Bass Line 2008-09

Assessing the sexual HIV prevention needs of African people in England

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Original Research Report

Acknowledgments

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- Action For Men
- Addington Afro-Ethnic Health Promotion Group (AAEGRO)
- Africa Advocacy Foundation
- African Caribbean Resource Centre
- The African Child
- African Communities Team at Camden PCT
- African Community Involvement Association
- African Community Development Association
- African Community Partnership
- African Culture Promotions (ACP)
- African Development Network <www.actionforcd.org>
- African Families Support Service (AFSS)
- African Health Care and Counselling Service
- African Health for Empowerment and Development (AHEAD)
- African HIV Policy Network (AHPN) <www.ahpn.org> <www.nahip.org.uk>
- African Institute for Social Development
- African Refugee Community Health and Research Organisation (ARCHRO)
- African Support & Project Centre (ASPC) <www.hackney.gov.uk/servapps/CommunityDirectories>
- African Youth Organisation
- Barnet African Health Organisation
- Begin & Our Project
- Black Gay Men's Advisory Group
- Black Health Agency <www.blackhealthagency.org.uk>
- Body Positive Luton
- Body Positive North West
- Bromley PCT
- The Brunswick Centre <www.thebrunswickcentre.org.uk>
- The Cara Trust <www.caralife.com>
- Catholic HIV / AIDS Ministry – Westminster Archdiocese (CATHAM)
- Central Liverpool PCT
- Centre for All Families Positive Health (CAFPH) <www.cafph.org>
- Centre for HIV and Sexual Health Sheffield <www.sexualhealthsheffield.nhs.uk>
- Che Jama at NHS Norfolk
- Community Health Action Trust (CHAT)
- Community of Congolese Refugees in Great Britain (CORECOG) <www.corecog.org.uk>
- Congolese Community Council
- Congolese Youth Association
- Crescent Support Group <www.thecrescent.org.uk>
- Derbyshire Friend
- DHIVERSE <www.dhiverse.org.uk>
- Embrace Community Support Centre (Embrace UK) <embraceuk.org>
- French African Welfare Association (FAWA)

- Freshwinds <www.freshwinds.org.uk>
- George House Trust (GHT) <www.ght.org.uk>
- GR Consulting
- Great Nile Trust
- Group Evangelists
- Hampshire PCT HIV Prevention Services
- Health Action Charity Organisation (HACO) <www.healthaction.co.uk>
- Hope Gate (formerly HIV/AIDS Association of Zambia, HAAZ) <www.hopegate.org.uk>
- Humanitarian Support Services
- International Gospel and Health Group
- Jesus Kingdom City <www.jesuskingdom.com>
- The Junction <www.bromleypositive.org>
- Kenya Women's Association
- Lambeth PCT
- Leeds Skyline Service (formerly Leeds Support and Prevention Centre) <www.leedsskyline.org.uk>
- Leicestershire AIDS Support Services (LASS)
- The Lodge
- London Ecumenical AIDS Trust (LEAT)
- MDC Training & Consultancy
- Milton Keynes PCT
- Morden CAB HIV / AIDS Project
- MS Development Corporation
- MyHealthnet
- National Institute for African Studies (NIAS) <www.nias.info>
- Naz Project London (NPL) <www.naz.org.uk>
- Organisation of Positive African Men (OPAM)
- Pamodzi
- Pan Afrique Centre <www.panafrique.org.uk>
- Piccadilly Project / Lifeline Project
- Positive East <www.positiveeast.org.uk>
- Positive Parenting & Children
- Positive Place
- Positively Women
- The Rain Trust
- Rise Community Action
- Sahara Communities Abroad (SACOMA) <www.sacoma.org.uk>
- Sahir House
- Shaka Services
- Shea Project
- Solar <www.solargroup.org.uk>
- Southern Africa Aids Foundation
- Staffordshire Buddies <www.staffordshirebuddies.co.uk>
- St. Mary's Hospital, Sexual Health Service, Isle of Wight PCT <www.iow.nhs.uk>
- Sutton & Merton PCT
- Terrence Higgins Trust (THT) <www.tht.org.uk>
- Together In Prosperity (TIP)
- Uganda AIDS Action Fund (UAAF) <www.uaaf.org.uk>
- UK-CAB <www.ukcab.net>
- West African Networking Initiative (WANI)
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- Zimbabwean Women's Network UK

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Black History Month <www.blackhistorymonthuk.co.uk>,
Mister Seed <www.misterseed.com>,
SWRadio <www.swradioafrica.com>,
The Voice <www.voice-online.co.uk>,
The Zimbabwean <www.thezimbabwean.co.uk>,
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Sigma RESEARCH

African HIV Policy Network
empowering African communities affected by HIV

NAHIP

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Glossary

Term	Explanation
behaviourally bisexual	A person that has had sex with men and women (in this instance, in the last year) whether or not they identify same-sex desire.
HIV	Human immune deficiency virus – a viral infection that can be passed during sex.
mean	The sum of all values divided by the number of cases (commonly referred to as an 'average').
measure of central tendency	A measure that describes the position of a distribution by representing the "middle" of a population. In this report, means and medians are used as measures of central tendency.
median	The middle value in a set that has been ordered from lowest to highest.
missing	The number of respondents not represented (usually because they did not answer a particular question, rather than because they fall into a separate category than the one being discussed).
n=	The number of respondents represented.
p<0.05	Probability less than 5% – If we had done the survey multiple times, this difference would probably be observed in *fewer than one in twenty of the surveys*, purely by chance.
range	The highest and the lowest values in a set of data (i.e. if the oldest person is 79 and the youngest is 16, then the range is 16-79).
sdUI	Sero-discordant unprotected intercourse – sexual intercourse without a condom between a person with HIV and a person without HIV.
significant	If we had done the survey multiple times, this difference would be observed in *fewer than one in every twenty surveys* ($p<0.05$), purely by chance. In tables significant differences are indicated by shading and **bolding** the highest figure and underlining the lowest.
standard deviation	A measure of the *spread* of a group of numbers – how widely dispersed the numbers are on either side of the mean.
STI	Sexually transmitted infection – infection acquired during sex (including HIV).
UI	Unprotected intercourse – penetrative anal or vaginal sex without a condom.
<	Less than
>	More than

Executive Summary

This report concerns Bass Line 2008-09, a community-based research project which recruited African people living in England to a HIV prevention needs assessment survey. It is divided into two parts. Part One has six chapters including the background and methodology (Chapter 1), and an overview of the key variables grouped as follows: demographics (Chapter 2); HIV testing (Chapter 3); sexual HIV transmission behaviours (Chapter 4); HIV prevention needs (Chapter 5); and HIV prevention interventions (Chapter 6). The purpose of Part One is to identify HIV transmission behaviours and unmet HIV prevention needs which are common across diverse groups of African people in England.

Part Two (Chapters 7 - 13) looks at how these key indicators regarding testing, sex, needs and interventions vary across the demographic groups. Part Two aims to identify sub-groups of Africans with high levels of risk behaviours and / or high levels of unmet prevention needs.

Chapter 1 describes the way in which we undertook the survey. Recruitment to this second Bass Line survey was carried out from October 2008 to January 2009 by Sigma Research in partnership with 105 health promotion organisations and companies that operate websites accessed by Africans in England.

Chapter 2 describes the **demographic profile** of those people recruited to the survey. It demonstrates the similarity to respondents in our first Bass Line survey in 2007.

Chapter 3 describes the extent of **testing for HIV**, HIV test results, recency of testing and reasons for never testing. It then compares respondents' current perceived HIV status with their HIV testing history before exploring testing for other sexually transmitted infections.

- Overall, a third of all respondents had never received an HIV test result and a similar proportion had never been tested for other STIs.

About one-in-eight respondents said they did not know where to go for an HIV test.

- Many Africans would test for HIV if they knew where to go for a test. This simple need should be addressed as a matter of urgency.
- However, influencing testing in other Africans requires increasing their perception of risk from HIV infection, understanding the benefits of testing and the potential consequences of not knowing their HIV status.

Almost half of all respondents had previously received a negative HIV test result, half of whom had tested in the previous year. A high proportion (12.1%) were living with diagnosed HIV, as agencies recruiting respondents included many that support African people with HIV.

Chapter 4 describes **sexual risk and precaution behaviours.** Overall, three quarters of all respondents were sexually active in the last year. More than half had a regular sexual partner, which was more common among men than in women. One-in-four of those with regular partners said they had other sexual relationships outside the regular relationship, again more common in men than women.

One-in-ten who said they had sex in the last year reported definitely or probably having sexual intercourse without a condom with someone of a different HIV status to themselves (sdUI). The risk of sdUI increased with larger numbers of sexual partners.

- Interventions to reduce potentially sero-discordant unprotected intercourse should target those in multiple sexual relationships, particularly men.

Individuals who reported having sex with both men and women were more likely to have multiple sexual partners than those who reported sex with opposite sex or same sex partners only.

A quarter of respondents who had sex in the last year had not used condoms at all in that time. Those with fewer sexual partners, and those in a regular sexual relationship were less likely to use condoms. Condom use was more common in men than in women, and mostly reported by those aged between 20-39 years. Among those who used condoms, a third had experienced condom failure in the last year.

- High levels of condom failure may be detracting from their use. Interventions to increase the use of condoms should include elements to ensure minimum condom failure.

Chapter 5 considers **HIV prevention need** and demonstrates that general knowledge about the basics of HIV was fairly high, although many people perceived the need to know more. About one-in-

ten did not know that people can have HIV without knowing; that there is still no cure for HIV; and that one cannot know whether someone has HIV by just looking at them. A fifth did not know about the existence of HIV medicines and that condoms are free at various service settings. A further two fifths were not aware that there have been prosecutions for HIV transmission in England and that Africans were not deported from the UK simply for testing positive for HIV. Respondents were most likely to be unaware of the high prevalence of HIV among Africans in England.

There was also evidence of problems with condom access and use. One of the barriers to condom use was stigma as indicated by a third of respondents who said they would worry about what people thought of them if they were seen carrying condoms. In addition, safer sex negotiation skills were lacking among nearly a third, who said they were not sure that they could easily talk about safer sex and HIV with new sexual partners.

There was also evidence of some powerlessness in relation to avoiding participation in HIV transmission. Among those not diagnosed HIV positive, more than one-in-ten did not feel they were in control of whether or not they became infected. Similarly, among those with diagnosed HIV, one-in-every ten disagreed or was unsure that they had control over exposing sexual partners to the virus or getting infected with another type of HIV.

Chapter 6 outlines the diversity of preferences for **HIV prevention interventions** and confirms that no single intervention (or programme) will suit all African people in England. Three quarters of respondents identified reading and writing as their preferred medium of learning more about HIV followed by talking to someone. However, more than half would still opt for a mixture of reading and writing and talking and listening interventions. Health professionals were the most common preferred source of information.

Chapter 7 examines variations by **HIV testing history** in indicators of sexual risk and need. It suggests HIV testing increases people's awareness of whether their sexual behaviour is putting them or their partners at risk of infection but it does not necessarily prevent that risk. It also demonstrates that interventions intended to increase motivation, knowledge, access to resources and social confidence should disproportionately benefit those who have never tested, while those intended to increase sexual skills and confidence should disproportionately serve those with diagnosed HIV.

Chapter 8 examines variation by **gender and gender of sexual partners** in HIV testing history and indicators of sexual risk and need. We found no sexual risk behaviours or unmet HIV prevention need that was more common in women than men. These findings suggest interventions and programmes should prioritise encountering men over women if they wish to maximise their impact on HIV transmissions. Furthermore, HIV prevention programmes for African men should pay particular attention to homosexually active men, including those who also have sex with men and women.

Chapter 9 examines variation by **age** in HIV testing history and indicators of sexual risk and need. Findings demonstrate that HIV prevention programmes are required across the age range but with a definite bias towards those under 40.

Chapter 10 examines variation by **educational achievement** in HIV testing history and indicators of sexual risk and need. Of all the population characteristics considered, education showed the largest number of reliable associations. These findings suggest that all HIV prevention programmes for Africans should be biassed towards those with lower levels of formal education. This is both in terms of their targeting (ensuring Africans with lower education encounter the interventions) and their tailoring (ensuring interventions are relevant and useful when they are encountered).

Chapter 11 examines variation by **country of birth** in HIV testing history and indicators of sexual risk and need. Evidence of sexual risk and unmet HIV prevention need was found in all country of birth sub-groups with few reliable differences between them. All African communities in the UK could benefit from HIV prevention activity.

Chapter 12 examines variation by **length of time resident in the UK** in HIV testing history and indicators of sexual risk and need. African people arriving in the UK do so in a very wide variety of circumstance and knowing how long someone has been here is only a very broad indicator of what they may need in terms of sexual health promotion and HIV prevention.

Chapter 13 examines variation by **religion** in HIV testing history and indicators of sexual risk and need. There was evidence of sexual risk and unmet HIV prevention need in all religion groups. Although followers of African traditional religions were relatively few, intervention planners and implementers need to be aware of the acute prevention needs among the group.

Contents

Part one

Part two

1 Introduction and methods

1.1 RELATIONSHIP TO BASS LINE 2007

This second Bass Line survey shared the same methodology as the first, but the content was not identical and different agencies were involved in recruitment. This brings strengths and weaknesses to the survey but we judged the survey worth repeating for a number of reasons.

Bass Line is a community research project. The survey provides a health promotion tool that collaborators could use to maximise HIV prevention activities. The questionnaire had educational value as many of the questions contain factual sexual health information that could be used by front line health promotion workers to engage the participants in sexual health discussions. For this reason we wanted as many agencies as possible to participate. This means however that the recruitment base for the survey changes, making comparisons with the previous Bass Line hazardous.

Many of the questions in this second survey were identical to the first. We have used these to seek to establish the reliability of cross-sectional associations (for example, between gender and perceived control, or between religion and sexual behaviour). It is important to stress that this second survey is looking at the reliability of cross-sectional patterns and not at changes over time in the indicators since the first survey. Our samples are opportunistic and therefore not representative of African people resident in England. One way of increasing confidence in survey findings is to repeat the survey among a different group of Africans. The final section of each chapter in Part Two of the report summarises the associations found in both surveys.

Other questions were new (and some from the first survey were dropped) in order to allow us to extend the number of indicators of risk and need. The new questions arose from discussion with our health promotion colleagues and extends the evidence bass for HIV prevention planning.

Lastly, the survey provided an opportunity for NAHIP partners and other organisations involved in HIV prevention work with Africans to work collaboratively in a single project. It provided an opportunity to create joint working relationships among the stakeholders and to build relationships for the future.

1.2 CONTENT OF THE REPORT

This report contains the main findings of second Bass Line survey, a quantitative HIV prevention needs assessment among Africans in England. Recruitment to this second survey was carried out from October 2008 to January 2009 by Sigma Research in partnership with 105 health promotion agencies and organisations working with Africans across England (see *Acknowledgments*) and with companies that operate websites accessed by Africans in England.

The information reported here is about the sex that African men and women living in England have and their sexual HIV prevention needs. All sexually active people have needs that reduce their likelihood of participating in HIV transmission – including people who have been tested HIV negative, those who have been diagnosed HIV positive, and those who have not been tested for HIV. The intended audience for the report includes people who plan, deliver, and commission HIV prevention programmes targeting African people in England. The survey has collected a large data-set on the HIV prevention needs of Africans in England that complements existing qualitative and quantitative research undertaken with this population (Fenton *et al.* 2002, Chinouya & Davidson 2003, Weatherburn *et al.* 2003, Chinouya *et al.* 2003, Chinouya *et al.* 2004, Mayisha II Collaborative Group 2005, Dodds *et al.* 2008a).

The report is divided into two parts. Part One has six chapters and provides the background and methodology of the survey, and an overview of the variables grouped as follows: demographics; HIV testing; sexual HIV transmission behaviours; HIV prevention needs; and HIV prevention interventions. The purpose of Part One is to identify HIV transmission behaviours and unmet HIV prevention needs which are common across diverse groups of Africans. Part Two looks at how key indicators regarding testing, sex, needs and interventions vary across the demographic groups. Part Two aims to identify sub-groups of Africans with high levels of risk behaviours and / or high levels of unmet prevention needs.

This chapter provides the background to the survey and explains how the sample was recruited. It also describes the criteria used to exclude invalid returns prior to the analysis in the rest of the report. Chapter 2 describes demographic and socio-sexual characteristics of the final sample of 2,580 African men and women in England. Chapter 3 is concerned with the needs of respondents in relation to HIV testing and diagnosis, as well as testing and diagnosis of other sexually transmitted infections (STIs). Chapter 4 reports on sexual HIV risk behaviours including multiple and concurrent partnerships and condom use. Chapter 5 considers needs relating to HIV prevention, namely: knowledge about HIV and AIDS, confidence accessing and using condoms, and perceived control over HIV transmission or acquisition. Chapter 6 reports on intervention preferences by looking at respondents' preferred medium of learning more about HIV and preferred sources of information.

Part Two of the report includes seven chapters. Chapter 7 draws out the relationship between respondents' HIV testing histories and their answers to other key questions. Chapter 8 examines the influence of gender (and the gender of respondents' sexual partners) in the same way. The remaining chapters explore the extent to which respondents' age (Chapter 9), level of education (Chapter 10), country of birth (Chapter 11), length of residence in the UK (Chapter 12), and religion (Chapter 13) play a role in their HIV prevention needs.

1.3 DEVELOPMENT OF THE BASS LINE 2008-09 SURVEY

The Bass Line survey used a self-completion questionnaire to collect a limited amount of information from a substantial number of African men and women. Questionnaire development began with interviews with representatives from The National African HIV Prevention Programme (NAHIP) partner agencies, and with the Programme Manager. These interviews elicited a set of essential HIV prevention needs of Africans identified by NAHIP service providers and planners. In August 2008, a long list of potential questionnaire items was sent out to NAHIP partners and other key collaborators who were asked to check the questions for cultural and linguistic appropriateness and to prioritise them. Ten agencies and individual stakeholders gave feedback on the draft.

The questionnaire was shortened and revised in light of these comments and a second version was prepared for piloting among African men and women. An experienced researcher undertook twelve cognitive interviews with African people in community settings. Individuals were asked to complete the survey in front of the interviewer and were then interviewed for approximately 30 minutes to see how they read and understood each question and its instructions. Interviewees were paid £10 for their participation. The questionnaire was modified in light of these interviews.

The Bass Line 2008-09 questionnaire and research methodology received approval from the Faculty of Humanities and Social Sciences Research Ethics Committee, University of Portsmouth.

1.4 RECRUITMENT METHODS

The questionnaire was made available online and as a printed A6 (pocket-sized) booklet that was self-sealing for Freepost return. Discussions with NAHIP partner agencies working with francophone Africans resulted in production and distribution of a French language version of the survey in booklet format.

English language posters and business-sized cards were made available to all collaborators to generate awareness of the survey and to direct individuals to the survey website. These materials were designed to be of use in agency premises, as well as in community locations where booklet distribution may have been less practical (such as nightclubs, churches *etc.*).

1.4.1 Booklets

A total of 113 potential collaborators were invited to distribute booklets. A total of 16,334 English language booklets, and 2,217 French language booklets were requested by and sent out to 74 agencies delivering services to African people in England. Participant recruitment ran for three months from October 2008 to early January 2009. Following the recruitment challenges faced during the previous survey in 2007, Sigma Research recruited two research support officers to liaise with collaborators and respond to any challenges or concerns from the agencies during the data collection period.

We do not know the exact number of booklets distributed by agencies. Overall, 2504 (2347 English language and 157 French language) survey booklets marked as distributed by 46 different agencies were received by Sigma Research via Freepost return, representing a 15.3% return on all booklets sent out to agencies (when undertaking similar community-based surveys among homosexually active men, return rates range from 15% to 20%). We received 20 or more valid booklets from 20 different agencies.

1.4.2 Online

In addition to booklet distribution, the internet was used as a setting for the questionnaire and as a method of recruitment to the survey. Sigma Research's use of the internet for research among other populations has demonstrated that the use of this method can enhance the diversity of a survey sample – particularly across variables such as geographic location, ethnicity and age (Weatherburn *et al.* 2005). The survey was available for completion online in English only. The online questionnaire contained the same 53 questions as the booklet.

The online questionnaire was prepared and hosted using an online survey instrument <www.demographix.com>. The design of the online surveys allowed data to be captured and viewed as soon as the respondent pressed 'submit' at the end of the survey. The online version was available for completion for the same three months as the booklet version (October 2008 to January 2009). It was substantially promoted by seven African commercial websites (see *Acknowledgments*) and by 31 community groups via their websites and / or via their email contact lists. Overall, we received 626 online responses.

1.5 EXCLUSIONS

Not all of the Bass Line questionnaires returned to Sigma Research were included in the final sample. In this section we describe the process that enabled us to determine returns that were valid and those that were not (the latter being excluded as a result).

It became apparent during the data entry and cleaning processes that some returns from some agencies were invalid for a number of reasons. The majority of the exclusions were based on the survey inclusion criteria. To be included, respondents had to indicate that they: were at least 16 years of age; in England at the time of completion; identified themselves as African; and had not already completed the survey. Some participants were under-age (less than 16 years old) which meant that their responses were disqualified. Some returns had no demographic information making it impossible to include them in the final sample. Some responses were from people who were not in England, more common among online recruits. Some respondents said they did not identify themselves as Africans, hence we could not include them in our final sample.

Some respondents also said they were answering the survey for a second time or there was evidence of repeat responses. For example, there were cases of identical responses to some questions, identical hand writing and identical patterns of unanswered questions among other factors we used to examine valid returns. Further anomalies were excluded during data analysis which allowed for further data testing. Overall, invalid returns formed a very small proportion of each agencies' returns.

The structure of the online survey meant that respondents that did not meet the inclusion criteria were asked no further questions and were informed of the reason why. The proportion of returns that were excluded based on these criteria, as well as those identified as invalid are indicated in the table below.

Survey returns, exclusions and final sample	number (%) French BOOKLET	number (%) English BOOKLET	number (%) ALL BOOKLET	number (%) WEB	number (%) ALL
TOTAL RETURNS	157	2347	2504	626	3130
Invalid returns	91 (58.0)	69 (2.9)	160 (6.4)	0	160 (5.0)
Under 16 years of age	1 (0.6)	4 (0.3)	5 (0.2)	0	5 (0.2)
Not in England	0	58 (2.5)	58 (2.3)	93 (14.9)	151 (4.8)
Not African	0	41 (1.7)	41 (1.6)	17 (2.7)	58 (1.9)
Already completed the survey	0	94 (4.0)	94 (3.8)	5 (0.8)	99 (3.2)
Insufficient data (mostly blank)	0	50 (2.1)	50 (2.0)	27 (4.3)	77 (2.5)
TOTAL EXCLUSIONS	92 (58.6)	316 (13.5)	408 (16.3)	142 (22.7)	550 (17.6)
TOTAL SAMPLE FOR ANALYSIS	65 (41.4)	2031 (86.5)	2096 (83.7)	484 (77.3)	2580 (82.4)

Overall, 82.4% (n=2580) of the returns were included in the final analysis. A slightly higher proportion of booklet returns (83.7%) were retained compared to online responses (77.3%). Internet exclusions tended to be based on respondents not being in England (14.9%), or not identifying themselves as African (2.7%), or because of incomplete survey data (4.3%). However, the majority of booklet returns excluded (6.4%) were a consequence of the data validity issues described above.

2 Description of the people who took part

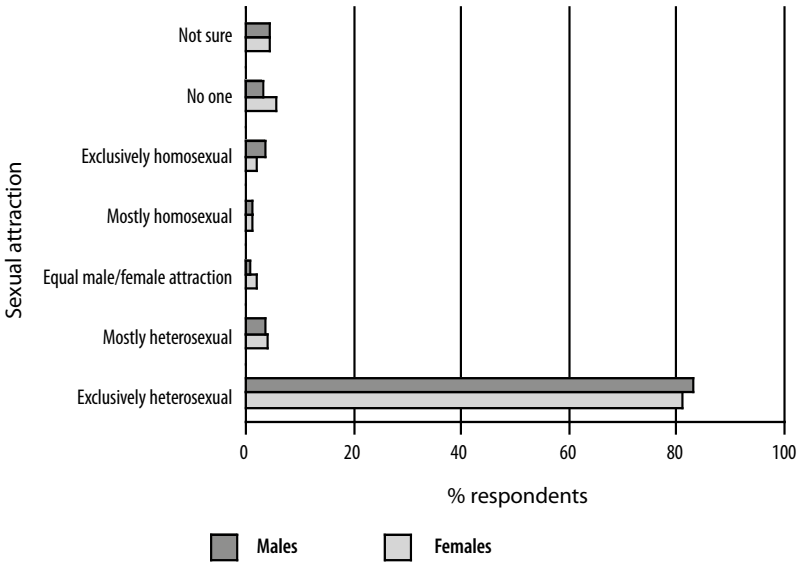
The study recruited 2,580 adults in England who considered themselves African. This chapter describes these participants based on their: gender; sexual attraction and gender of sexual partners; age; ethnicity; length of residence in the UK; area of residence; household composition; current economic activity; education; religion; regular and primary sexual partnerships and circumcision.

2.1 GENDER AND SEXUALITY

The final sample was made up of slightly fewer men (48.2%, n=1220) than women (51.8%, n=1320), reversing the situation from the first Bass Line survey. This was true for both recruitment methods including the online sample which included 41.8% (n=200) men and 58.2% (n=279) women. This is contrary to the common asssumption that less women than men encounter online interventions and service information. Comparisons by gender run through the rest of this report.

2.1.1 Sexual attraction

All respondents were asked *Are you sexually attracted to men / boys or women / girls?* and were offered seven options displayed in the graph opposite. Overall, 4.4% said they were not sexually attracted to anybody, and this was less common in men (3.1%) than women (5.5%). A further 4.4% were not sure whether they were attracted to men or women. The proportions were very similar to the first Bass Line survey.



Sexual attraction by gender (n=2383, missing 197)

The majority of respondents (82.0%) said they were exclusively heterosexual (attracted to the opposite sex only), which was slightly more common in men (83.2%) than in women (81.0%)

Exclusive homosexual attraction was reported by a minority (2.8%), and was more common in men (3.7%) than women (1.9%).

2.1.2 Gender of sexual partners

Respondents were first asked *Have you had sex in the last twelve months?* and provided with *yes* or *no* options. They were then asked *How many men / boys* and *How many women / girls have you had sexual intercourse with in the past twelve months?* Overall, 72.6% said they had sex in the past year while 27.4% did not have sex. Men were significantly more likely to have had sex (78.8%) than women (67.0%). The table below shows the gender of sexual partners in the last year, for men and women.

Gender of sexual partners in the last year by gender	**% MALES** (n=1096)	**% FEMALES** (n=1212)	**% ALL** (n=2308)
No sexual partners	21.2	33.0	27.4
Opposite sex partners only	67.6	59.7	63.5
Both opposite and same sex partners	7.8	6.0	6.9
Same sex partners only	3.5	1.2	2.2

Overall, a quarter of the participants (27.4%) were not sexually active in the last year: one-fifth (21.2%) of men and a third (33.0%) of women. Given that HIV transmission involving Africans in England is mainly through sexual contact, this finding is significant because it suggests that a large number of people were not exposed to risk of infection at all in the last year. However, the finding should be treated with caution because reporting sexual activities is very subjective and also depends on personal meanings attached to 'having sex' or 'sexual partner'.

More than two-thirds of all respondents (70.4%) had heterosexual sex partners in the last year, lower than the proportion reporting heterosexual attraction. Men were more likely to report heterosexual sex than women (and more women than men reporting no sex in the last year).

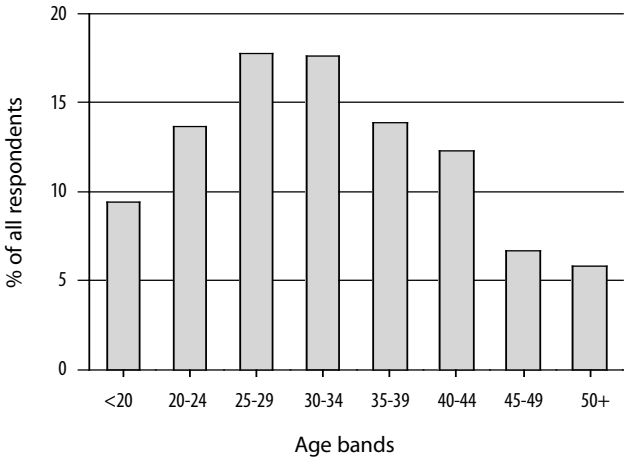
A significant minority (9.1%) had same sex partners in the last year. Men were more likely than women to report only same sex partners in the last year (3.5% of men compared to 1.2% of women) and to report having both male and female partners. This compares with sexual attraction reported in section 2.1.1 as well as the findings of Bass Line 2007 (Dodds *et al.* 2008a).

There was an imperfect association between reported sexual attraction and gender of sexual partners. For example, more than half of men (51.3%) and women (52.2%) who had sex with both men and women in the previous year said that they were exclusively heterosexual (only attracted to opposite sex). There were also individuals who said they were only attracted to same sex partners but reported sex with opposite sex partners in the last year (5.3% among men and 4.6% among women). These findings demonstrates that sexual desire is not entirely predictive of sexual behaviour.

We report variation by respondents' gender and the gender of their sexual partners further in Part Two (Chapter 8) to identify differences in behaviour, HIV knowledge and prevention needs.

2.2 AGE

The respondents' ages ranged from sixteen to seventy eight years. Overall, the mean age of the sample was 32.4 years (standard deviation 10.1, median 31), very similar to the first Bass Line survey. Again there was no significant difference in age between men and women.



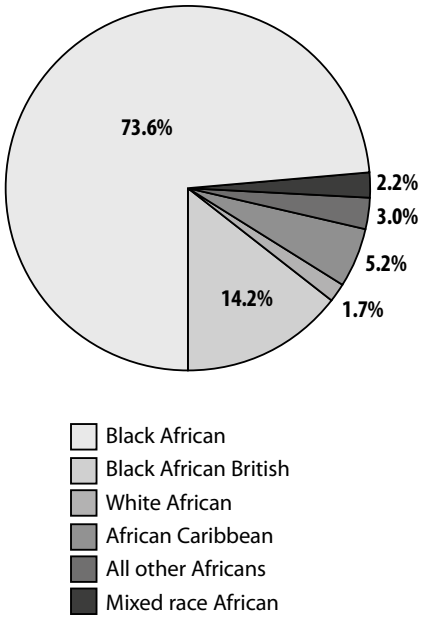
Age groups (n=2478, missing 102)

Those who answered the survey online were older (mean age 35.6 years, standard deviation 8.4, median 35) than those recruited through the booklet (mean 31.7 years, standard deviation 10.3, median 30.1). This might have resulted from the websites used to recruit respondents. Most of the websites were news websites (mainly country specific news – Zimbabwe, Zambia, Kenya *etc*.), health promotion agency websites or social websites which might have been more appealing to the older audience.

We present detailed age bands in the bar chart here, but simplify the age groups (under 20; 20s; 30s; 40s; 50 and older) to look at indicators of behaviour, knowledge and needs by age in Part Two (Chapter 9).

2.3 ETHNICITY

Self-identification as African was an inclusion criteria for participation in the study. All the respondents were asked *What is your ethnic group?* They were asked to choose from the following: Black African, Black African British, African Asian, African Arab, White African, African Carribean, mixed race African, and *other*. The figure shows the proportion indicating each option, with almost three quarters choosing Black African. The distribution of ethnicities was broadly similar to the first Bass Line survey.



Ethnicity (n=2579, missing 9)

Women were slightly more likely than men to indicate Black African British or African Caribbean and slightly less likely to indicate all other options.

Those identifying as Black African were, as a group, older (mean 33.1, standard deviation 10.0, median 32.0, range 16-78) than other ethnicities.

2.3.1 Country of birth

Respondents were asked the open ended question: *What country were you born in?* In total 76 different countries were represented. African countries accounted for 82.7% of responses, the UK for 13.6% and the rest of Europe, Asia, North America and South America together accounted for 3.6% of responses. The table below shows the 20 countries in which at least twenty respondents were born, the proportion of the total sample that group represents, what proportion of that group were male and the age profile of people from that country.

Country of birth (n=2498, missing 82)	% ALL	% of country sub-sample that were male	Average age (median)	Age range
Zimbabwe	16.9	48.2	35	16-72
United Kingdom	13.6	48.8	26	16-52
Nigeria	12.9	55.9	29	16-65
Kenya	8.7	42.4	34	17-59
Uganda	7.2	36.0	32	16-68
Zambia	4.1	27.7	27	16-45
Democratic Republic of Congo	4.0	67.3	33.5	18-59
Ghana	3.7	53.3	30	17-65
Republic of South Africa	2.9	47.1	33	16-65
Cameroon	2.6	53.1	30	16-47
Republic of Congo	2.5	50.8	31.5	16-59
Malawi	1.8	44.2	30	17-57
Somali	1.5	37.8	26	18-52
Sudan	1.5	83.8	33.5	16-52
Ethiopia	1.2	56.7	31.5	19-65
Jamaica	1.2	29.6	31	16-57
Sierra Leone	1.0	28.0	30	20-52
Burundi	1.0	48.0	33.5	19-51
The Gambia	1.0	24.0	27	16-45
Tanzania	0.9	43.5	30	19-53

The five most common countries of birth (representing almost half of respondents) were the same five as in the first Bass Line survey. Overall, 13.6% of all respondents were born in the UK, a similar proportion to the 17.3% found among Black Africans aged 19-59 in the Labour Force Survey in 2002 (Lindley, Dale & Dex 2004), and a higher proportion than in Bass Line 2007 (Dodds *et al.* 2008a).

Both men and women were represented in all country of birth sub-samples although the ratio of men to women varied. The countries of birth with highest male-to-female ratio were Sudan (83.8:17.2) and the Democratic Republic of Congo (67.3:32.7). The two country sub-samples with the lowest male-to-female ratio were the Gambia (24.0:76.0) and Zambia (27.7:72.3).

All country of birth sub-samples showed a wide range of ages. The youngest country of birth sub-sample were those born in the UK, among whom more than a third (33.5%) were under the age of twenty. The oldest groups according to country of birth were from Zimbabwe and Kenya.

In the table above, the countries are ranked by the proportion of survey respondents who identified that country as their place of birth. In Chapter 11 comparative data for the 10 most common countries of birth is presented in alphabetical order.

2.4 LENGTH OF TIME LIVING IN THE UK

Respondents were asked *How long, in total, have you lived in the UK?* More than half of those who were born in the UK had lived in this country all their lives. They are represented in the last row of the table below. The length of time respondents had lived in the UK ranged from 1 month to 52 years with a mean of 8.8 years (standard deviation 9.2 years, median 7 years). The following table shows the proportion of respondents who had lived in the UK for increasing periods of time and the age profile of each group.

Length of time resident in the UK (n=2486, missing 94)	% ALL	Average age (median)	Age range
less than 1 year	6.3	26	16-55
over 1 year – less than 3 years	10.5	27	16-76
over 3 years – less than 6 years	21.3	30	16-78
over 6 years – less than 10 years	26.3	34	16-72
10 years or more (not born in UK)	23.8	37	16-68
10 years or more (born in the UK)	11.7	25	16-52

The length of time respondents had lived in the UK was broadly similar to the first Bass Line survey. The average (median) age of people who had lived in the UK for 12 months or less was 26 years, and it increased as length of time living in the UK increased with the exception of those who have lived in the UK their whole lives, who tended to be younger (median age 25 years)

In Chapter 12 we compare groups of respondents who had lived in the UK for different lengths of time using the following bands: up to one year (6.3%, n=157); between one and three years (10.5%, n=261); between three and six years (21.3%, n=530); between six and ten years (26.3%, n=654); and more than ten years (35.6%, n=884). In that subsequent analysis, the last of these groups (resident more than ten years) includes those who have always lived in the UK.

2.5 AREA OF RESIDENCE

Respondents were asked the open-ended question *What local authority do you live in?* They were asked to write in the name of their city or town if they were unsure of their local authority. A minority of respondents (2.6%, n=67) did not answer this question compared to a quarter (24.9%, n=1040) in the previous survey (Dodds *et al.* 2008a). This was mainly due to re-designing the question to allow people to just write their city or town of residence rather than their local authorities. The following table shows where all respondents lived, broken down by the 10 Strategic Health Authorities (SHA) in England.

Strategic Health Authority of residence (n=2580, missing 0)	Number of respondents	% ALL	% of those that answered
SHA not known	67	2.6	–
East of England	201	7.8	8.0
East Midlands	217	8.4	8.6
London	1022	39.6	40.7
North East	4	0.2	0.2
North West	157	6.1	6.2
South Central	112	4.3	4.6
South East Coast	136	5.3	5.4
South West	52	2.0	2.1
West Midlands	401	15.5	16.0
Yorkshire and The Humber	177	6.9	7.0
Outside England	34	1.3	1.4

The vast majority of the respondents lived in England. In the 2001 Census 78% of Black Africans living in England lived in London (Dobbs *et al.* 2006), although this proportion is now likely to be lower. However, in our survey only 39.6% of respondents were living in London. The geographic distribution of respondents is broadly similar to that of the first Bass Line survey but with slightly fewer respondents in London and an increase in those in the West Midlands. This is most likely a result of the geographic distribution of our research collaborators.

2.6 HOUSEHOLD COMPOSITION

Respondents were asked *Who do you live with?* and were offered the responses: *I live alone; partner / husband / wife / civil partner; parent(s) / step-parent(s); children I am responsible for; other family (specify); friends; house-mates; other*.

The household composition of respondents was very similar to the first Bass Line survey. Overall 29.4% (n=735) lived alone. Men were more likely to live alone than women (34.7% compared to 24.4%). A third (32.0%) lived with a partner, including spouses. A partner was by far the most common co-inhabitant indicated. Men were also more likely to live with a partner than women (36.2% versus 28.1%).

A smaller proportion lived with parents or step-parents (10.9%) and men were less likely than women to live with their parents or guardians (9.0% compared to 12.8%). As would be expected, two thirds of the people living with parents were aged below twenty years. A small proportion lived with other family members (5.3%), including siblings, uncles, aunts, sister / brother-in-law and cousins.

About one-in-seven respondents (14.8%, n=376) lived with children for whom they were responsible. This was far less common among men (7.5%) than women (21.7%) but was still considerably less common than the 48% of Black African women reported in 2001 census data who lived with children (Lindely, Dale and Dex, 2004). Of those that lived with a child they were responsible for more than two thirds were aged above thirty years and 45.2% (n=170) also lived with a partner. This indicates that single-parenthood is not uncommon among those who live with dependent children, especially among women, which is likely to influence their access to interventions.

Some respondents (6.3%) lived with friends and this was more common among people in their twenties than any other age group. Some also shared with house-mates (10.9%). The likelihood of sharing with others decreased as length of time living in the UK increased, which may be explained again by increased economic independence over time.

2.7 WORKING AND STUDYING

Respondents were asked *Which of these best describes your current situation?* and were offered the responses that appear in the table below, as well as being given an opportunity to describe an activity not appearing in the list. People could tick more than one answer.

Current activity (n=2539, missing 41)	**% ALL**
Employment (formal and informal)	
Full-time employment	33.8
Part-time employment	14.6
Casual / cash-in-hand employment	2.1
Carer / homemaker	2.7
Education / training	
Full-time education	32.8
Part-time education	10.9
On a training scheme / back-to-work activity	2.2
Unemployment / other	
Not in employment and registered for benefits	4.3
Not in employment and not registered for benefits	5.0
Unable to work (long-term illness / disability / medically retired)	1.4
Not allowed to work (immigration reasons)	8.3
Retired	0.4
Other	1.5

The work and study status of respondents was very similar to the first Bass Line survey. Most people were either involved in some form of employment (48.1%, n=1221), or in some form of education (45.5%, n=1154), or both of these activities. One contributor to some individuals' lack of engagement in economic activity is their immigration status as evidenced by the 8.3% of the respondents who said that they were disallowed from work due to their immigration status.

There was no gender variation for all forms of educational engagement but gender was significantly associated with full-time employment and carer or home-maker employment. Men were more likely than women to be in full-time employment (37.7% compared to 30.5%), but were less likely to engaged in home-caring work (1.2% compared to 4.1%).

Women were more likely than men to be not allowed to work because of their immigration status (8.8% compared to 7.6%) or to be unemployed (5.6% compared to 4.3%) whether they claimed benefits or not.

Lastly, there was association between education and age. Younger people (less than thirty years old) were more likely be engaged in full-time or some form of education than the older age groups. On the other hand, older people (50+) were significantly more likely to be engaged in some other form of employment, were unable to work because of illness or disability, were unemployed or retired or were registered for benefits. There was no age difference for casual employment and home carer occupations.

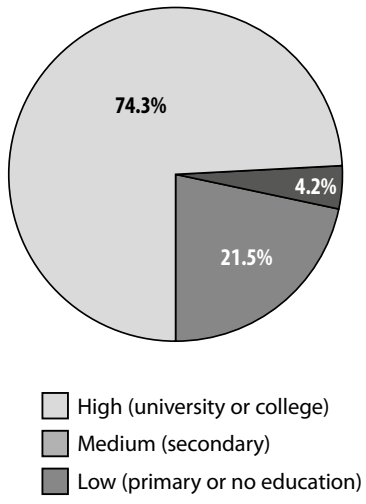
2.8 EDUCATIONAL ATTAINMENT

Respondents were asked *What is the highest level of education you have achieved?* and were offered the responses: *none; primary / elementary school; secondary / high school; university / college; other*. For ease of reporting, educational attainment was re-coded into the three categories as shown in the pie chart below. However, the use of the word college is context dependent and can imply medium level (high school/A-level equivalent) or higher level (post A-level education) attainment. In some settings, the word college might refer to A-level or specialist school whereas in others it might mean training in specialist trades such as plumbing, mechanics and other vocational training. To some people, college can also be used to refer to a university institution. This means that the high proportion of respondents with higher educational attainment will include some medium level responses (particularly among the half of respondents aged below twenty years who said they had higher education attainment).

Most respondents had a high level of education (74.3%, higher than the 64.4% in the first Bass Line survey) and only a small proportion reported low educational attainment (4.2%). Respondents recruited online were significantly more likely to have higher education (87.2%) than those recruited using the booklets (71.3%). There was no significant difference in educational attainment between men and women.

Almost three quarters of those with low (72.3%) and more than half (56.7%) of those with medium level education were currently engaged in some educational activity. With no gender difference, this was especially common among the younger respondents.

The level of educational attainment showed a relationship with the length of stay in the UK. The longer respondents had been in the UK, the more likely they were to have achieved a higher educational level, compared to those that had been in the UK for less time, maintaining a trend from the previous survey (Dodds *et al.* 2008a). In Part Two (Chapter 10) these three education groups are used to compare HIV prevention need across the sample.



Education groups (n=2504, missing 76)

2.9 RELIGION

Respondents were asked *Which religion do you belong to?* and were offered the responses: *Christian, African traditional religion, Islam, Buddhism, other* and *none*. Space was offered for specifying denominations and other religions not included in the list. The majority of respondents said they were Christians (76.9%). A substantial proportion of respondents said they were Muslims (12.5%), while fewer belonged to an African traditional religion (ATR) (1.8%), Buddhism (0.7%) or other religions (1.0%). Three respondents identified themselves as Jewish.

More than half of the Christians identified themselves as Roman Catholics, Evangelical / Pentecostal and Protestants. The remaining Christians either did not specify their denomination, or gave a denomination which was not classifiable – they are shown as 'Christian unclassified' in the table below. The Protestant category includes those who specified their denomination simply as Protestant, which is called here 'Protestant unspecified', as well as those who indicated a denomination that can be identified as a sub-category of Protestantism.

Religion (n=2539, missing 41)	**Number of respondents**	**% ALL**
Christian	**1952**	**76.9**
Christian unclassified (no denomination given)	825	32.5
Roman Catholic	351	13.8
Evangelical / Pentecostal	326	12.8
Church of England	143	5.6
Orthodox	17	0.7
All Protestants	290	11.2
Protestant (unspecified)	*127*	*5.0*
Methodist	*56*	*2.2*
Seventh Day Adventist	*46*	*1.8*
Baptist	*45*	*1.7*
Jehovah's Witness	*14*	*0.6*
Mormon	*2*	*0.1*
Islam	**317**	**12.5**
African traditional religion	**45**	**1.8**
Buddhism	**18**	**0.7**
Other religion	**25**	**1.0**
No religion	**182**	**7.2**

The respondents religions were broadly similar to the first Bass Line survey but with slightly more Christians and slightly fewer Muslims, and showed the same gender differences. More men followed Islam (15.0%) compared to women (10.3%), the opposite for Christians (72.2% men, 81.2% women). Men were more likely than women to belong to ATR (2.1% vs 1.4%) or to indicate that they did not belong to any religion (8.7% vs 5.8%). There are several possible explanations for these gender differences. Muslim men may have been more likely than Muslim women to be actively involved in the social and community settings where the majority of recruitment occurred. Religious involvement tends to be more heavily viewed as an aspect of femininity rather than masculinity, providing some explanation for the finding that more men than women belonged to no religion.

Respondents' religious affiliations have been condensed to four groups: Christian, Muslim, African traditional religion and no religion in the comparison of HIV prevention needs across the sample by religion that is reported in Part Two (Chapter 13).

2.10 REGULAR SEXUAL PARTNERS

Respondents were asked *Do you currently have a STEADY sexual partner (someone you have sex with on a regular basis)?* and were given the five options in the table below. The proportions with regular sexual partners was broadly similar to the first Bass Line survey.

Number and gender of regular sexual partners (n=2411, missing 169)	**% MALES** (n=1155)	**% FEMALES** (n=1256)	**% ALL**
No steady sexual partner at present	33.4	44.4	39.2
One FEMALE regular partner only	54.0	1.3	26.5
More than one FEMALE regular partner	6.5	0.2	3.2
One MALE regular partner only	4.5	51.0	28.7
More than one MALE regular partner	1.8	3.3	2.6

Sexual partners was significantly associated with gender. Men were more likely to have a regular partner than women and also more likely to have multiple regular partners than women as shown by 8.3% of men in relationships who had more then one regular partner compared to 3.5% of the women. Men in their twenties were the most likely of all age groups to have more than one regular sexual partner (11.5% of those in their 20s, 10.0% of those under 20, 7.5% of those in their 30s and 3.4% of those aged 50 and above). For women, it was those in their 40s who were most likely to have more than one regular partner (4.8% of the 40s, 3.0% of the under 20s, 3.1% of the 20s and 3.0% of the 30s).

2.11 CIRCUMCISION

All respondents were asked *Have you been circumcised?* and were offered the responses: *No, Yes, Don't Know.* Overall, more than a third of the respondents (36.1%) had been circumcised and another 4.8% (n=118) said they *didn't know* if they were circumcised or not. A minority, 6.3% (n=162) did not answer the question.

Circumcision by gender (n=2418, missing 162)	**% MALES** (n=1160)	**% FEMALES** (n=1258)
YES	64.7	9.6
NO	31.8	84.4
Don't know	3.4	5.9

The proportions of men and women circumcised were broadly similar to the first Bass Line survey. Again, circumcision was far more common in men than in women. When we excluded those that did not know if they had been circumcised or not, there was no relationship between being circumcised and age. There were associations between ethnicity and circumcision as well as religion and circumcision

There was also an association between circumcision and country of birth for both males and females as shown in the following table, which also excludes those who did not know their circumcision status (the 20 most common countries of birth are shown below in order of reported prevalence among men).

Circumcision by country of birth (n=2349, missing 231)	**% (n) MALE circumcised**	**% (n) FEMALE circumcised**
The Gambia	100.0 (6/6)	47.1 (8/17)
Sierra Leone	100.0 (7/7)	38.9 (7/18)
Cameroon	97.0 (32/33)	0.0 (0/29)
Ghana	93.8 (45/48)	14.3 (6/42)
Burundi	91.7 (11/12)	0.0 (0/12)
Nigeria	88.7 (149/168)	21.1 (28/133)
Kenya	84.4 (76/90)	6.6 (8/122)
Democratic Republic of Congo	82.5 (52/63)	7.1 (2/28)
Tanzania	80.0 (8/10)	7.7 (1/13)
Ethiopia	76.5 (13/17)	38.5 (5/13)
Republic of Congo	76.0 (19/25)	7.1 (2/28)
Sudan	75.0 (13/17)	66.7 (4/6)
Somalia	66.7 (6/9)	45.5 (10/22)
United Kingdom	66.5 (105/158)	7.1 (12/168)
Republic of South Africa	54.5 (18/33)	5.7 (2/35)
Jamaica	50.0 (4/8)	11.8 (2/17)
Uganda	39.7 (25/63)	2.8 (3/107)
Zambia	24.0 (6/25)	5.7 (4/70)
Malawi	23.5 (4/17)	4.3 (1/23)
Zimbabwe	20.3 (39/192)	1.4 (3/207)

The countries in this table are not the only countries where circumcision is practiced, but are countries of birth reported by more than twenty respondents in our sample. This data however is a good indicator of the rates of male and female circumcision among Africans coming into contact with NAHIP partners in England.

Among the men, circumcision was more common among those born in The Gambia (100%), Sierra Leone (100%), Cameroon (97.0%), Ghana (93.8%) and Burundi (91.7%). Among the women, circumcision (known as Female Genital Mutilation or FGM) was more common among those born in Sudan (66.7%), The Gambia (47.1%), Somalia (45.5%), Sierra Leone (38.9%) and Ethiopia (38.5%). The prevalence of circumcision in this survey reflects the findings of our previous survey (Dodds *et al.* 2008a). The countries we have reported here with higher prevalence of female circumcision also reflects the prevalence reported eleswhere (The Population Council 2009)

There is no targeted campaign in England for uncircumcised men and NAHIP partners are not involved in any interventions specifically with this group of men. However, all Africans have information needs around the effect of foreskins and circumcision on the risk of HIV transmission. Circumcision reduces but does not eliminate the risk of HIV transmission from women to men during vaginal intercourse (UNAIDS 2007). NAHIP partner agencies may face the possibility of increased enquiries and requests for circumcision among some men as the evidence and information about circumcision continues to diffuse through communities.

For women, circumcision and other types of female genital mutilation (FGM) can lead to array of health consequences. Short-term problems can include pain, excessive bleeding, infection of the wound, injury to the adjacent tissues and urine retention. Long-term complications can include infertility, increased risk of child birth complication and recurrent bladder and urinary tract infections (WHO 2008). Other problems include pelvic inflammatory disease, and genital injury due to vaginal tearing during sex (Brady 1999). All of these features probably leave women with FGM more vulnerable to HIV, as well as being more likely to pass it on. The HIV prevention needs of women who

have experienced FGM can be incorporated into the planning of interventions that will target women from countries where the practice is common.

2.12 SUMMARY

Although the number of people recruited to this second Bass Line survey was smaller than to the first, and our collaborating agencies changed somewhat, the profile of respondents is very similar to the first Bass Line survey.

The study recruited nearly equal proportions of both men and women both online and through the booklets. This suggests that interventions intended for Africans living in England can reach both men and women online and through community organisations.

There was a mismatch between sexual attraction and sexual behaviour among the respondents. Homosexually active men and women may be less likely to engage with services intended for them because many of them do not identify as gay, lesbian or bisexual.

Almost three quarters of the respondents had lived in England for more than three years, with more than a third living in London. This signifies the need for higher investment in interventions intended for Africans in London than any other region. However, a minority had lived in England for less than three years and indicated great need for information and access to sexual health services.

Christianity and Islam were the leading religious affiliations which also showed significant gender variation. Women were more likely than men to say they were Christians whereas there were more Muslim men in the sample than women.

Lastly, men were significantly more likely to have more than one regular sexual partner than were women. Men in their 20s were most likely to have multiple regular sexual partners.

3 HIV testing and diagnosis needs

A central goals of *The Knowledge, The Will and The Power* (Dodds *et al.* 2008b) is to reduce the length of time between HIV infection and diagnosis among Africans in England. Health promoters' hope is that Africans with undiagnosed STI infections get tested and treated as quickly as possible. There are diverse needs related to having an HIV test, including knowledge, desire and ability.

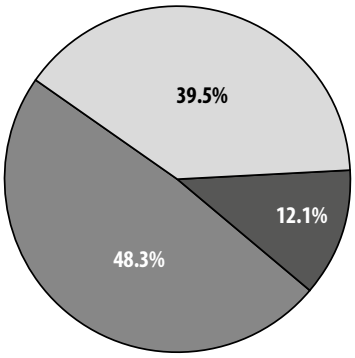
This chapter describes the extent of testing for HIV, HIV test results, recency of testing and reasons for never testing among those who have never tested for HIV. It then compares respondents' current perceived HIV status with their HIV testing history before exploring experience of testing for other sexually transmitted infections.

3.1 HIV TESTING HISTORY

Respondents were asked *Have you ever personally received an HIV test result from a health professional?* and were given the options: *yes I've received a POSITIVE test result (I do have HIV), yes I've received a NEGATIVE test result (I did NOT have HIV at the time of the test)* and *No, I've never tested for HIV.*

Of those who had ever had an HIV test result, the result was missing for 1.5% (a similar proportion as in the first Bass Line survey). The pie chart below shows the history of HIV testing among the entire sample.

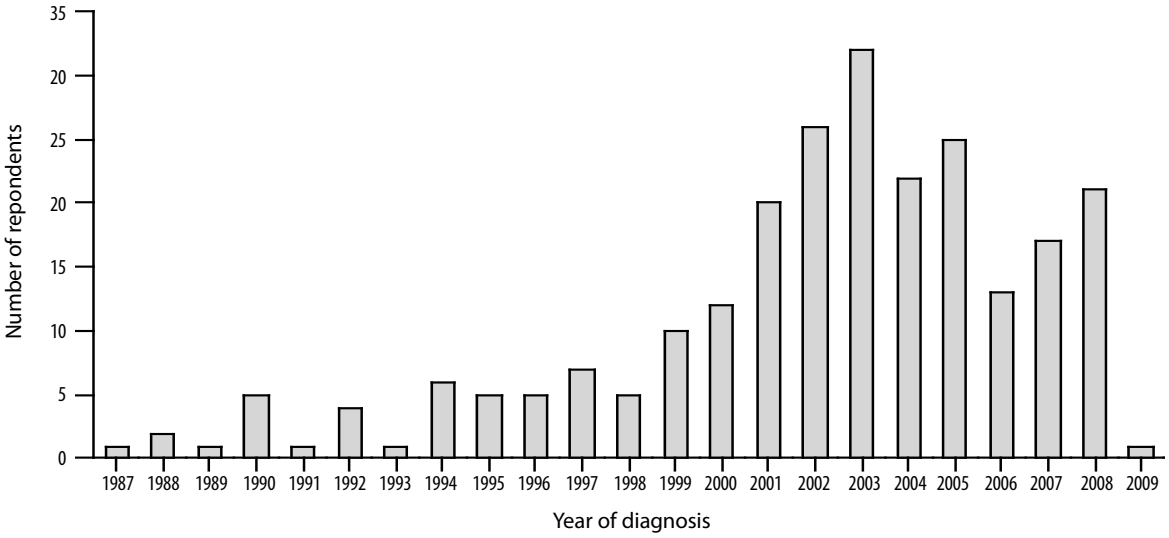
Just under half (48.3%) of all respondents had tested HIV negative at some time prior to the survey, somewhat more than the 34.9% in the first Bass Line. Half (50.7%) of those who had tested negative had done so in the previous year, including 12.2% who had tested negative in the previous month. Among the remainder who had tested negative, the majority (37.5%) had done so in the 2-5 years previously.



Education groups (n=2542, missing 38)

Overall, 12.1% of all respondents had diagnosed HIV infection (or 20.1% of those that had tested and who disclosed their result). This is slightly lower than the 15.5% in the first Bass Line survey but is still much higher than National estimates. National surveillance systems estimate a 3.7% prevalence of diagnosed HIV infection among Black African adults in England (HPA 2008). Because the respondents are a snap-shot of the people who come into contact with NAHIP partner agencies and other providers of HIV prevention, treatment and care services, it is not surprising that there is a higher proportion of people with diagnosed HIV than in the general African population in England.

This large number of people with diagnosed HIV in the sample makes it possible to compare this group with those who do not have an HIV diagnosis, in order to describe differences in HIV risk behaviours and unmet prevention needs (see Chapter 8 in Part Two).



Year of diagnosis with HIV (n=242, missing 144)

There was great variety among the respondents living with diagnosed HIV. The length of time they had been diagnosed ranged from one month to more than twenty years. The year of diagnosis mirrors the national surveillance data trends in that the peak was 2003 and thereafter the numbers have declined (HPA 2008).

3.2 HIV STATUS BELIEF

Before answering any question on HIV testing, respondents were asked *What do you think your current HIV status is (whether or not you've ever tested)?* and offered the five options in the table below. Alongside HIV testing history, the answer to this question gives an insight into the potential disparity between people's HIV testing history and their current HIV status belief. This is particularly important for those that have tested negative a long time previously and those that have never tested. When considering the sample *as a whole*, the majority of respondents fell into two categories: those who had never tested and thought they were negative (29.1% of all respondents); and those who had previously tested negative and who thought they were still negative (44.6% of all respondents). The following table shows the proportion of those in each of the three testing history groups who gave each answer.

Current HIV status belief (n=2417, missing 163)	**% NEVER tested** (n=948)	**% tested NEGATIVE** (n=1176)	**% tested POSITIVE** (n=293)	**% ALL**
definitely NEGATIVE	55.8	78.2	6.1	60.7
probably NEGATIVE	18.4	13.4	1.7	13.9
not sure / don't know	23.5	6.9	2.0	12.8
probably POSITIVE	1.6	0.8	5.8	1.7
definitely POSITIVE	0.7	0.8	84.3	10.9

Among those who had not had an HIV positive test result, the majority believed they were HIV negative. For those whose last HIV test was negative, 91.6% thought they were currently negative (of whom two thirds thought they were definitely negative). Three quarters (74.2%) of those who had never tested also thought they were negative (of whom half thought they were definitely negative).

Almost one-in-ten (9.8%) of respondents who had received a positive HIV diagnosis said they were HIV negative or were unsure of their status. This could be attributed to many factors including lack of understanding of test results, denial of positive status, or fear of stigma and discrimination making individuals shy away from reporting their positive status. Large, low threshold self-completion surveys also have a considerable degree of 'noise' (random data) in them, which could account for some of this apparent anomaly.

In addition, there was a small group who believed they were HIV positive but had not been diagnosed (2.3% of those who had never tested and 1.6% of people whose last test was negative).

Of similar interest are the 12.8% of all respondents who were unsure, or did not know what their status was. It is likely that these people who are unsure of their status have considerable unmet HIV testing needs. However, it is unclear whether they are more or less likely to have undiagnosed HIV infection than those who are confident they are negative. Testers at a community HIV testing clinic were poor at predicting the outcome of the test they were about to undertake (Weatherburn *et al.* 2006a, 2006b) with most of those expecting to be positive receiving a negative result, and most of those who were diagnosed positive, not expecting to be so.

3.3 UNMET HIV DIAGNOSIS NEEDS

3.3.1 Desire to take an HIV test

In order for sexually active people to confidently know whether they have HIV or not, they need to have taken an HIV test. To take an HIV test, people need to want to take a test. Respondents who had not tested positive were asked *Would you like to take an HIV test (or another test if you have tested before)?* Respondents were offered the answers: *No; Yes; Not sure*.

Overall, 38.4% of those who had not tested HIV positive said they did want to take an(other) HIV test, 21.0% were not sure and 40.7% did not want to take a test, similar proportions to the first Bass Line survey. Again, people who had previously tested negative were more likely to want to a test (50.4%), than those who had never tested (24.1%). Not being sure of about taking a test was more common among the never tested (30.2%) than among those who had previously tested (13.2%).

There was a relationship between recency of a previous negative test and willingness to take another test. Those that had tested negative for HIV more than five years ago were less wiling to take a test compared to those who had tested within the last year.

3.3.2 Not knowing where to test

Among people who want to test for HIV, knowing where they can access a test would increase their chances of doing so. All respondents who said they did want to take a test, or were unsure if they wanted to take a test, were asked *If you wanted an HIV test, would you know where to get one?* A quarter (25.3%) of respondents who wanted to take a test or who were unsure said *No*, they would not know where to go for an HIV test. As would be expected, a much larger proportion of those who had never tested did not know where to test (37.9%) than people who had previously tested negative (16.3%).

Overall, this meant 12.2% of the entire sample wanted to take an HIV test (or were not sure if they wanted to) but did not know how to access one. How this proportion varies across the other characteristics of the respondents is described in each chapter of Part Two.

3.3.3 Reasons for never testing for HIV

More than a third of all respondents (39.5%) reported never having tested for HIV. They were asked *Why have you never tested for HIV?* They were presented with the list of reasons in the table below and were allowed to give more than one answer.

Reasons for NEVER having had an HIV test (n=886, missing 84)	% by HIV status belief			% of ALL never tested
	Think they are negative (n=661)	Not sure of their status (n=206)	Think they are positive (n=19)	
I've no reason to think I have HIV	59.6	33.5	21.1	52.7
I've never had intercourse	19.4	4.9	5.3	15.7
It's not important to me to know my HIV status	12.6	18.0	26.3	14.1
I am too afraid I might have HIV	6.7	19.4	15.8	9.8
I don't know where to get tested	5.9	8.7	5.3	6.5
I am afraid of being treated differently if I take a test	4.2	12.6	0.0	6.1
I am afraid of being treated differently if I have HIV	4.2	11.2	10.5	6.0
It would cause problems in my relationship	4.4	5.8	15.8	5.0
I don't trust the places I know where I could test	3.8	7.3	5.3	4.6
I am concerned about the impact it might have on my children	2.3	6.3	5.3	3.3
People I know do not approve of HIV testing	2.9	3.4	10.5	3.2
I do not want to use'official' services	1.4	5.8	5.3	2.5
I may not get treatment if I need it	1.1	1.9	0.0	1.2
Other reasons	5.0	5.3	5.3	5.1

The most common reason for never testing, given by more than half (52.7%) of all the respondents who had never tested, was having *no reason to think they had HIV.* Among those who thought they were negative, 19.4% said they *had not had intercourse* and thus had no need to test. A further one-in-eight (12.6%) said they did not think it was important for them to know their status. These reasons for not testing among those who thought they were negative suggest that wanting to test is strongly related to wanting to clarify their HIV status.

For those who were not sure of their status, there was a wider range of reasons for not testing. A third (33.5%) said they never tested because they had no reason to think they had HIV. However, their other reasons for never testing were predominantly fear related as demonstrated by 19.4% who said *I am too afraid I might have HIV,* one-in-eight (12.6%) who said *I am afraid of being treated differently if I take a test* and one-in-nine (11.2%) who feared being treated differently if they had HIV. Just like the other subgroups, some were also indifferent as almost one-fifth (18%) felt it was not important to know their status

Finally, among those who thought they had HIV but had never tested, a quarter (26.3%) said they had never tested because it was not important to them to know their HIV status. They also expressed fear as a reason for not testing: fear of having it confirmed they had HIV (15.8%) and fear of being treated differently if they were confirmed as having HIV (10.5%). They were also concerned about relationship problems (15.8%). A fifth (21.1%) said they had not tested because they had reason to suspect they were infected, yet they thought they were already infected, suggesting fear, denial or lack of information.

Most of the *other* reasons given re-iterated or confirmed answers in the table above. Many were further explanations as to why people had said *I've no reason to think I have HIV* such as: monogamy, reliance on a partner's negative test result, never really giving testing a thought, lack of recent sexual activity and some simply said they had no reason or they did not know why they had never tested.

3.4 TESTING FOR AND DIAGNOSIS OF SEXUALLY TRANSMITTED INFECTIONS

All respondents were asked, *When was the last time you were tested for ANY sexually transmitted disease, other than HIV?* In a separate question they were also asked, *When, if ever, were you last diagnosed with a sexually transmitted disease, other than HIV?*

STI testing and diagnosis	% Most recent TEST for any STI other than HIV (n=2450)	% Most recent DIAGNOSIS with STI other than HIV (n=2370)
In the last month	10.7	1.8
In the last 12 months	23.6	4.6
1 to 5 years ago	16.3	7.0
More than 5 years ago	9.3	11.1
Never	34.1	69.4
Don't know	6.1	6.1

A third of the respondents (34.3%) had tested for STIs in the last year, including 10.7% that had tested in the previous month, and a half (50.6%) had done so within the last five years. However, a third (34.1%) had never been screened for an STI.

In response to the question about diagnosis, almost two thirds (69.4%) of all respondents had never been diagnosed with an STI, and another 6.1% said that they *did not know* whether they had received an STI diagnosis or not. Among the remaining quarter (24.2%) that had ever been diagnosed with an STI, 6.4% had been diagnosed with an STI in the previous year.

3.5 SUMMARY AND IMPLICATIONS FOR PLANNING

Overall, a third of all the respondents had never received an HIV test result and a similar proportion had never been tested for other STIs. Almost half of all respondents had received a negative HIV test result at some point, half of whom had tested in the previous year.

A high proportion (12.1%) of all respondents were living with diagnosed HIV infection, as agencies recruiting respondents included those that support African people with HIV. About half of the respondents with diagnosed HIV infection were diagnosed in the previous five years. Given that a primary target group for NAHIP prevention activities are African people with diagnosed HIV (Dodds *et al.* 2008b), their high degree of participation in this survey indicates a strong engagement with this group.

HIV testing rates are not as high as health promoters would like them to be. Only a half of those who had never tested for HIV said they were willing to test. Among those who had tested negative at some point in the past, willingness to take another test decreased with time since the last test.

About one-in-eight respondents said they did not know where to go for an HIV test. Not knowing where to test was more common among people who did not think they had HIV.

- **Many Africans would test for HIV if they knew where to go for a test. This simple need should be addressed as a matter of urgency.**
- **However, influencing testing in other Africans requires increasing their perception of risk from HIV infection and understanding of the benefits of testing.**

The main reason respondents gave for never having tested was perceiving no need. Many relied on indicators such as "assumed monogamy" to maintain their safety from HIV infection.

- **To increase testing uptake among those who have never tested and repeat testing among those who had tested negative in the past, there is a need to increase awareness of their vulnerability to HIV and the potential consequences of not knowing their HIV status.**

4 Sexual risk and precaution behaviours

The major route of HIV infection among African people in England is heterosexual contact (HPA 2008). This chapter describes the sexual behaviours with HIV transmission potential that health promoters endeavor to influence in order to reduce HIV infection among African people. It reports only on those 72.6% of respondents who said they had sex in the year preceding the survey. Included here are measures of: high numbers of sexual partners, unprotected intercourse with partners with unknown HIV status, sex with others outside primary relationships, (non-)condom use and condom failure.

4.1 NUMBER OF SEXUAL PARTNERS IN THE LAST YEAR

Respondents were asked, *In the last 12 months, how many MEN / BOYS have you had sexual intercourse with?* and *In the last 12 months, how many WOMEN / GIRLS have you had sexual intercourse with?* The table below gives a summary of the responses to these questions.

Numbers of sexual intercourse partners (n=1750 people who had sex in the last year, missing 201)	**% MALES** (n=906)	**% FEMALES** (n=844)	**% ALL** (n=1750)
None	4.2	3.6	3.9
One	46.2	63.9	54.7
Two	19.2	18.6	18.9
Three	9.8	6.4	8.2
Four	4.9	2.3	3.6
Five	3.4	1.8	2.6
6 to 12	7.0	1.9	4.5
13 or more	5.3	1.7	3.5

More men (4.2%) than women (3.6%) said they had not had sexual intercourse in the last year although they had sex. This may indicate that sex is not synonymous with intercourse.

More than half (54.7%) of the respondents who had sex had intercourse with one partner only in the last year (less common in men than women) leaving 41.4% who had multiple sexual intercourse partners in the last year.

There was a significant association between gender and number of intercourse partners with men being more likely to have higher numbers of partners. More men (9.8%) than women (6.4%) had three sexual partners in the last year. Men were twice as likely as women to have four or five sexual partners in the last year and three times more likely to have six or more intercourse partners.

4.1.1 Number of sexual partners among men

By definition, men who had sex with both men and women could not have one partner only, hence the blank space in the table below. However, men who had sex with both men and women were more likely to have six or more sexual partners (35.7%) than men who had sex with men only (31.6%) or men who had sex with women only (8.6%).

Number of intercourse partners in the last year, among MEN who had any sex (n=863, missing 1)	% FEMALE partners only (n=741)	% both male & female partners (n=84)	% MALE partners only (n=38)	% of all (n=901)
One	54.4	–	42.1	46.5
Two	17.9	44.0	10.5	19.3
Three	11.1	4.8	7.9	9.9
Four	4.3	13.1	2.6	4.9
Five	3.6	2.4	5.3	3.4
6 to 12	5.4	19.0	18.4	7.0
13 or more	3.2	16.7	13.2	4.8

4.1.2 Number of sexual partners among women

Among the women who had any sex in the last year, those that only had sex with men were more likely to have one or two partners (88.8%) than those that had sex with both men and women (58.9%) or those that had sex with women only (66.6%). Though the numbers were very few, women who had sex with women only (26.7%) or both men and women (19.2%) were more likely to have had six or more partners than those that had sex with men only (1.4%).

Number of intercourse partners in the last year, among WOMEN who had any sex (n=812, missing 0)	% MALE partners only (n=724)	% both male & female partners (n=73)	% FEMALE partners only (n=15)	% of all (n=842)
One	73.3	–	53.3	64.0
Two	15.5	58.9	13.3	18.6
Three	6.2	11.0	6.7	6.4
Four	2.1	5.5	–	2.3
Five	1.5	5.5	–	1.8
6 to 12	1.0	11.0	6.7	1.9
13 or more	0.4	8.2	20.0	1.4

4.2 REGULAR SEXUAL PARTNERS AND EXTRA-RELATIONAL SEX

All respondents were asked *Do you currently have a STEADY sexual partner (someone you have sex with on a regular basis)?* Overall, 79.0% of the sexually active respondents had a regular sexual partner, the same proportion for men and women. However, men were more likely than women to say they had more than one current regular sex partner (10.2% versus 4.9%).

Respondents with a regular sexual partner were asked *How many OTHER people have you had sex with while you have been with this steady partner?* Overall, 28.9% of those with a regular sex partner said they had sex with at least one other person while with that regular partner, what we will call extra-relational sex. Men were much more likely to have extra-relational sex than women (39.2% versus 17.8%) and to report higher numbers of extra-relational partners if they did so. The table below illustrates the numbers of sexual partners men and women said they had in addition to their current primary relationship.

Number of other sexual partners during current primary relationship (people with a regular sexual partner n=1416, missing 39)	**% MALES** (n=735)	**% FEMALES** (n=681)	**% ALL with a regular partner** (n=1416)
None	60.8	82.2	71.1
One	16.5	9.7	13.2
Two	9.9	4.1	7.1
Three	4.8	2.2	3.5
Four	3.1	0.4	1.8
Five	0.7	0.3	0.5
6 to 12	2.9	0.7	1.8
13 or more	1.3	0.3	0.9

Extra-relational sex was related to co-habitation. Among men with a regular partner who lived alone, 49.0% (100/204) had extra-relational sex compared with 30.9% of those who co-habited with their partners. The corresponding figures for women were 25.2% and 12.6%.

4.3 LIKELIHOOD OF SERO-DISCORDANT UNPROTECTED INTERCOURSE

Respondents were asked, *How likely do you think it is, that in the last 12 months, you've had sexual intercourse WITHOUT A CONDOM with someone who had a DIFFERENT HIV status to yourself?* The following table shows the responses separately for men and women and for those who had and had not been diagnosed with HIV (6.7% of those who had sex did not answer this question).

How likely had sdUI in last 12 months (n=1711 people who had sex in the last year, missing 240)	**Not diagnosed HIV positive**		**Diagnosed HIV positive**	
	% MALES (n=825)	**% FEMALES** (n=687)	**% MALES** (n=70)	**% FEMALES** (n=129)
Definitely have	7.4	5.7	12.9	14.0
Probably have	6.9	4.9	5.7	4.7
Don't know	20.4	16.0	2.9	12.4
Probably have not	13.5	12.5	7.1	7.0
Definitely have not	51.9	60.8	71.4	62.0

Those who had tested HV positive were more confident about whether they had been involved in serodiscordant intercourse without a condom (sdUI) – fewer said 'don't know' than those who had not tested positive.

Among those not diagnosed HIV positive, women were more confident they had not been involved in sdUI than were men (which accords both with women being more likely to have tested for HIV and having fewer sex partners). Among those who had tested positive their was no significant difference between men and women.

For both men and women, the likelihood of sdUI had a significant association with the number of sexual partners, and increased as the number of sexual partners increased. Men with six to twelve sexual partners were more likely to report definitely or probably engaging in sdUI (30.0%) than those with one (15.9%) or two (21.7%) partners. Likewise, women with one partner were less likely (21.9%) to definitely or probably engage in sdUI compared to those with six to twelve partners (40.0%).

4.4 CONDOM USE

All respondents were asked *How often have you used condoms for intercourse IN THE LAST 12 MONTHS?*. The following table shows the frequency of condom use among men and women who had sex in the last year.

Frequency of condom use for sexual intercourse among all respondents, in the last 12 months (n=1811, missing 140)	**% MALES** (n=951)	**% FEMALES** (n=860)	**% ALL** (n=1811)
Always	42.5	40.1	41.4
More than half the time	16.4	12.4	14.5
About half the time	7.5	6.6	7.1
Less than half the time	10.1	11.3	10.7
Never, NO CONDOM USE in last year	22.7	28.7	25.6
Not had intercourse in the last 12 months	0.8	0.9	0.7

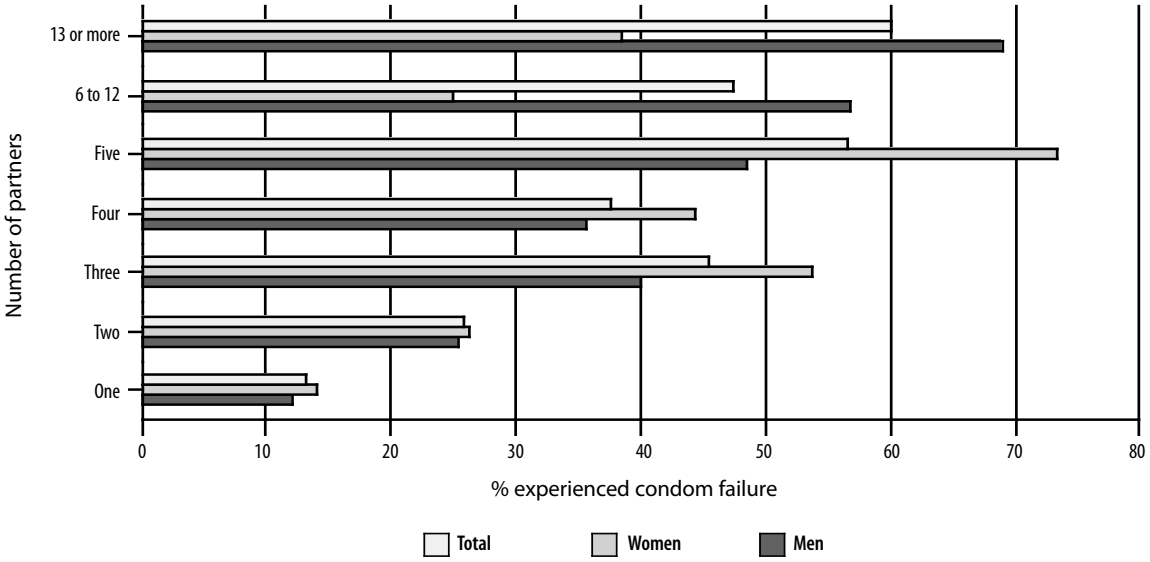
Two-fifths of the respondents (41.4%) said they always used condoms for intercourse in the last year and a quarter (25.6%) had never used condoms in that time. That leaves nearly a third who used condoms intermittently in the last year. As would be expected, condom use was more common among men than women, possibly because condom is a male-dependent intervention.

Condom use was less common among the people who thought they did not have HIV than those who thought they did have HIV. Apart from status belief, sexual behaviour also influenced condom use. Respondents who said they only had heterosexual intercourse in the last year were less likely to always use condoms compared to those who were homosexually active. Condom use was also less common among older men than younger ones. For example, men in their 40s were less likely to always use condoms (33.3%) than those in their 20s (47.1%) or those in under the age of twenty (59.8%).

4.5 EXPERIENCE OF CONDOM FAILURE

All respondents were also asked *Have you or a sexual partner had a condom break or come off during intercourse IN THE LAST 12 MONTHS*? About a third (32.2%) of those that had used a condom in the last year had experienced a condom failure. Though it is similar to our previous survey (Dodds *et al.* 2008a) this proportion is very high. It represents an elevated risk of infection and other sexual health problems among individuals who are trying to reduce their risk of infection.

Condom failure was reported more by those with lower educational level (32.8%) than medium (26.0%) or higher (22.2%) educational level. Of all the respondents who said they had experienced condom failure, those whose last HIV test was negative were more likely to report condom failure (50.7%) than those who never tested (29.5%) or those who had tested positive (19.8%).



Condom failure in relation to numbers of sexual partners

Condom failure was related to numbers of sexual partners as well. Men with more sexual partners reported higher rates of condom failure as illustrated in the graph above. For the women, the risk of condom failure was highest among those with multiple sexual partners but beyond five sexual partners there was a reduction in reported condom failure.

Respondents were given a list of factors that can lead to condom failure, regardless of their answer to whether they had experienced condom failure in the last year. The following table illustrates the responses for those respondents who had sex and used condoms in the last year.

Behaviours associated with condom failure in the last year (n=1219, missing = 138)	**% MALES**	**% FEMALES**	**% ALL**
Having intercourse for over half an hour without changing the condom	61.9	56.0	60.0
Using a condom that is too big or baggy	59.3	56.5	58.0
Using saliva as a lubricant	57.4	54.5	56.3
Using a condom that is too short for the penis	55.6	57.5	55.7
Not using additional water-based lubricant	54.8	53.8	50.6
Tearing the condom with jewelry or fingernails	54.2	45.6	49.6
Unrolling the condom before putting it on the penis	50.0	39.5	46.0
Using a condom that is past its expiry date	40.9	34.8	38.6
None of the above	15.6	17.2	16.2

For each of the behaviours related to condom failure, except use of a condom past its expiry date, those who had engaged in the behaviour were significantly more likely to have experienced failure in the last year, than those who had not engaged in the behaviour.

The most common behaviour associated with condom failure was use of a condom for more than thirty minutes. Use of condoms without water based lubricant was also common as was using condoms that were too large or too small. This finding is similar to other studies which have reported poor condom fit as a common cause for breakage or slippage of condoms (Reece *et al.* 2008).

4.6 SUMMARY AND IMPLICATIONS FOR PLANNING

Overall, three quarters of all respondents were sexually active in the last year. More than half had a regular sexual partner, which was more common in men than in women. One-in-four of the people with regular partners said they had other sexual relationships outside the regular relationship, again more common in men than women.

In addition, one-in-ten who said they had sex in the last year reported definitely or probably having sexual intercourse without a condom with someone of a different HIV status to themselves (sdUI). The risk of sdUI increased with larger numbers of sexual partners. Individuals who reported having sex with both men and women were more likely to have multiple sexual partners than those who reported sex with opposite sex or same sex partners only.

- **Interventions to reduce potentially sero-discordant unprotected intercourse should target those in multiple sexual relationships, particularly men.**

A quarter of all respondents who said they had sex in the last year never used condoms. Those with fewer sexual partners, and in a regular sexual relationship (especially a monogamous relationship) were less likely to use condoms. Condom use was more common in men than in women, and mostly reported by those aged between twenty and thirty nine years. Among those who used condoms, a third experienced condom failure.

- **Current levels of condom failure seem very high and may be detracting from their use. Interventions to increase the use of condoms should always include elements to ensure minimum condom failure.**

5 Indicators of HIV prevention need

The aim of HIV health promotion is for people to be educated and empowered about HIV and its prevention and to be able to exercise control over their own actions. The current survey tried to establish how well-informed respondents were about HIV, and to what extent they felt confident in their own ability to avoid transmission. All respondents were asked a range of questions to assess their knowledge of HIV and AIDS, their confidence and control over HIV.

The data presented here compliments existing needs assessments and contributes to an on-going picture of HIV prevention needs among Africans in England. This being our second mapping of HIV prevention needs among Africans in England on this scale, we wanted to establish whether there would be similarities or differences in patterns across different characteristics observed in Bass Line 2007 (Dodds *et al*. 2008a).

Indicators of prevention need were in two formats. In the first format, knowledge items were headed *All of the following statements are TRUE – did you know this before today?* Respondents were then provided with what we and our collaborators consider thirteen statements of fact. For each, respondents were asked to give one of the four responses:

- ☐ I knew this before today
- ☐ I wasn't sure if this was true or not
- ☐ I didn't know this
- ☐ I don't understand this

Giving respondents facts about HIV and asking them to indicate whether or not they knew this already probably under-estimates unmet need as some people will say they knew this when they did not, but fewer are likely to say they did not know this when they did. Although this method gives a more optimistic picture than is the case, it increases the educational value of the survey and minimises the probability that respondents finish the survey believing incorrect information (as is the danger with a *true / false* question format).

The second question format was used for indicators of HV prevention motivation and ability. Respondents were presented with seven short statements and asked to agree or disagree on a five point scale:

- ☐ strongly agree
- ☐ agree
- ☐ don't know / does not apply
- ☐ disagree
- ☐ strongly disagree

All respondents were asked to rate three indicators about condoms and one indicator about sexual communication. All respondents were also asked about their motivation to avoid HIV transmission, their perception of risk of HIV infection and their control over it. A further fifteen topics were offered as subjects respondents might want to know more about.

5.1 KNOWLEDGE AND UNDERSTANDING

Knowledge is necessary but not sufficient of people to manage their sex lives to achieve what is, for them, the best sex with least harm. Knowledge helps us to understand the potential consequences of our choices and equips us with an essential element of the power to reduce risks. While some people may require specialist knowledge, NAHIP partners agree that there is a basic set of information we would like all Africans to have.

5.1.1 Thirteen facts about AIDS

Thirteen HIV knowledge items were offered in two separate sections of the survey. The first set of five were headed: *Some questions about HIV and AIDS* ... and appeared relatively early in the questionnaire. A set of eight statements appeared later in the questionnaire headed: *Some questions about HIV and AIDS treatment and transmission*.... Both sets of the knowledge items are reproduced in the table below, showing the overall proportions of responses to each to each statement. Apart from *I knew this before today*, any other answer is treated as an indicator of need. The final column shows the overall proportion in need of each knowledge item. Items are ordered from most commonly known at the top of the table, to least known at the end.

Knowledge of HIV and AIDS among all respondents	% Knew this	% Not Known	% Not sure	% Do not understand	% in need
A person with HIV can pass it to a partner during sexual intercourse. (n=2469)	94.5	2.2	1.7	1.5	5.4
AIDS is caused by a virus called HIV. (n=2553)	93.8	2.4	3.1	0.7	6.2
There is a medical test that can show whether or not you have HIV. (n=2534)	93.1	2.8	3.1	0.9	6.8
HIV is never passed on through shaking hands or touching people. (n=2475)	92.3	2.7	3.6	1.5	7.8
People can have HIV without knowing it. (n=2519)	88.7	4.7	5.2	1.3	11.2
There is no cure for HIV infection once someone has it. (n=2478)	88.7	3.9	4.9	2.5	11.3
You cannot tell from someone's appearance whether they have HIV or not. (n=2536)	86.2	4.8	7.8	1.2	13.8
There are HIV medicines that can help people with HIV to stay healthy. (n=2467)	83.8	7.9	6.1	2.1	16.1
Condoms are free from sexual health clinics, family planning clinics and some community organisations. (n=2464)	79.7	12.5	6.2	1.6	20.3
HIV medicines work better if people with HIV take them before they become ill. (n=2461)	62.5	23.1	9.6	4.8	37.5
Africans are NOT deported from the UK solely because they have HIV. (n=2508)	62.2	16.5	17.3	3.9	37.7
Some people with HIV have been imprisoned in the UK for passing their infection to a sexual partner. (n=2465)	59.7	26.5	9.9	3.9	40.3
At least 1-in-20 of all Africans living in England have HIV infection. (n=2457)	31.1	47.6	15.8	5.6	69.0

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Only a minority of respondents did not know basic facts such as: HIV is a virus that can be passed during sexual intercourse, existence of a medical test that can show whether one is infected and that HIV cannot be passed through everyday contact. However, gaining this knowledge for this small proportion of the population will be essential before it is possible to go on to meet their more complex HIV prevention needs.

About one-in-ten respondents did not know that people can have HIV without knowing it, that there is no cure for HIV once somebody has it and also that one can not tell whether an individual has HIV or not by just looking at them. These knowledge needs can have big impacts on testing uptake because individuals with such need will most likely have no reason to suspect they could be infected (the leading reason given for not testing by those respondents who have never tested for HIV). A further one-in-six did not know that there are HIV medicines that help people with HIV to stay healthy and more than one-in-three did not know that these treatments work better the earlier they are taken.

In the first Bass Line survey there was evidence confirming the feeling among our collaborators that one of the impediments to HIV testing was the false belief that Africans are deported from the UK if they are found to have HIV. The current survey found that more than a third (37.7%) of all respondents who did not know that this is *not* the case.

The most commonly unknown fact concerned the prevalence of HIV among Africans in England. This suggests a lack of awareness of the proximity of HIV, making some people less conscious about their risk of HIV infection or transmission. Another important fact about HIV in England that was commonly unknown concerned the legal implications of HIV transmission under some circumstances.

Lastly, one fifth of all respondents (20.3%) were unaware that condoms are freely available from sexual health clinics and other service providers, indicating a service need. This is a noteworthy finding, given that the sample was largely recruited by agencies that undertake condom distribution.

5.1.2 Knowledge about post exposure prophylaxis (PEP)

All respondents were asked a series of questions about their knowledge of PEP including *Have you heard of Post Exposure Prophylaxis (PEP)?* and *Have you ever taken PEP.* The response options for these question were *Yes* or *No.* Respondents who were not living with diagnosed HIV were then asked, *If you thought you had been exposed to HIV would you consider trying to get PEP?* For this question the response options were *Yes, No* or *Maybe.*

Overall, 68.1% of all respondents said they had never heard of PEP (the group in need of awareness). Those who had never tested for HIV were more likely to be ignorant of PEP than those who had tested (81.1% versus 60.2%) and men were more likely than women to have never heard of it (73.4% versus 63.2%).

Respondents were further asked *Have you ever taken PEP?* Overall, 3.7% of all respondents said they had ever taken PEP. This proportion did not very by gender.

Respondents who had not been diagnosed with HIV were then asked *If you thought you had been exposed to HIV would you consider trying to get PEP?* They were given response options *Yes, No, Maybe*. Overall 60.7% said they would consider taking PEP and a further 27.8% said *maybe*. Women were slightly more likely than men to say *yes*, they would use PEP (62.7% versus 58.8%) while men were more likely to say *no* (13.6% versus 9.3%).

5.1.3 What do Africans want to know more about?

All respondents were also asked *Which of the following would you like to know more about...?* and given the list of fifteen items in the table below (ordered by the proportion who indicated wanting to know more).

Which of the following would you like to know more about...? (n=2406, 176 missing)	**% ALL**
Post-exposure prophylaxis (PEP)	36.8
Treatments for HIV infection	35.7
Safer sex and how to prevent HIV	31.8
Preventing discrimination against people with HIV	31.5
How to reduce HIV stigma	30.8
Managing relationships	30.7
HIV testing	30.6
The law and HIV transmission	30.4
Living well with HIV	27.0
How to be more confident in sexual situations	26.9
Who is able to get free HIV treatment	25.2
Testing and treatment for other sexually transmitted diseases	24.2
How to stop condoms breaking or coming off	21.7
What different kinds of condoms are available	18.1
Where to find a boyfriend / girlfriend	16.2

Overall, 11.3% (n=272) of all respondents did not want any further information on any of the knowledge items listed and said they wanted to know about nothing else. This implies that 88.7% of all respondents wanted more information. The study suggests Africans are not saturated with information about HIV but interested and wanting more knowledge in an accessible and convenient form.

At the top of information need were treatment topics. Although PEP has been recommended for prevention of sexual exposure (non-occupational exposure) to HIV in England for more than three years, more than a third of the respondents felt inadequately informed about it. A similar proportion also indicated need for information on HIV treatments, how to prevent transmission and how to deal with HIV related discrimination. Other common information needs were related to managing and living with HIV, access to services and safer sexual practices.

Details of how respondents said they would like learn more about these issues and who they would prefer to give them the information is reported in chapter six.

5.2 ACCESS TO CONDOMS

The aim of health promoters is not to tell individuals how to have sex, but to provide information and services so that people who want to have sex can make informed choices based on their needs and preferences. People employ different ways to protect themselves against HIV transmission. Some of these include; abstinence, non-penetrative sex, condom use, or intercourse without a condom with someone they know has the same HIV status as themselves. Condoms are not always required to prevent HIV transmission. However, where individuals decide to use condoms, they would need access to condom supply, be confident enough to carry it to where they intend to use it and then know how to use it properly.

The following table describes responses in agreement or disagreement when presented with statements about condom access and stigma, *I sometimes have a problem getting hold of condoms,* and *if I carried a condom I would worry about what people thought of me.*

Access to condoms	% strongly agree	% agree	% don't know	% disagree	% strongly disagree
I sometimes have a problem getting hold of condoms. (n=2428)	7.3	13.2	21.1	28.3	30.1
If I carried a condom I would worry about what people thought of me. (n=2464)	17.9	14.4	15.0	25.6	27.2

Any agreement with either statement was taken as an indicator of need. Overall a fifth (20.5%) of respondents indicated sometimes having a problem getting hold of condoms, and a third (32.3%) indicated they would worry about what people thought of them if they carried condoms. There was a significant association between these two needs. People who had difficulty in accessing condoms were also more likely to worry about what people thought of them carrying condoms. Although the survey did not ask any questions about social acceptability of condoms, the stigma indicated above could have a significant effect on condom use because people would not want to use something that is perceived to be socially unacceptable.

Further details of how condom access varied across different groups is reported in Part Two of this report.

5.3 CONFIDENCE IN SEXUAL COMMUNICATION AND CONDOM USE

Two indicators of HIV prevention need concerned people's confidence in their ability to communicate about HIV prevention with partners and about using condoms. People's own belief in their ability to do things, sometimes called self-efficacy, is important in making behaviour changes and maintaining the changes in behaviour.

Confidence in sexual communication	% strongly agree	% agree	% don't know	% disagree	% strongly disagree
I would find it easy to talk about safer sex and HIV with new sexual partners. (n=2452)	43.7	27.1	19.0	6.6	3.7
I can use condoms with a sexual partner if I want to. (n=2453)	51.8	29.1	10.3	4.7	4.1

Any disagreement with either statement was taken as the indicator of unmet prevention need. Only 10.3% disagreed they would find it easy to talk about safer sex with new partners and fewer still, 8.9% disagreed they could use a condom with a new partner.

Again, there was a significant association between the ability to talk about safer sex and HIV, and a sense of self-efficacy in condom use with new partners. This implies that any improvement in one of these areas of need is likely to lead to improvement in the other.

Further details of how confidence and communication varied across different groups is reported in Part Two of this report.

5.4 MOTIVATION TO AVOID HIV (RE)INFECTION

In order for people to take action to reduce the risk of HIV transmission they ought to be motivated to avoid risk. All respondents were asked to respond to two statements concerning motivation and risk perception. The following table shows the proportions giving each response grouped according to HIV testing history.

The will to reduce risk		% strongly agree	% agree	% don't know	% disagree	% strongly disagree
I do not want to get or pass on HIV. (n=2308, missing=272)	Never tested (n=918)	80.0	11.5	4.4	1.9	2.3
	Last test negative (n=1146)	85.9	8.6	2.4	1.7	1.6
	Tested positive (n=244)	89.3	7.4	1.6	0.0	1.6
I think I am at risk of getting or passing on HIV (n=2273, missing=307)	Never tested (n=918)	10.3	8.9	21.1	18.3	41.4
	Last test negative (n=1146)	7.9	9.6	17.1	26.0	39.4
	Tested positive (n=244)	26.0	12.1	8.7	17.7	35.5

Overall, there was an indication of very strong desire to avoid involvement in HIV transmission. More than nine-in-ten of the respondents agreed that they did not want to get or pass on HIV. This was slightly higher among people who had tested positive (96.7%) than those whose last test was negative (94.5%), possibly because of counselling interventions offered during testing for those who test positive. Individuals who had never tested for HIV were more likely to disagree about their desire the avoid involvement in HIV transmission.

On the question on risk, people who had tested positive were twice as likely as those who had never tested and three times as likely as those whose last test was negative to feel at risk of HIV transmission. This is possible because they were experiencing life with HIV and therefore understood the risk more than the other two groups. Our study did not seek to find out why people whose last test was negative felt least at risk of HIV transmission. Further research is necessary to understand why some people indicated a lack of desire to avoid involvement in HIV transmission.

5.5 BELIEF IN CONTROL OVER HIV TRANSMISSION

HIV health promotion seeks to empower people to have control over HIV in their everyday lives. In terms of HIV transmission, this implies a sense of being in control of one's involvement in HIV transmission. All respondents were asked to agree or disagree with *I have the power to reduce my risk of getting or passing on HIV*. The responses to the question are sumarised in the table below.

The power to reduce risk (n=2274, missing 306)		% strongly agree	% agree	% don't know	% disagree	% strongly disagree
I have the power to reduce my risk of getting or passing on HIV	Never tested (n=2064)	61.0	22.2	10.5	1.9	4.4
	Last test negative (n=331)	70.6	18.7	5.4	1.5	3.8
	Tested positive (n=318)	78.4	12.7	2.5	2.1	4.2

Overall, a very high proportion felt they were in control of whether they got or passed on HIV. This was most common among those who had tested positive followed by those whose last test was negative. However, about one-in-six (16.8%) of those who had never tested for HIV were not sure or felt they were not in control of whether they got or passed on HIV compared to one-in-ten (10.7%) among those whose last test was negative and a slightly smaller proportion (8.8%) among those living with diagnosed HIV. This suggests that a significant proportion of African people lack the power, the knowledge and the resources to protect themselves and their sexual partners from getting HIV.

Details of how the proportions of people who felt they were not in control varied across the different groups is reported in Part Two of this report.

5.6 SUMMARY AND IMPLICATIONS FOR PLANNING

General knowledge about the basics of HIV (causes and transmission) was fairly high among the respondents. However, a significant number perceived the need to know more. About one-in-ten people did not know that people can have HIV without knowing, that there is still no cure for HIV and that one can not know whether someone has HIV by just looking at them. A fifth did not know about the existence of HIV medicines and that condoms are free at various service providers across the country. A further two fifths were not aware that there have been prosecutions for HIV transmission in England and that Africans were not deported from the UK simply for testing positive for HIV. Respondents were also most unaware of the high prevalence of HIV among Africans in England.

These information gaps have a big impact on individual's perception of HIV risk, decisions about their sexual behaviour and attitudes towards services available including HIV testing and treatment. In recognition of their own knowledge gaps, a third of all respondents said they wanted to know about each of the following areas: PEP, HIV treatments, stigma and discrimination, safer sex, HIV transmission and the law, managing relationships with HIV, living well with HIV and HIV testing. A quarter of the respondents wanted to be more confident in sexual health discussions and safer condom use. This represents a ready desire to learn and an opportunity for interventions aimed at improving awareness of HIV.

This report shows evidence of problems with condom access and use among African people in England. The findings also indicate that one of the barriers to condom use could be stigma as indicated by a third of respondents who said they would worry about what people thought of them if they were seen carrying condoms. In addition to condom problems, safer sex negotiation was also lacking among nearly a third of respondents, who said they were not sure that they could easily talk about safer sex and HIV with new sexual partners.

There is also evidence of some powerlessness in relation to avoiding participation in HIV transmission. Among those not diagnosed HIV positive, more than one-in-ten did not feel they were in control of whether or not they became infected. Similarly, among those with diagnosed HIV, one-in-every ten disagreed or was unsure that they had control over exposing sexual partners to the virus or getting infected with another type of HIV.

6 Interventions past and future

Bass Line 2008-09 was used to generate data about both past and potential interventions. It measured the coverage of two national multi-method interventions carried out by NAHIP (called *Let's Talk HIV* and *Do It Right*) using prompted recognition. The findings from these questions are being reported separately by University College London's Migration, Ethnicity & Sexual Health project.

NAHIP partners and other organisations with an interest in HIV prevention involving Africans in England can improve how they tailor their services if they know more about the intervention preferences among the African people they target. Our survey asked respondents who wanted to know more about HIV about how they would prefer to learn more about HIV and who they would prefer to give them the information.

6.1 PREFERRED METHODS FOR LEARNING MORE ABOUT HIV

This section gives an account of intervention preferences related to information needs outlined in section 5.1. The reason why we have separated the two sections is because section 5.1 outlines needs but this section outlines intervention preferences which are not limited to only those needs discussed in the previous chapter.

Those who wanted to know more about HIV were asked *How would you PERSONALLY like to learn more about these topics in the future?* (referring to topics outlined in section 5.1 of this report) and offered the responses outlined in the table below. The items are ordered by their popularity, among each method of interaction.

How would you PERSONALLY like to know more ... (n=2324, 256 missing)	**Number**	**% of those who would like to learn more**	**% of ALL**
Reading and writing			
Reading in private	1105	50.5	47.5
Reading websites	892	40.8	38.4
Reading booklets, leaflets and postcards	677	31.0	29.1
Reading articles in newspapers or magazines	614	28.1	26.4
Reading newsletters	570	26.1	24.5
Reading adverts in newspapers or magazines	561	25.7	24.1
Talking and listening			
Talking to someone	784	35.9	33.7
Talking to a health worker at a voluntary organisation or charity	618	28.3	26.6
Talking to a health worker at a sexual health clinic or HIV clinic	534	24.4	23.0
Taking part in an information group or workshop	511	23.4	22.0
Talking to a health worker at a GP surgery / local doctor	431	19.7	18.5
Talking to a health worker in community settings	370	16.9	15.9
Talking to a health worker on a telephone via a help line	265	12.1	11.4
Talking to a health worker in an internet chat room	267	12.2	11.5
Others	83	3.8	3.7

Overall, more respondents preferred to get further information through reading compared to talking and listening. Three quarters (76.9%) chose at least one reading option compared just over half

(56.7%) choosing any talking option. However, respondents were did not all fall into the two outright categories. More than half (54.3%) chose both reading and talking interventions as preferences.

Respondents were also given an opportunity to list any other specific preferences that were not listed in the question, under an *Other* option. Most of the items mentioned were more specific media that clarified individuals' choice of either talking, reading or both. They included things like training in HIV, and songs as well as drama with HIV themes.

6.2 PREFERRED INFORMATION SOURCES

Respondents were then asked the open-ended question *Who would you most prefer to give you information or advice about HIV?* The responses to this question were closely linked to the previous question and are shown on the table below. Initial analysis showed that the response mainly described the roles or the characteristics of individuals with whom respondents wanted contact. One outright theme that emerged was the profession of preferred information providers. Health professionals were the most popular (49.0%) whereas some wanted non-health workers to be their source of information (24.8%). A small proportion of respondents described demographic characteristics of preferred information providers.

Who would you most prefer to give you information? **Open ended question** (n=1318, missing 1262)		**Number**	**% of those responding**	
Health professionals (talking and listening)	Doctor	135	10.2	49.0
	GP	129	9.8	
	Health worker	115	8.7	
	Health professional	91	6.9	
	Clinic	46	3.5	
	GP & other health professionals	27	2.0	
	Health worker at a sexual health clinic	25	1.0	
	HIV consultant	19	0.7	
	Health advisor / visitor	17	0.7	
	Nurse	15	0.6	
	African health worker	15	0.6	
	Sexual health worker	14	0.5	
	Health worker at a GP surgery	11	0.4	
	Community health worker	28	2.1	
	Counsellor	23	0.9	
	Consultant	10	0.4	
Others (talking and listening)	Anybody knowledgeable	192	14.6	24.8
	Family and friends	91	6.9	
	Person living with HIV	31	2.4	
	Expert	24	0.9	
Age preference	Young people	20	0.8	0.8
Gender preference	Female	18	0.7	1.0
	Male	8	0.3	
Service provider	Community based organisation	34	2.6	3.1
	Community groups	12	0.5	
Media (reading and writing)		87	6.6	6.6
Others		52	3.9	3.9
Don't know		24	0.9	0.9

The responses were further analysed to determine common themes and to generate a picture of preferred sources of information. The largest number of respondents identified medical authorities of various kinds as their preferred source of information or advice about HIV, but expertise was also important. Among the healthcare professionals, doctors in general and General Practitioners were the most preferred sources of information. Apart from healthcare workers, a quarter of respondents said they would like information passed onto them through anyone knowledgeable about HIV and sexual health, not necessarily a healthcare professional. While some respondents preferred family members, friends or peers, only a minority identified their preference based on gender, age, ethnicity or HIV status.

Only a tiny minority expressed a preference for someone of African origin. This is a significant finding because it suggests that the strongest consideration respondents had is expertise of the individual in the subject rather than their ethnicity, or age or gender.

Some respondents preferred reading and writing sources and wanted their information through the media. They preferred to receive their information through small and mass media such as TV, radio, leaflets, books, magazines and the internet. Some mentioned emails and online interventions. Other options included telephone and online instant counselling (instant chat) and mailing lists.

6.3 SUMMARY AND IMPLICATIONS FOR PLANNING

These findings suggest a great diversity of preferences among African people and confirm that no single intervention (or programme) will suit the whole cross-section of Africans.

Three quarters of respondents identified reading and writing as their preferred medium of learning about HIV followed by talking to someone. However, more than half would still opt for a mixture of reading and writing and talking and listening interventions.

Respondents wanted to get information from someone knowledgeable in HIV and sexual health issues. Health professionals were the most common preferred source of information. Findings also indicate that social structures such as family, friends and peers were also seen as reliable sources of information. This implies that health promotion workers in community organisations involved in HIV prevention work with Africans in England need to have sufficient expertise in HIV and related issues to enable them to engage adequately with their service users.

Part two: variation across the demographic groups

In the second part of this report we look at how HIV testing (chapter 3), sexual risk behaviours (chapter 4) and indicators of HIV prevention need (chapter 5) varied across the demographic characteristics (chapter 2), noting differences across different groups. Our objective is to identify which areas of prevention needs are widely unmet and which sub-groups of African people in the UK have extensive unmet needs relative to other groups.

This should assist in identifying priority needs and priority target groups. However, the data in this report is not sufficient to design interventions with impact, and further local investigations may be required during intervention development.

How to interpret tables in Part Two

The tables consist of rows (going across) and columns (going down).

The columns represent groups of people sharing the same characteristic (eg. teenagers, women, Ugandans).

Each row represents a single indicator of either HIV testing, sexual risk behaviour or prevention need. For each row, the table shows if there is a statistically significant difference in the level of the indicator across the different groups of people (a difference the size of which we would expect to see fewer than 1-in-20 times purely by chance). If it is significant, the group with the highest level of the indicator is shaded and the group with the lowest level is underlined. No shading or underlining means we found no evidence that the indicator varies across the characteristic.

In a table overall then, a column with a lot of shading means that group of Africans have higher levels of risk or need relative to the other groups.

7 Variation by HIV testing history

Overall, two-fifths of all respondents (39.5%, n=970) had never tested for HIV three fifths (60.4%, n=1484) had taken an HIV test at some time before the survey, of whom 48.3% (n=1186) had tested negative and 12.1% (n=298) had tested positive. This chapter compares key risk behaviours and indicators of HIV prevention needs across these three testing history groups. A full analysis of testing history is given in Chapter 3 (Section 3.1).

7.1 HIV TESTING HISTORY AND SEXUAL BEHAVIOUR

The following table shows the key sexual behaviour measures by HIV testing history.

Sexual behaviour by HIV testing history	% NEVER tested	% tested NEGATIVE	% tested POSITIVE
Two or more sexual intercourse partners in the last year	29.8	32.9	25.4
Four or more sexual intercourse partners in the last year	9.7	11.2	10.8
Any sexual partners outside their current regular relationship	16.4	19.3	13.8
Any unprotected sexual intercourse in the last year	40.0	53.3	23.7
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	11.7	9.6	15.1
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	19.4	15.1	7.5
Any experience of condom failure in the last year	14.0	19.4	19.1

People who had never tested for HIV were slightly more likely than those who had tested to have more than one sexual partner but higher numbers of partners did not vary by testing history, nor did extra-relational sex.

Any unprotected intercourse (UI) was most common for people who had tested HIV negative. However, despite people who had tested positive having fewer sexual partners and less UI, they were still more likely to think they had probably been involved in sero-discordant UI.

Condom failure was a problem for all testing history groups.

7.2 HIV TESTING HISTORY AND HIV PREVENTION NEEDS

The following table shows how the indicators of need varied by HIV testing history among all respondents.

Unmet HIV prevention need by HIV testing history	% NEVER tested	% tested NEGATIVE	% tested POSITIVE
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	8.5	5.6	3.3
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	16.9	10.7	8.9
AGREE: I sometimes have a problem getting hold of condoms.	22.8	18.5	13.7
AGREE: If I carried a condom I would worry about what people thought of me.	35.7	30.0	26.0
DISAGREE: I can use condoms with a sexual partner if I want to.	9.4	7.0	12.1
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	12.1	7.5	13.5
Mean knowledge items NOT known out of 13 (median)	3.51 (3)	2.26 (2)	1.77 (1)

There were significant differences in need across the testing history groups.

In terms of knowledge, people who had never tested were in greatest need followed by those whose last test was negative, suggesting all basic HIV education interventions should be inclined more towards people with little experience of HIV.

Those who had never tested were also most likely to be unconcerned or unsure about being involved in HIV transmission, to feel they had no control over HIV transmission, to have poor access to condoms and to worry about what people thought about them carrying condoms, and were considerably less knowledgeable about HIV overall.

On all these indicators, people with diagnosed HIV showed the lowest level of need of the three groups. However, people with diagnosed HIV were most likely to say they had problems with the interpersonal needs related to HIV prevention, such as influencing their partners and discussing safer sex and HIV. People with diagnosed HIV were more likely than those who had not tested positive to acknowledge that they were at risk of infection with another type of HIV or of transmitting HIV.

Among those who were not living with diagnosed HIV, those who had tested negative felt less at risk of getting HIV than those who had never tested. Those who had never tested were more likely not to be sure about wanting to avoid HIV and to report not feeling in control of whether they got HIV compared to those who had tested negative. This may be because testing involves counselling or other interventions that increase individuals' knowledge or perhaps finding out one's HIV status increase's a sense of control over the virus.

7.3 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

The following associations between HIV testing history and indicators of risk and need were found in both the first and second Bass Line surveys.

Sex

- People tested HIV positive were least likely to have unprotected intercourse but most likely to have unprotected intercourse they knew to be HIV sero-discordant.
- People whose last test was HIV negative were most likely to have unprotected intercourse but least likely to have unprotected intercourse they knew to be sero-discordant.
- People who had never tested for HIV were most likely to have unprotected intercourse without knowing whether it was sero-discordant or not.

This suggests HIV testing increases people's awareness of whether their sexual behaviour is putting them or their partners at risk but it does not necessarily prevent that risk.

Needs

- Those who have never tested were least: motivated, empowered, resourced, socially confident and knowledgeable about HIV.
- Those who had tested HIV positive were least sexually confident and skilled at negotiating sex.

This suggests interventions intended to increase motivation, knowledge, access to resources and social confidence should disproportionately benefit those who have never tested, while those intended to increase sexual skills and confidence should disproportionately serve those tested HIV positive.

8 Variation by gender and sexuality

A detailed description of the gender and sexuality of respondents is given in Chapter 2 (Section 2.1). Slightly fewer men (48.2%, n=1220) than women (51.8%, n=1310) took part in the survey.

One-fifth (21.2%) of men said that they not had sexual intercourse with anyone in the previous year. Among those who had sex, two thirds (67.6%) only had intercourse with women in the past year, while one-in-twelve (7.8%) had sex with both men and women, and one in-twenty (3.5%) had sex only with men.

One third of all female respondents (33.0%) reported not having had sexual intercourse with anyone in the past year. Women only having sex with men accounted for about two thirds (59.7%) of responses. Sex with women only and with both men and women was reported by small proportions of women (1.2% and 6.0% respectively).

This chapter compares key risk behaviours and indicators of HIV prevention need by gender and by the gender of respondents sexual partners.

8.1 GENDER, SEXUALITY AND TESTING BEHAVIOURS

The following table shows how the measures of HIV and STI testing varied by the gender of respondents.

Testing behaviours by gender	% MALES	% FEMALES
Never HIV tested	41.9	34.5
Tested HIV positive	7.3	16.5
Wants test but does not know where to get one	14.8	9.8
Diagnosed with STI in last year	7.5	6.3

Men were significantly more likely than women to have never tested for HIV, reflecting both the wider range of testing services serving women, and men's greater reluctance to use health services. Conversely women were more likely to be living with diagnosed HIV, as reflected in HIV surveillance data.

The following table shows how testing behaviours, sexual behaviours and prevention needs varied by the gender of respondents' sexual partners in the last year (separately for men and women). The significant differences are *within* the group of men and *within* the group of women, and not between men and women as groups.

Testing behaviour by gender of sexual partners in the last year	% of MEN who in the last year had sex with...				% of WOMEN who in the last year had sex with...			
	No one	Women only	Men & Women	Men only	No one	Men only	Men & women	Women only
Never HIV tested	57.2	38.2	42.4	21.1	51.8	26.1	27.8	33.3
Tested HIV positive	5.8	6.4	8.2	33.3	17.8	14.7	15.2	0.0
Wants test but does not know where to get one	21.4	12.7	12.2	14.3	12.8	7.9	13.0	20.0
Diagnosed with STI in last year	7.8	3.7	28.1	28.6	3.1	5.8	20.0	20.0

Among the men, not having tested with HIV was associated with not having had sex in the last year. Among those who were sexually active, behaviourally bisexual men were least likely to have tested but were slightly more likely to be have diagnosed HIV than men who had no sex or sex only with women. However, having diagnosed HIV was most common among the men who had sex with men only. Unlike HIV, other STIs were equally common among both behaviourally bisexual and exclusively homosexual men.

Among women, not having tested was also most common in those who had no sex. However, having diagnosed HIV did not vary across the sexuality groups, although none of the women who had sex only with women had diagnosed HIV. Curiously, other STIs were much higher among the homosexually active women, whether or not they also had sex with men.

8.2 GENDER, SEXUALITY AND REASONS FOR NOT TESTING

Among those who had never tested, the reasons given for not having tested were similar for men and women except women were more likely to say they had never had intercourse (22.1%) than were the men (10.3%). All other reasons were given equally by men and women.

Among those who had never tested the reasons given for not having tested were very similar by sexuality. However, among the men, those who had sex with men were more likely to say that they did not trust the places they knew where they could test (7/43, or 16.3%) than those who did not have sex with men (15/389, or 3.9%). A similar pattern was observed among the women, with 13.6% (3/22) of homosexually active women giving this answer compared with 3.5% (13/374) of women who had not had sex with a woman. This could suggest that perceived homophobia or racism many be barriers to HIV testing among homosexually active African men and women.

Among the men, fear of a positive result was much higher among men who had sex with other men only (5/7, or 71.4%) than in men who had sex with both men and women (6/36, or 16.7%) and those who had not had sex with men (39/389, 10.0%).

8.3 GENDER, SEXUALITY AND SEXUAL BEHAVIOUR

The following table shows the key sexual behaviour measures by the gender of respondents.

Sexual behaviour by gender	% MALES	% FEMALES
Two or more sexual intercourse partners in the last year	40.8	22.7
Four or more sexual intercourse partners in the last year	16.9	5.3
Any sexual partners outside their current regular relationship	26.8	10.4
Any unprotected intercourse in the last year	47.1	41.3
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	14.0	9.5
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	18.4	13.8
Any experience of condom failure in the last year	21.1	15.2

Men were significantly more likely to indicate all sexual risk behaviours than were women. Men were more likely to report multiple sexual partners, extra-relational sex, unprotected intercourse, sero-discordant intercourse and condom failure. This pattern is very similar to the Bass Line 2007 findings.

The following table shows the sexual behaviour measures by the gender of sexual partners for men and women separately (those who had no sex are excluded). The significant differences are *within* the group of men and *within* the group of women, and not between men and women as groups.

Sexual behaviour by gender and gender of their sexual partners in the last year	% of MEN who in the last year had sex with...			% of WOMEN who in the last year had sex with...		
	Women only	Men & women	Men only	Men only	Men & women	Women only
Two or more sexual intercourse partners in the last year	45.6	100.0	57.9	26.7	100.0	46.7
Four or more sexual intercourse partners in the last year	16.5	51.2	39.5	5.0	30.1	26.7
Any sexual partners outside their current regular relationship	30.8	49.4	24.3	13.3	34.3	20.0
Any unprotected intercourse in the last year	59.2	59.5	48.6	61.1	52.9	60.0
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	12.6	41.8	19.4	10.8	30.0	13.3
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	16.8	24.1	27.8	15.2	20.0	6.7
Any experience of condom failure in the last year	25.3	40.5	19.4	21.1	26.5	13.3

Among men, those who had sex with men only and those who had sex with both men and women were the most likely to report most of the sexual behaviours that increase risk of HIV transmission. Almost half of behaviourally bisexual men and only a slightly smaller proportion of exclusively homosexual men had more than four sexual intercourse partners in the previous year, compared with 16.5% of exclusively heterosexual men. Behaviourally bisexual men were also much more likely than other sexually active men to have sexual partners outside of their current regular relationship. Bisexual men were most likely to indicate they probably had sero- discordant UI and men who only had sex with women were least likely to think they had done this. Finally, condom failure was most commonly experienced by behaviourally bisexual men.

Among women, those who had sex with men and women were most likely to indicate multiple intercourse partners, extra-relational sex and to think they had engaged in sero-discordant UI.

8.4 GENDER, SEXUALITY AND HIV PREVENTION NEEDS

The following table shows the indicators of need for all men and all women.

Unmet HIV prevention need by gender	% MALES	% FEMALES
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	9.3	4.7
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	13.3	12.9
AGREE: I sometimes have a problem getting hold of condoms.	25.9	15.7
AGREE: If I carried a condom I would worry about what people thought of me.	33.4	31.6
DISAGREE: I can use condoms with a sexual partner if I want to.	9.3	8.3
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	8.6	11.3
Mean knowledge items NOT known out of 13 (median)	2.88 (2)	2.57 (2)

Four of the indicators of HIV prevention need showed a difference between men and women. Compared to women, men were more likely to be unconcerned about being involved in HIV transmission , and more likely to have a problem getting hold of condoms, and were significantly less knowledge about HIV, in general.

Women on the other hand were more likely to have a problem with communicating about safer sex and HIV with their sexual partners (but were not less confident about getting partners to use condoms or any less empowered to reduce their HIV risk). Concern about carrying condoms did not vary by gender.

The following table shows the indicators of need by the gender of respondents' sexual partners for men and women separately. The significant differences are *within* men and *within* women.

Unmet HIV prevention need by gender of partners in the last year	% of MEN who in the last year had sex with...				% of WOMEN who in the last year had sex with...			
	No one	Women only	Men & women	Men only	No one	Men only	Men & women	Women only
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	14.0	5.7	19.8	11.4	5.8	2.7	13.0	13.3
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	21.6	9.0	26.3	12.1	14.7	9.9	19.4	20.0
AGREE: I sometimes have a problem getting hold of condoms.	17.6	25.6	40.5	28.6	13.7	14.0	34.7	40.0
AGREE: If I carried a condom I would worry about what people thought of me.	39.6	30.2	37.8	27.9	32.8	29.1	44.4	40.0
DISAGREE: I can use condoms with a sexual partner if I want to.	11.6	8.3	15.7	8.3	6.3	8.2	10.0	26.7
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	9.3	8.1	9.8	19.4	11.1	11.1	18.3	13.3
Mean knowledge items NOT known out of 13 (median)	3.79 (3)	2.44 (2)	4.76 (4)	2.33 (2)	2.86 (2)	2.16 (2)	4.40 (3)	4.89 (4)

Among the men, as in Bass Line 2007 (Dodds *et al.* 2008a), the majority of prevention indicators that showed a difference across sexuality showed the highest levels of need among the behaviourally bisexual men. They were most likely to be unconcerned or unsure about involvement in HIV transmission, to have problems accessing condoms and to be less knowledgeable about HIV generally.

Among women, need was also associated with same-sex partners, with those who had sex only with women or those who sex with both women and men showing higher need on some indicators.

8.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

There were many findings found in both the first and second Bass Line surveys about the associations between gender and sexuality and indicators of need.

Testing

- Men were less likely than women to have tested for HIV, to have diagnosed HIV and to know where to test for HIV.

Sex

- Men had more sexual intercourse partners, more extra-relational sex, and were more likely to have unprotected intercourse and HIV sero-discordant unprotected intercourse.

Needs

- Men were less motivated to avoid sexual HIV exposure and had more problems accessing condoms.

We found no sexual risk behaviours or unmet HIV prevention need that was more common in women than men. These findings suggest interventions and programmes should prioritise encountering men over women if they wish to maximise their impact on HIV transmissions.

Among the men the following associations were found in both surveys.

Testing

- Exclusively homosexually active men were most likely to have tested for HIV, most likely to have diagnosed HIV and most likely to be diagnosed with another STI.
- Exclusively heterosexually active men were least likely to be diagnosed with an STI.
- Those who had no sex were least likely to have tested for HIV.

Sex

- Exclusively homosexually active men were most likely to engage in unprotected intercourse without knowing if they were HIV sero-discordant with their partner or not.
- Behaviourally bisexual men were most likely to have multiple intercourse partners, extra-relational sex, unprotected intercourse they knew to be HIV sero-discordant and condom failure.
- Exclusively heterosexual men had fewer partners, and were less likely to have unprotected intercourse they knew to be HIV sero-discordant or where they did not know their HIV concordancy.

These findings suggest HIV prevention programmes for African men should pay particular attention to homosexually active men, including those who also have sex with women.

There were no associations found across both surveys among the women.

9 Variation by age

Overall, one-in-ten (9.8%, n=242) of all respondents were aged under twenty; a third (32.8%, n=812) were in their twenties, and a further third were in their thirties (32.2%, n=797). Those in their forties accounted for nearly a fifth of the sample (19.5%, n=483) but only one-in-twenty (5.8%, n=144) were aged 50 or older. This chapter compares key risk behaviours and indicators of HIV prevention need across these five age groups. An analysis of respondents' ages is reported in Chapter 2 (Section 2.2).

9.1 AGE AND TESTING BEHAVIOURS

The following table shows how the measures of HIV and STI testing and diagnosis varied by age.

Testing behaviour by age groups	% <20	% 20s	% 30s	% 40s	% 50+
Never HIV tested	71.0	45.0	26.2	31.0	30.6
Tested HIV positive	2.6	3.6	15.1	22.6	30.5
Wants test but does not know where to get one	20.1	15.9	10.5	6.9	8.3
Diagnosed with STI in the last year	7.2	7.1	7.2	6.0	3.5

HIV testing history varied by age in a similar pattern to Bass Line 2007. Never having tested was most common among those under 20, and they were least likely to have diagnosed HIV. People aged 50 and over were most likely to have diagnosed HIV, reflecting the ageing of the HIV positive population.

Not knowing where to test for HIV was most common among the youngest age group and declined with age. Although having been diagnosed with an STI in the last year declined with age, this was not significant suggesting a much greater gap between need and service use among the younger rather than older groups.

9.2 AGE AND REASONS FOR NOT TESTING

Most of the reasons given for not testing did not vary across the age range. However, fear of a positive test result prevented people in their 30s from testing (32/194, or 16.5% gave this reason) much more often than other age groups, and perhaps not unrelated, this group were also most likely to say testing may cause problems in their relationship (16/194, or 8.2%).

People under 20 were most likely to say they had not tested for HIV because they had never had intercourse (63/156, or 40.4%), and this reason declined with increasing age.

9.3 AGE AND SEXUAL BEHAVIOUR

The following table shows the key sexual behaviour measures across the age range.

Sexual behaviour by age groups	% <20	% 20s	% 30s	% 40s	% 50+
Two or more sexual intercourse partners in the last year	26.5	39.0	30.6	25.6	17.6
Four or more sexual intercourse partners in the last year	13.3	13.6	9.5	8.1	5.3
Any sexual partners outside their current regular relationship	10.2	19.6	19.9	19.1	10.2
Any unprotected intercourse in the last year	17.8	39.6	52.1	55.1	38.3
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	9.1	12.3	11.0	12.3	11.8
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	13.2	20.0	16.0	11.4	13.4
Any experience of condom failure in the last year	16.1	23.5	18.1	12.3	5.1

Sexual behaviours showed significant relationships with age. People in their 20s were most likely to have multiple sexual partners and (correspondingly) to be unsure as to whether they had engaged in sero-discordant UI and to have experienced condom failure.

Extra-relational sex was almost equally common among those in their 20s, 30s and 40s, and less so among the younger and older groups.

9.4 AGE AND HIV PREVENTION NEEDS

The following table shows how the indicators of need varied across the age range.

Unmet HIV prevention need by age group	% <20	% 20s	% 30s	% 40s	% 50+
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	10.7	6.8	6.7	5.8	0.0
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	17.1	13.7	14.1	9.3	9.3
AGREE: I sometimes have a problem getting hold of condoms.	18.5	23.3	19.2	18.8	16.3
AGREE: If I carried a condom I would worry about what people thought of me.	29.4	34.6	30.7	33.0	30.4
DISAGREE: I can use condoms with a sexual partner if I want to.	6.4	7.7	9.3	9.3	9.9
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	12.4	11.4	7.8	9.8	11.2
Mean knowledge items NOT known out of 13 (median)	3.66 (3)	2.84 (2)	2.54 (2)	2.32 (2)	2.32 (2)

Three of the indicators of prevention need showed significant differences across the age range, with all three showing greatest need among the youngest age group and least need among the oldest group.

9.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

The following associations between age and indicators of testing, risk and needs were found in both the first and second Bass Line surveys.

Testing

- Ever having tested for HIV is least common in the under 20s and most common among people in their 30s.
- Having diagnosed HIV is least common in the under 20s.

Sex

- Unprotected intercourse is least common among those under 20.
- Having two or more intercourse partners, having unprotected intercourse without knowing sero-concordancy and condom failure are all most common among those in their 20s.
- Extra-relational sex is lowest among the under 20s and over 50s and peaks among those in their 30s.

Needs

- Knowledge about HIV is lowest among the under 20s who are correspondingly most unsure about their motivation to avoid it and most likely to feel powerless to do so.

HIV prevention programmes are required across the age range but with a definite bias towards those under 40 years of age.

These findings suggest the focus of HIV prevention with those under 20 should be on clear, accessible and accurate information. HIV prevention with younger people is insurance for the future, even though those people most likely to acquire HIV in the very near future are somewhat older.

Interventions addressing multiple partners and extra-relational sex should be biassed towards those people in their 20s and 30s.

10 Variation by education

Overall, 74.3% (n=1860) of all respondents had a high of level of educational attainment, involving university or college. A further 21.5% (n=538) had secondary or high school (medium) level attainment and only 4.2% (n=106) reported having only primary school or no formal education (low education).

This chapter compares key risk behaviours and indicators of HIV prevention between those with high, medium and low educational levels. Respondent's educational attainment is reported fully in Chapter 2 (Section 2.8).

10.1 EDUCATION AND TESTING BEHAVIOURS

The following table shows how the measures of HIV and STI testing and unmet diagnosis needs varied by education level.

Testing behaviour by education	% LOW education	% MEDIUM education	% HIGH education
Never HIV tested	51.5	51.2	33.3
Tested HIV positive	20.7	16.0	10.6
Wants test but does not know where to get one	16.3	15.3	11.0
Diagnosed with STI in the last year	18.2	10.4	5.2

HIV and STIs were strongly and consistently associated with lower education. Unlike gender and age (where ever having tested and having diagnosed HIV are positively associated), education shows the same group who were both *less* likely to have tested for HIV but *more* likely to have diagnosed HIV. Africans with a lower level of education were less likely to know where to test for HIV but were more likely to have been diagnosed with another STI in the last year.

This data suggests an inverse relationship between need and service uptake across education with regard to HIV testing. It also suggests bundling HIV testing with other STI services may be particularly useful for Africans with lower levels of education.

10.2 EDUCATION AND REASONS FOR NOT TESTING

Three of the reasons given for not testing (among those who had never tested) varied by education level as shown in the following table.

Reasons for not testing by education	% LOW education	% MEDIUM education	% HIGH education
I've no reason to think I have HIV	36.7	48.8	55.7
It's not important to me to know my HIV status	26.5	19.4	11.1
I am afraid of being treated differently if I have HIV	14.3	5.8	4.9

Respondents with high education were more likely to say they had no reason for thinking they had HIV (and indeed they are more likely to not have HIV). On the other hand, both not feeling knowing their status was important, and being fearful of discrimination if found to be positive, were more common among those with lower levels of education.

10.3 EDUCATION AND SEXUAL BEHAVIOUR

The following table shows how the sexual behaviour measures varied by level of formal education.

Sexual behaviour by education	% LOW education	% MEDIUM education	% HIGH education
Two or more sexual intercourse partners in the last year	40.0	34.9	29.8
Four or more sexual intercourse partners in the last year	21.1	13.4	9.5
Any sexual partners outside their current regular relationship	26.8	20.0	17.2
Any unprotected intercourse in the last year	41.7	37.9	46.5
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	22.6	14.9	10.2
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	32.3	18.0	14.1
Any experience of condom failure in the last year	22.9	17.9	17.6

Almost all indicators of sexual risk showed a gradient across education level. Respondents with lower levels of education were significantly more likely to report multiple sexual partners, extra-relational sex, unprotected intercourse (UI) with a risk of HIV transmission and condom failure. Interestingly the group with the highest levels of education were most likely to report any UI.

10.4 EDUCATION AND HIV PREVENTION NEEDS

The following table shows the indicators of need by level of formal education.

Unmet HIV prevention need by education	% LOW education	% MEDIUM education	% HIGH education
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	18.2	8.3	5.9
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	30.2	28.3	10.8
AGREE: I sometimes have a problem getting hold of condoms.	42.3	26.6	17.6
AGREE: If I carried a condom I would worry about what people thought of me.	54.0	36.5	29.8
DISAGREE: I can use condoms with a sexual partner if I want to.	17.9	8.9	8.1
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	20.8	12.1	9.2
Mean knowledge items NOT known out of 13 (median)	4.84 (4)	3.78 (3)	2.30 (2)

All of the indicators of HIV prevention need showed a strong and significant association with education level, without exception showing higher levels of unmet need among those with lower levels of education, and least need among those with higher levels of education.

10.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

Of all the population characteristics considered, education showed the largest number of reliable associations with HIV and STI testing, sexual risks and unmet prevention need across the first and second Bass Line surveys. The following associations were found in both surveys.

Testing

- Compared to those with higher education, those with lower education were less likely to test but more likely to be have diagnosed HIV. Education is the only demographic variable to show this pattern (for all others, ever having tested and having tested positive are highest in the same sub-group).
- Compared to those with higher education, those with lower education were more likely to be diagnosed with an STI other than HIV.

Sex

- Compared to those with higher education, those with lower education had higher numbers of intercourse partners; were more likely to have extra-relational sex; more likely to have unprotected intercourse known to be HIV sero-discordant and of unknown concordancy and more likely to experience condom failure.

Needs

- Compared to those with higher education, those with lower education were less likely to have motivation, power, access to resources, social confidence, self-efficacy, communication skills and knowledge regarding HIV prevention.

These findings suggest that all HIV prevention programmes for Africans should be biassed towards those with lower levels of formal education. This is both in terms of their targeting (ensuring Africans with lower education encounter the interventions) and their tailoring (ensuring interventions are relevant and are understandable and useful when they are encountered). If interventions are not disproportionately benefitting Africans with lower education, not only are they failing to serve those most at risk and most in need, they are actually contributing to health inequalities by disproportionately benefitting those in less need.

11 Variation by country of birth

Five countries of birth, Zimbabwe (n=422), United Kingdom (n=340), Nigeria (n=321), Kenya (n=218) and Uganda (n=179), accounted for more than half (59.2%) of all respondents. In addition the following countries of birth make up the ten most common countries of birth in the sample: Zambia (4.1%, n=102), Democratic Republic of Congo (Zaire) (4.0%, n=99), Ghana (3.7%, n=93), Republic of South Africa (2.9%, n=73), and Cameroon (2.6%, n=66).

This chapter compares key risk behaviours and indicators of HIV prevention need by the ten most common countries of birth reported. In each table, the *two* countries with the highest and the *two* countries with the lowest levels of the indicators are shaded or underlined. A full analysis of ethnicity, including respondents' country of birth is reported in Chapter 2 (Section 2.3).

11.1 COUNTRY OF BIRTH AND TESTING BEHAVIOURS

The following table shows how the indicators of HIV and STI testing behaviours and unmet testing needs varied by country of birth, for the ten most common countries of birth.

Testing behaviour by country of birth	% Cameroon	% D. R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Uganda	% UK	% Zambia	% Zimbabwe
Never HIV tested	38.5	43.3	54.8	30.6	36.4	30.1	24.7	49.7	24.2	29.9
Tested HIV positive	4.7	3.3	3.3	9.3	3.6	14.1	23.5	6.0	33.7	25.0
Wants test but does not know where to get one	20.6	15.2	26.4	11.4	15.1	19.4	12.7	10.2	6.7	7.0
Diagnosed with STI in last year	5.3	9.9	6.2	3.5	3.8	6.2	7.5	7.8	6.2	5.9

Ever having taken an HIV test varied strongly by country of birth. Respondents born in Ghana and the UK (followed by the Democratic Republic of Congo) were least likely to have tested for HIV while those from Uganda and the Zambia were most likely to have tested. The prevalence of diagnosed HIV among groups of people from each country broadly reflects the prevalence of HIV in those countries according to global estimates (UNAIDS 2008). Being diagnosed with another STI did not significantly vary by country of birth.

11.2 COUNTRY OF BIRTH AND REASONS FOR NEVER HIV TESTING

Two of the reasons offered for never having tested varied by country of origin. It not being important to know their HIV status was most common among people born in Ghana (12/45, or 26.7%) and Zambia (5/23, or 21.7%) and least common among those from Kenya (5/63, or 7.9%) and Cameroon (0/25).

Fear of a positive diagnosis was most common among people born in Kenya (14/22.2%) and Zimbabwe (22/117, or 18.8%) and was least often a concern for Nigerians (4/108, or 3.7%) and Ugandans (1/40, or 2.5%).

11.3 COUNTRY OF BIRTH AND SEXUAL BEHAVIOUR

The following table shows how the key sexual behaviour measures varied between groups of people born in the ten most common countries of birth.

Sexual behaviour by country of birth	% Cameroon	% D. R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Uganda	% UK	% Zambia	% Zimbabwe
2+ sex partners last year	28.6	27.4	25.3	28.1	33.6	42.0	24.8	38.2	28.1	26.1
4+ sex partners last year	3.2	9.5	6.3	8.1	11.2	26.1	6.1	14.5	11.5	8.0
Extra-relational sex	14.5	25.0	16.5	20.5	15.7	20.5	16.8	19.3	16.5	17.0
Any UI last year	43.1	43.2	48.2	56.9	43.5	39.7	40.7	48.3	50.0	43.2
DEFINITELY/ PROBABLY had sdUI	11.5	20.7	12.3	9.9	8.8	14.7	11.9	9.4	17.0	11.8
DON'T KNOW if had sdUI	13.1	17.4	13.5	14.4	13.5	19.1	13.8	19.5	14.9	13.1
Any condom failure last year	10.6	13.4	15.3	13.7	20.6	24.6	14.8	22.6	9.2	16.0

There were significant differences in the sexual risk profile of the country of birth sub-samples. Respondents from South Africa and the UK were most likely to report multiple sexual partners and to have experienced condom failure. Condom failure is partly a reflection of condom use and the South African sub-sample were also least likely to say they had engaged in any UI.

Thinking they had been involved in sdUI did not vary by country of birth.

11.4 COUNTRY OF BIRTH AND HIV PREVENTION NEEDS

The following table shows how the indicators of need varied across groups of people born in the same country.

Unmet HIV prevention need by country of birth	% Cameroon	% D. R. Congo	% Ghana	% Kenya	% Nigeria	% R. South Africa	% Uganda	% UK	% Zambia	% Zimbabwe
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	1.5	16.7	4.4	2.9	3.6	9.9	3.0	5.6	4.3	5.2
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	7.7	16.3	22.0	5.9	10.5	13.0	11.8	14.0	13.2	11.6
AGREE: I sometimes have a problem getting hold of condoms.	22.2	33.7	21.7	15.3	17.2	19.1	22.4	17.5	17.5	17.0
AGREE: If I carried a condom I would worry about what people thought of me.	25.8	39.2	33.3	28.6	36.9	21.4	31.4	20.4	32.6	31.8
DISAGREE: I can use condoms with a sexual partner if I want to.	7.9	11.7	6.8	7.5	6.8	4.3	5.8	7.6	11.3	8.8
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	4.7	9.2	8.9	7.6	7.6	14.1	5.3	14.6	10.2	8.3
Mean knowledge items NOT known out of 13 (median)	3.07 (2)	3.36 (3)	3.34 (3)	2.48 (2)	2.68 (2)	3.05 (2)	2.19 (2)	2.58 (2)	2.23 (1)	1.83 (1)

Several of the needs indicators varied by country of birth. The sub-sample born in the Democratic Republic of Congo most commonly showed high levels of prevention need (in the top two for four of the seven indicators), while the Ghanaians and the South Africans showed higher levels of need on two indicators. Rather than the differences across the country of birth groups, what is striking is the similarity in levels of needs across them.

11.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

There were few reliable associations with country of birth suggesting these sub-groups are diverse within themselves. The following associations between country of birth and testing and sexual risk were found in both the first and second Bass Line surveys:

Testing

- Ever having tested for HIV is relatively low among Ghanaians and relatively high among Ugandans.

Sex

- Africans born in the UK are most likely to have large numbers of sexual intercourse partners. Those born in Uganda are least likely to.
- Any unprotected intercourse was relatively high among Kenyans.

Evidence of sexual risk and unmet HIV prevention need was found in all country of birth sub-groups with few reliable differences between them. All African communities in the UK could benefit from targeted and tailored programmes of HIV prevention activity.

These findings suggest that programmes serving Ghanaians should make HIV testing a notable feature of their interventions.

12 Variation by length of residence in the UK

The length of time that respondents had resided in the UK is reported in five time bands. A minority (6.3%, n=157) had lived in the UK for less than one year, 10.5% (n=261) more than a year, but less than three years, while 21.3% (n=530) had lived in the UK for more than three years but less than six. A quarter of all respondents (26.3%, n=654) had lived in the UK for more than six years, but less than ten and a further third (35.6%, n=884) had lived in the UK for more than ten years.

This chapter compares key risk behaviours and indicators of HIV prevention needs by these five bands. Further detail on respondents length of residence in the UK can be found in Chapter 2 (Section 2.4).

12.1 LENGTH OF RESIDENCE AND TESTING BEHAVIOURS

The following table shows how the measures of HIV and STI testing and unmet diagnosis needs varied by the length of time people had lived in the UK.

Testing behaviour by length of time in UK	% less than 1 year	% from 1 year up to 3 years	% from 3 up to 6 years	% from 6 up to 10 years	% 10 years or more
Never HIV tested	29.9	45.2	38.7	31.0	42.6
Tested HIV positive	2.6	7.6	12.8	18.6	10.5
Wants test but does not know where to get one	24.5	18.1	13.2	9.1	10.1
Diagnosed with STI in last year	2.2	10.7	4.8	6.4	7.1

Paradoxically those who had been in the UK for less than a year were most likely to have ever tested, but those living in the UK between one and three years were least likely to have tested. This pattern was not found in the first Bass Line survey and may be a consequence of changes in countries of origin among recent arrivals.

What was found in both surveys was that recent arrivals showed the lowest levels of diagnosed HIV. Those who had lived in the UK between six and ten years were the highest proportion of people with diagnosed HIV.

Less surprising was that recent migrants were least likely to know where to test in the UK. This need showed a consistent decline with increasing time spent in country.

12.2 LENGTH OF RESIDENCE AND REASONS FOR NEVER TESTING

Among those who had never tested, two reasons for not testing varied by length of time in the UK. Only 1 of the 44 people (2.3%) who had been in the UK under a year said knowing their HIV status was not important to them, compared with an average of 14.8% for all others. Conversely, never having had intercourse was a reason more commonly given by the recent arrivals (13/44, or 29.5%) than by others.

12.3 LENGTH OF RESIDENCE AND SEXUAL BEHAVIOUR

The following table shows variation in sexual behaviour by the time people had been in the UK.

Sexual behaviour by length of residence in UK among all respondents	% less than 1 year	% from 1 year up to 3 years	% from 3 up to 6 years	% from 6 up to 10 years	% 10 years or more
Two or more sexual intercourse partners in the last year	27.6	27.9	30.6	29.6	34.8
Four or more sexual intercourse partners in the last year	7.6	11.3	11.0	9.6	12.4
Any sexual partners outside their current regular relationship	10.7	14.1	16.7	20.2	20.0
Any unprotected intercourse in the last year	36.9	31.2	39.2	49.0	49.8
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	4.8	10.8	10.8	13.6	11.7
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	14.3	19.9	16.3	13.4	16.3
Any experience of condom failure in the last year	14.5	15.3	17.6	18.5	19.2

The few sexual risk indicators that showed a difference across length of residence suggest that risk was lower among recent arrivals (less extra-marital sex, less UI, less known sero-discordant UI) than among those more established in the UK. This may because new migrants are still establishing their social networks and have fewer opportunities to meet new partners.

12.4 LENGTH OF RESIDENCE AND HIV PREVENTION NEEDS

The following table shows the indicators of need by the time people had lived in the UK.

Unmet HIV prevention need by length of time in UK	% less than 1 year	% from 1 year up to 3 years	% from 3 up to 6 years	% from 6 up to 10 years	% 10 years or more
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	5.3	12.3	5.1	7.1	5.6
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	13.5	13.8	11.4	14.0	12.6
AGREE: I sometimes have a problem getting hold of condoms.	15.8	25.4	21.2	21.7	18.6
AGREE: If I carried a condom I would worry about what people thought of me.	45.7	42.2	34.1	33.0	26.3
DISAGREE: I can use condoms with a sexual partner if I want to.	8.5	8.2	8.2	10.2	8.1
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	7.3	10.3	10.0	8.9	11.5
Mean knowledge items NOT known out of 13 (median)	2.94 (3)	3.51 (3)	2.86 (2)	2.45 (2)	2.68 (2)

Only three of the indicators of prevention need showed a significant difference by length of time living in the UK. Two of these (being unconcerned or unsure being involved in HIV transmission and knowledge) suggested greater need among those that had lived in the UK between one and three years. The third (concern about the social implications of carrying condoms) was highest among very recent arrivals. Overall, these findings suggest little variation in need by length of time in the UK although need is sometimes higher among more recent arrivals.

12.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

Several indicators showed the same associations with length of time in the UK across both Bass Line surveys.

Testing

- Having tested HIV positive was lowest among new arrivals and rises to peak among those having lived here for 6 to 10 years before dropping again slightly.
- Being open to HIV testing but not knowing where to test is most common among new arrivals and drops to a low among those having lived here for 6 to 10 years before rising again slightly.

Sex

- Any unprotected intercourse is most common among long-term residents and lower among recent arrivals.

Needs

- Need for knowledge about HIV prevention appears most acute among those living in the UK between 1 and 3 years.

Africans arriving in the UK do so in a very wide variety of circumstances. Simply knowing how long someone has been here is only a very broad indicator of what they may need in terms of sexual health promotion and HIV prevention in particular.

13 Variation by religion

The respondents identified with four main religious categories: Christian (76.9%, n=1952), Muslim (12.5%, n=317), African traditional religion (1.8%, n=45), or having no religion (7.2%, n=182).

This chapter compares key risk behaviours and indicators of HIV prevention need by these four religion categories. A more detailed description of respondent's answers to questions about religion is given in Chapter 2 (Section 2.9).

13.1 RELIGION AND TESTING BEHAVIOURS

The following table shows how the measures of HIV and STI testing and unmet diagnosis needs varied by religion groups.

Testing behaviour by religion groups	% Christian	% Muslim	% African traditional	% No religion
Never HIV tested	34.2	50.3	38.1	50.8
Tested HIV positive	13.7	5.4	7.7	9.9
Wants test but does not know where to get one	11.2	13.0	20.0	17.2
Diagnosed with STI in last year	5.3	9.0	26.8	12.7

As with gender, age and country of birth (but not education), the religious group with the highest level of testing, the Christians, also showed the lowest level of not knowing where to test and the highest levels of diagnosed HIV. Muslim respondents were least likely to have ever tested for HIV, but those following African traditional religions had least access to HIV tests while also being most likely to be diagnosed with another STI. Again, this suggests bundling clinical sexual health services may go some way to addressing what may be an inverse relationship between need and access.

13.2 RELIGION AND REASONS FOR NEVER TESTING

Three reasons for never having tested varied by respondents' religion. Knowing people who disapproved of testing was more commonly given by Muslims (13/150, or 8.7%) than by others (15/713, or 2.1%). Those following African traditional religions were more likely than others to say they did not trust the testing services they knew about (2/15, or 13.3%, compared with 34/848, or 4.0% or all others), and were also be most likely to be fearful of a positive result.

13.3 RELIGION AND SEXUAL BEHAVIOUR

The following table shows where sexual behaviour carrying an increased risk of HIV transmission was significantly associated with respondents' religion. The pattern of relationships was consistent across five of the seven indicators.

Sexual behaviour by religion groups	% Christian	% Muslim	% African traditional	% No religion
Two or more sexual intercourse partners in the last year	28.6	35.9	53.8	47.0
Four or more sexual intercourse partners in the last year	8.9	13.6	23.1	20.2
Any sexual partners outside their current regular relationship	16.7	21.6	26.8	23.7
Any unprotected intercourse in the last year	44.2	44.7	48.8	48.0
DEFINITELY OR PROBABLY had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	10.2	12.8	34.1	17.5
DON'T KNOW if had unprotected intercourse with someone who had a DIFFERENT HIV status in the last year	14.4	19.1	15.9	26.5
Any experience of condom failure in the last year	16.6	20.2	38.1	22.8

The small group of respondents belonging to African traditional religions (n=45) had a higher sexual risk profile (more multiple partners, more extra-relational sex, more known sero-discordant UI, more condom failure). However, not knowing whether they had sdUI was most common among those with no religion. All of the sexual risk indicators that showed a religious group difference were lowest among the Christians. Muslims and those of no religion generally fell between these two groups.

13.4 RELIGION AND HIV PREVENTION NEEDS

The following table shows the indicators of need in each of four religion groups.

Unmet HIV prevention need by religion groups	% Christian	% Muslim	% African traditional	% NO religion
DISAGREE/NOT SURE: I do not want to get or pass on HIV.	5.1	13.4	13.6	10.1
DISAGREE/NOT SURE: I have the power to reduce my risk of getting or passing on HIV.	10.2	19.9	30.2	25.0
AGREE: I sometimes have a problem getting hold of condoms.	18.0	29.6	31.0	23.8
AGREE: If I carried a condom I would worry about what people thought of me.	29.8	45.3	46.5	33.1
DISAGREE: I can use condoms with a sexual partner if I want to.	8.3	12.8	14.3	2.3
DISAGREE: I would find it easy to talk about safer sex and HIV with new sexual partners.	9.2	14.5	9.3	11.9
Mean knowledge items NOT known out of 13 (median)	2.40 (2)	4.03 (4)	3.97 (3)	3.26 (2)

All the indicators of prevention need significantly varied by religious orientation of respondents. Five of the seven indicators showed highest need among members of African traditional religions, who were least likely to want to avoid HIV transmission, least likely to feel empowered to reduce risk, most likely to have problems accessing condoms and to be concerned about carrying them, and least likely to feel confident about instigating condom use.

However, the Muslim sub-sample were most in need of general knowledge about HIV and least confident about sexual communication. Overall, the Christian sub-group showed lowest levels of unmet prevention need.

13.5 RELIABLE FINDINGS AND IMPLICATIONS FOR PLANNING

Several indicators showed reliable associations across the two Bass Line surveys.

Testing

- Christians were most likely to have ever tested for HIV and to have diagnosed HIV.
- Muslims were least likely to have ever tested for HIV.
- People following African traditional religions were, as a group, most likely to have recently acquired an STI (trend in 2007).

Sex

- Multiple intercourse partners, condom failure and self-rating of sexual HIV exposure were all highest among those following African traditional religions.
- Christians had fewest partners and were least likely to engage in unprotected intercourse with partners of unknown HIV concordancy.

Needs

- Those following African traditional religions were least motivated to avoid HIV transmission and had least self-efficacy and access to condoms to do so.
- Muslims were the group most likely to have difficulty with sexual communication.
- Christians had the best access to condoms.

There was evidence of sexual risk and unmet HIV prevention need in all religious groups, therefore HIV prevention activities should raise awareness of the consequences of sexual choices among all religious groups. Although followers of African traditional religions and those of no religion were relatively few, intervention planners and implementers need to be aware of the acute prevention needs among these groups.

STI testing uptake seemed to be higher than HIV testing across all religion groups. Providing testing for HIV and STIs side-by-side could help increase HIV testing uptake.

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