Thinking Black: Britain, 1964-1985* (Berkeley: University of California Press, 2018). M. Matera, *Black London: The Imperial Metropolis and Decolonization in the Twentieth Century* (Berkeley: University of California Press, 2015); K. Connell, *Multicultural Britain: A People’s History* (London: Hurst, 2024); M. Matera et al., ‘Marking Race: Empire, Social Democracy, Deindustrialization’, *Twentieth Century British History*, 34 (2023), 552–79.

[8] J. Bailkin, *Afterlife of Empire* (Berkeley: University of California Press 2012); R. Waters, *Colonized by Humanity: Caribbean London and the Politics of Integration at the End of Empire* (Oxford: Oxford University Press, 2023).

[9] R. Bivins, *Contagious Communities: Medicine, Migration, and the NHS in Post-War Britain* (Oxford: Oxford University Press, 2015).

[10] Redhead, ‘A British problem’; J. White, ‘Black Women’s Groups, Life Narrative and the Construction of the Self in Late Twentieth-Century Britain’, *The Historical Journal*, 65 (2022), 797–817.

[11] H. Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception 1800-1975* (Oxford: Oxford University Press, 2004); K. Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960* (Oxford: Oxford University Press, 2006); A. Hanley, *Medicine, Knowledge and Venereal Diseases in England, 1886-1916* (Cham: Palgrave Macmillan, 2017); R. A. McKay, ‘Before HIV: Venereal Diseases among Homosexually Active Men in England and North America’ in M. Jackson, ed, *The Routledge History of Disease* (Abingdon: Routledge, 2016); C. Rusterholz, *Women’s Medicine, Sex, Family Planning and British Female Doctors in Transnational Perspective (1920-70)* (Manchester: Manchester University Press, 2020); C. Rusterholz, *Responsible Pleasure: The Brook Advisory Centres and Youth Sexuality in Postwar Britain* (Oxford: Oxford University Press, 2024); S. Szreter and K. Fisher, *Sex Before the Sexual Revolution: Intimate Life in England 1918–1963* (Cambridge: Cambridge University Press, 2010). For work on abortion services see S. Sheldon et al., *The Abortion Act 1967: A Biography of a UK Law* (Cambridge: Cambridge University Press, 2023).

[12] C. Jones, ‘“Human weeds, not fit to breed?” African Caribbean Women and Reproductive Disparities in Britain’, *Critical Public Health*, 23 (2013), 49–61; A. Hanley, ‘Migration, Racism and Sexual Health in Post-war Britain’, *History Workshop Journal*, 94 (2022), 202–22; C. Rusterholz and L. Kelly, ‘Depo-Provera, Class, Race and the Domiciliary Family Planning Services in Glasgow and Haringey, 1970-1983’, *The Historical Journal*, 68 (2025), 216–38; N. Thomlinson, *Race, Ethnicity and the Women’s Movement in England, 1968-1993* (Basingstoke: Palgrave Macmillan, 2016), 168; C. Lambert, ‘“The objectionable injectable”: Recovering the Lost History of the WLM through the Campaign Against Depo-Provera’, *Women’s History Review*, 29 (2020), 520–39.

[13] For an overview of these historiographical developments see V. Berridge, ‘Foreword’, in J. Weston and H. J. Elizabeth, eds, *Histories of HIV/AIDS in Western Europe: New and Regional Perspectives* (Manchester: Manchester University Press, 2022), xviii; Severs, *Radical Acts*, 3–6.

contexts.[14] New work is underway to understand the ways in which HIV/AIDS was racialized in modern Britain, of which this article is one contribution.[15]

This article focuses on migrants' lived experiences of attending SRH services in London in the 1980s–2000s through analysis of eight oral history interviews with women and men who migrated to London and were/are living with HIV in London. Looking closely at the experiences of these interviewees provides a markedly different lens into the history of HIV/AIDS in the UK. As such, they offer a series of cautionary notes about the ways in which historians have thought about that history, and help us to question whose experiences have informed histories of sexual and reproductive health more widely. In analysing their migration trajectory and access to SRH services, this article makes four key contributions to the field of modern British history. First, it contributes to the recent historiography that has focused on Britain in its decolonizing decades, adding a new exciting case study to the later decades of the 1980s–2000s. While the earlier period of decolonization has received a great deal of historical attention, few scholars have focused on the later decades of the 1980s and 1990s. This article follows Rob Waters' lead by looking to this later period, beyond the years defined by legislative efforts to restrict formal migration routes to the UK, which have animated most scholarship in this field.[16]

Secondly, SRH has remained largely overlooked in histories of racialized minorities.[17] This article contributes to the history of lived experiences of migration and SRH by centring migrants' experiences and voices in our analysis. Doing so provides a detailed understanding of minoritized individuals' knowledge of and access to SRH. This article explores the ways the interviewees recalled their SRH journeys before and after migrating to London, which include sex education (both formal and informal), access to SRH services, and HIV diagnoses.

Thirdly, by focusing later in this article on the history of HIV/AIDS through the perspective of migrants to London, this article provides valuable insights which have hitherto occupied only a peripheral space in the literature. Centring these experiences offers a distinct chronology of the HIV/AIDS epidemic in the UK, and makes visible the international resonance of what have been understood as nationally bound public health campaigns. Such insights should prompt historians to be cautious about our understandings of turning points and progress narratives within these histories. When much of the UK 'AIDS sector' was heralding the advent of highly active antiretroviral therapy (HAART) from 1996, migrants, their advocates, and medics were concerned about the increase in cases of HIV/AIDS they were experiencing, and the disproportionate levels of dangerously late diagnoses.[18] Rather than jettison milestones like this, migrant voices prompt historians to ask who experienced these turning points, resulting in a more detailed experiential map of HIV/AIDS in the UK. Finally, this research complicates understandings of SRH services over the second half of the twentieth century, by underlying the uneven and often prejudicial provision of SRH services for racialized minorities in late twentieth-century Britain.

Resharing: an ethical and methodological approach

The sources that inform this article emerge from an oral history collaboration, one aspect of a broader partnership that undergirds this project. An ethos of collaboration and shared authority anchors our work, and can be thought of as a methodology of resharing. Thinking of our interviewees

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[14] D. Royles, *To Make The Wounded Whole: African American Responses to HIV/AIDS* (Chapel Hill: University of North Carolina Press, 2020); A. Johnson, 'More than Pushing Pills: Black AIDS Activism in the Bay Area, 1981-1996', PhD thesis, University of California, San Francisco, 2022; M. J. Bosia, 'AIDS and Postcolonial Politics: Acting up on Science and Immigration in France', *French Politics, Culture and Society*, 27 (2009), 69–90; C. Ewing, 'Highly Affected Groups: Gay Men and Racial others in West Germany's AIDS Epidemic, 1981-1992', *Sexualities*, 23 (2020), 201–23.

[15] For others see Cann, 'Race, Homosexuality, and AIDS'; Biswas, 'HIV/AIDS and the NAZ Project'; Severs, *Radical Acts*, 56–67, 136–45, and Lola Dickinson, 'The "Prostitute" and the "Client" in the Making of England's AIDS Policy', *Social History of Medicine* (published online December 2025).

[16] R. Waters, 'Small Boats, Border Incredulity, and the Hostile Environment in Britain, 1967-1978', *History Workshop Journal*, 98 (2024), 27–54, see esp. 27–28.

[17] This is despite some tantalizing source material suggesting avenues for further work. See, for example, K. Connell, 'An African American Anthropologist in Wales: St. Clair Drake and the Transatlantic Ecologies of Race Relations', *Journal of British Studies*, 63 (2024), 176.

[18] McMunn, Mwanje and Pozniak, 'Issues Facing Africans in London with HIV Infection', 157.

as enacting a process of ‘resharing’ their stories allowed us to acknowledge that these were not narratives which we were uncovering for the first time, nor were these narratives being told for the first time. Instead, we were participating in a process in which interviewees trusted our partners and us with their memories, and in which we aimed to disseminate these experiences through academic and community outputs—another form of sharing.[19] In particular, we sought to form relationships with people and organizations working to deliver SRH care and advice. These relationships were formalized as part of the project. Of specific interest to this article is the oral history partnership that we forged with NAZ, a SRH charity established in 1991. Founded by the HIV/AIDS activist Shivananda Khan, NAZ aimed to ‘develop and provide culturally and linguistically appropriate HIV/AIDS services for the South Asian, Turkish, Arab, and Irani communities in Greater London’. Despite its base in London, NAZ quickly ‘became one of the leading ethnic minority HIV/AIDS and sexual health agencies in the United Kingdom’.[20]

NAZ undertook to conduct a series of oral history interviews ‘in house’, which would then be shared between NAZ and us, and used in ways which were useful to each. To this end, NAZ recruited Stephen Hart to conduct interviews with around twelve of its members. Hart is a person of colour living in London with HIV, whose ‘Hart Talks’ YouTube videos have documented the experiences of several people living with HIV and working with HIV/AIDS organizations. Despite having no formal oral history training, Hart’s combination of lived experience and interviewing credentials made him uniquely well-suited to this role. The interviews were all conducted in English, which all interviewees were ‘familiar with and were happy speaking’, even if it was not their first language.[21] Hart’s lived experiences were invaluable, ensuring that interviewees felt safe and that they were telling their story to someone who understood many of their experiences. As Amy Tooth Murphy has noted, experiences of injustice, hatred, violence, and oppression can create communities ‘that can be sceptical or suspicious about appeals for information, especially from institutions or authorities, and wary of voyeuristic intrusions’.[22] Hart’s presence as an ‘insider’ interviewer was able to allay such fears in the most part, though not wholly. Two participants withdrew, one noting that she did ‘not feel comfortable with [her] voice being used’.[23] Indeed, it is important not to overemphasize or homogenize the impact of Hart’s insider status. He himself acknowledged his pre-existing relationships with the interviewees during some of the interviews, wary that the interviewees may gloss over issues which the two had discussed privately. By being aware of this risk, Hart was able to frame questions to mitigate this risk, asking one interviewee: ‘So, I, I know that *I* know this but, just for the sake of the recording, what’s your relationship like with your parents.’[24] Hart’s ability to put the interviewees at ease led to the recording of interviews rich in emotional and empirical detail. His relationships and experiences were necessary in making those who took part feel safe, secure, and heard. One interviewee, for example, told Hart at the end of their interview that ‘you’re a wonderful friend, a wonderful interviewer. Yeah, like the way you’ve interviewed me, it’s like I, at times I’m forgetting that you’re interviewing, just talking’.[25]

This article discusses eight of the twelve interviews. Two interviewees withdrew from the project at different stages, and the authors decided to exclude a further two from the analysis undertaken here as their age and country of origin did not allow for a meaningful comparison (one was much younger than the eight interviewees discussed here, and another was not from the African continent). It focuses specifically on the experiences of individuals who migrated from Kenya, Zambia, Nigeria, Sudan, Uganda, and Angola. Two interviewees opted to be anonymized in outputs arising from their

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[19] We elaborate on this methodology in C. Rusterholz, N. Samake-Bäckert and G. J. Severs, ‘Who does History? Reflections on Writing an Intersectional History of Sexual and Reproductive Health in Britain’, *Traverse*, 1 (2026), 39–48.

[20] S. Khan, ‘Culture, Sexualities, and Identities: Men Who have Sex with Men in India’, *Journal of Homosexuality*, 40 (2001), 112.

[21] Email from Stephen Hart, 6th May 2025.

[22] A. Tooth Murphy, ‘Listening in, Listening out: Intersubjectivity and the Impact of Insider and Outsider Status in Oral History Interviews’, *Oral History*, 48 (2020), 37.

[23] We discuss this more in Rusterholz, Samake-Bäckert and Severs, ‘Who does History?’.

[24] Angelina interviewed by Stephen Hart 05/05/2024.

[25] Charity interviewed by Stephen Hart 03/06/2024.

interviews, though the majority did not want to be. In order to respect all interviewees' wishes and to ensure simplicity and clarity, only first names are used, and asterisks indicate the use of pseudonyms.[26] These eight interviewees were selected to allow for meaningful comparative analysis. All eight interviewees are similar in age, share relatively similar migration trajectories, were exposed to similar SRH services, and are or were living with HIV in London. The interviewees were mostly from relatively comfortable socio-economic backgrounds; their families owned properties and/or businesses, most had significant experience of international travel, and many were university-educated. While these socio-economic factors shaped their ability to migrate to London and marked their experiences in particular ways, the structural racism they encountered in Britain drastically shifted the ways they understood their own class status, an experience common to many who migrated to the UK during the post-war period.[27] The interviewees also have meaningful differences; despite all coming from the African continent, their experiences are drawn from six national contexts. Their countries of origin all experienced colonization, mostly by the British but also by the Portuguese in the case of Angola.

The age range and African origin of the interviewees in this article are significant for historical epidemiological reasons. The 1990s saw concern grow about Black African people living with HIV in the UK. By 1994, numbers of 'black African people with AIDS' made up nearly a quarter of all UK cases (24 per cent), up from just 7 per cent at the turn of the decade.[28] With most migrants from the African continent settling in London, with some (particularly Ugandans) being disproportionately impacted by HIV/AIDS, African-born Londoners in particular attracted attention.[29] In 1991, for example, Black adult Ugandans made up nearly 60 per cent of 'AIDS cases among the Black Africans living in London', despite making up only 7 per cent of that cohort.[30] Not only was there an epidemiological concentration of Black HIV-positive people in London, but there was also significant organizing from these communities too. While Manchester and Leicester each boasted a Black HIV/AIDS Forum, research conducted in London in 1996 found that 38 African-led organizations were providing HIV/AIDS information, advice, and support services to the Ugandan, Kenyan, Tanzanian, Zairean, Zambian, or Zimbabwean communities, and this was done on a regular basis.[31]

This sample is small, yet the richness of these testimonies from across five Commonwealth nations and Angola provides a variety of lived experiences of family life, migration, healthcare experiences, and everyday life, which larger qualitative migration or medical data do not capture. While memories of HIV diagnosis differ across the interviewees, their experiences migrating to London as young adults in the late 1980s and early 1990s and living with HIV provide points of commonality and comparison across richly varied lives.

This article teases out the experiences of SRH that emerge from these oral history interviews. Chief among these themes are experiences of HIV diagnosis and engagement with SRH medics and charities (given the common thread of HIV running throughout the interviews). By placing those in conversation with experiences of sex education, migration, and racialization, a more detailed and textured history of migration and SRH in late twentieth-century London emerges. Migration was not a limited experience in time, but an ongoing process where embodied social inequalities continued to be reshaped across the life course. This 'postmigrant thinking' makes visible 'the embodiment of

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[26] We deploy an asterisk the first time that an interviewee's name is used.

[27] P. Washington Miller, 'Downgrading and Discounting the Qualifications of Migrant Professionals in England: The Case of Overseas-trained Teachers', *Education, Knowledge and Economy*, 2, 1 (2008), 15–25; J. Bornat, P. Raghuram and L. Henry, 'Oral History Voicing Differences: South Asian Doctors and Migration Narratives', *Economic and Political Weekly*, 49, 30 (2014), 60–66; G. J. Severs, 'Composing and Narrating Black Memories of Sexual and Reproductive Health in Jamaica and England in 1990s Birmingham', *Journal of British Studies,* 64, e60 (2025), 1-24, see 14-15.

[28] A. M. McMunn, R. Mwanje and A. L. Pozniak, 'Issues Facing Africans in London with HIV Infection', G*enitourinary Medicine*, 73 (1997), 175–58, quote at 157.

[29] The five areas of the UK which gained the largest number of 'Black' migrants at the end of the 1990s were all London boroughs. See L. Simpson and N. Finney, 'Spatial Patterns of Internal Migration: Evidence for Ethnic Groups in Britain', *Population, Space and Place*, 15 (2009), 37–56, figure at 42.

[30] McMunn, Mwanje and Pozniak, 'Issues Facing Africans in London with HIV Infection', 157.

[31] McMunn, Mwanje and Pozniak, 'Issues Facing Africans in London with HIV Infection', 158. On the Manchester group, see Severs, *Radical Acts*, 140. On the Leicester group see, for example, Record Office of Leicestershire, Leicester and Rutland: DE8600/2.

inequalities' which cut across so many interviewees' lived experiences, including those of SRH.[32] Notions of identity and belonging were in flux across this period; individuals' understandings of their own identities shifted across time, and were not always in line with the ways in which they were categorized and understood by others within Britain. While our sample is not representative, we follow Lindsey Dodd's example that even a single oral history interview can illuminate 'broad social processes'.[33] Specifically, these interviews offer a glimpse into varied migration trajectories, highlighting instances of alienation but also of inclusivity, offering a different sexual healthcare landscape than is currently available in the historiography. These preliminary findings shed light on key themes that could be further studied by larger research projects, as well as inform inclusive health care practices and policies.

Sexual knowledge and experiences

Lack of sex education and sexual knowledge during the formative years of discovering one's own body was a key feature of our interviewees' SRH journey. These experiences are in line with the literature on the subject. Research on Kenya, Zambia, Uganda, and Nigeria has emphasized the scarcity of sex education in schools up until the late 1990s, the prevalence of the abstinence-only approach, based on negativity and 'scare tactics', as well as the lack of sex education from parents.[34] This ignorance on matters of sex information and experiences and sexually transmitted diseases is not particular to migrants' experiences but was also shared by British young people up until the 1990s. Indeed, research on sex education in Britain has constantly highlighted how young people felt ignorant about sex, how little information they received at school, and the constant opposition of moral traditionalists towards compulsory sex education in school.[35]

Born in 1968 in Zambia, Rebecca is a compelling example of this lack of information on sexual health and contraception, especially the use of scare tactics. Rebecca attended a Dominican convent secondary school for girls, where she was shown a documentary on abortion that traumatized her:

> There was one particular lesson where they taught you about abortion. It was a video, and it scarred us for life, because they just showed these really vivid videos of actual terminations taking place. And I think we all came out about thinking we're never going to go near boys again. But, yeah, that was the only time that we ever got taught about, you know, anything to do with sex education.[36]

Staying away from boys was also recommended by her grandmother, who explained to her that 'boys have got this very large insect between their legs, so you better stay away from it'. Similarly, Esther, born in Kenya in 1967, remembered that her mum could not even say the word sex, and the only information she got from her was to stay away from men because when 'a man touches you, you are going to be pregnant'.[37] The silence and taboo around sex in the family discussions were also experienced at school. Esther went to a Church school and learnt about the reproductive system in science, but did not remember that sex was ever mentioned. She emphasized the stigma surrounding sex in her high school years, where sex was not something that was easily discussed or talked openly about,

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[32] G. Yurdakul, 'Postmigrant Thinking: Definition, Critiques and a New Offer', *International Migration*, 62 (2024), 120–23.

[33] L. Dodd, 'Small Fish, Big Pond: Using a Single Oral History Narrative to Reveal Broader Social Change', in Joan Tumblety, ed, *Memory and History: Understanding Memory as Source and Subject* (Oxford: Routledge, 2013), 34.

[34] J. Shiffman, et al., 'International Norms and the Politics of Sexuality Education in Nigeria' *Globalization and Health*, 14 (2018), 1–13; N. Mbugua, 'Factors Inhibiting Educated Mothers in Kenya from Giving Meaningful Sex-education to their Daughters', *Social Science & Medicine*, 64 (2007), 1079–89; D. Kayongo-Male and P. Onyango, *The Sociology of the African Family* (London: Longman, 1984); B. De Haas and I. Hutter. 'Teachers' Conflicting Cultural Schemas of Teaching Comprehensive School-based Sexuality Education in Kampala, Uganda', *Culture, Health & Sexuality*, 21 (2019), 233–47.

[35] C. Rusterholz, *Responsible Pleasure. The Brook Advisory Centres and Youth Sexuality in Postwar Britain* (Oxford: Oxford University Press, 2024). H. J. Elizabeth, ''Private Things Affect Other People': Grange Hill's Critique of British Sex Education Policy in the Age of AIDS', *Twentieth Century British History*, 32 (2021), 261–84.

[36] Rebecca interviewed by Stephen Hart, 23/04/2024.

[37] Esther interviewed by Stephen Hart, 14/06/2024.

except in the gossip forms where young women who had sex in high school were treated like ‘outcast’.

Winnie, born in Sheffield in 1961, where she spent 3 years before moving to Uganda with her parents, also had no sex education at school. The only form of information she had about sex from her family and relatives was that she should ‘not associate with boys’ and she stressed the gender dimension of this warning by adding that she was told ‘as a woman you can’t do that’.[38] The gendered nature of sex information was also emphasized by Mustafa*****, born in Sudan in 1964. Growing up, Mustafa did not have sex education at school, emphasizing his feeling of being left in the dark in this matter. Yet, he briefly mentioned the double standard in his school about sexual activity. He recalled that a teacher approached the subject of wet dreams for boys and that he told the girls that they needed to wait. Mustafa emphasized how his female peers were ‘all very embarrassed, very embarrassed’.[39] This anecdote stressed the limited level of information that Mustafa received and hinted at the gendered access to even scant information.

Rebecca from Zambia was exposed to more information on sex through her relatives. She emphasized the peculiarity of the sex education system amongst certain tribes where girls ‘coming of age’ were sent away to relatives for a definite period of time to learn the ‘nitty gritty’ of sex in marriage. Rebecca experienced such a practice but remembered how she felt confused about the stories she was hearing as a 15-year-old girl without sexual experience. This sex education was a one-way process in which the young girl received information from other women but could not ask questions herself. In addition, she explained, ‘everything was very centred around pleasuring man and how the best way to do it’.

In Uganda, Winnie was sent to her aunt’s house for similar purposes but her aunt ‘told her nothing’. Winnie underscored how talking about sex and sexual health was taboo. Similarly, Charity, born in 1970 in Zambia, mentioned that when she got her period, her aunties told her, ‘if a boy touches you, you’ll [get] pregnant’.[40] This warning frightened Charity, and she would often come home crying, convinced she was pregnant because a boy had touched her. A very similar memory was shared by Angelina, born in 1967 in Kenya. She mentioned that she did not receive sex education at school, but recalled hearing the voice of an elder saying ‘don’t play with boys. You’ll get pregnant’. How she was going to get pregnant, she added, nobody told her. Later in the interview, she reiterated the absence of sexual health information, explaining that as a teenager, what she received were ‘warnings’ rather than education: ‘it’s not even sexual health. It’s not about good sexual health. It’s not about good relationships. It’s just about you must not interact with boys in that way.’

In a society where talking about sex was taboo, sexual information was often distributed through jokes and gossip.[41] Interviewees, by and large, learnt about sex in informal ways through peer discussions. In Uganda, Winnie remembered having discussions with her classmates about other people’s experiences and later about her friends’ excitement of falling in love, of having sex but not going into ‘too much’ detail. Angelina from Kenya explained that sex was ‘alluded to’ amongst her friends. She knew which of her friends were doing it, but the ‘intricacies and the ins and outs’ were not developed. Some interviewees remembered that jokes and gossip circulated about people having sexually transmitted diseases. For instance, Charity mentioned that everyone would make fun of ‘men walking with their legs wide apart’, assuming they had gonorrhoea. Likewise, she remembered hearing adults whispering about HIV/AIDS and being told not to go out ‘with somebody who’s skinny as they might have it’.

Only three interviewees accessed birth control in the country where they grew up before moving to Britain. Contraceptive services were available in Kenya, Uganda, Zambia, and Nigeria, but awareness and usage remained low. In Kenya, despite launching one of sub-Saharan Africa’s earliest family planning programs in 1967, the 1977–78 Kenya Fertility Survey (KFS) showed persistently high fertility

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[38] Winnie interviewed by Stephen Hart, 05/06/2024.
[39] Mustafa interviewed by Stephen Hart 20/08/2024.
[40] Charity interviewed by Stephen Hart 03/06/2024.
[41] Gossip between young English teenage girls has also been identified as a channel of sexual information. See Charnock, ‘Teenage Girls’.

rates. However, by the late 1980s, fertility began declining, attributed in part to modern contraception use following the creation of the National Council for Population and Development in 1982. [42] Uganda's Family Planning Association (FPAU) was founded in 1957, but was banned in the 1970s under Idi Amin. Although reinstated in 1975, the 1980s civil war hindered contraceptive information, and a 1989 survey showed only 5 per cent of married women used birth control, with just 3 per cent using modern methods.[43] In Nigeria, the Pathfinder Fund supported the Planned Parenthood Federation of Nigeria, but an official family planning policy was not adopted until 1988. Even then, contraceptive prevalence was just 7.5 per cent, with contraceptive and medical methods at 3.8 per cent in 1998.[44] In Zambia, the Family Planning Welfare Association of Zambia (FPWAZ), established in 1972 with International Planned Parenthood Federation (IPPF) support, faced opposition from the Catholic Church and the Women's League. Only in the mid-1980s did policy support grow after the UN Population Fund (UNFPA) persuaded influential leaders like Chibesa Kankasa to support family planning programmes. The 1988 Contraceptive Prevalence Survey recorded 9 per cent usage in rural areas and 14 per cent in urban areas in Zambia.[45]

When Charity from Zambia had a sexual relationship for the first time, her boyfriend went to a clinic pretending to be married to obtain the birth control pill, but she emphasized to him that it was a 'secret and if her parents or neighbours found out about it you are dead'. Rebecca from Zambia used the coil after giving birth to her first son. She explained that she was not using birth control when she became sexually active, and did not know she was pregnant, only finding out after collapsing on the road. At the time, she worked in a bank with access to private health care, allowing her privileged access to sexual and reproductive healthcare not available to all of her peers who inhabited less affluent socio-economic realities.

> I collapsed on the road, and then they rushed me to my, like I said, the bank that we were working, so the medical care who immediately thought, well, maybe it's an ectopic pregnancy. They established it wasn't. And then when that finished, then they said, now you need to go on contraceptive. So I took the tablets for a while and realized I'm not very good at tablets. I then opted for what they call the copper coil at the time. Yeah, and I haven't looked back, that's been my go-to thing. I've always had a coil inserted in instead, and that was the same when we arrived in this country.

Prompted by a question about the relationship with the doctors, Rebecca stressed the power relationship at play by answering, 'there was no trust, it was hierarchical'. In her narrative, Rebecca drew a distinction between her reproductive health and sexual health. As will become clear later in this article, she became aware of her sexual health once she moved to Britain and was given information on the subject when she received her HIV diagnosis. Yet, her reproductive choice was shaped by her interaction with reproductive health services in Zambia; the coil, which she had had inserted in Zambia, remained her go-to method in Britain. Rebecca's interview is an important reminder that it was not migration alone that impacted interviewees' SRH trajectories. These were affected as much by generational change as geographic shift.

Similarly, Winnie never encountered any official sexual health information as such. She recalled that sexual health in Uganda was not widely talked about, and it was difficult for her to know how to access services. Sexual health services, she understood, were usually for desperate situations and could only be accessed via private providers. She herself attended a private clinic for a sexually transmitted disease and felt she was doing something that she 'wasn't supposed to do', experiencing shame and explaining that 'she did not like that feeling'. She stressed how little information she was

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[42] W. Njogu, 'Trends and Determinant of Contraceptive use in Kenya', *Demography*, 28 (1999), 83–99.

[43] E. M. Kaijuka et al., *Uganda Demographic and Health Survey, 1988/1989* (Entebbe: Ministry of Health, 1989), 31.

[44] K. H. Martinez and Rahman Naveen, *Women's Reproductive Rights in Nigeria: A Shadow Report* (New York: Centre for Reproductive Law and Policy, 1998), 6.

[45] D. Lucas, 'Fertility and Family Planning in Southern and Central Africa', *Studies in Family Planning*, 23 (1992), 145–58; K. Lee et al., 'Family Planning Policies and Programmes in Eight Low-income Countries: A Comparative Policy Analysis', *Social Science & Medicine*, 47 (1998), 949–59.

given, ‘I remember being, you know, given this prescription, and me not asking, what is it? You know, okay, just presume the doctor knows, and the pharmacist will know, okay. And you get it and you take it.’

Shame was central in Winnie’s narrative and she described the multiple ways in which this emotion manifested for her.

> It was shame going in [for] anything that affects your private parts. Yeah, shameful. And then when you have somebody you know examining you, you know your private parts, that’s added shame. And when you’re you know when an STI is confirmed, that’s another level of shame. And then, you know, if you have to, to share that shame with a partner or somebody you’ve been, you know, having sex with, that’s a whole other layer of shame, right? Yeah, you know, so for me, it was just levels and levels of shame, shame, right?

Winnie also spontaneously contrasted these feelings with her experience a few years later in the UK where she felt she gained ‘the most sexual health knowledge’. Exposure to sexual and reproductive health services and information occurred for the majority of the interviewees once they had migrated to Britain, not least due to their relocation to an urban environment in the midst of the ongoing HIV/AIDS crisis.

Sexual and reproductive health services in Britain before HIV diagnosis

Once the interviewees moved to Britain, they were increasingly exposed to SRH services and became increasingly aware of their sexual health. This was mainly due to two key reasons: easier access to SRH services in part due to the urban environment in which they relocated, and increasing sexual activity due to the age at which they moved to Britain and the lack of social control. The interviewees migrated to London in the late 1980s and early 1990s. London at that time had many different SRH services in the different neighbourhoods of the city. Key charities had their headquarters in London, such as the Family Planning Association, the Brook Advisory Centres, and Margaret Pyke’s Centres. In the 1990s, family planning services and sexual health services under the responsibility of district health authorities were available in most districts in London, despite recurrent cuts in these services.[46] Besides family planning clinics, general practitioners (GPs) in the NHS were the main source of contraceptive advice and methods. Yet, these services did not always offer supportive and unbiased care as made clear by Black women activists. In their landmark book *The Heart of the Race: Black Women’s Lives in Britain*, Beverley Bryan, Stella Dadzie, and Suzanne Scafe shed light on doctors’ obsession with controlling their fertility and the many instances of racism they experienced while visiting sexual and reproductive health services.[47]

Despite this history of coercive medical population control, none of the interviewees mentioned feeling pressured to limit the size of their families. They framed their arrival in Britain as a turning point in their SRH journey, where they actively sought more information and methods to protect themselves from sexually transmitted diseases and pregnancy. GPs held a central role in informing women about contraceptive methods and referring them to appropriate sexual health services. Charity, who had obtained the pill through her boyfriend and who decided to take birth control when she moved to London, recalled her newfound access to such information and services as an increase in her personal agency. She emphasized the variety of options she had and the surprising ease with which she could access contraceptives.

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[46] Barbara Kenmir, *Family Planning Clinic Cuts: A Survey of NHS Family Planning Clinics in Greater London* (London: Family Planning Association, 1990).

[47] B. Bryan, S. Dadzie and S. Scafe, *Heart of the Race: Black Women’s Lives in Britain* (London: Verso, 2018 [1985]), 99-107.

> You know, so when I came to UK, I decided to, to … go and have the birth control. It was, it was like, Yeah, you can choose yet, all these options. I'm like, what? I can just go and have without anybody asking me for my signature, proof of marriage, certificate for marriage to to get all these? So I did, but I had complications with the birth controls I was reacting to. I tried about three or four of them. You know, I was having some issues with them, and then my GP decided it cannot help me anymore, because I was getting, one was making me depressed, the other one I ended up with, what do you call it, rash? Rash or pimples, and then beard growing like little hairs coming up. We're like, we tried all these, like, three months or four months each time. At the end, my GP just said, I think we stop. You carry on with condoms.

Esther also contrasted her knowledge of birth control before and after moving to Britain. What is salient in her testimony is the emphasis she put on the support that, for her, characterized her SRH encounters in Britain. Her GP was central in facilitating access to services and referring her to sexual health clinics.

> When I came to England, you know, I didn't know much. I think when I was young, I just knew about the pill. And you could buy it down the road, […] and just take it. Nobody was telling how to take it or anything. But as soon as I came to England, it was the GP that referred me, you know, to a clinic where they helped me with maternity, you know, if I wanted to have children and also have a smear test and have my sexual health and and if, ah, like, for example, I've had the coil, which was also through that process. And I have two children, which also through the support of GP clinic, antenatal clinics, that, was you know, welcome.

Like Charity, Esther underlined that different birth control methods were offered to her. She tried the pill, then the implant but gained unwanted weight, so she gave this method up for the coil. In this process, she stressed the ongoing support she received and the fact that she was closely monitored for side effects: 'they were really good in terms of follow ups and just looking at how well I'm doing with each contraceptive.' She even explained how close she was with one of her doctors and the happiness she felt when visiting him regularly at Royal Free Hospital because 'they'll talk about everything, talk about relationship'. He asked questions about her children and helped her with immigration issues and housing problems. Support, trust, and the feeling of being cared for were key features in her testimony. The emphasis she placed on support may be linked to her own experiences, as she had a profound need for it. As a teenager in Kenya, she was sexually abused, and she carried this trauma with her to Britain. Reflecting on this, she explained: 'As much as we might get older, you can still be living in that room.' In Britain, she also received trauma therapy, which enabled her to take 'a step forward in healing'.

Angelina, born in Kenya, remembered relying on the 'safe period' 'for a long, long time', which she learnt about through conversation with friend. She started using contraception in Britain and reflected that 'it was late, later than I should have been starting'. As Angelina and several other interviewees remembered, their knowledge of SRH increased vastly because of their proximity to, and place within, the HIV/AIDS epidemic.

HIV/AIDS

The interviewees in our sample experienced AIDS for the first time in several ways. Some first heard about the virus around the same time as most of the UK population, namely around 1987. This year is generally agreed to be a major turning point in the British history of HIV/AIDS. Virginia Berridge characterizes it as the start of a period of 'wartime response', including a large-scale public information campaign, which ran under the title 'AIDS: Don't Die of Ignorance'.[48] The campaign is best remembered by its television adverts, which were designed to prompt viewers into preventative action

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[48] V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996), 81.

through fear. In one, the word 'AIDS' is dramatically chiselled into a large gravestone. In another, 'AIDS' is revealed as the enormous submarine level of an iceberg.

These adverts were accompanied by a leaflet, delivered to every house in Britain, which contained information on HIV, how it was transmitted, how to avoid it, and who to call for more information.[49] It was via this leaflet that Angelina first heard of AIDS. 'I think I remember the leaflet came through the door'. She recalled this being 'in the late 80s' on 'one of the times I'd come to visit my mum', who had moved to London from Kenya in the early 1970s. Angelina herself moved to the UK in 1989, splitting her time between London, where her family lived, and Manchester, where she was a student. She was diagnosed with HIV in 1992, having been advised by her GP to take a test after discovering she had hepatitis B.[50] Angelina's memory diversifies the historical picture of the audiences and reception of the Don't Die of Ignorance public health campaign. This was not simply a national public health campaign, but one which had an international reach, especially in ethnically diverse centres such as London, as friends and family visited from overseas and were exposed to its outputs.

The way that some interviewees recall the public health campaign helps to nuance understandings of the ways in which it was experienced and remembered, problematizing the extent to which the campaign has been constructed as a homogenizing national turning point. Esther, who was born in Kenya in 1967, told Hart that 'I remember the tombstones. I remember the adverts very, very clearly. And it was quite scary'. She positioned these memories 'around the '92, the 90s', several years after the adverts had aired. What at first appears to be a misdated memory in fact reveals a deeper truth. As Alessandro Portelli put it, 'the importance of oral testimony may lie not in its adherence to fact, but rather in its departure from it', precisely because 'it tells us less about *events* than about their *meaning*'.[51] Indeed, both of Esther's memories are 'true'. Esther likely saw the tombstone adverts when they were first broadcast in 1986–7, or could have heard about it from Kenyans who, like Angelina, encountered them while travelling between family members in the UK and Kenya. But it is also true that, for Esther, these adverts were more pertinent if they were recalled in the early 1990s, the period in which the numbers of heterosexual cases of HIV/AIDS, as well as those from African-born Londoners, was rapidly increasing.[52] In this way, Esther moved the 'tombstone' adverts of 1986/7 into the early 1990s, repositioning a collective memory into a period which spoke more directly to her own experiences of the virus. In doing so, Esther 'composed' her narrative, constructing it to allow her to make sense of her own experiences within a broader and more available cultural framing. She did this by reorienting her own memory of encountering the Don't Die of Ignorance campaign, bringing it into line with the national account, which dominates the histories and discourse around HIV/AIDS public health campaigns.[53] By noting this process of narrative composure, the extent to which migration narratives have been marginalized within, or excluded from, that broader framework becomes apparent.

Exposure to adverts about HIV/AIDS did not equate to greater understanding of the virus. Jide, for example, was born in London but spent his childhood and adolescence in Nigeria, where his parents returned in the late-1960s. He recalled arriving in London in the mid-1980s, characterizing it as 'the gloom and doom of HIV/AIDS'. Jide quickly immersed himself in London's gay scene, frequenting clubs and bars. Despite the fact that this was the period of the 'wartime response', and followed increased campaigning efforts by groups like the Terrence Higgins Trust, Jide recalled that 'any information related to AIDS or sexual health was not easily available'. Jide's recollection that sexual health information was not easily available reinforces the findings of historians such as Jason Okundaye and Lucy Cann, who have argued that Black gay men were ignored by and ostracised from these earlier HIV/AIDS campaigns.[54] It is likely that Jide was one of many Black gay men who were

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[49] Department of Health and Social Security, 'AIDS: Don't Die of Ignorance', Government Information 1987, Wellcome Library: EPH503:3.

[50] A. Namiba et al., eds, *Our Stories Told By Us: Celebrating the African Contribution to the UK HIV Response* (no place of publication: ZZUK Press, 2023), 20.

[51] A. Portelli, 'What Makes Oral History Different', in R. Perks and A. Thomson, eds, *The Oral History Reader* (Oxford: Routledge, 2016), 53 and 52, respectively.

[52] McMunn, Mwanje and Pozniak, 'Issues Facing Africans in London with HIV Infection'.

[53] G. Dawson, *Solider Heroes: British Adventure, Empire and the Imagining of Masculinities* (London: Routledge, 1994), 23.

[54] Okundaye, *Revolutionary Acts*, 178–83; Cann, 'Race, Homosexuality, and AIDS in London'.

overlooked by majority-white HIV/AIDS organizations. While some HIV charities were organizing Black women's groups from the late 1980s, most remained blinkered about the needs of Black heterosexuals until the mid-1990s when ethnic minorities in Britain gained increased attention as constituting 'most of the cases of heterosexually-acquired AIDS'.[55]

Whether they were familiar with the public health campaign or not, the interviewees in our sample were all diagnosed at various points as being HIV-positive. The ways in which they narrate their diagnoses reveal the emphasis placed on migration to Britain as a major turning point in their sexual health histories. Of course, these interviewees migrated to Britain at a point in their life course in which they were more likely to engage with SRH services. These turning points were recalled with both positive and negative value judgments: life in Britain appeared to offer greater opportunities for diagnosis and HIV treatment, but while sexual health clinics were often recalled fondly, their memories of HIV diagnosis and treatment were also impacted by racism.

When asked about when she first became aware of her own sexual health, Rebecca equated this with her arrival in London. Her first consciousness of her sexual health came 'when I came to this country, and that would have been when I first got my diagnosis in the HIV clinic'. Both she and her husband were diagnosed with HIV in 1996, the year after they migrated to London, after a shift in her husband's health suggested the need for an HIV test. For Rebecca, this was the first time 'I'd stepped into a sexual health clinic or centre'. For many, this could be a daunting experience, but Rebecca recalled this as an affirming and empowering one. As she explained: 'they're very good at explaining what they're doing, what the process is, what else they're checking you for, they're also very good at encouraging you to ask questions. So they'll ask you, do you understand what that means? And then you'll say, no, actually, I don't, they'll explain it further'. For Rebecca, the specialisms contained within the HIV clinic ensured that her experience of HIV diagnosis was one that left her feeling more informed.

Similarly, Winnie felt that her HIV status and the relationship she developed with the nurses and doctors left her knowing more and being more in control of her sexual health. 'I feel that through my journey of living with HIV, my sexual health knowledge has improved humongously. Yeah, you know, I'm able to have conversations with my you know, with my doctor, my individual sexual health has improved'. This is despite the fact that Winnie felt somewhat forced into discovering she was HIV-positive, after being obliged to be tested for the virus as one of the conditions of an unpaid internship she was undertaking at the time while living in the USA. As Winnie explained:

> I presented myself at a clinic, you know, to to, you know, to get to be tested, but not specifically for HIV. Yeah, I went because I was required to do this because of an internship that I was part of. So it was almost through, like a work experience, unpaid work experience, that I was able to get a core series of tests and then found out that I was HIV positive.

Compulsory HIV testing such as this was more common in America, but did occur in Britain.[56] As Somak Biswas shows, several international development schemes, including the British Council, mandated their grant recipients to take an HIV test ahead of entering the UK as part of a multi-layered informal border regime that used HIV/AIDS as a means of denying entry to the UK.[57] For Winnie, it was the relationship with her specialist HIV medical team in London that left her feeling more empowered, especially in contrast with memories of being forced into her diagnosis by circumstance. For both Winne and Rebecca, their move to London appeared to mark a more open and accessible relationship with SRH services.

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[55] BBC Panorama, 'Heterosexual AIDS: The Myths and the Menace', broadcast 20 July 1992, British Film Institute: 392908. On the establishment of an HIV positive 'African women's group', see Severs, *Radical Acts*, 55–6.

[56] George J. Severs, 'A Crisis of Consent? Police Surgeons and HIV/AIDS', in Rhian Keyse, Adeline Moussion-Esteve and Emma Yapp, ed, *Sexual Violence in Medicine and Psychiatry: Addressing Harms Through Interdisciplinarity* (Cham: Palgrave Macmillan, 2026).

[57] S. Biswas, 'The "Screening Debate": AIDS and Immigration in Late Twentieth-Century Britain', presentation at the European Histories of HIV/AIDS Symposium at the University of Copenhagen (Sept. 2025).

Regardless of their experience of HIV diagnosis, many interviewees found that medical professionals began to treat them differently, especially in non- specialized clinical settings. This was the case for Charity, who was diagnosed with HIV after realizing that she had acquired herpes and subsequently requested a full sexual health screening. She recalled an incident in a general hospital where she was awaiting surgery for a lump on her neck and framed it as a 'racial experience'. Having been given an appointment at nine o'clock in the morning, Charity was still waiting several hours later:

> then this receptionist comes, and [says] "Oh, your surgery won't be done until all these people have had theirs because you have HIV", in front of the other patient in the corridor, and then one of the patient just looked at me. She said, "why is she saying that in front of all of us?" I said, "I don't know".

Charity experienced having her HIV status publicly declared as a form of racism, one which also underscores the importance of confidentiality for HIV patients. Such confidentiality was, as Charity's experience makes clear, not guaranteed. Patient confidentiality and consent were heavily emphasized aspects of medics' work during the late twentieth century, though the HIV/AIDS epidemic could serve to weaken these clinical commitments.[58] In particular, one interviewee, Sara*, experienced several traumatic instances at the hands of medics, both before and after her HIV diagnosis. Sara was born in Angola, where she was subjected to a forced virginity test and later an abortion without her consent. At the age of twenty, she migrated to London. There, she had two children and was diagnosed with HIV during her second pregnancy. Sara recalled facing discrimination during her second delivery, when a nurse asked her in front of other patients in a maternity ward that lacked privacy whether she was taking her HIV medication. The other patients, feeling uncomfortable, complained, and Sara was moved to another room. Just as with Charity, Sara emphasized that discrimination was closely tied to her HIV status and the care she received during her second pregnancy. These memories served to deepen the connection between trauma, discrimination, and medical care. These were connections with long trajectories, often formed before migration to the UK but frequently cemented in British medical settings.

Patients' need for confidentiality and anonymity was particularly acute for racialized individuals. This was clear during Mustafa's interview. Mustafa, who acquired HIV from a contaminated blood product shortly after migrating to the UK in the early 1980s, told Hart that:

> my wife, when she one day, she went to hospital, … Anyway, the doctor, he asked her, how did, how did you get the HIV? Because he saw - this guy, he's a Sikh, right? And she's a Muslim, you know? So because you are a Muslim, or you are religious, you shouldn't [get?] that even here.

As this example shows, ethnic and religious minorities in Britain often faced questions about their HIV status, which were rooted in a belief that their religiosity or non-Western heritage precluded them from being at risk. Indeed, as Mustafa's wife found out, this could come just as easily from clinicians as from the general public. Certainly, these attitudes were common and actively reinforced by many within religious communities.

Besides these negative experiences, there were also instances where an HIV diagnosis resulted in increased care and emotional support. Esther contrasted her first pregnancy with her second one. Even though her first pregnancy 'went very well', having been diagnosed with HIV following a referral from her GP ensured she received additional care during her second. Esther remembered having 'more attention from different people' to ensure she was 'in a good place'. This experience contrasted with those of Black women in Britain who have consistently identified the poor maternity care they received.[59]

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[58] Severs, 'A crisis of consent?'.

[59] Angelina referred to these inequalities in her interview. See also M. Adesina et al., 'Maternal Health Inequalities: Focusing on Black Pregnant Women', *British Journal of Midwifery*, 33, 4 (2025).

In the case of Esther, her HIV status seemed to have acted as a driver for better maternity care services. Yet the difficulties faced by minoritized individuals prompted activists to set up what would come to be known as ‘by and for’ services, that were founded and made up of a particular group and aimed to serve their specific needs, be they linguistic, religious, cultural, geographic, age, or based on particular sexuality and gender identities. One of these services was NAZ.

NAZ and emotional support

Given that the interviewees were recruited through NAZ, all had attended some of its services. The sample is therefore biased towards a positive assessment of these experiences. Yet, the cultural sensitivity of the service, the safe space NAZ created, and the support services it offered all featured prominently in the interviewees’ recollections. In particular, interviewees emphasized the role of the Joyful Noise choir, a choir of people living with HIV, as a meaningful source of care and community. Following the lead of our interviewees and building on recent scholarship on NAZ, we use Joyful Noise as a way into the history of NAZ here.[60]

Some participants discovered NAZ through voluntary or professional involvement in sexual health prevention. Rebecca first joined NAZ as a volunteer from another sexual health charity to do rapid testing before she joined the choir. Her testimony reveals the emotional difficulty of attending support groups with people at different stages of HIV:

> for those of us that have been diagnosed for a really long time, you tend to drop out of those groups, because then what tends to happen is–which is not a good thing or a bad thing. It just means you keep getting retraumatized or keep getting taken back, because there’ll always be new people that are diagnosed that come in feeling, “oh my god, this is the end of life, and” blah, blah, blah, and they’re in a very different space from where we are now.

For her, Joyful Noise offered another social experience based on singing, rather than always ‘taking you back to that place’.

The choir was, and for some still is, fondly cherished as a safe and empowering place where people could be themselves without fear of judgment or constant reminders of their HIV status. The emotional toll of living with HIV was acutely felt by the interviewees, who at times shared feelings of isolation and alienation. The choir became a key moment in their week, a space where they could express their emotions through music in a safe, peer-support environment. For instance, Esther, who had been involved in many HIV campaigning groups, remembered hearing people talking about the choir, and her friend Angelina recommended it to her. She joined the choir while she was having back pain, walking with a stick, and she felt ‘energised’ and ‘happy’. She recalled ‘it just makes it very empowering. Yeah, Joyful Noise is very, very empowering to so many people and there is no judgment’. Similarly, Charity, who volunteered for Positive UK, a nationwide HIV/AIDS charity, underlined the positive effect of being amongst her peers and being able to forget about her HIV status after being invited to join the choir:

> we never talked about what we’re going through, like HIV, while we are in that session. This was just us, you know, screaming, our voice, whether they were cheesy voices, there was no like “you can’t sing”, or “this one seems better than that”, because we are all just amateurs. We just wanted somewhere where we could get the peer support, where we can just forget about what we are going through.

The Joyful Noise choir became a safe space for people living with HIV, where they could find support and joy, standing in contrast to more traditional SRH services that focused primarily on emotional counselling. In this way, NAZ distinguished itself from other organizations.

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[60] Biswas, ‘HIV/AIDS and the NAZ Project’.

Conclusion

Drawing on eight interviews collected as part of an oral history collaboration, this article has reconstructed elements of the SRH landscape in late twentieth-century London. Interviewees all migrated to London as young adults from countries across the African continent. Their testimonies result in rich and dynamic micro-historical accounts of the ways in which migration shaped experiences of SRH. Equally, these accounts demonstrate the central importance of SRH as an experiential lens through which migration was embodied. This point is often overlooked in histories of migration. Of course, SRH plays a particularly central role in the life stories of the interviewees since they are all living with HIV and had been actively involved in varying ways with the SRH charity NAZ, resulting in more memories of SRH than are usual in oral history interviews.[61] It is for this reason that the interviews are so valuable; not only do they speak to broader experiences in the history of migration and medicine, but their textured and nuanced accounts also begin to counteract the historiographical and archival erasure of experiences such as theirs.

Interviewees recalled a lack of SRH knowledge before migrating to London, frequently contrasting it with increased access to services and information after arriving in Britain. This is a history of change which was marked as much by generation as by migration. The interviewees' experience of gaining access to SRH information and services coincided with their move to London and a significant generational shift, with that migration occurring during their teenage years or into their early twenties, a period in the life course in which SRH is a more pertinent concern. This points to the ways in which SRH formed part of 'postmigrant' experiences in late twentieth-century London. Interviewees brought their experiences of limited SRH knowledge with them and contrasted it with the expanded access to services they received in Britain. By focusing on SRH in this way, it is possible to see the ways in which individuals with experiences of such migration emphasized change as an embodied reality. This change was never homogeneous or neatly progressive. The interviewees in this study recalled traumatic experiences of healthcare before and after migrating to London. Racism was a present reality in several medical settings, and several interviewees recalled their own SRH being used as a tool of racism against them, especially their HIV status. The interviewees' experiences of living with HIV not only illuminate the ways in which anti-AIDS sentiment and racism so often aligned, but they also serve to diversify historical understandings of HIV/AIDS in Britain. Memories of public health campaigns point to a more international story than has been appreciated and, in some cases, serve to push against accounts of national 'turning points' which are in danger of homogenizing historical experiences. Finally, the interviewees' involvement with NAZ and, more specifically, its Joyful Noise choir, continues to remind historians to be attentive to the multifaceted ways in which HIV/AIDS was embodied, responded to, and lived with.

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[61] Severs, 'Composing and Narrating'.

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